

PLENARY SESSION - THE ART OF HOLISTIC CARE

Family Medicine in South Africa today

My task is to speak on family medicine in South Africa today, within the context of the conference theme. I will provide you with some background on the art of family practice in general, share with you the state of this art with regards to training, research, professional development, organisational issues and unity in the profession of family medicine. Lastly, I will attempt to motivate you to work with renewed energy towards achieving the art of holistic care.

The Art

The organisers have chosen the conference theme as "The art of holistic care". Now we could well argue that the family doctor needs particular scientific rigour to practise holistic care. We all know what a challenge it is to care for a patient with regards to his/her promotive, preventive, curative and rehabilitative needs. For this, the doctor needs to be a master of many sciences. And when we take this to the individual, family and community context of our patients, we need an even wider variety of scientific knowledge and skills. But we also know that the family doctor needs something more than just scientific respectability. What is this something, how do we define it and can we measure it? This, ladies and gentlemen, is indeed the art of family practice.

Art is defined in the Shorter Oxford dictionary as "skill as the result of knowledge and practice". David Morrell, in his book *The Art of General Practice*, reflects that art is usually concerned with creating an ambience, delivering a message and expecting an emotional response. The artist uses knowledge, be this of colour, melody, timing or perspective, expressing these by constant practice through physical skill to create an impression and achieve an objective. Morrell goes on to pose the question: What then is the art of general practice? I quote: "Effective family practitioners develop their knowledge and skills from a wide variety of basic and clinical sciences. They should retain throughout their professional lives, a scientific approach to new knowledge, including that which they derive from their own personal experience. Our skills include the ability to listen, to observe, to examine and to interpret; to communicate and share with our patients our thoughts, conclusions and advice; to establish a relationship that at different times is diagnostic, therapeutic and supportive. In this we create an ambience and involve our 'audience', our patients."

Teaching and learning in Family Practice

There is a Department of Family Medicine at each of the eight medical schools in South Africa. All of these departments are involved in training undergraduate students in family medicine. Undergraduate training in family medicine is undergoing a shift from hospital-based to community-based training. Aims of undergraduate training in family medicine are to introduce the student to the principles of family medicine within the primary care milieu. Feedback from our students indicates that they want more and earlier exposure to family medicine. During a focus group discussion at the University of Stellenbosch recently, a student expressed the value of the training as follows:

"We saw a little girl who lives in Elsies River. We went to see what kind of environment she lived in. When we went there, there was basically a small piece of ground with a stone house with one room in it and she was not even living in that; there was an old lady living in that place and then in the back there were two shacks, four people living in the one shack and five people living in another shack. Between them they shared a tap and one toilet and the toilet had a hole in the roof and there wasn't a door. It shows you and gives you an insight of where your patients are

*Address by the
National Chairman,
Dr M de Villiers*

coming from. That for me was an eye-opener."

It is important that our undergraduates understand the principles of community-oriented primary care, identifying the needs of the community and looking at ways that these needs can be met. Family-oriented primary care is also of particular importance. We emphasise to our students the

Stott's model, with the opportunities presented in each consultation, the importance of continuity of care, the primary health care team, how to prevent illness, how to do health education and how to care for the chronically ill.

Despite advances made in undergraduate training in family medicine, many faculties of medicine still give little time and emphasis to family medicine in the curriculum. The perception that family medicine is less important, by not giving weight to evaluation, remains. We have to work tirelessly to make students and faculty aware of the importance of family medicine in the undergraduate curriculum.

Post-graduate courses in family medicine are presented by all the family medicine departments in South Africa. We have come a long way with curriculum development and will, through a co-ordinated effort in the future, continue to endeavour to raise the standard of post-graduate training in family medicine to be on par with that of any specialist discipline. Our curriculum includes teaching and learning on how to be a competent clinician, the primary task of the family doctor. Evidence-based medicine forms an important part of our teaching, so that the clinician can base her/his clinical practice on the best evidence available, as well as develop the ability for critical evaluation of the medical literature. Ethics and social responsibility receive special attention, so that our family doctors can be aware of the social and ethical issues in our society and have some guidelines to act on.

Research

Research is the lifeline of a discipline. We have to know what kinds of patients we see and what their problems are, what our patient profile looks like and what are the needs of our patients. A number of morbidity profiles have been done in South Africa over the years, so that we now have a reasonable idea of reasons for encounter and presenting complaints. Each family doctor however must know his/her patient profile, have an age-sex register for the practice and have an idea of the needs of the patient community. The assessment of needs is unfortunately notoriously difficult and cumbersome. An instrument must be developed that can be used by family doctors to assess the needs of their patients in an easy but comprehensive way, incorporating community views as well as epidemiological methods.

The South African Sentinel Practitioners Network (SASPREN) is doing sterling work on the development of a surveillance system for some tracer conditions in primary care. The network needs more members to become part of the surveillance project, especially in rural areas. SASPREN also conducts a number of other research studies and is currently one of the most active family medicine research groups in South Africa.

Family practice must also be able to answer questions about our workforce. Who are we, where are we, how many are we, what are our practising habits? At the recent 15th International WONCA Congress in Ireland, the Canadians presented the JANUS Project, a phenomenal piece of research resulting in the 1997 National Family Physician Survey. This is a comprehensive national survey looking at the demographic information, practice profile, professional activities and practice environment of family doctors in Canada. This is the kind of information that we need in South Africa.

We must also be able to demonstrate that our methods do indeed work. Questions like: How effective is the patient-centred method? Does a good doctor-patient relationship improve compliance? Is patient care improved by the practice of holistic care? -

*De Villiers M, Dept of Family Medicine & Primary Care,
University of Stellenbosch, PO Box 19063, Tygerberg 7505*

these reach into the heart of family medicine. We must not shy away from using qualitative as well as the usual quantitative methods to research this.

The family doctor is first and foremost a clinician. There are many questions in our clinical practice that we also need to examine. The time has passed when randomised-controlled trials remained the domain of the specialists. The departments of family medicine have put a lot of effort into training a large number of masters in family medicine and you are the people who should take the lead, together with our academics, in conducting clinical trials in family practice.

Another aspect that begs for research and where funding is easily available, is health systems research. With the formation of a district health system, integration of primary health care services, community participation, etc., there are many opportunities for us. Once again the family doctor is ideally situated to conduct this research.

So, my learned friends, it seems that the art studio in South African family medicine research has plenty of blank canvasses eagerly awaiting a few strokes of paint. I sincerely hope that when we meet like this again in a few years time, we will see answers to some of the questions I have raised here.

Professional development

Continuing professional development (CPD) is the new term for what was previously known as CME or continuing medical education. CPD spans more than mere attendance at a few lectures. It encompasses a holistic strategy whereby the doctor assesses his or her needs in both personal and professional development.

The Interim National Medical and Dental Council for South Africa has announced its intention to introduce compulsory re-registration for medical practitioners in 1999, through a system of continuing professional development. Practitioners will have to apply for re-registration every five years. This will be granted on submission of proof of credits earned through accredited CPD activities. The idea is that a total of 250 points will have to be earned over five years, or 50 per year. Approval of congresses, courses or self-study evaluations, for CPD purposes, will have to be obtained from the Medical Council through accredited bodies such as the College of Medicine, the South African Medical Association and the Academy of Family Practice. This will be according to guidelines and criteria yet to be drawn up.

Compulsory re-registration holds threats and opportunities. Professional bodies like the Academy are now able to introduce accreditation guidelines for our own discipline. We can now set the standards for CPD for our profession and control the quality of continuing education. We are no longer dependant on fly-by-night CME schemes or outsiders with money for our CPD needs. The stick rather than the carrot in compulsory re-registration must however be considered seriously. Will doctors now attend CME grudgingly, looking for the occasions where they can get the most in terms of entertainment? How will we enthrone those doctors who only attend because they have to? Will doctors still only attend those free-meals-and-trips so-called CME? I hope not. I hope that my profession will take pride in its own CPD and not continue to sell its soul for the proverbial (now even literal) plate of soup.

Doctors face many problems in their personal lives. Substance abuse, depression, suicide and divorce indicate that doctors are not always happy people. We suffer from high stress levels for prolonged periods of time and are often the last to do anything about our own well-being. The art of holistic care for oneself lies in caring for the carer. The doctor also needs healthy food, enough rest, exercise, friends and a good laugh. Let's not be shy to acknowledge our problems and let's take the advice that we so readily dish out to our patients. I hope that this Congress contributes not only towards your intellectual growth, but also provides you with enough relaxation as well. Make time to have fun!

The professional development of women doctors is an emerging priority. International research has consistently shown that female doctors face unique problems, challenges and different experiences. Our undergraduate student population currently consists of 50% female students, yet they are still trained in a very

much male-dominated environment and culture. The lack of women in leadership positions and academic medicine indicates the very real presence of the invisible glass ceiling. It is important that we look at ways of supporting women in medicine and look for answers to their problems.

The Organisation of Primary Care

Perhaps the most profound changes in the South African family doctor's environment in the last few years have taken place in the organisation of primary care services. The Government has introduced a new health plan, embracing the comprehensive primary health care approach, as a strategy towards equitable health care for all South Africans. Although the shift to primary care has obvious advantages for the primary care health worker, many doctors were disappointed about the extent to which the family doctor did not feature in the Government's health plan.

Restructuring of the health care system has also brought about severe financial restrictions, with a resulting closure of health facilities and downsizing of staff complements. This has resulted in an even more difficult working environment for the doctors in the public sector. More patients have to be managed by fewer staff, with ageing equipment, shrinking resources and less medicine. Disputes on overtime disagreements cause resentment, loss of loyalty, a general feeling of demotivation and sometimes despair.

Our family doctors in the private sector suffer a similar fate. Decreased payments by medical aids, restructuring of district surgeon services and other contracts with the state, as well as the emergence of managed health care, to mention but a few, all threaten the financial survival of many doctors.

I am therefore not surprised that many doctors have no energy left even to attend a congress. Or are they too busy packing for Perth? Or sailing for Saudi? Or canoeing to Canada? The fact remains that doctors perceive that their services will not only be better remunerated, but also more appreciated, outside South Africa. I have no ready answer to that, except to say that maybe we should start looking beyond ourselves, stop complaining and see what we can do to change our working environment to a win-win for us and our patients; how we could add value, not only to our services but also to our lives; how we could support each other to put the heart back into the art.

Unity in the profession

Family practice in South Africa remains fragmented. Even after the formation of a new South African Medical Association in June, there are organisations not happy with the process. Somebody once said that trying to organise doctors is like herding cats. Be that as it may, academic family medicine has taken the lead in exploring ways of forming a unitary academic body for family practice. The advantages are multiple. Such a merger will establish a unitary body that can better attend to the academic needs of all family practitioners and not only those who have completed the College examination. This body could combine the considerable expertise of the member organisations in CME, publication and evaluation skills. This body will play a major role in the accreditation and certification of family practitioners and it will form a multi-faceted body to lobby and negotiate on behalf of our profession. We hope to make an important announcement about the formation of a unitary academic body for family medicine at the conference dinner on Wednesday night.

I have tried to take you for a short walk through the South African family medicine art studio. We have seen many beautiful sculptures and portraits, perhaps a few Rembrandts and even a Picasso or two, which represent milestones in our profession. There are also a few Tretchikoffs on our walls, which some may like and others not. We have seen quite a few promising emerging paintings, which will need lots of nurturing in the years to come. We have seen a few Hieronymus Bosch horror pictures too. And we have seen many clean canvasses awaiting the first stroke of the brush. I sincerely hope that I have succeeded in giving you a perspective on this difficult and challenging era in the history of family practice in South Africa and provided you with some creative energy to go out there and get your hands dirty. ●