

# The importance of being different

## *Inaugural Dr Ian McWhinney Lecture*

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I felt grateful, humbled, and somewhat overawed to be invited to deliver the inaugural Ian McWhinney lecture.\* Like so many people in family medicine around the world, I knew and admired Ian from a distance, through his influential writing and from the rare privilege of being in the audience when he spoke at a global family medicine conference.

Ian was one of the giants of global family medicine. Whether he liked the epithet or not, he was often referred to as the *father of family medicine*. Ian influenced the careers and attitudes of family doctors in all parts of the world and he led the development of the academic basis of our professional discipline. As a global community we are indebted to Ian for his many contributions to family medicine and health care—and for the many lessons he shared with us all. We grieve his passing.

Like many great people, Ian's legacy lives on through his writing. I took the title of my lecture from Ian's 1996 William Pickles Lecture.<sup>1</sup> William Pickles was a British GP and a pioneer of family medicine research in the early 20th century. He was a keen observer and demonstrated that collecting simple practice information about his patients over many years could lead to important discoveries about health and illness. He went on to become the first President of the Royal College of General Practitioners, establishing the academic credentials of the UK college.

### Principles

My own introduction to Ian's work came shortly after I joined the Department of General Practice and Community Medicine at Monash University in Melbourne, Australia, as a junior academic family doctor in 1988. The following year, my boss, Neil Carson, another pioneer in academic family medicine, handed me a book he had been sent by a publisher to review to see if it might be suitable for teaching our medical students. He asked me to read the book and let him know what I thought. The book was the first edition of Ian McWhinney's *Textbook of Family Medicine*.<sup>2</sup> I am sure you know it well.

The first chapter was about the origins of family medicine, and I found Ian's brief history of our discipline very interesting. But it was the next chapter, about the principles of family medicine, that opened my eyes to a new way

of looking at my chosen career. The 9 principles articulated in clear terms what we do as family doctors, no matter where in the world we live and work. I have shared these 9 principles with so many medical students and residents over the years that I can recite them in my sleep.

*Family physicians are committed to the person rather than to a particular body of knowledge, group of diseases, or special technique.* In this simple sentence, Ian captured the humanity of the work we do and our commitment to person-centred care, long before that term became fashionable.

*The family physician seeks to understand the context of the illness.* Ian asked us to consider how the experience of illness affects each individual, again highlighting the person-centred focus of our work.

*The family physician sees every contact with his or her patients as an opportunity for prevention of disease or promotion of health.* Prevention has been neglected in recent years in some parts of the world, but its importance is returning to the fore with our understanding of the global effects of so-called noncommunicable diseases and the importance of prevention and health promotion in avoiding or delaying the onset of heart disease, diabetes, many cancers, and other chronic conditions.

*The family physician views his or her practice as a "population at risk."* I like this principle because it captures the work we do in primary care to improve population health. This was the secret to William Pickles' own work observing the illnesses that affected his population and looking at ways to prevent further morbidity and mortality.

*The family physician sees himself or herself as part of a community-wide network of supportive and health care agencies.* In some parts of the world, team-based care and the gatekeeper and referral roles of family doctors are seen as something newly discovered, but they are of course part of our rich tradition.

*Ideally, the family physician should share the same habitat as their patients.* This one is my personal favourite. You cannot truly understand the health needs and concerns of a community unless you are truly a part of that community. Being a member of a community allows us to understand our patients' social contexts.

\*This commentary is based on the inaugural Dr Ian McWhinney Lecture given by Dr Kidd at Western University in London, Ont, on September 23, 2015.

**The family physician sees patients in their homes.** This is another important part of the work we do. It is an extraordinary privilege and an opportunity to understand our patients' lives better and the challenges that they face each day. Although home visits have become less common in many parts of the world, they are making a resurgence through the development of family health teams in some countries and even through telehealth, which at least allows us a glimpse of our patients' home surroundings.

**The family physician attaches importance to the subjective aspects of medicine.** This is another important lesson we learn as family doctors. Trust your instincts. Listen to your patients, and especially listen to your patients' caregivers. Never ignore a parent's concerns about his or her child, or a child's concerns about a parent.

**The family physician is a manager of resources.** At the time I thought this final principle was a bit dry, but I now realize it is one of the main contributions of family doctors. Through judicious use of expensive investigations and appropriate management of referrals, we ensure that our nations have the finances available to provide health care to all people, rather than just to an entitled subgroup.

## Indebted

These are 9 seemingly simple principles that encapsulate our role and our contribution as family doctors. For me, this is part of Ian's great legacy, his ability to describe with such clarity the important work we do.

A few days after giving me the book, my boss asked me what I thought about it. I said we should be using it as part of our teaching. He said he would think about that and asked if he could have the book back. I told him I was keeping it. He got the message.

As family doctors, we are all indebted to our teachers—our family doctor colleagues, like Ian, who have taught us how to practise medicine in our communities using a combination of “scientific knowledge and tender loving care.” Indeed this is the Latin motto of the Royal College of General Practitioners in the United Kingdom and my own college, the Royal Australian College of General Practitioners: *cum scientia caritas*. Our teachers during our medical training and subsequent careers influence the sort of doctors we become.

This is also part of the mission of WONCA, our World Organization of Family Doctors, started 43 years ago by 18 family medicine colleges and academies, including the College of Family Physicians of Canada, which banded together to create a world body that recognized the importance of strong family medicine in all nations, and which shared an ideal of supporting training and education for family medicine and high standards for clinical care. Member organizations now represent more than 500 000 family doctors in 145 countries who together have had

more than 2.5 billion consultations with patients.<sup>3</sup> That's the scope of our current work and our influence.

But we need to do more. We must strive to ensure that every family doctor, every GP, every primary care doctor joins us in our commitment to deliver high-quality primary care to our patients and communities. We need to expand our commitment to the education and training of family doctors, high-quality care, and primary care research to the 60 nations of the world where WONCA does not yet have a presence, including some of the poorest and most troubled nations on earth. This is one of my personal goals as WONCA President.

## Relationships

The first of the 4 key messages from Ian's William Pickles lecture was that family medicine differs in that it “is the only discipline to define itself in terms of relationships, especially the doctor-patient relationship.”<sup>1</sup>

One privilege of being WONCA President is that I am invited to visit family doctors in their clinics across the world to gain insights into the challenges our colleagues face in providing the best possible care to their communities. It is striking how similar the doctor-patient relationship is in family medicine settings around the world. In each country our colleagues value the relationships they have with each individual patient and his or her family. Ian of course recognized this as well—how despite being different, family doctors are also very alike. One of the traits of family doctors Ian noticed in his own travels around the world was “the combination of joy and sadness in our daily lives.”<sup>4</sup>

Katia Medina Matos, a family doctor, lives in Lechuga village, a small rural community on the island of Cuba. Katia works with a community nurse, Gladys Garnier Martinez. Together they provide health care to 844 people based in 4 rural villages. They know everybody in these communities. Working together, they see 40 patients on average each day, including up to 15 in their own homes. How do they travel between the villages? They walk.

The relationship that Katia and her family medicine colleagues in Cuba establish with each person is the basis of the primary care-based health care system in that country. This is personalized family medicine in action, based on quality and equity, ensuring every member of the community has access to high-quality primary health care delivered by well-trained doctors and nurses. This system is the envy of many much wealthier countries. In Cuba, 36 000 family doctors care for the entire population of 11 million people. This includes teams based in 3000 clinics in rural areas, like Katia's, across the country. Every Cuban, including those in rural areas, has free access to their own primary health care doctor and nurse team. These teams have a list of all people in their communities and they are expected to know the health status of each of them, including the elderly, the disabled, and the housebound, and they will go to visit these

people, rather than expecting them to come to their clinics. It is a proactive approach to ensure all people—especially the most vulnerable—are getting the care they need.

Cuba offers a model of cost-efficient, effective, and equitable primary care that can be adapted by many other countries struggling to provide health care coverage to their entire population. Cuba demonstrates the potential for family medicine to ensure health coverage for all people in each nation of the world and demonstrates how much we can achieve by working together.

### Diversity

Where our careers take us as family doctors is often chosen for us as a result of the things that make each of us different. Our special interests and the patients who seek us out are related to our diversity. When I finished my own residency training and needed to decide which community I was going to work in, the choice was clear. It was the early 1990s and the AIDS epidemic was at its peak. As a gay man I knew many people affected by HIV and I had lost some of my friends to this awful disease. I also knew, to our collective professional shame, that many doctors were refusing to treat people with HIV, or were treating people with HIV, or those deemed at risk, poorly. So I did some further training in HIV management and joined the staff of the Gay Men's Health Centre, a community-owned clinic in Melbourne.

It was a very challenging time; HIV was an inevitably terminal disease and many of our young patients, mostly gay men, succumbed to this awful condition. I worked in a clinic with a multidisciplinary team including doctors, nurses, psychologists, dietitians, massage therapists, acupuncturists, and traditional Chinese medicine practitioners, all doing what we could to relieve the symptoms and support our patients. We were assisted by a small army of volunteers from the community who worked with us to help our patients with their daily needs and, when the time came, to die with dignity, in their own homes if they wished. The death toll among our patients was terrible.

Then, in 1995, one of the great miracles of modern medicine occurred with the introduction of triple therapy. We suddenly had access to effective treatment for HIV, and a terminal condition was transformed into a chronic one. I now spend most of my time as a family doctor managing HIV as a chronic disease, one of a number of physical and mental health comorbidities affecting members of my, thankfully, aging patient population. It has been a rare privilege to work as a family doctor in this field over the past 30 years. Yet, although my clinical work is different from that of many of my colleagues, the underlying principles are the same.

### Importance

Ian's second message in his William Pickles Lecture was how family medicine "is based on an organismic

rather than a mechanistic metaphor of biology."<sup>1</sup> As family doctors we understand the complexity of human beings and we well understand the challenges of uncertainty that accompany treating individuals. We do not see the human body as a machine. We are conscious of the healing powers of nature and understand that medicine works best in supporting natural processes. Ian described the values of "The traditional regimens of balanced nutrition, rest, sound sleep, exercise, relief of pain and anxiety, and personal support"<sup>1</sup> provided by those we trust and those who love and care for us.

I like the organismic metaphor because I think it also applies to the role of WONCA in supporting our discipline of family medicine; WONCA provides the global voice of family medicine, advocating for the important work family doctors do every day. As family doctors working together we provide the eyes and ears of global health care, observing and listening to our individual patients and our communities and identifying their health care needs. We are the head and the heart of global medicine—combining our scientific knowledge with tender loving care.

Why do we do this? We do it because, as Ian understood so well, family medicine is important; because the evidence is clear that health systems based on strong primary care, which includes strong family medicine, are the most efficient, equitable, and cost-effective; because strong family medicine is the best way to improve the health of individuals, families, and communities; because we believe every family in every community in every country should have a family doctor they can trust; and because family doctors and the members of our primary care teams are part of the social fabric of many of our societies and we work with one another to keep the fabric of health care together.

### Equity

One of the main inequities in global health is the lack of access to health services for people in rural and remote areas around the world. There are lessons from Canada that can inform the rest of the world about how to reorient our health systems to better meet the needs of the people of rural communities. One of my dear friends, from growing up in Melbourne, Roger Strasser, is now Dean of the Northern Ontario School of Medicine in Sudbury and Thunder Bay. Roger gained his postgraduate experience in family medicine at Western University in London, Ont, working with Ian and his remarkable colleagues. One of the measures of leadership is the career trajectories of the junior staff and students a leader has mentored. How delighted Ian must have been to see former residents like Roger take the lessons learned at Western University and adapt them in different contexts to meet the needs of different communities in different parts of the world.

Last year WONCA released our new *Rural Medical Education Guidebook*,<sup>5</sup> which reinforces our commitment

to ensuring we meet the health care needs of the 50% of the world's population living in rural areas. In one wonderful chapter, Canadian family doctor Susan Phillips from Queen's University in Kingston, Ont, writes about the challenges of attracting doctors to work in rural areas and attributes this to images of rural doctors. Susan challenges the stereotype of the rural doctor as a "rugged male."

The typical picture of the family physician and the rural doctor in particular is the rugged male .... Although hardly scientific, a Google search of why doctors choose rural practice unearthed many images of male physicians hiking across fields and forests (often wearing stethoscopes), riding horses, or roasting pigs on a spit. On those rare occasions when women are pictured, they are at work, smiling at children, and wearing those white lab coats most of us abandoned years ago .... [S]uch images can deter young female doctors from rural family practice. If learners do not see themselves in their preceptors or mentors, they will avoid such practice settings. Yet while the icon of the rural physician is stereotypically male and not inviting for women, women are drawn to remote practice with the same frequency as men .... Perhaps it is the attraction of the rural setting as "a place to make a difference" that explains why women doctors might choose a career as a rural family doctor.<sup>5</sup>

Susan is reinforcing the importance of being different. While our clinics might differ from country to country, and from remote and rural areas to the suburbs and the inner cities, what binds us is the ways we are the same—through our commitment to comprehensive, continuing, coordinated whole-person care that is person-centred, and family and community oriented; through first-contact care, acute care, chronic disease management, prevention, and health promotion; and, as Ian taught us so well, through our understanding of the interplay between population health and the health of individuals in our communities.

Another rural family doctor, Dr Yin Shoulong, practises in Tai Shitun village in China, a 2-hour drive north of Beijing and a very different world from the densely populated metropolis to the south.

Dr Yin lives in a typical Chinese rural village house built around a central courtyard with his clinic occupying one side of his home. His patients are from his farming community and many are impoverished, elderly, and frail.

Dr Yin has devoted his career to supporting the health and well-being of the people of his village and the surrounding district. Recently he has begun providing experience in rural medicine to young family medicine trainees on rotation from the prestigious Capital Medical University in Beijing. He is part of the primary care revolution under way across China.

China has embarked on a massive drive to train and recruit up to 400 000 GPs in the next 7 years in order to reform the country's health system to meet the current and future needs of the population, especially the 800 000 000 people living in rural areas. Such reform will have implications for the rest of the world, and especially for those countries where family medicine is not yet well established. If the challenge of training a family doctor work force to meet the needs of both urban and rural China can be met with success, then this should provide lessons that will flow to many other parts of the world facing similar challenges. All around the world governments are waking up to the importance of ensuring health care for all people and are looking at ways to strengthen primary care through the family practice model. We are entering a renaissance—a golden age—for family medicine.

### Outreach

In Canada the leadership of Dr Katherine Rouleau and the wonderful work of the Besroul Centre global family medicine initiative of the College of Family Physicians of Canada is linking family medicine academics from medical schools across Canada with colleagues in low- and middle-income nations around the world and especially nations in Africa. The Besroul initiative has been funded by a Canadian family doctor, originally from Tunisia, Dr Sadok Besroul, a key philanthropist in global health care.

One of the most exciting developments in Africa has been the recent establishment of the first family medicine training program at Addis Ababa University in Ethiopia, developed with support from family medicine educators from the University of Toronto in Ontario and the University of Wisconsin. The potential contribution of family medicine to the Ethiopian health care system is immense. The country is growing at a rapid rate and its population is approaching 90 000 000. Many still have difficulty accessing anything more than basic care provided by community health workers with 1 year of training. The country's doctor-patient ratio is extremely low—roughly 1 per 20 000 population, well below the World Health Organization's (WHO's) recommendation of a minimum of 1 per 10 000. In recent years Ethiopia has opened 13 new medical schools using an innovative community-based curriculum and will soon be graduating 3000 new doctors each year. The community-based curriculum should be an ideal foundation for attracting new graduates to family medicine. The development of family medicine in Ethiopia, supported by family doctors from Canada and the United States, provides another wonderful example of how much we can achieve by working together.

Ian's third message in his William Pickles lecture was how family doctors "tend to think in terms of individual patients rather than generalized abstractions."<sup>1</sup> It is our commitment to individuals that drives the innovations that are led by family doctors around the world. Nowhere



is this more stark than in situations where the health and well-being of individuals is challenged by natural disaster.

In February last year I was invited by another of Ian's famous former students, Ryuki Kassai, to travel to the Fukushima Prefecture in Japan to visit communities affected by the terrible 2011 tsunami, which killed thousands of people, and the damaged Fukushima nuclear power plant, which exploded releasing radiation into the atmosphere and resulting in more than 100 000 people being evacuated from their homes. I had the privilege of seeing how Ryuki's former residents are working with their elderly patients, who are still living in temporary accommodation 4 years later, to reduce the effects of the forced relocation and social isolation.

Again I can imagine how proud Ian must have been to see the work of his former student in response to this terrible event. It is in times of community peril that family doctors and the members of their primary care teams often rise to the challenge and do so brilliantly.

One of the greatest health challenges that has faced our world in the past year has been the Ebola crisis in West Africa. Many brave front-line doctors, nurses, and other health workers were infected while providing treatment and support to their patients, and this has left the health services in affected countries vulnerable and unable to cope with the continuing care needs of their communities.

I want to share a personal face of the Ebola crisis through the story of one remarkable family doctor involved in tackling the crisis: Dr Atai Omoruto from Uganda.

Atai has long been a strong voice for family medicine in Africa. In July last year, Atai traveled to Liberia as the head of a medical unit of 12 health workers brought from Uganda by the WHO to fight the Ebola outbreak. Uganda has experienced several outbreaks in the past, and through her experience in her own country, Atai has become one of the world's most experienced clinicians in managing Ebola.

On arrival in Liberia she saw dead bodies everywhere. There were more dead bodies than patients, and nobody seemed to know what to do. Atai and her team got to work, treating those affected and supporting the training of local health care workers. Atai and her team made an important contribution to changing the course of this terrible epidemic. It was not without its toll. At least 2 Ugandans died while assisting the people of Liberia. Atai stayed for 6 months, working under arduous conditions and not returning home to her family in Kampala until last December. The world owes a huge debt of gratitude to Atai and to the many other health workers from across Africa and the world who came to provide their support during this dark hour.

Atai has shown us the extraordinary contributions that family doctors can make. I admired Atai greatly before the Ebola crisis. She is now one of my all-time heroes of family medicine.

## Wellness

Ian's fourth and final message in his William Pickles Lecture was how family medicine "is the only major field which transcends the dualistic division between mind and body."<sup>1</sup> At WONCA we are committed to the importance of mental health and, in partnership with the WHO, we have been leading global initiatives to integrate mental health into primary care. Managing both mental and physical health in family practice is normal in Canada, but it is still unusual in many parts of the world. Yet mental health is central to the values and principles of the Alma Ata declaration. Holistic care and universal health coverage will never be achieved until mental health is integrated fully into primary care.

As a family doctor, I often feel I have not had a good day unless at least one person has cried in my consultation room. This does not mean that I am mean to my patients, but I see a lot of people with chronic disease, and depression is a common comorbid condition. I need to be prepared to pick up on the cues provided by the 1 person on average each day who comes into my consulting room with undiagnosed depression. If I ask the right questions, the tears start to flow and we can start to work together on tackling this condition.

I visited Brazil recently to see in action their famous family health team model of universal access to health care, and to see how mental health is being integrated into primary care in that country. At a family medicine clinic in one of the *favelas*, or shanty towns, of Rio de Janeiro, I met a young family doctor, Euclides Colaço, and his colleagues. Euclides works with a family medicine resident, 2 nurses, and 6 community agents, or community health workers, providing comprehensive clinic-based and home-based care as a team to a defined population of 4500 people. They are expected to know about the health status of every single person living in the geographic area they are responsible for. The community health agents in Brazil play a key role; they go out into the community and visit everybody and bring those in need of assessment and assistance to the clinic, or they escort the doctor or one of the nurses on a home visit. This family health team model delivers true comprehensive primary care to an entire community. There are nearly 40 000 such teams in operation across Brazil, providing care to nearly 200 000 000 people.

I was keen to hear how psychiatrists link in with their primary care colleagues in Brazil. There were challenges developing collaborations, and some psychiatrists were afraid that family doctors would take their place in caring for patients with mental health problems. What they did not realize was that in Brazil at least 70% of mental health care was already being provided by family doctors. So they developed "matrix support teams" that integrate mental health professionals within the family health team. In Rio, 1 psychiatrist and 1 psychologist are

attached to 10 family health teams, covering a population of around 40000 people, many of them extremely poor. They visit each family health team at least once a month and the team members report that they feel better supported by this integration. This has improved access to treatment for the members of these communities and has had a remarkable effect on the continuing education of the members of the family health teams.

We need to build effective partnerships like this between primary care and other specialties. This requires willingness to think differently and to work together to negotiate professional and cultural understandings of serious health problems and how best to manage them. Through innovations like these, family medicine has the power to transform our world and create opportunities to bring health care to the 1 billion people around the world who currently do not have access.

Through family medicine we can also tackle stigma and discrimination, which too often are attached to mental health problems. Every human being should be treated with dignity and respect. As health professionals we should be leading by example. Our common humanity compels us to respect people's universal aspiration for a better life and to support their attainment of a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity. This is all part of universal health coverage.

## Responsibility

As family doctors we strive each day, along with the other members of our practice teams, to deliver the best quality care to our patients and our communities, yet it can be difficult to know exactly how our work as individual doctors is contributing to the health and well-being of our nations as a whole, and, unless we work in Cuba or Brazil, to know if everyone in our communities is benefiting from the health care services we provide. Are some people missing out and, if so, who and why?

These are among the important questions that the new Primary Health Care Performance Initiative<sup>6</sup> seeks to answer. The initiative includes important health system indicators that show how well a nation's primary care system is working toward achieving universal health coverage. It will help us "unpack" what happens in primary care systems across the world and shine a light on areas that need attention to ensure high-quality health care is being made available to all people. Given Ian's enthusiasm for primary care research, I like to think he would have been as excited about the potential of this initiative as I am.


Among the greatest strengths of the people working in family medicine are our diversity, our community leadership, our resilience, and our unwavering commitment to our patients and our communities. These are qualities that we need to reinforce and cherish. The importance of being different applies to each of us as family doctors.

Family doctors, as clinicians, as teachers, as researchers, and as members of our global community, should embrace what makes us different from our peers in other branches of medicine, and together aspire to follow the example set by Ian and other leaders of our profession.

Iona Heath, former President of the UK Royal College of General Practitioners, said a few years ago that family medicine and general practice are a force for good throughout the world.<sup>3</sup> I agree. Through my work around the world, I am impressed with the commitment of family doctors and the members of our primary care teams to human rights issues, and I am sure this comes from our daily experience of working with our patients and communities. Ian believed that family physicians attain *philia* with our patients,<sup>4</sup> described by Aristotle as the highest form of friendship, and it leads us to think in concrete rather than abstract terms, because so much of our thinking about clinical medicine relates to individual patients we have known. As family doctors, we understand and respect the basic expectations all people have about how we and our families and all people should be treated.

As family doctors we recognize our social responsibilities. Each of us needs to advocate for social justice and human rights. We need to speak out for what is right, to say "this is not OK," and in so doing contribute to social change in our communities and nations. We need to contribute to ensuring equity of access to health care. We need to care for the health of our planet as well as that of our patients. After all, what is good for the environment is also good for our patients and communities.

If family doctors, with our privileged position in society and our access to pretty much the entire population in our communities, do not stand up for these things, who will?

As family doctors we can be proud of our discipline. Each of us has a set of values and principles that determine how we behave as ethical medical practitioners and as decent human beings. Like Ian, each of us has the potential to be a role model for our medical students and residents, and to contribute our own lasting legacy through the examples we set in the way we live our lives and practise medicine. As Ian reminded us in the concluding sentence of his William Pickles Lecture, "The importance of [family doctors] being different is that we can lead the way."<sup>1</sup> 

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**Competing interests**  
None declared

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