SPECIAL ARTICLE

FAMILY MEDICINE IN PERSPECTIVE

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Abstract Family medicine is part of the process by which medicine adjusts itself to the changing needs of society. Family physicians have in common the fact that they obtain fulfillment from personal relations more than from the technical aspects of medicine. Their commitment is to a group of people more than to a body of knowledge. Their experience gives them a distinctive perspective of illness that includes its personal and social context.

Medical knowledge includes information, skill and insight. Medical education has tended to emphasize the former: to concentrate on foreground rather than background. In the training of family physicians the education setting and the role of instructors are of crucial importance. (N Engl J Med 293:176-181, 1975)

I PROPOSE to discuss family medicine in two perspectives: the perspective of history and the perspective of contemporary ideas. My purpose is to show family medicine in two lights: as a part of the historic process by which medicine adjusts itself to the changing needs of mankind and as a part of a larger movement of ideas that is beginning to change the current view of the world.

The End of an Era

In 14 years the centenary of one of the landmarks of recent medical history, the foundation of Johns Hopkins, will be celebrated. Johns Hopkins played a crucial part in the changes that have transformed Western medicine in this century. Together with a few other institutions, it provided a model against which Abraham Flexner[1] could measure medical education in his time. Then, as now, demonstration models had an important part to play in the reform of medical education. I like to think that our own department of family medicine —and others like it — will have a similar role in educational reform.

Twenty-one years separated the foundation of Johns Hopkins from the publication of the Flexner report. The cycle of changes that followed the report has only now, after 60 years, come full circle. The changes were brought about, like all reforms, by a number of influences: by the effect of Flexner's facts on public and profession alike; by the impact of forceful personalities; and by the provision of funds, both private and public, to those willing to make the changes.

Great historical movements like these can be viewed on two levels: on the institutional level of hospitals, medical schools and institutes, and on the deeper level of ideas. The Flexner reforms were marked not only by the great institutional changes apparent today, but by profound changes in ideas about the nature of medical knowledge and the role of the physician. Medicine stands now at the end of an era: a vantage point from which the changes and their effects, both good and bad, can be surveyed. If I appear to dwell on the bad, that fact does not mean that I do not recognize and welcome the great benefits that have accrued to us. The Flexner reforms prepared the way for medicine to become a technology. As in so many other areas of modern life, however, the benefits of technology have been reaped without steps taken to contain and control its negative effects.

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Primary Care

Among the most serious problems thrown up by the reforms is that of primary care. This has been identified by many writers as the central issue.[2,3] Primary care is not a single problem, but several. The term itself, for whose introduction I must take some responsibility,[4] has tended to focus attention on one of these problems: the question of who should be the doctor of first contact. At the same time it has tended to divert attention from a more crucial issue: the question whether physicians are prepared to put their commitment to people above their commitment to technology. I must hasten to say here that by commitment to people I do not mean an interest in, and concern for, people, which one should be able to take for granted in any physician, whatever his field of work. What I have in mind by commitment to people will become clearer as I pursue some of its implications.

Commitment to the Person

It is difficult for a doctor to commit himself to a person and at the same time to limit his commitment to certain diseases or certain types of problem. I do not mean to suggest that personal commitment can be completely unconditional. There must be some limits, even if they are only geographic. Nevertheless, the kind of commitment I am speaking of implies that the physician will "stay with" a person whatever his problem may be, and he will do so because his commitment is to people more than to a body of knowledge or a branch of technology. To such a physician, problems become interesting and important not only for their own sake but because they are Mr. Smith's or Mrs. Jones's problem. Very often in such relations there is not even a very clear distinction between a medical problem and a nonmedical one. The patient defines the problem.

Now this process presents a difficulty. If a doctor makes this kind of personal commitment, there are certain things he cannot do. He cannot match the specialist in detailed mastery of one field. Specialist knowledge requires concentration of experience, entailing irreconcilable conflict with commitment to the person. A doctor who devotes

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himself to the care of 1500 people cannot achieve the technical mastery of one field that is attainable by a specialist who selects his patients from a population of 50,000. This is not to say that the personal physician cannot be scholarly, knowledgeable and technically skilled. His knowledge, however, is of a different order from that of the specialist — a theme to which I will return shortly.

A doctor who has committed himself to a group of people, and attained fulfillment by doing so, can renounce without regret much of the expertise of the specialist. My observation from meeting large numbers of family doctors from all over the world is that they have in common the fact that the source of their fulfillment is the experience of human relations that medicine has given them. This feeling is beautifully expressed in books like *A Fortunate Man*,[5] by Berger and Mohr, Lane's *The Longest Art*[6] and William Carlos Williams's autobiography.[7] In *A Fortunate Man* Berger describes with great insight the gradual evolution of the physician Sassal's sense of vocation. Seeing himself at first as a technical expert, a dealer in crises and emergencies, he gradually begins to perceive his role in terms of the human relations that he has established.

The Nature of Medical Knowledge

When he has made his commitment to a group of people and seen where his true vocation lies, the physician begins to see some other issues in a different perspective. One of these is whether or not to be a family doctor. To a physician who achieves fulfillment from human relations it may not make much sense to say, "I will commit myself to people provided they are over 14, or under 65, or under 14, or male, or female, or provided they are not pregnant." The personal commitment transcends any particular problem. If, for example, the physician does not practice obstetrics, he can still remain the patient's personal physician during pregnancy while the obstetrician shares the prenatal care and does the delivery.

One of the greatest objections to the idea of the family doctor has been that one physician cannot effectively master the whole field of medicine. The root of this objection is a concept of medical knowledge that I hold to be fallacious. I call it "the lump fallacy." According to this view, knowledge is a lump of material that grows by accretion. Having reached a certain size, it becomes too large to be assimilated and must be broken up into smaller lumps. These smaller lumps, however, continue to grow at an ever increasing rate and in their turn have to be fragmented, and so on.

This view of knowledge is surely a distortion of the truth. A physician uses three kinds of knowledge. The first, which I will call information, is the only one to which the simile of a material mass can be applied; the second, clinical craftsmanship, is a skill; the third, which I will call insight and awareness, is an integral part of the personality. These three kinds of knowledge are acquired in quite different ways. Information comes from observation, listening and reading; clinical skill, like other skills, comes from constant practice and the emulation of others; insight and awareness come from human intercourse and deep reflection on the self and on experience. Excellence in one of these areas of knowledge does not in any way guarantee excellence in the others. One tends to think of poor physicians as badly informed physicians. But everyone has encountered superbly informed physicians, who can quote all the latest references, but are woefully lacking in clinical judgment, and also excellent clinicians who in their dealings with people are incredibly naïve. Excellence in medicine requires a blend of all kinds of knowledge. My own observation is that error in medicine arises more often from a failure of skill or insight than from a lack of information. A lack of information is most readily remedied by reference to book or consultant. Defects of skill or insight are far more difficult to remedy — not least because the physician, lacking self-knowledge, cannot recognize his own failings.

It is apparent, therefore, why I consider the conventional view of medical knowledge to be a very limited one. The deepest and most vital knowledge — the knowledge that determines how information will be used — does not "explode" or "have a half-life of five years" as the catchwords have it. It is also apparent why I do not believe that a family doctor need sacrifice any of this vital type of knowledge. On the contrary, by caring for the whole family, he stands to gain personal knowledge that can be gained in no other way.

The Family Doctor

In caring for the whole family, the physician not only gains in knowledge but also enlarges his scope of action. Whenever the situation requires it he can change his focus from individual to family and back again. In the many situations in which the illness of an individual is accompanied by family dysfunction he can quite readily direct his actions to the family as a whole.

The family doctor not only knows about the family — he knows them. This personal knowledge can be put to good use. He knows, for example, the kind of feelings different members of the family arouse in him, and he can use this knowledge in making hypotheses about problems he encounters in the family. In this, as in all things, he cannot have everything as he would like it. Some families will inevitably be better known to him than others. There will always be families who prefer to divide their care, for all types of reasons. These wishes must be accepted even though looking after part of a family gives a family doctor an inhibited feeling.

The family doctor can gain very useful knowledge of the family from other members of the health team. This knowledge is additionally useful in that it is gained by a person of background and training different from his own. This knowledge, however, cannot be a substitute for his own personal knowledge. Team work will be counterproductive if it is allowed to increase the distance between doctors and their patients. It would, for example, be much to the detriment of medical knowledge if all home visits were made by nurses.

There is no conclusive evidence that care of the family by one physician is either better or worse than care by a pediatrician-internist-obstetrician team. I hope I shall not

be considered nihilistic if I say that I doubt if there ever will be. I say that for several reasons: because instruments for measuring differences of this kind are extremely difficult to develop; because there is such an enormous difference between the "in vitro" of a social experiment and the "in vivo" of the outside world; and, most important, because social issues of this kind are in the final analysis political issues and have to be decided by political means.

I do not use the term "political" here in any pejorative sense. Nor do I not mean that it will have to be decided in legislative assemblies. It is a political issue in that it will be decided according to deeply held feelings and values of people, and by the rigorous test of what works best in the practical world. The great issues of public health and medicine have always been decided in this way — and rightly so. There were no controlled trials before the apothecaries were absorbed into the medical profession, before the sanitary reforms of the 19th century, or before the Flexnerian reforms of this century. There were, of course, plenty of reports, plenty of facts, plenty of argument and analysis. Social reformers from Florence Nightingale to Ralph Nader have made extensive and effective use of facts. In the final analysis, however, the question is one of values, to be decided by the political process rather than by scientific experiment.

Social Mobility and Family Practice

Since 20 per cent of the population of the United States moves every year, and each family moves, on the average, every seven years, it has been maintained[8] that it is unrealistic to place much emphasis on continuity of care. These statistics, however, are open to serious misinterpretation. It is misleading, for example, to think in terms of the "average family." The general population does undoubtedly include highly mobile individuals and families, who move far more frequently than once in seven years. It also includes very large numbers of people who move very infrequently — in many cases only on marriage and retirement. Moreover, many of these moves are within the same municipality and do not necessarily, therefore, break continuity of care.

The following statistics on internal migration in Canada illustrate my point. From 1956 to 1961, 42.4 per cent of the population over five years of age moved at least once. Of these moves, 60 per cent were within the same municipality, 32 per cent were within the same province, and 8 per cent were between provinces.[9] Thus, 16 per cent of the population left their municipality in five years. Moreover, the group from 20 to 39 years of age accounted for 50 per cent of the moving population: an age group that includes most of those marrying, starting families and making their way in the world.

In London, Ontario, a study of family practice and primary health care has recently been completed.[10,11] In 1974 there were in London 128 family physicians for a population of 233,000. Between 1961 and 1973, 97 family physicians started in practice in the city. Of these, only 15 have left practice. Two have retired, two have entered a specialty, three have moved, and six have moved to appointments in academic family medicine (two to our own department). These figures suggest to me that family physicians may prove to be a particularly stable element in the population.

Finally, I believe it would be wrong to assume that the present pattern of population movement will continue indefinitely into the future. I think there are good reasons for believing that the population in North America will become less rather than more mobile. Far from being pessimistic about continuity of care, I would go so far as to predict that family physicians will be once again, as they have been in the past, an important part of that cement that holds society together.

The Hospital

The Flexner reforms accelerated two processes: the concentration of both medical care and medical education in the hospital. It is small wonder that this focalization has influenced whole generations of physicians in their concepts of health and disease. The hospital tends by its very nature to separate the disease from the man and the man from his environment. It is not surprising, therefore, that the medicine of this century has been the medicine of entities rather than the medicine of relations and that modern medicine has, as John Ryle[12] remarked in 1948, neglected etiology in its widest sense.

How many physicians going into practice have found themselves totally unprepared by their training for the encounter with illness outside the hospital! In 1919 Sir James Mackenzie wrote of his experience 40 years previously:

> After a year in hospital as house physician, I entered general practice in an industrial town of about 100,000 inhabitants. I started my work fairly confident that my teaching, and hospital experience, had amply furnished me with competent knowledge for the pursuit of my profession...I was not long engaged in my new sphere when I realized that I was unable to recognize the ailments in the great majority of my patients.[13]

This experience must have been repeated countless thousands of times. Mackenzies's first reaction, like that of most people, was to ask not "What was wrong with my education?" but "What is wrong with me?" Such is the power of early training to form one's view of the world. Nevertheless, many general practitioners found that their world view was being gradually changed by their experience. They saw many illnesses that could not be fitted into the neat categories that they had learned. They learned that illness is intimately related to the personality and life experience of the patient. They learned the inseparability of patient and environment. This change in world view can be likened to a change in visual gestalt. The general practitioner, trained to see illness in terms of the figure, began gradually to see both figure and ground. He found that to understand illness it is necessary also to understand its context.

Let me illustrate from a recent experience. A well dressed young man of 19 came with chest-wall pain of short duration. He had been several times during the previous year with a similar pain. Examination was negative except for some local tenderness. Given an opportunity to

talk, he unfolded a story of such desperate loneliness that he had on two occasions telephoned "contact" — a voluntary social service for those in despair. His chief problem — and the one for which he so much needed help — was a personal crisis of identity and adjustment.

Any family doctor could cite a similar case from any day's experience. It would be easy, too, to quote examples in which an organic disease interacted with a personal problem to produce an episode of illness. This is why statements like "Family practice is predominantly internal medicine" beg the question. Family practice can be called internal medicine if that is the physician's perspective. The young man's illness could be categorized as intercostal myalgia and appear in the statistics under "musculoskeletal disorders." To describe family practice in these terms, however, would be a gross distortion of reality. It is a similar distortion of reality to talk as if people's problems are neatly divided into "organic" and "psychosocial" categories. People are ill as wholes not as parts.

In some circumstances it is, of course, quite appropriate for a physician to focus only on the foreground of illness. In emergencies, accidents and many acute illnesses the background can for practical purposes be ignored — at least until the acute phase is over. The longer an illness lasts, however, the more important the background becomes.

Learning Family Medicine

It will be understood, therefore, why I do not think that training in a medical specialty — as it is known today — can be applied "in toto" to the experience of being a family physician. Learning to be a family physician requires a change of perspective that can only take place where the new perspective is dominant. It will also be apparent why I think that attempts to produce a family doctor by putting together a conventional training in pediatrics and internal medicine — and adding some psychiatry — are doomed to failure. "The whole is different from the sum of its parts." Family doctors may emerge in this way, but they will do so by the arduous route of rising above their training and learning from their own experience.

The Future Family Doctor

As they design programs for the education of family physicians, educators must have in mind a clear conception of the type of person they would like their students to become. Ideal human types are the embodiment of the ideals of an age. In medicine, Dr. Pellegrino[14] has given a reminder of the influence of two ideal types — the German physician-scientist and the Oslerian scholar-consultant — on the evolution of internal medicine.

What kind of people, then, do educators want their students to become? They should have a deep commitment to people and obtain their greatest professional fulfillment from their relations with people — to believe, in Lewis Mumford's phrase, in the primacy of the person, to use technology with skill, but to make it always subservient to the interests of the person. Educators want physicians who can think analytically when analysis is required but whose usual mode of thought is multi-dimensional and holistic. They want them to be concerned with etiology in its broadest sense and to be ever mindful of the need to teach their patients how to attain and maintain health. They want people who are not afraid of recognizing and talking about feelings: people who know themselves and can throughout their career recognize their defects, learn from experience and continue to grow as people and as physicians.

A Philosophy of Education

In his essay on the educational ideas of Coleridge, William Walsh[15] describes modern education as being "under the dominance of the foreground, the sustained and peremptory dominance of subject-matter." Subject matter, the readily accessible, examinable information "has distended to monstrous proportions, monstrous in its immensity, shapelessness and horrid incoherence." Yet how little of this foreground remains and influences the remainder of one's life? A good education transcends subject matter. What lasts, says Walsh, again, is "a blend of value, attitude and assumption, a certain moral tone, a special quality of imagination, a particular flavour of sensibility — the things that constitute the soul of our education. A good education persists not as a collection of information, an arrangement of intellectual bric-a-brac, but a certain unity of self...and a certain method of thinking and feeling."

If subject matter is the foreground, what is the background, and how does one ensure that it receives its due emphasis? What is it that allows that "unity of self" — that "method of thinking and feeling" — to grow in the learner? Of critical importance, certainly, is the setting of education. If students are to have certain values and certain ways of thinking and feeling, they must be educated in a setting in which these qualities are all-pervasive. And their teachers must be people who exemplify those qualities.

I have maintained earlier that family physicians have certain distinctive values, and ways of thinking and feeling. It follows that nobody is going to learn family medicine from those who are not family physicians, or in an environment that is alien to its ethos. This is not to say that the student can learn nothing from other teachers and in other environments. It does mean, however, that the core and essence of his education must be the experience of family practice.

What else must the environment do? It must help the student in every possible way to develop the insight, awareness and self-knowledge that is the key to his growth as a person and as a physician. It must provide him with the experience on which to base his observations, the genuine and intense experience of being a family doctor. It must provide the stimulus to thought, reading and reflection. His teachers must foster his growth by helping him to look critically at his own ways of thinking and feeling. There are many ways of so helping him, each with its special merits. One of the most effective is direct observation of the student through one-way glass or closed-circuit television. The latter has the additional advantage of allowing the student to see himself. Thus, modern technology can be used to enhance personal development. Anoth-

er is the process of record audit, particularly if problem-oriented records are used. Last, but not least, are the methods of group learning, developed by people like Michael Balint, Carl Rogers and, in our own department, Michael Brennan, which help students to understand themselves. By working with members of other health professions, the student will learn, as everyone learns, that there are other ways of thinking about problems than the ways in which doctors have learned to think about them as physicians.

Creating this kind of learning environment poses many problems and some dilemmas. The problems are there whether the environment is a university model practice or a service practice. In the university center, the demands of academic life — of teaching, research and administration — are often in conflict with the task of being a family doctor. Teaching and scholarship are essential activities, but must not be allowed to over-ride the personal care of patients. It would in my view be very unfortunate if educational efforts raised a generation of academic physicians who were superb teachers and scholarly writers but had ceased to be family doctors in any genuine sense. To achieve this balance, it will be necessary for academic family medicine to have a different scale of values from that of some other walks of academic life. Primacy of the person may be incompatible with the primacy of publication. As for administration, as much as possible should be left to those most fitted to do it: professional administrators.

In the service practice, the problems are the converse of these. Amid the constant demands of patient care, how can time and energies be freed for scholarship and teaching? I am convinced that in both university practices and service practices a balance can be found and that either kind of practice can create a superb learning environment. Better still, the two kinds of practice can be melded into one educational program, so that each can contribute its own particular strengths.

Another dilemma facing the university practice is the extent to which, in exploring and testing new ideas, it should make itself different from the norm of community practice. It is the function of the university and its professional schools to be in advance of the world at large. This predominance will create tensions, and, if the professional school is doing its job, there will inevitably be tension between the school and the profession. I am aware of this tension in our department, and I regard it as creative. The challenge is to keep creative tension from deteriorating into destructive conflict.

Finally, there is the dilemma of continuity. To learn family medicine, the student must experience family practice in both its intensity and its continuity. Yet the duration of his experience can be no longer than the length of his training program. The only present solution I see is to make some kind of compromise between intensity and continuity. An experience that is continuous over three years but of very low intensity is, in my view, less satisfactory than one that is shorter and more intense. In our own department the practice is for residents to spend one year, full time, in the teaching practice, and to make this experience continuous as far as is humanly possible.

Family Medicine and Contemporary Ideas

Medicine always reflects the values of the society that it serves. A materialistic and mechanistic society must expect to have a materialistic and mechanistic medicine. If science is exclusively reductive and atomistic, and maintains an illusion of objectivity, medical science will tend to be likewise. The dominant values and ideas of contemporary society explain much about the direction that medicine has taken in the last hundred years. There are many indications, however, that values and ideas are changing, and as they do, the values of medicine can be expected to change with them.

What changes can be discerned? I see first a new concern for what Lewis Mumford[16-18] calls "the primacy of the person." "Our machines," says Mumford, "have become gigantic, powerful, self operating, inimical to truly human standards and purposes: our men, devitalized by this very process, are now dwarfed, paralysed, impotent. Only by restoring primacy to the person — and to the experience and disciplines that go into the making of persons — can that fatal imbalance be overcome."

To restore the primacy of the person, one needs a medicine that puts the person in all his wholeness in the center of the stage and does not separate the disease from the man, and the man from his environment — a medicine that makes technology firmly subservient to human values, and maintains a creative balance between generalist and specialist. These I believe to be the aims of family medicine.

It is no accident that family medicine is emerging at a time when the inter-relatedness of all things is being rediscovered, when the importance of ecology is being forced on one's awareness, when the limitations of the closed-system way of thinking are being more and more appreciated, and when scientists, especially those in the life sciences, are beginning to react to the scientific bias against integration, synthesis and teleology. Nor is it coincidence that this movement of ideas is taking place at a time when the virtues of economic growth are being questioned, when bigness for its own sake is ceasing to be considered good, when human values are being asserted over technology, and when the importance of enduring and stable human relations is being discovered anew.

I think family medicine is looked on in some quarters as a subversive movement, just as ecology has been called "the subversive science." It depends on one's point of view. In truth, family medicine is a deeply conservative movement, since it seeks to restore to their rightful place certain values and modes of thought that have always existed in medicine but have in recent times become submerged.

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