(Mis)understanding family medicine

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MY AIMS

- At the end of this presentation you will:
  - Remember your dreams
  - Understand how we are different
  - Recognise the importance of our existence
  - Know how to be happy in your profession

ACKNOWLEDGEMENTS

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CAST

- Myself
- Dr. Kildare
- Sherlock Holmes
- 5 patients
- 7 beautiful ladies
- Penelope
- Romeo and Juliet
- Mother Theresa
- Fred Astaire and Ginger Rogers
- Lawrence Olivier

THE GOOD OLD DAYS

OUR DREAMS

- To help people
- To be valued
- To be happy

THE HARD REALITY OF MEDICAL SCHOOL

THE PARADIGM

- Medicine is performed in a world of hard reality.
- Everything can be measured and classified.

PROCESS OF CARE

- You get ill
- You go to a doctor
- You are examined
- You receive treatment
- You get well

THE ROLE OF THE DOCTOR

- To be a detective that discovers the reasons for poorly defined problems.
- To discover the correct diagnosis, the correct agent that is causing the disease.

THE DIFFERENT REALITY OF EVERYDAY PRACTICE

A 82-year old lady who has remained alone after her husband has died.

She has many health problems, most of them will never been cured.

She comes to my practice regulary and is very grateful for my time, because she rarely has a chance to have someone listen patiently to her.

A 42-year old lady with low back pain, hypertension and obesity,

She fails to lose any weight

She is complaining about the services she is being offered

Wants another appointment with a specialist for which I know will not help her.

A 76-year old patient with terminal phase of prostate cancer

He is aware that he is dying, but refuses to talk about his disease

His family is urging me not to tell him he has cancer because they are convinced that this will be very bad for him.

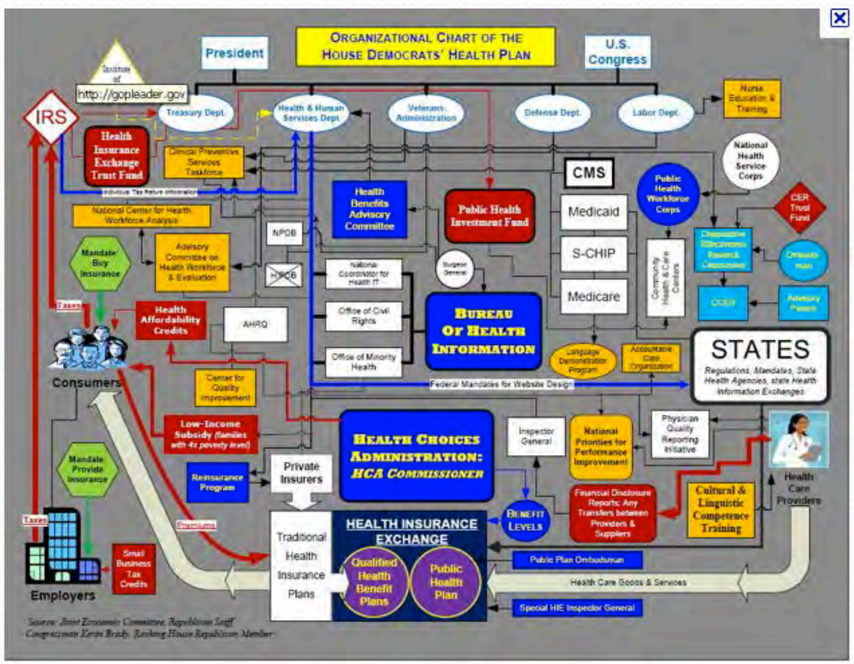
SOME OBVIOUS DIFFERENCES

PATIENTS' PROBLEMS

- You never quite know who or what will walk through your door next.
- Textbook cases are exceptions to the rule.
- Some problems are not biomedical.

THE HEALTH CARE LABYRINTH

For the doctor



For the patient

PATIENT PREFERENCES

- Life is not "the supreme good."
- Sometimes life is worse than death.

Gervas J, BMJ listserver discussion, april 2013

FOCUS ON HEALTH

- We have to encourage our patients to look around and discover places where they can smile and laugh, where life can be rewarding and inspirational.

Dowrick C: http://wellbecoming.blogspot.com

THE ART OF DOING NOTHING

- Doing nothing, but having the courage sometimes to wait – to use time as both a diagnostic and and a therapeutic tool – to see what nature does – to wait and see. These are essential skills…that are profoundly important if we are not to fall into the seductive traps of over diagnosis and overtreatment.

Heath I. The art of doing nothing. Eur J Gen Pract 2012; 18: 242-246

A DIFFERENT PARADIGM

SCIENCE AND CARE

- The greatest challenge facing contemporary medicine is for it to retain … or regain its humanity, its caritas, without losing its essential foundation in science .

Willis, JAR. The sea monster and the whirlpool. Keynote address. Birmingham: Royal College of General Practitioners; 2002.

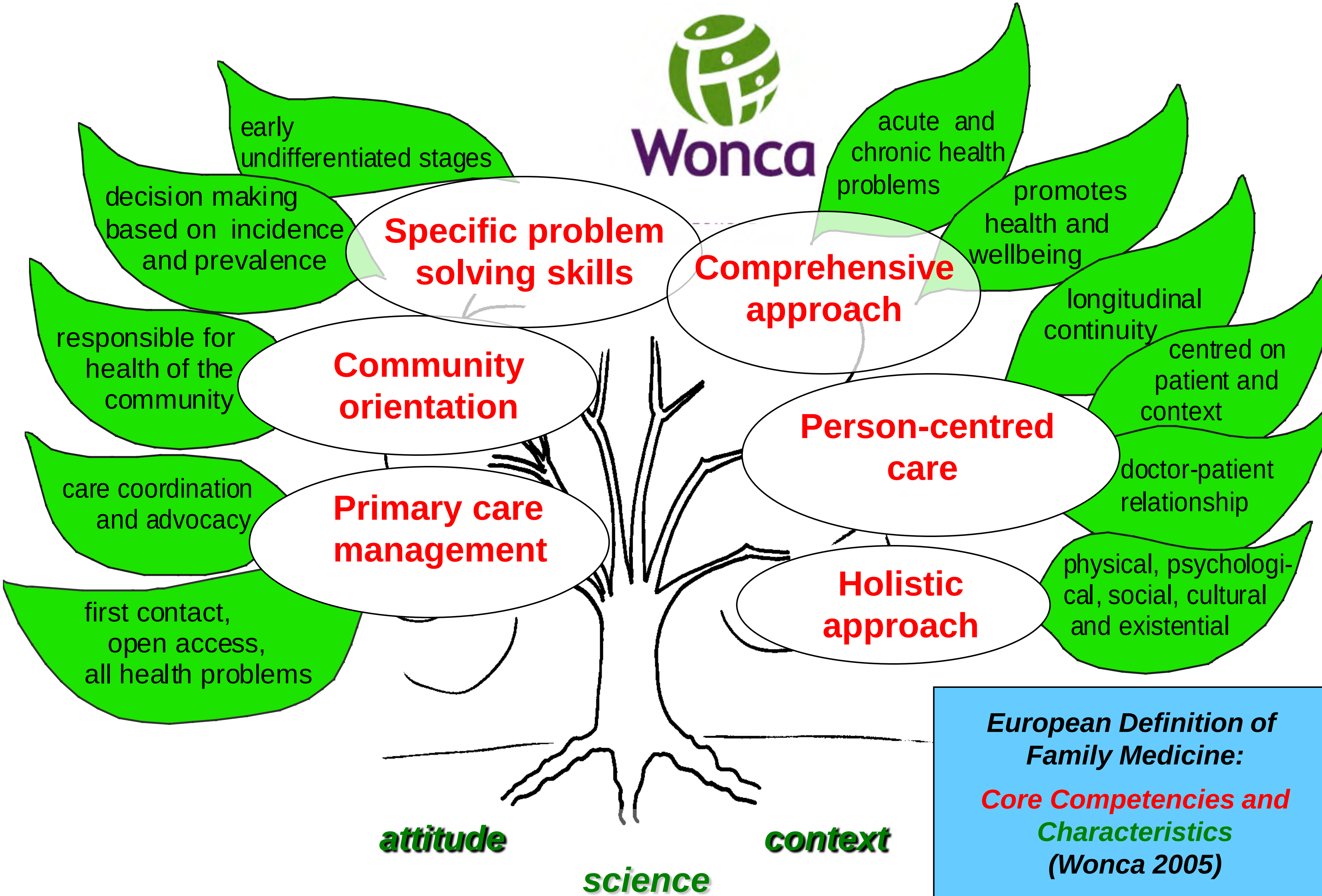
SCIENCE AND CARE 2

Hippocrates

- Correct is to recognize what diseases are and whence they come; which are long and which are short; which are mortal and which are not; which are in the process of changing into others; which are increasing and which are diminishing; which are major and which are minor; to treat the diseases that can be treated, but to recognize the ones that cannot be, and to know why they cannot be; by treating patients with the former, to give them the benefit of treatment as far as it is possible.

Charlie Brown

- Have you been lying awake worrying? Don't worry...I'm here. The flood waters will recede, the famine will end, the sun will shine tomorrow, and I will always be here to take care of you.



European Definition of Family Medicine:

Core Competencies and Characteristics

(Wonca 2005)

TEACHING AGENDA

- Learning and teaching process is focused on 6 competencies, specific for GP/FM:

1. Primary Care Management
2. Person Centred Care
3. Specific Problem Solving
4. Comprehensive approach
5. Community Orientation
6. Holistic approach

RESEARCH AGENDA

1. To further develop and evaluate generic models or strategies
2. To encourage comparative research
3. To promote and support longitudinal cohort studies
4. To promote and support intervention studies and randomized controlled trials which take into account broad issues.
5. To encourage research focussing on diagnostic strategies and reasoning
6. To promote studies assessing effectiveness and efficiency in everyday care
7. To develop and validate functional and generic instruments and outcome measures for use in GP/FM research and care.

POLICY SUGGESTIONS

Conventional ambulatory medical care in clinics or outpatient departments	Disease control programmes	People-centred primary care
Focus on illness and cure	Focus on priority diseases	Focus on health needs
Relationship limited to the moment of consultation	Relationship limited to programme implementation	Enduring personal relationship
Episodic curative care	Programme-defined disease control interventions	Comprehensive, continuous and person-centred care
Responsibility limited to effective and safe advice to the patient at the moment of consultation	Responsibility for disease-control targets among the target population	Responsibility for the health of all in the community along the life cycle; responsibility for tackling determinants of ill-health
Users are consumers of the care they purchase	Population groups are targets of disease-control interventions	People are partners in managing their own health and that of their community

World Health Organization. Primary Health Care –Now More than Ever. Geneva, Switzerland, 2008.

WHERE ARE WE NOW?

Goal 1: HELPING PEOPLE

Mortality

- In both England and the US, each additional primary care physician per 10,000 population (a 12-20% increase) is associated with a decrease in mortality of 3-10%, depending on the cause of death. This is true even after adjusting for sociodemographic and socioeconomic characteristics.

Source: Gulliford, J Public Health Med 2002; 24:252-4, and personal communication 9/04.

Specific mortality

- Primary care physician supply is consistently associated with improved health outcomes (all-cause, cancer, heart disease, stroke, infant mortality, low birth weight, life expectancy, self-rated health).

  A 12% increase in such physicians (1 per 10,000) improves outcomes an average of 4% (range 1.3-10.8% depending on particular outcome and geographic unit of analysis).

Source: Macinko et al, mss 2005

PRIMARY CARE ORIENTED COUNTRIES

- Have more equitable resource distributions
- Are rated as better by their populations
- Have primary care that includes a wider range of services and is family oriented
- Have better health at lower costs

Sources: Starfield and Shi, Health Policy 2002; 60:201-18.
van Doorslaer et al, Health Econ 2004; 13:629-47.
Schoen et al, Health Aff 2005; W5: 509-25.

WHICH MEANS…

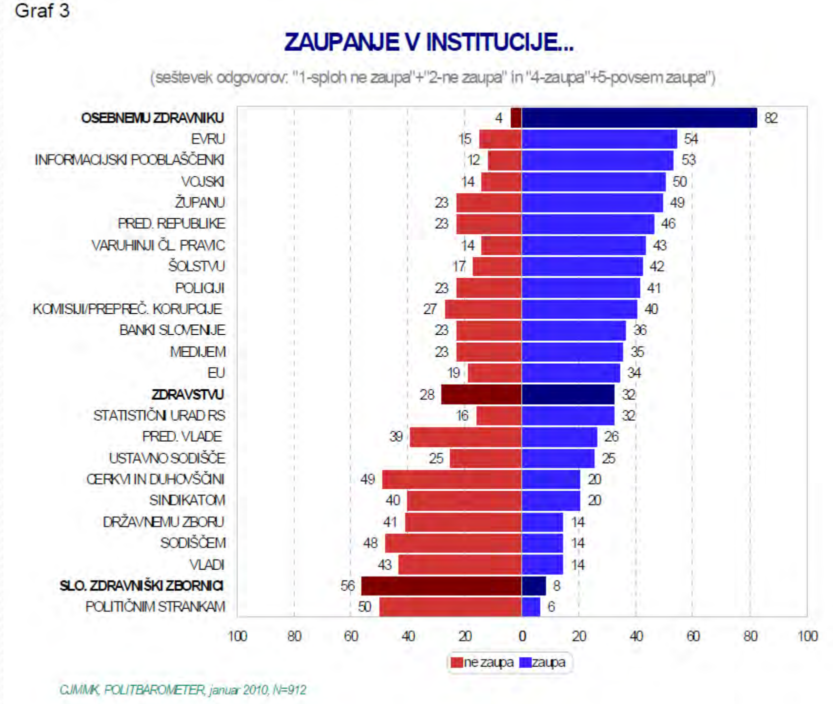
- Although this is not visible every day, my work seriously affects people's wellbeing.

Goal 2: TO BE VALUED

DO PEOPLE LIKE ME?

- The patients are the only judge.
- Family medicine ranks high in all public opinion surveys

Graf 3



THEREFORE…

- I contribute to people's benefit

SUMMARY

- Using hard data we have demonstrated that we contribute to people's health and that we are important.
- Because of that we are valued by our patients.

WHAT PROBLEMS REMAIN TO BE SOLVED?

HAVE ALL OUR DREAMS BEEN FULFILLED?

- To help people
- To be valued
- **To be happy**

Goal 3: HAPPINESS

THE CRISIS OF MEDICINE

- We are witnessing the culmination of a process which has been going on for many years - the gradual replacement of individual human judgement by a structure of external rules.
- By thinking that only the measurable counts we adhere to methodologies an values accepted by other disciplines in medicine.
- This brings the danger that we will forget the essential contribution of family medicine: the human approach.
- By doing this, we are denying our patients our feelings, our wisdom, our caring, our love..
- .. the very values that are so needed today.

Charlton B. The double-blind, randomised controlled trial and its place in medicine. British Journal of General Practice, 1991;41:355-6

LOSS OF MEANING IN FAMILY MEDICINE

- If family medicine is assessed only by..
  - Seeing a lot of patients
  - Fast access
  - Ticking boxes according to protocols
  - Spending less money
  - Making patients happy
- What does it lose?

CONSEQUENCES

- Pay for performance schemes stop improving quality when a target is reached. They also adversely affect continuity of care*
- There were no significant changes in quality of care for communication, coordination, and overall satisfaction**.

*Campbell SM,Reeves D, Kontopantelis E,Sibbald B, Roland M. Effects of Pay for Performance on the Quality of Primary Care in England. NEJM 2009;361:368-78
**Campbell SM, Kontopantelis E, Reeves D, Valderas JM, Gaehl, E, N Small N, Roland M. Changes in Patient Experiences of Primary Care During Health Service Reforms in England Between 2003 and 2007 Ann Fam Med 2010;8:499-506.

HOW DOES THIS AFFECT HAPPINESS?

- I often meet doctors and ask them three simple and difficult questions:
  - Are you happy in what you do?
  - If not, why?
  - What do you think should be done?
- What do they tell me?
- What obstacles do they find?

OUR UNIQUENESS

- We are special
- We deserve a special position in society

STRUGGLE FOR OUR RIGHTS

- We have to fight for our position.
- If we do not do that, we will lose our reputation.

US AND THE OTHERS

- The others (clinical specialists, politicians, economists, lawyers) earn more than we do.
- This is unfair.

OUR NEEDS

- We need more influence
- We need to earn more
- We need special status and some privileges

FUN

- We have the right to enjoy life as well.
- We need time to relax from the heavy burden of work.

SETTING BOUNDARIES

- People are spoiled, they usually ask for the impossible.
- We have to limit their use of our services.

OVERWORKED DOCTORS

- We work too hard
- We need to reduce our workload

MY COMMENT

- You are right, of course:
  - We are special
  - We need to fight for our rights
  - We need to be comparable to others
  - We need to have more influence
  - We need time for ourselves
  - Patients are often demanding
  - We are often overworked
- But learning how to fight will not bring you happiness
- And do not overdo it…

VANITY

ANGER

ENVY

GLUTTONY

LUST

AVARICE

SLOTH

THERE ARE SIDE EFFECTS

OTHER SKILLS MAY ALSO BE USEFUL…

THE SKILLS OF A HAPPY FAMILY DOCTOR

- If family medicine is different, it is because it is predominantly a caring profession that uses science as a tool.
- In caring for patients, family doctors use the most sophisticated tool of all: the whole human person.
- This requires special skills, that are usually not adressed in curricula, but are learnt over the years in practice-
- Which are the skills I have learnt?

THE DETECTIVE

- To be a detective that discovers the reasons for poorly defined problems.
- To make sense of an overabundance of information.

- Uncertainty is a mystery to be explored.

THE FAITHFUL PARTNER

- To be a faithful to your patients throughout their life and your professional career, regardless their problems.
- To be faithful to the core values of medicine and humanism.

THE LOVER

- To love your patients regardless their problem, gender, or age.
- To love them because they are sometimes emotional and I can discover their unique personalities.

- In return, we are greeted with a reciprocal sense of love, a respect, a trust, and an invitation to join them as they make their ways in life, with gratitude when things go well as well as when they do not.

THE BELIEVER

- To accept that in encounters with patients, often something inexplicable happens, which can not be explained by strictly biomedical logic.

- To assist when lives are not tidy and manageable or predictable
- To observe, to recognize, to bear witness to, and to offer a path amidst the unknown.

THE DANCER

- To lead and help your patients and their families to feel a sense of competency in the face of challenge.
- To follow and allow them room to express their fears as well as their strengths.

THE ACTOR

- To play the roles of:
  - interpreter,
  - guide,
  - diagnostician,
  - advocate,
  - healer
- By doing this , you will be supported by what you learned in training. This is the framework for my play, which has developed into something more whole, more complete, and more authentic — the work of a family doctor.

CONCLUSION

AN OBVIOUS BIAS

- This is a personal opinion
- It may even be considered as a biased belief of a senile professor who has lost all touch with reality

But I still feel that..

- To discover mysteries like Sherlock Holmes
- To be faithful like Penelope
- To love like Romeo and Juliet
- To have faith like mother Theresa
- To dance like Fred and Ginger
- To play like Lawrence Olivier

- Is the most difficult and the most beautiful job in the world

CONCLUSION

- Family medicine is complex and often poorly understood by people having the power to decide
- In doing our job well, we use the most complex tool of all: the human person, not only science
- We need to maintain humanity and and be different, because
  - This will ensure our existence
  - This may hold the key to solving some of the crisis of modern medicine, driven by technology and money
  - This is the ideal of our youth that makes us good and happy persons

A WARNING

- *It ought to be remembered that there is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things*.*

*Macchiavelli N. The Prince, 1505

Thank you for your attention!