

## Paradigms Lost: A Central Dilemma for Academic Family Practice

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Although thrust onto the academic scene by political forces, family medicine has struggled over the past two decades to define itself as a scientific discipline. An observer, participant, and analyst of this effort, McWhinney<sup>1</sup> wrote in 1978:

Perhaps we are on the brink of a new paradigm in medicine. If we are, then I suggest that it is more likely to come from family medicine than any other field, because it is in family medicine that we see most clearly the incongruities of our current systems of abstraction.

These sentiments parallel those expressed by Engel<sup>2</sup> in his presentation of the biopsychosocial model as a basis for understanding and guiding patient care. Addressing the inadequacies of current concepts of medicine, Engel spoke of "our adherence to a model of disease no longer adequate for the scientific tasks and social responsibilities of either medicine or psychiatry."

This attraction of physicians involved in the general care of patients to the academic stature and trappings represented by such models is eloquently countered by Dr. Dormidor Oreshchenkov, "The Old Doctor" in Alexander Solzhenitsyn's brilliant novel *Cancer Ward*.<sup>3</sup> Dr. Oreshchenkov's career has followed a trajectory from general practice to the practice of a variety of specialties, to radiology and oncology, and back to general practice, where "after the age of sixty-five he began to lead the sort of unhindered life he regarded as right for a doctor." A visit from a former student seeking care for her own illness becomes an occasion for Dr. Oreshchenkov to air his views on the practice of medicine. "He claimed that if a man was called a 'Scientist' during his lifetime, and an 'Honored' one at that, it was the end of him as a doctor." It would "get in the way of his treatment of his patients just as elaborate clothing hinders a man's movements. . . . The [primary care] doctor ought to be an all-rounder [and] treat each patient as a subject on his own. Treating

diseases separately is work on the 'feldsher' [roughly, physician assistant] level."

Is family practice a field of endeavor waiting for a new paradigm to confer academic respectability to it, or is it a field that, for its full realization, must maintain some distance from the trappings of academia? A consideration of the works of McWhinney and Engel with a decade of hindsight strongly supports the latter position.

### THE NOTION OF SCIENTIFIC PARADIGMS

In his writings in this area, McWhinney frequently acknowledges his debt to the historian of science Thomas Kuhn.<sup>4</sup> Kuhn analyzed periods of great changes in scientific understanding—scientific revolutions. Such revolutions occur when an existing central theory in one of the sciences—a paradigm—is threatened by an accumulation of unexplainable observations, and a new model or paradigm is available that accounts better for these discrepancies, as the theory of relativity accounted for certain solar and planetary phenomena not explained by Newtonian physics. Surely as family physicians we must agree with McWhinney that existing theory in the biomedical, behavioral, and social sciences fails to account for much of what is seen in clinical practice. But can a new paradigm rescue us from this predicament and launch us toward academic respectability? Or would such a model become "elaborate clothing" hindering our real work?

The paradigm that McWhinney and Engel seek is a tool to understand and solve problems. Kuhn's scientific paradigm is much more. Rather than simply serving as a tool of a scientific discipline, the paradigm in many ways defines, even becomes, the discipline. Perhaps the observation of a falling apple contributed to Newton's hypothesis that an object falling to earth accelerates at a constant rate. Having formulated this theory, Newton, as a physicist, lost all interest in apples as such. Fruit became just another class of objects to which the laws of mechanics applied. The paradigm or model—not the object of study—defines the scientific discipline. Theory further determines what

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questions seem sensible to ask, what observations should be made, and what instruments should be used to make these observations. Along this line Einstein commented, "The theory determines what can be observed." As a field of scientific endeavor develops, its paradigm combines with social and cultural forces to determine the language and forms of communication of that discipline. Once the paradigm is articulated, its development and application proceed quite apart from the particular characteristics of any particular object of study.

Academic approaches to the study of the ubiquitous clinical phenomenon of depression serve as examples of this process. Biomedical science views depression as a manifestation of faulty neurotransmission. Analytic psychology sees it as unresolved grief. Other schools of psychology invoke concepts such as "learned helplessness" to explain depression. Sociologists examine role conflicts and demography in their studies. For each discipline depression is different, a phenomenon constructed by its own theory. Dopamine has no more significance to the sociologist than do early childhood memories to the neurophysiologist. An extreme position on these differences was expressed by Émile Durkheim, a founding father of modern sociology and a student of suicide. He wrote in his *Rules of Sociological Method*,<sup>5</sup> "Every time a social phenomenon is directly explained by a psychological phenomenon, we may be sure that the explanation is false."

Each model, of necessity, simplifies a complex human phenomenon to fit the rules of the particular study method chosen. While these methods are essential for the researcher, they may prove wholly inadequate or even misleading for the everyday practice of medicine. None of these scientists studying depression has any immediate or particular interest in the 44-year-old man contemplating suicide in your waiting room. As scientists, their primary orientation and allegiance is to the concepts and methods of their disciplines, not to any person with the problem.

## THEORY AND PRACTICE: TWICE REMOVED

No scientific field is free of tensions between theory and practice. While scientific theories provide explanations for a wide variety of phenomena, many objects of study, in both laboratory and clinical settings, fail to be fully captured by existing theory. While the tension created by this fact exists in the basic physical and biological sciences, it is even more evident in clinically related fields such as psychology and social work.

The theory-practice split in family practice is, in fact, a double split. Lacking a central theory or paradigm of his own, the family physician, to produce acceptable scholarship, must embrace the theory of another discipline. An example would be the use of sociological theories to

guide a study of social concomitants of an illness in a family practice setting. Both the researcher and the audience for the research report will necessarily be somewhat naive as to the place of the methods chosen in contemporary sociology. Even more important, such studies often leave unexamined the question of applicability of such methodology to the patient in a family practice setting.

## A TOLERANCE FOR AMBIGUITY

Theory-practice tensions are everywhere evident in family practice. Innumerable articles promulgate a variety of screening questionnaires for mental illness, especially depression, in primary care, while such a sagacious observer as Fry<sup>6</sup> comments, "The use of special questionnaires and inventories . . . has no real practical place in normal practice." Psychiatric training in family practice places heavy emphasis on proper diagnosis and treatment by *Diagnostic and Statistical Manual*, ed 3, criteria, while Michael Balint<sup>7</sup> ascribes the successful treatment of the most difficult psychological problems of family practice patients to ". . . the doctor's way of dealing with patient, or, in other words, his personality." Quantitative-minded researchers portray "The Content of Family Practice" as a list of medical diagnoses,<sup>8</sup> while Metcalfe<sup>9</sup> provides us with the metaphor of the crucible to describe the work of the family physician in the patient encounter.

Just as we must learn to tolerate ambiguity in the practice of medicine, we must learn to tolerate it in our self-image and that of our discipline. While no academic theory can capture adequately what we do in practice, neither can simple descriptions or observations of what we do become the standards for good practice or good education. This sort of acceptance of the status quo would doom us to stagnation and continuation of the many misconceptions under which we currently labor.

Theory, or more properly theories, must be examined in the context of practice and vice versa. The practice of medicine must be thoughtfully and closely examined from a variety of perspectives. Balint,<sup>7</sup> Berger and Mohr,<sup>10</sup> and Fry<sup>6,11</sup> have provided some such perspectives: Quantitative research, which is necessarily reductionistic in nature, will continue to allay our ignorance in many aspects of practice. The translation of research findings into prescriptions for practice and for education, now done so glibly in the "discussion" sections of our research reports, must be tempered by a thoughtful and holistic review of our clinical experience with the problem being studied and, more important, of our experience in caring for patients who have that problem.

No theory from any scientific field will replace the experience of the practice of family medicine, nor should any theory be allowed to displace the patient as the center

of our study and practice. Each theory should be evaluated and valued according the extent that it can offer a useful critical system to help us to examine aspects of what we do. Conversely, thoughtful attention to and reflection on both our own personal practice experience and that described by others in literature should serve as a critical system by which we can evaluate the knowledge and techniques generated by more constrained and focused research.

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