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Twenty-Five Years In Retrospect: From General To Family Practice

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I am honoured to have been invited by the College of General Practitioners Singapore to deliver this Sixth Sreenivasan Oration, and I wish to thank the Council of the College for the invitation and Dr Frederick Samuel for his very gracious introduction. It is indeed a singular honour, but I must admit that I am anxiously aware of my own inadequacies. Many may deserve it more, but no one can appreciate it more, for Dr Sreenivasan was not only my teacher but also my mentor and guide. The life of Dr Sreenivasan, the Founder President of our College, was both remarkable and inspiring. The main principles that guided his life as a Consultant Physician and later as a General Practitioner can still guide ours today. His work as a Consultant Physician was very obviously different from his work as a General Practitioner and over the years he proved that the specialist and the generalist clearly complement each other in their roles and that general practitioners cannot be generalists and specialists simultaneously and vice-versa.

The early years

Twenty-five years ago this month, I entered general practice in a sub-urban area in Singapore, and I soon found myself doing a job for which I had not received any special training. My hospital training with its concentration on selected cases, its emphasis on morbid pathology, and on exhaustive investigation and intense treatment of advanced disease, largely contributed to my entering practice with a distorted view of how health and sickness is in the ordinary human family. It was difficult to unravel the physical, physiological and social origins of disease, In addition, like many of my erstwhile colleagues, I also held the view at that time that the problems which patients present to general practitioners are mostly minor ones, of which a high proportion are psychological or social. A General Practitioner was therefore nearly the same as a social worker, except that he had some medical knowledge. His main diagnostic task was to sort out what was minor from what was major and to refer the latter to specialists. There was no necessity to listen to patients, examine them, do tests or talk to them. General practice was mostly common sense. There was no need for specialist training, because common sense cannot be taught. All that was needed was a good bedside manner and a collection of medicines of dubious quality for dispensing. All these were predominant views twenty-five years ago and are still held by some today, whose thinking has not kept up with the new developments in Family Practice.

I entered practice with only limited hospital experience in medicine, surgery and out-patient care, and with no formal training in such areas as family dynamics, human development, behavioral sciences or the influence of social factors on disease. I n the early 1 960s I saw medicine with an exclusively pathological framework of diseases. My notes were littered with diagnostic labels with 'itis' endings, such as tonsillitis, pharnygitis, bronchitis, urethritis and cystitis and these labels were triggers in my mind to antibiotic treatment. I saw the disease clearly against the blurred background of the person.

In the mid-1 960s, psychosomatic medicine was in vogue, and the importance of non-organic factors in medicine dawned on me. Patients began to appear to me more as people rather than vehicles of disease, and resuited in more prescriptions for tranquillizers.

By the early 1970s depression became a common diagnosis with the resultant switch from prescribing tranquillizers to anti-depressants. But by the mid-1970s 'depression' was no more a diagnosis than 'anaemia', each requiring investigation to find its cause. Treating depression with antidepressants now seemed no more logical than treating anaemia with iron, without reference to the aetiology.

I began to realize that a large number of depressed people are experiencing unsatisfactory human relationships normally at home or at work, and they are people out of step with their own stage of

development or at odds with society. These relationship problems, especially marital and parent-child emerged as dominant problems. This submerged phenomenon of anxiety-depression and the stress on the integrity of the family, pushed themselves into my consultation room more frequently than before. Suddenly psychotropic drugs seemed not only less often indicated, but were creating problems of their own, such as evasion and dependency.

Today, in the early 1980s, my current interest are in the surveillance of chronic diseases like asthma, epilepsy, diabetes, hypertension, arthritis, myocardial infarction, and increasingly in the possibilities of practical preventive medicine. I have several options which I usually share with my patients. These options range from taking no action to prescribing drugs, counselling, surgical intervention, referral, consulting or a combination of treatments.

Every attempt is made to institute treatment that is rational, appropriate to the patient, economic, effective and safe. In all such areas of practice, in individual or family therapy, I have realized that it is imperative that the doctor must be conscious of his own limitations. He must be willing to seek further knowledge and skill and appropriate consultative advise or referral for patient problems that he is not equipped to handle.

How many general practitioners going into practice have found themselves totally unprepared by their training for the encounter with illness outside the hospital! Their first reaction, like mine, was to ask not "What is wrong with my education?", but "What is wrong with me?" Such is the power of early training to form one's view of the world. Nevertheless, most general practitioners found, as I did, that these early views gradually changed by their experience —an experience they gained as they began to develop a continuing relationship with their patients who returned to them periodically with different complaints and illnesses. As they become increasingly familiar with individual family members that they care for, they begin to see the family as more than simply a collection of individuals. Instead they become aware of the unique interactions and dynamics within each family, and realize that the family is a living unit and the basic social group. Consequently the proper management of a patient's health problem requires the involvement and participation of his family.

As this relationship develops, the general practitioner gets to know the families on a more intimate level. Their trust and confidence gradually **move beyond the usual fee-for-service episodic** type of patient-doctor contact to the establishment of a continuous relationship in which the General Practitioner has an ongoing responsibility for the health of the family and to preserve their physical and emotional health, and even **using the illness visit as an opportunity to practise** preventive medicine. This concern by the General Practitioner of the total management of the patient's and the family problems, completes his transition from general practitioner to family doctor.

The Family Doctor

Time and again, I have been asked "What is a Family Doctor?". 'What is the difference between a family doctor and a general practitioner?". To me, the family doctor is one whose primary function is to help families manage current illnesses and show them how to prevent or at least reduce the likelihood of further illness. The family doctor must accomplish this function in the framework of an increasingly complex social system characterized by rapid technological advances, taking into account the changing patterns of illness and changing expectations about health. Caring for the whole family, the family doctor not only gains in knowledge, but also enlarges his scope of action. Whenever the situation requires it, he can change his focus from individual to family and back again. In the many situations in which illness of an individual is followed by family dysfunction, he can quite readily direct his actions to the family as a whole.

The family doctor not only knows about the family—he knows them. This personal knowledge can be put to good use. He knows for example, the kind of feelings different members of the family arouse in him, and he can use this knowledge in making hypotheses about problems he encounters in the family. In this, as in all other things, he cannot have everything as we would like it. Some families will inevitably be better known to him than the others. There will always be families who prefer to divide

their care, for all types of reasons. Their wishes must be accepted even though looking after part of a family gives a family doctor a feeling of dissatisfaction. By caring for the whole family he starts to gain personal knowledge that can be gained in no other way.

I am of the opinion that a doctor who has committed himself to a group of people and attained fulfilment by doing so, undergoes a gradual evolution of a sense of vocation—first as a technical expert, a dealer in crises and emergencies, then gradually beginning to perceive his role in terms of the human relations that have been established. My observation from meeting large numbers of family doctors from all over the world is that the source of their fulfilment is the experience in human relations that medicine has given them.

The Role of the General Practitioner/Family Doctor

Dr. Pereira-Gray (James McKenzie Lecture, 1977) has classified general practitioner care into six components:

1. Primary
2. Family
3. Domiciliary
4. Preventive
5. Continuous
6. Holistic

Each one can be delegated to a colleague in another caring profession or to a consultant. However, it is the unique blend of these six aspects of medical practice which comprise our job. He went further to arrange all medical activities in a hierarchy by the point at which the doctor intervenes in the disease process:

1. The prevention of disease

2. The presymptomatic detection of disease

3. The early diagnosis of disease

4. The diagnosis of established disease

5. The management of disease

6. The management of the complications of disease\

7. Rehabilitation after active treatment has been completed

8. Terminal care

9. Counselling the bereaved

"The higher in this hierarchy the doctor is able to work, the better for the patient. As generalists we have a unique opportunity to operate at all nine levels of medical care, although traditionally we have primarily been concerned with the diagnosis and management of disease. Most of our patients want to be diagnosed, treated and if possible be cured. But most of all they would prefer not to be ill in the first place. If medicine is to serve society, then its single most important function must be to prevent ill health."

Providing first contact medical care means being closest to the patient. Initially it means that one is the first doctor that the patient contacts when sick. But from then on it involves the responsibility of being the personal advocate, protector, interpreter and care integrator for the patient no matter where he or she is required to be- at home, in the doctor's clinic, in a hospital or in a nursing home. When one problem is solved, the doctor must be available to help with the next one.

Continuity of care therefore is the quintessence of family medicine permeating every aspect: first contact, longitudinal responsibility, integration of care and the concept of the family as the unit of care.

As McWhinney has emphasised, the patient's relationship with the family doctor is not limited by the duration of illness. It ends either when the patient or the doctor elects to end it, when either party dies, or when the doctor ceases to practise. **Otherwise care should continue to be available either directly from the doctor or from deputized** colleagues.

Continuity of care has four dimensions:

(1) Chronological
(2) Geographical
(3) Interdisciplinary
(4) Interpersonal

(a) doctor patient relationships
(b) understanding of family relationships
(c) interprofessional relationships

Very often the family doctor applies different combinations of these dimensions at the same time. These are the dimensions of continuity which are to be found throughout the family doctor's activities. The understanding of families, the skills of anticipation and prevention, the awareness of how people decide to seek their doctor's help when they are sick, and finally the ability to discriminate clinically which patients need which services in the health care system are all part of caring for patients continuously — the family doctor's job.

The renaissance of Family Medicine

The renaissance of family medicine has been hailed by communities and supported subsequently by some governments. The upsurge of interest is seen specially in Canada, U.S.A., United Kingdom, the Netherlands, Mexico and South West Pacific. Health planners all around the world now recognize that the most satisfactory health care systems are those built on community based care, complemented by hospitals.

As the health care becomes increasingly and fragmented, it is vital that the patient has direct access to a doctor of first contact who is continually involved in his care, and who can share with the patient the responsibility for the maintenance of his health. The most appropriate person for this role is the family doctor whom the community expects to be knowledgeable, skillful, understanding and readily available. It is this community demand that will ensure the future of family medicine.

Medical educators around the world have also acknowledged that it is just as essential for the family doctor to have comprehensive vocational training and to participate in continuing education as it is for the physician or surgeon. Without this he cannot fulfil his proper role in community health care. Indeed no doctor should engage in clinical practice unless he has had training appropriate to his responsibilities and unless he maintains and enhances his skills through regular assessment and continuing medical education.

The stimulus that formed the College of Surgeons and Physicians before the last war spread to family and general practice soon after the war. Sound principles were laid down and comprehensive programmes prepared embodying all the educational techniques as well as the most up-todate assessment methods. Even the content of family medicine has been defined and is now recognized as a major medical discipline.

Training of Family Medicine

What about training? The educational changes that have influenced the General Practitioner/ Family Physician in developed countries during the past decade have been described as revolutionary. From a position during the sixties, when little if any, attention was paid to the specific training of the General Practitioner/Family Physician at either the undergraduate or graduate levels of medical education, training programmes in family medicine are now in the educational "limelight" —the in-thing in medical education. Great progress has been made to establish family medicine as a distinct educational discipline. Most medical schools in developed countries have University Departments of Family Medicine providing training programmes in Family Medicine with teaching responsibilities at both the undergraduate and graduate levels of medical education.

It must be understood that training in a medical specialty —as it is known today —cannot be applied "in toto" to the experience of being a family doctor. Learning to be a family doctor requires a change of perspective that can only take place where the perspective is dominant. It will also be apparent that attempts to produce a family doctor by putting together a conventional training in paediatrics and internal medicine—and adding some psychiatry —are doomed to failure. "The whole is different from the sum of its parts". Family doctors may emerge in this way, as I did, but they will do so by the arduous route of rising above their training from their experience.

For many years now, we in the College have talked about the establishment of a Department of Family Medicine in the National University of Singapore. Its role we have felt should not be just to expose undergraduates to general practice — then it has no right to exist at all. Its role should be to advance knowledge of general practice and to feed this into both undergraduate and postgraduate education in the discipline- and i dare to say, to set standards in patient care, at the highest possible standard, furtherance of the subject by research and teaching with the twin purposes of encouraging a spirit of enquiry amongst undergraduates and of providing for the training and postgraduate development of future academic practitioners of the subject. This is the role of academic departments in all other subjects. The time has arrived, and the College must now in all earnestness call for the formation of a Board of Studies on General Practice for the establishment of a Department of Family Medicine in the National University of Singapore.

As we design programmes suitable for the education of family doctors in Singapore, our educators must have a clear conception of the type of person they would like their students to become. The students should have deep commitment to people and obtain their greatest fulfilment from their relation to people- to believe in the primacy of the person, to use technology with skill, but to make it always subservient to the interests of persons. We want doctors who can think analytically when analysis is required but whose usual mode of thought is multi-dimensional and holistic. We want doctors to be concerned with aetiology in the broadest sense and to be ever mindful of the need to teach their patients how to attain and maintain health; doctors who know themselves and can throughout their career recognize their defects. learn from experience and continue to grow as people and as doctors.

It is particularly unfortunate that we do have some bad general practice where the general practitioner makes no effort to organise either his method of working, his premises or his staff. They work so fast and inevitably trivialize their patients' problems or restrict them solely into a single physical, psychological or social dimension, There is indeed evidence to show that a doctor working under pressure — seeing 80-100 patients per session — is more likely to prescribe unnecessarily, to ask for unnecessary investigations or refer to a specialist. Such practice not only fails to serve the patients' own interests, but also spoils the reputation of general practice. The bad practices of a small minority affects consultants and even students, in the teaching hospitals, quite out of proportion to their numbers. This has led to a breakdown of our referred system and an ever-increasing number of open-access services by specialists in the private sector. The General Practitioners are the proper co-ordinators for care of patients, and should be given opinions by those to whom they refer so that continuing and co-ordinated patient care may be useful and meaningful. If this co-ordinating function of the general practitioner is replaced by episodic, symptomatic care with a quick turnover, only minimal medical care is provided. We must have the ability in our own way to show patients that we care by providing more than minimal medical care. This cannot be done unless we five patients time and show our competence. If we do this there can be no excuse for doctor hopping as well as

circulaer referrals among specialists. Circular referrals although profitable to specialists lead to poor co-ordination of patient care, overservicing of needs, are costly and occasionally harmful. There is therefore an urgent need and the right of patients to receive good general practice and doctors to practice it.

In a modern environment like Singapore, with its highrise satellite towns and industrial centres, primary medical care should evolve an advanced system of health care and bring to bear advanced technology and skills to the health problems of the community. The approach should be family-based and community-orientated - especially when the 3-tiered family is being encouraged and closer neighbourhood ties are being promoted by Government. It does not promise to be a cheap solution to safeguarding the health of a community, but it will certainly be the most cost-effective, representing the most efficient way to utilise health resources.

The great majority of people seeking treatment for health problems are seen and treated without admission into a hospital. This has given an impetus to the search for improved management of disease through early diagnosis, management and treatment, so that as far as possible the individuals under care remain economically and socially active. The understanding of the cause of the disease, the identification of controllable risk factors, the development of strategies to control these factors and the great advances of modern medicine in the last three decades have made possible the ambulatory care of a great many disease for which there has been no effective treatment even in hospital until a few years ago. The psychotropic drugs, the newer anti-biotics, the steroids for beta-1 stimulants, home dialysis and effective immunization are a few examples of new developments that have transformed the prospects of primary medical care.

In order to take advantage of the great new possibilities in medicine, it is necessary to train a new type of general practitioner whose training will combine therapy with the new concepts of prevention and continuity of care that have become the hallmarks of family medicine.

Primary medical care must be the central axis on which the health services of a nation revolves. In 1980, according to the Ministry of Health Survey, fourteen million consultations were carried out at the primary car level of which about 70% (approximately ten million) were conducted by the private sector. Only a very small proportion of all sick people (less than 10%) needed the expensive technology of the hospitals, a fraction that can and must diminish with effective care at the primary level. This will enable the most effective utilization of expensive hospital beds.

Our specialist colleagues in hospital also need competant generalists in the community whom they can trust, so that they are not off-loaded with unnecessary referrals. An important achievement of specialist medicine has been the shortening of hospital admission times, but early discharge depends on the consultants' ability to refer the patient back to a competent primary care doctor. Our specialists should also go deeper into their specialization, the deeper they go the better it is for the patient- for example, one-operation surgeons function better than surgeons who do that operation only occassionally. Our specialists should direct their efforts into the numerous advanced techniques that have been developed in every specialty in the light of breath-taking advances that are coming into Medicine.

The challenge today is to provide good clinical care on average in our discipline as the consultants do in theirs. The solution must lie, first and foremost, with education and training for our discipline at both undergraduate and graduate levels of medical education.

The Government has now a vested interest in the competance of general practitioners and primary care doctors. It is becoming increasingly aware of the cost-effectiveness of good general practice and the price being paid for bad.

Twelve years ago, this College was founded- founded at a time when general practice in Singapore was in teh doldrums. Our First President, Dr Sreenivasan, had at that time enumerated the functions of a College of General Practitioners in the First College Lecture held in 1972. He even called for the establishment of a Department of General Practice as early as 1972. We have come a long way since then and some of our dreams have come true. It is our privilege now as members of the

College to rise to the challenge of our founder-president, Dr Sreenivasan. I am happy and proud to have been involved in the activities of the College during the past ten years. I believe that in the years ahead the College will continue to raise the standard of care for our patients through intergrating the natual with the behavioural sciences. I am confident that we have now come of age and that our discipline will respond to patients' needs.

The Sreenivasan phenomenon, the Renaissance Man of many talents, we cannot expect to see often. Instead every physician must expect to specialize, and as the hospital specialities divide into more concentrated and narrow areas of expertise, the greater will be the need for the integrative skills of the primary physician providing continuing care. We are all members of an ancient and noble profession. Our newsest responsibility is to raise the standards of primary care, and I should like to think that it is a task that we all share as members of a single profession. This youngest College will need all your friendship and support to succeed in the task that lie ahead.