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Rukhsana Wamiq Zuberi

*Aga Khan University*, [rukhsana.zuberi@aku.edu](mailto:rukhsana.zuberi@aku.edu)

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# **FAMILY MEDICINE: A BRIEF REVIEW OF ITS HISTORY AND CONCEPTS AND ITS RELEVANCE TO PAKISTAN**

Pages with reference to book, From 102 To 106

Rukhsana W. Zuberi ( Department of Community Health Sciences, The Aga Than University Medical Centre, Karachi. )

## **INTRODUCTION**

In most countries of the world some form of family medicine is being practiced by members of the medical profession. In over fifty countries distinct practitioners of this form of medicine are recognized and in some countries formal designation as specialists is accorded to them. In certain countries the physicians are called family practitioners and in others they are called general practitioners. Both terms are correct as these physicians have broad-based clinical skills (generalists) and also take care of the families. In Pakistan health care is usually available only to those who can afford it. A large segment of population consists of people struggling to survive, who also carry a disproportionately heavy load of illness (L. Lee. Family Medicine; Some concepts, unpublished data, 1987). Furthermore, the health care system lacks a solid base of primary care physicians, both in number of practitioners in areas of greatest need and the quality of care provided. Competition in primary care private sector between family practitioners and specialists frequently leads to ineffective or inefficient utilization of scarce resources. Specialists with hospital based experience may tend to over-utilize the diagnostic and treatment modalities when dealing with first contact presentations, while general practitioners with inadequate training/experience are in general poorly prepared to provide scientific, comprehensive and flexible care to the community (B. Mi, R. W. Zuberi and B. Inam, unpublished data, 1990). The lack of referral facilities, in the case of the latter, compounds the issue. The broad-based training in family medicine, the high quality ambulatory clinical care and the strong community medicine base may fulfil many varied functions and meet the obvious deficiency in the health manpower training and development in Pakistan. It may also be a major solution to face the daunting challenge of health for all (A.H. Jiwani. The question of residency training in primary care unpublished data 1987).

## **THE HISTORY OF FAMILY PRACTICE**

Historically, family medicine represents the common trunk from which the various branches of medicine emerged and later developed as separate specialities and sub-specialities<sup>1</sup>. But the acceptance of family medicine is a relatively recent one. It is now recognized as a distinct medical discipline, with a defined core of skills, a distinct body of knowledge and a set of attitudes and commitment. The realization that doctors entering this field require special preparation was a postwar II phenomenon.

### **In the United States of America**

Medical education became progressively more scientific and research oriented during the middle decades of the present century. There was an era in which technology seemed to promise solutions to every problem, specialists were seen as the best physicians and general practitioners went into decline. By the mid 1960s general practice seemed destined for extinction. The morale and self esteem of the practitioners was low, public image was poor, the field was generally unattractive to medical students and there were no departments of general practice (as it was then called) in the medical schools<sup>2</sup>. A comparison can be drawn to the present state in Pakistan. In the early 1970, there came a widespread disenchantment with speciality medicines. Specialists were perceived by the public and the Government as doctors who cared more about an organ or a group of diseases, but not about the patient as a person. American medicine was "doing better" but the people were "feeling worse". Legislation

was passed in 1974 as public law 94-484 for the return of the generalists physician. Departments of family medicine in medical schools/hospitals were created throughout the nation to train family physicians; who would understand and care for the physical diseases, behavioural and emotional problems of patients and who would be trained to care for the entire family. The Society of Teachers of Family Medicine was formed in 1967 and the American Board of Family Practice in 1974. By 1984 about 85% of American medical schools had established family practice training programmes or had become affiliated with them. Now nearly a quarter of all young doctors enter the family practice residency each year.

### **In the United Kingdom**

Similar conditions were operational in the United Kingdom as in the United States. The postwar era of specialization and sub specialization had nearly driven the general practice to extinction. Some rural practitioners, working singly and in isolation, practised obsolete medicine and presented a poor image indeed. About 15 years ago a handful of committed general practitioners assembled to form the Royal College of General Practice. Only lately, however, has there been a general acceptance of the proposition within the profession and beyond. Now no-one may enter general practice without vocational training, although certification is not mandatory. Formation of the Joint Committee on postgraduate training for general practice with its responsibility towards some mandates of the vocational training are recent advances<sup>1</sup>. Today, there are more doctors in general practice than in any other branch of medicine<sup>3</sup>. This change in popularity arose from professional as well as practical considerations. The appeal of general practice lies in the variety of medical experience it offers, its orientation towards persons rather than to diseases and its relative freedom from large impersonal institutions. The professional status of the speciality has also greatly improved due to the acceptance of general practice as a medical discipline and that a general practitioner will be recognized as competent only after appropriate training.

### **In Pakistan**

Traditional medicine in Pakistan has been the prerogative of hakims, vairs, faith healers and pirs. Homeopaths also offer a scope of alternate medicine. Some families had their own doctors, but we never entered into an era of family doctors. Medical graduates might prefer specialization and sub-specialization, but the large majority who qualify from the medical colleges of Pakistan, enter general practice (family medicine). Some doctors enter this field through choice, others because of financial constraints and still others because all else has failed. They do so without any training outside the walls of hospitals. Is it not incumbent on the teachers in medical colleges to train them in appropriate delivery of care? <sup>4</sup>. In 1986, The Aga Khan University Medical College was the first to incorporate the undergraduate family medicine programme within its curriculum. In 1990, the College of Physicians and Surgeons of Pakistan held the first diploma in family medicine examination. This was the start of the acceptance of family medicine in Pakistan as an entity and a separate discipline. In 1990, the Department of Community Health Sciences took on its first batch of family medicine residents. In 1992, the College of Physicians and Surgeons of Pakistan approved of a fellowship in family medicine, accepting it not only as a discipline but as a speciality in its own right. It is obvious that family medicine is a very young but steadily growing discipline.

### **THE NEED FOR FAMILY MEDICINE IN PAKISTAN**

The health care needs of Pakistan demand preventive and holistic care and the need for special training in the delivery of high quality comprehensive health care is becoming more and more evident. As 70% of our population resides in the rural areas, the training must incorporate rural experience and rural needs. Also, the delivery of health care should be appropriate to the pocket of the people and the Government. Secondary and tertiary care systems cannot function effectively if the primary care infrastructure and the link in between is missing. (Figure 1).

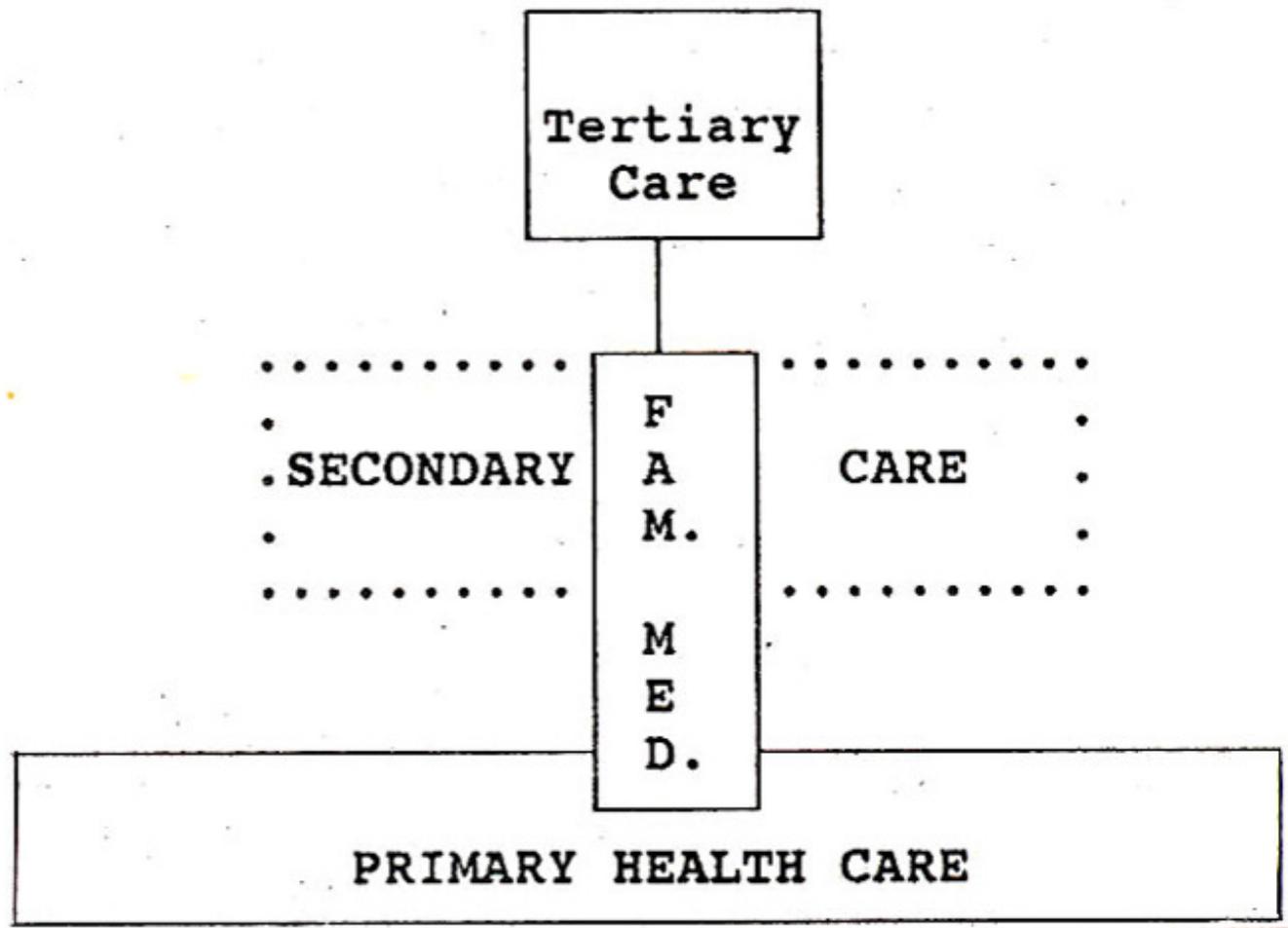


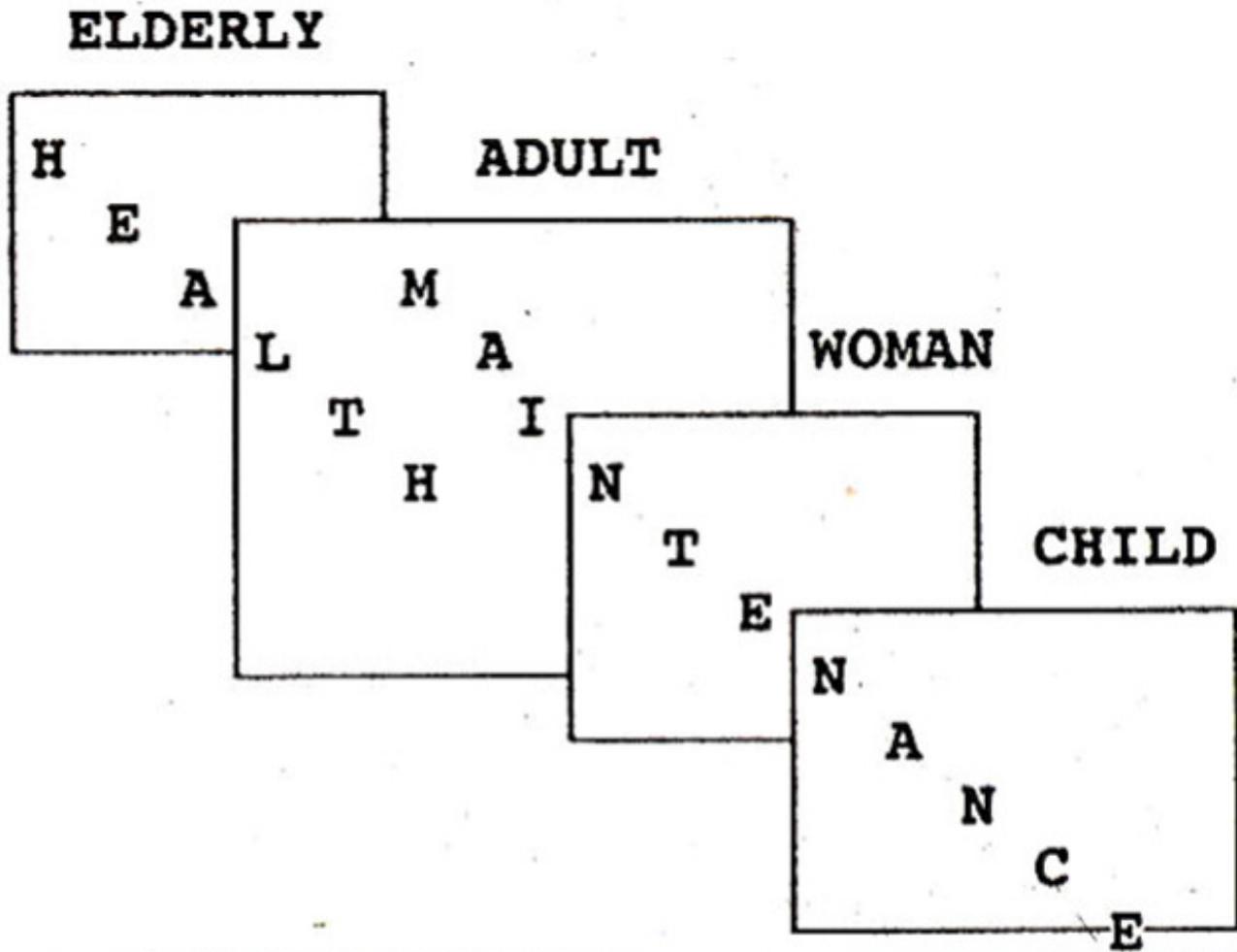
Figure 1. Family medicine; the missing link.

### **The need of Family Physicians**

The very real need for recognition and accreditation of family physicians, is directly related to the need for appropriate postgraduate training in family medicine. This should include continuing medical education programmes after entering practice, to discuss/acquire newer concepts, interventions and skills. Integration of primary, secondary and tertiary care must give direction to the delivery of health care and will alleviate the feeling of demoralizing isolation of family physicians.

### **The need of the family**

Families are made up of children, parents (adults) and grandparents (elderly). Women have a separate and distinct place in the population. Most health problems of women of child bearing age are different from those of postmenopausal women and are again different from those of adult males (Figure 2).



**Figure 2. Needs of the families; health problems according to ages and sex.**

The need of the family is not restricted to care when ill. Care must be available and delivered to maintain health. Family members should have the option of being under the care of one doctor; where the doctor understands the patient's problems within the framework of the family unit and is familiar with past problems through repeated interactions with the family.

**CONCEPTS OF FAMILY MEDICINE**

**Family Medicine: speciality in breadth**

Family medicine is a broad base speciality. The quantity of core knowledge and skills in family medicine are the same as those in other specialities and sub-specialities. They are along two different axes. (Figure 3).

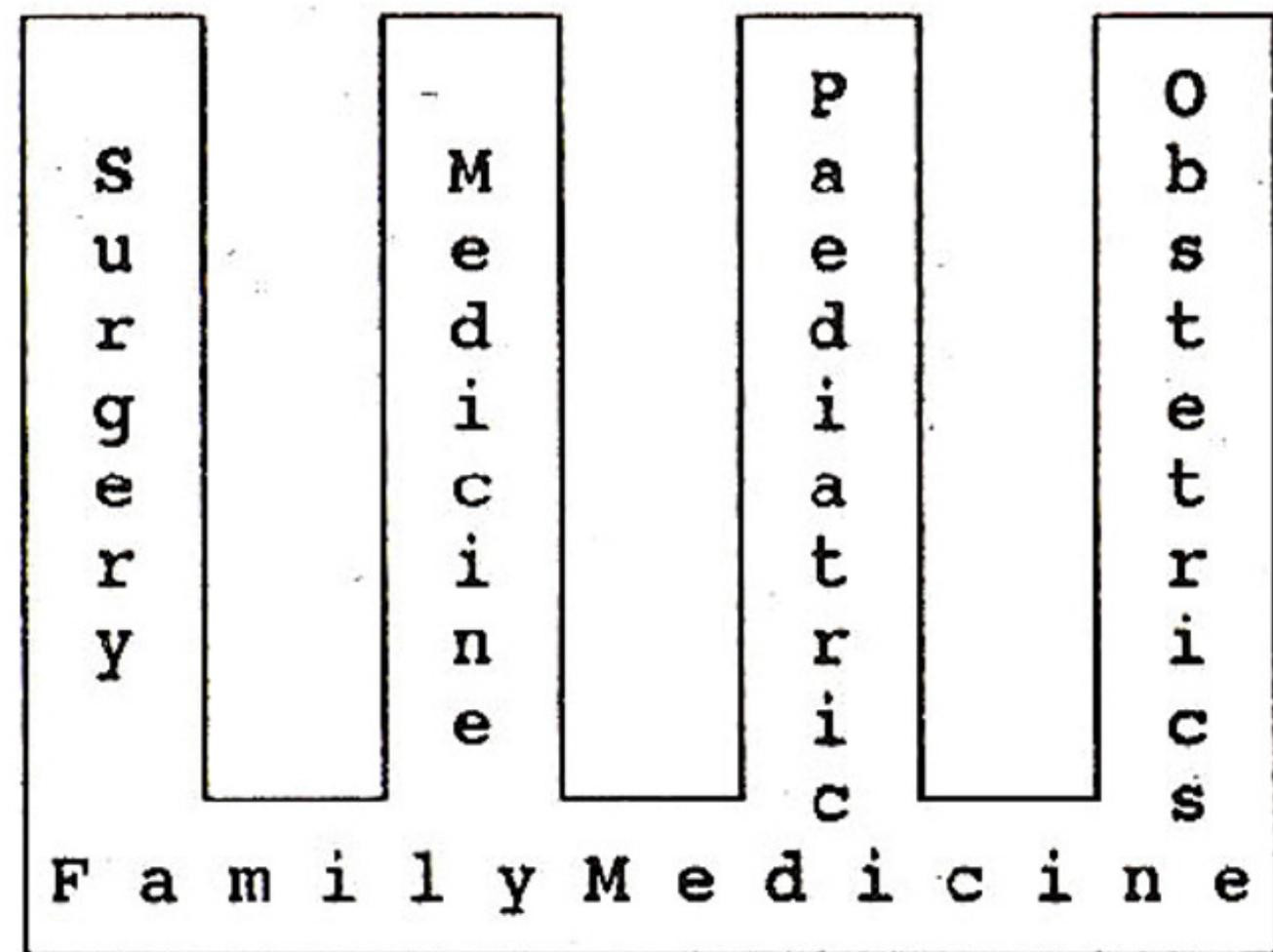


Figure 3. Family medicine; A speciality in health.

There are some basic concepts of family medicine which are different from other specialities<sup>5-7</sup>. These are as follows:

**1. Primary Care**

Primary care is first contact care. This is provided when the individual or the family first seeks help from a health care provider. It may be provided by paramedical staff, internists, pediatricians, family practitioners and to a restricted extent, by obstetricians and surgeons.

**2. Ambulatory Care**

In several countries and under special circumstances family practitioners provide hospital based care to patients, but the key-stone of family medicine is still ambulatory care.

**3. Community Care**

Family physicians must be available within the community for easy access for the people at time of need. They must also be aware of community concerns and help to work out ways of mobilization of communities into instruments for change. As most diseases in Pakistan are related to environment and life style, community care becomes an important aspect of family medicine.

**4. Comprehensive Care**

American studies have documented that a family physician working within the community can deal with 90-95% of the patients who come to him for care<sup>5</sup>. Only 5-10% need referral to consultants or admissions. When a physician can appropriately manage 90% of the health problems of the patients,

children and grandparents, he is able to deliver comprehensive health care to families. This is one of the major strengths of family medicine and no patients are excluded from care on the basis of their age or sex.

### **5. Holistic Care**

The doctor manages most of the varied health problems of the individual. The person is seen as a whole and not as an organ system.

### **6. Personal Care**

Medicine is sometimes taught with the idea that diseases exist and that the doctor's job is to treat diseases. Family medicine lays emphasis on the fact that it is the people who exist and they have different kinds of health problems. Personalized care is emphasized both in curative and preventive management.

### **7. Cost Effective Care**

The usual concept of cost effective care is that it is simple and cheap. It may not be either. It is the application of appropriate technology depending on the presenting problem, available resources and probable outcomes.

### **8. Continuity of Care**

Out of all the health care providers, family physicians are best able to maintain continuity of care seeing individuals and families over and over again. Continuous care is essential for management of chronic problems, e.g., diabetes mellitus, hypertension, heart disease, etc. These are life-long illnesses that the patients have to live with, where therapy and regular follow-up has to be the rule to keep the disease under control. Repeated visits offer golden opportunities to promote self-help, appropriate triage, preventive programmes and healthy life styles for the patients.

### **9 Special doctor-patient relationship**

The concept of continuity of care becomes particularly important in building trust and confidence leading to rapport development. The latter is a very special physician-patient relationship which, on the one hand, leads to a high degree of patient satisfaction about the care provided and, on the other hand, leads to a deep professional contentment<sup>8</sup>. This special relationship has been defined as having four components<sup>9</sup>:

(a) affinity, meaning bonding; (b) intimacy, mediated through the physical examination, where the patient is more willing to undergo further examinations by his own doctor rather than by a new doctor; (c) reciprocity, a sense of trust between doctor and patient. The patient trusts the doctor and the doctor trusts the patient and this leads on to continuity and (d) continuity, the last of the cycle and the beginning of the next.

### **10. Biopsychosocial Care**

Family physicians not only look after the diseases of patient/families but also delve into psychological and socio-cultural backgrounds. Addressing psycho-social issues is inherent to the practice of family medicine. It takes into consideration the thoughts, feelings, likes and dislikes of individuals and families. It takes into consideration the social status, the cultural and religious beliefs and how these may be modified and adapted to provide good health care. Counselling in health matters is equally, if not more, important than the drugs prescribed.

### **11. Health Maintenance**

Disease prevention, health promotion and disability reduction is interwoven into the very fabric of family medicine. This starts from the prenatal period, goes through childhood, adolescence, adulthood and old age to the grave<sup>10</sup>.

### **12. The proper utilization of ancillary personnel**

In the milieu of private practice this is crucial to the smooth running of the practice, where the health care team is responsible for a group of families.

REGULATIONS OF THE PAKISTAN MEDICAL AND DENTAL COUNCIL REGARDING

## GENERAL PRACTICE<sup>11</sup>

### 1. General Education Objectives

“The general objective of the MBBS curriculum should be to prepare a general purpose community oriented doctor who should be competent to deal with common health problems of the people on scientific basis and in accordance with the code of medical ethics prescribed by PMDC and should be able to continue postgraduate medical education in the speciality of his/her choice.”

### 2. Curriculum

#### General Principles (iv)

“Clinical teaching should partly be conducted in teaching hospitals (tertiary level) and partly in community health installations (primary level) when students should actually participate in the primary health care to experience the effect of social, economic and cultural factors in community setting and undertake community health projects.

6) General Practice - recommends that exposure of the medical students to the pattern of work that general practitioners face is extremely relevant and important. Therefore, students should visit clinics of selected general practitioners and take part in their work.

The department of community medicine should implement this project.

#### FAMILY MEDICINE TRAINING IN PAKISTAN

Family medicine is part of the undergraduate medical curriculum of the department of community health sciences at Aga Khan University. The curriculum is horizontally and vertically integrated (B. All, S. Abedin, R.W. Zuberi, unpublished data, 1987), with two weeks of family medicine in the third year, two weeks in the fourth year and eight weeks in the fifth and final year. While the students train in family medicine, they also strengthen their community medicine concepts and skills. At Aga Khan University, fresh medical graduates may choose to undergo six weeks training in family medicine as part of the community health sciences internship. There is a three years residency programme in family medicine<sup>12</sup> and several continuing medical educational programmes are held. The Pakistan Army Medical Corps has started a course to prepare their own medical officers to take the diploma in family medicine examination.

## CONCLUSION

The Pakistan Medical and Dental Council has laid down their requirements for training undergraduate medical students in general practice. Who is going to teach them? Is it going to be the community health doctors? or the specialists who are uncommitted to the very basic concepts of family medicine and untrained in the delivery of comprehensive care to the public? We need to develop faculty and trainers in this field. The College of Physicians and Surgeons of Pakistan has taken the first step of national accreditation and certification. The next step is to develop training sites with appropriate training. The graduates of the postgraduate family medicine programmes will form the future faculty for the medical colleges of Pakistan and a critical body of trainers in the community. The choice of practice sites is varied. The work may be university-based, hospital-based, community-based or in the rural areas. In due course of time, a practitioner will change as he gains experience and develops his expertise, adapting his practice to advances in medicine, changes in society, the practice site and his own inclinations and that is how it should be. Learning general practice is a life long test.

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