Perspective

A Reflection of Longitudinal Family Medicine Care

Message from the Editor

During their first year of medical school McGill students take part in the Longitudinal Family Medicine Experience program. This unique program pairs each student with a practicing family medicine physician across the island of Montreal and allows students to shadow and experience firsthand a primary care practice. Throughout approximately a dozen half-day sessions during their first year, students are exposed to the entire spectrum of family medicine practices; in the emergency department, Centres locaux de services communautaires (CLSCs), labour and delivery rooms, home visits and refugee clinics. This unique, integrated program was designed in tandem with McGill medical school's new curriculum to allow early exposure to the depth and breadth of community practice and family medicine.

Each year as they complete their LFME sessions students complete a reflective essay looking back on their experiences and highlighting personal learning points. Below are three examples of these essays which have been chosen to highlight the diverse nature of family medicine.

A Reflection by Alyssa Smith

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During my first year of medical school, I had the opportunity to shadow a family physician at a Centre Local de Services Communautaires (CLSC) Youth Clinic in the West Island of Montreal. The Youth Clinic was open to teenagers and young adults, aged 12 to 25 years old. The experience allowed me to reflect on the four principles of family medicine described by the College of Family Physicians of Canada.

The family physician is a skilled clinician

While many family physicians have a diverse practice, I learned that a family physician could also develop a more specialized practice. My preceptor, having worked at the CLSC Youth Clinic for many years, had encountered numerous teenagers and young adults struggling with eating disorders, and she had dedicated herself to learning how to effectively assess, monitor and treat these difficult cases. Over the years, she became known for her expertise in managing eating disorders and would often receive referrals for eating disorder assessments from other family physicians and high school nurses.

Since most patients with eating disorders continue to decline before they improve, the family physician must first use their expert judgment to gauge the severity of their disease and to decide whether they should continue to monitor the patient in a primary care setting or whether the patient's condition requires more immediate attention. During the nine months I spent at the clinic, I learned that treating a patient with an eating disorder is not something that can be achieved in a single visit but, rather, something that requires a long-term treatment plan with regular follow-ups that involve the patient's family, as well as a multi-disciplinary team. It takes a skilled clinician to navigate the complex psychosocial underpinnings of eating disorders, and much patience and dedication to work with patients who are often not seeking help of their own volition.

Family Medicine is a community-based discipline

A family physician is a valuable member of the community and must often act as an advocate for their patients. In the case of eating disorders in youth, the family physician must collaborate as part of a larger multi-disciplinary healthcare team, working closely with school nurses, psychologists, and nutritionists, to come up with a unified and achievable treatment plan for each patient. Moreover, a good family physician recognizes that their role in the community extends beyond the clinic. In the case of eating disorders, this could mean giving talks and educating school nurses, other family physicians and CLSC members on the topic of eating disorders, to further contribute to improving patient care for this unique patient population.

Through my observations, it was clear that a patient's eating disorder affected more than just the individual, but the entire family. My preceptor would often see the parents or siblings of a patient with an eating disorder to learn what was going on at home, to understand the family's perspective of the disease, to educate the family and provide reassurance, and to assist in identifying outside resources that might be helpful for the entire family, such as family counseling. Many of the parents we encountered struggled to understand their child's eating disorder and often blamed themselves or felt that they had failed as parents. My preceptor felt it was important not only to reassure and provide resources to these parents, but to acknowledge and encourage their important role as part of their child's treatment team.

Family physician is a resource to a defined patient population

At the CLSC Youth Clinic, my preceptor worked almost exclusively with teenagers and young adults, a particularly sensitive and impressionable patient population. This population is a prime target for patient education and primary prevention since promoting healthy habits at a young age can reduce the risk of disease, thereby avoiding burdens on the healthcare system in the future. Moreover, this young patient population is particularly vulnerable to societal pressures and bullying, factors that predispose to mental health disorders, including eating disorders. My preceptor recognized that her entire patient population, including boys and girls, was susceptible to developing eating disorders and she took the time to ask each of her patients about their home and school life, as well as their eating and exercising habits. She began with open-ended questions, probing deeper if there was any concern. In particular, she would ask her patients how often they exercised, how many meals they consumed each day, how frequently they weighed themselves and whether they counted calories. Recognizing the subtleties and early signs of an eating disorder is important, as catching an eating disorder in the early stages can lead to improved treatment outcomes.

Patient-physician relationship is central to the role of the family physician

Developing trust and a rapport with a patient with an eating disorder is a critical component to their treatment. There is a delicate balance between pushing a patient just enough so that there is some improvement, but being careful not to push so hard that the patient does not want to return to see you. My preceptor would tackle this challenge by focusing on small, achievable goals. For instance, rather than telling a patient who is consuming less than 1000 calories a day that they must now start eating 2000 calories a day, she would talk with the patient to try to understand what foods they like or dislike and would come to an agreement with the patient to introduce one or two new food items into their diet after each visit. This does not seem like such a drastic change to the patient, but it is enough for them to start to feel the positive effects of their treatment and be motivated to keep it up.

Another important skill of a family physician is the ability to provide care in a way that empowers patients, making them feel that they are in control of their own health. This is particularly important in the case of eating disorders, as these patients tend to be stubborn and do not like to give up control of their eating habits. One particularly effective technique that I observed involved asking patients to draw two pie charts breaking down how they spend their days, including activities such as how much time they spend exercising, counting calories, and thinking about losing weight. The first pie chart represented their current situation while the second pie chart represented the patient's ideal day if they didn't have an eating disorder. This allowed patients to see for themselves how time-consuming their eating disorder was, and helped them to refocus their attention on the more enjoyable activities they might be missing out on. This motivated patients to set goals and make small steps towards recovery in a way that they didn't feel as though they are following "doctors' orders".

Finally, an important challenge to consider when treating youth is patient confidentiality. Oftentimes, patients would come to their appointments with a parent. While learning a parent's perspective of their child's eating disorder is often helpful, the patient can feel uncomfortable expressing themselves openly with a parent in the room. A technique that my preceptor often used in this case was to ask the parent to leave the room when it came time for the patient's physical exam. This allowed for some time alone with the patient and an opportunity to ask more personal questions. Often, the patient's entire demeanor would change and the patient would appear much more at ease once their parent left the room.

These are just a handful of anecdotes exemplifying my preceptor's dedication to improving the health and well-being of her patients with eating disorders. Through my observations shadowing at the youth clinic, I developed an appreciation for the important role of the family physician as an expert, as a member of the community, as part of a healthcare team, and perhaps most importantly, as an advocate of and ally to their patients.

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A Reflection by Lucy Teresa Shum

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As a first-year medical student, I shadowed a family physician in her clinics at St. Mary's Hospital in Montréal for eight months. My preceptor was a family physician with a specialization in obstetrics and had over ten years of experience. This interaction allowed me to fully experience the field of family medicine and to realize the skills and qualities that go into making an outstanding family physician.

The family physician is a skilled clinician

The craft of a family physician requires a breadth of knowledge about many different health conditions. My preceptor can see up to eight patients in one afternoon, most of whom are expectant mothers and children. They often visit as a family, and she sees them all together in her office. Despite the limited space, the office has a cozy feel to it, probably because of the colorful doodles and drawings hanging on the wall above the desk. Or perhaps it is the way her toddler and school-aged patients sit on the stool as they listen and wait for their turn to be seen. I recall my clinical sessions to be very fun -— tickling kids, answering all the "why's" they ask as I examine them, and hearing the babies' heart beats as the parents marvel over them. There were also older patients with chronic illnesses and adults with mental disorders. The patients were diverse in culture, age, social background, religion, education, health status, and needs. With all her patients, my preceptor demonstrated compassion, listened attentively, and tried to walk them through solutions. There was a couple who was struggling in their marriage; one had to take medication for his anxiety while the other struggled with alcohol abuse. My preceptor saw each separately, and I was fortunate to be present during each of the appointments. I witnessed how my preceptor took on the role of a counselor: being as objective as possible without revealing any information about one spouse to the other.

It takes a wide set of scientific, technical, and interpersonal skills to attend to the breadth of family medicine cases, both chronic and acute, in patients of all ages. However, only through forging a relationship with trust and confidence can the technical and scientific knowledge get through to the patient.

Family Medicine is a community-based discipline

Family medicine is a specialty concerned not only with the individual patient, but also the community as a whole. Family physicians working in the community attend to patients from birth to final moments in life. They learn about all aspects of their patients' lives including daily routines, work life, education, and even hobbies. Family physicians are guided by the lifestyle and evolving needs of their community members and constantly strive to adjust their practice. For example, with the increase in the number of women pursuing a career and starting a family later in life, my preceptor is following many more expectant women above 35 years of age. These women have a higher risk of developing health issues in both themselves and their babies. Naturally, many wish to be screened for congenital malformations in their unborn babies, as well as to be monitored closely for illnesses such as gestational diabetes and pre-eclampsia. As our health system resources are limited and often involve long waiting lists, my preceptor is knowledgeable of alternative places that she can recommend to her patients to speed up certain tests. She also counsels them as they balance career and family life, and advises them on the process of adoption and youth protection when needed.

Working in the community means that my preceptor does not work alone. She has over a dozen family medicine colleagues with whom she can discuss a case in times of need. By seeking a second opinion, she provides the best care for her patients. My preceptor knows the local pharmacists and is only a phone call away from verifying or fixing a prescription. Furthermore, my preceptor has developed a rich network of multidisciplinary health professionals and she often knows the appropriate specialist that could attend to a specific health issue beyond her scope of practice. This is extremely important and adds value while providing the best care to her patients because it ensures efficiency and effectiveness in the coordination, collaboration, and mobilization of resources.

Family physician is a resource to a defined patient population

My preceptor is a knowledgeable resource for pregnant women and works to ensure their health and welfare outside of the clinic. For example, I vividly remember a young immigrant student who was an expectant mother but was alone in the country. My preceptor kept a close follow-up on her biopsychosocial well-being: she counseled her on the pregnancy, soothed her worries, and answered all her questions. In addition, she provided medical documents for the visa applications for the woman's partner and mother. My preceptor's medical-legal support was crucial in strengthening and speeding up the visa process so that her patient could be reunited with her partner and mother. Being alone after giving birth in a foreign country can have many negative implications for the physical and mental well-being of the mother and her newborn. My preceptor also worked to accommodate the patient's needs at school, since the patient worked with chemical solutions and needed to request alternative school assignments. Thus, my preceptor was instrumental in preventing possible congenital health problems in the baby as she advocated for her patient to be excused from chemical exposure in school. My preceptor is truly an indispensable resource for this patient population.

Patient-physician relationship is central to the role of the family physician

One of the most important things I have learned from my preceptor is the value of establishing a healthy patient-physician relationship. Respect for the privacy of the person is a key aspect of this relationship. My preceptor told me a poignant story, which emphasizes this notion. She once attended to a complex case of child abuse in the family. After the child was taken into a foster home, my preceptor remained their pediatrician. Despite a biological parent's inquiries about the health of the child, my preceptor maintained the patient's confidentiality by not divulging sensitive information. My preceptor recognizes that respect for the privacy of her patients cultivates a healthy and strong patient-physician relationship that is central to the role of the family physician.

Long-term care is another aspect of family medicine and a significant factor in forming the patient-physician relationship. My mentor once said, "To me, what is very important is the relationship that I have with my patients. The best part is being able to see them again and again and to follow them throughout the course of their life while making a difference." Throughout her career, she has cared for many expectant women at the prenatal, perinatal, and post-partum stages. She has also taken their babies under her care as a pediatrician, thus being able to follow families

throughout their growth and development. She has seen many babies go from breastfeeding to crawling to walking to running and many other life stages. Being able to accompany and naturally become familiar with her patients as they grow from one stage of life to another puts her in the best position to provide them with excellent care. She knows their past medical history inside out.

At the end of the experience, I am grateful that my preceptor taught me one of the secrets to being a successful family physician – that is, the physician-patient relationship is the core of a family physician's role. It is the key that allows the physician access to the patient's heart and mind.

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A Reflection by Burnett Johnston

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During my LFME session I was incredibly fortunate to be allowed to observe the intimate relationship of a family doctor and their patient, and gained an appreciation of the fundamentals of excellent primary care. My experience took place in three different practice settings with my preceptor, an independent office practice on the south shore of Montreal; a family medicine group practice just outside downtown Montreal; and at the walk-in urgent care at the old Queen Elizabeth hospital. This experience ultimately showed me the power of primary care and the utmost importance of truly patient centered care founded on communication and building strong relationships with patients

The family physician is a skilled clinician

Throughout the different settings of my LFME exposure I witnessed a vast spectrum of skills, ranging from the very technical, to the more nuanced and subtle. I was fortunate to get to see numerous technical skills modeled including suturing, incision and drainage, interpreting x-ray imaging, and casting among others. These technical skills are critical in order to provide adequate and timely care for patients, as well as to alleviate the burden on emergency rooms for urgent but not emergency situations. In addition to knowing these technical skills, I was also very impressed by my preceptor's understanding of their limitations, knowing when to refer and ask for help. A clear example of this was an older patient was diagnosed with an aspergillus sinusitis. Given the difficult nature eradicating this fungus and the high risk of morbidity and mortality, my preceptor quickly reached out to colleagues in infectious disease, otolaryngology, and neurosurgery to manage the infection. Although the technical skills are an undeniably important part of medicine, they cannot exist in a vacuum. They require clear communication with the patient to understand what their conception of illness as well as their treatment goals and ensure that the treating teams actions are in line with these goals.

Another critical skill that was continuously modeled by my preceptor was continuing education, in a variety of contexts. Given the rapidly evolving nature of medicine, continuing education is paramount to good patient care. In addition to participating in continuing medical education my preceptor as purposefully took shifts at the urgent care to work with different colleagues to engage in peer learning. To learn from "hallway consults" in a way. This was especially interesting since my preceptor spent most her time at her independent practice. At the urgent care setting, there were frequent opportunities to discuss diagnosis and management with other physicians at the urgent care, as well as to interact with other specialists at the clinic such as infectious disease specialists. I thought that this was a very useful method to work on appropriate implementation and supplementation of the more formal continuing education.

Family Medicine is a community based

The flexibility of practice opportunities in family medicine provides an incredible opportunity to meet the needs of a community, and to evolve with the community dynamically to address rising needs. All my preceptor's patients knew that if they had an urgent matter they could stop by in the evening at the urgent care. This allowed for short visits in the urgent care to improve efficiency (i.e. a cough with fever that was likely bacterial), as well as longer more comprehensive visits with follow up at the family medicine clinic that could truly work to address the needs of the whole patient for more nuanced presentations. At the family medicine clinic office, the visits were quite lengthy (on average about one hour), whereas the urgent care appointments were seldom longer than 15 minutes. My preceptor worked with vulnerable patients who had multiple comorbidities who often saw multiple specialists. It was very interesting to see how my preceptor handled the responsibility of ensuring whole patient care, and coordination among the specialists.

This was especially crucial since when there were so many treating physicians it seemed more likely that primary health care needs could be missed since the more people involved in care, the higher the risk that one team member may think another physician will cover a problem. Ensuring adequate coordination required close communication with both the patient and other specialists involved in care, as well as other allied health care professionals involved such as physical and occupational therapists. This was done by taking the time to write correspondences, make phone calls to clarify various referral managements, and most importantly ensuring that the patient understood how all the different parties were coordinating to provide care. This coordination and ultimate responsibility of patient care was one of the most admirable aspects of family medicine, and a clear demonstration of the incredible value that strong primary care can provide not only to the patient but to the entire health care system.

The family physician is a resource to a defined patient population

A very interesting aspect of my preceptor's practice was that she focused on serving vulnerable patients with complicated medical conditions. This included patients with mental health concerns, patients with diabetes and heart disease among many other chronic conditions. This served a critical need since many of her patients had difficulty finding family doctors due to the complexity of their cases. Although this meant added complexity, especially in the role of coordination of care between specialists, it provided a much-needed service to patients desperately in need. This meant that visits could be difficult to schedule, with certain appointments necessarily taking a very long time (up to two hours). Although the multifactorial, complex management, and large treating teams provided intellectual stimulation, the most rewarding aspect of working with these patients was their gratitude and comfort to find a family physician. It is an absolute privilege to be able to accompany and guide patients both through some of the most difficult times of their lives. But dealing with the fallout and consequences of a major life altering illness and helping patients adapt thereafter is also extremely important. One patient who comes to mind was a gentleman who was in a major car crash, and sustained severe trauma, severely limiting his mobility, rendering him wheelchair bound. Unfortunately, during the recovery course he developed an addiction to opioids. His addiction coupled with multiple complex medical issues made it impossible for him to find a family physician, until he met my preceptor (who incidentally first had him as a walk-in patient at the urgent care, and took him on as a patient when she learned his history and difficulty finding a family physician). Working together he managed to overcome his addiction and was feeling in a much better place when I met him. He was much more comfortable in the medical system since he had family physician to help him navigate the complexity and long list of follow ups.

The doctor patient relationship is central to the role of the family physician

To me, the most important skill modeled during my LFME sessions was the alliance building and development of meaningful relationships with patients. One of the aspects of medicine that I find most fascinating and compelling is mix of interpersonal skills, and scientific knowledge that is required. It is critical for the clinician to have a clear dialogue with the patient to determine what the true problem is, and what the goals of the patient are, before the knowledge of biomedical sciences can be leveraged to address the concerns.

If a good relationship and open communication can't be established, then the fundamental aspects of patient care cannot be accomplished, no matter how encyclopedic the clinician's medical knowledge may be. I was very impressed with the alliance building that took place within my preceptors practice, and how genuinely it was applied to different patients. It could be as simple as sharing pictures of grandchildren with patients, or asking about their beloved pet, or asking about an update on an important project in the patient's life. Although these exchanges resulted in limited or no scientifically relevant information about the biomedical formulation of the problem, they were invaluable for forming a trusting relationship with the patients and formulating the psychosocial aspect of the problem. This was especially clear with how much more at ease the patients would become after these small yet personal exchanges.

The following is an example of how this information learned in alliance building lead to a direct clinical impact. A woman in her late forties had a passion for cooking. She was starting to have symptoms of menopause that she felt were interrupting her life, however she did not want any medications. Knowing her interest in cooking my preceptor discussed the recipe of a "menopause cake" that could potentially

help with symptom control, although she mentioned there was no definitive evidence of efficacy. Although this may seem like quite a small and potentially inconsequential suggestion, I could tell that it was very powerful for the patient to feel acknowledged and to have a suggestion that incorporated their passion of cooking. An activity that was so important to the patient's life. These small gestures lead to increased trust and provide the foundation for the family medicine relationship. Moving forward, I will be sure to regularly take the short amount of time to connect with patients on a personal level at every opportunity available, so that at critical junctures of medical care there is a strong foundation for subsequent decision making.

My experience in LFME has provided me with a wealth of incredible experiences illustrating the power of effective primary care. It emphasized the absolute importance of patient centered care based on clear communication and alliance building. It has truly been a privilege to experience the diverse array of skills that a family physician can leverage, as well as an honor to get to meet and learn from patients so early in my career

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