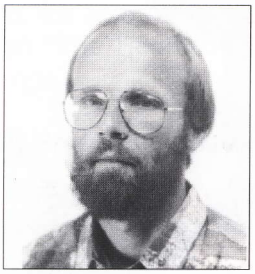
Sound Primary Health Care demands a Strong Role for Family Medicine

Dr M de Jonge



Curriculum Vitae

Maarten de Jonge was born 11.12.55 in the Netherlands. He studied medicine at the Erasmus University in Rotterdam from 1974 to 1981. In 1981 and 1982 he worked as a medical officer in the department of surgery in a hospital in the Netherlands. He worked from 1983 to 1992 at Gelukspan Community Hospital in Bophuthatswana, at first as a medical officer and later on as medical superintendent. He obtained a DPH at Medunsa in 1990. In 1991 he started with M. Prax. Med. at Medunsa (part time course). In 1992 he went back to the Netherlands for the full time course for 'huisarts' (comparable with the M. Prax. Med.). He obtained his qualification in December 1994. At present he is working as a family physician in private practice in Deventer (the Netherlands).

Dr M de Jonge
Sandberg 4
6462 HN Kerkrade
The Netherlands

"The integration of personal and population medicine is one of the tasks facing us in the next 25 years. In general practice as in no other field of medicine the two come together"

(Ian R McWhinney[1]).

S Afr Fam Pract
1995;16:161-71

KEYWORDS
Primary Health Care;
Family Medicine;
Education, Medical, Graduate;
Teams;
Family Physicians;
Philosophy

Summary

The author has worked for a period of ten years as a medical doctor in the Gelukspan Health Ward in the former national state Bophuthatswana in southern Africa. During this period he observed that most family physicians (FPhs) in southern Africa are in private practice. Only a limited number of FPhs participate as members of primary health care (PHC) teams. A literature study on the role of FPhs in PHC in southern Africa is presented. On the basis of this literature study and his own experiences the importance of incorporating a FPhs in PHC teams is argued. It is concluded that an active role for FPhs in PHC in southern Africa is essential for the future quality of the health services and consequently for the health status of the people.

Introduction

The declaration of Alma Ata identifies primary health care (PHC) as the key to attaining "health for all by the year

2000."[2] It describes PHC as essential health care made universally accessible to individuals and families in the community, rendered by means acceptable to the community, through their full participation and at an affordable cost.

Soon after the Declaration of Alma Ata in 1978 many governments all over the World committed themselves towards the PHC approach. They made it the cornerstone of their comprehensive health services (CHS). The term CHS stands for the total package of health related services for a given community, by both the private and public sector. The government of Bophuthatswana also committed itself to this approach. The management of Gelukspan Health Ward (GHW), one of the health wards in the former Bophuthatswana, started with PHC in 1978.[3] The PHC approach as cornerstone of the CHS in GHW has proved to be very effective in improving the health status of the people.[3-11]

I started working in GHW in 1983 and at first my duties were mainly in the curative field. Soon I got involved in PHC activities and later on in the management of the health services. I was an enthusiastic supporter of the PHC approach. I acknowledged that successful PHC depends on a strong health team with a large number of nursing staff, paramedics and some general practitioners (GPs). They were all available at GHW. Besides general practitioners (GPs) there were also one or more family physicians (FPhs) in the PHC team as from 1983 (FPhs are GPs with a masters degree or comparable qualification in Family Medicine). I realised it was exceptional to have them in the team. Most PHC teams in southern Africa had no FPh.

Although I was convinced it was important to have FPhs in PHC teams I could not articulate the case for a long time. In 1992 I started to study the subject of Family Medicine (FM) in PHC. I started with McWhinney's text book,[12] the declaration on the role of the doctor in PHC[13] and the declaration on the role of the general practitioner/family physician in health care systems.[14] One statement in the latter document struck me particularly. "High quality PHC depends on the availability of well trained FPhs as members of health care teams in the community." It implies that FPhs have characteristics which are of additional value to PHC teams and which are a necessity for a high quality service.

My reading and experiences with FPhs working as members of the PHC team in GHW resulted in this study which aims to answer three questions:

1. Do FPhs have characteristics which are of additional value to PHC teams and are such characteristics identifiable?

2. Do FPhs play a significant role in PHC in southern Africa at present?

3. What happens to the quality of the health services if we introduce FPh into the PHC team?

Methodology

To answer the question on characteristics of family physicians (FPhs) which are of additional value to primary health care (PHC) teams the specific characteristics of both FPhs and of PHC teams need to be described and compared.

PHC teams consist of different

ABBREVIATIONS

CHS = Community Health Services

FPh(s) = Family Physician(s) [GPs with extra qualification in Family Medicine

FM = Family Medicine

GHW = Gelukspan Health Ward

GP(s) = General Practitioner(s)

PHC = Primary Health Care

professionals who all have their own training. This makes it difficult to describe the characteristics of the team as a whole. For the purpose of this study the description of the characteristics of PHC as mentioned in the declaration of Alma Ata was used.[2] This description is internationally accepted and it forms the basis of training programmes for PHC workers.

To describe the characteristics of FPhs, a literature search was undertaken. The Textbook of Family Medicine by McWhinney was the starting point because the second chapter of this book was an eye-opener for the author on the specific characteristics of FPhs. According to McWhinney those principles, when taken together, form the characteristics of FPhs and of the discipline of family medicine (FM).[13] Relevant references were studied. A MEDLINE search with keywords: history, origins, characteristics, family practice and family medicine was undertaken for the period 1986 to 1993 to determine if corrections or additions to this list of characteristics were required.

Only those characteristics of FPhs which are not discussed in PHC are presented and discussed in this article.

To answer the questions on the present role of FPhs in PHC services and the quality of health services if we introduce a FPhs in PHC teams the declarations mentioned in the introduction were studied.[13,14] A MEDLINE search with three groups of keywords for the period 1986 to June 1993 was done. The one group consisted of: family medicine; family practice; general practice and family care. The other group consisted of: primary health care; comprehensive health services and public health. The third group consisted of only one keyword: Africa. In the first instance all possible combinations with one of the keywords for either one group were searched. This was extended to combinations of words from the first with the third group only.

Results

The specific characteristics of primary health care (PHC) are described in the declaration of Alma Ata under the headings VII and VIII.[2] For the easy reference they are presented in appendix I.

Most PHC teams in South Africa do not have a FPh in their team

Ian R McWhinney, in describing family medicine (FM), has given a list of nine principles that govern the actions of family physicians (FPhs).[12] These principles form the characteristics of the discipline of FM. He says on this list that none of the principles is unique to FM but that, when taken together, they do represent a distinctive worldview, a system of values and an approach to problems, that is identifiably different from that of other disciplines. These characteristics are presented in appendix II.

Most FPhs in SA are in private practice

The literature search on characteristics of FM revealed no differences or additional characteristics to the above mentioned nine.[1,14-17] Each of the studied articles describes the importance of one or more of them except the WONCA declaration in which all characteristics are mentioned in describing the role of FPhs in PHC.[14]

Family Medicine has distinctive characteristics which are different from other disciplines

In comparing the characteristics of FM with those of PHC there are five out of the nine characteristics of FM

corresponding with one or more of those of PHC. These are presented in appendix III.

For the purpose of this study only the four characteristics of FM which are not well developed in PHC and which can be of an additional value to PHC are presented and discussed.

1. In FM there is a commitment to the individual person which is not limited by the type of health problem. FPhs are available for any health problem. Even ones not strictly defined as health problems are attended to; the patient defines the problem. The commitment has a long-term nature which makes the doctor-patient relationship especially important.

   The personal commitment is not inherent in PHC. Patients may see another doctor or nurse at each visit. The commitment in PHC is to specific services and to the major health problems of groups of people. This also implies that not all problems presented will be addressed by the health worker. Some problems will not be addressed at all and for some other problems the patients are referred to other health workers when the problem they present does not fit into the service that specific health worker renders at that specific moment. And often the PHC workers do not have a long-term commitment. Most doctors do not work longer than a few years in a specific setting. Nursing staff usually rotates from clinic to clinic and between the clinics and the hospital.

2. In FM specific attention is given to the personal, the family and the social background of the sick.

   Many of the health problems can not be fully understood and/or managed well unless they are seen in their context.

   In PHC there is little or no attention given to an understanding of the context of the illness. Gumede comments on it in his book on traditional healers. He states that the modern healers are treating diseases, destroying the offending organisms and the patients get well. The traditional healer treats the patients within his or her environment, physical, spiritual, emotional, past and present.[18] Diseases rather than patients are treated in PHC. A tuberculosis patient may be hospitalised without any attention given to the consequences it has for the family and the job.

Diseases rather than patients are treated in PHC

3. FPhs acknowledge the importance of the subjective aspects of medicine such as sensitivity to feelings and an insight into relationships. This includes an awareness of the self. FPhs understand that their own values, attitudes, and feelings are important determinants of how they practice.

   In PHC there is little attention given to the subjective aspects of medicine. There is a strictly objective and technical approach to health problems. The feelings of neither patients nor the doctors are given the required attention.

PHC has a more objective, technical approach

4. FPhs attach value to their own presence in the community they serve. They realise they can only understand the community and its problems fully when they are part of that community. The higher educated health workers in PHC usually do not stay within the

Long-term commitment does make a difference

community they serve. They often have a house in a nearby city. Those, who do stay within the community they serve, often do not participate in the activities of the community.

The literature search on the role of FPhs in PHC in Africa over the period 1986-1993 did not reveal any general articles on this subject. The few articles found through this search only dealt with some of the characteristics[19-21] and its applicability in developing countries.[22] It is noteworthy that this literature search only revealed articles by Henbest and Fehrsen, both working at the Medical University of Southern Africa (MEDUNSA).

The question on the quality of the health services if we introduce FPhs into PHC teams can not be answered by this literature study. Only predictions can be made on basis of the experiences from the field by the author. This is done under the discussion.

Discussion

The literature search on the characteristics of family physicians (FPhs) revealed only two publications with a comprehensive description of those characteristics.[12,14] The reason for this small number might be that family medicine (FM) is a young specialty and that the principles on which FPhs operate have not changed very much as yet.[17]

The literature search on the role of FPhs in PHC did not reveal any general articles. Apparently this is not yet a field of study, though the articles of Henbest and Fehrsen probably mark the beginning of it. Consequently the research question on the probable impact on the quality of the health services if we introduce FPhs into the PHC teams could not be answered by this literature study.

The discussion which follows is based on my experiences from ten years working in PHC in the Gelukspan Health Ward (GHW) and on studying in the fields of FM and PHC. It is a discussion on the probable impact on the quality of the health services of both incorporating and not incorporating the four specific characteristics of FPhs as found in this study in PHC by equipping PHC workers with them. It is my view that equipping PHC workers with the four characteristics will have an impact on the quality of the health services and introducing FPhs themselves in PHC will have an even greater impact.

The trend to allocate junior doctors to TB work and then change them as soon as a new junior arrives, is part of the failure in our TB work

At first the predicted consequences of the incorporation of the specific characteristics of FPhs are discussed. Thereafter the same is done for not incorporating the characteristics. Illustrations to support these predictions are given where available and applicable.

1. *The predicted impact on the quality of the health services if the specific characteristics of FPhs are incorporated in PHC.*

With a personal commitment the patients will get a feeling they are respected as people. They will appreciate that all their problems are taken seriously and that attention is given to problems related to their illnesses such as sick leave. With the understanding of the personal and family context many more problems will be understood and solved. When health workers live within the community they serve and participate in activities in the community, they

No FPh in the team meant no person-centredness in the services

will detect more health problems. They will also be in a better position to manage them. When the health worker is sensitive to both his or her own feelings and the feelings of the patient this will lead to a better understanding and improve communication. The personal commitment of the health workers is probably the most important characteristic required.[1,23] Incorporation of all the characteristics of FPhs into PHC will result in a more person centred approach. This will ultimately lead to an optimal acceptance of the services. The people will be more satisfied with the services. Consequently there will also be an improvement in compliance with advice and medication and the overall use of the services will increase.

The success of the tuberculosis (TB) control programme in the GHW is a good illustration to support these predictions. This programme compares favourably with other programmes in southern Africa regarding case-finding, case-holding and trends in incidence rates.[11,24] In analysing the TB control programme in GWH several characteristics of FPhs in the execution of the programme can be identified. There is a long-term personal commitment by both the nursing staff and the doctors. Several nurses have worked for more than 5 to 10 years in this programme. They do home-visits and work both in the district and in the hospital. They know many patients and their families very well. The trend in southern Africa to allocate junior doctors to the TB work and to allocate them elsewhere as soon as a new doctor joins the team is not followed at Gelukspan. Doctors are also allocated for longer periods to the TB control programme. There is a good doctor-patient relationship. The doctor also attends to problems at home and at work or school. If he or she refers a patient to the social worker the doctor keeps control, hereby showing personal commitment. This approach explains at least part of the success of the TB control programme in GHW. On the contrary, the lack of using those characteristics specific to FPhs in TB programmes elsewhere is responsible for the failures of such programmes. This is documented. Several authors indicate that the lack of a good worker-patient relationship and personal commitment play an important role in the failures.[25,26]

The failure of many TB control programmes is probably because they lack FPhs in the team

A case presentation by van Oord illustrates both the importance of FPhs in PHC and also the possibilities of an approach specific to the discipline of FM in a PHC setting.[27] He describes a patient with elective mutism. The patient, a five year old boy, was admitted in the hospital under the diagnosis deaf and dumb. The correct diagnosis was made using a patient-centred diagnostic approach. Successful management of this patient was only possible after the attempt to get an understanding of the context of the illness, namely the contextual aspects of his personality development and the environmental influences on his development.

A FPh serves members of his practice even if they do not present themselves at his practice

2. *The predicted impact on the quality of the health services if the specific characteristics of FPhs are not incorporated in PHC.*

A FPh needs to be a visible presence in the neighbourhood

Lack of personal and long-term commitment and lack of attention to certain problems presented by patients will result in many problems remaining unsolved. Patients will get the feeling they are not taken seriously, there is lack of interest in them as unique human beings. When

little or no efforts are put into an understanding of the context of the presented health problems many of them will not be managed well. Often people are told they do not have a health problem because the doctor does not find any abnormalities. It also occurs that the doctor finds an illness and that he or she will concentrate on the cure of that disease without paying any attention to the meaning of the illness for the patient. When health workers do not pay attention to the feelings of their patients it may lead to friction, clashes and disappointment.

Health workers who do not stay in the community they serve will need more time to detect health problems and health hazards within that community. They will not fully comprehend all problems and might never detect certain problems. Consequently they are in a poor position to manage such problems. The community will not understand why health workers are not able to detect and manage the problems well and lose confidence in them.

By not incorporating the characteristics of FPhs in PHC there will be a lack of person centredness in the services. The overall consequences thereof are expected to be far-reaching. The dissatisfaction of people on many aspects of the services will result in a decrease in use of the services. People will increasingly attend traditional healers and private FPhs. The decrease in the use of the PHC services will result in a loss of the successes specific to PHC such as the control of infectious diseases. The increase in the incidence of infectious diseases will lead to deterioration of the health status of the community. In conclusion it can be argued that a person centred approach is a basic requirement for community participation and that PHC, in which community participation is one of the main characteristics, can not fully prosper without person centredness.

The failure of many TB control programmes in southern Africa illustrates the direct consequences of a lack of FPhs in PHC. The technical aspects of such programmes are good but they lack committed health workers and a good health care worker-patient relationship.[25,26]

The large number of complaints by the communities about the health services in southern Africa also form a good illustration. Most complaints relate to lack of commitment and communication problems.[28] Good management of such complaints is difficult as long as health workers do not understand and appreciate the feelings of the complaining people.

Conclusions and recommendations

Comparison of the characteristics of both family physicians (FPhs) and primary health care (PHC) as described by McWhinney[12] and in the declaration of Alma Ata[2] respectively reveals that FPhs have four characteristics which are of an additional value to PHC teams. The personal commitment of the health workers is probably the most important of them.[1,23] Incorporation of the four characteristics will result in a more person-centred service.

The author is of the opinion that an active role of FPhs in PHC is essential for the future of the PHC services in southern Africa and consequently for the health status of the people.

It is recommended that the disciplines of Family Medicine and Community Health work more closely together in the training of health workers. PHC workers should also be trained in the basics of FM and they should be equipped with the specific characteristics of FPhs which are mentioned in this article.

In the second place all PHC teams should at least employ one or more FPhs.

Finally the general practitioners working in PHC should be motivated to obtain a masters degree in FM. FM and PHC are complementary to each other. The statement by McWhinney 15 years ago still stands. "The integration of personal and population medicine is one of the tasks facing us in the next 25 years."[1]

Acknowledgements

Contributions to this paper made by the following colleagues are gratefully acknowledged:

M Bac, Family Physician in private practice, the Netherlands. Former Medical Superintendent of Gelukspan Health Ward and Director of the Goldfields Nutrition Institute, MEDUNSA, Pretoria, RSA.

GS Fehrsen, Professor, Department of Family Medicine, MEDUNSA, Pretoria, RSA.

DJ van Oord, Family Physician in private practice, the Netherlands. Former Deputy Medical Superintendent Gelukspan Health Ward, Bophuthatswana, RSA.

J van Thiel, Family Physician, Department of Family Medicine, University of Limburg, Maastricht, the Netherlands.

Literature

1. McWhinney IR. The future of Family Medicine. Can Fam Physician 1979;30:976-1063.
2. World Health Organisation. A report of the international conference on Primary Health Care, Alma-Ata, 6-12 September 1978. Health for All series No.1;1983, Geneva: WHO.
3. Bac M. Primary health Care in practice – Gelukspan Health Ward. S Afr J Continuing Med Education 1989; 7:1325-38.
4. Bac M. Measuring and managing protein-energy malnutrition in rural communities. S Afr Fam Practice 1984. Booklet Series No. 1.
5. Ferrinho P. Diarrhoeal diseases in the Gelukspan Health Ward 1983-84: Part I. S Afr Fam Pract 1985; 6: 107-13.
6. Ferrinho P. Diarrhoeal diseases in the Gelukspan Health Ward 1983-84: Part II. S Afr Fam Pract 1985; 6: 140-6.
7. Ferrinho P. Diarrhoeal diseases in the Gelukspan Health Ward 1983-84: Part III. S Afr Fam Pract 1985; 6: 175-81.
8. Bac M. Evaluation of child health services at Gelukspan Community Hospital. Radithuso, Bophuthatswana, 1976-1984. S Afr Med J 1986; 70: 277-80.
9. Ferrinho P, Gear JSS, Reinach SG. Some aspects of vaccination coverage in the Gelukspan Health Ward. S Afr Med J 1987; 72: 341-2.
10. Bac M. Progress towards Health for All in the Gelukspan Health Ward, 1985. M.D.thesis, MEDUNSA, 1988.
11. de Jonge M. An evaluation of the Tuberculosis Control Programme in the Gelukspan Health Ward 1983-1990. S Afr J Epidemiol Infect 1991; 6:67-72.
12. McWhinney IR. A Textbook of Family Medicine. New York – Oxford: Oxford University Press 1989.
13. Consensus document. The role of the Doctor in Primary Health Care: Declaration. S Afr Fam Pract 1992;13:8.
14. World Organisation of Family Doctors. The role of the general practitioner/family physician in health care systems. Jolimont, Victoria: WONCA, 1991.

15. Stephens GG. The Intellectual Basis of Family Practice. Fam Pract 1975; 2:423-8.
16. Adams DP. Evolution of the Specialty of Family Practice. J Florida MA 1989; 76:325-9.
17. Frey JF, Ventres W.B. Voices from Family Medicine. Fam Med 1992; 24:317-20.
18. Gumede MV. Traditional healers, a medical practitioner's perspective. Braamfontein, RSA. Skotaville Publishers 1990. ISBN 0947479198.
19. Henbest RJ, Stewart MA. Patient-centredness in the consultation. 1: a method for measurement. Family Practice 1989;6:249-54.
20. Henbest RJ, Stewart MA. Patient-centredness in the consultation. 2: does it really make a difference? Family Practice 1990;7:28-33.
21. Fehrsen GS, Henbest RJ. In search of excellence. Expanding the patient-centred clinical method: a three-stage assessment. Family Practice 1993;10:49-54.
22. Henbest RJ, Fehrsen GS. Patient-centredness: Is it applicable outside the West? Its measurement and effect on outcomes. Family Practice 1992;9:311-7.
23. Bac M. A call for personal commitment (guest editorial). S Afr J Cont Med Ed 1989; 7:1291.
24. Department of Health and Population Development. Tuberculosis Control Programme 1988. Epid Comments 1990; 17;3-13.
25. Conradie HH. S Afr Fam Pract 1990; 11: 393 (letter).
26. Wilkinson D. An approach to tuberculosis control (letter). S Afr Med J 1990; 70:482.
27. Oord DJ van. Geneeskundig handelen in Afrika; niet wezenlijk anders. Ned Tijdschr Geneesk 1991; 135: 1649-51.
28. SECOSAF. Record of the forum on primary health care training HSRC Conference Centre Pretoria, 11 and 12 February 1992; M:\162\DOC\PHC\0012.RPT.

Appendix I. Characteristics of primary health care (PHC):

1. It is essential health care, health care a community can not do without.
2. It is based on practical, scientifically sound and socially acceptable methods.
3. It is affordable to the community it serves.
4. It is instituted and maintained through full participation of the community.
5. It is accessible to the whole community.
6. It forms an integral part of the comprehensive health service, of which it is the central function and main focus.
7. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.
8. It addresses the main health problems of the community.
9. It also involves other sectors outside of the health sector (agriculture, education and others).
10. It promotes self-help and self-reliance.
11. It should be linked to adequate referral systems for secondary and tertiary health care and should give priority to those most in need.
12. It makes use of cost-effective appropriate technology.
13. It provides all 5 levels of intervention, namely: health promotion, specific protection, early diagnosis and treatment, limitation of disability and rehabilitation.
14. It includes at least a number of well described activities, namely: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunisation against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and the provision of essential drugs.
15. It relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries, and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

Appendix II. Characteristics of family physicians:

1. A commitment to the individual person which is not limited by the type of health problem and which has a long-term nature.

2. Specific attention to the personal, the family and the social background of the sick. The family physician seeks to understand the context of the illness.

3. Attachment of importance to subjective aspects of medicine such as sensitivity to feelings and an insight into relationships.

4. A commitment to maintain health in the members of the practice whether or not they happen to be attending the office. The family physician views his or her practice as a population at risk and will also undertake steps to serve patients and people at risk for specific diseases who do not present themselves.

5. Attachment of importance to preventive medicine by considering each contact with a patient as an opportunity for prevention and health education.

6. Deployment of all resources of the community to the benefit of the patients. The family physician sees himself or herself as part of a community-wide network of supportive and health-care agencies, both formal and informal. He or she uses this network for the benefit of the patients and coordinates if necessary.

7. Living within the community served. To be fully effective, family physicians need to be a visible presence in the neighbourhood.

8. Contacts with patients at the practice; at home and in the hospital

9. Management of (limited) resources. As a generalist and first-contact physician, he or she has control of large resources and is able, within certain limits, to control admission to hospital, use of investigations, prescription of treatment, and referral to specialists.

Appendix III. Characteristics of family medicine (FM) which are also present in primary health care (PHC) in numbers; numbers used correspond with the numbers in appendices I and II

Characteristics of FM	Characteristics of PHC
4	8
5	13,14
6	4,9,10,12,14,15
8	5,7,13,14,15
9	3,11,14,15