SHAPING THE FUTURE OF GENERAL PRACTICE/FAMILY MEDICINE

A discussion document

(Please note that the term GP used in this document refers to both general practitioners and family practitioners. It is necessary that a universal term be adopted so that the confusion around terminology is ended.)

A workshop attended by the leadership of general practice was held at the UCT Medical School in Cape Town on 7 March 1998. This was very successful in that it managed to put issues of general practice to the fore and participants focussed on how best general practitioners can be represented. The following input is a discussion paper that aims to expand on those views and suggest a way forward.

Situational analysis

The following questions were posed to the workshop and no amount of discussion could adequately answer them, as they unearthed more and more questions:

- What is a general practitioner/family practitioner?
- What are the needs of general practitioners?
- How best can all those needs be met?
- What role do GPs have in health care?
- How can GPs shape their own future?

One needs to look at the set-up of general practice first before attempting to answer. General practitioners are a diversified group in terms of location, practice population and so on. These relate to whether the practice is rural, peri-urban or urban and whether the doctor works in the private sector or in the public sector. Other ramifications are whether it is a cash or non-cash, up-market or working-class practice. All these minor arrangements have unfortunately misled many to believe that there are different kinds of general practice and GPs. If you look even further you will not fail to notice that it is affected by our material drive, too. The actual practice of medicine is no different. The skill a doctor has is used similarly whether in a rural or urban practice. I raise this issue because I believe that it has led to a "lone wolf" syndrome where each GP feels that his/her situation is very different from a colleague's and needs only his/her attention and no-one else's. This has unfortunately translated to a bigger problem where any semblance of organisation has tended to follow the same route.

The changing environment

No situation stays the same forever. Health care is therefore no exception. Changes to the Medical Schemes Act in 1994 signalled the start of drastic changes to the way GPs received payment for services they rendered for patients who have some form of insurance. The trust between doctor and patient became strenuous. Election of a new government also came with its own challenges in the form of health care reform bills, most of which have since been signed into law. Managed Health Care is at the doorstep, too.

All these challenges have pressed panic buttons and represent half-hearted attempts at presenting a united face of GPs. Considering that there is little evidence of ignorance about GPs on the side of those who pose the challenges, it is not surprising that they easily saw through such attempts and managed to bulldoze their way through.

"General practitioners are a diversified group in terms of location, practice population and so on ... this variety of minor arrangements has misled many into believing that there are different kinds of general practice and GPs ... but the actual practice of medicine is no different ..."

Opportunities have come and gone begging, simply because this vast GP community did not, as a unit, identify them. Divisions within the medical profession have been exploited to the full by many. The medical aid industry is a perfect example. Some have even gone to the extent of undermining the clinical judgement of doctors. This has so far been met by a deafening silence, except for mild murmurings in dark corners.

Organisations

General practitioners are not short of organisations. There is a multitude of organisations doing almost exactly the same functions. These have collectively been ineffective, if one judges by the comments and complaints GPs have about being dominated by other disciplines in medicine. We do not have proper communication systems, but instead depend on ad hoc means driven by issues of the day. Looking closely at our structures, we cannot fail to notice that they still have a strong resemblance to the past, in that they are shaped along racial lines.

Even though many GPs are worried about the problems they face, especially in their surgeries, there is still lack of coherence. Some groups respond to policy issues on their own without seeking collective, input while others do not even bother to respond. While the IPA movement has taken off at some speed, it seems the medical political organisations for GPs have been waning in terms of their influence on events. It seems clear that IPAs will find it very difficult to fill that void if it is left to increase.

I, however, wish to contend that GPs have good leadership material, but it has not been fully exploited. There is so much duplication and unnecessary competition that resources have been drained in a very short space of time. The pharmaceutical companies now find it difficult to support one doctor group for fear of criticism by another. All organisations are struggling to keep services going let alone increasing membership numbers. We are all so occupied with protecting what is left of our organisations that we send wrong messages to potential helpers. My call is for us to put interests of general practice foremost. We need to create better policy making structures and go on the offensive for the development of general practice. There are rising expectations of doctors not only from the government and funders, but also from the patients.

The pressure from health care funders will not go away but needs a united response. It is only when general practitioners/family practitioners are united in one body that the future of general practice will become clearer. We need to develop and share a vision for the long-term survival of our profession.

What structure/s can possibly serve GPs/family practitioners?

The models detailed below attempt to examine different structures that can be used to set up a unified GP/FM body. The following criteria should apply:

- Affiliation to the South African Medical Association;
- Membership open to doctors who are classified as general practitioners in the private and public sectors (including medical officers);
- Doctors with specialist qualification in Family Medicine.

We can develop and build good structures that are representative, but the test will always be how relevant they are both to doctors and the public. Doctors must work hard at improving their credibility and social standing. This will depend heavily on the policies and programmes put in place by the envisaged body and the South African Medical Association. I believe that there are plenty of opportunities for us.

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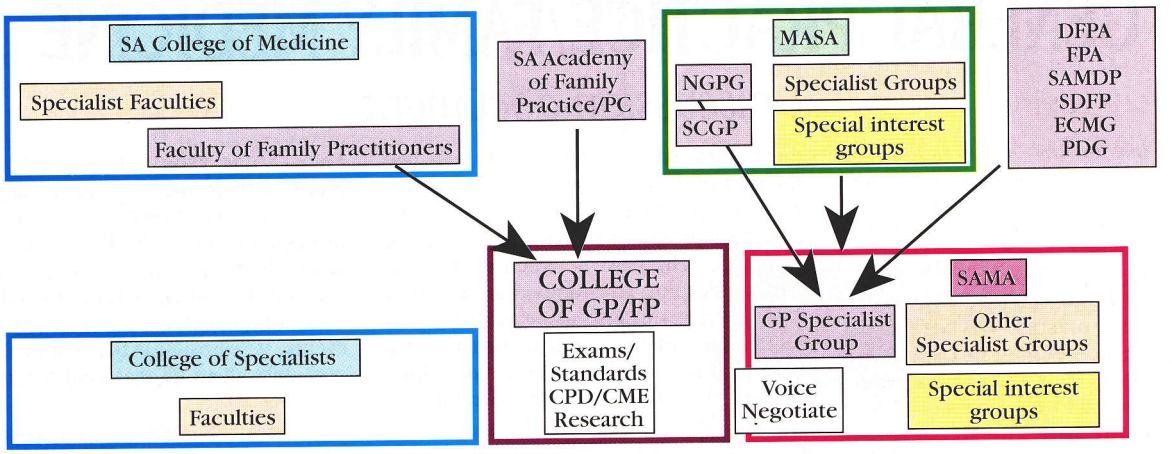
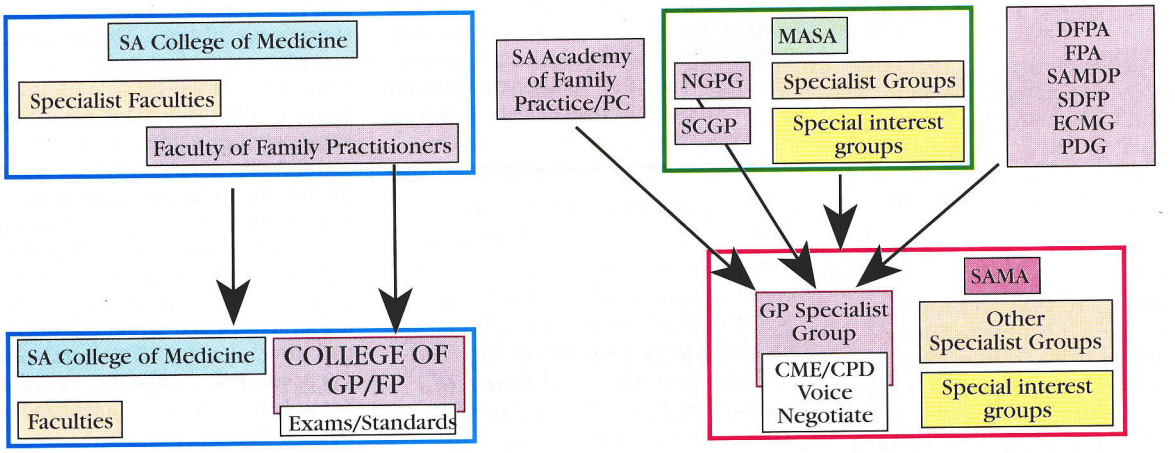
Proposed organisational structures of general practice/family medicine

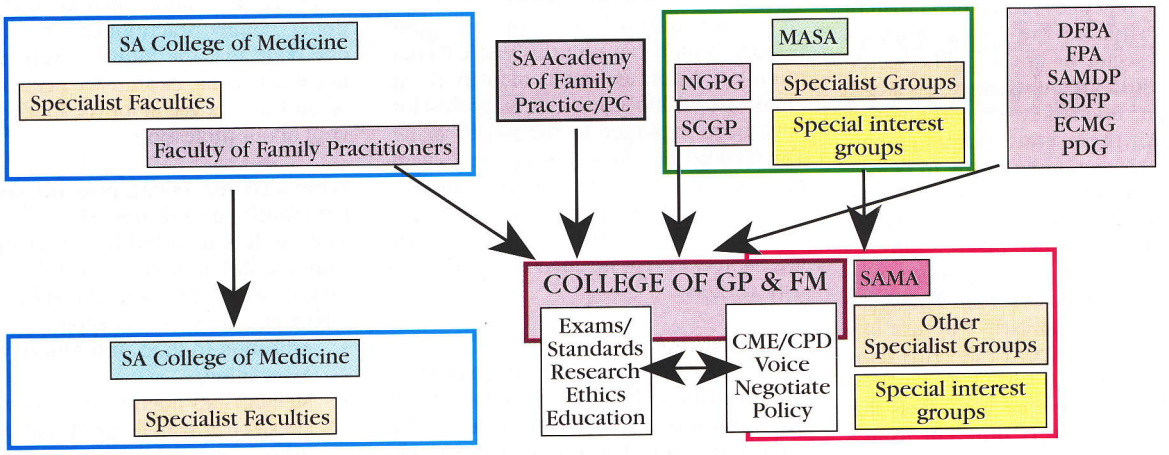
Model I



Model II



Model III



Proposed Structure Model I

Advantages:

- Clear GP/FP identity;
- Decisions and policy not influenced by other disciplines;

Disadvantages:

- Fragmentation into College GP/FP and Association GP/FP;
- Negative competition between GPs/FPs;
- Have to establish own administration;
- Competition for funding with the new association;
- Many GPs/FPs may find negotiating voice more appealing than educational voice.

It is envisaged that this College or Council will essentially have three subdivisions with responsibilities as follows:

- *Education* - responsible for accreditation of continued professional development (CME) programmes, setting of standards, ethics, research, examinations;
- *Political* - responsible for representation, policy, negotiations, tariffs, co-ordination of campaigns;
- *Business* - responsible for business education and education about managed care and so on.

However, I must point out that various IPAs must continue to exist. The business education sub-committee should ideally draw leadership from these IPA formations.

Proposed Structure Model II

Advantages:

- Bring GPs under one roof politically;
- Pool resources including Academy's resource.

Disadvantages:
- Division on educational grounds;
- May lead to rival educational body being formed in the new association;
- Will leave GP specialist education under dominant influence of other specialties.

Proposed Structure Model III
Advantages:
- Single GP/FP mouthpiece;
- Strengthens unification of the profession;
- Administrative support from the South African Medical Association;
- Strong organised discipline less prone to domination;
- Closer relations between the private and public sector;
- Access to other service products of the association.

Disadvantages:
- Limited autonomy as a subgroup of the Association;
- Possible competition for membership with Senior Hospital Doctors' Association (medical officers/family practitioners).

Comments
Model III seems to be more appropriate for our circumstances. However, I would appeal that a better universal definition of what general practice and family practice mean, be agreed upon. That definition may help remove the confusion and unnecessary labelling that leads to further division of doctors doing essentially the same work.

It should also be noted that GP/FPs are coming together not because of fears of domination by other disciplines, but because it is absolutely necessary that they be united. Such unity will help them determine the future of their trade. The medical profession faces numerous challenges and therefore cannot afford to be divided any further. There will always be tensions between different groups of the profession. Such tensions must be translated into creative tensions so as to make the association as democratic as possible.

The administrative infrastructure of the South African Medical Association will provide a good backup for the new College/-Council of General/Family Practice. There is no need to duplicate services anymore. It should be noted also that the National Council of the South African Medical Association will have generalists in the majority. The approach and emphasis of any group within the SA Medical Association should be to promote the interests of the medical profession and eliminate division.

We must also make sure that we are represented by visionary leaders in all other sub-committees like the Private Practice Committee, Finance Committee, Health Policy and so on.

I sincerely hope that this short discussion document stimulates debate among generalists and lays the platform for us to set up a body that will play a very vital role in planning a better future for general/family practice. ●

A SINGLE PROFESSIONAL ORGANISATION FOR GENERAL/FAMILY PRACTICE

A personal viewpoint of a possible model

It became clear during the deliberations about a new professional organisation for general/family practice, that there was overwhelming support for the single-organisation model. But what will such an organisation look like, and how can it represent the different interest groups that make up general/family practice today? I believe the best way is to start from the coalface, building the organisation upon principles and logical functional units.

1. The Principles
I suggest that the principles upon which to build a new organisation should be, amongst others, the following:
- There should be maximal unity in order to unite all practitioners in the discipline of general/family practice. Ultimately, there must be only one voice (remember the dictum of the past: divide and rule?).
- There must be room to accommodate strong interest groups, like the academic function and private practice, as examples. If there is not, it will create tension between factions and undermine common interests.
- The organisation must remain part of the greater profession of medicine, but have autonomy over the affairs of general/family practice.
- The organisation must be independent in a legal and business sense, have its own sources of income, be able to acquire or dispose of assets, and appoint staff. There must also be room for utilizing existing infrastructure within the medical profession to avoid wasteful duplication.
- The organisation must create a new culture, have new symbols, and be built around a single loyalty and interest: general/family practice. It must build on those loyalties and symbols of the past without retaining them as dividing factors.

Bearing these principles in mind, a new unitary professional organisation for general/family practice may look something like the organogram shown overleaf. The description that follows starts from the bottom.

2. Divisions/ functions
There are several distinct functions and interest groups that have to be accommodated with maximal autonomy over own affairs, almost like ministries of a government. These functions could be called divisions or sub-committees, depending on their nature.

The *academic function* is about the setting of professional standards of practice (e.g. accreditation of Continuing Professional Development activities for re-registration points), training and education, professional exams and qualifications, the development and conducting of the research and professional publications. It also has an important international liaison function with similar organisations, particularly WONCA (the World Organisation of Family Doctors). I suggest that this division be called a college, to give it the necessary academic status. It could even have sister college status with the present College of Medicine. All general/family practitioners with approved postgraduate qualifications in family medicine should qualify for membership of this college.

Private practice has developed into a very distinct interest group. There is a need for negotiating fees, the setting of standards for dispensing and liaison with business conglomerates of general/family practitioners.

General/family practitioners in *full-time practice* also need specific representation, especially with regard to conditions of service, specific training needs and the promotion of rural health.

Another definite function to be performed is the screening of *health policy and health related legislation*. The formation of specific proposals in this regard could be the function of a sub-committee.

Another sub-committee could be responsible for the evaluation of *professional conduct* of fellow practitioners ("peer review") and the formulation of *ethical guidelines* and norms of general/family practice.

3. Co-ordinating functions
All these different functions need to be co-ordinated at national and provincial levels. Elected national and provincial councils could perform these functions. The *National*

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