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Vital Literacy in Family Medicine: A Person-Centred Framework for Integrating Lifestyle Medicine, Social Connection and Meaning-Making into Primary Healthcare

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ABSTRACT

Family medicine increasingly encounters patients whose health problems do not fit neatly into single-disease categories. Hypertension, obesity, sleep disturbance, chronic pain, anxiety, depression, loneliness, caregiver burden, medication non-adherence and social vulnerability often coexist in the same consultation. Conventional biomedical measurement remains indispensable, but it is insufficient when the determinants of illness are distributed across daily habits, family dynamics, social connection, meaning, work, stress and community resources. This narrative review and practice framework proposes Vital Literacy in Family Medicine (VITAL-FM) as a person-centred, family-sensitive and community-oriented model for integrating lifestyle medicine, social connection and meaning-making into primary healthcare. The model is grounded in contemporary primary healthcare principles, preventive recommendations, lifestyle medicine, social prescribing, evidence on loneliness and social isolation, and validated screening instruments for common psychosocial risks. VITAL-FM defines vital literacy as the practical capacity of individuals and families to understand, enact and sustain the behaviours, relationships, routines and meanings that support health across the life course. The framework contains five clinical domains: Vital screening of hidden suffering; Integrated lifestyle prescription; Ties and social connection; Agency, narrative and meaning-making; and Longitudinal follow-up with community linkage. It is designed for use in short consultations through a stepped workflow: identify risk, protect safety, co-create one or two micro-prescriptions, mobilise family or community assets, and follow measurable outcomes over time. The article discusses implementation across adolescence, adulthood, older age and palliative contexts, with attention to equity, non-stigmatisation, digital tools and clinician workload. VITAL-FM is not a substitute for mental health treatment, specialist care or structural action on social determinants; rather, it offers a clinical grammar that helps family physicians convert fragmented lifestyle advice into a coherent, ethical and measurable form of whole-person care.

Keywords

Family medicine, Primary healthcare, Lifestyle medicine, Social prescribing, Loneliness, Health literacy, Preventive medicine, Wellbeing, Patient-centred care, Chronic disease prevention.

What is already known

- Primary healthcare is expected to address health promotion, prevention, treatment, rehabilitation and palliative care close to people's everyday environment.
- Lifestyle factors, mental health, social isolation, sleep and social determinants influence chronic disease outcomes and healthcare utilisation.
- Family physicians are often the first professionals to detect hidden suffering, multimorbidity, loneliness, caregiver burden and behavioural risk.

What this article adds

- It introduces Vital Literacy in Family Medicine (VITAL-FM), a new practice framework that translates whole-person prevention into a usable consultation structure.

- It links lifestyle medicine, social connection, narrative identity and community referral without reducing health to individual willpower.
- It provides implementation tables, screening domains, outcome measures and safeguards for equity, safety and clinical responsibility.

Introduction

Why family medicine needs a wider clinical grammar

Family medicine has always been more than episodic treatment. Its central promise is continuity with people, families and communities over time. The consultation room is where biological risk, emotional pain, family relationships, social vulnerability and daily habits converge. A patient may present with uncontrolled blood pressure, but the clinical story may also include poor sleep, bereavement, financial anxiety, isolation, low physical activity and a sense that life has become unmanageable. Another may ask for medication for gastric symptoms while silently carrying depression, domestic fear, alcohol misuse or caregiving exhaustion. These realities do not weaken biomedical care; they show why biomedical care must be integrated with a broader view of human functioning.

The World Health Organization describes primary healthcare as a whole-of-society approach that focuses on people's needs as early as possible across the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, delivered as close as feasible to everyday life [1,2]. This definition is especially relevant for family medicine because many of the strongest determinants of health are not visible in laboratory results. They emerge in eating patterns, sleep routines, movement, stress physiology, medication adherence, tobacco or alcohol exposure, loneliness, family conflict, meaning, housing, employment and access to safe community environments. Good family medicine therefore requires two forms of precision: biomedical precision and biographical precision.

Contemporary evidence reinforces this need. The U.S. Preventive Services Task Force recommends screening adults for depression and, for adults younger than 65 years, screening for anxiety disorders when systems exist for accurate diagnosis, effective treatment and appropriate follow-up (U.S. Preventive Services Task Force. The American Heart Association's Life's Essential 8 places sleep, diet, physical activity, nicotine exposure, body mass index, blood lipids, blood glucose and blood pressure within a measurable cardiovascular health construct [3,4]. The WHO guidelines on physical activity and sedentary behaviour recommend that adults perform 150 to 300 minutes of moderate-intensity aerobic activity per week, or an equivalent combination, and emphasise that some activity is better than none [5,6]. The WHO Commission on Social Connection has also identified loneliness and social isolation as widespread health and social concerns, with important implications for mental and physical health, a concern also emphasised by the U.S. Surgeon General's advisory on loneliness and isolation [7,8].

The practical challenge is not the absence of recommendations. It is the fragmentation of recommendations. Patients are often told to lose weight, exercise, reduce stress, sleep better, eat differently, stop smoking, manage medication, socialise more and remain positive, but they are rarely offered a coherent clinical pathway that respects their reality, resources and family context. Advice becomes a list of imperatives rather than a living prescription. Family physicians and primary care teams also face intense time pressure, administrative burden and workforce limitations. A framework for whole-person prevention must therefore be clinically realistic. It must fit into ordinary care rather than exist only in idealised wellness programmes.

This article proposes Vital Literacy in Family Medicine (VITAL-FM) as such a framework. Vital literacy is defined here as the practical capacity of individuals and families to understand, enact and sustain the behaviours, relationships, routines and meanings that support health across the life course. It extends the concept of health literacy from understanding medical information to living health in daily life. It is not a diagnosis, a therapeutic brand, a substitute for evidence-based treatment or a moral judgement on patients. It is a clinical grammar for asking better questions, designing smaller and safer actions, and linking patients with family and community assets when appropriate.

The aim of the article is threefold: first, to justify why vital literacy belongs in family medicine; second, to present the VITAL-FM model and its consultation workflow; and third, to outline implementation, measurement, limitations and research priorities. The central argument is simple: family medicine can become a clinic of life without ceasing to be scientific medicine. It can protect biomedical rigour while expanding clinical attention to the daily conditions in which health is gained, lost and recovered.

Methods

focused narrative review and framework development

This manuscript is a narrative review and conceptual practice framework. It does not claim to be a systematic review, meta-analysis or clinical trial. A focused literature mapping was conducted in May 2026 using publicly available guideline repositories, biomedical databases and institutional sources relevant to family medicine, primary healthcare, lifestyle medicine, social prescribing, social connection, preventive screening and common validated instruments. Priority was given to international organisations, preventive task forces, peer-reviewed reviews, consensus statements and high-impact primary care or public health publications. The primary care orientation was also informed by evidence on the contribution of primary care to health systems and population health [9].

The literature was interpreted through four guiding questions: (1) Which health determinants repeatedly appear in family medicine as modifiable, measurable or clinically actionable? (2) Which determinants are commonly missed when consultations focus only on disease labels or biometrics? (3) What kind of framework

could be implemented in short primary care encounters without increasing stigma or replacing necessary medical treatment? (4) How can a family physician move from general advice to co-created micro-prescriptions that are safe, measurable and socially realistic?

The framework development process followed a pragmatic synthesis logic. First, domains were extracted from existing evidence and guidelines: mental health screening, physical activity, sleep, cardiovascular risk, social connection, social determinants, medication adherence, community referral and patient-centred care. Second, these domains were reorganised around the clinical sequence of a family medicine visit: recognition, risk stratification, prescription, support and follow-up. Third, safeguards were added to prevent two common errors in lifestyle-oriented medicine: over-individualising responsibility and under-recognising clinical danger. Fourth, the VITAL-FM acronym was developed to facilitate memory and implementation while retaining clinical seriousness.

Because the framework is intended for international family medicine contexts, it avoids dependence on one national health system. The term social prescribing is used broadly to describe structured referral from healthcare settings to non-clinical community resources, while recognising that formal link-worker models vary across countries [10,11]. The framework can therefore be adapted to well-resourced integrated primary care teams, small practices, community clinics, corporate primary care services and low-resource settings where referral networks are informal.

Conceptual foundation: From health literacy to vital literacy

Health literacy traditionally refers to the ability to access, understand, appraise and use health information [12,13]. It remains a core determinant of patient safety, medication adherence, preventive behaviour and shared decision-making. Yet many patients who understand information still struggle to transform it into daily practice. Knowing that physical activity is beneficial does not automatically create time, energy, confidence, safety, social support or meaning. Understanding a low-salt diet does not eliminate food insecurity, cultural habits, emotional eating or family patterns. Recognising depression symptoms does not guarantee access to care or the courage to disclose suffering. The gap between information and embodied practice is the territory of vital literacy, and it is consistent with behaviour-change and motivation theories that emphasise stages of change, autonomy, competence and relational support [14,15].

Vital literacy has four components. The first is behavioural comprehension: the patient understands what action matters and why. The second is contextual adaptation: the action is translated into the patient's real life, including family obligations, work demands, culture, income, neighbourhood and digital environment. The third is relational support: change is not left to isolated willpower but is supported through family, peers, groups, community assets or professional follow-up. The fourth is narrative ownership: the patient can connect the action with identity, values and purpose. A walking plan becomes more sustainable when it is not merely an instruction to burn calories but a way to recover agency, accompany a partner, reduce anxiety, protect a heart, sleep better or return to a meaningful role.

The concept is particularly suitable for family medicine because family physicians often care for several members of the same household, observe life transitions over years and understand the interaction between illness and biography. They see adolescence, pregnancy, parenting, divorce, unemployment, chronic disease, ageing, bereavement, palliative care and caregiving within continuity. This continuity allows them to detect small shifts that episodic care may miss: a widower's increasing silence, a teenager's sleep inversion, a mother's invisible exhaustion, a worker's alcohol escalation, an older adult's loss of appetite after isolation, or a patient with diabetes whose glycaemic control collapses after social disruption.

Vital literacy also reframes prevention. Prevention is often communicated as risk reduction in the future. For many patients, the future is too abstract. Vital literacy makes prevention present-tense and experiential: more energy next week, better sleep this month, less breathlessness on stairs, fewer panic episodes, more stable meals, a call with a trusted person, one protected hour of movement, or a medication routine anchored to breakfast. The clinical objective is still long-term risk reduction, but the patient experiences the intervention as a dignifying recovery of daily life.

This approach must not be confused with wellness consumerism. Vital literacy is not a privilege aesthetic, a demand for constant self-optimisation or a message that disease is caused by insufficient positivity. It is a structured way to help people live the treatment plan under real constraints. It explicitly recognises that poverty, discrimination, unsafe housing, food insecurity, caregiver burden and poor access to care may limit what an individual can change alone. For this reason, VITAL-FM includes social assessment and community linkage as clinical domains rather than optional additions.

The VITAL-FM framework

VITAL-FM organises whole-person prevention into five domains. Each domain corresponds to a recurring clinical need in family medicine and can be scaled according to time, risk and resources. The acronym is not intended to simplify complex care into a slogan; it is intended to create a shared map for clinicians, patients and teams.

The first domain, Vital screening of hidden suffering, asks what is clinically important but not immediately visible. Beyond conventional vital signs, family physicians can screen for mood, anxiety, sleep quality, pain impact, loneliness, harmful substance use, intimate partner violence when appropriate, caregiver burden, social needs and medication barriers. This does not mean every instrument must be administered at every visit. Rather, the clinician develops a disciplined habit of asking the missing question when

symptoms, disease control or life events suggest hidden drivers.

The second domain, Integrated lifestyle prescription, translates evidence-based recommendations into small, actionable behaviours, consistent with the growing emphasis on integrating lifestyle medicine into primary care [16]. Lifestyle advice fails when it is too general, too large or too disconnected from the patient's life. A vital prescription should specify the behaviour, frequency, context, barrier plan and follow-up. For example: "Walk for ten minutes after lunch on Monday, Wednesday and Friday with your neighbour; if it rains, walk inside the building; we will review breathlessness and mood in four weeks." This is different from "exercise more". It is clinically humble but behaviourally precise.

The third domain, Ties and social connection, recognises that relationships are health infrastructure. Social connection is associated with mental and physical health, and loneliness or isolation may be especially relevant in older adults, adolescents, caregivers, migrants, unemployed adults and people with chronic illness [17,18]. Family medicine can identify social risk and prescribe reconnection in ethical ways: a group visit, community class, volunteer role, bereavement group, peer walking group, caregiver support, family meeting or referral to a link worker where available.

The fourth domain, Agency, narrative and meaning-making, addresses the fact that behaviour change requires more than compliance. People sustain change when they can see themselves as capable actors in their own care. Narrative questions can be brief: "What would be different in your life if this symptom improved?" "Who would notice the change first?" "What kind of person are you trying to become in this illness?" "What small action would make you proud this week?" These questions are not psychotherapy; they are patient-centred medicine. They help the patient connect medical goals with values and identity.

The fifth domain, Longitudinal follow-up with community linkage, protects the model from becoming a one-time motivational conversation. Family medicine has a unique capacity to follow small changes over time. A plan can be reviewed at two, four or twelve weeks, using both biomedical markers and patient-reported outcomes. Community linkage may include social prescribing, physical activity groups, nutrition education, cultural activities, faith or civic communities when chosen by the patient, digital coaching, public health programmes, mental health services or specialist referral. The key is continuity: the patient is not merely advised; the patient is accompanied.

Why VITAL-FM belongs in family medicine

Family medicine is the natural home for VITAL-FM for five reasons. First, family physicians often see undifferentiated problems. A headache may reflect migraine, sleep deprivation, hypertension, medication overuse, anxiety, domestic stress or work-related tension. A framework that invites systematic exploration of hidden drivers improves clinical reasoning rather than distracting from it. Second, family physicians practise continuity. Continuity allows behavioural plans to be tested, revised and reinforced over time, which is essential for habit formation and chronic disease management.

Third, family medicine is family-sensitive. Many health behaviours are not individual behaviours. Meals, sleep schedules, screen use, caregiving, medication routines, emotional climate and physical activity are shaped in households. A patient with obesity may live in a family where celebration, stress and food are inseparable. An older adult with heart failure may depend on a daughter whose own health is deteriorating. A child with asthma may be affected by housing conditions and parental smoking. The family physician can see the relational system rather than treating each person as an isolated unit.

Fourth, family medicine is community-oriented. Primary care teams know local barriers and assets: parks, pharmacies, social workers, schools, patient associations, community centres, cultural groups, sports clubs, municipal services, addiction resources and mental health pathways. Social prescribing is not an abstract

Table 1: VITAL-FM domains and clinical translation.

Domain	Clinical question	Possible tools or prompts	Micro-prescription examples
V - Vital screening of hidden suffering	What clinically important factor is not visible in routine biometrics?	PHQ-2/PHQ-9, GAD-2/GAD-7, sleep questions, pain interference, loneliness item, social needs questions, medication barriers.	One hidden domain selected for follow-up; safety escalation when red flags appear.
I - Integrated lifestyle prescription	Which small behaviour would improve the highest-priority clinical risk?	Physical activity, diet, sleep, tobacco, alcohol, medication routine, stress regulation, symptom monitoring.	Ten-minute post-meal walk three times weekly; fixed medication anchor; sleep wake-time agreement.
T - Ties and social connection	Who or what can support this patient beyond the consultation?	Family map, caregiver assessment, loneliness questions, community asset directory, social prescribing pathway.	Walking partner; bereavement group; caregiver support; community class; family meeting.
A - Agency, narrative and meaning-making	Why does this change matter to the patient's life and identity?	Values question, patient-valued goal, narrative prompt, confidence scaling, barrier planning.	Goal linked to playing with grandchildren, returning to work, reducing fear, or protecting independence.
L - Longitudinal follow-up and linkage	How will we know whether the plan is working, and who will accompany it?	Two-week or four-week review, patient-reported outcome, clinical marker, referral completion, EHR prompt.	Review blood pressure and walking log; call after referral; adapt plan after barrier review.

intervention when the clinician knows where a patient can actually go. The literature on social prescribing has shown international growth but also emphasises the need for stronger evidence, clear models and realistic implementation [11,19]. VITAL-FM can help organise those referrals around measurable clinical goals.

Fifth, family medicine is ethically positioned to prevent blame. A narrow lifestyle discourse can make patients feel responsible for illnesses shaped by structural conditions. Family medicine, when practised well, knows that behaviour is constrained by context. VITAL-FM therefore frames action as supported agency, not moral judgement. The question is not “Why have you failed to change?” but “What change is possible, safe, meaningful and supported in your real life?”

Clinical workflow: from hidden risk to micro-prescription

The clinical workflow of VITAL-FM is designed for time-limited practice. It can be used in a full preventive visit, a chronic disease review, a mental health consultation or a brief opportunistic encounter. The workflow has six steps: identify the trigger, screen the hidden domain, stratify safety, co-create the micro-prescription, connect the patient to support and schedule feedback.

The trigger may be clinical, relational or biographical. Clinical triggers include poor control of blood pressure, diabetes, asthma, chronic kidney disease, obesity, pain, insomnia, frequent attendance, recurrent medication non-adherence or unexplained somatic symptoms. Relational triggers include bereavement, separation, caregiver strain, loneliness, family conflict or loss of work. Biographical triggers include transitions such as adolescence, pregnancy, menopause, retirement, migration, diagnosis of a chronic disease or entry into palliative care. Each trigger suggests that the consultation should widen from disease to life context.

Safety stratification is non-negotiable. Vital literacy cannot become a substitute for urgent care. Suicidal ideation, severe depression, psychosis, domestic violence, safeguarding concerns, unstable cardiovascular symptoms, severe substance withdrawal, neurological red flags, uncontrolled pain, severe asthma, acute infection, or rapid functional decline require immediate clinical pathways. The micro-prescription is appropriate only after urgent risk has been assessed and managed.

Micro-prescriptions should be small enough to succeed and meaningful enough to matter. They can target movement, sleep, meals, social contact, medication routines, stress regulation, screen boundaries, creative expression, family communication or community participation. The clinician should avoid prescribing too many changes at once. A useful rule is one biomedical priority, one behavioural priority and one relational support. For example, in a patient with hypertension and loneliness: adjust antihypertensive treatment if needed, prescribe ten minutes of walking after breakfast four days per week, and connect the patient with a local walking group or neighbour-supported routine.

Follow-up transforms advice into care. The follow-up question is not merely “Did you do it?” but “What happened when you tried?” Barriers become clinical data. If the patient did not walk, the reason matters: pain, fear of falling, unsafe neighbourhood, shame, fatigue, depression, weather, caregiving, lack of shoes, or misunderstanding. Each reason implies a different clinical response. In this sense, VITAL-FM is not a motivational monologue but an iterative diagnostic process applied to daily life.

Application across the life course

In adolescence, vital literacy can help family physicians integrate physical health, mental health, sleep, identity and family communication. Adolescents may present with headaches, abdominal pain, fatigue, school avoidance, disordered sleep, anxiety, obesity, asthma symptoms or excessive screen exposure. The clinical task is not to pathologise adolescence but to identify patterns that threaten development. Brief screening for mood, anxiety, sleep, bullying, substance use, eating behaviour and family stress may be clinically appropriate. Micro-prescriptions should respect autonomy: a sleep anchor, a movement choice, a trusted adult conversation, a screen boundary co-designed with the adolescent, or referral to a youth group or mental health service when needed.

In early and mid-adulthood, the family physician often meets the collision between productivity and health. Patients may carry work stress, parenting strain, financial pressure, sedentary habits,

Table 2: A 20-minute VITAL-FM consultation structure.

Minute	Task	Clinical purpose	Example language
0-3	Name the agenda and trigger	Clarify biomedical priority and widen context only when relevant.	“Your blood pressure is still high. I also want to understand what is making control difficult in daily life.”
3-7	Screen one or two hidden domains	Avoid indiscriminate questioning; target likely drivers.	“How are you sleeping?” “How often do you feel alone?” “Have you felt down or anxious most days?”
7-10	Assess safety and red flags	Protect patient before behavioural planning.	“Have you had thoughts of harming yourself?” “Do you feel safe at home?”
10-15	Co-create a micro-prescription	Move from advice to a specific behaviour.	“What is the smallest realistic action you could try before we meet again?”
15-18	Add relational or community support	Prevent isolated willpower.	“Who could support this?” “Would a group or community resource help?”
18-20	Measure and schedule follow-up	Create continuity and accountability.	“We will review your blood pressure, sleep and walking plan in four weeks.”

sleep restriction, weight gain, hypertension, migraine, anxiety or depressive symptoms. Preventive care must be framed not as another demand but as a recovery of function. A vital prescription may involve a structured lunch break, medication routine, alcohol reduction plan, two weekly strength sessions, breathing practice before sleep, couple or family communication, or social reconnection after separation. The clinician can help the patient distinguish between ambition that gives life and overexertion that consumes it.

In later life, VITAL-FM is especially relevant because multimorbidity, polypharmacy, frailty, bereavement, sensory impairment, cognitive change and isolation often interact. The National Academies report on social isolation and loneliness in older adults called attention to opportunities for the healthcare system to identify and respond to these risks [18,20]. Family medicine can integrate medication review, fall prevention, nutrition, physical activity, hearing and vision assessment, caregiver support, advance care planning and social connection. The question "Who would know if you were unwell tomorrow?" can be as clinically revealing as a laboratory test.

In palliative and end-of-life care, vital literacy does not mean extending life at all costs. It means preserving dignity, meaning, comfort and connection. Family physicians may help patients clarify what matters most, reduce treatment burden, support caregivers, manage symptoms and maintain relationships. The micro-prescription may become a conversation, a farewell letter, a pain plan, a family meeting, a spiritual resource, music chosen by the patient, or a daily comfort ritual. Here, vital literacy becomes literacy in what still gives life when cure is no longer the goal.

Measurement and evaluation

A framework that cannot be measured risks remaining rhetorical. VITAL-FM should therefore combine biomedical outcomes, patient-reported outcomes, behavioural indicators and implementation measures. The exact measurement set must be adapted to the patient's condition and healthcare setting. For cardiometabolic risk, blood pressure, body mass index, waist circumference, lipids, glycaemic markers and smoking status may be relevant. For mental health, instruments such as the PHQ-9 for depression and GAD-7 for anxiety can support screening and monitoring when used within appropriate diagnostic and follow-up systems [21,22]. For physical activity, instruments such as the International Physical Activity Questionnaire can support monitoring when feasible [23]. For sleep, brief sleep questions or validated tools such as the Pittsburgh Sleep Quality Index may help identify insomnia, sleep duration or sleep quality [24]. For social connection, validated loneliness scales can be used when feasible, but even structured clinical questions can reveal risk.

Patient-reported outcome measures should include function and meaning, not only symptom reduction. A patient may value the ability to climb stairs, walk to the market, sleep through the night, attend a grandchild's event, return to work, reduce panic episodes, cook a healthier meal or call a friend. These outcomes are not soft; they are clinically relevant expressions of health in daily life. They also increase motivation because the patient sees the plan connected to lived consequences.

Implementation measures matter because primary care interventions fail when they are too burdensome. Clinics can track the percentage of eligible patients screened for depression, anxiety, loneliness or social needs; the proportion receiving a documented micro-prescription; referral completion; follow-up attendance; clinician time; patient satisfaction; equity of access; and adverse events. In resource-limited settings, a minimal dataset is preferable to no measurement: one clinical marker, one behavioural marker and one patient-valued goal.

The purpose of measurement is learning, not surveillance. Patients should not feel that every imperfect week is failure. In VITAL-FM, measurement is used to adapt the plan. If a micro-prescription fails, the question is whether the goal was too large, the support too weak, the barrier underestimated or the diagnosis incomplete. This learning stance protects dignity and improves clinical accuracy.

Equity, culture and the danger of blaming the patient

Any framework centred on habits and agency must face an ethical risk: the risk of blaming patients for conditions shaped by poverty,

Table 3: Suggested measurement set for VITAL-FM implementation.

Dimension	Examples	Frequency	Interpretation
Biomedical	Blood pressure, HbA1c, lipids, BMI, waist circumference, smoking status, medication adherence.	Baseline and clinically appropriate review.	Tracks disease risk and response to standard care.
Mental health	PHQ-9, GAD-7, clinical interview, risk assessment.	Baseline, 4-12 weeks, or according to risk.	Supports detection and monitoring; positive screens require diagnostic follow-up.
Behavioural	Physical activity minutes, sleep duration, meal pattern, alcohol use, medication routine.	Weekly self-check or visit review.	Identifies whether the micro-prescription is being lived.
Relational/social	Loneliness question, caregiver burden, social needs, community referral completion.	Baseline and follow-up when relevant.	Identifies support gaps and social risk.
Patient-valued outcome	Function, energy, confidence, ability to perform a meaningful activity.	Every follow-up.	Connects clinical care to lived health and agency.
Implementation	Time used, documentation completion, referral success, clinician workload, patient satisfaction.	Monthly or quarterly team review.	Determines feasibility and sustainability in real practice.

discrimination, unsafe environments, trauma, food systems, commercial determinants, work precarity or limited access to care. Recent surveillance on social determinants and health-related social needs among adults with chronic disease reinforces the clinical relevance of this overlap [25]. VITAL-FM addresses this risk by treating context as clinical data. The patient's capacity to change is not assumed; it is explored. A person working two jobs cannot be given the same sleep prescription as a retired adult with flexible time. A patient living in an unsafe neighbourhood cannot be told simply to walk outdoors at night. A family facing food insecurity cannot be instructed to buy expensive healthy foods without assistance. Equity requires realistic prescriptions.

Cultural humility is also essential. Health behaviours are embedded in meanings, rituals and identities. Food, family roles, body image, ageing, masculinity, femininity, spirituality, grief, discipline, independence and care differ across cultures and households. The family physician should ask before advising. "What does a healthy meal look like in your family?" "Who decides what happens at home?" "What kind of movement would feel acceptable?" "What would make this plan disrespectful or impossible?" These questions prevent the clinician from imposing a middle-class wellness template.

Digital equity is another concern. Apps, wearables and online coaching can support vital literacy, but they can also exclude older adults, low-income patients, migrants, people with disabilities or those with low digital skills. Digital tools should therefore be offered as optional supports, not prerequisites for good care. The most powerful intervention may still be a written plan, a phone call, a family member, a community nurse, a group visit or a local activity.

Finally, VITAL-FM must not medicalise all forms of sadness, loneliness or existential difficulty. Some suffering is a normal response to loss, injustice or transition. The role of family medicine is to recognise when suffering becomes clinically dangerous and to support people without reducing every life problem to a disorder. This balance requires clinical judgement, humility and continuity.

Implementation in primary care teams

Implementation should begin small. A clinic does not need to redesign its entire workflow to adopt VITAL-FM. It can start with one patient group, such as adults with uncontrolled hypertension, patients with frequent attendance, older adults living alone, adolescents with sleep problems, or caregivers of patients with dementia. The team can select two screening questions, one micro-prescription template and one follow-up process. After four to six weeks, the team can review what worked and what created burden.

Team roles should be clear. Physicians can identify clinical risk, diagnose, prescribe medical treatment and co-create the vital plan. Nurses can support education, self-monitoring, medication adherence and follow-up. Social workers or link workers can address social needs and community referral. Psychologists or counsellors can support mental health pathways. Pharmacists can review medication complexity. Community organisations can provide places where health behaviours become socially supported. The family physician remains the integrator, but the work is shared.

Electronic health records can help if used carefully. A brief VITAL-FM template may include four prompts: hidden domain screened, micro-prescription agreed, support person or community asset, follow-up date. The template should not become another bureaucratic burden. Its function is to preserve continuity and make behavioural care visible. Documentation also protects clinical safety by recording red flags, referrals and escalation plans.

Group visits are a promising implementation format. Patients with similar needs, such as diabetes, hypertension, obesity, chronic pain, menopause, caregiver burden or loneliness, can receive education, peer support and structured goal-setting in groups. Group care may reduce isolation and normalise difficulty. It can also make efficient use of clinician time. However, confidentiality, cultural sensitivity and patient preference must be respected.

Training clinicians in VITAL-FM requires more than teaching lifestyle facts. It requires communication skills, narrative competence, motivational interviewing principles [26], awareness of social determinants, trauma-informed practice, cultural humility and knowledge of local resources. Training should include simulated consultations in which the clinician practises moving from advice to micro-prescription: from "You need to exercise" to "What is the smallest movement plan that is safe, possible and worth doing this week?"

Table 4: Safety and equity safeguards.

Risk	Potential harm	Safeguard
Over-individualising responsibility	Patient feels blamed for disease shaped by poverty, trauma or social conditions.	Ask about barriers, social needs and resources before prescribing change.
Missing urgent clinical risk	Behavioural plan delays emergency care or specialist treatment.	Screen for red flags and escalate before micro-prescription.
Cultural imposition	Advice conflicts with family, religious, cultural or identity meanings.	Use cultural humility questions and shared decision-making.
Digital exclusion	Patient cannot use apps or wearables and feels excluded.	Offer non-digital alternatives and low-resource options.
Clinician overload	Framework becomes another bureaucratic burden.	Start with one population, one template and team-based roles.

Research agenda

VITAL-FM should be tested empirically. A first research step could be a feasibility study in family medicine clinics evaluating acceptability, time burden, documentation quality and patient understanding. A second step could be a pragmatic pilot trial among patients with a defined condition, such as hypertension plus loneliness, obesity plus sleep disturbance, or depression symptoms plus physical inactivity. Outcomes could include blood pressure, PHQ-9 or GAD-7 scores, sleep quality, physical activity, loneliness, medication adherence, patient activation, quality of life, healthcare utilisation and clinician workload.

Implementation science frameworks could help evaluate reach, adoption, fidelity, equity and sustainability. The model should be studied in diverse populations, including adolescents, older adults, migrants, rural communities and low-income settings. It should also be compared with usual lifestyle advice to determine whether structured micro-prescription and social linkage improve adherence and outcomes.

Economic evaluation is important. If VITAL-FM reduces avoidable visits, improves chronic disease control, prevents deterioration or supports earlier identification of mental health risk, it may generate value for health systems. Yet this should not be assumed. The evidence base for social prescribing and lifestyle integration is growing but heterogeneous, and high-quality studies remain necessary [11,19]. The framework should therefore be presented as a promising clinical model requiring rigorous evaluation, not as a proven universal solution.

Qualitative research would also be valuable. Interviews with patients could explore whether the model increases dignity, agency, trust and perceived relevance of care. Interviews with clinicians could identify barriers, risks and adaptations. Family medicine is relational work; some of its most important outcomes are not fully captured by numbers. A strong research agenda should therefore combine quantitative and qualitative methods.

Limitations

This article has several limitations. First, it is a narrative review and conceptual framework rather than a systematic review. The literature was selected for relevance to family medicine, primary healthcare and whole-person prevention, but the article does not provide pooled effect sizes or formal risk-of-bias assessment. Second, VITAL-FM has not yet been validated as an intervention. Its proposed domains are grounded in existing evidence, but the model as a complete workflow requires empirical testing.

Third, implementation may be difficult in overstretched primary care systems. Clinicians may already lack time for recommended screening, chronic disease management and administrative tasks. VITAL-FM must therefore be implemented in small, team-based and context-sensitive ways. If it becomes another checklist without resources, it will fail.

Fourth, the model may not fit all cultures, health systems or patient preferences. Some patients may prefer biomedical discussion only, may not want family involvement, or may feel uncomfortable with narrative or meaning-oriented questions. Consent, autonomy and cultural humility are essential. Fifth, the framework cannot solve structural determinants of health by clinical action alone. It can identify and respond to social needs, but policy, public health, housing, education, labour conditions and social protection remain indispensable.

Conclusion

Family medicine stands at the intersection of disease and life. Its future will not be secured by choosing between biomedical science and human complexity, but by integrating both with discipline. Vital Literacy in Family Medicine offers a practical framework for this integration. It helps clinicians identify hidden suffering, translate lifestyle evidence into realistic micro-prescriptions, recognise social connection as health infrastructure, strengthen patient agency and follow change over time.

The model is deliberately modest in its clinical mechanics and ambitious in its human vision. It does not promise that every disease can be prevented through habits, nor does it deny the need for medication, specialist care, psychotherapy, social policy or emergency intervention. It simply insists that many patients need more than information and more than isolated advice. They need a plan that can be lived.

If family medicine is the medical specialty closest to ordinary life, then it is also the specialty best placed to transform prevention from a lecture into a relationship. VITAL-FM invites primary care to measure what matters, ask what is missing, prescribe what is possible and accompany what is meaningful. In doing so, family medicine can become not only the first contact of healthcare, but also one of the most important places where people recover the capacity to live with health, dignity and purpose.

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