General practice — a post-modern specialty?

NIGEL MATHERS

STEPHEN ROWLAND

SUMMARY
The 'modern' view of the world is based on the premise that we can discover the essential truth of the world using scientific method. The assumption is made that knowledge so acquired has been 'uncontaminated' by the mind of the investigator. Post-modern theory, however, is concerned with the process of knowing and how our minds are part of the process, i.e. our perceptions of reality and the relationships between different concepts are important influences on our ways of knowing. The values of post-modern theory are those of uncertainty, many different voices and experiences of reality and multifaceted descriptions of truth. These values are closer to our experience of general practice than the 'modern' values of scientific rationalism and should be reflected in a new curriculum for general practice.

Keywords: theoretical models; curriculum; randomized controlled trials.

Introduction

'How are things at home?' the student asked the patient. 'Fine' the patient replied. The student struggled. 'Um… tell me who lives with you?' he asked. When presenting this incident later, the student recited a list of people with all their ages and occupations. He was rather pleased with himself and his ability to take a 'full social and psychological history'. However, he was unable to show any sensitive understanding of the patient in her context or what the illness might mean to this patient. This is the problem. Sometimes, when we try and teach our students or registrars how to take a social and psychological history in general practice, they may persist in using such an inappropriate biomedical or teaching hospital model to elicit the information. Indeed, the problem is even wider in that trying to design an appropriate curriculum for general practice is extremely difficult. Not only are we sometimes unsure what 'good' general practice is,[1] but also what is an appropriate model for general practice to teach and how it might be best learnt by our students.

The current curriculum for general practice has, to a large extent, gradually evolved over the years by 'plugging the gaps' in the main medical school teaching. For example, academic departments of general practice are usually responsible for the teaching of communication skills. The difficulty has been not only in defining what exactly we mean by the discipline of general practice but also how we can establish our credentials as a 'serious' academic subject alongside the major medical specialties of medicine and surgery. As one dean suggested to one of the authors (NM) recently: 'You have managed to create a "dog's breakfast" out of service provision.' The infamous comment of the 1960s that general practice is the repository of those who 'have fallen off the ladder' with no particular claims to either special knowledge or an academic specialty in its own right is alive and well in medical schools up and down the country! Clearly, with the growing importance of primary care in the National Health Service and increasing amounts of undergraduate teaching in the community, we need to think carefully about what a curriculum for general practice should contain and how it should be delivered.

A 'modern' approach to curriculum design would suggest that all that needs to be done to prepare a curriculum for general practice is to define the:

- aims and objectives
- content
- process
- assessment and evaluation.

And the rest is a question of resources! Much effort has been devoted to this, but there remains the problem of what we mean by general practice. A further difficulty is that this approach is based on a 'scientific' model of general practice, and this way of thinking can lead to the problem described at the beginning of this article. A curriculum designed in this rather mechanistic (or biomedical) way is very limited in that, for example, it does not allow for the dynamic and continuous influence of evaluation on planning, or indeed for any differences between the 'planned' curriculum, the 'taught' curriculum and the 'learnt' curriculum.[2]

The process of curriculum design may alternatively be regarded as essentially a form of applied philosophy[3] with the major concern being conceptual analysis. The prime purpose of studying the curriculum is to 'achieve conceptual clarity in thinking about the curriculum as a basis for ensuring practical coherence in the implementation of that thinking'.

A quest for a satisfactory curriculum for general practice leads on from here to the necessity for an appropriate matching of both theory and practice.

A new curriculum for general practice?

The 'modern' view of the world is based on the premise that we can discover the essential truth of 'out there' (i.e. outside of our minds) using scientific method. Our certainty that we have discovered the 'real truth' about the world is based on the rigour of the scientific method that has been used. A randomized clinical trial (RCT), for example, gives us the best approximation of what is 'really happening' and can support a cause and effect relationship between an intervention and an outcome. The assumption is made, however, that the knowledge so acquired has been unmediated or 'uncontaminated' by the mind of the investigator. This is the evidence-based approach to general practice, and those of us who work in the 'swampy lowlands' of everyday practice rather than the 'sunny uplands' of academia recognize that this is fine as far as it goes, however, this is not very far, and such an approach has very limited application in our day-to-day work, concerned as it is with managing illness in context. This can create very real difficulties for both doctors and students as they struggle to apply such a model that does not very often or necessarily fit. A different and complementary way of looking at our work is necessary if we are to achieve an appropriate matching of theory and practice for a curriculum that truly reflects the 'real' world of general practice and introduces our students to it.

Post-modernism and the curriculum

N Mathers, BSc, MBChB, MD, PhD, MRCGP, senior lecturer, Institute of General Practice, University of Sheffield; S Rowland, MA, MEd, FRSA, senior lecturer in education, University of Sheffield.
Submitted: 25 March 1996; accepted: 1 November 1996.

© *British Journal of General Practice,* 1997, **47,** 177-179.

Post-modern theory is difficult to explain. The word post-modern itself comes from the Latin meaning 'after just now', so in one sense everything that is happening now is post modern. However, the theory itself is a consequence of the twentieth century's obsession with language and is rooted in structuralism, which is a school of formal linguistics. In a nutshell, the theory originated with the premise that you cannot stand outside language to understand it. Post-modernism is concerned with the process of knowing and how our minds are part of that process. Our perceptions of reality and the relationships between different concepts are important influences on our ways of knowing. Derrida[4] wrote about presence, meaning that the status of any knowledge that we claim as true is true because of the process we have used to come to know it. In other words, the knowledge we gain using an RCT, for example, has presence because we believe that such a method gives us access to the underlying truth of the world, i.e. an objective reality. It is this belief that is important, described in post-modern theory as the scientific discourse. However, beliefs do not arise in isolation, and scientific discourse is rooted within the social community of scientists. Post-modern theory states that such a discourse (and there are others) is based on power (the ability to claim presence) and knowledge (the presence that is claimed).

The other component of post-modern theory that is necessary to understand is the idea of difference. Since we are always constrained by our perceptions, any description of underlying reality is a reflection of its difference from other things rather than its essence.[5] Language can only convey meaning in this way. We know what something is because of what it is not. Diabetes, for example, can only be recognized and known as diabetes because we can contrast it with a central concept of health (i.e. not diabetes). This idea of difference means that the harder we try to define precisely what we mean by a concept, the more it slips away from our definition. Indeed, any definition we try to make of the 'underlying truth' of a concept can only be understood in relation to everything else. A description of reality, therefore, is only ever a changing approximation, and however hard we try to make it 'more real' by particular methodologies, the more it slips from our grasp.[6]

What might this mean for a general practice curriculum? Hopefully, it is clear from the above that the values of post-modern theory are those of uncertainty, many different voices and experiences of reality, and multifaceted descriptions of 'truth'. This, it seems to us, is closer to the values and experience of general practice than the 'modern' values of a 'scientific' rationalism. It also clarifies why such a biomedical model does not seem to 'fit' our daily reality and why our students have such difficulty in crossing the 'cultural divide' from secondary to primary care. A post-modern approach to a curriculum for general practice would therefore consider the claims of our current curriculum to presence and reflect on the themes of power (what the basis is for the ability to claim presence) and knowledge (what counts as a valid model).

Towards a post-modern curriculum for general practice

This article has given a brief overview of some of the post-modern ideas that might underlie a new curriculum for general practice. To define such a curriculum is, in post-modern terms, almost a contradiction. However, we can consider how a curriculum could be related to our current teaching and practice, and how this knowledge is affected by general practice's claims to both power and knowledge.

One of the authors (NM) recently attended the Annual Scientific Meeting of the Association of University Departments of General Practice (AUDGP) in Newcastle. A great deal of high-quality scientific work was presented. However, 'high quality' tended to be synonymous with a 'modern' model of scientific endeavour. For example, an RCT comparison of out-of-hours care provided by the deputizing service and own-practice doctors was presented, and a fine, elegant study this was. However, the danger is that RCTs can sometimes be used to answer only relatively trivial questions in primary care. Indeed, in some cases the questions asked in general practice using such a model have been severely constrained or even 'driven' by the methodology. The chosen design may result in the 'wrong' questions being asked. Such a claim to 'presence' based on a 'modern' claim to knowledge, and a claim to power based on the emulation of secondary care methodology can only play one part in a post-modern curriculum for general practice.

Other sessions at the AUDGP presented results from more qualitative studies. Here, general practice's claim to presence was associated with a more subjective model — 'soft' rather than 'hard' science. The rigour of the methodology enabled a claim to knowledge to be made. Such claims, however, can sit uneasily with doctors whose training has been based on the traditional biomedical model. GPs have a natural distrust of claims based on such 'soft' methods and can find difficulty in incorporating such knowledge in practice.

Some studies presented were particularly concerned with evaluating educational initiatives, and the difficulties of producing 'high-quality' educational research were discussed. These educational initiatives assumed a training model as a basis for claims to knowledge and power, and the focus was more on process than content — such an approach to the teaching of general practice may be rather more appropriate to a post-modern curriculum.

Schön[7] has attempted to define a reflective or critical model for the teaching of professional practice. He cites the widespread disillusion with the professional 'experts' and their objectivist philosophy that focuses on the technical and the testable, and separates the ends from the means, yet fails to train for the real problems of practice. He suggests a model for professional practice based on reflection both in and on practice. Such claims to power and knowledge would be appropriate for a post-modern curriculum in which the knowing is in the doing. The process consists of problem setting and problem solving.

Problem setting in general practice is the process by which we name the problem we wish to consider or the question we wish to ask and define the context in which it should be answered. This involves, for example, the use of 'critical incidents' in the curriculum. Problem solving is a reflective conversation whereby a unique and uncertain situation comes to be understood through the attempt to change it, and changed through the attempt to understand it in conjunction with peers and general practice tutors.

The educational values of a curriculum based on such a reflective or critical model of professional practice would be practical, active and pragmatic, and could encompass all the current models of general practice. The implied teaching methods of this model, such as practical attachments ('apprenticeship') and small group teaching, would be more appropriate than didactic lectures. Methods of assessment would be mainly by portfolios, projects, continual assessment, competencies and peer review rather than MCQs and OSCEs. The factual overload identified by the GMC[8] in *Tomorrow's Doctors* would be reduced. In addition, the curriculum would have 'street credibility' with the majority of GPs, since it would be based in the 'real world' — the 'swampy lowlands' of everyday practice where chaos and uncertainty are ever present!

Many observers believe that a 'paradigm shift' is now overdue in medical practice and education. James Willis[9] is one such author. In his book, *The Paradox of Progress,* he writes: 'We understand the world we live in more completely than we have ever done before, and yet we understand it less'.

References

1. Toon P. *What is good general practice?* [Occasional Paper No. 65.] London: Royal College of General Practitioners, 1994.
2. Lowry S. *Medical education.* London: BMJ Publishing Group, 1993.
3. Kelly AV. *The curriculum: theory and practice.* (3rd edn.) London: Chapman & Hall, 1989.
4. Derrida J. *Of grammatology.* Baltimore, MD, USA: Johns Hopkins University Press, 1976.
5. Lemert C. General social theory, irony, postmodernism. In: *Postmodernism and social theory.* Seidman S, Wagner D (eds). Oxford: Blackwell, 1992.
6. Fox N. *Postmodernism, sociology and health.* Buckingham: Open University Press, 1993.
7. Schön DA. The crisis of professional knowledge, and the pursuit of an epistemology of practice. *J Interprof Care* 1992; **6:** 49-63.
8. General Medical Council (GMC). *Tomorrow's doctors.* London: GMC, 1993.
9. Willis J. *The paradox of progress.* Oxford: Radcliffe Medical Press, 1995.

Address for correspondence

Dr Nigel Mathers, Department of General Practice, Community Sciences Centre, Northern General Hospital, Herries Road, Sheffield S5 7AU.