Continuing Medical Education

The Basis of Family Medicine

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Curriculum vitae

Ronald J Henbest was born in Edmonton, Alberta (Canada) where he qualified in 1974 with a BSc in Maths and Psychology and in 1978 with an MD from the University of Alberta. He then completed two years postgraduate study (residency) in Family Medicine with the Department of Family Medicine at the University of Western Ontario (Canada) and obtained his CCFP from the College of Family Physicians of Canada. Ron joined the Department of Family Medicine at Medunsa in 1980. He has a particular interest in the doctor-patient interaction and its importance for healing. He returned to the University of Western Ontario in 1984 to take their Master of Clinical Science Degree in Family Medicine (MCLSc), which emphasises patient care, teaching and learning, and research. His thesis on Patient-Centred Care involved the development of a method for measuring patient-centredness and testing it against patient outcomes. In 1989, Ron returned to his home city, Edmonton, for a period of 21 months where he was engaged as an associate professor in the Department of Family Medicine at the University of Alberta. During this time, he also completed further training in systemic family therapy. In October 1990, Ron returned, with his wife Judy and son Benji, this time as associate professor and deputy head of the Department of Family Medicine at Medunsa.

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Summary

One of the advances in the practice of medicine as a whole, is the development of the discipline of family medicine. At the basis of this discipline today lie three relation -ships: (1) A changed relationship with disease (no longer is disease seen as an enemy, but part of our experience of this life and one of the many possible causes of illness-symptoms). (2) A changed relationship with patients (where a very important aspect of good patient care is merely getting to know your patient well – the doctor-patient relationship). (3) A changed relation ship to the patient's life circumstances (the systems theory, where the world of the patient and his interaction and integration eg with other family members and the community become part of his disease-picture). How these three relationships are put into practice by the family physician, is illustrated by a parable (personal story).

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Introduction

The basis of family medicine equals relation-ships

It is a delight to have this opportunity to share with you some thoughts about our discipline. I note that many of the sessions of this symposium are labelled *advances* in the management of one or other problem or disease and it seemed to me that perhaps we might be so bold as to call this first address: *An Advance in Medicine – Family Medicine*. That is, we could consider the development of the

discipline of family medicine, itself, to be an advance in the practice of medicine as a whole.

Now, family medicine is not new to this audience, and it would be inappropriate and unhelpful for me to give the kind of lecture that one might give to those unfamiliar with our discipline, a lecture that spelled out its theory and described its key principles. No, this has already been superbly done by Ian McWhinney,[1-3] John Geyman[4] and Robert Rakel[5] to name just a few. Rather, I shall use this opportunity to attempt to put into words just a few thoughts about some of the essential aspects of our discipline.

And that brings me to the topic that I have been asked to address, namely: *the basis of family medicine.* What is the *basis* of family medicine? What is that something that underlies it, supports it, that something that is essential to it?

If I were to choose just one word to encapsulate the basis of family medicine, it would be the word *relationship* or rather, *relationships.* There are three relationships that I think are essential to the practice of family medicine and I would like to describe them for you.

Our relationship to disease

The first one, one could call simply, our relationship to disease. There are many aspects to this relationship. Let me start with theory and then discuss its influence on practice. All of medicine is based on theory, but the theory has been mainly implicit rather than explicit. In fact, it has been our discipline that has helped to make the theory more explicit. The conventional theory of medicine, often referred to as the biomedical model, conceptualises people as machines and thus, patients as 'broken machines'. Symptoms are viewed as faults in the machine and are called diseases. Diseases, in turn, are seen to be the enemy. These enemies are still most commonly thought of as being from the outside, but internal enemies are also recognised. In this theory, symptoms are virtually synonymous with disease.

The old biomedical model conceptualises patients as "broken machines"

This theory is very familiar to you, and much has been said both in terms of its strength and its weaknesses. However, its implications for and influence on relationship have gone largely unnoticed, or at the very least have been grossly underestimated. If disease is seen as the enemy, our job as doctors, is to identify (diagnose) and destroy (treat). The results have been entirely predictable:

Disease is only one possible cause of symptoms amongst many possible causes

1. a very heavy emphasis on disease, evidenced by it becoming virtually one hundred percent of most medical curriculums,
2. a distorted relationship with disease, (just as there is with any perceived enemy) leading to decreased understanding of disease and a distancing from it, and
3. the specialisation and fragmentation both in our profession and in patient care that has resulted from the attempt to do battle with disease.

Trying to escape from the problems of life frequently results in symptoms

But what about our relationship to disease, our relationship as family doctors at our best? Part of what underlies family medicine, that is, part of the basis of family medicine, is a changed relationship with disease that has been made possible by a change in understanding that involves not only the concept of disease, but also that of illness.

An early description of this different theory is the biopsychosocial model by Engel[6] that broadened our understanding of the causes of symptoms. Something that all family doctors know well and far better than most others, is that disease is only one possible cause of symptoms amongst many possible causes. Often it is the least likely cause and even more astounding, it is frequently relatively unimportant. I am reminded of the opening sentence in Scott Peck's book, *The Road Less Travelled*, where he makes the statement, "Life is Difficult".[7] Peck describes how we try to avoid difficulties as if our goal in life was to get through it unscathed. When we do experience problems, we feel sorry for ourselves, indignant that such a thing could happen to us. He describes how a life of attempted escape frequently results in symptoms. Or in McWhinney's words, 'symptoms of underlying problems of living', rather than disease (organic pathology).[8]

More recently, this different theory has been expressed in terms of a patient-centred model,[9,10] which includes the concept of two agendas. In this model, disease is not the sole agenda. There is the additional agenda of the person, of understanding the person and all of his or her reasons for attending, including symptoms, thoughts, feelings and expectations. Thus it recognises the importance of understanding the meaning of the experience of the illness for the person as an important part of understanding the person's symptoms. This different theory has led to a different relationship with disease. Disease is seen in perspective – not as the whole picture, but as a part of the picture. It is recognised that a diagnosis of disease is not only often not possible, it is not sufficient to help many patients. Symptoms no longer equal disease. Rather than being seen as the enemy, symptoms are recognised as important messengers, and a potentially valuable source of information. Even diseases, themselves, are not thought of as enemies, but as symptoms on another level, and as part of the experience of this life. This changing perception about disease allows a greater and more useful understanding of it. Family medicine has an important contribution to make in rewriting the medical books about illness and disease and in particular, family doctors may be thought of as having a special relationship with and knowledge of chronic disease. But most important, the change in our relationship with disease has led to the rediscovery of an even more important relationship, our relationship with patients.

Disease is seen as part of the picture, not the whole picture

Our relationship with patients

Symptoms do not equal disease

Evolving slowly at first, and then more rapidly and dramatically since the 1960s, the importance of the doctor-patient relationship has been rediscovered. As mentioned earlier, one of the key concepts to emerge has been that of patient-centred care.[9,10] This understanding of patient care not only has implications for our relationship with disease, but also with our relationship with patients. Patient-centred care means focusing on the person, relating to the person, understanding the person and his or her experience of the illness, including the patient's thoughts about the symptoms or problems experienced, feelings and often fears, and expectations of self, the situation and the doctor. In addition to, and as a necessary part of the understanding

the disease, person-centred care offers both doctor and patient a richer experience, a much richer relationship than one could ever have with a disease or 'broken machine' a rich enough experience to sustain us, to sustain us in a lifetime of practice. This richness has to do with the nature of human beings and the existence of different aspects of levels of being, including physical, mental and emotional, and spiritual aspects. To quite an extent, understanding the disease requires understanding the physical; understanding the patient requires at least an understanding of the mental, emotional and spiritual as well. This requires a different type of inquiry and relationship. It is subjective, in fact, inter-subjective and this inter-subjective dialogue has the potential to benefit both patient and doctor. Patients may come to a deeper level of self-knowledge and awareness with consequent enhancement of quality of life as well as resolution of symptoms. Doctors have the opportunity to learn more about the human condition and, if they dare, more about themselves.

One of the exciting things happening these days is the research demonstrating the important differences that the doctor-patient relationship makes. Patient-centredness has been shown to make a positive difference to patient satisfaction,[11,12] compliance,[11,12] patients feeling understood,[13,14] patient-practitioner agreement,[14] patients feeling that their reasons for coming have been ascertained, discussed and understood by the doctor,[13] and also to patient outcomes including symptom and concern resolution[13,14] blood pressure control,[15,16] diabetes control,[15,16] peptic ulcer resolution[16] and headache resolution.[17]

Thus, getting to know our patients as people is not only a humane thing to do, but also a very important part of effective patient care. However, as soon as we start to get to know patients as people, something else also starts to happen. We begin to become aware of their circumstances, their home, work, school and family, in short, their life situations, and this takes us to the third and final relationship that I want to mention.

Diseases are not seen as enemies

Our relationship to the context or system

This third relationship, the relationship to people's life circumstances, to their contexts, may be called our relationship to the system.

Here I need to speak for a moment about general systems theory. General systems can be viewed, at least in part, as a response to the mechanistic world view and reductive methods of 19th century science, which dealt with problems by cutting them down to size. Systems theory seeks to do the opposite. It seeks to understand problems by including all the significant relationships. Von Bertallanfy defined a system as a 'dynamic order of parts and processes in mutual interaction with each other'.[18] According to systems theory, nature is ordered as a hierarchy of systems.

We should rewrite medical textbooks, especially illness and disease

Where do patients and doctors fit into this hierarchy of systems? What is our relationship, as family doctors to the system? All people, including doctors and patients, fit into this hierarchy at the highest level of the organismic hierarchy and at the lowest level of the social hierarchy. As family doctors, we become part of the patient's world, the patient's system, and thus introduce change to the system. We may also interact with

different aspects of the patient's world, the patient's system, and thus introduce change to the system. We may also interact with different aspects of the patient's system, perhaps most often with family members. We also interact with various aspects of the larger system, including the community and society of which we are a part. Perhaps the most positive and challenging roles that we can fulfill within the system, are those of rehumanisation and integration, which in a small way enable us to play our part in transforming the world in which we live.

Concluding comments and a parable

I have spoken of the basis of family medicine as having to do with relationship and have mentioned three important relationships: with disease, with people (our patients) and with contexts. This may be referred to as a 3 stage assessment. The three stages are the clinical (disease), the individual (person) and the contextual (especially family, work and community).[19]

If we take relationship in all of its aspects and ramifications as the basis, the essential something of our discipline (essential clearly means: not an optional extra) then the question is raised, "How are we to cope? Doesn't this ask too much of us? What are we to know about disease? Everything about everything? What are we to know about people? You don't expect us to be psychologists too, do you? And what about society? Surely we are not expected to be social workers as well? No, just family doctors who are competent in dealing with the patients and problems with which we are commonly confronted and able to make appropriate plans for the rest. But how are we to define our responsibilities so that they are manageable or at least definable?" I offer the following parable for your consideration.

A parable

One day, a final year family medicine registrar, who was nearing the end of her training, asked her teacher, "What must I do in order to practice family medicine at its best?" The teacher replied, "How do you understand it?" The registrar answered, "Firstly, to continue to study my discipline lifelong with all my strength, not just with my head, but also with my heart, and secondly, to apply the principles of family medicine in my care of patients." The teacher replied, "You have answered well. Do this and you will be a fine family doctor." But the registrar was concerned about the potential enormity of the task, the enormity of understanding all diseases, patients, and contexts and so, in the hope of limiting her responsibility to an amount she could handle, asked, "But who is my patient?" The teacher replied: "There was a young woman of 21 years who presented to the casualty department of a teaching hospital complaining of lower abdominal pain. The casualty officer, having ascertained that she had missed a period, referred her to the gynaecological outpatient department with the tentative diagnosis of ectopic pregnancy. The gynaecological consultant, however, found the menstrual cycle to be otherwise normal and demonstrated nothing abnormal on abdominal and pelvic examination and referred her to the family medicine department. It had closed for the day, but a remaining family practitioner took

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compassion on her and decided he had time for one more consultation. As it turned out the family practitioner was not only compassionate, but also knew how to listen. Before long, the young woman had told him everything about her pain, about herself, and about her boyfriend. She even told him about her inability to conceive and about her desperate desire to be pregnant. The practitioner, of course, could not instantly provide her with a baby, nor did he know if it would be the best thing even if he could. But, the young woman felt understood by the family practitioner and he was able to help her mobilise her own resources for dealing with her situation and the problems she was experiencing." The teacher concluded by posing the question, "Now, which of these three practitioners do you think was the most help to this young woman?" The registrar answered, "The one who took the trouble to understand not only her presenting complaint, but also her feelings and expectations, and her circumstances." To which the teacher replied, "Go and do likewise."

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