A practical foundation

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amily medicine intersects with the other specialties by virtue of the scope of its content but diverges from them in its approach to the individual patient and the variety of clinical settings in which it it practised. Caring for people with multiple, frequently transient and often undifferentiated problems over a long period of time in a range of settings is what family physicians do. A patient may experience illness in any of the organ systems. The job of the family physician is keep that patient well as a whole person.

A number of organizational and clinical issues may be remembered as representative in family medicine in 1997. Rural medicine continues to move forward politically and in its research base. The restructuring of our health care system and the distribution of physicians still preoccupy us. The promotion of evidence-based medicine and the consequent development of clinical practice guidelines continue to charm some and worry others. Alternative or complementary medicine is always looking over the clinician's shoulder as an option for patients. The physician–patient interaction continues to be studied. And, on a very practical front, we finally seem to have a logical, evidence-based approach to the management of a common presenting problem: sore throat.

The *Canadian Journal of Rural Medicine*, a peer-reviewed scientific journal and the voice of the Society of Rural Physicians of Canada, has completed its first full year in publication. The lack of a clear, quantitative definition of "rural" has made comparisons of findings from research studies difficult and has hindered the development of rural health policy. However, we may take heart in the fact that Leduc[1] has developed a General Practice Rurality Index (GPRI) for Canada. The index incorporates 6 variables: remoteness from the closest advanced referral centre; remoteness from the closest basic referral centre; drawing population; number of general practitioners; number of specialists; and the presence of an acute care hospital. This provides, for the first time, a means of mapping the whole of Canada according to quantitative scores (out of 100). Maps similar to contour or population distribution maps could be developed on the basis of these scores and used to facilitate rural health care planning and research.

A Canada-wide survey by Hayward and colleagues[2] assessed physicians' attitudes toward and confidence in clinical practice guidelines. Survey respondents were generally positive about guidelines if they were issued by physician organizations but were wary of those issued by ministries of health or health insurance plans. Most respondents felt they were a useful source of information but actually used them only about once a month — much less frequently than more traditional sources of information such as books and journals. It seems that — with some caution and a little concern about losing autonomy — physicians agree that clinical practice guidelines are good and potentially useful, but have not yet really incorporated them into their practice. The development and dissemination of guidelines are going well, but their actual implementation will take more time.

Alternative therapies are on the rise, running the gamut from "reasonable changes in lifestyle and relaxation methods to patently absurd practices such as iridology, crystal healing, and colonic irrigation."[3] Millar[4] analysed data from 17 626 respondents to the 1994–95 National Population Health Survey related to the use of alternative health care practitioners, including chiropractors, by Canadians

Determining the sore throat score

Does the patient meet the following criteria?
- Absence of cough?
- History of fever over 38°C (101°F)?
- Tonsillar exudate?
- Swollen, tender anterior cervical nodes?

Number of criteria met	Chance of streptococcal infection in a community with usual levels of infection (%)	Suggested action
0	2–3	No culture or antibiotic is required
1	3–7	
2	8–16	Culture all; treat with penicillin if culture is positive
3	19–34	
4	41–61	Culture all; treat with penicillin on clinical grounds*

*If patient has high fever or is clinically well, and presents early in disease course. Use erythromycin if patient is allergic to penicillin.

The sore throat score should not be applied to patients younger than 15 years of age or in a community where an outbreak of group A streptococcal pharyngitis is occurring.

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over 15 years of age. Fifteen percent received some form of alternative health care in the year preceding the survey. Use of alternative health care services was most prevalent among women, people aged 45 to 64 years and those in higher income groups. Although only 9% of people free of chronic disease consulted alternative health care providers, 26% of people with 3 or more chronic conditions did. Family physicians are faced daily with patients who have sought help from alternative practitioners or are seeking advice on whether they should. Medical training does not deal with alternative paradigms or ways of thinking of our body and the healing process. Should they be addressed in medical school? Should we accept them or insist on evidence? After all, we expect evidence from researchers and practitioners in our own field! Of course, much of what we do in medicine lacks clear evidence — but it at least makes sense to us, from within our own frame of reference.

For years the approach to sore throats in family practice has been controversial. Some clinicians felt that they could diagnose streptococcal pharyngitis clinically in a high percentage of cases. Others did studies that showed that physicians' judgements were about as accurate as flipping a coin. There really is just 1 question: "Is it strep throat?" If not, it's likely a virus and grandmother's remedy is as good as ours. If it *is* strep throat, then penicillin is needed to decrease the patient's likelihood of acquiring rheumatic heart disease. Should we take a throat swab from everyone and wait for the results? Should we give everyone antibiotics? Should we take swabs periodically to get a sense of what is circulating in the community? Should we take the "best guess" approach, treating patients that we think have strep throat and ignoring or taking swabs from the rest? After a detailed review of the literature and a survey of physicians' practice patterns, McIsaac and colleagues[5–7] have come up with a scheme that is reasonably evidence based, and that seems to be acceptable to most physicians (see table). They have developed a means of assigning a sore throat score to the patient; on the basis of this score, the likelihood that the patient has strep throat can be determined. They also suggest what course of action to take on the basis of the score. This model should become the standard by which we approach sore throats in family practice.

Once again it has been shown that we should avoid episiotomies if at all possible. This is particularly true for median episiotomies. Labrecque and colleagues[8] demonstrated in a retrospective cohort study that median episiotomies were strongly associated with third- and fourth-degree perineal lacerations in primiparous women. An episiotomy should be done primarily to facilitate the birth of a baby in distress; even then, mediolateral, not median, episiotomy should be performed.

McWhinney[9] and others have been discussing and studying the concept of the patient-centred approach to the physician–patient encounter for a number of years now. The patient-centred approach is taught in most residency programs and is accepted as a core concept by the College of Family Physicians of Canada, which bases the scoring of oral exams largely upon it. But the most convincing proof that the patient-centred approach gets to the very essence of how family medicine should be conducted is the fact that a group of general practitioners in Europe have come up with a nearly identical model. Although the language used is slightly different, it is essentially the same concept. It has 9 steps that can be remembered by the mnemonic P-R-A-C-T-I-C-A-L.[10] The letters stand for Prior to the visit, Relationship, Anxieties, Common language, Translating, Interaction, Converting, Agreement check and Leave. An explanation of each of these terms is beyond the scope of this brief review, but suffice it to say that it involves a step-by-step model for conducting the patient interview in general practice.

The research and philosophical basis of family medicine is evolving with each passing year. Information from the Insitute for Clinical Evaluative Sciences in Ontario[11] shows that family physicians account for 41% of OHIP (Ontario Health Insurance Plan) expenditure on physicians and for over 50% of all physician–patient encounters. Nevertheless, only about 5% to 10% of articles published in 1996 in general medical journals were related to primary care or family medicine. The challenge for the future is for family physicians to increase their research and publication output to strengthen the evidence-based foundation on which family medicine is built.

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