

## 9. The Emergence Of Family Practice

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The past 50 years have seen tremendous advances in medicine. Modern scientific medicine is a recent development: It is a new area of technology that has also inherited the ancient traditions of medicine. The fragmentation of medicine into subspecialties has produced brilliant advances in our understanding of pathology and in the treatment of diseases. Continuing technological and scientific advances have brought exciting prospects for the tasks of the family doctor in preserving health, preventing disease and managing ill health.

### **Why the Family Physician?**

The fragmentation of medicine into subspecialties slowly diminished the place in the community of the generalists: The general physician/general practitioner and general surgeon. General medicine languished, while spectacular advances were made by subspecialists concentrated in hospitals, with expertise in single organs, systems or diseases, in the performance of specific procedures or in the use of expensive and advanced equipment. It is precisely the development of these subspecialists and their concentration in hospitals that gave rise to a demand in the community for a physician in the tradition of the old family doctor, who was caring and accessible and who was also more expert and better trained than the general practitioner of those days, but who could act as the patient's guide, protector, philosopher and friend.

More was needed from this reborn family doctor. Advanced medical technology, new approaches and new techniques had become available in the consulting room

or were easily accessible from it. New advances made a real difference to the outcome of medical care. It was imperative, therefore, that the physician in primary care should have the training and expertise required to use these new advances effectively and efficiently. This led to the emergence of family practice as the natural inheritor of the ancient traditions of general medicine.

*“As both medical knowledge and specialism increase, I believe that the need for a special kind of generalist who will need a special kind of training will more and more emerge. He must be an astute diagnostician, particularly if he is to recognize and intelligently control the significant beginnings of disease. The management of chronic illness and its rehabilitation will be among his most important activities. His function will be to maintain and promote health as well as to prevent disease ... One of the fundamental responsibilities of this physician will be to guide his patients through the growing complexities of medical care. He will be keenly aware of the importance of utilising those community resources having something to offer in the management of his patients. In essence, then, I am proposing a new specialty.”<sup>1</sup>*

Distinct differences have emerged in the practice of medicine in hospitals and in the community. There are differences in the core content of information and skills, and more particularly in the attitudes and clinical methods appropriate to the physician in the different environments. Indeed these are two different subcultures of medicine.

### **A Question of Terminology**

New disciplines need new terminologies, especially when the older terminology implied lower levels of specialised training and competence as well as lower status.

The different historical backgrounds to medical practice in each country have produced different terminologies. In the UK, where the term ‘general practice’ was firmly entrenched by custom and statute, terms such as ‘the new general practice’ and ‘family doctor’ are in use. The leaders of general practice in the UK founded their college almost surreptitiously, in the face of hostility from the older royal colleges, but it has subsequently gained acceptance.

*“By the time of qualification, the graduate should have sufficient knowledge of the structure and functions of the human body in health and disease, of normal and abnormal human behaviour and of the techniques of diagnosis and treatment, to enable him to assume the responsibility of a pre-registration house officer and to prepare him for vocational training.”<sup>2</sup>*

In Australia, the term ‘general practitioner’ is still in use, but the state-funded training programme is called the ‘family medicine programme’. In Europe the term ‘medicine generale’ is in use. In the USA, three alternatives to the term ‘general practitioner’ have been proposed: Personal physician, primary physician and family physician.

A succession of commissions proclaimed the community’s urgent need for a family doctor, urged the creation of the new specialty and delineated an ambitious role for these new specialists.

The term ‘Primary Physician’ was used in the report of the Citizen’s Commission on Graduate Medical Education (1966) chaired by Dr. John Millis. This report saw the need for a primary physician who would assume primary responsibility for the patient’s welfare in sickness and in health, providing continuing and comprehensive care. This primary physician was conceived of as *“the primary physician assuming primary responsibility for the patient’s welfare in sickness and in health; providing continuing care and comprehensive health care.”<sup>3</sup>*

The term ‘family physician’ comes from the USA. It was necessary to distinguish between family medicine and traditional general practice which was regarded, by the community and even by some of its practitioners themselves, as a career that did not call for graduate training and certification. In 1962, the National Health Commission and the American Public Health Association set up the Folsom Committee, which reported four years later:

*“The certificate for family practice should be the primary and major certification provided by the board and not secondary to that of some other specialty. The board itself should not be subsidiary to any other board. The board should be recognised by the American Medical Association Council on Medical Education and by the Advisory Board for Medical Specialty in the same manner as all other speciality boards. The certification should fall within the established*

*framework for specialty certification, be judged by the same general standards, and have the same status as other kinds of specialty certification.”<sup>4</sup>*

The adoption of the term ‘family physician’, by the American Academy and the Canadian College, provided a powerful impetus to the universal use of this term to describe the new specialist.

*‘The Ad Hoc Committee is convinced that the opportunity for specialty board certification is essential for those properly prepared for a family practice. Board certification is the only appropriate recognition for physicians who have invested the time and effort necessary to complete prescribed training programs and who have demonstrated their competence in this important field of medicine. Certification is necessary to provide status to the field and to reward those who have prepared themselves in a suitable manner. Both status for the field and regard for the individual are essential to attract young physicians to careers in family practice. The provision of board certification is not the only requirement to be satisfied if an adequate number of family physicians is to be prepared in the future, but it is an important point.’<sup>5</sup>*

This use of the word ‘primary’ was soon overshadowed by the WHO’s primary health care movement for basic and minimal health care services which would include traditional medicine and lay healers. Nevertheless, primary care medicine remains a useful generic term. ‘Primary physician’ or ‘primary care physician’ may be appropriate terms in most developing countries where family practice takes on a strong community orientation in the context of a national primary healthcare programme. The term ‘general medicine’ has a respectable lineage, but in many countries has been appropriated by general internists in unspecialised practice.

*“Every individual should have a personal physician who is a central point for integration and continuity of all medical and medically related service to his patient ... Every hospital should have a service for the personal physician and each physician should have a staff appointment in one or more accredited hospitals”.<sup>4</sup>*

Notwithstanding these differences, there is a common core of knowledge, skills, attitudes and common interests shared by family physicians worldwide, which

means that they are able to partake in scientific exchange in a common international organisation, the World Organization of National Colleges, Academics and Academic Associations of General Practitioners/Family Physicians (WONCA). WONCA is now better known as the World Organization of Family Doctors.

### **What is Family Practice?**

A number of questions had to be answered, both within the profession and in the community, before family practice gained its present status and acceptance. Was it a separate discipline of medicine? Could it be taught? Did it need postgraduate training? Was it examinable? Over the past three decades, all these questions have been answered and the issues laid to rest. It is now a rare medical school, except in the poorer developing countries, that does not have a department of general practice, family medicine or primary care medicine. According to the Royal Commission on Medical Education, the purpose of the undergraduate course in medicine *“should be primarily education. Its object is not to produce a fully qualified doctor but an educated man who becomes qualified in the course of postgraduate training”*.<sup>6</sup>

The family physician is a specially trained doctor who accepts personal responsibility for providing continuing and comprehensive care to individuals of both sexes and all ages. In providing this care, the family physician takes a preventive approach that is oriented to the family and based in the community.

When necessary, the family physician has the duty to refer to or consult with appropriate subspecialists or institutions, in order to achieve the best possible outcome in health care.

The family physician accepts personal responsibility for continuing and comprehensive care. Continuing care encompasses:

- first-contact care
- initial care
- emergency care
- episodes of illness
- long-term care for chronic disease

- advice and counselling
- rehabilitation

Comprehensive care includes:

- whole-person care
- total care
- referral and consultation
- co-ordination and integration

The knowledge and skills needed to perform these functions mean that the family physician must constantly be evaluating his own competence, and be prepared to make a lifelong commitment to education.

The family physician practises in the community, and the life of the practice is closely woven into the intimate life of the community. The differences that exist between practice in the community and institutional practice have a profound influence on the personality of the physician and the character of the practice. The areas of difference include the following:

- the practice environment
- doctor-patient relations
- presentation of health problems
- process of care.

### **Practice Environment**

The practice environment in the community is informal, while that institution is formally regulated. Family practice requires relatively small funding, whereas hospitals are heavily capitalised, with expensive equipment and very heavy running costs. A family practice is part of the community, whereas a hospital tends to be distant.

### **Doctor-Patient Relations**

The individual seen in a family practice is autonomous, ambulant and wearing everyday clothes. The individual in hospital is psychologically institutionalised, dependent and is most often seen by the physician as a 'patient', often wearing

pyjamas and recumbent in bed. The institutional arrangements of a hospital create a vast social distance between the physician and the patient.

The physician in a hospital is an official of the hospital with a white coat and title; he has a rank in a hierarchy and must follow officially laid down procedures. He practises in one of the multiple disciplines for specific disorders or procedures. In contrast, the family physician seeks to behave more like a friend, dealing with a broad range of health problems and working with his peers, improvising solutions to problems. The family physician is also very sensitive to relations with the community, whereas the physician in an institution tends to be insulated, if not isolated, from the community.

In family practice, the physician takes personal responsibility for health care in a continuing relationship. The family physician's relationship with his patients is based on trust, and he seeks to be persuasive to gain patient compliance with advice and treatment.

At each encounter, the family physician must win access to the thoughts and feelings of the person seeking care. Hospital care tends to be episodic, and responsibility for care is taken by an institutional unit or department. The individual in a hospital is treated as a member of the public rather than as part of a family. The physician in hospital exercises a certain official authority and dominance over his patient.

Finally, family practice is culture-specific and the ambience of a practice closely reflects the customs and preferences of each community, whereas the hospital is culture-neutral and the environments of hospitals anywhere in the world tend to be very similar.

Families interact with their physicians over long periods of time so that a comfortable and trusting relationship develops between the individual and his family, and their physician. The family physician enjoys a uniquely intimate relationship with the family and sees each member growing into the different phases and roles of life (Table 13.1).

Caring for successive generations, the family physician is aware of the inter-relationships and interactions within the family as they evolve over several

decades. This background of knowledge adds depth to the encounter when an individual presents with a health problem.

**Table 13.1 Doctor-Patient Relations.**

General practice	Hospital
	<i>Patient</i>
Person	Patient
Autonomous	Dependent
Wears own clothes	Wears hospital pyjamas
Ambulant	Recumbent
	<i>Physician</i>
Friend	Official
Improvises	Follows procedure
Peer	Hierarchical
Sensitive to community	Insulated from community
Has one generalist discipline	Has multiple narrow disciplines
Cares for a broad range of problems	Cares for specific medical health disorders
Deals with person-oriented problems	Deals with pathology-oriented problems
	<i>Doctor-patient interaction</i>
Continuing	Episodic
Based on trust	Dominant
Persuasive	Authoritarian
Sees individual as a member of a family	Sees individual as a member of the public
Culture-specific	Culture-neutral

**Presentation of Health Problems**

The full spectrum of the natural history of disease is seen only in general practice. Health problems are presented by a wide range of people: Those who are normally healthy, those who are at a higher risk of certain diseases and those with early signs and symptoms of disease, to the acutely sick, the disabled and the dying. Diseases present in an undifferentiated manner, in contrast to the highly selected cases seen by each hospital unit. Symptoms are described in spontaneous dialect,

unlike the tutored vocabulary needed for the chronic hospital case. Health problems in family practice frequently include psychological illness, potentially as disabling and life-threatening as any organic condition. There are also problems that are principally social or economic in their origins. As a general rule, it can be said that an individual who sees a family physician has multiple problems which have physical, social and psychological dimensions.

The characteristic presentation of health problems in family practice determines the function of the family physician. The presentation of problems can be considered in the categories below. .

### **People in Good Health**

Families cherish easy access to a doctor, which encourages them to visit him when they are troubled about their health for any reason, even with minor complaints or merely to discuss their health. Preservation of good health is the first priority, and the family doctor must scrutinize family and occupational history for risk factors; he must look into the social and economic background, and evaluate the physical and mental status for the earliest signs of diseases or for factors predisposing to disease. Advice and counselling on nutrition, exercise, recreation and lifestyle are important tasks of the family doctor. Such opportunities are uniquely available to the family doctor.

### **Common, and Usually Self-limiting, Diseases in Family Practice**

Hidden among so-called minor or trivial illness seen in general practice are serious conditions such as acute rheumatic fever and carditis, acute glomerulonephritis, acute glaucoma and iritis, acute abdomens, meningitis and malignancies, to mention a few.

Even if the conditions are ‘trivial’ and self-limiting, the family physician regards whatever troubles the individual as worthy of his attention. If the physician has a different hierarchy of importance for the patient’s problem, this has to be explained and interpreted to the patient.

## **Major Illness in Family Practice**

Serious diseases seen in family practice include asthma, hypertension, ischemic heart disease and diabetes. These are serious conditions that are potentially life-threatening or can significantly diminish life expectancy or impair the capacity to work. Most people suffering from these diseases are seen in family practice, and few need to be seen in hospital until complications occur. These diseases are the most important causes of morbidity and early death, and good prognosis depends on continuing care of a very high standard.

## **Emergencies**

Many emergencies are first seen by the family physician and most are dealt with entirely in family practice. The ability to identify an emergency and to provide an appropriate response quickly, are important skills of a family physician. The child with fits, the victim of an accident or of rape, the woman with the pain of a ruptured ectopic, all turn first for help to their family doctor. Many grave emergencies will present in the first few minutes or hours with vague symptoms. The acute appendicitis seen in its early stages presents a very different picture just a few hours later. The family doctor must be able to pick out these serious problems from a multitude presenting with similar transient complaints.

## **Health Problems Requiring Mainly Preventive Care**

Prevention is the most important activity in family practice. The family physician identifies different groups at risk and endeavours to lower the risk by advice and counselling to modify habits and lifestyle that are inimical to health, such as unbalanced diet, tobacco consumption, excessive alcohol intake, lack of physical activity or dangerous driving.

We now know that myocardial infarction, cerebrovascular accidents and renal failure can be prevented by early treatment of asymptomatic hypertension and other risk factors in healthy persons. New knowledge of the aetiology of the conditions shifts emphasis away from more intensive care units, more bypass surgery and more renal dialysis to prevention by cost-effective interventions. It has been discovered that diabetes, hypertension and obesity are best managed as a single entity and that the family doctor is in the best position to do this.

### **Problems with Important Social and Psychological Consequences**

Many problems presenting in family practice have effects on the lives of others in the family or the community. A man with a urethral discharge or a child with a bruise must not be treated simply for the presenting complaint and sent away. There is a wife in danger of infection, a child's life in danger or a mentally sick person needing help, whose interests also need to be taken into account, often urgently. Again, a mother attending frequently for minor illness or bringing a healthy child for examination may be appealing for help in dealing with her own alcoholism or with an alcoholic husband at home, or with a delinquent child. Often a somatic complaint is tentatively proffered to justify a visit and to test the physician's receptivity before social and emotional problems are exhibited. The family physician sometimes has a pastoral role to fulfil in response to the needs of certain patients.

Particularly in developing countries, the family physician also has a welfare role and is called upon to provide free or reduced fee services to indigent families or to those going through temporary difficulties. This means not only waiving consulting fees: in a dispensing practice it means prescribing free medicines as well. The family physician must also struggle to obtain a share of welfare funds for the most needy, and arrange for the care of the deaf, the blind, and other physically or mentally disabled people seen in the practice.

### **Process of Care**

The options in diagnostic and therapeutic procedure differ in primary care from those obtainable in hospital care. The range of investigations possible within the walls of a clinic have widened considerably. Only a few decades ago, diagnosis was limited to a clinical examination, height, weight and blood pressure measurement, and to boiling urine for albumin and glucose. Even a pregnancy test needed reference to a laboratory for a biological urine test. Today a wide range of dipsticks and office chemistry tests are available for urine and blood clinical chemistry, for the measurement of substances from phenylketones to chorionic gonadotrophins in urine to glucose, creatinine, cholesterol and CPK levels in blood. The range of tests available continues to increase in number and reliability every year with new developments in biotechnology and immunology. Ultrasound and endoscopy are technologies whose value in primary care is being

proved in many practices. The family doctor provides the unique combination of high technology with personal care, in a cost-effective manner: High tech with low cost.

The options in therapy are also multiplying. New psychotropic drugs have opened the doors of so-called 'lunatic asylums', so that most cases of psychosis are managed at home. The vast majority of cases of anxiety and depression are seen and managed entirely in family practice, with the aid of very effective anxiolytic and antidepressant drugs when necessary.

The treatment of acute upper and lower respiratory tract infections, soft tissue infections and urinary tract infections can be carried out on the ambulant patient, it being the rare infection that requires hospitalisation. The treatment of asthma, hypertension and diabetes is now carried out far better in family practice than was conceivable in hospitals only a few decades ago. Medical advances have greatly expanded the capabilities of the family physician in the management of a broad range of health problems. .

### **The Delivery of Health Care in Family Practice**

We have seen the range of health problems that present in family practice. The responsibility of the family physician in managing these problems is to provide continuing and comprehensive care.

Continuing care begins with the initial contact of the individual or the family with the healthcare system. Initial care is for all health problems. The initial decision on treatment is a crucial one, whether it involves referral, consultation or the initiation of treatment. Continuing care implies the ability to provide care in an emergency, to deliver care in episodes of illness, and to carry out the long-term care of chronic disease, rehabilitation, and the care of the dying. Continuing care therefore ranges from care in pregnancy and child health care to monitoring complications in the life-time management of hypertension and diabetes mellitus.

Comprehensive care means seeing the individual not just as a patient but as a whole person, and accepting responsibility for organising care for his total health needs. This may involve advice and counselling, referral or consultation. Comprehensive health care is principally about the maintenance of health and

the prevention of disease. This may involve changing habits and lifestyles, which is possible only when the relationship of physician and patient is close and trusting.

The choice of referral or consultation can have far-reaching effects on the outcome of an illness, determining the course, cost and effectiveness of treatment.

The family physician has a wider choice for referral and consultation than a physician working in a hospital, as the family physician is usually not restricted to experts belonging to a particular institution. He must be familiar with the availability of expertise in the community, the relative competencies and predilections of each consultant, and the likely cost to the patient. The patient's medical destiny is often determined by the family physician's initial choice of consultant or institution.

Comprehensive care considers the social, economic and psychological factors affecting the individual, as well as the organic pathology. It implies an understanding of the internal dynamics of the family, and of its social and economic situation.

The words 'continuing' and 'comprehensive' care summarize the great diversity and complexity of care provided by a family physician. The immense cultural changes in our societies as we approach the 21<sup>st</sup> century, and the rapid advances in science and technology, will make great demands on the family physician but they will also provide opportunities for better care.

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