Review Article

Principles of family medicine practice: Lessons gleaned over a lifetime in practice

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Abstract

The term "principles" refers to a set of defining attributes and values that lie at the heart of a discipline. These are largely discovered by reflection and practice rather than learned by formal instruction. This article is written as a reflective dialogue between two teachers of family medicine, one who has been practicing for nearly five decades and another with training in contemporary academic family medicine, using a selection of case stories drawn from the practice of the first author. Several principles of family medicine such as "broad-based specialty"; "person and family orientation"; "continuity of care"; "community based care"; "building a trusting relationship"; "counseling"; and "an effective steward of resources" are highlighted. It is hoped that the above discussion will enable students and practitioners of family medicine to be more effective in delivering primary care and appreciate the privilege they have of serving as family physicians in the community

Keywords: Family medicine, India, principles of family medicine

Introduction

The term "principles" refers to a set of defining attributes and values that lie at the heart of a discipline. These are largely discovered by reflection and practice rather than learned by formal instruction. This article is written as a reflective dialogue between two teachers of family medicine, one who has been practicing for nearly five decades and another with training in contemporary academic family medicine, using a selection of case stories drawn from the practice of the first author.

By reading this article, you will be able to: (a) learn the principles of family medicine; (b) state how a family medicine specialist is a uniquely trained physician; and (c) reflect on your own practice and determine personal strengths and areas in need of further attention as a family physician.

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A Near Miss (1990)

He came in, supported on the one side by his son and the other by his daughter-in-law. With some difficulty, we succeeded in getting him to lie down on the examination table. The history that I could get was that this gentleman was feeling sleepy and tired and not his usual self for the past 2 weeks. He had seen several doctors, and he was in a hospital for a few days. They had a sheaf of papers which included laboratory reports and X-rays. Those days, there was no computed tomography/magnetic resonance imaging available in Bengaluru and I am sure had these modalities been available, these would have been used as well. All the reports were normal.

I proceeded to examine him. He answered my questions fairly correctly but in a slow slurring manner. He was more interested in sleeping than getting examined but was quite docile and cooperative. I did not find anything wrong with him. I found he was on medication for high blood pressure with a combination of a beta-blocker (a popular drug in those days) and a diuretic.

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I knew this combination can rarely produce some weakness and electrolyte imbalance. As I had nothing else to cling on to, I changed his blood pressure medications and asked the relatives to bring him after a few days.

A week later the gentleman came, this time unescorted. He looked and behaved perfectly normal. I too found him normal on examination and told him that it is possible that his blood pressure medication was the cause. He seemed to agree but on parting told me that there had been periods when he felt perfectly normal even when he was on the old medication. This dampened my spirits a wee bit. Nevertheless, seeing him normal was a relief, and I hoped that he would continue to be normal henceforth.

He came back 2 weeks later. *Status quo ante*. Same story, nothing abnormal on examination but patient distinctly abnormal. When I was literally scratching my head, the daughter-in-law said, "doctor, he suffers from acidity and takes Daonil tablet once in a way, and whenever he has acidity he has this problem." Now I had the answer to the problem my friend was having. Daonil is the trade name for an antidiabetic drug called glibenclamide and he naturally was going in for hypoglycemia whenever he took it.

But why was he taking this drug for acidity? I asked her. "Doctor prescribed it" she said. I know, there are lots of fools among us doctors but none as foolish as this. I asked her to get the old prescriptions and sent the patient for an urgent blood sugar test and gave him some sugar water to drink after the blood draw. Within the next 15 min, the patient became near normal.

The blood sugar came as 40 mg/dL, low enough to cause problems. The lady came with the old prescription. The writing was not very legible but I could surmise that the name meant was Diovol (an antiacid drug) and not Daonil and the chemist was happily dispensing Daonil whenever our friend developed hyperacidity and that explained why he went into hypoglycemia. It also explained the prolonged periods when he was normal.

It was a relief to all concerned. The patient was put back on his old medication for blood pressure which had controlled the blood pressure better than the one I had started. It was thus a happy ending. Doctors are known for bad handwriting. However, this was my first experience of it causing a near disaster.

RKP: That was indeed a close miss! Doc, from a principles of family medicine practice point of view, what stands out in this case?

BCR: What stands out in my mind is the principle of continuity and my relationship with not just the patient but other family members as well.

This patient was seen by me three or four times before the diagnosis became obvious. The continuity of care which is one of the basics of family medicine made it possible. Another factor which came into play was the relationship the family doctor builds with the relatives, who feel free to discuss problems other than the actual complaint. In this case, that of acidity, which the daughter-in-law pointed out. One might argue that it is more serendipity than medical knowledge that helped me to find out the cause, but then had I not known the daughter-in-law or had she not come with him, the serendipitous event would not have happened. Hence, what I mean to say is that, it is unique in family practice that it happens, it would not have happened in a one-off consultation with a strange doctor.

A Friendship is Born (1969)

Forty-five years ago, when I put up my board, Indira Nagar was very undeveloped to say the least. It was full of swamps with agricultural fields in between, with no pukka roads, connectivity with the city was a single bus that plied twice a day. Mosquitoes were ubiquitous, with an invasion at nightfall, and there I was with an open door leading to the road, sitting and waiting for patients. Occasionally, however, I used to get busy and when BR visited me all in a panic that forenoon it was one such occasion.

He pushed his way through, and said, "doctor, my wife is unable to breathe, please hurry and come with me." "How long has she been ill?" I asked. "Since 3 days and she is worse, she has asthma, and her medicines are not working" he answered.

Asthma and Bengaluru city have been great friends and continue to be so. In those days, it was even worse, the whole area of nearly two to three square kilometers, slated for development of an extension, was full of parthenium weed. The abundant spore-producing parthenium was one of the most important causes of allergic rhinitis and asthma. Over the years, buildings came up all over and this noxious weed disappeared, and the incidence of asthma came down. It is very much present on the outskirts of the city and doctors practicing in the periphery of the city must be seeing quite a few cases of asthma even now.

Coming back to BR, I said, "if she has been having this for 3 days, it can't be an emergency, I will come with you after seeing these patients" He did not take kindly to this. He said, "no, no, it is serious, she will die if you don't come, my home is just across the street."

Seeing his panic and my reluctance to leave the waiting patients and go with him, one of the patients said, "Doctor, you go with him. We will wait."

I had no option but to go with him. I took my black foldable bag which had all the emergency aids and went out with him, He had no vehicle with him, and as it was a short distance, we walked, him carrying my bag and virtually running, and I following him. Across the street, we went but he would not stop, his "across the street" was not *just* across but across many streets! When asked where the house is, he pointed in the general direction and said, "there." No point in asking this man, better go and face the problem when we get there, I thought. After walking nearly a kilometer, we reached that single storied small bungalow. Both the gate and the front door

were open. We went in, heading straight to where the patient was half sitting and half reclined.

Mrs. J was then a young woman of 25, recently married, new to the city, and was in real trouble. One look at her, I realized that BR was not exaggerating when he said it was an emergency. She could hardly breathe, with a cyanotic tinge and she was perspiring all over. There was no need or time for any detailed check. Subcutaneous adrenaline was the drug of choice and I gave her this and followed it up with IV deriphyllin and decadron. Her breathing eased, but she became nauseous and even before BR got a basin to hold the vomit, she brought out all her breakfast on to my shirt front. This happened as I was keenly watching her recovery and did not withdraw quickly enough to escape the projectile.

It was not an uncommon sideshow of using adrenaline. I took off the soaked shirt and baniyan (vest) and sat watching her recovery. Within the next 10 min, like a miracle, she was normal, and wanted to make tea for me!

Where was BR? He had disappeared with my clothes. He returned after a few minutes with a new shirt of his. Different color, different make, and size. I had no options but to put it on and return to my waiting patients. BR came with me carrying the bag despite my telling him not to.

On reaching the clinic, one patient asked me, "doc do your patients give you a shirt also when you make a house call? I had no patience to explain or appreciate his humor. I must have given him a dirty look, to make him keep quiet."

That night after the evening clinic, I dropped in to see her. She was perfectly normal, and gave me a paper bag which had my clothes neatly washed and ironed. The friendship that began that day has lasted even to this day.

RKP: That is certainly a dramatic way to forge a new friendship! Doc, I was struck by the fact that because you made the house call, you managed an emergency and also won the confidence of the patient. It was also interesting to see that your relationship with family transitioned from that between a doctor and a patient to friendship. I am curious to learn the influence friendship has on a family physician's work. Does it not interfere with decision making?

BCR: Yes, sometimes it is a disadvantage to have an intense relationship, and indeed it interferes with decision-making. Here one must try and draw a line. The family physician should keep the relationship as one between a patient and a doctor. Letting the relationship become a personal friendship can cloud judgment. You might have experienced this yourself when called upon to treat a family member. This easier said than done and I did have difficulty on occasion. To remain dispassionate in one's judgment is indeed tough, but one learns.

Death and After (1985)

It has been my lot over the years to visit the homes of those who die. There is always an atmosphere of somber sadness at the place with relatives and friends busy consoling the bereaved family. There is also quite a bit of whimpering and often loud crying. Sometimes I detect contrived sorrow and avoidable histrionics.

There, however, was one instance still green in my memory though it occurred more than 30 years ago. Those days, in the locality (Cox town) of my practice, lived a fair number of Anglo Indians, most of them retired, and some of them were my patients. One such family was the Smiths. Mr. Smith (I have forgotten his first name) was past 75 and suffered from episodes of angina. In those days, we practiced what from today's standards would be considered as primitive cardiology. The drug for angina was a nitroglycerine tablet placed under the tongue. Mr. Smith had a stock of these and needed to use only rarely. He was full of life and told me once that a shot of whisky worked better than the pills I gave him. They were a nice couple and whenever I visited them I was sure of a cup of tea and homemade biscuits.

When the call came to see Mr. Smith one evening, it was nearing to my closing time in the clinic and when I went to see him, he was already feeling better and was sitting with his evening shot of whisky listening to music. Having gone there I took his blood pressure and found his heart ticking well. I reassured them that all is well and promising them a visit next morning, I returned home.

Next noon when I went to their home, I found a small group of people outside. And when I went in I found Mr. Smith's body laid well prepared for the final journey. Speechless and distressed I went inside to see his wife, Mary. If she was shocked and sad, she did not show it, instead when I told her how sorry I was, she said, "doc, he had it coming, and he went well without any pain" and got herself busy receiving other visitors.

I visited her a week later, except for a cousin, the house was empty. I said, what a fine man her husband was and how I was missing him and his wit. Her pent up emotions cut loose and she broke down with huge sobs, holding on to me for support.

When I finally took leave of her, her cousin came up to the gate and told me, "now she will feel better."

RKP: Doc, I don't know how I would have handled a situation like this. Have there been occasions that you felt guilty or felt you could have acted better?

BCR: Of course, yes. Here, I possibly made a wrong decision and the family did not even think so. Instead of holding me responsible, they went out of their way to comfort me while dealing with the death of a loved one. It is possible that the family knew instinctively that I was feeling bad for having made a wrong

decision. As family physicians, we are many times privileged to have such experiences.

A Futile Exercise (2002)

He had a big file tucked under his arm when he came in. He said, "all appears OK." "What all appears OK?" I asked. "The tests," he said, pointing to the thick file that he had now placed on my desk.

Who asked for these tests? I asked, as I didn't remember having ordered any tests neither did I remember having seen him recently.

"No doc. You didn't but I went and got these done on my own." "Why did you do it?" I asked. "Because I felt weak," he said in defense. "Has your weakness gone after doing the tests?" I asked. "No doc, it is worse and that is why I have come, the tests all show normal values." He stopped.

"I have another of these fools who has fallen prey to the advertisement blitz in the lay press and electronic media. He has spent over 7000 rupees on tests without getting any medical advice and he wants me to advise him as to what he must do."

This has become a none too uncommon experience for me and my irritation continues to grow with each such incident of doing the tests and seeing the physician later. Yearly tests have become the norm. Most of these tests are unnecessary but are done anyway. This is because there is a widespread misconception among people that such tests need to be done periodically to assess their health status. This has come about because of successful salesmanship by laboratories and hospitals for their services, regardless of need.

Coming back to this patient, I told him I will look at his glossy file after giving him a history and physical. He readily agreed. Examination revealed overt anemia and no other cognizable illness. I had a look at his reports and found all were normal except borderline low hemoglobin and red cell numbers. I felt the most likely diagnosis was blood loss, in need of evaluation. He gave no history of a rectal bleed. Still, I did a rectal examination and that showed active second-degree hemorrhoids.

Did he not know he was bleeding from there? Possible. Unless one's bathroom is well lit it is easy to miss blood in the commode.

To exclude possibility of colon cancer endoscopy was also done.

Finally, it was proved that his tiredness was from recent blood loss due to the rectal bleed. He regained normal health after stopping the bleed by a minor procedure. The expensive tests didn't reveal his hemorrhoids.

Moral of the story: When in trouble see your doctor first. It will save you time and money.

RKP: Primary care is the most cost-effective way of health-care delivery and we have often spoken on this issue. This case is a perfect example, is it not?.

BCR: Indeed. Marketing of annual checkups has been hugely successful and even doctors are enticed with incentives to recommend these tests. A family physician has to constantly be on guard regarding these market forces and commercial interests that try and sweep him of his feet.

Full Circle (1978)

"No, it is not he, it is I who wants it," she said. A statement of bare fact which took my breath away. This was uttered 40 odd years ago when the age of permissiveness had not as yet set in. I thought then (now I know better) that it was the boy who wanted it more than the girl. So, I asked this 17-year-old if she knew the consequences. She replied, "Yes I know. I have to have it. I think of it day and night and it is interfering with my sleep, my studies, I am snapping at everyone around me, and I don't want to become pregnant."

So this teenager has come for advice on contraception and not to listen to stupid moral advice. Like a good lawyer who accepts briefs with the belief that all are innocent till conviction, I too offered her the advice. She went beaming.

Miss K is from a fairly orthodox Brahmin family and they had been my patients for some years then. A few months later Mr. S, Ms. K's father, came to see me. He looked very worried. Although I could guess the reason for his coming to see me, I kept silent as to the meeting his daughter has had with me. "Doc, I am very worried about my daughter, she is into bad ways." I thought the next thing that he will tell is that she has become pregnant. Instead he said she is moving around with a Christian boy.

Patients come to us doctors not necessarily for medical advice. Often, we act as counselors to the family. I knew then that Mr. S had two worries. One was that his daughter may land up in trouble and second that the boy was a Christian, a major disaster for an orthodox Brahmin family (vice versa is also true). "Is he a bad person?" I asked him. "No doc, he is nice and well mannered and we all like him, but she is too young for this sort of thing." "What sort of thing?" I asked. He kept quiet. I wanted to reassure him that there is no possibility of her getting pregnant but did not want to let the cat out of bag, so kept quiet. He requested me to talk to his daughter about the danger and after getting an assurance from me, he went his way.

Many years later, a middle-aged lady dressed in an orthodox Hindu style, came to see me. She could make out that I did not recognize her. She said. "I am K, daughter of Mr S, we used to see you many years ago, remember?." Of course, I remembered now. Obviously she had not married that Christian boy [I could make out by the typical Hindu style of her bearing]. Still I asked

her. She said, "that useless fellow, he had no guts, I did well to break that relationship."

I did not ask any further questions about her past. After a momentary pause, she said, "I have a teenaged daughter, who is going around with a boy, and I want you to advise them as you did for me. It was a great help." Unlike her father, K had not a bit of worry on her face. I became witness to a full circle.

RKP: Doc, this case brings up such a Pandora's box of social complexities. It made me acutely aware of the tightrope walking we as family physicians often need to do. But how does one know what is right or wrong in a situation like this?

BCR: Yes, there is a gray area of right and wrong and one has to play by the ear, as I did. The key is maintaining confidentiality and being nonjudgmental. One has to be careful to not let one's own beliefs interfere with our larger responsibility to patients.

Discussion

The above cases highlight several principles central to the practice of family medicine. These are summarized below.

Family medicine is broad-based specialty

In contrast to the system-based specialties such as cardiology, neurology, hematology, and the like, family medicine practice involves all ages, all organ systems, and their interplay with the personality of the patient and his psychosocial and cultural environment. Quite often, the illness involves multiple systems and the sufferer often has to do a merry-go-round if he were to seek help in a specialty-based set up. This may also result in loss of time, money, and often without a satisfactory outcome.

In contrast a family medicine practitioner, with his or her broad-based knowledge, succeeds in coming to grips with the problem and is able to prioritize management options. For example, an illness involving the heart and the kidneys, a family physician must decide which one needs to be tackled first and how? It also happens on occasions that the patient has multiple complaints and it is not always possible to come to a diagnosis at the first consult. In such situations, a family medicine specialist can see the patient again, wait, watch and come to a possible diagnosis toward a solution.

Person and family orientation

Illness is one of the many events that occur in one's life. The signs and symptoms produced by the same illness vary from individual to individual and many other factors such as age, sex, and personality patterns influence the presentation of these signs and symptoms. Many social, cultural, and sometimes religious parameters also affect the incidence and presentation of illness. In some, the presentation may be may be obvious while in others it is hidden. A family physician who knows the person well and has been treating him for various illness episodes is well placed to assess the severity or otherwise of the illness and plan management that is tailored to that unique individual.

Continuity of care

Seeing the patient in the same family and in the community setting has several advantages. The reasons for seeking care may be the same or varied and the background may differ. These factors will be known only if the physician has knowledge of that particular person and his family over many years. Through a sense of relationship and continuous partnership, family physicians are committed to the whole person including his or her physical, mental, emotional, social, and even spiritual well-being. He may even be able to anticipate an illness and take preventive measures. A family medicine specialist can provide this kind of care which is often spread over generations.

Community-based care

A family physician lives and works in the community. He is therefore much more accessible and approachable. Often his working schedules are designed to suit the patient's needs. Another aspect of this community-based care is that family physician visits the patient at home (as illustrated in case stories above). House visits provide a unique opportunity to assess the psychosocial and economic conditions of the patient. This also helps to strengthen the bond between the doctor and the patient and his or her family.

Building a trusting relationship

Family medicine is probably the only branch of medicine, in which there is a strong mutual trust based on doctor–patient relationship. This trust is built over years of interaction between the patient and a family physician in a series of events that occur in a family's life. Patients get to believe and trust the family physician to do what is best for them. This could be one reason why we don't hear as much about family physicians being abused or manhandled by irate patients and their relatives.

Counseling

From the time, a baby is born till he or she dies, one comes across problems not entirely related to physical or mental health. These problems are usually due to faulty adjustments with others in the family, community, school, friends, and growing up. Issues related to behavior with the others of the same sex or the opposite sex or scholastic performance pressures play a part in the way a given person lives in the social set up. Is he well-adjusted or ill-adjusted? If ill-adjusted how much of his presenting problem is due to this? Is he a victim of substance use or victim of domestic violence? These are some of the many issues that often come to the knowledge of a family practitioner. These problems need a nonjudgmental approach, tact, and careful handling as they involve more than one person. A family physician is uniquely placed to offer advice and help in these situations.

An effective steward of resources

A family physician acts as a patient advocate through collaborative leadership and management of available resources in a cost-effective and evidence-based manner. This is one of the major contributions family doctors can make to patients and families. By judiciously investigating and appropriately referring, family physicians ensure that their patients are saved unnecessary procedures and costs.

Conclusion

It is hoped that the above discussion will enable family physicians and students of family medicine to better appreciate the privilege they have of serving as family physicians. We end with a quote from William Osler, "A good physician treats the disease, a great physician treats the patient who has the disease." The ideal of family medicine emphasizes the latter.

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