



THE EUROPEAN DEFINITION OF GENERAL PRACTICE / FAMILY MEDICINE

**WONCA EUROPE
2002**

THE EUROPEAN DEFINITIONS of

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.

Prepared for WONCA EUROPE (The European Society of General Practice/ Family Medicine), 2002.

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1. INTRODUCTION

This consensus statement defines both the discipline of general practice / family medicine, and the professional tasks, it also describes the core competencies 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.

There are significant differences in the way that health care systems are organised and family medicine is practiced throughout Europe. For European Union countries, and those aspiring to join the Union, medical education is governed by EU Directive 93/16 which is primarily intended to promote free movement of doctors. Unfortunately within the Directive there is a lack of emphasis on the content and quality of postgraduate training. It is therefore self-evident and of great importance that, for the protection of patients, family doctors should receive training that will equip them with the necessary skills to practice in *any* member state.

This statement has been produced on behalf of WONCA Europe (The European Society of General Practice / Family Medicine) the Regional Organisation of the World organisation of Family Doctors (WONCA).

WONCA Europe provides the academic and scientific leadership and representation for the discipline of Family Medicine throughout the continent. Its membership comprises the national academic organisations of Family Medicine from 30 European countries, and direct membership from individual family doctors. Its main role is to promote and develop the discipline in order to achieve and maintain high standards of education , training ,research and clinical practice for the benefit of individual patients and communities.

Reform of national health systems is a common feature in Europe as elsewhere in the world. Given the changes in demography, medical advances, health economics , and patients' needs and expectations new ways of providing and delivering health care are being sought. International evidence¹ indicates that health systems based on effective primary care with highly -trained generalist physicians (Family Doctors) practising in the community, provide both more cost effective and more clinically effective care than those with a low primary care orientation.

It is vital that the complex and essential role of Family Doctors within health systems is fully understood within the medical profession , but also by the professions allied to medicine, health care planners, economists, politicians and the public. Within Europe increased investment in Family Medicine is required to enable health systems to fulfil their potential on behalf of patients . Investment not just in relation to human resources and infrastructure but with regard to education, research and quality assurance.

These new definitions and the statement of core competencies are published in order to inform and to contribute to the debate on the essential role of family medicine within health systems, at both national and pan –European levels.

REFERENCE

1. Starfield B. Primary care: balancing health needs, services and technology. Oxford: Oxford University press, 1998.

2. THE EUROPEAN DEFINITIONS 2002

THE DISCIPLINE AND SPECIALTY OF GENERAL PRACTICE / FAMILY MEDICINE

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.

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

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.

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

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

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

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

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

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

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

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

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

ii. The Specialty of General Practice / Family Medicine

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 and providing cure, care, or palliation. 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.

iii. The Core Competencies of the General Practitioner / Family Doctor

A 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.

§1. The eleven central characteristics that define the discipline relate to eleven abilities that every specialist family doctor should master. They can be clustered into six core competencies (with reference to the characteristics) :

1. Primary care management (a,b)
2. Person-centred care (c,d,e)
3. Specific problem solving skills (f,g)
4. Comprehensive approach (h,i)
5. Community orientation (j)
6. Holistic modelling (k)

§2. To practice the specialty the competent practitioner implements these competencies in three areas :

- a. clinical tasks,
- b. communication with patients and
- c. management of the practice .

§3. As a person-centred scientific discipline, three background features should be considered as fundamental:

- a. Contextual: using the context of the person, the family, the community and their culture
- b. Attitudinal: based on the doctor's professional capabilities , values and ethics

- c. Scientific: adopting a critical and research based approach to practice and maintaining this through continuing learning and quality improvement.**

The interrelation of core competencies, implementation areas and fundamental features, characterises the discipline and underlines the complexity of the specialty.

It is this complex interrelationship of core competencies that should guide and be reflected in the development of related agenda's for teaching, research and quality improvement.

3. EXPLANATORY NOTES – THE NEW DEFINITIONS

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.

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

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) 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.

e) 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.

f) 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.

g) 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.

h) 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.

i) 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.

h) 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.

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

The discipline has to recognise 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. The Specialty of General Practice/Family Medicine

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 and providing cure, care, or palliation. This is done either directly or through the services of others according to their health needs and 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.

This definition of the role of the family doctor 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 responsibility is that of maintaining skills, which may be a particular difficulty for family doctors who often work in isolation.

4. EXPLANATORY NOTES – 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. They are grouped in three paragraphs, in relation to the discipline (§1), to the practice of the specialty (§2) and some basic features as background (§3).

§1. The eleven central characteristics that define the discipline relate to eleven abilities that every specialist family doctor should master. They can be clustered into six core competencies :

1. Primary care management

- a) the ability to manage primary contact with patients;
- b) to co-ordinate care with other professionals in primary care and with other specialists leading to effective and appropriate care provision, taking an advocacy position with the patient when needed.

2. Person-centred care

- c) the ability to adopt a person-centred approach in dealing with patients and problems;
- d) to develop and apply the general practice consultation to bring about an effective doctor-patient relationship;
- e) to provide longitudinal continuity of care as determined by the needs of the patient.

3. Specific problem solving skills

- f) to utilise the specific decision making process determined by the prevalence and incidence of illness in the community;
- g) to manage conditions which may present early and in an undifferentiated way, and to intervene urgently when necessary.

4. Comprehensive approach

- h) to manage simultaneously both acute and chronic health problems in the individual;
- i) to promote health and well being by applying health promotion and disease prevention strategies appropriately.

5. Community orientation

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

6. Holistic modelling

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

§2. To practice the specialty, the competent practitioner implements these competencies in three important areas :

- a. clinical tasks
- b. communication with patients and
- c. management of the practice .

§3. As a person-centred scientific discipline, three background features should be considered as fundamental:

- a) Contextual: using the context of the person, the family, the community and their culture
- b) Attitudinal: based on the doctor's professional capabilities, values and ethics
- c) Scientific: adopting a critical and research based approach to practice and maintaining this through continuing learning and quality improvement.

The interrelation of core competencies, implementation areas and fundamental features characterises the discipline and underlines the complexity of the specialty.

It is this complex interrelationship of core competencies that should guide and be reflected in the development of related agenda's for teaching, research and quality improvement.

5. ACADEMIC REVIEW AND ANALYSIS; THE NEW DEFINITIONS

Introduction

The Leeuwenhorst group produced its statement "The General Practitioner in Europe" in 1974¹. At that stage general practice/family medicine was in its infancy as a discipline, particularly with regard to its teaching and research base. Almost 30 years later the world has moved on and nowhere has this change been more apparent than in the provision of health care. General practice / family medicine is now well established in all health care systems in Europe and is recognised by health service providers as being of ever increasing importance. This has been emphasised by WHO Europe in its 1998² framework document, and by the way that in most countries in the former Soviet block general practice/family medicine is being introduced as the basis for their new health care systems.

Society has changed over the last 30 years and there has been an increasing role for the patient as a determining factor in health care and its provision. The opinion of the clinician is no longer regarded as sacrosanct and a new dialogue is emerging between health care consumers and providers. The future family doctor has to be not only aware of this change but to be able to thrive in such an environment. It is important that the discipline of general practice / family medicine continues to evolve as the health care systems in which it operates change, and that it responds to the health needs of patients. Family doctors must be involved in the continuing development of their health care system, and as individuals must be able to change in order to meet these new challenges.

Van Weel, in his recent lecture to the RCGP Spring Meeting³, emphasised the need for academic development to enable transfer of knowledge, expertise and experience, to develop techniques and methodology addressing the specific requirements of general practice, and to explore the effectiveness of general practice care. He also emphasised the importance of the value basis of family medicine itself and the need for a common culture of teaching, research and training. It is timely therefore to re-examine the definitions of the role of the family doctor, and to develop a clear statement of the characteristics of the discipline of general practice/family medicine.

There is a further imperative for European Union countries, and those aspiring to join the Union. EU Directive 93/16⁴ is intended to promote free movement of doctors, and therefore, for the protection of patients, it is self-evident that family doctors should receive training that will equip them with the necessary skills to practice in *any* member state, as their qualification entitles them to practice anywhere in the EU without further training. It follows that it is important to have a consensus view defining the characteristics of the discipline and the tasks that family doctors should do.

Directive 93/16 only defines a training period of minimum of 2 years and a minimum of six months in a general practice setting; this has been lengthened to 3 or more years by some countries. The UEMO Consensus document of 1994 on specific training for general practice⁵ argued the need to prolong the period of training to a minimum duration of 3 years including a practical and theoretical part, of which a minimum of 50% of clinical training time must be spent in a general practice environment. The Advisory Committee on Medical Training (ACMT)⁶ accepted the views of UEMO and advised the European Commission to revise the Directive accordingly - to establish a training period of 3 years, 50% to be located in practice, and general practitioners to be involved and responsible for general practice training at all levels. However unfortunately this advice has not yet been accepted by the European Commission.

Problems with bringing about change to Title 4 of the medical directive, which relates to general practice/family medicine and the need to develop the place of family medicine within the curriculum of medical universities have led to the suggestion that further developments in the discipline could be better achieved if "specialist in family medicine" became one of the medical specialties listed in Title 3 - which covers all of other medical specialties. It is not part

of this paper to explore this issue; the purpose here is to elaborate the principles that underpin the discipline of general practice/family medicine.

ROLE, DISCIPLINE AND HEALTH CARE SYSTEM

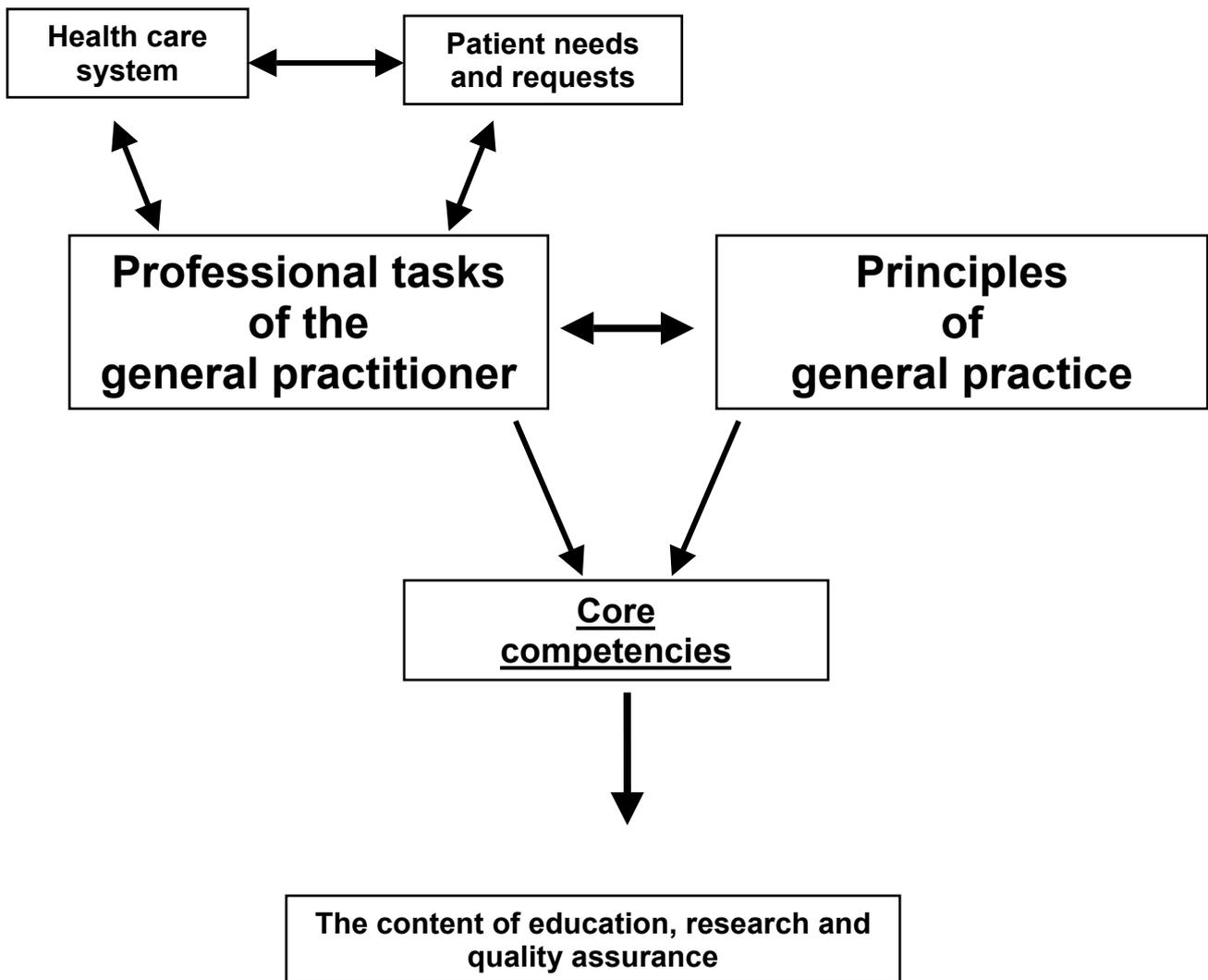
There are different ways of approaching the problem of producing a new definition. The method used by the Leeuwenhorst group, and more recently by Olesen et al⁷, was to define the parameters of the discipline by describing the types of tasks that a family doctor has to carry out. An alternative approach is to try to define the fundamental principles of the discipline of general practice/family medicine. This approach has been taken by Gay in a presentation to the inaugural meeting of WONCA Europe in Strasbourg in 1995⁸ and was also used in the framework document developed by WHO Europe.

Gay has suggested that there is a relationship between principles and tasks with some influences on the task required from both the patients and the health care system. This should then lead to definitions of competencies which will determine the content of general practice education. This is represented in figure 1.

This indicates the dynamic relationship between the underlying principles of the discipline and the tasks that family doctors have to perform. These tasks are determined to a considerable extent by the health care system in which GPs work and the changing needs and demands of the patients.

The characteristics as described by WHO Europe, can also be considered as the aims for general practice within the health care system. These concepts bring into play ideas of effectiveness and if one accepts that the health care system determines to a greater or lesser extent the task that a family doctor is able to undertake, any new definition must take into account the context in which the family doctor works and reflect the changing needs of patients and advances in health care delivery.

Figure 1



These approaches are not mutually exclusive and any new definitions will have to take into account the underpinning principles of the discipline, the core tasks of the family doctor within the health care system and the influence of the health care system on the provision of family medicine.

The principles of the discipline as suggested by Gay were: -

1. Patient centred approach
2. Orientation on family and community context
3. Field of activities determined by patient needs and requests
4. Unselected and complex health problems
5. Low incidence of serious diseases
6. Diseases at early stage
7. Simultaneous management of multiple complaints and pathologies
8. Continuing management
9. Coordinated care
10. Efficiency

and are in many ways similar to the characteristics of general practice/family medicine described in the WHO framework statement: -

- | | |
|------------------|-------------------------|
| A. General | E. Collaborative |
| B. Continuous | F. Family orientated |
| C. Comprehensive | G. Community orientated |
| D. Co-ordinated | |

The WHO statement goes on to elaborate what it means by these 7 characteristics.

General: -

- Unselected health problems of the whole population
- Does not exclude categories because of age, sex, class, race or religion, nor any category of health problem
- Easy access, unlimited by geographical, cultural, administrative or financial barriers

Continuous: -

- Person centred
- Longitudinal health care, over substantial periods of life, not limited to one illness episode

Comprehensive:-

integrated care involving

- Health promotion, disease prevention, curative, rehabilitative and supportive care
- Physical, psychological and social perspectives
- Clinical, humanistic and ethical aspects of the doctor – patient relationship

Co-ordinated: -

- Care managed at first contact
- Referral to specialist services
- Providing information to patients on available services
- Co-ordinate and manage care

Collaborative: -

- Working in multidisciplinary teams
- Delegating care where appropriate
- Exercising leadership

Family oriented care :-

addressing individual problems in the context of

- Family circumstances
- Social and cultural networks
- Work and home circumstances
-

Community orientated:-

suggests that family doctors should consider individual problems in the context of: -

- The health needs of the community
- Other professionals and agencies

WONCA in its 1991 statement on the Role of the General Practitioner/Family Physician in Health Care Systems⁹, produced a definition of the general practitioner role and linked it to features of general practice/family medicine which it describes under the categories of commitments and specifications.

The WONCA 1991 statement includes the following

- Comprehensive care
- Orientation to the patient
- Family focus
- Doctor/patient relationship
- Co-ordination with other services
- Advocacy
- Accessibility and resource management.

There is a great overlap in the WHO characteristics, the “specifications” in the WONCA document and in the principles as defined by Gay. This can be demonstrated by cross-mapping them as in the following table:

WHO 1998	WONCA 1991	“Principles” as described by Gay
General	Comprehensive care	3. Field of activities determined by patient needs and requests 4. Unselected and complex health problems
Continuous*	Orientation to the patient	1. Patient centred approach 8. Continuing management
Comprehensive	Comprehensive care	3. Field of activities determined by patient needs and requests 4. Unselected and complex health problems
Co-ordinated	Co-ordination with other services	9. Coordinated care
Collaborative	Co-ordination with other services	9. Coordinated care
Family oriented	Family focus	2. Orientation on family and community context
Community oriented	Commitment to the Community	2. Orientation on family and community context

* Confusion in the use of language in the WHO document may cause some difficulty. The confusion is between the words “continuous”, and “continuing” and in the context of the WHO document “continuing” would be more appropriate.

Continuous - means without a break; uninterrupted; such as the perimeter fence around a prison.

Continuing - means that a process or activity will be maintained; kept up; continue for the future not ceaselessly, but “ongoing”.

This can be illustrated best by its use in relation to medical education. Continuous medical education would mean that one never did anything else – but morning noon and night one was undergoing medical education. Continuing medical education on the other hand would describe a process which could well be intermittent or episodic, but which would go in indefinitely. The longitudinal care of the family doctor is best described as continuing.

However there are some interesting differences. The items described by WHO and WONCA are dealing with professional activity in the health care system and not the discipline as a

medical activity with a specific process. Indeed, the 3 following items concern the discipline and are not really integrated in the WHO or WONCA characteristics.

“Low prevalence of serious diseases”, “diseases at early stage”, and “simultaneous management of multiple complaints and pathologies” in Gay’s presentation are part of the “comprehensive care” in the WONCA paper, but are not covered in the characteristics of WHO. They cover a crucial aspect of general practice – that it is a people based discipline (as opposed to pathology or organ based), and that it is normality orientated (as opposed to the abnormality orientation of secondary care), but that family doctors will also meet and need to manage serious illness at an early and undifferentiated stage. The statement from WONCA also makes the point that the incidence of illness, and the signs at presentation are very different in primary care from those seen in hospital, where these are usually taught.

The WHO Framework fails to explore in any depth that which must be regarded as the cornerstone of general practice/family medicine, the individual consultation between patient and family doctor. Gay proposed a theoretical model of general practice: a GLOBAL MODEL, open minded, considering the disease as the result of organic, human and environmental factors. This concept, in which health is a complex framework, is like the bio psychosocial model of Engel: it's a "holistic" model

The consultation is included in the WONCA statement, which also describes the need to express problem definition for patients in both biomedical and humanistic terms; that is in physical, psychological and social terms. This has its origin in the report of a working party of the Royal College of General Practitioners (RCGP)¹⁰, and has become so embedded in the thinking of the discipline that it is in danger of being taken for granted.

Efficiency is a further statement by Gay which is not specifically mentioned in the WHO characteristics. This presumably refers to the cost efficiency which is accepted as a characteristic feature of well developed family health care systems. The WONCA statement develops this idea further, suggesting that the family doctor has a role in resource management in health care systems.

The close inter-relationship between the defining principles of the discipline as previously described and the various role descriptions can be seen if one examines the latter in some detail. (See appendix 1.) The original Leeuwenhorst definition appears to have the advantage over the others of having stood the test of time and being widely accepted. It was very much set in its own time when general practice was a very new discipline with a limited research and education basis and was usually regarded as the branch of the medical profession to which one sank if one was unskilled in all others. It was informed, at least in part, by the job definition produced by a working party of the Royal College of General Practitioners in 1972¹⁰, which also seems to have informed the WONCA definition. It covers many of the characteristics later described in the WHO framework but put them into the context of day-to-day work in general practice. However it is not sufficient in itself to be the only definition; it is not comprehensive – for example curative, rehabilitative and supportive care are not specifically mentioned.

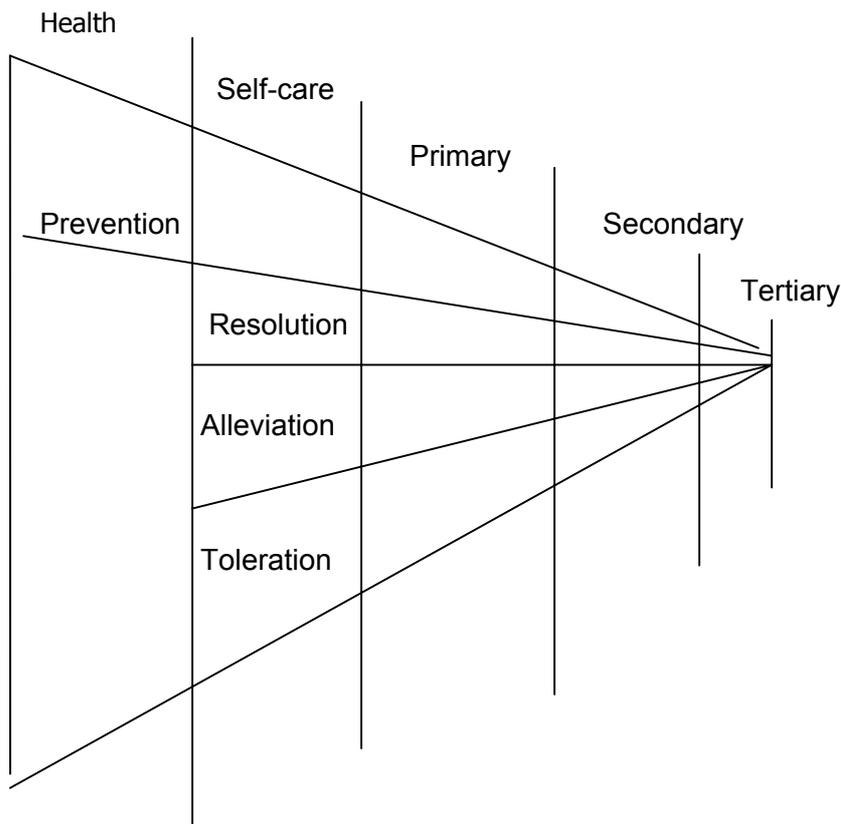
Olesen et al have stated that the original Leeuwenhorst definition is out of date and does not reflect the reality of family medicine today. However it would appear that much of the detail of the dissatisfaction expressed by Olesen et al is because many of those who regard themselves as family doctors are working in healthcare systems in which it is not possible to comply with all of the characteristics. Thus they drop some of the features that many would regard as key to the work of the family doctor, particularly losing the concept of the community setting of the discipline and of longitudinal care - continuity. They cite examples such as family doctors working in emergency departments as support for their viewpoint.

The two succeeding definitions, those of WONCA 1991 and Olesen 2000, still seem to have their roots very much in the Leeuwenhorst definition. The WONCA 1991 statement appears to have made it much more relevant to different health care systems and incorporates, as has been described, some descriptors of the discipline. In its clinical decision making section it describes the early presentation of undifferentiated clinical problems, the large number of

problems which do not fit with standard biomedical diagnoses and the different prevalence of illness and disease within the general practice setting as compared with the secondary care setting.

When considering health care systems the model of health care shown in figure 2 is now generally accepted¹¹. If we use the definition of primary care that is used in the introduction – “the setting within a health care system, usually in the patient’s own community in which the first contact with the health professional occurs” – we are brought into a consideration of the context in which the family doctor works. The interfaces between self-care, primary, secondary and tertiary health care and the interactions between the various health care providers in each are important issues to be considered.

Figure 2



There are a number of patterns of primary health care delivery in Europe, with differences in the patient population dealt with by family doctors, and an increasing number of different health professionals working in primary care in the different health care systems. The contexts in which such family doctors work are very different, but the underlying principles of the discipline should still apply. Obviously some health care systems may not be the most conducive to good family medicine, and, though such systems are not easily amenable to change, we should not be afraid to put forward a view of the ideal model of the health care system which is likely to provide the best health outcomes and cost-efficient care. That is one

which is based on high quality Family Medicine. This was one of the main thrusts of the WHO Framework document

The task is to define that which is the unique activity of the family doctor – the clinical generalist. Family doctors should through their activities in preventive medicine and health education have an influence on self-care. In some health care systems they influence the provision of both secondary and tertiary care and may have a facilitating role in co-ordinating appropriate access to these services. In others, narrow specialists also work in a primary care setting, often dealing with problems that in other countries would be managed by family doctors. In some health care systems family doctors, working predominantly in primary care, may have a limited secondary care role.

DISCUSSION

Can all these varied statements and definitions be combined into one definition? Do we need a new definition, and should it be a description of the task/role or of the features of the discipline? This was put to the test in a workshop at the 2001 WONCA Europe Conference in Tampere, Finland, where a substantial majority felt there should be a new definition, and that it should encompass a description of both task and the principles of the discipline.

There are many similarities between the statements of the principles which define our discipline, and in the task descriptions of a general practitioner, but there also significant differences. As has been pointed out there are gaps in all the statements, which may be due to differences in the way in which the statements are interpreted. None of these definitions *per se* encompass all the key features of the discipline of general practice. There is therefore a need for a synthesis of the various statements considered thus far to examine the differences, fill the gaps and ensure completeness

Much of the concern regarding the Leeuwenhorst definition Olesen et al expressed in their paper appears to be in its interpretation in absolute terms. For example what is meant by personal care? Is it care by the same doctor on every occasion? If not what are the conditions when it is acceptable for a deputy – e.g. out of working hours. Or do we mean care for people rather than pathology – the person orientation of care described by Gay and the WHO? Again the Tampere workshop was consulted on this; very few participants felt that GPs should be providing 24-hour personal care, but a substantial majority felt that they should provide continuing personal care over a substantial period of time.

When we come to consider our definitions there are a number of other issues that must be emphasised. The unique interaction between family doctor and patient that is the general practice consultation merits further exploration. This has been described as a covenant by McWhinney¹², which has its own therapeutic effect. This relationship between doctor and patient in general practice caused Balint¹³ to coin the term “the drug doctor”. Using the consultation interaction as a therapeutic tool must be regarded as a key feature of general practice and must be part of its training. Pereira-Gray¹⁴ has further explored the issue of continuity and the use of time by considering the separate consultations between the GP and the patient over time as part of a continuum. He noted that the average citizen in the United Kingdom consults their GP five times per year making a cumulative time of 47 minutes per annum.

An area of increasing importance over recent years has been the concept of patient autonomy and with it the role of the family doctor in developing the expertise of patients in managing their own illness, and contributing to this management by changing behaviour. This is likely to become increasingly important as patients become better informed due to the wide variety of information systems now becoming available to them, for example the Internet.

Advocacy is featured only in the WONCA statement, although it was in preliminary drafts of the WHO framework. It is described as “helping the patient take an active part in the clinical decision-making process and working with the government and other authorities to maximise equitable distribution of services to all members of society”. There would appear to be a further function of the family doctor, which is about assisting patients negotiate their way around the secondary and tertiary parts of their health care systems.

The epidemiology of general practice is essentially different from that of secondary care. Major illness presents early and in an undifferentiated way; many minor, self limiting problems are only or predominantly seen in primary care; and family medicine manages much of the longitudinal care of chronic illness. Many consultations are to relieve the anxiety of the possibility of illness in patients who have no pathology – the normality orientation of primary care. The concept of normality orientation is complex and covers a number of issues. It encompasses the activity of promoting health and well-being, and the expectation that many of the problems presented to them have no basis in pathology. At the same time general practitioners must diagnose and manage serious illness, the incidence of which is different compared to secondary and tertiary care. They must use problem-solving skills to resolve the dilemma that this presents. A very complex task, which requires a specific decision making process, based on the low incidence of serious disease, and the fact that the positive predictive value of symptoms and signs, and of diagnostic tests is different in primary care, **and, for a number of important conditions, lower than in the hospital setting.** There is often no biomedical cause for the distress that is presented by the patient, and it is important to know when to stop investigating whilst continuing to care. There is also a need to protect patients from the damage of over-medicalisation of their problems, if necessary by “rescuing” them **from unnecessary screening, tests, and treatment.**

McWhinney¹⁵ emphasised the organ based model of biological processes, in which the way a particular organism behaves will in part depend on its history, context and environment. This requires general practitioners to seek complexity and to accept uncertainty and he makes the point that, of all clinical disciplines, general practice operates at the highest level of complexity, and consequent uncertainty. In this lecture he emphasised several of the issues already discussed – relationships, individual person orientation, and the dualism between mind and body (physical, psychological and social).

In these days of consumerism and performance management there is an expectation that family doctors maintain their skills through lifelong learning, and demonstrate them through quality assurance. In some health care systems this is leading to compulsory reaccreditation on a periodic basis. Other societal changes will alter the consumer view of the way healthcare is provided, and the general practitioner must be flexible in order to respond to these changes. This flexibility has to cope with the rapid changes in the bio-medical field, which for the clinical generalist occurs over the whole spectrum of disease management.

Increased travel and immigration can cause rapid changes in the distribution of health and disease. This presents new challenges for the general practitioner and a change in the epidemiology of general practice. The family doctor needs a broader understanding of cultural, ethnic and religious differences and their impact on illness and health, and their implications for treatment.

There is also a developing role in relation to resource management. With the ever-increasing costs of health care the clinical generalist, in partner with his/her patient is in a unique position to determine priorities in health care provision and resource allocation. Family doctors also need to be aware of their role in promoting cost effective practice, not only in themselves but also in their colleagues. There may be a conflict between the wants and needs of the

individual patient, and the needs of the community as a whole; the family doctor needs to be aware of this, be able to strike an appropriate balance, and communicate this to the patient.

An area which is not specifically addressed in any of the previous definitions is the concept of high-use skills and high-risk skills. High-use skills are those which are used frequently in a general practice setting because of the frequency that they are required, for example the examination of children, history taking under time limited conditions, examination of the ear nose and throat etc. High-risk skills are required in situations which present infrequently to the general practitioner where there is a major risk for the patient for example dealing with cardiopulmonary resuscitation, a patient with convulsions or an aggressive/dangerous patient.

Finally it must be clear that our education process must prepare family doctors for the very different clinical processes which are not primarily mechanistic or technical in nature which is the way that medicine is still predominantly taught in medical schools throughout the world.

There is a need for an authoritative statement which defines both the discipline of general practice/family medicine and the tasks of the general practitioner, and relate them, at least in general terms, to the context of the health care system.

It should define:

- 1) Those essential elements of the discipline which define it and are not dependant on health care systems .
- 2) Those professional tasks which are generally applicable but can be varied by context. An example of this might be that referral to secondary care is an essential component but that the gate keeping function to secondary care was not.
- 3) The professional tasks which, as a result of contextual differences, are not generally applicable but where that situation is regarded as unsatisfactory (e.g. if we believe that family doctors should deal with all ages including children and this is not possible in a particular health care system) we should suggest that that health care system should change, in order to maximise the benefits to patients regarding health outcomes and to society in relation to cost – effective care.

This leads us towards some new or at least revised definitions. We require a definition of the characteristics or principles of the discipline of family medicine **AND** a definition of the role of family doctors, categorised by reference to the health care system in which they work.

THE EUROPEAN DEFINITIONS 2002

The Discipline and Specialty of General Practice/Family Medicine

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

1. The characteristics of the discipline of general practice/family medicine 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.
- 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.
- c) develops a person-centred approach, orientated to the individual, his/her family, and their community.

- d) has a unique consultation process, which establishes a relationship over time, through effective communication between doctor and patient
- e) is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient.
- f) has a specific decision making process determined by the prevalence and incidence of illness in the community.
- g) manages simultaneously both acute and chronic health problems of individual patients.
- h) manages illness which presents in an undifferentiated way at an early stage in its development, which may require urgent intervention.
- i) promotes health and well being both by appropriate and effective intervention.
- j) has a specific responsibility for the health of the community.
- k) deals with health problems in their physical, psychological, social, cultural and existential dimensions.

2. The Specialty of General Practice/Family Doctor

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 and providing cure, care, or palliation. 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.

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6. ACADEMIC REVIEW AND ANALYSIS; THE CORE COMPETENCIES

§1 Preamble

1.1 The description of competencies is the result of a hierarchical process. From the principles of the discipline of general practice, the professional tasks of the specialty of the general practitioner (GP) are derived, and from these tasks follow the core competencies.

1.2 Defining core professional tasks and competencies implies that there are also non-essential elements. Very often these are related to differences in the health care system and society in which the GP is working. Europe has a variety of health care systems and diverse situations where care is provided by the GP. There are basic cultural (including religious) and political differences in the societies and the populations the GP is serving. This may lead to a variation in job descriptions. General practice is the clinical discipline, which more than any other is dependent on societal differences. The GP is the mediator between society and medicine.

1.3 Competence can be defined as the GP's capability to successfully perform series of discrete observable tasks in isolation from actual work.¹ Thus, competence can be seen as the capability of an individual to act at the required level in a given situation. In the Miller pyramid the levels 'knows' (basic facts), 'knows how' (able to apply knowledge) and 'shows how' (able to show skills) are related to the concept of competence.

Performance can be defined as what a doctor is actually doing in clinical care and communication with patients in daily practice; performance relates to Miller's 'does' level.¹ It is considered highly dependent on existing health care conditions and requirements, financial and structural opportunities, practice opportunities and support.

Because of broad European applicability, the present document limits itself to the core competencies of GP/FM. The competencies thus form a theoretical model or framework. The reality of practice may and will differ from these competencies.

§2 From basic principles of General Practice / Family Medicine to core competencies

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

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.

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 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 provide longitudinal continuity of care as determined by the needs of the patient, referring to continuing and co-ordinated care management.

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;

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.

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 .

6. Holistic modelling includes the ability :

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

§3 Three areas of implementation

To practice the specialty the competent practitioner implements these competencies in three important areas¹⁻³ :

a. CLINICAL TASKS

- the ability to manage the broad field of complaints, problems and diseases as they are presented;
- to master long-term management and follow-up
- to balance evidence and experience in an effective way.

b. COMMUNICATION WITH PATIENTS

- the ability *to* structure the consultation;
- to provide information that is easily understood and to explain procedures and findings
- to understand deal adequately with different emotions

c. PRACTICE MANAGEMENT

- to provide appropriate accessibility and availability to the patients;
- to effectively organise, equip and financially manage the practice, and collaborate with the practice team;
- to cooperate with other primary care staff and with other specialists.

§4 Background features of the discipline

Three features are essential for a person-centred scientific discipline : context, attitude and science.⁴⁻⁸

CONTEXTUAL ASPECTS

- Use contextual aspects of the patient, his history, his situation and social background in diagnosis, decision making and management planning.
- show personal interest in the patient and his environment and *be* aware of the possible consequences of disease for family members and the wider environment (including working environment) of the patient.

ATTITUDINAL ASPECTS

- Being aware of one's own capabilities and values
- identifying ethical aspects of clinical practice (prevention/diagnostics/ therapy/ factors influencing lifestyles).
- justifying and clarifying personal ethics.
- being aware of the mutual interaction of work and private life and striving for a good balance between them.

SCIENTIFIC ASPECTS

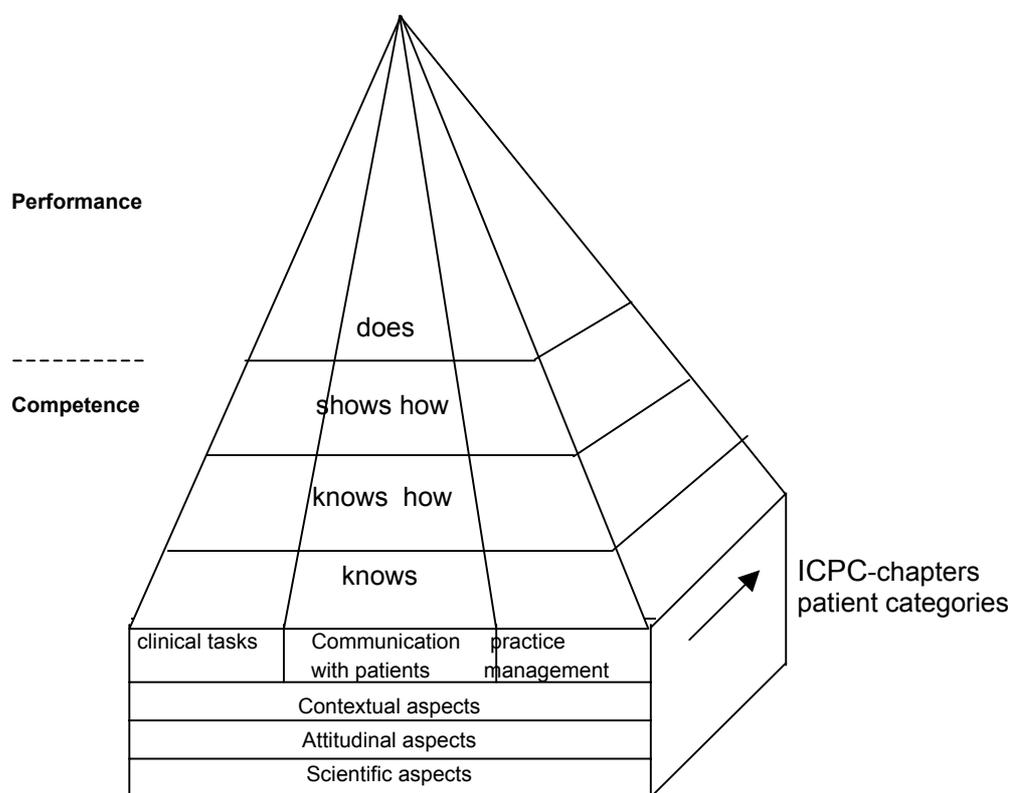
- being familiar with the general principles, methods, concepts of scientific research, and the fundamentals of statistics (incidence, prevalence, predicted value etc.);
- having a thorough knowledge of the scientific backgrounds of pathology, symptoms and diagnosis, therapy and prognosis, epidemiology,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

§5 The interrelated competence framework, a visual scheme.

The interrelation of core competencies, implementation areas and fundamental features characterises the discipline and underlines the complexity of the specialty.

Various models have been used to visualise the interrelations of core competencies: Miller's triangle, Fabb's cube and Donabedian's framework of structure, process and outcome. Previous research by Ram et al. elaborates on these.^{2,3}(see figure 1).

Figure 1 : The interrelated competence framework .



The extensive domain of general practice care has been ordered into three main areas on one axis: clinical tasks, communication with patients and practice management (see §3).

To list patients' complaints and diseases, a classification can be used according to the chapters of the International Classification of Primary Care (ICPC)⁹. These aspects and patient categories are represented on the second axis.

On the third axis the model reflects the current developments of theoretical views *and* medical expertise, from competence (cf. .knows, knows how, shows) to performance (cf. does). The top of this pyramid, the performance level, represents clinical and communicative performance as well as practice management in daily practice.

Donabedian's framework is also represented in this pyramid. Structure (practice organisation and management), and process (communication with patients and clinical performance) are included in the horizontal axis. Patient outcomes (disease-related parameters and general quality of life) can be seen as the result of the dynamic interaction between the three axes.

Being a person centred scientific discipline, three features of specialty competence are positioned, building up the basis of the pyramid: contextual, attitudinal and scientific aspects (see §4). The person centred professional uses the context of the person in the decision making process. Although communication with patients includes attitude, by introducing attitude as a separate feature one includes the professional behavioural aspects of the discipline. As General Practice training is an academic endeavour in which an evidence based approach is implicit, a scientific disposition should pervade all the professional tasks.

The figure shows the complex interrelationship of core competencies. It is this complexity that should guide and be reflected in the development of related agenda's for teaching, research and quality assurance.

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7. APPENDICES

APPENDIX 1

Leeuwenhorst definition 1974

"The general practitioner is a licensed medical graduate who gives personal, primary and continuing care to individuals, families, and a practice population, irrespective of age, sex and illness. It is the synthesis of these functions which is unique. He will attend his patients in his consulting room and in their homes and sometimes in a clinic or hospital. His aim is to make early diagnoses. He will include and integrate physical, psychological and social factors in his consideration about health and illness. This will be expressed in the care of his patients. He will make an initial decision about every problem which is presented to him as a doctor. He will undertake the continuing management of his patients with chronic, recurrent or terminal illnesses. Prolonged contact means that he can use repeated opportunities to gather information at a pace appropriate to each patient and build up a relationship of trust which he can use professionally. He will practice in co-operation with other colleagues medical, and non-medical. He will know how and when to intervene through treatment, prevention and education to promote the health of his patients and their families. He will recognise that he also has a professional responsibility to the community."

WONCA definition 1991

"The general practitioner or family physician is the physician who is primarily responsible for providing comprehensive care to every individual seeking medical care and arranging for other health personnel to provide services when necessary. The general practitioner/family physician functions as a generalist who accepts everyone seeking care, whereas other health providers limit access to their services on the basis of age, sex or diagnosis.

The general practitioner/family physician cares for the individual in the context of the family, and the family in the context of the community, irrespective of race, religion, culture or social class. He is clinically competent to provide the greater part of their care after taking into account their cultural, socio-economic and psychological background. In addition he takes personal responsibility for providing comprehensive and continuing care for his patients.

The general practitioner/family physician exercises his/her professional role by providing care, either directly or through the services of others according to their health needs and resources available within the community he/she serves."

Olesen Definition 2000

"The general practitioner is a specialist trained to work in the front line of a health care system and to take the initial steps to provide care for any health problem(s) that patients may have. The general practitioner takes care of individuals in a society, irrespective of the patient's type of disease or other personal and social characteristics, and organises the resources available in the health care system to the best advantage of the patients. The general practitioner engages with autonomous individuals across the fields of prevention, diagnosis, cure, care, and palliation, using and integrating the sciences of biomedicine, medical psychology, and medical sociology."

Appendix 2

Preparation and Consultation Processes

This paper was initially prepared by a working group of the Council of the European Academy of Teachers in General Practice (EURACT) and subsequently modified during the WONCA Europe meetings held in Barcelona, Spain in October 2001 and Noordwijk, Holland in March 2002. It is intended as a first step in the process of achieving a European consensus. From these definitions the core competences can be derived, and agenda for research, quality assurance and teaching developed to meet the needs of family medicine in the 21st century.

The trigger for the initial work within EURACT Council was the publication by Olesen et al 4 of their proposed revised definition of the role of the family doctor. They argue for a new definition based on the "ideal content of the speciality". They suggest it should be universal and not country specific and should provide a framework for teaching and training, and went on to produce a new definition. Although their intentions were supportive it was not felt that their definition had in fact met their own requirements.

The questions that the EURACT Council working party was asked to consider were as follows:

What is a GP? What do they currently do, and what should they do?

Should we define the discipline by defining the tasks of the family doctor, or the underlying principles or both?

There are many working in the discipline to a limited extent (by their health care system); are they to be regarded as general practitioners? Is there a difference between a general practitioner and a specialist in family medicine?

The process used was to debate these issues over a period of time, to explore some of the main international publications in this area, rather than an exhaustive exploration of all of the extensive literature around these topics. A mapping process, looking for similarities between the different approaches previously described, was undertaken and the reason for the differences explored. Then, by an iterative process, draft versions of this paper were produced, which were discussed more widely. A limited consultation was undertaken on a draft version of this paper with an international workshop in Tampere in May 2001 in which more than 90 GPs from all over Europe took part.

WONCA Europe, in conjunction with EURACT, SEMFYC, WHO Barcelona, EGPRW, EQUiP and EUROPREV organised an invitational consensus conference to which key organisations were invited. This took place in October 2001, and a draft statement was agreed for consultation more widely. This was carried out by WONCA Europe, which sent the papers for comment to all European colleges and national associations, and other organisations involved in Family medicine in Europe. The responses were collated and presented to a conference of these organisations in Noordwijk, in March 2002, following which this paper was finalised.

Appendix 3

Acknowledgements

WONCA EUROPE is grateful to all those organisations and individuals who have contributed written comments or who have taken part in the consultation processes leading to the development of this document. These include:

Austrian Society General Practice/Family Medicine
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College National de Generalistes Enseignants, France
Danish College of General Practitioners
Dutch College of General Practitioners
European Academy of Teachers in General Practice
European General Practice Research Workshop
European Network for Prevention and Health Promotion in Family Medicine and General Practice
European Union of General Practitioners
European Working Party on Quality Assurance
The Icelandic College of Family Physicians
Malta College of Family Doctors
Norwegian College of General Practitioners
Royal College of General Practitioners, United Kingdom
Slovak Society of General Practice/Family Medicine
Spanish Society of Family and Community Medicine
Swedish association of General Practice
Swiss Society of General Medicine
WHO, Barcelona office
World Organisation of Family Doctors

Dr M Boland
Dr G Buckley
Dr J Horder
Prof. C Lionis

APPENDIX 4

WONCA EUROPE - MEMBER COUNTRIES

ANDORRA
AUSTRIA
BELGIUM
CROATIA
CZECH REPUBLIC
CYPRUS
DENMARK
ESTONIA
FRANCE
FINLAND
GERMANY
GREECE
ICELAND
IRELAND
ISRAEL
ITALY
LITHUANIA
MALTA
NETHERLANDS
NORWAY
POLAND
PORTUGAL
ROMANIA
SLOVAK REPUBLIC
SLOVENIA
SPAIN
SWEDEN
SWITZERLAND
UKRAINE
UNITED KINGDOM

English Language Definitions

There is a lot of confusion regarding both the language used about general practice / family medicine^{8,9} and its interpretation. In order that there can be no misinterpretations or misunderstandings for the purposes of these discussion papers the following terms are defined as follows

General practitioner} Family doctor }	Synonyms, used to describe those doctors who have undergone postgraduate training in general practice at least to the level defined in Title 4 of the Doctors' Directive.
Primary care physician	A physician from whatever discipline working in a primary care setting.
Secondary care physician	A physician who has undergone a period of higher postgraduate training in an organ/disease based discipline, and who works predominately in that discipline in a hospital setting.
Specialist	A physician from whatever discipline who has undergone a period of higher postgraduate training.
Primary care	The setting within a health care system, usually in the patient's own community, in which the first contact with a health professional occurs (excluding major trauma).