CHALLENGES FOR FAMILY PHYSICIANS IN THE 21ST CENTURY

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ABSTRACT

Surveys tell us that far too many patients, even in wealthy countries, express dissatisfaction with the care they are getting from doctors, clinics and hospitals. Many times it comes down to what we can call a lack of connectedness. To answer this issue, seven questions may be raised: What are the social forces that shape our civilization today and the major diseases that affect us in the 21st century? What condition was responsible for 25 percent of deaths from 1998 to 2002 in Japan? What are the causes of this increasing suicide rate? Why is health promotion neglected in spite of the evidence of positive impact? Why are patients dissatisfied with health care services despite advances in medical science and technology? Will family physicians have a competitive advantage in the 21st century? Why is family medicine not an attractive career option for graduates in some countries? The solutions to these questions are in the following five messages. I urge you to: promote family medicine by demonstrating its relevance and value; establish family medicine as a more legitimate area of professional practice; inspire young students to pursue family medicine by providing effective, high-quality and certified training; shift from a narrow medical perspective to include matters that influence the health of the people; and be catalysts in revitalizing your communities by reaching out to all people and by being innovative in bringing together diverse groups to address root causes of disease. As family physicians, you have a special mission because you have genuine concern for people and your work gives you a unique opportunity to reconnect yourselves with the world around you.

INTRODUCTION

Medical patients today should be more than pleased with the health care they receive, it would seem, given the modern advances in medical science and technology. But surveys tell us that far too many patients, even in wealthy countries such as Japan and the United States, express dissatisfaction with the care they are getting from doctors, clinics and hospitals. Sometimes their disappointment is directly linked to an incorrect diagnosis or an ineffective treatment. But more often than not, their concerns are tied to way modern medicine is practised. Busy clinics and big hospitals rarely create an atmosphere that's conducive to patients who need to vent their anxieties and fears. Patients who want to discuss their own care and treatment feel as if they have been given short shrift. Too often, a patient leaves a doctor's office, a clinic or a hospital feeling as if he's paid too much and received too little.

There are many reasons why many of our patients seem so dissatisfied with the care and treatment they are receiving, but many times it comes down to what we can call a lack of connectedness. Changes in modern life – the breakdown of the traditional family, the globalization of commerce and culture – have provided many material benefits, but have left us all feeling a little less connected to our families and our communities. Modern medicine is suffering from this same lack of connectedness.

But I firmly believe that we can put the human element back into the medical equation and better serve our patients by bolstering the role of the family physician. After all, family physicians are the doctors who know their communities and their patients best. They are in the best position to offer the kind of "patient-centred care" that more and more health care consumers are demanding. With this in mind, I'd like to examine the challenges and opportunities that face family physicians in the 21st century.

This is an issue that is very close to my heart because of my own experience. Before I joined the World Health Organization (WHO) in 1990, I worked in a variety of different medical jobs. I was a clinician in a very big hospital in the middle of metropolitan Tokyo, assigned at times to specialized areas such as surgery and the emergency room. I also did laboratory research on the hepatitis B virus and worked as an administrator in the Ministry of Health in Japan. But some of my fondest memories are from my days as a general practitioner – the sole doctor, in fact – on remote islands in the Pacific Ocean where not many doctors wanted to go.

So when I think about family physicians and family medicine, it's not really in my capacity as WHO Regional Director for the Western Pacific. Rather, it's as someone who holds family medicine close to his heart.

I would like to raise seven questions, starting with bigger-picture questions such as the relationship between civilization and disease. I then want to raise some very critical questions about the relevance and value of the family physicians, particularly when compared to so-called specialists. I will also offer five messages that those of us concerned about family medicine need to consider.

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DISEASE AND CIVILIZATION

First, let's look at the history of disease and civilization. According to Dr Tony McMichael[1], social forces occurred in waves across history, dramatically influencing the spread of diseases, which in turn had a tremendous impact on civilization.

[Editor's note: graphic available]. In prehistoric times, human beings lived as hunters and gatherers. And they were free of major communicable diseases because their groups were so small that the chain of transmission could not be sustained.

The first wave of social forces that McMichael recognizes was triggered about 5,000 years ago, when hunter-gatherers settled into agrarian villages. Over time, these settlements were established in many different parts of the world and later evolved into different civilizations. But living together in large groups also gave rise to a first wave of communicable diseases, demonstrating how social patterns can influence disease patterns. Smallpox, measles, chicken pox and tuberculosis first emerged in places like ancient Sumeria and Egypt.

The second wave of the social forces was facilitated by contact between civilizations through trade, travel and even military conflict. During this period, smallpox and measles spread from Europe to Asia, often via the Silk Road. Black Death, or the bubonic plague, started in Europe and the Roman Empire in the 6th century and spread to Asia. And in the 14th century, when the outbreak reached its peak, Black Death killed roughly one third of the population in Europe and 50 percent of the population of China. Black Death is said to have eroded the orthodoxy of the established Christian Church and paved the way for a more liberal and secular society that helped to give rise to the so-called Renaissance. This is an example of how disease can affect the society.

The third wave of social forces was characterized by trans-oceanic travel of seafarers starting 700 years ago. Smallpox, measles and influenza spread to America from Europe, destroying around 90 percent of the infected native population. On the other hand, new diseases such as influenza were brought to America by seafarers. In the same manner, diseases like malaria and yellow fever, which were endemic in Africa, also were brought to Europe by seafarers.

SOCIAL FORCES AND MAJOR DISEASES

This provides background for the first question we have to ask: What are the social forces that shape our civilization today? And what are the major diseases that affect us in the 21st century?

The first social force that comes to mind is Urbanization. Today we have more than 20 "mega-cities" with populations of 10 million people or more. The second major social force is Globalization. Consumerism certainly is another important social force that shapes today's civilization. Previously, people consumed what was necessary for survival. But now it seems that consumption has become an end in itself. A fourth factor is the pervasiveness of science and technology. Cellular phones were developed a little more than 10 years ago, but now you can hear them ringing even in remote areas of Africa. The final social force I want to emphasize is the ageing of the population. It increases demands on health and social services, which in turn put constraints on the entire world.

These social forces have helped disease patterns have changed. In 1990, traditional diseases such as infectious diseases and issues such as maternal mortality accounted for almost 70 percent of the disease burden. But it is estimated that by the year 2020, even in developing countries, non-communicable diseases, such as lifestyle-related diseases or cancer or some psychiatric and mental health problems, as well as trauma, will account for more than 70 percent of the disease burden.

But communicable diseases won't disappear altogether. Globally, an average of one new infectious disease has emerged each year between 1983 and 2003 – most of them being zoonoses. Examples include the Avian Influenza A(H5N1) virus that is now ravaging Cambodia and Viet Nam and the SARS virus that emerged in 2003. And I am sure we will have more of these in the years to come.

SUICIDE

The second question I would like to pose is: What condition was responsible for 17.8 percent of deaths between 1993 and 1997 in Japan and increased to about 25 percent of deaths in the period 1998 to 2002. Surprisingly, the answer is suicide. Usually, you don't see this type of rapid increase in the death rate except in wartime or in times of grave natural disasters, such as famines. Obviously, suicide is a very serious problem in Japan. But the problem is not unique to Japan. It is a global problem and a significant one for the Western Pacific region.

The global suicide rate beginning in 1950 and projected out to the year 2020, you'll see a 49% increase for men and 33% increase for women[2].

CAUSES OF INCREASING SUICIDE RATE

This takes us to my third question: What are the causes of this increasing suicide rate?

As WHO Regional Director, I asked a group of experts that included anthropologists, psychiatrists, sociologists and epidemiologists why the suicide rate was rising so rapidly in Asia. Of course there are many factors, but these experts were unanimous in concluding that everything boils down to one thing – a lack of connectedness. And this lack of connectedness permeates modern life, impacting society at three distinct levels – the family, the community and the work place.

The basic building block of society is the nuclear family: a mother, a father, children and sometimes grandparents. But more and more, we see this breaking down. Fathers are forced by economic pressures to seek work far from home. Mothers are also forced to spend more time in fields and factories, with little time left for their children. The very fabric of our communities is being torn apart, breaking down traditional ways of thinking, of believing, of acting. The overwhelming flow of images from television and advertising often have a more profound influence on our children than do our schools, churches, temples and mosques.

Our work places used to be stable economic anchors that ensured our living, if not our prosperity. But globalization and the pressures of market-driven economies have pushed untold millions into unemployment, only adding to the feeling of a lack of connectedness.

If we really want to address this issue of the ever-increasing mental health problems, like suicide, I believe that we have to revitalize our communities so that the connectedness people once felt in their communities, work places and even families will be restored.

Returning back to the history of disease and civilization – the Fourth Wave of diseases is characterized by what we call double burden of both non-communicable diseases and communicable diseases.

Although communicable diseases, both emerging and re-emerging diseases remain as a threat to the public health, non-communicable diseases including lifestyle-related diseases and mental problems like suicide will certainly continue to be on the rise all over the world. Non-communicable diseases will be the predominant diseases of our century.

Let's looking at smoking rates and coronary mortality in California, the largest state in the United States. In 1989, effective anti-tobacco legislation, known as Proposition 99, was implemented. It had three major components: 1) an aggressive public awareness campaign in the media; 2) the creation of an environment conducive to smoking cessation, such as the creation of tobacco-free restaurants, tobacco-free work places, etc.; and 3) the application of economic measures, such as increased taxes that made smoking a more expensive habit.

Immediately after this Proposition 99 took effect, the number of packs smoked declined, and there was an accompanying decline in coronary mortality with no or little delay[3]. However, as soon as the media campaign was suspended, that downward trend nearly stopped. But when the media campaign was reinstated, the downward trend resumed. Proposition 99 was multi-pronged approach. I like to call it an upstream approach because it addresses the root cause of the problem and tries to eliminate the risk factors.

Prevention, health promotion and the consideration of psychological, socioeconomic and environment factors all are effective upstream approaches in ensuring health and preventing diseases.

HEALTH PROMOTION IGNORED

The fourth question I would to ask is: Why are these powerful "upstream approaches" being ignored or not given sufficient emphasis?

In finding possible answers to this question, let's take the example of health promotion. Why is health promotion neglected or given insufficient emphasis in spite of the evidence of positive impact? Of course, it is impossible to single out one specific reason, but there are multiple factors involved, depending upon your perspective.

Consumers often aren't well informed about value of disease prevention and health promotion. Reporters usually are only interested in the Three Ds: dichotomy, disaster and drama. Political leaders find that health promotion won't bring out the votes the way building a new hospital will. And the private sector is not necessarily a strong ally in health promotion because it is largely driven by profits. The pharmaceutical companies, for example, are interested only in selling drugs. Promoting healthy lifestyles doesn't necessarily help their business. And finally, medical practitioners themselves see little incentive for prevention and health promotion because these activities do not necessarily pay off in terms of career development, promotion to higher positions or even in terms of financial reward.

If you treat the diseases of patients, you will certainly be appreciated. But if you successfully advise people on how to prevent diseases and promote health, you are not necessarily rewarded – although all of us know that an ounce of prevention is worth a pound of cure. In a nutshell, it seems that "stakeholders only pursue immediate rewards".

Because of the preference for immediate rewards on the part of all the stakeholders, health promotion and disease prevention – as well as other upstream approaches – are neglected despite the fact that these upstream approaches are very powerful and cost-effective interventions for preventing disease and promoting health. And this is a challenge, certainly, that all professionals have to overcome.

PATIENT DISSATISFACTION

My fifth question: Why are patients dissatisfied with health care services despite advances in medical science and technology?

The United States spends quite a bit of money on health care, but registers low patient satisfaction levels. Japan spends less, but has the same low level of satisfaction as the United States. Europe has spent almost the same amount as Japan or even less but their satisfaction level is higher than Japan[4]. In the United States and Japan, two countries where technology is quite advanced, satisfaction does not seem directly related to the money that is being spent on health.

Something else needs to be considered. Let's start with the most obvious reasons. Based upon a report of Institute of Medicine in the United States, published in 1999, only 55 percent of patients were diagnosed and treated adequately. Meaning the remaining 45 percent was given inadequate diagnoses and treatment. This really is shocking news. And based on the report, "An Organization with a Memory", published by the Department of Health in the United Kingdom in 2000, about 10 percent hospital patients suffer adverse effects.

If your condition is not diagnosed or treated adequately, and you are also subjected to adverse medical errors, of course you will not be happy. But in addition to these obvious reasons, there are other more fundamental issues that raise important questions about our health care systems.

The first reason for the disappointment with health care is that medical services focus more on "disease" than "illness". For the sake of clarity, let's define "disease" and "illness". Disease refers to the biological abnormalities alone, while illness is the personal, emotional and interpersonal reaction to the disease. So in other words, disease is a health problem, looked at from the doctor's perspective. While illness is a health problem,

looked at from the patient's perspective. Needless to say, hepatitis is a disease, but psychological anxiety or distress associated with the disease is an illness.

The second reason for dissatisfaction is that today's medical services limit a patient's voice on his or her own care and treatment decisions. This is partly because of the traditional paternalistic attitude of medical practitioners.

The third reason is that today's medical services do not always offer an atmosphere conducive to the expression of patient anxieties and distress. And this is due in part to the fact that doctors are so pre-occupied with examinations and the diagnosis of diseases that they sometimes do not allow patients to express their feelings and unburden their emotions – things that might assist not only diagnosis, but also in curing the patient.

The fourth reason is that medical services provide only mechanical care for terminal patient. Except in cases of injuries and accidents or some other acute diseases, death usually doesn't come unexpectedly. Rather it is a process in which people are supposed to close the last chapter of their life with dignity, surrounded by loved ones and friends. But sometimes, unfortunately, the dying process is treated very mechanically, devoid of emotional and social support.

And fifth reason for disappointment with health care is that medical services do not offer an environment conducive to care. Too often, there is little or no privacy and sometimes patients have to sleep in very small rooms or even in hospital hallways.

Finally, medical services charge too much. The lack of prepayment schemes, like health insurance, often force people to pay a lot from their own pockets, pushing poor families further into the vicious cycle of poverty.

But what's the bottom line? Modern medical science has been dominated by we might call the biomedical approach, which has three major characteristics.

The first characteristic is its "reductionist" approach. It assumes that if you explore further into the patient, from the body to the organs to the tissues and finally to the cells and DNA, it will clarify all issues and provide all solutions.

The second characteristic of the biomedical approach is that it assumes that there is always a simple link between disease and its corresponding biological base. So if there is a disease, they assume there is corresponding underlying cause for it.

And the third characteristic is that it adopts study methods that focus only on factors that can be measured objectively, in terms of quantity and quality. So it is selective. And this selective study method chooses only those biological phenomena that are amenable to this method. So in that sense it is again selective. In other words, "focused double selectivity". Because of this very "focused double selectivity", the biomedical approach has been a very powerful tool making great contributions to medical science in clearly defined areas. A case in point is progress in bacteriology, pathology, anatomy and similar fields.

However, there are also weaknesses. Because the biomedical approach relies on a methodology that focuses only on factors that can be measured objectively, anything outside the scope of that highly focused medical approach is neglected. A typical example of this is the patients' emotional agony and anxiety associated with diseases. Because those psychological experiences fall outside the biomedical scope, they are neglected.

The second weakness is that, because the biomedical approach has been such a powerful tool in contributing to progress in medical science, people sometimes have a perception of the infallibility of medical science.

Knowing that patients are not happy with medical services and understanding the limitations of biomedical approach, an increasing number of physicians are becoming aware of the need to become more "patient-centred" and to be good listeners and good communicators. Even super specialists, such as cardiac surgeons, acknowledge the need to be patient-centred.

FAMILY PHYSICIANS NEEDED OR NOT

So now my sixth question: If all the specialists become good communicators, who display a caring attitude and good bedside manner, do we still need family physicians? In other words, will family physicians be in demand and have a competitive advantage in the 21st century?

In order to answer these questions, let us think about a hypothetical situation. Let's suppose I know that I have stomach problem based on my past history. And this is a hypothetical situation in which there are three doctors with various strengths and weakness.

The first doctor excels in professional competency. Let's suppose he is an expert in gastro-endoscopic examination, meaning that he can pick up even very, very early stages of cancer. But this doctor has a very poor bedside manner, meaning that he is quite paternalistic, spares no time for communication with patient.

The second doctor is mediocre in both professional competency and bedside manner.

The third doctor is not considered excellent with gastro-endoscopic examinations, meaning if I have very advanced stage of cancer, he can pick it up. But if I have a very early stage of cancer, he will miss it. But his bedside manner is excellent, meaning he is a good communicator and listener, and has a very warm heart. Now which doctor I would like prefer?

Certainly, I would like to go to the first doctor even if his bedside manner is not good, because I expect my doctor to detect even the slightest abnormality in my stomach. So it means if I know my problem, I would like to go a specialist who can best diagnose and treat that disease, even if his bedside manner is not good. If his personality and bedside manner are good, that is icing on the cake.

Specialists will continue to be in great need in the midst of ever increasing expectations from consumers. However, there are many cases where the unique *raison d'etre* of family physicians can clearly be seen. Here are three examples I've come across. A 40-year-old woman had been operated on due to ovarian cancer. She then experienced muscular weakness and had difficulty breathing. She visited a specialist who diagnosed myasthenia gravis. Then dyspnea set in, and a second specialist reject the earlier diagnosis and prescribed anti-anxiety drugs. Finally, she consulted Dr Yamamoto, a very well-known

physician in Japan. After listening patiently to her complaints and providing intensive counseling, he realized her symptoms were due psychological stress and agony she was under during those years. She was able to reduce the amount of anti-anxiety drugs and has since led a productive life. It's an example of how a patient-centred approach, in which the patient's concerns were given

A venue for full expression, the doctor found that the treatment was actually quite straightforward.

A second case that also bolsters the case for patient-centred care comes from he files of Dr Hinohara, a famous Japanese physician know for his holistic approach. An elderly woman who had earlier suffered cardiac failure was living a very restricted life. She had been hospitalized intermittently and was taking digitalis and diuretics. When she finally consulted Dr Hinohara he learned in interviews that she had been living many years in a fifth-floor walk-up apartment. He had a social worker arrange for the woman to move to a first-floor flat. Such a simple intervention, by a doctor who looked at the patient's life in its entirety, allowed her to enjoy a far more normal life. This second case illustrates the importance of other factors that can be easily overlooked by clinical specialists.

In a third case, a patient felt mass in his right inguinal region and saw a variety of specialists – surgeons, neurologists, urologists – and underwent various examinations, such as x-rays, fiber-scopes and MRIs. But there was never a satisfactory diagnosis. The urologist was not able to give any explanation of what is causing the mass since all the tests showed no abnormalities in the urinary bladder, kidney and urinary tract. The patient's anxiety persisted until he consulted a family physician, Dr Kaji, another Japanese physician

After a thorough examination and extensive interview, Dr Kaji found that the patient had mistaken his spermatic cord for an abnormal mass. The doctor showed the patient that he could feel, at both sides of the inguinal region, the same "mass", which was actually the normal spermatic cord. This is an example of how "tunnel vision" didn't serve the patient very well. Each specialist focused exclusively on the clinical diagnosis in his own field of expertise and thus missed the simple, obvious diagnosis.

All three of these cases show many a simple patient-centred approach, carried out by family physicians, can provide answers the specialist often misses. This clearly illustrates the value of Family Practice.

From these three cases, we can see the major differences between clinical specialists and family physicians.

First, the basic difference between specialists and family physicians is in terms of their primary orientation and interests. The primary orientation and interests of the clinical specialists are to deepen their knowledge and skills and improve competence in their own speciality. Therefore, specialists are excellent in treating diseases, which fall within the scope of their speciality. The primary motive of the family physicians, on the other hand, is to try and see the patient as a whole. They are mindful not only of biological factors, but also of psychosocial factors. Therefore, their primary orientation and interests are to respond to patient needs no matter what, even when the cause of problem is unclear.

Both groups of doctors, I believe, are important, but both also have their limitations.

Specialists face certain inherent limitations. Although specialists excel in knowledge and skills within their scope, they are often unable to address diseases or problems outside their scope of specialty.

Family physicians grapple with their own set of inherent limitations. They have a broader knowledge of skills, particularly in dealing with common diseases. But they often are not updated on the latest knowledge, and they cannot provide sophisticated interventions in specialized areas.

Family physicians are good at seeing the patient as a whole, and providing holistic services. With their broad knowledge and skills, they are good at dealing with treating common diseases. In addition to these advantages, there are three other comparative advantages of family physicians.

First, since family physicians are mostly community based they can provide continuous support to their patients, taking into account the psychological context in which they live.

Secondly, because they are closer to the people, they can empower patients via health literacy, meaning they can give more advice as to how to prevent disease and promote health.

Thirdly, since family physicians are closer to the community and the people, they are not only best placed to coordinate follow-up patient care, including referrals to specialists, but also to participate or take the lead in community activities that go beyond health sector to address social and environmental issues.

But do these comparative advantages of family medicine and family physicians automatically guarantee the distinct place and status of this field in the medical world.

The literature shows that there are challenges for family physicians as their numbers are either not adequate to meet the needs of the populations or in some cases, they are in decline or unevenly distributed within their populations.

Let's take the case of the United States. There were 150 physicians per 100,000 population in 1900 but this number gradually decreased and stabilized at about 25 to 30 per 100,000 between 1970 and 1998[e]. The Council on Medical Education recommends a minimum of 60 to 80 family physicians per 100,000 population to meet the population needs, so the United States has a long way to go. The challenge is that, since 1998, the number of graduates choosing family practice has declined by one half. As a matter of fact, less than 10 percent of medical graduates chose family medicine as a career.

Yet, in the United States, family physicians serve as gatekeepers, meaning without consulting them first it can be very difficult to get access to specialists.

Of course, the situation varies from one country to another. But in general in the Asia-Pacific region the proportion of family

[e] Source: Council on Graduate Medical Education (CGME); Update on the Physician Workforce - August 2000.

physicians is quite low and shortages do exist.

For example, in Malaysia and New Zealand 34 percent of all doctors are family physicians and efforts are being made to increase those numbers. In Japan, the proportion is low and many graduates from medical schools want to become specialists.

Of course there are some countries where the proportion of family physicians is high, such as Australia where there are post-graduate programmes in family practice and incentives schemes, such as scholarships and additional payments to some doctors providing family practice services. But even in Australia, the majority of family physicians live in the big cities, creating an uneven distribution of practitioners.

Since the situation varies from country to country, it is difficult to make a general statement. But overall, I believe, every country is trying to improve the balance between family physicians and specialists. The specific reason for the shortage is somewhat different from country to country. But certainly, one of the common reasons for this shortage seems to be that family practice cannot attract many young graduates in some countries.

FAMILY MEDICINE AS A CAREER

This brings us to the seventh question we need to consider: Why is family medicine not an attractive career option for graduates in some countries?

The issue can be examined from the perspective of both the general public and the medical professional.

There are several reasons why family medicine is not so attractive in the general public's eye. And these also present challenges for family physicians.

The first reason or challenge is the simple fact that family medicine is not well recognized as a specialty by the public in some countries. The public too often does not understand the special role of family physicians or the value of their holistic, patient-centred approach.

The second challenge is the scepticism over whether a single-care family physician can provide the high quality medical interventions to so many health problems. The general public sometimes has a perception that "jacks-of-all-trades" are in fact "masters of none".

The third challenge is that the public is enamoured with high-visibility specialists and that the family physicians are given less social prestige compared to specialist counterparts. This is partly because specialists use state of the art technologies and sophisticated interventions that can lead to dramatic cures and specialists do more clinical research and publish scientific papers in major widely read scientific journals.

Now, let's look at the challenges for family physicians viewed from the point of view of the young graduates of medical schools.

The first challenge is lack of appreciation from patients. When a cardiac surgeon performs a bypass operation, the patient will feel as if the doctor has saved his life. On the other hand, when general practitioners provide counselling on lifestyle and other health promotion-related issues, they do not often receive the same kind of appreciation.

The second challenge is the perception of less excitement for the family physician due to his distance from scientific and technological frontiers.

The third challenge is that there are less opportunities for continuous training for family physicians, whereas specialists already have established training programmes in many countries.

The fourth challenge is that there are fewer chances for promotion to higher posts. Specialists can often be promoted to higher posts in hospitals or in academic institutions. Family physicians, on the other hand, do not have these opportunities, no matter how good the services they provide to the community.

The final point is that the family physician receives less academic prestige, reflecting research-oriented values in the medical world. In some countries, those specialists publishing scientific articles in prestigious journals are more valued than family physicians who serve people in the community in a more down-to-earth manner.

These then are the challenges for Family Physicians.

OPPORTUNITIES FOR FAMILY PHYSICIANS

Now let's move away from challenges and consider some opportunities that exist for Family Physicians.

The first opportunity grows out of the ever-increasing public demands for holistic and more humanistic medicine, even in developing countries.

The second opportunity is tied to the need for long-term holistic care due to rise in chronic conditions. Elderly people, in particular, have all sorts of health problems, including mental, physical and degenerative conditions.

The third opportunity comes from the mounting evidence available to indicate the impact of psychosocial factors on health outcomes, as I had mentioned earlier in three case from Japan. This evidence shows the value of the more holistic approach in improving the health outcomes of medical services, when not just biological factors but psychosocial factors are taken into consideration.

And the last opportunity emerges from the ever-increasing public pressure for the health sector to achieve better health outcomes with fewer resources. No country is spared of the pressure of budgetary constraints, and this fact also works in favour of family medicine and family physicians. As a matter of fact, we already have evidence that where family practitioners are put in place they can achieve better population health at lower costs.

MESSAGES FOR FAMILY PHYSICIANS

I would like to conclude with five messages that grow out of the scenarios of family medicine I have described.

First, I urge you to promote family medicine by demonstrating its relevance and value so that general public appreciates its unique raison d'être, and is aware of its powerful

impact on the health of the people.

I also urge you to promote family medicine by working not only with health professionals but also with consumer groups for feedback and evaluation that will improve customer service and transparency. In the 21st century, external as well as internal evaluation, and even self-evaluation, will be crucial, if family medicine is to gain the credibility it needs to be established as its own specialty.

Secondly, I urge you to establish family medicine as a more legitimate area of professional practice, so that it can be considered its own field of specialty. I urge you to establish family medicine with strong professional associations and formal certification – so that family practice will be given a distinct place in the field of medicine.

And also I urge you to engage in research on issues given less emphasis by specialists, such as the impact of psychosocial factors on health or the effect of behavioural changes and lifestyle on health – so that you can have an even stronger scientific basis for the holistic approach.

I urge you to establish family practice by publishing journals and other materials that document best practices and successes of the patient-centred approach. This is rather a sharp contrast with majority of today's journals that are more academically oriented. I am sure these kinds of journals will convince both the general public and medical professionals at large of the value of family medicine.

Thirdly, I urge you to inspire young students to pursue family medicine by providing effective, high-quality, certified training. This type of training will ensure young students of the professional esteem if they choose this career path.

I also urge you to inspire young students by being their role models and mentors because a person they respect carries more weight in influencing both their personal and professional life than articles in scientific journals.

And I urge you to offer greater opportunities for career development because I believe that those family physicians who serve people in the community, day and night, should be given due recognition and a chance for promotion to a higher position.

Fourth, I urge you to shift from a narrow perspective, what some people might call "tunnel vision", to a much broader perspective beyond medical boundaries and play a stronger role in shaping decisions in such areas as achieving the optimal balance between the numbers of specialists and family physicians, health insurance coverage, and other matters that influence the health of the people.

This broader perspective is critical now that we all recognize that health is determined not just by biological factors but multi-psychosocial and economic factors as well.

Finally, I urge you to be catalysts in revitalizing your communities by reaching out to all people in the community and by being innovative and bringing together diverse groups to address the root causes of disease.

Admittedly, this is certainly a tall order. But as family physicians you sometimes provide services to people in your clinic, and at other times you go out in the community for health promotions or visit schools to promote health initiatives for youngsters. Or perhaps you visit nursing homes to provide care for elderly people with disabilities, or you approach politicians to discuss health budgets.

So it means family physicians are in a unique position to deal with all groups of people in the community, young and old, men and women, rich and poor.

Yes, this is a tall order. But I am sure family physicians can do it.

Everyone, at every corner of the globe, feels the overwhelming impact of globalization. Far too often, people are driven by economic or financial incentives alone, pushing humanity aside. As a result, the connectedness we once felt with our communities, our schools, even with our families, has eroded.

In order to reconnect ourselves with the world around us, each and everyone one of us must be part of the solution.

But as family physicians, you have a special mission because you have genuine concern for people and your work gives you a unique connection to your community.

You are the ones who can bring a new vision and a new philosophy to this 21st century.

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