THE PRACTICE INTERVIEW

GARTH BRINK

As health care is transformed in South Africa, what role will be allocated to the general practitioner?

AN OUTSIDER GLANCING IN upon the health care scene in South Africa might be forgiven for believing that the general practitioner, that old-style family doctor, has an extremely limited role to play. But how accurate is such an observation?

The short answer is that, however regrettable, it is substantially true.

Of necessity, the delivery of primary health care in the public sector is nurse based. Certainly, GP doctors (usually called medical officers) perform a crucial curative service in the various levels of government hospitals, but in the private sector, especially in the urban setting, what is happening to the ordinary, non-specialist GP?

Dr Garth Brink, executive member of the South African Academy of Family Practice/Primary Care

'They are the forgotten element in health care,' says Dr Garth Brink, an executive member of the South African Academy of Family Practice/ Primary Care (SAAFP). 'Their role has changed. It is no longer that of the so-called generalist and family friend with an intimate knowledge of patients' health histories. These days, GPs have become little more than referral stations.'

But why have these highly trained medical professionals been so undermined? Brink provides two answers to this question.

'The first relates to a shift in public demand,' he says. 'People's expectations have been raised by various factors, not least by the impact of the media and society at large. Having a GP is no longer enough. Parents must have their paediatrician, women their own gynaecologist. The GP is being circumvented – but I believe to the detriment of the total care of the patient.'

The second reason for the undermining of the GP's traditional role, explains Brink, lies in the increasing demands made on the family.

'More and more now, both husband and wife work. Women have moved out of their traditional role of looking after the needs of the family, and the extended family is usually too dispersed to lend a hand. The pressure is on, therefore, to find instant cures for sick children so that parents can get back to their jobs. This translates into pressure on the GP to refer. But, again, often to the detriment of the patient.'

The results of these processes and expectations are clear: overprovision of health care escalates, becoming at the same time increasingly expensive; the advantage of the continuity of treatment by one doctor over a sustained period is lost; and (an often forgotten side-effect) the GP loses much of his or her previous job satisfaction.

What can be done with South Africa's approximately 7 000 GPs which will maximise their usefulness in the complex process of improving health care for all?

To find answers, Brink turns his attention to the rural GP. In fact, he spends some time explaining a congress which is to take place in Durban next year. Organised by the SAAFP (Brink is the congress administrator) in conjunction with WONCA (the World Organisation of General Practitioners), the congress carries a

significant name: 'The rural practitioner: a model of health care for the 21st century'.

'In the bush,' Brink explains, 'the GP acts as a generalist out of necessity. He is not surrounded by specialists and complex medical technology. In general terms, he has to solve his medical problems on his own. Because of this, he's community oriented and is able to provide a coherent primary care service which is cost-effective and satisfying both to himself and his patients.'

This special rural practitioner focus at the Durban congress will provide two distinct results. The first, as Brink expresses it, 'will be to seek, through a thorough examination of the work of rural practitioners, a new model for urban health care as well.'

The second focus, therefore, is this thorough examination of GPs in a rural setting. Brink talks enthusiastically of what he calls 'pre-congress workshops'. These will be held in Australia, Nigeria, Canada, Scotland and the USA, as well as here in South Africa. Workshop subjects include curriculum development and training programmes for rural practice, rural incentive programmes, the recruitment and retention of rural doctors, and improving rural health care in a pluralistic free market system.

The congress itself will be attended by delegates from many parts of the world. But will it be able to influence the process of health reform already well under way in South Africa?

Brink believes that it can. 'Although the basic concern of the SAAFP is not political, but more specifically directed at continuing medical education and research in family medicine, we believe the congress could play a significant role in the health policy arena.'

The SAAFP has already contacted the national Department of Health, and documentation has been forwarded to Health Minister Nkosazana Zuma in the hope of obtaining her endorsement of next year's congress.

'We are aware of the government's apparent reluctance to include the GP in its new health care plan,' says Brink. 'But we believe that the congress will engender a birth of concepts and projects which will have an impact on such thinking. We may even be able to set in motion processes which will entice doctors lost via the brain drain to return to South Africa. We'll certainly be making a special effort to address these issues at the congress so that we can provide input to the government on any aspects which might improve the delivery of health care and the process of policy reform.'

There could be a great deal that falls within these parameters, and Brink does not shy away from the implications. 'We are keen to build relationships with government, and also with other countries, especially in the rest of Africa. Our firm belief is that generalist care delivered by GPs is going to be a cornerstone of health care in the future, both in the rural and urban setting. But we recognise that we must work in a partnership with the state.'

David Robbins

Reprinted by kind permission of The Star

LETTER TO THE EDITOR

Sir,

READING YOUR INTERESTING ARTICLES ON CANCER AND cancer management[1] reminds me of a patient and her problem that has constantly bothered me. The case is as follows:

A 48-year-old black female with advanced Ca Cervix (at least Stage III (b)) who has been treated at King Edward and Addington hospitals.

She now presents to me on a monthly basis (three consults to date) and refuses to go to any hospital for further treatment. She is disillusioned with treatment at the hospitals. I have consulted the family about the seriousness of her condition, but they want to abide by her wishes.

She is pale and weak and in constant pain. The only help she wants from me is analgesia and haematinics. She needs a blood transfusion.

It bothers me as to what more I can offer her in the light of her refusal of further medical treatment. How do I approach the problem as a general practitioner?

Dr I Govender

Please make suggestions in the form of a 'letter to the editor' – Editor

REFERENCE:
Ellis C. Oncology Parts I-III. S Afr Fam Pract Volume 17 Aug-Oct 1996.