Finding the particulars

The search for the identity of family medicine through generations of change

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Modern family physicians describe themselves as specialists in people and interpersonal systems. General practitioners were the predecessors of family medicine—community-based physicians who went into practice without specialty training. Originally medical school and a brief internship was sufficient to practice medicine. Nowadays, a general practitioner can either refer to a trained family physician, especially internationally, or to these old-school doctors who saw and did so much with so little up front training to guide them.

Many of the forefathers (and they were nearly all men) of family medicine were general practitioners. The formation of family medicine from general practice was partially reactionary. There was not a clear definition of their domain in the face of an increasingly specialized medical world. The formation of the specialty was also introspective in that general practitioners came to realize that a year of hospital-based internship was inadequate to care for an ambulatory population. The problems that arise in a hospital often have little to do with the problems that present in a community.

Dr. Ian McWhinney was an English general practitioner who became a Canadian family physician, and spent his career defining and unifying the field. The writings and oral histories that he left prior to his death in 2012 describe the tremendous changes that he undertook and withstood, in family medicine.

McWhinney's general practice

McWhinney was born in 1926 to Scottish parents. His father was a general practitioner in Stratford-upon-Avon, Ian joined his practice in 1954. He had finished medical school five years earlier, completed an internship that was a one-year residency, which was a novelty at the time. Following his internship, he then completed two years of military service.

McWhinney later reflected that being in practice in those early days was like "being thrown into the deep end."[1] Beginning his career in Stratford, McWhinney described a sense of clinical ennui, "I went through a period of restlessness and thought about leaving practice."[1]

McWhinney eventually acclimated to his new life and stayed on in his practice full-time for another nine years. However, a restlessness led him to question what his role as a physician was. "I didn't have a concept of what it meant to be a family doctor…I remember searching for answers," he said in an interview.[1] This search for answers would frame McWhinney's academic career.

McWhinney directed his search for definition within the exam room, focusing on trying to figure out how family doctors think. "I got interested, right from the beginning, in the thinking patterns in general practice," he said.[1]

Fifty years later, this seems less remarkable since excellent books have been published. Dr. Jerome Groopman's (AΩA, Columbia University, 1976) *How Doctors Think* is a breakdown of the biases and heuristics that govern physicians actions in practice. Medical students are taught classes on medical decision-making and clinical judgment is a well-conceptualized idea.

Experts and textbooks

In the early 1960s, much of medicine was based on experience, which was based on compiled observation. Applying research to clinical practice was not yet widespread. Patients and doctors both believed that the doctor knew best. Patients relied on the doctor having read about or experienced a similar case in the past, and having the

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insight to know and recognize patterns. In 1964, after having been in practice for 10 years, McWhinney published his first book, *The Early Signs of Illness: Observations in General Practice*. It was a first step in addressing the questions of what doctors do when they are in the room with the patient.

The Early Signs of Illness reads like a classic medical textbook. There is a chapter on cancer, one on abdominal pain, and one on cardiac disorders. However, it begins to show the features and philosophical thinking that set McWhinney apart from other general practitioners.

McWhinney had never been satisfied with the training

he received prior to entering practice. Therefore, he focused his text on the early signs of illness.[2] He found stark differences between the pedagogical, hospital-based world, and the practical, community-based world. He further found that it was difficult to translate the medical knowledge and skill he learned through more medically progressed hospital cases to less medically progressed community cases. *The Early Signs of Illness* blends case-based observation with unifying approaches to general practice as a whole, not just pathophysiologically, but diagnostically and therapeutically. Like most family doctors, he approaches the diagnosis in terms of the dispensation of the patient.

The chapter on appendicitis begins not with epidemiologic data on the number of cases in the United Kingdom in the prior 10 years, or with the costs and burdens on society. Nor does McWhinney begin with a review of the history and physical exam findings of acute appendicitis. Instead, he opens the chapter with a philosophical accounting of the four possible outcomes when a physician sees a patient with a possible acute abdomen: "At the first examination, he must decide one of four things:

1. That the condition is harmless and the patient may be reassured.
2. That the findings are suspicious enough to make admission to hospital necessary.
3. That the diagnosis of 'acute abdomen' is in doubt and a period of observation at home is justified.
4. That he is in doubt about the significance of his finding and requires the advice of a surgical colleague." [3]

In his earliest work, McWhinney shows the bent toward higher-level principles, rather than strict biomedical ones, to explain how to treat a medical illness like appendicitis. First, he says, the doctor must decide if this is in fact appendicitis. Defining appendicitis (classically, fever, right lower quadrant pain, and an elevated white blood cell count) is straight-forward, and admitting the patient and making a surgical referral is easy. McWhinney focuses on the hard parts of primary care: teasing out the non-appendicitis from the appendicitis cases, and knowing which patients need referral not only for treatment but for diagnosis as well. Much of family medicine happens in the "hard parts."

Early Signs of Illness is also notable because it contains case examples from McWhinney's practice. The chapter on appendicitis, for example, contains six case examples in just six pages of text.

Ian McWhinney, MD.

In a 2001 editorial, McWhinney wrote about the importance of cases in writing and teaching:

> "An actual case brings things alive for us in a way that aggregated data cannot do. We learn differently from individual cases. They stimulate the imagination, open up possibilities, provoke us, and perhaps disturb us. They fill in the gaps left by powerful generalisations." [4]

Patient-centered teaching and practice would persist throughout McWhinney's career, and would go on to be a tenet he spread throughout his writings and teachings.

McWhinney attempted to answer the question "What do doctors do?" He explained that they see patients, observe patterns of signs and symptoms, make diagnoses, and offer treatments. But, that still felt inadequate to McWhinney. He was starting to think systematically, outside the exam room. General practice was the foundation not only of his work, but of the entire National Health Service he was working in.

He continued to think about what made a general practitioner, considering the essential components and work of the family doctor. "General practice was still thought of in those days as what you did if you didn't specialize—the rest of medicine," McWhinney noted later in life. [1] It was not thought of as a specialty, let alone an academic pursuit unto itself.

This presented a problem for McWhinney, who was hoping to define the first principles and fundamental features of the pursuit. He saw general practice as its own enterprise, a thing to be taught and learned. He knew

from his own training and practice that general practice required skill and art, which needed thoughtful education to develop. McWhinney found that his training had little overlap with his life in practice, either practically or philosophically. He learned that the creation of a new family doctor from an undifferentiated medical student required a certain amount of understanding about what the specialty meant. However, defining the specialty—let alone codifying its training—had not occurred.

Identity crisis in general practice

In the early 1960s, family medicine was undergoing a crisis of identity. This crisis lagged McWhinney's personal identity crisis by 10 years, but it was similar in nature: why not see a specialist in children as a child and a specialist in adults as an adult, heart doctor for heart problems, and a pregnancy doctor for pregnancy? General practitioners in both the U.S. and the UK could enter practice by graduating from medical school and hanging out a shingle. "This may be good in that it promotes lusty individualism," McWhinney and colleagues wrote in 1961, "but it is bad in that it fosters professional isolation which can cover low standards of work."[6]

North American primary care was facing the same problems of standardization and training McWhinney was facing as a general practitioner in Stratford. There was debate over how to transition from the general practitioner model—four years of medical school plus one year of general internship—to the family medicine model—four years of medical school plus three years of specialty residency training.

Medicare and Medicaid were being developed in their current iterations. There was significant interest in the developing work force, and concern that it might not be enough to support the future needs of the country. In 1964, the percentage of U.S. medical school graduates going into general practice fell to 19 percent, down from 47 percent in 1900, and family doctors in the U.S. noted the decline with alarm.[7] In 2016, the latest numbers available, 8.7 percent of U.S. medical school graduates entered family medicine.[8] If a work force could be recruited, what—and how—should they be taught?

North American fellowship

McWhinney expanded his focus to be outside the exam room, and outside of the UK. In 1963, he obtained a grant and set off for the U.S. and Canada. He asked questions and carefully observed as he traveled, assembling patterns and gathering data. He focused on philosophies of training programs and the relationships among communities, hospitals, and family doctors.

McWhinney spent eight weeks at Harvard and Stanford (neither of which then had, nor has yet developed, a Department of Family Medicine), and the University of Chicago, which started their Department of Family Medicine in 2002. In the 1960s, these were places with robust interest in general practice, but their focus in general medicine became internal medicine-driven departments of primary care.

McWhinney met with faculty and observed the work and training of general practitioners. He met with leaders at the Academy of General Practice in Kansas City, (now the American Academy of Family Physicians). He also visited places that have gone on to be powerhouses of family medicine training, practice, and research, like the University of North Carolina.

McWhinney returned to England with notebooks of observations, and began to write. He published a summary of his observations in the *Early Signs of Illness*. These articles lay out the philosophy for the future of the new specialty, and describe how to train its practitioners.

The keys to excellent generalists, McWhinney determined, included intellectually rigorous training, research, knowledge, and a "unique field of action."[3] These articles are now considered seminal works of family medicine. The articles describe the fundamentals of family medicine, and how it is different than other specialties through the relationships with patients, the study of human interpersonal dynamics, and the interest in social determinants of health. The articles lay out the first paths of a formal training program for family medicine.

Though general practice and early family medicine training programs already existed, these articles served to coalesce— in a way that is still true today— the underlying, unifying themes of family medicine as its own specialty.

Codifying the principles and particulars

By 1969, early family medicine leaders had formed the American Board of Family Medicine, with the goal of standardizing and supporting family medicine training and practice. The potential problems with general practice were clear—lack of training, lack of standards, lack of quality.

The formation of the Board alone wouldn't solve all the problems. It needed to create standards and definitions along with philosophies, values, principles, and requirements for training and board certification. Family medicine needed to crystallize its academic place in medical school and postgraduate training.

McWhinney was invited to lead this change at the University of Western Ontario, as its Chair of the Department of Family Medicine. He moved to Canada in 1968, where he stayed until 1987. McWhinney set up the department based on his original theories from his *Lancet* articles, emphasizing contact, comprehensive, continuing care. Articles, essays, and editorials about what it was *really* like to work in the department in the early days are lacking. Based on results and outcomes, though, it was extraordinarily successful. McWhinney grew the department to include a Center for Research in Family Medicine, a residency training program for family physicians, and a clinical department that includes five clinical sites.

McWhinney is revered as the father of family medicine and physicians he trained are known as leaders in academic family medicine.

In spite of the many successes, McWhinney notes that the administration was at times bewildered by his intentions and actions. The idea of teaching family medicine in family practices was revolutionary at a time when nearly all training was done in university-based academic medical centers. "It soon became clear that a lot of the faculty of the medical school…didn't really understand what we were driving at," he said. "The first basic principle was that family medicine can really only be learned in a family practice…. We, in the department, very soon came to a unanimous conclusion that a hospital was not the place to run a family practice."[1]

McWhinney drew distinctions between family medicine as a primarily community-based specialty and family medicine as a hospital-based outpatient clinic. This was one of his major pushes, and it also resonated with family physicians across North America.

Another revelation involved the teachers. "The second basic principle for the department was that family practice should be taught by family physicians…the actual teaching of family medicine had to come from people who had experienced it themselves…. [G]eneral practitioners were being taught and trained by those who had never experienced general practice."[1]

Nowadays, this seems silly. Of course, family medicine faculty teach family medicine residents. However, this was a concept that had to be introduced, as the idea that family medicine was a cohesive specialty rather than a mosaic of organ systems was slowly removed. Since family physicians are not just an amalgam of specialists, they can't be effectively taught to do family medicine by specialists alone.

In the *Lancet* article "General Practice as an Academic Discipline," McWhinney crystallized his vision for training and for the future of the specialty. General practitioners should have formal, rigorous, standardized, and supervised training, and that training should reflect real general practitioner practice.[9] Today, that is a given, but at the time it was novel.

"Attending to particulars"[1]

McWhinney's work provided enduring lessons. Acknowledging that doctors deliver medical care to patients in systems, McWhinney showed the need for good science, and patient-oriented practice. "The family doctor not only knows about the family— he knows them," McWhinney wrote in 1975.[10] McWhinney called this skill "attending to particulars." His *Textbook of Family Medicine* describes the origins:

> "In the preface to *The Varieties of Religious Experience*, William James wrote, …a large acquaintance with the particulars often makes us wiser than the possession of abstract formulas, however deep…. A large part of medical knowledge is made up either of particulars or of generalizations at a low level of abstraction."[11]

McWhinney called doctors to know and listen to patient stories—to attend to particulars—but also to be aware of overgeneralizations.

Stories are not histories and physicals. We have moved toward systems-based medicine. Family medicine takes place in the space between "56-year-old female with bereavement; ICD10=Z63.4," and "Mrs. Deval's 24-year-old son died of a heroin overdose three months ago, and she presents with overwhelming sadness and daily crying." Story-based medicine is the origin of evidence-based medicine, since is it careful observation and reporting of cases that lead to observational studies and then, when important or applicable, randomized trials. These are both the skills of the family physician.

"Medicine always reflects the values of the society that it serves," McWhinney wrote in 1975.[10] Today, medicine has shifted toward being more corporatized, more systems-based, more outcome-driven medicine. This says something about our society. At the very least, it says something about the system that pays for our health care.

McWhinney did not leave us with a lot of advice for reconciling the stories patients need to tell— the things that we need to understand in order to care for them— with the things our society values— efficient, outcome-driven health care. But he did leave us with some very useful perspectives on coping with the changes.

Historical perspectives on modern problems

In 1975, McWhinney noted, "Medicine stands now at the end of an era: a vantage point from which the changes and their effects, both good and bad, can be surveyed."[10] In 1967, he wrote "Pediatricians…are discontented. Their grievances [include]…long hours, inconsiderate parents, trivial complaints, unnecessary night calls."[12] He could have written any of these things in the last six months, and been referring to just about any specialty.

McWhinney graduated from medical school in 1948, the same year that the National Health Service began in the UK. When he joined his first practice, the entire framework for medicine was brand new. The way that doctors got paid had changed, the ability to access a consultant or hospital, the lines of communication, and nearly everything else had evolved from plans to reality over the course of his years at Cambridge.

He moved to Ontario when Canada was working through the political processes to establish universal health insurance plans. He moved into an optimistic but deeply uncertain fiscal situation.

Practicing medicine has always felt unstable. We feel nostalgic about how things used to be, but even in the good old days, they weren't that certain. Medicine has always been changing, through evolving science and systems. Change isn't unique. We fall back on our values, on our philosophy, on our principles, during times of change, to remind us what needs to stay the same. For those practicing family medicine, Ian McWhinney laid those first principles of commitment to the person; the inseparability of the person and his/her environment;and the difference between information, knowledge, and wisdom—where information deals in facts, knowledge applies fact to context, and wisdom is the reflection of knowledge after experience.

These basics sustain us through periods of substantial change. As a specialty, we can choose to focus less on the environment, or less on interpersonal relationships. It's McWhinney's wisdom, and respect for his knowledge and experience that contributes to why, more than 40 years later, we still have the same basic principles. He was right about the things we seek as family doctors, and about the things our patients seek from us. It is the particulars of each patient and each relationship that make the diagnoses possible. We are trained to know the generalities and identify the particulars.

"Core values in a changing world"

In 1998, McWhinney wrote the first of a series of articles in the *BMJ* about the principles of primary care. In "Core Values in a Changing World," McWhinney revisits and reframes the familiar themes of commitment to the patient through availability and continuity, community-based primary care, teamwork, professional freedom, and responsibility.[13] He called on the value of tradition to support and guide medicine through tumultuous times.

Though written nearly 20 years ago, McWhinney's messages are still applicable and practical today. While we still struggle with change, we still look to tradition to inspire us and guide our values.

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