

Voices from Family Medicine: Ian McWhinney

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Ian McWhinney is one of the most widely respected philosophers and investigators in medicine. He has received numerous awards from academic societies—among them the Curtis Hames Award and the Certificate of Excellence from the Society of Teachers of Family Medicine—has been appointed a Member of the Institute of Medicine of the National Academy of Sciences in the United States, has been awarded an honorary MD by the University of Oslo, and has had a long career of publication and teaching in countries all over the world. In 1968, he became first the professor and chair of family medicine in Canada, at the University of Western Ontario. During his career, he has constantly explored the meaning of medical practice for both physicians and patients. His writing has influenced generations of scientists in family medicine and beyond. This transcript is an abridged and edited version of interviews with Dr. McWhinney in May 1991 and February 1992.

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I went into general practice in 1954, after graduating in 1949 and doing an internship, then military service and a one-year medical residency. I hadn't made up my mind what I was going to do. Because my father was in practice in Stratford-on-Avon, I decided to go into general practice with him and his partner. It was the practice my father founded in 1939. He was the son of a Scottish steelmaker, left school at 14 but was encouraged to go back, and eventually entered medical school in Glasgow. He served in World War I and didn't get out of medical school until he was older. He went straight into practice as an assistant. Young physicians were exploited in those days, working until about 9 pm and on call every night, with office hours on Sundays. Even when I started in practice there were Saturday evening office hours. It was just what one expected to do. It didn't seem unusual.

Beginning practice, for me, was really being thrown into the deep end. In my medical residency, I saw pretty well everything that came in; it was a very broad experience. So I was well prepared in one respect, as a classical clinician, but I very soon became aware of my deficiencies. I went through a period of restlessness and thought about leaving practice and doing internal medicine. In my early days in practice, I thought of myself as an internist. I didn't have a concept of what it meant to be a family doctor.

I remember searching for answers. I was particularly concerned with how one helps people with vague problems. I used to go on psychiatry postgraduate courses and found they didn't help. I found I was thinking in a different

way and got interested in inspecting what these differences were and why they were different. Joining the College of General Practitioners put me in touch with a group of people who were having similar thoughts. So I got interested, right from the beginning, in the thinking patterns in general practice.

Quite soon, I became interested in the problems of early diagnosis. I started keeping case notes. I can't remember when the idea of putting them in a book began, but I remember a visit from a colleague to whom I mentioned what I was doing, and he said, "Why don't you write a book?" I said, "I couldn't write a book," and he replied, "Well, who else is going to do it?" So I said, "Why not?" *The Early Signs of Illness*¹ was published.

I had a personal interest in the career of James MacKenzie because my father practiced in Burnley from 1924 to 1939,



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where MacKenzie did all his original work and practiced. I was born and raised there. I had the grandiose idea of writing a biography of MacKenzie myself but found out that someone else was writing "the official biography" so I dropped the idea. It was probably a good thing. I don't think I would have written *The Early Signs of Illness* if I had continued on the biography.

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I became involved with the College of General Practitioners and started thinking about education for general practice. I met George Swift, who established the first model of postgraduate training in Britain. Right from the early days of the National Health Service the government would pay for a trainee to be in practice for a year. It was a very disorganized system, and there were no formal requirements. But the basis was there, and that is what the College started working on. It became increasingly clear that there had to be some kind of definition of what the discipline was. General practice still was thought of in those days as what you did if you didn't specialize—the rest of medicine.

In 1963, I applied for and was given a Nuffield Traveling Fellowship. I read an editorial in the *New England Journal*² about Bob Haggerty's fellowship in family medicine at Harvard. I wrote Bob and asked if I could come. I got a very nice letter back. He suggested that I spend eight weeks at Harvard and then spend the rest of the time visiting other parts of the country that were beginning to think about those educational issues. So the whole family came over. I did the fellowship the year after Lynn Carmichael, but we didn't meet at that time. By the time I got there, Joel Alpert had succeeded Bob Haggerty.

I visited the University of Maryland, which had some general practitioners in their teaching program. I went to see the University of Chicago's Department of Medical Education and Stanford's Division of Primary Care. Then I went to Kansas City to the Academy of General Practice, then to Columbus, Ohio, Lexington, Ky., and Chapel Hill, N.C., visiting practitioners. I visited the Department of Community Medicine in Burlington, Vt. I also went to Canada and visited the Canadian College of General Practice. I never actually went to London, Ontario, though. I met a few deans, leaders of academic medicine, and they showed a good deal of skepticism about general practice's potential to produce people with the necessary academic qualifications or brainpower.

As a result of that experience, I wrote a couple of articles in *Lancet*.^{3,4}

The articles published in Lancet first outlined the four criteria for an academic discipline—a unique field of action, a defined body of knowledge, an active area of research, and an intellectually rigorous training—that would endure throughout all future discussions of academic general practice and family medicine.

In 1968, Dr. McWhinney left his practice in England to become the founding chair of the Department of Family Medicine at the University of Western Ontario.

Out of the blue, I got a letter from Western Ontario saying they were establishing a chair in family medicine, the first one in Canada, and inviting me to apply. After a lot of

discussion with the family and heart-searching and agonizing, I decided to have a look. I don't think anybody would believe how naive you could be in those days. I had never really applied for a job before, and Western Ontario's was a very unique recruitment process. Instead of asking my wife and me to go over there, they sent three people to England to spend the day with us. A few weeks later, there was this call from the dean.

I had it in the back of my mind that at some time I would like to establish general practice in the medical school. I was thinking of doing it in Britain. My wife didn't really want to go to Canada and my older daughter, who was 10 then, plotted all kinds of terrorist activities, like putting prickly holly in the overcoats of the visitors. We were all very happy where we were but my wife agreed for my sake because she saw that I wanted to do it. Another traumatic part to the move was that although my father put his best face on, it was a very big blow to him. It's one of those things one doesn't foresee, one of the hazards of father and son working together in any business or profession.

It was a traumatic few years, though, to be uprooted and transplanted. I was 40, which seemed to me to be the time when, if I didn't dare take that opportunity, it wouldn't recur. I know now that I was wrong—there would have been plenty of opportunities. But that's the way I saw it at the time, although I also had self-doubts; I felt that I was ready to do it.

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Joining the department in London, Ontario, was certainly exciting. There was a group of people who were thinking very hard about new educational ideas, and there was also a strong core of local general practitioners who were committed to becoming involved with medical education. It's interesting that 25 years later that core group remained together, and many are still members of the department, full- and part-time. Within the medical school, there were also people with progressive ideas. Carol Buck, the head of the Department of Epidemiology, was important in establishing the chair of family medicine. They were insistent that it be a full chair and, against opposition, pressed for it to be the first in Canada. The dean, Dr. Boeking, was also a very supportive figure.

It soon became clear that a lot of the faculty of the medical school, not surprisingly, didn't really understand what we were driving at—what family medicine was and what our objectives were in getting into the medical school. The principles on which we operated were laid down very early and really haven't changed very much.

The first basic principle was that family medicine can really only be learned in a family practice. One learns many other useful things by working in other settings, but the core experience had to be in a family practice setting. It was based on the educational principle that if you want to learn to swim, you go to a swimming pool, and if you want to learn how to ski, you go to a ski hill. For some reason, it was a very difficult thing for people to grasp.

One of the teaching hospitals in London made a teaching practice in the hospital available to us. We, in the department, very soon came to a unanimous conclusion that a hospital was not the place to run family practice. People got us confused with an outpatient department. We had to make clear the difference between a family practice and an

outpatient department. Based on experience, we decided that all our teaching would be outside of the hospitals. So the two teaching hospitals either built or converted family practice units at a distance from the hospital. Money was less tight in those days. A third center was opened about 15 miles out of town, financed by the ministry of health, with a community board, and finally we had a fourth one in a suburban area about five miles from the hospital. The four practices were group practices based on teams. Members of the department formed the group practices, and residents were attached to each.

The second basic principle for the department was that family practice should be taught by family physicians. Residents had a lot to learn from others, but the actual teaching of family medicine had to come from people who had experienced it themselves. It is interesting that James MacKenzie makes the same point in his book *The Future of Medicine*,⁵ that general practitioners were being taught and trained by those who had never experienced general practice.

We also began to build a network of teaching practices, which were private practices of different sizes throughout the province stretching a thousand miles, from London right up to northern Ontario. Residents and students from our clerkship were able to learn family medicine in these practices.

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In the mid-1970s, the department at Western Ontario began a research and faculty development program, sponsored in part by the Kellogg Foundation, which resulted in a program that offered a Master of Clinical Science degree in Family Medicine. This program and further work resulted in the establishment of the Centre for Studies in Family Medicine at the University.

The development of a Master's degree program was important for a number of reasons. First of all, it was a tremendous impetus for the faculty. Our principle that all the courses should be taught by our own family medicine faculty meant that it wasn't a program where we went to other departments for the teaching. It was a great challenge for us. For example, there is a course in research methods taught by our research faculty. The examples are from family medicine. Although the methods have much in common with other disciplines, the context is all family medicine.

The program was a great source of faculty development for both full-time and part-time faculty members and brought people from many different backgrounds to the department as graduate students. A lot of participants had been in practice for five or 10 years, some were from other countries. They brought a lot to the program themselves.

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The Centre for Studies in Family Medicine has been a 10-year task developed on the basis of the first small research group in the department. It was always difficult to get money to provide career positions for research faculty, and now it is still a struggle. But we eventually did succeed in building up a research team, and that is one of the things that has really come to fruition in the last few years.

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In 1972, Dr. McWhinney published an article in the New England Journal of Medicine that developed a taxonomy of social factors in illness and a classification system of patient behaviors in the health care system.⁶ This stimulated the work on an international classification process for health problems in primary care. A later article, also in the New England Journal of Medicine, has, along with the work of G. Gayle Stephens, established the philosophical basis of family medicine.⁷

There are three things that I get ideas from, and they all interact. One is talking to people. Those day-to-day contacts within the department, working with people, are really important for me—to always have people that I can discuss things with. I spoke recently with a young physician about the loneliness he felt where he was; I have been fortunate never to have had that problem. I had my father and my partner in those early years in practice, or people in the College of General Practitioners, or some of my neighboring practitioners in Stratford, who I used to meet with every two weeks to discuss issues in practice.

The second source of ideas is reading. I've always done lots of reading and have books I go back to time and time again, creating kind of a dialogue between different books. For example, about 20 years ago I read VonBertalanffy's book on general system theories,⁸ and I picked it up again last week. One of the last chapters, which I had completely forgotten, related to things I'm thinking about now. That kind of interaction between what I read is a thought-provoking process. If a book has a lot of depth, you get just so much from it in one reading. Five years later you have moved on and experienced more, and then on rereading the book you find things in it and think "now why didn't I find that before?". It is a continuing process. One can never exhaust it.

Finally, I learned a tremendous amount from clinical medicine. When I stepped down from the chairmanship, I started working in palliative care. I have just finished a five-year appointment as medical director of our local unit. As a general practitioner, I had always cared for dying patients but not in such a concentrated way. I have developed a lot more understanding now. I see in retrospect some of my failings in my early years in practice, in what I did for dying patients. I realize how much we have to learn from some of our sister professions, like nursing. One of the things I've thought a lot about is the importance of touching in healing. It struck me how good nurses are at this and how, on occasions, they will sense that somebody needs physical closeness and there's nobody else there to provide it. Touching becomes supremely important for the AIDS patients we have in our unit. It is of such symbolic significance that they are touched, that their dressings are changed, and that no one who comes to see them hesitates to touch them, to shake their hands.

Dr. McWhinney's experiences on both sides of the Atlantic have given him ample perspective from which to reflect on the direction for future clinical work and research for family medicine and for all of clinical medicine.

I have become much more aware as I've gotten older of

the healing role of medicine as contrasted with the more technical aspects. I was reading something that Cardinal Newman said about changes that occurred in him, saying it wasn't an intellectual thing but a maturing process. It is not just a change in thinking but a personal change. A part of it I suppose is getting older, and a major trigger for change is experiencing illness oneself. It is a great teacher. An illness or a traumatic experience, particularly in middle life, can pull one up sharply and lead one to reflect and look at oneself very critically. I had that kind of experience in my 50s. It gave me much more feeling for the spiritual aspect of life and medicine.

The greatest task is going to be to reconnect medicine with its spiritual roots. This is going to be difficult to do because, I think, when one talks in this way people will very often misunderstand. Yet wherever I go and do try to express it, I always find that there's somebody who comes up afterwards and says that it is where they have come to as well. I do feel that this is a sort of groundswell, something that is growing, perhaps a reaction to what William James called "medical materialism."

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A number of things interest me on the philosophical level at the moment. 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. We have to think about synthesizing the things we have broken down into watertight compartments and find new ways of thinking about some of the other compartments we have made for our-



selves, like mind and body, biological and social, subject and object, and facts and values.

It is a very difficult process and requires a different way of looking at the world. I may not attain it myself, at my age, but future generations will need to develop these major transformations of worldviews, not just in medicine but in the whole of society. There are some paradigmatic examples of what our present worldview has not dealt with very effectively. One of them is the whole range of conditions in which the symptom is the main problem, such as chronic pain. We are often unable to help people with conditions because we think of them as divided between mind and body. We seem to be completely blocked by our dualistic way of thinking. "What is *the* cause?" *The* cause has to be something external that attacks the body, rather than something in the organism that's triggered by an external factor. That type of very compartmentalized thinking means that we can't help thousands and thousands of people who have illnesses. Often, we leave them with the feeling of being rejected by the system, by their physicians.

We need to start reframing some of the old questions, because they're not answerable within our old framework. We need to use terms that are not dualistic, that raise different kinds of questions that symbolize different ways of thinking. One example would be a word like "function." If we talk about function, we need to talk about whether somebody can do his or her shopping, walk out and get on the bus, go to the shop, count change, and then understand what he or she bought. Everything contributes to function. It's a word that transcends all aspects of mind and body.

Of all the branches of medicine, family medicine is at the forefront of this thinking. Our colleagues in other disciplines might be surprised to consider us on the cutting edge, but I believe it is true.

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