

Defining family medicine – A slowly evolving process

As the journal embraces its second year of publication the range, quality and diversity of work undertaken in our region is being chronicled through our pages. While acknowledging the problems of 'information overload' we believe this journal offers the benefits of concentrating primary care research in a primary care source making retrieval much easier. With time this may help correct the situation where '266 randomized controlled trials relevant to family practice . . . were published in 110 different journals, of which only 10 were specifically family practice journals.'¹ However, the statement that 'many primary care doctors will find more of relevance to their working life in the pages of personal-finance magazines than in their own medical journals'² is a prompt, indicating that we need to do more than just be a repository of knowledge but actively seek to meet our readers needs. As our concern is the total gamut of family medicine as it is practiced in a diversity of cultures and contexts, this means working from a clear definition of what family medicine is. While full consensus on this seems difficult to achieve a useful synopsis is that it 'is continuous, coordinated and comprehensive care provided over time to populations undifferentiated by a particular disease, organ system, or gender.'³ This would seem to be a distillation of nine principles announced by Ian McWhinney⁴ that govern the actions of a family physician:

- the family physician's commitment is to the person and is not limited by either the health problem or defined by a specific end point
- the context of the illness is paramount to understanding the nature of it
- ideally every contact with a patient provides an opportunity for prevention or health education
- while the focus of the practitioner is the individual patient the practitioner maintains concern for the overall population from which the patient has come
- the family physician works as an integral part of other community support and health care agencies
- a shared habitat between family physicians and their patients aids understanding of the patients' context
- ideally the family physician is able to attend patients in any setting whether it be home, office or hospital

- the biopsychosocial model of medicine is one the family physician is well versed in. This provides a perspective on the subjective as well as the objective components of medicine
- the family physician is a manager of resources.

While we may not all agree with every point that McWhinney makes, many of his 'principles' strike a cord with the nature of the story which is evolving through these pages. A brief glimpse over the last four issues reveals a tale of clinical medicine embedded in the patient rather than the disease. The 'focus on families' series is a strong example of this. This important teaching initiative which has evolved out of the program for postgraduate education for family physicians in the Philippines, reflects the importance of doctors casting their minds beyond the consulting room and exploring the life of a patient through various facets, be they the working environment, the social or political environments. All these aspects have been shown to impact on the well being of a patient and exploring these can hold rich rewards for the patient as the example in this issue shows of a patient struggling with the ravages of HIV.

These examples of course highlight the complexity of family medicine which raises unique problems as we struggle to define, understand and extend the knowledge base of our discipline. Finding the right tools to do this often proves difficult. This has been reflected in many of our original contributions which have involved various methods to look at aspects of family practice which have perplexed the authors. An interesting example in this issue is the article by Young-Mee Lee *et al.* who explores the evidence base of a number of therapeutic interventions used in one family medicine setting.⁵ In this article the problem is discussed of finding the best evidence to support our clinical decision-making.

While providing, accurate, relevant and useful information to support our clinical decisions is an area that drives much continuing medical education, the debate of the place of evidence based medicine (EBM) in family practice is an ongoing one. Finding the right information is one side of the issue with 'a lot of high quality, relevant evidence already there, but it remains invisible to most GPs, even those who keep up to date with the mainstream journals'⁶, but an even more elementary component of this issue is 'what, in general

practice, determines current best evidence?⁷ Charlton and Miles points out that 'EBM involves the elevation of certain methodological principles . . . to "gold standard" status as criteria against which all other types of "evidence" should be judged.'⁸ In particular he is referring to the randomized controlled trial and many have pointed out 'good research does not always mean a randomized trial';² and 'certain factors make reliance on RCT-based evidence in general practice more complex than in medical specialist disciplines.'⁷ Unfortunately, this has not stopped some from using the dearth of RCT's in family medicine as a means of undermining the discipline. Regardless, though of how we define and utilize our knowledge base the fact remains that resources are limited and there is a need for a rationale base for our decision making.¹

Accessing the best available knowledge to deal with the problem that the patient sitting in front of us offers is not likely to correspond to a neat formula but will require individual interpretation by us. Walter Rosser provides a useful approach to this ongoing dilemma. 'Before evidence can be effectively applied

for the benefit of all, irrespective of country, the quality and relevance of the evidence together with the context and values of the country and its population must be taken into account.'⁹

While issues of clinical care are a preoccupying component to our work an increasing element is the interface of this with the social dimension. This is never more relevant than in a 'refugee' population. Mitchell Smith's article in this issue reminds us that many people can find themselves outcasts and destitute where once they lived in stable and thriving societies. The problems of homelessness and displacement are global problems that affect and concern all of us and dealing with patients confronted with this situation is one that often tests the care, compassion and empathy which are the foundations of the family practitioner. In recognition of this we would like to dedicate this issue to all those patients and colleagues who find themselves, through force of circumstance in difficult or dangerous situations.

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References

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