Why continuity matters

Ian McWhinney's insights for 21st-century medical education

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Dr Ian McWhinney's (1926-2012) deep reflection on his own experience of 14 years in full-time general practice and his wide reading in medicine, philosophy, education, and the humanities gave him an unparalleled understanding of family medicine as a unique discipline and how best to prepare its practitioners. In the limitations of a short article, we cannot describe McWhinney's numerous contributions to the development of postgraduate education for family practice; instead we will concentrate on his insights about the central importance of continuity in learning to be a family doctor.

General practice as a unique discipline

In 1955, McWhinney joined the practice of his father and Dr David Ferguson in Stratford-on-Avon, England, after internships in medicine and surgery and 2 years of military service. He had expected that the long years of education would have prepared him for practice but instead he found it "both exhilarating and puzzling." McWhinney described beginning practice in his memoir: "[It] was in some ways like being thrown into the deep end .... I was confronted by the radical difference between the world of the hospital and the world of general practice."[1]

Many of the patients he saw could not be given a precise diagnosis; they presented much earlier than he was used to in the hospital practice where he had trained, and many of them did not fit the textbook descriptions of disease. The 2 textbooks of general practice available at the time were not helpful because they were written from the perspective of internal medicine, not family practice.[1] Refresher courses were not very helpful either. "I found I was thinking in a different way and was interested in inspecting what these differences were and why they were important."[1]

McWhinney considered leaving family practice and entering training in internal medicine, but instead he chose to tackle the challenge of deepening his understanding of family medicine. In 1964 he applied for and received a Nuffield Travelling Fellowship to spend 6 months traveling throughout the United States and Canada, exploring the early developments of family medicine in North America. This experience inspired his 2 seminal papers published in *The Lancet* in 1966[2] and 1967,[3] in which he described general practice as a unique academic discipline and outlined his recommendations for reform of education for general practice.

At that time, training for general practice was "based on an outdated concept of family medicine: that the general practitioner is a pale image of a number of different specialists."[2] Training for general practice consisted of a series of short rotations in a variety of hospital specialties that ill prepared physicians for the realities of family practice.

> Students are trained in a sphere utterly remote from primary care and by physicians who have had little experience of it. When the young doctor enters primary medicine for the first time, he needs a reorientation so basic that he may lose his bearings completely.[3]

McWhinney emphasized that learning to think like a family physician required spending time in a family practice setting.

> Values and attitudes are not transmitted by lectures or books. They have to pervade the whole environment in which learning takes place. This is why the learning environment is crucial to the education of family physicians. This is why we maintain that graduates can only learn to be family physicians if a major part of their education takes place in a setting which is pervaded by the ethos of family medicine.[4]

Many of McWhinney's recommendations sound obvious now, but at that time they were revolutionary. He recommended that training in family medicine be no less than 2 years and planned as a whole; that there should be opportunities to follow patients with chronic conditions in the outpatient department and at home over a long period; and that trainees should learn to deal with undifferentiated problems. He suggested that training in psychiatry should not be a separate rotation but integrated throughout the program; and that each trainee should be guided from the beginning by a family physician in good academic standing. Perhaps McWhinney's most revolutionary recommendation was to move away from short rotations and replace them with longer blocks that emphasized continuity of relationships with patients and teachers.

It is only recently that programs have introduced long blocks of training in a family practice, in which residents have the opportunity to develop ongoing and

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deeper relationships with a group of patients and with their supervisors.[5-7] Now recognized as a core construct for the discipline of family medicine, continuity is enshrined as 1 of the 3 *C*'s in the Triple C Competency-based Curriculum, which provides the framework for all Canadian family medicine residency training.[8-10]

Continuous commitment

McWhinney said the "essence of general practice is an unconditional and open-ended commitment to one's patients. We define ourselves in terms of this relationship."[11] While elaborating on this, he stated:

> [T]he kind of commitment I am speaking of implies that the physician will "stay with" a person whatever his problem may be, and he will do so because his commitment is to people more than to a body of knowledge or a branch of technology. To such a physician, problems become interesting and important not only for their own sake but because they are Mr. Smith's or Mrs. Jones's problem.[12]

It takes time to develop this understanding and commitment when caring for a group of patients. It is a central reason that continuity is important in learning to be a family physician. In addition to learning about the importance of relationships with patients, continuity also provides our postgraduate learners with opportunities to learn the natural history of problems in primary care. McWhinney described the "satisfaction of observing patients with illnesses of all kinds, in their own habitat, and over long periods of time," and suggested that "observation of the natural history of disease is *the* basic science of medicine."[13] Fry[14] and Hodgkin[15] provide detailed descriptions of the content and natural history of illness in family practice. Pathographies (ie, personal narratives by patients describing their experiences with illness) have become more common in recent years.[16] Such observations provide physicians with a rich understanding of disease and the many ways in which patients cope and come to terms with their illnesses.

In addition, continuity allows residents to develop comfort with the practice setting and the team to which they are assigned. This allows residents to focus on learning and gradually increasing their responsibilities rather than repeatedly starting fresh in new settings where their level of independence will be initially reduced. It takes time for supervisors to assess the abilities of new residents, and, in the interest of patient safety, supervisors will limit the responsibilities entrusted to residents until they are comfortable with trainees' conscientiousness, their honesty in their reporting of clinical findings, and their ability to recognize when they need help.[17,18]

In his memoir, McWhinney described an early experience that taught him about the important and heavy responsibility of clinical supervisors. During the interlude between completing medical school and beginning postgraduate training, he assisted his father in the office and by doing housecalls. He visited a young man at home with acute abdominal pain and, finding no abnormalities on abdominal examination, diagnosed gastroenteritis. Two days later, the pain was much worse and he had all the signs of a ruptured appendix, which resulted in the patient's death.

> I was devastated .... I should have asked my father to see him. I now think that, like many student doctors, I failed to ask for help because I did not have the experience to recognize the danger. This lesson stayed with me for the rest of my life. It made me realize how serious a commitment it is to supervise inexperienced trainees .... When I began teaching—and teaching teachers—I insisted that doctors in their first postgraduate year must be closely supervised. This meant reviewing with them every case seen in the day. On no account should consulting the supervisor be left to the student.[1]

Continuity in the teacher-learner relationship also makes it possible for the teacher to get to know the learner and his or her learning needs and to address issues related to the developmental process of becoming a family physician, not just the learner's cognitive learning needs.

In a 1996 article, McWhinney wrote, "We can only attend to a patient's feelings and emotions if we know our own, but self-knowledge is neglected in medical education, perhaps because the path to this knowledge is so long and hard." He then asked the following: "Could medicine become a self-reflective discipline? The idea may seem preposterous. Yet I think it must, if we are to be healers as well as competent technologists."[19]

Echoing McWhinney's emphasis on the learner as a whole person, in a recent landmark text on medical education, Cooke and colleagues argue that professional formation—the "forging of a professional identity"—should be the fundamental goal of medical education.[20]

Core principles

One of McWhinney's most important contributions to the discipline of family medicine was his thoughtful articulation of core principles and values of our generalist approach to medical care. McWhinney had a rare talent for considering the very personal and particular in broad philosophical and conceptual terms. This leads us to think of illnesses in terms of individual patients rather than diseases as abstracted concepts. This focus, argues McWhinney, is fundamental to our capacity to provide compassionate care, as a caring approach requires close attention to the specific and particular.[21] Too much abstraction, conversely,

leads to detachment and limits our ability to engage as healers with our patients' suffering.

McWhinney describes 2 essential components of this understanding. First, we need to think of the human body as an organism rather than by using mechanistic metaphors. Second, we should avoid simplistic mind-body dualism. By thinking this way, we see each patient as a particular individual living in a particular community or environment at a specific time. In this way, the uncertainty and complexity of life are automatically included in our conception of each patient's problems, and we avoid linear, reductionist understandings of disease.[19]

Still relevant

In preparing this commentary, we reread many of McWhinney's ground-breaking publications and were struck with the beauty of his language, his many insights, and the continuing relevance of his ideas for postgraduate medical education. We recalled our initial response to his writings: "Of course, yes, that's what it's all about!" McWhinney gave us the words and concepts to understand the unique and very special qualities of our discipline. His words and concepts can and should continue to guide us as we move forward in building our discipline, discuss the value of what we do as family doctors, and teach our learners about why embracing the core values of family medicine is important for ourselves, our patients, and our society.

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References

1. McWhinney IR. *A call to heal. Reflections on a life in family medicine*. Regina, SK: Benchmark Press; 2012.
2. McWhinney IR. General practice as an academic discipline. Reflections after a visit to the United States. *Lancet* 1966;1(7434):419-23.
3. McWhinney IR. The primary physician in a comprehensive health service. Further reflections after a visit to the United States. *Lancet* 1967;1(7481):91-6.
4. McWhinney IR. Rigor and humanity. *Can Fam Physician* 1972;18(9):129.
5. Tannenbaum DW. New "horizontal" curriculum in family medicine residency. Mount Sinai Hospital makes changes. *Can Fam Physician* 1998;44:1669-75.
6. Reust CE. Longitudinal residency training: a survey of family practice residency programs. *Fam Med* 2001;33(10):740-5.
7. Hirsh DA, Ogur B, Thibault GE, Cox M. "Continuity" as an organizing principle for clinical education reform. *N Engl J Med* 2007;356(8):858-66.
8. Kerr J, Walsh AE, Konkin J, Tannenbaum D, Organek AJ, Parsons E, et al. Continuity: middle *C*—a very good place to start. *Can Fam Physician* 2011;57:1355-6 (Eng), e457-9 (Fr).
9. Delva D, Kerr J, Schultz K. Continuity of care. Differing conceptions and values. *Can Fam Physician* 2011;57:915-21.
10. Kerr JR, Schultz K, Delva D. Two new aspects of continuity of care. *Can Fam Physician* 2012;58:e442-9. Available from: **www.cfp.ca/content/58/8/e442.full.pdf+html**. Accessed 2013 Nov 21.
11. McWhinney IR. The essence of general practice. In: Lakhani M, editor. *A celebration of general practice*. Abingdon, Engl: Radcliffe Medical Press; 2003.
12. McWhinney IR. Family medicine in perspective. *N Engl J Med* 1975;293(4):176-81.
13. McWhinney IR. The naturalist tradition in general practice. *J Fam Pract* 1977;5(3):375-8.
14. Fry J. *Common diseases: their nature, incidence and care*. Lancaster, Engl: MTP Medical and Technical Publishing; 1974.
15. Hodgkin K. *Towards earlier diagnosis in primary care*. 4th ed. New York, NY: Churchill Livingstone; 1978.
16. Hawkins AH. *Reconstructing illness: studies in pathography*. West Lafayette, IN: Purdue University Press; 1999.
17. Hauer KE, Soni K, Cornett P, Kohlwes J, Hollander H, Ranji SR, et al. Developing entrustable professional activities as the basis for assessment of competence in an internal medicine residency: a feasibility study. *J Gen Intern Med* 2013;28(8):1110-4.
18. Ten Cate O. Entrustability of professional activities and competency-based training. *Med Educ* 2005;39(12):1176-7.
19. McWhinney IR. The importance of being different. *Br J Gen Pract* 1996;46(408):433-6.
20. Cooke M, Irby DM, O'Brien BC. *Educating physicians—a call for reform of medical school and residency*. San Francisco, CA: Jossey-Bass; 2010.
21. McWhinney IR. The value of case studies. *Eur J Gen Pract* 2001;7(3):88-9.