ROLES OF THE GENERAL PRACTITIONER IN DIFFERENT CONTEXTS

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Summary — The word “general practice” denotes different contents of work as we look at different contexts. General practitioners may provide first line care, function as secondary care providers at hospital level, take responsibility for the management of health care systems. These different roles can be seen as results from historical processes of division of work in the field of health care, which gave general practice its present shapes.

During the first half of the 20th century, western general practitioners were gradually excluded from hospitals as well as from public health activities. When they started to react in order to increase their legitimacy, they strived — with variable success — to gain recognition as curative first line care providers, as this had become the only place in the health care system they could claim for. They gradually defined their specificity in terms of polyvalence enabling them to deal with unselected problems, and in terms of global view allowing for adequate priority setting.

In developing countries, the organisation of medical care was and remains influenced by western models. As in western countries, emphasis has been put on specialisation and hospital technology. General practice was not exported to developing countries: general practitioners appear rather as cheap substitutes for specialists. The most typical workplace for general practitioners in developing countries remains the rural hospital. But their role model refers to the hospital based specialist: they tend to focus on patient care for hospital users rather than on dynamising health care delivery to the whole community in the district. In urban areas, the recent expansion of (mostly private) first line medical care is also not specific to general practice and tends to be in favour of specialists.

What is the common denominator to these different roles, if any? A possible answer lies in the primary health care approach. It allows to define the specificity of general practitioners in terms of multifactorial approach and global view on health and illness, which differentiates them from specialists. Whether they provide this care themselves or organise it at district level could be less important to their professional identity than the general attitudes and knowledge they rely on.

Introduction

What is meant by “general practice”?

Obviously, the same word denotes a different content of work as we look at different places in the world, at different times and even at different persons in similar settings.

We find general practitioners acting as first line care providers, others as rural hospital doctors, others dealing with managerial issues as district medical officers. They may play one of these roles or combine them.

This observed variation raises the question of the universality of general practice: is there a common denominator to these different functions filled by general practitioners throughout the world? Or are they so radically different that medical education preparing for these functions must be conceived distinctly?
I shall not answer this question, but rather attempt to introduce to the discussion, by taking a point of view of social scientist: general practice can be looked at as a social construction, resulting from a process of division of labour in the field of health.

Health care is universal. But the occupational groups providing health care are social constructions. And the fields of action of these occupational groups vary with the context. For example, according to the place in the world, deliveries will be assisted by traditional midwives or by obstetricians. Running well-baby clinics is the task of nurses in Thailand, and of paediatricians in Belgium.

This is also the case for the division of labour among medical doctors, and in particular between general practitioners and specialists: it does not follow a standard pattern throughout the world but varies with the context. These variations can best be understood when we look at the historical processes of division of labour in health care, which gave general practice its present shapes.

Division of labour involves two dimensions: a technical dimension and a social dimension. Technical division of labour refers to the fact that modern health care calls for different and complementary roles, whose boundaries are more or less clearly defined: no single person can be handle all tasks involved in health care. Social division of labour refers to unequal distribution of prestige and authority between occupational groups. As we shall see there is frequently confusion between these two dimensions.

This presentation will address the following questions:
* What realities underlie the word "general practice"?
* What are the historical processes which gave general practice its present shapes, both in Western countries and in developing countries?
* Are district GPs and first line GPs two different kinds of doctors?

1. What realities underlie "general practice"?

Various words are associated with general practice: generalist, general practitioner, family physician, primary care doctor, community physician, district doctor, polyvalent doctor. But they are not used in the same way in different places of the world.

In Western countries, general practitioners work as first line care providers and are almost never hospital-based. This does however not mean that they have a monopoly over first line medical care: in many Western countries they compete with specialists in first line care (United Kingdom and the Netherlands being notable exceptions). In the USA, primary medical care is considered as a legitimate field of action for doctors in internal medicine, paediatrics and family medicine — the latter being the closest equivalent to the British general practitioner or the Dutch “huisarts”.

Typically Western GPs attend patients and their families, irrespective of age, sex and illness: this is what characterises their generalist or polyvalent approach. Although efforts are made to strengthen their preventive functions, they are in practice mainly involved in curative care. As we shall see, attempts
to conceptualise this western role of first line general practitioner emphasise human and social aspects of care in addition to cure in its technical aspects of diagnosis and treatment.

In developing countries we find general practitioners at two different places of the health care system. The most typical one is the rural district level. The content of work of these GPs is variable. They may concentrate on care to hospital users (secondary care, but often also first line care at hospital OPD). They may have managerial duties for the health district as a whole. In most countries, different doctors are responsible for hospital care and district management, but it also occurs that the same general practitioner combines both clinical and managerial functions.

In urban areas, hospital care is increasingly provided by specialists. Urban GPs tend to work as first line medical care providers, either in public service or in private service. Some countries employ general practitioners in governmental first line services in urban areas. But this is not the rule, and urban governmental services tend to concentrate on hospitals. What is strongly developing however is the provision of first line medical care by private practitioners. But, as in Western countries, these private medical doctors are not necessarily general practitioners and compete with specialists for the provision of this first line care to the segments of population who can afford it.

It seems thus that there are at least two types of general practitioners: first line care GPs and district GPs. I propose to look now at the historical conditions under which general practice became what it presently is.

2. What are the historical processes which gave general practice its present shapes, in western countries and in developing countries?

I shall start by looking at the evolution of general practice in Western countries. I do not imply that this evolution should or even could necessarily be replicated in developing countries. But Western influence on medical care organisation in developing countries was and remains strong, as well in former colonies as in developing countries which were not under colonial rule. What I want to suggest is that the non-development of general practice is to a large extent due to the fact that Western medicine was exported to developing countries along the patterns dominant in Western countries. It is thus useful to understand first the evolution of the position of general practice in Western countries.

2.1. Historical approach to general practice in Western countries

General practice is not new: western medicine started as general medicine. What is more recent is the emphasis on the importance of general practice and its increasing legitimacy.

Specialties started growing between the two World Wars. But during the first half of the XXth century, general practitioners constituted the bulk of medical doctors. As relatively few effective treatments were available (as
compared with nowadays), they needed a good deal of common sense and of what we now would call “global approach” to treat their patients properly. This was however not explicitly clarified and certainly not valued, as the medical profession had based its legitimacy on scientific progress as their distinctive feature from “quacks” and traditional healers.

Specialisation increased during the first half of the XXth century, and specialists achieved gradually formal legal recognition. But in the process of division of labour between GPs and specialists, social factors were prominent whereas technical division of labour remained unclear. Both specialists and generalists were allowed to work in hospitals, but it was more difficult for general practitioners to obtain hospital appointments, and they had lower positions. Both specialists and generalists cared for ambulatory patients (on a private basis or under insurance schemes), but specialists tended to care for upper- and middle-class patients whereas generalists dealt more often with lower-class patients.

As a result of this competition within the medical profession, general practitioners were gradually excluded from the hospitals (in a context of high value recognised to hospitals). In some countries (such as UK) they clearly became first line care providers, but more often specialists continued to provide first line care on a more prestigious level.

During the same period there was a development of special services (which we would now call vertical services) dealing with specific health problems and issues, in particular with preventive activities. Specialised infant welfare clinics for example developed throughout Europe, competing with the general practitioners who had filled this function so far on an informal basis.

As to health care management, it remained embryonic in most countries and dealt mainly with public hygiene and prevention. But at any rate general practitioners were not involved in these functions, which were attributed to new specialties of community physicians or public health doctors.

Around the 1950’s — that is at the beginning of the period of independence for most colonies — the position of general practice in western countries was the following: they existed, they were even quite numerous, but had no formal place in the health system; they had been excluded from the hospital, they were competing with specialists for first line care delivery, they were not associated in preventive activities related to social medicine or public health, and had no managerial functions within the health system.

In several Western countries, the general practitioners started to react as a professional group (in the 1950’s and 1960’s) in order to gain legitimacy, recognition, status and professional autonomy distinct from specialists.

Leadership for general practice was taken by professional associations of general practice who attempted to found general practice as a discipline and to promote specific teaching and research in general practice. They did so in a context where the only place they could claim was curative first line care. I want to underline this fact that general practice as first line care provision in Western countries is the historical result of power relations and not of guiding conceptual views on medicine, which came later to give a content to this role.
In their attempt to develop general practice into a discipline, GPs made explicit what they had been doing so far without conceptualisation.

Initially the definition given to general practice as a discipline insisted on the parenthesis with specialties (mainly biomedical) but with a specific way of integrating them: "In defining a discipline, it is not enough to list all the subjects in which it has its roots. These parent disciplines must be melted down, amalgamated, and moulded into a new form which is vitally different from each of its ingredients. It is not sufficient therefore to say that general practice consists of internal medicine, paediatrics, psychiatry and social medicine..." (7).

Later evolution emphasised the importance of social and psychological factors, next to bio-medical ones, for the practice of general medicine (or family medicine). Reference to a "biopsychosocial model" (1) rather than a bio-medical became central to the discourse (if not to the practice) of general medicine. Emphasis shifted from "disease-centredness" to "patient-centredness".

By making explicit what they claimed to be their specific competence, Western GPs were striving to give a technical basis to the division of labour between themselves and specialists, and simultaneously to improve their status: GPs considered that they were better — not cheaper — first line care providers than specialists.

These strategies for autonomy were not successful in all Western countries. General practice has gained obvious recognition in countries such as UK (4), the Netherlands or Canada. But in most countries specialists remain more or less dominant. Factors explaining the relative success or failure of the recognition of GPs include:

* the strength of the resistance of specialists: their opposition to rising legitimacy of GPs was and is particularly strong in countries where GPs and specialists compete for first line care;

* the support of health authorities in recognising a place to general practitioners within the health care system; however, this support was usually granted after the 1970’s in periods of cost-containment and economic crisis calling for "cheaper care"; this was of course a different logic than the one proposed by GP leaders who claimed to be better first line care providers than specialists.

* changes in demand: dominant culture evolved from unlimited hopes in technology to demands for humanisation of care and for more concern for human beings against technology; obvious iatrogenic problems also contributed to reorient the demand;

* finally Alma Ata provided the general practitioners with an excellent opportunity to legitimise their specificity as primary care providers (understood as primary medical care rather than primary health care).

In Western countries, GPs themselves as a professional group played an essential role in the promotion of general practice. They have not managed to impose fully their superiority as first line care providers. But they have given a content to this role in which historical circumstances had brought them.
2.2. Historical approach to general practice in developing countries

Western medical care was introduced by colonial powers in their colonies along dominant views in the metropolis. It was initially intended to meet the needs of Europeans as well as of non-European workers employed in the colonial administration or in mines and plantations.

Extension of care to larger populations was based on a view in development which George Foster calls the "silver-platter model", dominant until the early 50s: it was assumed that medical care and medical organisation experienced in the West would apply equally well in every country and could only benefit the populations it was intended for (2).

The colonial health care system emphasised — as in the metropolis — the importance of urban hospitals as well as struggle against specific diseases (which in this case were tropical diseases such as trypanosomiasis or malaria) These features both were coherent with the dominant view that specialised medical care was the best care available.

General practice, though it existed in the metropolis, was not exported as such as it had — at that time — no legitimacy. However medical assistants were trained, mainly in Africa; they worked in rural dispensaries and delivered care to rural populations in a way similar to the work performed by general practitioners in Western countries. But they were not members of the medical profession.

Independence did not bring major reorientation of the national health care systems. National experts were scarce, and the new national health policies were influenced by Western experts who continued to play a major role, no longer as representatives of the colonial power but within the frame of technical aid for development.

Efforts concentrated mainly on increasing accessibility to medical care as it existed in the colonial period, without questioning the inherited organisation of medical care itself. The standards for "quality of care" remained the same, that is emphasising technically and biomedically defined criteria and perpetuating the social hierarchy between hospitals and specialised services on one hand and non-specialised ambulatory facilities on the other, which were considered as poor substitutes.

Most developing countries had extremely few national medical graduates at the time of independence. The development of medical schools was badly needed. But it occurred, with Western technical aid, on the basis of American or European models of medical education, calling for large teaching hospitals: the place of the urban hospital became stronger than ever, as well as emphasis on specialisation as token for quality care.

Vertical campaigns were reinforced during this period, influenced to a large extent by the type of funding made available by international agencies or bilateral co-operation.

Rural dispensary networks also expanded but to a lesser degree. In spite of declarations in favour of rural health, the bulk of expenses continued to be spent on urban hospitals. This was even stressed in the 1970's when stagnation in economic growth severely affected public expenses, resulting in stagnation or regression of rural health facilities.
The Alma Ata declaration in 1978 represented an official acknowledge-
ment of policies departing from the dominant hospital centred view. However,
in their mistrust towards hospitals, many interpretations of primary health care
ignored the role of hospitals. Not much changed in reality: hospitals continued
to function on a self-sufficient basis, rather than as supports to first line care;
and lack of resources continued to affect the functioning of dispensaries.

The role of the rural doctor had become, theoretically at least, to act as a
"teacher, organiser, supervisor and consultant to a team of auxiliaries" (6). In
practice however the general practitioners sent to rural areas were not in
adequate conditions to play this broad role of "health district dynamiser".
They were overburdened with curative work, as the delegation of tasks to
medical assistants or other auxiliaries was increasingly limited to preventive
activities and covered only "minor ailments" in the curative realm. This left the
GP almost no time for organising and supporting the other health workers in
the district. In addition, this clinical work was consistent with what he had
been taught for: his role model was (and still is to a large extent) closer to the
hospital based specialist than to a community physician.

It was difficult to find doctors willing to move to rural areas. As they were
trained at University hospital level within a technically sophisticated environ-
ment, they found themselves unable to utilise their technical knowledge and
skills: rural hospitals were not only comparatively more poorly equipped than
hospitals, but often dramatically under equipped as a consequence of the
economic context. It was also difficult for GPs to find satisfaction in the
managerial functions expected from them, for which they were not prepared,
and which were interpreted as routine bureaucratic and administrative work
rather than in the sense of dynamising the health system of their district.

In order to staff rural district hospitals, many countries resort to compulsory
service in rural areas for young medical graduates. These general practicion-
ers however are still not prepared for this work, usually have no role models,
and are given little support (if any) from authorities or professional associa-
tions. It is thus not surprising that their main ambition is to move to town as
soon as their service is over and to apply for specialisation.

Some attempts are made to reorient the rural GP's role towards the
community, bearing responsibility not only for the hospital users but for the
population of the district at large (8). In this perspective he retains clinical
functions required at secondary level, but these functions are not central to
his professional identity. His major task is to organise health care for the
population of the district as a whole, by teaching, supervising and supporting
other health workers to whom he delegates most of his clinical work. We shall
have the opportunity during this colloquium to share some experiences in
training district general practitioners in such a community perspective. This
approach however remains marginal.

In urban areas, specialists are increasingly replacing general practitioners
in hospitals. In a view where all doctors belong to hospitals, the division of
labour is mainly social: specialists work in more prestigious hospitals, while
general practitioners are relegated to rural hospitals.

But urban general practitioners also practice increasingly as first line care
providers, at least in urban areas. In several countries (North Africa, Latin
America,...), public urban first line health centres are run by general practi-
tioners. To some extent, this type of medical care can be comparatively less expensive than medical care provided at large hospital OPD level. And, as in many Western countries, this is also how these GPs are predominantly perceived: as cheap substitutes for hospital specialists. Few efforts were made so far to provide them with satisfactory role models. (One example is an ongoing experiment of creating urban health centres staffed with general practitioners in Ayutthaya, Thailand). Although lessons may be drawn from Western general practitioner models, it appears that they require adaptation to different cultural, social and economic contexts.

But in most cities of the developing world, the governmental sector has concentrated on hospitals, and urban primary care facilities, when they exist, do not provide acceptable curative care. This has left an open market for private practitioners. Since the colonial period private medical practitioners (GPs or specialists) have provided care to Europeans and to the wealthy elite of the country. But for a long time this remained a marginal phenomenon. With an important increase in medical graduates in the 1970’s and 1980’s, exceeding the capacities of restricted governmental budgets, private office-based practice has been strongly growing during the past decade in most towns of developing countries. However, as in the case of Western countries, this type of private practice is not specific to GPs: they compete with specialists, and the division of labour occurs usually along lines of social class of their patients. But for both specialists and GPs, major problems are involved in the control of quality of private practice.

3. District gps and first line gps: two different kinds of doctors?

I started by raising the question of the universality of general practice, beyond different contents of work: are first line GPs and district GPs two different kinds of doctors? Do they have a common denominator founding the specificity of general practice?

If general practice is a social construction resulting from historical processes involving power relations and gradual conceptualisation, there is no “right answer” to this question. General practice can be conceptualised in different ways. However the type of answer that is given will bear different consequences.

When thinking about the future of general practice, we must keep in mind that patterns of division of labour in the field of health care are rapidly evolving under changing conditions, and that today’s content of work for GPs may not be tomorrow’s. Several scenarios are possible.

A frequent conception is that both types of GPs do what could be done (better) by specialists, but in a less expensive way. This is of course no basis for defining their specificity. In that perspective, GPs might survive, but the “ideal” situation would be that specialisation gradually supersedes general medicine. We see immediately the danger of fragmentation of medical care of such a scenario.

Another scenario is that in the future GPs will increasingly function as first line care providers, and that — as in Western countries — they will be gradually excluded from the hospitals, at least if enough specialists are
available. It may well be that, in the long run, there will be no place for GPs at hospital level. To what extent the Western “biopsychosocial model” for first line general practice would be reinterpreted to fit different cultural contexts of the developing world is another question.

But in the meanwhile GPs do work at rural hospital level. This may be temporary. But they could also increasingly take responsibility as District Medical Officers responsible for organising and supervising health care to communities. This is a role which is lacking in most Western countries.

The primary health care approach allows to establish a conceptual continuity between the roles of first line care provider and of District Medical Officer. Of course a difference between them is that the first provides care himself, whereas the second delegates it to other workers. But in order to delegate tasks (and to teach and supervise them properly) the DMO must be able to perform them himself. Both need a generalist approach to problems and competence in biomedical as well as human sciences. Both can be expected to synthesise fragmented knowledge in order to apply it adequately to human beings in a problem-solving approach. This way of dealing with health problems applies as well to the management of individual patients in first line care delivery as to the district medical officer organising care for a community. The differences in content of work may be less important than the similar global attitude towards medical work, which differentiates them from the narrowing focus of specialists.

4. Conclusion

There is an increasing concern for the social status of GPs in the developing world. GPs are needed, and as specialisation increases, less and less general practitioners will be available. It is widely considered that medical care should not be provided by specialists only, although for different reasons: GPs can be looked at as cheaper, they can also be looked at as better to deal with unselected problems.

Visions focusing only on economic reasons to call upon GPs rather than specialists are not likely to promote GP’s position within the medical profession. They will remain cheap substitutes for specialised care. Division of labour between GPs and specialists is given no technical content which would establish complementary relations between them, and relies only on social distinctions: GPs caring for the urban poor and the rural masses, specialists for the wealthy.

Health authorities and Universities thus face the challenge to give a valuable technical content to the function of GPs, in which they can utilise their medical expertise in ways complementary with those of specialists.

REFERENCES