

Training for General / Family Practice in the 21st century

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Dr. Chandrasekar the immediate past president, other past presidents, council members, distinguished guests, ladies and gentlemen

Thank you Dr. Sekher for your appreciative words of introduction and you my friends and colleagues for leaving your busy schedules to come here today to wish me well. I like to start my talk by going back in time to 1983 when I started my career in Family Medicine. I joined the Post Graduate Institute of Medicine (PGIM) with the idea of specializing in a clinical discipline and I selected family medicine, a clinical specialty related to ambulatory care. Later, even though there were some doubts as to the status of this specialty in the Ministry of Health, I decided to do the MD as I really believed in the importance of this specialty. You see, practice of family medicine gave meaning to the disease centered medicine I had learnt. It taught me patient centered care, to sustain continuity of patient care effectively, to help people in the best possible manner particularly when in distress. This practice has given me much satisfaction and contentment in life.

At the heart of healthcare delivery, lies our patient. People can become ill at any time of the day and they come to us doctors with their stories which may either fit into a disease pattern that we know of or one that needs much more understanding of the patient in totality. We see illness mostly in the early stages of disease but there are also patients presenting for the first time in later stages of the illness. We also see conditions that rapidly progress. A core clinical skill that we need to master is accurate diagnosis and correct management in the context of other conditions they may have and the impact on the life they lead. Management requires good communication with the patient, family and sometimes the secondary or tertiary care specialist. The appropriate plan of management could be even to support the patient in self management. This entire process needs a system of high quality generalist care and requires formal training of doctors going to General/ Family Practice.

The Sri Lanka Medical Council recognizes MBBS with internship covering only two disciplines as adequate to function as an unsupervised General Practitioner (GP). With the vast improvement in the provision of health care,

it is time that the policy makers thought of introducing specialty training for General Practice.

Some facts to support this statement.

1. The global electronic medline indexes 900,000 clinical articles every year. The disease patterns and their management are changing the generalist doctor needs to keep abreast of new developments.
2. Public now have direct access to specialist care as well as internet facilities and as such their expectations are also changing.
3. There is a fast growing ageing population with multiple co morbidities needing home based care with very little training provided either in the medical school and during internship.
4. Constantly emerging new interventions and treatment schedules have altered the course of some rapidly fatal illnesses. Some of these have become chronic conditions.

At present the family doctors who work full time delivering primary care are in the private sector. Few universities also have model family practice centres. However, the majority of doctors delivering primary care are part time practitioners while being employed by the state. There are also a few specialists in family medicine who have undergone or undergoing clinical training to obtain board certification as specialists in the Ministry of Health (MOH).

According to the Annual Health Bulletin, 100 million consultations take place every year in out patient settings, 50 million in the state sector and 50 million in the private sector as outpatients. All these doctors who work as generalists need to be given due recognition as General Practitioners as they too are responsible for the care they deliver. To achieve this the College of General Practitioners of Sri Lanka (CGPSL) is now in the process of discussing with different stakeholders, the establishment of a General Practice register. The registration will require training in general practice at some point in their career once they have set up their practice or before. The western countries are looking at enhancing their already existent training programmes which give doctors the license to practice as a GP in their countries.

The Royal College of General Practitioners in the recent years has brought in a new concept called modern

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medical generalism which encompasses patient care at all levels of care be it primary secondary or tertiary. This is quite new and new to us as well.

According to the Royal College of General Practitioners of United Kingdom (RCGPK) the definition of medical generalism is as follows

‘Medical generalism at its root, is a way of thinking and acting as a health professional and more than that, a way of looking at the world. They argue that that it is possible to be a generalist in any specialty or profession and equally one can work as a GP without being a true generalist. The essential quality here is that the generalist sees health and ill health in the context of peoples wider lives recognizing and accepting the wide variation in the way their lives are lived, and in the context of the whole person.’

This takes me towards the patient centeredness in Family Practice. Family medicine is centered round this. However, to say that patient centeredness is peculiar to a generalist is untrue and unfair. A specialist may well be patient centered. In fact most of my senior colleagues in the faculty are truly patient centered. Particularly when in contact with a person with longstanding illness.

In this new model there is integrated care where patients are always put first and the professionals work closely together irrespective of specialty or location be it the community or hospital. Medical generalism is not a synonym for general practice. Eventhough it is the essence of good general practice it is needed in secondary care as well.

One would look at a generalist as a person who takes an interest in all parts of the body and mind. This enables a generalist to act as the point of first contact to deal with acute and chronic conditions and to manage illness which is undifferentiated. Thus a generalist needs to be competent in the coordination of care and to have an understanding of the variable impact in a person’s life course. More demands are made on the 21st century GP. It demands a deeper and richer interpretation of a generalist role. An approach oriented to individual family and community. Provision of coordination of care over a long period of time leading to promotion of health and well being of individual families and a cohort of people followed up over long term.

The generalist then is trying to look at patients health or illhealth from the patients perspective through the patients lens. This is the biopsychosocial approach. An emerging refinement of this is the biology of biography, which takes a whole life view of the patient and trace much illness to childhood and even to prenatal experience. This is a more complete approach and enhances clinical management strategies. This needs responsibility for a cohort of patients. This population focus is important for maintenance of health and well being. According to Sri

Lankan statistics for 2012, there is one medical officer per 1278 population. As we go along producing over 1000 graduates an year, I see no great difficulty in allocating the responsibility of care to a particular GP in the long term.

Training for general practice

Challenges and opportunities

The fulltime general practitioners and the CGPSL members have undergone formal training either through the training programmes conducted by the CGP or through the PGIM. Some have undergone training abroad.

The training courses available at Diploma level at present are

1. The newly SLMC recognised Diploma for the membership conducted by the CGPSL.
2. Diploma in Family Medicine (DFM) at the PGIM Colombo. Even though there are over 1000 Diplomates, these doctors do not go into primary care situations in the MOH nor into private general practice thereby causing a loss of manpower for primary care. Also the selection into the course does not give any weightage for people working in the primary care situations or want to continue in GP.
3. MRCGP(INT) conducted by the CGPSL in collaboration with the RCGP(UK).
4. The MD in family Medicine by clinical training and Exam and by theses recognized by the MOH for specialist status.

We have the expressed support of the International Chair of the RCGP who have been working with us over a decade. We also have the support of the World Organisation of Family Doctors and those in the Region. It was our own Dr. Preethi who was the President of the South Asia Region of World Family Doctors for 6 years. And in fact we have won the bid to host the next sar world conference in Sri Lanka in February 2016.

Preparing the future GP in Sri lanka

Basic generalist skills could be taught in medical school by different specialists in collaboration with generalists in Dept. of Family Medicine. The curricula should be drawn up to focus on learning to deal with problems seen in general practice in consultation with the Dept of Family Medicine. The breadth of general practice could be covered to some extent this way.

At the second level, skills specific for general practice should be learnt in the natural setting of general practice. If the trainee is attached to the MOH, the GP trainee could select to work in a primary care situation under the supervision of specialists in the department of family medicine or be attached to training centres now manned

by the consultants in family medicine properly trained and board certified. This would not be a burden on the MOH as the said trainee would man a primary medical care unit or work in a divisional hospital and carry out assignments in family practice under a supervisors guidance who is not physically near them. There could be an exit exam after this. These people then should be given preference when selecting doctors for family medicine courses. The 4th level will be specialist level which is already in place.

Those going into full time general practice have the CGP backing with the Diploma for the MCGP, MRCGP (int) and a mentoring programme by a senior general practitioner.

The College of GPs is willing to provide expertise to train many doctors in general practice if the Ministry provides the infrastructure and resources. It was the College members headed by Prof Nandani de Silva who established the first online course for the Diploma in Family Medicine. Alas it is no more. There are many doctors trained to carry out online education. We could reestablish one. We have now committed members of the CGP and over 20 doctors from the MOH and universities having finalized their MD or waiting to do so next year. These doctors are enthusiastic about family medicine and will work with commitment. We have had initial discussions with the Hon Minister and the top officials of the Ministry. I will do my best to establish or initiate a course of training during my year at the CGP which would take in many doctors.

I would like to end my talk today remembering those who helped me in my career. My parents and my grand mother who are no more. My aunt Tressie who has always guided me The Principal of Holy Family Convent both at Wennappuwa and Bambalapitiya Late Revd Mother Malachy who was my mentor through many years. I

remember her often with much love. My teachers late Dr. Nihal Markus with whom I worked as an intern, who taught me so much clinical medicine, late Dr. DN Atukorala and late WDH Perera who not only taught me dermatology but many facets in organizing national and international conferences. The Deans of the Faculty of Medical Sciences Late Prof. MTM Jiffry, Prof. Narada Warnasuriya, Prof. Dayasiri Fernando, Prof. Jayantha Jayawardene, Prof. Mohan de Silva, Prof. Surangi Yasawardene and the first Coordinator Dr. HHR Samarasinghe whose commitment to improving family medicine in the faculty of medical sciences has been enormous. A special word of thanks go to Prof. Narada who had been a pillar of strength to us always.

And last but not the least I remember late Dr. Heennilame and his inimitable ways, late Dr. Desmond Fernando who guided us. A special thank you to Prof. Leela Karunaratne who motivated me to take up family practice as a career and is my right hand and left at all seasons. And Dr. Dennis Aloysius who remembers to give a call every week to find out how I am doing, not forgetting Prof. Ferdinands who is also a pillar of strength always. Of course my peers Preethi and Ranjan, Nandani, Shekar, Eugene are always available for any help. Lastly I am ever grateful to the staff of my Dept. Shyamalee, Hiranthini, Chandima, Chamath and Chandimal, who always go out their way to support me. They are my strength. And my patients from whom I still learn and teach clinical medicine.

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