

The perils and the promise of proximity

Dr Ian McWhinney Lecture, 2016

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I was very touched and, of course, deeply honoured to be invited to present the 2016 Dr Ian McWhinney Lecture,* the second in the series. We are still in the early days of these lectures, and Michael Kidd, then President of the World Organization of Family Doctors, who presented the first McWhinney lecture last year,¹ will be a tough act to follow.

For me, Ian McWhinney has always existed. He has been a feature of my professional universe since the beginning of my family medicine residency in Quebec. This was in 1976, when family medicine was just getting started in Quebec's 4 medical faculties. Western University's family medicine department in London, Ont, the first such department in Canada, founded in 1966, was the trailblazer. Ian McWhinney, who arrived at Western University in 1968, was the first chair of the department, indeed the first professor of family medicine in Canada. The members of the team formed by Dr McWhinney were deeply involved in all the debates about this young academic discipline and worked intensively with him and with the leaders of the College of Family Physicians of Canada (CFPC) to establish the principles of our discipline and build its corpus of knowledge. These were very exciting times for the young family physician that I was.

I never had the pleasure of meeting and talking with Ian McWhinney, but I felt that I had gotten to know him through his writings and through my collaborations with his colleagues over the course of my career. For me, Ian McWhinney was the father of family medicine in Canada, the founder of the patient-centred clinical method, and a leader in the development of research in our discipline. The invitation to give this lecture prompted me to immerse myself once again in his writings, and especially in discovering his memoir² and one of his first books, *The Early Signs of Illness*,³ I realized that Ian McWhinney was not only the father of family medicine in Canada, but also a great clinician and a great humanist. These 2 books, read from the vantage point of almost 40 years in this profession, touched me deeply. So, my thanks for the opportunity to present this lecture are double: first, for the honour of the invitation, and then for the pleasure of re-entering the McWhinney universe and for what I learned from that, which I would like to share with you.

*This commentary is based on the 2016 Dr Ian McWhinney Lecture given by Dr Beaulieu at Western University in London, Ont, on September 21, 2016.

I have chosen to explore what we call in French *médecine de proximité*.^{4,5} In English this translates directly into "proximity medicine," although a proper term has yet to be worked out. For today, let's stick with this label—then maybe we can, together, find a new and better one. This concept of proximity medicine, as we will see, moves beyond our current understanding of patient-centred care into the realm of partnerships with patients, wherever they are in their lives or communities. I selected this topic because I believe it corresponds, on the one hand, to the core of Ian McWhinney's philosophy and vision and, on the other, to the direction that medicine and our health care systems needs to move to achieve the profound cultural transformation that is called for. It holds promise but carries some risk. I would like to convince you that family physicians are uniquely positioned to contribute to this change, if we dare take the risk. I hope to share my reflections on 4 of the main challenges facing us and why proximity medicine is one of the solutions; to illustrate how the fundamental principles of family medicine advocated by Ian McWhinney position us to contribute to the creation of true proximity medicine; and to suggest how, based on his work, we can envision taking on the risks—and the rewards—of this very demanding medical practice and make a difference.

Four challenges

A culture change is imperative. In several respects, medicine is coming up against a wall. As diagnostic and treatment approaches become increasingly sophisticated, technological developments are distancing us from the knowledge, skills, and know-how we need to cope with the challenges facing us.

To turn this situation around, many people are looking to a kind of medicine—what I am calling here *proximity medicine*—that would be able to take on, observe, diagnose, treat, guide, monitor, and alleviate the effects of problems, as well as prevent them^{4,5}—a medicine that can take into consideration individuals in their entirety and in their complexity, support them in their journey, and place them at the heart of the health care system. Proximity medicine involves a range of considerations that are much more complex than simply geographic access to care. It encompasses the social, psychological, cultural, and financial aspects of accessibility. The goal of proximity medicine is to keep as many services as possible within people's reach. This is an important factor in quality of life for people with chronic health problems.⁵ What are these challenges that call for profound culture change, for a paradigm shift that would overturn the

hierarchy of our current health care systems? I propose 4, not because they are the only ones, but because they have to do directly with clinical practice and are within reach:

- action on the social determinants of health;
- timely access to care;
- care transitions and service integration; and
- overdiagnosis and overtreatment—our practice of maximally intrusive medicine.

Social determinants of health. We are not all born equal. I am not telling you anything new when I report that our medical interventions, in the broadest sense, account for only about 15% to 20% of health outcomes, whereas social and economic factors, rightly called *social determinants of health*, explain 40% to 50%.⁶ We can develop all the new technologies we like, but in the end, they will not have all that much effect on our overall health status. Hence the first challenge.

Like most professionals, we physicians feel powerless in the fight against social inequalities and their effects on health. We consider these to be matters for politicians and decision makers. It is true that the broad social determinants of health—socioeconomic policies and the political context—are “structural” and not within our direct sphere of influence. But in fact, health professionals, and in particular family physicians, are able to intervene, in their everyday practice, to counter the effects of several social determinants of health, such as material living conditions, poverty, and inequalities based on sex or ethnicity. How can we do this?

First, family physicians in particular can make a difference in their patients’ health and social conditions through specific actions aimed at social determinants, such as signing certificates so they can obtain income supplements, supporting and guiding them to other resources, taking measures that foster social participation and personal empowerment, being change agents in our communities, and most of all, by adopting nonstigmatizing practices. Isn’t one of the principles of family medicine that we should be anchored in the community we serve? Ian McWhinney proposed that family physicians should ideally share their patients’ “habitat.”⁷ Who, in fact, is in a better position than the family physician—who knows the person, his or her life story, and the environment—to assess the full effect of all these factors on the health of that patient and the community and take action on them? As physicians, we can and must act on the social determinants of health. This is a high-priority issue for the CFPC, which is working to provide its members with tools for action not only at the clinical level, but also with communities and organizations.⁸

But there is more. We can fight stigmatizing practices by ensuring that our services are accessible to all our patients, regardless of their sociodemographic characteristics, and by providing the same quality of services to all—again, regardless of these characteristics. Unfortunately,

in Canada, it has been clearly shown that people who are more disadvantaged experience greater difficulty in accessing family physicians, and that low socioeconomic status, older age, being a member of a visible minority or a recent immigrant, and being a woman are more often associated with both preventive and acute care services of lower quality.⁹ Years ago, my colleagues and I audited the quality of preventive services provided to our patients. To our chagrin, we discovered that patients we were following for mental health problems underwent fewer screening tests, such as Papanicolaou tests, than did other patients, even though we saw them more often.¹⁰ More recently, a team at the University of Toronto in Ontario conducted a very simple study: 350 clinics were called to obtain a new patient appointment. Callers who presented themselves as having a higher socioeconomic status were given appointments more often than those presenting a lower status (22.6% vs 14.3%).¹¹ I was President of the CFPC at the time and had to comment on the study, which attracted quite a lot of media attention. Are we creating barriers to our services for the disadvantaged without realizing it? Do we let ourselves be influenced by our prejudices in our routine clinical practices? Is our clinical acumen distracted by a disheveled appearance, less-than-articulate speech, or behaviour we might consider “inappropriate”?

Being truly patient centred is the most effective way of fighting, day to day, the effects of social determinants of health. Being patient centred is more than adapting to the patient’s agenda for a visit or than “finding common ground” on a diagnosis or a course of action. It is developing the capacity to self-reflect and to be aware of our own reactions during a consultation. We will see later what Ian McWhinney had to say about that.

Accessibility. Accessibility is a fundamental characteristic of primary care service quality. As we have just seen, access to primary care and to a family physician is a key determinant of health. In an age when everything is expected to be instantaneous, the issue of accessibility has often been neglected by our profession—dismissed as “consumerism” rather than understood as a core dimension of quality. While several quality-of-care indicators in Canada have been improving, access to services, and particularly to family physicians, has stalled.¹² We have been slow to adopt advanced access, particularly in Quebec. There are several reasons for this situation. First, it has to be said that accessibility has been absent from the quality discourse for a long time, not only among professionals, but even among managers. In a study on the determinants of primary care quality, my colleagues and I observed that, for many of the physicians and nurses we interviewed, the concept of *service quality* referred primarily to whether practices conformed to guidelines rather than to comprehensiveness, timely access, or continuity of care.¹³ But even more fundamentally, underlying this

observed reticence to make ourselves available was the fear of being overwhelmed by patients and a devaluing of the importance of continuity of care in the treatment of acute, unforeseen problems.¹⁴ We have built fortified castles around our clinics. Let me explain.

The prevailing discourse on the management of chronic illnesses, with its emphasis on planned and proactive care, has resulted in a devaluing of emergent acute problems and of reactivity. It is as though we have said: “The family physician and the primary care team are there to manage chronic, complex problems; when other problems come up, go elsewhere; you don’t need our expertise.” Yet it has been demonstrated that the investigation and the treatment of emergent acute problems are more appropriate when a patient consults his or her usual physician.¹⁴ We have, inadvertently, allowed different models to emerge that offer rapid and uncomplicated access to a health professional without the patient’s having to explain or seek permission to consult, which then leads to discontinuity of care. And we are not even talking here about access to online virtual doctors, which are becoming more and more popular.

Still, talking about patient-centred care means talking about accessibility. Not immediacy, of course, but definitely timely access. Timely access to care is one of the pillars of the Patient’s Medical Home.¹⁵ With a growing number of clinics adopting the advanced access model, we are seeing that patients do know how to use us appropriately. By involving them in our service reconfigurations, as proposed in the Patient’s Medical Home model, we will find that they can help us solve certain problems of accessibility without our being overwhelmed—quite the contrary, in fact. Being accessible brings relief.

Care transitions. Our health care system operates in silos. Fragmentation of care is a scourge, one of the primary causes of gaps in care and medical errors. The highest-risk situations are, without question, care transitions, when patients move from home to hospital, hospital to home—with or without a transition through rehabilitation care—and then back into the care of their family physicians and primary care teams. Advocacy for primary care has produced unintended casualties: it has allowed the specialized services sector to feel unconcerned about health system reform, and the primary care network to put itself forward as entirely capable on its own of managing the care continuum. The result is that we have a rhetoric that favours primary care, but policies that have not yet caught up and that are still focused on hospital-based care. Anyone who lives with a chronic health problem navigates, presumably seamlessly, between primary and secondary care and manages most of their everyday care at home, at work, on vacation. This navigation is meant to be fluid. Of course, the issue of care transitions and services integration is complex and does not depend only on professional practice. Organizations must grapple with this problem,

and the solutions lie in both interorganizational and inter-professional collaboration. Proximity medicine should be geared toward finding new ways of doing things to facilitate these transitions. In proximity medicine, the hospital is part of the community and needs to build bridges with services and professionals outside its walls. How do we persuade hospitals to be part of the proximity medicine community? To develop functional links with the primary care team, which more often than not is carrying the case? Family physicians, by training and practice, are particularly well poised to contribute to these innovations. Let’s not forget that family medicine practice is not limited to primary care. The family physician has solid training in managing episodes of hospital care. As a profession, we are responsible for an important proportion of care provided in hospitals in Canada.

Overdiagnosis and overtreatment: “maximally disruptive medicine.” Symptomatic of a society that dreams of immortality and that is obsessed with zero risk is another considerable challenge: overdiagnosis and overtreatment. The quest for more and more precise tests that can provide even earlier diagnoses, and for treatments that will postpone for months, or even just weeks, an inevitable unhappy outcome, has plunged both medicine and society into a vortex from which we cannot extract ourselves without a drastic change in culture. Moreover, with the best intentions in the world, we have embraced the chronic care model. However, in situations of multimorbidity—which are the rule more than the exception—we offer people increasingly complex treatment plans. We interfere with their work, their leisure, and their lives overall. Being a patient has become a full-time job. It is this situation that has given rise to the Choosing Wisely initiative¹⁶ and to the concept of practising “minimally disruptive medicine.”¹⁷ How will we manage this? How can we ensure innovations are accessible to those most likely to benefit from them? Despite what some would have us believe, the solution does not lie in biological markers or pharmacogenetics. In fact, that route of so-called personalized medicine, or precision medicine, promises to generate even more difficulties. No, we need a medicine that truly involves patients as full partners in their own diagnoses and care, which is what proximity medicine is all about. We need darn good clinicians.

The pressures are enormous. They come from society, our patients, industry, and medicine itself. We need to distinguish between necessary and unnecessary care, and to know when it is time to intervene aggressively and when to watch and wait. A few years ago, I was invited, as a family physician, to take part in an ethics conference on the role of professionals as guardians of health system sustainability. Some people would like to make us, family physicians, the managers of an ethics of rationalization that is negotiated piecemeal, from one consultation

to the next. Not being an ethicist, I explored a concept that an American colleague had raised in a discussion on the Choosing Wisely initiative, which had recently been launched in the United States. That concept was the ethics of parsimony, in contrast to the ethics of rationalization.¹⁸ Even though the term *parsimony* can have negative connotations—being parsimonious can mean being a little tight-fisted—I found the idea interesting. Indeed, in science and in clinical reasoning the principle of parsimony is admired and to be striven for. What is parsimonious medicine? First of all, it is evidence-based and proposes only those things that can make a real difference for patients. It is a clinical approach that calibrates the intensity of an intervention according to the severity of the illness and the goals being pursued. It is, above all, based on sound clinical judgment. It is a medicine that knows how to use time as a diagnostic tool, and that is not in a hurry to do tests all the time. And it is a medicine that tolerates uncertainty. Patients do not tolerate it well. Because of this, it needs to be a medicine that communicates with reassurance.

This is the art of diagnosis and of the patient-centred clinical method developed by Ian McWhinney.

Opening to the risks of proximity: becoming a participant observer

I hope by now I have convinced you that proximity medicine extends beyond simple geographic accessibility and that it holds promise to address many of the challenges we are facing. It requires really knowing the community where patients live, understanding the interaction between the biological and psychosocial factors that determine the incidence and evolution of illnesses, valuing continuity of care and the therapeutic relationship, and being able to manage clinical problems without overintervening. Proximity medicine is not practised in isolation. It is based on teams of professionals and calls for a service organization model in which the patient is at the foundation of the pyramid.

But family medicine is at the heart of this transformation. It is distinguished by being anchored in the community; by knowing the “habitat” of their patients, even if they do not live there, as recommended by McWhinney, and by seeing themselves “as part of a community-wide network of supportive and healthcare agencies,”¹⁷ family physicians are well equipped to act, to the best of their ability, on social determinants of health and on service organization to improve accessibility, make transitions seamless, and avoid overtreatment and overdiagnosis.

But it is certainly in our command of the patient-centred clinical approach, and in the art of diagnosis, that we play a unique role that cannot be claimed by others. As McWhinney tells us in *The Early Signs of Illness*,

The early symptoms of serious disease differ so subtly from those of minor ailments that to the unpracticed eye

they are identical The recognition of disease in its earlier stages calls for clinical expertise of the highest order.³

Beyond the semiological dimensions of diagnosis, which he studied in his first years of practice, and which were the subject of his first book, his observations and his research taught him the importance of taking into account the patient’s beliefs and emotions, and of naming the illness clearly in a way that makes sense, “to find common ground,” as he said, with patients and, in this way, to arrive at a diagnosis together. Practising proximity medicine, true patient-centred medicine, thus means agreeing to engage with, and be close to, the people to whom we are providing care.

How can we develop these clinical and relational skills without burning out on the job? For McWhinney, the answer was that we need to learn to become “participant observers.”² Participant observation is a sociological and ethnological study method that involves studying a society by sharing in its lifestyle, becoming accepted by its members, participating in group activities, and becoming involved in members’ issues. The observer learns from observing not only the persons or society he is trying to understand, but also his own reactions. The capacity for self-reflection is at the heart of participant observation, as is curiosity and respect. For McWhinney, the physician is an integral part of the natural history of the patient’s illness. This is why the physician must learn to see himself as a determining factor in his patient’s “healing.” His study on headaches is enlightening.¹⁹ It was at the root of the elaboration of the theory behind the patient-centred clinical method. The main finding, in a nutshell, was that after 1 year of observation of 272 patients presenting with a new complaint of headache, cases in which patients and physicians reached “common ground” on the nature of the problem and the course of action to take were better off 1 year later. Indeed, “reaching common ground six weeks after the initial consultation” and the absence of visual symptoms classical of migraine headache were the only 2 variables independently associated with a positive outcome at 1 year.

In his memoir, McWhinney described how the idea for that study emerged when about 20 of his colleagues, with whom he wanted to study the evolution of headache, suggested adding another variable besides clinical signs and symptoms. This variable was the physician’s feelings about the patient. They wanted to see whether the fact of a physician’s liking or not liking a patient had an influence on the outcome. To everyone’s surprise, it turned out that patients who were “liked” by their physician had better outcomes.² In his memoir, Ian McWhinney also provided several examples of discoveries that were made because the researcher had become integrated into the environment of the subjects under study. This involvement of the researcher and clinician comes at a cost, however: it invariably influences the observer.

To listen to a person with total, undivided attention is one of the greatest gifts we can bestow ... but it comes with a price, for the relationship between doctor and patient is subject to the same stresses and weaknesses as other human relationships The doctor's own need for affection may be stronger than his ability to give it.²

How, then, do we reconcile scientific and clinical objectivity with participation? The key lies in the level of involvement. We need to learn how to become involved without doing it for our own gratification. As McWhinney cautioned, "If we participate at the level of our egoistic needs, we may well lose our objectivity. But if we have attained the ability to step outside our own perspective we can be objective about our own egoistic needs."² Self-knowledge, self-reflection—these concepts are very close to the concept of mindfulness, which is now recognized as essential in the training of health professionals. It's a skill you develop over time. But what you need basically is to never lose your curiosity, consider your patients as partners, trust their intelligence and capabilities, and work as a team player.

Family medicine's unique contribution

The emphasis given to the relationship with the patient as being inherent to our clinical method, the understanding we have of the effects of the patient's environment and life course on his or her current situation, and the fact that we need to become participant observers to do our work well—all of these have led us to become more comfortable with an "organic," rather than linear, understanding of health phenomena, according to McWhinney. We are more at ease with the holistic vision than with body-spirit dualism. As McWhinney says: "We have difficulty thinking about diseases as separate from the people who 'have them.'"² This understanding prepares us particularly well for carrying out the culture change needed in medicine today. Thinking "organic" means thinking "complexity" and "uncertainty." The linear view of the causes of illness, which has until recently dominated medicine, is no longer appropriate to resolve the great riddles that still persist regarding the causes and cures of diseases. In a complex system, causes and effects are not necessarily close in time and space. What triggers a phenomenon is not necessarily what maintains it. Family medicine, with its long tradition of clinical observation and its roots in relationships, is particularly well positioned to contribute to this profound change in scientific culture. According to McWhinney, we have not yet really measured the advantage of our position. To get there, we need to work on becoming true "participant observers." I leave the final words to Ian McWhinney:

As clinical scientists we will be participant observers, hanging out with our patients, until we know

them through and through. And if we do, we will be rewarded by new knowledge of some of those mysterious conditions that defy explanation, such as chronic fatigue and chronic pain We are protected by participating non-egoistically and by being humbled by knowing how we know. Our objectivity is also protected when our involvement is not on the level of our egoistic emotions. In the self-surrender of participation, a non-egoistic love of our subjects becomes possible and the subject-object dichotomy melts. The withdrawal of participation is an ever-present moral danger for medical science and medical practice.² 🌿

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None declared

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