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FAMILY PRACTITIONER AND FAMILY PRACTITIONER'S CATCHMENT AREA

METHODOLOGICAL RECOMMENDATIONS

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Introduction

In order to develop family medicine in this country we need to solve all problems related to family doctors' training, structure and functions of family doctor's office, catchment area and family dispensary. Unfortunately, there are almost no publications on the subject. Our recommendations are based on special studies conducted in pilot wards at polyclinics ## 27 and 24.

Results of the studies will be useful for primary care physicians of many profiles.

FAMILY PRACTITIONER

An institution of a family practitioner does not exist in this country. There are no family physicians among personnel of polyclinics and hospitals. There are no training programs for family practitioners in universities and institutes. The work in this field did not start until recently. The current training programs and curriculae are oriented to narrow specialization and nosologic principles and, thus, do not give a full picture of a patient, social roots of diseases, environmental concepts of public health and preventive practices. This happens because of a weak material base of the universities and institutes and a gap between medical education and practice. Absence of special training programs for family doctors makes us use the existing training and re-training programs, conferences, seminars, etc.

In these conditions the social order should be well-defined, and family doctors should be used rationally and effectively. The role of family physicians should be determined. We should realize what knowledge and in what disciplines must a family physician have. It is clear that a family physician has to know how to work with pregnant women, children, adults of workable age, retired people, invalids and anti-social elements. Family doctors should work with families, medical activists and community. To do all that a family doctor needs to have special and general skills.

Family practitioners should have the following qualities: high moral principles, ideological conviction, decent way of life, especially if the doctor lives in the community area.

Family doctors examine patients who are surrounded by their relatives and it is very important for the process of treatment. Many recommendations concerning catering, motion regimen and hardening will be useful for all family members. Many diseases have a family nature. Every family may be considered an isolated unit from the epidemiological point of view. Many chronic diseases originate and spread within the family. This is why genetic, psychic, social and medical aspects in each family are interdependent and affect each family member. Of great interest are the following systems: mother-daughter; father-son; parents-children, etc. With no doubt, all family members contribute in treatment and influence the patient. Family physician is a new field of practical medicine. He will bridge the gap between science, health care and specific practices.

We believe that community pediatricians and therapists are the closest analogs of family practitioners. This is why we will be working with them until the system of training of family practitioners is created.

Family practitioners should have the in-depth knowledge and understanding of: social problems of health care; patient education techniques; healthy life-style; comprehensive preventive measures; decrees issued by the Central Committee of the Communist Party of the Soviet Union; orders of USSR's Health Ministry; comprehensive programs "Health"; main health indicators; correlation between them and environmental factors; environmental, demographic, social and economic changes; capacity of specialized services; rational catering; sanitary education; implementation of a mass-scale physical training practices. In this connection, family physicians should receive good medical and social training. The training programs should be scientific, politically aware and practice-oriented. We believe that a combination of political, moral, professional and environmental education on the basis of comprehensive approach and new computer technologies and with consideration of the

best achievements of the Soviet medical science and socialism create a good basis for family practitioners' education. In professional terms, family practitioners must have specific objectives and provide medical and social services to women, invalids and teenagers. In some areas medical services are not provided appropriately to the above-mentioned groups of population.

In some countries (i.e., in England) family practitioners visit their patients, see patients in polyclinics, make decisions concerning hospitalization, preventive and curative activities. Majority of family physicians are not connected with hospitals. Family practitioner's salary is proportional to the number of registered patients. All additional services (i.e., shots, labor, night visits, services for the elderly) are paid for separately.

Patients can choose between several family physicians. Family doctors usually work under agreement with state services. Family practitioners deal mostly with preventive care.

What are the main responsibilities of a family practitioner?

Family doctor must:

1. Provide emergency care;
2. State diagnosis and provide treatment for chronic diseases;
3. Provide care in accordance with specialists' recommendations;
4. Have a workplan and a schedule of home visits and office hours in the polyclinic he is assigned to;
5. Know the main work indicators, public health indicators and do everything to improve them. His work should be aimed at specific final results;
6. Know advanced methods of prophylactic medical examinations;
7. Know life-supporting and anti-recurrence methods of treatment;
8. Know the schedule and methodology of curative activities;
9. Know and assess medical, social and economic indicators within his catchment area;
10. Carry out organizational, ideological, preventive work to disseminate healthy life style, physical culture, balanced catering, and, also, to struggle with anti-social phenomena;
11. Refer patients to diagnostic centers, specialists, hospitals and sanatoriums;
12. Arrange patients' documents for different eligibility assessing commissions.
13. Work in high schools, day care centers and other children's facilities.

Forms and methods of a post-graduate training and further professional training of family practitioners

1. Post-graduate courses and programs.
2. Internships.
3. Work in the best polyclinics, family dispensaries and training health care facilities.
4. Primary specialization on the basis of professional qualification improvement facilities.
5. Courses of further professional training.
6. Certification and work on report.
7. Experience exchange.
8. Work in the local scientific societies.
9. Seminars, conferences, workshops for family practitioners.
10. An on-going seminar for family practitioners held by municipal health department.

11. Political education.
12. Individual work with literature. Scientific work and analysis of obtained results.

Family health passport

1. The number of families within the catchment area and their composition.
 - families with many children
 - families with small number of children
 - families without children
 - lonely mothers
2. The number of families who have problems
 - alcohol abuse
 - smoking
 - anti-social phenomena
3. Health status of family members
 - parents
 - children
 - other family members
4. Are family members registered at dispensaries?
 - parents
 - children
 - other members
5. Family members need:
 - hospitalization
 - treatment in sanatorium
6. Housing conditions
 - good
 - satisfactory
 - bad
7. Financial status
 - good
 - satisfactory
 - bad
8. Atmosphere in the family
 - good
 - satisfactory
 - bad
9. Do family members go in for sports?
10. Family members have:
 - serious chronic diseases
 - invalidness.

Family practitioner carries out preventive work and educates all family members. The plans of preventive and curative activities are based on comprehensive medical examinations and specialists' recommendations. Consultants of all profiles work at family dispensaries. Considering the fact that Soviet experience in family medicine is limited, it makes sense to use high-qualified obstetricians, gynecologists, pediatricians and gerontologists as consultants. Our research has shown that about 35 percent of patients need consultations and

examination by specialists. As a rule, those are the most serious cases. Family practitioners assess their work and take stock of a month (quarter, year) together with specialists and consultants. All categories of patients are discussed.

It is clear that family practitioners deal primarily with disease prevention and patient education. Special attention should be paid to preventive activities, since they consume some 76 percent of physician's time. Diagnostic services are provided by specialists at family dispensaries and diagnostic centers. Emergency care is provided in traditional manner. The issues of payment for family practitioner's services is of exceptional importance. According to our research, family practitioner's income on the first stage should and must be a sum of three separate salaries (those of a community practitioner, pediatrician and gynecologist). On a second stage his salary should depend on the results of his work.

We believe that family practitioners should work under contracts with multi-profile polyclinics and family dispensaries. Family practitioners will have their own bank accounts and conduct transactions with specialists, diagnostic centers, consultants, etc. Practitioner's budget may consist of funds allocated by the polyclinic or family dispensary under the contract on one hand, and by funds allocated by trade unions and employers in accordance with social, medical and economic effectiveness, on the other.

Allocation of additional funds to family practitioners for specific preventive activities will not only allow us to increase the number of physicians, but promote specific social-oriented policy as well.

Problems of quality control will become a priority on the first (preparatory) stage. We deem it important to set an independent controlling committee. It will be also responsible for resource utilization control.

Catchment area (medical territorial unit - "uchastok")

Territorial principle of health care delivery is a great achievement of the Soviet health care system. Although this principle has several drawbacks (i.e., patient's assignment to one doctor or polyclinic) and gets criticized by both physicians and patients, it should remain unchanged.

There is a need to issue a special order or decree on a free choice of physician. Medical, physician's or medico-sanitary area is the area family practitioner is assigned to. We believe that well-organized work and sufficient number of personnel (surgeon, gynecologist, therapist, pediatrician, stomatologist) who have had special training in social medicine in rural areas is an ideal combination for rural areas. This is why rural "medical uchastok" (medical territorial unit) may become a subject for serious discussion, if it is decided to develop a concept of medical territorial unit for urban and rural areas. There are many problems concerning medical territorial units ("uchastki"), community doctors, pediatricians and gynecologists. These problems are the following: high occupancy rate; high patient volumes; low quality of care in primary care rooms; abundance of documentation; professional isolation; complicated access to specialists, diagnostic facilities and laboratories. All these factors affect effectiveness of physicians' work, lead to a loss in qualification and impede preventive care activities in the catchment area. This is why it is so important to create a new concept of medical territorial unit and probe them.

According to one of the concepts, medical territorial unit is a structural component of health care system. It unites social, medical, preventive and tertiary care, connects primary care sector with medical sciences (teaching hospitals, specialists), unites adult and children's health care facilities, pharmacies, sanitary services, high schools, police, public, Soviet and communist organizations, administration of large enterprises, etc. Medical territorial unit is an arena for a comprehensive medico-social process.

Our two-year experiment has shown that medico-social territorial unit may become a structural component of the Soviet health care system. Organization of medico-social territorial units all over the country will not demand additional resources and targeted allocations. Medical territorial units will concentrate our efforts on disease prevention, problems of public health and social policy of the Communist Party.

We should focus our attention on dissemination of healthy life style and struggle with anti-social phenomena. Our main goal is to improve the public health. Medico-social territorial unit will be organized by territorial principle and the number of people living in the territory. It will be based on the existing pediatric, obstetric and therapist's territorial units. In rural areas this model already exists (the rural medical territorial unit).

We have developed and probed a model of medical territorial unit that can be used both in rural and urban areas. This model unites the efforts of health care facilities, sanitary services, police, local CPSU committees, military registry offices and high schools to improve disease prevention. This model can be used both in rural and in urban areas.

One of the special features of our model is that we have included stomatologist, gerontologist, social workers, sanitary services and pharmacies into the complex. From 10 to 12 thousand people live in the pilot medico-social territorial unit.

We planned to locate family practitioners' offices and rooms for medical personnel in apartment houses. In this case, polyclinics served as specialized institutions providing diagnostic services, tests and rehabilitation facilities. Family practitioners conducted all examinations, preventive and diagnostic work right in their offices. There was no need for them to go to the polyclinic and meet their patients there. Each unit served the following categories: adults of workable age - 6,000; old people - 2,400; teenagers - 1200; children - 2400. Thus, the polyclinic providing services to 60,000 people had 6 territorial medical units. Number of required personnel was calculated in accordance with the current regulatory acts.

All doctors who would like to work in the medico-social territorial unit should receive special training in the form of lectures and seminars on disease prevention, comprehensive medical examination, medico-social roots of human diseases and social medicine. Doctors for teenagers and gerontologists need to have additional training in continuity of care for older people and teenagers. Questions of emergency care in home conditions and preventive care for industrial workers were very important.

Results of our experiment have shown that the medico-social territorial unit is a complicated structure. We saw lack of cooperation among the doctors and lack of joint efforts.

Developing a concept of APTKs (obstetric therapist's pediatric complexes) we tried to adjust existing territorial units to the new conditions and adapt them to our concept.

It is noticeable that a territory of two therapist's territorial units is equal to one pediatric unit.. This is why it is reasonable to include two therapist's territorial units into one medical unit. So one medico-social territorial unit will serve 4,400 people, including 800 children between 0 and 14, 620 teenagers, 2,200 adults of workable age and 880 old people. Considering the fact that the polyclinic covers 60,000 people, the structure of the assigned population will look as follows; 11,100 children (18,5%); 5400 teenagers (9%); 30,900 adults of workable age (51,5%); 12,600 retired (21%).

Doctors and nurses working in such unit must have sufficient number of rooms, including: women's consultation room; dentist's room; room for general examinations; nurse's room; operation room; diagnostic room; physiotherapy; pharmacy kiosk. all those premises are located on the ground floor of an apartment house. It is desirable that all medical workers have apartments within the territorial unit.

The work in such territorial unit organizationally united a gynecologist, general physician and pediatrician. However, it could not totally eliminate the lack of cooperation between them. Moreover, this model did not provide separate preventive and medical care for teenagers and retired people. The forms of continuity remained unchanged. There was a lack of communication with polyclinics and women's dispensaries.

The final results of the experiment have not revealed any advantages of this model. On the contrary, we faced additional organizational difficulties.

Our experiments in the selected polyclinics and pilot medical territorial units have convinced us that a radically new model of family territorial units had to be created and probed. This model will become an alternative to the existing medical territorial units.

For example, in Cuba one family practitioner serves 700 patients, that is, 140 families. There are about 4,000 family doctors in Cuba. In Germany, family practitioners live within their catchment areas and serve about 270 people each. In our research we used a simple structure of a catchment area: 350 families and 500 families. Public survey in these two areas showed that 93% of people wanted to be assigned to one doctor; 63 % voted for free choice of physician. 90 percent of people in England are served by family practitioners. Our analysis has shown that some 400 or 450 families is an optimal number for one catchment area (family practitioner's territorial unit). Structure of medical and preventive care changes from month to month . For example, in the beginning of the year, 63% of all rendered services were specialists' consultations and diagnostic examinations. By the end of the year this figure fell down to 19,9%. We believe that there are three most important documents in family practice: Individual health passport, Family health passport and Medical territorial unit's passport (description).

Medical territorial unit's passport

1. Territory description. Its sanitary condition
2. Population:
 - children;

- teenagers
 - women
 - men
 - invalids, retired older people
 - adults of workable age
 - fertile women
 - number of families
 - anti-social elements and problematic families
3. Industrial and other objects.
 4. Schools, day care centers, colleges, institutes, universities.
 5. Main health indicators.
 6. Morbidity structure:
 - acute diseases
 - chronic diseases
 7. Medical and other personnel
 8. "Health improvement" program
 9. Plan of social and economic development of the medical territorial unit.
 10. Family health passport.
 11. Individual health passport.

Medical, physician's or medico-sanitary area is the area family practitioner is assigned to. We believe that well-organized work and sufficient number of personnel (surgeon, gynecologist, therapist, pediatrician, stomatologist) who have had special training in social medicine in rural areas is an ideal combination for rural areas. Doctors and nurses working in such unit must have sufficient number of rooms, including: women's consultation room; dentist's room; room for general examinations; nurse's room; operation room; diagnostic room; physiotherapy; pharmacy kiosk. all those premises are located on the ground floor of an apartment house. It is desirable that all medical workers have apartments within the territorial unit. Each medical territorial unit is registered by a family dispensary.

Proceeding from the following structure of the population of a territorial unit you can easily calculate the number of families: children between 0 and 14 - 18,5%; teenagers - 9%; adults - 51,5%; the elderly - 21%; normative indicators for therapist's and medical territorial units - 1880 and 800 people, respectively. Age and sex mix of the population plays an important role here. Our research has revealed the following distribution: people between 15 and 19 - 6,5%; 20-29 - 16,2%; 30-39 - 21,7%; 40-45 - 14,1%; 50-60 - 14%.

We have developed and probed a different model of medico-social territorial unit based not only on the experience of APTKs, but also on our own studies and experience. We used existing regulatory documents and standards in our calculations. One of the special features of our model was that we included stomatologist, gerontologist, social workers, sanitary services and pharmacies into the complex. The model was designed for serving 12,000 people. We planned to locate all premises in one of apartment buildings. The polyclinics served as diagnostic and consultative institutions. However, the model has proven inflexible. It was too far from effective family care models. This is why we think that the implementation of family practice will face many problems. Only new studies in this field will help us find appropriate solutions to the problems.

System analysis shows that a well-trained family practitioner can serve about 500 families, and 350 families at preparatory stage. We should keep in mind that, according to our studies, 35% of all services rendered within each medical territorial unit are emergency care services. 40,2% of the population are registered and constantly observed by enterprises' physicians. Considering the above-mentioned facts, it is important to promote cooperation between family practitioners and physicians who work at the enterprises. And the last question is: how will the families be served during family practitioner's leave? We think that this question has to be solved by family dispensary.

Conclusion

We have studied family practice, the work of a family practitioner and a structure of medical territorial unit. We believe that both urban and rural areas should use one model of medical territorial unit. We have studied selected pilot medical territorial units that combined the principles of pediatric, gynecologic, therapist's, or only therapist's and pediatric territorial units.

We firmly believe that family practitioner's territorial unit is a priority now. There are many unsolved problems. However, it is obvious that a shift to family medicine and family practices is inevitable. This is why it is important to train personnel, create family dispensaries and medical territorial units.