SAPIENZA
UNIVERSITÀ DI ROMA


E-ISSN 2531-7288
ISSN 0394/9001


MEDICINA NEI SECOLI
Journal of History of Medicine and Medical Humanities
35/2 (2023) 53-68

Received: 13.03.2023
Accepted: 27.04.2023
DOI: 10.13133/2531-7288/2775

Corresponding Author:
Roberto Sani roberto.sani@unimc.it
Fabiola Zurlini fabiola@studiofirmano.net

# From Medical Officers to Family Doctors: Historical and Training Paths (Historical and Pedagogical Reflections on the Italian Context)

*Fabiola Zurlini*
Studio Firmano for the History of Medicine and Science, Italy

*Andrea Vesprini*
Studio Firmano for the History of Medicine and Science, Italy

*Roberto Sani*
Department of Education, Cultural Heritage and Tourism
University of Macerata, Italy

ABSTRACT

**From Medical Officers to Family Doctors: Historical and Training Paths**

This article reconstructs the historical path, which passes from medical officers to family doctors-today's general practitioners - between the 19th and 20th centuries, highlighting the juridical, professional and training aspects, which determined the uniqueness of these figures in a medical context. Even today, these figures are the only ones in the medical context whose training takes place outside the academic area, unlike what happens in other European countries. The key role of general practitioners in the territory and the relationship with patients, family and social context requires a rethinking about their training, taking into account the complexity of General Practice, which cannot be limited only to technical biomedical knowledge. Medical Humanities can play a strategic role for a reform in the training of general practitioners to be hopefully brought back to the academic field, in also defining all those transversal skills at a methodological level for a coherent and effective training at a professional level.

**Keywords**: Medical Officer - Family Doctor history - General practice training

## Introduction

Family Doctors, who are now formally called General Practitioners, represent a *unicum* in the context of contemporary medical training: they are the only professional figures in the medical universe whose training takes place outside university through specialized courses managed by regions.

The structural reform of the training and the professional path for General Practitioners is long overdue and repeatedly invoked by the Federazione Italiana dei Medici di Medicina Generale (FIMMG) – the Italian Federation of General Practitioners – and the Federazione Nazionale degli Ordini dei Medici, Chirurghi ed Odontoiatri (FNOMCeO) – the National Federation of Doctors, Surgeons and Odontologists. A bill was introduced to the Senate and is currently debated; it heralds significant innovations in the field of training for general practitioners and should represent the first step of an overall structural intervention. This reform, which has the equalization of training path for general practitioners to other specializations in the medical area as its main purpose, will necessarily have to take into account the complexity required by this training in General Practice, which appears greater and less linear than in other specialized medical areas. A dominant common perception is the one of second-order healthcare figures at the base of the medical hierarchical pyramid whose training outside the academic area confirms their "minor" value. In reality, the situation is very different: these are figures who even historically arise as anomalies in the professional paradigm precisely because of their complexity, introducing objective difficulties when it comes to defining their necessary skills at a training level.

It is scientifically evident that the only acquisition of biomedical skills is insufficient to ensure an effective professional practice for general practitioners, while remaining a fundamental component for medical training. It must be necessarily supplemented by humanistic - ethical, social, anthropological and psychological - knowledge in order to create a single set of knowledge, which is able to make general practitioners able to respond to the complex needs for health expressed by citizens today. It should be highlighted how the dimension of the assistance and the related care, with respect to diagnosis and therapy, acquire a decisive importance in the practice of general practitioners. The recent pandemic has clearly shown the strategic role of general practitioners in the relationship with community, territory and national health system. Where these figures are inadequate in relation to the territory, the critical issues due to the lack of first-level assistance for people have an immediate impact on hospital facilities and district health services. The lack of new recruits replacing retired doctors, which is repeatedly complained by FIMMG, confirms the lack of attraction exercised by this profession on young doctors due to several problems, which are still unresolved, relating to these figures.

Through a historical analysis of the figure of family doctors and their evolution from medical officers to general practitioners, this article intends to outline those peculiar

aspects, which have always characterized their work, and, therefore, it highlights their training needs according to different and original paradigms in a professional medical context. It is an experimental - and challenging - field for the significant contribution, which Medical Humanities can offer in outlining a new training model.

**From medical officers to general practitioners: two centuries of anomalies**

Analysing the historical evolution - from medical officers to today's general practitioners - a first reflection concerns the fluidity of these professional figures who still today act in ways similar to the ones of the past, unlike other figures in the medical area: from the 19th century medical officers to the panel doctors between the 1950s and the 1960s up to today's general practitioners, it is possible to draw a continuous line along a chronological span of about two centuries, which connects these professional figures whose activity has not been substantially changed by the reforms taking place since the post-war period, which have significantly affected other health system components instead. As professional figures with respect to the rest of the medical class, the 19th century medical officers contain all the atypical characteristics, which will emerge better and better during the following century. The medical office - an institute which dates back to the Middle Ages - is the first place where medical knowledge was built as a privileged observatory of the hygienic and moral conditions in which people lived in the nineteenth century[1]. Local communities firstly had the obligation to pay doctors and even midwives and vets for the care of the poor, but also for guaranteeing assistance to people in general. However, resources were often insufficient and salaries were not congruous, the career was not very attractive to the point that several offices remained deserted, especially in mountainous and rural areas. Following the example of the contemporary literature of the Galatei Medici[2], the publications of the time did not fail to demonstrate innumerable difficulties, which medical officers met on their way with the intention of warning those who entered the profession against various dangers, which were up to the profession[3].

The obligation for Municipalities to earmark the costs for sanitary offices had been introduced by the municipal and provincial law of March 20th, 1865, no. 2243[4], while the establishment of the offices was left to the discretion of Municipal Administrations in the previous law of November 20th, 1859, no. 3793. The precarious and difficult situation faced by medical officers in their professional activity led to the birth of the Associazione Nazionale Medici Condotti (Anmc) - National Association of Medical Officers - in 1874 to protect the interests of the medical officers, who substantially differed from the ones belonging to the rest of the medical class. The main goals, which the Association set, were claiming the compulsory office system application by Municipalities on the one hand and trying to guarantee decent salaries to the medical officers, who often got in a conflict with Municipal Administrations in their indifference to economic and organizational difficulties in the daily activity of the profession

of medical officers on the other hand. It was up to medical officers to obtain a mount and the tools necessary for professional practice at their own expense and to provide for a substitute, who had to remunerate out of their own pocket, in case of absence from office.

The so-called Crispi-Pagliani law on the protection of hygiene and public health, which was promulgated on December 22nd, 1888, had better defined the professional profile of medical officers[5]. First of all, this law conferred stability to these figures, forcing their definitive employment after a three-year trial period, taking into account that the fate of medical officers was in the hands of the notables of the place, who could indiscriminately fire them up to that moment, given that their appointment was obtained with Municipal Councils[6]. This law also gave medical officers a public responsibility: if no other doctors lived in the Municipality, he was also a municipal health officer with the obligation to supervise the hygienic-sanitary conditions of Municipality, keeping provincial doctors constantly informed, and to draw up annual reports with information and statistical data useful for Government to know the Italian health conditions[7]. It should not be forgotten that medical officers had already been involved in the famous agricultural investigation, which has been carried out since 1877 to collect all the information on daily life in the countryside precisely because of this direct relationship with patients, families and environment in which they lived and it would have been expensive to obtain in any other way. Medical officers were called to answer one hundred and eight questions divided into general topics in questionnaires, which were sent by the State: housing, food, personal property, upbringing, education, social uses, physical and social conditions, morality, economic conditions. No one better than medical officers could offer such a capillary picture of the general conditions in which the agricultural class was in Italy, highlighting its precarious hygienic-sanitary conditions, malnutrition with correlated diseases, such as pellagra, or malaria due to the environmental conditions. In addition to the agricultural investigation, it should be mentioned the 1885 hygienic-sanitary investigation after the cholera epidemic in 1884, thanks to which Government tries to acquire the elements of knowledge indispensable to intervene on those environmental factors, which had favoured the spread of this infectious disease in such a devastating way, through questionnaires, which were sent to all the Italian municipalities[8]. In addition to representing an example of collaboration between medical officers and Government in improving healthcare organization, these investigations provided the guidelines leading to the Crispi law[9].

A medical officer - Salvatore Bonfiglio - had underlined the importance of medical officers in the construction of a health organization in a new state and had observed a few months before the enactment of the Crispi law that medical officers could have represented the basic cell for the organic construction of the national health administration through establishing a nucleus of hygienic-sanitary studies in each municipal office instead of considering them as municipal employees by making their fate de-

pend on the whims of the parties and the fluctuations of budgets[10]. The knowledge of environment and territory where medical officers act is also documented by a lot of historical-literary, climatic, hygienic-statistical publications - brochures, guidebooks -, which deserve a greater attention in terms of research[11].

What emerges is the particularity of the status of medical officers on the borderline between public and private in this framework of health statistics during the post-unification period. They assume the form of professionals who perform a public service employed by a Municipal Administration, but with important tasks for hygiene and public health. At the same time, medical officers can practise their profession and the most affluent classes make use of their services at home for a fee in a period when hospitals and hospices are still mostly conceived as places of care for the poor. The mixed remuneration formula was introduced by Johann Peter Frank as head of the Medical Directory in Lombardy-Venetia in the late 18th century. With a certain realism, he had tried to contemplate the public responsibility of medical officers as employees paid by Municipality for the care of the poor -since the State had the duty to treat sick people belonging to all the social classes at its own expense and to support those who spent their lives working for this - with the private need to get a fee from the care of wealthy people[12]. Here were the premises for the age-old question, which would be widely debated between the late 19th century and the early 20th century, on the adoption of a full office by Municipalities where the free treatment of medical officers had to be guaranteed to all the citizens living in the municipality and not just to the poorest.

Historical analysis show the roots of an anomaly, which still persists today. Like paediatricians of free choice, family doctors are still freelancers under an agreement with the public service. It is known that their legal framework varies at a European level, since general practitioners are only public employees in some countries, while they are only freelancers in others. In Italy, family doctors are not employed by healthcare companies and, once they have fulfilled the obligations provided for by the agreement, they are free to practise their profession. It is understood that - as in the 19th century! - the expenses for the surgeries used, the professional equipment used, any collaborators, such as secretaries and nurses, and the replacement during holidays and illness are borne by family doctors[13].

However, the current juridical status of general practitioners as freelancers operating within the national health service is supported by FIMMG, despite its atypical nature for the following reasons: they are the only ones who consider and allow the free choice of citizens and, consequently, the establishment of a trusting doctor-patient relationship. This connotation for general practitioners as figures on the borderline between public and private confirms their atypical nature on the one hand and emphasises the fiduciary dimension as the essence of the relationship with patients and their professional legitimacy on the other hand[14]. This fiduciary choice is also combined with the autonomy the figure of family doctors has and, however, it can represent not

only an advantage, but also a limitation in the professional practice: family doctors carry out their profession in an isolated way, because they are disconnected from other professionals in the public system. This is a critical issue, which general practitioners try to face through associations. It is no coincidence that various legislative initiatives in relation to general practitioners have precisely arisen since 1978 to encourage their associations in the professional practice in different forms, which found a full legal recognition in 2005 - after DPR 270/2000 -, such as associated doctors or network doctors. In their peculiarity, the figure of general practitioners continues to represent a challenge and a stimulus to legal and practical definition for new forms of professional practice and new training models.

**The training of medical officers between the nineteenth and twentieth centuries: an out-of-the-box paradigm**

The same peculiarity characterizing the legal status of medical officers marks their training whose specificity is determined by the relationship they have always had with patients, community and territory in which they act. In the second half of the 19th century, these figures have already contrasted with the dominant paradigm of medical training, which is increasingly oriented towards a specialist culture. On the contrary, medical officers are characterized by competence and preparation: the more consistent they are, the more extensive on the surface and less examined in the individual sectors they are. Professional practice requires the coexistence of multiple skills due to the difficult conditions where they are called to intervene. Medical officers often work even as official surgeons and where there are no pharmacists and midwives, as in the most impervious rural and mountainous areas, they also replace these figures[15]**.** What may appear to be a weakness compared to the rest of the medical community actually becomes a strength: they are the only doctors who maintain a general vision of patients and the context where they live, favouring a different approach to specialist medicine.
This office remained an obligatory choice for most of the new graduates in terms of employment: all the municipalities - even the smallest ones in mountain and rural areas - had to provide medical care for their poor inhabitants by law and, therefore, the new doctors had plenty of opportunities for immediate employment after graduation, which would have been denied elsewhere due to the scarcity of places and competition, such as in hospital career, public employment or as freelancers. The demand for doctors to be employed was so high to the point that several offices in mountainous or rural areas remained deserted[16]. Despite modest salaries and various difficulties, which young medical officers have, there were not many other employment alternatives for most of the new graduates - especially for the ones without attested family traditions -.
What were the requirements, which Municipalities required for the selection of medical officers during the post-unification period, is attested by various printed booklets published by Municipalities to inform about the results of the competitors' selections

carried out for the office with respect to the notice published[17]. By comparing their data, we can note a common framework of the qualifications required and the certificates, which had to be obligatorily deposited in order to compete: a one-year diploma for professional practice had to be added to the degree in medicine and surgery in most of the cases; having carried out service in other offices, having held positions in hospitals, hospices, charitable institutions, having got teaching appointments in medical schools and also having a curriculum of publications were preferential qualifications of merit, too. The latter is a requirement, which the aspiring medical officers had more than we might think about: there were numerous hygienic-statistical studies, especially published by medical officers after the epidemics. Although the Crispi law had reduced the power and the arbitrariness of Municipalities in forcing them to hire medical officers after a three-year trial period, the medical class still did not like that their destiny was entrusted more into the hands of public officials of which the evaluation commissions were largely composed than in the ones of technicians[18]. Always on the subject of requirements for professional practice, the Crispi law had clearly defined the access qualifications in articles 23 and 24, such as the doctoral degree obtained in an authorized university of the Kingdom with the obligation of depositing and registering the diploma at the city hall where the office was practised in order to supervise their regularity. The achievement of more diplomas and qualifications gave the right to cumulatively practise in the corresponding branches of the healthcare art – in addition to the profession of doctor or surgeon, they can also practise as phlebotomists, dentists, vets, except as pharmacists.

It is significant that between the late 19th century and the early 20th century some medical officers precisely suggested some proposals for the reform of medical studies. The practice of the office normally followed only a little the degree of young doctors, who ventured into the profession in the face of large daily case histories with limited means and, above all, armed with their senses and their intuition. These difficulties more clearly brought out the critical issues of their training, which were common to the entire medical class in practice, but they appeared more immediately in the case of medical officers for the reasons already given. These critical issues mainly concerned three aspects: practical experience, which was insufficiently provided by university courses, lack of specialist training – an aspect which may appear as a paradox in terms for general practitioners as medical officers are – and continuous need for updating.

The insufficiency of practical training, which was provided by university studies, was a problem mostly felt by the young medical officers, who found themselves having to deal with large case histories, without having a good practice – a year of professional practice after graduation was not enough to train the young doctors to face the complexity of the professional practice in an office. However, after graduating, sacrificing other years to practice meant imposing further years of sacrifices and costs - especially for the less well-to-do -, which followed the ones already borne for a demanding and expensive

course of study, such as medicine and surgery. Abbreviating the theoretical part of university training - concentrating it in five years - in favour of the practical one, to which to devote the entire sixth year with day and night stays in a hospital with at least sixty beds for one calendar year, was a proposal, which was made in 1912 by Luigi Daneo, President at the Asti section of the National Association of Medical Officers[19].

In the last decades of the Nineteenth century, the problem of specialization affected the whole world of medical profession. In the academic field, it translates into a multiplication of teachings and chairs and the birth of scientific-practical institutes of medicine (1881) while, in the professional practical field, it translates into the need for knowing the progress of diagnostic and therapeutic methods of investigation. In the medical magazines of the time, it is not infrequent to find the protests of medical officers and surgeons of the time, who denounced difficulty of not being able to make use of the specialists' expertise, especially in rural areas, in the face of the wide range of case histories they faced in the daily practice of their offices and the impossibility of having the knowledge of all the medical branches[20]. In the face of these voices, there were also different positions dictated by a moderate anti-specialism, which re-evaluated the diversity of medical officers: unlike the specialists, who were only interested in details - and the fee, in many cases! -, they knew their patients like no other specialists and were able to treat them thanks to the progress, which medical science made available with the discoveries of biochemistry and hygiene[21]. Therefore, the figure of medical officers - general practitioners - emerges as doctors, who are able to harmonize different aspects of medical science. Their dimension of care expands especially in rural offices, where doctors run into the poorest social class, the agricultural one, paying attention to the social and family context of patients and being lavish with their therapeutic, hygienic-sanitary, pedagogical and moral advice[22].

In the second half of the Nineteenth century, the pressing progress of medical science placed all the doctors in the face of the need for continuous updating, but it was a need, which was even more felt by medical officers, who had to daily deal with a wide range of case histories involving different fields of general practice. However, updating was much more difficult precisely for medical officers in rural and mountainous areas: the scarcity of means at their disposal to attain to up-to-date knowledge and the isolation and the solitude in which they carried out their profession made the need for updating and professional comparison even stronger. In the debate held on the occasion of the second national congress for the Association of Medical Officers, a medical officer coming from Frosinone had suggested an intervention by the State among various proposals for the improvement of the service, so that it forced municipalities to finance district scientific libraries and, at least annually, one updating course lasting a few months[23].

In 1908, accelerated courses for medical officers lasting a few months were also added at the Clinical Institutes of Specialization in Milan. Luigi Mangiagalli praised the

results of these courses, which enjoyed the large participation of medical officers of all ages, who came from all over Italy and were eager to attend lessons and clinics to adapt to the progress of science[24]. The increase in quality for training and updating decreed an improvement in the preparation and the professional practice of medical officers in the territory, which does not correspond to a change in the conditions where they found to carry out their work, especially in the countryside, being without means of study, scientific equipment, means of investigation, control and diagnostics. The Fascist health policy did not involve particular changes in training but, above all, in the methods of professional practice: the regime had exalted socialization of general practice as a tool for modernizing the country. However, it did not deal with a health system, which was extended to everyone, but the introduction of a mutualistic system – a proliferation of bodies, which guaranteed therapies and assistance to the members coming from various productive sectors on the basis of trade union and insurance agreements. Social security subjects were not citizens, but workers and their families and, therefore, only a part of the population could have access to assistance. At a professional level, mutualistic system ended up becoming the main job offer for new graduates in medicine who accepted modest salaries in the hope of building up a customer base. The Fascist health policy had ended with the approval of the law on compulsory health insurance for everyone and the foundation of Inam (Istituto Nazionale per l'Assicurazione contro le Malattie – National Sickness Insurance Institute) in 1943. During the post-war period, they were aware of the need for health reforms, but the need to primarily concentrate efforts on economic reconstruction overshadowed other matters, preferring a policy of caution in demolishing the existing systems.

In the light of this, in the second half of the Twentieth century, non-hospital care was entrusted to three professional figures, who often fluidly merged into each other: the first one is the *medical officer*, a municipal employee, who was mainly responsible for the care of the poor enrolled in the lists of municipalities, the second one is the *mutualist doctor*, who provided services to various members of insurance-mutualistic service categories and the third one is the *family doctor*, who assisted citizens in a freelance way. These were three professional profiles, who did not have an exclusive legal status, since a specific training path did not correspond to them. They were also fluid figures as one's practice did not exclude the others. It was not infrequent that medical officers were also mutualist doctors and also family doctors to ensure an adequate income through their professional practice[25]. During the post-war reconstruction phase, various professional medical associations were reconstituted and reorganized in general. The First Congress of Mutualist Doctors, where the Statute of the Fimm (Federazione Italiana Medici Mutualisti - Italian Federation Mutualist Doctors) was approved, gathered in Rome in 1947. In 1948, the National Doctors' Trade Union was established with the adhesion of five professional associations (medical officers, dentists, freelance doctors, mutualist doctors, hospital doctors). Therefore, we witness

a reorganization phase for autonomous trade unions of medical profession, which forebode a health reorganization as a whole.

**General Practitioners: training courses and the role of Medical Humanities**

A crucial year for the birth of the new figure of general practitioners was 1978 when the national health service was established with the law of December 23rd, no. 833, and the figure of general practitioners, to whom a central role in treatment was attributed in community nursing, was introduced. The aim of the law was to integrate hospital and non-hospital healthcare into an overall project, which was able to activate synergies between local healthcare services and hospitals. Key figures in this integration process were general practitioners, taking into account the concept that health protection was not limited to specialist treatments, but it also included prevention.

Therefore, the new figure of general practitioners rises from the ashes of medical officers and mutualist doctors, preserving their best aspects. Medical officers, who became general practitioners, kept their main professional characteristic unchanged: being the person's doctors before illness, having a privileged relationship with patients before illness and this almost in opposition to a medical intervention, which was always becoming more technological. In an increasingly fragmented health service system, general practitioners assume the role of guides, who are able to orient patients in a complex system, which is not always easy to understand with its hierarchical service structure. General practitioners retain the best professional aspects of mutualist doctors, such as having approached the weakest and the neediest part of the population through mutualistic assistance. At an associative and trade union level, the changement was sanctioned by the transformation of FIMM (Federazione Italiana di Medici Mutualisti - Italian Federation Mutualist Doctors) into FIMMG (Federazione Italiana di Medici di Medicina Generale - Italian Federation General Practitioners) in 1979.

Two years later, in 1981, the practical aspects of this profession were also defined through the first series of national collective agreements, which disciplined a very particular kind of professional practice, such as the one of general practitioners whose exceptional nature from a legal point of view has already been examined. During the 1980s, the normative construction of the figure of general practitioners continued, but the attention to the aspects related to training and professionalization was only paid in the following decade.

The path, which will lead to the famous legislative decree no. 256/91 regulating the two-year training course in Medicine, is long and complex and it is possible to remember only a few outlines of it here. EEC directives 362/1975 and 363/1986 relating to free movement of doctors did not have any provisions on mutual recognition of diplomas proving a specific training in general practice, nor relating the criteria by which such a training should have abided. In any case, the European Council had noted that a movement tending to enhance the role of general practitioners and the importance of their

training was emerging in a certain number of Member States and, therefore, it had asked the Commission to study the problems posed by this evolution. The need for a specific training of general practitioners emerged, particularly taking into account the fact that the development of medical science had produced an ever-widening gap between teaching medical research on the one hand and general practice on the other hand to the point that important aspects of general practice could no longer be taught satisfactorily within the framework of basic medical training in Member States. The 1986 Directive EEC/457 was born on these premises on which some cornerstones were established: each Member State had to establish a specific training for general practitioners whose entry would be conditional upon the successful completion of at least six years' study within the framework of the full-time medical training course lasting at least two years to be carried out under the supervision of authorities or competent bodies. The orientation was towards an essentially more practical than theoretical training. For at least six months, practical teaching had to be given in a certified hospital centre, which had the necessary equipment and services, as well as, for at least other six months, in an approved medical clinic or an approved centre where doctors provided primary care. EEC directive 457 was assimilated with the Decree of August 8th, 1991, no. 256, establishing the two-year specific training course in medicine, which was reserved for graduates in medicine and surgery, who were qualified to professional practice, and was articulated for at least two thirds in practical activities, identifying regions and autonomous provinces as the subjects responsible for organizing and activating courses. Decree 256/91 was subsequently modified and integrated by legislative provisions, such as Legislative Decree of August 17th, 1999, no. 368, which changes the certificate into a specific training diploma in medicine and defines the contents of the course with art. 26.

This is divided into theoretical and practical activities - which make up most of them - for a total amount of at least 4800 hours. For carrying out practical activities, it provides for a five-month training period in hospital structures for training in clinical and laboratory medicine; a three-month training period for surgery; a four-month training period in mother and child departments; a twelve-month training period in general practitioners' surgeries operating within the national health system; a six-month training period in the basic structures of the Local Health Authorities (districts, clinics); a two-month training period for training in obstetrics and gynaecology and a three-month training period in emergency rooms and casualty departments.

Being provided by territorial administrations, at least in appearance, the course, which is largely focused on practical training, should bring doctors closer to the territory, making them familiar with the health structures operating there.

Taking into account the lack of general practitioners and the poor attractiveness, which the course in medicine has for young graduates in medicine, we must wonder whether this training course is consistent with the needs and the complexity of this profession.

The critical issues highlighted are different, also in the light of interviews, statistical surveys and analysis carried out both in the academic field and by FIMMG[26].
Despite a store of skills acquired during training, it emerged how general practitioners find themselves to rather informally construct their training through direct experience in the field. Training is parcelled out into specific skills closed within technical-scientific disciplinary boundaries. The risk is having a poorly integrated hyper-specialist knowledge, as the required professional complexity of general practitioners would be necessary instead. Practice with the wide range of different case histories, which general practitioners have to deal with every day, is the litmus test, which reveals how a disintegrated and hyper-specializing knowledge needs to be recomposed and made fluid in a broader context, in order to be useful in dealing with patients as people even before their illness. They assume an active role in the treatment path focused on patients, clearly bringing out the role of doctors as consultants, facilitators and advisers[27]. In addition to clinical, diagnostic, theoretical-scientific and therapeutic skills, general practitioners need psycho-social, pedagogical and ethical skills. Practice precisely brings out the need for transversal skills, which are able to overcome the technicalities of science and to recompose general practice into a single unit. But we witness a paradox in terms: while the need for knowledge and updating on biomedical topics is referred to institutionalized training, there is a creeping trend to believe that other skills, for example, related to the relationship and the communication with patients and the ethical dimension of this relationship can be learned not in a formal and scientific way, but through experience, and derive from more or less personal skills.
There is a lack of perception for the need to learn these skills by integrating knowledge and methodologies belonging to humanities with the ones in the biomedical area. The role of Medical Humanities in hopefully rethinking - and more properly reforming - the training of general practitioners in an academic context appears strategic[28]. If it is true that the role of constantly updating technical knowledge cannot be ignored, biomedical skills cannot also be considered as the only ones necessary to understand the complex health need expressed by patients, especially in general practitioners' training.
Therefore, it is urgent and necessary to also reflect on the complexity of medical knowledge at a biological, psychological and social level for the integration of a different knowledge into a corpus of a complex knowledge in which general practitioners must be trained.
However, more than thirty years after the establishment of the training course in medicine, the regional management of postgraduate training in general practice, the absence of criteria for monitoring the training quality of numerous teaching centres, as well as the non-existence of evaluation tests, which allow a certification of the skills acquired during the course, have led to a considerable heterogeneity among the teaching centres from different regions. As it is known, the training of general practitioners

outside the universities remains only an Italian anomaly in a European context. In Italy, Medicine and University are still having difficulty in communication. Currently, there is no pre- and post-graduate trainings in general practice, since the course is managed by Regions. It is as if Italy has remained extraneous to the experiments, which have taken place in the international academic medical field in all these years.
The most interesting and advanced experience in Europe is certainly in the United Kingdom where the first chairs in General Practice were established more or less in the same period of the birth of Family Medicine in the USA[29].
In 1986 - the year when the Mackenzie Report, a historical document illustrating the state and the prospects of General Practice in the English academic system, was published -, there were already twenty-four Departments of General Practice in action, the result of a collaboration between Universities and organisations of General Practitioners with the support of the Royal College of General Practitioners and the National Health Service[30]. In this model, University makes available the ability to organize teaching and to produce research, while General Practitioners make available their experience joining the Department of General Practice as professors. Therefore, in order to become family doctors in the United Kingdom, it is necessary to attend the five-year academic specialization in General Practice whose first two years are common to all the medical specializations and the following three years are equally divided into hospital activities, family medicine activities and primary care. In the English experience, it is clear that General Practice seems to be the discipline, which is able to make students better appreciate concepts, such as the continuity of treatments, the individuality of patients, the influence of social factors on the perception of health and illness, the consequences of illness on a family background. It is clear how general practice is particularly harmonious with the biopsychosocial model[31] and introduces the perception of the complexity and the multifactorial nature of health - perhaps in a humble and very effective way -.
Almost everywhere in Europe, one becomes a family doctor after having attended an academic specialization. The European Society of General Practice/Family Medicine (Wonca Europe - World Organization of National Colleges and Academies of Family Medicine/General Practice) defined the core competencies, which universities must provide in training family doctors: Primary care management, Person-centred care, Specific problem solving skills, Comprehensive approach, Community orientation, Holistic approach to which three other fundamental aspects (Contextual Aspects, Attitudinal aspects, Scientific aspects) must be added.
Returning to the Italian reality, an analysis on the causes for training delay would require a shared examination of the responsibilities between University and General Practice. However, this training anomaly in comparison with the European training stands out more clearly: all the first, second and third level Italian health training is entrusted to University with the only exception of the courses in general practice,

which are still in the hands of regions. The opportunity to bring it back to the university context has been and is invoked from many quarters in a context of an overall reform in general practice. Various proposals for pre- and post-graduate training of medicine and surgery students have been formulated to General Practice. It was also highlighted that universities already have regulatory tools to develop these training skills. In indicating the Specialization in Community Medicine and Primary Care, the Decree of Medical Specializations (DIM 68, 2015) recognizes the university role in the specialist medical training, which is devoted to Primary Care system with skills of medical clinics integrated by managerial skills (coordination, clinical governance of treatment paths, management and direction of simple and complex OUs). Taking into account the need to integrate the teaching contents of this specialization, the evolution of the Specialization in Community Medicine and Primary Care into the Specialization of General Practice and Primary Care was proposed. The recognition of the Specialization in General Practice in the academic field would significantly contribute to a re-evaluation of the professional figure of general practitioners. At the moment the scientific societies, the government and the professional associations are still debating on the matter to outline the reform.

**Conclusions**

In rethinking a training in General Practice oriented towards a biopsychosocial model in the academic context - which will inevitably have to open up in the consequences of the pandemic phase -, the change cannot fail to contemplate a teaching, which provides for an interdisciplinary approach to complex health problems, considering the contribution provided by Medical Humanities strategic for a training, which places at the centre the people considered as individuals and in their family context and places the doctors in relation with other social and healthcare professions and makes them able to treat and to take care of people through the active participation of families and communities.

If it is true that the doctor-patient relationship remains the central bond where the patients' fiduciary relationship with family doctors - the only doctors who are chosen in the public health system - is articulated, numerous challenges (from telemedicine to artificial intelligence, migratory phenomenon and much more), which stand out for family doctors, strongly impose a reflection on their training in an increasingly less technical direction, taking into account that the training heritage they must have to deal with them must be various: not only technical, but also cultural, medical and non-medical. An unrepeatable moment is standing out in a post-pandemic multifactorial convergence, which focused the attention on general practice in general and the local one in particular, so that we can finally reach a reform for General Practice and its training in an academic context where Medical Humanities cannot only acquire adequate teaching places, but they can also provide methodologies and useful paradigms for the redefinition of this professional figure.

## Bibliography and notes


1. Soresina M, La politica professionale e la legislazione sanitaria 1859-1978. In: FNOMCeO (ed.), Centenario della Costituzione degli Ordini dei Medici. Rome: Health Communications; 2010. pp. 109-125.
2. Zurlini F, The Galatei Medici and Medical Education in the Nineteenth Century. HECL 2022;17(2):517-530.
3. Zappoli A, Annotazioni critiche pei medici e chirurgi condotti che possono servire di norma anche ai municipi. Pesaro: tipografia del Nobili; 1839.
4. Municipal law of March 20th, 1865, no. 2243, in art. 116, had introduced the compulsoriness principle of a doctor, a surgeon and a midwife for the poorest as an expenditure in municipal budgets. For an examination of the post-unification legislative framework on medical offices, please see: Zurlini F, La sanità pubblica a Fermo e nel territorio fermano dopo l'Unità d'Italia. In: Zurlini F (ed.), Luoghi e Forme dell'Assistenza Sanitaria: ospedali, medici condotti e operatori sanitari a Fermo e nel Fermano dopo l'Unità d'Italia. Fermo: A. Livi; 2011. pp. 17-47. See also: Iorio S, Zurlini F, Training and practice of the profession of midwife in the Napoleonic age in the March of Fermo. HECL 2022;17(2):701-712.
5. Santonocito G, Storia del diritto alla salute. Milano: Franco Angeli; 2022. chapt. 3.
6. Frascani P, Il medico nell'Ottocento. Stud Stor.1982;23(3):617-637.
7. Guzzanti E, L'evoluzione dell'Assistenza Primaria nell'Italia pre e post-unitaria: il ruolo delle condotte mediche. In: Guzzanti E (ed.), L'Assistenza Primaria in Italia: dalle condotte mediche al lavoro di squadra. Rome: Ed. Iniziative Sanitarie; 2009. pp. 95-105. I medici attraverso secoli di storia tra saper essere e saper fare: atti del Convegno, Salerno 14 marzo 2008. Cava dei Tirreni: tip. Tirrena; 2010.
8. Frascani P, Medicina e statistica nella formazione del sistema sanitario italiano: l'inchiesta del 1885. Quad Stor. 1980; 45(3):942-965.
9. Lupano F, I medici condotti e l'inchiesta agraria: la salute materno-infantile nel 1878. Quad ACP 2007;143:131-133.
10. Bonfiglio S, Sulle condotte mediche di Girgenti. Giornale della R. Società Italiana di Igiene 1888;4:256.
11. As an example of this nineteenth-century literary genre, we can cite the work by Achille Marini, a medical officer from Montottone, who still today represents a historical reference guide for the municipality of the Fermo area: Marini A, Storia della terra di Montottone nelle Marche. Fermo: Tipografia E. Paccasassi; 1863.
12. Zocchi P, Il Comune e la salute. Amministrazione Municipale e igiene pubblica a Milano (1814-1859). Milano: Franco Angeli; 2006. p. 38, n. 35. Cea R, Il governo della salute nell'Italia liberale: Stato, igiene e politiche sanitarie. Milano: Franco Angeli; 2019. pp. 54-56.
13. Toth F, Professione medico. Bologna: Il Mulino; 2012. pp. 74-88.
14. Betri ML, Dalla sconfidenza nel medico al ricorso al cultore di una scienza di fiducia. In: Malatesta M (ed.), L'invenzione della fiducia. Medici e pazienti dall'età classica ad oggi. Roma: Viella; 2021. pp. 101-115.
15. The creation of pharmaceutical "cabinets" with the Crispi law in 1888 introduced the possibility for the medical officer to set up and to manage even a small medicine cabinet by way of derogation from practising the pharmaceutical profession with the aim of making the distribution of medicines more extensive. Cea R, Il governo della salute

nell'Italia Liberale. Stato, igiene e politiche sanitarie. Milano: Franco Angeli; 2019. pp. 217-221.

16. Many offices remained uncovered in the extreme northern Italy - Udine - like in the extreme southern Italy - Messina - around 1880. Forti Messina A, Il sapere e la clinica. La formazione professionale del medico nell'Italia Unita. Milano: Franco Angeli; 1998. pp. 187-194.
17. For example, please see: Estratto dei requisiti dei signori concorrenti alla condotta medica egual primaria in Jesi. Jesi: tipografia fratelli Ruzzini; 1873. Sunto dei requisiti del dr. Piccinini di S. Elpidio per la condotta medica di Ancona, Ancona: Tip. G. Cherubini; 1880.
18. Avezza L, Dove si andrà a finire? Corriere Sanitario 1891;2(21):2-3.
19. Forti Messina A, Ref. 15, p. 231.
20. Turazza G, Corrispondenza. Gazzetta degli Ospitali 1886;7(9):72.
21. Forti Messina A, Ref. 15, pp. 248-250.
22. The medical officer becomes an interlocutor and an interpreter of the peasant mentality. Cosmacini G, Curare e "avere cura" nel primo Ottocento. La Ca' Granda 2001;42(4):18-26.
23. Insegni G, Sullo Stato delle condotte mediche in Italia: Mezzi morali e finanziari pel miglioramento del servizio e della classe, pel secondo Congresso dell'associazione Nazionale dei Medici condotti in Napoli. Frosinone: Tipogr. Stracca; 1904. p. 19.
24. Mangiagalli L, L'insegnamento della medicina in Milano nel passato e nel presente. Milano: Società per le Arti Grafiche "La Gutenberg"; 1912.
25. Vicarelli G, Medicus omnium. La costruzione professionale del medico di medicina generale (1945-2005). In: Cipolla C, Corposanto C, Tousijn W(ed.), I Medici di Medicina Generale in Italia. Milano: Franco Angeli; 2006. pp. 50-99.
26. Molteni L, Migliorati L, La formazione alla professione di Medico di Medicina Generale. In: Cipolla C, Corposanto C, Tousijn W (ed.), I Medici di Medicina Generale in Italia. Milano: Franco Angeli; 2006. pp. 50-99.
27. Scarponi T, Costruzione complessa della relazione di cura nella medicina di famiglia. La Professione. Medicina, Scienza, Etica e Società 2016;17(3):191-195.
28. Bleakley A, Medical Humanities and Medical Education. How the medical humanities can shape better doctors. London and New York: Routledge, 2015. pp. 100-131.
29. In the late 1960s, the birth of Family Medicine in the USA took place under the impetus of a group of doctors, who were convinced of the need to oppose a bio-psycho-social model to the paradigm of ultra-specialist medicine. In order to understand and to solve multidimensional health problems, doctors must turn their attention to the psychological, social and family aspects of the people interacting with each other and able to influence global health. Engel GL, The need for a new medical model. A challenge for medicine. Science 1977;196(4286):129-36.
30. Howie GR, Hannay DR, Stevenson SK, The Mackenzie report. General practice in the medical schools of the United Kingdom, 1986. BMJ 1986; 292:1567-1571.
31. Among the key documents referring to the biopsychosocial model, there is the definition of health by the World Health Organization, which provides for a concept of human health not exclusively limited to a lack of pathologies/diseases, but as a more complex and full psychosocial expression of individual potential and resources (WHO, 2001, International Classification of functioning, disability and health).