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Family Practice: A Proposed Solution to the Problem of Meeting the Medical Needs of the Community

R. G. McAULEY, M.D., *Hamilton, Ont.*

Difficulties in meeting today's community medical needs are outlined, followed by a proposed solution in which the first-contact physician is the trained family physician. The McMaster Family Practice Course is described. The potential research contribution of a Department of Family Medicine is stressed.

L'auteur, en rappelant les difficultés que rencontre la population à se faire soigner, propose une solution par laquelle le premier chaînon du contact médical est le médecin de famille bien formé à cet égard. Il expose le cours de McMaster pour la pratique de la médecine de famille et souligne la contribution potentiale que peut apporter un service de recherche dans les soins donnés par le médecin de famille.

The Problem

A MAJOR task confronts the profession in trying to meet the medical needs of the community with the manpower available. Many factors have precipitated this crisis—an enlarging and ageing population; increasing educational levels; the degree of sophistication pertaining to health and disease; increased wealth and medical care insurance; the knowledge explosion which has resulted in increasing specialization and fragmentation.[1, 2]

An editorial in the September 1966 issue of *Modern Medicine of Canada* starkly outlines the dilemma (Table I).[3]

TABLE I.

Year	*General practitioner*	*Certified specialist*	*Total*	*Canadian population*
1955.....	9818	4842	13,660	15,698,000
1965.....	10,221	9423	19,644	19,440,000

94.6% increase in specialists.
4.1% increase in general practitioners.
18 % increase in Canadian population.

To make matters worse, as far as first contact care is concerned, the specialty programs in medicine and pediatrics are being directed toward subspecialization. This is necessary if the best care is to be provided using the latest knowledge; but the problem is in the perspective—no one is filling the void in the ranks of the declining number of first-contact doctors.

Even if men were entering general practice in sufficient numbers today, after one year of internship, they would hardly be equipped to fill the new role on the medical team, nor would the specialists in medicine and pediatrics, who are hospital-trained and disease-orientated. Neither the general practitioner nor the specialist is trained for the role he attempts to fill today. A realistic example of this can be found in two recent studies pertaining to first-contact pediatricians. A *Medical Economics* survey found that only 46% of pediatricians were satisfied with their role.[4] This may be explained by a time-motion study reported in the August 1966 issue of *Pediatrics* which showed that pediatricians spent only 50% of their time with their patients, and of this time 50% was spent in well-child examination and 22% in dealing with respiratory conditions.[5] This is certainly not the emphasis which the residents received in their training programs.

With reference to our highly specialized consultants, we must realize that they are not maximally effective if they do not receive the right cases at the right time.

We are all aware of the fact that the majority of first-contact care is within the scope of a personal physician, provided he is well trained.

A study of the practices of four family physicians in Hamilton in the summer of 1966 revealed that 85% of the families received all their first-contact medical care from one family physician, and that 91% of those who saw specialists were referred by their family physicians.[6]

Magraw,[7] in his recent book "Ferment in Medicine", outlines four possible solutions to the problems of first-contact care.

1. All physicians should provide first-contact care. This assumes that no special knowledge is required.

2. The general practitioner, as a provider of first-contact care, should require less medical training and be a "second-class citizen" in this respect. This assumes that first-line medical care is less demanding intellectually, and that personal medical care is less technically skilful than specialty care. If the shortage of first-contact physicians increases, then a new type of second-class generalist, say a family nurse, might, by default, assume the role.[8]

From the Department of Family Medicine, McMaster University, Hamilton.

Reprint requests to: Dr. R. G. McAuley, Department of Family Medicine, McMaster University, Hamilton, Ontario.

3. The general practitioner should be replaced by a better-trained personal physician, drawn from the ranks of current specialists. As already mentioned, today's specialty training programs, are disease-, hospital-, and research-orientated, and are not tailored to meet the needs of the family or its members.

4. The general practitioner should be trained in a different way, upgrading his training in length and range to that of any other specialty. This is not an easy solution, when students see the decline of general practice as a field.

Two things must happen if the personal family physician is to play successfully a part in the reintegration of medicine:

1. His training must be as extensive and rigorous as that of other specialties, and

2. The practice of medicine itself must be so structured that his role is recognized.[9]

As stated by Pellegrino,[10] "Though we may deprecate specialization for the problems it may introduce, its growth is essential to the continued practice of medicine. To the extent that it does flourish, there is concomitant need for integration, interpretation, and generalization. The values, systems, methods and organization of medical education and practice have adapted well to the needs of society for training specialists, but have left largely unsolved the corollary development of equal stature for the integrating function of medicine. We now face the task of interweaving the benefits of specialization into general medical care. Neither the internist, nor the general practitioner, as presently constituted, are equipped to perform optimally this integrating function. A new kind of generalist is required, not just the introduction of general practice into medical education."

We now come to the question, what do the medical students think? Has the pendulum swung too far in our disease-centred, specialty-orientated medical schools? Surprisingly not! In a study conducted last year and reported at the Association of Canadian Medical Colleges in September 1966, Fish and Mount[11] found that 55.6% of fourth-year students had selected definite fields. Of fourth-year students 22.5%, that is, almost half of the committed group, had selected general practice, whereas 8.5% had selected medicine and 4.3% had selected pediatrics.

Out of this comes the realization that many students are interested in general practice but probably because of the lack of good graduate programs, they are entering specialty fields, hoping to be better equipped for clinical practice.

PROPOSED SOLUTION

It is the contention of the group at McMaster University who have been studying this problem that: first, there is a need for first-contact physicians; second, a physician caring for the needs of the family, not individual physicians for each age group, can provide more personal, effective, and economical care; and third, the family physician must be trained for his role. To date, we feel that this has not been done.[12]

In planning a graduate program in family medicine, we first endeavoured to define the field of practice. We believe that this is a nontechnical specialty centred about the family and the medical problems of the family. Its body of knowledge consists of medicine, pediatrics, psychiatry, obstetrics, minor surgery and trauma. The whole, however, is more than the sum of the parts.

We believe there is a need for a personal interest in people and not just their diseased organs—to consider the patient as a whole.

There is also a need to emphasize that common disorders are common, and rare disorders are rare. Granted it is necessary to recognize the uncommon conditions so that proper care may be provided; but the graduate student should be highly proficient in the day-to-day problems he will encounter in practice. Therefore, there is a need to shift the emphasis from the horizontal hospital patient to the vertical ambulatory family member.[13]

In order to undertake such a program we propose the concept of the medical team where specialists serve as consultants and the family physician serves as a first-contact personal physician, assisted by nurse, receptionist, laboratory technician, social worker, psychologist and other paramedical members. In fact, the family physician in part becomes the co-ordinator or team manager by providing the services that only he can best provide and delegating those duties best done by others.[1, 14] This is in effect what many general practitioners, pediatricians and internists do now in a less structured way.

In distinction to most general practice programs attempted in the United States, the program at McMaster will be an integral part of the educational program of the Faculty of Medicine.[15] There will be a program director who will co-ordinate and integrate the various components. In all areas an effort will be made to present the graduate student with experience in model teaching units where the team concept applies. The service responsibilities will be related to the educational needs, and the responsibilities assumed will be in keeping with their knowledge and experience.[21]

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At McMaster, at present, we have an Advisory Committee of seven family physicians studying the content of major fields which apply to family practice—and the methods of integrating these into our program. Even this is a radical departure from most centres where the last person consulted is the man in the field—the one who knows the needs. An interim report submitted by this committee in October 1966 stressed the need to define the boundaries of family medicine and emphasized the need to train the students in the behavioural sciences while downgrading the importance of technical areas. It stressed the need to train the students in ambulatory care.[16]

If the family physician is to provide first-contact care in the future, he must have training in this area. We feel that preceptorships, while helpful, do not meet all the needs—the experience is spotty and too short. It is difficult for offices geared to service to meet the educational needs of the residents, that is, for the residents to participate actively in patient care with the desired amount of supervision and continuity of care.

Our approach is a Family Practice Unit—a group practice staffed by full-time family physicians who are faculty members in a Department of Family Medicine. The first such unit will begin operation in July 1967, with four experienced family physicians, based at the Henderson General Hospital, Hamilton. The private patients in the practices of these men represent a cross-section of the community in contrast to the traditional outpatient department.[6] The postgraduate students will spend about one-third of their time in a Family Practice Unit caring for some of the patients under the supervision of the family physician. The amount of supervision needed will depend upon the knowledge and experience of the students. In this way, they will gain first-hand experience at managing common problems and utilizing the various members of the medical team. The time spent in the Family Practice Unit will be long enough so that there will be a good measure of continuity of care. If administratively possible, we would like the postgraduate students to be responsible for the total medical needs of a group of families throughout their program. During their time in the office, we hope they will learn by experience when and how to obtain a consultation, the advantages and disadvantages of group practice, the use of other health personnel, and the efficient use of their professional time and talent through effective office management.

In addition to direct patient care in the Family Practice Unit, we will have seminars and group discussions in which the students will participate, and in some cases organize and lead the discussion. Consultants will be utilized in formal consulting sessions and informal meetings in proportion to the demands in the various fields.

The students will spend the rest of their time in general hospitals acquiring the knowledge, skills and attitudes necessary for their proposed role on the medical team. They will participate actively in clinical teaching units in medicine, pediatrics, obstetrics, psychiatry, minor surgery and trauma. In these clinical teaching units the relationship between the family physician and the consultants of the community will, we hope, serve as proof that the team model does work. Psychiatry will be presented as a continuing program throughout the course—rather than as an isolated block of training. We hope that the emphasis will be on the total care of the patient —and not just the diseased organ. We feel it is more important to know how to diagnose the conditions requiring surgical intervention and to refer the patients to the best-trained person to do the job, than to have lengthy experience assisting at surgical operations. The same may be said for other technical areas. Surgeons, pediatricians, obstetricians and other consultants with special areas of competence limit their practices and privileges. Should not family physicians also limit the scope of their practice to areas of special importance?

The family practice residents in the hospital, as in the Family Practice Unit, will be given increasing responsibilities as they progress through the course. Where feasible, training will be restricted to 50 hours a week to allow the students time for independent study, rest and social diversion.

The family practice program, when it starts in July 1967, will be so constructed that the graduate students may enter and leave in blocks of one year. We will encourage them to take a minimum of two years from graduation, but preferably three. Again, as this is a new venture, we hope to keep an open mind and a flexible outlook so that we may adjust the course as we go along.

RESEARCH

Research must have an active role in developing the discipline of family medicine. Many suppositions and rules of thumb must be critically assessed. There is an urgent need to study the family and the medical problems of the family. Are we right in assuming that the family is the structural unit in society? How does it react, one member with another, one family with

another? Such studies will lean heavily on the social sciences. What are the medical problems of the families? Are these needs being met by our present system of medical care? What is the quality of the care being provided? High on the list of priorities for research must be the development of a suitable record system for ambulatory care. No longer is it enough simply to record the diagnosis submitted to insurance companies. A system must be developed which will tell us what is going on in family practice and how well it is being done. The British College of General Practitioners have made an admirable beginning with their E,[17] W and F[18] Books. There is a need for further studies such as that of Sellers comparing clinic and solo practice.[19] It is time we adopted some of the operations research skills used in industry to look at what we are doing—and why.[20] Are we using our time, knowledge and skills to the best advantage? Are we walled in by convention, unable or unwilling to adapt to the changes in medicine and society? How can other health professions contribute to the recognition and management of the health problems of the family? These are but a few of the areas in need of study.

SUMMARY

A proposed solution to the problem of meeting the medical needs of the community has been outlined, based on the concept of the trained family physician. The Faculty of Medicine, McMaster University, will begin a graduate course in Family Practice in 1967. This is an experiment in medical education founded on carefully considered but untested objectives. Therefore, it will be necessary to evaluate this venture carefully before conclusions can be drawn. If the trained family physician is able to fill a satisfactory role on the medical team, it is possible that in the future more and more first-contact care will be provided by the family physicians and more specialists will assume consultant roles in practice. In the meantime, family physicians in practice who accept these goals must undertake to educate themselves and expand their knowledge in deficient areas, such as growth, development, school and behavioural problems.

If family medicine is to become a new specialty, it must be centred on a clearly defined body of knowledge and be supported by well-conducted research. The research should deal with the family itself, the health needs of the family and the methods of providing health care. Many disciplines will be involved in these broad projects.

The speculations put forward in this paper will undoubtedly require further study and revision before family medicine becomes an established clinical discipline.

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