

Report on the Proceedings of the 2nd Research Day of the Department of Family Medicine and Primary Care, University of Stellenbosch

20 October 1994

The department of Family Medicine and Primary Care of the University of Stellenbosch held its second annual research day on 20 October 1994, at the medical school in Tygerberg. The aim of the day is to give the MFamMed candidates who have completed their research project, as well as other researchers in the department, the opportunity to present their work to an audience of peers. This forms part of the educational process of becoming a master in family medicine.

The meeting was well attended by family physicians in both the private and public sector, ex-MFamMed graduandi, nurses from the day hospitals and the present MFamMed class. The associate dean of the medical faculty, Prof WL van der Merwe said in his opening address that the discipline of family medicine is now in the forefront of change and development in the health sector of South Africa. He emphasised that much more primary care research will be needed in future and that he is heartened by the fact that family physicians themselves are taking responsibility to do research in their practices, as is proven by the work presented on this occasion.

The guest speaker at the occasion was Prof Bobby Erasmus of the department of Family Medicine at the University of Pretoria. He spoke on the Family Physician and Essential National Health Research. A summary of his paper is included in the list of abstracts.

Nine papers were delivered, and those of the MFamMed candidates were evaluated by a panel of

judges, competing for the Jutta's book prize for the best paper delivered. The panel of judges were Prof RJE Erasmus, Mrs J Barnes, Dr J van Zyl and Dr Saville Furman. The winner of the 1994 prize was Dr Rodney Butters with his study titled: "Feverish children presenting to a general practitioner in King Williams Town – A descriptive study of the presenting features, the diagnosis made and the management of these children."

The afternoon's proceedings were concluded at a finger buffet. All the expenses of the research day were sponsored by Smith Kline and Beecham.

It is envisaged that this research day will develop into a regular opportunity for also other family physician researchers to present their work and to meet other primary care researchers. Closer co-operation with the Academy of Family Practice/Primary Care in the Western Cape will hopefully achieve this in future.

Die Huisarts en Essensiële Nasionale Gesondheidsnavorsing

Prof RJE Erasmus, Dept Huisartskunde, Universiteit van Pretoria

1. Inleiding

Die woord *navorsing* wek by die meeste geneesher 'n gevoel op van weersin en afsydigheid omdat dit beskou word as iets wat deur verstokte mense in afgesonderde laboratoria ver weg van die werklike lewe gedoen word. Wat die praktiserende geneesheer egter nie besef nie, is dat dit wat hy of sy elke dag doen, in werklikheid navorsing is, want

navorsing beteken niks anders nie as die soeke na oplossings vir vraagstukke wat daagliks opduik. 'n Baie belangrike aspek van 'n professie, soos geneeskunde, is dat die lede van die betrokke professie voortdurend daarna sal streef om die standaard van die professionele handeling te verbeter omdat die professie sy eie standarde stel. Die beste manier om dit te doen is om voortdurend 'n opname van wat gedoen word, te maak en die resultaat krities te beoordeel. Dit staan in praktiese terme as *Praktyk-Oudit* bekend en is 'n belangrike aspek in die proses van standaardhandhawing. Oudit van mediese praktyke is reeds vroeg in hierdie eeu as 'n vorm van kwaliteitskontrole toegepas. In die Verenigde Koninkryk is daar alreeds gedurende 1823 'n geboorteregister ingestel om die resultate van destydse behandelingsmetodes te kontroleer. In 1953 is 'n vertroulike register van moederlike sterftes ingestel waarin die moontlike oorsake van sterftes nagegaan is. *Praktyk-oudit* is dan inderdaad ook 'n goeie beginpunt vir navorsing in huisartspraktyk.

2. Wie is 'n Huisarts?

Die term Huisarts is aan Nederlands ontleen om die geneesheer te beskryf wat al die mense wat in een huis woon medies versorg. In Suid-Afrika dui die term egter 'n geneesheer met 'n wyer werksveld aan, en stem dit meer met die Engelse "general practitioner" ooreen. Die huisarts is deur van den Berg (1977) beskryf as die geneesheer wat gemoeid is met die lewering van daardie soort primêre geneeskundige sorg wat die eerste of basiese pasiënt-dokter-raakvlak uitmaak. Die bekendste is die algemene praktisyn wat sy eie praktyk bedryf, maar daar is dan ook die geneesheer in voltydse aanstellings by hospitale se buitepasiënt- en noodgevalle afdelings, die industrie, en vele ander instansies.

Die "American Academy of Family Practice" en die "American Board of Family Physicians" het die volgende definisie van Huisartspraktyk aanvaar:

"Family practice is *comprehensive* medical care with particular emphasis on the *family unit*, in which the physician's continuing responsibility for health care is neither limited by the patient's age or

sex, nor by a particular organ system or disease entity. Family practice is the speciality in breadth which builds upon a core of knowledge derived from other disciplines – drawing most heavily on internal medicine, paediatrics, obstetrics and gynaecology, surgery and psychiatry – and which establishes a cohesive unit, combining the behavioural sciences with the traditional biological and clinical sciences. The core of knowledge encompassed by the discipline of family practice prepares the family physician for a unique role in patient management, problem solving, counselling and as a personal physician who co-ordinates total health care delivery."

3. Wat is Essensiële Nasionale Gesondheidsnavorsing?

Volgens die Internasionale Kommissie van Gesondheidsnavorsing vir Ontwikkeling is essensiële nasionale gesondheidsnavorsing 'n proses wat lei tot gelykheid in gesondheid deur op die volgende doelwitte te fokus: verbetering in die lewensgehalte van alle mense, veral die armes en verontregtes; instaatstelling van individue, hul gesinne en gemeenskappe om verantwoordelikheid vir hul eie gesondheid te neem; fokus nasionale hulpbronne – mense, organisasies en finansies – op die gesondheidsprobleme van alle mense, maar veral die armes en verontregtes; en vind realistiese, effektiewe en bekostigbare oplossings vir hierdie gesondheidsprobleme.

Volgens die Mediese Navorsingsraad is daar 'n dringende behoefte aan 'n essensiële nasionale gesondheidsnavorsingsprogram in Suid-Afrika met die doel om effektiewe skakeling, gesprekvoering en 'n vennootskap tussen die besluitnemers, navorsers en gemeenskapsvertegenwoordigers te skep sodat gesamentlike besluitneming oor plaaslike gesondheidsprioriteite op grond van geloofwaardige datagebaseerde navorsing geneem kan word. Die breë doelwit is om essensiële navorsing se vaardighede en prosesse deel van die dag-tot-dag werking van gesondheidsdienste te maak en dit te koppel aan navorsers op 'n nasionale, regionale en plaaslike vlak. Dit is dus 'n dinamiese en noodsaaklike proses.

Gesondheidsnavorsing behels hoofsaaklik 5 areas, naamlik gesondheidsprobleme, etiologie, intervensie, bestuur en gesondheidsisteme.

Wat gesondheidsprobleme, etiologie en intervensie betref, is dit belangrik om die bydrae wat 'n gesondheidsprobleem tot morbiditeit en mortaliteit in 'n gemeenskap maak, te identifiseer en sodoende navorsingsprioriteite daaraan toe te ken. Daar is sekere gesondheidsprobleme, byvoorbeeld psigiatriese en gedragsafwykings, met 'n baie lae mortaliteit maar hoë morbiditeit. 'n Ander belangrike komponent is om te bepaal of die frekwensie van sekere siektes toeneem, staties bly of afneem aangesien dit sal bepaal of verdere navorsing nodig is of nie.

Verskillende databronne word vir navorsing gebruik, soos mortaliteit, uitgesoekte aanmeldbare siektes, spesiale registers, hospitaalgebaseerde studies en opnames. Volgens die MNR is data oor infeksie- en parasitêre siektes, neoplasmas, hartvatsiektes, respiratoriese siektes, swangerskapsverwante toestande, perinatale en kongenitale afwykings, en trauma geredelik beskikbaar. Areas waarin daar onvoldoende navorsing uitgevoer is, is geestes- en gedragsafwykings, senuweesisteme- en velsiektes, terwyl basiese inligting ten opsigte van voeding, veral wanvoeding en vitamien A-, jodium- en ystertekorte, nog nie op 'n nasionale basis bestudeer is nie.

Een van die knellendste tekortkomings in hierdie tipe epidemiologiese navorsing is die gebrek aan geloofwaardige inligting wat uiters noodsaaklik is om navorsingsprioriteite en befondsing te bepaal.

Met betrekking tot intervensienavorsing is dit beter om hoër vlakke van voorkoming eerder as om laer vlakke van behandeling daar te stel. Met ander woorde, die fokus was tot nou toe gerig op die verlaging van die voorkoms van byvoorbeeld tuberkulose en diaree deur vroeë behandeling eerder as op voorkoming. Min navorsing oor primêre en sekondêre intervensieprogramme vir toestande van die oë, ore en muskulo-skeletale stelsel, soos osteo-artrose, is al gedoen, maar werk wat fokus op tersiêre intervensie en rehabilitasie is alreeds ver gevorder. Die MNR is ook van mening

dat die kundigheid om primêre voorkomende strategieë te definieer, te ontwerp en te implementeer in Suid-Afrika nog nie ver genoeg ontwikkel is nie.

Gesondheidssteeมนavorsing behels navorsing van die bestuur van gesondheidsisteme, met ander woorde bestudering van die impak van die bestuurs, institusionele, ekonomiese en maatskaplike dimensies van gesondheidsorg met die primêre doel om effektiwiteit te verseker. Die hoofstimulus vir gesondheidsorgsisteeมนavorsing is gebore uit die gebrek aan bestaande inligting oor gesondheidsorgsisteme. Die inligting wat wel beskikbaar is, word beskryf as onakkuraat, onbetroubaar, niegestandaardiseer, onvolledig, te laat, nievertegenwoordigend, swak geanaliseer en geïnterpreteer.

Gesondheidsorgsisteeมนavorsing behels veral die volgende 5 areas:

1. Roetine-inligting: dit is inligting wat op 'n deurlopende basis deur veral primêre-sorg werkers ingesamel en veral vir die montering van hulpbronne, pasiëntlading en personeelprestasie aangewend word.
2. Basislyn-demografie: word benodig op plaaslike, streeks- en nasionale vlak om dienste te beplan en die effektiwiteit van aktiwiteite te beoordeel. Dit sluit die volgende in: geboortes, sterftes, bevolking volgens ouderdom, geografiese area en migrasiepatrone, en behuising.
3. Pasiëntbehoefte en -gedrag: navorsing op hierdie gebied sentreer op drie gebiede, naamlik die verspreiding van gesondheidsprobleme in 'n spesifieke area, ook bekend as 'n gemeenskapsdiagnose, die hindernisse vir effektiewe gebruik van dienste deur verbruikers en hoe dit oorkom kan word, en die optimale gebruik van gesondheidshulpbronne beskikbaar in die gemeenskap.
4. Hulpbrontoedeling en aanwending: navorsing op hierdie gebied is veral gerig op menslike hulpbronne, fasiliteite, toerusting en finansiering van dienste.
5. Kuratiewe en voorkomende programme: navorsing op hierdie gebied behels hoofsaaklik gesondheidsvoorligting en bevordering, maar ook die beoordeling en ontwikkeling van nuwe intervensieprogramme ten opsigte van 'n aantal

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gesondheidsprobleme asook die beoordeling van sekere intervensieprogramme wat alreeds bestaan.

Daar is ook 'n aantal spesifieke vraagstukke wat rondom bevolkings eerder as gesondheidsprobleme of sisteme ontstaan en wat nagevors behoort te word: stedelik of voorstedelik, plakkerskampe, landelik, vrouens, die jeug of adollesent, die bejaardes, werkers en gestremdes. Hierdie groepe is belangrik omdat hulle kwesbaar is en dus meer van gesondheidsdienste gebruik maak.

4. Kan die Huisarts 'n Rol hierin Speel?

Ek is oortuig daarvan dat die huisarts 'n baie belangrike rol in essensiële gesondheidsnavorsing kan en moet speel omdat die huisarts in die unieke posisie van die raakvlak tussen die gemeenskap en die gesondheidsorgsisteme as hekwagter sit.

Wat benodig die huisarts om hierdie rol suksesvol te kan vervul?

Eerstens, toewyding aan die pasiënt as mens binne die konteks van die gesin en die gemeenskap.

Tweedens, 'n sensitiwiteit vir die totale spektrum gesondheidsprobleme wat in die gemeenskap wat bedien word, voorkom. Die huisarts mag homself nie distansieer van die gemeenskap waarin hy of sy werksaam is nie.

Derdens, voldoende kennis en vaardighede aangaande epidemiologie.

Vierdens, 'n kritiese denkvermoë om bestaande programme en sisteme te evalueer en nuwe metodes daar te stel indien nodig.

Vyfdens, voortdurende selfbeoordeling. Die huisarts moet homself gedurig afvra of dit wat hy doen nie beter gedoen kan word nie en of die resultate wat behaal word, die beste is ten opsigte van tyd en geld. Koste-effektiwiteit moet die wagwoord wees.

5. Samevatting

Essensiële gesondheidsnavorsing bied aan die huisarts die geleentheid om 'n belangrike rol in die

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gesondheidsorgsisteem van ons land te speel. Ons moet bewus wees van die vereistes wat gestel word en ons moet deel daarvan word sodat ons ons plek as 'n onmisbare lid van die die gesondheidsplan kan verseker.

Ek sluit graag af met 'n aanhaling uit 'n artikel van Prof Cronje, Hoof van die Departement Obstetrie en Ginekologie aan die Universiteit van die Oranje Vrystaat wat in die Augustus-uitgawe van VMO verskyn het:

"Navorsing is direk op ontwikkeling gerig. Onlangs het ek 'n kollega hoor sê: 'Wat is die nut van navorsing? Ons soek nie akademiese hoogdrawendes nie, maar praktiese en goed gebalanseerde klinici.' Dit laat my dink aan 'n uitspraak van professor Howard Jones van die VSA, 'n groot naam in Obstetrie en Ginekologie: 'Ek het nog nooit 'n departement of eenheid sien doodloop wat navorsing doen nie. Dié wat ek wel sien kwyn en wegsterf het, was almal gevalle waar daar nie navorsing gedoen is nie.' Navorsing is skeppend, dit vereis kreatiewe denke en is die fontein van ontwikkeling. Van die beste klinici wat ek al gesien het, was uitstekende navorsers."

Mag dit ook waar word van die huisartse van ons land!

The Family Physician and Essential National Health Research (ENHR)

Prof RJE Erasmus, Department of Family Medicine, University of Pretoria

Although research is a word that creates anxiety with most practising doctors, the process of research is, in fact, familiar to most doctors and it has an immediate application in practice (medical) audit.

Essential National Health Research (ENHR) is defined as a process of improving the health status of especially the disadvantaged communities through intersectoral collaboration and priority driven research. The main areas to be targeted are health problems, etiology, intervention, management and health systems. Epidemiologic data about

mental and behavioural problems, nervous system and skin problems as well as nutritional problems are still severely lacking. Intervention research should, in future, be aimed at primary, as opposed to secondary, prevention, and the development of primary prevention strategies needs to be developed in the RSA. Health systems research should be developed around: routine information, baseline demography, patient needs and behaviour, resource allocation and utilisation and curative preventative programs. The Family Physician has to play an essential role in ENHR, because they are at the cutting edge of the health system and the closest to the community. The essential skills needed are:

1. dedication to the patient as human being within the context of the family and the community;
2. sensitivity to the whole spectrum of health problems of the served community;
3. epidemiologic knowledge and skills;
4. a critical intellect to evaluate existing and new methods of health systems;
5. ongoing self-appraisal with special emphasis on cost-effectiveness.

Antimony tartrate Lesions in Factory Workers on a Boland Town – A Case Series Study

Dr Japie le Roux (Worcester), Department of Family Medicine and Primary Care, University of Stellenbosch

At a new antimony tartrate pesticide factory in a country district town a workers' force with dermatological lesions was identified. A descriptive case series study of the workers' milieu together with their occupational disease profile was done.

On site inspection examinations and exposure controls were done at the factory. Although the authorities were satisfied by the exposure threshold limit values (TLV) control, the workers still had 100% incidence of some health impairment, especially skin and mucous membrane lesions. For

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TLV of antimony to be reconsidered as zero risk seems only possible at zero exposure. Results of examinations of 13 workers done over a two week period is described with specific reference to clinical, pathological and histological description of the skin lesions. Histology showed stages of necrotic ulceration due to direct toxic effect.

The study also proves that by applying some basic principles of Family Medicine, (that a patient is not only an individual but part of the whole population at risk), the family physician can solve industrial occupational health problems successfully.

A Prospective Study in a Semi-Urban Practice of the General Practitioner's Role in Motivating Volunteer Overweight Patients to Comply with a Weight Reduction Programme Through Lifestyle Changes

Dr Piet du Toit (Kraaifontein), Department of Family Medicine and Primary Care, University of Stellenbosch

Obesity is a big problem, globally and locally. We weighed 316 adults and measured for height to determine their BMI with the assistance of the researcher's partners in a semi-urban practice. There were 201 females and 115 males aged from 18 to 65 years in this survey during October 1993. A total of 68% of the males were overweight (BMI 25 to 30) and obese (BMI>30). Of the females 62% were overweight and obese.

Obesity seemed to be rife in this practice and the incidence is in accordance with findings of surveys done in the UK, USA and the CORIS study in the RSA. Fifty one (51) patients were enrolled and followed-up over a period ranging from 3 to 31 weeks. 50% of the patients were followed up for at least 20 weeks. In this voluntary prospective study, overweight and obese patients were identified during a consultation for any complaint.

The study was briefly explained to them and if interested, they were given an appointment for a full medical examination. A target mass was set by



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deducting 15% of the starting weight and a goal of half a kilogram of weight loss per week was set. The patients received handouts (compiled by the author) aimed at educating them in various aspects of a healthy lifestyle. It was attempted to gradually change lifestyle by giving information and support.

No anorectic drugs were used although their place in the treatment of obesity is not denied. During this period of 31 weeks, 34 of the 45 patients analysed for statistical purposes (all females) lost weight ranging from 0,5kg to 11,5kg. Three (3) patients remained static and eight (8) patients gained weight ranging from 1kg to 4,7kg. The mean age of the women ranged from 20 to 56 years with an average age of 39 years.

It seems as if the general practitioner as health manager can play a role in managing obesity more effectively thus preventing serious morbidity later in the life of obese patients. There should be a plan of action when the obese patient walks through the door of the surgery. This plan should be aimed at educating the patient to eat correctly, generally to live a more active lifestyle, to pay special attention to behavior modification and to stay motivated in order not to revert back to those habits that caused the problem.

Medical Management of Radiation Accidents – A Model Adapted for Use by Medical Practitioners

*Dr Charles de Leeuw (Eskom – Koeberg),
Department of Family Medicine and Primary Care,
University of Stellenbosch*

The management of radiation accidents is generally believed to be outside the scope of general practice. In developing an emergency medical plan for Koeberg Nuclear Power Station many accidents were studied. Literature clearly shows that radiation accidents happen most frequently outside that of the well regulated Nuclear Power Industry and thus falls into the field of general practice.

There is a perceived increased risk for these accidents due to the progressive use of radiation sources in medical, food and other industries,

despite (an often inadequate) regulatory control. This is very true for most developing countries where the most and more severe accidents have happened.

A pro-active response to this would be an increased awareness of the clinical identities of radiation related conditions and a simple systematic approach toward the detection and management thereof.

To achieve the above, general practitioners are presented with an introduction to radiation physics, biological effects of radiation and the medical management model in a single session. The presentation and the model's acceptability and applicability is also evaluated.

The model is a step by step approach to the basic three types of radiation accident problems, namely:

- (i) over exposure which may be localised radiation burns or generalised eg acute radiation syndrome;
- (ii) contamination with radio isotopes both externally (on the skin) or internally;
- (iii) conventional trauma or illness in a radiation workplace. Any combination may occur in up to 65% of accidents.



Oorhandiging: Juta-prys vir beste referaat. Links: Dr Rodney Butlers van King Williams Town. Regs: Prof Pierre de Villiers, Hoof: Departement Huisartskunde, Stellenbosch

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The management steps include specific questioning to the radiation accident history, performing triage, initial treatment and decision making eg where to transfer and how to transport; specific treatment and longterm follow up.

Empiric rules and indicators for the medical management are given and support structures are identified eg Metro paramedics trained in radiation accidents and Tygerberg Hospital Radiation Casualty Facility.

The general practitioner can play an extremely important role in guiding patient and family through the psychological trauma and uncertainty of radiation accidents as well as long term follow up, but more important is that we can prevent a major disaster by the early correct management of a possible radiation accident.

A Study about Sick-Leave Patterns of Workers at a Sawmill in the Tsitsikamma-Region with Comparisons Between Hostel Dwellers and House Owners, with Special Reference to the Role of Alcohol

Dr André Louw (Kareedouw), Department of Family Medicine and Primary Care, University of Stellenbosch

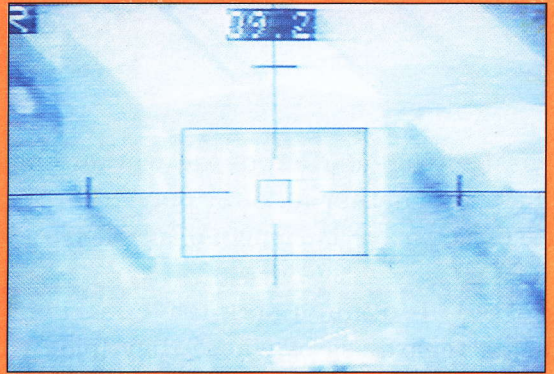
Objective – To detect tendencies and causes of abnormal sick leave patterns at a sawmill and to formulate solutions for problems identified.

Design – A prospective study of all sick certificates received at the personnel offices of a sawmill during the study period, comparing the certificates as to living quarters of the worker, day of sickness incident, diagnoses and whether alcohol played a roll in the cause of sick-leave.

Subjects – 683 workers at the Boskor Sawmill of whom 535 stay in single quarters on the premises and 148 in their own homes in the area.

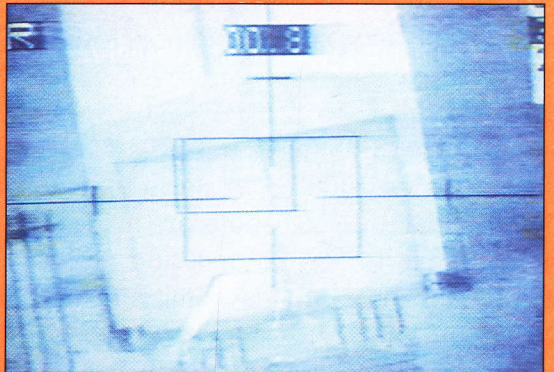
Main outcome measures – Identifying problem areas with patterns of sick-leave with respect to day

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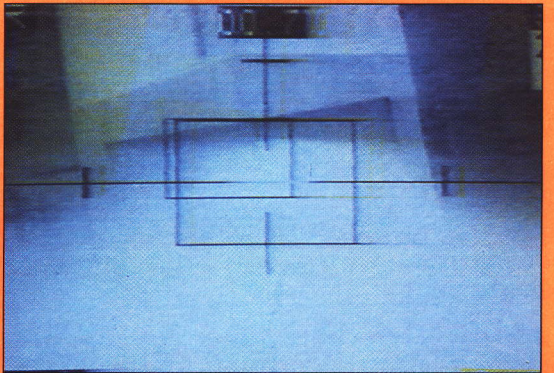
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of onset, living quarters of the workers involved, diagnoses, whether alcohol played a roll in the cause of sick-leave and length of sick-leave given.

Results – Too much sick-leave is given to all subjects regardless of where they live. Alcohol plays a major role in causing sick-leave in all workers, especially on Mondays after paydays. Mondays are a huge problem day with most incidents of sick-leave certificates. Certain diagnostic groups are identified as causes for sick-leave which may reflect on working or living conditions.

Conclusion – Sick-leave patterns at the sawmill reflect a lax attitude of workers to their duty of being productive. Suggestions are made for curbing sick-leave due to alcohol use and also to reduce sick-leave taken on Mondays and after paydays. A more open approach to the problem of curbing unnecessary sick-leave is advocated, involving management, the workers, the doctors and the industrial nurse.

Community-Based Education for Health Personnel: The Development of a Model for the Medical Faculty of the University of Stellenbosch

Dr Marietjie de Villiers, Department of Family Medicine and Primary Care, University of Stellenbosch

Community-based education for health personnel forms an important part of the International Collaborative Programme for Reorientation of Medical Education (ICP). This strategy was designed by the World Summit on Medical Education in August 1993 to generate and facilitate change in medical education on a global basis. Through the Bishop Lavis Primary Health Care Project, the medical faculty of the University of Stellenbosch has progressed some way in achieving these reforms. The aims of the project include, amongst others, the establishment of a comprehensive and integrated primary care health service, providing community-based education to a variety of health personnel and to obtain and

maintain maximum community involvement through all the stages of the project. The process of development of the project is a dynamic ongoing process and different stages are described. Students of six courses do training at the Bishop Lavis Community Health Centre and the content of the training as well as the opinions of the students are discussed. Finally, a future strategy to address the ICP as a whole is proposed and this includes a community-oriented medical education approach, a move towards integrated multiprofessional training, the development of curriculum strategies and a major drive towards health education of the community.

Student Feedback on a Primary Health Care Input

Dr David Whittaker, Unit of Family Practice/Primary Care, University of Cape Town, Medical School, Observatory

Aim: To identify points of students' dissatisfaction with a six lecture Primary Health Care input into a first year course in Human Biology.

Method: At the end of a six lecture input intended to introduce first year students in the biomedical sciences at the University of Cape Town to the principles underlying the ANC health plan, two hundred and fifty-three medical, occupational therapy and physiotherapy students taking Human Biology in 1994 were invited to complete an anonymous eight question Likert-scale questionnaire designed to assess the lecturer's effectiveness in communicating this subject to the class. The findings from the one hundred and sixteen (116) completed questionnaires were hand tallied and the percentage responses determined. The ratio of satisfied to dissatisfied students was then calculated for each question.

Results: Students were:

1. not satisfied that the lecturer had presented the material clearly and logically; and adequately covered the ground;
2. just satisfied that the lecturer had made his material intelligible, meaningful;
3. satisfied that the lecturer showed an expert

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knowledge of his subject matter; adopted an appropriate pace in the lectures; maintained continuity in the course; enabled them to understand the basic principles of the subject; and could be heard.

Conclusions: Structured feedback can help lecturers to identify the weak points in a brief series of lectures.

The Current Status of Post-Graduate Training for Family Physicians in the Republic of South Africa

Dr Ahmed Moosa (Elsiesrivier), Department of Family Medicine and Primary Care, University of Stellenbosch

A selective literature study was undertaken to determine the status of vocational training for family practitioners in South Africa. International developments in family medicine were identified and the growth of the discipline traced. The objectives of vocational training were examined and against this background the various VT programmes were outlined. The various University-based MFamMed courses were reviewed along historical lines, their courses were examined for content, objectives and structure and assessment procedures.

It was found that the course objectives were very similar but that the courses had a different philosophical emphasis.

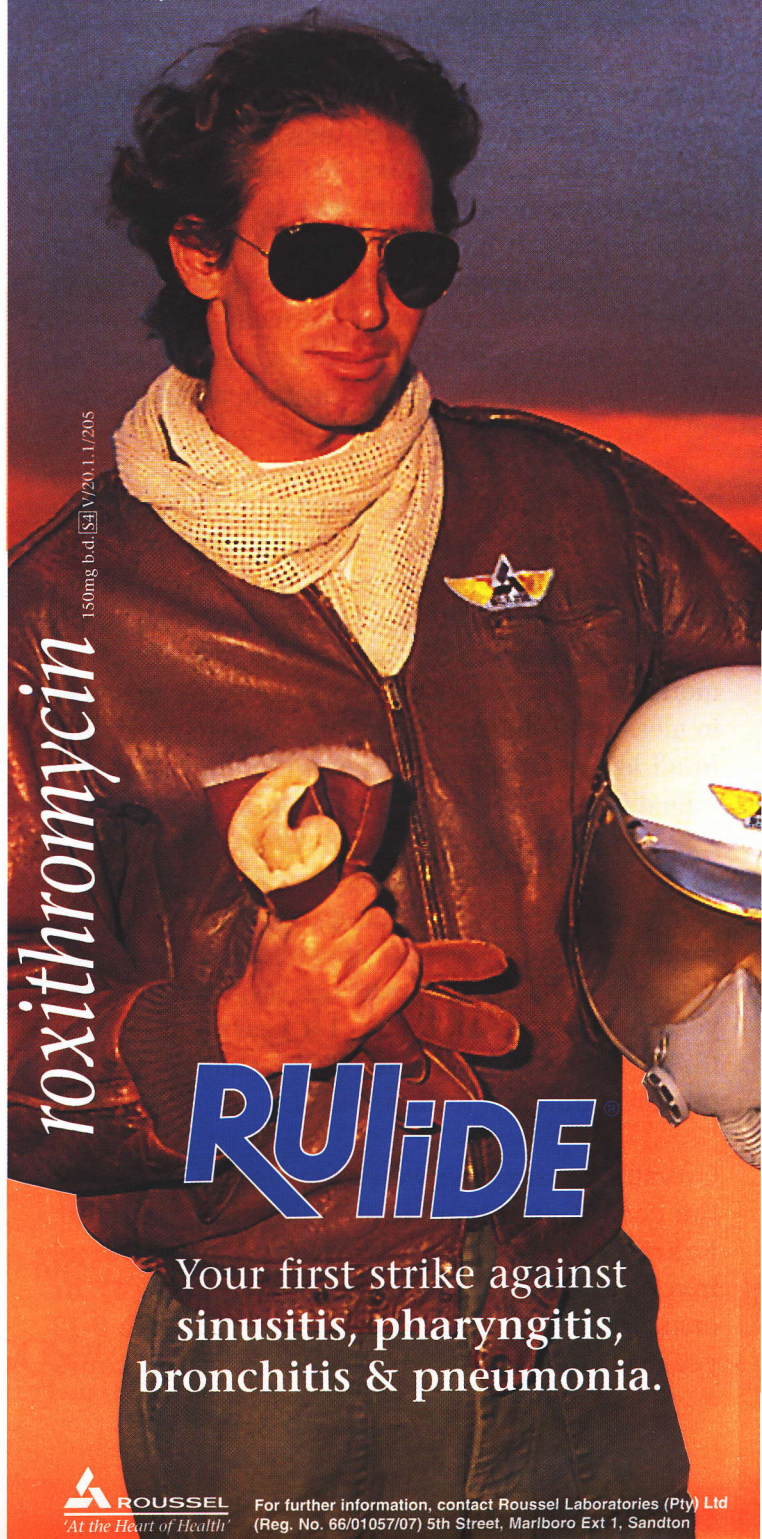
Courses at some universities are well established and are backed by strong and visible departments of Family Medicine.

Vocational training is also offered by the South Africa Academy of Family Practice in three regions in the country.

The role of the MFGP(SA) examination in its present status is questioned and suggestions made. Recommendations have been proposed to standardise training, examination and courses. It is lamented that UCT is lagging behind the rest of

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Research Day Proceedings

South Africa and the world in not establishing a full department of Family Medicine.

Feverish Children Presenting to a General Practitioner in King William's Town – A Descriptive Study of the Presenting Features, The Diagnosis Made and the Management of these children

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This descriptive study looks at 166 children under 13 years who are feverish when they presented to their general practitioner in King William's Town over a one year period. The aim was to see if parents' actions are appropriate with respect to measuring temperatures, timing of presentation and methods to reduce temperature, what the main causes were; and the outcome of these cases with emphasis on special investigations, hospitalisation, and specialist referral.

The results showed that only 48 (29%) parents measured the temperature; 120 (72%) had given oral medication and 25 (15%) had used another method to reduce temperature. There was not much difference in these in the age groups. Working mothers and lower social class parents fared worse in measuring and attempting to reduce temperature. In all age groups 72% present within one day with little difference in the various groups.

Respiratory tract infections were the commonest diagnosis made (82%) in all groups, with tonsillitis the commonest overall diagnosis (25%). The commonest diagnosis in the age groups were: 0-1 years – otitis media (36%), 1-4 years – tonsillitis (37%), 5-8 years – bronchitis (26%), and 9-12 years – other respiratory infections (43%).

Overall 15 cases (9%) were complicated. This was the case if one or more of following occurred: Febrile seizure (2), hospitalised (6), special investigations (7), specialist referral (4) or considered unwell at examination (12). No 9-12 year old child was complicated. After hours

consultations (26) were similar in most aspects to normal hours' consultation.

The conclusions made are that 9-12 year olds can be encouraged to wait longer before consultation, in most cases unless another emergency is present after hours consultations can wait for the morning; thermometer usage can be increased by training and using a digital thermometer; non-medication measures must be taught and encouraged; teaching must include all, but especially child minders and lower social classes.

The reality of the situation in this practice is different from what is taught at hospitals with respect to antibiotic usage and some investigations, and that fever in a child is a problem which has many unanswered questions and causes considerable, but probably unnecessary, anxiety.