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The James Mackenzie Lecture 2013

The Tao of Family Medicine 家庭醫學之「道」

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Introduction

The provision of high-quality healthcare in the 21st century faces a large number of challenges. General Practice, in particular, faces the challenges of an increase in the prevalence of long term conditions and multimorbidity coupled with increasing demand and the need for improved collaborative partnerships with our patients. If we are to address these challenges, then I believe we need a fundamental change in our definitions of health and healthcare, the way we 'do' General Practice and a transformation in our partnerships with our patients.

Classically, medical anthropologists distinguish between *disease* and *illness*. *Disease* is defined as a disorder of biological and/or psychological processes which is diagnosed by doctors. However, patients have *illnesses* ie they bring to the consultation their psychosocial experience and their own interpretation of their symptoms. As a result, when doctors meet patients in consultations, there is often a mismatch between the *explanatory* models of the practitioner and patient used to explain the *meaning* of the patients' experience. The difficulty for patients is that the power of the doctors' explanatory model is much greater than that of the patients. Consequently, it is very difficult for the patient to challenge the doctors' interpretation of their symptoms and this can make it very difficult for both parties to develop an effective, collaborative partnership.

One example of this mismatch between the explanatory models of patients and doctors can be seen in the case of "*heartsink patients*" (O'Dowd, 1988). The original definition of heartsink patients were "*those patients who evoke an overwhelming mixture of exasperation, defeat and sometimes plain dislike that causes the heart to sink when they consult.....*".

The problem here by definition is firmly located in the realm of the patient rather than the doctor and his or her explanatory models for the patient's symptoms. However, subsequent work (eg Mathers et al, 1995a, 1995b) showed that doctors were more likely to label patients as "heartsink" if they reported: a greater perceived workload, a lower job satisfaction, little training in counselling/communication skills and fewer postgraduate qualifications.

A series of interviews with "heartsink patients" revealed little in common apart from frequent attendance and complex problems. In addition, this group of patients did not perceive themselves to be any different from any other General Practice patient. So called "heartsink patients", therefore, are a *social construct* of the doctor whose explanatory model for their presentation is used to create a description of a dysfunctional clinical relationship.

“Clinical Reality”

The creation of “heartsink patients” by the doctor as the “clinical reality” of the doctor-patient relationship, encompasses all the “beliefs, expectations, norms, behaviours, communications associated with doctor and patient relationships, therapeutic activities and health outcomes evaluation.....” (Kleinman, 1980). However, the clinical reality of the consultation is not just *socially constructed* by the different explanatory models of doctor and patient, but it is also *culturally determined*.

For example, a number of studies on postnatal depression and somatisation from Taiwan and Malaysia of the impact of culture on the definition and perceived prevalence of disease have shown that they are created through a *culturally constructed* explanatory model (eg Huang and Mathers, 2001; Khoo and Mathers 2012). My contention in this lecture is that as GPs we need to be aware not only of the limitations of our own explanatory models but also appreciate the difficulty which our patients may have in challenging these models.

Challenges for General Practice in the 21st century

- *An increase in long term conditions (LTCs) and multimorbidity*

An LTC is generally defined as any medical condition that cannot currently be cured but can be managed with the use of medication and/or other therapies. More than 15 million people in England have LTCs - accounting for some 30% of the population and 70% of NHS spend (DH, 2011).

People with LTCs account for some 70% of all GP appointments.

In addition, the older we become, the more LTCs we are at risk of developing and this challenge for us can only increase as more of the population gets older. However, the current provision of healthcare remains rooted in the 1940s. Indeed, the underlying assumption of a great deal of health policy development is still based on the 1948 World Health Organisation (WHO) definition of health; ie ‘health is a state of *complete* physical, mental and social wellbeing and not merely the absence of disease or infirmity’ (WHO, 1948).

The problem with this definition is that it is impossible to know whether we are in a state of *complete* physical, mental and social wellbeing and this can be used to justify the “wholesale lead to the *medicalisation*” of society (eg the *whole* population should be on statins). In addition, it takes no account of the increasing prevalence of LTCs and the growth in multimorbidity in all parts of the world.

- *A new definition of health*

I believe that what we need now is a *new* definition of health – one that includes the ability to “*adapt and self-manage*” (Huber et al, 2011). Such a definition can provide us with a framework which focuses on the empowerment of our patients and helps improve doctor and patient communication within the current biopsychosocial model for general practice. It also provides for a more refined definition of *physical* health as the maintenance of allostasis, for *mental* health as providing a sense of coherence and a capacity for coping and for *social* health which involves the development of

successful strategies for adaptation.

- *Increasing demand*

There has been a huge rise in the number and length of our consultations in recent years; eg between 1995 and 2008, there was a 75% increase (from 171 to >300 million consultations per year). The average number of consultations/person/year also increased from 3.9 to 5.5 and, in addition, the length of our consultations has increased from a mean of 8.4 minutes to 11.7 minutes (RCGP, 2013).

Coupled with this increase in the number and length of our consultations there has been a rise in the complexity of the problems which our patients present to us. Indeed, it is my view that we are now working in the community dealing with a similar level of complexity as the general hospital physicians did a decade ago in secondary care.

One way of responding to this increase in demand has been the RCGP's campaign for more resources for General Practice. The campaign points out that we, as GPs, are now responsible for some 90% of patient contacts in the NHS and we do this on less than 9% of the overall health budget (RCGP, 2013) – in fact, the real share of NHS resources going into General Practice in the past three years has been significantly cut and our “Put Patients First” campaign aims to rebalance the spend between primary and secondary care. (<http://www.rcgp.org.uk/campaign-home.aspx>)

There is no doubt in my mind, that with more resources and an appropriate level of funding we would be able to not only increase the number of GPs, but we would also have more time to spend with our patients to address the increasingly complex problems presented. In addition, more money for General Practice would also help us to innovate and improve the quality of service delivered to our patients.

The problem is, however, that if we were to succeed in winning a fair share of resources for General Practice and we continue to try and deliver care in our “usual way” (ie more of the same), then in the words of neuro-linguistic programming: “*if we always do what we've always done, we'll always get what we've always got*”. Couple this with increasing demand and we have a recipe for an ever increasing strain on the system, our patients and on ourselves.

Our patients want better partnerships

The evidence is unequivocal that our patients want improved collaborative partnerships with us. Indeed, for the last decade, the findings from NHS patient surveys have been consistent: between 46 and 49% of our patients want more involvement in treatment decisions. In 2010, this translated as 1 in 3 patients in General Practice and 1 in 2 patients in hospital. (DH, 2011). There has, in recent years, been a number of responses to this by developing new approaches to improve our partnerships with our patients. These include such initiatives as care planning (eg Mathers et al, 2011), support for self-management (eg Newbronner et al, 2012) and shared decision making initiatives (eg Salzburg Statement, 2011).

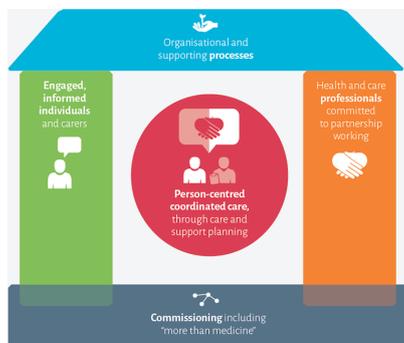
Figure 1 shows the “*House of Care*” (Coulter et al, 2013) approach to care and support planning originally pioneered by Diabetes UK and the RCGP as a way of improving the

quality of care for people with diabetes by developing improved collaborative partnerships and resulting in improved health outcomes (eg Mathers et al, 2011). The evidence is that ‘building’ the ‘House of Care’ in General Practice can achieve both of these objectives.

Care Planning (CP)

At the heart of the ‘House of Care’ is the collaborative care and support planning consultation. The consultation cannot be viewed in isolation since the process of care planning requires all four components of the House to be in place for it to be successful: ie practitioners need to be committed to partnership working and have the necessary skills to do this and people with long-term conditions need to be both engaged and informed in the process.

Figure 1: The ‘House of Care’
(<http://coalitionforcollaborativecare.org.uk/>)



Underpinning the House of Care are the essential organisational arrangements to ensure, for example, that in Practices, people receive the results of their investigations in a timely fashion to inform their next care planning consultation. Commissioning (the ‘base’) is also necessary to ensure that appropriate resources are available to support the whole process of care and support planning.

Support for Self Management (SSM)

The Health Foundation, amongst others, has pioneered “*support for self-management*” (The Health Foundation, 2012). It has drawn attention to the fact that during the course of a year, a person with a long term condition spends relatively little time with a health professional - day to day management *is* self-management, ie of the 8760 hours in one year, only 2-3 hours would normally be spent by a person with an LTC being seen by a health professional.

Figure 2: Levels of Patient Activation*



Hibbard et al, 2007

In addition, most people with an LTC in the UK are at relatively low-levels of “*patient activation*” (Hibbard, Mahoney et al, 2007) (Figure 2). At level 1 activation, for example, individuals do not feel confident enough to play an active role in their own health and they are predisposed to be passive recipients of their care. If we are to support our patients to ‘adapt and self-manage’, then one of our objectives to improve our doctor-patient partnerships must, therefore, be to increase levels of patient activation - whereby people are able to develop sufficient knowledge and confidence to take action and maintain their own health and health behaviours.

Shared Decision Making (SDM)

A third approach to improving patient partnerships is through *shared decision making*. This is a process by which clinicians and patients work together to select tests, treatments, management or support packages based on clinical evidence of the patient’s informed preferences (Coulter and Collins, 2011). It involves the “provision of evidence-based information about options, outcomes and uncertainties together with decision support counselling and a system for recording and implementing patients’ informed preferences”.

There is a good evidence base for the effectiveness of shared decision making. Indeed, it has been seen in some quarters as being the “holy grail” of patient partnership and a very large number of benefits have been reported such as better consultations, clearer risk communication, more ‘appropriate’ decisions and fewer unwanted treatments (Salzberg Statement, 2011). In addition, improved confidence and self-efficacy, safer care, reduced costs and better health outcomes have also been claimed as the benefits of SDM. The question arises, however, if we have such a good evidence-base for an effective health intervention, why is it not ‘embedded’ in routine clinical practice?

A recent cluster randomised controlled trial of SDM in General Practice demonstrated that people with diabetes were able to make their own decisions about when to start treatment with insulin with support from their clinician and a personalised decision aid (the intervention group). At the start of this trial, concern was expressed in some quarters that “allowing” patients to make their own decisions about whether or not to start on insulin might cause them some harm if they had poor diabetic control. However, this was shown not to be the case and there was no evidence of worsening diabetic control in the intervention group. In addition, no increase in the length of consultation was seen and there was a >20% difference between the control and intervention groups in the proportion of people making *autonomous* decisions about their treatment (43% vs 64%, $p=0.012$) (Mathers et al, 2012).

The story so far....

There are good evidence bases for the clinical effectiveness of care planning, support for self-management and shared decision making, although it is important to distinguish between these three interventions as there remains some confusion about their precise definition. One of the easiest ways to distinguish between these is to identify the practitioner skills necessary to engage in each of the different processes. There is a generic skills base for all three activities, ie those of communication and

empathic consultation skills. However, the specific skills required for care planning include those for agenda and goal setting as well as action planning. Similarly, the skills required by practitioners for supporting self-management include health coaching and the facilitation of behaviour change, whilst for shared decision making deliberative and negotiating skills are key components for successful outcomes.

One of the key work streams of the recently created ‘Coalition for Collaborative Care’ (which now comprises 65 organisations) is to develop these primary care practitioner knowledge skills and attitudes (<http://coalitionforcollaborativecare.org.uk/>). One of the overall aims of this new Coalition is to support communities of practice to build their own House of Care and to embed it into usual NHS general practice by ‘whole system’ change. The “Year of Care” training programme has clearly demonstrated that it is relatively easy for both nurses and doctors to acquire the essential knowledge and skills to support the introduction of Care Planning into their clinical practice but the key issue remains one of *attitude* – the most difficult thing to change.

Attitudinal Change

Sue Roberts, a leader of the Year of Care Programme (personal communication, 2013) has recently summarised the key areas of challenge in practitioner *attitude* which need to be addressed if care planning is to be embedded in usual NHS practice. These are illustrated by the following common quotes from General Practitioners undertaking the “Year of Care” training:

- “Where is the evidence?”
- “We are already doing it.”
- “I haven’t got time for all this.”

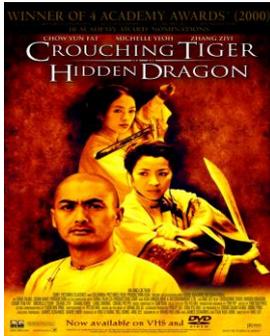
In response to these concerns, I offer you the following:

- There is a *wealth of evidence* from the past 20 years which supports the improved health outcomes associated with initiatives such as care planning, support for self-management and shared decision making, starting with Wagner’s Chronic Care Model and more recently with the ‘House of Care’ Coalition.
- As far as “*we are already doing it*” is concerned, it is clear that although we, as GPs, may think this, our patients do not agree. The results from patient surveys have been consistent for the past 10 years – people with LTCs in General Practice want more collaborative partnerships with us.
- The challenge that “*we do not have time to do this*” is not sustainable – the point is that we cannot afford *not* to do this because more and more people with LTCs and multimorbidity are going to consult us and if we don’t increase the engagement of our patients in their own care, our current clinical practice is unsustainable.

In summary, I believe that *attitudinal* change by practitioners is essential if we are to improve our patient partnerships and health outcomes.

How can the Tao of Family Medicine help us to address the challenges?

The Tao of Family Medicine 家庭醫學之「道」



The film '*Crouching Tiger, Hidden Dragon*' (臥虎藏龍) (Director Ang Lee, 2001), is a deeply Taoist film which can be understood on at least three levels. On one level, it is a Romeo and Juliet story (but with martial arts!) which recalls two famous Chinese lovers (Liang Shanbo and Zhu Yingtai, the classical “butterfly lovers”) in an exciting story about the recovery of a lost sword. The fight between the two main female protagonists is often voted as one of the top ten cinematic fights of all time.

On another level, however, it compares and contrasts two sets of lovers – the first is a young passionate couple (Jen (dragon) and Lo (tiger)) and the second is an older couple (Shu Lien and Li Mu Bai) who have loved one another deeply for many years, but because of the call of duty have been unable to either express or consummate their love. The sword which both couples wish to recover is called *Green Destiny*. This represents the Taoist idea of Mercury Green – the ultimate source of being.

On yet another deeper level, the title of the film [‘Wohu Canglong’ in Pinyin transliteration of the Chinese characters] is a colloquial Chinese expression which describes the emotional undercurrents of polite society – the hidden desires and passions of our unconscious minds that we all possess below our “civilised exteriors” (Whitney-Crothers, 2007).

What is the Tao?

The Tao Te Ching, or Tao virtue book, has two parts and 81 short sections, and is traditionally attributed to Lao Tse (“the Old Master”). Lao Tse is believed to be a contemporary of Confucius and wrote the Tao Te Ching sometime between 500 and 300 BCE. Many scholars both in China and elsewhere, however, now regard Lao Tse as a purely legendary figure.

Tao concepts underlie the Tao Te Ching – the first, ‘Tao’, is literally a way or a pass but in Taoist writings it has a far more comprehensive meaning referring to a metaphysical first principle which embraces or underlies all being – ultimately, it lies beyond the power of language to describe. However, although the Tao may be unknowable, it teaches us, as human beings, we must learn to sense its presence and movement in order to bring our own lives and our own movements into harmony with it. Some have described this as bringing ourselves into alignment with the “laws of heaven” (Addis and Lombardo, 1993).

The second concept, the ‘Te’, denotes the moral power or virtue which a person acquires if they follow the Tao, ie ‘Te’ is the virtue we can get from following the Tao.

There are already more than 100 translations of the Tao Te Ching into English but most of these are interpretations about what Lao Tse meant rather than what he said. In the same way, this lecture will examine some of the principles of Taoism and interpret what they might mean for the consultation between GPs and people with long term conditions and professional artistry.

These are the four principles of ‘do without doing’, ‘go with the flow’, ‘effortless being’ and Tz’u (compassion) [Figure 3].

The Tao of the Consultation

“Do without doing” 無為而治

Just imagine you’re trying to catch a cricket ball. Unlike a computer you don’t need to know the wind speed, the weight of the ball, the speed of the ball etc in order to catch it. You catch it without thinking about it and the secret of a successful catch is your ability to estimate the angle of the ball to the ground.

Figure 3: Taoist Principles:

無為而治..... ‘Do without doing’
順流而下..... ‘Go with the flow’
毫不費力..... ‘Effortless being’
慈..... Tz’u - ‘the first treasure’

*The Tao is a way of being – a way
of being - NOT a way of doing*

[*Lao-Tse ~400 BCE]

This is called the ‘gaze heuristic’ (‘rule of thumb’) and all of us use “different rules of thumb” every day for different purposes, effortlessly and automatically.

This process has been described as the use of our “unconscious intelligence” or more simply, “winning without thinking” (Gigerenzer, 2007). It is not uncommon, for example, for many of us to arrive at work with no conscious memory of the journey.

Driving to work is a highly complex and challenging task and yet, unless something untoward happens, we are able to drive both safely and effectively without necessarily engaging our conscious mind.

A parallel process in the General Practice consultation is the use of our “clinical intuition”.

Clinical Intuition

Clinical intuitions, by definition, appear quickly in our consciousness and we are not fully aware of the underlying reasons for them. However, they are generally strong enough to act on. One example of the use of clinical intuition in the consultation is a recent study examining the significance of “gut feelings” about serious infection in children (Van Den Briel et al, 2012). This observational study of a consecutive series of 3890 children and young people aged 0-16 presenting to primary care investigated the basis and the added value of clinicians’ “gut feeling” that infections in children are more serious than suggested by usual clinical assessment.

Of the 3369 children assessed clinically as having a non-severe illness, 6 were subsequently admitted to hospital with a serious infection. A clinical intuition by the GP that something was wrong (despite the clinical assessment of non-severe illness) substantially increased the risk of serious illness (likelihood ratio 25.5). Acting on this ‘gut feeling’ had the potential to prevent 2 of the 6 cases being missed at a cost of 44 false alarms. Small numbers, but very important if it is *your* child who is ill.

Can we trust our clinical intuition?

There are many studies which suggest not – indeed, in 60% of reported studies, statistical algorithms are claimed to be more accurate than clinical judgment. However, these studies have, in the main, been concerned with single point biomedical decisions, be it the review of x-rays and ECGs or the clinical assessment of the acutely ill patient. Few studies have been conducted in the “messy chaos” (the “swampy lowlands”) of frontline General Practice where the problems presented are undifferentiated, complex, rarely solely biomedical in nature and rooted in the social context of the person ie problems of a ‘holistic’ or biopsychosocial nature.

The concept of ‘*associative memory*’ has been used to explain clinical intuition by Simon, (2002), who describes it as the “*recognition primed decision model*”; ie associative memory produces a tentative plan, the plan is then mentally assimilated and intuition is explained as the recognition of a pattern. However, for our associative memories to become both valid and reliable, it is important that they are continually refreshed through working in a regular environment with prolonged practice and feedback. The Teaching General Practice provides us with excellent opportunities for the development of associative memory and thereby our clinical intuition.

Cognitive Errors

Only 4% of incorrect diagnoses have been attributed to inadequate medical knowledge (Groopman, 2008). Most of the mistakes we make regarding diagnosis are due to cognitive (thinking) errors.

The first of these is ‘*anchoring*’. This is when we give a very high predictive value for an initial symptom and follow our own internal algorithms towards diagnosis. An example of this could be the person who presents with “tired all the time” - which for most of us is “depression and/or anxiety until proved otherwise but don’t forget anaemia or hypothyroidism!”.

The ‘*attribution*’ heuristic is when we “stereotype” an individual patient with a label such as “heartsink”. Heartsink patients, of course, get serious illnesses too!

Our third most common cognitive error in diagnosis is the ‘*availability*’ heuristic. This means that because we have seen other patients with similar symptoms who did not develop any serious problems, then we assume that this is also probably the case with the person sitting in front of us in this individual consultation.

So how can we reduce or avoid our common cognitive errors in diagnosis?

Not surprisingly, improving our patient partnerships can help us to avoid such cognitive errors. For example, Groopman (ibid) recommends that we invite our patients to ask us the following questions when we are discussing a diagnosis with them:

- What else could it be?
- Could two things be going on to explain my problem?
- Is there anything in my history, examination or lab results which does not fit with my diagnosis?

The Tao teaches us that an attitude of ‘*do without doing*’ – one which uses our unconscious intelligence (ie our clinical intuition) in conjunction with our patients’ partnerships - can help us to use our clinical intuitions more effectively and avoid thinking errors in the consultation.

“Go with the flow” 順流而下



You know how it is – you’re sitting in the waiting room waiting to see the doctor or a nurse mentally rehearsing what you want to say to them and putting your symptoms in some sort of order with a possible explanation. However, once you are in the consulting room and you are starting to explain your reason for consulting, the doctor or nurse usually interrupts you before you’ve finished! Most of us will have had this experience at some point. The problem is, that is it hard to take in what the doctor or nurse is saying to you if you haven’t finished what you had been planning to say. Having a different explanatory model from the doctor for the meaning of our symptoms certainly doesn’t help! Unfortunately, on average, the first interruption by a doctor is between 18-20 seconds after the start of the consultation (Langewitz et al, 2002) and the problem appears to be getting worse.

The Tao teaches us to “*go with the flow*” of the interaction between ourselves and the person sitting in front of us. We teach our registrars to “elicit the patients’ ideas, concerns and expectations” in the vain hope that this will somehow translate into “*patient-centredness*”. However, this reduces the consultation to a series of tasks – a series of things that we *do* rather than a process in which we engage.

Learning consultation skills – from unconscious incompetence to unconscious competence.

Those of us who teach our registrars or undergraduate medical students will recognise the paradox of starting to teach consultation skills to learners who are naturally good at communicating with others – their performance deteriorates initially as they become increasingly self-conscious in their dealing with others. They move from a position of unconscious competence to one of conscious incompetence before finally returning to their original state of unconscious competence, hopefully improved! This is not the case, of course, for those with poor consultation skills at the beginning of their training – these learners move from a position of unconscious incompetence through conscious incompetence before (hopefully) also finally reaching the happy position of unconscious competence (with apologies to Donald Rumsfeld!) in consultation. Once they have acquired these skills, then they are able to demonstrate ‘*fluency*’ in their consultations (Tim Ballard, personal communication, 2013). They have moved from task-based consultations to one of paying attention to the process ie from ‘doing’ to ‘being’.

In essence, such fluency or patient-centredness is a way of “*being not doing*” (Neighbour, 2005). If we are, therefore, to “*go with the flow*”, then it is important for us not to interrupt people in the early stages of a consultation. If we are to be more patient-centred and follow the patients’ agenda, we also need to develop our ability to be quiet and fully engaged listeners so that we can hear the patient’s story clearly.

‘Effortless being’ 毫不費力



The Tao teaches us *to be* rather than simply *to do* but this is not the same as being *passive*. The idea is similar to the practice of ‘*mindfulness*’ a form of which is in the current NICE guidelines recommended for those with a history of three or more episodes of depression. There is a good modern evidence base for its effectiveness, although, the practice itself is thousands of years old. It is often spoken of as “the heart of Buddhist meditation”, but its essence, which focuses on *attention* and *awareness* is universal (Williams and Penman, 2011).

The practice of *mindfulness* teaches us that thoughts and feelings are transient – that they come and they go and ultimately one has a choice of whether to act on them or not. It, too, distinguishes between ‘*doing*’ and ‘*being*’. When we are in our ‘*doing*’ mode, we’re very good at solving problems and making sure that things get done. It is a very powerful way of thinking that breaks down a particular problem into its components, each of which is then dealt with in turn. It has proved to be a very powerful and effective tool in modern medicine.

However, ‘*doing*’ becomes a problem when it is used inappropriately for a task such as addressing a troubling emotion either in ourselves or in our patients. In this situation, it is necessary to shift from ‘*doing*’ into ‘*being*’ mode and this is what *mindfulness* provides – the ability to change gear and help us to distinguish between what is important and what is not. In brief, it is about developing an awareness that transcends thinking. In the words of the great Roger Neighbour, it is to be able to “*pay the right kind of attention to the here and now (so that) the rest will follow*” (Neighbour, 2005).

Anxiety and the Consultation

Recent work has examined the concept of *anxiety* as a driver of the consultation (Fischer and Erraut, 2012). This study identified three main sources of anxiety which both doctors and patients can experience during the course of a consultation. These may broadly be classified into anxieties which are *interactive*, *existential* or *concerned with entitlement*. People with LTCs can be worried about whether they will be heard by the doctor (interactive), whether or not they have a serious diagnosis (existential) or the risk of humiliation by being shown up as either ignorant or troubling the doctor unnecessarily (entitlement).

In parallel to this, our main anxieties as GPs tend to focus on whether a person could become “insatiable” and whether or not they follow any agreed management plan (interactive), the risk that we will get the diagnosis wrong (existential) and whether or not we are practicing good evidence-based medicine (entitlement). Being aware of these often unconscious anxieties can help us address them and use them to build better partnerships with our patients. *Mindfulness* can help us do this.

The adaptive unconscious

‘Starship Enterprise’: “To boldly go....”



Freud was right. We all have an unconscious mind - although our understanding of its function has been completely transformed in the past few decades by the findings of modern experimental psychology and advances in neuroscience. Our consciousness has been likened to a small snowball on the top of a very large iceberg of brain activity – indeed, we cannot know ourselves except through our observations of the

behaviour of others. We are, literally, “strangers to ourselves” (Wilson, 2002). Since we know, or can know so little about ourselves, we need to develop an attitude of *epistemological modesty* towards our lives and those of our patients (Brooks, 2011). Epistemology is the study of how we know what we know. Since most of what we think or believe is unavailable to conscious review and not knowing ourselves, we also have trouble fully understanding others.

Such an attitude of modesty and uncertainty does not produce passivity – this attitude is not only an important early part of the diagnostic process but also a strong motivator for action since diagnosis begins with an awareness of our own and our patient’s ignorance of the cause of their symptoms. There is no one method for solving problems, and although it is important not to ignore the quantitative and rational analysis of a problem (the ‘doing’ mode), this will provide only one part of the ‘truth’ of a situation rather than the whole picture. As GPs, we need to continually remind ourselves of the biopsychosocial aspects of the symptoms which our patients present. We need to ‘relax and be’ and trust the consultation process.

In other words, clinical intuition comes from integrating and synthesising diverse sources of information through the workings of our own associative memories. As the famous Japanese proverb says “*don’t study something, get used to it*”. When we are confronted with a new problem or a new patient, we need to hold on to those uncertainties around diagnosis until a diagnostic solution presents itself – diagnosis cannot be forced.

The point at which there is a moment of calm and disparate observations became integrated into a coherent whole has been described by Roger Neighbour as *Kairos* (ibid) - that point when we are no longer uncertain about a diagnosis.

Such a description of the way that our unconscious and conscious minds work together as clinical intuition may be referred to as the integrated workings of System 1 (the unconscious or ‘hot’ cognition) and System 2 (conscious thinking or ‘cold’ cognition) (eg Kahneman D, 2012).

System 1 (the ‘*characteristic self*’) generates impressions, feelings and inclinations which, when endorsed by System 2, these become beliefs, attitudes and intentions. It operates automatically and quickly with little or no effort and no sense of voluntary control.

System 2 is ‘*who we think we are*’. This system articulates judgements and makes choices but it often endorses and rationalises ideas and feelings that were generated by System 1.

System I is the origin of much that we do wrong, but it is also the origin of what we do right – which of course is most of what we do! Our associative memories are able to “*distinguish the surprising from normal events in a fraction of a second, immediately generate an idea of what is expected instead of a surprise and automatically searches for a cause or an interpretation of the surprises and events as they take place*” [Kahneman, 2012].

Achieving a balance in thinking between our two systems of cognition will enable us to be better doctors – able to strike the right balance between doing and being – the right balance which enables us to use our clinical intuition effectively. The writers of ‘Star Trek’ recognised this many years ago.....



The Optimal Experience

Those of us who have run marathons or, indeed, engaged in any sport which requires considerable effort for long periods of time will probably recognise the experience of being “*in the zone*”. When marathon running, for example, once you have “hit the wall” at around 22 or 23 miles, running often becomes “*effortless*”. Such a feeling of being able to run “forever”, has been described as “the optimal experience” (Csikszentmihalyi M, 1990) or getting “*into the zone*” whereby one can make considerable effort for long periods of time without exerting willpower. The people who experience such *flow* describe it as a “*state of effortless concentration so deep that they lose their sense of time, of themselves and of their problems*”.

In summary, this experience of *flow* is perhaps what the ancient Chinese wisdom of the Tao describes as “do without doing”, “going with the flow” and “effortless attending”. We do not need to invoke the laws of heaven to account for it – it describes our experience when the two systems in our minds, identified by modern neuroscience and psychology, function optimally during the consultation.

Tz’u (慈) The First Treasure (Compassion)

The importance of Te

Lao Tz’u describes compassion in the ancient Tao as the ‘*first treasure*’ because from compassion comes wisdom, and wisdom should be one of our main goals in life.

The Te of the Tao Te Ching represents the virtues such as compassion which we can acquire through following the Tao. The acquisition of such virtues enables us to become sincere and spontaneous in our dealings with others – necessary preconditions for developing *trust* in the doctor-patient relationship. Those of us who have received Rogerian counselling training will recognise the importance of this. This teaches us that for any sort of counselling to be

effective, we need to acquire the attributes of authenticity, congruence and unconditional positive regard.

Our RCGP motto “Cum Scientia Caritas” (with science and compassion) recognises that compassion is just as important as science in the delivery of our care. Compassion, kindness and “open-heartedness” are essential for the high quality care of our patients. However, we don’t always recognise that such an attitude of “open-heartedness” is also essential for our *own* emotional and mental health as well as that of our patients (Phillips and Taylor, 2009).

For us to exercise our compassion, our Tz’u, we need to be truly patient-centred, with the patient at the centre of our concerns and consultations. It is difficult to do this when we have a variety of other concerns during the consultation. It is a considerable challenge to be compassionate, for example, when we have one eye on the computer, one eye on the clock and one eye on the patient. Indeed, some recent work by Carolyn Chew-Graham and colleagues (2013) which examined the contrasting experience of practitioners with those of patients during QoF review consultations, showed that patients often left such consultations having not only played a passive role but also with continuing unmet needs. By contrast, the practitioner’s view of the same consultations were that they were purely functional and primarily concerned with surveillance rather than problem solving. This focus on the use of patient templates, although helpful in improving some aspects of the quality of biomedical care, may actually make compassion more difficult and cognitive errors more likely.

The Tao of the consultation – professional artistry

What then can the Tao teach us about family medicine and in particular consultations with people who have long term conditions in the 21st Century?

What does *professional artistry*, which develops patient partnerships and delivers high quality medical care, look like? (Figure 4).

Figure 4: The Tao of the consultation – professional artistry



How can we acquire professional artistry?

Lao Tse teaches us to stop “trying so hard” and ‘let go’ of our self-conscious thinking (System 2). The result of this is that we should be able to relate better to our ‘hot’ cognition (System 1) in order to align ourselves with our ‘true inner nature’. A balanced relationship between our System 1 and System 2 thinking will help us achieve that state of wisdom which the Chinese call the ‘Tao’ and the Greeks ‘Metis’

(Brooks, 2011). And from that wisdom comes compassion (T’zu).

In contrast to Lao Tse, the Confucian Analects emphasise the importance of training in acquiring Te (virtue) and the paradox is that to become followers of the Tao and to develop our professional artistry, we need to do the necessary training (ie develop our cold cognition) so that we can “*let go*” (ie allow the expression of our hot cognition) – this is the eternal paradox of the Tao – we need to do so we can do without doing.

In essence then, “*do without doing*” means we should develop and trust our clinical intuition as well as use our patient partnerships to reduce our cognitive errors. “*Going with the flow*”

implies that we shouldn't interrupt, we should listen quietly and follow our patients agenda to develop our partnership in terms of care planning, support for self-management and shared decision making. "*Effortless being*" teaches us to relax, to develop our own mindfulness, express our natural compassion but always remain modest about what we know. In summary, the Tao teaches us to try and get into that zone of "*effortless attending*".

Mackenzie, 2013

So, what might Sir James MacKenzie make of all this? He was probably unaware of the wisdom of the Tao and yet he was remarkably prescient in so many ways. He recognised and described clinical intuition as a 'sixth sense' of clinical practice:

"The mysterious power possessed by Dr Briggs of knowing what was going to happen to his patients was neither more nor less than accumulated experience. Each time he looked at a new case he saw, in reality, hundreds of old cases and remembered how they had fared".
(quoted in Wilson, 1926)

Plus ca change.....?

A Cultural Revolution

Chairman Mao launched his Cultural Revolution in 1966. He called for the smashing of the "four olds": old customs, old culture, old habits and old ideas.



Chairman Mao's Four Olds:

Smash the:

Old Customs

Old Culture

Old Habits

Old Ideas

I believe that it is now time for our own Cultural Revolution – a revolution in which we "**let go**" of our own four 'olds':

Our 'old' definitions of health

Our 'old' doctor-centred care

The 'old' way we 'do' general practice

Our 'old' QoF driven consultations

If we are to achieve fundamental change in the way we deliver health care in General Practice and transform our patient partnerships, not only do we need to address our knowledge and skills gap but we also need to transform our own attitudes towards our patients. The beauty of the Tao is that it speaks to us in the universal language of humanity. The axioms are capable of multiple interpretations and application in many different cultures. They are timeless and can provide us with great insights into the professional artistry required to care for people with long-term conditions. People with long-term conditions should expect their GPs to be

thinking and feeling doctors who use their intuition and compassion, based on good medical knowledge, critical reasoning and consultation skills.

The Tao teaches us a way to do this.

In the words of Chuang-Tse:

“the mind of wu-wei (do without doing): flows like water, reflects like a mirror and responds like an echo”.

Not such a bad way to start a consultation.....

Or more closer to home in the words of the old nursery rhyme which my mother taught me before I started school:

“A wise old owl sat in a oak, the more he saw the less he spoke, the less he spoke the more he heard, why can’t we be like that wise old bird?”

Nigel Mathers

November 15th 2013

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