CHANGING WORLD, CHANGING DOCTORS, CHANGING EDUCATION!
J. W. van Ree

S.F.S.P. | « Santé Publique »
2003/HS Vol. 15 | pages 151 à 155
ISSN 0995-3914

Article disponible en ligne à l'adresse :

Pour citer cet article :
DOI 10.3917/spub.hs030.0151

Distribution électronique Cairn.info pour S.F.S.P..
© S.F.S.P.. Tous droits réservés pour tous pays.

La reproduction ou représentation de cet article, notamment par photocopie, n'est autorisée que dans les limites des conditions générales d'utilisation du site ou, le cas échéant, des conditions générales de la licence souscrite par votre établissement. Toute autre reproduction ou représentation, en tout ou partie, sous quelque forme et de quelque manière que ce soit, est interdite sauf accord préalable et écrit de l'éditeur, en dehors des cas prévus par la législation en vigueur en France. Il est précisé que son stockage dans une base de données est également interdit.
Changing world, changing doctors, changing education!

Changer le monde, changer les médecins changer l’éducation

J. W. van Ree (1)

Summary: Future developments in the community will underline the need to provide a community-oriented health care system in which public health doctors collaborate with general practitioners, as the hospital-based health care system that currently exists in many countries will not be able to solve the problems of health care in the future. Increasing populations, increasing mobility all over the world, spread of new diseases (aids/hiv and ebola virus for example) will have great impact on our societies and the expectations of the societies and patients of their doctors. Most societies in which our young doctors will serve, expect their adults to live on healthily into their 80th. That means that the society of the future will be a double aging society (more older people who are older than before) with all concomitant burdens of degenerative chronic diseases. How should we handle the problems in 2025 when our capacities stay restricted to what we once learned in 2002? For this purpose the medical faculties have to change their curricula. The medical faculties will have to educate different kind of doctors, different from the doctors they have educated for many decades. These doctors must collaborate with other health care workers in primary health care teams. Collaboration in these teams requires mutual trust, win-win situations and agreement on the principles of health promotion programs. Only by collaboration between public health care and individual, personal health care it will be possible to achieve unity for health for all people. In the future both public health doctors and general practitioners need each other’s complementary support and since they share the same area of interest, they need to work together.

Résumé : Les évolutions futures des communautés vont mettre en lumière le besoin d’un système de soins orienté sur la communauté, dans lequel les médecins de santé publique collaborent avec les médecins généralistes. En effet les systèmes de soins basés sur l’hôpital, existant dans de nombreux pays, ne pourront résoudre les problèmes des soins de santé du futur. L’augmentation des populations, l’augmentation de la mobilité à travers le monde, la propagation de nouvelles maladies (SIDA/VIH, virus ébola par exemple) auront un grand impact sur nos sociétés et sur ce que les sociétés et les patients attendent de leurs médecins. La plupart des sociétés dans lesquelles les futurs médecins exerceront, espèrent que leurs membres vivront en bonne santé au delà de 80 ans. Ceci signifie que la société du futur sera doublément âgée (plus de personnes âgées, plus âgées qu’auparavant), avec un poids concomitant de maladies chroniques. Comment prendre en compte ces problèmes en 2025, si nos capacités sont limitées à ce que nous

(1) GP, PhD, Maastricht University, Dep. General Practice, Vocational training P. de Bijjplein 1, Paviljoen.- POB 616, 6200 MD Maastricht, The Netherlands.

Tiré à part : J.W. van Ree
Introduction

Long ago there was only one kind of doctor. All doctors were generalists and doctors visited their patients at home (‘house doctors’). But these doctors cared not only for their sick patients; most doctors had a combined function. They worked in their own practice as private doctors, often for the wealthier part of the community, and at the same time they worked in the public arena, where the community or the state paid for their care of the poor.

The subsequent development of medical science has resulted in differentiation in tasks of doctors. The growing body of knowledge and new technical options has resulted in the development of a range of medical disciplines. At one end of the scale, there are the doctors who have a more generalist task, working outside the hospitals, fulfilling a primary role in the prevention of diseases in populations, and charged with caring for the health of populations or parts thereof. At the other end of the scale, there are specialists who have become more and more focussed in narrow areas of health care, developing great expertise in specific diseases of certain parts of the human body. Thus, the gap between public health care and hospital-based care was born, and this gap has continued to exist until the present day in most western countries.

Developments in public health care

New insights into the causes and spread of diseases have in the past led to the discovery of the relation between nutritional food deficiencies and diseases such as the links between scurvy and vitamin C deficiency and between beriberi and vitamin B deficiency. The growing body of knowledge about the emergence and spread of diseases as a result of unhealthy habits (poor quality food, widespread alcoholism, smoking), poor working and living conditions have underlined the importance of disease prevention and the role of health education. Population-based health care has become a task for national or local authorities, resulting in the development of independent public health care organizations paid for from with public funds. These institutions were able to organize systematically and perform specific preventive tasks better than the hospital-based physicians, especially in cases where a systematic approach was essential to achieve adequate prevention.
Developments in general practice

The position and tasks of general practitioners have had a long development and a general practitioner is nowadays very different from a public health doctor. Nowadays, GPs are specialists, with a very specific task and a central position in the health care system in many countries. They are the only general medical doctors in primary care and they provide continuing care for individuals and their families in all phases of life, within the social context and society, recognizing the environmental circumstances.

The position of GPs in the health care system is not the same in all countries. The position of GPs depends strongly on the structure and principles of a country’s health care system, that is, on whether it has a hospital-based system or a public health based system. In a public health based system, GPs are the gatekeepers to the hospital system [4]. One of their main tasks is that of preventive medicine aimed at individuals and families in all phases of life, within the social context and society, recognizing the environmental circumstances.

One of their main tasks is that of preventive medicine aimed at individuals and families in all phases of life, within the social context and society, recognizing the environmental circumstances.

The position of GPs in the health care system is not the same in all countries. The position of GPs depends strongly on the structure and principles of a country’s health care system, that is, on whether it has a hospital-based system or a public health based system. In a public health based system, GPs are the gatekeepers to the hospital system [4]. One of their main tasks is that of preventive medicine aimed at individuals and families in all phases of life, within the social context and society, recognizing the environmental circumstances.

Primary health care, provided by the GP as a specific medical professional, has a position outside the hospital and within the communities. General practitioners are therefore in a unique position to play a linking role between individual health care and the care for the community that includes their practice population. In the future, it is this community-oriented primary care, which could play a crucial role in addressing some of the increasing health problems of the future.

Collective working but different approaches

Several publications have drawn attention to the considerable gaps between these two branches of medicine, but have also emphasized the need for collaboration, because they are increasingly working to the same agenda [2]. There are many arguments favouring such collaboration, including the close correlation between personal health and lifestyles in a population, the increasing interdependence between the quality of life of individuals and environmental factors, and the attention that must be given to prevention in communities, to health promotion aiming at groups, to medical risk reduction in high-risk groups and to the curative treatment of patients.

It has become increasingly clear that programs at the population level are much more successful if they are supported at the individual level [5, 7].

Can we bridge the gap?

We will not be able to bridge the gap by trying to transform GPs into public health physicians or vice versa. Primary care doctors and public health doctors have been conditioned by their education and training ever since they started it. They do their work as they have learned to do and they have been infused with the mode of thought that is characteristic of their discipline. We know that it is not easy to change such modes of thought or to learn entirely new skills. Both general practice and public health care have proved to be equally important disciplines for the optimisation of health care in the community. Both have proved to be very successful in their respective areas of care. But they are using different principles and different tools. Both play their own important roles, which cannot easily be taken over by the other discipline. In my view, only collaboration, including the sharing of knowledge and skills, can
lead to optimised care, produce better outcomes and add more value both for individuals and for society as a whole.

**Tasks for medical faculties**

The society of the future will be an aging society, with the concomitant burden of degenerative diseases, while high-risk behaviour will influence the health of populations and the levels of psychological stress. The health care problems in our future society cannot be solved with doctors who did not learn to adapt to new developments in the society but only learned to recall unrelated facts. Therefore we need different doctors than we educate now. The medical faculties should offer their students curricula and training that include community health related subjects [3]. There are only a relatively small number of medical schools that are basically community-oriented and express this in their curricula. Most of these universities are members of a collaborating group of educational Institutions: The Network: Community Partnerships for health through Innovative Education, Service, and Research [6].

Many traditional medical curricula still do not emphasise the importance of community related aspects of health. Subjects like medical sociology, health promotion skills and epidemiology are often not included in the curricula, and insofar as they are included, they are often not the most popular parts of the curriculum for medical students and teaching staff. Training programs should focus on collaboration and communications between the participating disciplines. Because of the continuously changing society and presentation of diseases and health related problems we have to educate our medical students to learn continuously and to develop themselves continuously. Therefore a continuously evolving, high medical education system is necessary to assure the delivery of high quality doctors. But what are we doing in our medical faculties? We are producing classic doctors who learned to provide episodic care to individuals. But we need doctors who support health promotion in the community and we need doctors who provide managed care. Based on evidence of effectiveness and safety, working together with other disciplines in primary care teams. Only collaboration, including the sharing of knowledge and skills can lead to optimised care, produce better outcomes and add more value both for individuals and for the society as whole. We need integrated curricula in which students meet patients in the early years and in which teaching of the basic sciences takes not only place in the first two of three years. Training of future doctors should not only take place in hospital, and absolutely not only in academic hospitals, but also take place in primary care situations and in public health. Training in working together, in collaboration in primary care teams, should have priority.

Israel has a long tradition in developing primary care and especially building primary health care teams. These teams have achieved the integration of community health care with the care for individuals and families. Prevention of cardiovascular diseases by this approach has been found to be very successful. The above activities often feature GPs in supportive roles, and their contribution has turned out to be essential in improving the outcome of public health programs [1].

One promising example of the integration of public health care and pri-
Private medical care is currently being implemented in the Netherlands, namely the Hartslag Limburg (Limburg Heartbeat) program in the Maas-tricht region. This project has been selected by WHO as a demonstration project to work out the collaboration between public health care and private medicine in the field of cardio-vascular prevention. In the Hartslag Limburg program we have designed a model in which the public health care activities are combined with (private) primary health care activities, in collaboration with cardiologists at the local hospital. This structure allowed us to promote continuity of care from the community, via general practitioners, to the level of the cardiologists. We also stated the need for individual and population-based interventions to achieve optimised prevention at all levels of care. In addition to the preventive activities in selected city areas, general practitioners working in these areas are treating high-risk patients individually, as well as referring them to, for example, anti-smoking clinics and local sports clubs. An essential element of the program is the attempt to achieve collaboration between all partners, medical or otherwise, in order to create win-win situations.

Conclusion

Future developments in the community will underline the need to cooperate and to provide a community-oriented health care system, as the hospital-based health care system that currently exists in many countries will not be able to solve the problems of health care in the future. Only by collaboration between public health care and individual, personal health care will it be possible to achieve unity for health for all people. Collaboration requires mutual trust, win-win situations and agreement on the principles of health promotion programs. In the near future medical faculties and schools offering medical training programs will have to take responsibility for this development and teach medical students about this need for cooperation. We need integrated curricula in which students meet patients in the early years and in which teaching of the basic sciences takes not only place in the first two of three years. Training of future doctors should not only take place in hospitals, and absolutely not only in academic hospitals, but also take place in primary care situations and in public health. Training in working together, in collaboration in primary care teams, should have priority.

BIBLIOGRAPHIE