# Editorial

*Tony Townsend has been a general practitioner for 30 years. Although he has dabbled in medical politics, medical ethics, community-based teaching, university-based teaching, quality improvement and assessment, his passion remains clinical general practice. He is currently a full-time general practitioner in Whangamata.*

## Celebrating the art of general practice

The focus of this year's College Conference, *New Horizons: Celebrating the art of general practice*, is the theme for this issue of the journal. We include contributions from some of the keynote speakers and from other commentators covering a broad range of topics from predictions for the future of general practice through to relationships with pharmaceutical companies and the epidemic of unhappiness.

In this editorial I will focus on the art of general practice. This is a difficult concept to analyse without running the risk of destroying it. I suppose that this is much the same as to take apart a beautiful painting or other work of art to determine how it was created would not tell us much about the impact of the final masterpiece on the observer.

Donald Schön, whose background is architecture, uses the term 'professional artistry' to refer to the kinds of competence practitioners sometimes display in unique, uncertain, and conflicted situations of practice:

*'Note, however, that their artistry is a high-powered, esoteric variant of the more familiar sorts of competence all of us exhibit every day in countless acts of recognition, judgment, and skillful performance. What is striking about both kinds of competence is that they do not depend on our being able to describe how we know what to do or even to entertain in conscious thought the knowledge our actions reveal.'*[1]

I remember a physician with whom I worked when I was a junior house surgeon many years ago. He would stand at the end of the bed and diagnose tuberculosis without having either any details of the patient's history or doing a clinical examination.

While not wanting to examine the building blocks of the art too closely, it is apparent that competence requires attributes such as attentiveness, recognition, sensitivity, empathy, interpretation, wisdom and intuition. These components of the art of practice affect assessment, management and prognostication.[2] As Schön has stated, we do not think about how we incorporate these skills into the everyday consultation as we do with knowledge, statistics and evidence, yet we all use some of these skills in every consultation. Using appropriate communication skills will reduce patients' complaints even more than the misuse of science.[3] In this issue of the journal, Susan Hawken reminds us of the importance of good communication. In the next issue she will consider some practical strategies for dealing with challenging patients. But good communication is only part of the art. Two of the medical mentors who have most strongly influenced the development of our discipline have commented on the art of practice.

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George Engel wrote:

*'The physician's need to know and understand at first glance may seem more exclusively cognitive. But while scientific understanding does mean getting all the facts and getting them straight, every bit as important is for the physician to display that human understanding which is so necessary if the patient is to feel understood. Again, the two are complimentary. For when expression of human understanding on the part of the physician is not forthcoming and the patient does not feel understood, then trust and confidence may be impaired and with it the patient's capacity and willingness to collaborate – critical if the physician's scientific aims are to be accomplished.'*[4]

Ian McWhinney has this to say:

*'The technique is only a beginning. The attainment of a full 'picture' of the patient requires of the physician all that he has, as a person and as a clinician. Once he begins to practice in this way, he soon encounters some very difficult and even disturbing questions.'*[5]

We can learn how to communicate well and we can develop skills to enhance the art of practice, as Schön implies:

*'If we focus on the kinds of reflection-in-action through which practitioners sometimes make new sense of uncertain, unique or conflicted situations of practice, then we will assume neither that existing professional knowledge fits every case nor that every problem has a right answer. We will see students as having to learn a kind of reflection-in-action that goes beyond statable rules – not only by devising new methods of reasoning, ...but also by constructing and testing new categories of understanding, strategies of action, and ways of framing problems.'*[6]

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However, it is the experience of clinical practice over many years that contributes most to the fine tuning of this art. In a paper discussing the use of intuition in general practice, Trish Greenhalgh states:

*'Intuition is a decision-making method that is used unconsciously by experienced practitioners but is inaccessible to the novice. It is rapid, subtle, contextual, and does not follow simple, cause-and-effect logic...It is a highly creative process, fundamental to hypothesis generation in science. The experienced practitioner should generate and follow clinical hunches as well as (not instead of) applying the deductive principles of evidence based medicine.'*[7]

This journal has, and will continue to be, a strong advocate for evidence-based medicine, with guidelines for peer review and CME papers explicitly stating this. We publish the evidence in Cochrane Corner and regular POEMs. However, even the founding fathers of evidence-based medicine espouse caution.

*'Evidence-based medicine is not "cookbook" medicine. Because it requires a bottom-up approach that integrates the best external evidence with individual clinical expertise and patients' choice, it cannot result in slavish, cookbook approaches to individual patient care. External clinical evidence can inform, but never replace, individual clinical expertise, and it is this expertise that decides whether the external evidence applies to an individual patient at all and, if so, how it should be integrated into a clinical decision.'*[8]

The integration of the science and art of medical practice is something that general practitioners do well. Shawn Tracy and colleagues at the University of Toronto, in a qualitative study of the use of evidence-based medicine by family physicians, found that:

*'Primary care physicians see no opposition between research evidence and clinical intuition, nor do they believe that evidence always trumps experience, particularly in cases where the evidence is contradictory or patients are expressing strong preferences...These results provide the first indication that clinical intuition is valued by clinicians on a par with research evidence.'*[9]

We know that patients have individual needs determined by the complexities of their unique biopsychosocial circumstances. Many of the patients that we see do not match the patterns that we read in the textbooks. In another editorial in the *BMJ,* Trish Greenhalgh comments on this:

**It is expertise that decides whether the external evidence applies to an individual patient at all and, if so, how it should be integrated into a clinical decision**

*'In general practice, for example, the usual diagnostic and therapeutic sequence of diagnosis, by epidemiological classification – symptoms and signs leading to identification of the disease, leading to treatment – may be less appropriate than diagnosis by prognosis – symptoms and signs leading to a provisional hypothesis, leading to watchful waiting, leading to the identification of the disease – or diagnosis by therapeutic response – symptoms and signs leading to a provisional hypothesis, leading to empirical treatment, leading to identification of the disease.*

*Failure to recognize the legitimacy of these variations in approach has created a somewhat spurious divide between those who seek to establish general practice on an equal 'scientific' footing to that of the secondary care sector and those who emphasise the value of the intuitive, narrative, and interpretative aspects of the consultation. Others have argued that both 'science' and 'art' are essential elements of evidence based care, which strives to integrate the best external evidence with all round clinical expertise. Nevertheless, debate continues as to whether all round clinical expertise can be dissected down to a set of objective and measurable components that are amenable to formal performance review or whether it is ultimately subjective and one of the unsolvable mysteries of the art of medicine.'*[10]

In her philosophical challenge to the outcomes movement (and all NZ GPs are encouraged to read this paper – free on the Internet) Sandra Tanenbaum contends:

*'Uncertainty is inherent in medical practice because patients present individual and complex medical circumstances. Physicians can never be certain how to transpose a biomedical theory or a clinical research finding to a particular case, yet this is what they are called upon to do. In an act of interpretation, not application, physicians make clinical sense of a case, rather than placing it in a general category of cases. As interpreters, physicians draw on all their knowledge, including their*

*own experience of patients and laboratory-science models of cause and effect. Clinical reasoning, of course, is not entirely idiosyncratic. There are standards of perceptiveness and coherence. In addition, physicians should certainly consider the findings of relevant outcomes research. Nevertheless, even the integration of all relevant findings creates, of necessity, an incomplete picture. No physician can know a patient in his or her entirety or be certain what inferences to draw from aggregate studies. In this sense, clinical medicine is entirely fallible. This is a limitation that outcomes research is powerless to remedy.*'[11]

How important is the art of medicine? A recent personal experience might illustrate this. An elderly but usually well man presented with weight loss and mild anaemia. My assessment, mostly intuitive, was that he had carcinoma of the stomach. He continued to lose weight and became progressively anaemic while waiting the obligatory several months for a diagnostic gastroscopy. He became depressed, fearing the worst, and was started on antidepressants. Finally his biopsy came through. He had large B cell lymphoma. I saw him with his wife and explained that, under the circumstances, this was a good diagnosis as treatment was available. A few days later my partner was called to find that he had hung himself in his garage. I talked with his wife who said that he would probably have rather been told that he had a terminal illness for which no treatment was available. More attention to the art and less to the science may have resulted in a different outcome.

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## Editorial Statement

*The paper by Walker and MacLeod, 'Palliative care knowledge of some South Island GPs' published in the April edition of NZFP was based on a questionnaire which was subsequently changed after pretesting. Because of this, there will be some discrepancies in the data and conclusions between Walker & MacLeod's paper and a paper which is currently being prepared by researchers in the Wellington region on a survey of primary health care practitioners.*