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Family Medicine and Community Health

Storylines of family medicine IX: people and places—diverse populations and locations of care

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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 'IX: people and places—diverse populations and locations of care', authors address the following themes: 'LGBTQIA+health in family medicine', 'A family medicine approach to substance use disorders', 'Shameless medicine for people experiencing homelessness', '"Difficult" encounters—finding the person behind the patient', 'Attending to patients with medically unexplained symptoms', 'Making house calls and home visits', 'Family physicians in the procedure room', 'Robust rural family medicine' and 'Full-spectrum family medicine'. May readers appreciate the breadth of family medicine in these essays.

INTRODUCTION

The ecology of care is an important consideration on both sides of the stethoscope. On one hand, ecology of care describes where patients present to and receive their medical care—remember, most people neither seek help from nor make their way to academic institutions. On the other hand, ecology of care also describes where physicians generally practice and the kind of services they provide. The essays below elaborate on some of the distinct patient populations that family physicians commonly care for, physical spaces they occupy when providing care and nature of the care they deliver.

LGBTQIA+ HEALTH IN FAMILY MEDICINE

Emad Abou-Arab

We must broaden our understanding of gender and sexuality to improve our clinical judgement.

A growing number of people in the USA identify as LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other sexual and gender minorities). Close to 6% of US adults identify as LGBTQIA+, and one in six adults in Generation Z considers themselves part of the LGBTQIA+ community. Additionally, the number of people identifying as transgender has also increased.[1] Members of the LGBTQIA+ community belong to almost every race, ethnicity, religion, age and socioeconomic group, and the health needs of sexual and gender minorities span the entire spectrum of family medicine. Though family physicians may not be aware of their patients' sexual orientation and gender identities, most family physicians encounter LGBTQIA+ individuals in their practices.

Sexual orientation is the emotional and sexual attraction one feels for others.[2] Sexual orientation can range from exclusively gay/lesbian (ie, same-sex attraction) to exclusively straight (ie, attraction to different sex only). However, there is a broad spectrum of sexual orientations that can vary depending on the gender identity of the person and that person's various attractions, which may include attractions to certain sexes, gender identities, gender expressions and combinations thereof.[3]

Gender identity differs from gender expression, but both are clinically important. *Gender identity* refers to a person's internalised concept of self as a particular gender regardless of physical appearance.[2] Since gender identity is internally defined, it is separate from a person's physical anatomy. To the extent that someone's gender identity is non-congruent with their sex assigned at birth, they may identify as transgender or non-binary. *Gender expression* is the way people communicate their gender to the world through clothing, speech and mannerisms.[2] A person may express a particular gender at any given time without changing their gender identity.[3]

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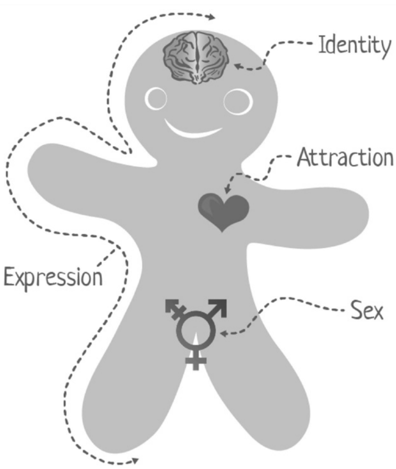

Figure 1 LGBTQIA+terminology: the gingerbread person. Adapted with permission.[7]

While societal acceptance of diverse patient populations has improved, people who identify as LGBTQIA+ continue to encounter stigma and biases against them.[4] These factors have led to significant health disparities that include higher rates of sexually transmitted infections, substance use, mental health disorders, obesity and certain cancers. These poor health outcomes are worse among minoritised communities.[5]

To offer high-quality, culturally competent care to our LGBTQIA+ patients, we as family physicians must continue to grow in knowledge and understanding. To meet the needs of the LGBTQIA+ community, it is important we develop a basic understanding of sexual orientation and gender identity. It is essential we understand the healthcare risks our LGBTQIA+ patients face. Both our clinical judgement and our abilities to address patient needs improve as we consider the context of gender and sexuality in our diagnostic and therapeutic planning.

As family physicians, we must also understand how interpersonal and structural factors affect our patients. Understanding the different dimensions and manifestations of sexual orientation and gender identity can help us build better therapeutic relationships with the LGBTQIA+ community.[6] This means avoiding assumptions, staying open to cultural differences, being culturally compassionate and creating inclusive workplace environments. The unique healthcare needs and experiences of the LGBTQIA+ population deserve no less (figure 1).[7]

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A FAMILY MEDICINE APPROACH TO SUBSTANCE USE DISORDERS

Julio Meza

Family physicians play a vital role in working with patients dealing with substance abuse.

Substance abuse continues to be a significant public health concern, affecting individuals of all ages, backgrounds and socioeconomic statuses.[8] As society grapples with the devastating consequences of substance abuse, it is increasingly clear that addressing this issue requires a comprehensive and holistic approach.

The holistic approach of family medicine—Family medicine focuses on providing comprehensive healthcare to individuals of all ages while also considering the impact of health and illness on the family unit. It emphasises a holistic approach that considers the physical, mental and social aspects of health. Substance abuse, a complex issue with multifaceted causes and consequences, necessitates a similarly comprehensive approach.

Understanding family dynamics—Family physicians are well positioned to address substance abuse because of their relationships with patients and resulting abilities to gain valuable insight into the family dynamics of their patients. They can assess the family's role in both contributing to and mitigating substance abuse. By considering the family context, family physicians can provide more effective interventions and support systems for patients dealing with substance abuse.

Early identification and intervention—One of the significant advantages of a family medicine approach is the ability to identify and intervene early in cases of substance abuse. Family physicians are trained to recognise subtle signs and symptoms of substance abuse and are skilled in conducting thorough assessments. With this expertise, family physicians can identify individuals at risk or in the early stages of substance abuse and offer appropriate interventions. Early identification increases the likelihood of successful treatment outcomes and reduces the potential for long-term harm.

Collaborative and supportive relationships—Such relationships are key to helping patients who struggle with substance use disorders. Family physicians can provide a non-judgemental environment where patients feel safe discussing their substance use concerns. This therapeutic alliance facilitates open communication, leading to a more accurate understanding of patients' needs and treatment preferences. By involving patients in the decision-making process, family physicians can tailor treatment plans that are acceptable to patients. This commitment to patients increases the likelihood of treatment adherence and success; it also helps physicians be present and attentive during periods of non-adherence or relapse.

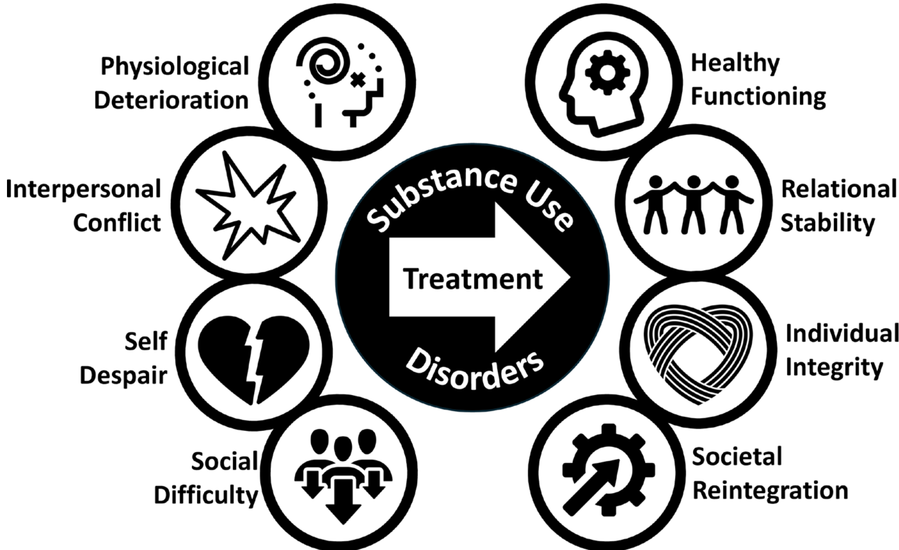

Figure 2 Treatment of substance use disorders: a holistic approach.

Coordinating multidisciplinary care—Although medicinal interventions in primary care practice are gaining acceptance, substance abuse often requires a multidisciplinary approach that involves various healthcare professionals and support services.[9] Family physicians are crucial to coordinating this care. They collaborate with addiction specialists, mental health professionals, counsellors and social workers to develop comprehensive treatment plans. By facilitating effective communication among these professionals, family physicians act as a kind of glue that holds together the treatment team.

The bottom line—Substance abuse poses significant challenges to individuals, families and communities.[10] By adopting a holistic approach, family physicians can make a substantial impact on the prevention, early identification and management of substance abuse. Their position vis-à-vis patients allows them to address the complex interplay between individuals, families and communities, and provide comprehensive care that considers the physical, mental and social aspects of health. Through collaboration and support, family physicians can work alongside patients to overcome the devastating effects of substance abuse and guide them toward a healthier and more fulfilling life (figure 2).

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SHAMELESS MEDICINE FOR PEOPLE EXPERIENCING HOMELESSNESS

Dave Buck and Jerome Crowder

How to create therapeutic relationships free of shame.

Working with people who are experiencing homelessness is challenging because of the negative experiences they have repeatedly suffered in their lives. We must meet them where they are, realise our work is not about 'saving' them (the modern remnant of a colonial mentality), and recognise their autonomy, authority, and power in the patient–practitioner relationship. To successfully provide care to homeless and other vulnerable populations, we must understand the power structures in which we all live and work. Shameless medicine places patients' values and agency squarely within the clinical dialogues of medical care.

Why *shameless medicine*? Our job as clinicians is to understand patients' values and keep health challenges from getting in the way of those values. We must also build a caring relationship free of shame. Whatever patients do—use drugs, eat fast food or engage in prostitution—should not hurt that relationship. Our objective is to figure out how to make the system of healthcare work better for them.

Unlike many of the other relationships in homeless patients' lives, the partnership between physician and patient must establish an environment in which patients cannot fail. You must first establish ground rules: 'My role is to be the best doctor I can be, and this means always being the doctor you need.' Note that the needs of the patients should not conflict with our efforts to be the best doctors we can be. Agree to disagree with patients, if

necessary, but focus on the positive: 'Are there behaviours that could help you feel better?'

The idea is to help patients realise they can succeed by working with us. Consider everything they try a success. When something does go wrong, that is not their fault—we hold our patients' shame at the same time we advocate, facilitate and help them do what they can to feel better.

Often, like many other people, homeless patients see immediate gains as good for them—doing crack, telling someone off and fighting are good examples. Nonetheless, what helps is being consistent about how we approach them, what we can do for them and what they can expect from us. Consistency grounds confidence.

In working with homeless patients, our job is to frame the care we provide in terms of their values, respecting what they see as a desired 'endpoint' of care. Work to agree on such endpoints, addressing what patients want from us and what we can do to help them achieve it.

Commonly, homeless patients blame themselves for failures in life: 'I screw up everything!' Many of them have heard this refrain since childhood; someone told them they were worthless or simply did nothing right. Counter this belief by saying, 'We all make mistakes, and that's part of being human.'

Like all of us, when homeless and other vulnerable patients realise their human nature, they become honest and authentic in interactions with others. It is our job to reinforce this honest engagement, encourage success in daily life and help our patients discover for themselves what things work for them (figure 3).[11]

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Figure 3 One view of homelessness. Adapted with permission.[11]

'DIFFICULT' ENCOUNTERS—FINDING THE PERSON BEHIND THE PATIENT

Jennifer Edgoose

Learning to work successfully with so-called difficult patients means listening to their stories—everyone's experience as a human being is unique. It also means exploring our own human responses to patients' expressions of distress.

Practising clinical medicine is an enormously rewarding profession that is sometimes creative and fun, and often meaningful and poignant. Remarkably, this depth and breadth of experience may encompass a single morning, especially in generalist disciplines. In the space of clinical encounters, however, there are also patients who may evoke a sense of heartsink and dread among the physicians who attend to them.

All physicians will invariably attend to 'difficult' patients. In fact, because of how physical and emotional stressors adversely affect people, such patients are very common. Unfortunately, clinicians who believe they are caring for many difficult patients are more likely to feel burned out; mitigating this situation is critical for fulfilment as a physician.

Experienced physicians who successfully work with difficult patients do so through collaboration, the judicious application of power and the use of empathy; they do not employ oppositional behaviours, misuse power or express compassion fatigue.[12] Still, how do they put these strategies into practice? They use patient-centred care and self-reflection.

Patient-centred care: reaching out—One important strategy is to seek to understand who the patient is. Listening to patients' stories and gathering medical histories are critical, as the practice of good medicine is all about context. While family physicians should embrace evidence-based principles and practices, they must also consider the circumstances of each individual and apply those principles and practices of evidence-based medicine accordingly.

When family physicians try to better understand their patients, they not only discover their unique needs but also their unique strengths, attributes and resources. They learn about the people and pets who love and need them and who the patients love and need in return; this approach is called 'mining for gold'.[13] By appreciating and incorporating this approach into practice, the application of knowledge and skills becomes far more nuanced, acceptable and effective. At the same time, doctor–patient relationships become more engaging and enjoyable.

Before the Encounter

BREATHE

B List one BIAS or assumption you have about the patient.

RE REFLECT on why you identify this patient as difficult.

A List the one thing you wish to ACCOMPLISH today.

TH THINK about what one question would enable you to further explore your assumptions.

E Before ENTERING stop and take 3 deep breaths.

Clinical Encounter

After the Encounter

OUT

O Reflect on the OUTCOME of the encounter. What was the patient's agenda? Did you accomplish your agenda?

U Did you learn anything UNEXPECTED?

T List one thing you would look forward to addressing if you were to meet with the patient TOMORROW.

Figure 4 BREATHE OUT: self-management. Adapted with permission.[15]

Self-reflection: looking inward—It is important to consider one's own presence vis-à-vis patients. This entails developing an attitude of equanimity and incorporating aspects of mindfulness. Mindful practice includes attending to the ordinary, observing ourselves as much as our patients, being curious and welcoming uncertainty.[14] This means family physicians should reflect upon their own agendas and consider why they label patients as difficult. It also means family physicians should explore what biases they bring to professional relationships with patients.

Using the structured BREATHE OUT approach can help family physicians achieve these goals. Before seeing a difficult patient, try asking the BREATHE questions before walking into the examination room. Take three slow breaths before you open the door. Then, immediately after leaving the examination room and before moving on to the next task, answer the OUT questions. These prompts only take a couple extra minutes and have been shown to improve physicians' experiences with heartsink patients (figure 4).[15]

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ATTENDING TO PATIENTS WITH MEDICALLY UNEXPLAINED SYMPTOMS

Alex Brown and Ellie Plumb

What is the secret to working with patients with medically unexplained symptoms? If the story is the pathology, listening is the intervention.

A 68-year-old woman presented to our family medicine office with a list of problems: cervical radiculopathy, joint pain, colitis, depression and anxiety. She would be seen by a second-year family medicine resident who was working in our morning clinic with the two of us (AB and EJP) jointly attending.

In our pre-visit huddle, the resident was uncertain whether she was treating the patient effectively, as the patient had not responded optimally to trial interventions. Indeed, the resident was not confident that the patient had been accurately diagnosed. We encouraged her to collect more of the story and reminded her that 'sometimes, the story *is* the pathology'.

By simply listening, the resident learnt that the patient had been routinely abused by her late husband, who she strongly suspected had sexually abused their daughter with whom she now had a fractured relationship. The patient had finally prepared herself to leave her husband later in life, only to find herself bound to his bedside as she cared for him as he slowly advanced toward death. Today, she is burdened by crippling debt and social isolation; her meaningful relationships have withered and disappeared.

This patient's story was painfully similar to the stories of so many patients who experience medically unexplained symptoms (MUS).[16] Although the patient's lifetime of accumulated trauma may not have directly caused her physical ailments, it was certainly making her symptoms worse.

MUS is a term that has become synonymous in certain corners of healthcare with psychosomatics, malingering and histrionics.[17] Even as the importance of holistic, biopsychosocial medicine is widely recognised and neuroscience

Figure 5 Patient distress: the maze of medical unexplained symptoms.

confirms the important link between chronic stress and inflammatory diseases, clinicians commonly meet patients with MUS, directly or indirectly, with frustration and disregard. The most obvious reason for this is that such patients' symptoms fail to fit within the strictly biomedical models of illness.[18] Clinicians routinely feel ill-equipped to treat these patients and have difficulty relying on one important principle: if the story is the pathology, listening is the intervention.

After speaking with the patient, the resident felt she had done more to help her patient in 20 min of attentive listening than in all their previous visits, in which she had focused on disease diagnosis and specialist consultations.

In bearing witness to the patient's story, the resident was able to accomplish two clinically relevant tasks. First, she began to establish the trust needed to develop the secure attachment necessary for true trauma-informed care.[19] Second, she began to reinforce that the patient's physical experience is linked directly to her emotional experience and social history, helping to create a new context for the patient to understand her illnesses.[20]

Caring for patients with MUS requires patience. That morning, the resident learnt an important lesson: often, it is not medicine, but the clinician, that is the therapeutic agent. Deeply listening helps ground both patients and clinicians in the shared understanding that just meeting *is doing something* and that sometimes saying 'thank you for sharing' is the only effective intervention available (figure 5).

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MAKING HOUSE CALLS AND HOME VISITS

Amber Norris

Home visits are family medicine in its purest form.

When first asked to conduct home visits for my institution, I was looking for a break from clinical responsibilities. I had begun to feel a bit like a cog in a wheel, and I wanted more individuality, creativity and independence in my work.

In the interview with my medical director, she explained the basics of house calls and some of the minimum criteria for home visits: severe illness, dementia and repeated difficulty with transportation, to name a few. Even then, it was evident to me that the house calls programme could easily become a 'dumping ground' for the sickest and highest utilisers in our system. However, I focused on the silver lining—the maximum number of patients I would see in a day was eight. At the time, I was drowning in chart notes and patient messages. I was willing to take on just about anything to ease my workload, so I said, 'Sign me up!'

I remember my first home visit. Betty, a middle-aged woman with Down syndrome who was bedbound due to a stroke. I spent two hours in her home—not because I was going through her medical history, which was extensive, but because I was talking with her and her family, getting to know them on a personal level. We talked about her favourite cartoons. Her family taught me how to check her blood pressure the way she liked. When I left Betty's home, I was smiling. I felt encouraged. I had helped someone. I was doing good work.

Why did I feel this way? Simply put, the visit was not about me, but rather the patient. Some may argue that all visits are about the patient, but those of us in this profession know that is a lie. Visits cannot be just about patients when doctors are 45 minutes late, push a prescribed agenda (one patients often do not want to have pushed on them) and leave without addressing patients' issues because, 'We don't prescribe "X" or "Y".'

Going into a patient's home changes the entire dynamic of patient encounters. I am still in a position of service but also one of vulnerability—I am on someone else's turf, immersed in someone else's space. I can no longer hide behind my computer.

Amazingly, the more I become vulnerable, the more my patients do too.

I have always understood health issues, but on home visits, patients cannot hide their dirty dishes, agoraphobia or poverty. My patients and I sit beside one another rather than across from each other. I am no longer positioned above my patients on a pedestal; I am down on the ground, in the muck of life, with the folks I care for.

By visiting patients' homes, I can build relationships, trust and respect at a faster rate than in the clinic with its time limits and restrictions. With everything out in the open, we—patients, families and I—make decisions as a unit, as a team. I am no longer agenda-building for

Figure 6 Home visits = family medicine.

myself. Instead, I plan for my patients, creating goals that are realistic and helpful to their current state of life.

Home visits have saved my belief in the profession of medicine and my chosen career, family medicine (figure 6).

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FAMILY PHYSICIANS IN THE PROCEDURE ROOM

Jay Allen, Lauren Giammar and John Wood

Never expect a farmer to drive three hours away to get a procedure. He'll say, 'Fine, Doc.' Then he'll drive home and do it himself.

Services provided in primary care settings can be largely organised into three categories: disease prevention, medical management and therapeutic procedures. Although disease prevention and medical management remain core tenets of every primary care specialty, only family medicine continues to place a significant emphasis on the development of procedural skills in residency training and their application in practice.[21 22] Why? Procedural care contributes to patients' trust in their family physicians: it nurtures the physician–patient relationship and breaks down barriers to healthcare access.

Common procedures in family medicine—What procedures do we as family physicians do? Because every medical ecosystem is different, as is every physician, there is no 'one-size-fits-all' list of procedures. As family physicians, we may do any of the following procedures:

- Remove things, including ingrown toenails, skin lesions or other tissues, skin tags, fishhooks placed by overzealous anglers and other foreign bodies.
- Shave, punch, excise, fulgurate, desiccate, cauterise, suture and freeze.
- Aspirate and inject, poke needles into joints and other spaces, often accompanied by point-of-care ultrasound.
- Drain abscesses.
- Splint and cast common fractures.
- Insert and remove long-acting reversible contraceptives, along with a variety of other procedures related to women's and reproductive health needs.

Procedures and physician well-being—The inclusion of procedural care in clinical practice positively affects many measured outcomes of clinician well-being. Physicians who do procedures are more likely to have greater job satisfaction, and they are less likely to experience burnout.[23] When they maintain a broader scope of practice that includes procedures,[24] both rural and urban physicians score higher on American Board of Family Medicine recertification examinations than their colleagues who exclude procedures from their skill sets. Procedures are a way for family physicians to improve their physician well-being and career longevity.

Patient satisfaction and access to healthcare—'Can't you just do it, Doc?' is a question we hear repeatedly. Many patients want their procedure done today. As well, perhaps it needs to be done today. Family physicians offer not only the convenience of timelier procedures but also the comfort of having it done by an individual who patients trust. Patients are more likely to use services when they are performed by someone with whom they feel comfortable.

Patients whose family physicians provide more services have lower healthcare costs.[25] With the nearly one month average wait time to see specialists and the current overwhelming burden on emergency departments,[26] it is easy to imagine the improvements in efficiency and satisfaction with offering these procedures—and more—in primary care offices.

Family medicine practices devoid of procedures can certainly run efficiently and properly. Only it is not efficiency, but our own patients, that lie at the heart of our profession. To care for our patients well, with the added

Figure 7 What family physicians do: three major categories of service.

benefit of improved physician well-being, we ought to offer care for all facets of robust primary care, procedural care included (figure 7).

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ROBUST RURAL FAMILY MEDICINE

Scott Dickson and Leslie Stone

Rural communities face daunting challenges that jeopardise the well-being of their residents. Family physicians are essential resources for these communities and well qualified to help improve the lives of all who call these communities home.

Rural America is struggling. Over the last generation, rural small businesses have been crowded out of their markets by larger corporate entities, and small family farms have similarly been bought out or replaced by larger producers.[27] As a result, limited educational and economic opportunities are contributing to the dramatic rise in what some call deaths of despair—overdoses of drugs and alcohol, suicides and alcoholic liver diseases.[28]

While family medicine cannot rectify all the ills that rural communities in the USA or elsewhere face, it can be part of the solution. This requires that family medicine be seen as a foundational element of a fully functioning healthcare system rather than as an appendage to subspecialty and hospital care.

Robust rural family medicine includes the following[29]:

- Provides medical care that is socially accountable and broadly centred on whole patients, families and communities rather than biomedical care that is narrowly focused and disease centred.
- Offers geographically decentralised care that is local and accessible rather than institutionally centralised care in distant and often poorly accessible medical centres.
- Relies on the democratisation of knowledge and the equitable allocation of financial, educational and technological resources.
- Encourages family physicians to exhibit clinical courage[30]—expanding the limits of the care they provide through broad training.

Certainly, there are barriers to such robust care in rural areas. These include geographical isolation and often limited means of transportation, extensive poverty, poor resource availability and few financial or social incentives to attract and retain a motivated professional workforce. On the flip side of the equation, rural medical facilities—community hospitals and local clinics—are often drivers of community development; they routinely spur the presence of other social, educational and healthcare services, and promote economic growth.[31]

To meet the needs of people living in geographically distant areas, a conceptual shift is critical: rather than simply viewed as a means by which patients can be funnelled toward urban specialty services and hospitals, rural primary care clinics must be valued by highly centralised institutions and supported as decentralised centres of excellence in and of themselves. Rural family physicians and distant healthcare institutions can partner together to provide dynamic clinician-to-clinician consultation services and link accessible broad-scope

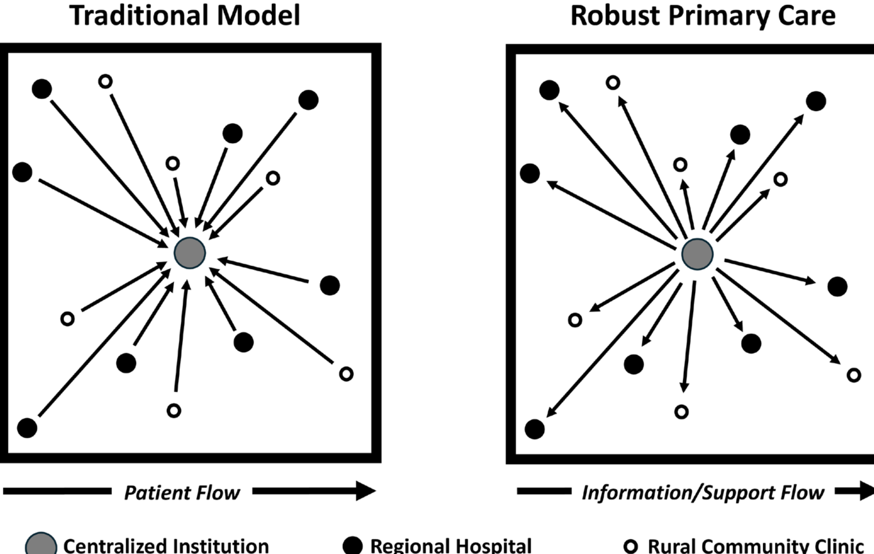

Figure 8 Rural healthcare: perspectives on excellence.

family-centred and community-centred care with up-to-date subspecialty expertise.

Such partnerships help rural family physicians provide comprehensive care, often across generations. They empower rural healthcare systems to address presenting problems both big and small, creating a sense of accountability among those who live and work on the periphery of the consciousness of urban-centred healthcare institutions (figure 8).

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FULL-SPECTRUM FAMILY MEDICINE

Austin Brown

Full-spectrum family medicine takes on different meanings in different contexts. Nonetheless, it is a foundational feature of the discipline.

Spend anytime in or around the discipline of family medicine, and you will likely come across the phrase 'full spectrum'. Although frequently used and overheard, accurate definitions of this phrase are seemingly difficult to come by.

'Full spectrum' is often used idealistically and with a hint of nostalgia to refer to family doctors who provide prenatal and intrapartum maternity care, including operative obstetrics; maintain an inpatient practice; and perform a variety of procedures. That is only one definition, and 'full spectrum' can represent a 'spectrum' of care.

Nascent family physicians—interns and residents—come to residency having inherited from their medical school experience a disease model of care that is nearly, if not entirely, grounded in the evaluation, diagnosis and treatment of pathological conditions. Their legacy upon graduation is one heavily influenced by a curriculum in the preclinical years that prioritises a reductionist interpretation of biomedical science and a model of clinical preparation that emphasises subspecialty practice in tertiary-level and quaternary-level hospitals.[32] They have also undoubtedly encountered the informal and hidden curricula of medical schools that routinely disparage primary care.[33]

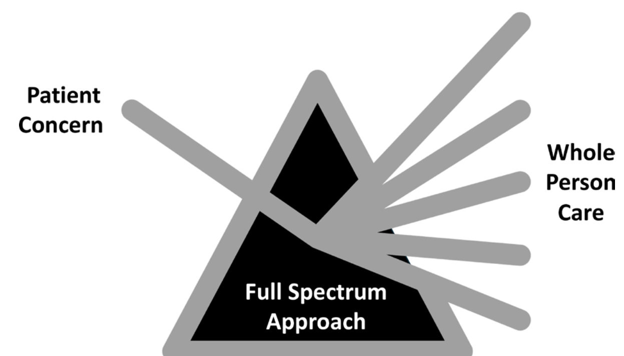

Figure 9 Full spectrum is family medicine/family medicine is full spectrum.

Historically, family medicine has rejected this model and these influences, though not entirely, of course, as family physicians still use conventional diagnostic evaluations and treatment interventions to attend to the physical complaints that concern patients. Rather, family medicine has promoted a different way of looking at patients and their problems and a different conception as to the central focus of medical practice. Patients are not 'dirty windows' through which clinicians look to ascertain correct diagnoses.[34] Rather, family physicians frame pathology in context of individuals living and working in communities, their lives and their illnesses, shaped by such factors as faith, gender, class and relationships.[35]

What emerges from this understanding of family medicine is *whole-person care*: treating people as whole people who have a wide variety of needs—psychological, social, biological and existential—that commonly present in clinical encounters as inter-related admixtures of distressing signs and symptoms.[36] In this regard, 'full-spectrum' family medicine means tailoring medical practice to meet as many of those needs as possible, all the while acknowledging patients—people—as objects of primary attention.

'Full spectrum' does not suggest a style of family medicine, neither does it imply what any one family physician does. Depending on resources, geography and local needs, what family medicine ultimately looks like will differ in different communities. Still—along with the drive to learn new skills, to widen the scope of practice as is required and to teach these characteristics to new generations of physicians—'full-spectrum' care is a key component of family physicians' professional identity. It is at the heart of why family physicians exist (figure 9).

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Author note All patient names are pseudonyms. Identifying data have been changed to protect patient anonymity.

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