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Articles

Following McWhinney's footsteps: from family medicine to traditional and complementary medicine

Seguindo os passos de McWhinney: da medicina de família à medicina tradicional e complementar (resumo: p. 16)

Siguiendo los pasos de McWhinney: de la medicina de familia a la medicina tradicional y complementaria (resumen: p. 16)

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Family physicians have developed a holistic approach to patients' care which can facilitate a mutual understanding of different Traditional and Complementary Medicine (T&CM) practices. This analytical paper considers three intertwined issues: (1) Ian McWhinney's critique of biomedical abstractions (i.e., disease categories); (2) The similarity between the cosmology of family medicine's organismic thinking and homeopathy's vitalism as an example of T&CM; and (3) The gradient of explanatory models (EMs) to delineate the space within which T&CM can be applied to patients' care. In primary health care predominates a blend of physiopathological and semiological EMs comprised of low to moderate risk patients. In this scenario, the introduction of T&CM practices can enhance family physicians' therapeutic scope. Thus, the combination of gradient of EMs, primary health care attributes, and family physicians' professionalism can provide the required safe environment for implementing T&CM services.

Keywords: Primary Health Care. Family practice. Homeopathy. Complementary therapies. Health promotion.

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Introduction

Universal health systems, organised through primary health care (PHC), present better health outcomes, greater equity, and lower costs than those systems not oriented through PHC[1]. The strength of PHC lies in the achievement of its attributes: access, longitudinal care, comprehensiveness, coordination of care, as well as, family, community, and cultural orientation[2]. At the core of PHC is family medicine, where general practitioners (GPs) are responsible for providing and coordinating personalised and continued care to a cohort of individuals in a given territory[3].

Family medicine is a biomedical specialty which has historically challenged biomedical knowledge. For instance, in the United States, after the World War II, "the GI Bill of Rights... helped increase the specialisation of many who had been general practitioners (generalists) before the war"[3] (p. 458). The restructuring of family medicine emerged as a movement contrary to the trend of super-specialisation in medicine. Through an international partnership, American general practitioners managed to stablish the required credential for a new medical specialty. From the 1970s onwards, postgraduate training became mandatory to practice family medicine in the US[3]. In the United Kingdom, this opposition to biomedical knowledge can be understood in light of institutional rearrangements. In 1948, the inception of the National Health Service (NHS) strengthened the role of general practitioners. For instance, the College of General Practitioners, founded in 1952, sought to create an academic identity for general practitioners that was not simply "an attenuated version of hospital specialisms"[4] (p. 790). Thus, GPs' core values have been gradually forged: starting in the late 1950s with Balint's biographical model of clinical care[5], endorsed by Engel's[6] biopsychosocial model of practice in the 1970s, and reaching the 1990s with McWhinney's[7] construct of "organismic thinking". This effort to transcend biomedical model's limitations contributed to develop a holistic approach in clinical practice. Holistic approach has been framed as "caring for the whole person in the context of the person's values, their family beliefs, their family system, and their culture in the larger community and considering a range of therapies based on the evidence of their benefits and cost"[8] (p. 44).

From the 1960s onwards, another movement emerged in Western societies that made a counterpoint to biomedical knowledge. Traditional and Complementary Medicines (T&CM) began to receive institutional support. Initially, the justification was to solve health problems of large population groups in the world, still in need of medical care. For instance, "in 1978 the WHO recommended that traditional medicine be promoted, developed and integrated wherever possible with modern scientific medicine"[9] (p. 90). In the following decades, high-income countries have been experiencing an increase and consistent revaluation of T&CM with progressive institutional regulations. Scientific research on T&CM has significantly grown concerning its modes of functioning, efficacy, and safety. Two main reasons for this growth in high-income countries include: (a) dissatisfaction with biomedicine: greater iatrogenic effects, invasiveness, impersonal character, and mechanistic approach; and (b) virtues of T&CM: better care experience, stimulus to patient's natural healing powers, philosophical and cosmological approach convergent with patients' values, and holistic meaning of illness[10].

The growth of T&CM has substantially influenced numbers of physicians, including family doctors. The percentage of physicians who apply T&CM or work in partnership with T&CM therapists is considerable: (1) In Switzerland, 46% of physicians have some form of training in T&CM[11]; (2) In Canada, general practitioners provide 57% of herbal therapies, 31% of chiropractic and 24% of acupuncture treatments[12]; (3) In England, 50% of general practitioners in the NHS apply or indicate some form of T&CM[13]; and (4) In the Netherlands, 50% of general practitioners prescribe herbal medicines, provide manual therapies, and acupuncture[12].

In Brazil, after the 1988 constitution, which set the bedrock of a unified health system, both family medicine and T&CM have nationally been fostered. The former via the inception of the Family Health Programme (FHP) in the 1990s. The FHP has evolved to become the main organising strategy of Brazil's PHC[14]. The latter gained some visibility and growth after the 2006 National Policy on Integrative and Complementary Practices (NPICP), which initially supported five types of T&CM: homeopathy, acupuncture/traditional Chinese medicine, anthroposophical medicine, usage of medicinal plants, and thermal/minerals water. In 2017, there was an expansion of the NPICP to incorporate 19 integrative and complementary practices, such as: art therapy, Ayurveda medicine, biodance, circular dance, meditation, music therapy, naturopathy, osteopathy, chiropractic, reflexotherapy, reiki, shantala, integrative community therapy and yoga[15].

The diversity in national, social, economic, and cultural contexts has forged PHC services. This has resulted in several conceptions and organisational standards in PHC globally. However, one issue is consensual: the provision of clinical care. The clinical care role of health professionals is common to all PHC scenarios, which justifies and supports the scope of the present discussion.

This article aims to facilitate a mutual understanding between family medicine and different medical rationalities. It explores similarities between the philosophical foundation of family medicine and homeopathy as an example of T&CM. Ian McWhinney's thoughts on family medicine and Samuel Hahnemann's concepts on homeopathy are used for this purpose.

McWhinney, an English GP, developed his medical and academic career in Canada. One of the issues he addressed in framing the academic basis of family medicine was the peculiarities of illness phenomena presented to family practice. This has also contributed to the development of Patient-Centred Clinical Method (PCCM). The PCCM aims to improve patient care by valuing patient's illness experience[16]. Nevertheless, McWhinney's ideas have not been widely applied and discussed within Brazilian (and, even international) PHC and Collective Health. A more familiar concept is Engel's biopsychosocial model[6]. This model displays a systemic framework for the biological, psychological and social dimensions in a hierarchical fashion such as molecules, cells, organism, person, family, biosphere, and society[16]. However, Armstrong[17] states that "systems theory... maintains the dominance of the biological over the social" (p. 1214). In this sense, there is a convergence with contemporary discussions of Brazilian Collective Health that comprises both the expanded clinic[18,19] and the philosophical, ethical and technological aspects of health care[20-22].

The biopsychosocial model has a built-in determinism within which an individual belongs to a level within the system. For McWhinney, it fails to "include a holistic

approach" which stems from a "meticulous observation and understanding of the patient's self"[16] (p. 70). For him, the holistic medicine comprises patient's wholeness and self-determination. Thus, it is possible to state that McWhinney was in search of an "epistemology of healing".

In Homeopathy, Samuel Hahnemann was in the same quest. He contends that "the physician's high and only mission is to restore the sick to health, to cure, as it is termed" and that "the highest ideal of cure is rapid, gentle and permanent restoration of the health"[23] (p. 85). Contrary to other T&CM such as Ayurvedic or Chinese medicine, homeopathy has a long presence in Brazil making it one of the most culturally accepted and easier to comprehend T&CM[24]. Thus, it serves as a concrete "model" for the purpose of this article. Homeopathy allows a first exploration of McWhinney's ideas towards T&CM, which, then, can also be exercised in relation to other medical rationalities. In this regard, the present article provides an organisational structure based on a gradient of explanatory models (EMs) to delineate the space within which T&CM can be better applied to patients' care. Finally, it contends that family doctors and other health professionals working in PHC can provide a safe environment for applying T&CM.

Philosophical foundation of family medicine

Ian McWhinney (1926-2012), considered the founding father of family medicine in Canada, influenced this specialty worldwide. In the process of academically rethinking the specialty, McWhinney published a series of articles on the conceptual foundations of family medicine. As family medicine is not defined by an organ, gender or technology, it needed to reflect upon itself to delineate its academic content and practice[7]. In 1978, McWhinney published an article questioning whether family medicine had reached the maturity required by science[25]. In his view, the immaturity of family medicine stemmed from adopting biomedicine's abstractions and presuppositions.

> The objects of science, then, are intellectual constructs. In medicine, the "diseases" which we have described have no real existence: they are abstractions which we invented to bring order to a mass of data about illness. Abstraction is an essential part of the scientific method, but its danger is that we can so easily become the prisoners of our abstractions[25] (p. 54)

McWhinney highlights that abstractions' organising nature can have unintended consequences. In biomedicine, pathologies have central and standardising role that dictates both medical practice and health research. This centrality not only limits and restricts medical work, but also permanently drive health professionals to think in terms of disease[26]. Thus, the contribution of family medicine to biomedical science would be to question these abstractions:

> In the scientific aspect of family medicine, the role of philosophy is to be, in Whitehead's phrase, a "critic of abstractions". So far, family medicine seems to have accepted without question medicine's current system of abstractions, i.e.

> its method of classifying diseases. We have done this, even though it often fits poorly with the "brute facts" of general practice. We continue, for example, to perform morbidity surveys in which we accept, without question, concepts like "psychiatric illness"[25] (p. 57)

Purposefully, McWhinney chooses psychiatry as an example of biomedical abstractions' inconsistency. The indiscriminate prescription of psychotropic drugs demonstrates the problematic nature of disease-oriented practice in medicine. Psychiatric disorders, as a disease construct, are ontologically and epistemologically very fragile. Thus, the author proposes that family medicine should revise the concepts of disease and illness, "because it is in family medicine that we perceive most clearly the incongruities of our current system of abstractions"[25] (p. 58).

In 1984, McWhinney published an article entitled "Changing Models: The Impact of Kuhn's Theory on Medicine"[27]. The author compares Thomas Kuhn's definition of "normal science" - an effort to put nature into its conceptual boxes - to physicians' struggle to adapt individuals' illness experiences into diseases' framework. In this process, dissociation occurs between abstractions and concrete facts, producing what Kuhn calls "anomalies". The accumulations of these anomalies would eventually challenge scientific assumptions, facilitating a paradigmatic revolution in Kuhn's theory. The new paradigm does not necessarily deny the old but has greater flexibility to accommodate the phenomena formerly ignored by the old paradigm. For McWhinney, biomedical paradigm cannot deal with certain anomalies such as: (1) Illness/disease dissociation: many people who feel sick do not have a classifiable disease; (2) Specific aetiology: a causal agent cannot always be established; (3) Mind/body division: illness manifests as three-dimensional phenomenon, i.e., biopsychosocial; and (4) Placebo healing effect: abundantly documented in clinical trials (mean of 35% - ranging from 10 to 90%)[16]. These anomalies challenge the implicit and inscribed idea of biomedical paradigm within which diseases are objects with autonomous existence, based on the occurrence of organic impairment in a chain of biological events, triggered by one or multiple causes[28]. This mechanistic understanding of human nature reduces physicians' task to that of repairing body's organic impairment, i.e., the disease component (Box 1). The biomedical-mechanistic paradigm completely obscures the effect of psychosocial and economic influences on the genesis and cure of diseases.

Box 1. Biomedical model[16].

- Diseases are categorised as natural phenomena.
- A disease is detached from the person and social context.
- Mental and physical diseases can be considered separately.
- Each disease has a specific aetiological agent.
- The occurrence of disease can be explained due to exposure to a pathogenic agent.
- The physician's main task is to diagnose the patient's disease and to prescribe a specific remedy to remove the cause and/or relieving the symptoms.
- Clinicians' clinical method is known as differential diagnosis.
- Physicians are detached observers and patients are passive recipients.

McWhinney's organismic paradigm

McWhinney proposes a "new paradigm" for family medicine called "organismic"[7]. It differs significantly from the mechanistic view of biomedicine. Box 2 highlights its main characteristics[7,16,28].

Box 2. McWhinney's Organismic paradigm[7,16,28].

- Human organisms have the following properties: growth, regeneration, healing, learning, self-organisation, and self-transcendence.
- Therapy usually consists of removing obstacles to healing, whether psychological, socioeconomic, and physical. The intervention depends on the body's healing powers.
- Traditional regimes - including balanced nutrition, rest, sound sleep, exercise, pain relief, personal support and peace of mind - support the body's natural healing powers.
- An organism reacts as a whole to life's traumas. Any significant disease affects the organism at all levels, from the molecular to the cognitive-affective.
- Self-organised systems, such as organisms, are multilevel. The multiple feedback pathways between the patient and the environment and between all levels of the patient's body require that we think of multidirectional, rather than linear, i.e., in terms of network of causal interactions.
- Organismic thinking implies the completeness between mind and body.

For McWhinney, the material description of diseases carried out by biomedicine is restricted to a physical level, or at most, the biological level of the human being. This understanding does not provide insight into the complex phenomenon of life, illness, healing, and death. The organismic paradigm stands out for its "multilevel" character and the possibility of "self-transcendence". Existence, for McWhinney is multidimensional.

> The simplest has three levels: the transcendental, the mental, and the physical. Whitehead (1926) maintained that if we wish to know the general principles of existence, we must start at the top and work down. Each higher level has capacities not found at lower levels. The higher cannot be derived from the lower. Biology cannot be fully explained in terms of physics, or psychology in terms of biology. Each higher level includes the lower levels, but transcends them[16]. (p. 80)

McWhinney is also influenced by E. F. Schumacher's concepts on the hierarchical levels of existence. In Schumacher's scheme, human beings are placed at the top of multidimensional hierarchy (Figure 1)[29].

Figure 1 illustrates the immaterial elements that manifest at each level of existence: life (x), consciousness (y), and self-consciousness (z). For Schumacher[29] there is an ontological discontinuity between each level. Following the same logic as Whitehead, the higher levels cannot be fully understood from the lower levels. For Schumacher, quoting Maurice Nicoll, "life, before all other definitions of it, is a drama of the visible and the invisible"[29] (p. 43-4).

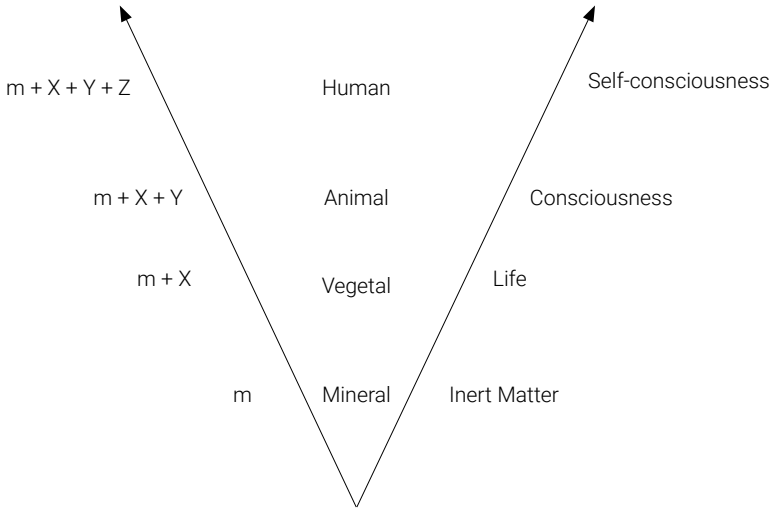

Figure 1. Schumacher's hierarchical construct of level of existence[29].

Source: elaborated by the authors.

McWhinney seeks to prompt family medicine beyond the positivism and biomedical materialism, through both philosophy (e.g. Whitehead, Liebnitz and Schumacher) and epistemology (e.g. Kuhn). Without denying the scientific basis of medicine, McWhinney attempts a paradigmatic expansion of biomedical knowledge. This facilitates the dialogue with other ways of conceiving human beings and nature. The organismic thinking can be considered a watershed in biomedicine as it makes the biomedical paradigm more porous to other disease/health conceptions. It includes invisible (immaterial) forces that organise biological processes such as growth, regeneration, healing, learning, self-organisation, and self-transcendence. This understanding of the human beings yields a different approach to care, illness, and healing beyond the conventions of material biology.

The same cannot be stated about the techniques and therapeutic means used by family medicine. They remain firmly rooted in biomedical tradition with almost absolute preference to pharmacotherapy. The exception is the therapeutic usage of doctor-patient relationship. This context, however, can be improved. Other medical traditions and rationalities can expand the therapeutic scope of family physicians as they include other levels of human beings, as proposed by McWhinney.

The organismic paradigm, to the best of our knowledge, has not been fully explored. Despite its critic depth, the disease abstractions persist the main conceptual and interpretive tool of family medicine. As consequence, biomedical paradigm still dominates and captures the bulk of therapeutic interventions in PHC, resulting in disease-risk control and medicalisation[30]. This adverse reality makes the discussion of the organismic paradigm very relevant as it opens the dialog with other contemporary knowledge and practices of health care. One of these possible relationships relates to homeopathy.

Homeopathy: Samuel Hahnemann's vitalism

Samuel Hahnemann[23] (1755-1843) was a critic physician of the medicine of his time. He questioned the "old medicine" or allopathy, which sought to remove the "morbid" agent from patients by means of bleeding, vomiting, diuretics, and so on. For Hahnemann, this process aggravated patients' suffering, by "depriving the organism of forces and fluids necessary for the heart"[23] (p. 11). Hahnemann advocated an eminently vitalistic conception of human being, as other physicians of the 18th century[31].

> The material organism, without the vital force, is incapable of feeling, acting, and preserving itself; all sensations are born, and all vital functions are realised through the immaterial being [vital force or principle] that animates it, both in the state of health and illness[23]. (p. 91)

According to Hahnemann, the nature of disease could not be elucidated by analysing human body's inner structures, i.e., its functioning, objectified in physiological constants and measurements. Health and illness resided in the vital principle's dynamic-equilibrium state that characterises human beings.

> The organism is indeed the material instrument of life, but it cannot be conceived without the vital force that animates, operates, and feels instinctively. In the same way, the life force cannot be conceived without the organism, and therefore the two constitute a unity, even if our mind separates this unity into two distinct conceptions, so that one can easily understand them[23]. (p. 96-7)

Illness occurs due to an imbalance in the vital force or principle. The source of the imbalance may be at multiple levels of existence. The influences upon the dynamics of the vital force can be both external (relational, social and environmental) and internal (psychological, emotional, spiritual). This vitalist conception was abandoned by biomedicine from the beginning of the twentieth century[32].

Hahnemann conceived and developed a specific stimulation method of the vital force called pathogenesis[33]. Pathogenesis consists in administering of diluted and dynamized substances capable of altering the vital principle in healthy human beings, producing states of artificial illness. Hahnemann began the first pathogenesis in himself, in acquaintances, and relatives[32]. This methodology was relatively known to the medicine of his time, but it had not been organised and systematised before him[32,33]. The compilation of innumerable pathogenesis constitutes the "Homeopathic Materia Medica".

Hahnemann's coherence, rational, and scientific foundations towards the vitalist principle resulted in the homeopathic approach or healing art. This is characterised by four principles: (1) Pathogenesis - systematic experimentation and documentation of medicinal substances' effects in healthy people; (2) The law of similar - *similia similibus curentur* - the process of selecting a medicine by the degree of similarity between symptoms produced in healthy persons (pathogenesis) and totality of patient's symptoms, i.e., the "best match"; (3) Single medicine - to prescribe one medication at a time to be able to observe the remedy's action on patients. A clear contrast to polypharmacy, common in his time, and a search for coherence with pathogenesis;

and (4) Dilution and dynamization of medicines - the successive dilutions and dynamizations of substances reduced its toxic effects and, simultaneously, enhanced its curative principles[23,32]. Homeopathic pathogenesis shows that even imponderable doses of medicines maintain active effects on sensations and functions of those taking part on the homeopathic pathogenesis. Paradoxically, little scientific research on pathogenesis has been carried out to date.

Hahnemann considered inappropriate to classify as chronic diseases those conditions resulting from daily exposure to preventable harmful influences (Box 3). According to him, "these states of ill-health, which persons bring upon themselves, disappear spontaneously, provided no chronic miasm lurks in the body, under an improved mode of living, and they cannot be called chronic diseases"[23] (p. 161).

Box 3. Conditions that produce artificial chronic diseases[23].

- The habit of indulging in injurious liquors or foods.
- Addiction to excess of many kinds which undermine the health.
- Prolonged abstinence from things that are necessary for the support of life.
- Residing in unhealthy localities, especially marshy districts.
- Live in cellars or other confined dwellings.
- Deprived of exercise or of open air.
- Overexertion of body or mind that ruins their health.
- Live in a constant state of worry, etc.

Hahnemann had a hierarchical conception of existence within which the vital force constituted an intermediate level between matter and the other levels of being.

> In health, the (autocratic) vital force that dynamically animates the material body (organism) governs with unlimited power and retains all parts of the organism in an admirable and harmonious vital operation, both with respect to sensations and functions, so that the spirit endowed with reason who resides in us can employ these living and healthy instruments "for the highest purposes of our existence"[23]. (emphasis added on page 91)

This hierarchical cosmology of being coincides with both Hahnemann's vitalism and McWhinney's organismic thinking. In this hierarchical cosmology "'higher' always means and implies 'more inner', 'more interior', 'deeper', 'intimate'; while 'lower' means and implies 'more outer', 'more external', 'shallower', 'less intimate'"[29] (p. 43).

Homeopathy is a complex and specific medical system that differs from biomedicine[34]. According to Luz and Camargo Jr.[35], homeopathy is a medical rationality due to the following coherent dimensions: cosmology, medical doctrine, vital principle, morphology, diagnosis, and therapeutics. These dimensions constitute a medical rationality insofar as the art of healing has remained the predominant knowledge element. The commitment to heal or restore patients' health constitutes the foundation of homeopathy as a medical rationality. Other medicines, such as traditional Chinese, Ayurvedic, and Anthroposophic medicines also share the same

characteristics. Their integrating cosmologies of man, nature, and the universe are associated with the vitalistic principle. These medical rationalities combine micro- and macro-universe elements on illnesses' genesis. Illness would be the consequence of an imbalance of material and immaterial forces. Human beings act at the same time as expressions and participants in this harmony rupture. To reach a new state of dynamic equilibrium, T&CM stimulates human beings' endogenous potentials for rebalancing and self-healing in health care processes[35]. This approach facilitates a dialogue between family medicine's organismic paradigm and T&CM as both conceptions transcend the biomedical model.

Different medical rationalities in primary healthcare

An organisational structure for implementing different medical rationalities in clinical care can be built based on a common understanding of illness phenomenon. In "Being a general practitioner: what it means"[36], McWhinney explains the differences between concrete and abstract thinking when caring for an illness. Diseases as biomedical abstractions offer taxonomic precision, correct application of biomedical technologies, great predictive and generalisation power. McWhinney contends that "the power of generalisation is gained by distancing ourselves from individual patients and all the particulars of their illness"[36] (p. 136). Nevertheless, clinical care involves individualisation of concrete illness situations that extrapolate biomedical abstractions, i.e., disease classification. McWhinney explores the difference between disease as abstractions and illness as concrete phenomenon through a visual representation (Figure 2). The original illustration was expanded to accommodate other explanatory models (EMs)[36].

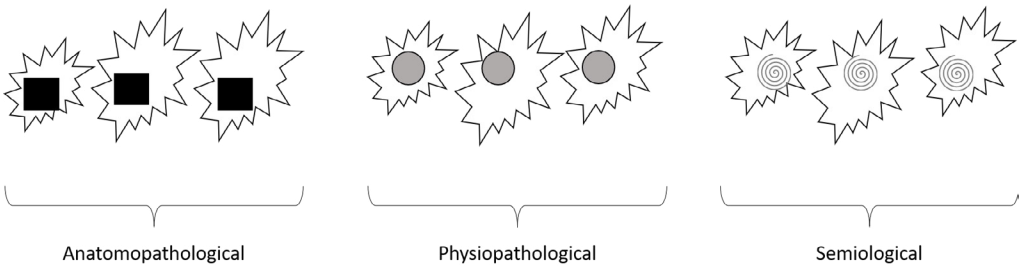

Figure 2. Disease/illness gradient of explanatory models (adapted from McWhinney[36]).

Figure 2 illustrates nine distinct clinical contexts of disease/illness grouped in triads. The central parts of each clinical context represent disease abstractions and the irregular external part the illness phenomenon. Disease categories vary in their predictive and generalising power: high (square: solidity), medium (circle: fluidity), and low (spiral: volatility). For example, the first three squares represent the diagnosis of tuberculosis in which the biomedical model has great predictive and generalising power. The irregular area with different formats around each square illustrates the individualised and unique experience of illness. According to McWhinney[28], family doctors should include the illness dimension within doctor-patient relationships. This

approach can enhance the curative effect of biomedical interventions by mobilising individual's own healing powers and/or by improving compliance to proposed treatments.

The anatomopathological EM begins to lose strength as it moves towards physiopathological and semiological EMs. Physiopathological EM explains disease in terms of enzymatic, biochemical, hormonal, immunological changes, such as in asthma, allergies, hypothyroidism, arthritis, and so on. Semiological EM represents a very common occurrence in PHC. This illness context is rich in symptomatologic data but correlates poorly with anatomopathological or physiopathological biomedical EMs. This includes clinical contexts of medically unexplained symptoms (MUS), functional disorders such as irritated bowel syndrome, dyspepsia, pains (headaches, back pains), and mental health problems (depression, anxiety, etc). In summary, the gradient of biomedical EMs loses predictive power and generalisation as it moves away from well-defined (anatomopathological) towards poorly defined (semiological) clinical disease frameworks[37]. In all these contexts, illness is present as concrete facts that individualise each clinical case.

This gradient of EMs has no clear cut and EMs may overlap. This does not invalidate the proposed framework as it aims to organise complex phenomenon. It seeks for resemblance, not precision, due to its practical nature. This gradient of EMs allows physicians to delineate spaces for including other medical rationalities. In clinical situations where biomedical model is hegemonic, the T&CM should have a complementary role. Nevertheless, in clinical contexts where illness lacks a robust biomedical EM (e.g. anatomopathological) that explains it, and/or where biomedical treatments have limitations, as in the case of mental health, other medical rationalities can gain in relevance. These medical rationalities utilise certain spectrum of illness information that has no value to biomedical clinical reasoning. In other words, the "mass of data about illness"[25] can help other medical rationalities to elaborate different understandings of illness and clinical care plan. Homeopathic approach values patient's information in terms of dream content, type of fears, certain attitudes (desire to be alone or in company, food aversion), body sensations (coldness, humidity, dryness, etc), triggers (weather or seasonal changes, loss of loved ones, loss of social position), feelings (sadness, hate, hopelessness), and so on. This data about illness contributes to tailor each patient's treatment. The homeopathic empiricism shows that the most therapeutic similarity is that which is revealed mainly in the details and peculiarities of illness singularities. In other words, it operates as if the "best match" of remedy capacity of stimulating patient's vital energy was dependent on a fine tuning with patient's illness singularities. Therefore, it transcends the biomedical disease classification based on the commonality of symptoms, which neglects and eliminates that which is singular, individual, and subject specific. In the case of other medical rationalities, they may value other aspects of illness manifestations as well.

In family physicians' PHC scenario there is a quantitative dispersion of clinical contexts that displays a continuum of clinical risk and severity[38]: low, medium, and high risk. The majority of patients seen in PHC has low to medium clinical risk profile, with low-risk predominating. These clinical scenarios are rich in symptomatology but are not easily framed into biomedicine abstractions, as in the case of medically unexplained symptoms. In this context of low or medium risk,

family physicians may resort to drug prescriptions as mean for controlling patients' symptomatology. This can expose patients to significant pharmaceutical side-effects and polypharmacy. Thus, especially in the low-risk, other medical rationalities or complementary therapies can be used, when it is culturally accepted.

This gradient of EMs[37], as an organising framework, allows to question evidence-based medicine (EBM) as the major criteria for validating the T&CM in universal health systems. Randomised clinical trials have a methodology that annihilates illnesses' peculiarities and individuality[34]. Moreover, RCTs are best employed in settings where the biomedical EM is well established. Undifferentiated clinical scenarios tend to be excluded from clinical trials as biomedical rationality cannot explain the bulk of patients' complaints. These excluded patients are usually the real and complex ones rich in symptomatologic data. Additionally, in individual clinical care there will always be uncertainty whether the intervention is effective for that patient. Therefore, one important guiding criterion in decision-making process concerning the use of T&CM is patients' safety. For instance, it is not uncommon to unduly treat viral upper respiratory tract infections (VURTI) with antibiotics, despite being a benign and self-limiting condition. However, if other non-biomedical therapeutic options were available, it would be possible to reduce the misuse of antibiotics by providing an alternative to patients. This framework for applying T&CM in clinical contexts where biomedical EM is fragile, and patients' safety is high, opens the therapeutic options for both patients and healthcare professionals.

Universal health systems can also reduce the commercial bias involved in T&CM since there is no out-of-pocket payments. The motivation for applying other medical rationalities is predicated on professional experience in relieving patients' sufferings. Professional ethics should guide these therapeutic processes. Additionally, family doctors have the potential of not medicalise every expression of humans' suffering[39]. In some cases, providing undivided attention to patients' complaints is enough to promote healing[28]. Patients' healing power is stimulated when individual's life cycle, socioeconomic and cultural contexts are considered[40]. Watchful Waiting is also another strategy as 40% of patients' complaints spontaneously improve[41]. Family physicians have a key role for incorporating different medical rationalities as they provide continuous and personalised care. The wealth of information obtained via contextualised understanding of each patient over time may enhance T&CM therapeutic effects. This also provides a safety net for possible adverse effects of T&CMs, which are admittedly smaller and less frequent than in conventional treatments.

A common argument against the plurality of medical rationalities concerns the structure, routines and organisational culture of PHC services. These are commonly biomedical oriented posing difficulties to other medical rationalities performances. For instance, homeopathy consultations usually require longer time which might conflict with standard shorter appointments of PHC services. This argument disregards two important issues. Firstly, 78% of Brazil's Unified Health System services that offer T&CM occur at PHC level. Additionally, 20% of Family Health Strategy teams utilise some form of T&CM[42]. Secondly, the access to a personalised continued care and community-oriented practice, including home-visiting, provide different clinical care scenarios for a team-based care provision in PHC. Specifically, in relation to

homeopathy and consultation-length, the longitudinal follow-up allows clinicians to elaborate with more precision patient's illness symptomatic spectrum[24]. This might facilitate the selection of homeopathic medication.

Despite the emphasis on family medicine clinical care due to its organismic thinking and homeopathic vitalism, the gradient of EM framework opens the space for changes to all PHC professions. The insertion of T&CM in primary care offers a potential for a team-based led care that could provide more diverse skills in handling patients' illness, especially in mental health.

Conclusion

The use of T&CM is a fact in contemporary societies. It is possible to overcome the immature dichotomy between biomedical knowledge and other medical rationalities. The present organising framework, based on gradient of EMs, offers a point of convergence between the biomedical paradigm and other medical rationalities. This alternative and safe approach for implementing T&CM comprises three variables: (a) gradient of explanatory models for an appropriate T&CM insertion combined with assessment of clinical risk and severity; (b) professionalism and competence of family doctors to contextualise individual cases; and (c) provision of services through universal health care systems oriented via PHC principles, focusing on health promotion. This approach to T&CM can enhance family physicians' task of helping patients to achieve a state of well-being.

Author's contributions

Armando Henrique Norman conceived and elaborated the article's first version. Charles Dalcanale Tesser contributed to the critical review of the intellectual content. Both authors equally contributed to the writing up of the article and actively participated in the content's review and in the approval of the manuscript's final version.

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Os médicos de família desenvolveram uma abordagem holística do cuidado, facilitando um entendimento mútuo das diferentes práticas de medicina tradicional e complementar (MT&C). Este artigo considera três questões interligadas: (1) Crítica de Ian McWhinney às abstrações biomédicas (por exemplo, as categorias de doenças); (2) Semelhanças entre a cosmologia do pensamento organísmico da medicina de família e o vitalismo da homeopatia como um exemplo de MT&C; e (3) Gradiente de modelos explanatórios (MEs) que orienta a aplicação da MT&C no cuidado dos pacientes. Na atenção primária à saúde (APS), predominam os MEs fisiopatológicos e semiológicos, compreendendo pacientes de risco baixo a moderado. A introdução de práticas da MT&C melhora o escopo terapêutico dos médicos de família. A combinação do gradiente de MEs, dos atributos da APS e profissionalismo dos médicos de família pode fornecer o ambiente seguro necessário para implementar os serviços de MT&C.

Palavras-chave: Atenção primária à saúde. Medicina de família e comunidade. Homeopatia. Terapias complementares. Promoção da saúde.

Los médicos de familia desarrollaron un abordaje holístico del cuidado, facilitando un entendimiento mutuo de las diferentes prácticas de Medicina Tradicional y Complementaria (MT&C). Este artículo considera tres cuestiones interconectadas: (1) Crítica de Ian McWhinney a las abstracciones biomédicas (p.ej., categorías de enfermedades); (2) Semejanzas entre la cosmología del pensamiento organísmico de la medicina de familia y el vitalismo de la homeopatía como un ejemplo de MT&C; (3) Gradiente de modelos explicativos (MEs) que orienta la aplicación de la MT&C en el cuidado de los pacientes. En la atención primaria de la salud (APS) predominan los MEs fisiopatológicos y semiológicos incluyendo a pacientes de riesgo bajo a moderado. La introducción de prácticas de la MT&C mejora el alcance terapéutico de los médicos de familia. La combinación del gradiente de MEs, de los atributos de la APS y del profesionalismo de los médicos de familia puede proporcionar el ambiente seguro necesario para la implementación de los servicios de MT&C.

Palabras clave: Atención primaria de la salud. Medicina de familia y comunidad. Homeopatía. Terapias complementarias. Promoción de la salud.

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