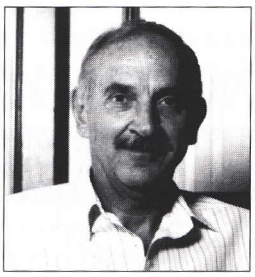
The role of the Department of Family Medicine at OFS

Prof GJ Pistorius MBChB M (Med Dom), MD
MVJ van Vuuren MBChB, MRCGP, Dip for Med(SA), MPrax Med
LA Hiemstra MBChB, MFGP (SA), MPrax Med

S Afr Fam Pract
1995;16:453-458

KEYWORDS
Physicians, Family; Education, Medical, Graduate; Education, Medical, Undergraduate; Universities.



Curriculum Vitae

Prof Gawie Pistorius *studied at the University of Pretoria where he received an MBChB in 1958 and an M Fam Med in 1970. For his thesis: "'n Analise van die werksaambede van 'n huisartspraktyk" he received an MD in 1984. After internship at the HF Verwoerd Hospital he spent some time in private family practice in Queenstown, Victoria-West, Pretoria and Brits. Since 1978 he has been Professor and Head of the Department of Family Medicine at the University of the Orange Free State. He serves on many professional bodies and has many publications in professional journals; he is also co-author of the book: "Family Practice Management". He loves computers and enjoys photography and masters athletics. Gawie is married to Pixie and they have three children, Vivienne, Esté and Gawie.*

Department of Family Medicine
PO Box 339 (M35)
University of the Orange Free State
9300 Bloemfontein

Summary

Family medicine has established itself as an academic discipline throughout the world. The challenges for Departments of Family Medicine are very real. They have an extended role to play, especially in the fields of reorientation of medical education towards a more primary care attitude; medical schools have a responsibility for addressing local health problems; greater awareness of managerial issues is required and an aggressively active role in building the infrastructure for community involvement must be taken. In facing these challenges the Department of Family Medicine at the University of the Orange Free State plays an important role in each of the fields of teaching/training, research, rendering of service and faculty administration. A description is given of the department's involvement in each of these fields. Certain minimum criteria for faculty involvement of Departments of Family Medicine are proposed. This involvement will allow the expected extended role of these departments to be fulfilled. A solution to the problem of funding of primary care services delivered as part of an academic complex, must also be found.

Introduction

Family medicine as an academic discipline in South Africa was born in 1968 when Dr Howard Botha initiated the first post-graduate course in Family Medicine at the University of Pretoria. In 1970 the first graduates obtained the M (Med Dom) degree. From 1971 the degree was renamed to the present M Prax Med.

The revival of family medicine as an

academic discipline became an international phenomenon, especially in countries like Great Britain, the United States of America, Canada, the Netherlands, Belgium, Australia and South Africa. In 1983 Marinker[1] declared:

In the United Kingdom today almost without exception, the medical school will have a university department of general practice. Indeed, not to have such a department is no longer the hallmark of the traditionalist or the super-technologist, but merely of the quaint.

Academic departments could then be found in 80% of WONCA-member states.[2] Much has been achieved in the international sphere regarding family medicine as an academic discipline. A world body, the World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) has been founded; FAMLI, an index of family medicine literature has been established; ICPC, an International Classification of Primary Care, has been developed and specific vocational training programmes for family physicians have been instituted in various countries.[3] Academic departments of family medicine are also increasingly involved in teaching both general practice and general medical skills at undergraduate level.[4]

In South Africa departments/divisions of family medicine now exist in each medical school. The challenges and expectations facing these departments are very real. Much attention is focused on primary health care and it is expected of departments of family medicine to play its rightful part. Medical education needs to be reorientated; medical schools have some responsibility for addressing local health problems and students need to learn about the real world and not only academic hospital medicine. More effort must be devoted to health promotion and disease prevention; greater awareness of managerial issues is required; and concern not only with individuals but with populations is necessary.[5] Academic medical centres must taken an aggressively active role in building the medical infrastructure for community involvement.[6] Faculty development, especially in family medicine, is therefore a very important issue.[7]

The four pillars of the functioning of a department in an academic medical centre are teaching/training, research, rendering of service and administration. The Department of Family Medicine at the Faculty of Medicine of the University of the Orange Free State plays an important role in each of these fields, especially with the view of serving the broad community.

"In the United Kingdom almost without exception the medical school will have a university department of general practice"

1. Teaching/training

Teaching in family medicine takes place at both under- and post-graduate levels. Undergraduate level teaching starts at the second year where the Department of Family Medicine forms part of the anatomy curriculum. At the end of each block a lecturer of the department explains the practical clinical application of the area covered. During the third year the Department of Family Medicine co-ordinates the teaching of Introduction to Clinical Medicine, which in essence is Primary Emergency Care.

Students need to learn about the real world and not only academic hospital medicine

The main theoretical contact takes place in the fifth year and consists of 50 lectures covering practice management, family health and clinical family medicine. Evaluation is by means of a mid-year test and a paper at the end of the academic year. The fifth year also includes a two week elective in a community primary care site, whether it be a general practice or a rural primary care hospital setting. Practical academic contact is obtained by means of a four-week residency programme in the Department of Family Medicine in the

sixth year. Because the Department of Family Medicine is in charge of all the polyclinics and the casualty departments, as well as a general primary care ward, the students are in a very good position to obtain hands-on experience of primary care problems. For the first time in their training they have the opportunity of seeing unselected and undifferentiated patients direct from the community.

Evaluation by the students of the residency programmes of the different disciplines of the faculty showed that the family medicine programme was rated the highest regarding *inter alia* relevance of clinical experience. Regarding the similarity between university residency programmes and community care, Gilchrist[8] found that the residency training sites of the Northeastern Ohio Universities College of Medicine provide patient care opportunities similar to those found in a national survey of family and general practitioners. Similarities between departmental clinics and general practice were also found in studies done in our department.[9, 10]

Although not an official part of the university training, student interns have a choice of a two-month internship period in the Department of Family Medicine.

Post-graduate teaching in family medicine leads to the acquisition of the degree Master of Family Medicine (M Fam Med). The course extends over four semesters when offered full-time, and over six semesters when offered part-time. The curriculum is based on the four corner stones of family medicine, namely clinical family medicine, family health, community medicine and practice management.[11] The subjects are applied anatomy, applied physiology, applied chemical pathology, clinical family medicine, family health, community health and practice management.

A dissertation, which must include an element of original research, must be handed in before admission to the final examination.

Since the course was introduced in 1980, 170 candidates obtained the degree; 44 full-time and 126 part-time. Of the latter 61% came from rural areas.

Training of primary health care nurses is also effected by the Department of Family Medicine. Since 1982, 447 nurses were trained in primary care management of common ailments. In that way the necessary skills needed for primary health care are being disseminated back to the community.

Teaching – research – service – administration

2. Research

An academic discipline is defined by the scope of its clinical interests and measured by the output of its academic researchers. Many factors can influence this output, not the least being a very heavy clinical workload. The most important factor, however, seems to be the individual's personal interest in research when first seeking a position in academic medicine.[12]

The main sources of research in our department are the dissertations submitted by the M Fam Med candidates. The topics vary widely and cover the broad field of family medicine in all its facets.

Most patients testify that patient care has benefitted enormously by the M Fam Med studies

Contract research projects on issues like pneumonia are being done by members of the department. Ongoing research by consultants in the department includes projects like morbidity studies of the casualty departments and polyclinics, the cost-effective treatment of hypertension, the outpatient treatment of the alcoholic and a profile of the final year medical students.

3. Rendering of service

Service rendering in an academic hos-

pital complex does not only consist of tertiary hi-tech marvels. On the contrary, much more service is rendered on the secondary and primary care level.

Total and cost-effective primary care in a tertiary and academic milieu is not only possible, but in actual fact is proved to be so daily in the different clinics of our department. According to the principles of the Reconstruction and Development Programme (RDP) and the Primary Health Care plan, the care must be acceptable, accessible, affordable, efficient and equitable. Within these visionary boundaries, the Department of Family Medicine delivers such a service to almost 200 000 patients annually at our different polyclinics, casualty departments and wards. These are the National, Pelonomi and Heidedal polyclinics, the Universitas and Pelonomi casualty departments and wards 10 (a short stay primary care ward) and 3/5 (detoxification of patients with alcohol or drug withdrawal symptoms).

They stretch from Universitas to Pelonomi and are thus within reach of the greatest majority of patients residing in the greater Bloemfontein. Home care is provided by primary health care nurses.

The extent of these services is set out in Table 1.

Apart from the escalation of total patients, especially over the last year, the figures show a remarkable consistency. Female patients make out almost 65% of the total patients seen. Viewed with the paediatric care section this has important fiscal implications.

On average only 7% of the total patients seen in the clinics are eventu-

Students now seen unselected, undifferentiated patients direct from the community

Table 1: Summary of patient contacts during a five year period

	Average/year	1990	1991	1992	1993	1994
National polyclinic	16 558	14 642	15 097	15 798	17 111	20 144
Pelonomi polyclinic	79 348	82 467	79 980	74 293	71 950	88 048
Heidedal polyclinic	19 023	20 364	20 273	18 355	15 163	20 960
Universitas casualty	22 202	21 121	22 079	22 483	21 990	23 336
Pelonomi casualty	44 536	43 981	42 936	43 368	45 166	47 231
Home care	6 735	6 876	7 428	6 585	6 067	6 719
Total	**188 402**	**189 451**	**187 793**	**180 882**	**177 447**	**206 438**
Average per day	516	519	515	496	486	566
Ward 10	675	642	723	638	666	705
Ward 3/5	184	175	172	191	162	221
Referral rate:						
National poly	7,8	8,4	7,9	6,7	7,8	8,4
Pelonomi poly (adult)	5,7	5,7	5,8	5,2	6,4	5,5
Pelonomi poly (child)	7,6	7,1	8,0	8,2	9,2	5,6
Heidedal poly (adult)	5,4	6,5	6,4	4,1	5,4	4,6
Heidedal poly (child)	4,1	5,2	4,1	2,8	5,0	3,5
Age and gender: %						
National poly >=65	54,6	61,0	57,8	56,0	52,4	45,6
Pelonomi poly <=12	21,2	21,1	21,6	20,5	19,0	23,7
Heidedal poly <=12	25,2	25,7	24,9	22,9	20,4	32,1
National poly (female)	72,5	75,0	74,7	72,5	71,1	69,0
Pelonomi poly (female)	64,8	65,0	63,9	64,0	65,9	65,3
Heidedal poly (female)	60,0	60,0	59,3	60,0	60,5	60,1

ally referred for specialist care. This referral rate may seem very low. If one, however, considers the fact that 70% of the doctors in the department have already or are in the process of obtaining a post-graduate qualification in family medicine, and are therefore in fact specialist general practitioners, this referral rate is more than acceptable. It also has additional financial benefits to the government because of the responsible and knowledgeable gatekeeper role that prevents unnecessary and expensive specialist care investigations.

The additional qualifications did not improve the salaries of the doctors in any way. Improved patient care was the sole motivation for these studies. Most patients will testify that patient care has benefitted enormously by this fact.

Regarding the rendering of service in the future, the department expects to get involved in the following: the present clinical component of the district surgeon services, the local government's action of conversion to curative clinics and the Mangaung University OFS Community Partnership Programme (MUCCP). This will obviously mean a considerably increased workload. Replanning in general, increase workforce and physical facilities and redistribution of patients for primary evaluation and intervention will have to be considered.

4. Administration

Martini et al[13] found that institutional policies, where implemented, have had a positive effect on the students' choice of generalist careers. The most influential factors under the control of the medical school are the criteria used for admitting students and the design of the curriculum, with particular emphasis on faculty role models. It is therefore imperative for members of the Department of Family Medicine to be actively involved in the administration and policy-making bodies of the faculty in order to be regarded as role models by the students and to influence the faculty towards a more generalist-orientated curriculum. Members of the Department of Family Medicine of this faculty are or have been serving as vice-dean and inter alia on the following committees: executive, student selection, education, finance, curriculum planning and quality care.

Discussion

Family medicine is an essential role player in the modern medical academic complex, especially in the southern African setting. It has an extended role to play, not only in the classical academic functions, but also in the delivering of primary care service to the community and of a motivated and suitably trained workforce for the proper execution of this task.

To be in a position to fulfill this assignment such a department must be able to influence faculty decisions on curriculum development and rendering of service to the community. There should be representation on the decision making bodies of the faculty. Regarding rendering of service it is essential that the poly clinics and casualty departments fall under the direct control of the Department of Family Medicine, and that enough opportunity of student exposure to these clinics/departments is possible.

Only 7% of total patients seen in our clinics are eventually referred for specialist care

The Department of Family Medicine of the University of the Orange Free State is in a position to accomplish this task. It operates in a milieu of mutual recognition and consulting with the other disciplines of the faculty. This allows it to play its expected extended role both in the faculty and also in the community. Its community role includes practising cost-effective medicine according to the principles of the RDP programme.

It has been clearly shown that a

Department of Family Medicine, although part of an academic complex, is an active role player in the rendering of primary care services. Funds are being deviated from academic complexes towards primary care, the latter by definition being health services which are performed outside hospitals. It would be a pity if such a service and infrastructure like Departments of Family Medicine that already exist must be curtailed by a lack of funds. It is absolutely imperative that a solution to this real problem be found.

References

1. Marinker M. Should general practice be represented in the university medical school? Br Med J 1983;286:855-9.
2. Rice DI. The challenge of Family Medicine Around the World in the 1980s. Can Fam Physician 1983;29:1201-11.
3. Rice DI. Quo vadis Family Medicine? Can Fam Physician 1981;27:1264-70.
4. Robinson LA, Spencer JA, Jones RH. Contribution of academic departments of general practice to undergraduate teaching, and their plans for curriculum development. Br J Gen Pract 1994;44:489-91.
5. Zwi AB, Zwarenstein M, Tollman S, et al. The introverted medical school – time to rethink medical education. S Afr Med J 1994;84:424-6.
6. Foreman S. Social Responsibility and the Academic Medicine Center: Building Community-based Systems for the Nation's Health. Acad Med 1994;69(2):97-102.
7. Steinert Y. Faculty Development in Family Medicine. Can Fam Physician 1993;39:1917-22.
8. Gilchrist V et al. Does Family Practice at Residency Teaching Sites Reflect Community Practice? J Fam Pract 1993;37:555-63.
9. Van Rooyen JP. n Siekteprofielstudie: University of the Orange Free State, M Fam Med-dissertation, 1983.
10. Slabbert RP. Statistiese ontleding: Pelonomi noodgevalle. University of the Orange Free State: M Fam Med-dissertation, 1986.
11. Pistorius GJ, Pistorius CWI. Family Practice Management. Pretoria:HAUM, 1990:8.
12. Hueston WJ. Factors Associated with Research Efforts of Academic Family Physicians. J Fam Pract 1993;37:44-8.
13. Martini CJ. Veloski J. Barzansky B, Xu G, Fielde SK. Medical School and Student Characteristics That Influence Choosing a Generalist Career. JAMA 1994;272:661-8.