CHAPTER 3
MEDICAL PRACTITIONER: GLOBAL OVERVIEW

3.1 PHYSICIAN

A physician is a health care provider who practices the profession of medicine, which is concerned with promoting, maintaining or restoring human health through the study, diagnosis, and treatment of disease, injury and other physical and mental impairments. They may focus their practice on certain disease categories, types of patients or methods of treatment – known as specialist medical practitioners – or assume responsibility for the provision of continuing and comprehensive medical care to individuals, families and communities known as general practitioners. Medical practice properly requires a detailed knowledge of the academic disciplines (such as anatomy and physiology).

Both, the role of the physician and the meaning of the word itself vary around the world, including a wide variety of qualifications and degrees, but there are some common elements. For example, the ethics of medicine require that
physicians show consideration, compassion and benevolence for their patients.

3.2 GENERAL PRACTITIONER:

A general practitioner (GP) is a medical practitioner who treats acute and chronic illnesses and provides preventive care and health education for all ages and all sexes. They have particular skills in treating people with multiple health issues and comorbidities. "The good GP will treat patients both as people and as a population"

The term general practitioner or GP is common in the Republic of Ireland, the United Kingdom and several Commonwealth countries. In these countries the word physician is largely reserved for certain other types of medical specialists, notably in internal medicine. While in these countries, the term GP has a clearly defined meaning, in North America the term has become somewhat ambiguous, and is not necessarily synonymous with the term "family doctor" or primary care provider.
3.3 ASIA:

3.3.1 INDIA:
The basic medical degrees in India are MBBS (Bachelor of Medicine, Bachelor of Surgery), BAMS (Bachelor of Ayurveda, Medicine and Surgery), BHMS (Bachelor of Homoeopathic Medicine and Surgery) and BUMS (Bachelor of Unani Medicine and Surgery). These are generally a four and a half years course followed by a year of compulsory rotatory internship. The internship requires the candidate to work in all the departments for a stipulated period of time to undergo hands-on training in treating patients.

The registration of doctors is usually managed by state medical councils. A permanent registration as a Registered Medical Practitioner is granted only after satisfactory completion of the compulsory internship.

3.3.2 PAKISTAN:
In Pakistan, 5 years of MBBS is followed by one year of internship in different specialties. Pakistan Medical and Dental Council (PMDC) then confer permanent registration, after which
the candidate may choose to practice as a GP or opt for specialty training.

The first Family Medicine Training programme was approved by the College of Physicians and Surgeons, Pakistan (CPSP) in 1992 and initiated in 1993 by the Family Medicine Division of the Department of Community Health Sciences, Aga Khan University, Pakistan. In 1997, the Royal College of General Practitioners, UK, unconditionally approved the Programme for the MRCGP Examination and additionally declared it as amongst the top 10 programmes in UK.

3.3.3 SRI LANKA:

In Sri Lanka to become a general physician, one must be registered at the Sri Lanka Medical Council (formally the Ceylon Medical Council). To do this one must gain a Bachelor of Medicine and Surgery (MBBS) degree after 5½ years of study at a local state university and undergo one year of internship. For physicians who gained their medical qualifications outside Sri Lanka must sit for a special exam conducted by the medical council known as the act 16. The Sri Lanka Medical Council confers permanent registration, after
which the candidate may choose to practice as a GP, opt for specialty training, and have a career in government or private health care institutions.

There are also assistant medical practitioners (AMP) who later on become registered medical practitioners (RMP) due to seniority. They follow a course of three years in a government institution and gain Sri Lanka Medical Council registration. These doctors also work in Sri Lanka as general practitioners, mainly in rural areas.

3.4 EUROPE:
3.4.1 FRANCE:
In France, the *médecin généraliste* (commonly called *docteur*) is responsible for the long term care in a population. This implies prevention, education, care of the diseases and traumas that do not require a specialist, and orientation towards a specialist when necessary. They also follow the severe diseases day-to-day (between the acute crises that require the intervention of a specialist).
They have a role in the survey of epidemics, a legal role (constatation of traumas that can bring compensation, certificates for the practice of a sport, death certificate, certificate for hospitalisation without consent in case of mental incapacity), and a role in the emergency care (they can be called by the *samu*, the French EMS). They often go to a patient's home when the patient cannot come to the consulting room (especially in case of children or old people), and have to contribute to a night and week-end duty (although this was contested in a strike in 2002).

The studies consist of six years in the university (common to all medical specialties), and three years as a junior practitioner (*interne*):

**3.4.2. DENMARK:**

In Denmark to become a general practitioner 6 years of training is required after medical school: 1 year of basic training and 5 years of specialist training. Of the 6 years approximately half will take place in general practice and the other half is hospital training. Having finished the program the doctor will receive the title "Speciallæge i Almen Medicin". This translates into
"specialist in general medicine", which can be considered a contradiction in terms. Every Danish citizen has an assigned general practitioner. Patients have to be able to contact their doctor Monday to Friday from 8 am to 4 pm. After 4 pm the patients can use the on-call doctor service which all general practitioners under the age of 60 are obligated to participate in. Treatments at hospitals require a referral from a general practitioner, as do treatment by specialists in private practice, e.g., gynecologists and dermatologists. Patients can freely consult ophthalmologists and otologists though.

3.4.3 IRELAND:

General Practice in Ireland largely follows the British model, with some exceptions. GP training in Ireland requires the completion of a primary medical degree. Entry to a General Practice Training Scheme is based on competitive interview. Most are of 4 years duration (one is 5 years). Generally the first 2 years are spent rotating through relevant specialties (medicine, paediatrics, obstetrics & gynaecology, psychiatry, accident & emergency, ENT etc.). Two years are then spent as a GP registrar in designated Training Practice. After successfully
completing the MICGP exams, the new general practitioner is free to practice. Typically Irish GPs work exclusively with private (i.e. fee-for-service paying) patients or have a mix of public and private. So-called "public" patients are those who qualify for a medical card under the General Medical Services (or GMS) system. This is free health care, provided by the government and is means tested. Other groups such as those with specified chronic illnesses and the elderly are also entitled to a medical card. A medical card entitles the holder to free GP consultations, free medications and free hospital treatment. In order to treat medical card holders a GP must apply for and be granted a GMS list. Applications for such lists are competitive as they can be very lucrative for the GP and vacancies do not often arise.

GPs deal with the entire spectrum of medical ailments. They are well placed to implement preventative measures and to manage chronic illness. They also act as "gate-keepers" for the tertiary care system, providing referrals to specialist services when appropriate. Some GPs are employed by private agencies.
3.4.4 ITALY:
In Italy the *medico di famiglia*, or "medico di medicina generale", is the first point of contact between patient and healthcare system. The equivalent figure in the UK and in most English-speaking countries is the General Practitioner. The "medico di famiglia" is a self-employed worker. For doctors graduated after 31.12.1994 the possession of this diploma is a necessary requirement for accessing to the regional ranking of general practice aimed to access agreements with the NHS as a General Practitioner.

3.4.5 NETHERLANDS AND BELGIUM:
General practice in the Netherlands and Belgium is considered fairly advanced. The *huisarts* (literally: "home doctor") administers first line, primary care 24 hours a day, 7 days a week. In the Netherlands, patients cannot consult a hospital specialist without a required referral. Most GP's work in private practice although more medical centers with employed GP's are seen. Many GP's have a specialist interest, e.g. in palliative care.
In Belgium, one year of lectures and two years of residency are required. In the Netherlands, training consists of three years (full time) of specialization after completion of internships. First and third year of training takes place at a GP practice. The second year of training consists of six months training at an emergency room, or internal medicine, paediatrics or gynaecology, or a combination of a general or academic hospital, three months of training at a psychiatric hospital or outpatient clinic and three months at a nursing home (verpleeghuis) or clinical geriatrics ward/polyclinic. During all three years, residents get one day of training at university while working in practice the other days. The first year, a lot of emphasis is placed on communications skills with video training. Furthermore all aspects of working as a GP gets addressed including working with the medical standards from the Dutch GP association NHG (Nederlands Huisartsen Genootschap). All residents must also take the national GP knowledge test (landelijke huisarts kennistoets) twice a year. In this test of about 160 multiple choice questions, medical, ethical, scientific and legal matters of GP work are addressed.
3.4.6 UNITED KINGDOM:

In the United Kingdom, doctors wishing to become GPs take at least 5 years training after medical school, which is usually an undergraduate course of five to six years (or a graduate course of four to six years) leading to the degrees of Bachelor of Medicine and Bachelor of Surgery (MB,ChB/BS).

Up until the year 2005, those wanting to become a General Practitioner of medicine had to do a minimum of the following postgraduate training:

- One year as a pre-registration house officer (PRHO) (formerly called a house officer), in which the trainee would usually spend 6 months on a general surgical ward and 6 months on a general medical ward in a hospital;
- Two years as a senior house officer (SHO) - often on a General Practice Vocational Training Scheme (GP-VTS) in which the trainee would normally complete four 6-month jobs in hospital specialties such as obstetrics and gynecology, pediatrics, geriatric medicine, accident and emergency or psychiatry;
- One year as a general practice registrar on a GP-VTS.
• This process has changed under the programme Modernizing Medical Careers. Medical practitioners graduating from 2005 onward have to do a minimum of 5 years postgraduate training:

• Two years of *Foundation Training*, in which the trainee will do a rotation around either six 4-month jobs or eight 3-month jobs - these include at least 3-months in general medicine and 3-months in general surgery, but will also include jobs in other areas;

• A three year "run-through" GP Specialty Training Program (GPSTP): 18 months as a Specialty Registrar in which time the trainee completes a mixture of jobs in hospital specialties such as obstetrics and gynecology, pediatrics, geriatric medicine, accident and emergency or psychiatry; 18 months as a GP Specialty Registrar in General Practice.
## NHS Medical Career Grades

<table>
<thead>
<tr>
<th>Year 1:</th>
<th>Old System</th>
<th>New System (Modernizing Medical Careers)</th>
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<tbody>
<tr>
<td></td>
<td>Pre-registration house officer (PRHO) - one year</td>
<td>Foundation Doctor (FY1 and FY2) - 2 years</td>
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<tr>
<td>Year 2:</td>
<td>Senior house officer (SHO)</td>
<td>Specialty Registrar (StR) in a hospital specialty: minimum six years</td>
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<td>Year 3:</td>
<td>a minimum of two years, although often more</td>
<td>Specialty Registrar (StR) in general practice: three years</td>
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<td>Year 4:</td>
<td>Specialist registrar four to six years</td>
<td>GP registrar—one year General practitioner total time in training: 4 years</td>
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<td>Year 5:</td>
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<td>Years 6-8:</td>
<td>Consultant total time in training: minimum 7-9 years</td>
<td>Consultant total time in training: minimum 8 years</td>
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<td>Year 9:</td>
<td>Consultant</td>
<td>Consultant</td>
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<tr>
<td>Optional</td>
<td>Training may be extended by pursuing medical research (usually two-three years), usually with clinical duties as well.</td>
<td>Training is competency based, times shown are a minimum. Training may be extended by obtaining an Academic Clinical Fellowship for research or by dual certification in another specialty.</td>
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During the GP specialty training program, the medical practitioner must complete a variety of assessments in order to be allowed to practice independently as a GP. There is a knowledge-based exam with multiple choice questions called the Applied Knowledge Test (AKT). The practical examination takes the form of a "simulated surgery" in which the doctor is presented with 13 clinical cases and assessment is made of data gathering, interpersonal skills and clinical management. This Clinical Skills Assessment (CSA) is held on three or four occasions throughout the year and takes place in the specially designed centre at Croydon. Finally throughout the year the doctor must complete an electronic portfolio which is made up of case-based discussions, critique of videoed consultations and reflective entries into a "learning log".

Membership of the Royal College of General Practitioners was previously optional. However, new trainee GP's from 2008 are now compulsorily required to complete the MRCGP. They will not be allowed to practice without this postgraduate qualification. After passing the exam or assessment, they are awarded the specialist qualification of MRCGP – Member of the
Royal College of General Practitioners. Previously qualified general practitioners (prior to 2008) are not required to hold the MRCGP, but it is considered desirable. In addition, many hold qualifications such as the DCH (Diploma in Child Health of the Royal College of Paediatrics and Child Health) and/or the DRCOG (Diploma of the Royal College of Obstetricians and Gynaecologists) and/or the DGH (Diploma in Geriatric Medicine of the Royal College of Physicians). Some General Practitioners also hold the MRCP (Member of the Royal College of Physicians) or other specialist qualifications, but generally only if they had a hospital career or a career in another speciality, before training in General Practice.

There are many arrangements under which general practitioners can work in the UK. While the main career aim is becoming a principal or partner in a GP surgery, many become salaried or non-principal GPs, work in hospitals in GP-led acute care units, or perform locum work. Whichever of these roles they fill, the vast majority of GPs receive most of their income from the National Health Service (NHS). Principals and partners in GP surgeries are self-employed, but they have contractual
arrangements with the NHS which give them considerable predictability of income.

Visits to GP surgeries are free in all countries of the United Kingdom, but charges for prescription only medicine vary. Wales, Scotland and Northern Ireland have abolished all charges.

A survey by Ipsos Mori released in 2011 reports that 88% of adults in the UK “trust doctors to tell the truth”.

3.5 NORTH AMERICA:
3.5.1 CANADA:

In Canada, the term general practitioner often has two meanings. The Canadian specialty that is equivalent to the British general practitioner training program is family medicine which accounts for almost 40% of the residency positions for graduating students. Following four years in medical school, a resident will spend 2–3 years in an accredited family medicine program. At the end of this, residents are eligible to be examined for Certification in the College of Family Physicians of Canada. Many hospitals and health regions now require this certification.
To maintain their certificate, medical practitioners must document ongoing learning and upgrade activities to accumulate "MainPro" credits. Some practitioners add an extra year of training in emergency medicine and can thus be additionally certified as CCFP (EM). Extra training in anesthesia, surgery and obstetrics may also be recognized but this is not standardized across the country.

General practitioners in Canada do operate in private practice, in that they are not employees of the government. They either own their own practice or work for a privately owned practice.

3.5.2 UNITED STATES:

Medical practitioners must hold a license to practice medicine in the United States. The requirement is to be enrolled in or have completed a year of residency, traditionally called a rotating internship. There are generally four years of undergraduate college and four years of medical school prior to the internship. All prospective licentiates (denoted as physicians and surgeons in most states, e.g., California) who pass step three of the United States Medical Licensing Exam and successfully complete an accredited internship may practice the full range of medicine.
The population of this type of medical practitioner is declining, however. Currently the United States Navy has many of these general practitioners, formally known as General Medical Officers or GMOs, in active practice. The GMO is an inherent concept to all military medical branches. GMOs are the gatekeepers of Medicine in that they hold the purse strings and decide upon the merit of specialist consultation. The US now holds a different definition for the term "general practitioner". The two terms "general practitioner" and "family practice" were synonymous prior to 1970. At that time both terms (if used within the US) referred to someone who completed medical school and the one-year required internship, and then worked as a general family doctor. Completion of a post-graduate specialty training program or residency in family medicine was, at that time, not a requirement. A physician who specializes in "family medicine" must now complete a residency in family medicine, and must be eligible for board certification, which is required by many hospitals and health plans for hospital privileges and remuneration, respectively. It was not until the 1970s that family medicine (formerly known as family practice) was recognized as a specialty in the US.
Many licensed family medical practitioners in the United States after this change began to use the term "general practitioner" to refer to those practitioners who previously did not complete a family medicine residency. Family physicians (after completing medical school) must then complete three to four years of additional residency in family medicine. Three hundred hours of medical education within the prior six years is also required to be eligible to sit for the board certification exam; these hours are largely acquired during residency training.

The existing general practitioners in the 1970s were given the choice to be grandfathered into the newly created specialty of Family Practice. As well, the American Academy of General Practice changed its name to the American Academy of Family Physicians. The prior system of graduating from medical school and completing one year of post-graduate training (rotating internship) was abolished. If one wanted to become a "house-call-making" type of physician, one needed to stay in the academic setting two or three more years.

Since many general practitioners were grandfathered into this specialty, the number of family practitioners initially grew
significantly. However, the number of medical students graduating into Family Practice drastically declined. Logically, students felt that they could complete similar residencies in higher-paying specialties in the same amount of time. As the number of medical students choosing non-primary care specialties increased, number of newly graduating family- and other primary care physicians decreased, while the demand for primary care did not decrease. In many settings, physician assistants, nurse practitioners, and other lower-cost and less-trained "medical extenders" make up the difference.

The American Academy of General Physicians, the only such organization representing general practitioners, it is also the only organization that provides a path for Board Certification in this specialty. Through the American Board of General Practice, there is a specialty of "General Practice with Board Certification". These organizations also actively train physicians and educate physicians with a prescribed body of knowledge through the American College of General Medicine. The American Academy of General Physicians is actively involved in providing a pathway to "Board Certification" for a large number of General Practitioners produced by the medical
colleges. These physicians have no other path to board certification save going back into a residency program, which is not feasible in most cases due to a variety of reasons.\textsuperscript{1}

The new system of academically trained "specialist" family practitioners has indeed produced well-trained physicians. However, many feel that these physicians are less likely to go to smaller towns and rural communities due to socio-economic conditions or circumstances as well as access to nascent technology. Statistics in 2009 show that medical students graduate with debt in excess of $200,000 for their education. This system has most likely created physicians who are more likely to work in a profit-driven, third-party-payer model as they provide a more assured income and ability to repay debt.

When the American Academy of Family Practice was created, the American Academy of General Practice was abolished. Several members of the AMA were in opposition to this and predicted that another General Practice organization would inevitably result, including Susan Black, MD. She predicted a "second coming" of a "General Practice Movement". Several
physicians nationwide created the American Academy of General Physicians. They prescribed a body of knowledge that defined a "General Practitioner". Along with the College of William and Mary they created a system of study and practice-oriented residency in order to board-certify the ten to fifteen percent of doctors in the United States who are not board certified, but who are "General Practitioners".

General practitioners have in the past, and currently are being created by the present system of producing doctors, with no way to codify or "board certify" their competency for numerous reasons. But this is changing with the advent of the American Board of General Physicians in 1999. It is charged with certifying the quality of the physicians who have completed a prescribed course of study and practice and has no relation to the American Board of Specialties. Presently doctors Board Certified by the American Board of General Practice are accepted for hospital privileges in some large and small hospitals.

Board certification of general practitioners is different from the board certification of family physicians. Testing for the
American Board of Family Practice involves a written exam. Testing for the American Board of General Practice involves a written exam as well as an oral exam as well as a practical exam with a clinical skills evaluation. Re-certification by the American Board of Family Practice is by written exam. It is the only physician-certifying board that does not use oral exams for initial certification or re-certification. The American Board of General Practice uses oral examination for re-certification as well as requiring 50 hours of continuing education per year for seven years to be re-certified.

Prior to recent history most postgraduate education in the United States was accomplished using the mentor system. A physician would finish a rotating internship and move to some town and be taught by the local physicians the skills needed for that particular town. This allowed each community's needs to be met by the teaching of the new general practitioner the skills needed in that community. This also allowed the new physician to start making a living and raising a family, etc. General practitioners would be the surgeons, the obstetricians, and the internists for their given communities. Changes in demographics and the growing complexities of the developing bodies of knowledge
made it necessary to produce more highly trained surgeons and other specialists. For many physicians it was a natural desire to want to be considered "specialists". What was not anticipated by many physicians is that an option to be a generalist would be abolished.

The general practice concept has historically been based on creating a physician who can "do anything" that may be necessary for the patient's life and welfare, as well as for the community. Sadly, the same physician that visits your home, takes out your tonsils or appendix, delivers your babies and cares for you from cradle to grave is long gone. As well, the general practice movement promotes the continuing education of its doctors using the Internet-based information systems, community-based educational resources as well as academic center based resources.

Certificates of Added Qualifications (CAQs) in adolescent medicine, geriatric medicine, sports medicine, sleep medicine, and hospice and palliative medicine are available for those board-certified family physicians with additional residency training requirements. Recently, new
fellowships in International Family Medicine have emerged. These fellowships are designed to train family physicians working in resource poor environments.

There is currently a shortage of primary care physicians (and also other primary care providers) due to several factors, notably the lesser prestige associated with the young specialty, the lower pay, and the increasingly frustrating practice environment. In the US physicians are increasingly forced to do more administrative work, and shoulder higher malpractice premiums.

3.6 OCEANIA:
3.6.1 AUSTRALIA AND NEW ZEALAND:

General Practice in Australia and New Zealand has undergone many changes in training requirements over the past decade. The basic medical degree in Australia is the MBBS, and New Zealand the MBChB degree (Bachelor of Medicine, Bachelor of Surgery), which has traditionally been attained after completion of a five or six-year course. Over the last few years, an ever increasing number of four-year medical programs that require a previous bachelors degree have become more common and now account for up to half of all Australian medical graduates. After
graduating, a one- or two-year internship (dependent on state) in the public hospital system is required for full registration. Many newly registered medical practitioners undergo one year or more of pre-vocational position as Resident Medical Officers (different titles depending on jurisdictions) before specialist training begins. For general practice training, the medical practitioner then applies to enter the three- or four-year "Australasian General Practice Training Program" (four-year for additional Fellowship in Advanced Rural General Practice), a combination of coursework and apprenticeship type training leading to the awarding of the FRACGP (Fellowship of the Royal Australian College of General Practitioners) or FRNZCGP (Fellowship of the Royal New Zealand College of General Practitioners), if successful. Since 1996 this qualification or its equivalent has been required in order for the GP to access Medicare rebates as a general practitioner. Medicare is Australia's universal health insurance system, and without access to it, a practitioner cannot effectively work in private practice in Australia. The Royal Australian College of General Practitioners also has a reciprocal agreement with the American Board of Family Medicine as the Australasian
general practitioner training program is recognised as equivalent to the US family medicine residency programs in the United States.

In New Zealand, most GPs work within a practice that is part of a Primary Health Organisation (PHO). These are funded at a population level, based on the characteristics of a practice's enrolled population (referred to as capitation-based funding). Fee-for-service arrangements still exist with other funders such as Accident Compensation Corporation (ACC) and Ministry of Social Development (MSD), as well as receiving co-payments from patients to top-up the capitation-based funding. In NZ new graduates must complete the RNZCGP GPEP (General Practice Education Program) Stages I and II in order to be granted the title FRNZCGP, which includes the PRIMEX assessment and further CME and Peer group learning sessions as directed by the RNZCGP. Holders of the award of FRNZCGP may apply for specialist recognition with the New Zealand Medical Council (MCNZ), after which they are considered specialists in General Practice by the council and the community.
Increasingly a portion of income is derived from government payments for participation in chronic disease management programs.

There is a shortage of GPs in rural areas and increasingly outer metropolitan areas of large cities, which has led to the utilisation of overseas trained doctors (international medical graduates (IMGs)).

REFERENCES: