Restoring the particular to family medicine

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The more specific we are, the more universal something can become. Life is in the details.

Jacqueline Woodson

The May issue of *Canadian Family Physician* features 2 articles that, on first reading, may seem completely unconnected to each other.

The first is a reflective commentary entitled "Missing the person. Are preventive medicine and clinical practice guidelines contributing to physician burnout?" by Dr Susan P. Phillips, an academic family physician in Kingston, Ont (**page 303**).[1] The second is a clinical review entitled "Shared decision-making approach to type 2 diabetes management" (**page 310**)[2] by 3 members of the PEER (Patients, Experience, Evidence, Research) group, Drs Blair J. MacDonald, James P. McCormack, and Ricky D. Turgeon.

Dr Phillips explores the potential causes of current high rates of family physician burnout. She makes the case that the proliferation and insinuation of preventive clinical practice guidelines into daily practice crowds out one of the essential, meaning-giving features of our work—not just knowing *about* the patient or the family, but knowing *them*—thus contributing to burnout. See if you agree.

Over the past decade, pharmacotherapy for patients with type 2 diabetes mellitus has become increasingly complex, making it difficult for both family physicians and patients to choose the best options. In their article Dr MacDonald and his colleagues present an online decision-making algorithm developed and tested by the PEER group and apply it to 2 different clinical scenarios, each with differing patient concerns or priorities.

What these articles have in common are different approaches to restoring what Dr Ian McWhinney called *the particular* into caring for patients: the first by making the case that burgeoning demands of delivering checklist-driven preventive care squeeze out the opportunity to find the particular in the person before us, to the detriment of both doctor and patient; the second by using algorithms and formulas to help restore the particular—what patients prioritize and value in their lives—into complex decision making when choosing drug therapies for people with type 2 diabetes mellitus.

In 1975 Dr McWhinney wrote,

> Medicine always reflects the values of the society that it serves.[3]

Though society as a whole favours system-based, outcome-driven medicine more than ever, this might not be the case for individuals, who have unique values and needs.[3]

In her wonderful essay "Finding the particulars: the search for the identity of family medicine through generations of change,"[4] summarizing the career and contributions that Dr McWhinney made to the discipline of family medicine, American family physician Dr Kate Rowland wrote,

> McWhinney did not leave us with a lot of advice for reconciling the stories patients need to tell—the things that we need to understand in order to care for them—with the things our society values—efficient, outcome-driven health care. But he did leave us with some very useful perspectives on coping with the changes.[4]

These he called our *core values,* and they include our commitment to our patients through availability and continuity, community-based primary care, teamwork, professional freedom, and responsibility.[5] They also include continued attention to the particular. Or, to paraphrase Jacqueline Woodson, the practice of family medicine is in the details.

References

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2. MacDonald BJ, McCormack JP, Turgeon RD. Shared decision-making approach to type 2 diabetes management. *Can Fam Physician* 2024;70:310-5 (Eng), 316-21 (Fr).
3. McWhinney IR. Family medicine in perspective. *N Engl J Med* 1975;293(4):176-81.
4. Rowland K. Finding the particulars: the search for the identity of family medicine through generations of change. *The Pharos* 2018;Autumn:35-40.
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