Core Values of Family Medicine

"Core means essential to the discipline irrespective of the healthcare system in which they are applied" (WONCA Europe 2011).

> "The development of family medicine and its identity as a discipline has been grounded in the core values of continuing, comprehensive, compassionate, and personal care provided within the context of family and community. …They have shaped the identity of individual family physicians and contributed to establishing a legitimate position for family physicians in academia and in the larger medical community. A challenge to the specialty is to articulate these core values in a sufficiently distinctive way so they are recognized by the public as central to what patients seek from their personal physician."
> (Martin et al 2004)

This session is necessarily long as the core values are very important to the discipline of family medicine and there are several of them. Complicating this, family doctors have different (even controversial) opinions among themselves about these values, especially in the past decade. The interpretation and definitions of these values have been changing over time. You might perhaps read through this session in two or even three separate occasions, especially the supplementary readings. Read the materials critically and pause here and there to ask yourself, "What are my opinions?"

I include and discuss as the core values of family medicine the following:
1. Personal care by the doctor
2. Compassionate relationship-centred care
3. Comprehensive and holistic care
4. Continuity of care
5. Coordinated care

1. Personal Care

The word "personal" could be taken to mean the patient or the doctor. Family medicine differs from other medical specialties in that it takes care of the patient's whole person. Its care is not limited by organs or systems, not by types of disease (acute, chronic), not by types of management (curative or palliative) and not by status of health (healthy or ill). Family doctors are thus (the patients') personal doctors.

The family doctor commits to give his/her personal care to patients in their personal perspectives. There are at least two persons: the doctor and the patient. Note the word "commit"; it means more than "do". In McWhinney's words (1998), it is a covenant: "A covenant is an undertaking to do whatever is needed, even if it goes beyond the terms of the contract" and "there are strong moral obligations and mutual commitments". The commitment is "to the person, not to 'the person with a certain disease'".

> "For the family physician, the challenge is not simply to treat diabetes, nor is it to treat Mrs Jones' diabetes, bursitis, depression, vaginitis, and

Handout

> 16-year-old son on drugs. The challenge for the family physician is to take care of Mrs Jones."
> (Phillips & Hayes 2001)

"Being there for patients" is the essence of the family doctor's personal care.

> "There are, however, predictable points in the life cycle of the individual and family where the family physician fits uniquely into the experience of health and illness. These nodal points include pregnancy and childbirth, the newborn child, lifethreatening and life-altering illness, loss and grief, and care at the end of life. Being there for the patient and family at these times is part of the privilege and the process of family practice. No substitute suffices. You can pretend to know, you can pretend to care, but you cannot pretend to be there. It is by being there for patients that family physicians provide the things patients seek: touch, trust, understanding, comfort, and healing."
>
> "What keeps the doctor devoted to the patient is the reflection at the end of the demanding day that he or she made a difference in the life of an important person, the patient. For the family physician, this reward is enhanced by understanding the patient's life, knowing the family, and living in the community."
> (Phillips & Hayes 2001)

2. Compassionate relationship-centred care

(A) Patient-centred care

"Patient-centredness" is strongly emphasized in discussions of consultation skills. While patient-centred care and patient-centred consultation are very similar in principle, there are theoretical and pragmatic nuances between the two. For clarity, this discussion spotlights patient-centred care (not consultation).

Definition

Though popular, patient-centredness lacks a universally agreed definition. "When defining patient centeredness, authors thus seem to have defined good care and communication. And, as a result every element in care that was considered good may have been called patient centred. Thus, a circular process seems to have evolved" (De Haes 2006). Mead and Bower (2000) and later Morgan (2012) reviewed the literature and collected several definitions or descriptions. Several components and terms are included:

- biopsychosocial perspectives of illness [patient's perspective of illness]
- patient-as-person [respect, individualized management plan)
- sharing power and responsibility [empowerment, autonomy, self-confidence]
- prevention and promotion of health
- doctor-patient relationship [therapeutic alliance]
- being realistic [about limitations of the healthcare system and the doctor)

The list above shows the complexity, if not the confusion, involved.

The important components of patient-centredness are taking patient's perspective and activating the patient to participate. In this respect, Wissow's definition is good:

> "Patient-centeredness is a philosophy of care, a characteristic of clinical encounters, and a set of clinician behaviors. Core components include a commitment to elicit and understand the patient's perspective and social context, basing treatment on a mutual vision of issues and goals, and facilitating patients' involvement and responsibility to the extent they desire it."
> (Wissow 2006)

Precautions

Patient-centredness could be considered as a concept as well as an approach. If we take it as an approach (e.g. in consultation), we must be flexible and tailor the approach to individuals. Using the same approach for every patient is in itself not patient-centred. A patient may, and have the right to, choose not to be involved in the decision-making of management options. A patient may have difficulties in making choices. The family doctor does not shed his/her responsibility to the patient but respect the patient's autonomy. De Haes (2006) claimed nine arguments against patient-centredness:

1. Patient-centeredness may not always be preferred
2. Patient-centeredness may not necessarily be effective [in general]
3. Patient-centeredness may not be effective under certain conditions
4. Patient-centeredness may not be effective for certain patients
5. Information may not necessarily be wanted [in general or specific conditions]
6. Information may not be wanted by some patients
7. Shared decision making may not be applicable
8. Patient may not want to have a choice
9. Patient may have to be dissuaded from taking a certain [irrational] decision

He pointed out five patient characteristics that make a patient *not* prefer, at certain points of life at least, a patient-centred care. These are older age, ethnicity, lower level of education, high anxiety level, and poor disease prognosis. It must be noted that without knowledge of the individual patient, patient-centredness has little meaning.

> ***Assignment 1:*** *Read the nine "none-supportive findings" and Fig. 3 in de Haes's article (pp. 293-295), "Dilemmas in patient centeredness and shared decision making: A case for vulnerability. Patient Education and Counseling 2006;62: 291–298". Write a case summary (300-500 words) of a patient of yours to illustrate one of the nine non-supportive arguments listed in the article.*

("Patient-empowerment" is probably the better term for the "patient-centeredness" discussed by de Haes (2006). "Patient-empowerment" will further be discussed in the Consultation Session.)

If patient-care is to be individualized as proposed by patient-centred care, "care should then be organized by patients' personal needs and preferences instead of

institutional standards or routines (Morgan 2012)". Family doctors have to balance the individual needs against the clinical practice guidelines (the "institutional standards"); the latter are derived from experts' opinions and population studies.

The term "patient-centred care" could be misunderstood as consumerism and does not describe in full the mutually beneficiary relationship between the doctor and the patient. This will be further discussed under doctor-patient relationship.

(B) Compassion — the family doctor-patient partnership

"General practice defines itself in terms of relationships, not in terms of diseases or technologies" (McWhinney 1998). This relationship is a special relationship, not to be described as retailer-and-customer or service-provider-and-clients. It is an ongoing (continuous) partnership ("mutual investment") that benefits all parties (win-win situation to doctor, patient and community). Compassion is sharing other's feelings.

Szasz and Hollander described three theoretical models of doctor-patient relationship in 1956: (1) activity-passivity (parent-infant model in which the doctor has complete control), (2) guidance-cooperation (parent-child model in which the patient has limited power and is expected to cooperate), and (3) mutual participation (adult-adult model in which both the doctor and patient are aware of the other's needs, wishes and individuality and participate for their common good).

"None of these three models is claimed to be better than the others; each has its place and each may be inappropriate at times" (Toop 1998). Different patients, and a patient at different times, may choose to take one of the three relationships with their doctors. For example, in an acute and life-threatening situation out of the patient's control, the patient might choose to have total dependency on the doctor. In other situations, the patient might wish to have all relevant information about the situation together with the doctor's experience and opinions, and make his/her own decision after discussion with the doctor. Throughout the patient's adult life-time, a mutual participation relationship is the one most preferable with the doctor.

The doctor-patient partnership relationship is a concept. Put into clinical activity, this is relationship-centred care (RCC).

> "RCC can be defined as care in which all participants appreciate the importance of their relationships with one another. RCC is founded upon 4 principles: (1) that relationships in health care ought to include the personhood of the participants, (2) that affect and emotion are important components of these relationships, (3) that all health care relationships occur in the context of reciprocal influence, and (4) that the formation and maintenance of genuine relationships in health care is morally valuable." (Beach & Inui 2006)

Leopold et al. defined the features of such sustained partnership that are partially quoted below (Leopold N, Cooper J, Clancy C. Sustained partnership in primary care. *J Fam Pract* 1996;42:129-137. [See Toop 1998]):

- Whole person focus
- Clinician's knowledge of the patient — personal history, family, work,

Trial Version

> community and cultural context, preferences, values, beliefs, and ideals about health care, including preferences for information and participation in clinical decision making
> - Caring and empathy
> - Patient's trust of clinician
> - Appropriately adapted care — to reflect the patient's goals and expectations
> - Patient participation and shared decision making — to the extent that the patient wishes
>
> (Toop 1998) [Though Toop's article was entitled "patient-centred primary care", he actually discussed "mutual participation" and "partnership".]

This partnership or mutual participation relationship is not new. It can be traced back to 1950s when Michael Balint talked about the relationship as a "mutual investment company".

> "Both patient and doctor grow together into a better knowledge of each other." The relationship is a "mutual investment company". "The general practitioner gradually acquires a very valuable capital invested in his patient, and, vice versa."
> (Michael Balint 2000, p. 250)

Michael Balint also introduced the concept of "drug doctor" that the doctor has built up such a rapport with the patient that the doctor could make himself or herself as a "drug". To achieve such a therapeutic relationship, the doctor has to (a) respect the patient (the person, the wishes) and (b) dedicate to work in the patient's best interests (including commitment for confidentiality and to do no harm, WONCA Guidebook 2002). This relationship is a challenge to every doctor. It does however suggest the desirable standard of the doctor-patient relationship: one that could enable the doctor to help the patient to change to health or better health.

> "Clinicians should not, for example, simply act as if they have respect for someone; they must also aim actually to have (internally) the respect that they display (externally)."
> (Beach & Inui 2006)

Of the doctor, the patient, and their partnership, the "doctor" is the least studied and least aware of element. Doctors must beware that they themselves are part of the cast and their personal characteristics, emotions, values, etc. play an important role in the process.

> "Physicians' personalities, personal histories, family and cultural backgrounds, values, biases, attitudes, and emotional 'hot buttons' influence their reactions to patients. Unrecognized feelings and attitudes can adversely affect physician-patient communication … and endanger the physician-patient relationship.
>
> Because physicians use themselves as instruments of diagnosis and therapy, personal awareness can help them to 'calibrate their instruments,' using themselves more effectively in these capacities. We define physician personal awareness as 'insight into how one's life experiences and emotional make-up affect one's interactions with patients, families, and other professionals'."
> (Novak et al. 1997)

Free Essay

In summary, the family doctor's relationship with patients is a partnership one, with dedication, respect and trust. This relationship builds on the understanding of the self and the other party. The results are: the patient is ready to reveal himself/herself, and the doctor is a drug.

Barriers to doctor-patient relationship

The patient, the doctor and the healthcare system individually and/or in combination affect the nurturing of the doctor-patient relationship. They affect one and other. Some doctors feel secure in being information dispatchers while some patients feel secure only with casual and short relationship. The healthcare system could become barriers by inadequate provision of time and/or continuity for the doctor and the patient.

> "Lack of time has become one of the catchphrases of health care in the 1980s and 90s. How can constructive, efficient, caring, and healing relationships be built up with more than a thousand individuals in a series of short and intermittent general practice consultations punctuated by constant interruption and coloured by anticipatory stress of further work commitments?"
> (Toop 1998)

> "Many patients and physicians are torn by factors that pull them in opposing directions for and against patient empowerment. Such diversity of expectation suggests that a 'one communication approach fits all' model will lead to frustrations and problems on both sides."
> (Lang 2000)

Read the article by Lang F ("The Evolving Roles of Patient and Physician." Editorial. Arch Fam Med 2000;9:65-66) to know more about the patient- and doctor-factors impeding the development of the partnership relationship. Also read the clinical vignette by Glazer JL ("Customer Disservice?" Annals of Internal Medicine 2006; 144:61-62). Do you find Dr. Glazer's "case" familiar? Did you meet/see/hear similar vignettes in your practice last week or last month? Why do family doctors call their relationship with patients "compassionate"?

I suggest you make a break here before you read on. Think critically over what you have read so far and make your own conclusions. What kind of relationship do you wish to have with your patients?

3. Comprehensive and Holistic Care

Family doctors look after people, not part (e.g. organ, system) of a person but the whole. The words "comprehensive" (廣泛的，綜合的，全方位的) and "holistic" (整體的) *both* refer to wholeness. "Comprehensive care" is easy to understand: "Since family physicians are available for any type of health problem, the care they provide is comprehensive" (McWhinney 1989, p. 19). Unfortunately, different people now use "holistic care" with different meanings, even to the extreme of "anything outside traditional allopathy" [every alternative/complimentary health/medical care] (Freeman

2005). The Longman Modern English Dictionary defines holism as: "life as concerned with the making of larger and larger organic wholes, greater than the sum of their parts". The Oxford Companion to Medicine defines holistic medicine as: "a discipline of preventive and therapeutic medicine which emphasises the importance of regarding the individual as a whole being integral with his social, cultural, and environmental context rather than as a patient with isolated malfunction of a particular system or organ".

The WONCA Europe definition of general practice / family medicine (2011) defines "comprehensive approach" as a core competence that includes the ability:

- to manage simultaneously multiple complaints and pathologies, both acute and chronic health problems in the individual
- to promote health and well being by applying health promotion and disease prevention strategies appropriately
- to manage and co-ordinate health promotion, prevention, cure, care and palliation and rehabilitation

It also defines holistic modelling as a core competence separate from comprehensive approach as the ability:

- to use a bio-psycho-social model taking into account cultural and existential dimensions

In this way, WONCA Europe makes a clear distinction between comprehensive and holistic care.

The holistic model

Dr. George Engel first formulated the biopsychosocial model in 1977 (Engel GL. The need for a new medical model: a challenge for biomedicine. Science 1977;196: 129–135). Engel's critique of biomedicine (Borrell-Carrio et al. 2004) included:

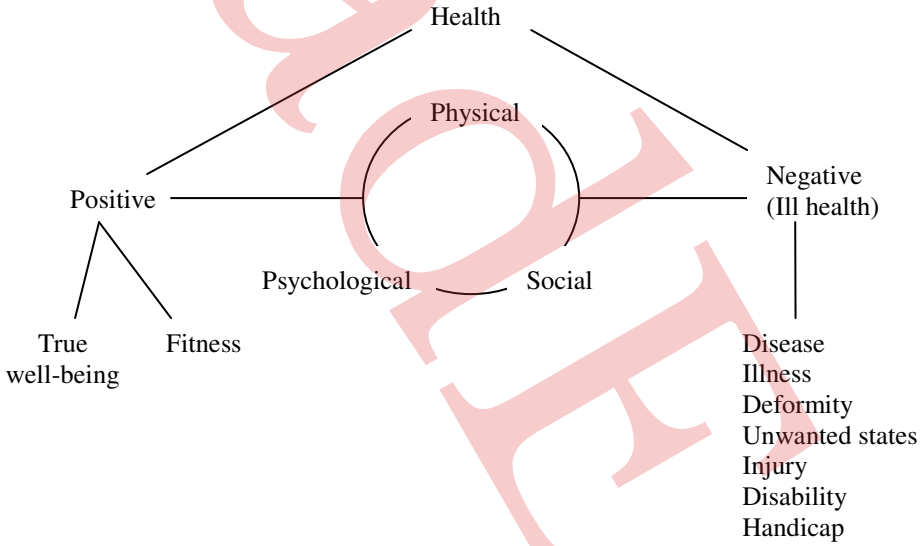
1. An illness results from the interaction of "molecular, individual, and social" factors. Psychological disturbance may manifest as a biochemical illness.
2. The derangement does not shed light on the meaning of the symptoms to the patient.
3. Psychosocial factors are important determinants of susceptibility, severity, and course of illness.
4. "Adopting a sick role is not necessarily associated with the presence of a biological derangement".
5. "The success of the most biological of treatments is influenced by psychosocial factors", e.g. the placebo effect.
6. "The patient-clinician relationship influences medical outcomes, even if only because of its influence on adherence to a chosen treatment".
7. "Unlike inanimate subjects …, patients are profoundly influenced by the way in which they are studied, and the scientists engaged in the study are influenced by their subjects" [equivalent to the argument for double-blind studies].

Later on, cultural (ethnic) and existential (spiritual) aspects are added to the biochemical, psychological and social triad.

The total health

For convenience, I shall call the biochemical-psychological-social-cultural-spiritual model the holistic model. What is the relationship between this model and health? Is the interaction of the five elements of the holistic model "health"?

World Health Organization (WHO) defines health as a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity. According to Downie et al. (1996), the WHO definition consists of two parts: positive (complete well-being) and negative (absence of disease or infirmity). They proposed a new model of health in which health is classified into positive and negative. Positive health comprises true well-being and fitness. True well-being is the state of having a "good life" (e.g. satisfaction of material needs, being able to choose what one wants to do, having control of one's life). Fitness is the state (strength, stamina, suppleness and skills) to perform daily tasks without undue physical discomfort.



"Wellbeing" is difficult to define but the concept encompasses positive physical, psychological and social states. The model of health by Downie et al is related to the concept of positive living. In many metropolitan cities, people without physical diseases but thinking that they are "not well" or "not well enough" spend tons of money on "health supplements" rather than healthy activities. Positive living is not just a concept but a behaviour or life style that leads to wellbeing.

Not everyone agrees with WONCA Europe in separating out holistic care from comprehensive care ("approach"). Some use "comprehensive care" to represent both. Let us keep away from debates on the glossary and have clear concepts. *The family doctor's care to patients spreads across dimensions of humanity (physical, psychological, social, cultural, spiritual), body systems, acute or chronic illnesses, all modalities of management (cure, rehabilitation, palliative, education, prevention and promotion), and different stages of life. This whole-person care (if I could call it such) is "whole-life" in the sense that it spans over the whole lifespan of the person, not confined to a single episode of illness or stage in the family/life cycle*. This leads us to the next core value of family medicine — continuity of care.

Hippocrates

4. Continuity of Care

The Webster Dictionary defines "continuity" as "uninterrupted connection". In 2003 Saultz reviewed the medical literature and found "little uniformity in how continuity of care has been defined by different authors". As early as 1980 Barbara Starfield pointed out that national or international bodies should define this important concept in order to avoid confusion in communication. Because of such diversity, I shall elaborate this topic more.

Due to the confusion in the meaning given by different authors, continuity of care may mean different things to different people. A few common ones include:

- Longitudinal continuity
  Care given by a doctor over a defined period of time (Freeman & Hjortdahl 1997)
- Personal continuity
  Ongoing therapeutic relationship between patient and doctor (Freeman and Hjortdahl 1997)
- Provider continuity
  The same attendees making visits to the same clinician(s), service, or facility as an uninterrupted succession of events over time (Buetow 2004)
- Informational continuity
  "Information on prior events is used to give care that is appropriate to the patient's current circumstance" (Reid et al. 2002)
- Management continuity
  "Care received from different providers is connected in a coherent way. … usually focused on specific, often chronic, health problems" (Reid et al. 2002). This can be achieved by compliance to the management guidelines.

Reid et al (2002) also named a "relational continuity" that in fact is the same as "personal continuity" by Freeman and Hjortdahl (1997)

Key features of continuity

McWhinney put responsibility as the key feature (obviously, the continuity meant by McWhinney is the personal continuity) and summarized family doctors' continuity of care best:

> "Continuity in family practice is an unbroken responsibility to be available for any health problem through to the end, whatever course it may take. Obviously, the physician cannot be available personally at all times, nor can he or she personally carry out all the care that the patient may need. The key word here is *responsibility*." [McWhinney's italics]
> (McWhinney 1989, p. 16.)

Saultz added one more feature, trust. He defined interpersonal [personal] continuity of care as: "Interpersonal continuity refers to a special type of longitudinal continuity in which an ongoing personal relationship between the patient and care provider is characterized by personal trust and responsibility" (Saultz 2003). The key features of continuity are not just the person (doctor or patient) and duration of time. The most important feature is the doctor-patient relationship, the mutual understanding of each other.

> "Interviews in both pilot and published studies have found some patients with a clear identity of their personal doctor even though they had not consulted him or her for a long time. Likewise in Norway some patients reported the feeling of personal doctoring after only a few consultations with a new general practitioner, while others had not attained this after several years of contact with the same doctor."
> (Freeman & Hjortdahl 1997)

> "A common methodologic problem in continuity research is confusion about the difference between knowledge of the patient and a relationship with the patient. One can know about a patient by reading a medical history, but knowing a patient's medical history does not imply any relationship with that patient."
> (Saultz 2003)

Wun (2008) illustrated how longitudinal continuity could exist without interpersonal continuity in an article entitled「二十年了，他是我的家庭醫生嗎?」

Evidences for continuity

Gray et al. (2003) gives a very good review on the research evidences of continuity of care in family practice and their article should be read. Here, I just summarize the "theories" of continuity of care for which Gray et al. presented the research evidences.

Good effects to patients

- Patients who get to know their doctor over time become more willing to disclose potentially embarrassing information
- Familiarity eases communication
- Continuity favours preventive care
- Continuity of care is associated with better diagnosis
- Continuity reduced later use of healthcare, perhaps through health education
- Personal continuity results in better adherence to advice
- Patients value continuity
- Continuity increases patient satisfaction
- Personal continuity is associated with better health outcomes
- Personal continuity is associated with better quality of care

Good effects to doctors

Consultations with familiar patients are shorter than with new ones, and extensive work-ups are less often needed.

Good effects beyond primary care

Continuity in primary care reduces demands on hospital services through more rational referral. (This is supported by De Maeseneer et al.'s finding (2003) that continuity with a family physician is related to lower total health care costs.)

Adverse effects of personal continuity

- "When an illness has progressed slowly, a doctor who has seen the patient regularly may miss a diagnosis that is obvious to a newcomer. Continuity may also lessen the doctor's objectivity, adversely affecting decisions on investigation, and generating reluctance to avoid confrontation."

Thesis Essay

- "Patients with insoluble problems can leave the doctor feeling frustrated, and this is made worse by long-term continuity. Eventually, the patient rather than the illness may come to be seen as the issue."

Barriers of continuity

Of the core values of family medicine, continuity of care is most vulnerable to abuse by changes in the healthcare system (particularly the growing number and size of group practices, and the rise of consumer movement). Many family doctors are not practicing personal continuity of care due to restraints imposed by the managed-care systems that do not put personal continuity as a priority above informational continuity.

> "Management's drive for efficiency can threaten relationships by rigidly defining professional roles and by penalising practitioners who step outside their role. No doubt it is inefficient for a doctor to attend to an old person's callosities and toenails, but it is through such little services that relationships are built. Some doctors and nurses may have special expertise in managing asthma, diabetes, or advanced cancer, but this does not mean that every one of these patients has to be transferred to their care. A patient's relationship with the primary care practitioner may be broken if there is poor coordination between primary, secondary, and tertiary care sectors. The organisation of a practice may itself be an impediment to continuity."
> (McWhinney 1998)

> "[The health care system] is increasingly designed to destroy continuity of care." "These ruptures in continuity destroy critical connections in the doctor-patient relationship. They affect the child whose growth and development is abnormal, the teenager who needs to discuss birth control with a trustworthy figure, and the woman with multiple symptoms whose family doctor has provided extensive listening."
> (Candib et al. 2001)

Some large practices emphasize "practice continuity" as continuity of care. This site or practice continuity is not personal continuity. Mainous III and Gill (1998) studied the difference between clinician (personal) continuity and practice (site) continuity. They concluded that practices without clinician continuity might not ensure cost-effective care:

> "The results of this study confirm that continuity with a clinician decreases the likelihood of future hospitalization. Moreover, high continuity with a site but low continuity with a provider was not significantly different than having low continuity with an individual clinician.
> ...
> The information available at a health care site does not match the accrued knowledge between patients and physicians."
> (Mainous III & Gill 1998)

Continuity of care is not just to know the patient's past. It is relationship-centred care that leads to better outcomes in patient's health and the community's healthcare system. It is an investment by the doctor, the patient, and the healthcare system. The investment gives good returns.

Assignment 2: *Take five patients with chronic illness. For each patient, write a short case summary under the following headings:*

Patient # 1, 2, 3, 4, 5
Sex / Age
Occupation
Social habits
Past medical health
Family history
The single person as the main link with the patient (e.g. care taker, informant)
Genogram
Chronic problems
Chronic medication
Patient's belief of his/her health and illness
Present health status (e.g. control of the chronic illness)
On-going care plan and management goal
Tailored education in self-management
Personal barriers and support

5. Coordinated care

The Future of Family Medicine report (Martin et al 2004) calls for "a personal medical home" for every one; this "home" serves as a focal point for coordinating health care across multiple specialties and medical disciplines. With the increasing prevalence of chronic and co-morbid illnesses and the enlarging elderly population, the maintenance of health in a person or community puts increasing demand on medical and social resources. The concept of coordination of care also changes over time. It could be taken as (Uijen 2012):

- arranging things "in proper position relatively to each other and to the system of which they from parts",
- "keeping each other up to date by effective communication and linking different programmes and activities", and
- "the delivery of services by different care providers in a timely and complementary manner in order to achieve connected and cohesive patient care".

The goals of coordination are to

> 1) gain access to and integrate services and resources, 2) link service systems with the family, 3) avoid duplication and unnecessary cost, and 4) advocate for improved individual outcomes
> (Committee on Children With Disabilities 1999).

"Integration" has a slightly different connotation. "The aim of integration was to provide unity by working together. To ensure integration, care providers needed to

establish common objectives, identify specific characteristics of the team members and it is necessary that the organization facilitates optimal cooperation, coordination and communication" (Uijen 2012). The family doctors' biopsychosocial approach and their breadth of knowledge and skills distinguish them from other specialties in coordinating health care to patients as well as the community.

Coordination may be horizontal, e.g. an elderly patient living-alone and with poorly controlled diabetes mellitus needs the expertise from the endocrinologist, dietitian, ophthalmologist, and home-helpers. Coordination may be vertical, e.g. a patient of chronic obstructive pulmonary disease discharged home from hospital after an acute exacerbation needs supervision for ambulatory oxygen, and modification of home condition for easy mobility.

Cost-effective coordination of care requires

1. Knowledge of the patient and available resources (medical, social, community)
2. Good communication (among different disciplines, as well as between patient and the care providers)
3. Patient-centred management (individualized management according to needs and backgrounds, and involvement of the patient for self-management)
4. Support systems that facilitate coordination (medical records, information transfer).

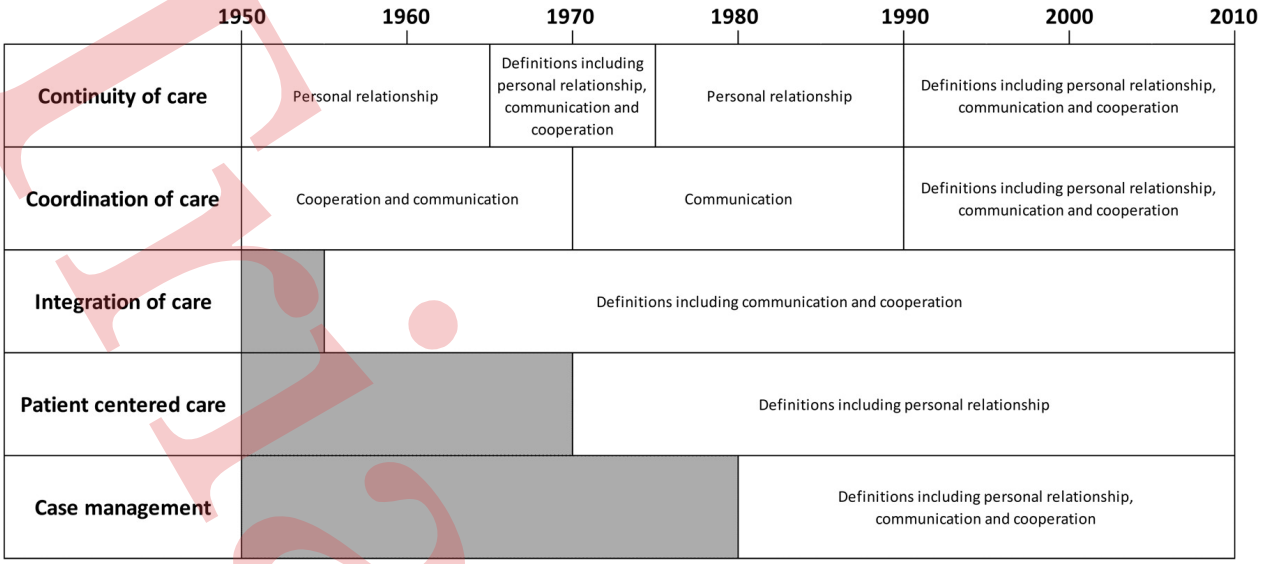
It is obvious that the healthcare system and its components must entrust the family doctors to take the coordination role and the family doctors must have the confidence, knowledge and skill to put different components in smooth gear. Unfortunately, these do not often happen.

Epilogue: the tradition and the modern trend

Asians and Caucasians are different in physical appearances. Inside them however are a set of genes that identify them as humans, not chimpanzees or apes. Family doctors are very much different among themselves in knowledge, skill, attitudes and styles. But they should share the same core values that identify them as family doctors. The core values are classic in the sense that they stand the test of time.

We have discussed the core values separately. You probably have noticed that each core value is related to (or entangled with) one and other. Personal care builds on relationship, and should be comprehensive. Relationship builds on continuity, and continuity enhances comprehensive care. Coordination of care should be patient-centred and needs good knowledge about the patient. The art of family medicine is assimilating these values into a whole solid piece.

What have been discussed above could be considered as the "traditional" views inherited from the pioneers of family medicine and still valued to date by many family doctors as the core of their discipline. The healthcare systems and the populations in the present world are changing. It is unknown whether, or how many of, the family doctors have changed their attitude. Uijen et al (2012), after extensive literature search, summarize the evolution and the definitions of these core elements of care in the following figure.



The core values of our discipline constitute what we are and should be the very last thing to change unless we wish to change our very nature, our identity.

> "Expectations are changing and the differences between the two ends of the spectrum, from the traditional practice to the one-stop McHealthcare, are widening. Caring for a diverse population is becoming increasingly complex. The generalist has to cater for an ever widening range of patients' expectations and develop the skills needed to switch between styles of interaction."
> (Toop 1998)

What a provocative (for serious thinking) and innovative term "McHealthcare"!

Nursing Essay

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* Supplementary Reading

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