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The case for family medicine in Pakistan

Saniya Raghil Sabzwari

Abstract

The specialty of Family Medicine enjoys a special position in the medical practice of the West, serving as one of the key primary care specialties. Family physicians act as providers of first contact catering to the medical needs of the entire family in all aspects of preventive, curative and rehabilitative stages of illness and to health maintenance. The growth of this specialty, however, has lagged behind in Pakistan for various reasons. Having both a high burden of communicable and non-communicable diseases in Pakistan; family physicians should form the frontline force in dealing with these health issues.

Several success stories of Family Medicine forming the base of medical services have been noted, validating its presence and propagation. The World Health Organisation also supported this in its 2008 report that discusses primary care for all. Growth of family practice needs to be encouraged at both undergraduate and postgraduate levels to ensure adequate training and provision of quality of medical care to our society. The need of the hour is that both medical institutions and the government develop policies to strengthen Family Medicine and incentivise family practice in rural and urban settings to cater to the needs of society at large.

Keywords: Family medicine, Family practice, Primary care.

Introduction

The year 1969 ushered new horizons of discovery, possibilities and promise of a better future for mankind. Whereas the momentous event of man's landing on the moon and the first in vitro fertilisation of a human egg dominated the scientific and medical scene, another quiet landmark event occurred that year: the recognition of the 20th primary medical specialty in the US; the Family Medicine.

Historically starting as general practice, the roots of this specialty date back to the 1800s in America and the 17th century in England where the "Society of Apothecaries" was established. These apothecaries and the barber

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surgeons both evolved through the apprentice system and acted as medical providers of first contact in those days.¹

With the rapid medical advances, however, the 20th century saw a paradigm shift in medical care from a generalist to specialist practice that focused more on organs, diseases rather than individuals and families. The physician responsible for the grandfather's knee pain, mother's headaches and the child's fever took a back seat to the provider that dealt with specific organ systems, ages or gender fragmenting care of the patient as a whole.

As this specialist phenomenon grew in the medical world, the health community became aware of the need of a holistic provider who could deal with common day-to-day health issues of the child, parent, grandparent regardless of gender and age. Coming back full circle, the need for a patient-centred physician of first contact who could provide holistic care after structured training was once again realised and the specialty of Family Medicine came into being in the US.

England, on the other hand, had realised this much earlier, making general practitioners (GPs) the foundation of its National Health Services (NHS) in the 1940s and later establishing the Royal College of General Practitioners (RCGP) in 1952² with an aim to provide education, training to physicians and ensuring quality in healthcare provision of primary care.

Regionally, the focus on Family Medicine appears to have started in the early 1970s in Singapore, gradually maturing and evolving in structured training programmes in the 1980s and three-year postgraduate training in the 1990s.³

The concept of Family Medicine took roots in Pakistan as part of Community Medicine introducing concepts of primary, preventive healthcare in the undergraduate curriculum of a private medical school in the 1980s. GPs took on the responsibility of familiarising medical students with the principles of community ambulatory practice. However, the core model of family practice was seen later in the 1990s when the same university developed its first postgraduate training programme in

Family Medicine, recruiting medical graduates for a four-year training programme that encompassed the principles of holistic, cost-effective, patient and family-centred healthcare and wellbeing.

Since then two other medical institutions have introduced formal training in Family Medicine at a postgraduate level and another has added Family Medicine in its undergraduate curriculum.

We, however, have yet to embrace Family Medicine as a specialty both at the community and professional level. It struggles to firmly establish its place in a country where this specialty could be the answer for a vast majority of its health issues.

To understand the rationale for the need to develop and strengthen Family Medicine several issues have to be understood and acknowledged. Here below some well-known facts:

Present Disease Burden in Pakistan

According to WHO, Pakistan still faces a myriad of communicable diseases along with a rapidly increasing burden of non-communicable illnesses. Despite improved mortality and increasing lifespans, morbidity remains high; approximately one-third of adults in Pakistan have hypertension, 11-15% of our population is at risk for diabetes. In addition, more than 33% of our males smoke. Mortality of children under-5 still continues to be one of the highest in the region and 40% of our children under-5 suffer from malnutrition. Moreover, tuberculosis (TB) rates are still higher than regional countries.⁴

Healthcare provision in Pakistan

In addition to disease patterns and numbers, it is important to look at other healthcare statistics in our country. Pakistan is the sixth largest country in terms of population that is estimated to be more than 180 million.⁵ Our urban population has risen from 58 to 69 million in the last four years.

According to the Pakistan Medical and Dental Council (PMDC), there were 140,000 registered physicians in June 2014 of which approximately 30,000 are registered as medical or surgical specialists⁶ leaving 110,000 generalists to cater to the medical needs of 180 million; simply put, one physician for a little more than 1600 people (reasonable numbers). However, the ground reality is quite different.

Most of these specialists and generalists work in urban settings. Rural healthcare provision is primarily by government-run basic health units (BHUs) that are supported by ancillary health workers in the community

(lady health visitors), district hospitals and private practitioners. However, for 60% of our country's population that resides in rural areas, healthcare provision is suboptimal. Reasons cited are underutilisation of existing services, poor quality of care and unwillingness of physicians to work in rural settings due to poor remuneration, substandard facilities and equipment.⁷

Even though the government provides affordable healthcare, it fails to meet standards of quality. This is evident by the fact that only 0.5% of Pakistan's gross national product is spent on health.⁸ People seeking quality often seek private healthcare that is expensive and at times hard to access not only because of affordability of the private payer, but also a culture where specialist care is sought for most of its medical needs.

How can 30,000 specialists primarily situated in urban secondary and tertiary care settings cater to a population of 180 million of which approximately 110,000,000 reside in rural areas?

Just looking at one major health issue as an example for the need of a robust primary care system, when we look at mental health problems in Pakistan, as an example, depression and anxiety afflict about one-third of our population i.e. 60,000,000 people.⁹ for which only 300 psychiatrists are available in Pakistan, according to the 2007 figures of the Pakistan Society of Psychiatrists, i.e. one psychiatrist for 200,000 patients. The question of who can help tackle this fast-growing issue of mental illness at the frontline, therefore, automatically arises.

Current Medical Culture

Whereas most of the developed countries have come back full circle from generalist to specialist and back to the generalist assuming care of the masses, we still equate quality of care provision to specialist care. Several reasons exist to promote this belief in our country, foremost being poor or no postgraduate training of the general practitioner, lack of awareness on the part of the consumers driven to seek specialists for organ/disease related care and, most importantly, a poor understanding of the scope of general practice/family medicine by the medical community itself. This misconception is further strengthened by the ground reality of the neighbourhood doctor who sets up shop after an MBBS degree, giving unknown pills and injections for various ailments, at times providing substandard care but often succeeding in managing acute illnesses with little preventive or holistic care or health education.

Quality medical care in Pakistan is therefore considered the domain of the specialist who provides expert care but

often fails to integrate healthcare needs of the individual and family, resulting in people seeking multiple providers for multiple issues.

Whereas the role of the specialist is vital in dealing with complex health problems, specific procedures and on-going care of those in need, the vast majority of health problems fall within the realm of the family physician. As an example, it is very common for a patient to see a neurosurgeon for a back strain, and ear nose and throat (ENT) specialist for a sore throat, a cardiologist for hypertension and a gastroenterologist for acute diarrhoea; all subspecialists who, despite providing quality care, fail to address the overall health of the patient, rendering organ-specific care that is expensive, time-consuming and hard to access.

Anecdotal evidence also suggests that patients often have to endure long delays to see the limited number of specialists for simple issues e.g. uncomplicated hypertension. A more efficient healthcare system with family physicians serving as the initial provider would, therefore, cater not only to the basic needs of the large majority of patients, but also streamline those requiring complex care via specialists allowing them to focus on such patients making healthcare more accessible, effective and well-organised for all.

Scope of Family Medicine

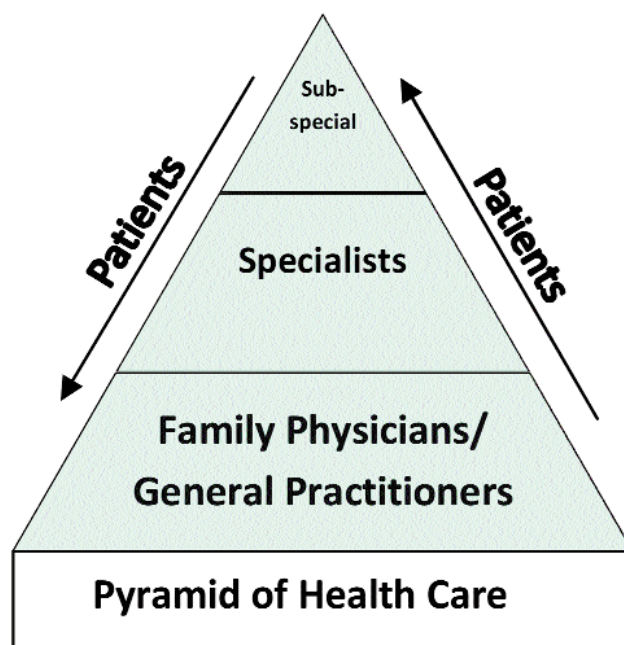
General or family practice is not commonly recognised as a specialty in Pakistan. As mentioned earlier, less than a handful of medical colleges include Family Medicine rotation in their undergraduate curriculum and only three to four postgraduate programmes exist for Family Medicine. Awareness of the scope of Family Medicine is limited to a physician capable of treating coughs and colds. An understanding of this field of medicine, therefore, becomes essential to break this myth about family practice.

A qualified family physician in the United States (Termed GP in Britain) undergoes a three-year training followed by an optional year that certain residency training programmes offer to further clinical experience in areas of rural health, obstetrics, paediatrics, geriatrics, sports medicine and academic tracks. Each resident goes through in-patient rotations of Internal medicine and subspecialties, paediatrics, obstetrics and gynaecology. Residents also spend time rotating through intensive care units (ICUs), orthopaedics, dermatology, psychiatry, ENT and ophthalmology, hence gathering a broad spectrum of clinical knowledge and experience encompassing common problems related to each specialty.

Moreover, these residents also spend time in geriatric settings like nursing homes, assisted living facilities, at times doing home visits to elderly patients receiving training and providing care in a much-needed and fast-growing segment of the population.

The training therefore equips each resident to deal with the diagnosis and management of common clinical problems across specialties while the home turf of Family Medicine places special emphasis on disease prevention and health promotion for the patient as well as the entire family of all ages. They are trained to be patient advocates, involving patients in their care and decision-making, serving as first point of contact for all health-related needs and referring when and as needed (Figure).

The patient would therefore see his family physician for his hypertension and diabetes on an on-going basis, visit his physician when febrile or for a sprained ankle or low back pain. In addition to all the above conditions, the spouse could also see the same physician for contraception, antenatal care, and common gynaecological problems. Their children could be seen for immunisations, common infections like diarrhoea, thereby covering the spectrum of acute, chronic and preventive care for all ages. Establishing long-term relationships and continuity of care also evokes trust between the patient and his physician¹⁰ and becomes a key factor in improved patient access and quality of care. Moreover, family physicians also act to coordinate care of



Figures: Healthcare pyramid.

many of their patients needing multiple care providers for complex health issues.

Many examples of the success of this model exist where better access and utilisation of services, cost-effective¹¹ quality of care provision have been reported.^{12,13} The WHO bulletin from 2008 reported the success of primary healthcare services in Brazil.¹⁴ The NHS, despite several deficiencies, had still managed to provide universal healthcare coverage for all through strengthening and refining its primary care provision.¹⁵ The WHO report of 2008, titled "Now More than Ever", very clearly delineated the complete plan of universal health coverage with primary care at its forefront.¹⁶

Misperception of what Family Medicine and Community Medicine are

Another common misconception in the medical community of Pakistan is the confusion between what Community Medicine and Family Medicine are. Community Medicine is a branch of medicine dealing with overall issues of the community at large with its focus on disease epidemiology, causative factors at large, and disease prevention encompassing some environmental, social and economic factors. Dealing with the individual patient as a whole in terms of disease prevention, diagnosis, treatment and on-going management falls more in the domain of Family medicine. Both often work in conjunction but fulfil vital but very different needs in the community.

Misconceptions about Terminology

Another common misconception both in medical and non-medical society is confusion between the terms GP (general practitioner) and Family Physician in Pakistan. A GP in Pakistan typically starts practice after medical college and does not have formal postgraduate training, whereas a Family Physician is the one with postgraduate degree or a diploma.

Status of Family Medicine training in Pakistan

The College of Physicians and Surgeons (CPS), the postgraduate licensing body of Pakistan, lists four accredited postgraduate training programmes for Family Medicine in Pakistan.¹⁷ This includes a formal residency programme of four-year duration, providing similar formal clinical experiences as programmes in the West. Other postgraduate training varies in duration and specialty from dedicated Family Medicine training of one year vs. diplomas in other specialties like obstetrics and gynaecology, self-study etc.¹⁸ Member of CPS (MCPS) degrees are also available for those wishing to obtain

basic qualification in Family Medicine without formal training. MRCGP Int., a collaborative South Asian initiative to advance quality of Family Practice, is another qualification for which the College of Family Medicine (CFM) organises continuing medical education (CME) sessions.

Since the inception of Family Medicine residency, approximately 90 physicians have obtained CPS fellowship (FCPS) qualification. This degree is recognised not only in Pakistan, but is valued in the Middle East and Gulf region as well. Unfortunately, however, a large majority of postgraduate trainees eventually seek lucrative jobs in the Gulf region, leaving a continuing paucity of qualified family physicians in Pakistan.

The way forward

So how do we strengthen Family Medicine in Pakistan? Despite progress in training, an understanding of the need of Family Medicine is lacking in the medical field and society at large. The key step would be the buy-in of all the stakeholders i.e. the medical organisations, including licensing and training bodies, training institutions, healthcare providers, trainees and, most importantly, policy-makers.

Very recently, PMDC has taken the initiative to introduce Family Medicine in the undergraduate curriculum (as it has been introduced by some private medical universities). This will allow more uniform exposure to this specialty through all public and private-sector universities. Trainees going through a five-year curriculum would then not only gain understanding of Community Medicine (which is currently already in place in a large number of institutions), but also understand the principles of Family Medicine, inclining some of them towards this specialty after graduation as seen in the US.¹⁹

At the postgraduate level, developing more training programmes in Family Medicine would encourage a greater number of individuals to seek this specialty. As an example, the National Residency Matching Programme in the US introduced 18 new Family Medicine residency programmes in 2012 and 2013 effectively creating close to 100 more positions in Family Medicine. Subsequently, the number of candidates selecting Family Medicine rose in 2013.²⁰

In addition to providing opportunities for exposure to structured training in Family Medicine, our health policy-makers at all levels of government (both federal and provincial), licensing bodies and institutions need to develop policies and strategies to allow expansion of this specialty and retention of its trained physicians in order to

fulfil our growing need for quality healthcare. The growing number of elderly seeking ambulatory healthcare also validates the need for such cost-effective accessible care.

As an example, incentivising primary rural health services for providers via monetary and other means (better infrastructure, equipment) may also help encourage physicians to serve the rural health sector.

Focussing on alternative training programmes or necessitating CME for the general practitioners already in practice to help improve/update their knowledge and care provision may also serve to strengthen their primary care practices.

In addition, on-going reviews of practice profiles of employed family physicians to identify system/individual deficiencies may yet be another way to strengthen primary care practices.

Awareness of the role of Family Medicine in the care of individuals and families needs to be enhanced at a public level as well through various media segments.

Conclusion

The need of the hour is to understand and incorporate in our healthcare system well-trained family physicians who may form the backbone of our healthcare system or the base of the pyramid of healthcare providers or delivering accessible, affordable quality healthcare moving up to specialists and subspecialists may focus their expertise where most needed.

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