SA DECLARATION

The Role of the Docter in Primary Health Care: Declaration

Preamble: A group of doctors concerned with Primary Health Care (general practitioners, family practitioners and primary health care doctors) held a meeting in Johannesburg on 16 and 17 February 1990.

After a follow-up meeting held on 21 May 1990 the group wishes to make the following strong statement about and commitment to the role of the doctor in primary health care (PHC)*.

The group recognizes:

1. the Alma Ata declaration on PHC as a basis for future PHC services and endorses its emphasis on equity accessibility and affordability;
2. that equity in all socio-economic areas of community life outside of medicine are important to good health;
3. that there are areas in South Africa where the health status as reflected by the commonly used indicators is below acceptable standards;
4. that there are sections of our population for whom health services are not readily accessible;
5. a challenge of PHC is to empower individuals and communities to become involved in health;
6. the contribution towards "Health for All" achieved by well organized PHC programmes in the past decade;
7. that the Department of National Health and Population Development has committed itself very strongly towards a sound PHC policy as its first priority for health, seeking a political commitment and entrenchment of the funding thereof;
8. that approximately 10 000 doctors working in both the public and private sectors within the comprehensive PHC level is a significant medical manpower resource that should be optimally utilized.

*Note: The initiative for the workshops was taken by the SA Academy of Family Practice/Primary Care (Academy) and the National General Practitioners Group (NGPG). In addition: 'The Working Group on the Role of the Doctor in Primary Health Care' had representatives from The University departments of Family Medicine. NAMDA, the Faculty of General Practice of the College of Medicine of South Africa, the Medical Research Council, MASA and the Department of National Health and Population Development. The Declaration is a consensus document from the individuals who were at the workshops. Thus far it has been endorsed by the Academy and the NGPG. The meetings were generously sponsored by ICI Pharmaceuticals.

We declare that:

1. A unitary health system will be cheaper, more effective and receive a greater commitment from the medical profession and the population, to achieve equity and high standards in PHC. The group recognizes that in order to achieve the necessary political will, the reorganization of health services will be necessary.
2. We understand that the PHC Strategy of the Department of National Health and Population Development, based on a particular interpretation of the World Health Organization PHC Strategy, is a *programme* that focuses on a minimal, basic, cost effective component of the *comprehensive* PHC *level*.
3. PHC amongst other perspectives is a level of care and as such it encompasses the provision, of health care up to the level of the basic medical specialist. PHC thus includes the doctor and the community hospital. We distinguish between levels of care and levels of facilities — PHC being rendered in all levels of facilities, eg immunizations in tertiary institutions.
4. Generalist doctors should be an integral part of the organization of the PHC services.
5. The appropriately trained doctor is well placed to act as gatekeeper to prevent avoidable cost-generation in dealing with the main health problems of a community by injudicious management, investigation or referral to secondary and tertiary care levels.
6. The ideal PHC team should consist of appropriately trained doctors, nurses and village health workers. Other health workers should be included whenever possible.
7. Any PHC team with a doctor-to-population ratio of less than 1:20 000 is unacceptable. This means teams with a minimum of 1 doctor to 8 PHC nursing professionals and the rest of the health care team should operate in the first line as a unit responsible for a particular defined population.
8. Equitable deployment and effective functioning within PHC can be achieved by purposeful and appropriate community based vocational training of doctors, done in under provided areas, specifically in order to enhance redistribution of doctors to areas of need. This should preferably be co-ordinated with the training of PHC nurses and other health workers.
9. Vocational training of doctors needs to be built on adequate community-based undergraduate training in family medicine/primary health care departments at all South African medical schools, in close association with departments of community medicine and other applicable specialities.
10. With regard to the maldistribution of doctors, attention needs to be given to the selection of medical students.
11. The PHC doctor should be an appropriately trained clinician, manager, administrator and epidemiologist, with the ability and commitment towards in-service training and the maintenance of good health in the community under his care.

WONCA DECLARATION

The Role of the General Practitioner/Family Physician in Health Care Systems

A Statement from the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians.

What are the characteristics of those medical doctors who describe themselves as general practitioners/family physicians? How are they trained? What is their role in health care systems?

The answer to these and related questions are to be found in this WONCA Statement of *The Role of the General Practitioner/Family Physician in Health Care Systems.* It is the result of a process which began in 1983 with the creation of a WONCA Working Party on Defining the Fundamentals of General Practice/Family Medicine, in response to a suggestion of Professor Bent Guttorm Bentsen of Norway.

The eight members of the Working Party are:

Bent Guttorm Bentsen, Norway (*Chairman*)
Charles Bridges-Webb, Australia
Lynn Carmichael, USA
Julio Cerilin, Argentina
Richard Feinbloom, USA
David Metcalfe, United Kingdom
Ian McWhinney, Canada
Kumar Rajakumar, Malaysia

With input from various world authorities, they have created a Statement which not only accomplishes its original objective but, with the aim of encouraging the training of more general practitioners/family physicians, has also been expanded to include the role of the general practitioner/family physician in health care systems. Its value has been enhanced by the incorporation of the 1988 Edinburgh Declaration on Undergraduate Medical Education.

The document opens and closes with statements, both of which represent WONCA articles of faith:

"High quality primary health care depends on the availability of well trained general practitioners or family physicians as members of health care teams in the community. The discipline of general practice/family medicine needs to be firmly established as the central discipline of medicine around which medical and allied health disciplines are arranged to form a cooperative team for the benefit of the individual, the family and the community."

The concise, comprehensive and lucid final product will assist member organizations in their negotiations with international agencies or their own governments and medical educators.

The document challenges existing, as well as future practitioners with respect to self-assessment, quality assurance and continuing education. Nor is research, a somewhat neglected area of general practice/family medicine, overlooked. Established programmes of vocational training for general practitioners/family physicians may be evaluated against the recommendations found in this document.

Last year saw amazing changes in the social and political structure of many countries. A number of health care planners, medical educators and general practitioners where they existed, have exhibited an eagerness to learn more about general practice/family medicine concepts. It is timely that this document has appeared at this moment in history.

Authorities in many developing countries struggle with the problem of attempting to supply affordable, equitable and accessible health care to their citizens. The document provides them with a guide to the effective use of general practitioners/family physicians in their health care systems. Even the relationship with traditional healers is discussed.

This document may well become the gold standard against which future statements on the subject are gauged.

Some wondered whether it would be possible to create a statement which could be supported by over forty member organizations scattered around the world and working in a number of different health care systems. It is a tribute to the membership of the Working Party that they have succeeded in doing this. Present and future health care authorities, medical educators, practitioners and patients will remain in their debt.

Donald W Rae
President, WONCA

Summary Statement

High quality primary health care depends on the availability of well trained general practitioners or family physicians as members of health care teams in the community. To this end, ministries, departments of health and the World Health Organization should adopt policies that will increase the number of trained physicians in general/family practice. Such policies will involve placing greater emphasis on primary medical care in medical schools, creating better opportunities for postgraduate training and research in general/family practice, and providing greater incentives for new graduates to

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choose a career in general practice. Medical schools should make the teaching of primary medical care an integral part of the undergraduate curriculum and establish or support strong postgraduate programmes in general practice/family medicine.

With the aim of encouraging the training of more general practitioners/family physicians, this document outlines their role in the health care system and the knowledge, skills, and attitudes required.

Definition of the General Practitioner/Family Physician

The general practitioner or family physician is the physician who is primarily responsible for providing comprehensive health care to every individual seeking medical care, and arranging for other health personnel to provide services when necessary. The general practitioner/family physician functions as a generalist who accepts everyone seeking care whereas other health providers limit access to their services on the basis of age, sex and/or diagnosis.

The general practitioner/family physician cares for the individual in the context of the family, and the family in the context of the community, irrespective of race, religion, culture or social class. He is clinically competent to provide the greater part of their care after taking into account their cultural, socioeconomic and psychological background. In addition, he takes personal responsibility for providing comprehensive and continuing care for his patients.

The general practitioner/family physician exercises his/her professional role by providing care either directly or through the services of others according to the health needs and resources available within the community he/she serves.

The set of commitments which follow identify principles which the general practitioner/family physician may apply directly to patients or which may be applied through the network of care givers with whom he/she works.

Commitments made by the General Practitioner/Family Physician

1. To the community

Overall objectives

- To have knowledge of the epidemiology of the community being served.
- To have maximum influence on any health problem in the community.

A broad approach

- To identify the people who constitute the community and to decide whether there are any limitations he/she would place on his/her willingness to serve that community.
- To identify problems in the community that go beyond the problems of the individual seeking care and to approach those who lack care by case finding and/or health education.

Support in the community

- To understand health-related behaviours in the community and to support the community's own efforts to promote and safeguard the health of the population.
- To look upon the services provided by practitioners of alternative systems of medicine which are scientifically acceptable as an essential resource and to make the fullest possible use of these.
- To include in the care provided: prevention of illness, promotion of health, management of illness, and rehabilitation.

2. To the Individual

Comprehensive care

- To identify all the problems presented by the patient, including undifferentiated problems, early states of illness, acute problems, chronic diseases, psychosocial problems, and rehabilitation needs.
- To define what is needed to heal the patient in both biomedical and humanistic terms that is, physically, mentally and socially.
- To diagnose prevalent disease, to eliminate possible serious disease, and to co-ordinate other health services when needed.

Orientation to the patient

- To understand why the patient comes with a particular presenting problem at a particular time.
- To identify and respond to the patient's expectations of outcome for a given encounter.
- To understand how the particular presenting problem affects the particular patient.

Family focus

- To identify who is actually the

patient: the person who makes the contact and/or others relating to that person.

- To recognize that the impact of family factors on the patient's health should be taken into account when considering preventive and curative measures, and that these factors should be addressed if a resolution of the patient's problem is to be achieved.
- To recognize the impact of the patient's health problem on the family.

Doctor-patient relationship

- To consider the relationships between the physician and the patient and the physician and patient's family, as important aspects of health care.
- To understand how the physician's feelings about the patient affect the patient's problems and the way the physician responds to them.
- To recognize the autonomy of the patient/family in the provision of care, especially in the plan for management.

Specifications required to fulfil the Commitments

Comprehensive care

The relationship between doctor and patient transcends episodes of illness to include long-term care and rehabilitation as well as preventive care and health promotion.

The general practitioner/family physician is concerned with the ongoing welfare of the patient as well as the diagnosis and treatment of particular diseases.

Co-ordination with other services

The general practitioner/family physician assumes personal responsibility for making the multiple resources of the health care system available to the individual and family, overcoming any difficulties as necessary. This role is consistent with the participation of other health care workers who may be involved in providing direct care to the patient.

The services of the general practitioner/family physician must be formally integrated into the overall health care system, including working in an explicitly defined way with other primary (including indigenous) health care workers, with secondary and tertiary levels of health care, and with relevant community and governmental organizations.

Advocacy role

The general practitioner/family physician continues to serve as the advocate for the patient regardless of the level of care within the system which the patient requires. Such advocacy includes helping the patient and/or family to take an active part in the clinical decision-making process. The plan for management is negotiated with the patient with due regard to cost effectiveness.

Advocacy by the general practitioner/family physician also includes working with government and private authorities to maximize equitable distribution of services to all members of society.

Information base

The general practitioner/family physician should know personal as well as clinical details about the patient as these are equally valid for practice.

Doctor-patient relationship

The doctor-patient relationship depends on the development of trust between the general practitioner/family physician and the patient. (Other terms used to describe such trust are: 'covenant', 'pact', 'partnership', and 'mutual commitment'.)

Accessibility

The services of the general practitioner/family physician must be reasonably accessible and available to the patient and other health care workers at all times.

Resource management

By virtue of his strategic position within the health care system, the general practitioner/family physician plays a major management role in the allocation of scarce health resources.

Clinical decision making

General/family practice differs from other specialities in the following important respects:

1. The general practitioner/family physician often deals with undifferentiated clinical problems, ie problems that have not been previously assessed by a physician.
2. Even after full assessment, a significant proportion of problems cannot and do not need to be diagnosed in the usual sense of the term. Many clinical decisions have therefore to be made without a precise clinical diagnosis. Knowledge of the patient often

plays a big part in these decisions. Often the most important task is to eliminate the possibility of serious disease.

3. The prevalence of disease in a general practice is very different from its prevalence in the selected population of a hospital clinic or ward. Since the predictive value of clinical data varies with the prevalence of a disease in a given population, the same symptom, sign or test will have a different predictive value in general/family practice from that in hospital practice.
4. The general practitioner/family physician often sees disease in an early stage, before the full clinical picture has developed. Since the sensitivity and specificity of clinical data vary with the stages of a disease, tests which are valuable in general/family practice may be different from those which are useful in hospital-based practice.

In view of these considerations, the traditional pattern of diagnosis in terms of a precise statement of pathophysiology as a requirement for treatment is sometimes of doubtful validity. The general practitioner/family physician's duty to protect his/her patients from risk and to relieve suffering will often mean that action must be taken before a pathophysiological diagnosis is established, or as part of the process of establishing that diagnosis. To this end, management decisions are made on the basis of probability and investigations used with due regard to their sensitivity and specificity. The passage of time and the therapeutic trial are also considered valid bases for arriving at diagnoses. The plan of action will be negotiated with the patient and his or her family, with an honest presentation of probabilities and possibilities so that they may make an informed choice.

Other disciplines relevant to general practice

In addition to knowing about the technical aspects of medicine, the general practitioner/family physician must learn about the applied aspects of epidemiology, behavioural science, environmental health, and basic health economics that are relevant to general/family practice.

Needs for Education and Research

Medical education

The traditional pattern of medical education has reached a critical point because of factors such as the rate at which medical knowledge has been increasing, the unwillingness of academics to be selective about what they teach, and over-reliance on the lecture format and student examinations which emphasize mainly factual, very specialized knowledge. With respect to clinical medicine, undergraduates are still taught largely on inanimate learning materials or bed-confined, undressed, non-autonomous hospital patients. Such patients are increasingly less representative of the morbidity in the population as a whole. The rising cost of hospitalization, combined with the expansion of technologies, has made it necessary to reassess the process of medical care. For all these reasons the new graduate with a traditional medical education is poorly fitted for the tasks of general/family practice.

Undergraduate education

The World Federation for Medical Education has stressed the need for radical reforms in its recommendations regarding undergraduate education, which are paraphrased below.

Those with responsibility for planning medical education should aim to:

1. Enlarge the range of settings in which educational programmes are conducted to include all health resources of the community, not hospitals alone.
2. Ensure that curriculum content reflects national health priorities and resources.
3. Promote the skills needed for continued learning throughout life by shifting emphasis from a passive approach to education to more active modes of learning, including self-directed and independent study as well as tutorials.
4. Build both curriculum and examination systems to ensure the achievement of professional competence based on social values, not merely the retention and recall of information.
5. Train teachers as educators, not solely as experts in bodies of knowledge, and reward educational excellence as fully as excellence in biomedical research or clinical practice.
6. Complement instruction about the management of the patient increased emphasis on promotion of health and prevention of disease.
7. Pursue integration of education in science and education in practice by extending problem-solving exercises in hospital to

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clinical and community settings as a basis for learning.

8. Expand the criteria for selection of medical students to include not only intellectual ability and academic achievement, but also the personal qualities desired in any good physician such as honesty, compassion, and the ability to solve patient problems.

Other improvements require broader institutional involvement in order to:

9. Encourage and facilitate co-operation between the ministries/departments of health, ministries/departments of education, community health services and other relevant organizations in order to develop joint policies in respect of programme planning, implementation and review.
10. Ensure admission policies that match the numbers of students trained with national needs for doctors.
11. Increase the opportunities for joint learning, research and service with other health and health-related professions, as part of the training for teamwork.
12. Clarify responsibility and allocate resources for continuing medical education.

These principles are valid everywhere in the world and imply the need for strong departments of general practice/family medicine in every medical school.

In recent years some medical schools have included:

- Participation of general practitioners/family physicians in the teaching of specialized departments (sometimes in the form of integrated teaching).
- Teaching of theoretical topics in primary care.
- Teaching how the roles of the general practitioner/family physician can be achieved.
- Teaching of the disease spectrum as seen in primary care as part of the core curriculum.

  Problem-oriented teaching based on the presenting complaints of patients rather than on disease processes.
- Experimental teaching/learning in primary care settings as well as in hospitals. This implies also an exposure to social, cultural and environmental factors in the local community.
- Examination of the students on subjects of primary care including the assessment and care of patients presenting with everyday health problems, be they physical, psychological or social.

Graduate/vocational postgraduate education

The general practitioner/family physician is faced with many challenging tasks. These tasks are based on *processes of care* rather than disease processes. These processes include: prevention, health education, screening, early diagnosis, evaluation, testing hypotheses, treating, rehabilitating, consulting, listening, and using the doctor-patient relationship. There is a series of tasks to be learned and mastered. Acquisition of these procedural skills will supplement traditional medical knowledge.

Recognition of the present and future functions and tasks of the primary care physician has made it clear that there is a need for a structured, special training scheme with defined goals. Just as specialists receive their education about organ systems in relevant hospital departments, so the general practitioner/family physician should to a great extent receive his/her education in a primary care setting.

Development of learning skills

Physicians must place greater emphasis on the development of learning skills in self-assessment, quality assurance and continuing education. Critical self-awareness can be taught and learned, as can awareness of self limitations and the ability to draw upon the services of other members of the primary care team, community resources, other agencies, consultants and hospitals. The general practitioner/family physician has an important role to play not in isolation, but as part of a comprehensive health care system.

Research

Research in and about primary care is not yet sufficiently developed. Such research faces great challenges. Many areas need investigation:

Education

There is a need for basic knowledge in primary care to be included in the education of medical students, physicians and other health care personnel, such as the health and health problems of the population, the natural history of diseases, the effects of risk factors, the clinical process, the doctor-patient relationship, and the effectiveness of medical care interventions.

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Planning

There is a need for knowledge about health problems, sociomedical problems and patterns of health care in the population to enable those planning health and sociomedical services to make the maximum use of available resources in the prevention of accidents and disease, and the promotion of health.

Quality assurance

There is a need to incorporate methods of self-assessment and quality assurance in clinical practice. A useful model is that of industrial quality assurance programmes, which are only now beginning to be adapted to health care services. The skill of critical appraisal of medical information is essential in the contemporary graduate who faces an ever increasing tide of medical literature.

WONCA Classification Committee

The work of the WONCA Classification Committee, partly in co-operation with WHO, has created a standardized, international base for research in primary care. Classifications of the reasons for encounters, health problems and diseases, processes of care, criteria for diagnoses and definitions of terms have already been published.[2,5]

Research methods

Research methods from other disciplines such as the biological and social sciences and the humanities may need to be adapted and integrated within primary care research. Statistical methods will play an increasing role in such research.

The future

For the objectives outlined to be met, properly resourced departments of general practice/family medicine are a minimum requirement for every medical school. General practitioners/family physicians from all over the world are called upon to become involved as educators and researchers.

The discipline of general practice/ family medicine needs to be firmly established as the central discipline of medicine around which medical and allied health disciplines are arranged to form a co-operative team for the benefit of the individual, the family and the community.

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