

8.

The Family Physician In Asia: Looking To The 21st Century

Rajakumar MK. The family physician in Asia: looking to the 21st century. Family Medicine Education in the Asia-Pacific Region. Core Curriculum for Residency/Vocational Training and Core Content for Specialty Qualifying Examination. The Philippine Academy of Family Medicine, 1993.

Those of us who live in the Pacific part of Asia are in the economically fastest growing part of the globe. Our societies are in the midst of rapid and continual change. The family doctor is subject on the one hand with the task of meeting new expectations and new needs amongst our people. On the other hand, the family doctor struggles to keep up with the rapid advances in medical technology and its increasing cost. I will speak briefly of the changes that societies are undergoing, and then of the changes occurring in our patients before I discuss the type of family physician that is needed.

Changes in Society and Its Consequences to Health Care

On my way here, I was glancing at the draft of my paper and read in the newspaper a statement by the Singapore Minister of Culture. What he said echoes my own thoughts. He said "...Culture follows economic dominance." He believed East Asia will be the dominant culture, and he projected that within 30 years, East Asia will have GNP exceeding Europe and twice the size of USA.

The people in our care are being shaken up in their daily lives. While we are in need, we don't notice we are moving very fast. But we have to stand pat and see great social, economic, and cultural changes overtaking our society and will inevitably change both our attitudes and the practice of our skills.

Look at the rapidly changing world around us. The population of the Asia Pacific region continues to grow. We remain a young population with a large proportion of young people. We are undergoing rapid urbanisation and industrialisation. Our cities are growing at a rate faster than the population. Cities are surrounded by the shanties of the urban poor. The elite of this region – in business, in politics and the professions – have a standard of living better than their equivalent social class in the West. But we also have extreme poverty, homelessness, gross undernutrition of children and high drop out rates from school occurring in some of the most populous nations of this region. Warfare and strife have been companions in the lives of the people in parts of this region, including the lives of the generous people who are our hosts today.

Although we are still nations of young people, the numbers of the aged have increased with population growth and increased life expectation. Educational levels of our young people have risen. Through TV, radio and the press, as well as books and magazines, they have windows into many societies and cultures and become contemporaneously involved with issues occurring in other parts of the globe. Their expectations of modern medicine are high; indeed they may be unrealistically high.

The health care system is also changing rapidly. Within this region we have both the diseases of poverty such as infant gastro-enteritis and tuberculosis as well as the diseases of affluence such as diabetes and ischemic heart disease. The state sector remains the most important source of health care for the majority of the people, particularly those in the rural areas. However, a vigorous private sector has developed, concentrating on private hospitals which attract most of the senior, most experienced and best qualified specialists.

Private medicine in the Asia Pacific region involves high capital expenditure, a strong procedure orientation and an expectation of high investment returns. The state sector in health concentrates quite rightly on public health but also provides hospital care mainly for acute illness and emergencies. Primary care is generally neglected. General practitioners usually do not have a stable panel of patients. Private hospital specialists are in primary care, seeking to combine procedural specialisation with pretensions to a universal curative gift. Thus, the so-called cardiologist may also do antenatal care, the dermatologist will treat infant illness and the specialist surgeon will also treat skin disease. The wealthier sections of

the population are creamed off by private hospitals that provide episodic primary care.

As a result, standards in subspecialties are low as specialists compete with each other, whilst trying to hold to everything that comes their way. General practice too suffers as practitioners work long hours, taking two or more jobs in some countries to earn an adequate income. Doctors are undertrained and have little time for continuing education, their staff is poorly educated and their premises are small and lacking in equipment and facilities.

The bright side is that things are also changing in general practice. The growth of academic organisations of general practice is one indicator of the great changes that are underway in general practice. We are the guests of one of the oldest academic organisations of general practice, the Philippines Academy. We have benefited from the advances made by sister organisations in developed countries, in the United States, the United Kingdom and Australia, and we are appreciative of their generosity in sharing with us the fruits of their endeavours in developing our discipline. Closest to us is the Australian College, and Prof. Wesley Fabb who is with us at this meeting is identified in our minds with the image of Australian willingness to share and learn together.

As for the United Kingdom College, they provided the impetus for the Australian College and have remained a distant friendly influence but I do wish we could interact more with them. I am delighted that Dr. Douglas Garvie, a friendly force of the British College, is here. The American Academy, pre-occupied though with its own problems, has had a profound influence on our region, most especially in the development of the concepts of family practice. Our host Academy is obviously created in the image of the American Academy.

Yet there is much that we too have to offer. The wealth of experiences that fill days in the life of a good practitioner in Asia is unrivalled. We see multiple problems with multiple diseases. We see a remarkable range of organic pathology presenting both as early and advanced disease. We see social and economic problems, psychological and spiritual crises, interwoven with organic pathology in the lives of our patients. We interface not only with scientific medicine but with magic and traditional healing arts on the one hand and with deep religious belief and piety on the other. Our patients fortify themselves with amulets and

charms, pray for divine intercession and take herbal medication. Often it is only when all these fail, that they turn to the physician and even then both magic, religion and science may have to go hand in hand. This adds profound complexity to the consultation, and the element of magic remains in the patients' expectations of their physician. The individuals and families in our care are subject to severe sociological stress as our societies undergo rapid cultural change compressing into decades the effects of urbanisation and industrialisation that were spread over a century in the West.

We may become the last of the true family doctors in the World because the family is strong and healthy in Asia. Indeed, it is the secret of our growth and prosperity. We do not need to invent a hypothetical group to be called family because the true family is disappearing in our society; the family of three generations flourishes side by side with the nuclear family which nevertheless retains close ties with parents and grandparents. The family in Asia transmits stable ethical and cultural values, is a reliable source of succour in adversity, and provides loving care to their disabled and handicapped on the tiniest of resources. I never cease to marvel at the young family surrounding the old man or woman brought to my practice and their determination to see good care provided, even at great financial distress to themselves. My task then is to help keep them out of the hands of rapacious for-profit private hospitals and to look for alternatives that would not ruin the family.

Yes, I do believe we have much to offer. I go further and say that the professional and personal development of a family physician trainee in a developed country is not complete without some experience of a Third World environment, perhaps within their own country, better still in the developing world. Such an experience, adding breadth to their clinical competence and depth to their personality, will make them better family doctors and better human beings.

I have spoken of the rapid changing socio-economic and cultural change in this region and of the changing character of the people we care for and of new developments in the health services of our countries.

The Type of Family Physician Needed

What sort of family doctor do we then need for the 21st century which lies only a

few years ahead? Physicians now in training as well as young people now in schools and universities will live most of their lives in the 21st century. It will be technologically a very different world but what is unchanging is the human need to be loved, to be cared for and to care. In health, in emotional distress and in economic adversity, families and individuals seek someone whom they can trust, to confide in, seek advice and direction. It is commonplace for general practitioners in Asia to provide free care to poor families, and often this means not only free consultations but free medicine too. We need this special kind of person to become family doctors. What can we do to produce such family doctors and to create an environment in which they can function effectively and efficiently? There are five areas of action.

[Editors' Note: Figure 1 has been omitted]

1. Training

The broad range of competencies that are essential to good family practice requires a sound scientific basis in undergraduate education and the acquisition of a comprehensive range of clinical skills during graduate training. In our region at least, it is clinical competence that is paramount and the family doctor, whatever other skills he or she may have, will be judged as a physician.

We need an intellectually and spiritually challenging programme for the young doctor in training and to be able to provide attractive role models for them. Undergraduate education is the foundation on which we build, and we must remember that training is only part of the educational process involved in undergraduate education. Education involves the opening of the mind to new ideas, the capacity for independent thought and finally socialisation into the role of physician. Such qualities are more important in family practice than in a proceduralist hospital practice.

2. Continuing Medical Education (CME)

The vocation of a family doctor is one that calls for a lifetime of learning, the continuous acquisition of new skills and the constant renewal of one's intellectual capacities. CME is integral to family practice. It must be a habit not a task, fun not a chore. It must be a voluntary activity. Provision of CME is the most important

role of our academic organisations. We have to seek ways to motivate our members and we have to provide a wide range of learning options to suit their individual needs and circumstances. There is a special problem in CME that we must take into account and that is catering to the needs of women who enter family practice in increasing numbers. Family practice is strengthened by the entry of many outstanding women who find family practice more congenial to their desire to combine family and work. Our CME program must be flexible and responsive to meet their needs.

3. Research

Research is the life blood of every medical discipline. Without research, we cannot provide effective health care and our discipline will wither away. Too much of our time and energy over the past few decades has been taken up in seeking definitions, justifying our existence and defending our role in patient care. Why are we not doing the important epidemiological studies that are best done by physicians working in the community? I can point to one exception: The longitudinal study of oral contraceptive users by the British College whose results are quoted to settle arguments on oral contraceptive usage. Where is the equivalent of the Framingham study on our side? In this region, we need morbidity data which is essential for planning health services. The outstanding example is the work of the Hong Kong College's collection of morbidity data from general practice. I hope that this regional meeting will provide the impetus for more research in each of our countries as well as open the door to collaborative studies in the region.

Community Involvement

The doctor in the community in Asia is an influential member of society. We need to provide leadership in improving the community. The physician's involvement is essential in improving the care of the handicapped and disabled. We should be active in organisations looking after handicapped children, battered women and old folk. Physician involvement gives more power to movements on the environment and action to improve the status of women and for plans against poverty. We must not only be in the community, we must also be part of it.

Recognition

This is the political aspect of the work of our academic organisations. It is pointless to train good family doctors if they are unable to deliver good care. It is universally acknowledged that primary care is the key to achieving Health for All. Equity demands that the majority of our people, the rural population and the poor in the urban areas should have better care. Yet it is the primary care physician who gets the poorest rewards in our countries. Our politicians may talk of the importance of providing better health care to the rural population, but then offer the lowest salaries and the poorest promotion prospects to the physician who goes to work in rural areas.

We have popular support and sound arguments behind our case but need to make them heard and make ourselves felt. We are close to the community and the majority of the people turn to us for care. We have to convert this into influence in decision making in each of our countries. The approach will be different, but the common thread is the necessity to use our numbers to bring national medical associations to our side and to use our presence everywhere to educate community leaders of the health needs of the people.

In the context of the five areas considered in the production of family physicians in the region, let us summarize the role of family physicians.

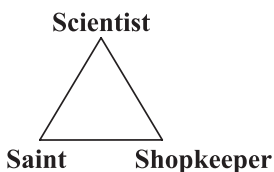


Fig 2. The Roles of the Family Physician

He is a scientist who is trained for a comprehensive range of competencies essential in good family practice; motivated to maintain his continuing medical education and does research. He is a saint who cares for his patients and families

not only in terms of medical needs, but also assists families with their other problems. He is a shopkeeper who coordinates the care given to the patient and his family.

In conclusion, I go back to my opening remarks. The Asia Pacific region is the most rapidly developing region in the world. We have within the region all the skills and the leadership to bring about change. I can see people already in academic family practice, Drs. Goh Lee Gan, Cindy Lam and so many others who provide skills we have lacked in the past. We are today in a country that was once the most prosperous in the region and I have no doubt will lead it again. I am grateful for this opportunity to share a few ideas with you and I am honoured to speak to an audience that has so many of the leaders in family practice from this region. And for this particular meeting, I extend my gratitude to Drs. Clarke Munro, Lindsey Knight and to Dr Zorayda Leopando. This meeting provides a good starting point to energize ourselves and I offer my thoughts as a small contribution to the process.