

**EURACT's DEFINITIONS OF GENERAL PRACTICE/FAMILY MEDICINE – Similarities to and differences from systemic family medicine?**Pekka Larivaara<sup>1</sup><sup>1</sup>Professor in Systemic Family Medicine, Department of Public Health Science and General Practice Oulu University, Finland**Abstract :**

In 2002 EURACT (European Academy of Teachers in General Practice) published a statement which defines the discipline of general practice/family medicine and describes its core competences. EURACT's definition includes eleven characteristics of the discipline, which are clustered into six core competences of the general practitioner/family doctor. The Euract Educational Agenda of General Practice/Family Medicine was published three years later and it wishes to contribute to the harmonization of the learning outcomes of different medical education training programmes all over Europe at this level. This article introduces these Euract's definitions and some main points of the educational agenda. It also looks for similarities and differences between the Euract's definitions and the basic premises of systemic family medicine.

**Introduction**

European general practice has a long history but not until in 1974 the first statement "The General Practitioner in Europe" was produced by Leeuwenhorst group (1). At that stage general practice/family medicine was in its infancy as a discipline, particularly with regard to its teaching and research base. Almost 30 years later the world has moved on and nowhere this change has been more apparent than in the provision of health care. General practice/family medicine is now well established in all health care systems in Europe and is recognised by health service providers as being of ever increasing importance.

Since the work of the Leeuwenhorst group several definitions of general practice/family medicine have been written and they are mainly focused on general practitioners' professional activities, not on the characteristics of the discipline.

Euract (European Academy of Teachers in General Practice) published the newest definitions of European general practice/family medicine in 2002 (2). This work came about as a result of revising previous definitions, as it had been felt that they had come updated and needed revising for the 21st century. By writing the new definitions Euract would like to produce a consensus document on definition and competencies. The statement was produced as an aid to individual teachers, students and practitioners. It defines both the discipline of general practice/family medicine and the professional tasks. The group of authorities in Europe felt that general practice must be identified as an academic discipline. It is not the sum of other specialities added together, but it is a specific discipline with its own education, research and practice.

**Corresponding Author:**

Pekka Larivaara, M.D., Ph.D.  
Professor in Systemic Family Medicine  
University of Oulu,  
Department of Public Health Science and General Practice  
P.O.Box 5000  
90014 Oulu University  
e-mail: [pekka.larivaara@oulu.fi](mailto:pekka.larivaara@oulu.fi)

### **Discipline and specialty of general practice/family medicine defined by Euract**

Euract wants to make sure that there is a need to define both the discipline of general practice/family medicine and the role of the specialist family doctor. The former is required to define the academic foundation and the framework on which the discipline is built, and thus to inform the development of education, research, and quality improvement. The latter is needed to translate this academic definition into the reality of the specialist family doctor, working with patients in health care systems throughout Europe.

The characteristics of the discipline of general practice/family medicine are that it:

- Is normally the point of first medical contact with the health care system, providing open and unlimited access to its users, dealing with all health problems regardless of the age, sex, or any other characteristic of the person concerned.
  - Makes efficient use of health care resources by coordinating care, working with other professionals in the primary care setting and by managing the interface with other specialities, taking an advocacy role for the patient when needed.
  - Develops a person-centred approach, and oriented to the individual and his/her family, and their community.
  - Has a unique consultation process, which establishes a relationship over time, through effective communication between doctor and patient.
  - Is responsible for the provision on longitudinal continuity of care as determined by the needs of the patient.
  - Has a specific decision making process determined by the prevalence and incidence of illness in the community.
  - Manages simultaneously both acute and chronic health problems of individual patients.
  - Manages illness which presents in an undifferentiated way at an early stage in its development, which may require urgent intervention.
  - Promotes health and well –being both by appropriate and effective intervention.
  - Has a specific responsibility for the health of the community.
- Deals with health problems in their physical, psychological, social, cultural and existential dimension.

General practitioners/family doctors are specialist physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for the provision of the comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness. They care for individuals in the context of their family, their community, and their culture, always respecting the autonomy of their patient. So, they integrate physical, psychological, social, cultural and existential factors. The specialist family doctors must take the responsibility for developing and maintaining their skills, personal balance and values as a basis for effective and safe patient care.

### **Core competences of general practice/family medicine defined by Euract**

The definition of the discipline of general practice/family medicine and of the specialist family doctor must lead directly the core competences of the general practitioner/family doctor. The eleven characteristics of the discipline relate to eleven abilities that every specialist family doctor should master. Because of their interrelationship, Euract clusters them into six independent categories of core competences. The main aspects of each cluster are:

- Primary care management: the ability to manage primary contact with patients; to co-ordinate care with other professionals.
- Person-centred care: the ability to create well –functioning doctor-patient relationship.
- Specific problem solving skills: the ability to relate specific decision making processes to the prevalence and incidence of illness in the community; to make effective and efficient use of diagnostic and therapeutic interventions.
- Comprehensive approach: to manage simultaneously both acute and chronic problems in the individual, to promote health and well being.
- Community orientation: the ability to reconcile the health needs of individual patients and the health needs of the community in which they live in balance with available resources.
- Holistic approach: the ability to use a bio-psycho-social model taking into

account cultural and existential dimensions.

### **Euract Educational Agenda**

The educational agenda was published in 2005 (3). It is a large and ambitious statement which includes 48 pages. The agenda aims to offer an educational framework for teachers and learners. It gives a guide for basic medical education, but its central focus is in specialist training. In the agenda the authorities emphasize that general practice/family medicine is best learnt in practice and recommends early clinical exposure of medical learners already at the beginning of medical school. Learning process in general practice/family medicine is a lifelong issue. The family doctors have to accept the complexity of the real practice which is holistic in outlook, dealing with illness and disease in the context of the patient, their family and the whole community. In the agenda a biopsychosocial model is introduced (4). It means a paradigm shift in modern medicine and it dissolves the body-mind split. The clarification of the biopsychosocial model can be occurred in different kinds of learning contexts: reading articles, listening lectures, conversation in small groups, doing role plays, exploring the family doctor's own personality and having supervision. Constructivism is also introduced as an educational model that puts "the learning process of the student/trainee as the central point. Teaching and learning should be very much based on case studies, narratives, patient stories, and the global context that can be taught and learnt in the practice context.

The agenda focuses mainly on the concepts of the contacts of the physician with patients, comprehensiveness, coordinated care, cost-effectiveness and patient advocacy. The most effective teaching tool is often role modelling. According to the agenda the teachers have to understand that there is a parallelism between the doctor-patient relationship and the teacher-learner relationship. The teachers/tutors should act as facilitators, stimulating self-directed learning, critical thinking, and reflection to enhance personal and professional growth. Tutoring should be solution-focused rather than problem-focused, with elements of a system-based approach to at least include the person, the family and the community dimension. The education should emphasize the student/trainee as a person, developing personal strengths. The doctor's own values, attitudes, and feelings are important determinants on how he/she practices

medicine. So, education should aim at understanding and learning to use one's own attitudes, strengths and weaknesses, values and beliefs in a partnership relation with the individual patient and his or her family. This requires a reflective approach and to develop an insight and an awareness of self.

Instruments like genograms, family tree; eco-mapping are specific and good methods for teaching and clinical work. During specialist training the family doctor has first to have personal experience of being "in a patient role" in which the teacher draws a family tree of eco-map for him or her. After that experience the doctor could be an expert for using these tools in the practice. Video patient-case recording are also good tools for reflective teaching and learning.

In the agenda the authorities also emphasize that the family doctors have to understand the structure of the whole health care system and have to understand the interrelationship between health and social care. So, he or she has to have an ability to work as a member or as a leader in interprofessional teams. For adopting these skills the doctor has to learn basic theories of effective team work.

The practice should be as much as possible based on scientific evidence that is relevant for and in general practice. Combining and balancing the experience based and evidence based approaches in the development of practice guidelines provide an authority-based approach which completes the support from scientific community. The specialist training programme should have a constructivist curriculum with enough learner exposure. There is a need for tacit learning from books and written documents, but the real cases are not in the books.

### **Some basic premises of systemic family medicine**

Systemic family medicine is a new field of medicine and its theoretical basis is on family therapy approach and it was begun to teach general practitioners/family doctors first in the US and Canada and later in several places in Europe (5, 6, 7). In systemic family medicine a family is defined as any group of people related either biologically, emotionally or legally. The physician mobilizes the patient's natural support system to enhance health and well-being. The basic premises of systemic family medicine are:

- Family-oriented health care is based on a biopsychosocial systems approach.
- The primary focus of health care is the patient in the context of the family.
- The patient, family and clinician are partners in health care.
- The family-oriented clinician reflects on how he or she is part of the treatment system.

In systemic family medicine the family is seen the primary source of health beliefs and behaviours. Stress of the family developmental transitions may become manifest in physical, psychological or psychosocial symptoms. Sometimes these symptoms can serve an adaptive function within the family and may be maintained by family patterns. Families are a valuable resource and source of support for the management of illness. In systemic family medicine the practitioners try to “destroy” the illusion of the dyad (doctor-patient relationship) in medical care. The main focus is the patient

in the context of the family. So, instead of the traditional dyad approach systemic practitioners propose a “triangular perspective”. This triangle involves the clinician, patient and family working together in a medical-care partnership.

In systemic family medicine a genogram is an essential tool to recall about information about family. Family is seen as a system: human body is more than organ systems operating to one another. The systemic-oriented doctor is interested in family structure: hierarchy, boundaries of subsystems and family members' role selection. Many families have alliances and coalitions. The doctor is also interested in what kind of processes are going on in the family. Do the family members have enough individual autonomy? Triangulation is an important concept, too. E.g. a child is drawn to his/her parents' conflicts. The systemic-oriented practitioner is also interested in family's developmental stage and family life cycle and intergenerational coalitions.

**Table 1:** Differences seen in the practice of general practitioner and systemic practitioner

General practitioner	Systemic practitioner
<ul style="list-style-type: none"> <li>• Bases his/her work mainly on professional practices, not on any special theory</li> <li>• Asks often linear questions</li> <li>• Primary focus is the patient, person-centred care</li> <li>• Focus mainly on biomedical symptoms and diseases, is interested in diagnoses and seeks methods to treat (care for) the patient</li> <li>• Offers often prescriptions</li> <li>• Works mainly alone with one patient as an expert</li> <li>• Almost never works with a family therapist</li> <li>• Works mainly in his/her office</li> <li>• Uses seldom the genogram as a tool</li> <li>• Has mainly collected his/her theoretical speciality training hours from short 1-2 days seminar fragments which deal with common diseases and thinks that several years work in primary care setting makes you competent.</li> <li>• Gives often answers and advice to the patient's questions</li> <li>• Sees himself/herself in an interprofessional team as a leader and other professionals as assistants</li> <li>• With somatizing patients pays often first attention to the patient's somatic symptoms and if doesn't find any disease, starts to seek psychological reasons</li> </ul>	<ul style="list-style-type: none"> <li>• Theoretical basis is on systems theory and on family therapeutic theories</li> <li>• Asks often circular questions</li> <li>• Primary focus is the patient in the context of the family (therapeutic triangle)</li> <li>• Focus on several levels in the biopsychosocial model, is also interested in family characteristics, structure, process and life style</li> <li>• Offers often descriptions</li> <li>• Works often with a co-worker and several family members and tries to get shared expertise</li> <li>• Works in a difficult case situation with a family therapist</li> <li>• Does also home visits</li> <li>• Uses often the genogram as a very important tool</li> <li>• Has participated in a longer (e.g. 1-2 years) process like training programme in systemic family medicine and thinks that such a training change their working style completely</li> <li>• Uses often reflective working style, sometimes reflecting team</li> <li>• Includes in interprofessional team work families and bases his work on social constructionism (helps the team and family members to create new meanings and realities)</li> <li>• With somatizing patients explores from the beginning of their collaboration both somatic, psychological, family and other social issues</li> </ul>

### Similarities and differences between Euract's definitions and the principles of systemic family medicine

It seems to me that these both disciplines have become closer to each others in theory during the last two decades. As I see it they both:

- Emphasize a holistic approach: Caring for the whole person in the context of person's values, his family beliefs, the family system, and the
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- culture and the socio-ecological situation in the larger community.
- Consider systems theory and the biopsychosocial model as the basis for general practitioners/family doctor's work.
- Introduce the idea that a human being is more than its parts.
- Respect the autonomy of their patients.
- Consider interprofessional teamwork as an effective tool in primary care setting.
- Consider doctors' own values, attitudes, and feelings important determinants on how practice medicine.
- Introduce the idea of the need of paradigm shift in modern medicine which dissolves the body-mind split.

However, in spite of these similarities in theory many differences can still be seen in practice. The differences are presented in table 1.

### Conclusion

In conclusion I would like to point out that during the last ten years the Euract's authorities have done very valuable and appreciated work in preparing the new definitions of general practice/family medicine and in writing the Educational Agenda. Now challenge has been given to the training

institutions and units in different countries all over Europe. In the University of Oulu in Finland the first 2-year training programme for specializing family doctors has been planned and it will start in the spring of 2008. The programme is mainly based on the Euract's definitions and Educational Agenda. It also includes some ideas from systemic family medicine. From now on we recommend that all would-be specialists in general practice/family medicine would go through this programme.

### References

1. The General Practitioner in Europe: A statement by the working party appointed by the European Conference on the Teaching of General Practice. Leeuwenhorst, Netherlands 1974.
2. Euract. The European definition of General Practice, London 2002.
3. Heyrman J (ed.) Euract Educational Agenda. European Academy of Teachers in General Practice, Leuven 2005.
4. Engel GL. The need for a new medical model: a challenge for biomedicine. *Science* 1977;196:129-136.
5. McDaniel SH, Campbell TL, Hepworth J, Lorenz. *Family-Oriented Primary Care*. Second Edition. New York: Springer, 2005.
6. Launer J, Lindsey C. Training for systemic general practice: a new approach from the Tavistock Clinic. *British Journal of General Practice* 1997; 47: 453-456.
7. Larivaara P, Väisänen E, Väisänen L, Kiuttu J. Training general practitioners in family systems medicine. *Nordic Journal of Psychiatry* 1995; 49: 191-197.