executive committee of the directing council

PAN AMERICAN HEALTH ORGANIZATION

working party of the regional committee

WORLD HEALTH ORGANIZATION

92nd Meeting
Washington, D.C.
June 1984

Provisional Agenda Item 14

CE92/17 (Eng.)
10 May 1984
ORIGINAL: SPANISH

FAMILY MEDICINE SITUATION IN THE AMERICAS

At its 91st Meeting (1983), the Executive Committee of the Pan American Health Organization requested the Director to prepare a report on the family medicine situation in the Region. The purpose of this report is to generate a discussion and examination of the subject.

I. INTRODUCTION

In requesting the preparation of a report for presentation to the Governing Bodies, the Executive Committee suggested that "national and international organizations active in the field of family medicine be consulted."

In compliance with this request, a study has been designed and performed to examine the subject for the following purposes:

- To delineate the frame of reference in which family medicine programs function in selected countries of the Region;

- To determine the concept of family medicine in each of those countries;

- To ascertain how the medical manpower of these family medicine programs is trained and used.

The study was addressed at two levels: a general level at which the existing literature was compiled and analyzed, and a particular level, involving two basic activities:

a) A review of the information provided in a questionnaire by selected countries on the conduct of existing family medicine programs;

b) Visits to three selected countries to observe their programs and to amplify the information obtained in the survey.

The questionnaire was sent to a group of countries in the Region already known to have family medicine programs.* For comparison purposes, the questionnaire was also sent to a number of countries known not to have such programs,** and additional information was obtained from two other countries having such programs.*** Three countries were chosen to be visited that have evolved other approaches to family practice and hence to the undergraduate and graduate training and utilization of medical personnel.****

II. BACKGROUND

In the Region of the Americas, family medicine was first practiced in Mexico in 1953.

A group of physicians of the Mexican Social Security Institute (IMSS) at Laredo, Tamaulipas state, considered the possibility of restructuring the medical care scheme, and began an experiment designed to assess how beneficial certain changes in medical practice could be to patient care, to the physician's efforts, and to the IMSS itself.[1]

At a seminar on social security held in Panama City in 1954, the IMSS presented a paper on the subject of "the family physician," in which it delineated the characteristics this physician should have, "notably that he would serve communities of very specific size and work as a member of a medical team."[1,2]

On the basis of this presentation and other evidence, in 1955 the IMSS gave its approval to the conduct of an experiment in two clinics of Mexico City. "The most notable features introduced were the allocation of a stated population to each family physician, which population included newborn children, adults and elderly people. The appointment

---

* Argentina, Bolivia, Colombia, Ecuador, Mexico, Panama and Venezuela
** Brazil, Chile, Ecuador, Guatemala and Peru
*** Canada and the United States of America
**** Brazil, Mexico and Peru

system was introduced, and it was established that house calls were the responsibility of the family physician. These changes were accompanied by others in the handling of the clinical record, the filing system, the allocation mechanism, etc."[2]

In 1959 this new approach to medical practice in the IMSS was consolidated at the national level, and the practice was subdivided into that of the family physician for adults and the family physician for minors. Family medicine became a specialty in May 1971, when it was introduced in the form of a medical residency in which the artificial distinction between family medicine for adults and for minors was disregarded.[3] In 1974 the Autonomous National University of Mexico (UNAM) extended accreditation to graduate studies in family medicine pursued in the IMSS.

"In 1977 Nuevo Leon University launched an internally-funded two-year residency program on completion of which the participants would seek employment."[4] In 1978 UNAM approached the Secretariat for Public Health and Welfare (SSA) and the Government Workers Social Security Institute (ISSTE)[5] with a view to the conduct of a course of specialization in family medicine. This program was begun in March 1980.

The second country in the Region to launch a family medicine program was Canada. In 1966 this country established two residency programs[6] under the aegis of the college of family physicians of Canada and two medical schools. These programs were begun after several years of experience in continuing education for general practitioners. The College of General Practitioners was founded in 1954 and later changed its name to the present College of Family Medicine. The certifying examination in the specialty was instituted in 1969 and is administered by the College, which also approves graduate training programs in the country.[6]

Up to 1980, general practitioners in family practice were eligible to take the certifying examination. Since that year, however, only those may take it who have completed an approved residency program. Today all the medical schools in Canada have a department of family medicine that offers undergraduate and graduate requirements. The first residency programs were of three years duration, but in 1973 the College of Family Practitioners decided that the prerequisite for the certifying examination would be two years of training in an approved residency, and since then the basic programs are of two years duration, plus an optional third year.

In the United States of America family medicine programs began much as they had done in Canada. The surge of scientific and technological progress in medicine after the second world war multiplied the number of medical specialties and specialists in the country, and the number of general practitioners declined. The population of the United States began to complain as much of the growing scarcity of general practitioners as of the rising cost of medical care.[7] Despite the launching of the federal Medicare and Medicaid programs in 1960, general

practitioners were scarce, and this prompted a study by the Millis Commission of the American Medical Association,[8] which produced a report urging a training program for "primary care physicians." At the same time, this Association launched a study by another Commission on Graduate Medical Education for the practice of general medicine. The report of this commission was published in 1966 and is known as the "Willard Report."[9] Meanwhile, another commission at Harvard University made a study of community health services and issued a report known as the "Folsom Report."[10]

On the basis of these three reports, the American Association of General Practitioners, founded in 1947, proposed in 1966 the establishment of a new specialty, called "Family Practice," and the Academy changed its name to "American Academy of Family Physicians." Although in 1960 graduate training programs in general medicine were already being offered with a duration of two years and encouraged experience in internal medicine, surgery, pediatrics and gyneco-obstetrics, it was not until 1969 that family practice was established and acknowledged throughout the country as the twentieth specialty.[11]

In Latin America and the Caribbean, family medicine programs, also at the graduate level, were launched in the last decade in Argentina, Bolivia, Dominican Republic, Jamaica, Panama, and Venezuela. Other countries, such as Brazil, adopted the residency arrangement, but for work in general medicine.

On the basis of the conclusions reached at subregional meetings sponsored by the Pan American Federation of Associations of Medical Schools (FEPAFEM), several countries in Latin America decided, however, that family medicine should be the conceptual basis for the training of the general physician in his undergraduate studies as well, and that, therefore, efforts should be directed towards a comprehensive revamping of his training in close collaboration between service and training institutions, that would bring about a real transformation of medical practice. For this new practice to function, the structure of the services would have to be changed at the same time.

In the first half of 1979 the Pan American Federation of Associations of Medical Schools drew up a three-year (1979-1982) program directed at taking the lead in Latin America and the Caribbean by promoting the training of the general/family physician in that Region.[12] This program was put in to execution with financing from the W. K. Kellogg Foundation.

III. FINDINGS AND ANALYSIS

1. Framework of Family Practice in the Countries

Everywhere in the world, and in Latin America in particular, the discussion of family medicine seems to generate as yet not well-founded doubts, opinions and hypotheses as to the validity or invalidity of

family medicine programs, and particularly as to the training of medical personnel.

The framework for the practice of family medicine in the Americas varies widely from one country to another and is usually determined by the dominant practice in each country.

In most of the Latin American countries considered, family medicine is practiced under the health care programs of the social security institutions. There are exceptions, however, such as Argentina and Jamaica. In Mexico, where the dominant practice is that of institutions and the social security system, family medicine has reached a high level of development within that institution. The "Estudio Monográfico sobre Sistema Médico Familiar" (Monograph on the Family Medicine System), published by Dr. Rubén Lavalle Argudín in 1958, explains how this system of care emerged in the Mexican Social Security, the highlights of which have been given in the preceding "Background" section.[13-14] As result of the first experiment at Nuevo Laredo and subsequent experience in the IMSS, this institution established a new organization for its services called the "Family Medicine System." This new system of organization was established for the purpose of extending the coverage of medical care in the IMSS, as well as to streamline the use of its resources and reduce the cost of care, and, according to Alárid (1984), has afforded gains toward those objectives.[13] The attending physicians in the institution's consulting rooms are called "family physicians" and each is assigned a population of "beneficiaries," currently 2,400 per family physician. On 30 September 1983 the family medical system comprised 1,454 centers as follows:

- 731 family medicine units (UMFs);
- 201 family medicine units with hospital beds (UMFHs);
- 104 area general hospitals with family medicine (HGZMFs);
- 69 "modified scheme" rural medical units (UMRMs);
- 349 auxiliary family medicine units (UAMFs).

Valdés Durán (1983) says that "these centers function around 8,616 family practioners, of which 2,013 have already completed the family medicine residency."[15] The rest are general practioners without specialization, or specialists in other branches of medicine but functioning as family physicians.[16]

The family practitioner's contract requires him to work eight hours a day, in six of which he sees patients in his office and in two he makes house calls. The work day is divided into two halves, four hours in the morning and four in the afternoon. For every seven family practitioners there is one dentist, and for every ten family practitioners, two social workers. In some centers expectant mothers at low risk are seen, from the third visit to the next to last before the probable date of delivery, by nurses trained for the purpose, in close collaboration with the family practitioner.[16]

In 1979 the Government Workers Social Security and Social Services Institute (ISSSTE) launched a family medicine program at the Ignacio Chávez Clinic in the Federal District on an experimental plan, and in 1980 began a residency in family medicine. The Valle Aragón Clinic was established and staffed with the first graduates of this residency. The family medicine program in this institution is confined to these two clinics. The family practitioner has a six-hour work day. The population is assigned to the consulting room and not to the physician (450 families per shift). The physician makes no house calls, the health team has an additional nursing auxiliary, and the program is connected to the Autonomous National University of Mexico (UNAM).[13]

In 1981 the Secretariat for Public Health and Welfare (SSA) began a family medicine program in the Federal District through medical care units in teaching-service relationships and, later, in January 1982, this approach was extended to all the health centers in the capital.

The programs that emerged from the establishment of the family medicine residency are today operating chiefly in the Secretariat's type T-III-A community centers in Mexico City. The operating module in these centers consists of a general-family physician contracted to work up to seven hours, a nursing auxiliary, and a health promoter. The physician is assigned 300 families and may make house calls. Most of these units are open mornings from Monday to Friday.[13]

There is in Mexico another family medicine program called the "Guadalupe Plan." This is an autonomous program academically dependent on Nuevo Leon Autonomous University (UNAL). The staff are paid by the SSA. or the DIF (Comprehensive Family Development System), and financial aid is supplied by the Kellogg Foundation. Family care is provided by medical residents (of the family medicine residency), and the staff includes student nurses and dentists. The quota of a "casa de salud" (center) is of up to 500 families. The resident is on hand to see patients mornings and afternoons.[13]

To summarize, the only family medicine program of extensive coverage is the IMSS's, doubtlessly because of the change in the organization of medical care rather than the existence of the family medicine residency program. It should be born in mind that only 23.4% of the family physicians have completed that residency[15] (2,013 out of 8,616).

All physicians completing the family medicine residency in the IMSS are hired by the institution, but not all graduates of the other programs.

According to the information obtained in Brazil, there is no family medicine program as such. Since 1975, however, some general community medicine residency programs have been started at Catia, and residencies of this type are currently offered in 13 institutions.[17] According to some officers in the Ministries of Social Security and Education, these residencies are equivalent to the family medicine

residencies of other countries, and some officials have suggested that their name be changed.[18] Community general medicine is regarded as a "primary health care medicine in which the family is the lowest functional unit of care."[19] The specialization in community general medicine and the residency programs were officially authorized by the Ministry of Education on 12 June 1981.[20]

Since the dominant practice in the country remains specialized private practice and specialization is predominant in the institutions of the Ministry of Social Security, physicians completing community general medicine residencies find no market for their services, and most of them are under-utilized or not utilized at all.[21] The social security institutions, which account for more than 40% of the public medical care in the country, have almost no general practitioners.[21]

In Peru the family medicine concept, as it exists in countries with programs of this type, is non-existent and, therefore, there are no programs of this kind.[22] Except for the directors of the "second specialty" (graduate) departments at San Marcos and Cayetano Heredia Universities, the persons interviewed in the country were opposed to a specialization in family and general medicine on the grounds that it is at the undergraduate level that the general physicians needed by the country must be trained. The "second specialty" directors, on the other hand, felt that programs for specialization in family medicine should be introduced in the country because, in their view, the family should be the unit of care and new university graduates were not properly prepared to address it as such.[23] In Peru the Ministry of Public Health is the source of most of the available medical care, most of which is provided by general physicians.[22,23]

In Argentina there are isolated family medicine operations in the provinces of Neuquén and Jujuy, and of general medicine in the Chaco. However, there has not yet been any government decision on the matter.

In the private sector, a seminar sponsored by the Center for Medical Education and Clinical Research (CEMIC) and the International Center for Family Medicine (CIMF) was held on 4 November 1983, and formed the committee for the promotion of the Family Medicine Association.[24]

In Chile there are no family medicine programs, and the terms "medico general" and "medico familiar" (general practitioner and family practitioner) are apparently synonymous. The country has a long record of training specialists. As a result, at the beginning of the seventies 80% of the physicians were specialists, and only 20% were still being trained as general physicians.

According Dr. Alberto Cristoffanini, dean of the school of medicine in Austral University, Chile, the first study of graduate training for general physicians used by the Chilean medical schools opened by asserting a need for and justification of a program of continuing education in general medicine with the following training "objectives":

- The renovation of forgotten and obsolete knowledge;

- The furnishing of new knowledge and techniques;

- The improvement of operating capacities;

- Providing for the transmission of experience;

- Encouraging self-training and research.[25]

Meanwhile, the national health service, reverting to this same approach, emphasizes the objective of "improving the problem-solving capacity of the physician at the primary level through a program of instruction focusing on the more frequent complaints and chief causes of death in the different age groups of the population."[25]

The most important characteristics of any continuing education program are that it be active, ongoing, susceptible of evaluation, and a source of incentives such as status, career development, academic recognition, etc.[25]

Two alternatives, which are not necessarily mutually exclusive, have been proposed for continuing education:

- Continuing education programs as such;

- Programs for the training of "specialists" or the equivalents thereof in general medicine.

The Ministry of Health of Chile has opted for the first alternative.

However, programs for the training of specialists in general medicine have been conducted for some years without much system; an example is the one at Austral University in Chile, which has been conducted on a half-day basis for the last four years. Three physicians have completed this program.

In contrast with several countries such as England, Australia and, more recently, the United States of America, France and others, which regard undergraduate instruction as insufficient to assure a proper level of professional practice in this field, Chile and other Latin American countries take the view that "if the medical schools have accomplished the purposes they have set themselves, every holder of a degree in medical surgery should be able to provide competent primary (health) care. This does not obviate the need for continuing training in this field. Quite to the contrary, the need is becoming increasingly clear, and it is seen as essential, that such training be regularized and its objectives spelled out, and that those teaching-learning exercises include provision for some evaluation of their accomplishments."[26]

In Panama, family medicine emerged in 1976 in the form of a residency program at the metropolitan hospital complex of the Social Security Fund, and of a general-family medicine service unit which, through a faculty committee, is promoting the academic side of the specialty. In 1983 a similar program was set up at Rafael Hernández hospital in the town of David, Chiriquí province, where a comprehensive health system is in operation.

Concurrently, the medical school has promoted the introduction of a course in community and family medicine in its curriculum and a phase of community service at the undergraduate level.

The faculty members in charge of the undergraduate program also direct and coordinate the graduate residency programs. In consequence, the residency training is accredited by the University.

So far, the programs have turned out eight specialists in family medicine, all of whom have found employment. It is felt that this group should act as a "multiplier group, as a source of incentives and a promoter of family medicine and not of coverage extension."[27]

In Ecuador today, no family medicine is practiced in any health institution in the country. No family physicians are trained at either the under-graduate or the graduate level. The Ecuadorian social security institute once intended to set up a graduate program, but nothing came of it.[28]

In the Caribbean area, in July 1980 the University of the West Indies, Jamaica, received a grant from the W. K. Kellogg Foundation with which to begin a graduate program of training in family medicine.

The program has two modes at present:

- Full residencies;

- Part-time training.

The part-time training is for physicians whose practice does not allow them to receive training full-time. The requirements for admission to this training is four years of experience in general medicine or three years of occupational experience in disciplines that are part of the residency program.[29-30]

The program opened in 1980 with one resident, who so far is the only graduate. Three more residents enrolled in 1981 and two others in 1982, and four were expected to enroll in 1983.

The residency has a duration of three years, plus an additional optional year for preparation of a thesis. The first year six months are taken up with family medicine and six months in hospital rotation between

the specialties of internal medicine and psychiatry. During the second year the resident is rotated through the specialties of gynecology, obstetrics, surgery, orthopedics, pediatrics, ophthalmology, and dermatology. In the third year two months are given over to community medicine, one month to applied sciences, three to an elective subject, and four months to family medicine. On completion of the training the residents sit for an examination, and the fourth year is spent on the preparation and presentation of a thesis.[29]

A very important part of the medical care in Barbados is that offered privately by "family physicians." A survey of 11 such family physicians in 1977 and 1978 showed that these doctors helped to reduce substantially the demand for specialized and hospital care throughout the country (it should be noted that no "family physician" in Barbados has had any formal graduate training). The 11 physicians surveyed had had practical experience ranging between six months and 26 years and averaging 9.7 years of personal practice. As a result of this survey, 52 physicians were added as full-time "family physicians."[31]

In the United States of America, family practice comes under the category of the private practice of medicine and of free enterprise, which is the dominant arrangement. According to McWhinney (1966), family medicine emerged in response to social pressure generated by the rising cost of medical care on the one hand and, on the other, as a response of general practitioners to the loss of prestige of general medicine.[32] In 1959, during a meeting of the American Medical Association (AMA) a group of 10 general practitioners members of that Association and of the the American Academy of General Practice (AAGP) decided to explore the possibility of obtaining a certifica- tion for family physicians, and to that end set up an organization to apply for and obtain from the AMA accreditation of the practice of family medicine as a new specialized discipline.[32]

For the AMA to certify a specialty, however, a graduate must undergo training usually of not less than three years' duration in an approved medical residency. The only training most general practitioners had had was one year of rotating internship, for which reason since 1956 the AMA had been recommending the formation of a committee to study the practice of general medicine. This committee was formed of members of the AMA, the AAGP and the American Association of Medical Schools, and in 1959 produced a report proposing two years of training for general practitioners in selected hospitals. According to Geyman (1971), these proposals rested on the same basis that later gave rise to the family medicine programs.[33] McWhinney (1966) notes that the founders of the specialty of family medicine found it necessary to disavow the name "<u>general medicine</u>"* because of its association with a kind of practice that is rejected in academic circles.[32]

---

* Underlining ours.

The practice of family medicine wrought several changes in medical practice in the United States (where there are more than 60,000 graduates). Evaluations under some programs show that the larger part of the family physician's working time is spent seeing patients in his office (73-83% of the weekly time), compared with an earlier predominance of hospital work. Though the basic documentation on family medicine emphasizes the importance of house calls, evaluations indicate that they takes up very little of the practitioner's time (0.2-2% of his work week) compared with the time spent in hospital practice (10.8-14.7%).[34-38] Moreover, and this a subject that needs more study, there appears to have been no substantial change in the cost of medical care.

In Canada the practice of family medicine comes under Medicare, the Government's universal insurance scheme, and most family practitioners are located in rural areas.[6] This is an important difference from the United States of America, where family practitioners are located chiefly in cities and suburbs.

2. The Family Medicine Concept in the Countries Considered

Several authors consulted have tried to explain the reasons for taking the family as the unit of care.[39-42] Others raise some objection either to the name,[43] to the practice itself[43-46] or to training medical personnel in family medicine as a specialty.[43,48] However, if we compare the views expressed on family medicine and its practice, they do not appear to differ from what the medical schools have said about the training of the general practitioner at the undergraduate level.

According to most of the authors consulted, the salient points in the definition of the family physician are as follows:

- He is the physician of first contact with the patient and stands at the portal of entry to the health care system.

- He evaluates the patient's total needs, provides personal medical care and, when indicated, refers him to specialized services while remaining responsible for him throughout.

- He assumes ongoing and comprehensive responsibility for the care of the patient and serves as coordinator of the health team.

- He accepts responsibility for the total care of the patient in that patient's setting, which includes his community and family.

- He deals with problems of all kinds without regard for the age or sex of the patient.[1,13,41,49]

These points in the definitions of the different authors are essentially in agreement with the points made by the medical schools for the training of the general practitioner.

The same findings result from an examination of some publications as to the abilities that the family physician must possess,[13,49,50] and the functions he must perform,[51] compared with the definition and functions of the general practitioner, according to a WHO expert committee.[52]

However, those who advocate family medicine draw some distinctions between it and general medicine:

In Alárid (1984), we read:

"General medicine. This is individual, occasional, episodic, discontinuous medical care, and hence provided on request and not anticipatory. In dealing with disease, focuses on the patient's hurts. It functions in the areas left by the specialist. It is practiced within the confines of medical premises. It uses elementary technology. There is no evidence that it generates any research. There are no prestigious generalists. Its practitioners neither promote nor evaluate it. It is not regarded as a specialty. It is practiced immediately following graduation. The approach is individual and clinical-curative. It is a stigma. Incomplete (biological) approach."[13]

Contrast the foregoing with the following from the same author:

"Family medicine. This is ongoing and comprehensive medical care to the individual in the context of his family and community. It functions during the health-disease process and emphasizes the production and preservation of health. It has its own body of knowledge. Its activity is intra- and extramural. It uses simple technology by its own methods. It conducts clinical and epidemiological research. It works out models in practice. Its practitioners promote it as a specialty. It is a specialty with university accreditation. It is practiced after three years of training. It is an attitude. Comprehensive (bio-psycho-social) approach. It identifies risks and forestalls harm."[13]

The review of authors turned up some who express similar views (Geyman, 1978),[11,33] (McWhinney, 1966),[13] (Taylor, 1983),[41] and (Ceitlin, 1980).[12] Others, however, find no differences between the two practices.[52,53]

It may be noted, however, that these theoretical views are not backed up by serious studies that demonstrate their validity in practice. Follow-up studies conducted under some programs in the United States of America do not searchingly inquire into the extent to which these premises are fulfilled, and make no comparison with the work of unspecialized generalists, nor have any follow-up studies been done in other countries of the Region.

However, an IMSS (Mexico) study of medical care in family clinics showed that their was no difference between the care provided by specialized and unspecialized family physicians,[54] which suggests that successful extension of coverage is due more to the organization of care than to the mere existence of family physicians.

3. Preparation and Functions of Family Physicians

In the countries considered that have family medicine programs specialization is virtually the rule. This specialization is acquired in medical residencies of 2-3 years' duration, depending on the country.

In Mexico and the United States of America, specialization takes three years, and in Canada two years plus one optional year. In Brazil, the special- ization in general and community medicine takes two years with an optional extra year.

In the curriculum worked out by the IMSS in Mexico, most of the time (more than 50%) is allocated to practice outside the hospital; the last year is devoted entirely to a rural practice.[55]

The total number of places in residencies and programs for any specialty in Mexico is 5,683, of which 811, or 14.27% of all residencies and graduate programs, are for family medicine.

In residency programs in the United States of America, about 70% of the training is in the hospital area, and the rest in the community family medicine centers.[34-37]

In the documents examined, the functions of the family physician are essentially as follows:

a) Maintenance of the health of the individual and family;

b) Prevention of diseases;

c) Extended care of chronic diseases;

d) Rehabilitation;

f) Coordination of total health care, including consultation with practitioners of narrower specialties;

g) Rational utilization of the resources available in the community for the care of health;

h) Performance of therapeutic measures beyond usual working hours.

IV. COMMENTARY AND CONCLUSIONS

It is seen from the foregoing that the concept of family medicine and its applications is still a subject of much controversy. The available information on the countries of Latin America yields no satisfactory conclusions, particularly as a basis for any statement of policy.

A review of the literature on the subject, and of the documentation and reports received from the countries, suggests, however, a number of considerations in addition to the foregoing.

There are arguments and opinions in favor of and against family medicine as a practice in its own right and as a field of specialization.

Advocates of specialization emphasize that family medicine is as much an academic discipline as any other specialty. They point out that medical schools do not and will not be able to train personnel of this type because knowledge and skills are required that are usually not offered or acquired at the undergraduate level. These acquirements are said to consist of knowledge and applications in the behavioral sciences, the social sciences, epidemiology and administration, but most particularly in the area of family dynamics and its interrelationships with the individual and the society. On the other hand, it is said that quality care requires a period of practice longer than that provided at the undergraduate level.[12,32,33]

There are important and informed views in favor of undergraduate training that will give the new physician the knowledge and skills needed to enter an organized general practice centered on the family or community. The general trend seems to be toward specialization, however, as emerges from an examination of the evolution of some programs of general medicine and family medicine in Europe, where these branches are specialties in most of the countries.

In the United States of America, specialization seems to be very important to the physician. From the moment it was decided to give family medicine the status of a specialty, and that those completing it would have charge of "primary care" in the country, a series of residency programs was established, and the result was that, between 1972 and 1983, this kind of training became very important and graduates in family medicine are now one of the largest groups of specialists in the country.

However, it would appear that not all the problems in the development of this specialty have been solved. In the United States of America, medical residencies are supported largely by funds generated by the practice of the specialties involved. Because of the way family medicine functions, it does not generate enough funds to support, on its own, residency programs. Hence, a substantial proportion of the funds is provided by government in federal, state and municipal funds, or else by foundations such as the Kellogg Foundation.

So far, admission to residencies is open to all graduates of medical schools in the United States. However, Stephens (1983) has called attention the growth of medical schools--and hence of the numbers of their graduates--both in and outside the country (he refers solely to U.S. citizens), which suggests a trend for many graduating physicians to be deprived in the not very distant future of any possiblity of acquiring a specialty.[56]

In the Latin American countries considered, the problem appears to be more serious. On the assumption that specialization will continue to be sought, which raises serious questions as to the soundness of such approaches in the actual socioeconomic setting of the countries, distinct doubts arise as to whether the countries will have enough residencies to accommodate all graduates. There is no correlation between the growth in the number of graduates and the establishment of new residencies. A case in point is Brazil, which has 76 medical schools turning out more than 8,000 physicians a year, but only a limited number of residencies, which could accommodate only 40% of the total number of graduates.[57] This refers to residencies in all specialties. In regard to the residency in general and community medicine, which is available at only three places, with a total of 68 residents in the first year, the limitations should be even greater. Programs of this type could admit less than 1% of new graduates. Moreover, the cost of augmenting these programs seems out of line with the requirements in medical training and the coverage of health services.

Something similar, though on a smaller scale, could happen in situations like Mexico's. The number of graduates in this country has been 50,000 over the last three years.[57] The number of residencies and the installed capacity for training programs in specializations, though greater, cannot provide training openings for a very large proportion of those who have just completed their undergraduate studies. In these circumstances, much of general practice must continue to be covered by unspecialized family physicians, which lends weight to the argument that, if medical schools do not produce the right physicians for primary care, it makes no sense to try to supply these shortages by graduate training. In every situation, however, in which considerations of status and occupational and professional claims interweave and mingle with educational trends and patterns of service organization, it is clearly emerging that the problem is essentially one of divergence between medical care practice and medical training, and that a harmonious effort is needed to bring them back together. Unilateral initiatives in either field would only widen the gap between them. As Ferreira very well says, "rigidity in the patterns of medical practice is what makes for resistance to change inside medical schools."[58] The changes accomplished by some institutions have been due not so much to the training of new personnel as to how services are organized and medical practice changed; this may be what has happened in the Mexican social security system.

The analytical findings commented herein indicate that there can be no doubt whatever of the need for more searching studies to provide the countries and the Organization with a better and broader base of data on which to take decisions in the matter. These studies should supply answers to such questions as:

- Is it valid to take the family as the unit of care?

- Or the individual as the unit of care within the family?

- Or what do others favor: the individual as a whole and in his social setting?

- Are the theoretical assumptions born out in the practice of family medicine?

- If general practice is promoted for the extension of coverage and to lower the cost of care, it is valid to promote it as a specialty?

- If medical residencies were promoted, what would be done about all the physicians who will acquire no specialty, or is this a way of limiting or delaying the practice of the profession?

- Will the countries in the Region have the monetary means and infrastructure to provide specialized training in family medicine or general medicine to most medical school graduates?

- If the medical schools in the Region do not turn out the physicians a given country needs, should the deficiencies be supplied through graduate training, or, at any rate, should the years of undergraduate study be increased, or the curricula revised in collaboration with the services and in response to the existing health needs of each country?

- The primary care strategy is directed not only at the extension of coverage but also at improving health services for the population and the quality of the care itself. Therefore, the medical personnel in charge of that care must be properly trained and have the necessary motivation to better themselves. Could this not be accomplished through continuing education and medical career development through incentives and promotions?

REFERENCES

1. Cárdenas de la Peña, Enrique: "Medicina Familiar en México, Historia". IMSS México, 1974.

2. Navarro R., José: "La Medicina Familiar en México" Capítulo Segundo de: "¿Qué es la Medicina Familiar?" Ceitlin, Julio, FEPAFEM/ Kellogg. Editorial Arte, Caracas, Venezuela, 1980, p. 57.

3. Residencia de Medicina Familiar. Programa IMSS, México, 1974.

4. Programa de Salud Guadalupe: Universidad Autónoma de Nuevo León, Secretaría de Salubridad y Asistencia.

5. Alárid, Humberto Jaime. "La Medicina Familiar en México", PAHO/WHO Report, 1984.

6. Mc Whinney, Ian: "La Medicina Familiar en Canada" Third Chapter of "¿Qué es la Medicina Familiar?". Ceitling, Julio, FEPAFEM/ Kellogg, Editorial Arte, Caracas, Venezuela, 1980.

7. Young, Paul: "La medicina familiar en los Estados Unidos de Norteamérica", Chapter 4 of "¿Qué es la medicina familiar?". Ceitlin, Julio, FEPAFEM/Kellogg, Editorial Arte, Caracas, Venezuela, 1980, p. 98.

8. Citizens' Commission on Graduate Medical Education: "The Graduate Education of Physicians". Chicago, American Medical Association, 1966.

9. Meeting the Challenge of Family Practice: The Report of the Ad Hoc Committee on Education for Family Practice of the Council on Medical Education. Chicago, American Medical Association, 1966.

10. National Commission on Community Health Services: "Health is a Community Affair". Cambridge, Harvard University Press, 1966.

11. Geyman, John P., "Family Practice in Evolution: Progress, Problems and Projections." The N. England J. of Med. Vol. 298, 11:593-601, 1978.

12. Ceitlin, Julio: "¿Qué es la Medicina Familiar?", FEPAFEM/Kellogg. Editorial Arte, Caracas, Venezuela, 1980, Chapter 5, p. 111-138.

13. Alárid, Humberto Jaime: "La medicina familiar en México", PAHO/WHO Report, 1984.

14. Cárdenas de la Peña, Enrique: "Medicina Familiar en México, Historia". IMSS, México, 1974.

15. Valdés Durán, José C.: "La Medicina Familiar en el Instituto Mexicano del Seguro Social". Rev. Med. IMSS, México, 21:524-526, 1983.

16. Personal communication during the preparation of this report.

17. Medicina General Comunitaria. Residencias. Photocopy annexed to report of Brazil, PAHO/WHO.

18. Personal communication during the preparation of this report.

19. Abbath, Guilherme: "Informe preliminar sobre medicina familiar en Brasil". PAHO/WHO, 1984.

20. Ministerio de Educaçao, Secretario de Ensino Superior. Resolution No. 07/81. Brasilia, Brazil.

21. Personal communication during the preparation of this report.

22. Zamora Castañeda, Rosa María: "La medicina familiar en el Perú". Report of Lima, Peru, 1984. PAHO/WHO, 1984.

23. Personal communication during the preparation of this report.

24. Information letter addressed to the representation by Drs. Julio Ceitlin y Jorge A. Montenegro. December 20, 1983.

25. Cristoffanini, Alberto P.: "Documento base de discusión sobre programas de educación continuada en medicina general: Responsabilidades y aportes de las facultades de medicina". Mimeographed, Chile, 1983.

26. Cristoffanini, Alberto P.: "Conceptos generales sobre formas de organizar programas de educación continuada en medicina". Ponencia para iniciar la discusión del tema en sesión de la Comisión Nacional Docente Asistencial (CONDAS), April 1983.

27. Informe sobre la medicina familiar en Panamá. PAHO/WHO Representation in Panama, 1984.

28. Communication from the Country Representative.

29. Family Medicine University of the West Indies, Residents Handbook, Kellogg Foundation Grant 1980-83. Kingston, Jamaica, 1982.

30. Información proporcionada por el Dr. Winsome Segree, Coordinator, Family Medicine Program. Family Medicine University of West Indies, Kingston, Jamica, 1984.

31. Hoyos, J.E. and col.: "Family Practice in Barbados". Bull. Pan American Health Organization 15:3-10, 1981.

32. McWhinney, Ian R: "General Practice as an Academic Discipline". The Lancet, febrero 1966, pp. 419-423.

33. Geyman, John P.: "Family Medicine as an Academic Discipline". J. of Med. Ed. 46:815-820, 1971.

34. Hecht, Rudolph C.: "Graduate Follow-Up in the University of Wisconsin Family Practice Residency Programs." The J. of Fam. Pract. 14:549-555, 1982.

35. Report of a Committee of Directors of Research of New York State Family Medicine Residency Programs, "Graduates of Family Practice Residency Programs in New York State". The J. of Fam. Pract. 11:753-760, 1980.

36. Ciriacy, Edward W. y col.: Graduate Follow-Up in the University of Minnesota Affiliated Hospitals Residency Training Program in Family Practice and Community Health. The J. of Fam. Pract. 11:719-730, 1980.

37. Geyman, John P. y col.: "Graduate Follow-Up in the University of Washington Family Practice Residency Network." The J. of Fam. Pract. 11:743-752, 1980.

38. Mayo, Fitzhugh: "Graduate Follow-Up in the Medical College of Virginia/Virginia Commonwealth University Family Practice Residency System". The J. of Fam. Pract. 11:731-742, 1980.

39. Curry, Hiram B.: "The Family as Our Patient". The J. of Fam. Pract., May 1974, pp. 70-71.

40. Rakel, R.: "Principles of Family Medicine". Philadelphia, W.B. Saunders, 1977.

41. Taylor, R.B. and col.: "Family Medicine, Principles and Practice", New York-Heilderberg Berlin, Springler-Verlag, Second Edition, 1983.

42. Geyman, John P.: "The Family as the Object of Care in Family Practice". The J. of Fam. Pract. 5:571-575, 1977.

43. Menkel, William T.: "The Family and Family Medicine: Should this Marriage be Saved?". The J. of Fam. Pract. 17:857-862, 1983.

44. Ramson, Donald C., y Vandervoort, Herbert E.: "The Development of Fam. Med. Problematic Trends". JAMA 225:1098-1102, 1973.

45. Schwenk, Thomas L., and Hughes, Charles C.: "The Family as Patient in Family Medicine. Rhetoric or Reality". Soc. Sci. Med. 17:1-16, 1983.

46. Stone, Robert S.: "The Family Practitioner: A Product of Orthogenesis or Natural Selection? Editorial". J. of Med. Ed. 46:813-814, 1971.

47. Petersdorf, Robert G.: "Internal Medicine and Family Practice: Controversies, Conflicts and Compromise". The New England J. of Med. 293:326-332, 1975.

48. Authier, Jerry, and Land, Trudy: "Family: The Unique Component of Family Medicine". J. of Fam. Pract. 7:1066-1068, 1978.

49. Ceitlin, Julio; Iturbe, Pedro; Owens, Tomás; de Carpio, Carmen C. and Ruiz Guzman, José: "La seguridad social y la medicina familiar". Ponencia en Congreso Americano de Medicina de la Seguridad Social. PAHO photocopy.

50. Baker, Collin: "What's Different about Family Medicine?" J. of Med. Ed. 49:229-235, 1974.

51. Saínz Janini, José Manuel: "Funciones del médico general en el sistema de atención médica". Bol. Med. IMSS, México, 20:191-196, 1978.

52. World Health Organization: "La Medicina General: Informe de un Comité de Expertos". Technical Report Series No. 267, Geneva, 1964.

53. World Health Organizlation: "La formación del médico familiar: 11° Informe del Comité de Expertos en Formación Profesional y Técnica del Personal Médico y Auxiliar". Technical Report Series No. 257, Geneva, 1963.

54. Personal communication during the preparation of this report.

55. Instituto Mexicano del Seguro Social: "Programa del Curso de Especialización en Medicina Familiar", Mexico, 1982.

56. Stephens, G. Gayle: "Unemployed Physicians". Cont. Ed., March 1983, pp. 235-236.

57. Personal communication.

58. Ferreira, José Roberto: "Capacitación de personal para la meta de salud del año 2000: Una propuesta metodológica". Ed. Med. y Salud, PAHO/WHO 17:54-68, 1983.