

## The Ecology of General Practice in South Africa: Part II – S Levenstein



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### Curriculum vitae

Dr Stanley Levenstein is a general practitioner practising in Cape Town. He is currently National Vice-Chairperson of the SA Academy of Family Practice/Primary Care and was Founder President of the SA Balint Society. He has authored numerous publications and papers relating to general practice, and has received several awards for his contribution to continuing medical education for general practitioners, the most recent being the 1988 Boz Fehler Fellowship. He has been invited to deliver a plenary session paper at the 7th International Balint Conference in Stockholm, Sweden, in August 1989 on the topic "Balint Work in Developing Countries". Dr Levenstein has been closely involved with developments relating to Vocational Training in General Practice and Community-based Medical Education (CBME). He is currently leading a vocational-trainee Balint Group in Cape Town.

### Summary

*In this paper it is argued that General Practice in South Africa has to be understood in relation to the broader health and Societal context of which it forms part in a manner analogous to a biological organism whose survival and functioning is inextricably bound up with its environment.*

*Part I of the paper deals with the relationship between general practice and other fields of health care eg Community Health. The lack of understanding between medical disciplines is viewed against the backdrop of inappropriate training at medical schools. It is argued that most medical graduates are not trained to become involved in thinking about, debating and contributing towards the resolution of health issues in South Africa. Two illustrative examples in support of this view are cited.*

*Part II of the paper begins by discussing the deleterious effects of primary and secondary school education on prospective doctors. The concept of Community-Based Medical Education (CBME) as an alternative to existing forms of medical education is discussed, with particular reference to its potential for ensuring the increased relevance of such training to national health priorities, and the contribution which General Practice in South Africa could make to CBME. It is argued that from an ecological perspective, the organism which is general practice will need to remain flexible, and its adherents will have to have the courage to question themselves constantly in order to remain viable and relevant in South African society.*

*S Afr Fam Pract 1989; 10: 475-84*

### KEYWORDS:

Education, medical; Family Practice; Philosophy, medical; Schools; Learning; Vocational Education.

It would be wrong to attribute the inadequate training of doctors solely to their medical school education. The process begins much earlier with primary and secondary school education. It is worth noting the views of some leading educationalists on traditional schooling.<sup>10</sup> Marshall McLuhan described it as "irrelevant"; Norbert Wiener as "shielding children from reality"; John Gordon said it educated for obsolescence while Jerome Bruner said it does not develop intelligence. Carl Rogers said it avoided the promotion of significant learning. Paul Grodman said it induces alienation, and Edgar Friedenberg, that it punishes creativity and independence.

Postman and Weingartner,<sup>10</sup> in their epoch-making book on education entitled "Teaching as a Subversive Activity" pose the question "Now, what is it that students *do* in the classroom? Well, mostly, they sit and listen to the teacher. Mostly, they are required to believe in authorities, or at least pretend to such belief when they take tests. Mostly, they are required to *remember*. They are almost never required to make observations, formulate definitions, or perform any intellectual operations that go beyond repeating what someone else says is true. They are rarely encouraged to ask substantive questions, although they are permitted to ask about administrative and technical details". (Small wonder, then, that George



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Bernard Shaw once commented that the only time his education was interrupted was when he was in school!

Highlighting the premium that is placed on recall of random facts (as opposed to problem-solving, and logical as well as imaginative thinking), Postman and Weingartner refer to the enormous popularity of quiz shows in our culture. They ask

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Schooling avoids the promotion of significant learning; it punishes creativity.

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How else we can explain the great delight so many take in playing Trivia (or Trivial Pursuit as we know it). Is there a man more prized among men, they ask, than he who can settle a baseball dispute by identifying without equivocation the winner of the National League RBI title in 1943? (The answer, for those of you who are interested, is Bill "Swish" Nicholson. Incidentally, I have no idea what RBI stands for!)

School children are forced to make their own adaptation to this anti-educational environment. Postman and Weingartner refer to the "carefully cultivated schizophrenia that is necessary, in present circumstances, to their academic survival". They quote Mencken who once wrote that the main thing children learn in school is how to lie! This latter assertion, shocking as it sounds, goes a long way towards explaining the lack of respect for the truth which I referred to earlier. It is a phenomenon so prevalent that it prompted the great writer Joseph Conrad<sup>11</sup> to say "There is a taint of death, a flavour of mortality in lies -

which is exactly what I hate and detest in the world".

Postman and Weingartner's book,<sup>10</sup> written twenty years ago, still has much relevance for us today, particularly here in South Africa. Our educational system is characterised by the very same emphasis on rote learning and authoritarian teaching processes which is described so graphically in their book. To make matters worse, our school children are deprived of what might be one of their most valuable learning opportunities, which is to sit side by side and engage in common school activities with children who have been classified as belonging to other racial groupings. Small wonder then, that the "cream" of our school graduates, the straight-As and the quiz-whizz-kids enter medical school ripe for the conditioning process which has been described earlier. It is this state of affairs which prompted Philpott<sup>3</sup> to say that "if we wait until students arrive in tertiary institutions of education before we become involved in the process of learning, we will only be running a casualty service for the

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### Schooling does not develop intelligence

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victims of twelve years of bad schooling. We need to put the resources of the University at the disposal of the existing departments of Education and also those who are involved in new initiatives in school education".

Having railed against the prevailing system of medical education for a substantial part of this paper, the question which must now be addressed is whether an alternative

option can be offered. The answer is that such an alternative already exists and is gathering increasing momentum in many parts of the world in the form of Community Based Medical Education (CBME) programmes.

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The highest standard of medical education is that which is most responsible to local need.

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In the decade that has elapsed since the Alma Ata Conference declared Primary Health Care to be the key to the achievement of "Health for All", the emphasis shifted to the promotion of improved training of health workers to ensure the increased relevance of such training to national health priorities.<sup>20</sup>

Only a few training institutions clearly demonstrated an understanding that "one is excellent only if one is relevant" and that "the highest standard in medical education for any country is that which is most responsive to local need".

The main characteristic of these few institutions is that their training programmes are community-based and use the *community* in addition to hospitals as a major learning environment.

These institutions were convened by the World Health Organisation to form a Network of Community-Oriented Education Institutions for Health Services.

The rationale behind the educational programmes was that education reform was desperately needed.<sup>21</sup>



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using problem-solving rather than rote memory, stressing active rather than passive learning, and emphasizing student-centred rather than teacher centred education.

The programmes were also motivated by educational research which has shown that the more closely the learning conditions can simulate the

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We need to move away from the hospital-based approach to a more community orientated approach.

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setting in which the learned material is to be applied, the greater would be the likelihood of successful transfer of knowledge and skills.<sup>12</sup>

One such programme has been in existence at the Medical School of the University of Newcastle in Australia for the past decade. A number of delegates, including some from South Africa, attended the celebration of the 10th anniversary of the programme at Newcastle earlier this year, and I am indebted to Dr Peter Owen of the Faculty of Dentistry at the University of the Western Cape for making available to me his as yet unpublished notes<sup>12</sup> on his impressions of the programme.

The Medical School of the University of Newcastle has attempted to be entirely community-oriented and problem-based in its educational programme. Most of the learning takes place in the community itself, very little in the hospital, and even less in the lecture-halls!

There is no division of the course into preclinical and clinical periods.

The entire course is integrated, though the proportion of basic to clinical science varies as the course progresses, in an inverse relationship.

The most important mode of learning is small tutorial group work that encourages self-directed learning. The tutor is not intended to be an expert in the topic, but rather a non-didactic facilitator who helps the students to organise their own work.

Significantly, behavioural scientists have played a leading role in the programme, both in respect of the learning process and in the democratic functioning of the Faculty. As far as the latter aspect is concerned, it is worth noting that there are no separate departments, only disciplines, all of which contribute to the curriculum and programme as a whole, funded and organised through an Undergraduate Education Committee.

The question which you may now ask is "does it work?", "has the programme fulfilled its academic objectives or is the accusation valid that it is a "2nd class education for 2nd class physicians for a 2nd class community" and that emphasis on community-based care must inevitably translate into a "less scientific" education in that too much practical learning mitigates against a solid grounding in scientific theory?"

A number of studies<sup>12</sup> have been carried out comparing the graduates from Newcastle with those of other universities, both at the level of final examination performances and during evaluation of intern years. The graduates would seem to have more adequately fulfilled the criteria and objectives set for them. In certain areas, most significantly in terms of

the broad area of interpersonal skills, they would appear to be significantly better equipped.

The need for medical education in general to move away from the dogmatic, traditional hospital-based approach to a more community-oriented approach has been recognised by more and more medical schools all over the world, from Bangkok to Boston. There seems little doubt that such an approach could be of enormous benefit to South Africa. The forthcoming workshop on Community-based Medical

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GPs can make major contributions to a community-based medical education.

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Education to be held at Wits Medical School from 7 - 9 December has the potential to be a major event in helping to determine the future direction of medical education in South Africa.\* It is to be hoped that this workshop will address the issues of defining the need for health professionals and other health workers required in South Africa, defining the attributes of these various kinds of health workers and, not least, defining the criteria for admission to medical-educational programmes in such a way as to maximise the chances to commitment on the part of the graduates to

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*\*The workshop referred to, took place after this paper was delivered. There was much enthusiasm about the need to implement community-based medical education in SA and several working committees were set up for different parts of the country.*



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meeting the health needs of the community.

I believe that we, who have been involved in the growth and development of General Practice in South Africa, can make a major contribution to the implementation of Community-based medical education in this country. We can bring to bear, amongst other things, our special insights into the nature of

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### A willingness to change

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patient-centred medicine, the doctor-patient relationship in the primary care setting, and the relationship between psycho-social stress and illness. Ours is a vantage point, not so easily described, but none the less useful for that reason. Sam Fehrsen,<sup>13</sup> in a paper entitled "Research, is it necessary for the GP?" says that at a time when researchers were looking at smaller and smaller sub-cellular elements down a microscope, Dennis Burkitt turned the microscope around and made it into a telescope.

He looked at the world from a busy real life situation in a Central African practice and counted the things that were absent in various places. In this way he postulated several associations between lifestyle and disease. Some of these are today established by further work; such as the connection between constipation and diverticulitis, haemorrhoids and cancer of the large bowel.

I would suggest that what makes general practice so challenging (and so rewarding) is that we are obliged, in a manner of speaking, to look

down the microscope *and* to use it as a telescope. We have to have a keen eye for detail, to be able for example, to observe and understand the significance of a woman leaving her handbag behind in the consulting room, on the one hand; and at other times to be able to take a more global view and be able to assess the incidence of alcoholism or child abuse in the area in which we are practising. It is necessary for us, in a sense, to combine the skills of the histologist with that of the social anthropologist. It is this versatility which is sometimes confused with unscientific diffuseness by our critics.

The contribution of general practice to medicine thus far has indeed been noteworthy. But, as mentioned earlier, it is important for us and for medicine as a whole, that while continuing to have our own distinctive characteristics, we achieve a greater degree of integration with other disciplines relevant to health care. To use a biological analogy, the organism which is general practice, while having a clear form, should be flexible and adaptable enough to survive in dynamic equilibrium with rapidly changing environments. The organism should be lined by a semi-permeable membrane which permits it to receive valuable nutrients from its surroundings as well as permitting it to get rid of that which is no longer of adaptive value to the organism. If what I have outlined makes people concerned that our discipline will lose its identity by too free an association with other disciplines, I would suggest that the opposite is more likely. Such interaction could have an invigorating effect on our discipline by forcing us to re-examine our assumptions constructively, while failure to interact with our

environment could result in atrophy. In any case, let us always remind ourselves that the health of our patients is more important than the question of which discipline claims the most credit for effecting it. As Thomas Huxley once put it: "it is not who is right, but what is right that matters."

What is called for if general practice is to continue to grow and thrive, is not that we discard all the valuable inputs that have contributed so much to the development of our discipline thus far, but rather that we are prepared to adapt them to a situation of rapid societal change. For example, one of the cornerstones of general practice, namely the practice of *continuing* care, is being undermined by the unprecedented mobility of practice populations in recent times. GPs can no longer assume, as they might have done in the past, that they will be caring for their patients from the cradle to the grave. The situation calls for an adaptation in the GP's approach which takes into account that his continuing care is now of a more relative rather than absolute

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### Fear as the main obstacle to learning

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nature and may need to be geared to a developmental stage or transition in a patient's life, rather than the whole of it. Any ecologist could tell you that a change in an environment is rarely only additive or linear. You seldom, if ever, have an old environment *plus* a new element. What you have is a totally new environment requiring a whole new repertoire of survival strategies.



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The ecologists have, I believe, laid bare the crux of our problem. It is impossible to talk about a new repertoire of survival strategies without talking about willingness to *change*. And as soon as we talk about change, we inevitably encounter resistance, resistance based on insecurity and fear.

I believe it is fear which is at the root of the resistance to more appropriate attitudes to health care delivery, medical education and the pursuit of truth and knowledge, all issues which I have referred to throughout this paper. It is the same fear which makes it so difficult for doctors to speak openly with their seriously ill or dying patients; the same fear that blocks co-operation and produces the internecine strife that characterises rival departments at universities (the famous philosopher and writer, Bertrand Russell, once described the

university as "a place for frightened people"). It is not surprising that the enlightened educationalist, A S Neill<sup>14</sup>, repeatedly identified fear as being the main obstacle to true learning. It must surely be apparent that the suggestion that those who are involved in "scientific" fields of work are not profoundly affected and influenced by irrational fears, is one of the greatest misconceptions imaginable!

I have identified fear, then, as an enemy of human knowledge and medicine. It follows that we can only combat it by facing our fears, both within our profession or discipline, and (especially) within ourselves. In order to do this we have to be prepared to recognise our irrational fears, so that we can then begin to understand and overcome them. In the process we will encounter our fear of the unknown, our fear of

having all that which is familiar and important to us taken away from us, our fear of being assailed and assaulted by hostile forces within our midst. It is only once we have faced these fears head-on that we can discover that they have been mostly groundless and be liberated from their restricting effects on us. What the situation demands of us is not so much intellectual understanding as *courage*.

We do not need to look too far back into the history of scientific progress to find some truly outstanding examples of the courage I have been referring to. One of these shining examples, perhaps the greatest example of all, is that of the founder of psycho-analysis, Sigmund Freud. When Freud first began propounding his theories concerning the unconscious mind and his concepts of infantile sexuality, he was ridiculed

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and vilified by all and sundry. His most vocal critics were his colleagues in the "scientific community", who, while claiming to reject his ideas on "scientific" grounds were clearly terrified by his insights, frightened out of their wits at having their own cosy notions of mental functioning shaken, and more importantly, at having attention drawn to their own sexual and aggressive impulses. Nowadays, even critics of psycho-analysis, speak of "slips of the tongue", of having an unconscious reason for "forgetting" things, and of the psychological importance of dreams without even recognising that they are acknowledging the validity of Freud's discoveries.

It is probably true to say that no man of science has been subjected to more sustained attack for propagating his scientific work than was Freud. It may be equally true that no-one responded to these attacks with greater courage and integrity than he. He was bewildered and hurt by the extent of the malice and the venom that was directed at him, but such was the strength of his commitment to his work and his search for the truth that he refused to be intimidated. Nor did he ever deviate

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### Not so much intellectual understanding, as courage

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from his own impeccable standards of meticulous observation, rigorous logic and unfailing honesty, even to the extent of making criticisms of his own work which no-one else had considered.

Another example of a courageous scientist was Charles Darwin, whose

brilliant research into the Origin of Species and the process of natural selection was likewise condemned as the work of the devil, not only by the church but also by the "scientific community" who might have been expected to know better. The mass of evidence which Darwin so painstakingly accumulated in support of his theories was ignored or derided by his colleagues. So much for the myth of objectivity which "scientists" enshroud themselves with! But this did not stop Darwin and those who believed in the value and importance of his work from persevering with their efforts. Unlike their detractors, they did not resort to emotive arguments or fall prey to the kind of hysteria with which they had been attacked and which was so ill-becoming of those who called themselves scientists. Today Darwin's discoveries stand alongside those of Freud's as amongst the most important contributions to our understanding of human life that have ever been made.

The history of the emergence of general practice as a discipline is also not without its examples of courage in the face of strong and often hostile opposition. People of the calibre of Ian McWhinney, Gayle Stephens, John Fry and Tudor Hart did not have an easy passage when they first propounded their ideas, but they fought on nonetheless and we all know how much we owe to them. But there is a tendency within any movement or discipline, once established, to rest on its laurels and for its adherents to resort to chanting the teaching of the founder fathers like catechisms until they become sterile and lifeless. Such practices do a disservice to the innovative spirit of these original thinkers, and seriously endanger the viability of that

discipline and its ability to adjust to rapidly changing circumstances. It is a danger which has constantly to be guarded against.

It has to be admitted that during our own brief history, we in general practice have not been untouched by this canker. In 1950 Michael and Enid Balint began working with groups of general practitioners at the Tavistock Clinic in London. They were both psycho-analysts by

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### The connection between the personality of a doctor and the number of drugs he prescribes

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training, but they were interested in working with general practitioners because they believed that the setting of the doctor-patient relationship in general practice was a largely unexplored area which needed to be studied closely in order to ascertain its full potential. They did not embark on this venture with any preconceived ideas, nor did they ever attempt to set themselves up to "teach" GPs psycho-analysis or anything else. They recognised that as psycho-analysts they were deprived of certain learning opportunities which were available to GPs every day, eg the opportunity to perform physical examinations of patients and the opportunity to visit patients' homes. The GPs in their turn recognised that they stood to benefit from the contact with psycho-analysts who had been specially trained to observe closely and to detect unconscious processes as they manifested in group inter-actions. The Balints and the participating GPs, worked together in a spirit of equality and genuine scientific enquiry. The results of their



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work have appeared, inter-alia, in the form of numerous publications, including the now famous "The Doctor, His Patient and The Illness"<sup>15</sup> which has been translated into nearly twenty languages.

There can be little doubt that the work of the Balints and the "Balint-groups" of GPs which have subsequently been formed all over the world, effectively transformed the face of general practice as a discipline. In the UK, certainly, it played a major role in putting general practice on the map as a branch of medicine deserving special attention academically and within the newly-formed National Health Service which the Labour Government had instituted after the Second World War. Yet in spite of the value of their work, it was anything but plain sailing for those who were promoting Balint-work. Within academic general practice circles they were regarded as a "lunatic fringe", and frequent jokes, which became known as "Balint-bashing" did little to conceal the underlying hostility and sense of threat of those who made them.<sup>16</sup> Later, when it became impossible even for those who had resisted the influence of Balint work most strongly to ignore the contribution it had made to general practice, the "Balint-bashers" began to pay lip-service to Balint work while making no attempt to understand what it really had to offer.

Once again it was only the determination and belief of those involved in Balint-work in the value of what they were doing which ensured that their efforts did not die out. Today Balint-work is well established within general practice and medicine as a whole, but it is

interesting and salutary to note that the Balint movement itself has not been without its problems of an old guard reacting strongly against any hints of ideas which are not consistent with the prevailing orthodoxy. Significantly, it has been Enid Balint<sup>17</sup> herself, who since the death of Michael Balint in 1970, has protested most strongly against the enshrinement and carving in stone of ideas which she and Michael Balint had previously expressed. Far from encouraging the blind acceptance of any viewpoints, Enid Balint<sup>22</sup> made a plea for all of us, as she put it, to "have the courage of our own stupidity!"

To my mind, one of the great contributions of the Balints to general practice and to the learning

The ecology of General Practice is a rapidly changing one.

process was that it promoted the realisation that we could not properly learn about our patients until we understand something about ourselves. I spoke earlier of the ecology, the environment of which our patients are a part, but of course we too are part of an ecology: a social background (for the most part more privileged than those of our patients); a family of origin; educational institutions, etc. Part of our ecology is also the world of our own feelings, our emotional responses to patients, and our irrational fears and prejudices (many of which we are not even conscious of) which blind us to so much of what is going on around us, and prevent us from changing, from learning and from growing.

(How naïve we are to suppose, for example, that there is no connection between the personality of a doctor and the amount of drugs he/she prescribes, the number of investigations he/she requests, and the surgical procedures she/he instigates!)

In this paper I have argued that ecology of general practice in South Africa is a rapidly changing one, and that in order for us to remain viable we urgently need to make certain adaptations. These adaptations include a much greater degree of co-operation and connectedness with others who have a part to play in determining the ultimate quality of health care in South Africa, as well as a greater rootedness in the community itself, in respect not only of determining health needs but also with regard to medical education. I would like to stress that the adaptation I have referred to is not merely desirable, but it is *essential* if our discipline is not to acquire the status of a specimen in a pathology laboratory - well preserved and having much that is admirable about its preparation, but as dead as a dodo! There may be those who think I am being melodramatic when I speak thus, or those who believe my warning to be of no practical importance. To those people I would like to respond by pointing out one concrete application of what I have been saying: we have recently embarked on an area of activity which is crucial to the future of General Practice in South Africa. I refer now to the implementation of *vocational training* programmes in various parts of the country. I have had the privilege of working in close contact with many of the young medical graduates who have commenced their postgraduate training in general



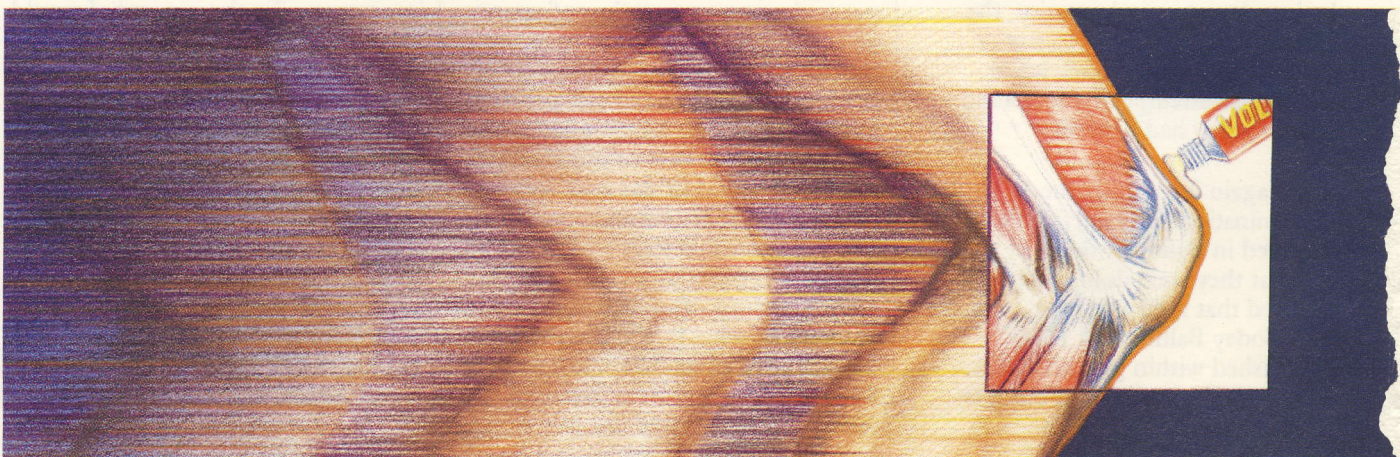
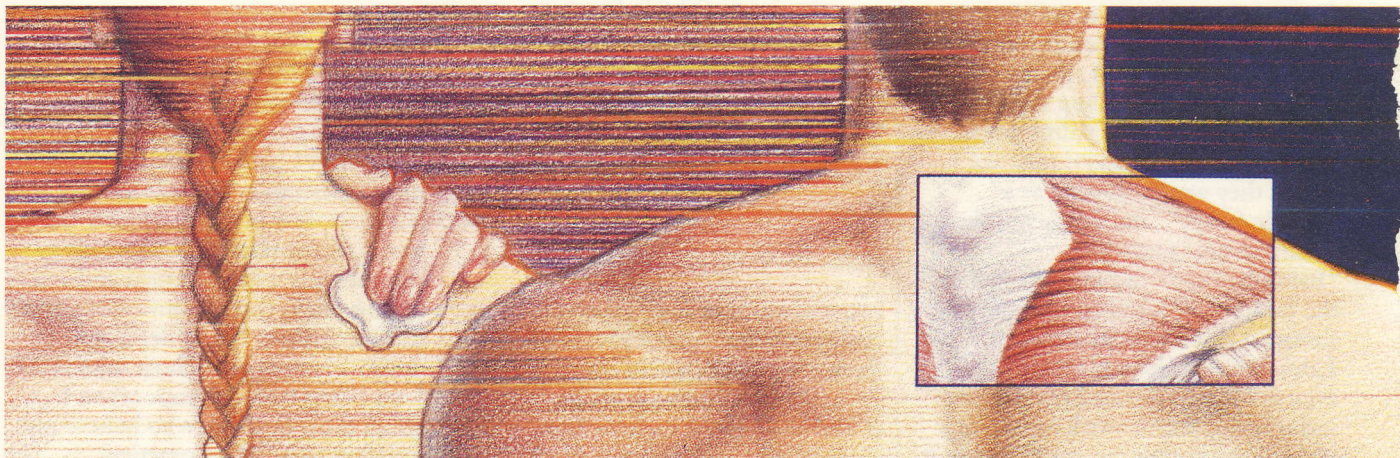
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practice in these programmes. They are, for the most part, enthusiastic, intellectually alert South Africans who are committed to making a meaningful contribution to health care in our country. Their minds are still open enough to evaluate critically the inputs which they receive from those of us who are their tutors. If they are satisfied with the standard of training they receive, we will be rewarded with a whole new generation of trained and talented general practitioners who will carry the torch forward into the future. If however, they decide that they are being dishd up a collection of dusty,

jargon-ridden clichés by doctors who have no appreciation of the real training needs of vocational trainees in present-day South Africa, then they will (correctly) decide that the training they are being offered is useless and irrelevant, and they will go elsewhere. They will be replaced, if they are replaced, by passive people who will undergo their training without questioning or challenging anything they are told, and general practice and medicine as a whole will be much the poorer for it. The Academy of Family Practice/ Primary Care has an important role to play in ensuring that our discipline

remains alive, vital, and relevant to the needs of our society. The noted journalist and music critic, Bernard Levin,<sup>18</sup> speaking about the Britten-Pears School for Advanced Musical Studies in Aldeburgh, said that its function was not to preserve the cause of music, but to advance it. Let us be able to say the same of our Academy - we have every reason to be proud of our accomplishments, and no reason to dismantle our sound foundations; but let us strive to ensure that we never become a museum!

These, then, are a few of my thoughts





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about the state of the art of General Practice in South Africa as we approach the 1990s. It may seem to many of you that I have asked much of our young discipline, indeed much more than other disciplines have achieved or even attempted to achieve. I will readily acknowledge the validity of such a charge. But please take note that I have called for these changes not only because I believe them to be essential to our survival as a discipline, but also because I have faith in my colleagues in general practice to meet the challenge that is facing them. There is certainly no shortage of goodwill and

commitment to high standards of patient care. We also have no shortage of people who are willing to plead our case, much as Boz Fehler and other pioneers of general practice in South Africa did in the past. The question is whether we will be able to muster the moral, emotional and intellectual courage to meet the demands of an increasingly complex and fluid situation.

I think that this is a question which each one of us has to face as openly and as honestly as we can. In order to do this we need to recognise that we cannot resort to any formulae or to

any dogmas of the right, left or centre. We need to be willing to be uncertain, ignorant and confused. We need, as Enid Balint has urged us, to have the courage of our own stupidity. It is a courage which I believe would be rewarded on a personal, professional, and societal level, both from our own point of view and that of our patients. Each one of us has to decide whether we are going to try to find this courage or not. The choice should be clear, even if the implementation of it is not easy.

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Not to be taken by mouth.

### Interactions as experienced with systemically absorbed diclofenac sodium

When given concomitantly with lithium, non-steroidal anti-inflammatory agents raise the concentration of lithium in the blood. The bioavailability of VOLTAREN is reduced by acetylsalicylic acid, and that of acetylsalicylic acid by VOLTAREN, when the two drugs are administered together.

### Pregnancy

The safety of VOLTAREN in pregnancy has not been established.

### Known symptoms of overdosage and particulars of its treatment

In the event of significant systemic side-effects occurring as a result of improper use or accidental overdosage (e.g. in children), general therapeutic measures of the kind normally adopted in order to treat poisoning with non-steroidal anti-inflammatory drugs should be resorted to.

Identification White gel.

Presentation Tubes of 20 g

Storage instructions Store below 25 °C  
Keep out of the reach of children.

Registration number J/3.177

### Name and business address of applicant

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Date of publication of this package insert  
1988.06.02

Registered Trade Mark

23480-8805

## FEATURE ARTICLE

### ... Ecology of General Practice

French psycho-analyst and writer, Frantz Fanon,<sup>19</sup> by quoting the last lines of one of his books:

*"At the conclusion of this study, I want the world to recognise, with me, the open door of every consciousness."*

*My final prayer:*

*O my body, make of me always a man who questions!"*

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