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GPs IN THE DISTRICT HEALTH TEAM

Transformation in the health services, like any significant change, elicits a whole range of emotional responses in people. This edition includes an article describing the experiences of clinic staff during the integration of clinic services from different public health services in the same district. "A district health system is the vehicle for providing quality primary health care to everyone in a defined geographical area."[1] This system is the focus of the government's efforts to make a success of primary health care. Development of health districts may or may not be happening all over the country. Numerous task teams, workshops, working groups and initiatives are underway to accelerate the development of district health services.

The implementation of the district health system will create a climate which will allow practitioners to apply the principles of good family practice. It defines the service in a geographical area; it aims to take services closer to the people; it promotes integrated and comprehensive care and brings the management and governance closer to the patients. The ultimate aim of this system is to improve the care for people in pain and trouble. Much of the final outcome depends on what happens in those few minutes of contact with the clinician. The consultation can make a vast difference to the future of the patient and his or her family. Drugs, equipment and facilities are essential, but cannot replace a proper, helpful consultation. The initial consultation with a patient, when a diagnosis of diabetes is confirmed, can make the difference between a changed lifestyle or total reliance on drugs for the rest of the person's life. It can make the difference for the anxious patient with a headache whose blood pressure is found to be increased, who is labelled as "high blood pressure" and sentenced to a lifelong saga of follow-up, non-compliance, side-effects and misunderstanding; not to mention never having the opportunity of being listened to. What can Family Medicine offer? Our strengths are patient care in the consultation, relationships, sharp, clinical reasoning, rational use of resources, continuity of care, gatekeeping and seeing the patient in the context of his or her family and community. We know how to be "the doctor as drug" through listening; how to involve the family to make sense of an impossible home situation; how to mobilise other community resources to work towards a better life for our practice population and how to improvise when something is not available. We can make sense of a six-minute consultation. All these skills are exactly what are needed in the overloaded district clinic where the staff is often not trained and supported for this complex task: action, support, participation, reflection and development at the level of actual patient care. We can make a difference. I would appeal to private general practitioners to see themselves as part of this district health team; to make contact with their local health service and to ask themselves, "Is there a district manager in my area? How do I relate to government clinics? Can I refer patients to them? How is the service? Can I support the clinic staff? Can I give them feedback that would improve their functioning?" If you are a medical officer in that imperfect government service, aim for the point of patient contact; build the team around patient care; do not forget the clinic in the furthest village and be proud of what you can offer.

To academic Family Medicine departments, I would say, "This is the time to become involved with patient care, research, quality improvement, service development and teaching. Far into the next century, we and many others will have to live with the difference that we do or do not make now."

Jannie Hugo, Guest Editor
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1. Harrison D. *A Pocket Guide to District Health Care in South Africa.* Durban: Health Systems Trust, 1997.

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