Family Practice and the Advancement of Medical Understanding

The First 50 Years

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In the last half of the twentieth century, family practice has emerged as a strong influence in both community practice and academic medical centers. Since the formation in 1947 of the American Academy of General Practice, family practice has changed from a group of physicians applying the knowledge of other disciplines into a recognized specialty with its own body of learning. Family medicine has advanced medical understanding in: (1) relationship-based health care as the foundation of a specialty; (2) the process of comprehensive clinical reasoning; (3) the recognition of problems of living as a health care concern; (4) the meanings of words such as pain, disease, and disability; (5) the systems approach to primary health care; and (6) the clinical encounter as the definable unit of family practice. These 6 concepts have helped expand the specialty's body of knowledge and clarify its values. They will also serve as a template for the future evolution of family practice as the specialty faces new challenges, including managed care, the aging population, the rapid growth of medical knowledge, and the increased use of computers and technology in health care.

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Family practice is the applied art and science of primary medical care. In patient care, the family practitioner travels through the multidimensional continuum of his discipline: vertically from biochemistry to sociology, horizontally from pathology to psychiatry, and temporally from infant to aged. During the journey, through the years of his and his patients' lives, the family practitioner creates and uses knowledge of many kinds.[1]

The American Academy of Family Physicians, which began as the American Academy of General Practice, celebrated its 50th anniversary in 1997. Accompanying this milestone is a growing emphasis on generalist medicine in medical education, as medical groups across America compete to hire family practice residency graduates. In 1999, the American Board of Family Practice marks 30 years as the certifying body for family physicians. However, there is still a widespread lack of understanding of how family physicians have contributed to the cumulative body of medical knowledge. This paper examines 6 areas wherein family practice has advanced our understanding of medicine and health care, and suggests the challenges that each area will face in the new millennium.

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SIX AREAS OF ADVANCEMENT

Family practice's contribution to the advancement of medical understanding may be grouped into 6 topic areas: (1) relationship-based health care with a personal commitment to continuity and coordination of care; (2) the process of comprehensive clinical reasoning when faced with undifferentiated problems; (3) problems of living as a health care concern, including difficulties with personal feelings, interpersonal relationships, work, and finances; (4) the significance of words and descriptions in health care, such as what "pelvic pain" might connote to the patient and to the physician; (5) the systems approach to primary health care, which includes social systems, such as family and community, as well as body systems; and (6) the clinical encounter as the family practice unit of care.

The first 2 concepts are the legacy of general practice. The next 3 were adapted from other disciplines and other medical cultures, notably the social sciences and the British and Canadian traditions.[2,3] The sixth concept—the clinical encounter as the definable unit of care—has mostly been advanced by family and general physicians. Each of these concepts, in its own way, has influenced the early history of the specialty, and each has evolved over time with the maturation of the discipline.

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Relationship-Based Health Care as the Foundation of a Specialty

Family practice is based on a personal relationship between the physician and the patient, and in this way, it is similar to the other primary care specialties. Family practice, however, differs in that the relationship may span a patient's life cycle and, in its highest expression, include all family members. Relationship-based care was a hallmark of general practice that was nearly lost in the rush to subspecialization that followed World War II. What saved generalism from extinction and allowed the transformation to family practice was the widespread public recognition that health care based chiefly on body organs and systems somehow did not meet the perceived needs of patients.

Various terms have been used to identify relationship-based health care, including patient-centered care, personal medicine, and longitudinal care. McWhinney[3] described "a continuity of personal responsibility which is terminated only by death, mutual decision, or a decision of one of the parties, rather than by the event of cure or the termination of consultation or treatment." The core value is the intentional development of a long-term relationship, with progressive sharing of information and increased trust with each successive encounter.

A leading determinant in choosing to become a family physician seems to be the opportunity for personal interaction with members of the entire family over time.[4] This probably reflects both a value decision and a personality trait. The social interaction component has utility in practice, and, on analysis of physician-patient encounters, Stewart[5] found significantly higher patient satisfaction when there was a high degree of patient-centered behavior. There are often pragmatic applications: Approximately 7% of patients in a primary care setting have been reported to engage in behavior that actively sabotages their own medical care,[6] and a close patient-physician relationship seems to be the best way to recognize such behavior.

Family practice has expanded the physician-patient relationship to include the family, asserting that family relationships influence illness causation, the diagnostic process, and management decisions.[7] The ongoing relationship with a patient and his or her family has always been the basis of family practice's core principle of continuing comprehensive care. As Loxterkamp[8] has observed, "Put another way, our saving grace rests upon faith in human relationships (of which the family is prototypical) as much as in our good works (no matter how skillfully or dutifully we perform them)."

The Process of Comprehensive Clinical Reasoning

The need to provide broad-based care to a large number of patients has required that general and family physicians employ a comprehensive approach to clinical reasoning in their encounters with patients. The family practice approach involves the selective collection of diverse data, early generation of hypotheses, and continually evolving diagnoses. Thus, when a young woman reports pelvic pain, that chief complaint alone allows the family physician to consider a variety of diagnostic hypotheses, including ectopic pregnancy, pelvic inflammatory disease, domestic violence, and the sequela of childhood sexual abuse. Clinical reasoning in family practice is empiric, incorporates the patient's current life events, considers the family contribution to disease and the impact of illness on the family, and follows well-worn branches on the clinical decision tree. The ability to deal effectively with undifferentiated problems and to tolerate clinical uncertainty are traits that characterize those who choose family practice as their specialty.[4]

The family practice clinical method is similar to qualitative research in that it places a strong emphasis on context. As Engel[9] points out, the comprehensive approach is the more scientifically valid, because it looks at all of the relevant evidence, rather than excluding what is value-laden. In contrast, biomedicine currently appears to be implicitly based on the reductionistic method, with the practitioner emphasizing measurable data in arriving at clinical decisions; this approach derives validation from the quantitative research method. Coulehan[10] writes of this method: "Because of its mechanistic models, it frequently resorts to looking at the wrong data. Irrelevant data are considered important because they fit in with current thinking in the biological sciences, and potentially important observations are lost because we cannot find a niche for them."

Problems of Living as a Health Care Concern

A recent article documented that homelessness is associated with substantial excess costs per hospital stay in New York City.[11] Sometimes the difficulty is problems of living; that is, the root of the physical complaint lies in what is happening in the patient's life. In 1972, McWhinney[12] listed problems of living as one of the 5 main reasons patients consult physicians. (The others are pain or malaise, anxiety about the meaning of pain or other symptoms, the need to legitimize sick-role behavior, and the prevention of disease.) In addition to fatigue, patients with problems of living may describe headache, palpitations, insomnia, or abdominal pain. The family practice clinical encounter involves personal and social perspectives, and it includes the possibility that such factors may, at times, be the primary issue.

One such patient of mine was a young wife and mother of 3 children aged 1, 3, and 5 years. Her complaint was fatigue, and she repeatedly returned to the office with this symptom. The physical examination findings were normal, as were the results of all laboratory tests. Eventually the underlying problem emerged: The patient's husband was working long overtime hours and was gone most nights and weekends, leaving her at home with the children. With

no extended family nearby, she felt lonely and trapped. She also felt guilty when complaining about her husband's absence, since he was working to support the family. The patient could not verbalize that she was an "overtime widow"; she did not consider it a legitimate complaint to offer the physician. Instead, fatigue became her ticket of admission to health care.

It is important to recognize the significance of problems of living, since awareness of life events can prevent the medicalization of social problems, such as the inappropriate prescribing of mood-altering drugs. When problems in living are present, often the best approach is to help the patient learn to cope with the situation so that, in the words of Balint, "the physician is the drug."[2]

The Significance of Meanings in Health Care

Family practice has encouraged the incorporation of meanings into the practice of medicine. In the family practice clinical encounter, for example, does the patient's recurrent low back pain mean forced incapacity, an excuse to skip work for a few days, or the opportunity to sue a motorist? Does a child's fever mean a harmless viral illness, or could it be a sign of the same meningitis that caused the death of another child? Might the meaning of reported symptoms be related to the patient's cultural beliefs that differ from those of the physician?[13]

In a series of clinical encounters, a middle-aged woman described severe, chronic, abdominal pain that seemed resistant to therapeutic trials yet eluded a specific somatic diagnosis. After 6 visits, she had established a trusting relationship with her physician and revealed her belief that the pain was a punishment from God for specific past sins. Only then could the patient and the physician work together to deal with the cause of her symptoms.

The emphasis on the concrete in traditional medicine led Engel to postulate, "Medicine's crisis stems from the logical inference that since 'disease' is defined in terms of somatic parameters, physicians need not be concerned with psychosocial issues which lie outside medicine's responsibility and authority."[9] This helped set the stage for the subsequent elucidation of the biopsychosocial model of illness, which emphasizes that what is happening in the patient's life—personal belief conflicts, issues at work, family stress, and so forth—may be the key to understanding and managing many clinical problems. The biopsychosocial model was soon integrated into the fabric of family medicine,[14] and today it is a core teaching concept in family medicine clerkships in medical schools.

The Systems Approach to Primary Health Care

The biopsychosocial model and the meanings of symptoms to the patient and his or her family are basic to the current understanding of the systems approach to health care and its integration into the family practice clinical method. This approach is based on systems theory, which describes a hierarchy of natural systems beginning with subatomic particles and extending through cells, tissues, organs, and systems, to person, family, community, nation, and biosphere.[15] All are interrelated, and any event—such as an insulin deficiency or a divorce—causes a ripple of change throughout the system. For example, a 15-year-old patient with diabetes often has trouble controlling her blood glucose levels when her father is drinking alcohol and verbally abusing her mother. And when a 34-year-old asthmatic factory worker is visited by his domineering older sister, who is a heavy smoker, his wheezing gets worse. Is the problem the second-hand smoke or the stress of the visit?

In contrast to a focus limited to the pancreas or lungs, the family physician's domain includes organs, body systems, person, family, and community. This has clinical relevance, because attempts to address the 15-year-old's hyperglycemia or the factory worker's wheezing without interventions elsewhere in the system will produce only partial solutions.

The systems approach to health care has fostered the current interest in population-based health care that focuses on a health problem within a community. Examples include teen pregnancy, alcohol use, and domestic violence. The family practice paradigm, with its emphasis on family and community, is fertile ground for population-based health care, and with their ecologic orientation and sensitivity to epidemiologic issues, family physicians have been among the leaders in hypertension screening, wellness education, and tobacco-cessation programs.

Population-based health care will likely be an important element in future practice.[16] Health maintenance organizations are assembling the needed populations, and any future single-payer plan would further define the denominator. A recent study of patients in a managed care setting "shows that a team approach to population-based health care is a real option."[17]

The Clinical Encounter as the Definable Unit of Family Practice

The clinical encounter may be considered the family physician's "procedure," just as the radiologist interprets roentgenograms and the gastroenterologist uses endoscopy. This is when the 5 previously described concepts are implemented in the setting of a patient-physician partnership.

The clinical encounter has the following phases: (1) initiation—deciding to seek health care and negotiating expectations with the physician; (2) information gathering and hypothesis formulation— determining the purpose of the visit, taking a medical history, and conducting physical examinations and laboratory tests; (3) integration—organizing and presenting test results, diagnostic conclusions, and prognoses; (4) management—providing therapy and patient education, considering patient preferences, and

planning ongoing care and guidance; and (5) continuation—calling to report laboratory test results and following the patient's progress between office visits.

Family physicians and family medicine educators have studied the various facets of the clinical encounter. One recent study showed that of 4454 outpatient encounters involving family physicians, 58% were for acute illness, 24% for chronic illness, and 12% for well care.[18] An earlier study of 200 clinical encounters described patients' and physicians' perceptions of the purpose of the visit, and found that according to patients' perceptions, 46% were for continuing care, relatively few visits either the patient or physician explicitly identified as being for social or emotional problems (4% and 5% respectively), and 13% of visits in which the patients' concern over the meaning of symptoms was misperceived by the physician as a physical problem.[19] Schauffler and colleagues[20] found that patients who reported that their physicians discussed health education topics with them were more likely to be very satisfied with their physicians. Bergh[21] reviewed the diagnostic possibilities considered by both patients and physicians during a visit for cough and concluded that a mutual understanding of the patient's illness should be a fundamental goal in primary care. Weyrauch[22] found in 1146 total visits, patient encounters with their own physicians were significantly more satisfying than those encounters when a patient visits another physician, even after controlling for confounding variables such as age, sex, and reason for the visit.

CURRENT CHALLENGES AND FUTURE PRACTICE

What will come next? How will family practice evolve and what new contributions will be made in the future? Current influences include managed care; the explosion of medical knowledge, technology, and computers; the aging population; and the possibilities of a pandemic disease, a radiation disaster, or some other threat that we do not yet recognize. Will family practice continue to describe and put into practice those concepts that advance the delivery of health care?

The greatest risks for family practice may lie in the waning of the passion for change and the threat to specialty identity. Family practice has been called "the specialty whose time has come."[23] Will family physicians become complacent and lose the evangelical zeal that has fostered the specialty's advances? External dangers are especially evident in academic medical centers—the very centers that have nurtured some of the specialty's great thinkers. As academic medical centers seek to control primary care practice within their integrated health care systems, academic departments of family medicine may be melded with other specialties into generic primary care departments or practice groups.[24] It seems unlikely that nondisciplinary, service-oriented, integrated primary care groups will produce significant innovations in medical care in the years to come.

Current changes in health care delivery help form some important questions. Is relationship-based health care still a realistic basis for a medical specialty—or is it a quaint anachronism? Will managed care's time-limited visits allow the consideration of problems of living and meanings in health care? Will health care become a commodity, with scant value assigned to philosophical concepts such as comprehensive clinical reasoning and a systems approach to health care? Will the clinical encounter, family practice's signature concept, become truncated and distorted in the quest for cost-efficiency? And, finally, will outcomes analysis validate the clinical worth of continuing and comprehensive health care in the context of family and community?

As young and bright graduates continue to enter the specialty, family physicians seem likely to continue to advance clinical thought and practice into the next millennium and to maintain the values of the specialty. Important as these contributions may be, their main challenge will be to pursue close partnerships with their patients, who will be the true recipients of our specialty's contributions to health care.

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