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FAMILY MEDICINE QUARTET

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ABSTRACT

Family medicine is a unique medical discipline centred on the patient and the doctor patient relationship. In this essay I use an arts based inquiry juxtaposing clinical narratives to illustrate the clinical philosophy of Ian McWhinney.

KEYWORDS: Narrative Medicine, Family medicine, Patient centred medicine

In honour of my mentors: Dr. Ian McWhinney (1926-2012), father of Family Medicine, Dr. Mark Yaffe, my first family medicine teacher (who introduced me to Ian McWhinney), and Joan Foster, home care nurse extraordinaire.

The College of Family Physicians of Canada recently celebrated its 60th anniversary. That milestone, led some family physicians to pause and reflect on their professional roots, and also to project about the future. Engaging in some of that introspection, myself, I chose the field of family medicine as a medical student in the mid 1980s, not only because I loved it all, paediatrics, gynaecology, internal medicine, psychiatry, geriatrics, etc., but because I fell in love with the philosophy of Dr. Ian McWhinney, the father of Canadian family medicine.[1,2,3]

In his 1996 Pickles Lecture entitled, "The importance of being different"[1] Ian McWhinney described four differences between general practitioners and specialists. Family doctors can take pride in defining ourselves based on our unique practice, rather than on the absence of a specialty. Family doctors are not frustrated sub-specialists, we have our own specialized training, we are family doctors.

In this essay I juxtapose narratives of practise to celebrate the importance of being different![3]

I. "It is the only field to define itself in terms of relationships, especially the doctor-patient relationship."[1]

Other fields of medicine include doctor patient relationships but they characterize themselves by disease, or organ, but family doctors will see treat a patient of any age, with or without a disease, over time. We also take care of the entire family.

The following was written by Tara McCarty, when she was a second year family medicine resident at McGill University. I include it as an illustration of relationships within family practice.

Mary (according to T. McCarty, MD, written communication, 2011)

Mary is a patient who takes longer than the usual allotted fifteen minutes. She is a 45 year old lady with AIDS, intellectual impairment, and multiple drug addictions supported by prostitution. She has no specialist to follow her AIDS because she misses her appointments, usually because she is off on a "crack binge", as she calls it. We see her at the clinic whenever she shows up, or when she calls, and we are a bit more accommodating- which, despite the inordinate time that she takes, is one of the reasons that I think we do such an excellent job here in family medicine.

I recently put her on some prophylactic Cipro. Her CD4 count is scraping 100, she is barely scraping by, and today I feel I am doing no better. I called her at home today. She missed another appointment.

Her mother answers, her mother who is not exactly very well adjusted herself. She immediately begins screaming into the phone. The vulgarities accost me.

"Do you know where my daughter has been, Dr. McCarty?! She has been out doing drugs, and doing terrible things with men, and you know exactly what I mean by that, Dr., AND, she didn't take your pills for three days." She barely stops to breathe as she goes on describing what indecencies went on.

My mind flashes back to myself as a girl in high school, to Sex Ed, to learning about why drugs are bad, to my nice quiet suburban upbringing, to my parents' dedication to me. What trick of the universe made it that we are these opposite ends of the telephone line, these opposite ends of the world? Nothing seems fair, and all I can wonder is what happened to her to make it all go so wrong?

Mary comes on the phone now to speak with me and she is crying, speaking in that childish way of hers. An old psychiatric evaluation in her chart said that due to her mental disabilities she has the intelligence of a twelve year old.

"Dr. McCarty, I have been a really bad girl, I am really sorry. I went on a crack binge again, and well, I needed to do...things...to get more money. "

I murmured some soothing sounds.

"I know you may think I'm bad. And I forgot to take your pills. But I promise you I will be good now!" She sobs out her next sentence, so that it is barely audible.

"I promise you I won't miss anymore appointments."

I tell her it's ok, and that I am sure she is trying her best, because what else am I supposed to say? She can be heartwarming and endearing in her earnest way of speaking, and, perhaps, this is one of the things that helps her....or harms her? I don't know anymore.

I am then slightly astonished at what comes next.

"Dr. McCarty, I love you for taking of me. I promise I will be a good girl now and I won't do any more drugs, and I will take my pills like I'm supposed to!"

I don't really believe her. Ten years of chart-o-megaly proves otherwise. But I know that in this moment she believes in herself and so, for just this moment, I do too. Because all we have is this moment. On that afternoon, in that hour, across a telephone line, we had faith in each other. And for that moment, it was enough.

II. "General practitioners tend to think in terms of individual patients rather than generalized abstractions."[1]

One way to portray the difference is the map versus the territory metaphor. Abstraction has given medicine the power to name and cure diseases like heart disease, and pneumonia, but at what price? Abstraction distances you from the individual and their experience of illness which in many cases can impede healing.

The following narrative of mine illustrates this.

Messy but Competent

She had a beautiful Irish accent; the vowels danced with her rolling R's and despite her medical misery she was entrancing! I was visiting Mrs. O to help the team assess mental competency and to decide whether she was able to stay in her own home or whether she needed to be placed against her will.

I noticed, big, red, pocked legs, glistening from cream, red fingers of infection going up in streaks from her right ankle. There was a big hole in her calf, as if a Doberman had bit into it; a scar from osteomyelitis two years earlier. Those were the parts of her I could see. She also had a rectal prolapse, a slimy mess that hurt each time she got up to take a few steps.

Another problem was that she wasn't taking her pills as prescribed. Some were in the ashtray on the kitchen table. The important ones, those she said really helped, were kept handy in the pockets of her thin housedress that revealed a little too much. She did seem to know all the names and reasons for the meds. I could not help but notice all those cats! One slept on the sofa, a white one slinked past me, another mewled in the corridor.

"Yes, I have to keep my sense of humour. If you want to survive... Ach, the pain is terrible when I move. Survival, life, feeling at home...is worth all the pain."

"The kids are talking about putting me in a home. I would be so worried about the animals. Who would take care of them?"

I couldn't stand the thought of her locked up in a residence but the apartment was so messy and those pills. I told her there are places that allow pets.

She smiled at my folly.

"Maybe, but where could I go with my little darlings? " she asked, illustrating that she was coherent.

There was also the big problem of the garbage. Reportedly Mrs. O was dropping her garbage down from the balcony onto the street attracting lots of domestic and wild life forms, thus angering her neighbours.

"But, Doctor Rappaport, I canna get down the stairs, and outside on garbage day, to throw out the refuse..."

The neighbours wanted her out of the building; her kids wanted her safely tucked away in a home.

Mrs. O understood the issues at hand. She knew she might fall and that her diet and medication compliance were not ideal. She realized she may be bathed more often in a supervised setting. But, she told me she would feel caged and lonely. This is the way she always lived and this is where she wants to die, surrounded by her precious cats. As for the garbage, her brilliant visiting nurse had a solution.

"Mrs. O, Joan, your nurse, has a great idea."

"Oh yes, the bossy one, with the short hair… "

"Joan and the rest of us need you to compromise if you don't want to be evicted from the building." I injected.

Mrs. O stopped petting the tiger cat and looked at me with interest. "You mean I can stay?" she asked, hopefully.

"Well, if you agree to let someone come in once a week to give you a bath and help you clean up a bit. And it's going to be on garbage day. So no more throwing garbage!"

Mrs. O brought a well-used handkerchief out of her right pocket and wiped watery eyes.

"It's a deal. Do you want to seal the deal with a wee whiskey?"

III. "General practice is based on an organismic rather than a mechanistic metaphor of biology."[1]

An organismic clinical method is one that is patient-centred that recognizes that the patient's experience of illness, the emotions and not just the mechanical body parts need to be attended to.

My narrative, aptly named, Heart Failure, illustrates this.

Heart Failure

Mrs. S was 86 when her husband died suddenly in the shower. She came to see me a few days later, obviously shocked and grief stricken, but also in florid heart failure! A thin, ninety pound woman, who never smoked, always ate her veggies, never buttered her toast, who took daily brisk walks to the store and had a heart attack when the love of her life died. Her arteries were clear; no stent was inserted, with a diagnosis of acute coronary syndrome, she was treated with a beta blocker, statin, and aspirin.

Mrs. S remained symptom free from a cardiac standpoint but a year later, on the anniversary of her husband's death, she returned more fatigued than usual. Her bowel movements were black. I'm not clear on the pathophysiology of this finding, but she definitely had a grief-induced upper gastrointestinal bleed. A broken heart, then a bleeding gut; I remember thinking if only, as a society, we engaged resources to support this childless widow in her time of need. Hospitalization, doctors' fees, when in the long run it would have been cheaper and better for Mrs. S if she would have had timely access to grief counselling and social support.

IV. "General practice is the only major field which transcends the dualistic division between mind and body."[1]

Except for palliative care, most medical disciplines lie on one side or the other of the body-mind divide. It is helpful not to wait until one is dying to recognize that there is no partition.

I have written a narrative that illustrates this very well.

The Carved Wooden Door

It's a singular moment when patients open the door to us, their family doctors, and let us into an intimate part of their lives. That is why I love being a family doctor, in general, and making house calls, in particular. The door to a patient's home is the physical entrance to something metaphorically healing and magical for both patient and doctor.

I had agreed to see Mrs. B, a 94 year old, at home because she was getting too frail to come to the office. Her daughter, Brenda, also a patient of mine, had called me a few days ago about a problem.

"Ma has been seeing things again! She says she sees a little girl rushing about her house."

The previous year Mrs. B had had similar symptoms, but the hallucinations were caused by new glaucoma drops. When she was put on different medication, the problem disappeared. This time there weren't any new drops.

"The worst of it is that she's calling me, or the neighbours, or the police at midnight, anxious and complaining of uninvited guests wandering in her house", decried her daughter.

While driving towards Mrs. B's place my mind wandered towards incidents from the office, dinner, upcoming arguments with my son over homework, and my daughter's night terrors. I pulled up to the address. It was good to get out of my car and walk the few steps to her front door. And what a front door! I have never seen anything quite like it before. It was a mahogany door, with 12 exquisitely carved raised panels depicting Caribbean scenes. The wood seemed to be a living thing with waves of gold and black breathing through the reddish brown. Does one knock on such a door, or use the plastic buzzer on the left side of it? I wondered since I had things to get done I quickly rang the bell.

"The door's open, dear, just let yourself in." she announced.

The voice was shaky but clear.

It was common for my patients to unlock their doors for me in anticipation of my visits, and I imagined them parking themselves and their walkers in the most convenient spot in the living room or kitchen while waiting for me. Getting up and down is not easy, nor expedient when 94.

Mrs. B resided in a small bungalow, typical of those built in the area in the 1950's. It seemed neat and uncluttered on the surface, but was shabby, with faint odours of urine, mould, and dust.

"Mrs. B, hello, it's Dr. Rappaport, how are you?"

I saw a head of beautiful, curly, pure white hair before I glimpsed the rest of her: hooked nose, big smile, a little body in a faded duster sitting at the kitchen table in the kitchen.

"I'd offer you a cup of tea and a piece of cake, Doctor, but I haven't had the chance to bake today and tea without something sweet..."

Her crooked, deformed fingers looked twenty years too old for baking.

Sometimes it's the doctor who needs to make the tea.

"Oh, I've just had my tea, but I can easily make you some if you want." I responded to her generous offer. The blue hues beneath the cataracts sparkled at me while I declined but I was progressively falling for her in that 1950's kitchen of hers.

During my visit there was an incident that disturbed the peace of that home; one more jarring than the neon orange Arborite that covered the kitchen counters. More than once she would turn towards a shelf in the far corner and say, "There you are, Susie you naughty girl, where are the rest of you? Don't bother me now. Can't you see I'm busy?"

Mrs. B was having visual hallucinations. Were they an ominous sign of an underlying dementia, brain lesion, vascular compromise? Was this what the nurses wanted me to rule out or just a medication interaction or neurological glitch in a visually impaired senior for me to adjust?

"Now, Mrs. B, do you know why I'm here?" I queried.

A small patch of eczema on her fuzzy left cheek reddened.

"You know, dear, I'm almost deaf, and partially blind. Glaucoma, that's what the eye doctor told Brenda. My eyesight has been getting worse. But I see what I see! Sometimes I see a little girl, Susie, rush in and out, like now. Often a little boy is with her, or two other girls. They run around or hide under the couch. Or sit here on the kitchen floor."

The pouches of her fuzzy cheeks flushed as her voice rose, she said, "I know it sounds crazy. But I see what I see. No one believes me. No one helps me."

"I believe you. You're not crazy, but your eyes may be playing tricks on you. Remember, like last year, when you used those other drops." I responded.

Visual hallucinations are usually medication induced and not unusual in a visually impaired, socially isolated, blind nonagenarian. In this case, however Mrs. B also heard the children call out to her, and even felt them. Consequently, I needed to probe more.

"These kids are mischievous. They come for sleepovers and creep into bed with me. Last night I chased them out but sometimes they don't listen to me. They are so troublesome I can't sleep, or cook, or wash...they're taking over my life." she insisted.

These uninvited guests were robbing Mrs. B of her independence. She was so clean and bright, like her painted white kitchen cupboards.

"No one helps me", she lamented. Tears formed in her droopy eyelids when she concluded, "I will be lucky to reach 95 in my own home!"

I endeavoured to explain about her sick eyes again, about tests we could do and pills that may help. Her story was etched in her face; in the lined skin, fallen jowls, wrinkles around her eyes. She listened but stared out sadly at the kitchen walls. Was she seeing the kids again?

“Let me tell you a story", she continued. "I grew up in an orphanage, two of them. Papa sold coal on the streets. He worked so hard he couldn't care for us when Mamma died. There were seven of us. My older sister Ann was twelve but she after a while she realized she just couldn't manage. My father was a good man, and he saw that between his working so hard, and Ann's frailty, he needed to find another home for us."

Mrs. B's eyes shimmered.

"My sister Ann bundled us up and took us to the Protestant orphanage. They took us in but we were unhappy there. They took away our clothes and dressed us in rags. I ran away once to where Ann worked in a candy store. She told me I must return to the orphanage even though she loved me. When I returned I was beaten. Ann came to visit the next day, and when she heard about the beating she dressed us in our own clothes and found another orphanage. The nuns said they would care for us. We weren't allowed to talk in line and there were so many rules. I was punished a lot for talking. The nuns would lock me in a dark room in the cellar. I would cry a lot but what could I do? But at least I was with my brothers and sisters and other children. There wasn't much that was funny in my life back then but we did have some fun when we got away with some mischief."

I took her old right hand in mine. Her skin was soft like well-worn leather. Then I examined Mrs. B and ordered tests. Bloods were drawn, medications were reviewed. Nothing amiss was found. I visited her regularly.

Mrs. B never complained about the little children visitors again. She once confided in me that she still saw them but that they no longer frightened her. I'd like to think that the cure was in the telling of her story. Perhaps the little children fading in and out of her life are related to the orphanage and the opportunity to share past struggles.

Mrs. B lived to see 95 in her home. Although she is no longer alive, I drive by her address once in a while to admire those beautiful wooden panels.

How does one measure a basic tenet of family medicine; the doctor-patient relationship?[2]

How does one design a health care system based on complexity (instead of mechanistic body parts), which is patient-centred (not provider centred) and anchored in primary care (instead of hospital based)?

In their article, "What would an Ian McWhinney health care system look like?" Wollard, et al expand on these themes.[4] They emphasize that relationships would be used as units of analysis to define success in health care.

In this era of healthcare cuts the bean counters would have us see our patients every five minutes, and in this context none of the above encounters could have occurred. I will quote Albert Einstein, "not everything that can be counted counts, and not everything that counts can be counted." Let us not forget the primacy of the patient centred model that puts the relationship between two human beings at the centre of each healing encounter, as seen in each of the above narratives which are based on true encounters.■

All identities and circumstances have been changed if consent to publish had not been possible to be obtained.

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