

## FROM COUNTERCULTURE TO INTEGRATION: THE FAMILY MEDICINE STORY

A/Prof Goh Lee Gan

I am indeed honoured to be invited to deliver the 17th Sreenivasan Oration perpetuating the memory of Dr Baratham Ramaswamy Sreenivasan. He was the founder President of the College of General Practitioners, Singapore in 1971.

### A TRIBUTE TO DR BR SREENIVASAN

I do not have the privilege to know Dr BR Sreenivasan but I do know his son Dr Gopal Baratham who is a neuro-surgeon. Dr Wong Heck Sing who was closely associated with him had this to say of him when he gave the First Sreenivasan Oration: "When Baratham Ramaswamy Sreenivasan was invited to be the first President of the College he said the founding of the College was a great step forward in the medical development of our country. He spoke with the wisdom of one who had devoted over forty years of his life to medicine, fifteen years of which was in hospital practice and the rest in private general practice. He shared the concern that the concentration of medical development in hospital medicine and its specialties with little being done in the field of general practice would not lead to a higher standard of health care for the nation as a whole. He recognised the initiative taken by the founders of the College as the first step that would lead to the establishment and recognition of general practice as a separate discipline." Indeed he was a man of great foresight and gave unstinted support to the College.

---

GOH LEE GAN, MBBS(Sing), MMed(IM), FCFPS, FRCGP  
Past Censor-in-Chief, College of Family Physicians, Singapore  
(1991-1999)

### CHOICE OF A TOPIC

In a paper in the Journal called *Family Medicine*, Dr JE Scherger<sup>1</sup>, a University don in Family Medicine in California wrote in 1997 of the three phases that family medicine has gone through in time namely, counterculture in the 1970s, parity (or seeking acceptance as equals with the hospital specialist world) in the 1980s, and integration in the 1990s and beyond. I thought this is a good way to remember the march of events in the development and growth of family medicine worldwide.

I chose to tell this march of events as a story for this Oration because the Singapore College has a thirty-year history of being part of the worldwide Family Medicine movement and also because I had some part to play in the Singapore movement. Hence my title of "From Counterculture to Integration: The Family Medicine Story".

I have divided this Oration into three parts and a conclusion. The three parts are Family medicine as a worldwide movement; the Singapore movement; and where do we go from here.

### FAMILY MEDICINE AS A WORLDWIDE MOVEMENT

#### The phase of counterculture

As a worldwide movement, family medicine had its prelude in the growing disenchantment of general practitioners and their patients with the fragmentation of care and impersonal care brought about by subspecialisation and growth of high technology.

There was clearly a need for a group of doctors to sound the warning of too much of fragmentation as well as to address the consequences of this phenomenon. The GPs on both sides of the Atlantic spearheaded the movement.

In 1947, the American Academy of General Practice was formed and in 1952, the British College of General Practitioners was formed. Another English speaking country that was to play an influential role in Asia-Pacific including Singapore had its College established in 1958. This was Australia.

The 1970s was also a period of social economic difficulty in many of the developing countries and WHO led the movement of Health for All By Year 2000 through primary health care.

In 1972, the world body of family medicine, Wonca was formed with 18 country members. Singapore was one of the early members. The Wonca Secretariat was in Australia and remained so until January this year when it moved to Singapore. Dr Alfred Loh is now the CEO, succeeding the immediate past CEO, Prof Wesley Earl Fabb who has all these years been a strong supporter of the Singapore College.

The family medicine counterculture<sup>2</sup> was particularly strong in America and the general practitioner community worked towards a new general practice and even changed the name of the discipline from "general practice" to "family medicine" to reflect a renaissance in its culture.

The central values of this counterculture to hospital specialist medicine are:

- Patient centred care and attention to the doctor-patient relationship,
- Holistic approach to the patient and his problems that recognizes contributions to ill-health and well-being come from not only physical disease but also from social and psychological dimensions in the patient as well as from the family and his community
- Greater emphasis need to be given to preventive medicine because this has greater

impact than curative medicine

- The family doctor looks after health problems that may be initially unclear in terms of seriousness
- The family doctor looks after people across the whole spectrum of age groups
- The family doctor is willing to look after the patient not only in the consulting room but also in the home and other settings as well.

### **Parity**

From the phase of counterculture which was quite successful because of people support and socio-economic circumstances, the champions of family medicine or general practice were able to establish family medicine as an academic subject in their medical schools.

### **Integration**

From the phases of counterculture and parity, family medicine moved into the 1990s. Here, the prevailing mood was for integration of clinical activities. The judgment call was whether family departments would want to integrate with hospital based disciplines like paediatrics, general internal medicine and even geriatrics. The danger was for departments of family medicine to be left behind if they choose to stand alone.

## **THE SINGAPORE MOVEMENT**

### **Counterculture**

Singapore, like the developing countries in the Asia-Pacific region, and the developed countries around the world, too received the family medicine message. The desire to set up a College of General Practitioners to develop standards of care in general practice was strong. This was set up in 1971.

Singapore is not exempt to the side effects of subspecialisation and this subject was expressed in

more than one Sreenivasan Oration, namely in the Oration given by Dr Wong Heck Sing (1978), Dr Victor Fernandez (1983), and Dr Lee Suan Yew (1995).

### **Parity**

The specialist image in Singapore remains overpowering to GPs and patients. The introduction of family medicine into the undergraduate curriculum in the National University since 1987 and the setting up of Master of Medicine (Family Medicine) programme since 1990 probably has improved the understanding and image of family physicians.

### **Integration**

Integration of health care activities and providers is now the focus of health care reform in Singapore. The formation of a 2-cluster system health care, the concepts of seamless care, disease management, stepped down care, and shifting the center of gravity to the GPs are steps in this direction. We would need to look into sustaining health care needs of not only the present but in the future as well.

### **WHERE DO WE GO FROM HERE**

Let us look at integration, parity, and counterculture in that order.

### **Integration**

The importance of integration has been alluded to. Family medicine has the role of integrating in the mind of every doctor, a balance between specialization and generalist approach in the care of patients. The organ subspecialist need to see how his expertise fits into the total well-being of the patient.

Specifically, we need to work on the following in our integrating efforts:

- Good preventive care – Preventive care must take the forefront of our care – the old adage of “prevention is better than cure” will always remain true.
- Good acute care – Acute care is where we really need to integrate knowledge, skill and experience and to share it with one another on how to do things right the first time. It is not always easy and takes a lifetime to perfect
- Good chronic disease care management – attention to these will surely reduce the burden of disease on the sufferers
- Good stepped down care – this is increasingly important with the rising cost of acute hospital care and the increasing numbers of the elderly who take a longer time to recover from their medical illnesses
- Good elderly care – the care of the elderly is the best example of the need for integrated care both vertically and horizontally. Care of these people cannot be good without adopting the paradigm of integrating the efforts of carers for a common purpose. And we have some 27% of such patients come 2030
- Good domiciliary care — this is a very much underserved area of care. It will grow in importance as an area of need as more and more people live to a ripe old age
- Good palliative care – This will include not only terminal care but also the care that can extend and enrich those with cancer who cannot be cured. Hope still springs eternal when one day we may be able to slow down the destructive effects of cancers and give the sufferers more life and longer life. The idea of controlling cancer just like the control diabetes mellitus may not be such a far-

etched idea. And good palliative care goes beyond cancers. It is also needed to slow down the progression of end organ disease states.

### **Parity**

Parity is the family physician being accepted as equal to the organ specialist in the eyes of the four Ps – profession, people, policy makers and the press. The journey to parity is the process of levelling up. To enable our GPs to do so, the College has in collaboration with the University and Ministry of Health develop family medicine programmes that span undergraduate to postgraduate levels. The GP community have enjoyed the support of our many specialist colleagues in training our GPs in the past and we are appreciative of their national service role.

### **Counterculture**

Is there a place for family medicine as counterculture into the future? The answer is yes. Family medicine as an academic discipline has the role to remind every doctor that there is a need for a balance between the subspecialist and the generalist perspective. Family medicine cannot abdicate this role.

### **TAKE HOME MESSAGES**

There are three take home message from this Oration:

- Integration between generalist and specialist care is a must to develop a cost effective and meaningful health care delivery system. The desire to do so must pervade the minds and values of every

medical practitioner, whether subspecialist or not.

- Family physicians need to level up to meet the healthcare needs of today and tomorrow, in particular in the seven areas of care: preventive care, acute care, chronic disease management, stepped down care, elderly care, domiciliary care, and palliative care
- Family medicine as an academic discipline has the role of teaching and reinforcing the paradigm that the patient is an individual, has a family and background, and is a member of the community and that he is more than a bag of organs and structures but has feelings too. A holistic approach to his needs is therefore needed.

### **ACKNOWLEDGEMENT**

I would like to take this opportunity to thank my many colleagues, both in Singapore and overseas; and my students too who have help me clarify the importance of a holistic approach to medicine and participate in the teaching programmes. I would in particular like to record my thanks to my mentor, Dr Lim Kim Leong. I come from a specialist background and it was Kim Leong who showed me the importance of a bigger world view to people with medical problems. To one and all, my thanks.

### **REFERENCES**

1. Scherger JE. Phase Three of Academic Family Medicine. *Family Medicine* 1997; 29(6):439-440.
2. Stephens GG. Family Medicine as Counterculture. *Family Medicine Teacher* 1979; 11(5):14-8 (Reprinted in *Fam Med* 1998;3(9):629-36.