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He spent 14 years in private family practice before joining the Department of Family Medicine at Medunsa in 1989 as senior lecturer and clinical head of the KwaNdebele division.

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# THE EVOLUTION OF FAMILY MEDICINE AS INDEPENDENT DISCIPLINE

**D**evelopments in medicine occur in response to various stimuli that could be scientific, technological or social in character. The traditional role of the general practitioner has developed due to these changes and therefore a new role player in the medical fraternity, called the **family physician**, has evolved. Family medicine is only one of many new disciplines that has developed in the course of medical history, and has evolved from an older branch of medicine - general practice. The term **general practitioner** was used for the first time during the early 19th century in *The Lancet*. The relationship between general practice and family medicine, however, is not a simple one<sup>1</sup>.

The modern medical profession has only been developing since the beginning of the previous century. Before that time there were a variety of healers, the minority of which were trained physicians. During the 17th and 18th centuries, physicians were a very small, élite group of trained people who were trained at a few European universities. They lived among and served the rich and influential people of their communities, performed no surgical procedures, provided no medication and did not associate themselves with the other, less qualified, healers.

Surgeons were artisans trained by apprenticeship and apothecaries were tradesmen selling medicines to patients. The physicians who were trained in Europe, and who returned to America, refused for many years to perform surgery or to supply medicines to their patients.

At the beginning of the 19th century, the

status of the surgeon and apothecary increased and their work became more medically oriented. Due to a slow process of socialisation and yielding to the claims of the community, surgeons and apothecaries became integrated with general practice surgeons to establish the modern medical profession. Surgical training improved and the movement away from general practice towards specialisation gained momentum.

The 19th century was an important period for general practice in Britain and America due to the influence of cultural, socio-economic and geographical factors<sup>2</sup>.

The industrial revolution in Europe caused an influx of many people to the towns and cities where there were no - or very few - organised healthcare facilities. The medical profession then organised itself into guilds and colleges but most physicians kept themselves busy caring for the rich in their mansions while the poor and indigent lacked health care.

Workers grouped together and for a few pennies a week they were assured of health care by general practitioners in the community. This was the start of prepaid medical insurance which was accepted as national policy in Britain during 1911 with the establishment of the **National Health Insurance Scheme**.

The **National Health Service (NHS)** was formed in 1948 by the merging of the **National Health Insurance Scheme** and the **Emergency Medical Service**, which was formed during the Second World War. The general practitioner plays a pivotal role in the NHS where a high quality service is rendered at an affordable cost to both the

**Are we different, unique? Is there place for family medicine in the medical school?**

**This series of articles helps to define where our own brand of medicine lies and what it is that makes family medicine a specialist discipline in its own right.**

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government and the patient.

At undergraduate level, training in general practice is done at all the medical schools in Britain and postgraduate vocational training has been compulsory since 1981 for anyone wishing to become a principal of a practice in the NHS.

The duration of training is three years, of which two years are spent in hospital rotations and one year in a training practice as a trainee. Most of the trainees sit the membership examination of the **Royal College of General Practitioners (RCGP)** after completion of their training, and every district hospital has a postgraduate centre where continuing education takes place.

The **American Medical Association** was established in 1847 by almost 250 doctors, to improve medical care in the whole country, and after 1900 it became actively involved in the improvement of training standards by campaigning against incompetent and superfluous faculties of medicine.

The 1910 Flexner Report was the main catalyst in the reform process and led to the closure of about 100 faculties.

Greater emphasis was placed on the biomedical sciences as a foundation for medical training and practice. The rapid development of specialisation since 1930 led to the ratio of general practitioners to special-

ists in the USA changing from 80:20 in 1930 to 20:80 in 1967.

The trend towards specialisation gained momentum through the 1950s and fewer physicians entered general practice.

In the early 1960s, leaders in the field of general practice began advocating a seemingly paradoxical solution to reverse the trend and correct the scarcity of general practitioners - the creation of still another speciality<sup>3</sup>.

The physicians envisioned a speciality that embodied the knowledge, skills and ideals which they knew as "primary care", which received official recognition in 1966. Three years later, the **American Board of Family Practice (ABFP)** came into being as the 20th speciality board, thus giving birth to the speciality of family practice.

In 1971 the American Academy of General Practice was renamed the **American Academy of Family Physicians** and this name change reflected a desire to increase emphasis on family oriented health care and to gain academic acceptance for the new speciality of family practice.

The ABFP was the first speciality board to introduce compulsory recertification every six years, to ensure the ongoing competence of its members by requiring at least 50 hours of acceptable continuing education each year (300 hours in six years) to be eligible for

recertification.

The consequence of this emphasis on quality of education, knowledge and performance is the prestige which the family physician enjoys in the American health system. Family medicine is now the only discipline in the medical fraternity which has training programs in all 50 states in the USA.

The College of General Practice of Canada was established in 1954 due to the need for postgraduate training and continuing medical education among general practitioners. The name was changed to the **College of Family Physicians of Canada (CFPC)** in 1967 and it is now responsible for the accreditation of the training programs at the Departments of Family Medicine of all the faculties of medicine in Canada.

The first three training programs in family medicine in Canada were started at the University of Calgary, McMaster University and the University of Western Ontario in 1966, while the first chair was established two years later. Training programmes are now run by all 16 medical schools in

Canada with the following four traits: supervised training by a trainer in a training practice; hospital-based training with rotation in internal medicine, paediatrics and obstetrics; clinical teaching with course work, seminars, ward rounds and patient studies; and an elective period where the trainee can gain experience in any field.

The first Faculty of Medicine in Australia was established at the University of Melbourne in 1864. There are currently ten faculties of medicine with Newcastle, the latest, being established in 1973. Each faculty has a Department of Family Medicine or General Practice.

The **Royal Australian College of General Practitioners (RACGP)** was formed in 1958 and is a leader in the field of medical education for general practice. The **New Zealand College of General Practitioners** is the only organisation in New Zealand with the sole purpose to improve the quality of primary medical care, and views the improvement of both the under- and postgraduate training in family practice as the best way to achieve its aims.

The College represents about half of the general practitioners in the country and is involved with health care organisations at all levels concerning primary medical care. It is also considered as the main source of information for general practitioners who are not involved in rendering a service in hospitals, except obstetrics.

From this short description of the histori-

*"During the 17th and 18th centuries physicians were an elite group who performed no surgical procedures, provided no medication and did not associate themselves with other, less qualified healers..."*

cal evolution of family medicine as an independent discipline, it seems clear that change has been brought about not only in reaction to the changing expectations of patients, communities and physicians as a whole; but more particularly, by the increased demand for personalised medical care.

In countries where general or family practice has been developing best, the following factors played a decisive role:

- A reduction in the number of family physicians as a result of an increased tendency towards specialisation during the previous four decades
- A limitation on the availability of health care, fragmentation of medical services and impersonal primary medical care
- The absence of comprehensive care, escalation of the cost of medical care and the maldistribution of primary medical manpower and
- The channelling of available financial and other resources from primary care to curative, secondary and tertiary care facilities.

Even though family practice has been expanding throughout the world, many countries still do not have family doctors, due to conceptual, political, financial and professional barriers<sup>4</sup>.

The status of family practice can be divided into

three levels, based on the degree of postgraduate training and career development:

- Level I: No identified system of postgraduate training of family physicians, eg. in most of Africa and eastern Europe.
- Level II: Postgraduate training programs being developed for family physicians, eg. South America, the southern European countries, Russia, China and India.
- Level III: Established postgraduate programs for family physicians, eg. Canada, United States of America, United Kingdom, Australia, New Zealand, Middle East, Egypt, Nigeria and South Africa.

The following barriers to the global development of family practice have been described by Haq *et al*<sup>4</sup>:

- Failure to appreciate that family medicine is a speciality.
- Failure to understand the need to integrate clinical and community health skills.
- Failure to understand the need to integrate preventive and curative care.
- Preference for selective over comprehensive care.
- Historical trends towards medical subspecialisation.
- Increased dependence on tertiary care technologies.
- Disproportionate funding of tertiary care.

- Preference for urban versus rural health development.
- Low intra-professional status of family physicians.
- Limited training opportunities in primary care.
- Lack of family practice leadership and role models.
- Medical education biased toward subspecialty training in hospital settings.
- Lack of commitment to comprehensive, accessible, primary health care.

The authors<sup>4</sup> propose the following strategies for successful global development of family practice:

- Obtain political and financial support for universal access to primary care.
- Integrate public health and medical care.
- Upgrade the status of general practitioners.
- Develop family physician faculty and clinician role models.
- Develop undergraduate medical school curriculum.
- Engage subspecialists in training and work with family physicians.
- Develop postgraduate (residency) curriculum.
- Develop organisations of family physicians.
- Establish specialty board certification with national medical society status.
- Encourage governments to

take a more active role.

- Involve leadership of international health organisations.
- Work with leadership of international family medicine organisations.

These historical events are not irrelevant to the position of the medical profession, and for the family physician in particular. There are two lessons that should always be pondered<sup>1</sup>:

*If the profession is failing to meet a public need, society will find some way of meeting the need, if necessary by turning to a group outside the profession; and*

*Professions evolve in response to social pressures, sometimes in ways that conflict with the expressed intentions of their members.*

Family medicine has evolved over the past century to become an important partner in the rendering of comprehensive, continuing care in a personalised manner to patients of all ages and their families, regardless of the presence of disease or the nature of the presenting complaint.

We should take cognisance of this evolution and the problems encountered on the way to the discipline's adulthood in order to prevent making the same mistakes, and we should build on the foundation laid. ●

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