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EDITORIAL

DIZYGOTIC TWINS – WHOLE PERSON CARE AND FAMILY MEDICINE – SIMILAR BUT NOT IDENTICAL

Patricia Lynn Dobkin, Editor-in-Chief
Department of Medicine, Programs in Whole Person Care, Faculty of Medicine, McGill University, Montreal, Canada
patricia.dobkin@mcgill.ca

Imagine this: as you enter a standing-room-only reception area you notice a mother cradling a newborn, a middle-aged woman with her elderly father's coat and hat heaped on her lap, a man in overalls clutching insurance papers hoping to extend his disability leave, a teenage girl with acne talking on her cell phone, among others. Patients crowd together, closer than they would elsewhere: near enough to infect one another should someone cough. They wait and wait on a continuum of resigned-to-reading magazines, to anxious, to angry about their appointment times ticking by. What they do not know is that their doctor is not in. She is home sick, tired of prescriptions dictating how to practice medicine, overwhelmed by time pressure – much like her patients she is stressed out – or worse – burned out. And her colleagues are too booked up to cover for her.

RESEMBLANCES BETWEEN WHOLE PERSON CARE AND FAMILY MEDICINE

Whole Person Care (WPC), with its goals to cure when possible and care always, match the objectives of family medicine in that patient-centered care is paramount. Both view the doctor-patient relationship as fundamental. Ideally, a family doctor provides continuous care whereby the psychosocial aspects of the patient's life, including family dynamics, lifestyle, and work-related issues are considered in the context of the patient's medical condition and genetic loading. Patients and their families are invited to collaborate in their health care. Based on their values and preferences they are supported in their choices with education and counseling.

WHAT HINDERS FAMILY MEDICINE DOCTORS IN THEIR INTENTION TO PROVIDE WPC?

Stressors faced by family doctors:[1]

Personal factors

1. Personality traits (e.g. perfectionism)
2. High standards/high achievement orientation
3. Strong sense of obligation/responsibility
4. Gender/multiple roles (e.g. doctor, mother, spouse)
5. Competency – continued medical education requirements
6. Feeling undervalued
7. Financial concerns

Occupational factors

8. High workload
9. Time constraints
10. Documentation requirements
11. Practice management (e.g. staffing issues)
12. Changing roles for family doctors[2]
13. “Challenging” patients

Systemic factors

14. Limited resources
15. Imposed rules and regulations
16. Lack of support from colleagues and specialists
17. Low physician-to-population ratio

HOW CAN THESE CHALLENGES BE MET?

In Quebec, Canada Family Medicine Groups have been formed; currently there are 48 of them. They consist of 6 to 10 physicians working with nurses (sometimes allied health care providers as well) and are affiliated with community health centers. Early research showed a positive impact on accessibility, coordination, comprehensiveness of care, and patient knowledge. Moreover, rates of preventive services were higher than in traditional fee-for-service practices. Annual fees are allotted for each registered patient, and supplemental fees paid for the inclusion of vulnerable populations. Funds for time spent in meetings, completing paperwork, and support for the use of information technology is provided.[3]

Lee et al.[1] conducted a qualitative study with family doctors in Canada who identified ways to deal with the stressors. For personal stressors, spiritual strategies included prioritization of values, reflection, and self-awareness. Psychological schemes mentioned were: acceptance of limits, acknowledging one's own feelings and using humour. Socializing, exercising, good sleep and proper nutrition, engaging in hobbies were also noted as helpful. Occupational stress factors were faced by setting limits, participating in continued medical education, seeking support from colleagues and staff, teamwork, exploring new forms of remuneration, scheduling appropriately, and improving patient-physician relations. For example, one doctor reframed "difficult" patients as "interesting" patients. With regard to system stress factors, two styles emerged. Reactive planners generally employed strategies only after enduring the impact of stressors. In contrast, proactive planners anticipated potential problems and took steps to avoid them. For example, the use of advance schedule planning helped alleviate time pressures. Lee et al.[1] propose that these three systems levels interact. Their systems approach provides a framework in which stressors can be tackled at each level.

In this volume, Dr. Minichiello aptly illustrates how he learned to deal with family medicine residency stress: via mindfulness, meditation, yoga practice, self-expression, energy medicine, and studying so as to gain needed knowledge – aspects of an Integrative Health Plan he designed for himself. In this way he found his voice and could breathe more easily through the demands of his training. Drs. Wilson and Chambers coach medical students by providing them with an opportunity to reflect when writing narratives about their experiences with elderly patients. Rather than simply describe what occurred, students are encouraged to explore the lessons learned. Snippets of students' essays provide insight into how they gained more than facts about how human bodies function: they were connecting with the altruistic aspect of their chosen profession. This made the hard work of medical school more manageable. Dr. Rappaport, a seasoned family doctor, finds solace in writing narratives and poetry. She celebrates the doctor-patient relationship that colors her work with meaning. Her narratives show how the twins, whole person care and family medicine, are related and thriving with the support from one another.

Thus, as health care systems change, budgets are cut, and challenges mount family physicians need to be proactive to deal with the stressors so that they do not end up like the doctor in the scenario herein – sick or burned out.■

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