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EDITORIAL

General practice and the science of care over time: why a new section?

Daniele Angioni

General practitioner and ultrasonographer; researcher and educator in artificial intelligence for healthcare; Section Editor, Family Medicine & Community Care (FM&CC), AboutOpen. Azienda Sanitaria Locale Novara (ASL NO), Novara - Italy

Family Medicine & Community Care (FM&CC), a new multidisciplinary section of AboutOpen, aims to strengthen the presence in Italy of a scientific home for general practice, open to different professions and international exchange. Our choice of Family Medicine affirms the identity of general practice as a clinical and scientific discipline with its own competencies, education and research (1).

Community Care expresses our commitment to caring for the whole person over time, within their family and social context. It connects responsibility towards each person with responsibility towards the community through clinical and relational care delivered in collaboration with other health and care professionals. This emphasis complements the population perspective of community health.

Our identity rests on three pillars: generalism as a clinical and scientific asset, longitudinal care as a defining specialist responsibility, and the therapeutic relationship as a foundation of care. These commitments are rooted in the European definition of general practice and are consistent with the vision of comprehensive, person-centred primary care set out by the US National Academies (1,2). Studying how education and technology can help these pillars work together in everyday practice is our distinctive scientific commitment.

Generalism as a clinical and scientific asset

The breadth of general practice is a form of expertise. Generalism requires clinicians to integrate disease-specific evidence within the complexity of an individual life. Conditions and treatments interact with risks, preferences, family responsibilities and social circumstances. Scientific precision depends on understanding these interactions and recognising which findings matter for this person at this point in their life. In multimorbidity, frailty and polypharmacy, this means setting priorities, reconciling recommendations and maintaining a coherent plan of care. The generalist contribution preserves depth while connecting knowledge across organ systems, diseases and professional boundaries. FM&CC intends to recognise, investigate and strengthen this competence.

Longitudinal care as a defining specialist responsibility

General practice takes responsibility for the whole person across changing states of health and illness, beyond the course of any individual disease. Repeated encounters bring previous history, symptom trajectories, individual baseline characteristics and family and social context into clinical judgment. A modest change may become meaningful when interpreted against years of knowledge of the patient. Following a person over time also means revisiting decisions, recognising evolving priorities and maintaining coherence through referrals, hospital admissions and transitions of care. Time becomes a dimension of clinical knowledge and responsibility. FM&CC will give scientific attention to this specialist competence, including the value of long-term observation, continuity and decisions refined through successive reassessments.

The therapeutic relationship as a clinical foundation

Trust, communication, therapeutic alliance, shared decision-making and accumulated mutual knowledge are part of clinical work. They shape how concerns are expressed, how uncertainty is discussed and how a plan becomes meaningful and feasible in a person's life. Psychology therefore has a substantial place within our scientific programme. Collaboration with psychologists and researchers in behavioural and social sciences can investigate how understanding, motivation, distress, adherence and trust enter the consultation and relate to clinical decisions and patient outcomes. We also welcome research on how workload, organisational change, telemedicine and artificial intelligence (AI) affect the conditions for listening, dialogue and relational continuity.

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Corresponding author:
Daniele Angioni
email: studiomedicoangioni@gmail.com

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Connecting the pillars through education and diagnostic competence

The three pillars operate together in each clinical decision. Generalism determines the breadth of the question, longitudinal care gives it a history, and the relationship brings the patient's experience and priorities into the decision. Sustaining this integration requires competence, accessible information, and cognitive capacity. Diagnostic capability can add relevant findings at the point of care; digital systems can connect information across encounters and services. Their value depends on whether they help the clinician understand the person more fully and make a more appropriate decision.

First-line diagnostics is, above all, an educational undertaking. Providing an ultrasound machine without investing in ultrasound training does not create diagnostic competence. That competence requires structured teaching, supervised practice, assessment and continuing support. It includes knowing when to examine, acquiring reliable findings, recognising limitations and deciding when specialist assessment is needed. The EURACT position paper on point-of-care ultrasound recommends integrating education throughout training and professional development (3). For FM&CC, education is part of the diagnostic intervention itself: its design, the competence achieved and the support available in practice must be evaluated alongside the device. This makes the passage from equipment provision to dependable clinical capability a scientific question.

This agenda includes electrocardiography and ambulatory cardiac monitoring, spirometry and other respiratory function tests, ultrasonography, point-of-care laboratory testing, blood pressure and physiological monitoring, dermatoscopy, remote monitoring and emerging diagnostic technologies. Evaluation should address accuracy, clinical utility, safety, feasibility, competency assessment and cost-effectiveness, together with referral appropriateness, timely specialist access and patient outcomes. The guiding question is which diagnostic capabilities can be brought closer to the patient, with what training and organisational support, and to what clinical benefit.

Our educational scope extends across undergraduate, postgraduate and continuing education. Clinical reasoning, simulation and diagnostic skills belong alongside communication and relational competencies, digital and AI literacy, interprofessional education and the development of new professional roles. We welcome studies of how these competencies are acquired, retained and applied, and whether they enable innovation to strengthen the generalist, longitudinal and relational dimensions of care.

AI as a cognitive infrastructure for general practice

AI has a central place in the scientific programme of FM&CC. We propose investigating its potential as a cognitive infrastructure for general practice: a set of functions that helps clinicians connect interdisciplinary knowledge, longitudinal clinical memory and the individual patient's circumstances. The ambition is to make this integration available at the point of decision and throughout care, giving AI a potentially decisive role in sustaining the three pillars together. This is a research hypothesis whose value must be established in clinical practice. Diagnostic competence and AI share the same purpose: connecting today's findings with what is known over time and what matters to the patient.

For generalism, this means studying whether AI can bring relevant evidence into a coherent assessment of interacting conditions, medicines and patient priorities. For longitudinal care, it means making the accumulated record usable across successive encounters: reconstructing trajectories, identifying changes that warrant reassessment and placing new diagnostic findings within that history. Such an infrastructure should preserve the provenance and chronology of information, distinguish documented findings from missing data and inferences, and make uncertainty visible. Clinical memory also includes understanding developed through the relationship; what has not been recorded must remain open to enquiry and dialogue. Interpretative and decision-making responsibility remains with the physician, in partnership with the patient. The clinician must be able to examine the information underlying an output, challenge its interpretation and revise it.

The connection with the relationship is cognitive and organisational. Ambient documentation and assistance with information retrieval could reduce the effort devoted to recording, searching and assembling data. A randomised trial of two ambient AI scribes found reduced time spent writing notes in the electronic health record with one system; secondary outcomes suggested benefits in self-reported workload, while users reported occasional inaccuracies (4). Translating any such gains into better care requires a further step: protecting the time and attention released for listening, explanation and shared decisions. If that capacity is absorbed entirely by additional tasks or appointments, relational benefit cannot be assumed. Evaluation must include the patient's experience and the effort needed to verify outputs and correct errors. Humanising care is an explicit objective to be tested in real consultations.

FM&CC welcomes research on AI, large language models, clinical decision support, ambient documentation and administrative automation, alongside telemedicine, digital therapeutics, interoperability and electronic health records. Their assessment should address clinical effectiveness and safety, diagnostic reasoning, cognitive and professional workload, continuity, autonomy and doctor–patient interaction. Accessibility, inequalities, human factors, implementation and ethical and regulatory implications are equally relevant. The defining question is whether integrating these functions improves decisions and continuity across repeated encounters, for whom and under what conditions. Technical performance alone cannot establish this clinical value.

A scientific home open to disciplines and professions

Research does not have to originate in general practice to matter to general practice. Contributions from cardiology, internal medicine, pulmonology, endocrinology, geriatrics,

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neurology, psychiatry, oncology, infectious diseases, paediatrics, dermatology, rheumatology, rehabilitation, public health and every other clinical field are welcome when their relevance to primary or community care is clear. This may concern prevention, diagnosis, treatment, follow-up, monitoring, referral, coordination or the organisation of care. The clinical question and its consequences for patients determine whether a contribution belongs here.

This home is equally open to nursing, pharmacy, psychology, epidemiology, health economics, engineering, data science, social sciences and health services research. Community nursing, pharmaceutical care, medication management and multidisciplinary rehabilitation are integral to our agenda. We welcome work that gives clinical substance to collaboration between professions and examines how responsibilities and information are carried across services. General practitioners, other healthcare professionals and researchers from universities, training organizations and scientific societies share a place in this community.

The clinical agenda extends from prevention, screening and early diagnosis to acute and chronic disease, patient-centred care, access and health inequalities. It includes integrated care at the hospital–community interface, transitions and referral pathways. Population health, real-world evidence, implementation science, workforce models, health policy and health economics can examine whether changes are workable, sustainable and useful where people receive care. Original studies, reviews, protocols, clinical cases, methodological contributions and critical perspectives can all contribute to this conversation, with methods and claims appropriate to each article type.

Healthcare context deserves explicit scientific attention. Regulatory frameworks, professional roles, reimbursement, workforce availability, referral pathways and digital infrastructure can shape both practice and findings. SQUIRE 2.0 recognises context as a fundamental component of reporting healthcare improvement (5). For FM&CC, a rigorous study focused on a country, region or organisational model can make a meaningful contribution even when its findings are not directly transferable elsewhere. Limited transferability and weak methodology are different judgments. Authors should explain which features of the setting matter, what may travel to other settings and under what conditions. This gives locally grounded research a defined place in an international scientific conversation, with the same expectation of rigour.

We want everyday clinical work to become a source of scientific knowledge. Questions arising in consultations, home care and collaboration between services can become studies when they are clearly formulated and investigated with appropriate methods. FM&CC brings this ambition together with diagnostic competence built through education, and AI developed around the responsibilities of care. Our shared purpose is to make scientific precision and a more human experience of care advance together. This is the home we invite our readers, authors, and reviewers to help build.

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