

The Making Of A Family Physician

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Let me begin by saying how honoured I am that you should ask me to deliver the 1982 Sreenivasan Oration and to be the first non-resident of Singapore to do so. I welcome the opportunity not only to address you tonight, but to pay tribute to Dr. B.R. Sreenivasan, the founder President of this College.

I first met Sreenivasan in 1972 when I was invited, along with Dr. Richard Geeves, another Honorary Fellow of this College, to assist with the development of the Membership examination of the College. I got to know him well during this time. His vast knowledge of medicine, his deep understanding of human nature and his devotion to the care of his patients quickly endeared him to me. I respected too his scholarly interests, which extended well beyond medicine into the classics of the literary world.

I need not tell you of his many achievements and honours. You know that he was awarded Honorary Fellowship of the Royal College of General Practitioners, the Royal Australian College of General Practitioners, and the Royal College of Physicians, as well as this College, and that he was awarded a Doctor of Laws by the University of Malaya. You will remember that he was President of the Malayan Branch of the British Medical Association, the Singapore Medical Association and the Singapore Medical Council.

We all will remember him as an able administrator, an inspired teacher and a charismatic leader, but most of all he will be remembered and revered for the man that he was, and for his qualities as a family physician. The tribute to Sreenivasan in July 1977 issue of **The Singapore Family Physician** puts it this way: "Dr. Sreenivasan was a man of great humanity and sincerity, and was admired, respected, even worshipped by his patients, indeed by all who came into contact with him. He was the epitome of what we are nowadays coming to call the ideal "family physician"—one who knew not only all about his patients and their illnesses and problems, but also the whole background against which the latter were set; and not only did he know all this, but he applied the knowledge for his patients' benefit."

What more would any of us wish for our epitaph.

I dedicate this address on **The Making of a Family Physician** to the memory of Dr. B.R. Sreenivasan.

All around the world, the family physician is recognised as the essential link in the health care system. He works at the interface between the community on the one hand and the health care system on the other. He is the doctor of first contact and provides primary care. And he provides continuing care for patients and families in their community setting. He is strategically placed to understand the health care needs of the community and how the health care system can meet them.

About 50% of the doctors in the world are family physicians. In Singapore, the figure is 60%. Yet it's only in recent times that any attention has been paid to the training of the family physician. In the past, he just grew, like Topsy. Today, it's recognised that this way of making a family physician is no longer acceptable. Exposure of the undergraduate to family medicine and specific postgraduate training is now regarded as essential if we are to make family physicians who can meet the current and emerging health care needs of the community.

Interest in training family physicians is running high here in Singapore. The need for training is recognised in College circles, by the Singapore Medical Association, by the Faculty of Medicine, and by the Government. Yet some may still shake their heads and ask, "What is family medicine?", "Why is

it necessary to undergo such intense training to be a family physician; surely GPs don't need that much training?". Tonight I hope to answer these questions.

My purpose in this oration is:

- to sketch some of the problems family physicians face
- to outline the conceptual framework of family medicine
- to suggest how family physicians might be trained.

I will do this by way of illustrative case histories in the belief that all clinicians, whatever their discipline, identify comfortably with the realities of the clinical situation.

Let's look first at Mrs. T.K.H., a 30 year-old housewife. Mrs. T, has brought her six month-old baby to see the family physician six times in the past three weeks. On each occasion, the child had a minor physical symptom, such as slight rhinorrhoea, slight regurgitation of food, a mild rash, a few loose stools. She also complained that the baby did not sleep well at nights. On this occasion, the baby had mild napkin dermatitis. The family physician recommended treatment for this. After dressing the baby and sitting down again, Mrs. T. said, "Before I go, Doctor, would you please prescribe something for me to sleep at night?".

This situation raises some interesting questions. Who is the patient—the child?, her mother?, both?, someone else?, the family? Is there an illness present? The baby might be labelled as having mild respiratory, gastrointestinal or skin conditions, or suffering from insomnia. But is the baby the real reason for the mother coming, or is the mother the real patient? If the mother is the patient, does she have an illness? If so, what is the name of the illness? Would you find it in the index of a medical text?

Michael Balint's label to describe this phenomenon is "The child as the presenting symptom of the parent". The mother has the problem but uses the child, either consciously or unconsciously, to gain access to the doctor. But if the doctor is not trained to recognise this presentation, if he has never heard of the concept of "The child as the presenting symptom of the parent", he may focus his attention wholly on the child, investigating unnecessarily, and giving it quite inappropriately such things as decongestant nose drops, mixtures, vitamins, or whatever, whilst the mother and her problems go unrecognised.

But even if the doctor has been trained to recognise the phenomenon, is that enough? What will he do for or about the mother? What sort of illness label will he select—anxiety, depression, inability, to cope, inadequate personality, inadequate education about child health, or some other label? If he selects anxiety or depression, what will he do? Prescribe psychotropics? Would that help?

Family physicians know that this sort of situation demands much more than a prescription. It demands a capacity to recognise that the mother has a problem, finely honed communication skills to elicit the nature of the problem, well developed counselling skills to explore the alternatives for action which both doctor and mother have, and skills in patient education when developing strategies for management. Without all of these skills, chances are that the mother will go away unrelieved, coming back again and again, or going from doctor to doctor seeking relief from her discomfort.

So what seems like a simple, even trivial problem, is not so simple. Yet without training, the doctor is likely to see it as such.

Let me give you another example.

Mrs. W.B.T. aged 40 presents complaining of headaches "like a tight band around her head" for three months. She's married, with three school aged children. She lives in a small apartment in a high-rise building. She's new to the neighbourhood and has few friends and no outside interests. The family income is limited. Her husband works long hours, comes home tired and seems disinterested in her. Physical examination is negative.

How does the doctor manage this problem? He needs to have the skill to elicit all the data required to decide whether these headaches are the manifestation of organic disease or the result of psychosocial problems, or both. He needs to be able to explore the patient's feelings about her life situation —the frustration and boredom of high-rise living, the loneliness of daily living with children at school and husband at work, the emptiness which results from lack of interests and hobbies, and the pain of social deprivation and separation from friends. He needs to recognise her problem as a maladaptive response to her environment and life situation.

But suppose he does uncover the problem, what can he do? What solutions exist? The biomedical solution might be to reach for the prescription pad and write "Valium". That might relieve the tension which causes the headache. But will that suffice? The doctor knows he can't alter the socioeconomic situation of the patient, nor the social system in which she finds herself. But he can do more. Provided he's properly trained, he can explore with her strategies for making more of her life. He can help her to recognise the nature of her problem and the resources she has to manage it. If he's been trained in neurolinguistics — a brilliant new concept in communication — he will work on the premise that the patient already has the resources she needs to improve her situation, and will help her towards more productive behaviours. He will help her to manage her life so that she's more fulfilled and contented. He will help her alter her maladaptive responses to her environment. He will help her to change.

But if he chooses, through lack of training or understanding, to label her "psychosocial" or "functional" or "inadequate personality" — not my problem, what will become of her? Her misery will continue, her pain will remain, her dull, boring, unproductive life will go on as before.

I wonder if some of you are thinking—"But that's not the stuff real medicine is made of! Should doctors be concerned with such psychosocial problems —the so-called "soft" areas of health care?" Those of us in general family practice know that these problems of living are impossible to avoid. They are inextricably woven into the fabric of illness. They cannot be ignored. They will not go away. They are part and parcel of family medicine.

However, lest there be some who are still uneasy about what might be seen as the soft psychosocial underbelly of family medicine, consider this problem. Mr. K.H.S., a 40 year-old sales executive, presents complaining of tiredness. He's having difficulty maintaining product sales in the face of stiff competition. His blood pressure is 160/100, he's obese, smokes 40 cigarettes per day, and often drinks 100 grams of alcohol per day.

This man has a physical problem —moderate hypertension —which we know in all likelihood will respond to appropriate treatment, which will reduce his chances of target organ damage. So what does the family physician do? Prescribe a diuretic, a beta blocker, or some other antihypertensive agent? In all probability, he will. He will have read many articles on the management of hypertension and attended many symposia on this subject. He will investigate the patient appropriately and commence treatment. But is that enough?

How will he effect compliance with his therapeutic regime? The problem of long-term compliance is well known. The doctor's success in this case will depend heavily on his skills in patient education, his ability to establish a good relationship with the patient, and the efficiency of his follow-up procedures which detect the defaulters —all the product of good training.

But treating the hypertension will not suffice. The obesity, the smoking, the drinking, indeed this man's lifestyle needs consideration and his work environment needs assessment.

If the doctor did have the skills to unravel the strands of this man's problem, what would he do? Is there any way of helping people with lifestyle problems? The answer is "Yes". If he has learned the skills of behaviour modification and has the time to apply them, the doctor can help the patient to lose weight, stop smoking, drink less, and respond more-appropriately to the stress in the workplace. Many techniques exist — neurolinguistics, biofeedback, hypnosis and psychotherapy and some in common use. And they work.

Let's look at another sort of problem often faced by family physicians. Mrs. R.C.H., aged 28, presents complaining of marked weight loss. She now weighs only 40kg. She has had incessant diarrhoea for six weeks, but admits to taking excessive laxatives. On further exploration, she reveals that she wants to return to her former occupation as a model. As she talks to the doctor she begins to cry—she has a hyperactive child who has a learning disability, and she is upset that recently her husband has been overlooked for promotion.

What is the problem? Has she thyrotoxicosis, or a gastrointestinal condition? Or is there more to it? The well trained family physician would recognise that this is a family problem and that the players in the drama are interacting with each other, each affecting the other in a way which would make the treatment of Mrs. R.C.H. in isolation a less-than-efficient exercise. The family doctor needs the skill to tease out the interwoven strands of conflict in the family, and the ability to assist the family to weave a new fabric of family life. Family therapy is a growing discipline. It has the potential for relieving the tensions, frustrations and pain that families suffer and which often cause more discomfort and disruption to living than physical illness.

Family physicians in training need the opportunity to learn about the family—the life cycle of the family, the dynamics of family life, how they can become disturbed by illness, disability and social deprivation, and how to recognise and manage family problems. Without this knowledge and these skills, he'll be little more than a provider of episodic care isolated from family considerations—a periodic people-patcher.

The perspective of the family doctor extends though beyond the family. He needs a community orientation which focuses on the social and cultural environment as well as the economic and physical. He needs to know the health beliefs of his patients, the cultural mores which affect health care, the economic and social factors which affect health in his community, and the effects of the physical environment on community morbidity. He requires an ecological orientation—he needs to know **homo sapiens** in his natural environment.

Without this, he will miss or misunderstand many of the problems which unfold in his consulting room. As a highly respected member of the community, the family physician can influence the community environment. Living conditions, working conditions, recreational facilities and environmental pollution can be subject to his influence. But he won't exercise his influence if he has no understanding of community issues; if his attitude is that his job is to treat only true blue medical problems, if he has a reductionist biomedical approach to health problems. Effective training can provide the appropriate understanding, attitude and approach.

Let's return to the consulting room.

Betty W., aged 20, a student, presents saying, "Doctor, Mum said I should come for a check-up before I get married." Superficially a simple problem, but what a rich opportunity for patient education, preventive care and health promotion. Provided he's trained for the task, the family doctor can talk about the adjustments needed for a happy married life, the sexual aspects of marriage and how to avoid the problems which can arise, and the pros and cons of various contraceptive methods, and he can promote a healthy lifestyle for the couple which will benefit them and their children. He can establish a relationship which will enable him to advise and support the couple in the future. He can advise them on when to seek help from him and how to do it. His educational role is to the fore. He is a teacher—a true doctor. Teaching is not easy. It is a skill which needs to be learned. Proper training provides such learning opportunities.

Let's look at just one more clinical problem. Janet L., aged 12, has leukaemia. She was diagnosed two years ago and has undergone all the standard treatment with the best specialists. She had a remission for several months, but it is now clear she's terminally ill. She has devoted parents, a younger brother and two older sisters. Technology has little to offer her now; further hospitalisation is considered inappropriate. So what can the family doctor do?

Without training, he may feel inadequate even helpless. He may be threatened by Janet's inevitable death and the effects this will have on her family. He may feel quite unable to cope with the emotional

trauma of the death of a child. Yet training can arm him with a wide range of strategies he can use. Training will confront him with the issue of death — his own mortality, the stages of the dying process, the fears of dying patients, the typical reactions of doctors to death, the reactions of relatives and the process of bereavement. He'll learn about himself, what a dying patient feels, what relatives feel. He'll know how to anticipate problems and will feel comfortable employing the helping strategies he's learned and mobilising the coping resources of the patient and the family. He can do more for the patient and her family in the days and weeks ahead, than any hospital with its specialised care. He can be the anchor the family needs during its time of stress. He can make the dying process an uplifting one for all—provided he is trained—provided he has an understanding of the cultural and religious aspects of dying and death, provided he has the appropriate attitudes and skills.

The illustrations I've used are just a few from the vast range of problems faced by the family doctor, but they do reflect some of the significant needs of people in the community. Unless doctors are trained to meet these and the other needs of the community, such as, for example, the need for child care, care of the aged, the care of chronic illness and disability, to mention only a few, these needs will continue to be inadequately met and the disillusionment with traditional medicine, which is so widespread in the world today, will heighten.

Care of the aged deserves special mention. As the aged population of Singapore increases, so will the need for family physicians to care for their illnesses, and more importantly to maintain their health. Preventive care and the early detection of illness by the use of simple, cost-effective screening procedures will become an increasingly important part of the family physician's work. Care of the aged has been, and will remain his responsibility. There is simply no need for an army of geriatricians to do this job. Proper training of the family physician will equip him with the necessary knowledge and skills.

There are two important lessons here for medical educators. Training is necessary for the family physician to carry out his work in the community, and that training must be related to the needs and expectations of the community. Appropriate training for all entering general family practice has the potential for effecting important changes to the health care system. Ian Kennedy puts it eloquently in his 1980 Reith Lectures, "If GPs were more adequately prepared for the real health needs of their patients, which are as much to do with social problems as with particular diseases, men the beginnings of a movement towards better health could emerge. Indeed the GP could well become an important focus for the sort of social reform necessary to produce the improvement in health we claim we desire. No one is better placed to gauge the social pressures and the problems of the day and pass the news up the line, and no one is better placed to act as an educator for better health and pass the word down the line."

How relevant are these words to the situation in Singapore? Professor Edward Tock, in his address to the Singapore Medical Association earlier this year, had this to say, "There is no doubt that, in Singapore, as in most countries, primary medical care constitutes the major portion of health care delivery to the country. A survey done recently by the Curriculum Review Sub-Committee of the Faculty of Medicine showed that about 60% of medical practitioners working full-time are either engaged in non-specialist private general practice or working in government outpatient clinics, that is involved in primary medical care type of work. This situation also reflects that the major component of the health needs of the country is in primary care or general practice."

What then is needed if we are to produce the sort of family doctor that can meet the community's needs, that can forge a new shape for health care in the future? Can the medical education currently available produce doctors with the necessary orientation, attitudes, knowledge and skills to meet the needs of the Singaporean community? For an answer to this question, I again quote from Professor Tock's address, "The training in most medical schools tends to propel students towards careers in specialty, and even subspecialty medicine, and away from careers in primary care. There is a tendency, although not intended, in most medical schools to convey the erroneous message to students that the real glory is in the sub-specialties —that primary care is somehow second-class. Such a system will produce medical graduates with inadequate knowledge and preparation for work in primary care, which the majority of them will take up as their life-long career. The training is therefore unsuited to the needs of first-contact care, where patients present with a mass of uncategorised symptoms and signs. There is also undue

concentration on disease, rather than on people and their problems, so that the day to day problems of primary care are a surprise to the newly qualified doctor."

So what needs to be done? Professor Tock points the way. "Our **medical school has been increasingly aware of this universal flow in medical education, and is currently involved in modifying and restructuring the curriculum and methods of teaching to put greater emphasis on preparing the students for future general practice or family medicine.**' and again, "**The existing teaching of general practice in our curriculum is inadequate, and needs to be improved on in quantum and structure.**" He goes on to talk about the possibility of creating a department of family medicine in the Faculty of Medicine of the National University of Singapore.

Experience the world over supports the view that if we are to train family doctors who can meet the community's needs, there needs to be initial exposure to the orientation, concepts and philosophy of family medicine at an undergraduate level, followed by specific vocational training for general family practice at a postgraduate level. To achieve this, undergraduate departments of family medicine and a postgraduate programme of training are needed.

A strong undergraduate department will I put students in touch with the conceptual basis of family medicine, the family and community orientation of the family physician, the philosophy of general family practice, its unique process of continuing care of patients and families in their community environment, and its special emphasis on prevention, health promotion and health education. These elements are not generally well known or understood by other disciplines. Specialist disciplines have different concepts, a different orientation, a different philosophy, and a different process of care. They use almost exclusively the biomedical model of disease, whilst family physicians use the bio-psychosocial model, considering simultaneously physical, psychological, social and environmental factors in assessing health and illness in their patients.

So an essential step in the process of providing for the health care needs of the Singaporean people would seem to be the establishment of an undergraduate department of family medicine. Because of the differences I've just talked about, it would be most appropriate for it to be established independent of other departments. The head will need to be thoroughly familiar with the concepts and philosophy of family medicine, a first-class clinician, an educator of repute, a skilled diplomat, and have the charisma needed to imbue undergraduates with the excitement of family medicine. The department would need to be well staffed so that its impact can be really felt.

Because the curriculum is already crowded, the main function of such a department would be to sensitise undergraduates to the challenges of family medicine and to familiarise them with its concepts, philosophy, orientation and approach to patients' problems. It would also very appropriately be involved in topic teaching, especially if an integrated curriculum is adopted or if a problem solving approach is instituted, such as is used at McMaster University. The department could not be expected to teach undergraduates all they need to know about family medicine—that is a postgraduate exercise.

I want now to turn your attention to the need for postgraduate training of family physicians. Training programmes have been established in many countries and there are many models: from the two year programme of training in Canada (which is generally regarded as inadequate in duration) through the three year programmes in the United States and the United Kingdom to the four year programme of the Australian College, the Family Medicine Programme, to even longer programmes in some European countries. The programme proposed by the Singapore College is an excellent one, including as it does a year of training in a special training centre in a modified polyclinic and a second year in an accredited general family practice.

During the training period, the trainee would attend a comprehensive educational programme and undertake personal study. At the end would be some sort of certifying procedure, such as an examination to assess competence in general family practice, Particular emphasis needs to be given to the wide variety of problems and conditions encountered in practice, to the prevention of illness, to health promotion and health education, to the development of communication and interpersonal skills, and to the acquisition of helping skills using a variety of counselling techniques, such as

psychotherapy and behaviour modification, as well as the traditional therapeutic and procedural skills used in general family practice.

The College of General Practitioners Singapore has made a submission along these lines to the Ministry for Health and hopes for a positive response. There seems no doubt from experience gained all around the world that specific comprehensive training for general family practice is needed. A superficial approach will not produce the goods; only an academically demanding programme will produce the sort of family physician who can meet the contemporary and emerging health care needs of the people of Singapore at a cost the community can afford.

The political reality, both here and in every other country of the world, is that funds for health care are insufficient to meet the needs. Governments need to be convinced that investing money in training family physicians is worthwhile **on economic grounds**. The evidence now accumulating from many countries is that funding such training is a wise investment for govern meets.

Let me briefly review the evidence for this and the arguments which flow from it:

At least 80% of health care expenditure is initiated by doctors.

Family physicians provide over 90% of the community's health care.

Family physicians are therefore the gate keepers to almost every other service.

Their management decisions have important economic consequences for both patients and governments.

Inappropriate expenditure results fro · over prescribing

- unnecessary investigations

- unnecessary referrals

- unecessary hospitalisation

- iatrogenic disease. Greater emphasis on care, health psychosocial , such as is will reduce preventive promotion, patient education, problems and non-hospital care provided by family physicians, this inappropriate expenditure.

There is substantial evidence that vocational training can modify doctor behaviour in this direction and reduce unnecessary expenditure. — As governments need to contain health care costs and since training can achieve cost effective practice, governments have a legitimate interests in investing in training at an undergraduate and postgraduate level.

Cost effective practice is unlikely to be achieved without such training.

This evidence supports the widely held view that since the family physician is the cornerstone of any good health care system, his proper education is of the utmost importance to governments and the community on the dual grounds of economics and quality of care. To fail to invest in such training is to invite a continuation of the escalation of health care costs.

Moreover, vocational training needs to be followed by a regular programme of continuing medical education to maintain and enhance the knowledge, skills and attitudes acquired during training. The College has had such a programme for some years, and is steadily expanding it to meet the needs of the family physicians of Singapore. The efforts of the College in continuing education deserve the highest commendation, and the experience so gained will enable the College to give appropriate advice on the establishment of a department of family medicine and postgraduate training for general family practice.

The purpose of my address tonight has been to focus the spotlight on the conceptual frame-work of family medicine by way of case histories drawn from practice, to show that these illustrate some of the health care needs of the community, to argue that if these needs are to be met now and in the future, undergraduate exposure to family medicine and specific postgraduate training of family physicians will be necessary, and finally to put the case that to achieve this an undergraduate department of family medicine and a postgraduate training programme will be needed. The College recognises this need, the Faculty of Medicine is aware of it, and the Ministry of Health has been appraised of the situation. As an Honorary Fellow of this College and as one most interested in Singapore and its health care system, I wish all involved success in the cooperative endeavour which will be needed to achieve these outcomes. I wish you every success in the making of family physicians for the community of Singapore. So long as concern for the welfare of the people of Singapore remains the pre-eminent objective, the outcome will not be in doubt.

Hippocratic Oath

(470-360 B.C.)

I swear by Apollo the physician, and Aesculapius, and Hygeia, and Panacea and all the gods and goddesses, that, according to my ability and judgement, I will keep this Oath and this stipulation—to reckon him who taught me this art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring on the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation, and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the art to my own sons, and those of my teachers, and to disciples bound by stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgement, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and holiness I will pass my life and practise my art. I will not cut persons labouring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and further, from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times! But should I trespass and violate this Oath, may the reverse be my lot!