

The South African Academy of Family Practice's Rural Health Initiative (RHI) is proud to be able to bring you the following section of the journal, that will concentrate on issues pertaining to rural health in South Africa. We hope to provoke discussion on these issues and would encourage anyone interested in rural health to offer contributions to future issues.



REPORT ON THE 5TH RUDASA CONFERENCE

INTRODUCTION

A highly successful conference attended by about 200 delegates was held between 9-11th August in Hartswater in the Taung district of the North West Province. The conference addressed the theme of 'The Role of the Doctor in the Rural Health Team' – Captain?, Goalie?, Ref?, On the bench?

Mrs G.A. Crisp Makoto, the Taung District Manager chaired the official opening session on Thursday evening. The delegates and their spouses/families were welcomed by Mr.K.N. Konkobe, the Mayor of the Greater Taung Municipality. Thereafter, Dr. I.D Couper chairman of RuDASA, gave a brief preview of the proceedings for the following two days.

Mr K.K. Motlhabane, the Regional Director of the Vryburg region introduced the MEC for Health of the North West Province, the Hon. Dr P.M. Sefularo who then officially opened the conference. He delivered an illuminating address on the realities of rural life and the challenges that face the rural health team in the South African context. The struggle for health and development in the past was outlined. The role of the doctor in the rural health team currently and in the future was also presented.

Mr. K.G. Tobelo, the Executive Mayor of Bophirima District Municipality concluded the session with a humorous vote of thanks. The very talented and enthusiastic Taung Hospital Choir rendered song and dance items throughout the evening and during supper.

The programme content consisted of two plenary keynote addresses, one on Friday and the other on Saturday. This was followed by either four or five parallel workshops, symposia or free paper sessions.

KEYNOTE ADDRESSES

The first keynote address was delivered by Dr. Trudy Thomas, former Health MEC of the Eastern Cape, on 'The Rural Health Team-Current Policy and Trends' and the second keynote address was delivered by Prof. Max Price, Dean, Wits Faculty of Health Sciences, on 'Training the Rural Health Team of the Future.'

The Rural Health Team – Current Policy and Trends

Dr. Trudy Thomas emphasized the role and what to expect of the rural doctor in the Health System of the new South Africa. Her inspiring personal and rich experiences and unique dedication and motivation of working for four decades in the rural areas of the Eastern Cape, as part of a health team, was shared with the delegates.

It was pointed out that the District Health System with its hospitals, clinics and communities with their involvement and participation is the habitat and field of operation of the rural doctor.

She reminded doctors that the transition, transformation and participative democracy taking place in the health system calls for a change in medical culture, from the previous situation where 'patients' were passive recipients of health services and the doctors and health professionals the dispensers of health, to some radical shifts in various

traditional comfort zones. She reminded rural doctors that the new system 'aims to reduce inequalities in access to health services, especially in the rural areas and deprived communities.'

She raised concerns about the effects of structural adjustments and budgeting strategies since 1997 which were harmful to health and which undermined management especially in the Eastern Cape where many of the rural poor were becoming poorer and sicker and worse served.

She warned rural doctors to be sensitive to communities expressed needs and to retain their critical faculties when working in rural areas. A well kept health information system can guide effective management interventions and research. The diligent practice of sound, established protocols achieves good health outcomes.

Team work is essential and necessary and individual members who know and do their job with verve are its main engine. Narrow medical activities are not sufficient for achieving health under conditions of poverty. 'You work for the people not for the government.' If necessary you work in spite of the government, and the more incompetent or perverse, the smarter and broader you must work. Rural health can be achieved without workshops. The challenges that will face rural doctors are the poverty, lack of infrastructure, neglect and the devastating effects of political and social injustices on the lives of the people there. She illustrated that despite these conditions, mostly activated by rural doctors but strongly supported by nurses, administrators and handy-

men, drivers, physiotherapists and village health workers, all willing and able to do the work, it is possible to bring much better health to all. She reminded those present of the many home grown examples of committed rural doctors eg; Kahn, Stott, Conradie, Bac and Prozetky etc. There is no doubt that in the old South Africa rural doctors played an important and central advocacy role.

She concluded that rural doctors like any other member of the team have a unique core task that they must do and do well i.e., medical management of patients. They have a unique body of knowledge which is broader and deeper than that of any other entry level health professional and in addition are more informed by principle and the scientific method. They must accept the responsibility that this imposes and to put it at the disposal of society who provided it for this purpose in the first place. The rural doctor will need above average clinical skills, surgical skills and where appropriate, community health and development skills.

The fully effective rural doctor also needs a sound grasp of basic management principles and economics, particularly social service economics. They must always be ready to support and mentor other team members and share their knowledge with them. If the rural doctor is a group of doctors, private and state, then this corporate doctor body can share the tasks according to inclination and aptitude, as long as they are all available.

‘The rural doctor must do and be all these things – all captured in one overarching and underpinning fundamental task, to maintain and promote the optimal individual community health outcomes in his service field whether this is a single clinic or a network of clinics, a district hospital or community programme’

Her experiences over four decades ‘sees the rural doctor still occupying centre stage on the health platform.

But there is a shift, s/he is no longer the only leading actor. With her stand the district manager, the hospital triad, the representatives of the PHC nurses, village health workers, paramedics, maintenance and house keeping staff, all in a community and intersectoral theatre.’

Transformation of rural health belongs mainly in the hands of rural doctors as advocates on behalf and with rural people.

The second keynote address was delivered by Prof. Max Price.

‘What is the future role of doctors and how should we train them?’

Prof. Max Price’s paper discussed essentially two diverse views of the future role of doctors and the implications for training. The one view is that all doctors should be trained so that they can work in rural and primary care environments. They will have to acquire a comprehensive range of skills such that they can function in the absence of specialists. They should also be frontline providers for Primary Care. This position further more demands that doctors should be able to provide a comprehensive service during their community service year and therefore all necessary training and competencies must be acquired during the undergraduate training programme. This has implications for an internship programme where a range of skills are acquired. This vision of training was advocated in the Cape Town Declaration on Medical Education in 1995.

The criticisms of the traditional doctor is one of the reasons driving the shift to the ‘Primary Health Care Doctor.’ The other is the high cost of the technology and the cost effectiveness of current health care and the desire to send doctors to rural areas and that they are equipped to practice in rural areas.

The other vision for the future training of doctors anticipates the international trend applying in South Africa too. This is that all doctors are specialists including those that practice primary care

and family medicine. Similarly, those that practice rural medicine are rural specialists with a required formal training programme to prepare them for that. This vision suggests that community service should not be done shortly after undergraduate training since it is wasteful to all graduates with a wide range of skills which they will never use again after community services. Instead it proposes that graduates need to have fewer competencies at the time of graduation and would do their community service after specialising.

The drivers for a high degree of specialisation in the profession is the explosive growth of medical knowledge. A doctor can no longer be good at everything and the public recognises this as well. This applies equally to family medicine. There will be little place for general practitioners who try to practice after one year of internship following a general medical education. A competent family physician will be trained to cope with 80 – 90% of all medical problems and reasons for encounter, without onward referral.

The question posed then ‘is there a path between these two visions that is appropriate to South Africa or are we going to choose to follow one of the global trends?’

While it would be desirable to have doctors doing primary care everywhere, the reality is that in rural areas, primary care will be provided by nurses, whereas in urban areas it can be provided by physicians. So in rural areas most doctors will have to be well skilled in hospital medicine. They will generally be doing very little primary care except for some supervision and training of primary health care nurses.

In urban areas doctors will either be specialists or they will be working in Primary care but generally will not be doing both. Family Physicians will therefore have to be much better trained to manage a wider range of medical prob-

lems without referral than would their counterparts in developed countries.

Based on South African specific realities, it is envisaged that in the future most if not all our doctors should be specialists. Prof. Max Price envisages that there will be three categories of specialists viz., hospital specialists including emergency medicine as a specialty; specialists in family medicine and primary care and the rural medicine specialist who will be the most highly trained of them all with obligatory formal training in surgery, anaesthetics, O&G, paediatrics, psychiatry, trauma, orthopedics, emergency medicine procedures as well as skills in management of hospitals, districts, epi-demiology, infection and outbreak control. Those are the people needed in rural areas and they have to be properly trained for the job. The current situation that prevails in South Africa is bizarre. It is regarded as the least complex of the areas of medical practice. Rural medicine requires no formal training, requires no special registration, it is treated as the least skilled area as we send our most junior and inexperienced doctors out there to do this enormous job of work.

For specialist training programmes, three important developments are needed viz., i) MMed or Fellowship in rural medicine should be created. Registrar posts for this will also have to be created. The HPCSA has to recognise this as a registrable specialty.

This will raise the quality of rural medicine in South Africa, ii) the need to promote opportunities for training specialists in family medicine. This is currently not recognised as a specialty, iii) the development of undergraduate medical education to strengthen the knowledge and skills that will be common to all career paths that a graduate might choose. All graduates should receive wide exposure to all specialties and to rural medicine so that they are in a position to make informed choices about

which career path to follow. This could permit shortening of the undergraduate curriculum.

There is a need to also develop a career path for the medical scientist and researcher soon after graduating.

The talk concluded with the question 'should all training institutions produce the identical product?' The Medical and Dental Professional Board has taken the view that we probably do not know the best way to train a doctor, and that different ways have different strengths and different weaknesses and that we should encourage a richness of experimentation in our eight medical schools in South Africa.

SOME WORKSHOP REPORTS

I. MEDICO-LEGAL WORKSHOP

- i) There is a great need for appropriately trained medical personnel in rural areas to perform medico-legal examinations. Doctors with no experience have to do this presently. Since the District Surgeon system which rendered this in the past was discontinued, there is a great vacuum at present. Untrained hospital or clinic doctors must not perform post mortem because it is a highly specialised area. The doctor must be first trained by a forensic pathologist. It is unethical for an untrained family physician or MO to do or give a report on a Post Mortem.
- ii) Forensic services must not be offered in the clinic or primary care level except in cases of assaults and for filling of J88 form.
- iii) Since this is such a specialised and sensitive field, it deeply affects the victims and the outcome of the Court proceedings. It seems most practical to train a person per area or region and that victims be transported there where they can be examined and appropriately counselled. eg: Rape Crisis Centre or

Trauma Centre as a one stop 24hour service directly accessible to women and children.

- iv) Some of the other subjects covered included the following viz. Medical Jurisprudence, human rights, medical ethics and forensic medicine, the politics of forensic services, planning a crisis centre, training in forensic medicine, consent to treatment, traditional circumcision, competency and liability by age, group think, rape typologies, the living will, STI's, voluntary total fasting, registration of deaths, maternal deaths, etc. Some topics could not be adequately covered because of time constraints.

Doctors could contact Prof. W. Coetzer at PO Box 131, Medunsa, 0204, Tel 012 5214352/5214257 or Fax 5214399(w). e-mail: commhealthmedunsa@hotmail.com

2. WOMEN IN RURAL MEDICINE

The overall recommendations from the workshop:

- i) There is a need for support structures (extended families, domestic workers, employment help),
- ii) Prevention of burn out (Time out - sabbatical),
- iii) Flexible duty rosters,
- iv) Staffing – Well staffed hospital helps with part-time work (recruitment, retention and incentives need to be looked at),
- v) Networking between hospitals (support group for rural female doctors)
- vi) Role of husbands/partners. (support needs to be negotiated early in relationship – input to medical students.)
- vii) Need for a RuDASA statement with strategies defined with regard to women in rural practice.

3. CLINICAL MANAGEMENT OF HIV/AIDS

The group suggested that a message go out to the government that HIV/AIDS be taken much more seriously.

Testing for HIV:- Any testing must have an objective and a bearing on further management. Notification must become legal. An HIV positive status must not be used to discriminate in giving health care of any type. Counselling must be properly conducted. Voluntary testing may be requested. It is important to obtain proper consent.

HIV/AIDS Care: A team approach is advocated. Doctors and nurses must work together. Terminal care must be provided with care and compassion. Attitudes of workers health care: - The attitudes of doctors and nurses must be positive. This will help remove the unnecessary stigma. HIV/AIDS problems are often exaggerated and sensationalised.

Clinical conditions: Common complications consists of an increased number of common diseases, most of which can be treated successfully. Commonly available investigations will suffice to further define the clinical problems. HIV/AIDS positive patients must be followed up regularly and closely monitored. Basic facilities for the diagnosis and work up must be provided. In some areas this is seriously lacking. Chronic organ disorders are problematic eg: Renal failure. Individual doctor discretion must apply in the treatment of HIV positive patients with trauma surgery, ICU, surgical procedures.

Disability Grants: HIV/AIDS patients are entitled to disability grants.

Terminal care: Mainly palliation, hospice care, family involvement and sympathetic care by the health team.

4. INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES (IMCI)

A brief history of development of IMCI by WHO from 1980 – 2001 was given. The study conducted at Kimberly Hospital clearly demonstrated the benefit of IMCI trained health workers in managing childhood illnesses in comparison to untrained workers. Acute

respiratory infection and diarrhoeal diseases were used as an example to illustrate the IMCI approach. Common mistakes in treating these were discussed.

The consensus among IMCI policy makers is to include TB into the programme (in South Africa) The presenter discussed the pros and cons of the national guidelines for diagnosing TB in children and proposed IMCI guidelines for the same. The role of the doctor in various stages of IMCI were enumerated. The discussion highlighted the lack of communication between the various role players in various health care delivery systems eg SANTA guidelines. Private practitioners were often not well versed with SANTA or IMCI guidelines.

There is strong support to develop a shorter course for doctors compared to the present 11 day course.

5. 'MAKING THE ESSENTIAL DRUGS PROGRAMME WORK' EDL ISSUES

The problem of non compliance of health workers in following EDL guidelines was identified. This was due mainly to poor training of nurses and doctors, non availability of drugs and inadequate implementation of national policy by provincial authorities. Previous bad experiences when following guidelines was also a problem.

To get the EDL policy to work the following were identified viz., better provincial/district support of this initiative, EDL books to be widely available, adequate training of primary care workers, doctors to support this within the team context, monitoring and feedback systems needs to be developed eg., peer review, audit and other QA mechanisms.

6. PRIVATE/PUBLIC PARTNERSHIPS (PPP)

A short introduction of the national policy on PPP's was given. This was followed by 3 case studies of PPP's in South Africa. The lessons learnt were analysed and discussed.

Generally the private and public sectors have different and conflicting objectives. Public sector cares for individuals and populations, private sector for individuals. It is mainly profit and service orientated. These differences must be discussed and appropriate steps must be taken to develop firm contracts. Quality assurance/improvement must be monitored within PPP's. (indicators are available ALOS etc, patient satisfaction measures)

PPP's in rural areas – are they sustainable? This depends on circumstances. Different models exist which can be applied to rural areas. A power point presentation and slides on this paper is available.

7. GUIDELINES FOR SECOND LEVEL CARE OF STI's

Some highlights from the workshop by Ron Ingle

1. Syndromic management at first contact level.
2. Referral needed for 'second-level' supervision to sort out inappropriate treatment, re-infection, non response, non adherence etc..
3. The non- availability of drugs must be clarified by direct contact with the Regional Pharmacist.
4. Condoms cannot be totally protective. This requires honest counselling.
5. STI terminology preferable to STD's.
6. There is a shift in prevalence of genital ulcers from syphilis and chancroid to herpes.
7. HIV delays healing of genital ulcers – record number and size of genital ulcers to detect response to treatment.
8. There is a need for insight into interpreting syphilis serology – WR + RPR titres.
9. Dr A. Hoosen would follow up recommendations that laboratory reports carry some interpretative advice.

8. HPCSA WORKSHOP AND RECOMMENDATIONS FOR RuDASA

Highlights by J. Hugo

HPCSA is prepared to structure the Board exams such that it will facilitate Foreign Qualified doctors to go to rural areas. RuDASA to make recommendations about the examinations and help to monitor this.

HPCSA is aware about the problems in rural health but was not aware about the extent of the problem. RuDASA to lobby the national and provincial Dept of Health about rural health issues. Clear message of dissatisfaction and disgust about the way in which Foreign Qualified doctors were handled in the past 6 years. Having heard the issues, Adv. Mkhize was prepared to share a platform with Dr Ntshaluba to discuss this further. RuDASA to organise such a meeting.

A request was put to HPCSA to visit the rural hospitals and clinics to observe the actual situation. RuDASA to pursue this. Board members and other officials may have to be included as well. CPD issues and problems were also discussed. The current system was explained and several questions were answered.

9. SEXUAL ABUSE OF CHILDREN

Studies have confirmed that approximately 1% of children experience some form of sexual abuse each year, resulting in the sexual victimization of 12% to 25% of girls and 8% to 10% boys by age 18.

A high index of suspicion is required as the presentation can be varied eg; sleep disturbance, abdominal pains, enuresis, encopresis or phobias. Specific signs are rectal or genital bleeding, STI's and developmentally unusual sexual behaviour.

When sexual abuse has occurred within 72 hours or there is bleeding or acute injury, the examination should be performed immediately. Specific attention should be given to the areas involved in sexual activity. Forensic studies should

be performed in all cases especially if it occurs within 72 hours of abuse. Cultures for STI's should always be collected. Often the diagnosis of child abuse can be made on a child's history. Many types of abuse leave no physical evidence and mucosal injuries often heal rapidly. Physical findings include, 1) Scaring, tears or distortion of the hymen; 2) a decreased amount of or absent hymenal tissue; 3) scarring of the fossa navicularis; 4) injury to or scarring of the posterior fourchette; 5) anal lacerations.

The presence of semen, sperm or acid phosphatase, positive STI/HIV infection makes sexual abuse a certainty. Details, records, drawings and/or photographs should be kept. The case must be reported to the Child Protection Unit. The evaluation of sexually abused children is increasingly a part of general practice. A team approach is required.

10. TB IN THE DISTRICT – THE TAUNG EXPERIENCE

Gladys Crisp Mokoto and others.

Organisation of TB services are essential to ensure a systematic approach for improving TB treatment outcomes. Management systems eg; communication, HMIS records and record keeping crucial to enhance early detection, treatment protocols, referral patterns, laboratory services and drug supplies. The supportive role of the district hospital and improved communication between the hospital and the clinics contributes to effective referral systems and continuity of treatment and care. Clinic supervision and support, and making DOTS supporters more effective are some of the strategies essential for improving case finding, case monitoring and treatment outcomes.

FREE PAPERS

Session one : Examples of Success

by David Cameron

1. A healthy village project: New Hanover case study by Dr Neethia Naidoo.
Applying the principles of Family

Medicine, fully involving the community, not allowing set backs and difficulties to interfere, Dr Naidoo and his team drew up a comprehensive local development plan and have managed to achieve their goal of a healthy village which has included a district water supply, social welfare services, victim support, job creation, poor relief, school sanitation and a crèche support programme.

2. Dr E Gazua, described the inefficient service which had previously been provided to victims of rape and child abuse in his area (Kudumane District, NWP). He attended a medico-legal training workshop and then went back to his rural hospital and applied what he had learnt and has radically improved their service. He arranged training for doctors, nurses, social workers, the community leaders, the police and the magistrates. Roles were defined, statistics were gathered, patients were followed up and procedures were stream-lined. The results have been improved efficiency, better care and increased convictions of rapists.
3. Dr Victor Fredlund has been working for 20 years at Mseleni in Northern Kwa Zulu-Natal. There is a high incidence of severe arthritis especially affecting the hip joints of young woman. By the age of 50 more than half of the population are disabled by arthritis. Initially severe cases were referred to major centres for surgery. When this system was stopped, he arranged for specialists to come to his hospital to operate on them there. Gradually they began doing more and more cases. As the specialists dropped out, Victor took over the task and now is doing total hip replacements in the middle of nowhere under spinal anaesthetic with 5 year results that are comparable to the best!

All three doctors had responded to a need and had refused to be put off by those who just shrugged their shoulders and did nothing.

Session two:

Developing the Rural Health Team

1. *Rural Anaesthetic Training* (Chadwich)

It was impossible for this rural doctor to complete a Diploma in Anaesthetics through the College despite several difficulties, especially travel, to recognised hospitals and to obtain the required number of hours. His way of overcoming the difficulties is inspiration for others to do diplomas or post graduate training without having to leave the hospital for a substantial amount of time.

2. *Teaching Young Doctors Old Tricks: Was Aristotle right?* (David Cameron)

Jubilee Hospital provides an adequate opportunity for junior doctors to gain a wide range of professional skills. You need both theory and practice to become competent. However, without proper supervision and constructive feedback, competence cannot be taken for granted. Both under-graduate and post graduate training must be adopted to meet the medical needs of our country: There was a plea to do evaluations on the experience and confidence for unsupervised community service doctors. It was explicit that this was no reflection on their competence.

3. *Learning Together: The PHC Nurse and the doctor.* (Sr. Mirriam Mokotong)

This was an important mutual learning experience. There was consensus that RuDASA should explore the role of the PHC Nurse broadly.

4. *The role of the visiting doctor in primary care clinics* (J Tumbo)

The research also prompted the recommendation that the relevant authorities should explore whether this was a cost effective service. There was a lot of mixed reactions concerning the necessity or cost effectiveness of such a service.

5. Developing a Distance Education Programme for rural doctors. A web-based Masters Degree in Family Medicine.

This was presented as a poster. Contact Dr Bob Mash. Dept of Family Medicine and Primary Care. University of Stellenbosch.

RESOLUTIONS ADOPTED AT THE CONFERENCE

RESOLUTION ONE: REGARDING FOREIGN QUALIFIED DOCTORS

1. This 5th RuDASA congress expresses its sincere appreciation to all those foreign-qualified colleagues who have worked for many years in the rural areas of South Africa, often under difficult circumstances and despite ongoing uncertainty about their own future in this country. On behalf of all rural people in South Africa, we say 'Thank You.'

2. This congress expresses its deep displeasure at the disgraceful way in which these colleagues have been treated by the Department of Health and Home Affairs. The actions of these two departments have been the main reason for many of these foreign-qualified doctors leaving the country. We believe that these two departments are morally responsible for the collapse of medical services in many rural areas and the resultant suffering and unnecessary deaths that have occurred.

3. We call on the South African government to introduce a system of registration which is efficient, speedy and fair to all foreign-qualified doctors without exception.

4. We mandate the RuDASA Committee to monitor the situation carefully and to report this matter to the HPCSA and to appeal to them to bring additional pressure to bear on the government.

RESOLUTION TWO : REGARDING FRINGE BENEFIT TAXATION ON HOUSING FOR DOCTORS IN RURAL AREAS.

Noting that:

1. the presence of a stable body of well qualified doctors in rural hospitals is essential for the provision of high quality health care to the most marginalized sector of the population, ie. the rural poor.
2. for a variety of reasons it is already extremely difficult to recruit and retain doctors in rural areas.
3. the Department of Health as the employer of rural doctors is obliged to respect their conditions of employment and not change these without proper consultation with the employees concerned.

The way in which the fringe benefit taxation on housing has been implemented has had serious implications for rural doctors and rural health:

1. Doctors have left rural health service because of the substantial decreases in salary they have experienced as a result of the fringe benefit taxation.
2. It has not been possible to fill vacant posts because of the uncertainty around fringe benefit taxation. Even if the matter is resolved in the near future, doctors who were considering taking up posts at rural hospitals next year have already accepted other positions.
3. The rights of rural doctors as employees have been infringed in that:
 - a) They were not informed that a substantial change in their conditions of employment was about to take place. This denied them the opportunity to make informed decisions about whether they wished to continue working for the reduced salaries.
 - b) Once the taxation was implemented the Department of Health failed to provide clear channels of communication through which the employees could send their grievances.

c) the various circulars put out since the implementation of the tax show that this tax was implemented without any legal clarity on the matter. The RuDASA conference thus resolves that:

1. the fringe benefit tax be withdrawn immediately.

2. doctors are refunded the tax that they have already paid.
3. any new developments with regard to housing rental are communicated to rural doctors before they are implemented.
4. each provincial Department of Health

appoint a suitably senior person to deal with the problems of rural doctors.

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News release

21 October 2001 - South African First – Top Academic Appointments For Prominent SA Academy Of Family Practice Women Doctors

Three prominent members of the SA Academy of Family Practice / Primary Care, Marietjie de Villiers, Julia Blitz and Adri Prinsloo, have recently been appointed professors and heads of their respective departments of family medicine.

Marietjie de Villiers is Professor and Head of the School of Public and Primary Health Sciences in the Faculty of Health Sciences at the University of Stellenbosch. Julia Blitz is Professor and Head of the Department of Family Medicine in the Faculty of Health Sciences at the University of Pretoria. Adri Prinsloo is Professor and Head of the Department of Family Medicine at the University of the Free State.

Not only are they the first women to hold these top academic appointments, but they are also office bearers of the SA Academy of Family Practice.

Prof de Villiers is National Chairperson of the SA Academy of Family Practice / Primary Care and presided over the successful WONCA World Congress of Family Doctors that was held in Durban earlier this year. She is also a member of the Health Professions Council of South Africa, serves on the Executive Committee of the Medical and Dental Professional Board and chairs the Board's Committee for Human Rights, Ethics and Professional Practice.

Prof Blitz is leader of the Continuing Professional Development (CPD) Task Team and Associate Editor of SA Family Practice, the mouthpiece of the SA Academy and FaMEC (Family Medicine

Educational Consortium), the only academic journal for family practice in South Africa and an important vehicle for the dissemination of family medicine knowledge.

Prof Prinsloo is Chairman of the Free State branch of the SA Academy and chairs the Academy's HIV/AIDS Task Team.

All three women received their medical training in South Africa, specialised in family medicine and worked in practice as family doctors before their initial university appointments.

Asked about key issues today in the training of family doctors and in family medicine generally, these are their responses:

Prof de Villiers: 'One of my aims is to encourage unity in family practice. As a discipline, it is still too fragmented, with too many organisations, each working on their own for the good of the profession. My ideal is to develop the discipline of family medicine, with an emphasis on ethical and caring family practice.'

Prof Blitz: 'The nature of the product of undergraduate training is a key issue, as well as the professionalism of medical practice and the development of a culture of lifelong learning for doctors. Doctors need more than just clinical skills today. They also need to function as part of a health care team. I feel that it is important that family medicine is seen as a challenging and rewarding career option. My department will be involved in more practice-based

research to collect more information on family medicine in the South African context.'

Prof Prinsloo: 'Doctors today have to be equipped to work in both the private and the public sectors and one of the key challenges is to render a comprehensive service to patients at all levels. Unification of the profession and ethics, with a proper code of conduct, are also important. We need to train doctors so that they are equipped to handle emergencies, but also know how to treat a patient in a holistic way. Doctors also need to be able to practise in an environment where medicine has unfortunately become a commodity as far as a large part of the general public is concerned. We need to be realistic. We can, as doctors, render services of a superior standard, but we are not here to change the world.'

There is no doubt that all three women are determined to make a difference, academically, with the training of doctors, in family doctors' Continuing Professional Development (CPD) and in their contributions to the SA Academy of Family Practice / Primary Care.

For further information on the SA Academy of Family Practice please contact Penny Bryce on 011 807 6605.

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