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The Complete Practitioner: The Role of a Family Physician

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Abstract

There is a strong continued need for dedicated primary or family physicians that can provide patient and family-centred comprehensive, coordinated and accessible health care. Family physicians have a broad as well as deep knowledge of medicine fundamentals and understand the family dynamics and community-based logistics that impact health and disease. The specialty emphasizes prevention and healthy life styles in the context of dignity and partnership.

The current brief review reflects on the different aspects of the family medicine specialty, highlights the impacts of family physicians and suggests benefits of adding the specialty to Saudi Arabia undergraduate and graduate training programs.

Keywords: Family medicine; Primary care; Saudi arabia

Introduction

"*A human being should be able to change a diaper, plan an invasion, butcher a hog, con a ship, design a building, write a sonnet, balance accounts, build a wall, set a bone, comfort the dying, take orders, give orders, cooperate, act alone, solve equations, analyse a new problem, pitch manure, program a computer, cook a tasty meal, fight efficiently, and die gallantly. Specialization is for insects*" (Edmond Noll, M.D.).

The year is 1899. Such medical giants as Halsted, Janeway, and Osler are in their heyday. Medical education is placed on a firm scientific foundation, and the teaching faculty, in its entirety, consists of specialists. The basic sciences of bacteriology, physiology and pathology are revolutionized and technology begins to transform medicine. Abraham Flexner's report in 1920 completes the transformation by proposing broad reforms in graduate medical training. The result is the age of specialization during the first half of the 20th century. Rapid technological progress maximises specialist prestige, emphasises research skills and laboratory science at the expense of personal care and de-popularizes general practice as a career field. By the 1950s super-specialization occurs. The fabric of the doctor-patient relationship deteriorates further; lay discontent rises with widespread disenchantment with technology and the neglect of personalized care. Super-specialization in medicine produced a very good thing for science, but a very bad thing for the profession.

There is no creature in Scotland that works harder and is more poorly requited than the country doctor, unless perhaps it may be his horse. Yet the horse is, and indeed must be, hardy, active and indefatigable, in spite of a rough coat and indifferent condition; and so you will find in his master, under an unpromising and blunt exterior, professional skill and enthusiasm. Intelligence, humanity, courage and science (Sir Walter Scott).

In order to stave off mortality, general practitioners formed the American Academy of General Practice (AAGP) in 1947. Public mandate grows for the dwindling number of independent primary care physicians in the 50s and 60s. The AAGP Congress applies for a certifying board in 1964. The reports of the Folsom Commission, Willis Commission, Willard, and the AAGP are released in 1966, and all come to very similar conclusions: The strong need for a primary or family physician that can provide personalized health care that is coordinated, comprehensive, continuous and accessible. The American Board of Family Practice, the 20th medical specialty, was formed in 1969, and the American Academy of General Practice became the American Academy of Family Physicians in 1971. Responding to professional and political pressures, the Institute of Medicine developed the criteria of primary care in 1977. To this day, only the specialty of family practice meets all criteria.

A country doctor needs more brains to his work possibly than the fifty greatest industrialists in the work require (Pitkin).

Yet, how many of us in the specialty have experienced a negative attitude towards generalists among allopathic faculty and little encouragement outside of primary care rotations to enter a generalist career? The typical academic medical culture suggests that patients with complex problems are better managed by specialists, that primary care physicians require less expertise, and that primary care training provides inferior clinical experience as compared to specialty training. Rarely do we hear a specialist describe a situation where a primary care clinician gave competent and compassionate medical care, rather citing multiple episodes of primary care clinicians missing diagnoses or providing inadequate care to their patients. There are still 10 orphan medical schools in the United States that do not recognize the specialty with a departmental status nor postgraduate fellowship training [1]. 2012 marks the 64th anniversary of the specialty. Indeed it has come a long way. There were 454 residencies with 10,100 residents, 106,000 AAFP (American Academy Family Physicians) members [students, residents, etc.] of whom 89% are board certified and 19% are fellows [2].

The Arab world population, consisting of some 350 million people, has a well-recognized need for family medicine specialists. According to a study published in 2011," there are 31 known family medicine residency programs in Arab countries graduating about 182 residents yearly" In Saudi Arabia a total of 9 family medicine programs graduate 25 family physicians per year with a total of 353 family physicians graduated to year 2009 [3]. In 1978, the Arab Board of Medical Specialization was established adopting specific standards towards

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improving residency training programs [4]. Saudi Arabia population reaches 25 million (18 million Saudis and 7 million non-Saudis). "The post graduate family medicine programs started in Saudi medical universities since 1983, and the Saudi Family Medicine Fellowship program incepted in 1993". Albar (Chairman of the Saudi Council of Family and Community Medicine. Kingdom of Saudi Arabia) during WONCA Emirates Congress last December 2011 pointed out that more than "90% of the 10,000 physicians working in Saudi primary health care are multinational non Saudis mostly not certified in family medicine [5]". However, Albar reflected an optimistic goal of certifying 3000 family physicians by 2020 through already set strategic plan to improve quality and quantity outcome.

Given one well-trained physician of the highest type, he will do better work for a thousand people than ten specialists (Mayo).

What are the characteristics of a family practitioner? Despite changing dogmas, evolving technology and differing social climates, the specialty embraces the enduring attributes of medicine, particularly the value of the interpersonal encounter. The covenant transcends the contract and compensation system. Family doctors provide primary care that is by definition continuous, comprehensive, coordinated, accountable, affordable and accessible. This approach to "dis-ease" and the patient in the context of the family and the community does not limit the patient's or family's access to the physician by predetermined barriers such as age, sex or disease. The goal of the family doctor is to help maintain an individual in harmony with his/her environment, help him/her regain this harmony if lost and help him/her minimize the disharmony. Although the basis of medical care is biologic science, the approach includes a great deal of art and a willingness to handle a healthy disease of uncertainty. The mainspring of family practice is people–well people, babies, adolescence, sick people, adults and the elderly. Most of these individuals are well known to the family physician; many are life-long friends. The needs of these patients fill the day of the family doctor. As a specialty, family medicine is concerned with the health of the family as the basic social unit of society–the unit of living, a significant group of intimates with a history and a future. The entire family is viewed as "the patient" and the individual as really a symptom-carrier whose physical complaints, behaviour and response to illness are influenced as much by the family with whom he lives as the disease process with which he is burdened. As patient examples, consider a pregnant wife, terminally ill grandparent, sick child, or alcoholic husband [6].

It is much more important to know what sort of patient has a disease than what sort of disease a patient has (Osler).

The family physician is neither a "jack of all trades" who does anything and everything he wants to do, and not always in the best fashion, nor is he a triage expert. Given 100 patients in a family doctor's office, approximately 90 can be cared for by the physician himself, 10 will require additional consultation or referral to a subspecialist. 15 of the 100 encounters will be managed along the "medical model" approach. The goal is to restore health or limit disability. Among these cases will be the occasional Ivory Tower "fascinomas". Eighty-give of the contacts involve psychosocial problems, self-limited illnesses, and prevention. As a "relationship model", the process is not evaluated in terms of ultimate outcome, but in terms of more proximate results, such as comfort through a care partnership. In looking at the whole organism and his environment, family medicine is best able to avoid a reductionist viewpoint. Common sense, compassion and an ability to deal with complex, ethical issues, characterize the family physician's role as integrator and administrator.

By all means, if possible, let (the young physician) be a pluralist, and–as he values his future life–let him not get early entangled in the meshes of specialism (Osler).

Although it is clear today that no physician can master the entire breadth of medical knowledge or even keep abreast of the developments in science that relate to his continuing ability to maintain professional excellence, it would be a mistake to further narrow our focus or scope of professional activity. Society need not accept the inevitability of further specialization in medicine because omniscience in medicine is no longer possible. It is not acceptable to equate the forces of malpractice, escalating costs of the needed care and education, decreased public funding, the oversupply of physicians and the increased role of data systems as dehumanizing and the raison d'être for further specialization. Rather, let us move with these changes proactively toward consolidation and integration.

Specialization precludes comprehensive thinking, and in fact may lead to extinction [Buckminster, Fuller]. Increased specialization in the animal kingdom results in a loss of general adaptability. We are already seeing the effects of the overabundance of certain subspecialties as the medical environment changes. Social and economic stress of precipitating paradigm shifts. The growing interest in wellness and society's determination to participate in decisions affecting their health care will shift the focus of health care to the community with primary care physicians serving as the key medical personnel throughout the system except in ICUs. Computerized data systems will actually promote this model by helping such physicians make clinical decisions with the full breadth and depth of medical knowledge literally at their fingertips.

The Guild paradigm of authority, prestige and economic advantages associated with medicine needs to be discarded. It is important that we be ever mindful that "the secret of care of the patient is caring for the patient" (Peabody). As patients enter the complex and frightening world to diagnostic tests, it becomes essential that they not be dehumanized into subjects simply undergoing this or that trial of study or treatment. It is time to break with some of the ossified concepts of our rich, immutable traditions.

Why should the Kingdom of Saudi Arabia consider adding family medicine to its graduate and undergraduate training program? Palpable benefits would include:

- Promote team practice values through coordination and accountability.
- Renew emphasis on the enduring attributes of medicine–covenant not contract.
- Expose other specialities and subspecialties to the family practice model; help dispel the "PMD-LMD" mind-set.
- Explore primary care and community health issues from a benefit-adjusted research perspective.
- Improve the quality of patient care through the provision of continuous, comprehensive, accessible family care.
- Facilitate horizontal integration of a community network family care.
- Reduce the overall costs of health care.
- Maximize the use of subspecialties.

Conclusion

It is time for us to move on. The cost conscious milieu of today's society creates a number of opportunities for KSA (Kingdom of Saudi Arabia) and the specialty of family medicine. The very nature of the breadth and scope of the new specialty will allow it to assume a leading role in the general education of medical student in the 21st century. Further, the family practice center of excellence will become a laboratory in experimenting with new models for the delivery of cost-efficient health care. Innovative ways of organizing and utilizing the mix of providers are possibilities. Strategic planning that is community-oriented and tailored to the economics, culture, epidemiology and demographics of the population can be accomplished. No matter what is the outcome, the vitality, flexibility and creativity of this discipline will move forward into 21st century in a partnership with the patient and his/her family. University medical centers should join in this partnership. Let's think positively. Let's get excited about the stewardship of our limited health care resources.

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