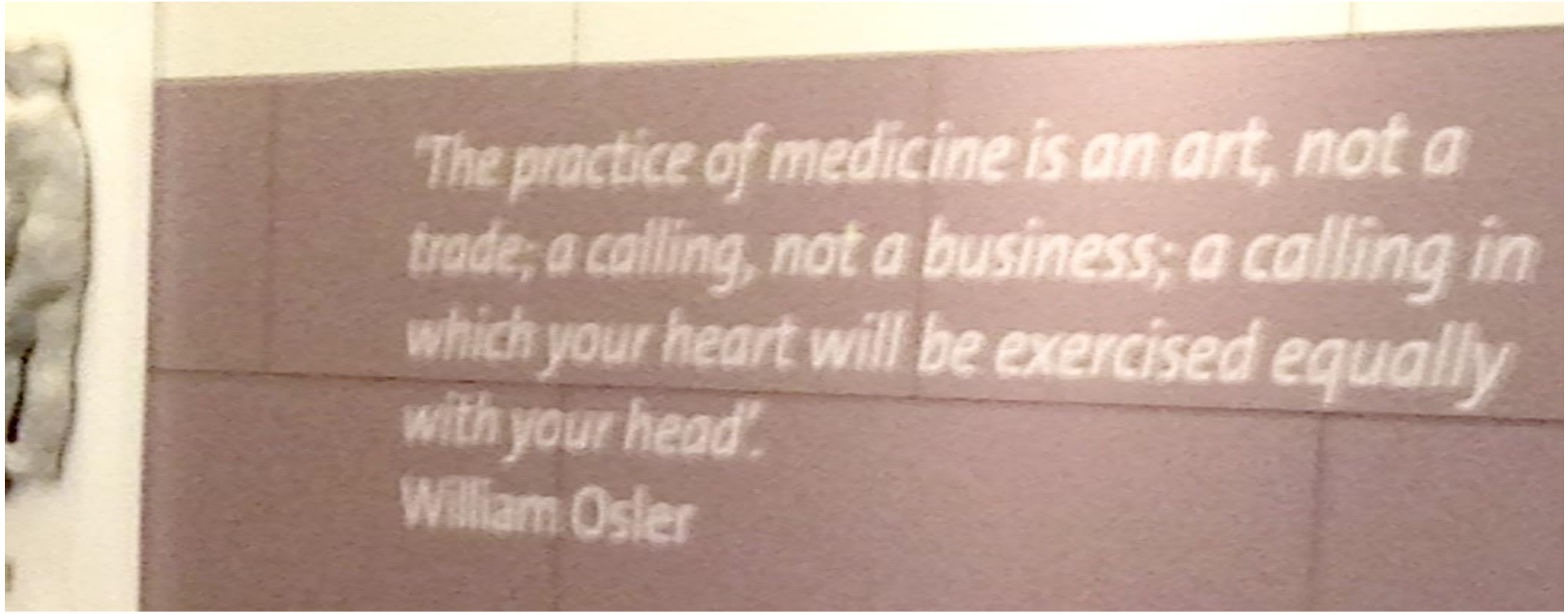
History & Current Structure of General Practice

Dr Abdul Jalil Khan
MBBS MRCGP CCT FRCGP FHEA MScMEd DDMPC FFPH
Assistant Professor & HOD Family Medicine, KMU
jalilkhan@kmu.edu.pk

What we going to talk about !

- History of General Practice
- Understand the role and importance of primary health care and Family Medicine.
- Understand the role of family physician and family medicine.
- To identify the benefits of effective and efficient family physician lead primary care.

Why Family Medicine ?



The History of Family Practice

- The Term General Practitioner (G.P) came into use at about the beginning of the 19th century

  Before that: * Physicians
  * Surgeons
  * Apothecaries

- In the beginning of the 20th century the overhelming majority of all physicians were Gps.

The History of Family Practice

- 1908 – 1910 Flexner study and report about the medical schools in USA and Canada

---→ shift towards specialization and sub specialization ---→ decrease no. of GPs.

- Then the problem of the decreasing number of GPs and its implications started to be recognized.

---→ many medical leaders asked for decreasing specialty residences and increasing residencies in general practice.

The History of Family Practice

- In 1947 foundation of the American Academy of General Practice.
- First training programme of General Practice in USA started in 1950.
- In England, the Royal College of General Practitioner was founded in1952. And then the vocational training for General Practitioners started.

* Dr. Ward Darley, the **Executive Director of the American Association of Medical Colleges** and previously the Dean of the University of Colorado Medical School and later President of the University of Colorado.
- Practicing internist from 1931 to 1944 prior to his full-time involvement in education, had long been an interested and outspoken person concerning **comprehensive medicine**.
- He declared that **“fragmentation of medicine in specialties continues to increase fragmentation of patient care”.**
- **Strongly endorsed the concepts of the family medicine**.

In 1961 Dr. Darley wrote,

"As both medical knowledge and specialism increases, **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 prevent disease.
- One of his fundamental responsibilities will be to guide his patients through the growing complexities of medical care. He will be keenly aware of the importance of utilizing those community resources having something to offer in the management of his patients.

In essence, then, **I am proposing a new speciality".**

The History of Family Practice

- 1962, WHO **Expert Committee on Professional and Technical Education and Medical Auxiliary Personnel** met in Geneva to discuss the **worldwide shortage of family physicians**.
- Identified the need to train family doctors to serve as physicians of first contact with the patient.
- **Medical student's training should include exposure to family practice**.
- **All graduates choosing family practice should experience some from of specially designed postgraduate study**.
- Need for more research in the field of family medicine.

The History of Family Practice

- **Now interest is high.**
  - More training programs.
  - More interest among medical students and doctors.
  - In many programs more applicants than openings.
  - **Societies are pleased**

Description of ROLE

- The general practitioner is a licensed medical graduate who gives care to individuals irrespective of age, sex, and illness.
- Attend his patients in his consulting room and in their homes and sometimes in a clinic or a hospital.
- His aim is to make early diagnosis.
- He will include and integrate physical, psychological and social factors in his considerations about health and illness.)++SPIRITUAL).

ROLE

He will practice in cooperation with other colleagues, **medical and non-medical**.

He will know how and when to intervene through **treatment, prevention, and education to promote the health of his patients and their families.**

He will recognize that he also has a **professional responsibility to the community".**

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⑩ **From "A system of training for general practice" Published by the Royal College of General Practice 1992.**

EDUCATIONAL AIMS

- S**ufficient knowledge** of disease processes particularly of **common diseases, chronic diseases, and those which endanger life or have serious complications or consequences;**
- Understands the **opportunities, methods, and limitations of prevention, early diagnosis, and management in the setting of general practice;**
- Understanding of the way in which **interpersonal relationships within the family can cause health problems or alter their presentation, course and management, just as illness can influence family relationships;**

EDUCATIONAL AIMS

- An understanding of the **social and environmental circumstances** of his patients and how they may effect **a relationship between health and illness;**
- His knowledge and appropriate use of the **wide range of interventions available to him;**
- Understands the **ethics of his profession** and their importance for the patient;
- Understands the basic method of research as applied to general practice.

EDUCATIONAL AIMS

(a). How to form diagnosis which take account of physical, psychological, and social factors;

(b). Understands the use of epidemiology and probability in his everyday work;

(c). Understanding and use of the factor ‘time’ as a diagnostic, therapeutic, and organizational tool;

EDUCATIONAL AIMS

(d). Can **identify persons at risk and take appropriate action;**

(e). **Can make relevant initial decisions** about every problem presented to him as a doctor;

(f). Capacity **to co-operate with medical and non-medical** professionals;

(g). Knowledge and appropriate use of the skills of practice management.

EDUCATIONAL AIMS

a) Capacity for empathy and for forming a specific and effective relationship with patients and for developing a degree of self-understanding;

(b). How is recognition of the patient as a unique individual modifies the ways in which he elicits information and makes hypotheses about the nature of his problems and their management;

(c). Understands that helping patients to solve their own problems is a fundamental therapeutic activity;

EDUCATIONAL AIMS

(d) C**an make a professional contribution to the wider community;**

(e). Willing and able **critically to evaluate his own work;**

(f). R**ecognizes** his own need for **continuing education and critical reading of medical information.**

Role of a GP/Family/Primary care Physician

- Provides personal, primary and continuing medical care to individuals and families
- Makes an initial decision on every problem presented
- Consults with specialists when appropriate
- Intervenes to promote health
- Clinical decisions influenced by prior probability of disease
- Has an advocacy role for the patient
- Specific responsibility for the health of the community

Sources: Royal College of General Practitioners 1992; WONCA Europe 2002

The Role of Primary Health Care

The primary care physician has a number of functions (World Health Organization 1971):

- to provide continuous and comprehensive care
- to refer to specialists and/or hospital services
- to co-ordinate health services for the patient
- to guide the patient within the network of social welfare and public health services
- to provide the best possible health and social services in the light of economic considerations

Role of Family Physician

A bit different

- More Holistic approach
- Treat patient as individual rather than treating the disease only
- Focus is illness and it’s effect on both individuals and families
- Effect of illness on patient and it’s socioeconomic and psychological impact on patients and their family
- Involve patients in decision making

Primary Health Care

Primary health care is frontline, ongoing care which is comprehensive and coordinated

Family Medicine

- Family medicine is the medical specialty which provides continuing, comprehensive health care for the individual and family. It is a specialty in breadth that integrates the biological, clinical and behavioral sciences. The scope of family medicine encompasses all ages, all genders, each organ system and every disease entity.
- (1984) (2019 COD)

The 3 C’s

- Continuity
- Coordination
- Continuing care

Defining Primary care

- Value driven: dignity, equity, solidarity and ethics
- Protects and promotes health
- Centered on people but allowing self reliance
- Focus is quality including cost effectiveness
- Sustainable finances, allowing universal coverage and equitable access

Source: Ljubljana Charter, WHO, adopted by EU, 1996

Role of Primary care

- Health education
- Identifying and controlling prevailing health problems
- Food supply and proper nutrition
- Provision of safe water and basic sanitation
- Maternal and child health care, including family planning
- Immunization
- Prevention and control of endemic disease
- Appropriate treatment of common diseases and injuries
- Promotion of mental health
- Provision of essential drugs

Current model of Primary Health care in Pakistan.

Presumably same as 30 years ago.

Current concept / obstacles

- Currently primary health care in Pakistan provided by GP's with no formal Family Medicine training, mostly in their early post qualification years.
- Gap filled by Layman, family members, friends, educated family member/friend (Babu Lala), Touts etc who plays the role of Advocate and guide on how to seek medical help.
- The Culture.
- Norm of society.
- Thoughts of Doctors /Specialists.

New Developments in collaboration with WHO

- FP approach for PHC, 3 GPs per 10,000 by 2030.
- Starting Diploma in Family Medicine at KMU.
- Pilot districts to start family medicine clinics.
- Other provinces considering similar options.
- Competency based assessment for BHU Doctors.
- Prime minister and KPK health insurance programme.
- FP to act as gatekeeper and provide cost-effective care.

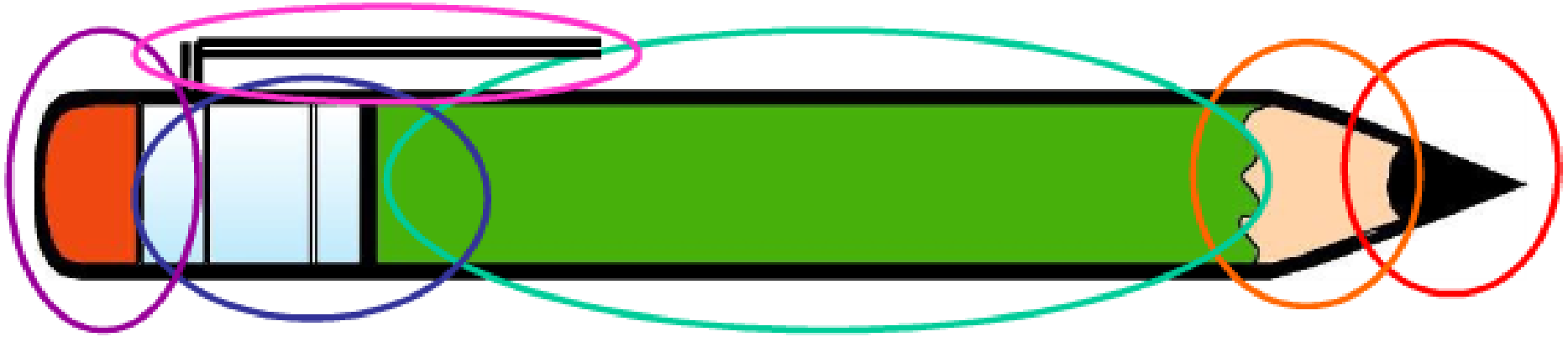
Why no Change ?

- Is it a new concept ?
- Is it Important ?
- Is it possible ?
- Is it Achievable ?

The Pencil Metaphor

Adapted from:

http://www.teachers.ash.org.au/lindy/pencil/pencil.htm



The Hangers-On

Hangers-on know all the right lingo, attend all the seminars, but just don't actually do anything.

The Erasers

These people endeavour to undo much, if not all of the work done by the leaders.

The Ferrules

These people hang on tightly to what they know. They keep a strong grip on their traditional teaching practices and feel that there is not a place for the technology in their classroom.

The Wood

These people would use the technology if someone would just give them the gear, set it up, train them and keep it running. All they need is help from some sharp person and they would be doing it too.

The Sharp Ones

These are the people who see what the early adopters have done, willingly grab the best of it, learn from the mistakes of others and do great stuff with their students.

The Leaders

These people are the first to take on the technology, the early adopters who usually document and enthusiastically share what they have tried, warts and all.

Is it a new concept ?
NO !!

- Hippocrates Oath
- Almata Declaration
- GMC Duties of a Doctor
- Family Medicine Training in Agha Khan established in 2003
- KMC & AMC been recognized for family Medicine training since 2004

Hippocrates Oath (Modern version: Written in 1964 by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University, and used in many medical schools today

I swear to fulfil, to the best of my ability and judgment, this covenant:

- I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.
- I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

Alma-Ata Declaration 1978

PHC as a concept was officially launched in 1978 at a (WHO)/UNICEF conference in Alma-Ata, in the former Soviet Union.

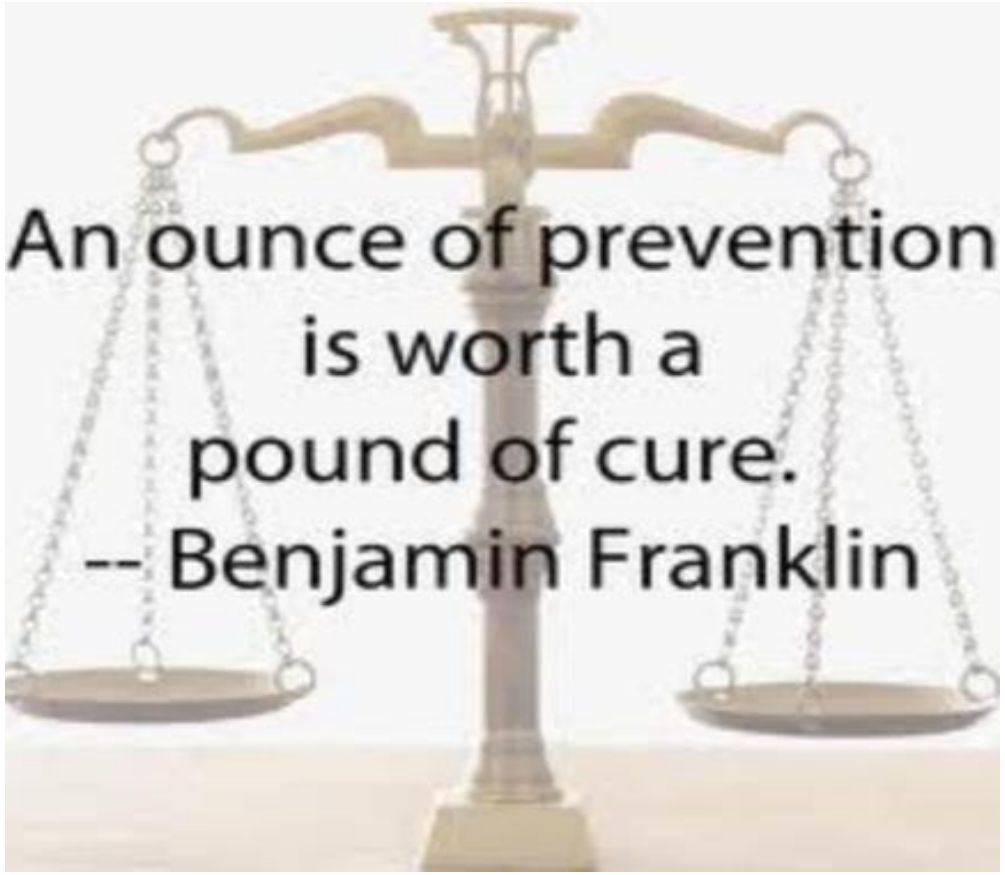
150 governments were represented.

The benefits of Family physician lead primary health care

Health service reforms in UK and around the world are moving towards primary care-centered services.

Health care systems with a higher primary care orientation tend to produce better health of a population at lower costs.

!! What would you prefer for your loved one ?



Primary & Secondary Prevention

- Stop smoking and avoid COPD vs. specialized centers with patients on ambulatory oxygen / bed side commodes / struggling to walk more than 10 yard due to dyspnea.
- Loose weight / healthy life styles and avoid diabetes and Hypertension vs. getting treatment in specialized diabetes centers using insulin pumps and taking 3-4 anti Hypertensive drugs.
- Screening for pregnancy induce hypertension & Gestational diabetes vs. presenting with complication.

Primary & Secondary Prevention

- Early screening for diagnosis of diabetes and managing it vs presenting with diabetes complications.
- Good control of Hypertension vs presenting to a specialized cerebrovascular centre with Haemorrhagic or ischaemic stroke and paralysis.
- Early screening for CVD risk vs presenting to specialized centre and have by pass for triple vessel disease.

How is it possible ?

- Comprehensive and accessible primary health care.
- Regular Health screening
- Health Education
- Health promotion

Evidence about effectiveness of PHC

Informe SESPAS

- Primary care: an increasingly important contributor to effectiveness, equity, and efficiency of health services. SESPAS report 2012

Barbara Starfield*

University Distinguished Professor, Department of Health Policy and Management, Johns Hopkins University, Baltimore, Maryland, USA

Evidence from United States

APHCP
Quality in Primary Care

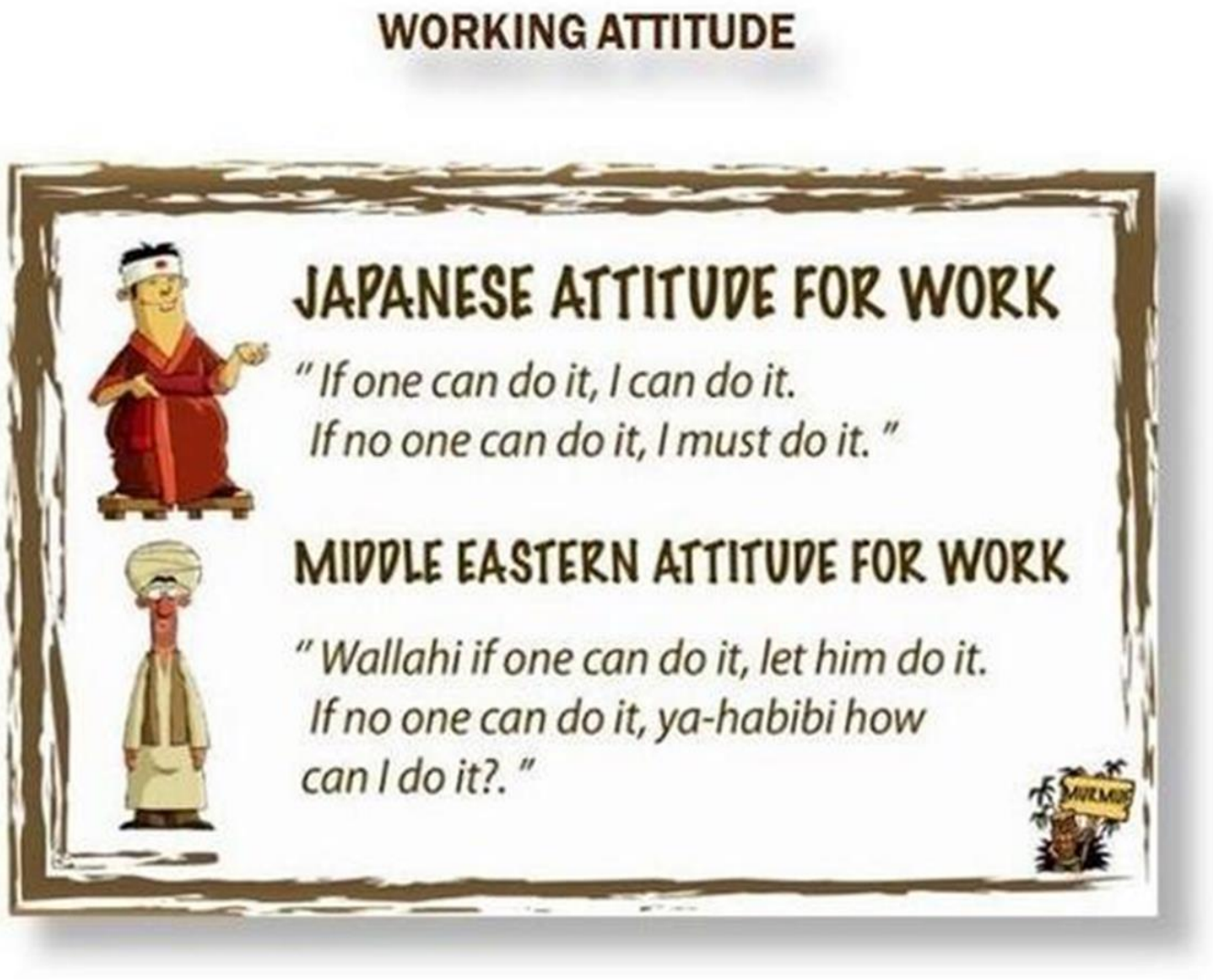
Changes	Effect
addition of 1 primary care physician per 10,000 population. (Ref 13)	1.44 fewer deaths per 10,000 population 2.5% reduction in infant mortality 3.2% reduction in low birth weight 6% decrease in inpatient admissions 5% decrease in outpatient visits 10% emergency room visits 7% less surgeries
adults and children with a family physician rather than a general internist, pediatrician or sub-specialist as their regular source of care, even after controlling for case-mix, demographic characteristics (age, gender, income, race, region, and self-reported health status. (ref 14)	lower annual cost of care, (ER spending, Hospital admissions, medications etc) made fewer visits 25% fewer prescriptions less difficulty in accessing care

Evidence from Developing Countries

Changes	Effect
In 1990, Brazil built a tax-based health services system based on strong primary care. During the period 1990-2007, marked improvements in maternal education.	Reductions in post neonatal mortality and under-5 mortality, Marked reductions in stunting, increased contraceptive use, vaccine coverage, antenatal care, skilled birth attendance, and marked decreases in absolute rich-poor differences in infant and child mortality across different areas. chronic disease mortality decreased (except diabetes). Reduce hospitalizations
In Thailand, as a result of expansion of the Rural Doctors Society insurance for medical services to cover entire population of Thailand by the early 2000s. At least one primary care health center was developed in each rural village	under-5 mortality was lowered by a much greater percentage in more deprived populations than in less deprived ones: 44% in the poorest quintile and 13% in the richest percentile. Both relative and absolute differences in under-5 mortality were reduced

Is it Possib

If one can do it I can do it !



PHCC Doha, Qatar

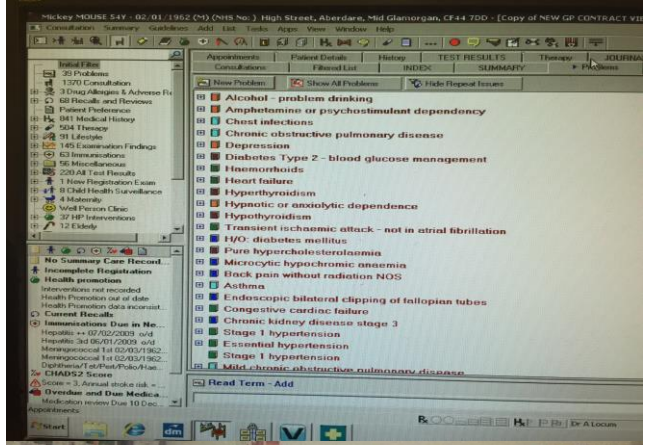
- First steps in PHC in 1954.
- Started comprehensive services in 1978.
- Now plenty state of art health centres and developing more.
- Workforce mostly Expats including Family Physicians of Pakistani Origin.

PHCC Vision:

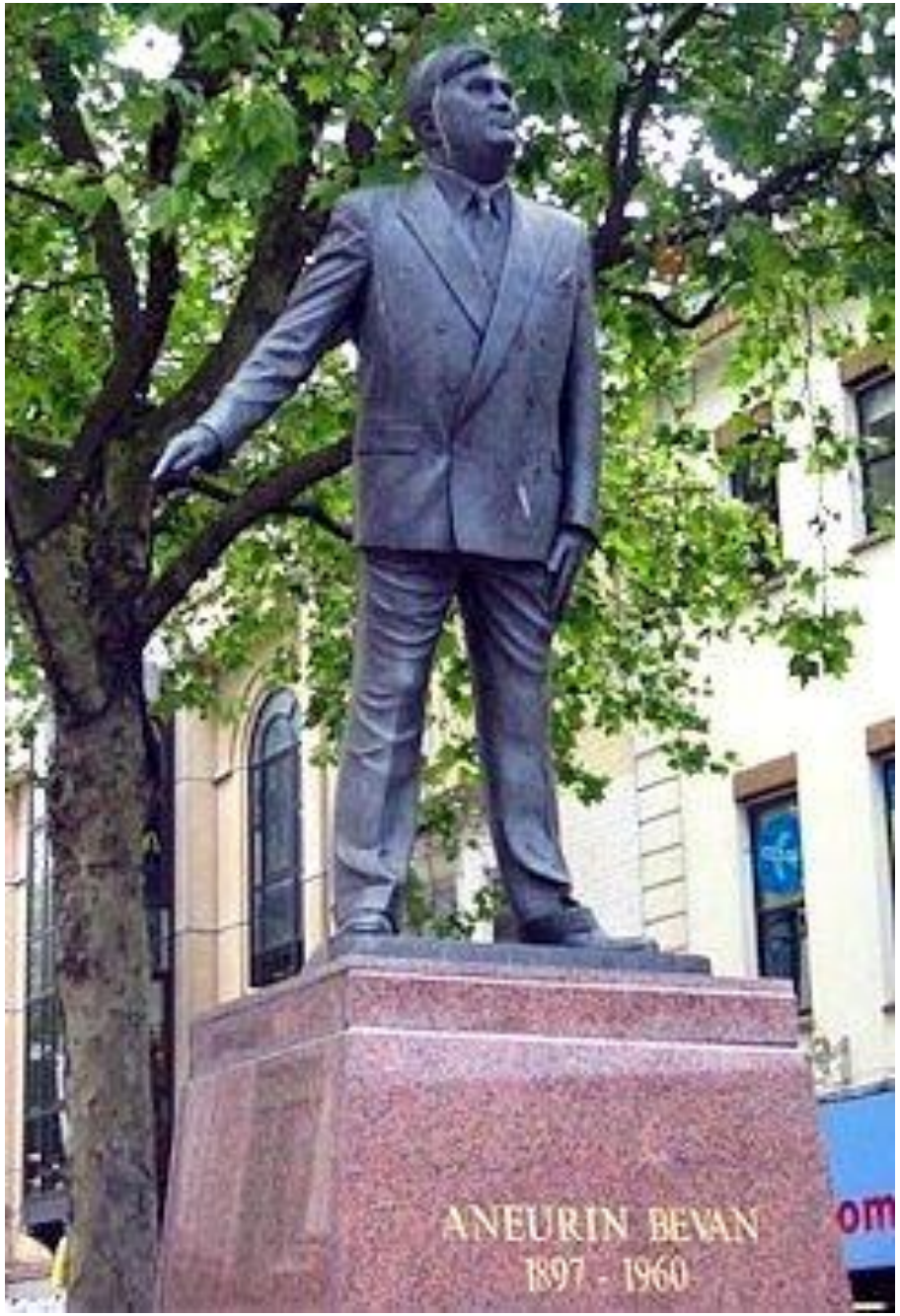
To advance health and well-being through primary health care services which are comprehensive e, integrated, person-centered and affordable.

UK General Practice

- Well established / first contact for patients.
- Primary care / Family Physicians are called GP's.
- Act as Gatekeeper to access specialist service




ORGANISE
OR
STARVE

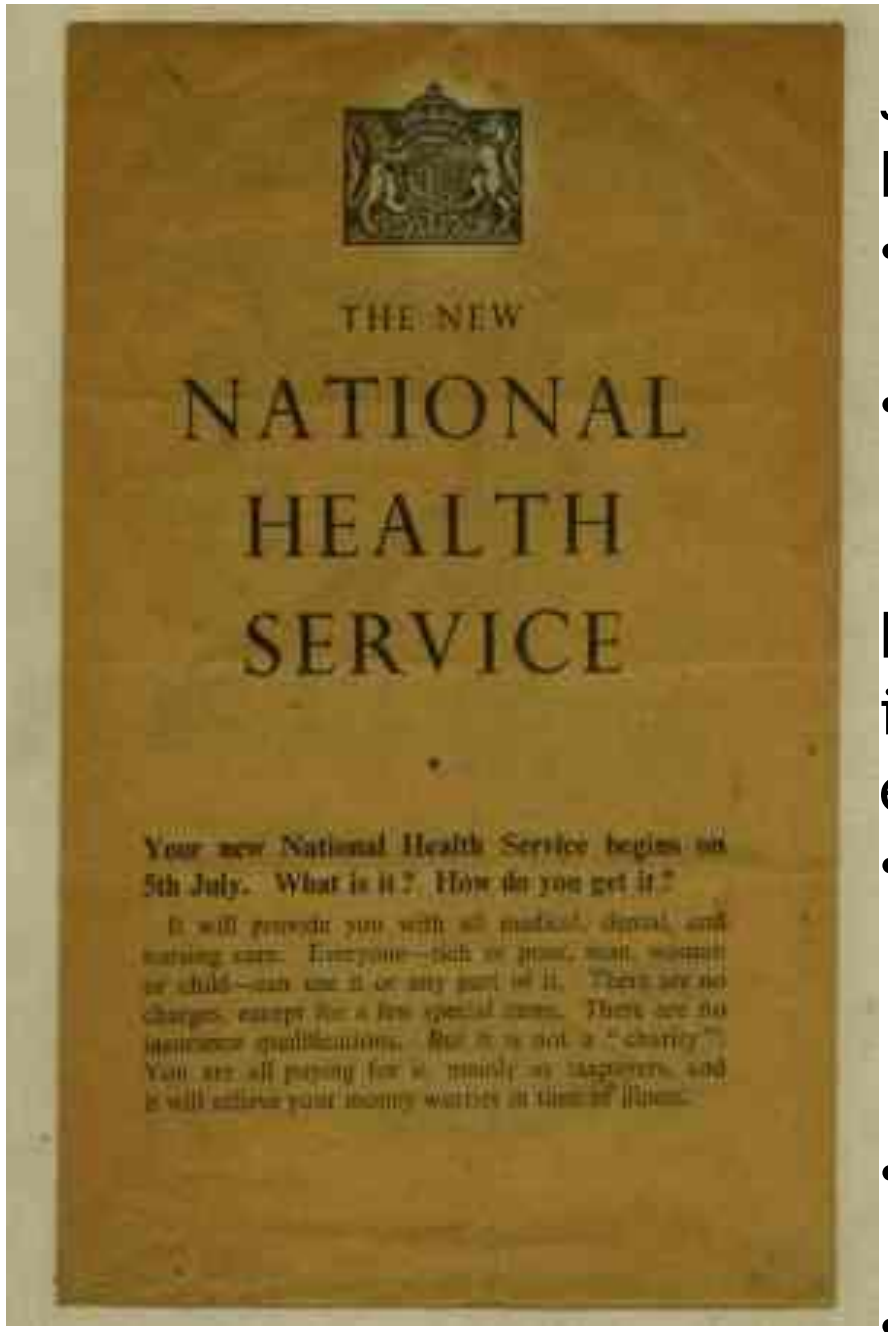


Labour's victory

Aneurin 'Nye' Bevan was appointed Minister of Health (and housing) by Prime Minister Clement Atlee.

- Bevan discards previous plans
- Took new proposals to Cabinet.
- The proposals included a system based on regions and taking all hospitals into public ownership.

Image: Statue of Aneurin Bevan in Cardiff. Credit:Wikimedia Commons, 2005 © Kaihsu Tai.



July 1946 : Aneurin Bevan publishes his National Health Service Act

- The Act sets out a duty for the Minister of Health to:
- “promote the establishment in England and Wales of health service designed to secure improvement in the physical and mental health of the people

For the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective

- Provision of services... The services provided shall be free of charge, except where any pn of this Act expressly provides for the making and recovery of charges.
- **Majority of doctors opposed to the introduction of the National Health Service (NHS).**
- **It goes ahead in 1948**

Evening Standard

The National Health Bill is out. It will cost £152,000,000 a year

STATE TAKE OVER DOCTORS, HOSPITALS AND DENTISTS

'Free for all'—1948

PRIVATE PRACTICE STAYS, BUT NEW DOCTORS DIRECTED

From 1948 everybody's health will be looked after by the State without fee. That is Mr. Aneurin Bevan's new National Health Service, details of which are published to-day. It is estimated to cost £152,000,000 a year.

Can they stay outside?

What you get—

FIGURES

HAMBURG WITHOUT BREAD

PLANE DIVES ON SCHOOL

200 children at play: All safe

Mr. Claude de Bernales

JOHN FROST COLLECTION

THE PLEBS

Organ of the National Council of Labour Colleges

VOL. XL. No. 3. MARCH, 1948. *Published on the 1st of each month.*

Address: Tillicoultry, Scotland. 'Phone: Tillicoultry 248 and 249. Annual Subscription, 4/- (U.S.A. $1.)

"Now before we start, are you for or against the National Health Scheme?"

- In 1950 The Lancet published a report, made by a visiting Australian doctor
- A small group of doctors form a steering committee (1951-1952)
- 7 GPs and 5 Consultants met
- They only met 8 times
- 1953 Undergraduate and Postgraduate committees were formed
- Final recognition and status came in 1972 from the HRH The duke of Edinburgh

Since its inception;

The royal college overseas training

Upholds standards of practice

Remains a strong voice for general practice

Specialty care is important

- Primary care alone cannot assure good health in the population and need to be complemented by prompt and adequate support from specialty services.
- Good professional relation is important b/w primary and specialty care
- However same respect and recognition need to be provided to GPs and Specialist.

THANK YOU FOR YOUR ATTENTION ANY QUESTIONS?

jalilkhan@kmu.edu.pk

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