Strengths and limitations of a family physician

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ABSTRACT

Family physicians (FP) practising in different parts of the world may require different sets of knowledge and skills to satisfy the needs of the communities in which they work as well as the requirements of the professional bodies with which they are registered. This article gives an overview of the strengths and limitations of the FP globally and more specifically within India, South Africa, and the United States of America. The historical context and evolution of FM as a clinical and academic discipline is discussed in this article. The article recommends suggestions for a better future for Family Medicine as a specialty thereby providing quality primary healthcare to the community, based on the needs of the population of each country.

Keywords: Future, historical context, limitations, strengths

Family physicians (FP) practising in different parts of the world may require different sets of knowledge and skills to satisfy the needs of the communities in which they work as well as the requirements of the professional bodies with which they are registered. These differences may be quite marked, but we are of the opinion that the basic principles of family medicine (FM) hold no matter one's location. This article gives an overview of the strengths and limitations of the FP globally and more specifically within India, South Africa, and the United States of America. The authors address both the academic components of training as well as the skills required to practice effectively in this specialty. This is based on the plenary session presentation made by the four authors at the Third National Conference of FM and Primary Care conducted by Academy of FP of India at Kochi, Kerala, India on January 29, 2017.

FM is a clinical discipline based on a synthesis of knowledge and skills from other clinical disciplines, public health sciences, and behavioral sciences including anthropology and psychology. It is unique in the integration and application of these disciplines to the individual patient, family and community in the clinical setting. The FP (well-trained generalist) is a licensed medical graduate who gives personal, primary, and continuing care to individuals, families and a practice population, irrespective of age, sex, or illness. She/he will attend to patients in the consulting room, in their homes and sometimes in a clinic or hospital. Prolonged contact means repeated opportunities to gather information at a pace appropriate to each patient and build up a relationship of trust which can be used professionally.

Like any other academic clinical discipline, FM has a distinguishable body of knowledge, a unique field of action, an active area of research, and intellectually rigorous training. The World Organization of Family Doctors (WONCA) in collaboration with the WHO has successfully promoted the FM approach in developing countries. November 1994 WHO/WONCA conference report calls for FM to be recognized as a discipline to be taught in every medical school. It noted that family practitioners have a central role in ensuring the delivery of comprehensive, continuous, coordinated, and personalized healthcare. Their role, along with other primary care providers, is considered important in the optimal use of health resources. Research continues to demonstrate the cost-effectiveness of family doctor-based services.

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Family practice is a patient-centered and community-based clinical method. Patient–doctor relationship is the key in family practice. The FP is often more than a “doctor” to the patient and family. A FP provides continuing care to patients and families. Development of a bond helps in understanding the person and the illness better. A FP can provide quality affordable care. FPs provide solutions to common illnesses. They win the trust of the patients and families.

No expensive resources or infrastructure is needed for practice. There are a variety of options for practice setting. A FP has no restriction of patients based on age, sex, or symptoms. He/she sees a wide variety of health problems which makes his/her practice interesting. The preventive aspect of FM makes a FP an educator. A FP also has the role of coordinator and leader of the team.

While these are the strengths of family practice, there are some limitations faced by a FP in clinical practice.

Patients often present to their FP with ambiguous, undifferentiated symptoms and not with a clear diagnosis. Therefore, all possibilities have to be explored, multiple aspects have to be considered and red flags should be watched for. FP is the first contact doctors and hence, exposed to fears, concerns, and anger of patients and families. Most family practice settings have limited available resources and limited access to technology. The maintenance of health records is also very important and is often difficult for FP with less resources and technical support. Updating knowledge requires more effort than a hospital-based specialist.

The FP has multiple responsibilities which includes service delivery, teaching, clinical governance, and research. These aspects of FM are at various stages of development in different parts of the world.

**The South African Perspective**

South Africa has a population of 55 million people of whom 51.3% are male and 48.7% female. There is a large disparity between rich and poor and the country has a GINI Index of 63.4. It has an under-resourced and over-utilized public health-care sector serving 85% of the uninsured population.\(^1\)

The average life expectancy is 63 years and the national burden of disease is led by HIV/AIDS, Tuberculosis, cerebrovascular disease, maternal and child mortality, violence and injuries, and noncommunicable diseases.\(^2\)

The need for postgraduate training for family doctors in South Africa became clear in the early 1970s, following international trends, and was one of the main reasons why the Academy was founded. Pioneers in FM worked hard to establish postgraduate programs at our universities, resulting in the establishment of the category of FM in 1994, and giving recognition to those trained as FP. In 2003, the approval of FM as a specialty was the result of a process that spanned more than 40 years, and although it was a compromise, it provided us the space for specific postgraduate training under the control of family doctors.\(^3\)

The main strengths of FM in SA are that it has a structured (though evolving) specialist training in FM since 2008. There is a close working relationship between state health services and the universities with regards to teaching and training undergraduate (UG) and postgraduate students. The FP is trained to deliver a broad scope of practice which provides person-centered, comprehensive care for patients, families, and communities within the District Health System and is paid on the same salary scale as other specialists. There is collaboration and integration of service, teaching and research with other disciplines to create synergies which is coupled with good leadership and governance. Palliative medicine forms an integral part of the practice of FM. In addition, there are strong partnerships between universities and its community-based partners. Developing and conducting socially relevant and accountable research at a district level forms part of this partnership.

The principal limitations of FM practice are that it has a poor profile compared to other disciplines. There are resource limitations as it is a relatively new discipline with the additional burden of division of time between service, teaching, research, and clinical governance. Teaching and learning platform space available is small compared to the number of residents, and there are insufficient consultant posts to ensure excellent resident supervision. Currently, resident training is hospital or facility based only and there is no exposure to private family practice.

To ensure positive development of the discipline in SA in future, efforts should be directed at increasing the profile of FM and engaging with government to play a central role in restructuring of the health services and medical curriculum. It should also strengthen linkages with the Health Department and General Practice fraternity to develop sites of excellence within the proposed National Health Insurance System, which could be used as sites for teaching. In addition, it could partner with industry to provide service and teaching on a shared basis. Finally, it needs to strengthen research output and vigorously pursue more international linkages and research collaboration.

**The Indian Perspective**

Decades after revival of the concept of the FP and the introduction of structured postgraduate training in the specialty of FM in India, there are still concerns and discussions regarding the role, scope, and future of the specialty. The strengths and limitations of a FP is a topic of debate and interest in the current health scenario of our country.

It has been acknowledged time and again that health-care systems based on a primary care model provide more cost-effective and
clinically effective care. In the Indian context, lack of access to effective primary care is a hurdle, as most of the population live in rural areas and carry a major chunk of the disease burden of the country. Unfortunately, health expenditure in India is mainly focused on curative services and “out-of-pocket expenses” – meaning these are mainly unplanned distress expenditures.

The main strength of FM in India is that the concept has a wide public acceptance as the “Family Doctor” has been an integral part of health-care culture of the nation. FM has the potential to integrate well with the Public Health Care system in India. Staffing in all the public health centers is as per the Indian Public Health Services standards and a FM specialist could efficiently fit in at each echelon of this model. The theme of FM has been receiving support from the government because India is embarking on an ambitious target of achieving Universal Health Coverage for all during the 12th and latest National Health Plan period.

There is lesser pay and lack of glamour compared to other specialists or subspecialists in the Indian context. There is also a lack of public awareness about the specialty, and they tend to equate FP with poorly or less qualified doctors. The attitude of other specialists to this specialty greatly influences the coordinated care for the patient.

Strengths of FM training in India include the structured 3-year postgraduate courses approved by the Medical Council of India (MCI). These include Diplomate of National Board (DNB), awarded by the National Board of Examinations (NBE), New Delhi and M.D. which is presently approved only at 2 medical colleges in India, viz. Government Medical College, Kozhikode, Kerala and CMC Vellore, Tamilnadu. The curriculum is laid down by NBE and MCI respectively, and this includes rotations in all major broad specialties and a mandatory community posting.

The drawbacks include lack of clear learning objectives in each rotation, lack of qualified FM trained faculty, and the pattern of examinations which are irrelevant to family practice to a large extent. Furthermore, most of the training is tertiary hospital based and since the faculty do not have a clear concept of the role and scope of FM, the training is not always in the right direction. No importance is accorded to the identity and principles of FM in the curriculum or the qualifying examination.

A FP has opportunities to address and conduct research in a wide variety of research questions, from the clinical problems encountered in daily practice. Primary care, comprehensive care, continuity of care, and role of families and communities in health of an individual are within the scope of research in FM. The limitations for research in FM include nonavailability of research articles in primary care for reference. FPs in India are more practice-oriented and there is little academic exposure.

The principal limitation of FM is that the Indian Medical education system has never conceptualized FM as a specialty. This has made primary healthcare a default or “out of compulsion” career choice and the majority of the young doctors want to pursue other specialty training. The curriculum at UG level plays a vital role in shifting the focus toward specialized training in hospitals and away from primary care in the community. The current system allows unrestricted and independent general practice after completion of graduation, without the need of proper training in family practice or primary care. The FM specialty is still not integrated with existing government services leaving the qualified FP competing with basic doctors for placement in government schemes. Health insurance does not cover FP services so patients are tempted to reach out to specialists in hospitals to recover “cost” of illnesses.

To ensure a positive future for the discipline, there is a need for medical education reforms to integrate FM training in the UG curriculum and students need to be trained for a considerable time outside of the tertiary care institutions in an environment focused on primary care. To meet the current or projected needs of FM specialists, there is a need for academic institutionalization of community-based health-care services such as District Hospitals and Community Health Centres.

If we are going to fulfill our nation’s promise of Universal Health Coverage to the public, we will need to enlarge and strengthen the primary care sector of the health system. There is great risk that if we do not do so, a significant portion of the population will continue to be without access to high quality and efficient primary care, and health-care costs will continue to escalate with dire consequences for the economies of individuals and the nation.

The USA Perspective

FM in the USA developed within the framework of a number of academic enquiries, namely, Folsom Report which recommended that every individual should have a personal physician, Mills Commission which said graduate medical education should produce a “different kind of physician” to replace the decreasing numbers of GPs and Willard Report which defined the “new FP” and outlined the specifics for FM Training programs and set to establish a certifying board in FM.

The American Board of Family Practice was approved in 1969. Fifteen programs were established in 1969. Over the next 10 years, the number of approved and accredited programs increased to 380. Currently, there are 452 accredited programs in FM. American Academy of General Practice changed its name to the American Academy of FP in 1970. The Society of Teachers of FM in the early 70’s took responsibility for the academic leadership of residency training programs and medical student curricula.

Today’s challenges include reimbursement concerns, prestige within the medical community, and limitation of practice because

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there is focus on specialty board certification and not competency or skills, public awareness and perceptions of the FM discipline, documentation due to the impact of Electronic Health Records on relationship building with patients and work-life balance issues causing productivity concerns, burnout, and high physician suicide rate in the USA.

Today’s rewards include focus on population health with greater emphasis for FM nationally which naturally has an impact on prestige, increased professional satisfaction by making a significant impact in communities and with your patients, recognition of FM in Medical Education both at UG and postgraduate level, relationship or rapport building with patients and entire families, ability to provide holistic care and variety in the breadth of practice being the first contact with patients.

**Summary**

There is consensus that FM does not have sufficient exposure in the UG medical curriculum. What is also clear thus far is that there is no uniformity in postgraduate teaching and training in FM and the picture differs from country to country. The United States of America has an established FM fraternity, South Africa is in the mid-evolutionary phase and India appears to be in the developmental phase.

Other specialties do not appear to take the discipline of FM seriously even though there is ample evidence that the delivery of primary care by a well-trained generalist doctor is very cost-effective.

There is also a great service load on FP leaving little time for self-development or research or for that matter supervision of trainees.

There should be a call for broader FM education in UG curriculum, including community and clinic-based teaching and learning. Each nation should develop postgraduate curriculum to meet the needs of the population and in line with international best practice. We should develop career advancement strategy for FP. Education of the general public with regard to the role of the FP is important. More resources should be allocated to FM service delivery, teaching, and research.

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