An Introduction to Family Medicine

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Ⅰ. THE HISTORY OF FAMILY MEDICINE

The emergence of family medicine

As early as 1963, a WHO Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel defined family physicians as “practicing physicians that have the essential characteristic of offering to all members of the families they serve direct and continuing access to their services.…These doctors accept responsibility for total care either personally or by arranging for the use of specialized clinical or social resources.” The committee noted that “in every country of the world there appears to be a dearth of family physicians, this applies to all countries irrespective of their stage of development.” It recommended that every medical school provide opportunities for students to train in family practice settings, and that in order to raise the standards of family medicine, all graduates choosing family practice should undergo a period of postgraduate training specifically designed to meet their needs in this field of medicine （WHO，1963）.This concern was again reflected in the 1995 World Health Assembly Resolution WHA 48.8 that urged all member countries to support reform of basic medical education “to take account of the contribution made by general practitioners to primary health care-oriented services.”

Family medicine has evolved at different rates in different areas of the world. In 1966, the United Kingdom started a general practice vocational training program. During the same decade Canada, the United States and several other countries initiated programs specifically designed to train family doctors. By 1995, at least 56 countries had developed specialty training programs. Many family practice training programs were established through partnerships with medical schools, community hospital and practicing physicians.

Family medicine education programs engage students and faculty in providing comprehensive care for patients and communities. In this process, family doctors become familiar with the problems, resources and special needs of the people they serve, and are able to adapt education, research and service programs to respond to these needs. Yet in many countries of the world, family medicine is still not recognized or established as a distinct medical specialty.

（Source： Wonca guidebook, 2002）

The Promise of Family Medicine: History, Leadership, and the Age of Aquarius

Family medicine began as a revolutionary movement with courageous leaders who had a compelling vision for the new specialty. Next came a growth era with the expansion of residency programs, medical school departments and community practices; organizationally adept, businesslike people managed family medicine's prosperity. Today medicine and America are troubled, reminiscent of conditions in the 1960s. As family medicine enters a new era, we once again need bold, innovative leaders, like our specialty's founders. By recognizing the nature of the times and seeking the leadership we need, we can fulfill the promises we have made to our patients, our colleagues and to America.

Leadership for the Future

If I have seen further, it is by standing on the shoulders of giants.

—Isaac Newton, writing to Robert Hooke, scientist and later architect, in 1676

Who were the giants? In science, some examples were Von Leeuwenhoek who invented the microscope and first saw bacteria some 300 years ago, then Louis Pasteur, and later Alexander Fleming. Fleming's laboratory discovery led to the widespread availability of penicillin, which might have saved my grandfather's life, if it had been available when he developed an infected foot with subsequent lymphangiitis that eventually caused his death in 1930. Throughout my practice lifetime, lymphangiitis has required only a brief office visit.

In family medicine, we build on the work of general practice (GP) and family medicine (FM) giants in the United Kingdom, Canada, and the United States of America. They include rural and urban practicing physicians, educators, philosophers, medical politicians, and even a few people from other specialties who banded together to establish family medicine.

To weave a tapestry of history, leadership, and our future, I will discuss FM in 3 eras: the *early years* when our specialty was founded; the *growth years* when FM expanded in communities, medical schools, and teaching hospitals; and then the *emerging era*, which will determine our future. For each of these, I will look at the promises we made as well as the leadership attributes and strategies that determined how the promises were met, or not met. To do this, I will use some analogies between the history of FM and American history, including the societal context of events and some characteristics of leadership. I will propose an interpretation of the societal forces we are currently experiencing. My discussion of leadership is intended to highlight the types of persons I believe we need now and in the future, with some challenges to our emerging leaders. And later in the discussion, I will explain the allusion to the Age of Aquarius.

The Early Years: 1960s through the Late 1970s

Nicholas J. Pisacano likened the beginning of our specialty to the American Revolution.[1] He compared the Royalists to the old guard in medical education and the family medicine movement to the rebellious kids – the revolutionaries.[2] For America, the revolution was the defining event of the 18th century, which brought the birth of our nation. For family medicine, the early years saw the metamorphosis of general practice into the specialty of family medicine, for us a seminal event.

The initial promise of family medicine was that we would rescue a fragmented health care system, put it together again, and return it to the people. Just as Henry Ford "democratized" the automobile in the early 20th century, putting convenient transportation that was once the privilege of the few into the hands of many, family medicine held out the promise of accessible, affordable, quality health care for America. We would do this by restoring order to a muddled health care delivery system and by being inclusive, rather than exclusive, in the care provided. Early steps in this endeavor included establishing 3-year residency training programs and periodic recertification to assure quality.

Societal Influences of the Times

The future of general practice was sealed by the rise of specialization that followed WWII. "In the post-war period, the specialists had hospital privileges, rising incomes, and increasing prestige. The remaining physicians were 'just GPs' and were expected to die off (and 'good riddance')."[3] The decade of the 1960s was also a time of social upheaval in areas outside medicine. Concurrent events included the Vietnam War, women's liberation and the civil rights movements. It was a time of activism that provided fertile ground for general practitioners to envision a new identity as family physicians. America, weary of disjointed and often impersonal health care, welcomed us, and federal and state governments provided financial support for residency and student training.

Leadership Styles and Strategies

For both America and for family medicine, the Early Years were the Age of Giants. The leaders of the American Revolution were the "founding fathers" we all know: George Washington, Thomas Jefferson, James Madison, John Adams and others. What were their attributes? They had been entrepreneurs, in their own way, many as farmers. They were personally powerful, daring, self-assured, and autocratic. In their hearts, they believed that they were doing the "right thing." They could envision a confederation of American states governed by Americans, and they were willing to stake their lives on their dream.

The early leaders of the FM revolution had similar attributes: Many had come from entrepreneurial solo practices; the day of the large medical group was still ahead of us. They were self-confident, sometimes overbearing, and occasionally combative. But they were visionaries who could imagine a new specialty, they had the audacity to create a new medical specialty certifying board, and they had the passion and energy

to go from town to town enlisting general practitioners to the FM cause. They knew in their hearts that family medicine was what America needed.

In residency training and medical student education we saw the rise of what I think of as the Guerrilla Residency Program Directors and the Warrior Chairs. The early program director was typically a general practitioner with a large practice that could form the nucleus of a model family practice center; these persons infiltrated the community hospitals with FM teaching programs. Eventually, residency programs which started as guerrilla campaigns often became the showcase elements of their hospitals.

In the medical schools, the battles raged. Warrior Chairs fought to gain beachheads on the campuses of academia, and some of these conflicts still simmer. At times, metaphorically, we saw blood flow in the medical school hallways, a phrase I learned from one of our early leaders, as new family medicine departments fought for hospital privileges, clinic space, and adequate funding. In some instances, early chairs left with mortal wounds, but most of the fledgling departments succeeded and began to grow.

How Did We Measure Success?

In any struggle to establish a new order of things, persistence of the new order constitutes some measure of success. As to the outcome of the American Revolution, The United States of America exists. So does the specialty of Family Medicine.

With the establishment of family medicine, society gained an infrastructure of generalist care, although we still have a long way to go in providing access to all. In community hospitals and academia, the new specialty had gained grudging acceptance, although we had yet to demonstrate the quality of family medicine clinical care.

In the early years, we counted things. We quantified our achievements by the number of "good family practice residency programs" established.[4] We measured the number of students selecting careers in FM, and number of diplomates of American Board of Family Practice (ABFP). By these measures we considered ourselves succeeding. And with more family physicians entering practice each year—committed to providing continuing and comprehensive care—a reasonable person would conclude that we had fulfilled our early promise: To save a patchwork health care system, make it whole, and return it to the people.

Then What Changed?

As the American Revolutionary War drew to a close, the battles ended, and the struggle to establish a unified nation began. We stopped revolting and began governing.

Family medicine was successful in becoming America's 20th medical specialty. We ceased to be counterculture revolutionaries, and we became part of the system we had come to fix.

The Growth Years: Sometime in the 1970s through the 1990s

The Growth Years in the 19th century brought America's great Westward Expansion. For family medicine, the Growth Years brought a steep rise in the number of medical school departments, the number of students entering family medicine, the number of residencies and residency positions, and the number of board-certified family physicians (FPs).

During the Growth Years, the promise of family medicine was: To return America's health care to a generalist-based model, led by family physicians who could provide quality health care for 85% to 90% of the health care needs of their patients.

Societal Influences of the Time

In the nineteenth century, America became aware of the potential of the land we inhabited, and we developed a sense of our "manifest destiny." It was a time of optimism and confidence. There were no limits to America's resources and to our future.

By the mid-1980s, family medicine was clearly succeeding: There was generous government support in the form of training grants. Battles for hospital privileges were being won. Health care cost-containment became popular, and it supported just the type of comprehensive care that we champion. In medical education, we were beneficiaries of the "generalist imperative"—with kudos to medical schools when more than half of their graduates entered generalist specialties. In fact, in the early 1990s almost every doctor wanted to be a generalist. OB-GYNs discovered body parts beyond the pelvis, and it was fashionable to be a "generalist" neurologist or ophthalmologist. Managed care made us the darlings of the health care system. We worked to have cost-efficient practices, we reveled in insurance industry support, and we learned new words such as "covered lives," "reimbursement," and "provider." But, were we aware of the subtle changes occurring in patient-physician relationships? Were we keeping our implied promise to society?

Leadership Styles and Strategies

For America and for family medicine, the era of growth became the age of administration. In the 19th century, the sons and daughters of the America's Revolution seized the opportunities for peaceful enterprise. Jefferson acquired the western United States through negotiation, without firing a shot. Once explored, the path to the West was to gain farmland and build businesses and cities. As America's early leaders were replaced, we read about presidents such as William Henry Harrison, James Tyler, James Polk, Millard Fillmore, Franklin Pierce, and James Buchanan. During the administrative years, and with few exceptions such as Abraham Lincoln and the Civil War, America was managing prosperity. We probably had just the leaders we needed for the times—levelheaded, rational, practical people with executive skills.

During our specialty's growth years, we family physicians were also managing prosperity. Our counterculture, revolutionary leaders were replaced by businessmen and women with management skills. The Guerilla Residency Program Directors and the Warrior Chairs had either changed their tactics or eased into retirement. The new residency directors understood residency curriculum design, program accreditation, and accounts receivable. The medical school chairs became experts in grant writing

and educational evaluation. They all worried about budgets and personnel management. Those in charge were generally facilitative, patient, and accommodating persons. For them, peace was very important. After all, things were going very well.

How Did We Measure Success?

Early on in the growth era, America counted new states in the union. Later we tallied miles of railroad track laid and tons of freight moved. New cities grew up along the railroad lines, and we began to be an industrialized nation.

FM learned to count value units (RVUs), covered lives, and budget surpluses or shortfalls. We tallied office visits and patients seen per hour, but with the nagging concern that cost-effectiveness might compete with quality care.

Then What Changed?

After the Civil War, America's rise continued, with only a few bumps along the way, until World War I, the Great Depression of the 1930s and then World War II. Then, in what should have been a time of prosperity, we faced economic inequities, broken promises, and leaders who had lost the trust of the people.

Family medicine's growth era ended as managed care plateaued, cost-containment faltered, and patient dissatisfaction with America's health care system rose. Government support of family medicine began to decline, and the affluence of the country became reflected in a willingness to pay more for health care—at least by those who could afford to do so. In 1998, the number of family practice residency positions filled by US medical graduates first began to fall.[5] The pendulum was shifting back to sub-specialized care.

The Emerging Era: from the Late 1990s and Beyond

Today we see a continuing fascination with technology, and patients seem to value convenience over continuity. Broad-based care seems less important than "expert" care. Family physicians feel undervalued, and the specialty has lost some of its attractiveness to students—the lifeblood of our future. Residencies are currently having difficulty filling positions with US medical school graduates, and in July 2005, 39.6% of our first year residents were international medical graduates.[6]

Can we characterize a new, third era at this time? Is there an analogy in American history to what we are seeing now? I considered some of the defining events of the 20th century: World War I; the Great Depression of the 1930s, which was a sobering time for America; World War II, which was a threat to all we valued; the Cold War, with the menace of nuclear annihilation; the Korean War, the Vietnam War, and recent wars in the Middle East. I thought a long time about this question, and concluded that there is no compelling analogy between a major era of American history and the current times in family medicine. Why might this be? Perhaps the reason is that we are now into a period of transition to a new era and, for both family medicine and for America, the nature of the dawning age has not declared itself. What is certain is that the character of this third era will define our future.

There is another historical transition at this time in history that I discovered while researching this paper. I found the concept intriguing, and I want to share it with you. Astrology holds that celestial bodies influence our lives as a global community. Owing to the movements of the Earth's pole vis-à-vis the planets, a new "age" begins approximately every 2000 years. Astrologically, we are in a time of transition—from the Age of Pisces, which began about the time of the birth of Christ, to the Age of Aquarius. As my curiosity grew, I went to the astrological web sites to learn a little about the various ages. Briefly, the Piscean Age has been characterized by spirituality and strong beliefs, sometimes causing friction among people. The Age of Aquarius will be characterized by rational science, technical progress, service, and synthesis.[7] Could this be rephrased as evidence-based, electronically advanced, continuing and comprehensive care? Could we be discussing a need to reaffirm family medicine values as they relate to society's needs in the 21st century?

Whatever happens, we are told that the transition from one age to the next will be gradual, and perhaps occasionally turbulent. And so, in this time of change, on the cusp, we are free to do some speculating.

A Promise for the New Era

The Future of Family Medicine (FFM) report clearly indicates that now is a time of change. In looking for the promise contained in the document, I conclude that it may be this: "to transform and renew the specialty of family medicine to meet the needs of people and society in a changing environment."[8] We are pledging to create "a new model of family medicine, a reordering of health care priorities, and a shift in the medical paradigm in the United States. . . ."[8] Is this not very similar to the promise family practice made in the 1960s?

During this transition time, there are headwinds and obstacles. Our residency graduates and community physicians risk the loss of influence and power in the health care system if they limit the scope of their practices, abandon hospital care, and retreat into their offices. Many family physicians find themselves, much as in the 1960s, practicing high-volume, assembly line medicine of sometimes worrisome quality.

As we seek change, we risk using a Maginot-line mentality. In the 1930s, remembering World War I, France built a line of forts on its eastern border to thwart a possible invasion by Germany. Of course, when World War II began, the fixed emplacements proved to be scant deterrent in modern warfare, and France was swiftly conquered. We cannot fight tomorrow's battle using the strategies of the last, by doing more of what worked for us in the past—training graduates in "model practices" that use a 1970s paradigm—just as we can neither maintain our incomes nor improve the quality of our care by seeing more and more patients, one by one, faster and faster.

In seeking to keep our promise to meet the needs of people and society, we have some assets and advantages: our patients like us, and our specialty colleagues value us.[8] Our practice style can and should be user-friendly; generally, we are temperamentally altruistic and service-oriented clinicians. Ours is the most comprehensive of all health care models, representing the rational application of science. It is the

synthesis of evidence, understanding, and skill. What we need is leadership to help change our practice model to adapt to today's changing environment.

The Leadership Style Needed Now

In times of crisis, strong leaders—giants—emerge. In America, Washington led us through the American Revolution, which by all military theory should have failed. Lincoln led us through the Civil War, which threatened to split the country forever. Franklin D. Roosevelt led us out of the Great Depression and through World War II.

In many FM settings today, we have facilitative managers in charge of a model that is not working well. Why do we have the leaders we have? One clue may be the differences between the generations: the Lost Generation (born during the years 1883 to 1900), the so-called GI Generation (1901 to 1924), the Silent Generation (1925 to 1942), the Baby Boomers (1943 to 1960), Generation X (1961 to 1981), and the Millennial Generation (1982 and after). Family Medicine's founders, ages 50 to 65 in the 1960s and early 1970s were largely part of the GI Generation; that is, born before 1924. The GI Generation has been characterized as one of "heroes," doing great deeds and honored in myth and memory.[9]

Howe and Strauss conclude that if we look back as far as the 17th century, a "hero generation" arises about every 4 generations, typically following a time of upheaval in society's culture and values. They suggest that "a hero generation directly follows a youth generation widely deemed to be disappointing... and fills a void left by the passing of an older generation known for civic purpose and teamwork."[9]

Today our senior leaders are Boomers, characterized as the "me generation," idealistic when they were young but now concerned about finances, respectful of authority, and valuing stability; they are willing to work hard and pay their dues.[10] The intergenerational contrasts, clearly studies in generalities, offer some insight into our current leadership. By being cautious and seeking stability and harmony, today's leaders are missing opportunities to foment change. Nevertheless, in all of family medicine today there must be some of the visionary, risk-taking leaders—as we nuture the promise of the hero generation that I hope is coming.

How Will We Measure Success?

Our long-term goal is a new model of FM "based on the concept of a relationship-centered personal medical home, which serves as the focal point through which all persons —regardless of age, gender, race, ethnicity, or socioeconomic status—participate in health care."[8] This calls for a change in what we measure. We will assure—and document—access to care for all. We must begin to measure actual outcomes of care, such as patient diseases prevented, complications avoided, and hospitalizations and preventable deaths that do not occur. We will identify the degree to which medical decisions are based on current evidence, and provide ongoing documentation that our residency graduates are well trained and that the care provided is measurably excellent.

Challenges for Tomorrow's Leaders

With full awareness of the recommendations of the FFM project, I believe that our successful journey through today's dangerous time of transition will call for powerful leadership in 5 areas: quality residency training and patient care, innovation, informatics, mentoring leaders, and anticipating tomorrow.

Quality Residency Training and Patient Care

To assure quality FM care, we must make some difficult decisions. Today the quality of some residency applicants and some training programs is not what it should be. During the 1990s, the leaders of anesthesiology and radiology cut training positions significantly when quality was threatened; today, a few short years later, they are increasing positions and attracting student applicants again. Now is a time when we must be leaders, acting on principle, rather than managers protecting programs that do not merit protection. We must overcome caution and close weak residencies, instead of accepting marginally qualified applicants to fill an excess of positions. To do otherwise will compromise the quality of FM care for decades.

Another approach is to extend residency training to 4 years, offering focused training to meet individual residents' needs and interests, and perhaps preparing some for future leadership roles, and others for clinical practice with a special area of excellence.

Innovation

America won the revolutionary war because we adopted a new form of warfare. Shooting at enemies from behind trees and stone walls instead of in long vulnerable ranks was an innovative tactic that allowed the colonial militia to overcome a better trained and better equipped regular army. The revolutionary family physicians created mandatory continuing medical education (CME) and required re-certification, and residency training in model family practice centers—all superb innovations at the time.

Vision plus action leads to innovation, and today we need once again to become the innovators in the health care system. We were the medical specialty that advocated family systems medicine; now our colleagues in pediatrics and internal medicine teach this to their residents. We innovated FM student interest groups; now most specialties in our medical school have copied these. Family-oriented health care, continuity clinics for trainees, community teaching practices, resident support groups—these are all things we implemented early in our history and that other specialties later adopted. But have we stopped innovating? One of the tasks of leadership is seeing possibilities and launching new ideas. What have we initiated lately that our colleagues in other specialties can eventually emulate? Today we must charge our strongest residencies and our premier medical school departments to envision the health care of the future, model these clinical innovations, and build educational programs that prepare our graduates to be ambassadors of change as they enter practice.

What might be some examples of innovation? Are we willing to take a "start with a blank slate" approach to changing residency training? Is there a better way to finance graduate medical education in FM, perhaps through the same funding mechanisms that

we see with federally qualified health centers and rural health clinics? Can we think of a better practice model than we have now, perhaps one with a committed panel of patients who have subscription-based ongoing access to their "medical home?" Should we reverse the current trend of truncating our clinical services and reaffirm ourselves as, to use Whitcomb's phrase, specialists in comprehensive medicine?[11] Can we think of a ground-breaking way to bring family medicine to the attention of America, so that—after almost 4 decades—our patients, communities, industry, and government come to understand who we are and what we do?

Informatics

We must lead—not merely join—the information technology transformation of health care. If we are to continue to be the leaders in offering continuing, comprehensive, and coordinated health care, then we must become the trailblazers in health information technology. The FFM report mentions the electronic health record (EHR), which should not only increase health care efficiency; it should allow us to monitor the quality of that care. We also must be the innovators in e-mail contact with patients, electronic prescribing, on-line group visits, and virtual office visits and house calls. Today the technology exists for the family physician to record a patient's blood pressure and pulse, examine the skin, peer into the throat, and listen to the heart—all without being in the same room. Although I enjoy seeing my colleagues at medical meetings, modern information technology can allow me to maintain my CME without getting on an airplane or sleeping in a hotel bed. We must find groundbreaking ways to bring tomorrow's information technology into our residency training curricula, our CME programs, and our community practices today.

Mentoring Leaders

We must identify and nurture future giants. In our residencies today, there surely exist young family physicians with the qualities of integrity, courage, diplomacy, and willingness to take risks. We need to find them early and offer the leadership training and experience that can get them ready for their future roles. If this calls for extending residency training for these persons, or perhaps providing some subsidy during early practice years, then we should do this.

For now, I challenge all of us to model leadership as we speak out in hospital, local, and state forums on health issues. Be active in state and national medical organizations. And then take your medical students and residents with you to meetings to see leadership in action. Almost 30 years ago, I visited Nik Zervanos' residency program in Lancaster, PA. At that time, Nik described a program where his residency held seats on the boards of local organizations—service clubs, youth programs, and others—and these seats were occupied by his residents and then passed on to the next class following graduation. Is it any wonder that some of today's academic and community leaders have come from that residency program? And so I challenge you: What are you doing to find and mentor the giants of the future? And what are you doing to support those who wish to lead today?

Anticipating Tomorrow

Pure leaders, by definition, can see tomorrow better than the rest of us. To use a

real estate analogy, they can help us "buy land in the path of progress." At this time, we need to anticipate the next change in health care in America. Some years ago I built a new house. Among my errors was my decision to have a wall cabinet to hold my 32-inch television. Of course, as televisions hypertrophied and wide screens became popular, my beautiful built-in TV cabinet turned out to be obsolete. I had failed to think ahead.

For years, I asked every expert I could find, "what comes after managed care?" The question now should be, "what is the health care model that can best serve society's needs?" Right now, by default, we have "stratified care" with about 4 or 5 levels of services, from motor scooter to Cadillac care. Where do family physicians fit in? Some may hold that we are properly the "motor scooter" doctors, but I believe that we need to be involved in quality care at all strata of America's health care system —until the system changes.

To assure our future, we need to understand our roots and our vulnerabilities. We began as a social movement to meet society's need for health care delivery. We practice "relationship-based medicine," and cannot claim exclusive ownership of an organ, age group, or specific medical technology. As such, we are vulnerable to the winds of change of America's values and social consciousness. To assure our future, we must plan for tomorrow and prepare the young family physician with the tools to do more than survive. It will be our leaders' job to see the coming opportunities for family physicians; the leaders must be, after all, the ones with the vision. To be ready, we need to increase our efforts to train leaders through workshops, seminars, and fellowships; we must seek out leaders with the temperament needed to stand up for our specialty and our values.

Fulfilling Our Promise

"What you have inherited from your fathers, earn again for yourselves, or it will not be yours" [Faust; von Goethe JW (1832)]. We are no longer managing the exuberant growth of our specialty, and there are clear parallels to the 1960. In the post-World War II period, the specialist had hospital privileges, rising incomes, and increasing prestige.[3] Before the FM revolution, our general practice predecessors—overworked and underpaid—were dinosaurs headed for extinction.

Today family physicians are once again being tested by the specter of more work for less pay, of losing prerogatives we once took for granted, and of being marginalized in the health care system. Our task now is getting through the transition and keeping the promises we have made. In a 1790 letter to Thomas Jefferson, Abigail Adams wrote, "These are the hard times in which a genius would wish to live. Great necessities call forth great leaders." In today's hard times, we need visionary "great leaders" for family medicine. We need to attend to the 5 challenges of our specialty: quality, innovation, informatics, mentoring, and anticipating tomorrow. We must assure that history does not look back at family medicine as a historical curiosity that flourished at the end of the 20th century. We must once again earn the right to be America's physicians of choice.

If leadership is about any single concept, it is about change. Science, medical education, health care delivery, and the needs of society do not remain static. We, as family physicians, must be at the forefront of change. Through our leaders, we must position family medicine to show the way to tomorrow's health care. If we do so, then we may reach the age of rational science, technical advancement, service, and synthesis—our Age of Aquarius. And the promise of family medicine—to meet the needs of people and society in a changing environment—will be fulfilled.

Notes

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Ⅱ. THE PRINCIPLES OF FAMILY MEDICINE

Family medicine can be described as a body of knowledge about the problems encountered by family physicians. This is, of course, a tautology, but then so are the descriptions of all applied subjects. As in other practical disciplines, the body of knowledge encompassed by family medicine includes not only factual knowledge but also skills and techniques. Members of a clinical discipline are identifiable not so much by what they know as by what they do. Surgeons, for example, are identifiable more by their skill in diagnosing and treating "surgical" diseases than by any particular knowledge of anatomy, pathology, or clinical medicine. What they do is a matter of their mental set, their values and attitudes, and the principles that govern their actions.

In describing family medicine, therefore, it is best to start with the principles that govern our actions. I will describe nine of them. None is unique to family medicine. Not all family physicians exemplify the whole nine. Nevertheless, when take n together, they do represent a distinctive world view - a system of values and an approach to problems - that is identifiably different from that of other disciplines.

1. Family physicians are committed to the person rather than to a particular body of knowledge, group of diseases, or special technique. The commitment is open-ended in two senses. First, it is not limited by the type of health problem. Family physicians are available for any health problem in a person of either sex and of any age. Their practice is not even limited to strictly defined health problems: the patient defines the problem. This means that a family physician can never say: "I am sorry, but your illness is not in my field." Any health problem in one of our patients is in our field. We may have to refer the patient for specialized treatment, but we are still responsible for the initial assessment and for co-ordination of care. Second, the commitment has no defined end point. It is not terminated by cure of an illness, the end of a course of treatment, or the incurability of an illness. In many cases the commitment is made while the person is healthy, before any problem has developed. In other words, family medicine defines itself in terms of relationships, making it unique among major fields of clinical medicine.

2. The family physician seeks to understand the context of the illness. "To understand a thing rightly, we need to see it both out of its environment and in it, and to have acquaintance with the whole range of its variations" wrote William James. Many illnesses cannot be fully understood unless they are seen in their personal, family, and social context. When a patient is admitted to the hospital, much of the context of the illness is removed or obscured. Attention seems to be focused on the foreground rather than the background, often resulting in a limited picture of the illness.

3. The family physician sees every contact with his patients as an opportunity for prevention or health education. Since family physicians, on the average, sees each of their patients about four times a year, this is a rich source of opportunities for practicing preventive medicine.

4. The family physician views his practice as a "population at risk". Clinicians think normally in terms of single patients rather than population groups. Family physicians have to think in terms of both. This means that one of their patients who ha s not been immunized, or who has not had his

blood pressure checked, should be as much a concern as one who is attending for well-baby care or for the treatment of hypertension. It implies a commitment to maintain health in the members of his practice whether or not they happen to be attending the office.

5. The family physician sees himself as part of a community-wide network of supportive and health care agencies. All communities have a network of social supports, official and unofficial, formal and informal. The word network suggests a coordinated system. Unfortunately, this is often not so. Too often, members of the health care and social services - including physicians - work in watertight compartments, without any grasp of the system as a whole. Family physicians can be much more effective if they can deploy all the resources of the community for the benefit of his patients. The kind of network to be found in most communities is described in Chapter 20.

6. Ideally, the family physician should share the same habitat as his patients. In recent years, this has become less common, except in rural areas. Even here, the commuting doctor has made an appearance. In some communities, notably the central are as of large cities, doctors have virtually disappeared. This has all been part of the recent trend toward the separation of life and work. To Wendell Berry (1978) this is the cause of many modern ills: "If we do not live where we work, and when we work," he writes, "we are wasting our lives, and our work too." The Love Canal disaster in Niagara Falls provides a vivid illustration of what can happen when physicians are remote from the environment of their patients. This abandoned canal had been used b y a local industry for the disposal of toxic waste products. The canal was then covered over and, some years later, houses were built on the site. During the 1960s householders began to notice that chemical sludge was seeping into their basements and gardens. Trees and shrubs died, and the atmosphere became polluted by malodorous fumes. About the same time, residents in the neighborhood began to suffer from illnesses caused by the toxic chemicals. It was not, however, until a local journalist did a health survey in the area that an official health study was done. This showed rates of illness, miscarriage, and birth defects far in excess of the norm (Brown, 1979). How did the cluster of illnesses in an obviously polluted environment escape the notice of local physicians? One can only assume that they treated patients without seeing them in their home environment. It is difficult to believe that a neighborhood family physician, visiting patients in their homes and interested in their environment, would have remained unaware of the problem for so long. To be fully effective, a family physician still needs to be a visible presence in the neighborhood.

7. The family physician sees patients in their homes. Until modern times, attending physicians in their homes was one of the deepest experiences of family practice. It was in the home that many of the great events of life took place: being born, dying, enduring or recovering from serious illness. Being present with the family at these events gave family doctors much of their knowledge of patients and their families. Knowing the home gave us a tacit understanding of the context or ecology of illness. Ecology, derived from the two Greek words *oikos* (home) and *logos*, means literally "study of the home".

The rise of the modern hospital removed much of this experience from the home. There were technical advantages and gains in efficiency, but the price was some impoverishment of the experience of family practice. The current redefinition of the hospital's role is now changing the balance again and we have the opportunity to restore home care as one of the defining experiences and essential skills of family medicine. The family physician should be a natural ecologist.

8. The family physician attaches importance to the subjective aspects of medicine. For most of this century, medicine has been dominated by a strictly objective and positivistic approach to health problems. For family physicians, this has always had to be reconciled with a sensitivity to feelings and an insight into relationships. Insight into relationships requires a knowledge of emotions, including our own emotions. Hence, family medicine should be a self-reflective practice.

9. The family physician is a manager of resources. As generalists and first-contact physicians, they have control of large resources and are able, within certain limits, to control admission to hospital, use of investigations, prescription of treatment, and referral to specialists. In all parts of the world, resources are limited—sometimes severely limited. It is, therefore, the family physicians' responsibility to manage these resources for the benefit of their patients and for the community as a whole. Since the interests of an individual patient may conflict with those of the community as a whole, this can raise ethical issues.

The skills of family medicine

Four skills can be described that are specific to family medicine:

1. The solution of undifferentiated problems in the context of a continuing personal relationship with individuals and families.

2. Preventive skills. The identification of risks and early departures from normality in patients who are known to the physician.

3. Therapeutic skills. The use of the doctor-patient relationship to maximize the effectiveness of all kinds of therapy.

4. Resource management skills. The deployment of the resources of the community and the health care system for the benefit of patients. This includes the skills of practice management and of consultation and referral.

Implications of the Principles

Defining our discipline in terms of relationships sets it apart from most other fields of medicine. It is more usual to define a field in terms of content: diseases, organ systems, or technologies. Clinicians in other fields form relationships with patients, but in general practice the relationship is usually *prior* to content. We know people before we know what their illnesses will be. It is, of course, possible to define a content of general practice, based on the common conditions presenting family physicians at a particular time and place. But strictly speaking, the content for a particular doctor is whatever conditions his patients happen to have. Other relationships also define our work. By caring for members of a family, the family doctor may become part of the complex of family relationships, and many of us share with our patients the same community and habitat.

Defining our field in these terms has consequences, both positive and negative. Not to be tied to a particular technology or set of diseases is liberating. It gives general practice a quality of unexpectedness and a flexibility in adapting to change. On the other hand, it is poorly understood in a society that seems to place less and less value on relationships. One major consequence is that we cannot be comfortable with the mechanical metaphor which dominates medicine, or with the mind/body dualism derived from it. Another is that the value we place on relationships influences our valuation of knowledge. Those who value relationships tend to know the world by experience rather than by what Charles Taylor (1991) calls "instrumental" and "disengaged" reason. Experience engages our feelings as well as our intellect. The emotions play a very significant part in family practice.

Long term relationships lead to a build up of particular knowledge about patients, much of it at the tacit level. Since caring for patients is about attention to detail, this knowledge of particulars is of

great value when it comes to care. On the other hand, it can make us somewhat ambivalent about classifying patients into disease categories. "Yes", we might say, "this patient has borderline personality disorder - but he is also John Smith, who I have cared for for 15 years." On the whole, our tendency to think in terms of individual patients more than abstractions is a strength, though it can lead us astray if it diverts us from the appropriate pursuit of diagnostic precision. Our valuation of particular knowledge, however, can make it difficult for us to feel comfortable in the modern academic milieu, where diagnosis and management are more usually seen in terms of generalizations than particulars. The risk of living too much in a world of generalizations and abstractions is detachment from the patient's experience and a lack of feeling for his suffering. Abstraction produces accounts of experience which, for all their generalizing power, are stripped of their affective coloring and far removed from the realities of life. The ideal for al l physicians is an integration of the two kinds of knowledge: an ability to see the universal in the particular.

The most significant difference between family medicine and most other clinical disciplines is that it transcends the mind/body division which runs through medicine like a geological fault line. Most clinical disciplines lie on one side or the other: internal medicine, surgery, and paediatrics on one side; psychiatry, child psychiatry, and psychogeriatrics on the other. Separate taxonomies of disease lie on either side: textbooks of medicine and surgery on one, the Diagnostic and Statistical Manual of Mental Disorders on the other. We divide therapies into the physical and the psychological. In clinical practice, internists and surgeons do not normally explore the emotions, psychiatrists do not examine the body. Since family medicine defines itself in terms of relationships, it cannot divide in this way.

One of the legacies of the mind/body division is a clinical method which excludes attention to the emotions as an essential feature of diagnosis and management. Another is the neglect in medical education of the emotional development of physicians. A contemporary writer has referred to the "stunted emotions" of physicians (Price 1994). We may be seeing the consequences of this neglect in the alienation of patients from physicians, the widespread criticism of medical care, and the high levels of emotional distress among physicians.

Since family medicine transcends the "fault line", the conventional clinical method has never been well suited to family practice. Perhaps this is why the moves to reform the clinical method have often come from family medicine. The most important difference about the patient-centered clinical method is that attention to the emotions is a requirement. Family medicine has also emerged as one of the most self-reflective of disciplines.

With developments in cognitive science and psychoneuroimmunology, and the high prevalence of illness which does not lie on one side or the other, the fault line is likely to become increasingly redundant. As medicine strives to achieve a new synthesis, it could learn much from our experience.

Conflicting Roles

Hidden among the principles are some potential conflicts between the family doctor's roles and responsibilities. The first principle is one of commitment to the individual patient, to respond to any problem the patient may bring. It is the patient who defines the problem. According to the third principle (responsibility for prevention) it is usually the doctor who defines the problem, often in situations where the patient has come for an entirely different purpose. It may be argued that anticipator y medicine is part of good clinical practice. Taking the blood pressure is part of the general clinical assessment, and if the diastolic pressure is 120 mm, good preventive and clinical practice requires that the problem be attended to, even if the patient has no symptoms related to high blood pressure and has only come for a tension headache.

The issue becomes more complex as one moves along the continuum from the presymptomatic detection of disease to the identification of risk factors arising from a patient's habits and way of life. The number of risk factors increases and the reduction of risk involves behavioural changes which may be very difficult to attain. All this may be successfully integrated with clinical practice, and may actually be demanded by a public who are educated to expect anticipatory care. At some point, however, a n emphasis on anticipatory care may compete for time and resources with care based on responding to problems identified by patients. Striking the right balance may be difficult if physicians are constrained either by requirements of managed care or by fun ding arrangements designed to emphasize anticipatory care.

The fourth principle (the practice as a population at risk) adds another dimension. Here, the focus is switched from the individual to the group. The measure of success is statistical. The motivation may be to extend effective care to all patients in the practice, especially those who may not be aware of its availability. The other extreme, however, is to judge success by the magnitude of compliance in the practice population. If funding is dependent on certain targets, outreach to the practice population may compete for time and resources with other practice services, and there may be pressure on patients to comply. The demand on practice resources may be increased by approaches aimed at identifying unmet needs in the geographic area of the practice, and of conducting audits requiring expensive epidemiological methods. Too much emphasis on the population approach, at the expense of meeting the needs of individual patients, may, as Toon (1994) suggests, have an effect on the orientation and thought patterns of the physicians. Rather than thinking about their patients, they may find himself precoccupied with their figures.

The ninth principle (management of resources) may also become the source of conflict if a practice becomes responsible for managing and paying for all the services needed by its enrolled patients. The time necessary for management may reduce the time for patient care, and conflicts of interest may arise when an individual patient's interest conflicts with the interests of the group, or if the doctor stands to gain from economies in expenditure.

Conflicting ideas on the roles of the family physician can make it difficult to agree on criteria of quality, especially at times of rapid social change like the present. Toon (1994) suggests that where there is already a strong tradition of general medical practice there may be an intuitive concept of good general practice which will eventually lead to a synthesis. The path to a synthesis will be easier if administrators and managers tread lightly in making changes which alter the balance between the doctors' responsibilities, especially those changes which can divert us from our traditional responsibilities to individual patients.

Continuity of Care

For a discipline that defines itself in terms of relationships, continuity in the sense of an enduring relationship between doctor and patient, is fundamental. Hennen (1975) has described five dimensions of continuity: interpersonal; chronological; geographic (continuity between sites: home, hospital, office); interdisciplinary (continuity in meeting a variety of needs, e.g. for obstetric care, surgical procedures); and informational (continuity through the medical records). I use continuity here in the sense of overall, direct, or coordinative responsibility for the different medical needs of the patient (Hjortdahl, 1992a). The key word here is *responsibility*. Obviously the physician cannot be available at all times, nor can he carry out al l the care a patient may need. The doctor is responsible for ensuring continuity of service by a competent deputy and for following through when some aspect of care is delegated to a consultant. Responsibility is the key in all important relationships.

Based on a sequence of studies from a number of perspectives, Veale (1995,1996)2 has described four types of general practice utilization. In the first, a consumer visits only one General Practitioner(GP). In the second, all the visits are to one practice. In the third type, the consumer visits a variety of GPs for different purposes. One doctor may be seen because of proximity to place of work, another for proximity to home, or the selection of G.P. may depend on the nature and severity of the problem and the doctor's expertise. This type of utilization appeared to work well for consumers who take responsibility for coordinating their own care. In the fourth type of utilization, the consumers decide which doctor they will see on a visit-by-visit basis, with no expectation that there will be continuity of care from any of them.

There was strong preference, both by consumers and doctors, for the first type of utilization. Three benefits were associated with visits to one GP: coordination of care, familiarity and openness in the therapeutic relationship, and the opportunity for monitoring of treatment and mutual agreement about management. However, consumers who had all their visits to one GP did not necessarily reap the benefits of continuity. Nor did visits to several GPs in the same practice, or to GPs in different practices preclude continuity.

Brown et al. (1996) have shown that continuity of care can be experienced by patients even in a university group teaching practice with frequent changes of trainees.3 Long term patients of the practice, recruited to focus groups, identified four factors contributing to their experience of continuity: the sense of being known as a person by the doctors, nurses, and receptionists; the relationship with a team of doctor-nurse-trainee-receptionist; the sense of responsibility demonstrated by the physicians, including their openness and honesty in dealing with uncertainty; and the comprehensiveness and availability of the services provided, including a 24-hour on call service and willingness to see patients at home and in the hospital.

Continuity in the doctor-patient relationship is a mutual commitment. Veale concludes that it is best understood, "not as an entity provided by doctors, but rather as an interaction over time, constructed jointly by consumers and their GPs". Continuity "cannot be delivered to a passive recipient by the G.P., however skillful." The essential preconditions of continuity were ready access, competence of the doctor, good communication, and a mechanism for bridging from one consultation to the next. There was a tendency for young and healthy people to prefer the visit-by-visit approach, for people with young children to have continuity with a practice, for those with several distinct problems to visit a variety of GPs, and for the elderly and people with serious illness to prefer continuity with one doctor. Attitudes to continuity may therefore change as people grow older and experience different needs (Veale, 1996).

It is difficult for a doctor to feel continuing responsibility for a patient who does not value it. Some experience of a continuing commitment is required for a sense of responsibility to grow. Hjortdahl (1993a) found that duration of the relationship and frequency of contacts (density) were important in developing the sense of responsibility. After one year, the odds of the doctor feeling this sense doubled, and after five years they increased sixteen fold. If there were four or five contacts over the previous year there was a ten fold increase in the sense of continuing responsibility, compared with only one visit.

Once this mutual commitment has developed, failure to honor the commitment may be seen as a betrayal of trust: if, for example, the doctor terminates the relationship when a patient develops AIDS or is too ill to leave his home.

The value placed on continuity of personal care is reflected in the way a practice is organized. Reception staff can make every effort to book patients with their chosen physician. The practice's philosophy of continuity can be clarified and conveyed to staff and patients. Individual patients'

preferences with regard to continuity can be noted, and if possible, accommodated. The on-call system can be organized so that patients see a doctor who communicates with their own doctor, has access to their medical record, and can make a home visit when required. Dying patients, and others with special needs, can be kept out of the on-call system. Continuity can be enhanced by having the patient's record available at all times to those providing care.

Comprehensiveness of care

Since the family physician is available for any type of health problem, the care he provides is comprehensive. He will never say to a patient: "I am sorry, but your problem is not in my field. You will have to see somebody else." He may of course, refer a patient to another physician, but this does not imply that his responsibility has ended.

Family care

Since the family physician cares for patients of both sexes and in all age groups, it follows that in many cases he cares for family units. This gives him advantages in diagnosis and management, which are discussed in Chapter 8.

Bonding

As a result of both duration and intensity of care, a process of bonding often takes place between the physician and the patient or family. The strength of the bond varies widely from patient to patient and family to family. In general, the strength is related to the number of contacts and the duration of the relationship, but these are not the only factors. It is a common experience that the bond is strengthened by certain types of care: by caring for a patient during pregnancy and childbirth; by helping a family through a crisis; by caring for a patient in his own home; or by supporting a patient and his family in a terminal illness.

Cumulative knowledge of patients

Continuous and comprehensive care allows the family physician to build up, piece by piece, a "capital" of knowledge about patients and families. This is one of the family physician's most precious assets. It is a fallacy to assume that he has a comprehensive knowledge of all his patients, however, even after many years. The knowledge is only acquired as the opportunity arises and when it is needed. Often it is only acquired when the patient is ready to give it. Family physicians I have spoken to agree that only in perhaps 10 percent of their patients does this knowledge amount to a *full* picture.

The role of generalist

The family physician is, by nature and function, a generalist. If any organization is to remain healthy, it must have a balance between generalists and specialists. If this seems like a statement of the obvious, let us remember that until very recently, many influential voices in medicine questioned the value of a medical generalist. The explosion of knowledge, this argument ran, has made it impossible for any individual to cover the whole field: it is inevitable, therefore, that medicine will fragment into specialties as it advances. The fallacy in the argument is the assumption that knowledge is a quantity—a lump of material that grows by accretion. I call it "the lump fallacy." The naivete of the assumption can be demonstrated by following the argument to its conclusion. Let us assume that the knowledge of one branch—pediatrics, for example—is at present of a quantity that can be covered by one physician. If knowledge is exploding, then after *n* years, it will have to fragment into pediatric subspecialties, and after another interval each subspecialty will have to fragment again, and so on. If the original assumption is correct, then there is no reason why the process should stop at any time, since further fragmentation is always possible. What we end with, of course, is a reduction and absorption. Nevertheless, the prospect of being a generalist is one

that many students and residents find daunting. It may be helpful, therefore, to examine the role of generalist in medicine and other walks of life, for the generalist/ specialist problem is one that runs through the whole of modern society.

The role of the generalist in any organization—whether it be a business, a university, or an orchestra—can be described as follows: He has a perspective of the whole organization: its history and traditions, its general structure, its goals and objectives, and its relationships with the outside world. He understands how each part functions within the whole. He is a communication center: information flows to him from all parts of the organization and from the outside world; information flows from him in both these directions. He helps the organization to adapt to changes, both internal and external. Problems arising within the organization, or between the organization and its environment, come to the generalist for assessment. Having defined the problem, he may either deal with it himself or refer it to a specialist. Once the problem has been defined as lying in his field, the specialist may then take on a decision-making role, with the generalist maintaining overall responsibility for ensuring that the problem is dealt with in the best interests of the whole organization. If the specialist finds that the problem is not in his field, he will refer it back to the generalist. If we substitute the words "organism" or "family" for organization, it is not difficult to see how these functions are carried out by the family physician.

Much of the apprehension about becoming a generalist is based on six misconceptions about the roles of generalist and specialist in medicine:

1. "The generalist has to cover the whole field of medical knowledge." The generalist's knowledge is just as selective as the specialist's. To use a spatial image, the generalist's knowledge is horizontal, the specialist's vertical (see Figure 2.1). Like the specialist, the generalist selects the knowledge he needs to fulfill his role. In subarachnoid hemorrhage, for example, the family physician needs to know the presenting symptoms and the cues that enable him to make an early diagnosis and referral. The neurosurgeon, on the other hand, needs to know the detailed pathology and the techniques of investigation and surgical treatment.
I have chosen as an example a condition in which the generalist's role is chiefly early identification of the problem. In other conditions, of course, the generalist will retain total responsibility for management and the knowledge required will differ accordingly.

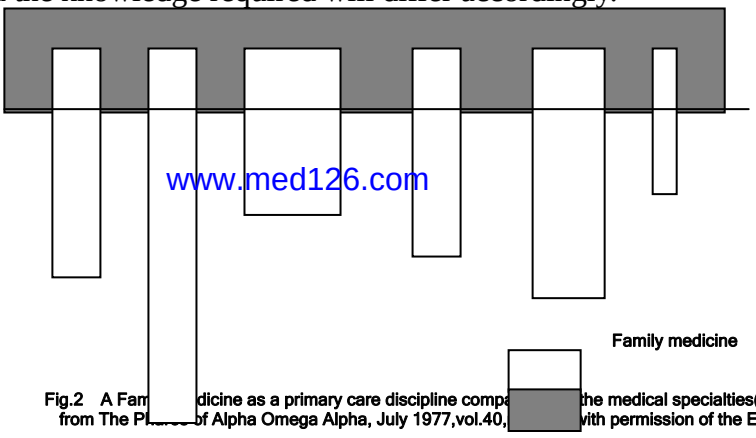


Fig.2 A Fam dicine as a primary care discipline compa the medical specialties(Reprinted from The Pl of Alpha Omega Alpha, July 1977,vol.40, with permission of the Editor.)

2. “In any given field of medicine, the specialist always knows more than the generalist.” This statement expresses the feeling of generalists that, when they survey the field of medical knowledge, there is no area they can call their own. Wherever they look, there is some specialist whose knowledge is greater than theirs. But this is not true. We become knowledgeable about the problems we commonly encounter. The specialist becomes knowledgeable about rarer variants of disease because they are selected for him by the generalist. The generalist becomes knowledgeable about the common conditions that rarely reach the specialist. A family physician sometimes encounters

this when, under pressure from a patient or his family, he consults a specialist even though he knows that he is in full command of the situation. He then finds to his surprise that the specialist is out of his depth, since it is a common variant of the disease that he has rarely encountered. The large circle represents a common disease：infectious mononucleosis, for instance. Each of the eleven segments of the circle represents the experience of one family physician. The outer circle represents the common variants of the disease and is the domain of the family physician. The inner circle represents the rare variants of the disease and is the domain of the infectious disease specialist. Note that the two domains complement each other. The specialist can only become knowledgeable about the rare variants because his experience is concentrated for him by the generalists. Note also that the small circle intersects the radial segments at different points. This illustrates the fact that all generalists do not necessarily have the same knowledge and experience. One of them, by virtue of his own interest or the age of his practice, may have had a greater experience of the disease than other generalists.

3. “By specializing, one can eliminate uncertainty.” The only way to eliminate uncertainty is, as Gayle Stephens（1975) pointed out, to reduce problems to their simplest elements and isolate them from their surroundings. Any clinical specialty that did this would soon cease to be of value.

4. “Only by specializing can one attain depth of knowledge.”This fallacy confuses depth with detail. The depth of a person's knowledge depends on the quality of his mind, not on its information content. The difference between depth and detail is illustrated in a story told of the Viet Nam war by Peer de Silva (1978). De Silva was listening to a briefing for Robert McNamara during one of his visits to Saigon. McNamara was bombarding the briefing officers with questions about yards of barbed wire and gallons of gasoline. “I sat there amazed," wrote de Silva, "and thought to myself, what in the world is this man thinking about? This is not a problem of logistics.…This is a war that needs discussion of strategic purpose and of strategy itself. What is he talking about?” McNamara was, of course, a generalist-and an able one. But in this case he was confusing depth with detail, thus failing to identify the main problem.

5.” As science advances, the load of information increases.” The contrary is true. It is the immature branches of science that have the greatest load of information："The factual burden of a science varies inversely with its level of maturity,” wrote Sir Peter Medawar (1967）.”As science advances, particular facts are comprehended within, and therefore, in a sense annihilated by, general statements of steadily increasing power and compass-whereupon the facts need no longer be known explicitly-that is, spelled out and kept in mind.” Imagine what it must have been like to learn about infectious diseases before the days of Koch and Pasteur!

It is true, of course, that information, as measured by publications, is increasing exponentially. This creates problems of its own, which 1 will discuss in Chapter 16.We must not make the mistake, however, of equating this information with knowledge. Much of it is of little value, much of it ephemeral, much of technical interest to specialists only, and much of it related to the testing of hypotheses that will eventually be rejected or incorporated into the main body of medical knowledge.

6. "Error in medicine is usually due to lack of information.” Very little medical error is due to physicians being ill informed. Much more is due to lack of care, insensitivity, failure to listen, administrative inefficiency, failure of communication, and many other factors that have more to do with the attitudes and skill of the physician than his lack of factual knowledge. Naturally, we want physicians to be well informed, but this will not guarantee medical care of high quality. The physician must also know how to obtain information and how to use it.

The role of the generalist has recently been described by Edmund Pellegrino（1978)in a passage that

I quote in full：

For it is the generalist function that constitutes what family medicine can bring to patient care. It subsumes intellectual and practical components that culminate in the process whereby a patient's condition is evaluated, his or her needs identified and placed in some priority, and a plan of management developed efficiently and optimally to satisfy the identified needs. The generalist is differentiated from the specialist by the types of clinical situations with which he is confronted. The generalist deals with patients in three categories:(1) those who have not yet been classified into some organ-or technique-oriented specialty, (2) patients in whom, having been so categorized, new signs and symptoms develop that mayor may not be related to the previous category, (3) patients with problems simultaneously in more than one organ system. These sets of patients may need primary, secondary, or tertiary care.

The generalist's decisions mayor may not lead to final diagnostic closure. They are always concentrated on a clearly defined end point, a set of actions or treatments designed to meet as many of the patient's needs as possible in an integrated and comprehensive fashion. Crucial to each decision is the early determination of whether the patient's major needs lie in the large universe of the common ills treatable by the generalist or whether they require the more restricted expertise of one or several specialties. In addition, the generalist must manage the range of decision-making processes in the patient's interest and establish an orderly plan for implementing them.

All patients, whether cared for by specialists or generalists, at some time or another have need of this generalist function on an intermittent or continuous basis. Human ills are too personalized and individualized to fit the tight frame of any specialty for long. The more technically confined the specialty, the more it needs the generalist, since the patient's problems can extend so readily beyond its categorical perimeters.

The specialist, on the other hand, deals with a partially or fully categorized disorder that has been located to a specific organ system, or a patient whose problem must be ruled in or out of a category or whose need is for a particular diagnostic or therapeutic technique. The specialist yields to another specialist whenever the problem exceeds the confines of his expertise. The specialist has personal responsibility only for the domain in which he has been declared expert. When he refers the patient to other experts, he is not responsible for managing the interface between clinical domains. The specialist does not have responsibility for integrating care that falls between specialists or comprises several organ systems.

All physicians perform some aspect of the generalist function at some stage of their encounter with a patient. Only the generalist, however, does so in the whole range of clinical possibilities. The generalist is distinguished, therefore, not by being the only one to perform the generalist function but by the personal responsibility for acting across the boundaries between clinical categories and over the whole spectrum of needs.

Generalists must, therefore, coordinate and manage the input of specialists and other health professionals, they must deal in an orderly fashion with multiple problems, they must make the confusing whole into an intelligible situation for the patient and his family, and they must assume personal responsibility to protect the patient's interests in what is often an overwhelming array of treatments, recommendations, and techniques. The generalist must explain the relative importance and priorities of what can be contradictory recommendations offered by the specialists. He has a particularly difficult moral responsibility to protect the patient from the overzealous espousal of the consultant's preferred technique, to the exclusion of other equally tenable alternatives.

Two final points should be made. Because the family physician is a generalist, this does not mean that all family physicians have identical knowledge and skills. All of them share the same commitment to patients. By virtue of special interest or training, however, a physician may have knowledge that is not shared by his colleagues. In any group of family physicians, this can be a source of enrichment. One may be skilled in reading ECGs, another may have a special interest in child health or the care of elderly patients. The important point is that this should not lead to fragmentation, with the physician interested in child health looking after all the children, and so on. Family physicians may be differentiated, but family medicine must not fragment. If it were to do so, the role of generalist would be lost.

The family physician acts not only across clinical boundaries, but across that very difficult one： the

boundary between medical and social problems. The boundary is difficult because it is seldom clear-cut. Patient's problems have a way of bestriding it. To the family physician, therefore, falls the responsibility of managing the interface between clinical practice and the counseling professions.

Is family medicine universal?

If the principles set out in this chapter have an enduring value, they should be applicable to all cultures and all social groups. If family medicine were to become a service available only to the affluent members of industrialized societies, it would soon lose adherents. Yet there are those who see the problems of poor countries and poor communities as so different that they require a different and more basic approach. Their needs, it is argued， are for clean water, better housing, sanitation， and immunization, rather than for the type of personal care provided by family physicians. There is some truth in this. Elementary public health measures are still the first need in many societies. But they are not the only need. Other problems will only yield to the personal, family-centered approach. Dr. Cicely Williams, well known for her description of kwashiorkor, became convinced that the answer to malnutrition was family-based health care. I have myself watched a nurse practitioner in a poor area of South Africa treating conditions like malnutrition and streptococcal infection on exactly the same principles that I have outlined here.

I believe firmly that these principles have universal application. How they are applied， however, will vary according to circumstances. If there is only one physician for 50,000 people, it is obvious that his role as a manager of resources, leader, teacher, and resource for difficult problems will be predominant. The application of the principles on the personal level will be the responsibility of other personnel working under his supervision. There is a parallel here with anesthesiology and obstetrics. The principles of anesthesiology and obstetrics are universally applicable. How they are applied, and the role of the physician anesthetist or obstetrician, depend on local resources.

Ⅲ. ILLNESS IN THE COMMUNITY

Recent studies of illness in the community have revealed that physicians see only a small fraction of the health problems experienced by the population at large. Kerr White et al.（1961) summarized the data from a number of community surveys in a diagram reproduced in Figure 3.1. Of a thousand people in the general population over the age of sixteen, 750 will in the course of a month report an illness；250 will consult a physician；five will be referred to another physician；nine will be admitted to a hospital， but only one to a teaching hospital.

In retrospective population surveys, more than 90 percent of adults report a symptom during the previous two weeks. Only one in every four or five of these have consulted a physician in that period (Wadsworth et al.， 1971； Dunnell and Cartright, 1972).

In a prospective study using the health diary method，adults recorded at least one complaint on 21.8 percent of days and only on 6 percent of these days was a doctor consulted (Roghmann and Haggerty, 1972). In another prospective study of women using health diaries, symptoms were recorded on ten days out of twenty-eight on the average. The yearly average of symptom episodes was eighty-one. A doctor was consulted for only one out of every thirty-seven symptom episodes (Banks et al., 1975).

It would be convenient to assume that there is a simple relationship between the severity of the symptom and consultation with a physician. Unfortunately, this is not the case. Some patients attend with very minor symptoms, others fail to attend even when their symptoms are serious. The factors

that influence the decision to consult a physician are many and various. If he is to understand his patient's problems it is obviously important for the family physician to know these factors.

Two concepts are helpful in analyzing the decision to consult：the sick role and illness behavior. The concept of the sick role was introduced by Sigerist（1960) and Talcott Parsons（1951）. According to Parsons, when a person has consulted a physician and been defined as sick, he occupies a special role in society. Entering the sick role has certain obligations and privileges. The individual is exempted from normal social obligations and is not held responsible for his incapacity. On the other hand，he is expected to seek professional help and to make every effort toward his recovery. Whether or not a person decides to enter the sick role when he becomes ill is dependent on many individual and group factors that are independent of the severity of the illness.

Illness behavior is defined by Mechanic (1962) as “the ways in which given symptoms may be differentially perceived，evaluated，and acted (or not acted) upon by different kinds of persons.” The illness behavior exhibited by an individual determines whether or not he will enter the sick role and consult a physician.

Factors influencing illness behavior

Variations between individuals and groups in their propensity to seek medical care may be due to actual differences in morbidity or to differences in illness behavior. Since illness rates are high in the very young and very old, it is not surprising that these groups make high demands for care. The high demand for care by women between the ages of 15 and 44 is more difficult to explain. The demand for care in women of this age is high even when obstetric care is excluded. Although some of this demand may be attributable to a higher morbidity rate, it is probable that social and cultural factors are also important.

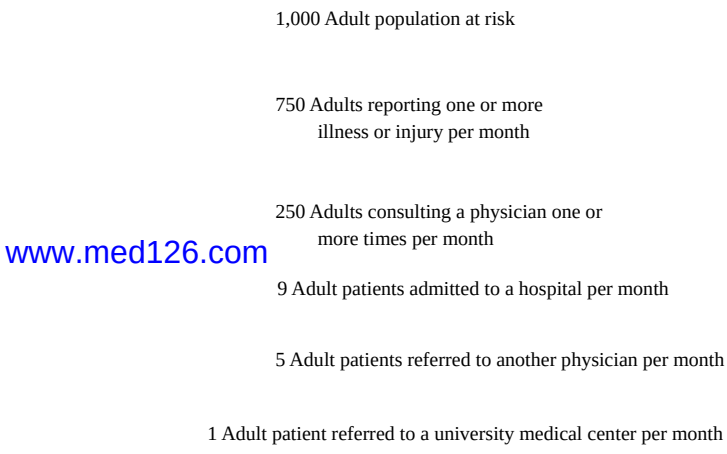
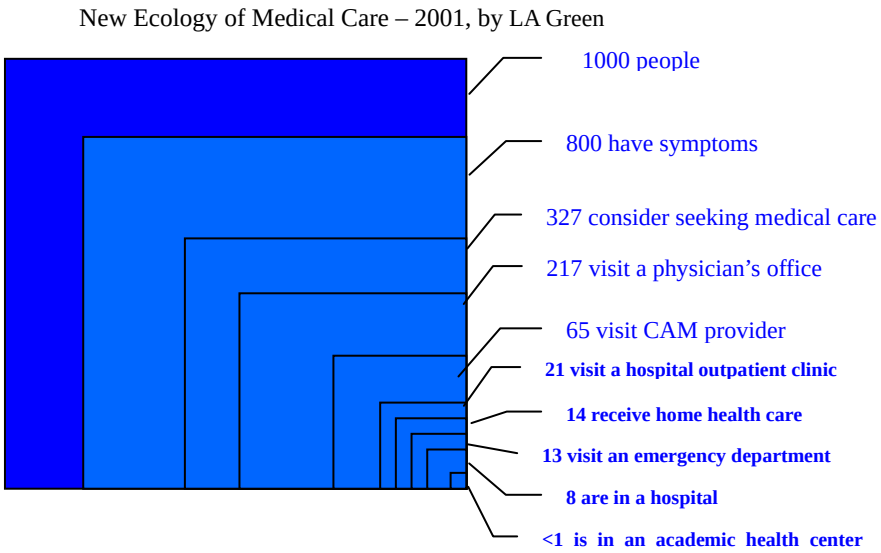


Fig. 3.1 Prevalence of illness and utilization of medical resources among 1,000 adults in the United States and Great Britain (From White, Williams, and Greenberg，1961.)



Factors that are known to affect illness behavior are ethnicity, social class, religion, personality, the existence of interpersonal problems and the nature of the illness.

Zola (1966) interviewed Italian and Irish patients before they saw the physician on new visits to hospital clinics. Information on the primary diagnosis, secondary diagnosis, potential seriousness and degree of urgency was obtained from the physician. Besides comparisons between the two groups, comparisons were also made between matched pairs of one Irish and one Italian patient of the same sex who had the same primary diagnosis, the same duration of illness and the same degree of seriousness.

Major differences emerged. The Irish more often than the Italians denied that pain was a feature of their illness. More Irish described their chief problem in terms of specific dysfunction， while more Italians described it in terms of a diffuse difficulty. The Irish tended to limit and understate their difficulties, whereas the Italians tended to spread and generalize theirs. In the matched pairs, the Italians complained of more symptoms, more bodily areas affected， and more kinds of dysfunction than did the Irish, and more often felt that their symptoms affected their interpersonal behavior.

Zborowski（1951）studied reactions to pain in patients of Jewish, Italian, and "Old American"stock, Data was collected from interviews with patients, from observation of their behavior when in pain, and from discussion with doctors and nurses involved in the care of the individual.

Jews and Italians were described as being very emotional in their responses to pain. Italians, however, were mainly concerned with the immediacy of the pain, whereas Jews focused their concern on the meaning of the pain and its long-term implications. The two groups also differed in their attitudes to analgesic drugs. The Italians called for pain relief and soon forgot their sufferings when this occurred. The Jews were reluctant to accept drugs, were concerned about their side-effects, and regarded them as giving only temporary relief.

The "Old American" patients tended to have a detached and unemotional attitude to their pain. Like the Jewish patients," Old Americans" were concerned about the meaning and future implications of their pain； but, whereas the anxieties of Jews were tinged with pessimism about the outcome, "Old Americans" tended to retain an attitude of optimism born of their confidence in the skill of the expert.

In his book, *The Health of Regionville*, E. L. Koos（1954) noted that upper-class persons more often

reported themselves ill than lower-class persons, and were more likely to seek treatment when ill. Lower-class persons had more symptoms, but reported themselves to be less often ill and were less likely to visit a physician. Some of these differences in relation to specific symptoms are illustrated in Table 3.1.

Propensity to seek medical advice is related to a person's religion. In one study(Mechanic, 1962) Jews and Episcopalians expressed a higher inclination to use medical facilities than Catholics and Christian Scientists. These differences held true when social class was taken into account. It is probable that these differences reflect different teachings about how to cope with life stress and illness.

Table 3.1 - Percentage of respondents in each social class recognizing specified symptoms as needing medical attention*

Symptom	Class I (N = 51)	Class II (N = 335)	Class III (N = 128)
Loss of appetite	57	50	20
Persistent backache	53	44	19
Continued coughing	77	78	23
Persistent joint and muscle pains	80	47	19
Blood in stool	98	89	60
Blood in urine	100	93	69
Excessive vaginal bleeding	92	83	54
Swelling of ankles	77	76	23
Loss of weight	80	51	21
Bleeding gums	79	51	20
Chronic fatigue	80	53	19
Shortness of breath	77	55	21
Persistent headaches	80	56	22
Fainting spells	80	51	33
Pain in chest	80	51	31
Lump in breast	94	71	44
Lump in abdomen	92	65	34

* From Koos, 1954.

Propensity to seek care is also related to an individual's personality. Banks et al.(1975) showed that women with a high level of free floating anxiety were more likely to consult their general practitioner about their symptoms. Jacob (1969) found that high users of services had a high neuroticism score using the Maudsley Personality Inventory. He also showed that introverts had higher demands than extroverts. Polliack (1971) showed that patients scoring high on the Cornell Medical Index made high demands on their general practitioners. Mechanic (1962) found that persons reporting high stress levels, especially interpersonal difficulties, showed a high inclination to use medical services. This finding is in accordance with the experience of family physicians. Many patients coming with symptoms have as their main problem an interpersonal difficulty which they find difficult to express in words. The symptom then acts as a "signal" of the underlying problem.

It is not difficult to see why the nature of the symptom or illness has a strong influence on the decision to seek care. An illness that is common, easily recognizable, and devoid of danger is less

likely to lead to a demand for care than one that is uncommon, unfamiliar, and threatening. Table 3.2 illustrates the wide variations in response to different symptoms.

Self-care

It will be clear from the above studies that the majority of symptom episodes are managed by the sufferers themselves without recourse to medical advice. Self-care refers to all the actions taken by a sufferer on his own behalf. These actions may replace medical advice or they may precede consultation with a physician. Self-care can take a number of forms:

Table 3.2 The likelihood of symptom episodes leading to consultation with a physician*

symptom	ratio of symptom episodes to consultations
Changes in energy	456: 1
Headache	184:1
Disturbance of gastric function	109: 1
Backache	52:1
Pain in lower limb	49:1
Emotional / psychological	46:1
Abdominal pain	29:1
Disturbance of menstruation	20:1
Sore throat	18: 1
Pain in chest	14: 1

* Adapted from Banks et al., 1975.

1. Self-medication. Studies in Britain and the United States have shown high rates of self-medication (between 50 percent and 80 percent of adults reported taking an over-the-counter medication in a two- to four-week period). The great majority of these are analgesics, cold remedies, and antacids. The pharmacist is often a source of advice on over-the-counter medication. In a study of primary care given by pharmacists in London, Ontario, Bass (1975) found that in neighborhood pharmacies, for every 100 prescriptions issued, about nineteen other people asked for advice on health problems. The commonest of these were: upper respiratory infections, stomach and bowel complaints, pain, and inquiries about vitamins.

2. "Non medical" actions. Although most attention has been focused on medication, a large number of other remedial actions may be taken. In a study using the health diary method, Freer (1978) found that a large number of non medical actions were reported. Some of these were social actions, like talking to friends or relatives, attending a club, or going out for a meal; others were individual actions, like doing housework, going out shopping, or gardening. All these actions were recorded because they were viewed as being therapeutic.

3. Lay referral. This refers to consultation with family members, friends, neighbors, and other nonprofessional people whose advice may be sought. Certain individuals in a neighborhood may have a reputation for being knowledgeable in health matters. Others may be valued for their advice on personal problems. All societies have resources of this kind, quite independent of the health care system.

It is likely，however, that in highly mobile societies there is less opportunity for such informal aid systems to develop. This may help to explain the large number of personal problems that are presented to family physicians in industrialized societies

Ⅳ. A PROFILE OF FAMILY PRACTICE

For reasons discussed in Chapters 3 and 7, it is difficult to convey in statistical terms a true picture of the content of family practice. One approach is to record the diagnosis made at each doctor-patient encounter. By this means, it is possible to obtain an accurate picture of the family physician's experience with well-defined diseases like diabetes. Many illness episodes seen by family physicians, however, are much more difficult to define and label. The reader will obtain some idea of the difficulty by reading Case 7.1 on page 84. The problems in this patient cannot be expressed by simple disease labels. There is no "diagnosis" in the usual sense of the term. Another approach is to record the patient's main symptom or complaint. Here again, however, the result may be a very partial picture of the illness, since a statement of the symptoms says little or nothing about its origins. If we were classifying Case 7.1 by disease labels we could call the illness "anxiety state" or "insomnia." If we were classifying the case by symptoms we could call it "insomnia" or "gastrointestinal symptoms." Whichever route we take, we provide only a partial picture, because we are doing something equivalent to taking a two-dimensional slice through a three-dimensional object. Another difficulty is that we have no assurance that any two physicians will classify the same illness in the same way. If one physician classifies the illness as "anxiety state," it will appear in the statistics under the rubric of "mental illness." If another classifies it as "gastrointestinal symptoms(not yet diagnosed)" it will appear under the rubric "gastrointestinal diseases." Given these difficulties of nomenclature and standardization, it is small wonder that there are wide variations in such estimates as the amount of psychiatric illness in family practice.

In spite of this, however, there are also some important areas of agreement regarding the content of family practice, not only in North America, but in similar countries in other parts of the world. In this chapter I have used data from the United States, Canada, and the United Kingdom to give a profile of the work of the family physician. In examining these statistics, the reader should keep in mind the cautionary statements made above, and also the different criteria used in different studies for defining symptoms and diseases.

Symptoms

Table 4.1 gives the ranking order, in males and females, of the twenty-five most common problems, complaints, or symptoms presented to family physicians participating in the United States National Ambulatory Medical Care Survey(1977-78). Only the first-listed or principal problem for each patient visit has been included.

These may be compared with the ten most common presenting complaints in one Canadian and one British study (Tables 4.2 and 4.3). When comparing these figures, allowance must be made for the different ways in which symptoms were classified. Even so, there is substantial agreement among the three lists, both for males and females.

Table 4.1 The twenty-five most common reasons for visits to family physicians/general practitioners, in descending order of frequency (National Ambulatory Medical Care Survey, 1977-78)

Males	Females
1. Symptoms referable to throat	Symptoms referable to throat
2. Head cold, upper respiratory infection	Cough
3. Cough	Head cold, upper respiratory infection
4. Skin rash	General medical examination (excl. gyn. and prenatal exams)
5. Fever	Skin rash

6. General medical examination	Abdominal pain
7. Physical examination for employment	Back symptoms
8. Earache	Earache
9. Chest pain (excl. heart pain)	Headache (excl. migraine and sinus headache)
10. Nonarticular rheumatism	Fever
11. Headache (excl. migraine and sinus headache)	Chest pain (excl. heart pain)
12. Abdominal pain	Pap smear
13. Physical examination for school	Vertigo-dizziness
14. Lacerations of upper extremity	Neck symptoms
15. Neck symptoms	Shoulder symptoms
16. Foot and toe symptoms	Stomach pain, cramps, and spasms
17. Physical exam for extracurricular activities	Nausea
18.Stomach pain, cramps and spasms	Leg symptom
19.Prophylactic inoculations	Pain, site not referable to specific body system
20. Nasal congestion	Dysuria
21. Shoulder symptoms	Prenatal examination
22. Leg symptoms	Weight gain
23. Hand and finger injury	Physical examination for school
24. Knee symptoms	Anxiety and nervousness
25 Diarrhea	Prophylactic inoculations

Table 4.4 Ranking order of twenty-Five most common diagnoses in the Virginia study (U.S.) and Second National Morbidity Survey (U. K.)

Virginia Study (male and female)	N.M.S. (male and female)
1. Medical exam for preventive purpose	Pharyngitis and tonsillitis
2. Hypertension	Coryza (nonfebrile)
3. Lacerations, contusions, abrasions	Acute bronchitis
4. Pharyngitis and tonsillitis	Oral contraceptive advice
5. Bronchitis	Febrile cold and influenza
6. Sprains and strains	Lacerations, contusions, abrasions
7. Diabetes mellitus	Prenatal` care
8. Coryza (nonfebrile)	Anxiety
9. Obesity	Depressive neurosis
10. Febrile cold and influenza	Acute vomiting and/or diarrhea
11. Otitis media	Sprains and strains
12. Depressive neurosis	Otitis media
13. Cervical smear	Cough
14. Prenatal care	Eczema and dermatitis
15. Anxiety neurosis	Cervical smear
16. Arteriosclerosis (including cardiovascular disease)	Vaginal discharge
17. Vaginitis, vulvitis, cervicitis	Medical exam for preventive purposes

18. Abdominal pain	Wax in ear
19. Congestive heart failure	Hypertension
20. Cystitis	Health education
21. Acute sinusitis	Acute laryngitis and tracheitis
22. Other signs or symptoms	Conjunctivitis
23. Other forms of arthritis or rheumatism	Osteoarthritis and allied conditions
24. Other signs or symptoms	Cystitis
25. Pneumonia	Diarrheal disease

Table 4.5 The twenty-five most common diagnoses made by general practitioners inthe National Ambulatory Medical Care Survey (1977-1978)

Male	Female
1. Medical or special examination	Medical or special examination
2. Acute upper respiratory infection	Acute upper respiratory infection
3. Acute pharyngitis	Acute pharyngitis
4. Acute tonsillitis	Bronchitis
5. Bronchitis	Otitis media
6. Otitis media	Eczema and dermatitis
7. Eczema and dermatitis	Prenatal care
8. Influenza	Acute tonsillitis
9. Essential hypertension	Influenza
10. Chronic sinusitis	Cystitis
11. Diarrheal disease	Diarrheal disease
12. Strains and sprains of back	Obesity
13. Synovitis and bursitis	Chronic sinusitis
14. No complaint or illness	Anxiety neurosis
15. Lumbago	Synovitis and bursitis
16. Wounds of fingers	Essential hypertension
17. Viral disease	Vaginitis and vulvitis
18. Medical and surgical aftercare	Viral diseases
19. Acute bronchitis and bronchiolitis	Lumbago
20. Anxiety neurosis	Menstrual disorders
21. Laceration of head	No complaint or illness
22. Radiological examination	Strains and sprains of back
23. Symptoms referable to nervous system	Urinary infection
24. Diseases of sebaceous glands	Strains and sprains of ankle and foot
25. Hay fever	Acute bronchitis and bronchiolitis

Tables 4.5 to 4.8 convey very vividly not only the high frequency of many illnesses rarely seen in the hospital, but also the low incidence of some, like carcinoma, that are commonly seen in hospital practice.

Table 4.6 Annual morbidity experience in average British general practice of 2,500 persons. (Omitted)

Table 4.7 Annual morbidity experience in average British general practice of 2,500 persons*

Minor illnesses (of short duration and minimal disability)	Persons consulting
Upper respiratory infections	500

Common gastrointestinal "infections" and "dyspepsias"	250
Skin disorders	225
Emotional disorders	200
Acute otitis media	50
Wax in external meatus	50
"Acute backache"	50
Acute urinary infections	50
Migraine	30
Hay fever	25

*From Present State and Future Needs, 1973.

Table 4.8 Annual morbidity experience in average British general practice of 2,500 persons*

Chronic illnesses	Persons consulting
Chronic "rheumatism"	100
Rheumatoid arthritis	10
Chronic mental illness	55
Severe subnormality	5
E.S.N. school	3
Vulnerable adults	40
Child guidance	4
Chronic bronchitis	50
Anemia	
Pernicious anemia	2
Hypertension	25
Asthma	25
Peptic ulcer	25
Strokes	15
Epilepsy	10
Diabetes	10
Parkinsonism	3
Multiple sclerosis	2
Pulmonary tuberculosis	2
Chronic pyelonephritis	1

*From Present State and Future Needs, 1973.

V. ILLNESS, SUFFERING AND HEALING

The Patient's Experience of Illness

A healthy person takes his body for granted. It does, of course, impose limitations on what he or she can do, but the person does not have to bring into consciousness the everyday acts of living. As I write this, I am not conscious of the coordinated movements of my hand. The sick become very much aware of the body and the limitations

it imposes. They have to think about activities that previously were carried out below the level of awareness. Will I manage this flight of stairs? Will I be able to get on the bus to do my shopping? Bodily functions, which previously formed the background to one's world, become the foreground; the rest of world recedes into the background. In health, the body and the self are one: we *are* our bodies. In sick ness, the body becomes something other than the self, something alien, over which the self has limited control.

Physicians see illness in terms of a disturbance of bodily function. Patients see it as a disruption of their "being in the world".

Critical illness leaves no aspect of life untouched. The hospitals and other special places we have constructed for critically ill persons have created the illusion that by sealing off the ill person from those who are healthy, we can also seal off the illness in that ill person's life. This illusion is dangerous. Your relationships, your work, your sense of who you are and who you might become, your sense of what life is and ought to be -- these all change, and the change is terrifying.(Frank,1991)

In Kay Toombs' words, "A patient does not so much have an illness as exist an illness." She takes to the physician a problem of existence but finds the physician's attention directed to her body rather than to her problems with existence. The patient feels "reduced to a malfunctioning biological organism" (Toombs, 1992).

Chronic disease, especially if it brings successive losses of independence and control, often engenders profound sensations of grief. With grief come the feelings associated with it: sadness and anger, guilt and remorse. If the illness is one that carries a stigma - such as epilepsy, cancer or AIDS - then feelings of rejection may add to the grief. Anger may be projected onto the physician, who may be viewed as responsible for delays in diagnosis or errors in management. Given the insidious nature of many chronic illnesses and the difficulties of early diagnosis, family physicians are especially liable to encounter this level of hostility. When the patient feels responsible for causing his or her own disease, the anger is turned inward. Those physicians who would like to convince people that they are responsible for their own healing should consider the consequences in guilt and remorse if their efforts do not improve their health or prevent deterioration.

Fear and anxiety are ever present in illness, even in minor illness. Fears are many and varied, rational and irrational. Physicians cannot assume that they know what patients' fears are until they make an effort to discover them. A patient may have come to terms with the fact that she has progressive cancer but may still fear that her death will be painful and distressing. Or she may fear for the future of her family. Dying patients may have a fear that they will be abandoned by their doctor if they complain too much. They then become reluctant to ask for a visit when they need one, and tolerate pain which could be controlled. This is why regular, rather than "on request" visits are so important for dying patients.

A number of physicians, most recently Eric Cassell (1990), have observed that illness may impair the faculty of reason. The most rational of people may become irrational,

and even superstitious. This impairment of judgment is rarely considered when we are enjoined to give patients responsibility for decisions about their treatment. As an ethical principle, this is no doubt correct. In real life the issue is rarely so clearly defined.

The threats to self that illness brings - the disruption, loss of autonomy, loss of control, and loss of confidence - make sick persons very vulnerable. They not only feel vulnerable, they are vulnerable. This vulnerability makes it impossible for t he relationship between the doctor and the sick patient to be an equal one, however much we may wish it to be so. This puts a great responsibility on physicians to respect patients' vulnerability and to use their power responsibly and with compassion.

Kay Toombs has commented on the changed sense of time and space that illness induces. The natural rhythms of the body - the rhythms of eating, sleeping, working, resting - are disturbed. The patient loses the sense of the future as a time of possibilities. Simple tasks like dressing and tying shoelaces may occupy a large part of the day. Hull (1990) says of his experience as a blind person:

Sighted people can bend time. For sighted people, time is sometimes slow and sometimes rapid. They can make up for being lazy by rushing later on... For me, as a blind person, time is simply the medium of my activities. It is the inexorable context within which I do what must be done. For example, the reason why I do not seem to be in a hurry as I go around the building is not that I have less to do than my colleagues, but I am simply unable to hurry.

"Perhaps all severe disabilities," says Hull, "lead to a decrease in space and an increase in time." Toombs (1992) remarks on how illness changes the character of one's sense of space. "... objects or locations [the bathroom for example] which were formerly regarded as "near" are now experienced as "far" ..." "Spaciality ... constricts in the sense that the range of possible actions becomes severely circumscribed. Rather than representing the arena of possible action, space is encountered as the restriction of possibilities."

Toombs (1992) writes of the "profound effects of the loss of upright posture." A person in a wheelchair at a social gathering, being low on the ground, may be treated like a child, in that people talk to their spouse about them, as if they were not able to speak for themselves.

In mental illness, the threat to the self is terrifying. The experience of dementia, depression, schizophrenia or anxiety may produce the most intense suffering. The experience is not limited to those with severe mental illness. It is often surprising to find that patients who are mildly depressed will express fears of insanity.

An account of the experience of illness would not be complete without mention of the response to illness. People do triumph over their disabilities. The body has remarkable powers of compensation and adaptation. A newly defined self can emerge from suffering. Suffering engenders the kind of introspection that can add a new depth to the personality. Although the patient may have little control over the course of the illness, he or she is free to choose how to respond to it.

So far, we have been considering the experience of illness and disability in a person who was previously healthy. The process is one of alienation of the body from the self. The situation is different in those who are born with a disability. In the se, the disabled body is the lived body, from the very beginning. Rather than the body becoming alien to the self, the body, with its disabilities, *is* the self. With some disabilities such as deafness, the person enters a culture with a strong sense of its place in the world. A child may resist a parent's attempts to correct some disability on the grounds that, if they corrected it, "it wouldn't be *me*." Rejection of the disability may be interpreted as rejection of the child. Harm may be done by attempts to correct "disabilities" which are themselves harmless variants. At one time, left handed children were forced to use their right hands. When a child has severe disability which can be corrected, the process of adaptation is the reverse of that in a person with an acquired disability. The child, whose body and self have grown within their limitations, has to develop a different way of "being in the world" - a world with wider horizons.

Although all sufferers from chronic disease and disability have something in common, each patient's story is an individual one. The experience of illness also varies with the course the illness takes: a sudden or gradual onset; a one time disability like stroke or injury, which then remains static; a progressively downhill course; or a process of remissions and relapses. Loss of vision, for example, is often a very long process ending in the state of blindness - a new way of being in the world. John Hull (1992 pp 184-185), a university professor, describes his own experience:

"First, there was a period of hope which lasted for a year or eighteen months. It was brought to an end by the deterioration of sight during the summer of 1981, although even as late as the summer of 1982, when I was still seeing a few lights, colors and shapes, I could not resist occasional flickers of hope.

Secondly, there was a period of business in overcoming the problems. This began about the summer of 1981, when visual work became impossible, and lasted until about the summer of 1984. It was not until Easter of 1985 that I began to have a feeling that I did not need any more equipment. A main drive to create a workable office system took place during 1982 and 1983. During this time, blindness was a challenge.

The third stage began some time in 1983, possibly late in the year, and lasted for about a year. This was the time when I passed through despair. These were the years during which my sleep was punctuated by terrible dreams, and my waking life was oppressed by awareness of being carried irresistibly deeper and deeper into blindness.

The fourth and current period has begun since the autumn of 1984, i.e., since the recovery from the visit to Australia, during which time blindness had engulfed me. I began writing my book on adult religious education in October of 1984 and conclude d it in March of 1985.

For most of the time now my brain no longer hurts with the pain of blindness. There has been a strange change in the state or the kind of activity in my brain. It seems to have turned in upon itself to find inner resources. Being denied the stimulus of much of the outside world, it has had to sort out its own functions and priorities. I now feel clearer, more excited and more adventurous intellectually than ever before in my life. I find myself connecting more, remembering more, making more link s in my mind between various things I have read and had to

learn over the years. Sometimes I come home in the evening and feel that my mind is almost bursting with new ideas and new horizons.

I continue to find deep need for that kind of sustenance. Even a single day without study, away from the possibility of learning something new, can precipitate a new sense of urgency and suffering. I still feel like a person on a kidney machine, but increasingly like a person who has managed to survive.

Primacy of the person has been mentioned as one of the fundamental principles of family medicine. To give primacy to the personhood of the patient requires that we attend very carefully to the meaning the illness has for him or her, not as an ″add-on ″ after clinical diagnosis but as a central obligation.

Ⅵ. THE DOCTOR-PATIENT RELATIONSHIP

The doctor-patient relationship in family practice

The nature of the doctor-patient relationship in family practice is a crucial determinant of many of the methods used by family physicians. To reiterate the point made in Chapter 2, the essence of this relationship is that the doctor's commitment to the patient is open-ended in two ways.

First, it is not limited by the type of problem. The family practitioner undertakes to accept responsibility for any health problem in any patient, regardless of age or sex. Even the definition of "health problem" is left deliberately vague: the patient usually defines the problem. Accepting responsibility for the problem does not necessarily mean dealing with all problems single-handedly. After the initial assessment, the help of specialists and consultants will often be needed. However, this is not the end of the family physician's responsibility, for his commitment is open-ended in a second way: it is not limited in time. The physician's responsibility does not end with the resolution of the problem, the referral of the patient, or the failure of treatment. This is because his commitment is to a person, not to a particular disease, age group or therapeutic technique. In fact, his commitment is often made before the patient has a problem.

This is a heavy and demanding commitment and it will at once be apparent that it cannot be unqualified. No physician can be always available to his patients; no physician can maintain complete continuity, with no absences for vacations, education, or illness. The key word here is "responsibility." If a physician accepts responsibility for a patient's primary and continuing care, he can fulfill this responsibility by arranging that when he is absent a. colleague is available to provide the same service.

Some methods physicians use to maintain continuity have aroused controversy. It would be difficult to defend the practice of directing all calls to the near estemergency department, where the patient will receive care from a doctor who is unknown to him and who has no access to his continuing record. The practice of signing out to commercial "on call" services has also aroused controversy. Here again, if the care is anonymous and provided by frequently changing personnel who have little communication with the patient's own physician, it would be difficult to accept this as responsible care. On the other hand, one could envisage a well-organized "on call" service where a more personal kind of deputizing service is provided.

The doctor-patient contract

Whatever the arrangements the physician makes for availability and continuity, they should be

made clear to all patients when they enter the practice. The idea of an explicit doctor-patient contract is a useful one here. This does not mean necessarily a written contract so much as a mutual understanding by doctor and patients of their respective commitments, rights, and responsibilities. Many of the things that have gone wrong with the doctor-patient relationship in recent years have been due, I believe, to a misunderstanding of the implied contract. In the days when most people lived in small communities, when most doctors were general practitioners, and when most practices were single-handed, people knew without being told what they could expect of their doctor. Nowadays, a patient may believe that his doctor will deal with any problem; yet when certain problems arise, the patient discovers that his doctors a specialist and does not deal with that kind of problem. .Or the patient may believe that his doctor will be continuously available, only to find that when he needs him he has gone away and has made no deputizing arrangements.

The contract will obviously vary in detail between one practice and another. In order to maintain the essential principles of availability and continuity, however, it should always include something like this:
1. I will be available to you for any kind of health problem. If I can deal with it myself, I will do so. If not, I will use whatever resources are necessary, including referral to a specialist. Whatever resources are used, however, I will maintain my responsibility for you. If your care is temporarily transferred to a specialist, for surgery for example, I will still maintain overall responsibility for your care. The same will apply if some aspect of your care, e.g., a special form of treatment, is the responsibility of a specialist on a long-term basis.
2. My services will be available to you at all times-either in person or through a colleague to whom I will delegate the responsibility.
3. Both of us have the right to terminate the contract. If I do so, I will notify you and help you to find another physician, while continuing to provide care until new arrangements have been made.

It is inherent in any contract that both parties have responsibilities. The physician can only fulfill his part of the contract if the patient also fulfills his. What are the patient's responsibilities? The main one is to use his doctor's services for all his health problems, not fragmenting his care by going directly to specialists. Both the public and. the profession sometimes have difficulty in understanding why this limitation of the patient's freedom is necessary. A moment's reflection should convince them that, if a patient bypasses his family physician by self-referral, he makes it impossible for the physician to maintain the overall responsibility that is his part of the contract. Their knowledge of human nature should also persuade them that the physician can only interpret self-referral as a lack of trust in him-hardly a good basis for the kind of relationship that good personal care requires.

Benefits of the relationship

At its best, the doctor-patient relationship in family practice is one of trust, mutual respect, and empathic understanding. Trust means that the doctor accepts the patient as he is, faults and shortcomings included. Empathic understanding means that the physician can "feel with" the patient and convey to him that he understand show he feels. This kind of relationship takes time to develop. Trust and respect of this kind only come when the patient has experienced the doctor's care in testing circumstances. Once the relationship has developed, however, it becomes a powerful base for helping patients with their problems. It means that when problems do arise, doctor and patient both have a "head start." They don't have to spend time getting to know each other or learning to trust one another both essential for a good therapeutic relationship - they have already done that.

This close personal relationship is the key to the success of the family physician as a psychotherapist. Actually, I prefer not to use this term, because it suggests a similarity. with psychotherapy as practiced by specialists. The similarity is not very close. The family physician's therapy is usually given in small increments over long periods of time, often as the opportunity

arises. The term "psychotherapy" also implies the treatment of an illness, whereas the family physician is more often help ingnormal people to grow by working through their problems and crises. Helping people to grow in this way often becomes the chief reward that family physicians get from their work.

Limitations of the relationship

A relationship like this can only be achieved at some sacrifice. For the family physician, what may have to be sacrificed is detachment. It is difficult to have a close relationship with a person or family without getting to some extent involved in their problems. This means that the physician cannot always bring to a problem the detachment that is sometimes necessary for diagnosis and therapy. This can be seen with family problems, when the family physician may himself be part of the web of family relationships. It is also seen at the clinical level, when the physician's closeness to a problem may lead to a failure to detect some feature that is immediately obvious to a fresh observer. The provision of a detached opinion is one of the most important functions of the consultant.

Another result of the close relationship is that the physician may feel more than the usual anxiety: It is well known that a physician's anxiety tends to be increased when the patient is a friend, relative, or colleague. The close relationship with a patient may have the same effect. A certain amount of anxiety is of course normal in medical practice: the problem with excessive anxiety, however, is that it may impair judgment. Another risk of the relationship is the opportunity it gives for dependency. The problem of dependent patients will be discussed later in this chapter.

Reassurance

As Kessel (1979) has written, "The utterance of reassurance should be as planned and deliberate as the use of any other medical skill." Although it is not possible to provide specific rules for the application of this skill, there are some principles that, if followed, will help the physician to be more effective in his reassurance and to avoid some errors and pitfalls.

1. The essential basis for effective reassurance is a trusting relationship between patient and doctor. It need hardly be said that the family physician starts out with the great advantage of having in many cases already established this relationship.

2. If reassurance is to be specific, the physician must know what the patient's anxieties are. Only then can he take the necessary steps to achieve reassurance. If a man with chest pain is worried about lung cancer, he will not be- reassured if the physician tells him - on the basis of an ECG - that he does not have coronary heart disease; Specific reassurance requires that his anxiety be identified and the investigation directed toward it.

3. Premature reassurance is ineffective and may be interpreted by the patient as a rejection. The patient must be convinced that the physician has obtained the information necessary for reassurance. If a patient says "Do you think this pain is anything to worry about?" it may be tempting to say "No, it's nothing to worry about." It may be better, however, to say "It doesn't sound like anything serious, but before telling you there's nothing to worry about. I'd like to ask you some more questions and examine you."

4. When reassurance can be given with confidence, it should not be delayed. When a patient is coming to hear the results of his tests, he has little thought for anything but the news he is about to hear. Questions about how he is feeling will attract only partial attention. Better to start straight away with: "Well, Mr. Smith, your x-rays are fine."

5. The patient's complaints-and his perception of them-should be taken seriously. It is very

disturbing for a patient to be told "There is nothing wrong with you." It suggests to him that he is malingering. Better to say: "I can assure you that your symptoms are not due to cancer or any other serious disease." If this can be followed by a description of what is producing his symptoms, so much the better.

6. Some hope should always be given. This does not have to be false hope. Patients do not always want to be reassured that they will recover from their illness. They may have accepted permanent disability and need to be assured only that they will still be able to go for a walk, do their gardening or some other activity they enjoy. Even interminal illness, the assurance that they will not suffer pain may be a source of comfort.

7. Emphasis should be given to the hopeful aspects of the condition. To say: "Eighty percent of patients get back to normal activity with this disease," sounds very different from "Twenty percent of patients have some residual disability after this disease." The information is the same, but its effect on the patient can be quite different. I have heard doctors being so hesitant and negative in their reassurance, even with diseases carrying a good prognosis, that the patient is left in doubt and anxiety.

8. When the nature of the disease is explained, everyday language should be used. This statement of the obvious would be superfluous, were it not for the fact that it is so often forgotten.

The above principles apply to the assurance of patients with what we may call "normal" anxiety: the anxiety that a person naturally feels when faced with the threat of death or disability. With abnormal anxiety, reassurance is ineffective, for it will not relieve the anxiety. In these patients, anxiety is part of a more deep-seated personality disorder and must be dealt with at that level.

Compliance

Only in recent years have we come to fully appreciate how frequently patients fail to comply with therapeutic regimens. In some diseases, failure of compliance is a major obstacle to achieving better results. In hypertension, for example, about half of all patients who are diagnosed fail to continue with effective treatment. Failure to attend for prenatal care is related to higher maternal and perinatal mortality. It may be argued that patients have every right to refuse treatment if they so wish. In the vast majority of noncompliant patients, however, there is no premeditated rejection of medical advice. Failure to carry out treatment is either due to common human failings like forgetfulness, procrastination, and misunderstanding, or to inadequate information from the physician. It is the physician's responsibility to ensure that failure from these causes is minimized.

The following factors are related to noncompliance (Stewart, 1979):

1. A large number of medications.
2. Family and personal instability.
3. A dysfunctional doctor-patient interview, with disagreements and unrelieved tensions.
4. An admission that doses of a drug have been missed. If such an admission is made in response to a simple question, it is likely that noncompliance is frequent.

The following factors are related to compliance (Stewart, 1979):

1. A personal relationship between doctor and patient. It follows that the family physician is in an excellent position to obtain compliance.
2. Good interviewing technique: giving the patient the opportunity to express tensions, anxiety, and feelings of shame or frustration; making sure that the patient agrees with and understands the instructions; being explicit about the instructions.
3. Avoiding multiple medications wherever possible. Where they are unavoidable, taking special precautions to avoid confusion, especially in the elderly. Enlisting the support of family members or visiting nurses may be very helpful.

4. The active involvement of the spouse in the therapeutic regimen.
5. Reinforcement by follow-up visits, with reminders to patients WHO fail to attend.6. Tailoring of the regimen to the patient's daily activities. If it is possible to do so, prescription of a single dose, taken regularly with the same activity, will enhance compliance.

Problems and pitfalls in the doctor-patient relationship
Medicine is often taught to students as if it were a relatively straight forward business. The patient comes to the doctor with complaints; the complaints are diagnosed; treatment is prescribed and followed; the patient recovers, or at least his symptoms are controlled. In the protected environment of the teaching hospital, the student may find much to support this view. In his family medicine practice, however, he is likely to discover that medicine is not so simple: patients do not necessarily have a diagnosis; they do not always follow the prescribed treatment; they sometimes obstinately refuse to get better, and they continue to make inordinate demands on the physician.

Most physicians encounter patients who trouble them in this way. For a specialist, however, the problem is often not so difficult. Having found no problem in his field, he can legitimately and appropriately refer the patient back to his family physician. The family physician, on the other hand, has no such recourse. Since his commitment is to the person, whatever the problem may be, he must learn how to manage the "difficult patient" without making things worse by being a "difficult doctor."

It is a universal experience in family practice that a large part of the doctor's time is devoted to a relatively small proportion of patients. Some of these are demanding for obvious reasons: they are persons with incurable or terminal illness, or illness that requires highly complex management. Others are demanding because their relationship with the physician or the health care system satisfies some personal need, which is not recognized or articulated. Balint (1964) called this state of affairs "the fat envelope syndrome" in reference to the bulging record folders accumulated by these patients. They are also readily identifiable by the feelings they arouse in the physician-feelings of irritation, frustration, anger, impotence, or depression.

Certain themes are common in this group of patients:

Frequent attendance
This may take the form of frequent and insistent demands for attention: telephone calls, often out of hours, or visits to the office every day or two without anappointment. Or the visits may be regularly spaced at weekly or monthly intervals, the patient presenting the same symptoms on each occasion, discussing the same treatment possibilities, and giving the -same reasons why none of them will help.

Hostility and aggression
Not all such patients are aggressive. Many are overtly cooperative and some show excessive gratitude. Others couple their demands with obviously hostile behavior. This may be a way of testing the doctor, of challenging him to reject the patient. Patients who behave in this way have often experienced life as a series of betrayals. If the doctor responds to their provocation by rejecting them, then he has confirmed their suspicion that nobody is, to be trusted.

Ineffectiveness of treatment
It is typical of these patients that whatever the doctor prescribes, it does not work. Small wonder that this arouses in the physician feelings of impotence and frustration. In its extreme form, this rejection of help is accompanied by self-destructive acts,varying from deliberate self-injury to continued drinking in a patient with alcoholic cirrhosis.

Dependency
This is a feature in all these patients. The long-term nature of the doctor-patient relationship in family practice means that dependency is a particular problem for family physicians.

Dealing with these problems is never easy. Some of the difficulties can be avoided, however, if certain common errors and pitfalls are kept in mind. The first of these is spurious diagnosis. This very common error arises from a failure to interpret the patient's complaints as indirect communication. The patient's symptoms are accepted at their face value and an intensive investigation is carried out. The more investigations performed, the more likely it is that some "abnormality" will be found, to which the patient's symptoms will then be attributed: a hiatus hernia perhaps, or a slight change in the ECG, or some osteoarthritic changes in the spine. The patient's illness will then be organized around a spurious disease. This may then lead to inappropriate treatment and unnecessary surgery. Neither doctor nor patient comes to grips with the real problem: the "diagnosis" is a way of avoiding it. The patient continues to attend and make demands, the doctor continues to try new forms of treatment or make further referrals to specialists-all without avail. When this has gone on for a number of years, the chances of changing the pattern of behavior are small. The best approach is to identify such "signal behavior" at the earliest possible time, avoid spurious diagnosis, and help the patient come to grips with the true problem.

The second error is for the physician to "act out" his feelings. As stated above, patients may arouse negative feelings in the doctor. Recognition of these feelings can often be of diagnostic value. It may also be helpful to speak of these feelings to the patient. If they are not expressed verbally, however, they may be unconsciously acted out by the physician in his behavior. He may in his turn be rude, aggressive, or rejecting. There is, of course, no reason why the physician should not express his feelings to the patient, but this should be done with full self-knowledge, not by acting them out. The physician's feeling of helplessness may be a reflection of the patient's feeling. This hypothesis can be tested by saying: "I get the feeling that you don't seem able to do anything about.... Is that what you're telling me?"

The physician may act out his feelings by rejecting the patient. Frustrated by the patient's refusal to get better, he may decide in desperation to refer him else where, often to a psychiatrist. Referral in this case, however, is a form of rejection and is usually interpreted as such by the patient. The response may be anger or despair.

Case 6.3:
A middle-aged widow had been attending every month with multiple complaints. These were always expressed in a whining, monotonous voice. The same complaints and problems were presented at each visit, the same remedies discussed and rejected. A chronic depression was suspected but treatment with antidepressive drugs produced no improvement. Eventually, against her will, she was persuaded to see a psychiatrist. Within a few days of her visit to him, she committed suicide.

Another common fault is lack of openness. At its best, the relationship between doctor and patient in family practice should be such that any problem can be discussed. Too often, however, our patients get the feeling from us that certain problems are not to be mentioned. There is some evidence that doctors who have an open attitude to patients' personal problems are confronted with less signal behavior.

Another form of acting out is avoidance. Instead of acknowledging his negative feelings, the doctor responds by avoiding the patient. One common form of this behavior is the avoidance of dying patients because of the anxieties they arouse. Another is the use of a prescription as a way of keeping the patient at arm's length, especially if it is issued after only a telephone call (Freeman, 1980).

Most of us have personal biases, some of them deeply rooted in our experiences as children. If these are not acknowledged at the conscious level, they may lead us to maltreat patients who arouse our biases. A doctor may, for example, find it very difficult to treat a male homosexual or a drug addict without unconsciously expressing his hostility. A doctor who knows himself will either control his feeling, or if he cannot do so, will suggest that the patient, in his own interests, should consult another physician.

Certain approaches to the patient and his problems can be helpful in dealing with these difficult problems. Much can be achieved by empathic listening. The origins of these problems are often buried in the patient's past life, frequently in his childhood. If the .physician is prepared to listen, the patient may unfold a story that casts light on the current problem. This can have two beneficial effects: it can deepen the physician's understanding of the patient, and it can deepen the patient's insight into his own problem. It is not unusual to find that this mutual understanding results in a change in the patient's attitude so that he no longer needs to seek attention for symptoms.

This is the biographical approach to medicine. Every patient is at some stage of personal development, and how he deals with that stage depends on his past experience of life. Seeing our patients' problems in their developmental context can greatly enrich our experience of medicine.
Acceptance of limited goals may relieve the physician of much anxiety and frustration. Doctors are trained to make people better. "Good patients" are supposed to get better. It is often difficult, especially for young physicians, to realize that seeing a patient every month for the same complaint may be a crucial factor in maintaining that patient's equilibrium. The prevention of breakdown in itself may be a major achievement.

However provocative his behavior, a patient needs to know that the doctor will not let him down. This may be the first trusting relationship he has ever had. It is important, therefore, for the physician to avoid behavior that may be interpreted by the patient as rejection. This does not mean, however, that the physician should allow himself to be manipulated. It may be necessary to set limits on the number of visits or out of hours calls.

A family physician has to be well aware of the risks of dependency. In any helping relationship some dependency is inevitable, even if temporary. The objective should be to help the patient work through temporary dependence to a state of self-reliance. We must accept, however, that this is not always possible. No family physician can avoid having some patients who are chronically dependent. What he can avoid is fostering dependency by seeing patients too often, recalling them for unnecessary follow-up visits, making too many house calls, and generally sustaining the myth that patients cannot survive without him.

Ⅶ. FAMILY INFLUENCES ON HEALTH AND DISEASE

An understanding of the relationship between family life and health and disease is central to the discipline of family medicine. In Chapter 2, the importance of the context of illness was discussed. The family is by far the most important part of the context. Although the family physician's commitment is to individual patients, he will always see the individual's problems in their family context. This implies not only an understanding of the individual's family relationships, past and present, but also a knowledge of how the family influences growth and development. The family physician's understanding of a family's relationships, his power to predict problems, and his capacity to help are greatly enhanced by caring for the whole family unit.

Having said this, we must not exaggerate the necessity of caring for the whole family unit. It is the

custom in many Western societies for young adults and even adolescents to leave home. Even if they remain at home, they may wish to have their own physician. Even in countries like Britain, where virtually all primary care is done by general practitioners, many families choose to divide their care between two or more physicians. Most practices, therefore, although consisting predominantly of family units, are likely to contain a significant number of single people and incomplete families. But even when the family physician is treating one individual, he should always maintain the family perspective.

When we consider the effects of family life on health and disease, we must bear in mind what particular aspects of the family are important. In genetic disorders, consanguinity is obviously an important variable. In the transmission of infectious disease, or in the causation of psychogenic disorders, any small group of people living under the same roof may act as family.

The function of the family

To understand the pathology of a body system, we need to know something about the system's functions. So it is with the family: to understand family pathology, we need to know how the family in health is supposed to function. Among the functions of the family, two are of special importance to us, the support and protection of each individual member, and the nurturing of children from birth to the age at which they become independent members of society.

The family has five main effects on an individual's health:

1. Genetic influences. Every individual is a product of the interaction between his genotype and the environment. Recent advances in our knowledge of genetic aspects of disease have made this an important subject for the family physician. Although detailed knowledge is not required, he must know when and how to use genetic counseling services and how to interpret their advice to the family.

2. Influence on child development. Although children have a remarkable capacity for overcoming early difficulties, there is a large body of evidence supporting the relationship between family pathology and childhood disorders-both physical and behavioral.

Parental deprivation for prolonged periods is associated with three psychiatric problems: suicide, depression, and sociopathic personality disorder. The relationship is by no means constant, and the outcome depends on individual factors such as the previous parent-child relationship and the availability of parent substitutes. The evidence is sufficiently suggestive, however, for the family physician to advise parents to avoid separation from the child whenever possible in the crucial stage between three months and four years. When separation is unavoidable, as in the serious illness of mother or child, care should be taken to minimize the trauma by providing a good mother-substitute or by keeping the child's time in the hospital to a minimum.

The Newcastle-on-Tyne "Thousand Families" study (Miller et al., 1960) is one of the few long-term studies of families designed to explore the relationship between child health and family function. A group of 1,142 infants were enrolled at the beginning of the study in 1947. These children and their families were observed and examined over a fifteen-year period by a team of health visitors and pediatricians. By 1962, 763 children remained in the study. The results are so important for family medicine that I will summarize them here. They are generally applicable to any industrial community, although allowances must be made for the preponderance of working-class families and the comparative poverty of the community in the early years of the study.

Respiratory disease was the most common health problem. In the first five years it accounted for half of all the illness and two-thirds of all infections. The frequency and severity declined during the school years, but the ratio of respiratory to total illness remained. At all ages the incidence and

severity of lower respiratory infection was strongly related to adverse family factors. In 1961, forty-five or 6 percent of children had some disability due to respiratory disease: six had suppurative otitis media, eleven recurrent bronchitis, ten asthma, six allergic rhinitis, and four bronchiectasis.

Intestinal infections were strongly related to inadequate housing, overcrowding, and poor maternal care.

In twenty "streptococcal families" there were repeated streptococcal infections indifferent family members over months or years. In twenty-five "staphylococcal families" there was a similar pattern of repeated staphylococcal infections. Staphylococcal infection in preschool children was strongly associated with large families, overcrowding, and poor maternal care.

Nonfebrile convulsions were significantly associated with low social class, a family history of seizures, mental illness, parental deprivation, and defective child care.

Accidents in the first five years accounted for 8 percent of the total illness and nearly 50 percent of noninfectious illness. The peak incidence was in the second year. In this age group, more than half the accidents occurred at home. Accidents during the school years more, commonly, occurred away from home. At all ages there was a significant association with poor maternal care and low intelligence in the child.

Enuresis affected 18 percent of children at five years, 12 percent at ten, 6 percent at thirteen and 2 percent at fifteen. Enuretic children were smaller than nonenuretic children; had a lower mean IQ, and more of them were maladjusted. Enuresis was associated with low social class, overcrowding, poor maternal care, and absence or ineffectiveness of the father. The authors conclude: "bedwetting is seen as a developmental disability, mainly determined by the interaction of adverse social, emotional and intellectual factors." Dysrhythmic speech was found in forty-three children, and nine still stuttered at the age of fifteen. Stuttering was more common in children from families with adverse factors.

Children with behavioral disturbance (nearly 20 percent) were below the mean in height; weight, intelligence, school attainment, and ability to communicate. Their parents were younger, more recently married, often lived with relations, and tended to be dependent on their parents. A high proportion of mothers had a history of mental illness and had experienced severe stress during pregnancy. The authors conclude: "At the center of maladjustment was a deeply unsatisfactory relationship between mother and child. Separation was a contributory factor, but mainly through intensifying preexisting family instability: The extent of maladjustment suggests urgent need for a critical study of existing methods of treatment and a more intensive search for rational ways of prevention."

More recent work has continued to demonstrate the importance of parenting and the harmful effect of parenting failure on child development. Klaus and Kennell(1976) have demonstrated the importance of early postnatal bonding between mother and child, a relationship enhanced by breastfeeding but made more difficult by some of the procedures used in obstetric units.

Parental neglect, both physical and emotional, is considered to be the most common cause of failure to thrive. In emotionally deprived children, the secretion of growth hormone is reduced. Parenting failure bring a range of effects on child development, from physical trauma at one end of the scale to mild behavior disorders at the other. What makes this doubly important is that children deprived of good parenting are likely to repeat the same pattern when they themselves become parents.

3. Influence on the spread of disease. The spread of disease within the family is seen with infections and neuroses. Streptococcal and staphylococcal family infections have already been mentioned. Meyer and Haggerty (1962) showed that streptococcal infection is related to acute and chronic family stress.

Virus infections have a strong tendency to spread from the index cases to other family members. In their study of family infections in Cleveland, Dingle et al. (1964) found that infections were introduced into the home in descending order of frequency by: schoolchildren under six, preschool children, school children over six, mothers, and fathers. Respiratory and intestinal infections decrease in frequency with increasing age. The number of infections is directly related to family size. Preschool children are the most susceptible to infections because they have not yet acquired immunity. Children starting school are more likely to bring infections home because they are exposed to other children at a time when their immunity is incomplete. The number of infections falls rapidly as immunity is acquired during the early school years.

The same infection may take different forms as it spreads through the family. A virus may produce sore throat in one member, diarrhea in another, cough and coryza in another. The mumps virus may produce parotitis in one member, orchitis in another.

Tuberculosis, venereal diseases, intestinal parasites, and skin infections must be included in any list of family infections.

Buck and Laughton (1959) have shown that spouses of people with neurotic illness tend to develop neurotic illness themselves, particularly after the seventh year of marriage, and that children of neurotic mothers are at risk for neurotic illness themselves.

4. Family influence on morbidity and mortality in adults. Mortality is significantly increased in widowers and widows in the first year after bereavement. This increase in mortality is not confined to one or two causes of death: it covers the whole range of diseases.

Mortality for most causes of death is much higher among widowed, divorced, and single people than among the married. Widowers are especially susceptible. Kraus and Lilienfeld (1959) have shown that young widowers (ages twenty-five to thirty-five) have a mortality rate twelve times higher than the comparable married group for tuberculosis, eight times higher for vascular lesions of the nervous system, ten times higher for hypertensive heart disease, eight times higher for influenza and pneumonia, and nearly five times higher for arteriosclerotic heart disease.

Bereavement is associated with an increase in consultation rate. This probably represents both a true increase in morbidity rate and an increased utilization of medical services.

In counties of North Carolina, stroke mortality in black males was significantly related to family disorganization as measured by rates of divorce, separation, and illegitimacy. In males between thirty-five and forty-four, mortality increased almost threefold as the level of disorganization increased from the lowest to the highest levels (Neser, 1975).

Medalie and Goldbourt (1976) have shown that males with severe family problems are three times more likely to develop angina than those with a low score for family problems. In males with high anxiety levels, the risk of developing angina was significantly lower in those who received much support and love from their wives than in those who did not.

For reasons that are little understood, husbands and wives are more often concordant for hypertension, than would be expected by chance.

Family factors affect not only the occurrence of illness, but also the utilization of medical services. Utilization increases at times, of family stress. Clustering of visits may be an important cue to family problems.

5. Family Influences on recovery from illness. Family support is an important factor in the outcome of all kinds of illness, but especially in chronic illness and disability. Pless and Satterwhite (1973) found that children with chronic disease fared better in well-functioning than in poorly functioning families.

Implications for the family physician

1. Family physicians can promote a healthier family life by encouraging early mother-child contact, breastfeeding, rooming-in, and the involvement of the father.

2. The quality of parenting is crucial. The family physician can identify families atrisk for parenting problems (see below). He can then provide re-education and support, both himself and through the health care team. This is perhaps the best prospect of breaking the "cycle of deprivation" that goes from one generation to another. Children from these families require special care and vigilance. The physician, for example, may decide to see them more frequently for well-child care.

3. Widows and widowers in the first years after bereavement are a high risk group. The family physician can often prepare relatives for the experience of bereavement. He should also pay particular attention to symptoms presented by the bereaved.

4. In any serious illness, acute or chronic, the physician will need to assess family function. A method of assessing function is shown in Tables 8.4 and 8.5. The level of functioning will influence his decisions on hospitalization, home care, and the amount of support needed from the health care team.

5. The physician should be sensitive to the cues to family dysfunction. (see below).

The family as a system

An understanding of the family as a system will help the physician to understand its responses to illness and crisis. The elements of systems theory were described in Chapter 2. In applying them to the family, the following points stand out.

1. Anything that affects one member of the family affects relationships within the family as a whole.

In any crisis or serious illness, acute or chronic, the family must adjust, and this adjustment may be adaptive or maladaptive. After a crisis or acute illness, the equilibrium may be restored to its previous state or a new equilibrium may be attained. The new roles a wife must take on when her husband is ill may be relinquished when he recovers. After long-term problems, roles may be difficult to relinquish. The wife of an alcoholic, for instance, may find it difficult to adjust to her husband's recovery,. Chronic disease and disability require permanent changes in the family system, often very stressful ones. Medalie (1975) has stressed the need to be alert for the "hidden patient" -often the caretaker of the sick member of the family-whose illness is concealed or unnoticed.

Case7.1:

An elderly woman with congestive heart failure was cared for during her long terminal illness by her husband. I saw him in the course of many home visits and although he always looked pale I never suspected anything amiss. Soon after the woman died, her husband came to see me complaining of severe fatigue. He had prostatic obstruction, renal failure and uremia with secondary anemia, all of which had been present for the duration of his wife's illness.

A family crisis may result in a cluster of illnesses in different family members. Caring for the whole family gives

the family physician a special advantage in understanding these patterns of illness.

Case 7.2:
A young married woman with no children came to see me with lower abdominal pains. Since she had previously had an ectopic pregnancy, this was suspected at first. Observation in the hospital was sufficient to exclude this diagnosis. The pains continued, however, and it became clear that the patient was going through a severe marital crisis. During the same week, her husband came to see me with intercostal muscle pain and her father attended with depression, neither of them connecting their problems with the family situation. The illnesses of husband and father took on a new meaning in the context of the crisis in the family. The crisis came to a head in the same week with the separation of husband and wife.

2. The patient in the office is not necessarily the sickest member of the family. When there is a family disturbance, the problem may present in different ways in different family members. The following are some common patterns:

（1）The child or adolescent as a scapegoat for the family's problems. The child is presented to the doctor by the parents as "difficult."

（2）The child as a presenting symptom of the mother's illness. A mother may express her own anxieties, depression, or guilt feelings by bringing the child frequently with minor ailments.

（3）School behavior problems as an indication of family problems.

（4） Anxiety symptoms in children as an indication of family problems.

Case 7.3:
A ten-year-old boy was brought by his mother with aches and pains. No physical abnormality was found. A few weeks later his teen-aged sister was admitted to the hospital for attempted suicide. On further investigation, the mother revealed that her husband had been waking in the night and terrorizing the family by violent behavior.

3. Problems of parenting are due not so much to single causes as to mismatches between parent and child. A mother who is able to cope with a normal child may become an abusing parent if her child is handicapped. The physician has to observe the interaction between parent and child rather than individual behavior.

4. After caring for a family for some years, the physician may himself become a part of the family's web of relationships. This has important implications for his position as therapist (see below).

The family life cycle

As described in Chapter 6, an understanding of the family life cycle, together with an understanding of individual development, can help the physician form good hypotheses about the problems his patients are experiencing. In the course of its development, the family goes through a number of predictable transitions: marriage, childbirth, school years and adolescence, school graduation and starting work or further education, children leaving home, involution, retirement, widowhood. The physician, by using his insight into these transitions, can help families anticipate and prepare for them, and at the same time can enrich his own understanding of the context of illnesses.

Families also experience unexpected crises that demand adaptive responses: illnesses, accidents, divorce, loss of job, death of a family member.

Duvall (1967) has developed an eight-stage schema of the family life cycle. Duvall's schema is reproduced in Figure 8.1, with the number of years an American family can be expected to spend in each stage. All families, of course, do not go through the complete cycle in sequence. One child may remain in the home after attaining adulthood and may stay there until the parents die. Divorced people with children, if they remarry, go through stages one and four at the same time.

Developmental tasks

Developmental tasks are defined by Duvall as tasks that arise at a certain stage in the life of the

individual or family, success at which leads to happiness and success with later tasks. Failure at these tasks, on the other hand, leads to unhappiness, disapproval by society, and difficulty with later tasks. In assuming a developmental task, an individual must (1) perceive new possibilities for his behavior; (2) form new conceptions of him; (3) cope effectively with conflicting demands; and (4) have the motivation to achieve the next stage in. his development.

Sometimes the developmental tasks of different family members are in harmony, as when a husband and wife are jointly learning to live in an "empty nest." Often, however, developmental tasks of family members are in conflict, and many of the tensions of family life are caused by these conflicts. The adolescent's need to achieve independence almost inevitably brings him into conflict with his parents' task of guiding his development to a responsible maturity. When husband and wife both have careers, their needs for education and career development can easily lead to conflict at some stage in the family life cycle.

Duvall's concept of the developmental tasks facing the family at each stage in its lifecycle is shown in Table 7.1. The family's developmental tasks are centered on the family's most important function: the nurturing of children from birth to maturity. They obviously relate closely to the developmental tasks of individual family members.

In recommending the family life cycle and the concept of developmental tasks as a perspective for family physicians, a word of caution is necessary. The expectations of individuals and families vary greatly between one culture and another. The stages described here apply in general to family life in North America. Other cultural groups, elsewhere in the world and even in North America, can be expected to have different norms. Hence the importance for family physicians of learning the cultural norms of their patients.

Cues to family dysfunction

1. Parenting failure. The family physician should be sensitive to cues that may indicate a risk of problems with parenting. It must be emphasized, however, that no single cue is a certain indication that a problem exists. It only indicates a need for extra vigilance. Some conditions in parents and children are known to be associated with problems of parenting:

1) Parents: unsatisfactory childhood experience with their parents; early marriage; single parents; psychiatric illness; immaturity; prison record in father.
2) Children: prematurity; handicapped children; unwanted children; babies who cry a lot.

The prenatal and postnatal period provide the family physician with opportunities for making systematic observations of maternal and child behavior. Tables 7.2, 7.3,and 7.4 list warning signs that may be observed during pregnancy, delivery, and the postpartum period.

2. Illness in individual members. Depression and anxiety are especially associated with family tensions.

3. Clustering of illness in the family or of consultations for illness may arise from a number of causes (Kellner, 1963).
- The effects of family stress in several members of the family.
- Family infections.
- Maturing of a resolution. Illness in one family member leads to consultation by another member who has been considering it for some time.
- The accompanying adult. A child's illness is the opportunity for an adult to consult the physician.

4. Acting-out behavior is most frequently seen in children and adolescents: school behavior

problems, juvenile delinquency, attempted suicide, for example.

Table 7.1 Stage-critical family developmental tasks through the family life cycle*

Stage of the family life cycle	Positions in the family	Stage-critical family developmental tasks
1. Married couple	Wife Husband	Establishing a mutually satisfying marriage
2. Childbearing	Wife-mother Husband-father Infant daughter or son or both	Adjusting to pregnancy and the promise of parenthood Fitting into the kin network Having, adjusting to, and encouraging the development of infants Establishing a satisfying home for both parents and infant(s)
3 Preschool-age	Wife-mother Husband-father Daughter-sister Son-brother	Adapting to the critical needs and interests of preschool children in stimulating, growth promoting ways Coping with energy depletion and tack of privacy as parents
4. School-age	Wife-mother Husband-father Daughter-sister Son-brother	Fitting into the community of school-age families in constructive ways Encouraging children's educational achievement
5. Teen-age	Wife-mother Husband-father Daughter-sister Son-brother	Balancing freedom with responsibility as teenagers mature and emancipate themselves Establishing postparental interests and careers as growing parents
6. Launching center	Wife-mother-grandmother Husband-father-grandfather Daughter-sister-aunt Son-brother-uncle	Releasing young adults into work, military service, marriage, etc., with appropriate rituals and assistance
7. Middle-aged parents	Wife-mother-grandmother Husband-father-grandfather	Rebuilding the marriage Husband-father-grandfather Maintaining kin ties with older and younger generations
8. Aging family members	Widow-widower Wife-mother-grandmother Husband-father-grandfather	Coping with bereavement and living alone Closing the family home or adapting it to aging Adiusting to retirement

* From Duvatl, 1977

Ⅷ. CLINICAL METHOD

The Patient-Centered Clinical Method

Every patient who seeks help has expectations, based on his understanding of the illness. Every patient has some feelings about his problem. Some fear is nearly always present in the medical encounter, even when the illness may seem to be minor: fear of the unknown, fear of death, fear of insanity, fear of disability, fear of rejection.

Understanding the patient's expectations, thoughts, feelings and fears is specific for each patient. The meaning of the illness for the patient reflects his own unique world. Frames of reference from biological or behavioral science come from the doctor's world, not the patient's. They may help the physician to explain the problem, but they are not a substitute for understanding each patient as a unique individual.

Figure 8.1

The patient-centered clinical method, like the conventional method gives the clinician a number of injunctions. "Ascertain the patient's expectations" recognizes the importance of knowing why the patient has come. "Understand and respond to the patient's feelings" acknowledges the crucial importance of the emotions. "Make or exclude a clinical diagnosis" recognizes the continuing power of correct classification. "Listen to the patient's story" recognizes the importance of narrative and context. "S eek common ground" enjoins us to mobilize the patient's own powers of healing. To these I would add another: "Monitor your own feelings" They may give you some vital cues; on the other hand, they may be anti-therapeutic (see page).

The key to the patient-centered method is to allow as much as possible to flow from the patient, including the expression of feeling. The consultation on page is a good example. The crucial skills, described in Chapter 7, are those of attentive listening and responsiveness to those verbal and non-verbal cues by which the patients express themselves. Failure to take up the patient's cues is a missed opportunity to gain insight into the illness. If cues do not provide the necessary lead, a question may help the patient to express feelings: "What is your understanding of your illness?"; "What is it like for you to ...?"; "Are you frightened ...?"

The following reconstructed example contrasts the doctor and patient-centered approaches to the same problem. A 68-year-old male patient, a retired priest who has recently gone to live in a home for aging clergy, has come for a follow-up visit after abdominal surgery.

The Doctor-centered Approach

Doctor: Hello Father Smith, how are you doing?

Patient: Fine - except for some headaches...

Doctor: How is your tummy?

Patient: Fine.

Doctor: Are your bowels working?

Patient: Yes.

Doctor: Every day?

Patient: Yes.

Doctor: Any constipation or diarrhea?

Patient: No.

Doctor: How is your appetite?

Patient: Not very good yet.

Doctor: Why do you think that is?

Patient: It's probably the move to the home.

Doctor: Any pain or discomfort at the operation site?

Patient: Not really.

(The doctor now examines the patient's abdomen.)

Doctor: I think that is a very satisfactory result. Your bowel function has returned to normal and your weight is constant. I would expect your appetite to improve gradually. Any other problems?

Patient: I'm getting these headaches.

Doctor: Can you tell me about them?

Patient: I've been getting them about twice a week at the back of my head and they bother me so I can't do anything, and have to lie down.

Doctor: How long do they last?

Patient: About four hours.

Doctor: How would you describe the pain?

Patient: It's a throbbing.

Doctor: Do you have any disturbance of vision, such as blurring, before or during the headaches?

Patient: No.

Doctor: Any nausea or vomiting with the headaches?

Patient: No.

Doctor: How long have you been getting them?

Patient: Ever since I moved into the home.

Doctor: Have you suffered from similar headaches in the past?

Patient: Yes, many years ago I remember having similar headaches.

Doctor: I am sure these are what is known as tension headaches. They tend to occur at times of stress and may be related to all the recent changes in your life: your retirement, your surgery and your move into the home. Your blood pressure and recent blood work are quite normal, and I can reassure you that they are not anything serious. Lying down and taking a simple pain reliever like aspirin is the best way of dealing with them.

Patient: Thank you very much.

Doctor: Come back if they don't settle down in a month or so.

Patient: I will, doctor.

Doctor: That's a nice home you've moved into. Lovely garden: peaceful spot.

Patient: Yes.

The Patient-centered Approach

Doctor: Hello Father Smith. How are you doing?

Patient: Fine, except for some headaches.

Doctor: What about your headaches?

Patient: I've been getting them about twice a week at the back of my head and they bother me so I can't do anything, and I have to lie down.

Doctor: You can't do anything? What's that like for you?

Patient: It's frustrating, they're interfering with the writing I'm trying to do, and nobody seems to understand....

Doctor: Understand?

Patient: The other priests are so much older than me. All they can talk about is their aches and pains. I'm ashamed to say they make me sick.

Doctor: Why ashamed?

Patient: Well I shouldn't talk that way. They mean no harm. They just don't understand that I wish to write.

Doctor: It must be frustrating....

Patient: Yes it is, and my headaches make it worse.

Doctor: How long have you been getting them?

Patient: Ever since I moved into the home.

Doctor: Why do you think that is?

Patient: I don't know. I haven't really thought about it. Could there be a connection?

Doctor: I think there could. They sound like typical tension headaches.

Patient: The whole situation at the home does trouble me.

Doctor: Would you like to talk more about it?

Patient: No, not now, perhaps later.

Doctor: All right. Let me ask you a few more questions about the headaches. Have you ever had them before?

Patient: Yes, many years ago.

Doctor: Do you remember the circumstances? Can you tell me about those?

Patient: I can't remember, it was so long ago.

Doctor: Do you get any disturbance of vision before or during the headaches?

Patient: No

Doctor: Any nausea or vomiting with the headaches?

Patient: No.

Doctor: How long do they last?

Patient: About four hours.

Doctor: Have you found anything that relieves them?

Patient: They do go if I lie down.

Doctor: Everything points to tension headaches. Were you concerned that they might be anything serious?

Patient: Well, one does wonder, especially after the scare with my bowel. But you've reassured me. I feel better about them now.

Doctor: Now, how are things with your tummy?

Patient: Fine.

Doctor: Are your bowels working?

Patient: Yes.

Doctor: Any constipation or diarrhea?

Patient: No.

Doctor: How is your appetite?

Patient: Not very good yet.

Doctor: Why do you think that is?

Patient: It's probably all connected with the home.

Doctor: Any pain or discomfort at the operation site?

Patient: Not really.

Doctor: That doesn't sound too convincing.

Patient: Well I do have a numb feeling around the scar.

(The doctor now examines the patient's abdomen.)

Doctor: I think that is very satisfactory. Your scar is well healed. The numbness is due to a little nerve supplying the skin being cut during the operation. Nothing serious. Your bowel function has returned to normal. Any questions?

Patient: No doctor. I'm really pleased with the result.

Doctor: Do feel free to come back if you're still troubled about those headaches or about those feelings.

In the doctor-centered example, the physician assumes that the patient's expectations are all related to his postoperative course. He pursues this agenda, cutting off the patient's early reference to headaches. When the headaches are discussed, cues to the patient's feelings are missed. The patient is not invited to ask questions or express fears. When he does mention the retirement home, the doctor pre-empts any expression of feeling by giving his own views. None but the most assertive patients would contradict him.

In the patient-centered example, the physician tries to understand the patient and his suffering, and to form a therapeutic relationship. He allows the consultation to be guided by the patient and ascertains that he expects his headaches to be discussed. He responds to cues by encouraging the expression of feelings. The one problem ostensibly related to the operation - loss of appetite - takes on a different meaning when seen in the patient's social context.

In addressing the patient's agenda, the physician is formulating and testing hypotheses based on the cues he receives and on his previous knowledge of the patient or of the symptoms. To an experienced physician some symptoms are associated with particular fears, such as the fear of cancer. This knowledge may enable the physician to identify the patient's fears very rapidly. But we must always guard against the fallacy of treating a hypothesis as an assumption. In the above example, the doctor-centered physician assumed without attempting validation that the main item on the patient's agenda was to follow-up on his surgery. This is a common pitfall with doctor-initiated visits of all kinds (Stewart, 1979).

The patient-centered is also illustrated in the following clinical example.

*Case 8.1**

An elderly woman complained of a suffocating feeling in the chest, occurring in the early hours of the morning, which was relieved to some extend by sitting by an open window. She first came in the middle of a busy office session when time was short. Given the above cues, the doctor formed a first hypothesis of nocturnal cardiac asthma and after a physical examination revealed no signs to support the diagnosis, sent the patient for a chest x-ray. When this too was normal, he asked the patient to com e in for a longer interview.

On this occasion he obtained the following history. Her main complaint was of very active peristalsis and abdominal discomfort occurring at night and keeping her awake. After lying awake for hours she would get more and more tense, get a suffocating feeling, and have to get up and go to the window. The abdominal symptoms had been present for twenty years, but the insomnia was of more recent origin. Many years previously she had had a cholecystectomy which failed to relieve her symptoms and a mastectomy for carcinoma. She had a fear of surgery and on direct questioning admitted to an anxiety that her abdominal symptoms might be due to cancer. She had been widowed several years and lived in an apartment by herself. Recently her landlord had raised her rent without giving her any notice. Her two children were both married and living away. Recently her daughter had moved near to her after living away for some years. During the interview, she expressed hostility toward her landlord, who, she felt, had been very unfair to her.

*I am indebted to Dr. John Biehn for this case history.

The process in this case is shown as a flow diagram in Figure 8.2.

Figure 8.2

Four questions are commonly asked about the patient-centered clinical method. First, is it always necessary to use the method? Suppose the problem is very straightforward: an injury, for example, or an uncomplicated infectious disease. The answer is that we do not know unless we ask. Patients have fears and fantasies even about common and minor problems. In emergencies, of course, the medical priority must take precedence, as in the above clinical example. But when these needs have been met, no patient is in greater need of being listened to than the one with sudden and severe acute illness or trauma.

Second, what if there is a conflict between the patient's expectations and the medical assessment? Suppose, for example, that a patient wishes to manage his diabetic ketoacidosis without admission to hospital. The physician must then try to reconcile the two conflicting views. The more he can understand about the reasons for the patient's position, the more chance there will be of a satisfactory conclusion. The reluctance to go into hospital, for example, may be due to a feeling of responsibility for a child or elderly parent. In some cases there will be an irreconcilable conflict, as in a demand for a narcotic drug, and the physician will have to refuse to meet the patient's expectations. In the more usual situation, doctor and patient have different interpretations of the illness, or conflicting notions about its management.

The patient, believing his pain indicates an organic disease, cannot accept the doctor's view that this is not the case. The doctor is reluctant to prescribe oxycodone for a patient who finds they relieve his periodic headaches. Our contribution to reconciling conflicting views is threefold. First, we can acknowledge the validity of the patient's experience and take his interpretation seriously, even if we cannot accept it. Second, we can be aware of the danger that our own prejudice, rigidity, dogmatism or faulty logic may be the cause of the difference. A mild narcotic used occasionally by a sensible person may be an appropriate remedy for headaches (see page 292). T he patient may actually be correct in saying that his symptoms are organic in origin. Third, we can make sure that the patient has all the information we can provide. Conversely, some humility may be called for, as when a very well-informed patient knows more than we do about his condition.

Third, is there not a risk of invading the patient's privacy? Suppose the patient does not want to, or is not ready to, reveal her secrets? If privacy is invaded, then the method has been misunderstood. The essence of it is that the doctor responds to cues given by the patient, allows and encourages expression but does not force it. If cues are not given, feelings are explored with general questions which invite openness. If the patient does not wish to respond, the matter is not pursued. At least the doctor has indicated that such matters are admissible.

Fourth, what about the time problem? How can we afford the time to listen to the patient? It is difficult to answer this, since little research has been done on the relation between consultation time, clinical method and effectiveness. From work done so far, we can say tentatively that patient-centered consultations take a little longer, but not much longer, than doctor-centered ones. Beckman and Frankel (1984) found that, when uninterrupted, patients' opening statements lasted only two and a half minutes on the average. Stewart (1995) reported that nine minutes or more was the critical duration for patient-centered consultations. What we do not know is how much time is saved in the long run by an early and accurate identification of the patient's problems. My hunch is that the patient-centered clinical method will prove to be a time saver in the long run.

It is important to distinguish between active and passive listening. Attentive listening, as described on page 117, is not a commitment to listen indefinitely to a rambling monologue. That would be passive listening. A flow of words usually expresses something, even if its significance is the feeling rather than the content. A response to the feeling may enable the patient to express herself in a different way. Making a home visit to a ninety-year-old man with lung cancer, I was detained by his wife who went on at great length about what she tried to get her husband to eat. Eventually I broke off the conversation and left. As I was driving away, the penny dropped. Surely she was trying to express her feeling of impotence at being unable to ca re for her husband in the way she believed to be best.

Validation

The ultimate validation of a diagnosis in the conventional clinical method is the pathologist's report. In the clinico-pathological conferences modeled by *The New England Journal of Medicine*, a clinician is presented with a case report and develops a differential diagnosis, which is then confirmed or otherwise by a pathologist. The clinico-pathological conference can be regarded as the quintessence of the conventional method. Other forms of validation are available, notably the response to therapy and the outcome of illness.

The ultimate validation of the patient-centered method is also the patient's report that his feelings and concerns have been acknowledged and responded to. This may be ascertained by qualitative studies and by periodic surveys of patients. In the norm al course of practice, validation comes from the natural history of the illness and the doctor-patient relationship. If common ground has been attained, therapy is likely to go more smoothly, reassurance to be more effective, and the relationship to be free from tension.

A physician wishing to have some external validation of his clinical method may choose to have his consultations evaluated by an observer using one of the rating scales developed for this purpose (Stewart et al., pp. 191-203). If these are used as a basis for coaching by an experienced teacher, they can be a source of valuable insights. It is difficult for any of us to be fully aware of recurring faults in our clinical practice. Until the coming of audio and video recording technologies, the consultation - the central event of general practice - remained hidden from view. After the fact reporting of the process could not possibly convey its nuances. An observer in the same room was liable to change the process, and discussion afterwards was limited by the inability to verify the observer's recollection of the process by recourse to a recording. Thanks to the evolving technology, all of us can now develop as clinical artists in the way that artists have always learned - by submitting our work to the judgment of a respected teacher.

Learning the Patient-Centered Method

It is important to distinguish between the process by which a physician learns a clinical method and the process by which he practice it. To assist learning, the process is broken down into a number of rules, tasks and stages. Learning these components is not the same as acquiring the process itself. No list of components can include all the tacit knowledge which can only be acquired by experiencing and "dwelling in" the process. One problem faced by the student is that it is impossible to be aware of the components and the whole process at the same time. Polanyi (1962) has clarified this issue by distinguishing between focal and subsidiary awareness. Focal awareness is awareness of the process as a whole. Subsidiary awareness is awareness of the components. Riding a bicycle can be described in terms of rules for correcting imbalance and of the adjustments made by the body in response to changes in equilibrium. Learning the rules, however, is not the same as riding a bicycle, since the rules cannot embody all the tacit knowledge involved in performing the task. To perform the task, one must be focally aware of the whole process, while remaining only subsidiarily aware of the components. Focusing on the components may actually

cause one to fall off the bicycle. Similarly, when practicing a clinical method, one cannot do so while trying to keep in mind the subsidiary rules and components. These can be learned beforehand and referred to afterwards, but in the performance of the task must remain at the level of subsidiary awareness. The tension between these two levels of awareness, and the need to alternate between them, can be difficult for students at first. When the skill is acquired, the tension resolves. The doctor "dwells in" the process and focal awareness is maintained throughout. Subsidiary awareness is brought into being only when teaching the skill to somebody else, or when reviewing one's own process after the fact.

Ⅸ. PREVENTIVE MEDICINE IN FAMILY PRACTICE

The family physician is in an unrivaled position for practicing preventive medicine. He sees each of his patients, on the average; three or four times a year for all purposes. Many of these visits are for self-limiting problems in healthy people. They provide, therefore, an excellent opportunity for health counseling and for the detection of disease in the presymptomatic phase. The continuing and comprehensive nature of the care provided by the family physician enables him to accept responsibility for the whole process of secondary prevention, from case finding, through investigation, to management of the problem. Because of his personal knowledge of patients and families, he may be able to identify risks to health that would not be apparent to another observer. His relationship with patients, and the trust it engenders, can be an important factor in motivating patients to comply with measures designed to maintain health.

General principles

By convention, preventive procedures are divided into three categories:

1. Primary prevention reduces the susceptibility of persons to disease. Immunization and health education fall into this category.
2. Secondary prevention is the early detection of disease so that treatment can be started before irreversible damage has occurred.
3. Tertiary prevention is the management of established disease so as to minimize disability.

In this chapter we will be concerned with four main types of preventive activity practiced by family physicians:

1. Immunization
2. Health education: This includes preparation for childbirth and parenting, nutrition education, sex education and counseling on smoking and weight reduction.
3. Developmental assessment: The monitoring of growth and development in infancy and childhood.
4. Screening and case finding: A screening procedure is one that is applied to an unselected population to identify those members who are either diseased or at risk for a disease. For example, a patient may be identified as hypertensive while attending for skin infection. It will be clear that case finding rather that screening is the method used in family practice. The family physician is responsible for the identification of the abnormality, its investigation, and its treatment and follow-up.

The evaluation of preventive procedures

To justify the application of a screening or case finding procedure, the following conditions should be fulfilled:

1. The disease in question should be a serious health problem.
2. There should be a presymptomatic phase during which treatment can change the course of the disease more successfully than in the sympatomatic phase.
3. The screening procedure and the ensuring treatment should be acceptable to the public.
4. The screening procedure should have acceptable sensitivity and specificity.
5. The screening procedure and ensuring treatment should be cost effective.

To summarize, both the detection maneuver and the ensuring treatment should be efficacious, effective, and efficient. Effectiveness is the capacity of the maneuver or treatment to achieve the desired results in those to whom it is offered. Efficacy is the capacity of the maneuver or treatment to achieve the desired results in those who comply with treatment. Thus, a maneuver may be efficacious in achieving the desired result, but not effective because many people do not comply with it. Efficiency is the capacity of the maneuver or treatment to achieve the desired results with an acceptable expenditure of resources.

Pitfalls in the evaluation of screening
The efficacy of screening is sometimes accepted on evidence that fails to take account of certain pitfalls. First, patients who volunteer for screening programs are often those who are destined for favorable outcomes for other reasons. Second, the increased survival demonstrated as a result of screening may be only the longer time the disease is known to exist. And third, screening programs will tend to identify slowly progressive variants of disease since these are more likely to have a long presymptomatic phase. For example, a very malignant carcinoma is unlikely to be identified by screening because it is likely to cause symptoms early in the course of the disease.

For all these reasons, the only completely satisfactory evidence on which to base a screening program is that obtained by a randomized, controlled trial, with mortality, rather than duration of survival, as the end point.

Evaluation of health education and developmental assessment
The evaluation of these aspects of preventive medicine is especially difficult. For onething, the desired outcome may be very much less specific than that of a screening maneuver. The desired effect of developmental assessment may be the improvement of parenting, and the objective of sex education may be an improvement in the quality of marriage. These end points are difficult to assess. For another thing, it is impossible to know what may be the cumulative effect of efforts to educate patients, which individually may seem ineffective. For example, it is difficult to know how much recent changes in people's smoking habits are due to the cumulative effect of counseling by physicians.

In health education we have to be guided by other criteria. Just because some aspects of health education have no demonstrable effect on health does not mean that they are of no value. Spreading information and providing reassurance are desirable objectives, irrespective of any identifiable effect on health. They can, indeed, be regarded as part of good medical care.

Preventive .methods in family practice
For many years one of the mainstays of preventive medicine in family practice has been the annual physical examination, at which a history and physical examination are combined with a battery of screening tests. The practice of applying a package of screening tests to a population is also called "multiphasic screening." Experimental evidence available has failed to show that the type of multiphasic screening applied during an annual physical examination has any benefits. In a well-designed controlled trial, 7,229 individuals between the ages of forty and sixty-four were randomly allocated into either a screening or control group. The screening group was invited to

attend two screening sessions held about two years apart, while the control group continued to receive conventional medical care. Both groups were then invited to undergo a health survey five to seven years later. This revealed no significant differences in morbidity between the two groups. Further follow up for a total of nine years after the initial screening revealed no significant differences between the two groups in any of the outcome measures: hospital admission rates, consultation rates, certified sickness absence from work, and mortality (Holland et al., 1977). The only other large-scale controlled trial of multiphasic screening was that done by the Kaiser Permanante group (Dales et al., 1979). This study failed to demonstrate any statistically significant differences in the overall death rates between the treatment and control groups seven years after the beginning of the study. However, mortality from some of the diseases to which screening was directed showed significantly improved rates in the screening group. These findings indicate that screening programs must be evaluated by specific rather than overall mortality.

As a preventive strategy for family practice, the annual physical examination is alsoopen to a number of other objections:

1. It bears little relation to the specific needs of different age groups.
2. Because of the global nature of the complete physical examination, it often includes tests that fail to fulfill the criteria for acceptance of a screening or case finding procedure - electrocardiography, for example.
3. Tests may be repeated at yearly intervals when a much lesser frequency would be equally effective.
4. In most practices complete physicals are given only to that section of the population who demand it or at least are compliant. If every member of a practice of 2,000 patients had a twenty-minute annual health examination it would occupy the physician for twenty-two weeks of every year.

In other words, the annual physical is an unscientific, imprecise, and poorly thought-out strategy for applying modern knowledge of preventive medicine in family practice.

The new approach to preventive medicine in family practice is based on the following principles:

1. Any preventive strategy must be applicable to the whole practice population. A family physician can surely not be satisfied if there are unimmunized children or undetected hypertensives in the families under his care. It may be objected that the family physician should not be held responsible for uncooperative patients. This is true, provided that the refusal of care is a deliberate one, made by people who have
been fully informed. Very often the "noncompliant" members of a practice are those with few resources, many problems, poor information, and little opportunity of taking advantage of the services offered.

2. Preventive procedures should be applied only after a critical assessment of their individual effectiveness. They may be grouped together in packages, but these should vary according to the needs of different age and sex groups.
3. Tests and other procedures should not be repeated more often than necessary.
4. When patients attend with symptoms, maximum use should be made of the opportunity to practice preventive medicine. In one year 70 percent of the practice population is seen at least once, and in five years more than 90 percent of the practice population is seen at least once. The average number of consultations for each patient is about four per year.
In the course of five years, therefore, virtually the whole population of the practice will pass through the physician's office. A large proportion of the necessary preventive procedures can be applied as case-finding maneuvers in the course of these visits. In order to do this effectively, however, the practice must have the necessary organizational tools. The use of this case-finding method does not, of course, preclude visits for purely preventive purposes: prenatal care,

developmental assessment, and "milestone examinations" at certain periods of life. Nor does it preclude special preventive examinations in those few patients who do not attend for other reasons.
5. The preventive strategies should be applied by the whole practice team, including the family practice nurse and public health nurse. In many cases, in prenatal care, well-baby care, and screening in the aged, the practice nurses may be responsible for a large part of the process.

Ⅹ. HOME VISITS

Twenty-five years ago home visits were a major part of the family physician's work. In the intervening years, many factors have combined to reduce their number. Increasing car ownership has made it easier for people to come to the office. Immunization and antibiotic therapy have reduced the incidence and duration of acute infections, especially in childhood. Technological developments have concentrated the care of serious illness in the hospital. Widespread telephone ownership has enabled physicians to give advice and receive follow-up information over the telephone. Less emphasis is now placed on bed rest for many conditions.

At the same time, traffic and parking problems in urban areas have made it very uneconomical for physicians to make house calls. Another factor has been the geographic dispersal of practices. Because of the infrequency of home visits, family physicians have accepted patients who live too far away to be within range of a home visit. Although a decline in the number of home visits was inevitable, the reluctance of doctors to make them has been one of the most frequent causes of public dissatisfaction with medical care. The reluctance to make house calls has not only been a source of inconvenience and discomfort to patients, it has also led in some cases to poor-quality medical care. Patients have been treated for serious illness entirely over the telephone; antibiotics and other drugs have been prescribed without the patient's having been seen and assessed.

There is little doubt that in some practices the home visit rate has fallen too low. However, some of the trends that led to the decline in home visits are beginning to bereversed. The proportion of elderly people in the population is increasing. The rising cost of hospital care is leading to earlier discharge and changing criteria for admission. Advances in electronics are making it easier to bring medical technology into the home. In these circumstances it has become important for family physicians to redefine the role of the home visit in family practice. As long as a commitment to making necessary house calls is part of the contract with patients, family physicians will have to pay regard to the geographic boundaries of their practices.

Home visiting policies are a matter for each practitioner to decide after consideration of all the demographic, geographic, and economic factors. The purpose of this chapter is to review the situations in which house calls are either necessary or desirable.

Indications for home visits

1. The assessment and/or management of acute illness: There are many reasons why it may be inadvisable for a patient to be transported to the office or emergency department. The patient may be:
1) too ill, as with a severe attack of influenza.
2) in severe pain that is exacerbated by movement, e.g., sciatica.
3) too old, for example, an elderly patient with a chest infection or a stroke.
4) in danger of having his problem exacerbated by movement and its attendant anxiety, e.g., in an acute asthmatic attack.
5) in need of some treatment before being moved to hospital, e.g., relief of pain, resuscitation,

treatment of cardiac asthma.
6) infectious to other patients, e.g., an adult with chicken pox.

Of course, many of these situations are a matter of judgment. A patient with a temperature of 39.5℃ (103℉) and influenza can come to the office, but not without discomfort. Patients in severe pain can be moved, but at the price of increasing their pain. Old people with mild pneumonia can be admitted to the hospital, but this condition can be diagnosed clinically and will usually respond very well to antibiotics at home. Acute asthma can be treated in the office or emergency department, but the treatment can be given equally well in the home.

Another reason for making a home visit in acute illness is assessment of the need for admission to the hospital. The home conditions and family supports are important factors in this decision, especially in children and elderly patients. If the patient is brought to the emergency department, an unnecessary admission becomes much more likely.

After a predominantly hospital-oriented training, young physicians often feel insecure when dealing with acute illness in the home, away from the supporting services of laboratory and x-ray department. It is important to remember that many illnesses can be managed using clinical judgment alone. If laboratory investigation is needed, it is a simple matter to collect specimens of blood, urine, stools; or sputum.

2． The assessment and management of patients discharged from the hospital. With the trend toward early discharge, patients are now returning home in the early stages of recovery from such illnesses as myocardial infarction and stroke or after major surgery. Their rehabilitation requires adaptation to the home and the activities of daily living, then to work. Sometimes the patient has to adapt to major disfigurements like amputation, mastectomy, or colostomy. Although these patients can be transported to the office or spoken to on the telephone, it is only at a home visit that their adaptation and its problems can be appreciated to the full. At an office visit, for example, the physician may not realize that the patient is spending too much time in bed. It is only at a home visit that the physician can understand some of the difficulties that the patient may be facing in adjusting to the home environment. Of course, the patient can be helped greatly by visits from the nurse, physiotherapist, or occupational therapist, who can keep the physician informed of progress. It is difficult, however, to see how the physician can remain in charge of management unless he has assessed the home situation for himself.

3. The management of patients with chronic diseases. Patients who are confined to the home with chronic problems like rheumatoid arthritis, congestive heart failure, or multiple sclerosis require periodic home visits so that their progress can be assessed and treatment monitored.

4. The management of patients with terminal illness. Until recently, most people in North America were admitted to the hospital for terminal illness. This trend is now being reversed. With the cooperation of families and the support of home care services, it is now possible for many people to die in the familiar surroundings of their own homes. Regular visits from the family physician are very important for patient and family, even when there is apparently "nothing to be done." It is not for technical reasons that the doctor's visits are appreciated, but for the succor and support he provides at the family's time of crisis.

5. The assessment of home conditions and family function. This kind of assessment may be a by-product of visits for other purposes. At other times, a visit may be made especially for this purpose. Pereira-Gray (1978) has given some reasons why a home visit may be helpful: "Patients express their feelings more easily at home and are often able to reveal not just the focus of their feelings, but their depth." The home expresses the values of the family. Often it is only at a home

visit that a doctor discovers the presence of another person in the home. For these reasons also, family counseling may be provided in the home in selected circumstances.

It is often said that most home visits can be delegated to allied health professionals or to paramedical workers. Although this is technically correct, family physicians should ponder the consequences of doing so. Visiting patients at home is one of the means by which bonds between a doctor and a family are forged and strengthened. A first-hand knowledge of the family home gives the physician an understanding of the patient and his family that he can get in no other way. Moreover, the greaten richment to the doctor's own working life from caring for patients in their homes must not be underrated. From the point of view of the patient, home care can be crucial. Norman Cousins, in his book *Anatomy of an Illness* (1979), has movingly described the peace of mind that comes from being cared for at home, even in serious illness.