The fifth principle
Family physicians as advocates

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My 3-year-old granddaughter tells me she wants to be a doctor. What will the medical world be like when she enters it in 2030? Will the exciting promises of the present be the reality of the future? Will there even be family physicians as we know them today? Will family physicians be remembered nostalgically as health caregivers from a former era? Will they be disparaged as inefficient and ineffective fuzzy thinkers, replaced by health technicians in walk-in clinics or Internet sites that dispense diagnoses and treatment by algorithms?

Our history

To understand who we can be, we must know who we are. Three seminal papers written by giants of our discipline describe the special nature of family medicine. Gayle Stephens published "The Intellectual Basis of Family Practice"[1] in 1975. Lynn Carmichael published "A Different Way of Doctoring," also in 1975, reprinted in *Family Medicine* in 1985[2]; and Ian McWhinney produced "The Importance of Being Different,"[3] the 1996 William Pickles Lecture, first published in the *British Journal of General Practice* and reprinted in *Canadian Family Physician*.[4,5]

Stephens, Carmichael, and McWhinney each highlight the distinctiveness of family medicine as a relational discipline, one that depends on the trust and mutuality that exist between two persons: the patient and the physician. There can be no family medicine without both persons. Stephens says: "Family physicians *know* their patients, *know* their patients' families, *know* their practices, and *know* themselves." He describes patient management as "the quintessential skill of clinical practice" and "the area of knowledge unique to family physicians." He distinguishes management from treatment in that managing means "alleviating most effectively the total impact of illness upon that person."[6] Stephens affirms in stirring words a central theme for family medicine:

> [*T*]*he constant is the skill of patient management*…the knowledge and skill that allows a physician to confront relatively large numbers of unselected patients with unselected conditions and to carry on therapeutic relationships with patients over time. This is what we should be teaching and learning and practicing. Everything else is secondary.[1]

Carmichael reminds us that there is no limitation to the practice of family physicians. He says, "we accept all persons and all problems. We never turn someone away and say, 'We can't help you.' We realize that we are not able to do all that we would like, and others may have to become involved, but at least we try." The content of the practice is defined by the patient, not the physician. "The location of the practice and the people who seek our help define the problems we encounter." He suggests that the physical examination is crucial for more than diagnosis. "A good doctor is a good groomer," says Carmichael, who views the physical examination as "a chance to groom the patient: hold his/her hand, remove ear wax. Sit and watch 'good' GPs, they can't keep their hands off the patient."[2]

McWhinney celebrates the difference of general practice, the characteristics that explain what he calls its marginality in the academic mainstream where, sotto voce, there is still the belief that bioscience trumps social science and molecular genetics is of more value than clinical investigation. McWhinney asserts first that general practice is the only discipline to *define* itself in terms of relationships, especially the doctor-patient relationship. The relationship usually precedes the illness and carries on regardless of defined disease.[3-5]

Second, general practitioners tend to think in terms of individual patients rather than generalized abstractions. Mrs Jones with diabetes is very different from Mrs Smith with diabetes, though

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both might have the same disease, according to the International Classification of Disease.

Third, general practice is based on an organismic rather than a mechanistic metaphor of biology: the discipline views humankind as complex systems wherein cause and effect are not usually close to each other in time and space, and it is difficult to predict the consequences of an intervention. My patient returns 5 years from now and says, "it was what you said on that visit in April 2000 that [made me] stop smoking," and I do not recall even having mentioned smoking at the time.

Fourth, echoing Carmichael, McWhinney points out that general practice is the only major field that transcends the dualistic division between mind and body. In formulating depression to a patient, I say, "we do not divide people at the neck; your physical symptoms are real manifestations of your mental state."

McWhinney speaks about affection growing in the relationship between doctor and patient, which, combined with charity, is a healing force. The price affection brings, however, is the stresses of relationship. When I tell my patient with the complicated history of childhood trauma, adult loss, and multiple illnesses whom I have known for 25 years that I am leaving Vancouver, BC, she tells me how angry she is because she will have to tell her story to someone else. She asks that, along with the medical record, I tell the doctor whom she will be seeing that she is trustworthy, that she knows her illnesses, and that she should be believed when she speaks of her symptoms or her thoughts about management.

I learn from my patients when I leave that they do not think family doctors are interchangeable physician-units. I like her and I trust her, just as she likes me and trusts me. There are emotional ties and tensions between family doctors and their patients. It is the physician who must have the self-knowledge as a whole person to ensure that communication in the relationship is in the service of the patient, not the physician; that emotional exchanges are unpacked and understood, to be used as information to assist in management. When a patient is angry, the doctor recognizes the emotion and does not react back in anger, but asks himself or herself: "Is this about the patient and me, about baggage brought in by the patient to the interview, or is it my unfinished business with my own mother that I am unconsciously acting out here?"

The fifth principle: advocacy

Our existing model in Canadian family medicine is described by the four principles[6]:

1. The family physician is a skilled clinician.
2. The patient-physician relationship is central.
3. The family physician provides care to a defined population.
4. The family physician is community-based.

This is an adaptive model that carves out a piece of territory for family medicine, and at the same time defines us as similar (therefore trustworthy) and complementary to our colleagues. We must, however, question whether the four principles are sufficient. Do they include those elements described by Stephens, Carmichael, and McWhinney? I submit that they are necessary but incomplete to describe what family physicians must be in the 21st century. Though advocacy is implied by the third principle of family medicine, I believe that a fifth principle must be explicitly stated: "The family physician must be an advocate for fairness and equity in health care and for responsible choice."

We need to defend individual patients; to defend individuals in the population; to defend the underdog—the homeless, the poor, the neglected, the battered—to defend independence of ideas and freedom of thought; to defend the idiosyncratic or unpopular question and questioner; and to examine the ethics of new models of practice. We need to be brave enough to embrace the future and its promise but wise enough and grounded enough in our personal covenant with patients to consider the costs for individuals and society of the decisions that we make.

Family physicians must judge whether information is knowledge; must decide whether that knowledge trumps other knowledge; must judge how various pieces of knowledge apply to a particular patient in all his or her complexity in a particular family in a particular community in a particular country; and must ensure patients' access to that knowledge so that they can make informed choices. Family physicians must advocate for their individual patients and therefore must become involved in developing new models of care and of funding to ensure that "health for all" does not mean "health for those who can pay."

What is the answer to evidence-based practice for treatment of HIV-positive patients? If you live in central Africa, the knowledge of western practice is irrelevant at best. Doctors must treat their patients in that community. But should some get treated adequately and others not? Is there one rule for Canada and another for Uganda?

What about genital mutilation of female children? Selective abortion of female children? As skilled clinicians, in a defined population, community-based,

responding to the request of our patients, do we go along with the current practice or do we question it? What about child abuse or spousal abuse?

There might be conflict with those of us in the system who make the wheels go 'round: chief executive officers, Deans, and Deputy Ministers who are constrained by limited resources and consequently searching for ways to increase revenues and decrease costs. But we need family physicians to keep patients with a face and name in front of them at all times, so that, along with the fascinating questions of molecular biology, we will also ask questions about the human condition, and we will appreciate the value of asking those questions.

We need mentors and role models, family physicians who are engaged with their communities; who think "health" in the broad sense; who work against smoking in the environment, against nuclear waste dumps, for seat belt legislation, for clean water, and for gun control. Family physicians of the future will need to be more political than family physicians of the past. They must partner with patients, to build public capacity to question and confront the implications of decisions taken by governments, health care and educational institutions, and professional organizations, for the health of individuals and the population.

So, too, our research agenda must include questions of impact, access, and fairness. We must study complex decision making (risk avoidance vs optimal care); ethical decision making (weighing competing interests, values-based); and new partnerships for providing health care. We must continue to study the patient-physician relationship.

Will family physicians still be needed?

I believe that family physicians will indeed be essential in 2030, as practitioners, researchers, educators, and advocates. They will be flexible, lifelong learners who can work comfortably and respectfully with other health professionals. They will share informed decision making with their patients. They will gain skills as needed to meet the requirements for care in their community. They will know their patients' names and share their own story in the service of the patient-physician relationship and the best interests of patients. They will work in a variety of funding arrangements, geared to provide fair wages for work while protecting access to medical services. They will advocate for patients as individuals within the complexity of the health care system, curing sometimes and caring always.

This is the legacy I wish to leave for my grandchild and for all of our children and grandchildren who will become the family physicians of the future.

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