

Updating formation agenda for the evolving family doctors

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FAMILY DOCTOR IS CONSIDERED A PHYSICIAN WHO TAKES OVERALL CARE OF A SICK PERSON IN HIS FAMILY AND SOCIAL ENVIRONMENT

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Family doctor (even ageographically) is well recognized as a person-committed doctor rather than a disease – oriented physician.

In the common sense this expression is taken as “a doctor who is attentive not only to technical aspects but also to human and social relationships”. So, family doctor is considered a physician who takes overall care of a sick person in his family and social environment, not only a technician who cures a disease. General practice, in different ways according to different countries, is strongly associated with indexes of better overall health and lower costs, however Primary Care is now on the verge of collapse due to a dysfunctional financing and delivery system. In US very few young physicians are going into primary care and those already in practice are under such stress that they are looking for an exit strategy. (1). Also general practice has a conflict: to do not enough, while specialist medicine tends to do too much. General practitioners do not let third parts earn, they, in fact, do not prescribe innovative, expensive drugs, neither adopt expensive medical devices for diagnostic or therapeutic purposes and therefore have few resources to develop and to promote themselves in the media and in decision makers, because they are not interesting for the various decision makers.

To motivate Family doctors to get targets (that are almost always uncritically accepted from international guidelines proposed by other specialists, often full of conflict of interests by stakeholders) some models of proactive medicine have been proposed, with disease addressed consultation services, separated like in other specialities and paid for performances, with process or surrogate indicators and poor results in terms of serious endpoints, as reduction in mortality or hospitalization rates (2, 3). At the same time the needs of accountability generate increase of bureaucratic tasks and of costs, and further reduction of time devoted to patient care. So it will be necessary to provide standard care by lower grade health professionals. Furthermore, the idea that informatics and telematics can solve any problem is just a delusion. As it was shown by the University College of London independent review of Summary Care Record in UK (4), triumphal expectations and huge investments didn't produce the expected results, on the contrary there are serious risks for privacy. Evident examples of these risks are the fight for opting out from the Spine and the request by Police to gain access to citizens' health information, causing potential risks for the patients reluctant to share vital information with their doctor (5-9).

In recent years, stakeholders have invested huge sums to medicalize more and more human life. The same WHO definition of health (10) is misleading and dangerous to the sustainability of public health and universal access to health care and it has been used to expand the margins of medical intervention. The total control of the media by advertisers, the uncontrollable circulation of false or exaggerated health news via social networks, increase noise and generate unrealistic expectations in the population. This results in an increase in litigation for alleged medical malpractice that, in turn, results in an increase in costs for defensive medicine. Supporting individual specialist disciplines, both via medical specialists and patient organizations, stakeholders and their conscious or unconscious bearers lowered more and more the thresholds, raised the bar of therapeutic targets, expanded prevention relegating it to a mantra slogan, devoid of any beneficial effect on health, but very useful for those who have to sell something to someone. The invention of new "diseases," the illusion of being able to always prevent the development of complications, has led States or Third Party Paying to try rationing care via a progressive increase in bureaucratic procedures and copayments, that take time away from care to patients. The result of this inflation of the tasks is the need to overcome the pattern of the individual

physician, and move towards a model of territorial medicine socio-epidemiological-based in which many general practitioners, paediatricians, and sometimes also some other specialists, work all together to deliver standardized care, controlled by nurses on the basis of rigid protocols, focusing on models of specialized care of the individual diseases. The risk is to lose completely the deepest sense of the complexity and of the time-continuum dimension of the personal care. At the same time the hospital is becoming increasingly reserved for acute patients, discharging the burden of chronic care management (more and more increasing, because of aging population and the inability of medicine to heal) on family doctors and families, left without resources to deal with a real biblical plague.

The economic crisis plaguing many western countries makes unbearable the weight of this situation, especially in the absence of provisional funds to manage disability, and threatens to blow up the universal health care system (11-15).

But in addition to these professional, economic and organizational aspects exists a problem of strategic perspective. The need to have evidence pushed towards a cure based on the reductionist method applying the theorem of Pareto that identifies the few factors that explain most of the variance in diagnosis and treatment of diseases. With such a model it is possible to cure 70-80 percent of the population, but the personalized care is another thing. There are clinical and biological factors (not just human or social) which are very important in a single person and unimportant in a population because they are rare. These factors are not assessable and correctable in complex multifactorial condition by the application of reductionist models, but through the application of the "System Medicine", an approach which borrows from molecular biology the ability to evaluate a large number of variables each of which has little weight, but which, taken together, makes the difference in individuals (16-18). This is even more true if one considers that the family medicine does not cure specific diseases, but persons with multiple problems connected to each other and modulated by the family and society environment.

All of these requirements, to which the general practitioner is unable to resist because he does not possess economic resources, political influence, and visibility in the media, should be taken into account in the training of future family physicians.

In the training process it should therefore be necessary to implement also theoretical and practical skills to conduct first level diagnostics in primary care facilities (ultrasound, doppler spirometry, for example) and to deal with the diagnostic anticipation expectation that comes, often wrongly misled by media, aimed to reduce patients hospitalization.

In addition, the need for complex territorial organizational models also makes it necessary to learn the rudiments of managerial and human resource management. Family and social disintegration, poverty back, loneliness of the elderly, blur the boundaries of social and health problems in a continuum that needs to be dealt with knowledge of the tools of social security and the possibilities offered by telemedicine in its various forms: from remote monitoring to remote diagnostics (i.e. Whole System Demonstrator preliminary results (19).

And finally there ought not be lacking the techniques that confer future family physicians the ability to communicate not only in doctor-patient relationship, but also with media, in order to get the attention needed to influence public opinion and beliefs of citizens towards health objectives really achievable and sustainable and to support models of medicine truly personalized.

Paraphrasing Edgar Morin (20), the agenda of the next training family doctors should be more geared to Pascal than to Descartes. The more general practice will be strong, not only from the point of view of the social perception of the value of individual physicians, but also of the awareness of identity, the more it will be able to develop its own paradigms and fight those the stakeholders are trying to implement.

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