

Approaching a global definition of family medicine

The Besroul Papers: a series on the state of family medicine in the world

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EDITOR'S KEY POINTS

- Family physicians provide valuable, comprehensive health services in more and more areas of the world. These physicians and their primary care teams have various role definitions based on local resources, geopolitical factors, and the regional definition of the discipline.
- With the various challenges facing vertical, disease-oriented models, it becomes important to develop integrated primary care in which family physicians collaborate with specialists in other disciplines to deliver comprehensive care at the community level.
- Commitment to relationships with patients, colleagues, and the community is a core principle that unifies family physicians globally.

POINTS DE REPÈRE DU RÉDACTEUR

- Les médecins de famille offrent des services de santé inestimables et complets dans de plus en plus de pays dans le monde. Les définitions du rôle de ces médecins et de leurs équipes de soins primaires varient selon les ressources locales, les facteurs géopolitiques et la définition régionale de la discipline.
- Compte tenu des divers défis auxquels sont confrontés les modèles verticaux axés sur les maladies, il devient important de développer des soins primaires intégrés dans lesquels les médecins de famille collaborent avec les spécialistes d'autres disciplines pour fournir des soins complets dans la communauté.
- L'engagement à l'égard des relations avec les patients, les collègues et la communauté représente un principe fondamental qui unifie tous les médecins de famille à l'échelle mondiale.

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Abstract

Objective To find a common global definition of *family medicine*.

Composition of the committee Since 2012, the College of Family Physicians of Canada has hosted the Besroul Conferences to reflect on its role in advancing the discipline of family medicine globally. The Besroul Papers Working Group, which was struck at the 2013 conference, was tasked with developing a series of papers to highlight the key issues, lessons learned, and outcomes emerging from the various activities of the Besroul collaboration. The working group comprised members of various academic departments of family medicine in Canada and abroad who attended the conferences.

Methods Searching both *definition of family medicine* and *history of family medicine* yields a variety of defining features. Visiting family medicine training programs worldwide highlights this discrepancy.

Report It is not an easy task to define *family medicine*—one of its key attributes is its adaptability to a local context, but this makes aggregation of data challenging. There is a lack of clarity regarding whether family medicine is the same discipline globally and what the core features are that define it. Unifying components of the definition have always included comprehensive care at all life stages and the management of the common illnesses of a particular community. The emerging global emphasis on competency and social accountability demonstrates commitment to the principle that family doctors provide health care for all in the context of the community. Although the competencies are not universal, the fact that family physicians fill in primary care “gaps” and tailor learning strategies to community priorities is a unifying distinction. We argue for a focus on the core competencies that bind us as a discipline.

Conclusion Family medicine can be practised in various forms. The unifying elements are the socially accountable responsiveness to local need, the adaptation of existing health infrastructure, and the ongoing development of the skills required to succeed in that role—always grounded in relationships of care. In this way, family medicine will continue to evolve to suit the health needs of communities and health systems.

Vers une définition mondiale de la médecine familiale

Les documents Besrou: une série sur l'état de la médecine familiale dans le monde

Résumé

Objectif Trouver une même définition mondiale de la médecine familiale.

Composition du comité Depuis 2012, le Collège des médecins de famille du Canada est l'hôte des Conférences Besrou dans le but de réfléchir à son rôle dans l'avancement de la discipline de la médecine familiale à l'échelle mondiale. Le Groupe de travail sur les documents Besrou, formé lors de la conférence de 2013, a reçu le mandat d'élaborer une série de documents pour mettre en évidence les principaux enjeux, les leçons apprises et les résultats qui ressortent des diverses activités de la collaboration Besrou. Le groupe de travail comptait des membres de divers départements de médecine familiale au Canada et à l'étranger qui ont participé aux conférences.

Méthodes Une recherche à l'aide de *définition de la médecine familiale* et *histoire de la médecine familiale* produit une variété d'éléments distinctifs. Une visite des programmes de formation en médecine familiale un peu partout dans le monde met en évidence ces différences.

Rapport Il n'est pas facile de définir la *médecine familiale*, l'un de ses principaux attributs étant son adaptabilité au contexte local, et cette réalité complique le regroupement des données. On ne sait pas clairement si la médecine familiale est la même discipline partout dans le monde et quelles sont les principales caractéristiques qui la définissent. Les composantes communes de la définition incluent toujours les soins complets à toutes les étapes de la vie et la prise en charge des maladies courantes dans une communauté en particulier. L'importance émergente accordée mondialement à la compétence et à la responsabilité sociale démontre l'engagement à l'égard du principe selon lequel les médecins de famille fournissent des soins de santé à tous dans le contexte de la communauté. Même si les compétences ne sont pas universelles, le fait que les médecins de famille combler les « lacunes » dans les soins primaires et adaptent leurs stratégies d'apprentissage en fonction des priorités de la communauté est un élément qui les démarque. Nous préconisons un accent sur les compétences de base qui nous unifient en tant que discipline.

Conclusion La médecine familiale peut être pratiquée sous diverses formes. Les éléments unificateurs sont la réceptivité aux besoins locaux de manière socialement responsable, l'adaptation à l'infrastructure existante en matière de santé et le perfectionnement continu des habiletés nécessaires pour réussir dans ce rôle, le tout toujours ancré dans des relations de soins. Ainsi, la médecine familiale continuera d'évoluer pour s'ajuster aux besoins des communautés en matière de santé et des systèmes de santé.

Family medicine is relatively young as an organized medical discipline. While before the turn of the 20th century most physicians practised as generalists, the explosion of medical knowledge and therapies in the early 20th century led to the development of medical specialties. It also led to the need for more comprehensive training of generalist physicians to coordinate the appropriate application of increasingly complex care to individual patients. The world's first Chair in General Practice was created in Edinburgh, Scotland, in 1963. By 1966 residency programs in family medicine were established at the University of Western Ontario in London, and the University of Calgary in Alberta. Soon afterward, the College of General Practice of Canada, established in 1954, changed its name to the College of Family Physicians of Canada (CFPC) to align with the newly created residency programs and reflect the evolution of the discipline.¹ Meanwhile, postgraduate medical training in primary health care began to expand throughout the world.²

Here we examine the progress of family medicine as a discipline globally, comparing it to the system as it emerged in Canada, and how its definition has evolved according to regional and health systems conditions. We ask whether there is a common defining feature of the practice globally, as we endeavour to find the core attributes of a discipline that has a variety of contextual manifestations. Without a common definition, data collection for research and advocacy is more challenging. There are many for whom the concept is alien, and distilling these universal features can begin important conversations.

One core feature emerging is that, by its very nature, family medicine is context-specific. This context specificity exists on a number of scales. It is grounded at the individual patient level where complex comorbidities make a non-family physician specialist approach for a particular disease inappropriate. It extends to the broader societal level where the work of the generalist physician will vary depending on history, culture, resources, and system organization. The flexibility and responsiveness of family medicine makes a common definition all the more elusive.

Composition of the committee

Since 2012, the CFPC has hosted the Besrou Conferences to reflect on its role in advancing the discipline of family

medicine globally. The Besroul Papers Working Group, which was struck at the 2013 conference, was tasked with developing a series of papers to highlight the key issues, lessons learned, and outcomes emerging from the various activities of the Besroul collaboration. The working group comprised members of various academic departments of family medicine in Canada and abroad who attended the conferences.

Methods

We searched both scholarly and non-scholarly definitions of family medicine in medical literature and alternate sources. We have also each worked with various family medicine training programs on 4 continents. Determining the common features of a discipline that is highly contextual means going beyond literature to seek what core features would apply to the myriad nuances that have been observed.

Report

Philosophical definition of the discipline. In its early years, the philosophical basis of family medicine was ill defined. Family medicine has necessarily evolved through the development of training programs to help distinguish between family medicine graduates and physicians who enter practice with no postgraduate training, whether in generalist or specialist care. It is also imperative to distinguish this group of postgraduate-trained physicians with a minimum of 6 years of training from other cohorts practising primary care—GPs with medical school training and possibly an internship, clinical officers or health workers with 2 years of mostly algorithmic-based practice, and community volunteers providing key peer-education programs, to name a few. All of these make up an important part of primary care in a variety of global settings, but with a greater number of fully trained family physicians comes the opportunity to shape primary care. This first happened in Europe and North America, and it is evolving in the global south.

Ian McWhinney, Canada's first Professor of Family Medicine, was a key figure in its development as an academic discipline. He stated:

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.³

This was an early definition of our role, focused on relationships with patients and knowledge of their context. It remains a defining principle of the discipline today despite ongoing tensions between the technological and humanistic aspects of medicine.

Although this context continues to define family medicine, it is not as easy to achieve locally or to extrapolate globally. In many countries worldwide, there are simply too few physicians to support individual relationships between physicians and patients. In these cases, the relationship and its implied commitment might be between the physician and a given community—its social context and its underlying determinants of health. The capacity of the discipline to bridge the divide between identifying causes of ill health at the individual and societal level makes it potentially unique, through interaction with both the public health and the clinical sectors. This was the inspiration for the subtitle of the 2015 Besroul Global Health Conference: "Family Medicine: At the Heart of Health Systems."

Family medicine has become the dominant model for primary care in many nations with adequate numbers of physicians in western Europe, North America, and Asia. Royal colleges of general practice and colleges of family medicine have been established in many countries, and the World Organization of Family Doctors (WONCA) was created to represent the discipline globally in 1972. Broadly, WONCA defines family physicians as practitioners who

care for patients of all ages; ensure access to comprehensive primary and secondary services; manage infectious and chronic diseases; provide emergency, active, and long-term care; and coordinate individual clinical, community, and public health services.⁴

However, WONCA further recognizes that

the scope of each family doctor's training and practice varies according to the contexts of their work, their roles, and the organization and resources of the health systems in each country ... to adapt to the health care needs of their individual countries.⁴

Although WONCA seeks to unite the discipline, a shared terminology and harmonization of training have not materialized over time. Confusion has reigned over the discrepancy in nomenclature from the European system pioneered in the United Kingdom, where it is still called *general practice*, and in other countries that have adopted the term *family medicine* to distinguish it from practitioners who do not have focused training in the discipline. Many nations in Asia, Europe, and Australia still use the term *general practice* to refer to those physicians with accredited training. Canada has gone another route, renaming its college the *College of Family Physicians of Canada* in 1967. Other countries call their physicians without any postgraduate training their *GP cohort*, leading to misunderstandings. Additionally, the training varies from 2 years (Canada) to 3 years (potentially soon 4 in the United States) and even 5 years (in

some African institutions where they learn surgical skills and advanced public health concepts). There is therefore a lack of clarity regarding whether family medicine is the same discipline globally and what the core features are that define it.

Regardless of what the discipline is called, unifying components of the definition have always included comprehensive care of patients at all life stages and the management of the common illnesses of a particular community. Family physicians thus have a broad knowledge base, with the patient relationship and an intimate understanding of the context in which patients live as a central feature. They take an approach that is preventive, curative, restorative, and rehabilitative. Wherever in the world family medicine has been established, these central principles remain intact. Indeed, it has been said that

general practitioners must honour the concept of equity—that is, giving patients equal access to equal services for equal needs—while paying attention to the need for setting medical priorities and showing due responsibility for appropriate use of resources. This is best achieved in systems that offer controlled access to specialists, preferably secured via a “gate-keeping” system staffed by general practitioners who know their duties and limitations. Where gatekeeping roles do not exist, a very important function is still to help patients to choose and obtain appropriate care from different parts of the system. Moreover, the definition implies that a general practitioner’s attention and effort must embrace the entire field of care—from prevention through detection of the first symptom to eventual palliation.⁵

It is the specific competencies that might differ as these physicians respond to their communities’ needs and interact with the wider health system.

Family medicine’s role within health systems. Family medicine can form the heart of health systems and contribute to their coordination and maturation. This contribution is made at important intersections: between the community and the individual; between the primary care and public health sectors; and between primary care practitioners and other specialists. The exact points of these junctions vary considerably from region to region, but part of defining family medicine within health systems is to determine the gaps in current care delivery and address these intersections.

The Four Principles of Family Medicine in Canada (developed in 1986) echo some of the definitions mentioned in this article: a family physician is a skilled clinician, a family physician is a resource to a defined practice population, and the patient-physician relationship is at family medicine’s core.⁶ The fourth principle—

family physicians are based in the community—speaks to family physicians’ wider role within the health system.

Family physicians evaluate, manage, and coordinate care for patients who might require community, hospital, or subspecialty services. A changing model in North America has shifted toward health care teams in patient-centred medical homes (or family health teams). Family physicians often work closely within teams of other health professionals (who sometimes serve as the first point of contact) consisting of nurses, social workers, pharmacists, physical therapists, and others. Nonetheless, it is increasingly clear that a focus on personal relationships and needs determines the success of any given model.

Hyperspecialization and excessive influence of technology can challenge enduring relationships and compromise the quality of health outcomes.⁷ A cardinal hazard in many of the initiatives in medical homes and multidisciplinary teams is the loss of relationships and the default to the non-family physician specialist view that widgets of care are interchangeable. Why would we import less patient- or community-centred models of care, such as those of hospitals or tertiary centres? The issue is a system of care with relationships as the unit of analysis, not only the practitioners and their special skills taken in isolation. It is increasingly clear that the ability to maintain continuity of relationships is essential, even in such complex environments.⁸

As family physicians are trained to respond to and be accountable for the context and needs of communities, and as these needs vary depending on the epidemiology of diseases and the demographic characteristics and socioeconomic resources of the population, they must be adaptable. Thus their scope of practice and training will vary around the world. In many health systems, such as in Canada and the United Kingdom, first-contact care is provided by the family doctor. The WONCA-Europe commission released a definition including this corollary in 2002. However, where a critical mass is not yet achieved (especially in lower-income countries within Asia and Africa), this might not yet be a functional model. To reflect this, the World Health Organization underscored the aspiration to build primary care throughout the world in *The World Health Report 2008*,⁹ with the knowledge that family medicine is an important piece of the puzzle.

Regions with smaller numbers of graduates have spent considerable time defining family medicine for advocacy purposes. African family medicine leaders released the Statement of Consensus on Family Medicine in Africa in 2009, which describes how family medicine contributes to equity in health care within the African context through horizontal programming, social accountability values, advocating for social and health policies to promote equal access, and empowering communities to

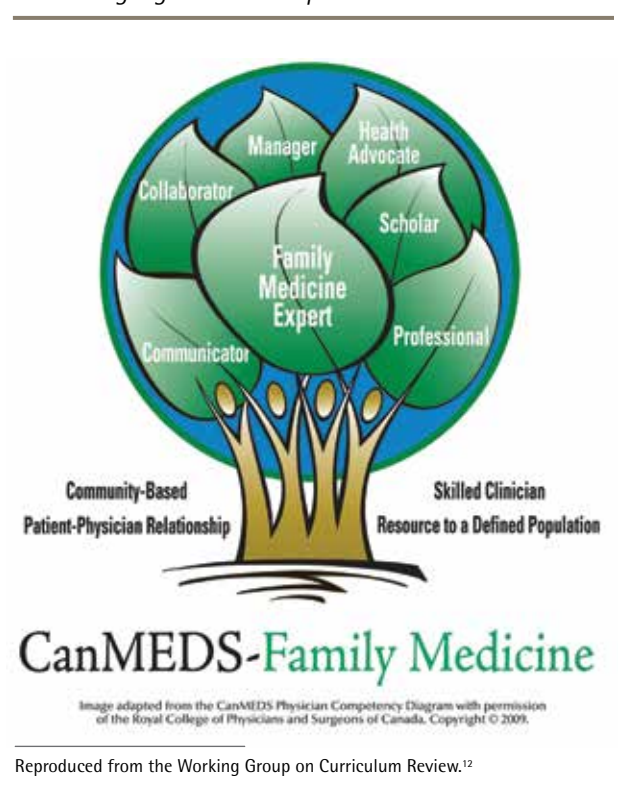
address the social determinants of ill health.¹⁰ The role of the family physician in Africa is outlined as the clinical lead for a (usually hospital-based) health care team. In rural or remote regions, as disparately located as Africa and northern Canada, there might be alternative care providers (nurses, clinical officers, or others) who will coordinate with a family doctor when making their management decisions. The family medicine practitioner often has a leadership or even administrative role within these teams. Therefore, searching for a role-based common definition is ultimately insufficient.

Competency-based approach. Now that family medicine is established in many health systems, there is scrutiny to ensure that training and accreditation are standardized and fit community needs. Definitions have become more technical, so that the skills required to perform the role are clear and contextual. In Canada, the Triple C Competency-based Curriculum¹¹ describes education and care that are centred in family medicine, comprehensive in terms of scope, and continuous across the life cycle. This marked a shift from a definition grounded in the educational framework of other disciplines to a set of specific methods for performance-based training and assessment now rooted firmly in family medicine ideology.

In 2009, the CFPC provided a “role definition” specific to the Canadian context. Adapted from the Royal College of Physicians and Surgeons of Canada CanMEDS roles, the Working Group on Curriculum Review within the CFPC developed the CanMEDS–Family Medicine roles. Family physicians’ competencies include medical expert (in family medicine), communicator, collaborator, manager, health advocate, scholar, and professional. All of these roles have the implicit dimension of relationships (Figure 1),¹² putting the emphasis on our responsibility to embrace the patient’s perspective and narrative, as well as our own journey balancing professional and personal responsibilities. The relationship with patients might not be unique to family medicine but it is central to our role and our professional identity.

There has been similar evolution in training and defining family medicine worldwide. Many nations with predominantly rural populations have adopted a community-based educational approach. They might decentralize training to ensure their students engage with communities, develop a population-health perspective, and adapt to limited-resource environments. The community-oriented primary care model describes family physicians who look to the health of their individual patients to diagnose community-wide issues, and then use public health or advocacy to intervene at that level. Many family physicians learn surgical and advanced obstetric techniques, depending on their intended practice location and community needs. These are examples

Figure 1. CanMEDS–Family Medicine tree: Interlocking roles to highlight relationships.



of when specific competencies learned in family medicine training suit the observed needs of a population, and how strategic competency-based learning enhances delivery of high-quality, focused care.

In addition, WONCA has introduced global standards for family medicine training and a definition that encompasses necessary skills. It produced the book *The Contribution of Family Medicine to Improving Health Systems*,⁴ which describes not just a philosophical definition (mentioned above) and an analysis of the family physician role within health systems globally and regionally, but also the factors that define family physicians in their context.


Many medical schools, residency programs, and continuing education courses are more focused on a modern competency-based educational framework. For family physicians, the competencies are defined by the needs of the population, and social accountability is prominent in the objectives. The emerging global emphasis on competency and social accountability demonstrates the commitment to the principle that family doctors provide health care for all in the context of the community. Although these competencies are not universal, the fact that we fill in primary care “gaps” and tailor our learning strategies to community priorities is a unifying distinction. Future work should elaborate on this unique approach and its benefits to patients and health systems.

Conclusion

Family physicians provide valuable, comprehensive health services in more and more areas of the world. These physicians and their primary care teams have various role definitions based on local resources, geopolitical factors, and the regional definition of the discipline. While the creation and promotion of our discipline might not be a panacea for all nations, where it does exist, the core attributes can help personalize a health system experience and encourage a people-centred approach.

With the challenges facing vertical, disease-oriented models, it becomes important to develop integrated primary care in which family physicians collaborate with specialists in other disciplines to deliver comprehensive care at the community level. Family medicine can be practised in various forms: the relationship-focused family physician who works primarily in the outpatient settings of Europe and North America; the population-based family physician who supervises teams of nurses, clinical officers, and other health professionals; or the community-oriented primary caregiver responsible for overseeing a broader health system. The unifying elements are the socially accountable responsiveness to local need, the adaptation of existing health infrastructure, and the ongoing development of the skills required to succeed in that role—always grounded in relationships of care. In this way, family medicine will continue to evolve to suit the health needs of our communities and health systems.

Commitment to relationships with patients, colleagues, and the community is a core principle that unifies family physicians globally. However, the heterogeneity of global family medicine presents substantial challenges when it comes to research and the effect of a complex system of primary care on the role of a family physician. The challenges range from how to capture what practitioners do and how they do it, to the effect of their role on health outcomes for individuals, communities, and

health care systems. We continue to explore ways of finding unity in the diversity of experience in the Besroul Papers series. 

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Contributors

All authors contributed to the literature review and interpretation, and to preparing the manuscript for submission.

Competing interests

None declared

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