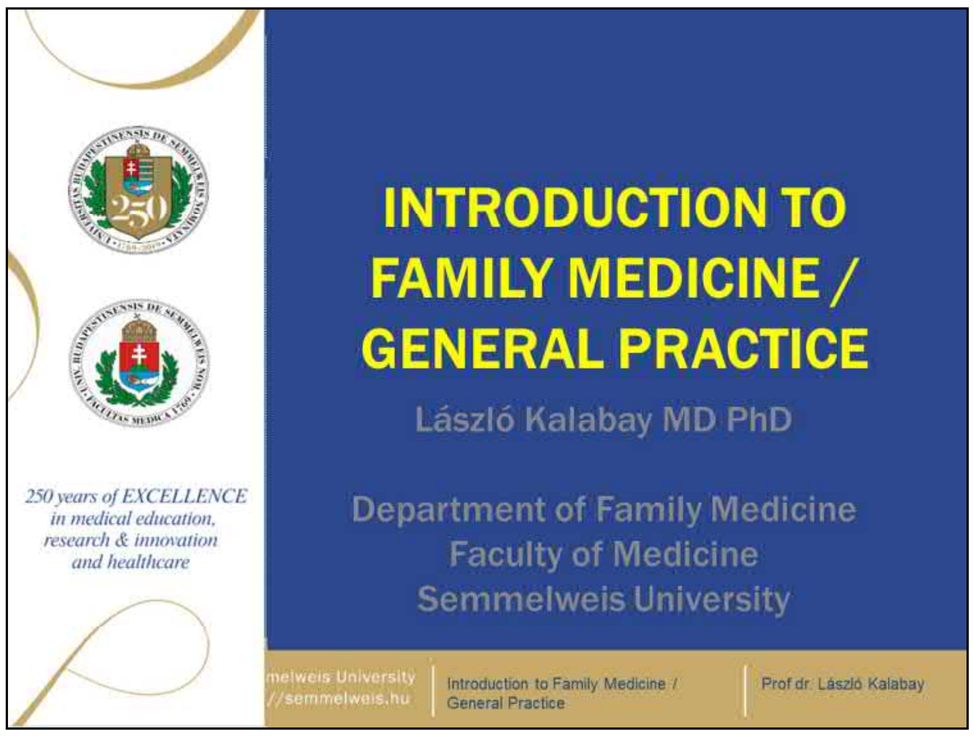
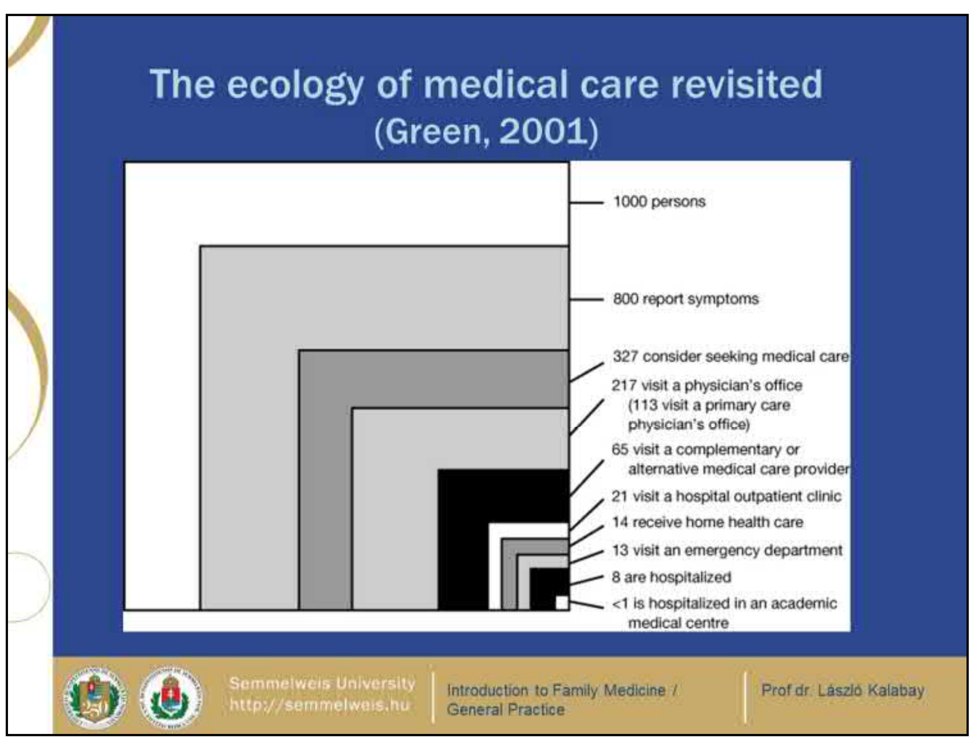


Warm welcome to students on the introductory lecture in Family Medicine! You have come from different countries with different historic, social, cultural and financial backgrounds. This lecture will show you

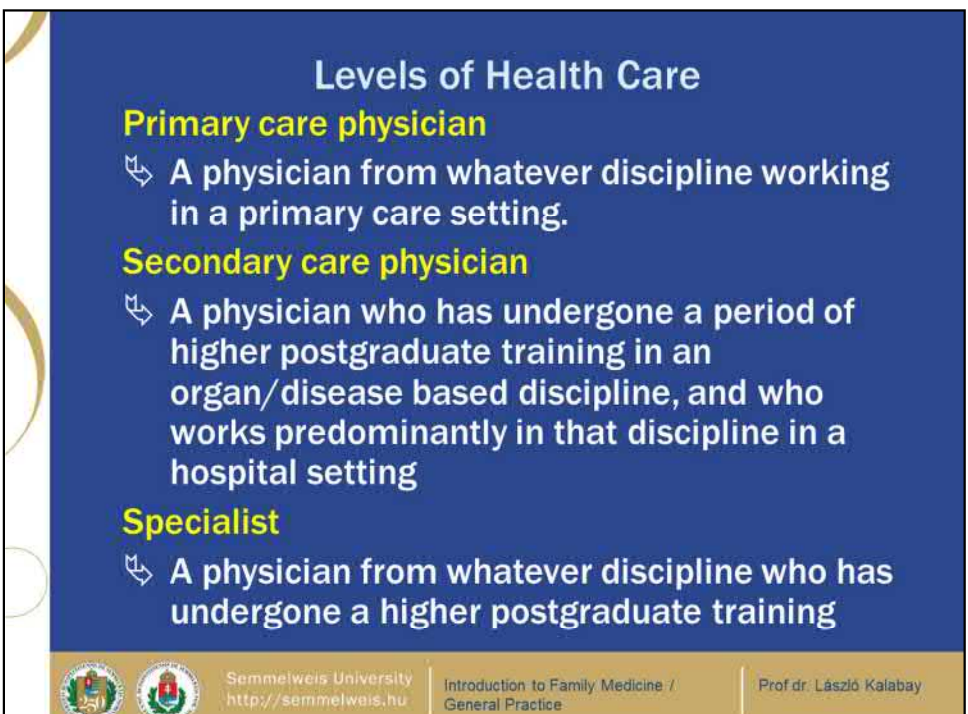
- the basic definition and characteristics of family medicine/primary care that are common in this discipline through the world,
- the importance and impact of family medicine,
- the history of family medicine,
- An outlook on different systems of primary care in the world,
- the European Definition and characteristics of family medicine/primary care.



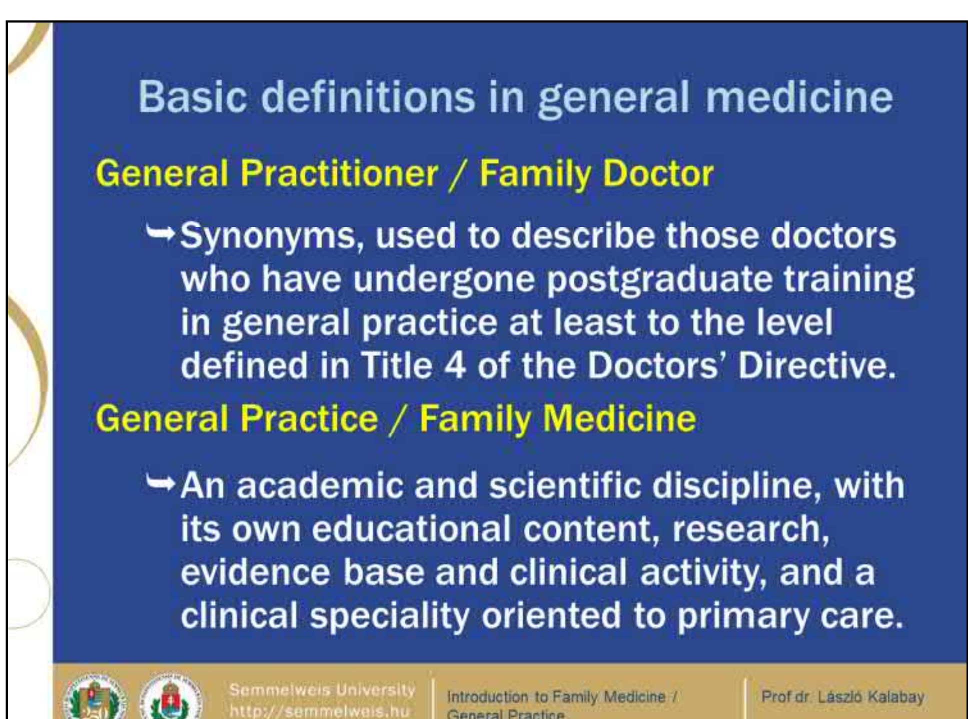
If ask 1000 people in the street whether they are satisfied with their health status, 800 of them woul mention some – minor or major – complaints, however, much less of them even think of going to the doctor. Even less (cca. 21%) will do so. Depending on the system available they will turn to family doctors, outpatient services, take alternative medicine. Of course, much less of them (1%) will be hospitalized and even less be referred to university departments. Two things follow from this:

Firstly, the GP (General Practitioner/Family Doctor, well' use these two terms interchangeably) is the first contact point of the health care system.

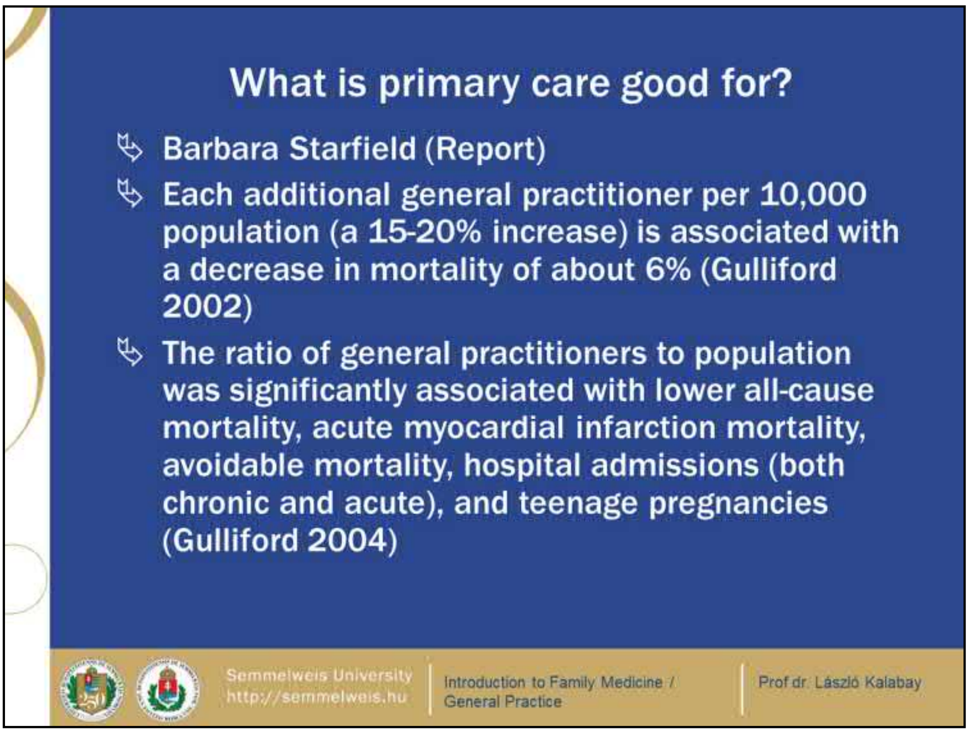
Secondly, if you were the ministers of health in your countries, and wanted to set off a campaign against obesity, hypertension, smoking, alcoholism, depression, etc., or to promote screening for cancer, which doctor would you turn to? To the family physician. It is no point to preach against the deleterious effect of smoking to patients with COPD, asthma or lung cancer in a pulmonology ward. You have to find those who feel themselves healthy and are not aware of hazards. In other words: prevention can be done only at the level of the primary care.



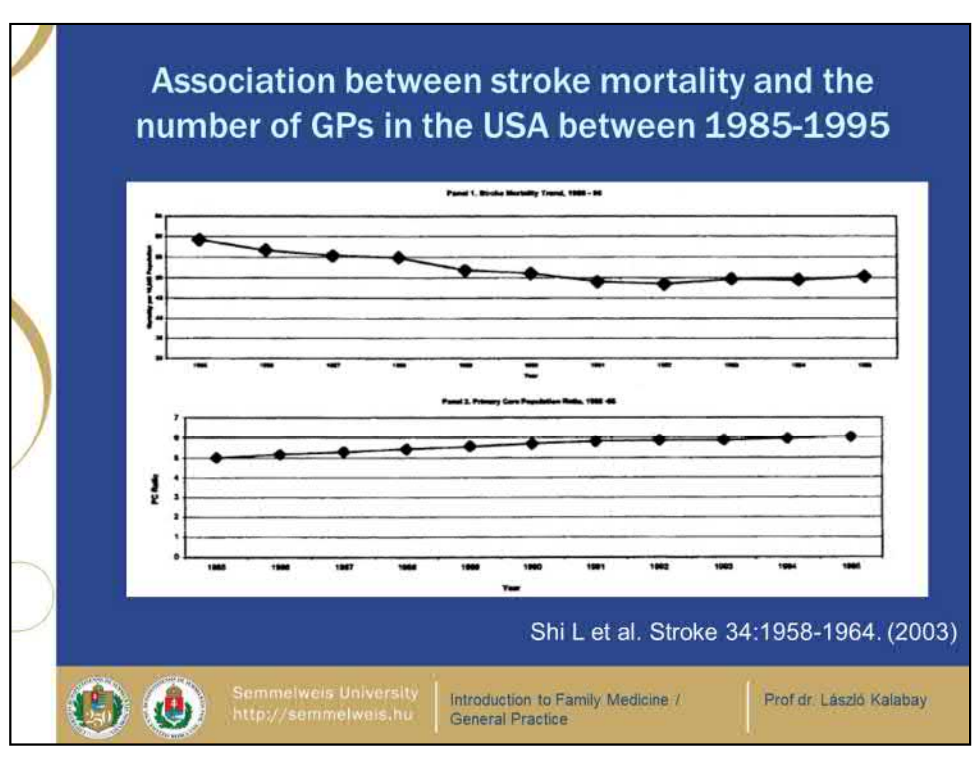
Health care has different levels, mainly primary and secondary (in some countries the secondary level has a subgroup with "specialists"). The statement on primary care is not exactly correct, because although on can start working in a GP's office without a board certificate but he has to get it within a certain time period (usually within 3-4 years). The value of the board certificate of family medicine equals to those in other disciplines (e.g., internal medicine or surgery). This and the next slides show definitions of the WONCA. WONCA is the world organization of family doctors (www.globalfamilydoctor.com).



Although we shall use terms “Primary Care” and “General Practice” interchangeably the former is broader. In many countries, including Hungary, primary care comprises family medicine, family pediatricians, school doctors, community nurses, occupational medicine, ambulance service, etc.



The following slides show you evidences of the usefulness of the primary care. Dr. Barbara Starfield was an American family physician who investigated the impact and importance of primary care. She and her followers performed studies in many countries in the world and have come to the same conclusion i.e., the introduction and development of the primary care system considerably improves the health status of the population. This was true, regardless of continents, socio-cultural and financial status of the country. Obviously, this trend will reverse with the drop in the number of GPs.


Association between stroke mortality and the number of GPs in the USA between 1985-1995
Shi L et al. Stroke 34:1958-1964. (2003)
Semmelweis University
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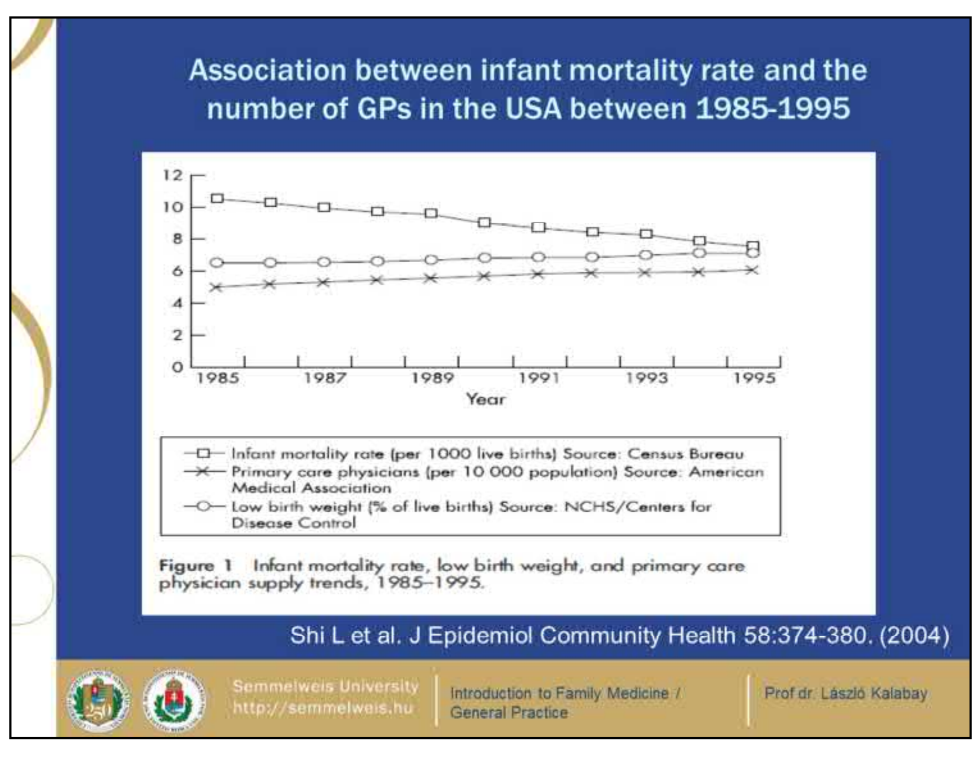
Introduction to Family Medicine / General Practice
Prof dr. László Kalabay


Association between infant mortality rate and the number of GPs in the USA between 1985-1995
12
10
8
6
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1985
1987
1989
1991
1993
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Year
Infant mortality rate (per 1000 live births) Source: Census Bureau
Primary care physicians (per 10 000 population) Source: American Medical Association
Low birth weight (% of live births) Source: NCHS/Centers for Disease Control
Figure 1 Infant mortality rate, low birth weight, and primary care physician supply trends, 1985–1995.
Shi L et al. J Epidemiol Community Health 58:374-380. (2004)
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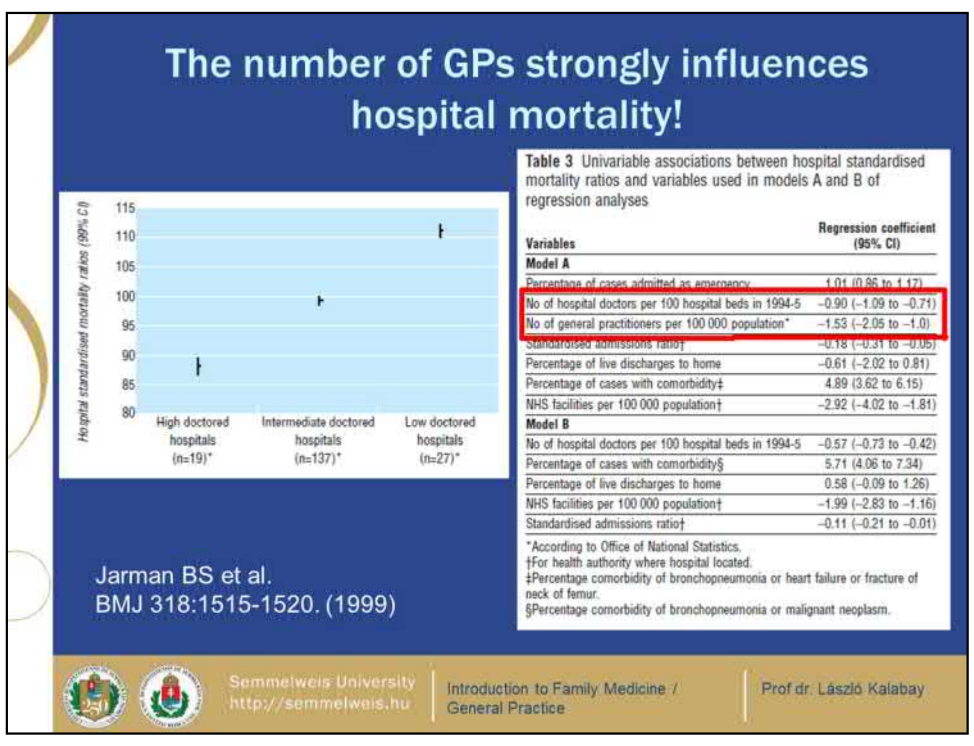


Table 3 Univariable associations between hospital standardised mortality ratios and variables used in models A and B of regression analyses

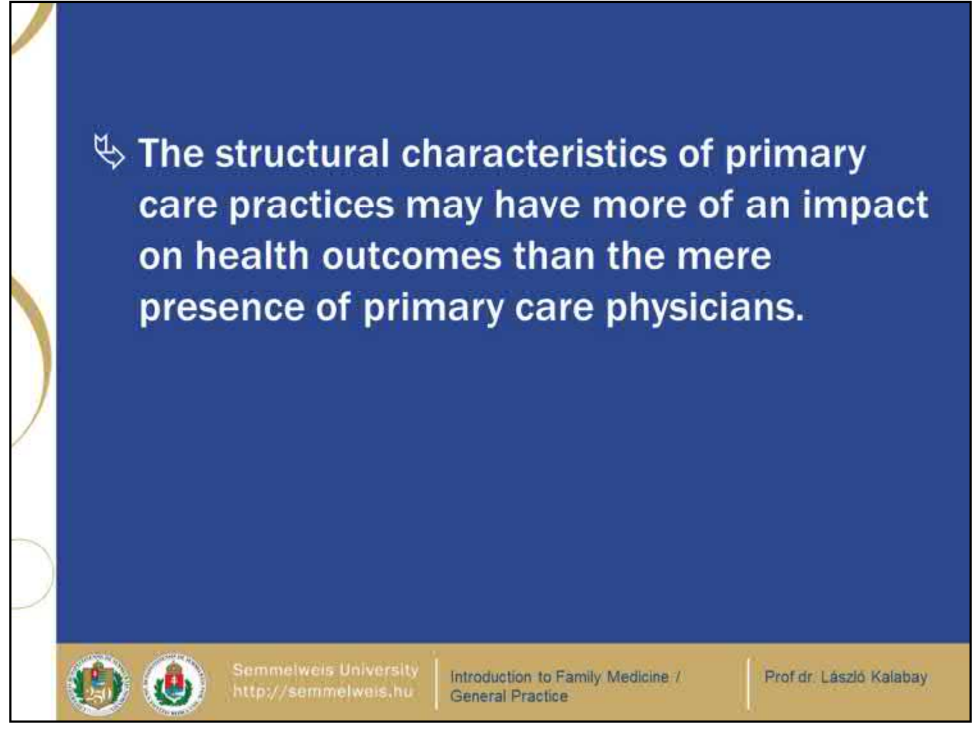
Variables	Regression coefficient (95% CI)
Model A	
Percentage of cases admitted as emergency	1.01 (0.86 to 1.17)
No of hospital doctors per 100 hospital beds in 1994-5	−0.90 (−1.09 to −0.71)
No of general practitioners per 100 000 population*	−1.53 (−2.05 to −1.0)
Standardised admissions ratio†	−0.18 (−0.31 to −0.05)
Percentage of live discharges to home	−0.61 (−2.02 to 0.81)
Percentage of cases with comorbidity‡	4.89 (3.62 to 6.15)
NHS facilities per 100 000 population†	−2.92 (−4.02 to −1.81)
Model B	
No of hospital doctors per 100 hospital beds in 1994-5	−0.57 (−0.73 to −0.42)
Percentage of cases with comorbidity§	5.71 (4.06 to 7.34)
Percentage of live discharges to home	0.58 (−0.09 to 1.26)
NHS facilities per 100 000 population†	−1.99 (−2.83 to −1.16)
Standardised admissions ratio†	−0.11 (−0.21 to −0.01)

*According to Office of National Statistics.
†For health authority where hospital located.
‡Percentage comorbidity of bronchopneumonia or heart failure or fracture of neck of femur.
§Percentage comorbidity of bronchopneumonia or malignant neoplasm.

This slide should be shown to each hospital doctor, who, for one reason or other, blames GPs.

Let's take three hospitals with different numbers of GPs in their designated referral area. The intermediate will be used as reference. Compared to the reference, the mortality will be less in the hospital with high number of GPs in its area, and the hospital mortality will be higher in low doctored areas. This is not surprising for the hospital will get not the moderate or severe hypertension but will get patients with stroke and myocardial infarction, will not get the moderate-severe diabetes but will get patients with end-stage renal disease, blindness or lower limb gangrene to amputate, it will get patients with stage III or IV cancer instead of less advanced (stages I or II), will not get patients with mild-severe depression but will get those who have committed suicide already. This is obvious. It is surprising, however that this relationship between the number of GPs and hospital mortality is stronger than that between hospital mortality and the number of doctors working in that hospital. These data underline the impact of the gate-keeper function of the GP/primary care.

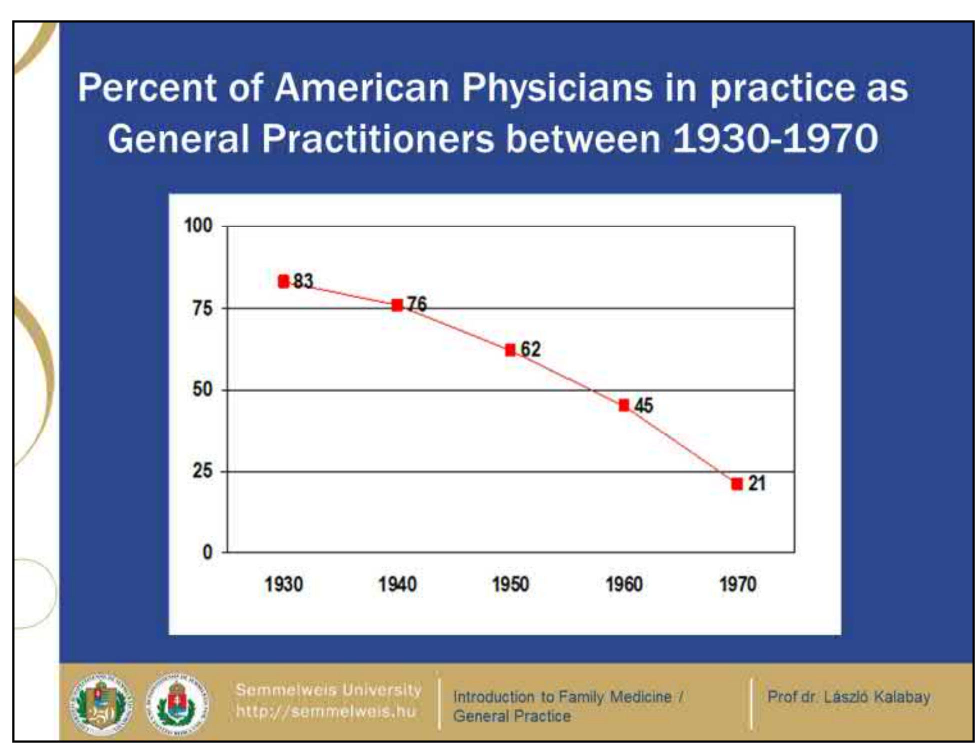
In addition, malpractice occurs at each level of health care, and even those occurring at the primary care are not always made by family physicians.



The organization of the primary care is even more important.

It has always been the desire of mankind to have a personal doctor to whom one can turn with any kind of complaints be asked, examined then to receive definitive treatment. We all know, however that this cannot be done in many cases because special consultations, acute referrals, ancillary laboratory or imaging tests are needed is several instances, yet this is the basic expectation. The patients to not expect the doctor to be familiar e.g., with the most recent guidelines of the treatment of the non-small cell lung cancer but they expect him to know when lung cancer is diagnosed – how to manage the patient.

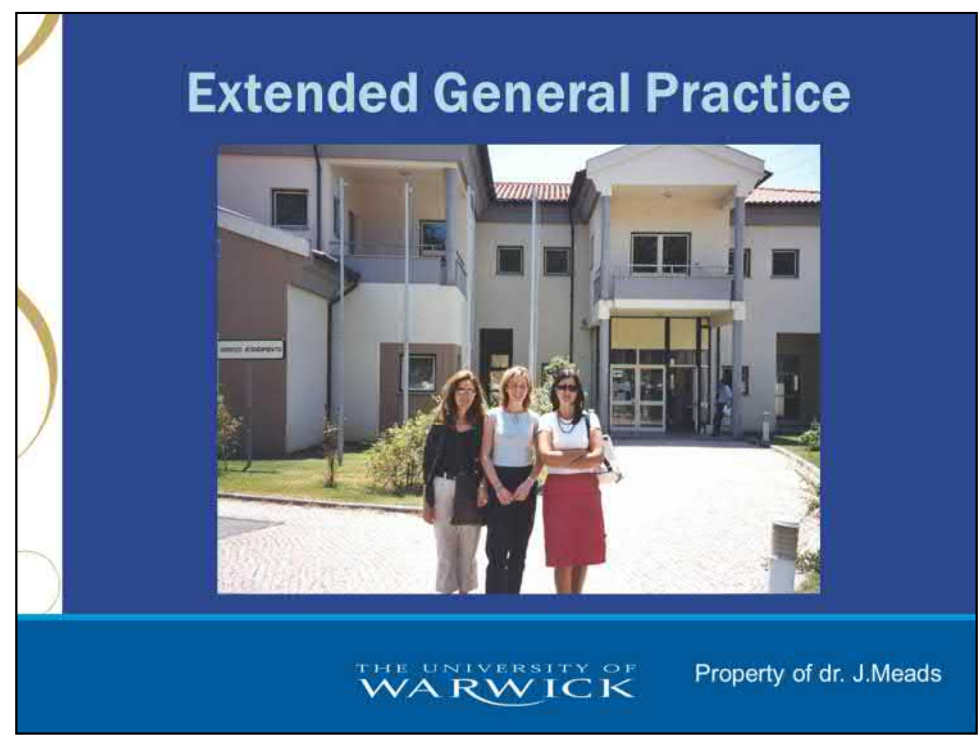
Over a period of time a confidential relationship between the doctor and the patient develops.



Family medicine became a unique discipline in the USA first. The population of the New World increased at a high rate from the middle of the 19th century. America was the home of endless possibilities of enterprise establishing. A considerable portion of the doctors started to specialize and there were less and less, who worked as GPs and “did everything”. Beyond a certain degree (see 45% in the curve) this process led to the development of severe risks. Let’s take a small city where someone develops acute abdominal pain and diarrhea and goes to see dr. “A”, who is a gastroenterologist. Somebody else in the neighboring house has the same symptoms and sees dr. “B”, who is also a gastroenterologist. A third person with the same symptoms sees dr. “C” with the same specialization. And there is not a single doctor who recognizes that there is an epidemic going on! The decline of the number and ratio of primary care doctors confers severe public health hazards, as well.

The danger of overspecialization has been warned even in the thirties. Thus family practice was declared as a unique discipline in 1966 and one could specialize in it after three years. (In Hungary one can specialize in general medicine since 1975). The World Health Organization composed the European Definition of General Practice.

EURACT: European Academy of Teachers (in family medicine).



And now let’s take a look on various models of primary care in the world.

This picture was taken in Portugal but in could have been taken in Finland, as well. The Finns are probably the best in the world providing extended primary care. This model far beyond the solo (one doctor, one nurse) practices. The do a lot of other things, e.g., melanoma screening, Pap smears, minor surgery, dietary consultation, physiotherapy, rehabilitation and health promotion. They also have diagnostic ultrasound, laboratory and X-ray facilities. This model ensures that only the severe and justified cases are referred to the hospital, were the diagnosis and treatment is much more expensive.

The Role of the Health Visitor in

1. An Extended General Practice

    Specialist Nurse responsible for Occupational Health, Prevention and Environmental / Community Development - population wide.

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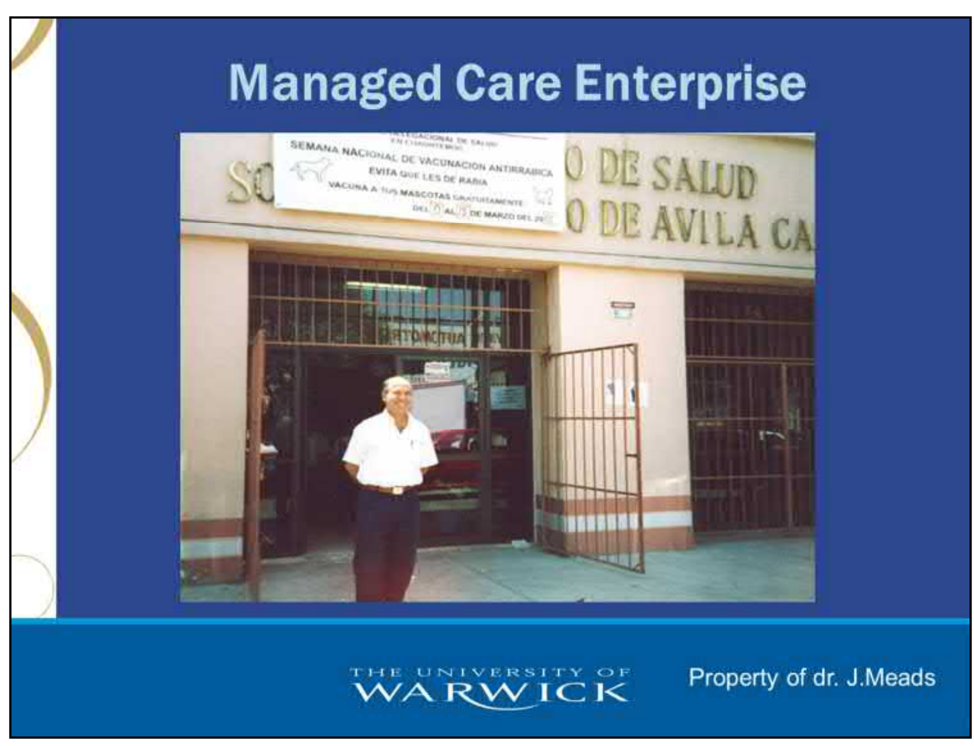

This picture was made in Mexico. There is an enterprise that vaccinates dogs and cats against rabies (for money) and provides primary care for the friable patients in order to avoid readmission to hospital. (Rabies is also spread by bats in this area.)

The Role of the Health Visitor in

2. A Managed Care Enterprise

A Sessional Worker targeting High Score DALYS Index Patients with high referral / readmission rates and administering cost-effective screening programmes.

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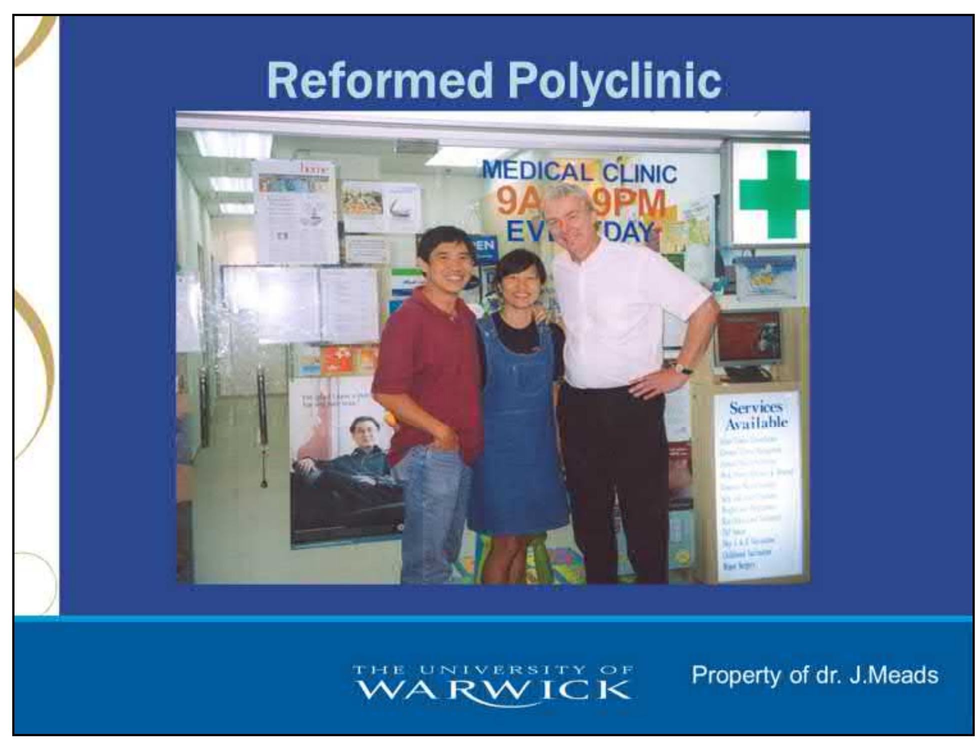

This picture was made in Vietnam but could have been made even in Hungary. This model is characteristic for the post-socialist countries. The Semaskho model, bearing the name of a minister of health in the Soviet Union forced to build huge hospitals with many beds. It turned out, however, that it was not necessary and many hospitals were changed to outpatient services including GP offices. Services were completely free in the socialist era, whereas today one has to pay for some of them (e.g., driving license extension).

The Role of the Health Visitor in

3. A Reformed Polyclinic

A clinical specialist site-based receiving direct patient referrals in relation to Clinic / Commissioning prescribed protocols and programmes for Fee for Service (e.g. inoculations).

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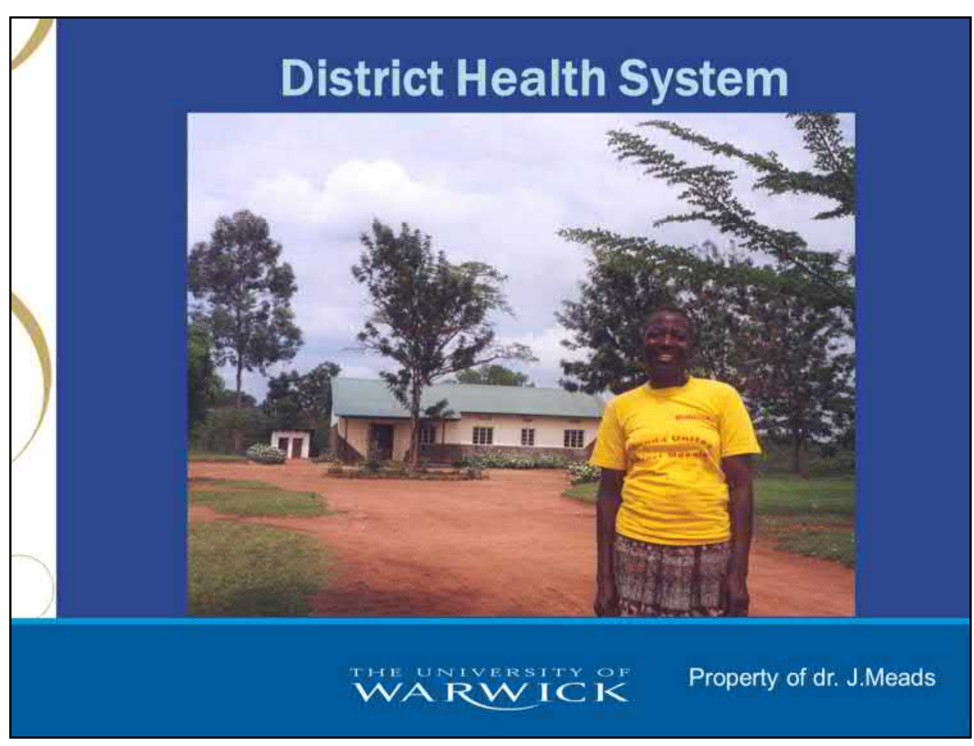

This picture was taken somewhere in Africa. The District Nurse has been trained to recognize diseases that are common in that area (e.g., malaria) and has drugs for treating patients. She calls the doctor in case her competence is not enough for the management of patient. The doctor may ether arrive by on a helicopter or airplane or the patient is sent to the hospital (charity or military). This model is exists in large, remote, scarcely inhabited areas – not only in the poor countries of Africa, but also in Australia (in the “bush”) and in the rich Canada, high up in the North, where the Eskimos live.

The Role of the Health Visitor in

4. A District Health System

Frontline Health Station Practitioner combining health promotion with acute and primary care under remote supervision of District Public Health / Medical Officer, with important local support from charities and churches.

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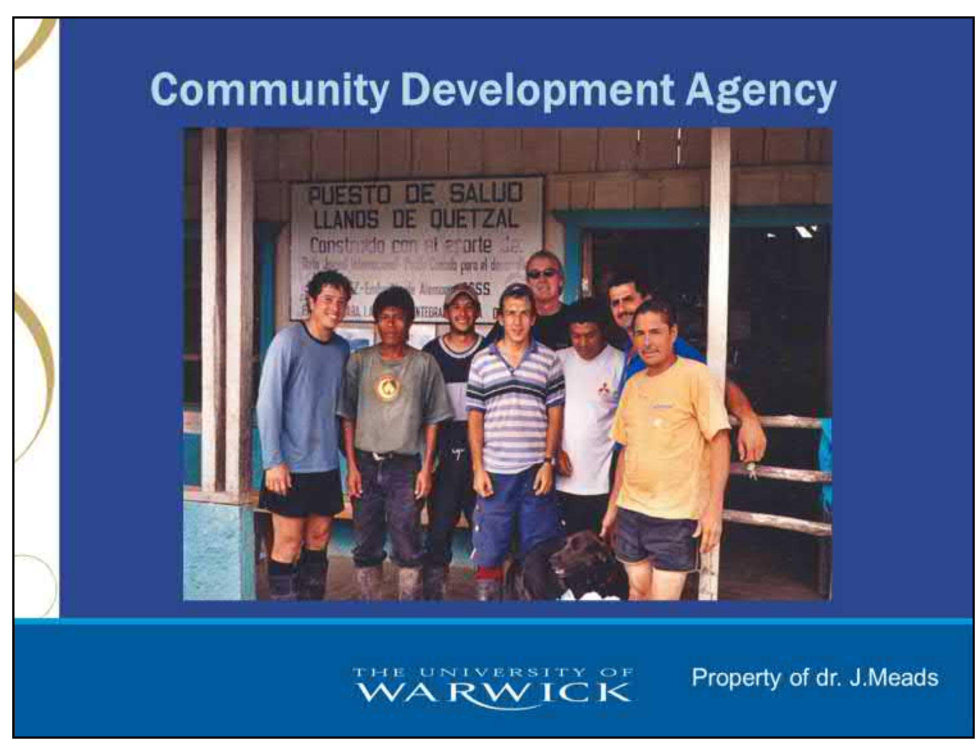
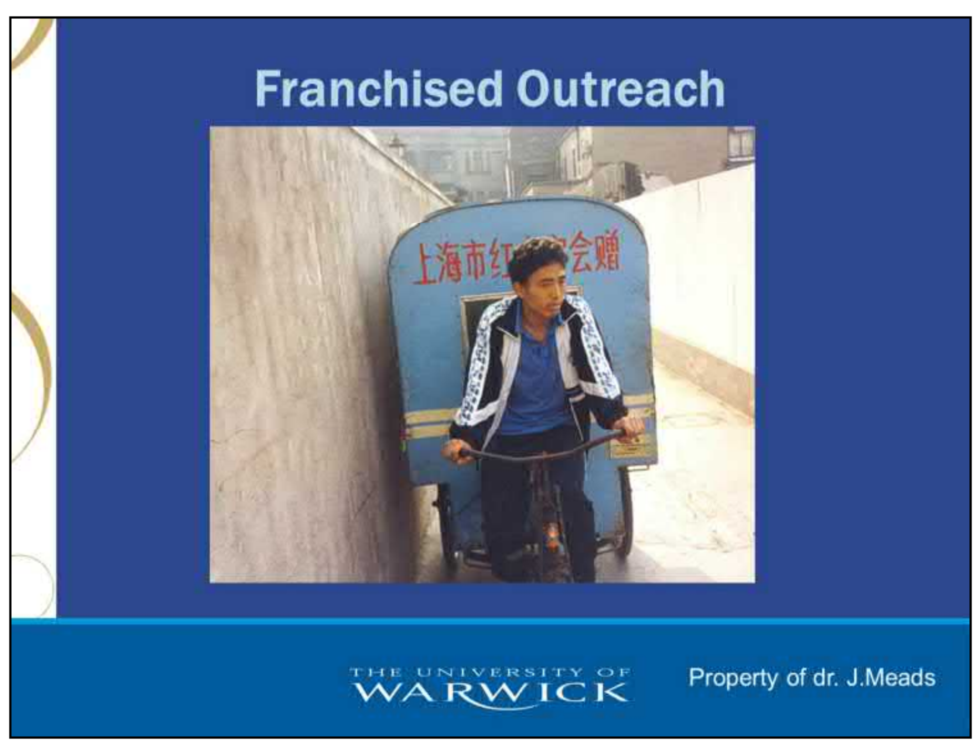


At the first glance you would not think that you see a medical team. But they are. These people can reach to and be accepted among people with very low socio-cultural state (e.g., slums). These volunteers do health education and promotion. The can also identify people at risk (alcoholism, drug abuse, sexually transmitted diseases, HIV infection, etc.) and refer them to the local doctor.

The Role of the Health Visitor in

5. <u>Community Development Agency</u>
   Expenses only Health Care Technician undertaking 6 monthly Household Health Assessment visits with targeted 'Health Impact' follow ups by local Family Doctor and Nurse. Leader of 5 person Health Promoter Volunteer Team each responsible for one local health priority.

Property of dr. J.Meads



This is the way the patient is brought to the doctor, in countries where primary care does not exist. Social welfare and health care are not separated from each other. (I have been told that the text is South Chinese).

The Role of the Health Visitor in

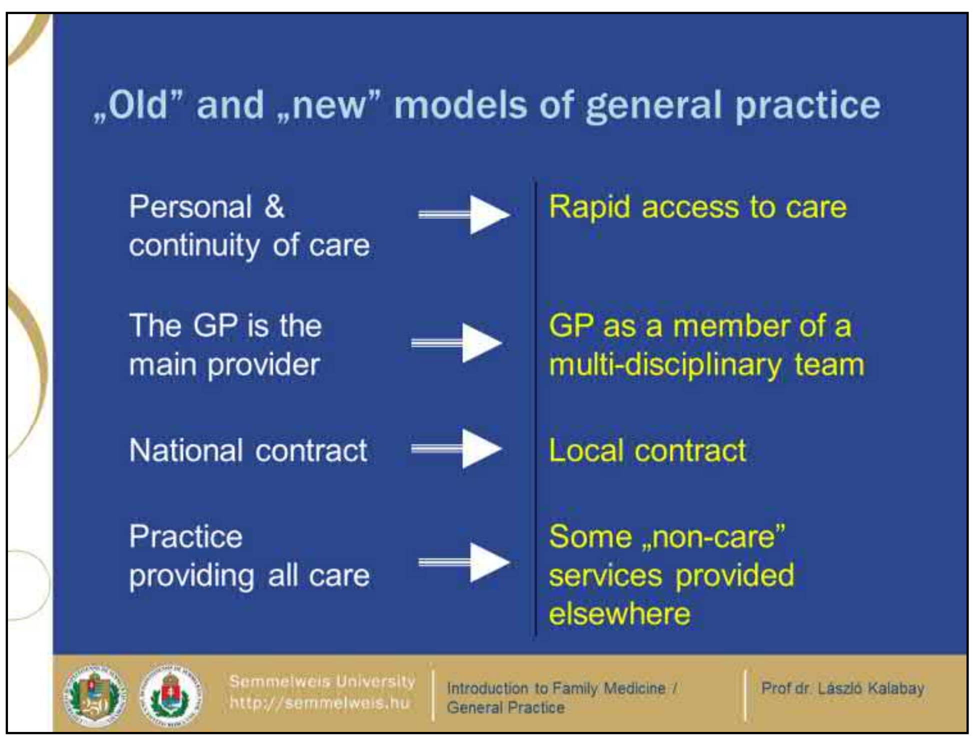
6. Franchised Outreach

   Outside Health Service employed on Municipal Public Health campaigns and accountable to elected Councillors. Part of Social Welfare Services.

Property of dr. J.Meads

The main characteristics of primary care.

No money is enough for health care. Health care systems are under continuous change in order to find the way how the limited amount of money for health care can be spent as effectively as possible. Obviously, primary care is the most effective way to spend money for the health of the population.



New ways of providing and delivering health care.

It is vital that the complex and essential role of Family Doctors within health systems is fully understood within the medical profession, but also professions allied to medicine, health care planners, economists, politicians and the public.

Within Europe increased investment in FM is required to enable health systems to fulfil their potential on behalf of patients.

Investment not just in relation to human resources and infrastructure but with regard to education, research and quality assurance.

This consensus statement (2002) redefines the discipline of GP/FM, the professional tasks, the core competencies required of GPs.

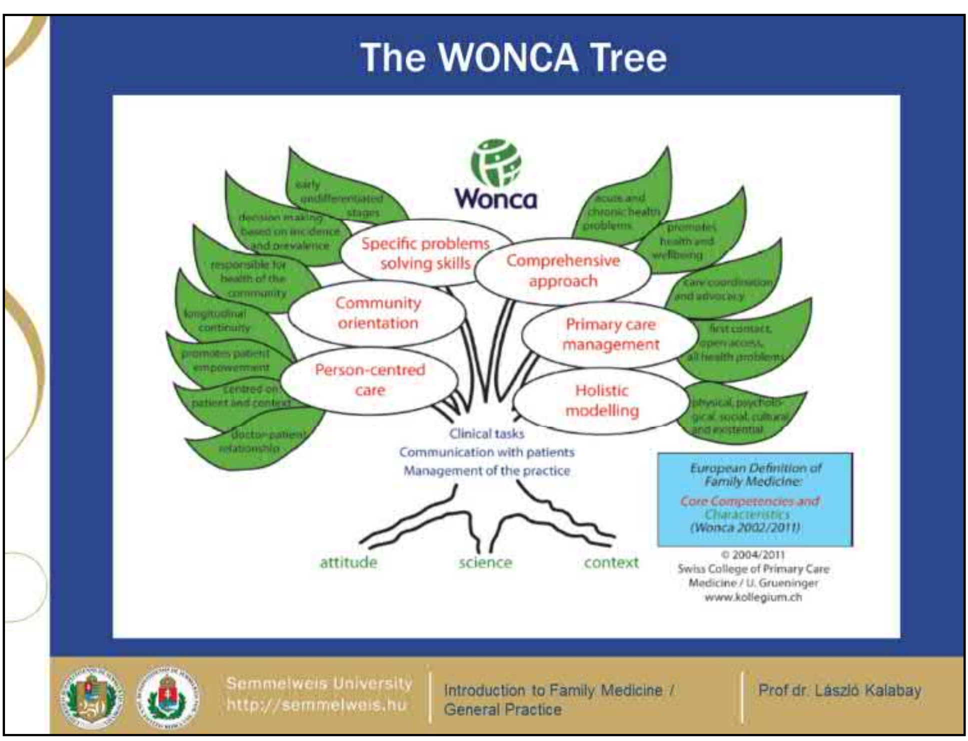
Delineates the essential elements of the academic discipline and provide an authoritative view on what family doctors in Europe should be providing in the way of services to patients, in order that patient care is of the highest quality and also cost effective.

WONCA Europe

The European Society of GP/FM, the Regional Organisation of the World Organisation of Family Doctors (WONCA).

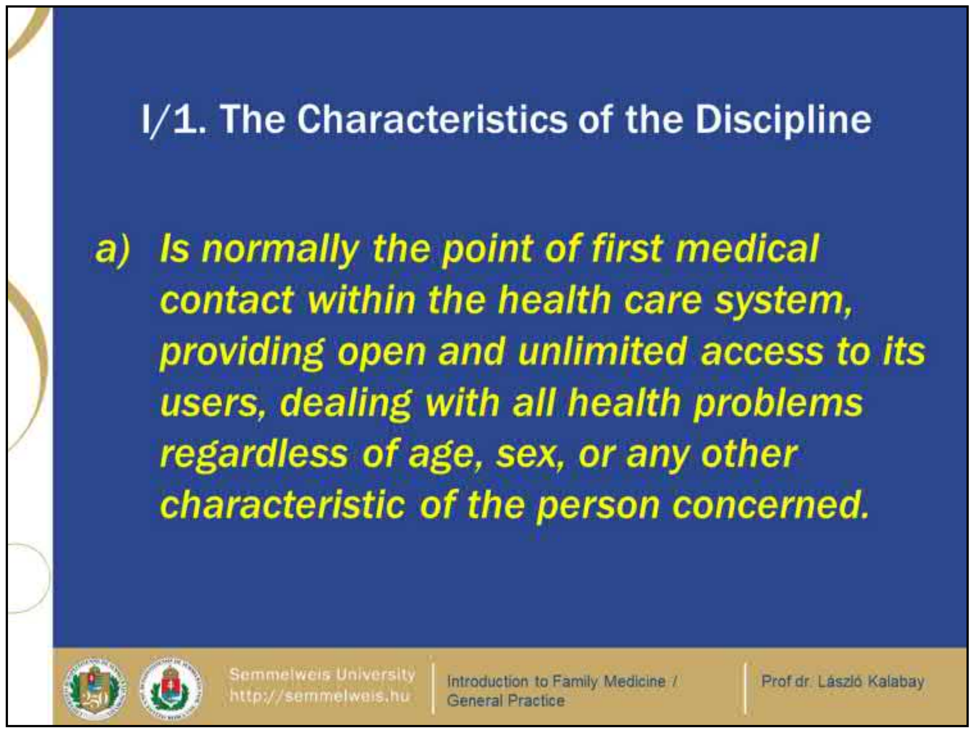
Provides the academic and scientific leadership and representation for the discipline of Family Medicine throughout the continent.

Its main role to promote and develop the discipline.

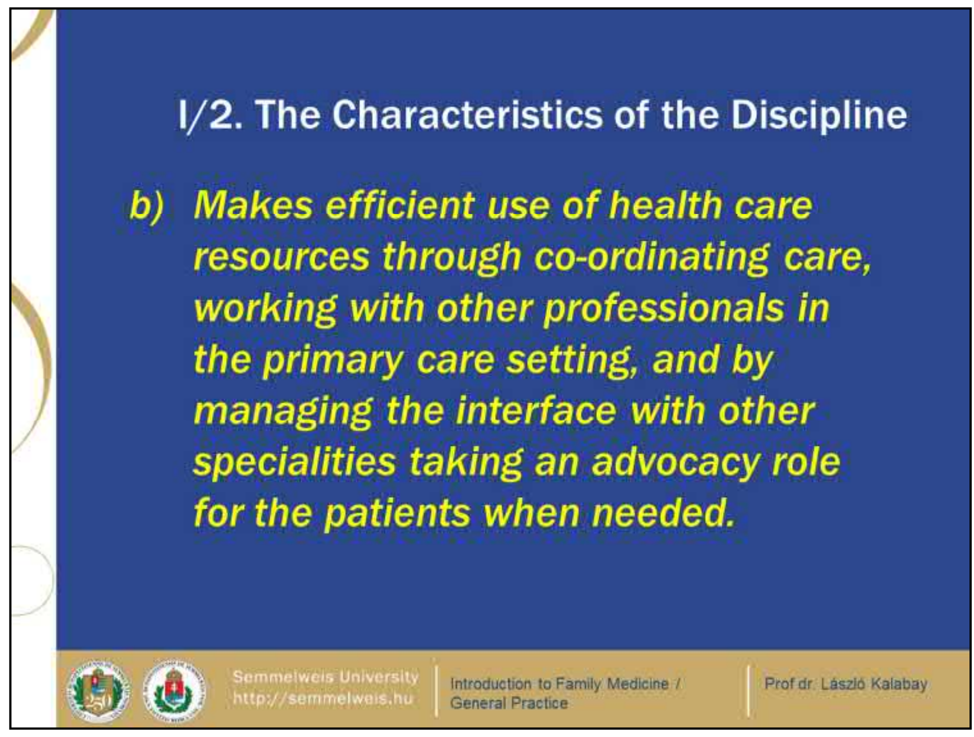


The main elements and characteristics and their relationship are likened to the roots, trunk, branches and leaves of a tree, the WONCA tree. Parts of it, along with the European Definition of Primary Care are discussed on the oncoming slides.

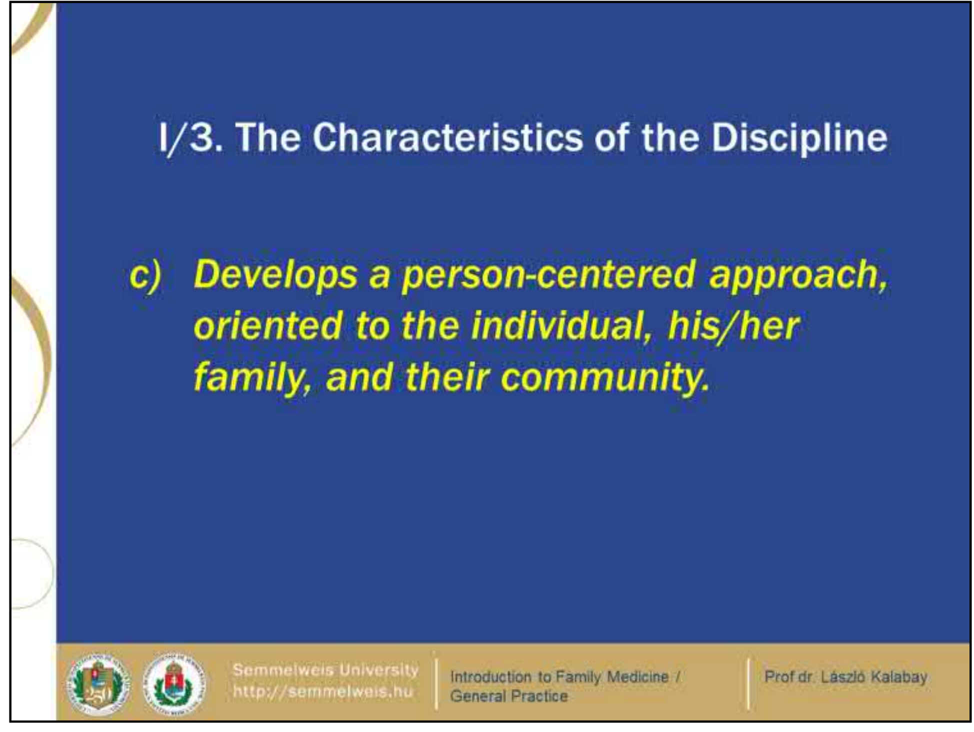
The three components of the European Definition of Primary Care.



Except for some circumstances, e.g. major trauma. There should be no barriers to access, doctors should deal with all types of patients.



The key feature of the cost-effectiveness of good quality primary care is to ensure that patients see the most appropriate health care professional for their particular problem.



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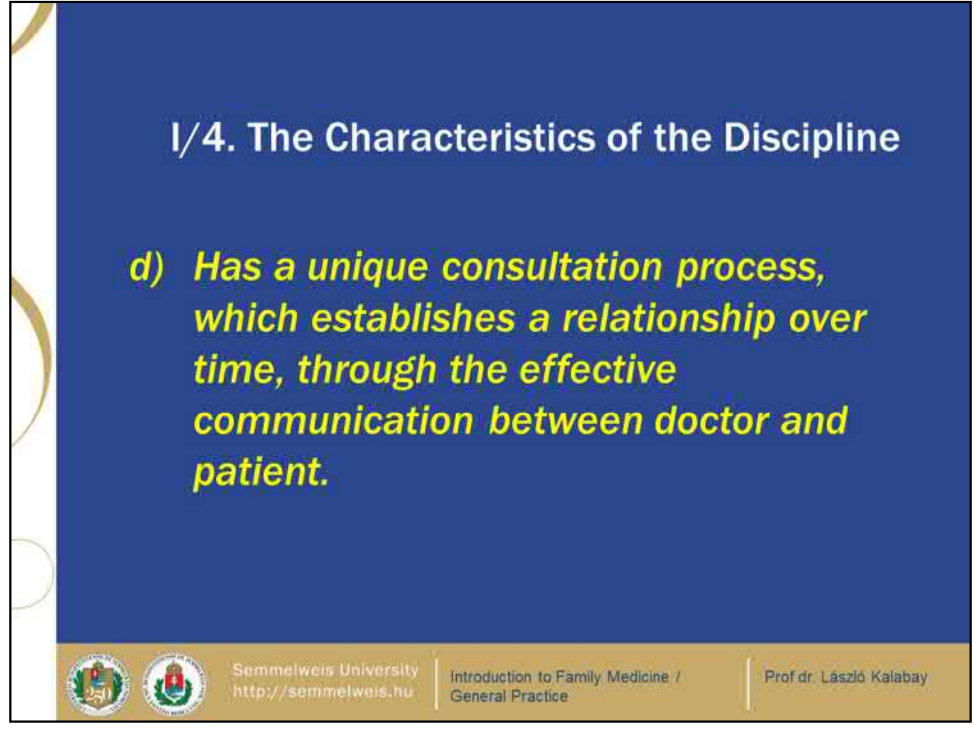
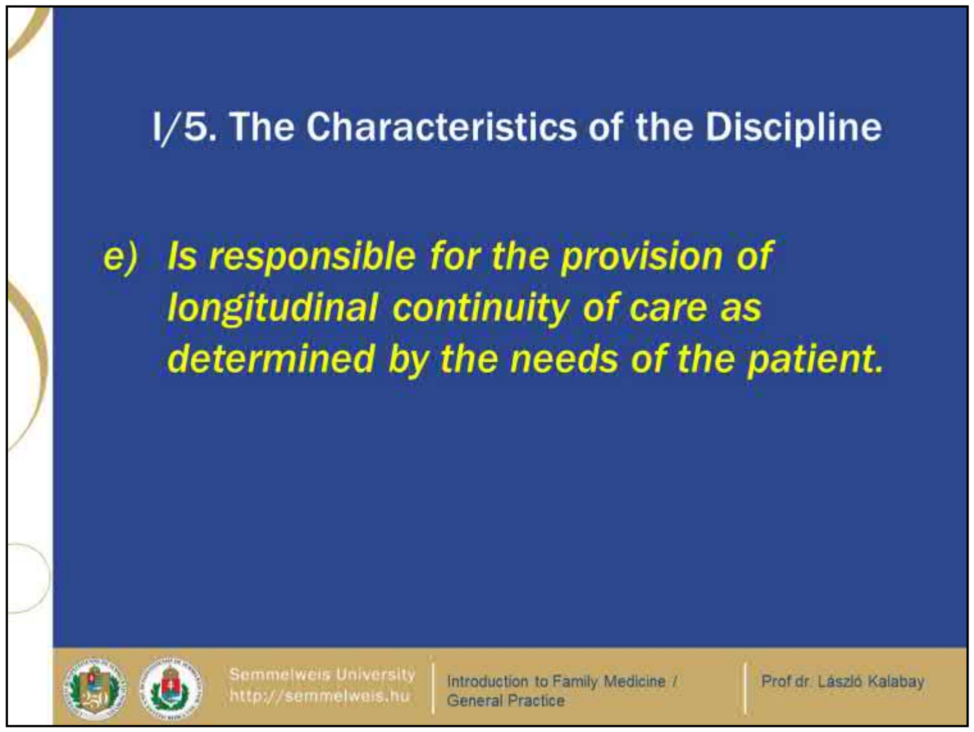
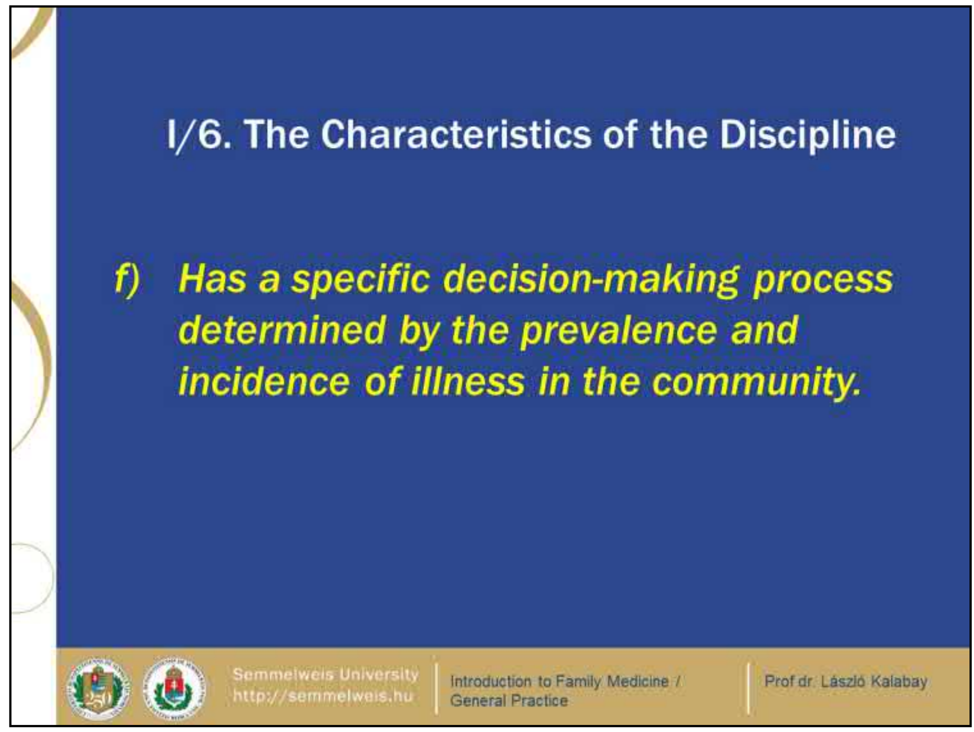


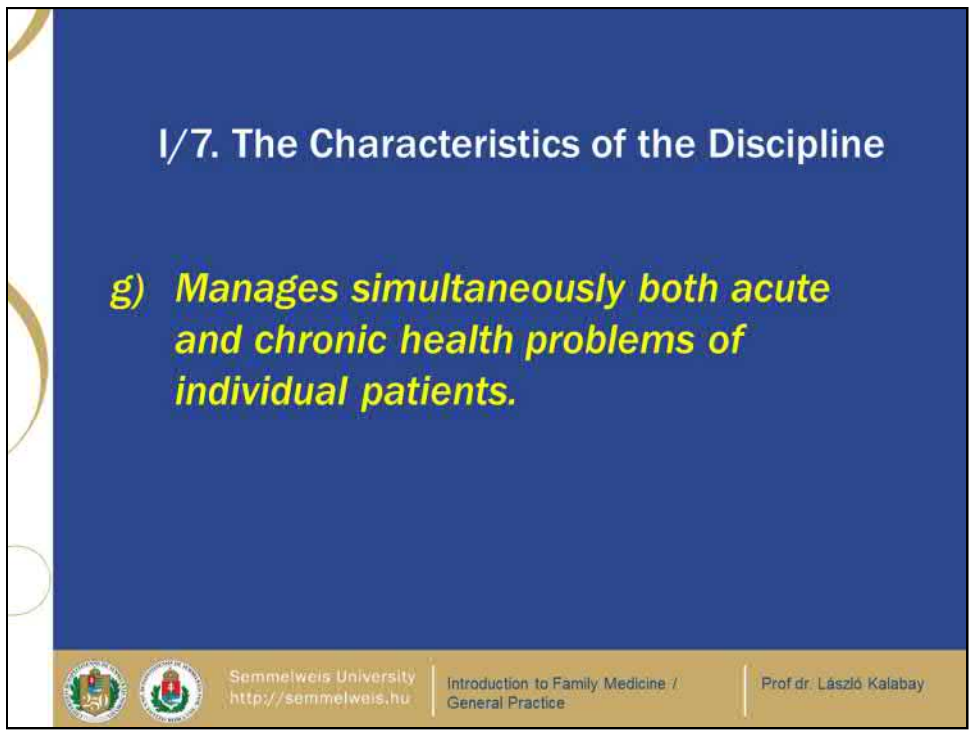
Each contact contributes to an evolving story, and each individual consultation can draw on this prior shared experience.



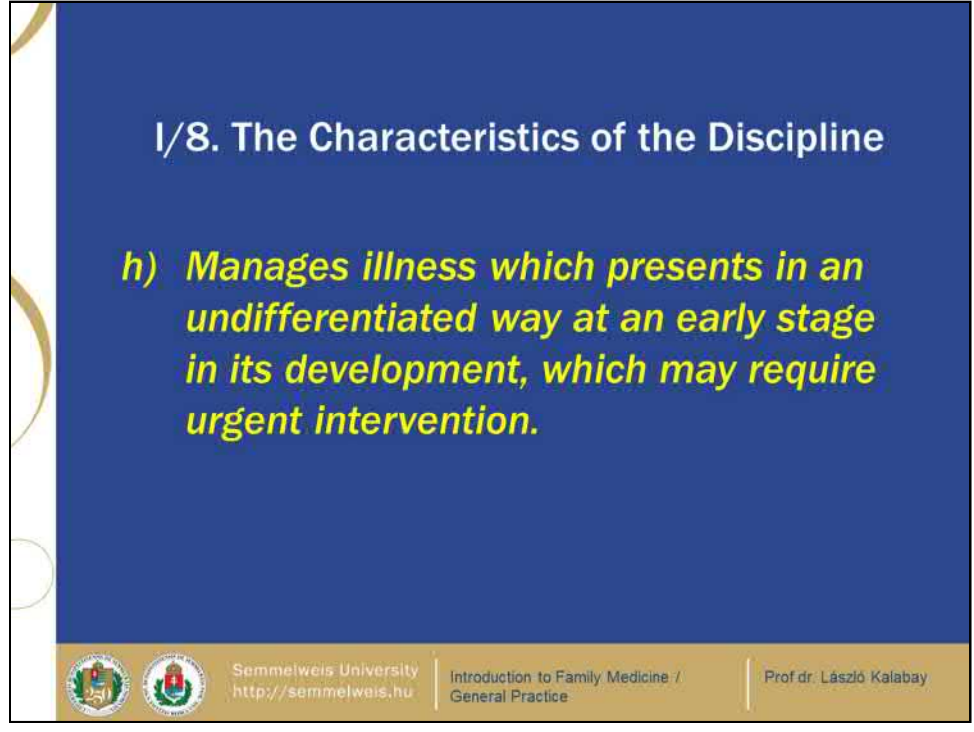
The approach must be constant from birth (and sometimes before) and death (and sometimes afterwards). Health care is provided throughout the 24 hour, commissioning and coordinating such care when they are unable to provide it personally.



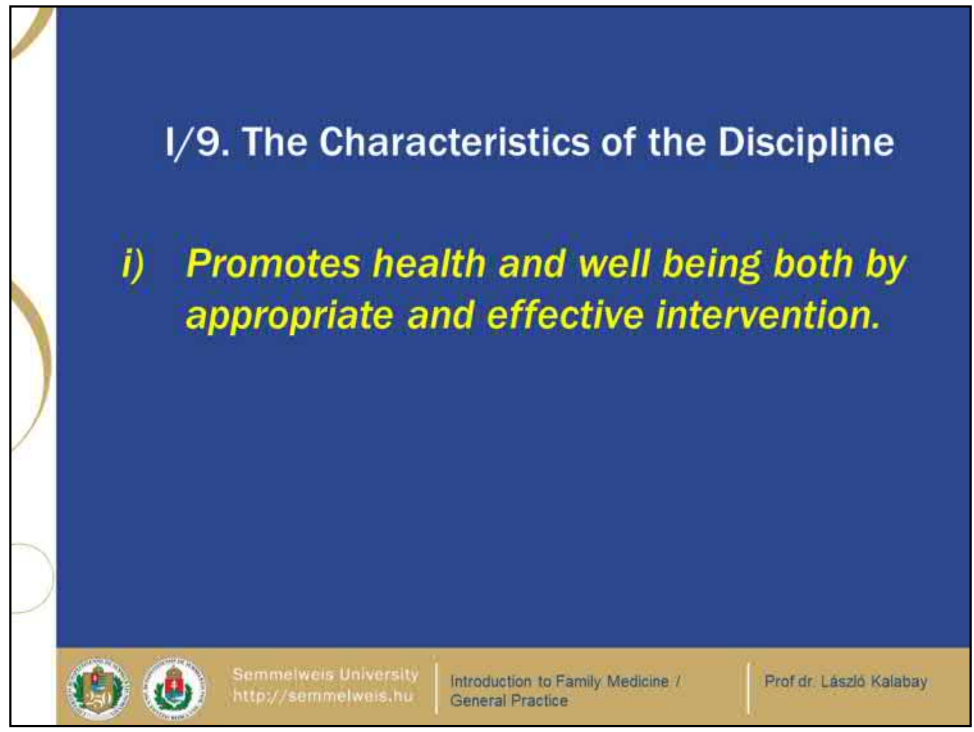
Problems are presented to family doctors in the community in a very different way from the presentations in secondary care. The prevalence and incidence of serious diseases presents less frequently. Reassurance is a common task, following exclusion of such illness.



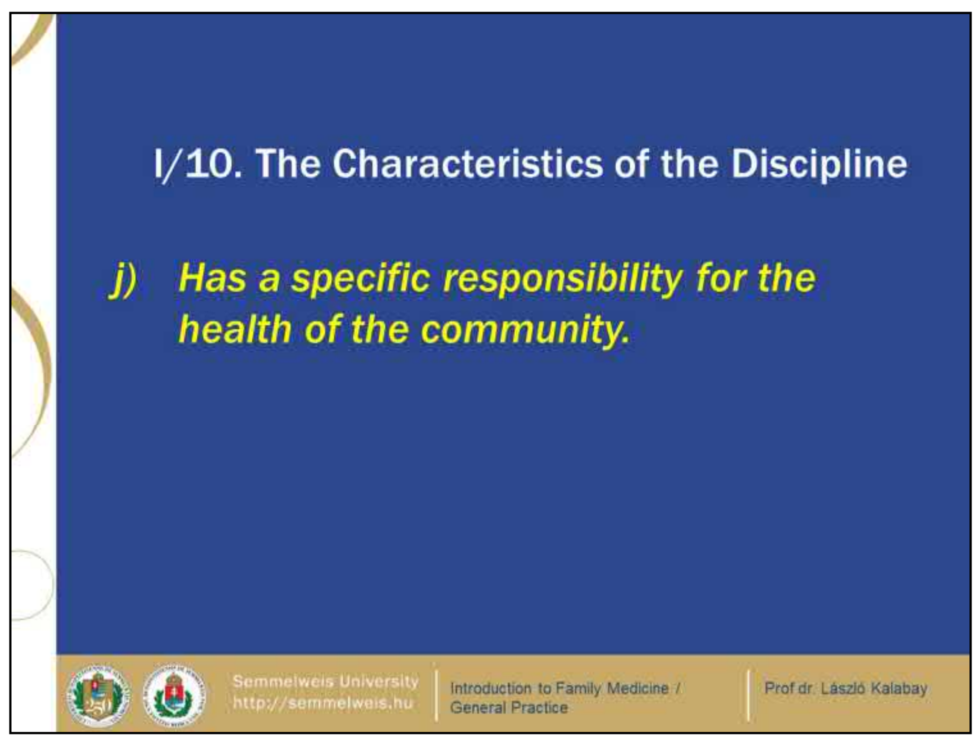
Family Medicine must deal with all of the health problems of the individual patient. A hierarchical management of the problems should be set up, which takes account of both the patient’s and the doctor’s priorities.



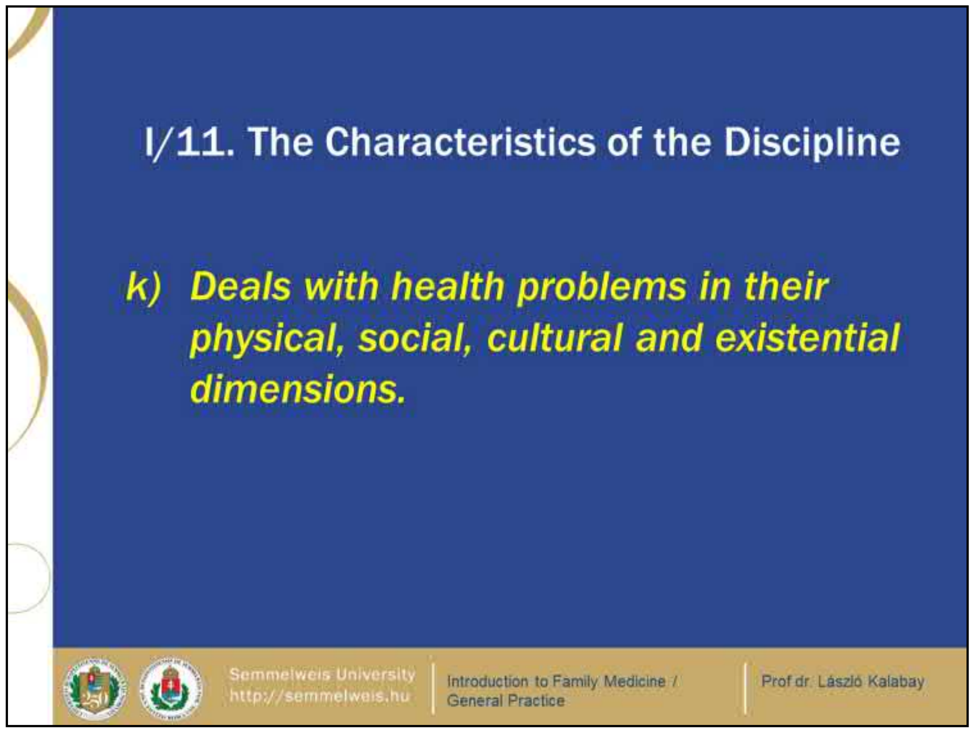
It is difficult to make the Dx at early stage. Important decisions have to be made on basis of limited information. Early signs are often non-specific. Thus risk management is a key feature of the discipline.



Intervention must be based on sound evidence whenever possible. When none is required it may cause harm and wastes valuable health care resources.



On occasions this will produce a tension and can lead to conflicts of interest, which must be appropriately managed.



The discipline has to recognise all these dimensions simultaneously, and to give appropriate weight to each. Illness behaviour and patterns of disease are varied by many of these issues and much unhappiness is caused by interventions which do not address the root cause of the problem of the patient.

II. The Speciality of General Practice / Family Medicine 1

General Practitioners:

- Are specialist physicians trained in the principles of the discipline.
- Are personal doctors, primarily responsible for the provision of comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness.
- Care for individuals in the context of their family, their community and their culture, always respecting the autonomy of their patients.

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A definition of the discipline and of the specialist family doctor must lead directly the core competencies of GP/FD. Core means essential to the discipline, irrespective of the health care system in which they are applied. The 11 central characteristics that define the discipline relate to 11 abilities that every specialist family doctor should master. They can be clustered into six core competencies.

II. The Speciality of General Practice / Family Medicine 2

General Practitioners:

- Recognise they also have a professional responsibility to their community.
- In negotiating management plans with their patients they integrate physical, psychological, social, cultural, and existential factors, utilising the knowledge and trust engendered by repeated contacts.
- Exercise their professional role by promoting health, preventing disease and providing cure, care or palliation.

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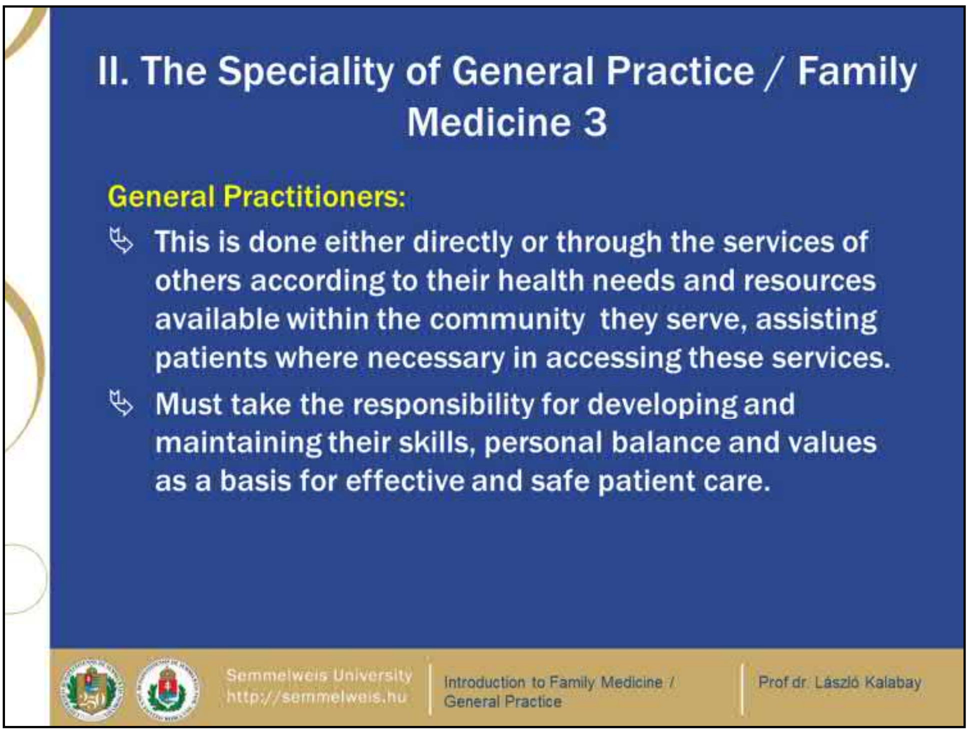
This should guide and be reflected in the development of related agenda's for teaching, research and quality improvement.



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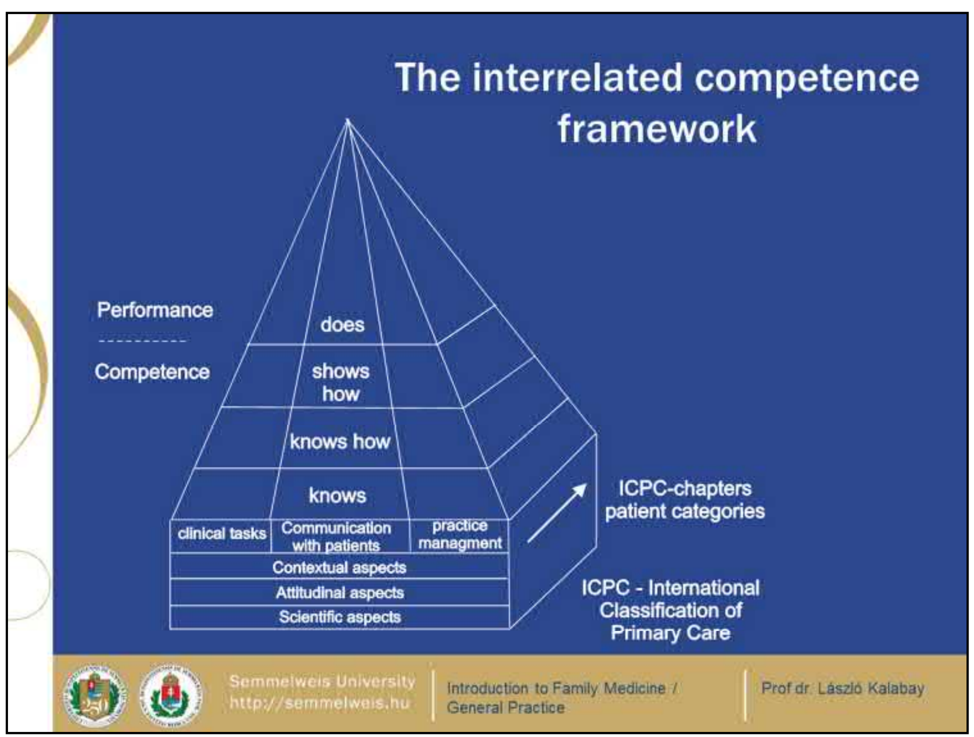
The core competencies of the GP/FM.



There should be a clear border of the GP's competencies: what he is supposed to do, to know or know about.

Point of first medical contact except major trauma. Essential and the first resource.

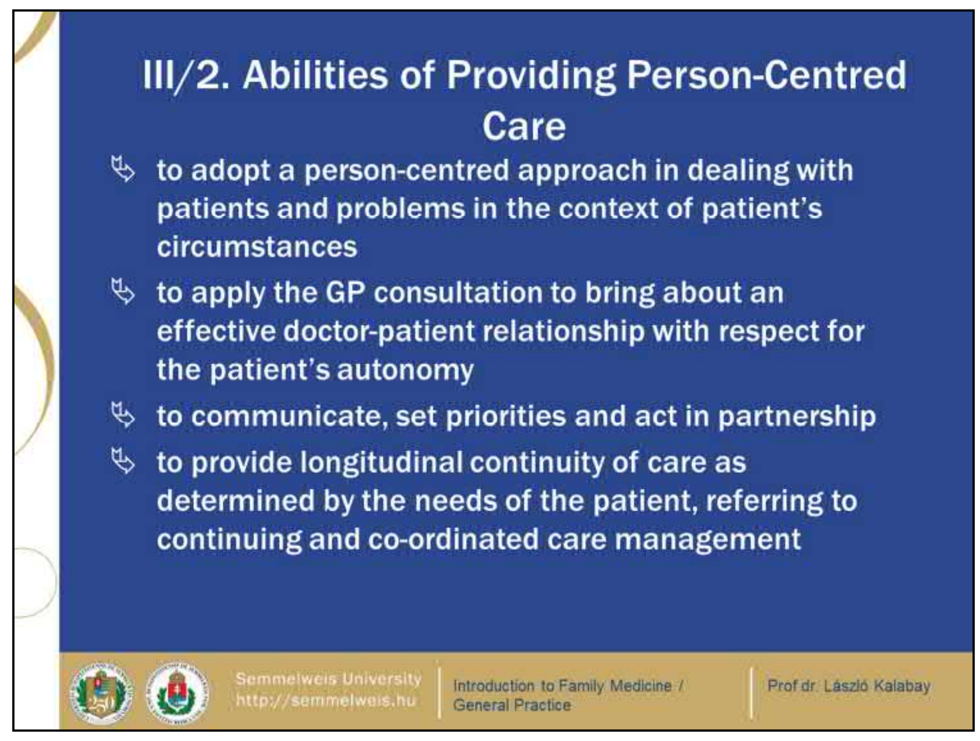
Providing open and unlimited access to its users - should be no barriers to access.

Dealing with all type of health problems regardless of the age, sex, or any other characteristics of the person concerned

GP should deal with all types of patients.

Makes efficient use of health care resources through co-ordinating care, working with other professionals in the primary care setting. This co-ordinating role is a key feature of the cost-effectiveness of good quality of primary care - ensuring that pt. see the most appropriate health care professional for their particular problem. Developing team work around the patient if the structural conditions allow.

Managing the interface with other specialities taking an advocacy role for the patient when needed protecting pt. from the harm of unnecessary screening, testing, and treatment, and also guiding them through the complexities of the health care system.



The abilities of providing person-centred care

III/3. Specific Problem Solving Skills 1

- to relate specific decision making processes to the prevalence and incidence of illness in the community
- to selectively gather and interpret information from history taking, physical examination, and investigations and apply it to an appropriate management plan in collaboration with the patient

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Problems are presented to GPs in the community in a very different way from the presentations in secondary care. The prevalence and incidence of illnesses is different from that which appears in a hospital setting and serious disease presents less frequently, because there is no prior selection.

This is requires a specific probability-based decision making process which is informed by a knowledge of patients and the community.

Frequently the GP has to reassure those with anxieties about illness having first determined that such illness is not present.

Many of the problems presented to the GP have no basis in pathology, no biomedical cause for the distress that is presented by the patient, and it is important to know when to stop investigating whilst continuing to care.

III/3. Specific Problem Solving Skills 2

- to adopt appropriate working principles e.g. incremental investigation, using time as a tool, and to tolerate uncertainty
- to intervene urgently when necessary
- to manage conditions which may present early and undifferentiated way
- to make effective and efficient use of diagnostic and therapeutic interventions

GP manages illness which presents in an undifferentiated way at an early stage in its development, which may require urgent intervention.

The patient often comes at the onset of symptoms, and it is difficult to make a diagnosis at this early stage. That means that important decisions have to be taken on the basis of limited information, and the predictive value of clinical examination and tests is less certain.

Early signs are often non-specific and common to a lot of diseases.

Having excluded an immediately serious outcome, the decision may well be to await further developments and review later.

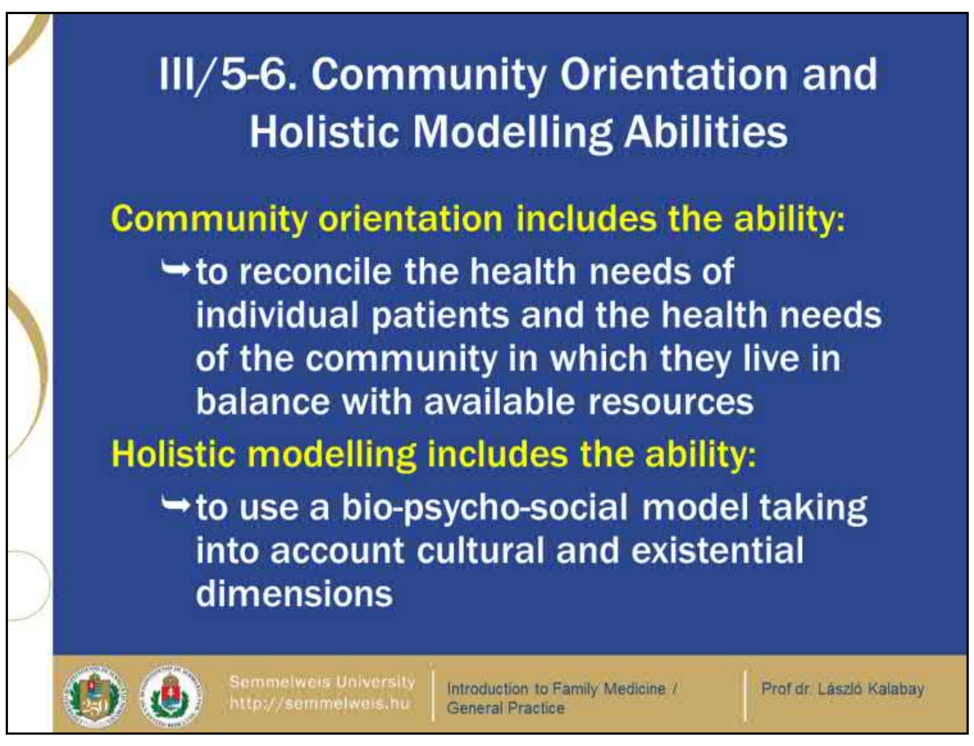
The result of a single consultation often stays on the level of one or several symptoms, sometimes an idea of a disease, rarely a full diagnosis.

GP manages simultaneously both acute and chronic health problems of individual patients. He cannot limit to the management of the presenting illness alone, often have to manage multiple problems.

The patient often consults for several complaints, the number increasing with age. The simultaneous response to several demands renders necessary a hierarchical management of the problems which takes account of both the patients' and the doctor's priorities.

Interventions must be appropriate, effective and based on sound evidence whenever possible.

Intervention when none is required may cause harm, and wastes valuable health care resources.

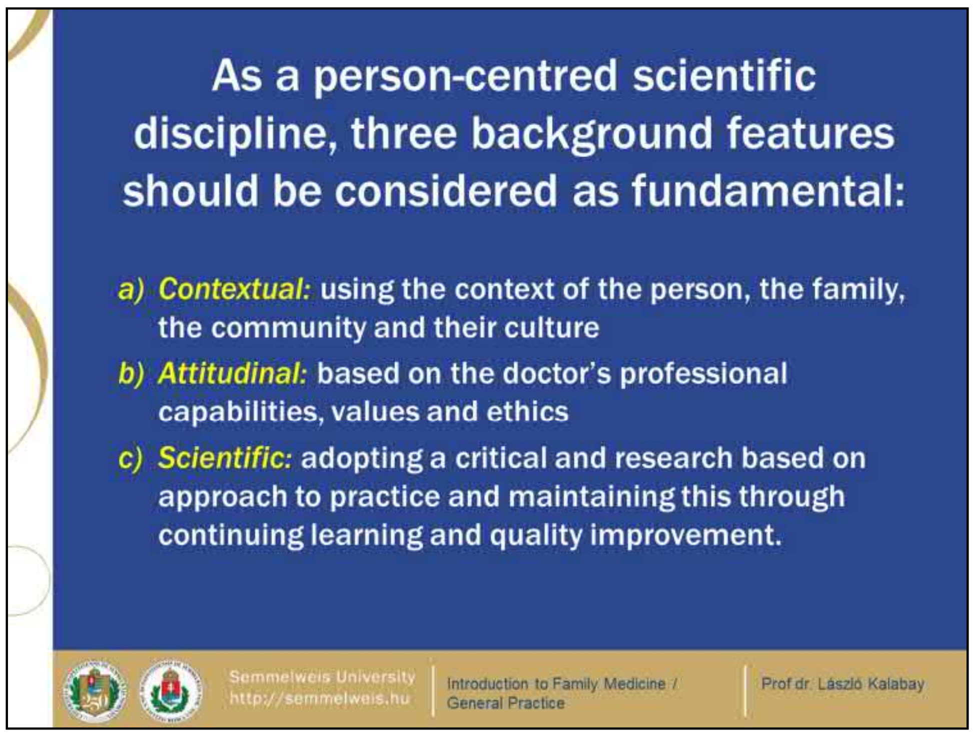


The GP has a specific responsibility both to the individual patient and to the health of the wider community in dealing with health care issues. On occasions this will produce a tension and can lead to conflicts of interest, which must be appropriately managed.

Maximise equitable distribution of services to all members of society.

The GP deals with health problems in their physical, psychological, social, cultural and existential dimensions.

Recognise all these dimensions simultaneously, and give appropriate weight to each. Illness behaviour and patters of disease are varied by many of these issues and much unhappiness is caused by interventions which do not address the root cause of the problem for the patient.



This is the root of the WONCA tree

This is the trunk of the WONCA tree.

This and the next slides summarize the negative characteristics, attitudes and practices of the GP. These should be avoided.

GMP for GPs - Good clinical care 2
The excellent GP
The unacceptable GP
•Does not possess or fails to use appropriate diagnostic and treatment equipment
•Consistently undertakes inappropriate investigations
•Show little evidence of a coherent or rational approach to diagnosis
•Draws illogical conclusions from the information available
•Gives treatments that are inconsistent with best practice or evidence
•Has no way of organising care for long-term problems or for prevention
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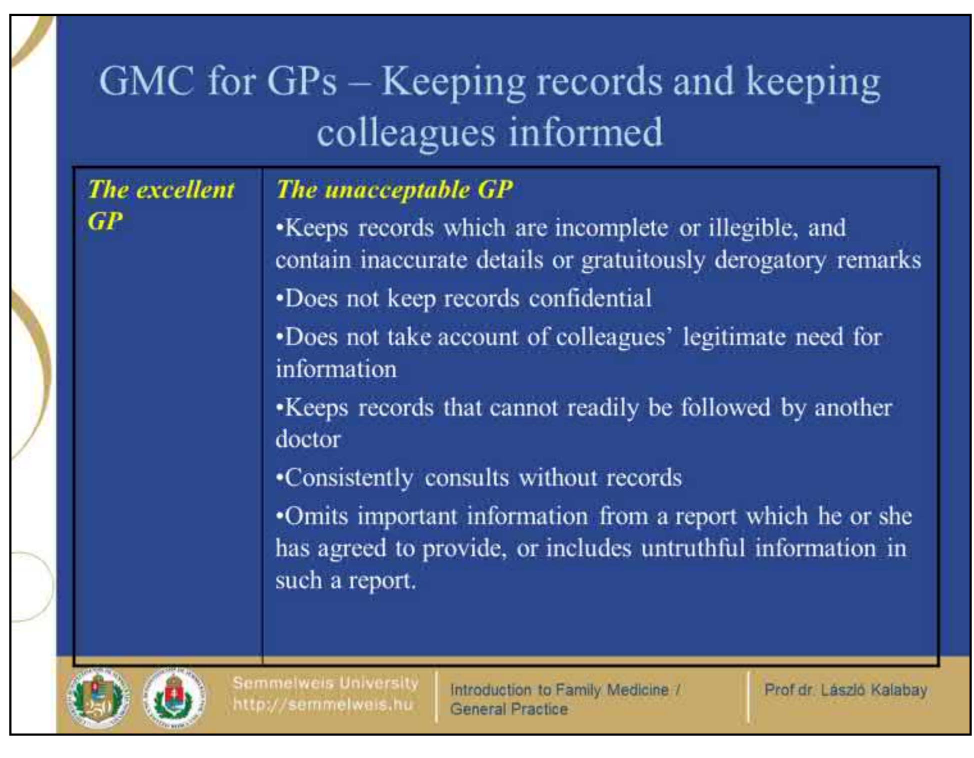
GMC for GPs – Keeping records and keeping colleagues informed
The excellent GP
The unacceptable GP
•Keeps records which are incomplete or illegible, and contain inaccurate details or gratuitously derogatory remarks
•Does not keep records confidential
•Does not take account of colleagues' legitimate need for information
•Keeps records that cannot readily be followed by another doctor
•Consistently consults without records
•Omits important information from a report which he or she has agreed to provide, or includes untruthful information in such a report.
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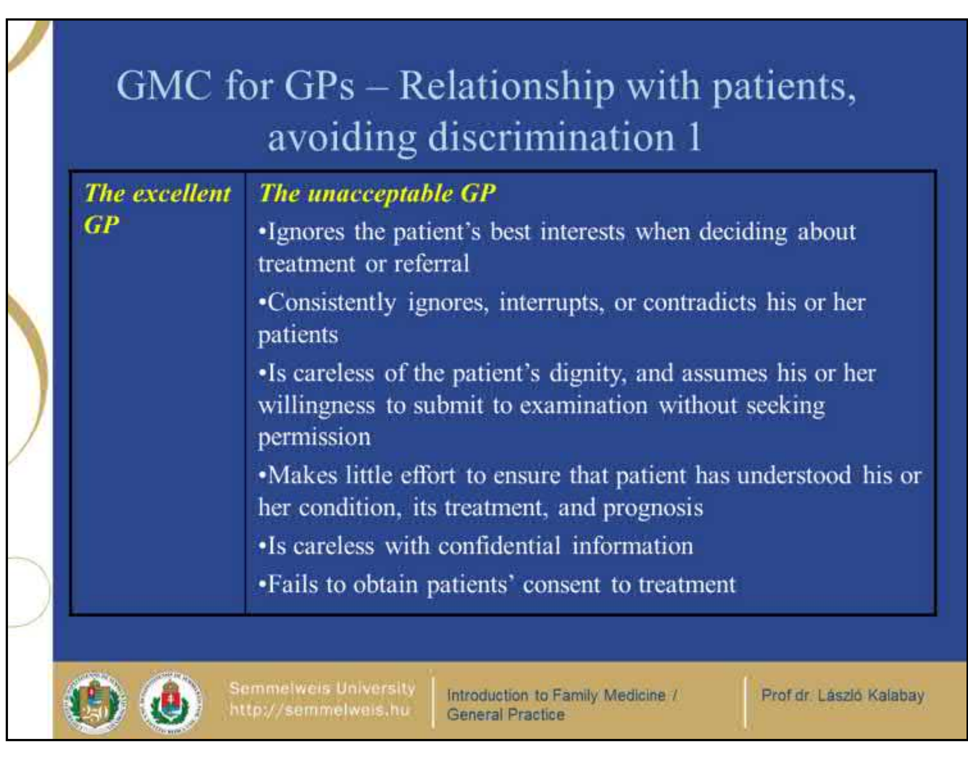
GMC for GPs – Access, availability and providing care out of hours

The excellent GP	*The unacceptable GP*
	•Has very restricted opening hours •Does not have adequate arrangements for patients to contact the practice by phone •Provides no opportunity for patients to talk to a doctor or a nurse on the phone •Cannot be contacted when on duty, takes a long time to respond to calls, or does not take rapid action in an emergency situation •Has no system for transferring information about out-of-hours consultations to the patient's usual doctor •Does not follow up relevant information about his or her patients that has been provided by another health professional.


GMC for GPs – Relationship with patients, avoiding discrimination 1
The excellent GP
The unacceptable GP
•Ignores the patient's best interests when deciding about treatment or referral
•Consistently ignores, interrupts, or contradicts his or her patients
•Is careless of the patient's dignity, and assumes his or her willingness to submit to examination without seeking permission
•Makes little effort to ensure that patient has understood his or her condition, its treatment, and prognosis
•Is careless with confidential information
•Fails to obtain patients' consent to treatment
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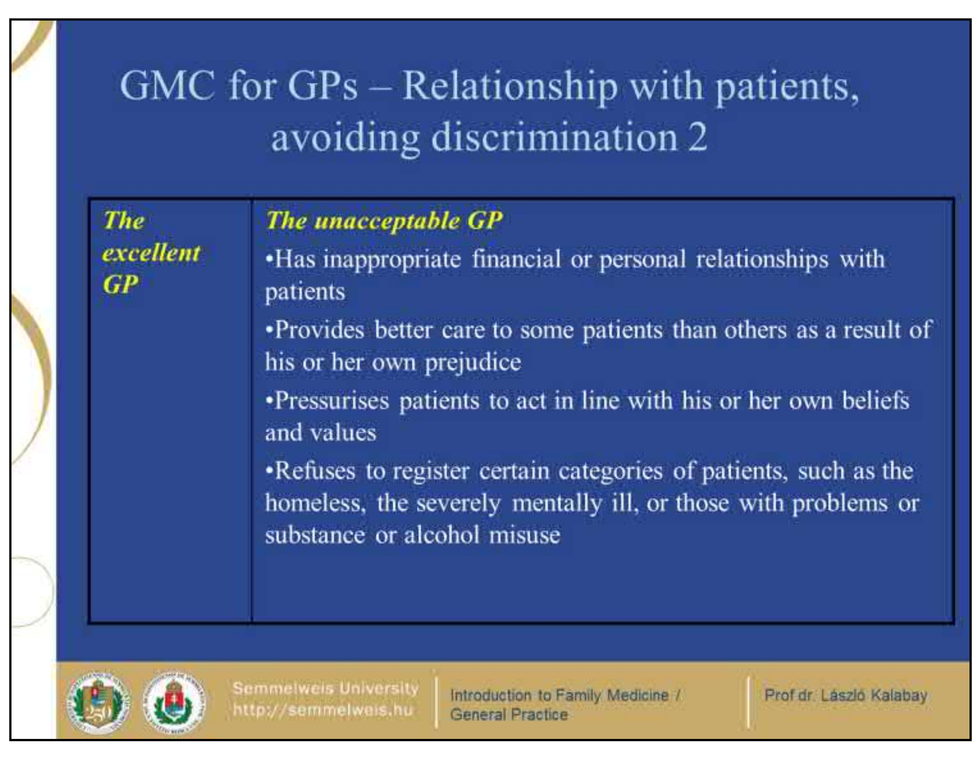
GMC for GPs – Relationship with patients, avoiding discrimination 2
The excellent GP
The unacceptable GP
•Has inappropriate financial or personal relationships with patients
•Provides better care to some patients than others as a result of his or her own prejudice
•Pressurises patients to act in line with his or her own beliefs and values
•Refuses to register certain categories of patients, such as the homeless, the severely mentally ill, or those with problems or substance or alcohol misuse
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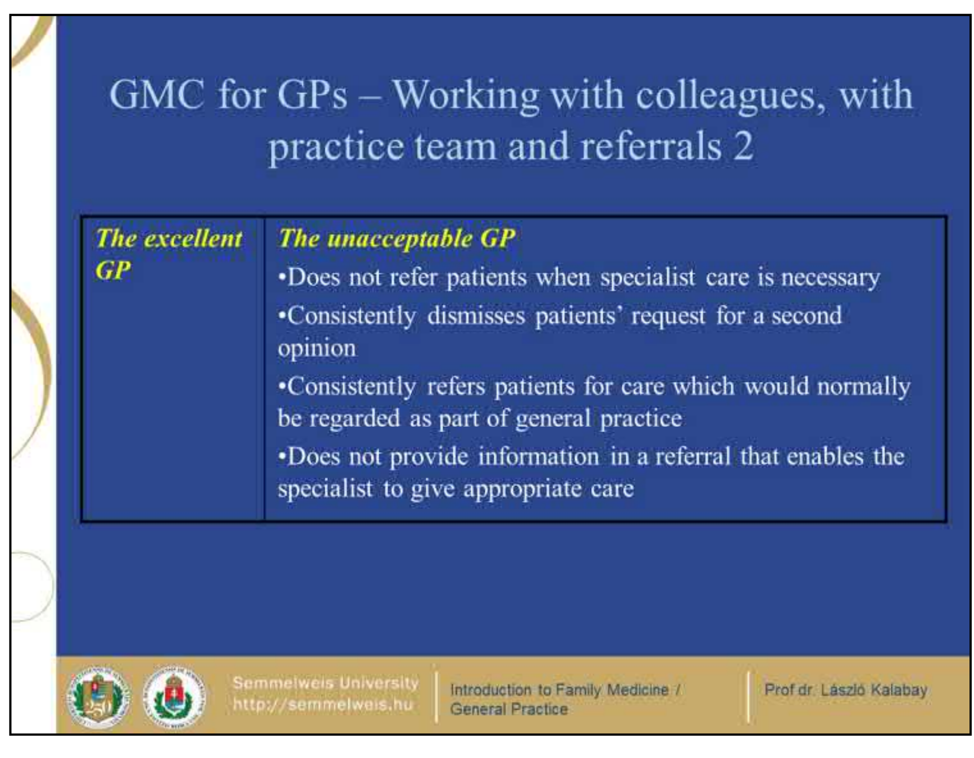
GMC for GPs – Working with colleagues, with practice team and referrals 1

The excellent GP	*The unacceptable GP*
	•Does not attempt to meet members of the primary care team (e.g. district nurses, health visitors), or even know who they are •Does not know how to contact primary care team members •Does not know what skills team members have •Delegates tasks to other members of the team for which they do not have appropriate skills •Does not encourage staff to develop new skills and responsibilities


GMC for GPs – Working with colleagues, with practice team and referrals 2
The excellent GP
The unacceptable GP
•Does not refer patients when specialist care is necessary
•Consistently dismisses patients' request for a second opinion
•Consistently refers patients for care which would normally be regarded as part of general practice
•Does not provide information in a referral that enables the specialist to give appropriate care
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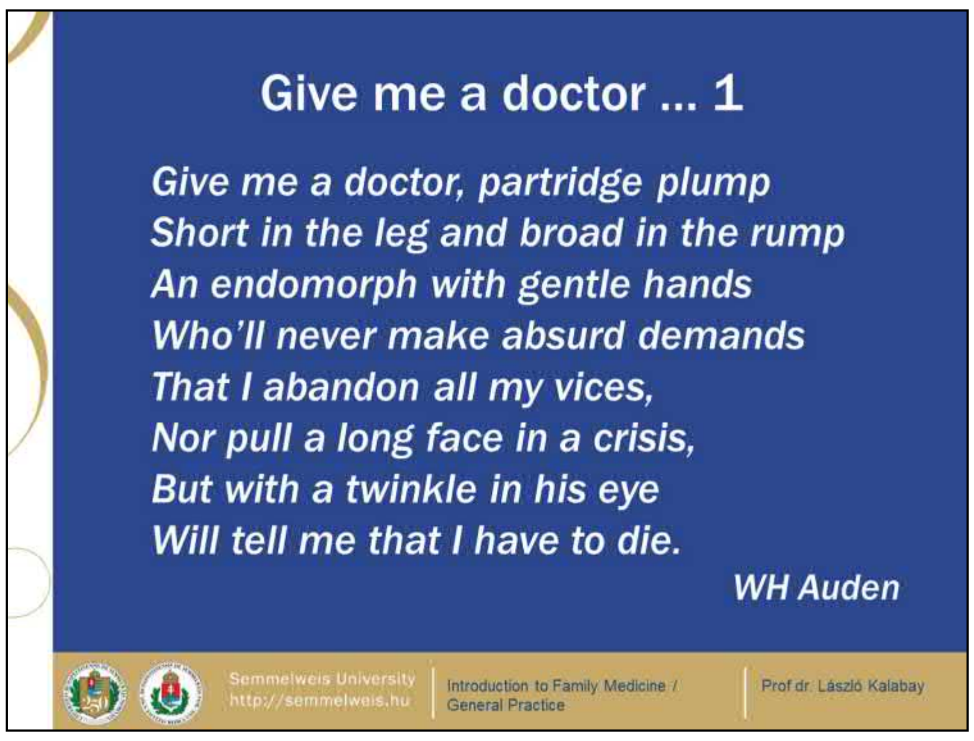
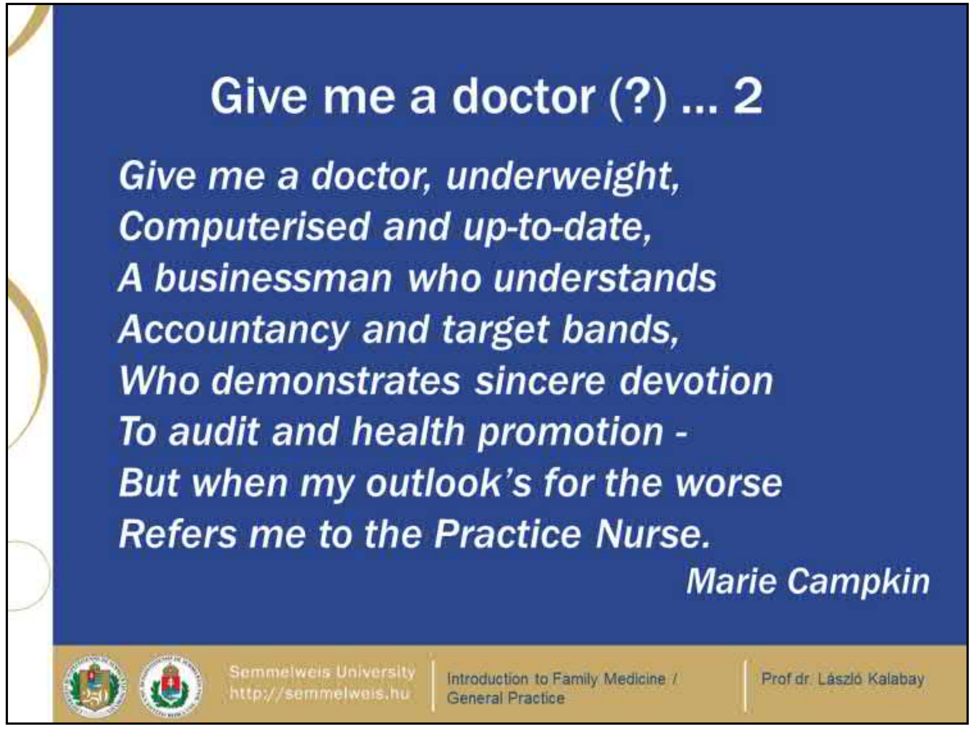


Will you chose this doctor as yours?



Or will you register to him as a patient?

Thank you for your attention.

Finally please watch a short video: Norvég videó.mp4.