Quality of mind

Dr Ian McWhinney Lecture, 2023

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Ian McWhinney became a guiding light for me in 1989 when I read the newly published second edition of his totally marvellous *A Textbook of Family Medicine,* and it gave me the title of this lecture: "Depth of the knowledge depends on the quality of mind, not on its information content."[1]

Ian not only wrote this but exemplified it. There is a lot of information in his textbook but the whole is illuminated by the quality of his mind and the consequent scope of his thinking.

In his *Textbook,* he wrote this:

> Human variability is such that for a seriously ill person, the physician cannot be a replaceable part. If we insist on treating ourselves as such, we should not be surprised if society treats us as laborers rather than as professionals. We should also not be surprised if it does something to us as people. As we withdraw from our patients, we will be the poorer for it. Our professional lives will be less satisfying and we will lose much of the depth of experience that medicine can give us.[1]

When I read this, I felt a real jolt of recognition. I had been in general practice for 14 years and could already sense that this was precisely what was happening around me, and my further 21 years in practice confirmed the truth of it.

Ian knew that the skill and the achievement of general practitioners lies within the relationship between doctors and patients and that these relationships were precious and that any withdrawal would be damaging. And it has been—deeply so.

Also in his *Textbook,* he wrote:

> In family practice, we often encounter illness without a discernible pathological process—illness without disease. Disease and illness belong to two different universes of discourse: one to the world of theory, the other to the world of experience.[1]

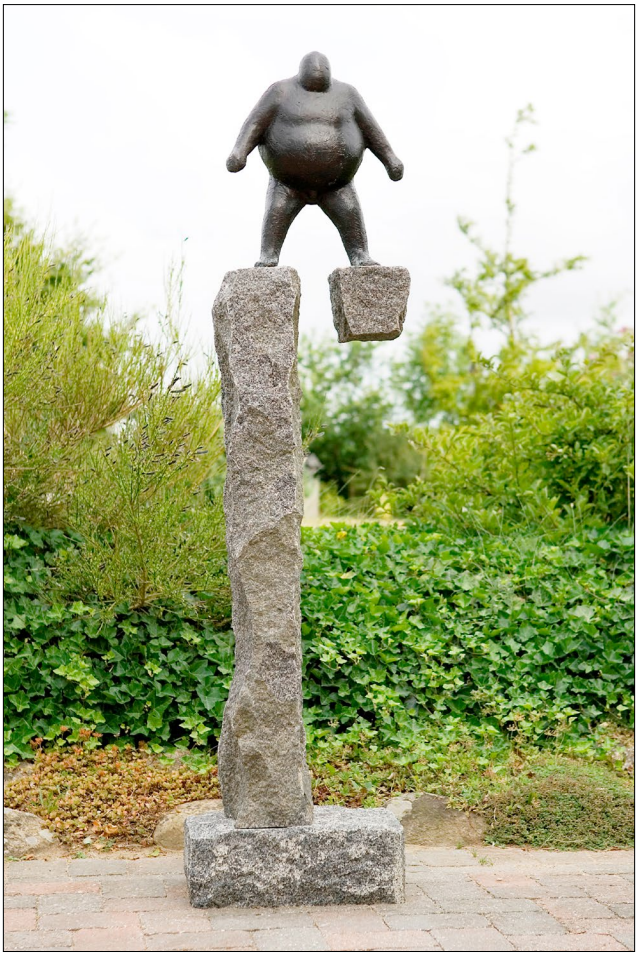
For me, this sentence is entirely characteristic: He very often identifies a contradiction and then sets out to explore the dialectic that emerges. He knows that both parts are essential but asks us to consider whether the balance between them is optimal and, in the process, there is much to learn.

So here, I want to consider five of these dialectics and see where it takes us, remembering that the great Danish physicist Niels Bohr is supposed to have said that "We shall never understand anything until we have found some contradictions."[2]

This reminds me of the sculpture *Utopia* by the wonderful Danish artist Keld Moseholm, who died in May this year aged 87. I take the figure to represent the whole endeavour of medicine and health care.

Theory/practice

If this sculpture is medicine, it is a somewhat bloated enterprise, with one leg safely grounded in the apparent, but fluctuating, normative certainties of biomedical



Artist: Keld Moseholm (1936-2023), *Utopia*, bronze and granite, 1 m x 30 cm x 30 cm, 2008.

This commentary is based on the 2023 Dr Ian McWhinney Lecture given by Dr Iona Heath at Western University in London, Ont, on September 20, 2023.

science—while the other leg, which should be grounded in the attempt to understand the subjective experience of illness within human existence and individual biography, is largely unsupported. As soon as theory predominates, we should seek to rebalance it with attention to the experience of practice or the whole edifice is at risk of collapse. As Ian understood so well, it is individual practice within relationships between particular doctors and particular patients that teaches us the power of the interaction between biology and biography and the need to balance our attention between them.

The British-American philosopher Stephen Toulmin, who died in 2009, seemed to perceive the same imbalance when he wrote about the urgent need to

> acknowledge and respect the essential differences between scientific and medical knowledge—notably, the physician's complex but indispensable fusion of the theoretical and the practical, the general and the particular, the universal and the existential.[3]

And Toulmin emphasized the importance of making "it clear just how far the fusion of medicine with biological science can afford to go, if it is not to destroy the essential character of medical practice and understanding."[3]

My fear is that, like the figure sculpted by Keld Mosehelm, we are teetering on the brink of this destruction. Doctors and perhaps particularly general practitioners are not biomedical scientists—they have a different responsibility, which is to attempt to relieve human distress and suffering and, to this end, to apply general scientific discoveries derived from the study of populations to a series of unique individuals. The science is usually, but not exclusively, biological and yet each individual has a particular biography that profoundly affects their personal biology and their experience of health, illness, and disease.

Most scientific research in medicine, and even in general practice, has prioritized biology over biography. We need to reclaim the maligned subjectivity of the anecdote and rename it *story,* and see it as a basic unit of research in general practice that reasserts the importance of biography alongside biology. Every story is different because, as Philip Roth observed, "the intrinsic nature of the particular is to be particular, and the intrinsic nature of particularity is to fail to conform."[4]

And every general practitioner or family doctor knows that failing to notice what is subtly different about this particular patient, their predicament, or their circumstances can have very serious implications.

Which comes first: theory or practice? Does it matter? I want to argue that yes, the answer to this first question really does matter to the future of general practice research and clinical practice. Research that starts out with a question of theory, which it seeks to answer by examining practice or even changing practice before returning to theory, is quite different from a research question that emerges in the daily experience of clinical practice, is tested against established theories or used to generate new ones, and then returns to inform practice. Not least because a practice-theory-practice loop carries a much greater possibility to speak to the subjective experience of both patient and doctor and to the solidarity between them.

In 1956, the English writer George Ewart Evans published his masterpiece of oral history, which he called *Ask the Fellows Who Cut the Hay*.[5] It would be timely if health care policy-makers the world over could be persuaded to reflect on this title. There is a pervasive and disturbing lack of knowledge of the daily experience of working at the front line of public service let alone any valuing of or respect for that experience. In the United Kingdom (UK), this applies to teachers, social workers, civil servants, police, firefighters, nurses, doctors, and many more. It is undoubtedly true for those working in health care, which is particularly sad as we see, every day, the effects of structural violence and social injustice working themselves out in premature illness and disease and in blighted and shortened lives.

The fellows who cut the hay in the health service in both the UK and Canada would, I think, agree with Dutch philosopher Annemarie Mol when she writes: "Our theoretical frameworks seem to be too exclusively adapted to the task of 'criticism'. They unmask. They tend not to explore or build ideals but to undermine them."[6]

So, to try to move beyond this rather depressing context, just like Ian McWhinney did so often, I am going to look beyond medicine for inspiration.

I have no religion and I count myself a theological ignoramus, but much of the inspiration for my thinking about these loops comes from conversations with my friend and colleague Stephen Pattison, Emeritus Professor of Religion, Ethics and Practice at the University of Birmingham in the UK and a former member of the medical ethics committee of the Royal College of General Practitioners. In a published discussion document from 2013 about practical theology, Stephen writes: "We start from where we are, in the middle of life and experience; it is in the contemporary moment of embodied being that we choose to attend to particular things and direct our gaze in specific directions."

And Stephen completes the loop by saying:

> If practical theology starts in the embodied here and now of experience and practice, it also finishes there by attempting to answer the fundamental structuring question, "So what?" … In what way does our research endeavour return us to the world of experience and practice, confirmed, changed or different?

From the perspective of a clinician, research always needs to be relevant to practice or it is useless.

The American anthropologist Clifford Geertz wrote: "Theory … grows out of particular circumstances and, however abstract, is validated by its power to order them in their full particularity, not by stripping that particularity away."[7] And again, you see that he is talking about a practice-theory-practice loop.

Ian wrote: "Much of diagnosis is a categorizing, generalizing process. Management is a synthesizing, individualizing process."[1] We see him reminding us of the necessity of balance and of a continual oscillation between practice and theory and back again. The emphasis and centring on practice makes me think of general practice as a craft.

In his book *The Craftsman,* a rather unfortunately gender-specific title, the American sociologist Richard Sennett wrote: "This is the absorption into tacit knowledge, unspoken and uncodified in words … the thousand little everyday moves that add up in sum to a practice."[8]

And I think Ian paid a lot of attention to these little everyday moves that make up our craft and our practice: "If we look closely, every patient is different in some way. It is in the care of patients that knowledge of particulars becomes crucial. Care is about attention to detail."[9]

Sennett writes that care is about those everyday moves of attention:

> The emotional rewards craftsmanship holds out for attaining skill are twofold: people are anchored in tangible reality, and they can take pride in their work. But society has stood in the way of these rewards and continues to do so today.[8]

I think those in clinical practice are still anchored in tangible reality unlike so many policy makers but, as Ian foresaw, it seems to me that it is becoming increasingly difficult to take real pride in our work and in our skill. The American philosopher Carl Elliott, writing from outside the profession, says, "financial and technological changes have placed intense pressure not just on the way medicine is practiced but on the values doctors profess to hold."[10]

And writing from inside the profession, Sandeep Jauhar says: "There is a palpable sense of grieving. The job for many has become just that—a job."[11]

This seems to be precisely what Ian was saying all those years ago when he talked about the damage that would be caused by insisting on seeing ourselves as replaceable parts.

Science/philosophy

I only had the precious opportunity to see and hear Ian in person on two occasions. The first of these was when he gave the 1996 William Pickles Lecture at the Spring Meeting of the Royal College of General Practitioners in Aberdeen, UK, on April 14, 1996.[9] It was a complete revelation to me. Ian was strikingly slight and his voice was soft, yet I had simply never heard such concentration from a large audience. It was after that totally brilliant lecture that I began to think of Ian as being part of the tradition of natural philosophy, which began to fade away centuries ago after Newton; before that, science was regarded as part of philosophy and philosophy as part of science. The separation of the two was unthinkable. And although in the UK young people wanting to study medicine now need only study science from the age of 15, somehow, for Ian, the separation remained unthinkable. To quote American bioethicist Edmund Pellegrino, "Philosophy tells us what is permanent in medical transactions, science what is changing and changeable."[12]

In his *Textbook* Ian quoted R.J. Baron, who wrote in 1985: "A great gulf exists between the way we think about disease as physicians and the way we experience it as people."[13] The former is always changing and changeable; the latter feels mostly permanent.

And we are back with the Moseholm sculpture and the instability of one leg grounded in science and one unsupported leg, which should be grounded in other modalities of human knowledge that can help us understand the subjective experience of illness and suffering where medical science has very little to offer.

In the William Pickles Lecture, Ian quoted 14 sources directly, most of them from outside medicine: from Charles Taylor and William James to Jean Piaget, C.S. Lewis, and Umberto Eco.[9] Science in general and medicine in particular have been profoundly weakened by the neglect of philosophy and the many other modalities of human thought, and it is as if Ian were recruiting great minds to try to bolster that unsupported leg. And to help us reprioritize what medical anthropologist Arthur Kleinman described as "the chief interests of the clinician: the exigent and difficult reality of illness as a human experience and the core relationships and tasks of clinical care."[14]

What can medical science alone—teetering on its one supported leg—tell us about the difficult reality of illness as a human experience? Ian seems to have been exploring the nub of this particular dialectic when he wrote

> the term psychosocial is an abstraction and strips away the poignancy of what happens. Shakespeare speaks of "that perilous stuff that weighs upon the heart." If we speak of suffering, we will not be tempted to distance ourselves from the experience. Facing a patient's suffering in this way, not from behind a barrier or as an expert practising a certain technique but as one person to another, is perhaps our most difficult task.[15]

It seems likely that, because of the degree to which it functions through relationships, and despite Ian's efforts, general practice has been most damaged by the neglect of philosophy and humanities within medical education, thought, and practice. In a 2019 essay, Nicholas Maxwell,

Emeritus Reader in History and Philosophy of Science at University College London, wrote:

> Far from being yet another specialised discipline, distinct from and alongside other specialised disciplines, as so much academic philosophy strives to be today, philosophy, properly pursued has, as a basic task, to counteract specialisation by keeping alive thinking about fundamental problems in a way that interacts, in both directions, with specialised research.[16]

This seems to me to be close to the task Ian set himself—to counteract specialization by keeping alive a commitment to thinking about the fundamental problems that arise constantly within the practice of medicine.

Map/territory

It was while listening to Ian in Aberdeen that I first heard about the Polish-American philosopher and scientist Alfred Korzybski, who is famous for his description of the gap between the map and the territory. Korzybski wrote: "A map *is not* the territory it represents, but, if correct, it has a *similar structure* to the territory, which accounts for its usefulness."[17]

Responding to these ideas, Ian said:

> We cannot experience the beauty or the terror of a landscape by reading the map.... There is a thrill in making a good diagnosis (finding our place on the map), and there can be beauty in a radiograph. But this is not the same as a feeling for the patient's experience of illness—and patients are very quick to sense the difference. If we are to be healers as well as technicians, we have at some point to set aside our maps and walk hand-in-hand with our patients through the territory.[9]

To view health as the opposite of disease is a category error: Health belongs to the territory and is more akin to love and hope; disease belongs to the map. The prevention of disease can never be the same as the promotion of health, and yet the two phrases are often used synonymously.

The experience of looking at a map, however detailed, is nothing like the experience of walking through a landscape. Similarly, the map of medical science is nothing like the landscape of human suffering—the territory, to use Korzybski's word. The map provides a guide but it does not even begin to capture the reality of experience.

It is the constantly recurring gap—the gap between a word and its object; between a diagram and what it tries to represent; between nature and our understanding of it; between the subjective and the objective; and even between Donald Schön's "high, hard ground" of technical rationality and the "swampy lowland" of professional practice.[18] Uncertainty is inevitable in the gap, according to Marcelo Pakman:

> This gap signals the space in which choices appear, ethics is born, democracy grows, justice evolves, secrets, lies and errors constitute communication, and human identity becomes a matter of self-delusion and composition.[19]

The freedom, challenge, and potential innovation of medical practice exist in this gap between the map of medical science and the territory of illness and suffering.

The task of making the medical map useful to those trapped within the territory of suffering is—and will always be—fraught with uncertainty because of the vast extent and infinite variation of the territory and because of the still comparatively rudimentary nature of the map. But the uncertainty and doubt that clinicians experience every day are also what make new knowledge and understanding possible. We have to doubt existing explanations if we are ever to discover better ones. So, the task demands wisdom and judgment as much as knowledge. The foundation of wisdom is doubt.

To work effectively, the doctor must maintain a clear understanding of both borders of the gap. This requires a thorough, robust, and continuously updated knowledge of medical science; an empathic willingness to recognize, acknowledge, and witness the true extent of suffering; and an appreciation of the details of individual lives, combined with a respect for the history, aspirations, and values that have made those lives what they have become.

The social and cultural context and the life story of the patient mould the nature and experience of illness and in this way make the standardized and schematic map more or less useful. The map can only become more useful, and even then, painfully slowly, if we are prepared to doubt its accuracy. If we can't see the gap, we're in trouble.

The key is to keep thinking (in John Ralston Saul's words): "absolute truths are ideology and are the opposite of language and the opposite of using the intellect and intelligence."[20]

For me, back in 1997, a short filler text in the *BMJ* underlined the imperative of doubt and of crediting the wisdom of patients. Trefor Roscoe wrote:

> The patient was a man in his middle years who had come for his tablets. He had acne rosacea and was on intermittent six week courses of oxytetracycline. He needed them only two or three times a year to keep it at bay. As I was new to the practice and he did not come in often, I remember asking him if he was otherwise fit and well. He mentioned his occasional indigestion and then said something that struck me as quite odd. My note of the consultation reads "Repeat Rx Oxytet 100. Occ. Indigestion. Says oxytet cures it!" I had underlined the latter and added the exclamation mark as I was so surprised. I remember asking him to

clarify which tablets he thought helped his indigestion and having it confirmed. He had not bothered to finish the course of cimetidine given by my colleague a few months before; they had not worked. At the time I thought him very strange. Antibiotics did not cure indigestion in 1987.

A few years later, when the bug that was to be named *Helicobacter pylori* was discovered, I had cause to remember this consultation. One of the original recommendations for the treatment of *H pylori* was tetracyclines, and some regimens still suggest them. Resistance is now a problem but this patient had made an observation.... Had I told my colleagues of this "breakthrough" I would have been laughed at—H_2 blockers were the mainstay of treatment then, not antibiotics.[21]

Roscoe concluded:

> This man taught me several things. The simplest consultation can stick in your mind in great detail and come back years later, when its significance is realised.... We ignore such things that do not fit into the standard view at our peril.[21]

In the relationship between doctor and patient, the doctor holds the biomedical map and he or she has a responsibility to have studied it well. The task of both doctor and patient is to explore the usefulness and the limitations of the map in relation to the territory of the patient's illness.

Any other health care practitioner carries a different map, which is no less valid for their professional world, but only a doctor is equipped with the map of medical science. All doctors carry the medical map, albeit with patchy and varying levels of detail, but only the medical generalist uses it to try to make sense of the whole human person, transcending all the arbitrary divisions of specialist practice.

Thinking/feeling

The dialectic tension between thinking and feeling is about reason and emotion and it mirrors that between theory and practice. Ian was worried about the neglect of feeling within medicine: both the feelings of patients and the feelings of doctors.

In his article "Medicine as an art form," he quoted Samuel Taylor Coleridge:

> "Deep thinking," said Coleridge, "is attainable only by a man of deep feeling." ... Intellect and feeling are two inseparable aspects of a fully rounded personality. Our modern system of medical education, by developing only one part of the person, has produced a generation of physicians who are analytically brilliant but in other respects stunted and naïve.[22]

I have never been accused of being analytically brilliant, but my patients have quite often made me feel stunted and naive. And we are back with the unsupported leg—both thinking and feeling are essential: "The central tasks of a physician's life are understanding illness and understanding people."[1]

Thinking to understand illness; feeling to understand people. "Experience engages our feelings as well as our intellect. The emotions play a very significant part in general practice, and as I will maintain, are seriously neglected in medicine as a whole."[9]

And Ian went on to produce two examples of the practical implications of this neglect. The first example:

> All kinds of technical and economic arguments have been used against home visiting. But how often do we hear of the home as an extension of the personality; of the personal knowledge that comes from seeing a patient in his own home; of the quality of the relationship that develops between physician, patient and family in the home setting; of the warmth and comfort of being attended for a sickness in one's home? I fear we have made human values so subservient to technologic and economic values that they do not even count in our discussions.[22]

And I could not agree more—it has to be meaningful that I can remember specific home visits so much more clearly than even the most dramatic consultations in the office—always something to see, always something new to learn, always a slightly deeper relationship. I remember deciding to go into general practice because I wanted to see my patients in their own clothes rather than those horrible hospital pinafores; how could I not enjoy the incredible privilege of home visits?

And the second example:

> A large body of evidence indicates that emotions can influence immune function, thus providing a physiological link between life experience and the course and outcome of illness.... Social isolation, for example, increases mortality from virtually all causes of death. The notion of a separate group of psychosomatic diseases is therefore obsolete.[9]

Regrettably, the notion of psychosomatic diseases is not yet obsolete more than a quarter of a century later, but it certainly should be!

Responsibility/guilt

So let me finish with one last juxtaposition, which seems to me to underline just how perceptive Ian McWhinney was, how deeply he thought, and how deeply he felt:

> Those physicians who would like to convince people that they are responsible for their own healing

should consider the consequences in guilt and remorse if their efforts do not improve their health or prevent deterioration.[1]

And so, as a final tribute to Ian, his particular quality of mind, and his immense contribution to me personally, to all of us here and to the profession as a whole, let me recruit Abdulrazak Gurnah, who won the Nobel Prize in Literature in 2021:

With time, dealing with contradictory narratives in this way has come to me to seem a dynamic process. Out of it came the energy to refuse and reject, to learn to hold on to reservations. Out of it came a way of accommodating and taking account of difference, and of affirming the possibility of more complex ways of knowing.[23]

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Competing interests
None declared

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Can Fam Physician 2023;69:821-6. DOI: 10.46747/cfp.6912821