# CPD - Caring for Patients and their Disorders

The first edition of 'Caring for Patients and their Disorders' -CPD- in 2001 has a slightly different format from our previous 'Continuous Home Evaluation of Clinical Knowledge' or ***Check***.

It is a brief exploration of what is considered by some to be the perhaps more esoteric aspects of Family Medicine — usually dispatched to the 'fringes' while people get on with what most consider to be the 'real work'. It includes something about 'reality', something about 'health education' and something about 'communication'.

**CPD points**

The novelty of collecting continuing professional development points has worn off somewhat and many doctors' concerns that they would not be able to 'collect' sufficient points within a year have been allayed.

Most of you will have noticed that the Medical and Dental Professional Board of the Health Professions Council of South Africa have in principle approved that the five-year cycle falls away and is replaced by an annual requirement of 50 points, with a maximum of 50 points able to be carried forward.

Our intention with the SA Family Practice Journal is to provide the most flexible and most interesting way of collecting your self-study points. This is a value-added component of your Academy membership fee. From this edition onwards, it will be possible to obtain CPD points per edition as well as annually. You can choose either or both options. The per edition points will cover only the CPD component of each journal whereas the annual questionnaire will cover information from the whole of each edition. There may be some overlap as the annual version will also cover the CPD components of each edition. However the questions themselves are likely to be different and may require you to go back to the articles again.

At this stage, mainly because of space limitations, there will be 2 'per-edition' points, with 13 points for the annual questionnaire. It is therefore possible to obtain 25 points in total in this manner.

Finally, a note about the 'check on check' of last year's August/September edition. In spite of some confusion in the instructions, for which I apologise, most doctors managed to complete the 'quiz' without any apparent difficulty. It is our intention to use different formats for the questions, so please be sure to follow the instructions carefully.

Roy Johnson

This three-part CPD section starts with one particular model of 'reality'; we explore the health belief model with the help of a patient; and finally we consider some aspects of 'deeper' communication.

## Part 1: 'Reality'

Many other disciplines have made major contributions to Family Medicine. Some of these have come to be considered 'soft' science and marginalised in most medical training. After all there is so much else that is vital to being a family physician. Consultation and examination skills, the expertise to perform certain procedures appropriately and safely, being a manager of resources, etc. Nevertheless it is increasingly important to have an idea of the kinds of perspectives that, for example social science, medical anthropology, and philosophy amongst many others, deal with and what impact they have on family medicine.

Our particular discipline has had a lot to say about the personhood of the patient[1] and even that of the doctor[2]. We talk about 'whole person medicine', 'patient-centred' or 'relationship-centred' consultations, incorporating the family, and being part of the community. These are all laudable and important aspects of Family Medicine. We also deal

with the day to day management of patient's problems, the systems in which we work and the contexts within which we live. We have not, in South Africa anyway, incorporated much thinking around socio-philosophical concepts of 'reality' and its relationship to family medicine.

Sometimes just keeping up with the living of life itself with its multiple and complex demands is all we can manage. Perhaps it is at these times more than any other, taking a 'reality check' is important.

Why is it necessary to ask questions such as:

- is reality an external given or is it just a product of the mind?
- do we have "free will", or are we simply products of our environment?
- must a person experience something in order to understand it?
- is understanding best achieved through the 'scientific method' or through direct experience?

when there is just so much work to be done?

Do these issues matter if we all share a common understanding of reality? Are there consequences (for our patients, our families, ourselves) if we do ***not*** ask these questions?

A useful starting point, and just one of many attempts at looking at reality is provided by sociologists Burrell and Morgan[3]. They propose a matrix of two axes which makes it easier to 'classify' different worldviews. These have been modified slightly for the purposes of this article. (Please note that this is not a comprehensive overview of the debates around reality. It is but one step in a multi-faceted, complex, ongoing and probably never-ending exploration of ideas.)

The first axis is a *Subjective–Objective* one, which spans the 'reality is out there and external' and the 'internal experiential reality' continuum. The second axis is an *Order–Chaos* one, which is a more dynamic continuum.

When combined, these axes provide a two-dimensional template against which we can assess one (perhaps simplistic) version of the reality of ourselves, our patients, our discipline, and the world in which we live.

**Objective–Order quadrant**

This is what most of us consider 'reality' to be. It's 'out there', rational, palpable, and manageable. Our scientific and medical training – including 'evidence-based medicine' – falls within this area Change is managed according to rules and regulations (and policies). As long as these are followed, the world keeps turning properly. The world is 'as it is'. Our patients and ourselves follow fixed patterns of relating and functioning.

**Subjective–Order quadrant**

Many philosophers, theologians, poets and mystics have this worldview. Understanding life, and making sense of the world we live in, are important. Change comes from within. Family Medicine's emphasis on the doctor–patient relationship is part of this dynamic. The world is 'as it is understood or perceived to be'. Our patients and ourselves are enabled to relate and function with more flexibility in terms of causes of, and solutions to problems.

**Objective–Chaos quadrant**

Burrell and Morgan have called this the worldview of the Radical Structuralist. Systems theory has a home here – especially in terms of 'changing the system'. This may lead to conflict and disorder (chaos) until things settle down again. Some approaches to family therapy focus on changes that destabilise a family system to a greater or lesser degree[4]. The 'Struggle' worldview finds its place within this quadrant. The focus is on the world 'as it should be'. The approach to 'changing the system from within' would find a place in the corner near the junction of the axes. 'Changing the system by changing the structures' would sit at the extremes of this quadrant. In Family Medicine our patients and/or ourselves are aware of inequity and injustice in the way we relate and function, but usually just accept the status quo. The unpredictability of functioning within this worldview

***Table I:*** ***Reality Matrix***

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|---|---|---|---|
| | ***Chaos*** | | |
| ***Subjective*** | Internal<br>Unpredictable<br>Unmeasurable | External<br>Unpredictable<br>Measurable | ***Objective*** |
| | Internal<br>Predictable<br>Qualitative | External<br>Predictable<br>Quantitative | |
| | ***Order*** | | |

makes it an uncomfortable place for most family physicians especially if it means confronting or challenging societal, political, and economic structures.

**Subjective–Chaos quadrant**

Burrell and Morgan have labelled this the Radical Humanist quadrant. Change comes through 'empowering' people to realise their full potential – as individuals and as groups. A truly empowered group becomes increasingly assertive about their rights and responsibilities. This is often extremely threatening to people already in positions of power. The focus is on the world 'as it must become'. Our patients and ourselves relate and function as agents for change or as activists, often within a human rights framework.

**The challenge**

Not only do we as individuals have different worldviews and ideas of reality, our discipline itself comes from a particular worldview and perception of reality. The reality of the society and culture in which we live and practise, is held together with the glue of a collective – mostly implicit, worldview and mindset.

Do you find yourself resonating with any particular aspect of this model? Have you ever had an experience where it was clear that you and your patient (or colleague) were coming from radically different worldviews?

Moodley's[5] outline of postmodernism is also helpful in considering these issues. A postmodern way of looking at reality, in terms of the Burrell and Morgan model, might be to figuratively 'take a step back', holding all quadrants of the model in your mind, recognising that they're all operating simultaneously – and beyond the model.

A thought question: From which quadrant of the model is part 1 of this edition's CPD most likely to have been written? Motivate your answer.

## Part 2: Health Education

One of the most commonly used models for health education is the Health Belief Model (HBM). Stott[6] uses the health belief model in his compact yet profound book, Primary Health Care: Bridging the Gap between Theory and Practice. The HBM is a 'value-expectancy' model and has four main constructs in determining health-related behaviour.

These are:

- perceived ***severity*** of the condition
- perceived ***susceptibility*** to the condition
- perceived ***benefits*** of avoiding the condition
- perceived ***barriers*** to avoiding the condition.

A fifth construct of '***self-efficacy***' has been proposed in addition to the others. Self-efficacy is the sense of 'I am able to do that'.

This model helps explain why doctors or nurses *educating* patients simply by giving information or telling them what to do is so often futile. It also has implications in terms of compliance.

Let us consider the HBM in the light of a topical issue such as HIV/AIDS – with the help of a young man named Peter.

Peter is nineteen years old and studying at a technikon. He had come to see me with a urethral discharge. This naturally led into a discussion about sex, STDs and AIDS. The appearance of the discharge had given him a big fright and he had many concerns. His primary concern was related to sexual performance, whether or not his girlfriend was 'satisfied' with his lovemaking, and how he could know if she was or wasn't.

He had been to a party the previous weekend, had had a bit of alcohol and ended up sleeping with a girl he met at the party. He said that if he hadn't, she would have thought of him as 'not being a real man'.

He'd thought of using a condom, but didn't have one with him and he didn't want to appear foolish in the girl's eyes by asking if she had one available. In the heat of the moment and under the influence of the alcohol he decided that he couldn't resist such an opportunity. Besides which, he preferred sex without a condom anyway. He also thought it would be interesting to compare how this woman responded to him sexually, with his girlfriend's response. He was sure that she couldn't possibly have any kind of infection because she was so clean and so well dressed – apart from being beautiful. 'It just shows that you can never trust a woman,' he said.

That remark brought my own agenda about women's rights to the fore, but I decided against saying anything about his remark, so that his concerns weren't lost in my need to correct his pejorative statement.

Our conversation turned to the possibility of him having been exposed to HIV, and what kind of risks there might be for his girlfriend if he had been exposed. They'd not had intercourse since he'd been at the party.

He went on to say that a man who was a few years older than him who came from the rural area he himself had grown up in, had recently died of heart failure. No one would confirm it, but it was widely believed that he'd died of AIDS, although some of the older members of the community said that he'd been bewitched. This man had had a reputation

for sleeping around. Peter said that he would not like to die of AIDS, but that as more and more people seemed to be dying from it these days, he wondered if he had any chance of *not* getting it.

I asked how he felt about abstinence. He said that he'd tried it for three months once, but he started having sex again after he realised that he was going mad. Many people had told him that if a man's semen does not come out regularly, it turns to salt, goes to the head and causes the man to go mad. He said that after his own experience he was convinced that this was true. I asked him how he felt about masturbation and he said that that was just disgusting. He also told me that it was a waste of sperms. When I asked him what he meant, he asked me if it wasn't true that it took ten drops of blood to make one drop of semen.

**Question One**

Analyse Peter's knowledge, attitudes and/or behaviours in terms of HIV/AIDS using the health belief model.

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**Answer One**

In terms of the perceived ***severity*** of AIDS, Peter is aware of the fatal consequences of the disease from the experience of the man from the rural area and his awareness of the increasing number of deaths. He does not seem to have much awareness of the illness process leading up to death however.

In terms of perceived ***susceptibility***, Peter's behaviour at the party would suggest that he did not feel susceptible to HIV at that point. Considering his age he more than likely felt invincible. However, he also worries that it is almost inevitable that he might be infected with HIV, and he states that he would not like to die of AIDS. It's possible that the experience of having an STD has now made him feel much more vulnerable.

The perceived ***benefit*** of not getting HIV would be that he wouldn't die of AIDS.

The ***barriers*** he faces include: his beliefs about abstinence, his preference for not using a condom during sex – and not having one available when he 'needs' it, his ego needs related to his concerns about virility and sexual prowess, the disinhibiting effect of alcohol, his chauvinism towards women, and the chances that in the future he will attend many more parties where alcohol is provided.

The one message that Peter has unequivocally assimilated is that AIDS is fatal. It would not be necessary to reinforce that particular message.

**Question 2**

To what extent do you think Peter's self-efficacy would help in discussing HIV/AIDS with him?

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**Answer 2**

It is hard to assess to what extent Peter would feel 'I can do that' in terms of any behaviour change suggested. At this stage his concerns and beliefs about sexuality are uppermost in his mind and these probably need to be addressed before he is likely to accept any advice or assistance.

**Question 3**

From which quadrant of the Burrell and Morgan model described in Part I is Peter primarily operating in terms of sexuality and how would this help in assisting him?

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**Answer 3**

Peter's wanting to experience and prove his virility and sexuality in relationship to different women. This fits into the ***Subjective–Order*** quadrant of the model. Working from the ***Objective–Order*** quadrant and providing him with 'scientific' information about his sexuality is unlikely to be of much help in addressing his particular issues.

**Question 4**

Apply the constructs of the HBM and self-efficacy to any other condition or aspect of health behaviour – for example, a newly diagnosed diabetic child. (Note: Answer 4 is not provided.)

**Question 5**

Use the HBM to briefly analyse the issue of medical professionals having to collect CPD points in order to maintain their registration with the HPCSA.

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**Answer 5**

Perceived ***severity***: For many practitioners this has changed. What initially seemed to be a huge and difficult task has turned out to be reasonably easy. The psychological mountain of 250 points in five years has been changed to a hillock of 50 points per year.

Perceived ***susceptibility***: It affects all practising practitioners in one way or another. No one is 'immune' from it.

Perceived ***benefits***: It has formalised CME for those who were already actively involved, and for those who weren't, it

has helped make it a priority. Whether or not it makes any difference to the way doctors practise has yet to be determined.

Perceived ***barriers***: Time, money, effort, feelings of inadequacy, anxiety about managing to keep up.

In terms of ***self-efficacy***, now that most practitioners have had an experience of collecting CPD points for just over a year, there is certainly a general sense of 'I can do that'.

**Part 3: Communication – one approach**

Effective communication does not necessarily start with words or with listening. It starts with a relationship. In Family Medicine the relationship is often not one of our choosing, but may be of the patient's choosing. In some circumstances neither doctor nor patient wish to be communicating with each other.

It is helpful to consider a deeper form of communication in terms of 5 'R's': Relationship, Recognition, Respect, Receptiveness, and Risk.

***Relationship***

This is self-evident. It applies not only to patients but to our families, the persons we pass in the street, people we need to negotiate or settle things with, people in authority such as the HPCSA, pets, the world around us, God, Creator, Spirit – or however you label this entity if you believe in such an entity. We also relate to inanimate objects in different ways – for example a gift from a loved one compared to a computer that is being 'uncooperative'. In recent years *virtual* or 'cyber-relationships' have become increasingly widespread with surprisingly intense levels of communication taking place.

***Recognition***

Again this is self-evident and we mostly do it subconsciously. 'Who is this person I'm relating to?' It is appropriate to relate to different people according to our social norms and roles. A new patient is different from a patient we already know well. A close family member is different from a distant relative in another country. Who the person is, often determines the level and depth of communication.

***Respect***

This may seem paradoxical in the light of the differentiation mentioned above. Respect in terms of relationships and communication with persons implies that no matter who the person is, we treat her/him with dignity. This goes beyond external trappings such as apparent wealth or status. The assumption is that we all accept the inherent worth of every human being on this planet as no more or no less than our own worthiness. It also implies having respect for oneself – which may, for all kinds of reasons, be difficult for some.

***Receptiveness***

Essentially this is about being able to hear or receive the other person. Listening is vital to communication, but more than listening is involved. Some people would call it a 'listening with the heart'. Carl Rogers 'unconditional positive regard'[7] is an aspect of this 'way of being'. Perhaps most important for family physicians is to be aware of when it is not possible for her/him to attain and/or sustain a receptivity towards a particular person. It could be important to reflect on this and determine the reasons why – not necessarily to correct that particular relationship, but for your own sake. For example: It may be difficult to be receptive to someone who seems to have an agenda that s/he wishes to impose on you. It may at times be difficult to be receptive to someone who is from a different culture or language group. It may be difficult to be receptive to someone who has a different belief system to your own. It may at times be more difficult than in any other relationship, to be receptive to the person(s) nearest and dearest to you.

***Risk***

Risking sharing yourself is the most potent and at the same time possibly the most difficult part of deeper communication, and requires wisdom and discernment as to its appropriateness. Risking means allowing the other person to see your humanity as an equal human being. It could mean admitting a sense of helplessness in the face of a patient's particular problem. It could mean sharing your own woundedness and vulnerability in certain circumstances. However it is important not to seem to be belittling or undermining the other person's story in any way through sharing something of yourself.

These principles can be applied to virtually any situation where effective communication is required.

References:


1. McWhinney IR. A Textbook of Family Medicine. New York and Oxford: Oxford University Press, 1989.
2. Balint M. The Doctor, His Patient and the Illness. 2nd Edition. London: Pitman Medical, 1964.
3. Burrell G, Morgan G. Sociological Paradigms and Organizational Analysis. Heinemann, 1979, 1-37
4. Van Deventer C. The Individual in Family-Orientated Care: A Paradox? SA Fam Pract 2000; 22(4): 6-8.
5. Moodley K. Family Practice Ethics: Postmodern Ethics for a Postmodern Discipline? SA Fam Pract 2000;22(2);5-9.
6. Stott NCH. Primary Health Care: Bridging the Gap between Theory and Practice. New York Berlin Heidelberg: Springer-Verlag, 1983.
7. Rogers C. On Becoming a Person. Boston: Houghton Mifflin Co., 1961.