Family Medicine- A luxury for the poor?

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Summary

In South Africa today, most family practitioners have poorer patients in their practices, or patients with no medical aid. By adhering to the principles of Family Medicine, physicians can improve the quality of care for these patients and at the same time, save money and time.

Introduction

At a recent Academy meeting we discussed the question, Is Family Medicine a luxury for the poor? Since I was leading the discussion, I searched the literature on the subject beforehand and came to the conclusion that Family Medicine (FM) was not a luxury but a necessity for the poor. What we should ask ourselves is how we can implement these principles, and especially how the private family physician can be involved in the process.

Low-income families carry a disproportionate burden of illness with significantly higher rates of morbidity and mortality[1]. Statistics illustrating the maldistribution of doctors and medical services between rich and poor in South Africa and indeed the whole world, are well-known.

If we really want to apply the worthy principles of FM for the benefit of the poorer people in our country, the private family physician will have to play an important role in the process. In most private practices, poorer people are seen as 'cash' or 'non-medical aid' patients. They are all too often squeezed in between patients with apppointments and dispatched of as quickly as possible, often before they have been given a chance to fully explain their complaints to the doctor.

Ironically, these patients often pay a larger percentage of their income for a medical consultation than wealthier patients who usually enjoy the benefits of medical aid.

The practical problems leading to this state of affairs should be addressed to ensure that rich and poor receive equal treatment when they consult a private practitioner.

It should, for instance, be taken into account that poorer people often do not have access to a telephone or any other means of making an appointment; they may be dependent on a bus or taxi to reach the doctor's consultation rooms. However, these problems are not insurmountable if the doctor has the will and the desire to accommodate poorer patients.

Looking at and thinking about the basic principles of FM brings one to the inevitable conclusion that these principles have been designed for the benefit of all patients, including the poor in the community. It is also evident that the usual objections, namely that the implementation of such lofty ideals are too time consuming, costly and impractical in the 'real world' of the poorer patient, are largely exaggerated. Properly implemented, these principles can save both time and money.

An examination of literature on the subject was initiated, starting with the principles of FM as mentioned. Three of the most useful tools of the FM discipline were also examined, namely the three stage assessment, the surface anatomy of primary health care and FM, and the genogram. In conclusion, the value of self-knowledge for the family physician was discussed.

***Principles of Family Medicine*[2]**

1. The family physician is committed to the person rather than to a particular body of knowledge, group of diseases or special technique.
2. The family physician seeks to understand the context of the illness.
3. The family physician sees every contact with patients as an opportunity for prevention or health education.
4. The family physician sees his or her practice as a population at risk.
5. The family physician sees him/herself as a part of a community-wide network of supportive and health-care agencies.
6. Ideally, family physicians should share the same habitat as their patients.
7. The family physician sees patients at the office, at their homes, at his surgery and at the hospital.
8. The family physician attaches value to the subjective aspects of medicine.
9. The family physician is a manager of resources.

While all the principles of FM, as originally formulated by McWhinney[2], apply to the poor, the first five are particularly relevant.

***Three-stage assessment*[3].**

- **Clinical diagnosis** - pertains to biological part of assessment or traditional diagnosis.
- **Individual diagnosis** - deals with how patient is experiencing illness including personal fears, feelings and reactions.
- **Contextual diagnosis** - assesses the patient's environment e.g. family, work, community and how this affects the patient and the illness.

Because of the multi-factorial nature of poverty, the poor have a particular need to be heard and seen within the context of their illness. Their fears, feelings and reactions are often more desperate than those of wealthier patients. Unfortunately their social ills are too often medicalized, inapprop-riately investigated and 'treated' with modern technology[1], especially in South Africa with its strange combination of first and third world medicine. This is a costly exercise, especially since the money they pay to consult a private practioner already respresents a disproportionate amount of their income. Private practioners should therefore make a conscious effort to be patient-centred during such consultations. They should listen to patients' accounts of suffering and disease, acknowledging their personal pain, affirming their will to survive and offering support[1]. These seemingly simple interventions can make an important difference in the lives of individuals and families and enable the family physician to become part of the patient's community-wide network of support.

To make a difference in this regard, we need continuity of care, identified before as a crucial element in family practice[4]. This also applies to our poorer patients. We must recognise that the problems they have in making and honouring appointments are real, usually because of a lack of communication systems and transport. However, if the physician's first encounter with the patient comprises a thorough, patient-centred consultation, dealing with fears and context, a follow-up visit - if at all necessary - can be much shorter, saving time and money. Such visits can be fitted in more easily at short notice, between other appointments, but they ensure continuity. If patients are shifted from doctor to doctor they can easily become victims of what Michael Balint calls the 'dilution of responsibility' where nobody takes charge of a patient's care[7]

One of the advantages of family practice is that it is often not necessary to finish or wrap up everything in one day. Thus through continuity a capital of knowledge is built up in a cumulative way - of people as individuals and their families[4]. A more intimate relationship between patient and physician only develops once the patient is ready and the physician has become a friend and confidante over a period of years. Such a relationship can be of enormous value for the poorer patient.

Figure 1:
***The surface anatomy of PHC / Family Medicine*[4].**

A. Management of presenting problems.
B. Modification of help-seeking behaviour.
C. Management of continuing problems.
D. Opportunistic health promotion.

Two other tenets of FM that are particularly useful in dealing with the poor include the modification of help-seeking behaviour and opportunistic health promotion[4] as illustrated by Stott and shown in Figure 1.

The former relates to the way in which the patient utilises available services. This may include excessive as well as insufficient help-seeking. In the first instance, patients can become overly dependent on a physician who has failed to recognise the power he or she holds over patients, or the fear in patients that can be exploited. This may lead to multiple visits to the doctor with serious financial implications for a poorer patient, accompanied by untold distress in a family. Much of this can be avoided by enpowering and educating patients to understand what a real emergency is, and by boosting their faith in their own ability to deal with minor illnesses through home remedies and the lay-healing network[4]. In the same way, patients may be experiencing serious problems and yet be too timid or unaware to seek help. Both types of behaviour should be changed and modified to avoid repeated, unnecessary visits or fatal delays with serious time and cost implications.

Opportunistic health promotion is another area where the family physician can exert influence without sacrificing too much of his/her time. Lifestyle changes usually take place over a period of time. Irrespective of the patient's original complaint, the physician could use the opportunity of a visit to check his weight and blood pressure, encourage lifestyle changes and realistic goals. Issues like smoking, alcohol use and dietary principles may be brought up on an ongoing basis.

The genogram

The genogram or family tree is a third and most useful tool available to the physician dealing with the poorer patient. The concept is illustrated in Figure 2 that shows two generations in one typical nuclear family. It can, however, be expanded during follow-up visits to include other generations. Thus one's understanding of a family can grow incrementally.

The genogram has been called the X-ray of a family and may indeed reveal 'family skeletons' like an illegitimate child or a 'dislocated and fractured family' with broken relationships, as well as other issues that may have an effect on the patient's health[5]. It is also one of the most effective ways of ensuring that one approaches a patient or family within a system that acknowledges and illustrates the interdependency and connectedness between members of the family and the resultant effects of this on health[5]. Recognizing the interplay between patient, family, the community and broad environment allows one to better understand those mysterious, vague or persistent clinical problems seen in daily practice[5].

Self-knowledge

A measure of self-knowledge is necessary for the family physician to understand and contextualise his actions. An inability to distinguish between his own needs and anxieties and the welfare of a patient can have grave financial and logistical consequences. When confronted by a person who is ill, the physician must take action that is constructive and affirmative and not compromised by behaviour that originates in unexamined personal issues. Longhurst[6] makes the interesting point that as doctors, we will not see what we cannot afford to see in a patient, and neither will we see anything that may threaten our defensive posture. For instance, a doctor may not recognise or acknowledge that a patient is an alcoholic because he is in the habit of denying alcoholism, due to a painful experience of alcoholism in his own extended family.

A doctor should always be aware of the agenda that he/she brings to the consultation and balance it against the patient's agenda, wishes, autonomy and wellbeing[1]. This relates to the first principle of FM that states that the family physician is more committed to the person than to any particular body of knowledge[2].

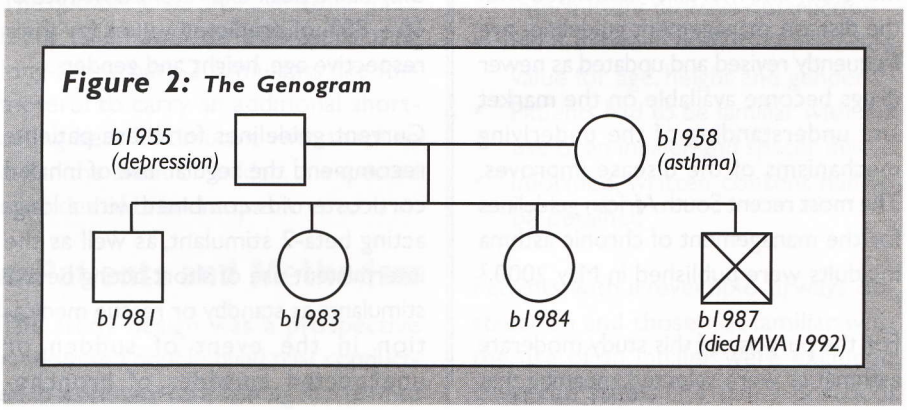

Figure 2: *The Genogram*

Conclusion

Family physicians today are fortunate to have the concise principles of Family Medicine at their disposal. However, these principles should be applied with the humility and compassion that are part and parcel of the physician's self-awareness as an individual and his awareness of the baggage that he brings to the consultation with a patient. If this combination can be managed, all patients - but especially the poor in our country - stand to benefit.

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