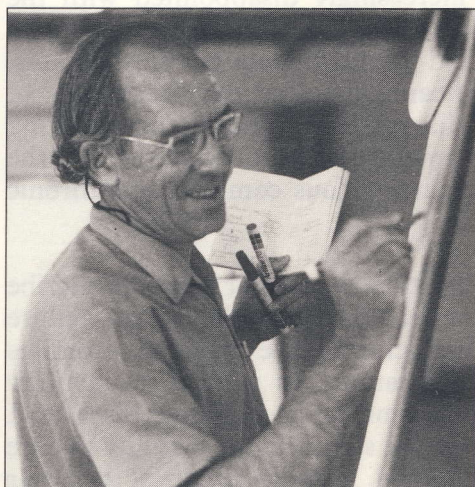


Patient dissatisfaction and the philosophical assumptions underlying modern medicine

— J R Kriel



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Curriculum vitae

Jacques Kriel started his studies at the University of Stellenbosch where he obtained a BA Hons (Philosophy) in 1961. He then studied medicine at Wits and received the MBChB in 1968. He worked as a Registrar in the Dept of Internal Medicine, UOVS from 1971-1974, received the MMed (Interne) in 1974 and FCP (SA) in 1973 and became Senior Specialist in this Dept in 1975. He then moved to Bophuthatswana where he worked from 1976-1982: first as Director of Health Services (1978-1979) and then as Rector of the University of Bophuthatswana (1979-1982). Since 1982 Professor Kriel has occupied the Claude Harris Leon Chair of Medical Education and is Director of the Centre for the Study of Medical Education.

KEYWORDS: Philosophy, medical; Patient satisfaction; Physician-patient relations; Physicians, family.

Summary

There is a growing dissatisfaction with high-tech medicine, the reason being the doctor's underlying philosophical world view of man and science. The dominant biomedical model with its mechanistic view of life excludes all other dimensions and phenomena (social, spiritual, environmental) related to health. The wide implications and limitations of this view are dealt with. The need is stressed for the GP par excellence, to make the paradigm shift and develop a different understanding of health and disease which would lead to more effective health care.

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"What do you mean, why's it got to be built?"; Prosser said. "It's a bypass. You've got to build bypasses".

Douglas Adams: The hitch-hiker's guide to the Galaxy

In this paper I would like to discuss the following three statements:

- i) In spite of the undoubted achievements of modern medicine, there seems to be a world wide and growing dissatisfaction, disenchantment and even disillusionment

amongst the general public with modern high technology medicine.

- ii) I believe that the root cause of this dissatisfaction does not lie in technology as such, but in the philosophical assumptions underlying medicine. These assumptions dictate how technology is applied. We cannot address the growing estrangement between doctor and patient without addressing these fundamental philosophical assumptions that have their origins in a 17th and 18th century view of man and of science.

A growing disillusionment with modern high-tech medicine

- iii) Alternative philosophies or frameworks or ways of understanding what medicine is all about, are being formulated. Some of these alternative concepts fall outside what could be called scientific medicine, for example the holistic health movement. But within medicine itself two alternative paradigms seem to be developing, the first based on systems theory and information theory and the second on a more phenomenological approach.

Dissatisfaction with modern medicine.

It is very difficult to document (or prove) the type of dissatisfaction to which I am referring. Although several books have appeared which could be classified as 'attacks on modern medicine'^{1,2,3} or which question the assumptions on which health care is predicated^{4,5}, very little research about the attitude of the public towards medicine or its perception of medicine seems to have been done. Index Medicus does not even have a category for 'patient dissatisfaction'. It only has a category for 'consumer satisfaction' which makes me think that for the editors it is unthinkable that patients cannot be satisfied with the marvels that we produce every day!

Because of the complexity of the topic I am simply going to quote a few extracts in order to get a feeling for what the dissatisfaction seems to be about. However, none of the authors document on what basis they make these statements.

'... (the) frequently voiced complaints by patients (are) that physicians are insensitive,

callous, neglectful, arrogant and mechanical in their approaches'.⁶

'... complaints of the public about doctors and medical care (are that) ... doctors don't communicate well, that they don't really listen, that they seem insensitive to personal needs and individual differences, that they neglect the person in the zeal to pursue diagnostic and treatment procedures. They stress the unavailability of health services, often as much indicative of psychological remoteness as of economic barriers or geographical distances.'⁶

'... an increasingly well-informed public is becoming increasingly disappointed with the failure of scientific medicine to live up to its promises and to fulfil popular expectations. Also significant may be the frequency of iatrogenic disease, high prices, the suffering caused by some diagnostic procedures, and the inability to cure various common and chronic diseases'.⁷

In the last quotation the author seems to ascribe the disappointment of the public to the failure of scientific medicine to live up to its promises and public expectations, as well as its inability to cure various common and chronic diseases. I believe that it is not so much our inability to cure these common and chronic diseases, but our inability to manage these conditions in a humane and meaningful way that estranges us from our patients and leads to the disappointment. My contention in this paper will be that it is the underlying philosophy of modern medicine that is in fact the root cause of the type of practice and attitudes that have led to this disappointment.

A growing estrangement between doctor and patient

The paradigm of modern medicine

Before outlining that philosophy, the first point to establish is that all of us practising medicine in fact *have* a common philosophy about what disease and health is all about. This concept of disease obviously determines what we perceive our task as doctors to be, and this understanding forms and guides our practice.⁸

This common philosophy is inculcated by our medical education system, by our role models,

even by our patients, and it is reinforced by all the professional institutions that are created by us in our own image — ie in terms of our own philosophy. It is this implicit and subconscious philosophy that gives our way of doing things an aura of naturalness, of having-to-be-that-way, of God-given normality, and which prevents us from questioning those very assumptions. In our daily practice we are therefore acting out a series of philosophical assumptions.

What medicine is all about

Engel puts it as follows:

'How physicians approach patients and the problems they present is very much influenced by the conceptual models in relationship to which their knowledge and experience are organised. Commonly, however, physicians are largely unaware of the power such models exert on their thinking and behaviour. This is because the dominant models are not necessarily made explicit. Rather, they become that part of the fabric of education which is taken for granted, the cultural background against which they learn to become physicians. Their teachers, their mentors, the texts they use, the practices they are encouraged to follow, even the medical institutions and administrative organisations in which they work, all reflect prevailing conceptual models of the era.'⁹

I want to call this dominant philosophical model in modern medicine, the *biomedical model*. This is the name used by the major writers in this field such as Engel, McWhinney, Capra etc. The name emphasises that modern medicine views disease primarily as a biological phenomenon. So we can conclude that we are all devotees of the biomedical conceptual model or philosophy or paradigm of medicine.

I now want to outline in very broad terms the philosophical assumptions which make up this paradigm.

i) Firstly, the biomedical philosophy is based on a *mechanistic view of life*. This view was first cogently formulated by Descartes in the 17th century but is still religiously adhered to by most 20th century doctors. According to this view man's body is assumed to be a machine that can be *understood completely* in terms of the arrangement and functioning of

its parts. The word '*understood completely*' are the operative ones in this sentence. The counterpart of this view in physics is the mechanistic world view of Newtonian physics, and Capra is quick to point out that biology and medicine are therefore still functioning within the framework of a Newtonian world view, while Physics has long since moved beyond the Newtonian understanding of 'reality'.¹⁰

- ii) Secondly, this approach is *reductionistic* in nature. The body is 'nothing but' a machine. Today this basic 17th century mechanistic and reductionist understanding is formulated more subtly in terms of physical-chemical events at cellular and sub-cellular level, but it is still the same Cartesian view. According to reductionism the whole is 'nothing but' the sum of the parts and can be *completely understood* in terms of a description of its components. Because of the reductionism, only physical-chemical data are seen as having any meaning, and furthermore, these data have ultimate explanatory power.
- iii) The model or exemplar for the doctor or the medical scientist (as the doctor becomes within this framework) is the laboratory experimental design of the bench scientist who singles out components for sequential study while holding all other variables constant.⁹
- iv) Based on these concepts, the biomedical model of necessity dictates our understanding of the concept of health and disease. It is important to realise that these concepts are not self evident. They are formed and given

Not necessary to cure, but to manage disease in a humane and meaningful way

content by our wider philosophical framework. Within this framework, health is understood as *faultless mechanical functioning of the body machine* to the exclusion of all other phenomena that could be related to health. The individual, social and ecological dimensions of health cannot be accounted for within this framework.

Disease in turn becomes a *purely biological phenomenon*, namely the malfunctioning of

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bodily mechanisms which are studied and understood purely from the point of view of cellular and molecular biology. Illness as a disorder of the whole person, ie as a biopsychosocial phenomenon cannot be considered and *illness becomes equated with disease*.

The Cartesian physician (that is you and I) not only concentrates exclusively on the body machine but must also neglect the psychological, social, spiritual and environmental aspects of illness. The minimal budget for preventive health in the state's health budget is therefore primarily a philosophical problem!¹¹

The reductionist model is a *very powerful* model. On the one hand it underlies the staggering technological achievements of modern medicine. It is this model that guides and justifies the type of research programmes and the patterns of expenditure of the MRC. And it is this model which has built monstrous 'disease palaces' such as the Parktown

Hospital, Tygerberg Hospital, the revamped Groote Schuur, and which justifies building a new (White) HF Verwoerd Hospital while the rural (Black) areas have only woefully inadequate health and medical services. It makes these decisions seem natural, correct and based 'on the truth'. The biomedical model therefore has some very serious implications and limitations.

Implications and limitations of the biomedical model.

The crippling flaw of the reductionist model is that it does not, in fact *cannot* include the patient and his attributes as a person, as *a total human being*. Yet, in the everyday work of the physician, the prime object of study with which we interact in the doctor-patient relationship, is the *whole person*.⁶

The model cannot make provision for the person as a whole nor for data of a social or psychological nature, for the reductionism on which the model is predicated requires that these must first be reduced to physical-chemical terms before they



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can have meaning. Psychological phenomena are considered to be 'subjective' and therefore 'epiphenomena'. The conclusion seems inevitable to me that *the very essence of medical practice* lies beyond the reach of medical science as understood within this model. That is why Engel refers to it as *an incomplete scientific model* — it cannot deal with the totality of phenomena related to health or disease.

The biomedical model also has implications for our view of *the task of the doctor*. The subjective reality of the patient is not really part of the disease. There is therefore a discrepancy between what we as doctors understand by the disease and what the patient understands and experiences as his or her disease. It seems obvious to me that here already there are serious grounds for misunderstandings, disappointments and dissatisfactions on the side of the patient. McWhinney has pointed out that it is impossible for the biomedical physician to 'get inside' the patient's world and therefore to understand illness from the patient's perspective.¹² This is true even if the doctor and the patient share the same

culture. It becomes a task of insuperable complexity when medicine is practised across cultures.¹³

Within the biomedical model the doctor's task is threefold:

- i) The precise definition of the disease *in biological terms*.
- ii) To determine *its specific cause*. (According to Capra, medicine and biology still operates with a Newtonian, linear concept of cause and effect, while physics and chemistry have long since done away with this specific philosophical understanding of causality.)¹⁰
- iii) To institute *specific treatment*. Therapy within this model is understood primarily in technological terms, ie as chemical or physical (surgery, radiation etc) intervention.

We can therefore see that the world of meaning of the patient, the patient's values, fears and hopes, responsibilities, independence, social and



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economic and cultural context etc have no way of entering our understanding of health and disease, and that this must of necessity lead to depersonalisation of the doctor-patient relationship and of medical care.

I just want to mention a few other complications. I believe that this model lies at the basis of the *ever increasing and inappropriate role that technology is playing* within modern medicine. It is now commonly accepted that this is the basis of the *soaring costs* of medical care which in turn is leading to the control of medical care being taken over by politicians and economists and is slipping from the hands of the medical profession. Within this framework technology not only creates a depersonalised and inhuman atmosphere but, according to Reiser, it is the basis for the tendency to *specialisation* which in turn leads to further fragmentation of medical care and depersonalisation.^{14,15}

This model also lies at the basis of the inability of medicine to deal *with the modern first world epidemics of 'lifestyle diseases'* such as obesity,

suicide, addiction (smoking, alcohol, sedatives, drugs etc), stress in all its various manifestations, the breakdown of interpersonal relations (eg divorce) and the violence inherent in much of modern society whether that be political or through industrial or motor vehicle accidents or homicide, and, of course, AIDS.

It is interesting to note the hesitancy, even slight embarrassment, when medical spokesmen have to deal with the prevention of AIDS. While they can talk about the necessity of the use of condoms or the possibility of the development of a vaccine, all is fine. But as soon as the moral issues inherent in human sexuality are broached, they withdraw — then it is no longer a medical problem. A Standard 9 pupil participating in a Public Speaking competition recently spoke about AIDS. 'It is clear' she concluded, 'today the only safe sex, is no sex!' One may not agree with her conclusion, but at least she confronted the human dimension head on!

This model also underlies the well-documented inability of modern scientific medicine to deal



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effectively with the health problems and epidemics of the third world. This is so because the dominant third world diseases fall outside the unilinear causal chain which this model postulates. *Third world diseases are all multifactorial* in their aetiology and include socio-political and economic and educational factors within their basic causal network.

Lastly, I believe that this biomedical model is the basic cause why the South African Medical fraternity has been able to acquiesce with such equanimity in the blatant injustice and inhumanity of our apartheid health care and social system, a system in which the White Johannesburg hospital stands half empty, while in the Coronation and Baragwanath hospitals Coloured and Black patients have to lie under the beds and in the passages.²³

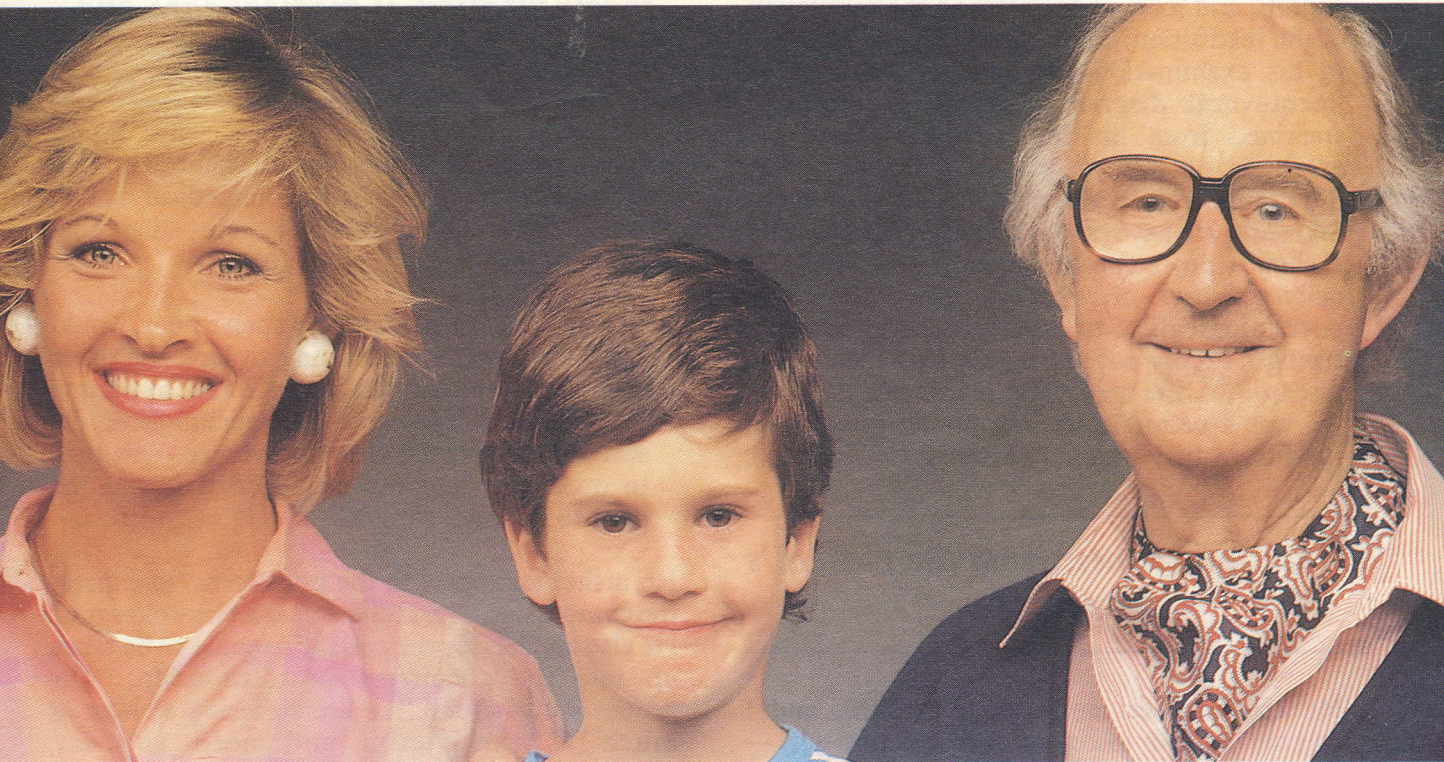
Within this model, as long as the technical provision in terms of diagnostic and therapeutic *machines* is roughly comparable, the inhumanity, injustice and horror of the patient's experiential world does not concern us. As long as we are

supplied with high technology hospitals in which we can display our technical brilliance, the injustices in the world out there which produce the biological defects on which we can display our technological brilliance, is of no consequence or concern to us — at least so we are told by our philosophical assumptions. Within this model, we cannot understand that the very fact of segregating the service is unjust and inhuman, even if the technical provision is absolutely equivalent.¹⁶

Biomedicine from a patient's point of view

It is interesting to see what this model looks like when viewed from the receiving end through the eyes of a colleague. Dr D Rabin, ex-South African and internationally recognised endocrinologist, described his experiences in the *New England Journal of Medicine* of August 19, 1982, after developing amyotrophic lateral sclerosis (ALS). The article is entitled 'Isolation from my Fellow Physicians'.¹⁷

In the early part of his career, Dr Rabin had shown precocious talent in clinical neurology, but did



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not choose neurology because the diagnostic problems seemed largely an academic exercise — ‘so little, if anything, could be done for the patient *in a definitive therapeutic way*’. This is of course a typical attitude directed by the biomedical model. However, Dr Rabin continues ‘the years, as well as my own illness, have taught me how wrong it is to focus on definitive therapy and how much can and should be done for the patient, even when one is confronted with so-called incurable illness’. In order for this to be done it seems to me that a different understanding of health and disease is required than that of the biomedical model.

The biomedical view excludes other dimensions of health

Dr Rabin then described his experiences with the biomedical medical care system.

‘I travelled to a prestigious medical centre renowned for its experience with ALS. The diagnostic and technical skills of the people were superb, and more than matched the reputation of the institution. The neurologist was rigorous in his examination and deft in reaching an unequivocal diagnosis. My disappointment stemmed from his impersonal manner. He exhibited no interest in me as a person, and did not make even a perfunctory enquiry about my work. He gave me no guidelines about what I should do, either concretely — in terms of daily activity — or, what was more important, psychologically, to muster the emotional strength to cope with a progressive degenerative disease. . . . the only thing my doctor did offer me was a pamphlet setting out in grim detail the future that I already knew about too well.

Understand illness from the patient’s perspective

He asked to see me in three months, and I was too polite or too cowardly to ask him why — what benefit was there for me to make the journey again? I still recall that the only time he seemed to come alive during our interview was when he drew the mortality curve among his collected patients for me. “Very interesting”, he said, “there’s a break in the

slope after three years.” When, a few months later I read an article by him in which he emphasised the importance of a compassionate and supportive role for the physician caring for the patient with ALS, I wondered whether he had been withdrawn because I was a physician’.

Rabin, in this article, tends to ascribe the withdrawal by his medical colleagues and his isolation to the fact that he was a physician. ‘The dichotomy of being both doctor and patient threatens the integrity of the club. To this fraternity of healers, becoming ill is tantamount to treachery.’ I think that he was just experiencing what patients experience in a similar situation — and that this is due to the biomedical model which cannot cope with this type of situation in which the patient *as a total human being* comes to the fore more dramatically than in the routines of daily practice. Rabin states ‘I state with total conviction that my colleagues never meant to hurt me. On the contrary, . . . they grieved for me, yet were unable to express their grief.’

Specialisation tends to lead to fragmentation of medical care and depersonalisation

He dramatically illustrates how the natural human reaction, not dictated to by the biomedical model, is much closer to the medical reality than that of the doctors.

‘How often, as I struggled to open a door, would I see a colleague pretending to look the other way? On the other hand, why was it so natural for the non-physicians — the technicians, the secretaries, and the cleaning women — to rush to open the door for me, even if it was the door to the men’s toilet?’

He makes an appeal to the physicians ‘to express the compassion they feel towards a sick colleague.’ He also appeals for the patient’s spouse to be taken up into the doctor-patient relationship. ‘The spouse and the children are suffering at least as much as the victim and need support, encouragement, and acknowledgement of their travail.’ This too is putting the finger on the inability of the biomedical model to conceive of the social reality of disease. For within this model the spouse and thus the family cannot be conceived of as part of the disease. Family

medicine is therefore *par excellence* the discipline which has to break out of the confines of this model.

But Rabin in the end works with a much wider concept of illness, and also of therapy, than is possible within the biomedical model.

'... bear in mind' he says, 'that the absence of a magic potion against the disease does not render the physician impotent. There are many avenues that can be helpful for the victim and his family. I am often surprised and moved by the acts of kindness and affection that people perform. Fundamentally, what the family needs is the sense that people care. No-one else can assume the burden, but knowing that you are not forgotten does ease the pain.'

First and Third world epidemics are lifestyle diseases

The problem is that the very philosophy which gives us the power to do something about the pain, causes us to forget the patient who is suffering the pain!

Technology and philosophy

Initially I mentioned that I do not think that the depersonalisation and dehumanisation of medicine against which patients are reacting, is due to technology as such. However, we cannot think of technology as 'theory free' or 'philosophically (or ethically) neutral'.

Technology is as old as homo sapiens — possibly even older. The use of natural objects as tools by which to transform the environment is possibly one of the actions which signals the emergence of homo sapiens from 'the animal world'. But modern technology is specifically the application of scientific understanding. It therefore shares all the peculiar assumptions of modern science.

Like biology and medicine, however, the 'science of technology' has not yet come to terms with the paradigm revolution in Physics and Chemistry.

It is therefore a matter of extreme urgency for Medicine to give attention to the philosophical underpinnings of the technological dominance in medicine. The *advantages* of technology are nearly

self-evident, the disadvantages are less obvious. Physician David Reuben has decried the inappropriately restrained desire to know, operating within medical diagnosis and thus the failure to distinguish research needs from clinical needs, leading to over-diagnosis.^{18,19}

Barger-Lux and Heaney point out the pressure which the availability of technology puts on physicians *to find out* more than they can do anything about, and *to do* more than may be good for the patient, as well as the problems about the patient's autonomy in this whole process.

Medical technology is driven by the assumption that because a technological development is possible, it *must* be developed, regardless of its psychological, socio-political or economic effects and its effects on human values. The next step is: because that technology is available, it *must* be used, or because something is technically possible, it must be done. Technological systems thus become self-perpetuating — alternatives are swept aside and disappear from the social and professional repertoire so that the technological dominance cannot be challenged in any manner. Winner therefore concludes that societies propelled by this technological imperative tend to become increasingly closed, inflexible, resistant to change, and insensitive to human needs.¹⁸

In 1987 South Africa recently witnessed the human drama and suffering generated by this technological imperative in the case of the two liver transplant babies. In both cases the parents decided that if they were faced with the same choice again, they would not allow their children to go through the same suffering. Medicine failed, not necessarily in developing the technology, but in not really giving the full picture to enable them to make a real choice.

The inability of doctors to express the compassion they feel to their patients

The point is, that it is quite legitimate to question the development and application of new technologies. Technological developments need to be justified, and this justification needs to be done against criteria and normative frameworks *extrinsic to technology*, ie against socio-political, economic, ethical and spiritual frameworks. And

this justification needs to be done democratically, ie before people who represent other areas of life than that in which the technology is being developed and applied. *Technology has to be democratized*. At present, under pressure of the 'technological imperative', technology seems to be its own justification as in the case of Mr Prosser.

New options

McWhinney has argued cogently and convincingly that medicine is firmly in the grips of a Kuhnian 'paradigm crisis'. This means that the old philosophical framework is no longer capable of interpreting new phenomena or interpreting the whole of 'reality' as it presents itself to the practitioners of a discipline.²⁰

According to Kuhn such a paradigm crisis leads to a paradigm revolution in which alternative paradigms begin to challenge the established paradigm. It seems to me that at present there are two closely related paradigms challenging the biomedical model. The first challenge is based

Our philosophy, which gives us the power to kill pain, also causes us to forget the patient who is suffering the pain

on systems theory. Engel's article⁹ entitled the Clinical Application of the Biopsychosocial model, is an extremely readable and liberating account of this approach. In an extremely important recent work Foss and Rothenberg²⁴ approach the problem from the perspective of information theory. Their *infomedical model*, they claim, truly demarcates a medical paradigmatic revolution in the Kuhnian sense.

The second challenge is coming from the theoretical and practical work of Ian McWhinney, Professor and Chairman of the Department of Family Medicine at the University of Western Ontario in Canada. McWhinney's philosophical base is localisable, I think, in phenomenology. McWhinney's two articles quoted in the reference are slightly more difficult to digest, but are vital for an understanding of the problems facing medicine today and for seeking meaningful options for the future. While Engel calls the approach based on systems theory the *biopsychosocial* approach, McWhinney refers to the

patient centred method. In South Africa we also need to take note of the work of Dr J Levenstein²¹ and of Jaros and Cloete.²² Levenstein works with the patient centred frameworks while Jaros and Cloete are systems theorists.

Whenever one mentions the word 'alternatives' you are accused of wanting to go back to witchcraft. It is therefore important to realise that both of these 'alternative paradigms' are still within the broad framework of 'Western Medicine'. Kuhn has pointed out that a new

... to find out more than we can do anything about, and to do more than may be good for the patient

paradigm does not simply 'replace' the old, but actually incorporates and extends it. Newtonian physics is still used in the macro-world of engineering in spite of the fact that quantum mechanics and relativity theory have fundamentally altered the Physicist's understanding of reality and of the scientific enterprise.

Both of these paradigms attempt to delineate the limitations of the biomedical model — limitations that underlie both the numerous problems facing medicine as well as the dissatisfaction of the public with medicine. Both therefore claim to give a more fully developed understanding of health and illness. They therefore claim that the alternative paradigms will not only give a better scientific understanding but also lead to *more effective health care* because it encompasses a much fuller understanding of all the phenomena involved in health and illness.

It therefore seems to me that the task of the proponents of the alternative paradigms is fourfold:

1. To continue the philosophical critique of the biomedical model and to show its limitations both in scientific understanding and in practical health care.
2. Specifically to relate the theoretical position in biology and medicine to the insights of the so called 'New Physics'.
3. To address the problem of validation as

referred to by McWhinney.²⁰ There is an extensive literature on this problem within Social Science Theory and the Philosophy of Science. Medical theorists need to take cognisance of this literature.

4. To develop case studies in the new clinical method which will help to delineate the new clinical method from the old, and will demonstrate its effectivity.

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From the Journals

Group therapy in a general practice setting for frequent attenders: a controlled study of mothers with pre-school children

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J Roy Coll Gen Pract 1988; 38: 539-41.

Summary: The frequent attendance of women suffering from anxiety and depression is a common problem in general practice and the problems are often externalized through the women's children. A small controlled study was carried out in a general practice surgery to see whether demand for medical attention by mothers of pre-school children would decrease after they attended a discussion group. Twenty women who fulfilled the study criteria of more than double the national average consultation rate for their age group and of having at least one pre-school child, were sequentially allocated to a treatment or control group. The group therapy was held over two terms of 10 sessions, each of 90 minutes, and was led by a psychologist and a general practitioner. Consultation rates (including surgery visits, house calls and prescription requests) were recorded for five consecutive six-month periods before and after the intervention. At follow-up six months after the end of the treatment a significant reduction in consultation rate had been achieved and maintained by the treated group compared with the controls ($P < 0.01$). This study shows the value of attending to the cause of frequent consultation as well as to the complaints presented.