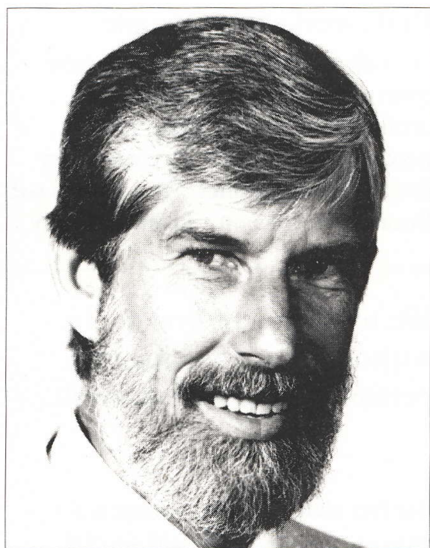
FEATURE ARTICLE

The Person in Comprehensive Primary Health Care — Prof GS Fehrsen



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Curriculum Vitae

Prof Sam Fehrsen is Head of the Department of Family Practice and Vice-Chairman of the SA Academy of Family Practice. He is a graduate of the University of Cape Town and worked in mission hospitals in the Transkei for ten years and the Student Health Service at the University of Pretoria before taking up his present post in 1977. He is President of the Transkei and Ciskei Research Society and has a strong interest in medical missions. Prof Fehrsen has publications to his credit on subjects ranging from healing to nutrition, tuberculosis and the requirements for training in Family Medicine.

Summary

The emphasis in medicine is slowly moving away from focussing on disease, to focussing on the patient as a person. Then, there is also the importance of community in PHC: a newfound excitement; and rightly so if the person of the patient is not neglected. By focussing on the community to the exclusion of the person, we are repeating the same false notes just in another key. The patient is a unique person, but so is the health care worker, and our teaching institutions need to create, for the student, the possibility to develop as a person. Three recent research findings are referred to: that the person-centred approach in PHC does make a positive difference; that unthought of connections (between mind, the hormonal and immune systems), in the patient have an influence on his own health (or disease); and that, thirdly, the placebo responses show how important the person of the doctor is in the whole healing process. Thus, the successful PHC worker needs to be trained as a caring person who enters a relationship with the patient as a unique person.

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KEYWORDS:
Primary Health Care;
Physician-Patient Relations;
Individuality.

In the field of primary health care today it is necessary to remind people of the importance of community; in other quarters it is necessary to remind health workers of the person.

In the past, medicine has concentrated on disease in a very individualistic way. Socialist theory has been a valuable corrective to this narrow focussed attention on the individual. My fear is that our newfound excitement in finding the importance of community, of socio-political determinants of health care, will just become a repetition of the same false notes, just in another key.

My concern is that previously, by not focussing on the individual but mostly on disease, we neglected the person. We are now in danger of repeating the same mistake by focussing on the group to the exclusion of the person.

The person will always remain important. More specifically the person is important for Comprehensive Primary Health Care (CPHC). When Mr Joe Marks told a Kelloggs Workshop in Gordon's Bay how the Steenberg community felt about health workers and health care, what did he do? He told us what individual people had said to him. He talked about the gangster who was badly sewn-up without local anaesthetic. He talked about a particular child from the community that was sent for training at a university, who returned looking down her nose at ordinary people and spoke in a strange accent. He spoke about individuals who came to

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'do good' but who were too scared to stay and help.

A community is a living organism. But it is difficult to say exactly what a community is, to define it. Most

> What a person feels and thinks has an important influence on health and disease

people have, however, had real experiences of being in community: when we experienced caring in a group; when we experienced oppression and hardship together; when we were joyful or worshipping together.

PHC workers work with people

A person is a more tangible reality to us and most of our interactions in PHC are with an individual, with a person.

A person gets sick, gets pneumonia, becomes anxious, becomes depressed or gets hypertension. A person feels nauseous, has a headache or feels dizzy – the things most health workers call minor ailments. To deal with them is a menial task. There are no minor ailments if you value persons. Minor ailments are only possible if your concern is disease.

It is also so if your concern is health, infant mortality and longevity. Then too, the person gets trivialised and ignored.

It is the person who gets looked down upon by health workers. A person gets shouted at. A person waits in a queue. A particular person gets told that he came on the wrong day after waiting hours to get to the front of the line. It is a person that does not get listened to in the consulting room

A person gets asked a multitude of questions we health workers call "systematic interrogation", until patients admit to, or deny, various things about themselves so that we can make a diagnosis.

We health workers put people in the witness box and make them feel guilty for coming for help.

We then go on to tell an individual
- what operations to have
- what medicine to take
- how to live without even knowing that person's name and address.

We tell her to do things that are impossible for her!
A person mourns.
A person gets drunk.
A person is loving or violent.

What am I saying? I'm saying, PHC

> A danger of excluding the person by focussing on the group

workers who practice in this way make a mess of their work because they ignore the person and focus on diseases, on ideologies, or statistics and on their own selfish needs.

PHC workers are people

We talk a lot about the health care team approach and of multi-professional teams. They are necessary. However, I've seen very few functioning ones. Why is this so? Because we have not taken seriously

> We tell a patient how to live without even knowing that person's name and address!

the fact that a health worker is a person. I've heard it said several times that it does not matter how objectional the moral behaviour of an applicant is: as long as he knows his job, and can do his job, he should be appointed even to become head of a teaching department in the medical school! After all, we are striving for excellence!

We can only ignore the person as patient, and the person as health worker, to our own peril. Most of the good in life (or in health care), comes from persons who have risked to act as people towards other people to bring healing and create community.

One person listens to another so that he is deeply heard and sheds a tear of gratitude.

It is a fearless person, who cares enough to step between warring factions, that stops violence. It is only a strong person who gives up his power and in meekness serves another so that they can be strengthened.

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It is the person of the health worker that allows another person to leave his/her presence, feeling better, feeling more human.

Research pointers

1. Patient-centredness or Person-centredness
Studies into the influence of patient centredness are showing that understanding the person, makes a difference:[1,2,3]
- people feel more understood

The health worker is also a person

- people feel less concern
- people are more relieved of their symptoms
- people get better

if they have experienced a more person-centred approach. This even happens when interpreters are used, and does not even take more time than the conventional medical approach.

2. Psycho-neuro-immunology
Studies are showing some previously unthought of connections between the mind, the hormonal and the immune systems.[4]

These systems of the mind, of immunity and the hormones each have their own memory and act simultaneously to the same thing and not necessarily one after the other in a chain of events. This might be a reaction to another person, to a particular food or a drug. And this demonstrates the inherent unity of the person, and that what a person feels and thinks has an important influence on health and disease.

3. Placebo-response
Another research area that shows how important the person is, is that of the placebo response. On average about 30% of patients get better from most diseases when taking placebos.[5] In experiments with peptic ulcers, the placebo response has been recorded from as low as 8% to as high as 83% in producing a proven cure of the ulcers.

I believe this means two things:

Firstly, that disease has no life of its own, separate from the person. Diseases are not merely things you can cut out, or cure with a magic bullet, or prevent by supplying enough food. The things that are said to cause illness and disease, whether

Health workers should become more user-friendly

they are germs, food allergies or psychosocial causes, are taken up and transformed by the person and the person as a whole functioning human being will determine if illness will follow; or growth and health.

Secondly, research is telling us that not only is the person of the patient important, but so too is the person of the health worker important. The person of the doctor has much to do with the difference between the 8% and the 83%. The relationship between patient and health worker is a major determinant in a further field of study which we health workers call, arrogantly, compliance studies.

There are no minor ailments if you value the person

My understanding of the research results is that people lie to us and don't swallow our medicines because we don't deal with them and listen to them as unique persons.

A Holistic or Systems Approach

Smuts[6] coined the word holism. He said that:
- in any holon, the whole is more than the sum of its parts.
- at that each holon has autonomy and a creative ability, thus a healing or corrective potential.

A living cell is such a holon. So, too, is a bodily organ like the liver.
A person is a holon.
A family is a holon.
So too is a community a holon; and a nation; and ultimately also the universe is a holon.

In CPHC we are seeking a democratic approach; a partnership approach with communities. Many are looking to change medical education to the extent that health workers will become more "user friendly" to communities. My concern is that we are coming from a medical tradition that has ignored the person and is equally likely to go into

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a community approach where we are concerned (and rightly so) with community structures, *but* where we are likely to fail again, because we are again ignoring the person.

The correct concern for the individual as a person is absolutely vital. After all, we deal with communities of people. You can't be democratic with the community and continue with undemocratic medical processes in our medical contacts with individuals. We cannot get to the community except through persons.

> Caring is in itself a healing thing

Leaders in the family medicine movement are showing how the person and interpersonal relationships are also important in health, especially in those matters where personal choices are possible in health promotion. The person is also important in healing, in the efficacy of treatment, in the ability to come to a diagnosis; and much more. We need to give attention to diseases, cells, organs, persons and communities as systems within systems, to succeed.

Caring

The last word in CPHC is care. Medicines are said *to cure* but never are they said *to care.* Alma Ata says very little about caring. Perhaps it will be good to realise that, next to God and animals, only people can care.

If we, as PHC workers don't care, we act mechanically. But people are not machines.

Dehumanised people use health workers, even abuse them. They lie when asked about their symptoms and habits. They do not comply with treatment and they exploit the system for their own benefit, especially if the health workers and the community leaders are lining their own pockets.

Caring costs something and is in itself a healing thing. With our medical or health expertise we keep a safe distance and forget that ultimately, cure (or improved health indicators) without care is more harmful than helpful. It is as dehumanising as a "gift given with a cold heart".

PHC is also where the buck stops. Unlike what many people say in tertiary care centres, there are many for whom the last refuge is in PHC. If this last refuge is uncaring, it's the final isolation, the final rejection, and hell for them! If the people who are sent back from the referral centres with the verdict, "there is nothing more that can be done", come home to a caring refuge, they can hope again. The patient dying from cancer can die with adequate pain and symptom relief, with having addressed his concerns and reconciled himself to family and friends, and hopefully to God.

> Cure, without care, is more harmful than helpful

Traditional healers in our communities are often consulted to find the meaning of their illness, the meaning of their suffering. If we in PHC do not address the question of meaning, where science and spirituality converge, we will fail people. A person without meaning in his or her life, drifts into alienation and may opt for violence.[7]

> Is their presence a healing presence?

Caring and labelling

There are those persons dumped in the community with derogatory labels as cripples, paraplegics, burnt-out psychotics. We are the appropriate people as PHC workers, to care for them. When the AIDS epidemic really becomes visible, people will have to be cared for at home.

We in PHC, the churches, and other groups will have to care for them in the community and to a large extent, out of our own resources.

In Conclusion

We need to think about the education of health workers as persons. I think it is our task to evaluate our institutions in relation to this; we need to ask: is there a

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possibility in this institution for the patient and the student to be recognised, and to develop as a caring person?

Our teaching needs to unlock the potential for caring in health workers. "If that gift, the gift of caring, would be set free and made available, miracles could take place", says Henri Nouwen.[8] We must, in our programmes learn to train health workers of whom the community will say, "When they listen, they listen to

Teaching needs to unlock the potential for caring in the health worker

you. When they speak, you know they speak to you. And when they ask questions, you know it is for your sake and not for their own. Their presence is a healing presence, because they accept you on your terms and they encourage you to take your own life seriously".[8]

We can then together become a community of people not trying to cover pain, but a community of partners sharing the pain as a starting point for healing.

In this time where medical education is being seriously re-evaluated, it is important to understand that the context in which we learn is very important. That is why we should be community-based. This will not necessarily work as well as we hope if we are not at the same time person-based, or person-centred in our work and learning.

We need to go radically further with both the community and the person. In CPHC we as health workers need to become integrated into a community of persons as opposed to the community being numbers in the CPHC system.

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