



Network organisation within WONCA Region Europe - ESGP/FM

*European Academy of Teachers in General Practice
(Network within WONCA Europe)*

THE EUROPEAN DEFINITION OF GENERAL PRACTICE / FAMILY MEDICINE

SHORT VERSION

**The European Definitions of General Practice / Family Medicine
The Key Features of the Discipline of General Practice
The Role of the General Practitioner**

and

**A description of the Core Competencies
of the General Practitioner/Family Physician**

Short version – 2005

EURACT

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INDEX

- 1. INTRODUCTION
- 2. THE EUROPEAN DEFINITIONS 2005
- 2.1. The characteristics of the discipline of general practice/family medicine
- 2.2. The Specialty of General Practice/Family Medicine
- 3. CORE COMPETENCIES
- 3.1. Primary care management
- 3.2. Person-centred care
- 3.3. Specific problem solving skills
- 3.4. Comprehensive approach
- 3.5. Community orientation
- 3.6. Holistic approach
- 4. ESSENTIAL APPLICATION FEATURES
- 4.1. Contextual Aspects
- 4.2. Attitudinal Aspects
- 4.3. Scientific Aspects

1. INTRODUCTION

This is a shortened version of the WONCA Europe statement published in 2002, and available from the websites of WONCA Europe and EURACT. It has been produced by EURACT in 2005, and revised by a working group of WONCA European Council in 2011, as an aid to individual teachers and learners, being shorter and easier to translate.

This consensus statement defines both the discipline of general practice/family medicine, and the professional tasks, it also describes the core competences required of general practitioners. It delineates the essential elements of the academic discipline and provides an authoritative view on what family doctors in Europe should be providing in the way of services to patients, in order that patient care is of the highest quality and also cost effective. From the definitions within this paper the agendas for education, research, quality assurance can be derived, to ensure that family medicine will develop to meet the health care needs of the population in the 21st century.

2. THE EUROPEAN DEFINITIONS 2002

The Discipline and Specialty of General Practice / Family Medicine

There is a need to define both the discipline of general practice/family medicine and the role of the specialist family doctor. The former is required to define the academic foundation and framework on which the discipline is built, and thus to inform the development of education, research, and quality improvement. The latter is needed to translate this academic definition into the reality of the specialist family doctor, working with patients in health care systems throughout Europe.

General practice/family medicine is an academic and scientific discipline, with its own educational content, research, evidence base and clinical activity, and a clinical specialty orientated to primary care.

2.1. The characteristics of the discipline of general practice/family medicine

There are twelve characteristics of the discipline. These are that it:

a) is normally the point of first medical contact within the health care system, providing open and unlimited access to its users, dealing with all health problems regardless of the age, sex, or any other characteristic of the person concerned.

"Normally" is used to indicate that in some circumstances, e.g. major trauma, it is not the first point of contact. However it should be the point of first contact in most other situations. There should be no barriers to access, and family doctors should deal with all types of patient, young or old, male or female, and their health problems. General practice is the essential and the first resource. It covers a large field of activities determined by the needs and wants of patients. This outlook gives rise to the many facets of the discipline and the opportunity of their use in the management of individual and community problems.

b) makes efficient use of health care resources through co-ordinating care, working with other professionals in the primary care setting, and by managing the interface with other specialities taking an advocacy role for the patient when needed.

This coordinating role is a key feature of the cost effectiveness of good quality primary care ensuring that patients see the most appropriate health care professional for their particular problem. The synthesis of the different care providers, the appropriate distribution of information, and the arrangements for ordering treatments rely on the existence of a coordinating unit. General practice can fill this pivotal role if the structural conditions allow it. Developing team work around the patient with all health professionals will benefit the quality of care. By managing the interface with other specialties the discipline ensures that those requiring high technology services based on secondary care can access them appropriately. A key role for the discipline is to provide advocacy,

protecting patients from the harm which may ensue through unnecessary screening, testing, and treatment, and also guiding them through the complexities of the health care system. The discipline recognises the responsibility to monitor and systematically assess the quality and safety in a range of aspects of the care delivered by GPs and practices followed by action aimed either at improving quality.

c) develops a person-centred approach, orientated to the individual, his/her family, and their community.

Family medicine deals with people and their problems in the context of their life circumstances, not with impersonal pathology or "cases". The starting point of the process is the patient. It is as important to understand how the patient copes with and views their illness as dealing with the disease process itself. The common denominator is the person with their beliefs, fears, expectations and needs.

d) promotes patient empowerment

Family medicine is in a strategic position to promote the goals of patient empowerment and self management. Longitudinal care, a multidisciplinary approach, a strong relationship based on a unique consultation process and on trust, a person-centred approach, are the starting points for a continuous educational process aimed to empower the patient.

e) has a unique consultation process, which establishes a relationship over time, through effective communication between doctor and patient

Each contact between patient and their family doctor contributes to an evolving story, and each individual consultation can draw on this prior shared experience. The value of this personal relationship is determined by the communication skills of the family doctor and is in itself therapeutic.

f) is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient.

The approach of general practice must be constant from birth (and sometimes before) until death (and sometimes afterwards). It ensures the continuity of care by following patients through the whole of their life. The medical file is the explicit proof of this constancy. It is the objective memory of the consultations, but only part of the common doctor-patient history. Family doctors will provide care over substantial periods of their patients' lives, through many episodes of illness. They are also responsible for ensuring that healthcare is provided throughout the 24 hours, commissioning and coordinating such care when they are unable to provide it personally.

g) has a specific decision making process determined by the prevalence and incidence of illness in the community.

Problems are presented to family doctors in the community in a very different way from the presentations in secondary care. The prevalence and incidence of illnesses is different from that which appears in a hospital setting and serious disease presents less frequently in general practice than in hospital because there is no prior selection. This requires a specific probability based decision-making process which is informed by a knowledge of patients and the community. The predictive value, positive or negative of a clinical sign or of a diagnostic test has a different weight in family medicine compared to the hospital setting. Frequently family doctors have to reassure those with anxieties about illness having first determined that such illness is not present.

h) manages simultaneously both acute and chronic health problems of individual patients.

Family medicine must deal with all of the health care problems of the individual patient. It cannot limit itself to the management of the presenting illness alone, and often the doctor will have to manage multiple problems. The patient often consults for several complaints, the number increasing with age. The simultaneous response to several demands renders necessary a

hierarchical management of the problems which takes account of both the patient's and the doctor's priorities.

i) manages illness which presents in an undifferentiated way at an early stage in its development, which may require urgent intervention.

The patient often comes at the onset of symptoms, and it is difficult to make a diagnosis at this early stage. This manner of presentation means that important decisions for patients have to be taken on the basis of limited information and the predictive value of clinical examination and tests is less certain. Even if the signs of a particular disease are generally well known, this does not apply for the early signs, which are often non-specific and common to a lot of diseases. Risk management under these circumstances is a key feature of the discipline. Having excluded an immediately serious outcome, the decision may well be to await further developments and review later. The result of a single consultation often stays on the level of one or several symptoms, sometimes an idea of a disease, rarely a full diagnosis.

j) promotes health and well being both by appropriate and effective intervention.

Interventions must be appropriate, effective and based on sound evidence whenever possible. Intervention when none is required may cause harm, and wastes valuable health care resources.

k) has a specific responsibility for the health of the community.

The discipline recognises that it has a responsibility both to the individual patient and to the wider community in dealing with health care issues. On occasions this will produce a tension and can lead to conflicts of interest, which must be appropriately managed.

l) deals with health problems in their physical, psychological, social, cultural and existential dimensions.

The discipline has to recognize all these dimensions simultaneously, and to give appropriate weight to each. Illness behaviour and patterns of disease are varied by many of these issues and much unhappiness is caused by interventions which do not address the root cause of the problem for the patient.

2.2. The Specialty of General Practice/Family Medicine

The following is a definition of the role of the family doctor which puts the characteristics of the discipline described above into the context of the practising physician. It represents an ideal to which all family doctors can aspire. Some of the elements in this definition are not unique to family doctors but are generally applicable to the profession as a whole. The speciality of general practice/family medicine is nevertheless the only one which can implement all of these features. An example of a common feature is that of the responsibility to maintain skills; this, however, which may be a particular difficulty for family doctors who often work in isolation.

General practitioners/family doctors are specialist physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for the provision of comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness. They care for individuals in the context of their family, their community, and their culture, always respecting the autonomy of their patients. They recognise they will also have a professional responsibility to their community. In negotiating management plans with their patients they integrate physical, psychological, social, cultural and existential factors, utilising the knowledge and trust engendered by repeated contacts. General practitioners/family physicians exercise their professional role by promoting health, preventing disease providing cure, care, or palliation and promoting patient empowerment and self-management. This is done either directly or through the services of others according to health needs and the resources available within the community they serve, assisting patients where necessary in accessing these services. They must take the responsibility for developing and maintaining their skills, personal balance and values as a basis for effective and safe patient care. Like other medical professionals, they must take responsibility for

continuously monitoring, maintaining and if necessary improving clinical aspects, services and organisation, patient safety and patient satisfaction of the care they provide.

3. CORE COMPETENCIES

The definition of the discipline of general practice/family medicine and of the specialist family doctor must lead directly to the core competencies of the general practitioner/family doctor.

Core means essential to the discipline, irrespective of the health care system in which they are applied.

The twelve characteristics of the discipline relate to twelve abilities that every specialist family doctor should master. Because of their interrelationship, they are clustered into six independent categories of core competence. The main aspects of each cluster is described.

3.1. Primary Care Management

Includes the ability:

- to manage primary contact with patients, dealing with unselected problems;
- to cover the full range of health conditions;
- to co-ordinate care with other professionals in primary care and with other specialists;
- to master effective and appropriate care provision and health service utilisation;
- to make available to the patient the appropriate services within the health care system;
- to act as advocate for the patient
- to continuously monitor, assess and improve quality and safety of care.

3.2. Person-centred Care

Includes the ability:

- to adopt a person-centred approach in dealing with patients and problems in the context of patient's circumstances;
- to develop and apply the general practice consultation to bring about an effective doctor-patient relationship, with respect for the patient's autonomy;
- to communicate, set priorities and act in partnership;
- to promote the goals of patient empowerment;
- to provide longitudinal continuity of care as determined by the needs of the patient, referring to continuing and co-ordinated care management.

3.3. Specific Problem Solving Skills

Includes the ability:

- to relate specific decision making processes to the prevalence and incidence of illness in the community;
- to selectively gather and interpret information from history-taking, physical examination, and investigations and apply it to an appropriate management plan in collaboration with the patient;
- to adopt appropriate working principles. e.g. incremental investigation, using time as a tool and to tolerate uncertainty;
- to intervene urgently when necessary;
- to manage conditions which may present early and in an undifferentiated way;
- to make effective and efficient use of diagnostic and therapeutic interventions.

3.4. Comprehensive Approach

Includes the ability:

- to manage simultaneously multiple complaints and pathologies, both acute and chronic health problems in the individual;
- to promote health and well being by applying health promotion and disease prevention strategies appropriately;
- to manage and co-ordinate health promotion, prevention, cure, care and palliation and rehabilitation.

3.5. Community Orientation

Includes the ability:

- to reconcile the health needs of individual patients and the health needs of the community in which they live in balance with available resources.

3.6. Holistic Approach

Includes the ability:

- to use a bio-psycho-social model taking into account cultural and existential dimensions.

4. ESSENTIAL APPLICATION FEATURES

In applying the competencies to the teaching, learning and practice of family medicine it is necessary to consider three essential additional features; contextual, attitudinal and scientific. They are concerned with features of *doctors*, and determine their ability to apply the core competencies in real life in the work setting. In general practice these may have a greater impact because of the close relationship between the family doctor and the people with whom they work, but they relate to all doctors and are not specific to general practice.

4.1. Contextual Aspects

(Understanding the context of doctors themselves and the environment in which they work, including their working conditions, community, culture, financial and regulatory frameworks)

- Having an understanding of the impact of the local community, including socio-economic factors, geography and culture, on the workplace and patient care.
- Being aware of the impact of overall workload on the care given to the individual patient, and the facilities (eg staff, equipment) available to deliver that care.
- Having an understanding of the financial and legal frameworks in which health care is given at practice level
- Having an understanding of the impact of the doctor's personal housing and working environment on the care that s/he provides

4.2. Attitudinal Aspects

(Based on the doctor's professional capabilities, values, feelings and ethics)

- Being aware of one's own capabilities and values - identifying ethical aspects of clinical practice (prevention/diagnostics/ therapy/factors influencing lifestyles);
- Having an awareness of self: an understanding that one's own attitudes, and feelings are important determinants of how one practises
- Justifying and clarifying personal ethics;
- Being aware of the mutual interaction of work and private life and striving for a good balance between them.

4.3. Scientific Aspects

(Adopting a critical and research based approach to practice and maintaining this through continuing learning and quality improvement)

- Being familiar with the general principles, methods, concepts of scientific research, and the fundamentals of statistics (incidence, prevalence, predicted value etc.);
- Having a thorough knowledge of the scientific backgrounds of pathology, symptoms and diagnosis, therapy and prognosis, epidemiology, decision theory, theories of the forming of hypotheses and problem-solving, preventive health care;
- Being able to access, read and assess medical literature critically;
- Developing and maintaining continuing learning and quality improvement.

The interrelation of core competencies, and essential application features characterises the discipline and underlines the complexity of the specialty. It is this complex interrelationship that should guide and be reflected in the development of related agendas for teaching, research and quality improvement. The WONCA Tree produced by the Swiss College (revised 2011) clearly demonstrates this interrelationship:



