# What's in a name?

## Dr Ian McWhinney Lecture, 2018

C. Ruth Wilson MD CCFP FCFP

Dr Ian McWhinney described one of the fundamentals of family medicine when he said, "What does it mean to be a family physician? For me it means that our relationship with our patients is unconditional … ended only by death, by geographical separation, or by mutual consent."[1] Dr McWhinney is known to Canadian family physicians as being the first professor of family medicine in Canada and the person who, with his colleagues, originated and named the patient-centred clinical method.[2] The title of this lecture, "What's in a name?," refers to an exploration of this legacy of Dr McWhinney's, along with some thoughts on the changing nature of family medicine; it is about calling patients by name and the name we give to our discipline.

### Relationship-based medicine

A recent transition challenged me to consider the elements of relationship-based medicine. I retired from my academic teaching practice, where I had 812 rostered patients. Many of these were people I had known for the 29 years I was at Queen's University in Kingston, Ont. There were a handful of families in which I had delivered a baby who grew up to be the mother of a second-generation baby whom I also delivered; on one occasion I remember the grandmother, also my patient, being in the delivery room. I also had the privilege of palliating patients at the end of their lives and being there to provide the final service to them and their families, that of pronouncing death. The last month of practice was exhilarating and demanding, as person after person recalled some of the experiences we had been through together.

As I reflected, together with my patients, on what it would mean for our relationship to end, I had some anxiety about how the new doctor would ever be able to know the richness of the stories my patients had shared with me. How could almost 3 decades of conversation be summed up in a few bullet points in the social history section of the electronic medical record? How would the new doctor ever learn 812 names? As I fretted over this with one patient, she reminded me gently that it was her story to tell, and that she might choose to tell the narrative a bit differently to a new doctor.

The sensation of leaving a narrative in the middle, while the plot was still unfolding, was also disconcerting. Abigail Zuger expressed this well:

> When I close the door to my airless little clinic room for the last time, I will be closing hundreds of charts in the middle and walking away before the stories end. In all of medicine, is there anything more difficult to do than that? …. Whatever will happen to her, my big worry and secret pride, my last great resurrection? What will happen to every last one of them? Someday soon I will lose the right to know.[3]

Confidence in continuity of care as a therapeutic tool is not misplaced. Mortality rates are lower in situations with high continuity.[4] The more comprehensive the services offered by the doctor, the better the outcomes.[5] And yet I have chosen to move to a northern locum practice in Yellowknife, NWT—partly as a way of leaving the opportunities for academic practice (and obstetrics privileges at a university hospital that was starting to limit the number of family physicians it would credential) for a new generation. The pull of family ties was strong, as was the opportunity to work again in a remote location, which is where I had spent the first 11 years of my career. Locums provide important relief for long-term doctors, and in underserved and rural areas of Canada they are often essential in supporting the provision of service. Nevertheless, I had some trepidation in entering a practice where I would strive to provide some continuity, but far less than I had previously.

### Brave new world

How do patients fare with discontinuity? Zuger muses,

> And what will my patients lose? Theoretically, not too much. All our guidelines and algorithms, herding us to march in lockstep, are intended to guarantee just that. When one soldier in the line crumples, another steps right in and the professional formation moves on. The quality metrics of my patients' health care should only improve when I go, assuming the new soldier thinks a little more highly of some of those guidelines than I do.[3]

A fellow locum expressed these ideas more positively when she reminded me that we could reassure patients that informational continuity and common standards of high-performing family medicine should reassure patients of the quality of care they were receiving from someone they might not see again.

Perhaps providing locum services is a way to guard against codependency, the ego-fulfilling danger of needing to be needed. In his William Pickles Lecture,[6] which I

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chose as my nomination for inclusion in the book *Family Medicine: The Classic Papers,*[7] McWhinney wrote,

> The relationship between doctor and patient is subject to the same stresses and weaknesses as other human relationships. The doctor's own need for affection may be stronger than his ability to give it. Could medicine become a self-reflective discipline? I think it must if we are to be healers as well as competent technologists.[6]

What is the role of a family physician who wishes to be a competent technologist as well as a healer? There are new challenges in this arena as well. As Regional President for the North American region of WONCA, the world organization of family doctors, I've had occasion to visit Geneva, Switz, headquarters of the World Health Organization. Geneva is also home to the Museum of the Reformation. It is a little more than 500 years since Martin Luther triggered the Protestant Reformation when he nailed his 95 protests to a church door. The ideas of the reformation spread rapidly partly because of the printing and distribution of the Geneva Bible. Published in 1560 in English, this was the bible of Shakespeare, the bible brought by the Puritans to North America. Being able to read the scripture in their own language meant that the faithful no longer needed to access knowledge through the intermediary of a priest; this "disintermediation" had subsequent profound effects on politics, economies, and the rise of democracy.

A similar disintermediation is taking place in medicine. People can access medical information directly using their mobile devices and have access to the wealth of medical literature and information as quickly as a physician does. We no longer have the priestly activity of holding knowledge that we interpret for our patients; they can find it themselves. Although we continue to act as curators, advisors, and gatekeepers to medical tests, procedures, and therapies, our roles are changing. Access to information is only part of the profound change that technology is bringing to our lives and to medicine. As information becomes digitized, it can be incorporated into electronic technology that makes data available more quickly and on smaller devices, as microprocessor sizes and speeds change. These technologies are monetized and spread quickly, in many instances leaping over and disrupting the older "wired" world.

Progress in the field of artificial intelligence has shown that machines can learn, initially by humans programming them with available human knowledge, but this is soon outstripped by the machine itself. In a short story Ian McEwan describes the time in our current era "when, at the dawn of the third millennium, a computer program, learning from its own mistakes by way of deep neural networks and 'self-play,' defeated a Grandmaster at the ancient Chinese game of Go."[8] He then imagines a future in which artificial intelligence and robotics have integrated so seamlessly that it was the equivalent of racism to inquire of robots as to whether they were actual human beings. "The first android became pregnant by a human and the first viable carbon-silicon baby was born …. Could a machine be conscious? Or put another way, were humans merely biological machines?"[8]

This dystopic view of the future, of disintermediation, of technology is frightening and challenging. Will there be a need for the kindly family doctor in this brave new world? Our diagnostic functions could be replaced by faster, more accurate formulations produced by reliable algorithms. Perhaps we will no longer be available in person to our patients, but rather our avatar will perform a physical examination, just as robotic assisted surgery is now possible remotely.

## To be called by name

What then is the need for continuous doctor-patient relationships in this new world? Evidence supports McWhinney's thesis that the doctor-patient relationship makes a difference in health outcomes. Starfield's synthesis reminds us that countries with strong primary care, characterized by continuity and comprehensiveness, provided at a usual source of care leads to better health outcomes at lower cost, with increased patient satisfaction.[9] This kind of primary care can also overcome the corrosive effects on health of economic inequity, a powerful argument for investing in a relationship-based family medicine.

Is it possible to selectively embrace new technologies while maintaining this powerful relationship-based medicine? McWhinney thinks so.

> I see a need to attain some kind of a new synthesis between science, technology, and art in medicine—I mean all of medicine, not just family medicine. I have tried to break down some of those words because I think they are artificial barriers. There isn't a hard and fast line between science and art, between public knowledge and personal knowledge. Between technology and art, for example, we're learning in our present industrial crisis that quality in technology depends on the interaction between the person and the technology.[10]

As family doctors we need to find ways to use electronic medical records to improve informational continuity, particularly when we cannot form long-term relationships with patients. We need to make much better use of virtual home visits and electronic communication with our patients. Disintermediation and technologies offer us new opportunities. We must use our expertise as trusted advisors to patients, not simply the holders of medical knowledge.

Family doctors do more than primary care; we need to value our discipline's ability to reach beyond the clinic,

to see our patients at home, in hospital, in long-term care, and in the community. As Dr Cal Gutkin wrote me earlier this year,

> It is important for everyone in our society—including system planners, medical school leaders, peers in other medical specialties and the public, and definitely medical students considering their career choices—to understand and appreciate that our specialty is Family Medicine—not Primary Care—and that Family Medicine, like all the other medical specialties, is a complex clinical discipline, with a comprehensive fund of required knowledge, skills, and attitudes, and a strong and growing research base.

The way we name our discipline has consequences for the scope and effectiveness of our work with patients. Including primary care in a more comprehensive set of services we provide for patients is good for their health and allows us the opportunity to deepen our understanding of their conditions.[1]

Medicine has been called the most humane of the sciences, the most scientific of the humanities.[11] From the time we are born into the arms of our parents, human relationships are part of our narrative. And narrative is part of our humanity. The move to person-centred medicine, which sees and names patients as individuals, not as persons in a particular role, is part of the key to a new medicine.[12] Ours is not the only part of medicine that values relationships, and we need to maintain humility about our claims of the patient-centred clinical method.

In our work we can be the nexus of wisdom and judgment, exploring with individuals the differences between what we can do and what we should do. In our work we can find ways to call people by name and stay with them in various health care settings, in their homes, and through the appropriate use of technology. As McWhinney reminds us, "The importance of being different is that we can lead the way."[6]

**Dr Wilson** is Professor Emerita in the Department of Family Medicine at Queen's University in Kingston, Ont.

**Competing interests**
None declared

**Correspondence**
**Dr C. Ruth Wilson;** e-mail **ruth.wilson@dfm.queensu.ca**



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