Millennium Series

Role and image of family physicians

Then and now

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I have just finished reading a series of articles written from 1958 to 1962 in the *Journal of the College of General Practice of Canada*. Back around 1960, I was blithely unaware of the articles, the College, and the journal. My chief concerns were acne, how come the basketball coach did not recognize my superior talent, and if I did not go to university could I join the army and play the bagpipes.

It was not that I was unaware of events beyond the dandruff on my shoulder; I knew all about Lester B. Pearson, John Diefenbaker, Robert Stanfield, and Ike Smith. I knew that Elvis Presley had been drafted and Fidel Castro had come to power in Cuba, and I could sing "Michael Row Your Boat Ashore" with some assistance.

Doctors were not unknown to me; my family doctor had recently treated me for pityriasis rosea, and my mother was very impressed with Dr Wilder Penfield. His name frequently came up during dinner conversations so I knew about the Montreal Neurological Institute and Dr Penfield's surgical and literary accomplishments. But other doctors were an amorphous lot. Drs Victor Johnston, Murray Stalker, Murray Fraser, and Arthur Van Wart and their ideas about the role and image of the future family physician had not registered on my perfectly good unused brain.

In fact, the whole concept of ideas was a little new to me. It was only much later that the significance of Victor Hugo's quote, "No army can withstand the strength of an idea whose time has come," and its application to family medicine became apparent. Meanwhile, the idea that was to embody the emerging discipline of family medicine was being articulated in those journal articles.

When you see for the first time the origins of the ideas that started a process that has come to fruition during your career, there is a great uplifting sense of rational progression. When you read Dr Murray Stalker's 1962 article on the "Future of General Practice In Canada" (**Figure 1**), you will see the call for general practitioners to raise their standards by educational means, to get involved with undergraduate education, to develop residency training in general practice, and to ensure that training is in a general practice setting. To my delight Dr Penfield is quoted in the article, adding his considerable prestige to our cause, "Only [the general practitioner] can bring to an end the present unsatisfactory and often

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Figure 1

And now we must consider how this specialist personal physician is to be trained and also I believe in addition we must consider the discipline that he is subject to in practice. I hope it is appreciated that I do not expect all practitioners to be able to follow this program. At first, like the experience of the Royal College of Physicians and Surgeons there would be few. They would increase as they prove their place in the profession. They would, however, be our leaders in all geographical areas towards supplying availability of modern comprehensive medical service. They would be leaders of continuing education. They should help to unite our profession during this time of reconstruction.

In the same editorial (Journal, Coll. Gen. Practice, Jan. 62) Victor Johnston makes another important statement. I quote, "They must be men of science applying the art of modern medicine. When the College of General Practice attempts this task it will get powerful help from our medical educationalists." At this time when the social consciousness of our citizens are demanding a better distribution of our science, we of the whole profession badly need this help. Dr. Johnston places the emphasis of responsibility upon the College of General Practice. Our members must appreciate the demand for "men of science to practice the art of medicine."

Let us look back that we may look forward. Less than a generation ago a physician could enter practice without any postgraduate or intern training. Now one year is compulsory and two is common in many centres. As mentioned, Dr. McCoy is asking for three years. Many men are doing this on their own initiative and more important, many specialists, notably internists and pediatricians are doing general practice. We have come a long way. We only want a change of emphasis so that young graduates may get credit, prestige, and enter this field.

Figure 2

"Jack of all trades and master of none" is certainly an unattractive description of the general physician. But it is essentially false. The role of the family doctor is not to wander from one field of medicine to another because we can spell out for him a most valuable and durable program of services. In doing this there must be no place for less qualified general physicians. They must be men of science applying the art of modern medicine. When the College of General Practice seriously attempts this task it will get powerful help from our medical educationalists. The College was organized for this type of pathfinding activity. W. V. J.

We do not need to outline the boundaries of general practice completely. Much can be left for time and experience to help determine. A beginning is overdue, however.

Any definition of general practice recognizes that the services of the general physician are rapidly expanding, just as specialist services are expanding. This is true in spite of contractions of general practitioner services in some areas such as in that of surgical hospital privileges.

Figure 3

Dr. F. M. Fraser says:

LET'S FACE THE FACTS

Delegates to the Fifth Scientific Assembly of the College at Vancouver in March were treated to a stirring and thought-provoking report from retiring President Dr. F. Murray Fraser. Here is a digest of it:

By Dr. F. MURRAY FRASER

Before I call upon Dr. Tim McCoy to receive the chain of office and thus perform the final act of my reign, I would like to take a few moments to say a great many thanks to a great many hard-working people.

Firstly to the members of our B.C. chapter, under the able direction of Dr. Howard Black, one of our illustrious past presidents.

To Dr. Peter Kinsey, chief organizer, and his able assistant, Dr. Alan Pengelly, go our annual vote of thanks.

To our guest speakers, from near and far, go our warm and sincere thanks.

To our scientific and pharmaceutical exhibitors, our grateful thanks for your share in the success of this convention.

What can I say of our amiable Chief of Staff, Dr. Victor Johnston? His unbounding energy, his tireless devotion to our College, his real sincerity in furthering its aims have made us all love him — more than that I need not say, except to wish him continued success, health and happiness — in the future!

Now, let's face the fact that governments, federal and provincial, must accept some responsibility for the provision of medical services to certain groups of our citizens.

As it is the duty of a father to give his children protection against starvation, poor housing, ill health and the other hazards of life until they can assume these responsibilities for themselves, so it must be the duty of those whom we elect to govern us to provide, among other things, the finest medical care to those unable to do so for themselves.

This responsibility of government has grown out of the advances we, ourselves, have made in medicine. Whether we like it or not, it is to our glory. The two-dollar house call which often gave our patient the best professional advice fifty years ago may now, with specialist consultations and laboratory studies, end in a cost of hundred times two dollars.

Our patient is getting better care; he must pay for it — or somebody must.

Let's face the fact that the traditional "doctor-patient" relationship, of which we speak so glibly, is on the way to extinction. Let's stop talking about its preservation. It dates us! The advent of prepaid medical care plans, of government sponsored health care, of labour inspired medical clinics, of provincial hospitalization plans, have all but destroyed that traditional war-cry of medicine. We, ourselves, with our development of "group" practice have hastened the destruction.

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Figure 4

A New Medical Approach to the Traffic Safety Problem

by Dr. Arthur F. Van Wart
President of the Canadian Medical Association

Part of an address at the Third Scientific Assembly of the College of General Practice of Canada

As general practitioners we are held in respect by the people of our communities. On the other hand they expect us to enter into their community activities. Thus we become members in a service club, athletic clubs, churches, school boards, boards of health, and even in municipal governments. We are also family advisors. Parents and children come to talk over personal problems and to seek our advice, which is gladly given even if it is not of a professional nature. We help them solve their problems.

I would like to say a few words as to how we, as individual general practitioners, can favourably influence the solution of a problem of our modern times. Have we not all given thought to the growing serious accident record in our communities, especially among the younger people. This problem becomes very real when a young life of one of our families has been snuffed out. A promising son or daughter lost to a deserving family.

Is there not somthing we as general practitioners can do? The highway traffic problem is a very complex one. The human factor enters prominently into this problem. Let us look at the human factor from a practitioner's point of view. A driver's license is granted when one demonstrates that he understands the mechanisms of driving, knows the common rules of the road, of lights and parking and so on. Everyone who so qualifies is granted a license.

In an emergency there are other human factors which determine whether there will be an accident or not. It is the response of muscle co-ordination and what is commonly called "timing". Timing is an intangible which all good athletes must have. It makes for good dancers, it makes for a smoothness of movement which allows people to mingle in crowds and groups with ease. It gives a finish to common practices in the home and promotes an accident free household. How then can we as general practitioners help develop better timing among our families and in our community?

Physical fitness programmes today are being promoted all over Canada. Unfortunately, too much emphasis is being placed on athletic programmes. These programs will promote timing — but only to a fraction of our population. Much more can be done in the home, starting with the child. A child who rides a scooter, later a tricycle, and then rides a bicycle, is better prepared to drive a car than one who has not had this experience. Failing these, then the cultivation of rhythmic movements as in dancing, swimming, old fashioned household games, routine chores, responsibilities, instruction in courtesy and consideration of others — these and many of the other methods of developing muscle co-ordination should be encouraged.

Such child training will have a good effect on future drivers. We should help inaugarate physical fitness programmes in our schools. These should start in the first years so that mental and muscle co-ordination may be developed along with the acquisition of academic knowledge. We can encourage parents to develop this timing and muscle co-ordination in their children. Our advice and cooperation will be a valuable service to the community. The human factor is an important factor in this very complex problem. The human factor, influenced by good timing and courtesy, will help reduce the terrible accident toll on our highways and in our lakes and streams.

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blundering efforts of patients to find the proper specialist."

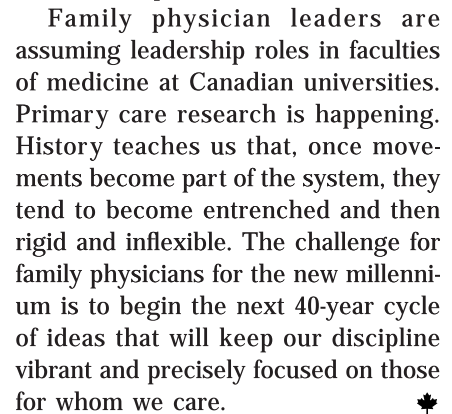
In a January 1962 editorial, the first Executive Director of the College, Dr Victor Johnston, identified the important role that experts in medical education would play in the future of the College of General Practice: "[We] will get powerful help from our medical educationalists. The College was organized for this type of pathfinding activity" (**Figure 2**).

Dr Murray Fraser, in his address as outgoing President of the College in 1961, "Let's Face the Facts," drew attention to fiscal matters, "Our [patients are] getting better care; [it] must [be paid for]" (**Figure 3**). He also talked about the changing role of general practitioners and how that would affect doctor-patient relationships.

Dr Arthur Van Wart, a general practitioner from Fredericton, NB, and 1959 President of the Canadian Medical Association, addressed the Third Scientific Assembly of the College of General Practice of Canada on the role of the general practitioner in the community (**Figure 4**). He specifically mentioned, "the terrible accident toll on our highways." In a remarkable geographic fulfilment 20 years later, Dr Steve Hart of Fredericton, the 35th President of our College, became the moving force behind the enactment of the seat belt legislation, better laws against impaired driving, and compulsory use of safety helmets in the province of New Brunswick.

During the same period, other articles advocated research in general practice and improved relations with the press. A seminal article discusses how the American Academy of General Practice commissioned an opinion poll of equal numbers of general practitioners and lay people to determine what they should call themselves. The winning term was "family physician."

The ideas of 40 years ago shaped what family medicine is today. Many of the ideas have found expression in the principles of family medicine, which in turn have become ingrained in residency



programs. Family medicine has led the way in developing a rational educational approach to medical training. Our discipline has become a presence in undergraduate medical education, and we have defined a postgraduate family medicine curriculum that incorporates a substantial amount of teaching by family physicians in their practices.

Family physician leaders are assuming leadership roles in faculties of medicine at Canadian universities. Primary care research is happening. History teaches us that, once movements become part of the system, they tend to become entrenched and then rigid and inflexible. The challenge for family physicians for the new millennium is to begin the next 40-year cycle of ideas that will keep our discipline vibrant and precisely focused on those for whom we care.

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