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Essay

Anesthesia – Resuscitation in the academic training of the family doctor☆

*Helen María Barreto Quintana**

Guest Professor of the Public Health Department, Universidad Nacional de Colombia, Bogotá, Colombia

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ABSTRACT

The comprehensive education that a family doctor needs should be underpinned by his/her state-of-the-art ethical, social and scientific-technical knowledge. These demands of primary care make it necessary for the academies to introduce curricular changes to make sure that family doctors develop the necessary skills, and hence accomplish an efficient and effective background. As a healthcare professional, the family doctor should be able to respond to any health challenges facing the population.

La Anestesiología-Reanimación en la formación académica del médico de familia

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RESUMEN

La formación integral que necesita un Médico de Familia, debe estar fortalecida en su preparación ética, social y científico-técnica de avanzada. Estas necesidades y exigencias creadas en la atención primaria, llevan a las academias la necesidad de implementar cambios curriculares que garanticen que los futuros médicos de familia adquieran habilidades, permitiéndoles de esta manera, alcanzar una preparación eficaz y eficiente para lograr la formación de un profesional en salud que pueda dar respuesta a los problemas de salud que se presentan en la población.

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* *Corresponding author at*: Universidad Nacional de Colombia, Carrera 45 No. 44-21. Bogotá, Colombia.
E-mail address: helenbarreto65@gmail.com

Family medicine "is a specialty that does not drill down into the knowledge of a limited field, but rather takes some pieces from every discipline to apply them in a unique and comprehensive approach to the individual, the family and the community."[1] It is a specialty that shares many things in common with other clinical disciplines, combining all of that knowledge and using it specifically to administer primary care.[1]

Similarly, Anesthesiology – Resuscitation is a "specialty that uses techniques and methods for making the patient painless and protect him/her from any aggression before, during, and after surgery, trauma, and diagnostic procedures. It also provides pain therapy regardless of the etiology and administers resuscitation whenever needed."[2]

The all-encompassing training of a family doctor shall be strengthened by the ethical, social, and technical/scientific background. Study programs have been governed by a scientific dimension and the selection of contents has been based on a scientific approach; the primary criterion for the selection of the curricula has been basically based on the traditional and current topics of a particular science, partially disregarding the relationship with other disciplines, frequently giving rise to contradictory approaches to specific situations, and hence requiring the development of multi, inter and trans-disciplinary coordination, team work and a scientific-methodological community that guarantees the expected quality level of the graduate.

Alma-Ata evidenced that "society is increasingly demanding improved quality of the services rendered by various professionals. As such, there is a growing demand for universal access to health care and comprehensive, continuous and effective services for specific populations."[3]

These needs and demands in primary care require the academies to introduce curricular changes that help future family doctors to become effective and efficient health care professionals with a strong ethical and social foundation, in addition to state-of-the-art technical-scientific preparation, to be able to face the challenges.

Family medicine and anesthesiology-resuscitation share some common features, including pain treatment, palliative care, cardiopulmonary resuscitation and training in the techniques and drugs used for local anesthesia that is so often required in the rural environment or in primary care. These factors shall all be considered when developing the family doctor competencies.

Pain is one of the most frequent reasons for primary care visits affecting a high proportion of people at some point in their lives. The prevalence of non-cancer chronic pain ranges from to 2 to 40% of the adult population. In terms of cancer pain, its prevalence at the time of diagnosis is estimated at 37% of patients and up to 67% in advanced stages of the disease.[4]

Since ancient times, the family doctor has treated pain because most patients can be effectively relieved with simple measures any doctor can administer. Pain clinics today are comprised by interdisciplinary teams, including family doctors with their bio-psyco-social approach, and more specialized practitioners. In addition to analgesics, it is critical that pain therapy treats both the symptoms and the emotional and social aspects involved.

Several studies have indicated that "there are multiple psychological and physical factors that influence the perception of pain, whether amplifying of reducing the sensitivity to pain; i.e., personality, the time or situation in life when pain is experienced, relationship with other people, gender, age, intellectual level, any pain experienced in the past and lessons learned from previous experiences."[4,5] All of these factors shall be considered not just by family doctors, anesthesiologists, and other team members who are key actors for pain care centers, providing proper diagnosis and treatment for improved quality of life of patients.

When evaluating how much people know about the WHO pain scale, a large number of family doctors are not acquainted with it. The World Health Organization states: "There are patients with cancer and other chronic conditions that do not receive adequate treatment for analgesia, either because of improper use of analgesics or because major opioids are underutilized. According to the WHO, the use of morphine is a good indicator of cancer associated pain control in the various countries."[6]

This organization believes that "only a small minority of the over one million people who die every week around the world, receives palliative treatment to relief their suffering.[7] In addition to the low utilization rates, morphine is misused because of a lack of training and education of professionals."[7,5] Being knowledgeable about the different drug types is an absolute requirement to use them appropriately and at the right time.

An analysis of the family physicians training in cardiopulmonary resuscitation highlights the deficiencies that have to be overcome in terms of education, since during the last few years, discoveries have been made about cardiovascular, respiratory and cerebral pathophysiology, applied to life support and maintaining life under critical situations."[8] It is then indispensable to strengthen these abilities in order to accomplish one of the most desirable goals of medical professors worldwide: integrating basic and clinical sciences.

The poor training observed to respond to cardiorespiratory arrest is extremely concerning, not just because it is a frequent occurrence in Primary Care, but basically because providing the right initial treatment and prompt action are critical to preserve the life of the patient and successful outcomes in secondary care, ensuring not only the patient's survival, but his/her functional recovery and social reinsertion that ensure a satisfactory quality of life following a critical event.

It is also critical to assess the psychological effects of the cardiopulmonary resuscitation maneuvers on health care staff. Even the best of hospitals with the best available system, four out every five resuscitation efforts fail and may lead to severe physical and emotional symptoms in the staff that participated in the unsuccessful cardiopulmonary resuscitation. The death of young people and accidents resulting in severe trauma are the most difficult situations to confront.

Using simulators for medical education, particularly to teach cardiopulmonary resuscitation is critical; this type of training is not intended to replace the personal contact of the resident with the patient, but rather to properly prepare the resident to respond to real life situations, with greater confidence and improved skills to perform clinical procedures in future patients Some of the benefits from the practice of simulation in medicine are: training under difficult or rare