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SMA NEWS

Sreenivasan Oration 2001
From Counterculture to Integration:
The Family Medicine Story

By A/Prof Goh Lee Gan

Editor's Note:
The Sreenivasan Oration 2001 was given by A/Prof Goh Lee Gan during the College of Family Physicians' 30th Anniversary Dinner at the Orchard Parade Hotel, on 26 August 2001. This article is only an abridged version. The complete article is available online at http://www.sma.org.sg/sma_news/newscurrent.html

FAMILY MEDICINE AS A WORLDWIDE MOVEMENT

The phase of counterculture

As a worldwide movement, family medicine had its prelude in the growing disenchantment of general practitioners and their patients with the fragmentation of care and impersonal care brought about by subspecialisation and growth of high technology.

There was clearly a need for a group of doctors to sound the warning of too much of fragmentation as well as to address the consequences of this phenomenon. The GPs on both sides of the Atlantic spear-headed the counterculture movement.

So, in 1947, the American Academy of General Practice was formed. In 1952, the British College of General Practitioners was formed. Then in 1958, another English-speaking country that was to play an influential role in Asia-Pacific including Singapore had its College established. This was Australia.

Now, the 1970s were also a period of social economic difficulty in many of the developing countries and the World Health Organisation led the movement of Health for All By Year 2000 through primary healthcare. So the counterculture was getting stronger.

In 1972, the world body of family medicine, Wonca was formed with 18 country members. The counterculture movement was to become worldwide. Singapore was one of the early members. The Wonca Secretariat was in Australia and remained so until January this year when it moved to Singapore. Dr Alfred Loh is now the Chief Executive Officer, succeeding the immediate past Chief Executive Officer, Prof Wesley Earl Fabb who has all these years been a strong supporter of the Singapore College.

The family medicine counterculture[2] was particularly strong in America and the general practitioner community worked towards a new general practice and even changed the name of the discipline from "general practice" to "family medicine" to reflect a renaissance in its culture.

THE SINGAPORE MOVEMENT

Counterculture

Singapore, like the developing countries in the Asia-Pacific region, and the developed countries around the world, too received the family medicine message. The desire to set up a College of General Practitioners to develop standards of care in general practice was strong. This was set up in 1971.

Singapore is not exempt to the side effects of subspecialisation and this subject was expressed in more than one Sreenivasan Oration, namely in the Orations given by Dr Wong Heck Sing (1978), Dr Victor Fernandez (1983) and Dr Lee Suan Yew (1995).

Parity

As far as parity goes, the specialist image in Singapore remains overpowering to GPs and patients. The playing field is still very much tilted in favour of the specialist in terms of payment and re-cognition for work done. Many, including patients, are reluctant to pay the GP for his true worth. But our GPs are not assertive enough because many have a poor image of their worth. Sad to say, but it is true.

The introduction of family medicine into the undergraduate curriculum in the National University of Singapore since 1987 and the setting up of the Master of Medicine (Family Medicine) programme since 1990 probably has improved the understanding and image of family physicians somewhat.

There is still much to be done to improve the image of the family physicians through training and to enable them and to inspire them to do high value professional work instead of skin peels. Not edifying.

Integration

Integration of healthcare activities and providers is now the focus of healthcare reform in Singapore. The formation of the 2-cluster system of healthcare,

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the concepts of seamless care, disease management, stepped down care, and shifting the centre of gravity to the GPs are steps in this direction. We would need to look into sustaining healthcare needs of not only the present but in the future as well. And we need to remember that eradication of poverty eradicates ill health. So health must integrate with social and economic development of the country.

WHERE DO WE GO FROM HERE

Integration

The importance of integration has been alluded to. Family medicine has the role of integrating in the mind of every doctor the balance between specialisation and generalist approach in the care of patients. The organ subspecialist needs to see how his expertise fits into the total well-being of the patient.

Specifically, we need to work on the following seven areas in our integrating efforts. You can remember them as 4 plus 3:

The first 4 are processes of care

1. Good preventive care – Preventive care must take the forefront of our care – the old adage of "prevention is better than cure" will always remain true. We therefore need to integrate preventive efforts in our curative work – this applies to the specialist too.
2. Good acute care – Acute care is where we really need to integrate knowledge, skill and experience and to share it with one another on how to do things right the first time. It is not always easy and takes a lifetime to perfect. And good acute care is very, very important in the elderly, particularly, the very old because the window of opportunity is small and we must act fast or they will never be the same again.
3. Good chronic disease care management – attention to these will surely reduce the burden of disease on the sufferers. Good chronic disease care is a good example of the need for integrative care. That is why across the world chronic disease care is still very poor. And good integrated chronic disease care will make a big difference in the reduction of disease burdens.
4. Good stepped down care – this is increasingly important with the rising cost of acute hospital care and the increasing numbers of the elderly who take a longer time to recover from their medical illnesses. Good stepped down care again hinges on integration. It is a baton relay of care.

The next 3 concerns are those where it is more care than cure

5. Good elderly care – the care of the elderly is perhaps the best example of the need for integrated care both vertically and horizontally. Care of these people cannot be good without adopting the paradigm of integrating the efforts of carers for a common purpose. And we have some 27% of such patients come 2030.
6. Good domiciliary care – this is a very much underserved area of care. It will grow in importance as an area of need as more and more people live to a ripe old age.
7. Good palliative care – This will include not only terminal care but also the care that can extend and enrich those with cancer who cannot be cured. Hope still springs eternal when one day we may be able to slow down the destructiveness of cancers and give the sufferers more life and longer life. The idea of controlling cancer just like controlling diabetes mellitus may not be such a far-fetched idea. And good palliative care goes beyond cancers. It is also needed to slow down the progression of end organ disease states. Think of the end stage heart disease, kidney failure and strokes. The care is all palliative.

Parity

Parity is the family physician being accepted as equal to the organ specialist in the eyes of the four Ps - profession, people, policy makers and the press. The journey to parity is the process of levelling up. To enable our GPs to do so, the College has in collaboration with the University and Ministry of Health developed family medicine programmes that span undergraduate to post-graduate levels.

The GP community has enjoyed the support of our many specialist colleagues in training our GPs in the past and we are appreciative of their national service role. We will continue to need their support in the future as partners.

Counterculture

Is there a place for family medicine as counterculture into the future? The answer is yes. Family medicine as an academic discipline has the role to remind every doctor that there is a need for a balance between the subspecialist and generalist perspective. Family medicine cannot abdicate this role and must not.

TAKE HOME MESSAGES

There are three take home message from this Oration:

- Integration between generalist and specialist care is a must to develop a cost effective and meaningful health-care delivery system. The desire to do so must pervade the minds and values of every medical practitioner, whether subspecialist or not.
- Family physicians need to level up to meet the healthcare needs of today and tomorrow, in particular in the seven areas of care: preventive care, acute care, stepped down care, chronic disease management, stepped down care, elderly care, domiciliary care, and palliative care
- Family medicine as a counterculture to hospital subspecialisation must continue. Family medicine has the role of teaching and reminding and reinforcing the values that are required of every doctor namely patient-centred care, holistic care and preventive care. ■

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