The 1960's: A Decade of Crisis in Canadian Family Medicine

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"No great improvements in the lot of mankind are possible, until a great change takes place in the fundamental constitution of their modes of thought." – John Stuart Mill

Much has been said and written in recent years about general or family practice. Since the early 1960's probably no other medical discipline has been the subject of so much discussion, attention, scrutiny, praise, and criticism. This attention has come from all levels of government as part of an attempt to make high quality medical care services available at little or no cost to the individual patient. Family practice has also captured the interest of a public disenchanted with the availability and quality of existing services, and of medical professional associations concerned about the increasing demand for their members' services. This paper will review the evolution of family medicine in Canada during recent years in the context of changing societal expectations and needs for medical care.

Increasing Specialization in the 1950's

The intense interest in general practice in recent years is in marked contrast to the 1950's, during which the specialties made enormous advances in numbers and scientific progress. The demise of general practice was widely predicted and, indeed, accepted in many quarters. The polyclinic concept of buildings and hospitals housing different types of specialists with immense treatment, laboratory, and radiological facilities seemed the logical future for the increasingly complex delivery of medical services. Scientific progress and an increasing array of effective medications seemed to prove that no single physician could be the jack-of-all-trades in this ancient profession. Hospitals ceased to be dreaded dens of death and disease and became more widely accepted as hotels of healing.

The surgical disciplines improved and expanded their techniques, so that more and more surgeons restricted their practices to limited areas, body systems, or age groups. Anesthesia became a more highly specialized field with advances in technology that increased the number of surgical procedures which could be safely performed. The internist increasingly abandoned his efforts to stay abreast of the expansion of knowledge in his field, so he progressively narrowed his sphere of interest. The pediatrician followed the internist in parallel subspecialization. All the specialties tended to restrict their intake of patients on the basis of age, sex, disease, or body system. But since the supply of physicians providing primary care was decreasing relative to the supply of specialists, in many parts of the country an adequate referral system never developed. Patients were frequently treated by several physicians and the family was divided in its medical care, usually among a pediatrician, internist, and gynecologist. Added to this, a great many economically and socially underprivileged people were unable to afford any medical care and were treated on an episodic basis by different general practitioners, or at hospital clinics and outpatient departments. As late as 1963 it was conservatively estimated that at least 30 percent of the population of Ontario was medically indigent.*[1] So it can be seen that because of the social, economic, and professional climate, and despite rapid advances in medical science, a system for the effective delivery of medical service failed to materialize for the whole population.

By the mid 1950's many farseeing and thoughtful generalists accepted the inevitability of change and began cutting back their broad medical and surgical activities. They felt that specialists' care could benefit their patients. Many generalists engaged in less surgery and other specialized treatments and concentrated instead on the prevention, early detection, diagnosis, treatment, and rehabilitation of the more common conditions. In greater numbers they pursued postgraduate education. Others, discouraged by what they perceived as annihilation by specialist medicine, left general practice to specialize, thus further thinning the ranks of those in primary care. Studies show that between 1951 and 1961 the percentage of civilian physicians in active general practice declined from 66.0 to 48.9, while certified specialists increased from 27.0 to 37.3 – the remainder choosing to restrict their practice to a particular field of medicine.[2] The number of specialists increased by 94.6 percent between 1955 and 1965, the total number of physicians by 36 percent, and the population by 18 percent.[3] Meanwhile the number of G.P.'s increased by only 4.1 percent.

Conflict and Reassessment in the 1960's

By the early 1960's a small but

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*Medical indigency is defined here as the inability to pay for necessary medical care or the premiums required for pre-paid medical insurance.

significant shift in attitudes, both public and professional, became detectable. Medical care was becoming not only more expensive, but also curiously unsatisfactory. For example, with the advent of government-controlled, prepaid hospital insurance in Ontario in 1959, bed utilization increased dramatically. This resulted in a huge demand for the services of all branches of the profession and provided further impetus to the process of subspecialization. Patients who had no regular physician to provide continuing follow-up care would repeatedly return to hospitals for treatments, and hospitals became increasingly accepted as the "Doctor's Workshop." Provincial governments, already planning for universal medical care insurance, were appalled at the prospective cost of such schemes. While the credo of the World Health Organization stating that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being"[4] was widely accepted in Canada, there was little understanding among politicians of how to attain the highest standard of health.

The G.P. had long been aware of the limitations of his training and armamentarium in improving or even maintaining the total social, psychological, and physical well-being of his patients. He had developed an awareness of their needs over the years of his practice and found many gaps between his training and actual practice of medicine. The gaps resulted from the fact that his training took place entirely in the hospital and classroom and was specialist-oriented and based on laboratory and clinical science. At no time was he taught, for example, that one of his greatest weapons against ill health was his ability to observe, listen, and talk to his patients – he had to learn this for himself, often through painful trial and error. The clinicians who had trained him were concerned only with his level of expertise in their own specialties and were ignorant of the nature of general practice.

An important factor in the new emphasis on family practice was the College of General Practice (now Family Physicians) of Canada. This organization, formed in 1954 and dedicated to the improvement of standards of practice through continuing education, was visible evidence of the pride of its membership in their discipline. Despite all indications to the contrary, they believed that a new and more important role in medical care lay ahead for what was sometimes referred to as the "personal specialist in total health care." In 1956, the College commissioned Dr. K. F. Clute to conduct a careful scientific study of quality of medical care in a sample of general practitioners.[5] The report was critical of current quality but it did not diminish the enthusiam of the College and its supporters. Rather, it inspired them to greater efforts to convince their colleagues of the need for continuing self-improvement. But the most important result of the Clute report went far beyond the analysis of quality: the report (imperfect as it was) did provide scientific evidence of the need for special training in this complex discipline.

The Clute report was followed in 1964 by the Report of the Royal Commission on Health Services which found that while "The quality of medical services available to Canadians compares favourably with the standards prevailing in other advanced industrialized nations ... there are grave deficiencies." Also, "the basic pattern for provision of medical ... services will likely rest for some time on solo practitioners. Nevertheless, we believe that the advantages of group practice ... far outweigh the disadvantages."[6] An additional finding was "that the present programs (of continuing medical education) are not reaching a sufficient number of practising physicians." This momentous report, which laid the foundation for present government medicare programs, seemed to envisage a health care delivery system based on the general practitioner providing primary and continuing medical care and consulting with or referring to specialists cases he judged to be outside his area of competence. Following these reports, the rate of change accelerated. The Federal Government produced its medical care legislation and the provinces quickly followed with their programs. The College of Family Physicians started planning and medical schools started implementing training programs in family medicine. The Federal and Provincial Governments commissioned more task forces and committees to look into all aspects of health care, and new concepts developed which would radically alter general practice for all time.

From the stimulus of these two great dynamic forces, ie, the expansion of medical scientific knowledge and the implementation of universal medical care insurance, the immediate results were an increased demand for medical professional services and a need for an improved health care delivery system.

Another factor in the decade of crisis included the growth of group practice. Many forms of such practice came into existence. Cooperation between physicians led, among other things, to the feeling that it was not necessary to be personally on call on a 24-hour-day, 7-day-week basis. Even outside formal group contracts, by 1970 most physicians had some arrangement with colleagues to alternate call on a daily or weekly basis. As the Committee on the Healing Arts, 1970, Report[7] puts it, "Independent solo practice, while still prevalent, is less and less the norm in modern medicine."

While in 1960 there was among doctors a growing fear of government involvement in the provision of medical care services, this possibility seemed comfortably remote and most physicians did not seem unduly nervous about such a distant prospect. They were rudely awakened on July 1, 1962, when the medical profession in Saskatchewan went on "strike" in opposition to the medical care legislation of T. C. Douglas' socialist provincial government. The ripples of shock from that province disturbed the profession from Vancouver to St. John's, and a new militancy grew throughout organized medicine. This, however, failed to stop, slow, or even seriously influence the federal and provincial governments' plans and programs, and their implementation further heightened the fear for the future which pervaded the profession.

Improvements in communications and transportation made their mark on patterns of practice. As more

patients acquired telephones and automobiles, the house call declined in popularity among physicians as a mode of delivering care, particularly in urban areas. More homes with television meant a more widely (if not better) informed public who began to recognize the benefits of medical care. People became aware of real and imaginary medical problems and began to seek out the available services. As the level of public expectation increased, so did their anxieties. In their living rooms they witnessed the assassination of popular political figures and the daily agonies of war, riot, poverty, disaster, famine, and man's disregard for his fellow's humanity. As social mobility increased and family and community became more fragile, North Americans more frequently suffered from emotional discomfort and breakdown. Unable to adapt their biological, social, and psychological needs to the rapid changes in modern society, many by 1970 were troubled by those handmaidens of despair: anxiety and depression. And if the public was uprooted by the violent change in all aspects of society, how much better off was the family doctor? Not only had he been subjected to the same forces as his patient, but in addition, the very bases of his professional life were assaulted. There were those of us who advocated radical change during the 1960's towards a revision of basic assumptions in the practice and delivery of health care. These changes included compulsory education for family practice, compulsory continuing education and peer review, and community involvement in the assessment of needs and provision of health services. Although these changes were proposed with what we believed were the highest of motives, the net effect on our profession was just another crisis in a long series of crises. Indeed, the fact that change in the practice of medicine did occur was probably due less to our specific efforts than to their effect as stress factors, which added to the total atmosphere of crisis. This is not to diminish their contribution to any improvement there may have been (they provided a new direction in which change could occur) but it is probably true that without an entire revolution in public and professional attitudes, the changes would have been much less marked.

Emergence of Family Medicine

Man in groups is said to react to crisis with successive and overlapping stages of denial, confusion, anxiety, resentment, recovery, and reorganization, loosely in that order. This was borne out in the history of general practice between 1960 and 1970. Seldom can such a reaction be seen so clearly in a single decade. If one looks at the G.P.'s complacent denial in 1960 followed by the confusion, anxiety and resentment of the succeeding years to the present stages of recovery and reorganization, one can see a very satisfactory process of adaptation. Despite immense changes in medical knowledge and technique, the G.P. in 1960 practiced much the same way as his pre-World War II counterpart. It is true that he employed more and different drugs, drove a different car, used the telephone more, worked more frequently in hospitals and/or in an office, and spoke a more sophisticated jargon. But he still practiced largely alone, referred infrequently, distained non-medical help, and attended fewer refresher courses than he does today. The difference is not only practical but conceptual. Whereas a decade ago he thought of himself as a mini-specialist and acted accordingly, the "new" family physician sees himself as practicing a discipline which is quite different from the specialties, and at least equal to them in importance to the overall delivery of high quality health care. He now recognizes the serious deficiencies in his medical education and is demanding changes in this area. He no longer attempts to compete with the specialists and concentrates instead on improving his skills in early detection and prevention of health breakdown, treatment of common disorders (physical and psychosocial), care and rehabilitation of the chronically ill, and emergency care of his more clearly defined patient population. He is interested in evaluating his activities through research, and less afraid than before of experimenting with new techniques. In the area of prevention, he is increasingly concerned with lowering the level of that vicious offshoot of modern medicine, iatrogenic disease. In brief, his is the first branch of clinical medicine to subscribe to the concept of health maintenance in addition to disease treatment. From his perspective as ongoing coordinator of health care for entire families he is able to detect, at an early time, behavior threatening the health of one or more members of the family. He is more comfortable than ever before in working with social workers, public health nurses, voluntary health agencies, and the many others involved in the community health service system. He is also rapidly becoming, with the help of the social worker, the prime authority on familiagenic disorders – physical, psychological, and psychosomatic. As a corollary, he is less comfortable with episodic and short term care. Although this was what he was trained for in his undergraduate years, it had always constituted a very small part of his work.

Admittedly there are deficiencies in this emerging discipline, and the most important of these is in the area of definition. While it is becoming clear what the family physician does and will do, it is not always so clear how to educate him and how he will perform his duties. Family practice educators are working on the content and methods of courses, but they lack the background of traditional medical education. However, this may be more of an advantage than otherwise. Hopefully, educators in family medicine will break away from the hospital-based type of program which is little more than a repeat of the rotating internship.

Family physicians themselves lack the security they had as the "jack-of-all-trades" of their profession. Until the early 1960's a G.P. could treat any condition *regardless of its rarity* or his familiarity with the best method of medical care. Today he is more likely to obtain a consultation and either continue care with supervision or refer the patient and provide supportive care. We must deal with the question of which medical or surgical conditions the family physician should treat and which he should refer. In addition, it has

become clear that his training in human behavior cannot be adequately taught only by psychiatrists, since their profession tends to deal with catastrophic, institution-based psychiatric dysfunction as opposed to the community and family-based psychosocial and psychophysiological dysfunction which the family physician sees every day of his working life. It is not surprising to any generalist, for example, to find that "General Practitioners in Ontario handle more psychiatric problems than do any other type of physician."[8] The report goes on to say that in a six-month period in 1967 G.P.'s gave 91,200 services of this nature on a short term basis to 38,900 patients, as opposed to psychiatrists who gave 31,600 services to 5,500 patients. With reference to long-term treatment of psychiatric conditions, the same study showed that G.P.'s in private practice treated more than three times as many patients as psychiatrists in private practice. As the report of this committee suggests, "General practice is carrying the major volume of medicine's contribution, outside Ontario Hospitals,* to mental health in the province." There are not enough psychiatrists to provide this care, and if the family physician were to abandon his role as psychotherapist, the provision of mental health services would be seriously compromised. Despite these facts, however, some teachers in the new university departments and divisions of family medicine are reluctant to engage too heavily in this area because they fear they will alienate themselves from colleagues already in practice by appearing to be "too psychiatrically oriented." It is my contention that we need to recognize the fact that the family physician of today and the general practitioner of yesterday have always carried the responsibility for treating most of the population who suffered from psychiatric, psychosocial and psychophysiological dysfunction. This area of practice *is* family medicine as much as any other area of clinical science, and we need a bold new approach to the understanding and integration of the social and behavioral sciences into our discipline. It is in family practice that mind-body dichotomy becomes blurred so that the physician can treat the whole person in his human ecology.

If the conditions which the family physician treats can be better defined, then his pharmaceutical and therapeutic armamentarium can be confined to those areas, so that he need not burden himself with information about the thousands of preparations so vigorously promoted by the pharmaceutical industry. Parallel with the growth of medical knowledge has been the increase in the number of drugs, most of which are of little value in practice, and all of which carry some danger. The family physician of today needs to maintain a highly critical approach to drug promotion and he must be better trained for this.

In addition to pharmacology and psychotherapy he should be trained in physiotherapy and occupational therapy so that he can recognize when they are preferable to drug therapy or when they can be used in connection with it. Spinal and joint manipulation is a technology long recognized as having therapeutic effects and, when carefully taught, can play an important part in non-drug therapy.

The well recognized advantages of having family physicians practice in hospitals (such as the provision of continuing and comprehensive care, the educational exposure to peers and consultants, and the coordination of specialist care of their patients) do not alter the fact that his primary sphere of operation is the community. Thus, it follows that the bulk of his specialized training should be community based. And since the body of knowledge which he utilizes is unique in clinical medicine,[9] it seems logical that he should be trained by knowledgeable and appropriately academic family doctors.

Magraw[10] has listed six factors in the changing needs and demands of patients and doctors – (1) comprehensiveness and continuity of care, (2) availability of care, (3) teamwork among physicians, (4) financing of care, (5) teamwork among all health professionals, and (6) continuing education and avoidance of professional obsolescence. In Canada all these changes are in progress. This is demonstrated by the development of many university programs in residency training for aspiring family physicians, the increasing number of publicly and privately financed group family practices and community health centers, the increased availability of allied health professionals, government commitment to the financing of health care, and the increased interest of the medical profession in continuing education and evaluation. The most recent figures indicate that while the population of Ontario has increased by 25 percent in the last decade, the number of physicians has increased by 45 percent. The proportion of primary physicians is being maintained,[11] and all the indications are that greater numbers of students are choosing family medicine as a career.

It seems not too optimistic to hope that we are witnessing a most satisfactory resolution of an historic crisis in medicine and health care delivery and the development of an exciting system which may serve as an example to other nations whose systems have evolved in ways that fail to meet the needs of the public. The many obstacles ahead should not prove insurmountable nor even comparable to the difficulties already overcome, if we use the experience we have gained and keep clear objectives.

"Forward, forward let us range, Let the great world spin for ever down the ringing grooves of change." – Alfred Lord Tennyson

*Provincial Psychiatric Hospitals

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