Family Medicine and Community Health

Storylines of family medicine II: foundational building blocks—context, community and health

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ABSTRACT

Storylines of Family Medicine is a 12-part series of thematically linked mini-essays with accompanying illustrations that explore the many dimensions of family medicine, as interpreted by individual family physicians and medical educators in the USA and elsewhere around the world. In 'II: foundational building blocks—context, community and health', authors address the following themes: 'Context—grounding family medicine in time, place and being', 'Recentring community', 'Community-oriented primary care', 'Embeddedness in practice', 'The meaning of health', 'Disease, illness and sickness—core concepts', 'The biopsychosocial model', 'The biopsychosocial approach' and 'Family medicine as social medicine.' May readers grasp new implications for medical education and practice in these essays.

INTRODUCTION

How family physicians perceive the world of medicine is significantly different from how other clinicians commonly see it. Starting with the basic definitions of context, community, health, disease, illness and sickness, family physicians regularly practise medicine from a systems perspective. Although the biological determinants of health are key to the work of family physicians, their distinct perspective is also rooted in other non-biomedical determinants, such as the psychological characteristics of individual patients and the social circumstances of patients' lives.

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CONTEXT—GROUNDING FAMILY MEDICINE IN TIME, PLACE AND BEING

Rupal Shah

> *Context: the 'situation within which something exists or happens, and that can help explain it.'*[1]

As a general practitioner working in inner city London, there are multiple contexts that influence how I care for people. Geography comes to mind first. Education, family, wealth and employment follow—we all know that health outcomes are closely related to social class.[2] Politics and policies also play a part in thinking about context.[3 4]

The neighbourhood in which I practice, Battersea, is one where people of extreme wealth exist next to those in extreme poverty. Although they live within a stone's throw of one another, their worlds rarely overlap. Our waiting room is one of the few places that breaks this social rule.

The practice, which serves a population of 14 500, is situated in a health centre that was built in the 1970s. At the time, it was the height of modernity; it has been subject to a slow decline ever since. This, too, is part of context, and it is full of contradictions. Although relationships constitute the core of our work, we are paid largely through incentivisation schemes that map performance against multiple targets—if items of 'care' are not recorded, they cannot be counted.[5] The computer in the clinic room—another element of context—reminds us (when it is working) to collect the necessary data by flashing a series of warning triangles at us during consultations.

I have worked in this setting for 19 years, almost the whole of my professional life. The nearby streets have particular meaning for me. They have been the stage set for countless dramas— violence, accidents, love stories, births and deaths. Now when I walk past a block of flats, I think of the people—my patients—who have died inside them. Ghosts and stories spill out of the windows above me.

'I don't want to bother you, Doc…it's just that my breathing isn't so good just now.'

My patient's breathing is, truly, more laborious than usual. She is 68 but looks much older—sagging skin, nicotine-stained teeth,

Figure 1 Context: locating, understanding, being, caring.

grey hair and a downcast gaze marking her clearly as one among the 'have-nots' in my practice community.[5]

I know this woman. I know she volunteers in an old people's day centre, making tea and lunches. I know her daughter, too, who almost died last year of a pulmonary embolism. Her granddaughter, Sam, recently tried to commit suicide after being raped. My patient accepts she is in the final act of her life, even if she shouldn't be.

I can see that there are lots of outstanding actions I should complete during our visit. I should record her smoking status, recheck her blood pressure and review her medications. Instead, I look at her and listen to her. I examine her. I hold her hand. I ask her how Sam is doing.

Context helps us to understand our patients' lives. It is up to us as clinicians to use it as a way of connecting along the path of healing, however, that may look. Context is more than the data we collect; it constitutes the soul of our work—knowing our patients, deeply and with love, in the here and now that surrounds all of us (figure 1).

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RECENTRING COMMUNITY

Tamala Carter and Geoff Gusoff

Adopting a community-centric view of health helps physicians work together with others and recognise that community is the true centre of the health universe.

For centuries, people thought that the Earth was the centre of the universe. Being at the centre meant Earth was of foremost importance. People clung to that belief, even though it stunted the growth of knowledge and the advancement of society.

That belief seems absurd today, but we believe something very similar about medicine. We consider hospitals, clinics and doctors to be the centres of the health universe. Even the word health conjures up images of hospitals and white coats, and most US investments in health go to clinical care.[6]

Remarkably, however, such clinical care impacts only about 10%–15% of health.[2] Overwhelmingly, what makes people sick or well takes place in the community, the places where people live, work, play and rest. While hospitals and clinics play significant roles in healthcare, the community is the true centre of the health universe.

A community-centric view of health reorients the role of doctors (figure 2). Instead of playing lead roles in determining health outcomes, doctors become supporting actors. They support patients not only with individual issues like diabetes, but also community issues like inadequate housing. They shift their focus to strengthening communities' capacities. They share medical expertise and integrate it with the expertise of partners. They help strengthen interventions by supporting research efforts developed by and for the communities in which they work. To accomplish this, they seek out partners who know their communities best, including community health workers and community organisers.[7]

How can physicians, including family physicians, make this shift? They can immerse themselves in communities in the same way their training immerses them in clinical settings. While some physicians come from the communities they serve, others may immerse themselves by living, playing or worshipping near where they work. They can also learn by deeply listening to community members, including locally residing staff members and patients; they can be open to hearing not only medical histories, but also life stories during daily practice.

None of this can happen without earning trust, but earning trust can be challenging: physicians represent a medical profession that has often been untrustworthy and even actively harmful to economically poor, black, brown, Indigenous, LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other sexual and gender minorities) communities.[8] However, trust can still be built by consistently acting in trustworthy ways: actively working to transform harmful policies and practices within the health system and broader community, honestly expressing humility and being reliable and true to your word—following through with what you say you're going to do.[9]

Why should family physicians pursue a community-centric model? By decentring themselves, they are freed from the burden of doing the impossible in challenging situations; instead, decentring enables family physicians

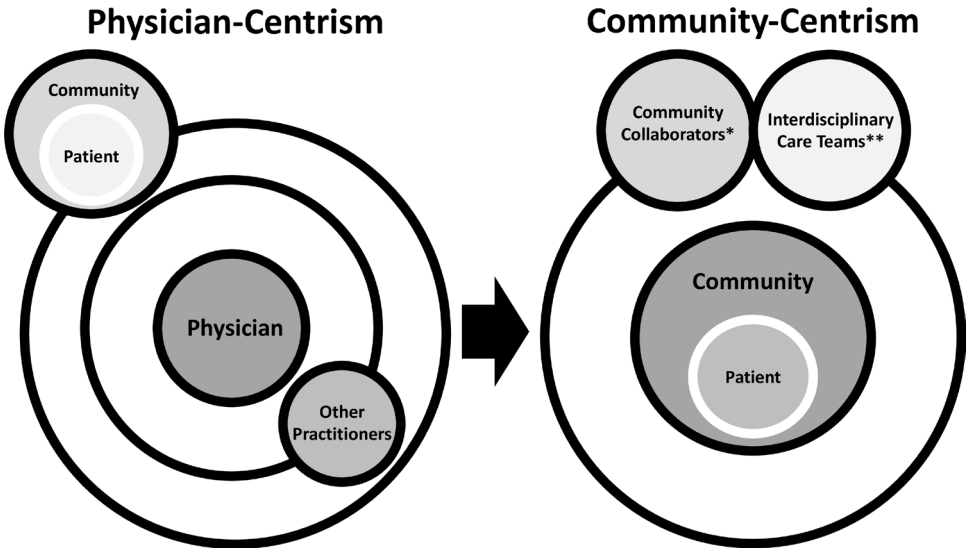

Figure 2 Conceptualising community-centric practice. *Community collaborators: community organisers, leaders and organisations **Interdisciplinary care teams: physicians, nurses, social workers, care managers, community health workers and others.

to do what they do well. Years of medical training provide them with healing tools that are indispensable, though incomplete. Working alone is a recipe for ineffectiveness and burnout. Working together and acknowledging the primacy of those who make up communities breeds camaraderie, engagement and action towards a collective goal.

Once people accepted that Earth was not the centre of the universe, they better understood the patterns of the stars and used them to navigate the world. Once we see communities as the centres of the health universe, we will better appreciate their healing capacities, navigate their waters of reality and accompany their members along paths of transformative healing.

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COMMUNITY-ORIENTED PRIMARY CARE

Winston Liaw and May Nguyen

> *A central tenet of Community-Oriented Primary Care is that primary care should be rooted in communities, designed for communities and delivered in collaboration with communities.*[10]

A primary care practice launches a Community-Oriented Primary Care (COPC) initiative after realising a high percentage of patients of the practice have poorly controlled diabetes. To start the COPC initiative, physicians in the practice identify the neighbourhoods served by the practice and develop relationships with stakeholders. These stakeholders report that many community residents are unable to afford food. In partnership with a local food bank, the practice opens an on-site food distribution centre that carries healthy foods and offers support from a dietitian. A year later, food insecurity rates fall and markers of diabetes control improve.

This case exemplifies a classic COPC initiative. Developed in the 1940s, COPC is a continuous process by which primary care is provided to a defined community based on its assessed health needs.[11] This is accomplished through planned integration of public health with primary care.[12] Done well, COPC integrates prevention, disease management, geography, epidemiology, community organising and health education.

To achieve the goals of COPC, COPC teams are composed of diverse members, including clinicians, nurses, community stakeholders, leaders from community organisations and public health experts (figure 3).[13] Because of its potential to address social, economic and environmental issues, COPC is the template that many community health centres use to improve the health of people they serve. Embedded within the model is a commitment to community engagement, which is needed to sustain projects and magnify impact.[12]

Employing the following four steps, COPC is an ideal way of nurturing community engagement[13]:

1. **Define the community of interest**—Accepting responsibility for those living in a defined geographical area ensures care is provided to all residents in that area, not just those coming to the clinic. One approach, known as geographical retrofitting, accomplishes this step by mapping the addresses of patients in a practice, selecting the most represented neighbourhoods

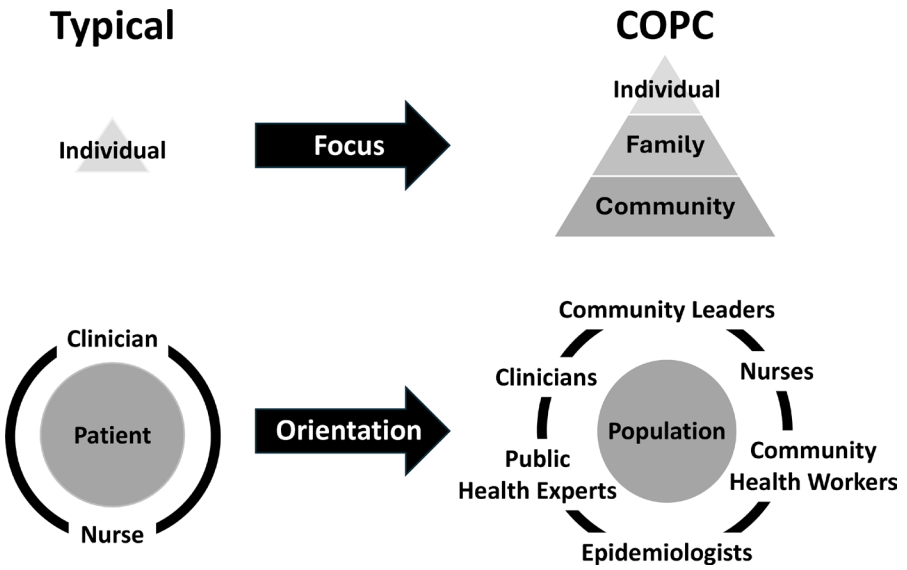

Figure 3 Clinic structure: moving towards community presence and involvement. Adapted with permission.[13]

and applying steps two through four in those selected neighbourhoods.

2. **Identify health problems**—Next, stakeholders identify problems affecting the community by analysing community data and talking to key informants. Once issues are identified, the COPC team prioritises the key problems and determines which will be addressed and in what order.
3. **Develop and implement interventions**—By reviewing the literature, the COPC team identifies what interventions have worked in other communities and then uses community input to tailor the intervention to their local context.
4. **Conduct ongoing evaluation**—Like a clinician who monitors drugs for side effects and efficacy, the team assesses the impact of the project. While studying the intervention, the team can uncover more pressing issues, identify aspects that are working well and fine-tune those that are not.

While COPC has often struggled under fee-for-service models of reimbursement, the model has received renewed attention due to changes in healthcare. For example, payers are increasingly prioritising the value of healthcare and not simply the numerical volume of patients seen. Society is searching for models that narrow, rather than exacerbate, disparities and family physicians are increasingly interested in tackling the root causes contributing to poor health.

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EMBEDDEDNESS IN PRACTICE

Joanna Rachelson and Mary Alice Scott

The concept of embeddedness recognises the relationship between individual people and the social context in which they act, acknowledging the ways each influences the other over time.

Family medicine is rooted in the idea that physicians must embed themselves within families and communities. In 1966, the Millis Commission confirmed that the USA needed a medical specialty that trained physicians to focus on whole people and the complex settings in which people live. In doing so, physicians could identify the root causes of disease.[14]

One year later, the Folsom report maintained that 'every individual should have a personal physician…(who) will be aware of the many and varied social, emotional and environmental factors that influence the health' of patients and their families.[15]

The 2023 ACGME (Accreditation Council for Graduate Medical Education) programme requirements for family medicine maintain a focus on this embeddedness, stating that 'family physicians champion holistic, empathic, compassionate, equitable, culturally humble and relationship-based care to patients across the broad spectrum of society.'[16]

This is not possible if physicians are not embedded in the communities in which they practise. Joanna, who cares for whole families, experienced this in her practice.

Before I (JVR) started working as a family physician in southern New Mexico, I had an idealistic view of what that really meant. I believed that family medicine's intention was to care for the whole family—I envisioned the old-time TV physician who showed up at a patient's house with a white coat and black bag. I imagined that they

Figure 4 Embeddedness in place and time: Las Cruces, New Mexico, USA. Reproduced with permission.[17]

knew everything about their patients because they had cared for their patients for many years.

It wasn't until I started residency that I realized this wasn't a fantasy; it was a realistic career path. I remember my first true experience as a family physician. I was six months into my family medicine residency, preparing for a well-child visit. The patient was a three day-old who was scheduled for a weight and color check. One week earlier, I had seen her mother in clinic for her last prenatal visit before delivery. I attended the birth and delivered the baby, a healthy baby girl. I performed the baby's initial exam and cared for the mother while she was in the hospital.

Six weeks later, I saw the mom in my clinic for her postpartum visit. Generally, she was doing well. She was breastfeeding, and we planned on doing a Nexplanon insertion at the visit.

Three months later, I saw the mother's five year-old son, who presented to the clinic for his well-child visit. He was adjusting well to being a big brother.

Now, the three day-old baby girl is six years old, and I am on faculty in the same residency program. I have done almost all her well-child visits and many of her sick visits. I am her physician, her mother's physician, and her brother's physician. I think back to those very first visits every time I see one of them, and I look forward to watching them grow as I continue to follow them into adulthood. My family and I have set down roots in southern New Mexico, and I am training new generations of family physicians who plan to do the same.

I am fortunate that this is just one example of many patient families that I care for. Being a family medicine physician in my community has given me the ability to provide care for many patients and their families. It is because of this embeddedness that I can provide more insightful care to meet the needs of my patients.

Embeddedness in family medicine is the experience of being deeply rooted with people in a certain place over time. It is what gives us as family physicians our special perspective on patient care. It is what gives joy and satisfaction in practice and life (figure 4).[17]

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THE MEANING OF HEALTH

Teresa Schiff-Elfalan and Seiji Yamada

Health depends on the actions—big and small—that each of us takes.

The preamble to the constitution of the WHO starts with 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'[18] Published in 1946, this document was meant to encourage optimism in the face of the preceding years of destruction, when the horrors of World War II were fresh in people's memory.

Many of these concerns persist at present, well into the 21st century. The threat of nuclear annihilation, armed political strife, and climate catastrophe all threaten much of life on earth. Despite these realities, however, aspirational hopes for a better world—a healthier world—have not faded away.

Many family physicians enjoy a special connection to the WHO definition of health. Why? In family medicine, we think in wholes: the health of the whole person, family and community. It is, therefore, natural for us to think about health in terms of all species on the planet, in addition to the environment in which we all live.

On a macrolevel, health implies that humans have a healthy relationship with the planet earth. It is important we as a species work to sustain the ecosystem that sustains human health, to be part of the natural world rather than its destroyer. Ancestral wisdom has taught us that this interconnectedness also spans across generations and time, carrying forward our history and sowing the seeds for our future (figure 5).[19]

On a microlevel, health implies that we as humans have healthy relationships with each other and ourselves. It is important we work to sustain the relationships that promote human health, to build interdependent bonds of connection rather than break them.

To help our patients move towards a state of health, we, as family physicians, must be attentive to what affects our patients outside of our exam rooms, including the social and political determinants of health; inequalities in income, wealth and resource availability; and generational trauma of peoples systematically oppressed throughout history[20]—all of which threaten the WHO's concept of complete well-being.

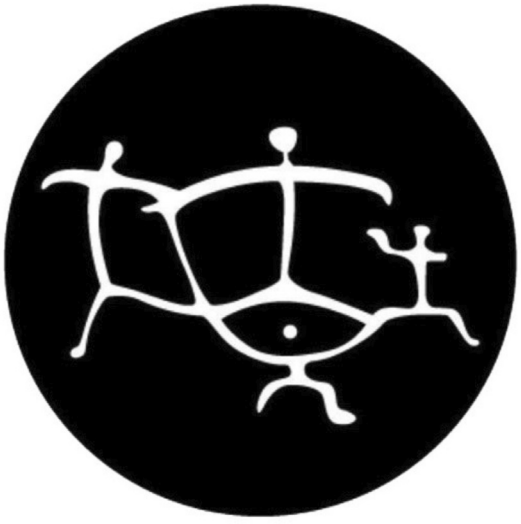

Figure 5 Health: an ancestral view this graphic—a Hawaiian petroglyph of four people linking arms—reminds us that 'health' is informed as much by ancestral knowledge as by modern medicine. Reproduced with permission.[19]

As family physicians, we can function as important vehicles for healthy change. How we define health depends on the actions each of us takes.

- **Where we practice**—Are we choosing to practise in places of social, economic or geographical marginalisation?
- **Who we serve**—Are we choosing to attend to the concerns of those in greatest need?
- **How we care**—Are we choosing to partner with our patients, regardless of their backgrounds, to help them move a bit closer towards the WHO ideal?

We are also free to choose whether to acquiesce in war, planetary death and monstrous disparities or to fight for peace, harmony with nature, and equality.[21] When we honour our patients' preferred names and pronouns, listen to their stories with open hearts and consider their realities when individualising assessments and plans, we can start to change the ways we and others think about achieving health. If we can be brave enough to look within ourselves to examine how our professional backgrounds and personal biases influence our words and actions, we can be braver still to do the hard work to undo these learnt thoughts and behaviours, and our individual intentions can create healthier institutions and, eventually—small step by small step—a healthier world.

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DISEASE, ILLNESS AND SICKNESS—CORE CONCEPTS

Bob Like

Understanding how physicians and patients mutually express the concepts of disease, illness and sickness in everyday clinical encounters can help facilitate the provision of high-quality, holistic and humanistic patient-centred and family-centred care.

Physicians are traditionally taught to interview patients to elicit their chief complaint(s), history of present illness, medical history, family history, social history and review of systems. Combining this information with findings from the physical examination enables physicians to generate clinical hypotheses and working diagnoses to guide further treatment.

In providing patient-centred care, however, it is important for physicians to go beyond this approach to better appreciate patients' understandings of their conditions, and recognise the family, work, social and community contexts of their visits. In doing so, physicians learn to distinguish between the concepts of disease, illness and sickness.

Disease is the 'malfunctioning or maladaptation of biological and psychophysiological processes in (an) individual,' whereas illness 'represents personal, interpersonal and cultural reactions to disease or discomfort.' Illness is the 'human experience of sickness.'[22]

Lay models of illness commonly shape patients' health and illness behaviours as well as the various relationships that exist between disease and illness.[23] For example, one can have disease without illness (eg, asymptomatic hypertension, hyperlipidaemia or cervical dysplasia), illness without disease (eg, the 'worried well'—psychogenic pain without known organic pathology or unexplained medical symptoms), or disease and illness together (eg, cough and wheezing thought to be asthma by the physician but believed to be breathlessness from exercising too much by the patient, chest pain thought to be angina pectoris by the physician but muscle strain by the patient). Sometimes physicians and patients agree as to their understandings of disease and illness; sometimes they do not. Sickness relates to patients' behaviours in respect to states of health or illness, specifically 'how a person's social role is defined or changed by social norms and institutions' (figure 6).[24]

A core therapeutic task is developing shared trust in the physician-patient relationship. Physicians can facilitate this development by eliciting patients' perspectives about their illnesses. Patients often have their own beliefs, worries and fears about what they think may be causing their symptoms (ie, illness explanatory models).[22] Also, they commonly have concerns about how illness will affect their lives and

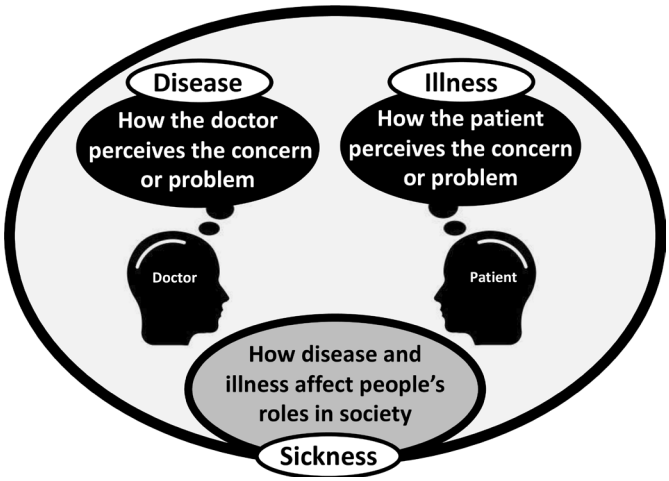

Figure 6 Disease versus illness versus sickness.

functioning. Hearing patients' stories—and through them patients' beliefs about their illness explanatory models—can help physicians uncover the underlying reason or reasons for clinical visits and help guide further treatment, management and health education plans.

Conflicting understandings of disease and illness can result in suboptimal patient experiences, low patient satisfaction and non-adherence to treatment plans. Such conflicts may also increase physician dissatisfaction as well. By demonstrating mutual respect, empathy and compassion, physicians can negotiate a shared understanding of the goals and expectations for clinical encounters. Seeking and achieving common ground—to whatever degree possible—can improve healthcare outcomes and increase satisfaction on both sides of the stethoscope.[25 26]

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THE BIOPSYCHOSOCIAL MODEL

Kathy Zoppi and Peter Catinella

The biopsychosocial model—a conceptual derivative of systems theory—offers physicians a way of integrating a whole-person perspective into the care of patients and decision-making about treatment plans.

Systems theory is the concept that the whole is greater than the sum of its parts. The parts, both natural and man-made (eg, environmental conditions, historical events, individual human beings and their respective beliefs) exist as independent factors that collectively form a unified web of existence that is both conditioned by and adaptable to changes affecting any other part of the web.[27]

The biopsychosocial model applies systems theory to the practice of medicine and informs physicians' understandings of the emergence and course of diseases.[28] During this ascendent time of disease theory (as informed by the control of infectious diseases, the emergence of genetics and the professional dominance of subspecialty care), the biopsychosocial model gives physicians a lens to appreciate patients' presenting concerns from a holistic point of view. It also enables physicians to better appreciate how their patients adapt to illness, giving insight into the intricacies of the human condition relative to the emergence and course of disease states.

Overall, the biopsychosocial model suggests that human pathology does not stem solely from physiological disorders of the body; instead, human pathology stems from a dynamic and complex network of interrelated factors that range from subatomic particles to the biosphere. The model submits that such wide-ranging factors contribute in some way to the development, function and outcome of patients' presenting concerns. As its name implies, it also endorses a broad awareness of how patients get sick and—hopefully—return to health; this awareness is not strictly limited to biomedical considerations and integrates the numerous psychological, social and environmental factors that influence patients' lives.

The initial description of the biopsychosocial model highlighted how psychological and social factors influenced patients developing and presenting with symptoms unexplained by narrowly defined biological mechanisms. It offered a heuristic device for physicians to contextualise diagnosis and treatment for those patients whose concerns did not fit into conventional biomedical reasoning (figure 7).

Soon after its introduction into the medical literature in the late 1970s, however, family physicians embraced the model as a guiding principle for the kind of care they sought to extend to all patients.[29] This was especially important given the reality that patients in generalist practices commonly present with poorly defined, undifferentiated problems. The biopsychosocial model also fit well with family medicine's countercultural resistance to professional overspecialisation, which arose out of a reductionist biomedical understanding of medicine and medical care, the discipline's evolving focus on family systems, and the impact of multigenerational family dynamics on health and illness.[30 31]

Subsequently, the biopsychosocial model led the way for the development of patient-centred care, relationship-centred care and shared decision-making, all of which have focused treatment decisions not solely on physicians' diagnostic reasoning, clinical judgements and

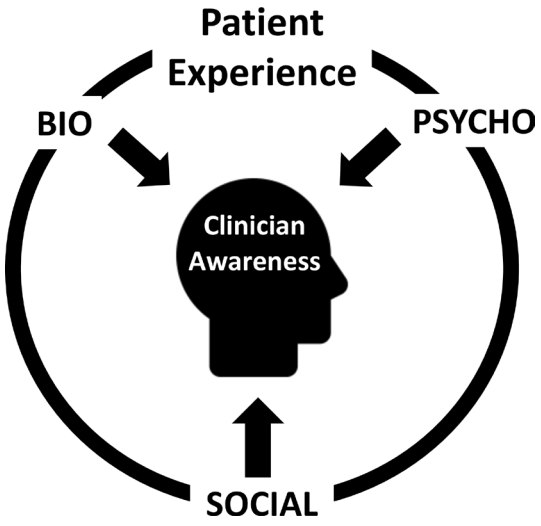

Figure 7 The biopsychosocial model.

therapeutic preferences but also on the metaphorical space between patients and physicians.[32–34] It has also expanded to include numerous other determinants of health, including culture, spirituality, environment and what we now refer to as social determinants of health (such as poverty, geographic isolation and racism).

Early on, the biopsychosocial model offered physicians—mostly family physicians and other generalists—a radical new way to conceptualise their care of patients, affecting not only the focus of clinical care but also the way in which physicians communicate with patients. Since then, it has opened the door for physicians of all disciplines—family physicians and subspecialists alike—to acknowledge that to practise effectively, they must hear and recognise the different experiences, beliefs and circumstances of the patients in their care.

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THE BIOPSYCHOSOCIAL APPROACH

Bill Ventres and Rich Frankel

The biopsychosocial model provides a framework for considering the many factors that influence patients' illness presentations. Whether and how family physicians use it in practice depends on their willingness to integrate its principles into their own understanding of humanistic care.

The biopsychosocial model grew out of systems theory as a way of conceptualising the range of factors that affect patients' illness experiences and clinical presentations.[28] Although initially the model focused attention on the interplay between patients' emotional responses and physical symptoms, its application has expanded to involve multiple clinical settings with relevance to a variety of diagnoses. The biopsychosocial model has also embraced, and been embraced by, other approaches to holistic clinical practice, including patient-centred and relationship-centred care.[32]

As the model has matured, it has become clear that what patients bring with them to their encounters and the personal and professional experiences that clinicians bring into the examination room are equally important.[35] Clinicians are influenced by the physical conditions in which they live and practise; their own emotional and cognitive understandings of illness and health; family, community and professional connections; spiritual beliefs; and the environmental conditions in which they live, among others. These same factors influence whether clinicians are willing to be vulnerable and open their eyes, ears, hearts and minds to the realities of their patients' lives beyond their presenting concerns (figure 8).

Such considerations transform the biopsychosocial model into a bidirectional approach to practice, one that places value on the organically produced insights that emerge both moment to moment in the evolution of clinician–patient encounters and, through thoughtful reflection, over the course of a career.[36] In this way, the biopsychosocial model is not set in stone. Rather than encourage physicians to primarily focus on the factors that patients bring to their encounters with physicians, the biopsychosocial model encourages physicians to maintain an attitude of curiosity and lifelong learning. In doing so, crucial questions often arise[36]:

- What are the lenses through which I recognise and understand the patients' presenting concerns, and how do they influence my cognitive and affective

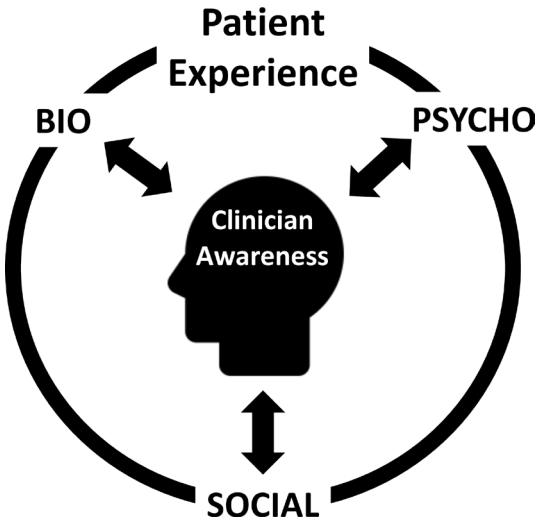

Figure 8 The biopsychosocial approach.

abilities to respond to patients' clinical realities accurately and honestly?
- How does my ability to verbally and non-verbally communicate with my patients either nurture or inhibit the development of trust, confidence and therapeutic efficacy, especially considering how these characteristics are coproduced between us?
- How can I use the biopsychosocial approach to connect my experiences of the culture of medicine in which I trained with the lived experiences, hopes and dreams of the patients I see every day?
- How can I incorporate emotional intelligence, adaptive expertise and clinical courage into my therapeutic repertoire? How can I use these skills as instruments of therapeutic change?
- How can I use the biopsychosocial approach to grow my professional awareness and my personal satisfaction with the work I do and how I do it?

Wise clinicians, among them many past and present family physicians, have attended conscientiously to such questions without having ever heard of the biopsychosocial model as a heuristic for understanding patients or as a guide for cultivating wellness on both sides of the stethoscope. Just as kindness, compassion and wellness go by a variety of names, we encourage clinicians, in particular generalists, to use heart, head and hands in a variety of healing ways to improve their patients' health while simultaneously attending to their own joy in the practice of medicine.

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FAMILY MEDICINE AS SOCIAL MEDICINE

Shailey Prasad

The discipline of family medicine embodies the tenets of social medicine: family physicians are present with patients and communities in times of sickness and health.

For centuries, we have understood that social conditions contribute to illness. This concept and the field of social medicine—a social science focusing on illness-generating social conditions—originated from the seminal work of the 19th century German physician Rudolf Virchow.[37] In addition to presenting observations and statistical data about the link between social conditions and illness, Virchow was also politically active, often advocating for a better state of affairs.

One area of present debate is the difference between social medicine and traditional public health. Whereas traditional public health approaches health issues analytically (eg, arithmetic rates form the basis of epidemiological phenomenon), social medicine perceives populations as social structures where the characteristics of the structures transcend that of the individual constituents.[38] A corollary of this is that social medicine looks at the gap between health and illness as a dynamic, multidimensional process rather than a discrete dichotomous category.[39]

The three cardinal principles of social medicine include the following[40]:
- Social and economic conditions profoundly impact health, disease and the practice of medicine.
- The health of the population is a matter of social concern.
- Society should promote health through both individual and social means.

Particularly in the USA, family medicine started as a countercultural movement to return healthcare to communities and eliminate ongoing barriers to care.[30] At the core of this essential primary care discipline was—and is—the premise of relationship building. This is accomplished by maintaining continuity of care in an intensely personal, family-oriented and comprehensive way.

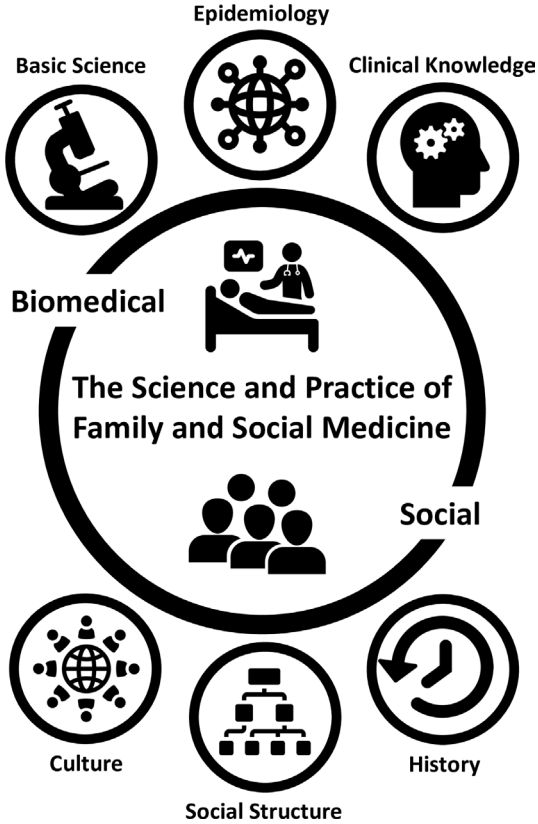

Figure 9 Family Medicine … social medicine.

The growth of family medicine has paralleled certain unfortunate trends in healthcare—growing consumerism, the prohibitive cost of healthcare, the growth of large hospitals and an emphasis on sophisticated care structures. While the development of newer, often more expensive modes of care can be beneficial to individual patients, there is an ongoing recognition that these innovations are unavailable to many in our society due to issues of access, acceptability and the tertiary and quaternary orientation of medicine.[41]

Family medicine plays an important role in reversing these trends. It embodies the tenets of social medicine by sitting at the interface of the healthcare system, patients and community. It advocates for policies that influence the social and political determinants of health. It works to build and sustain health-promoting relationships with patients over time.[42]

Although not a panacea for all that currently ails the healthcare system, at its best family medicine is what social medicine is all about (figure 9).

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