

The Ecology of General Practice in South Africa — Stanley 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.

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Boz Fehler Address — 1988

I feel much honoured to be delivering the Second Boz Fehler address.

Ecology¹ is the branch of biology dealing with the habits of living organisms; their modes of life, and relations to their surroundings.² When speaking of the ecology of general practice in South Africa, I am emphasizing the point that our

discipline does not exist and function in isolation from its environment. It operates ineluctably within a wider health and societal context which it affects and by which it is itself affected. General practice in South Africa (and any other country) cannot be fully understood without understanding its relationship to other fields of health care, the educational background from which our general practitioners emerge, and the society in which we and our patients live. The nature of the relationship of our discipline to these areas has important implications for the future survival and well-being of general practice, or "family medicine" as it is also known.

Perhaps the term "family medicine"³ is a good example with which to illustrate the point I have attempted to make. Family medicine implies that the family physician, unlike other physicians, not only works with whole families as his patients, but is closely concerned with the relationships between family members because these have an important effect on individual family members' physical and mental health. This postulate still holds true, but the fact remains that "family medicine" would not be true to its name if it did not take cognisance of the major changes which have taken place in the nature of family-life world-wide — the effects of rapidly changing social and economic circumstances, industrialisation, unemployment, changed moral attitudes, etc, etc.⁴ In South Africa "family medicine" is being practised in a society where the divorce rate is amongst the highest in the Western World. It is also a society in which the migrant labour system has rendered family life more or less non-existent for millions of South Africans. And what about the

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constant stresses and conflicts, (social, economic and political) which *all* South Africans, whether living as part of a family or not, are constantly subject to? This is the ecology of family medicine in South Africa, and to fail to recognise it, is to risk rendering our discipline irrelevant to the society which we are committed to serving.

The comments I have made thus far should have given some indication of the extreme difficulty facing general practice as a discipline in these

troubled times. As already mentioned, I believe that these difficulties can best be addressed by attempting to form a clearer understanding of our surroundings in order that we can best discover what adaptations we need to make and how best we can draw from our surroundings that which can most benefit our discipline and our patients. I have selected a few which I believe to be of particular importance for the future of our work.

Firstly, the relationship between

general practice and other fields of health care.⁵ I want to start with a general statement in support of the view that divisions between various scientific disciplines are largely artificial. I believe this is especially true of medicine where the different areas of study are so interdependent on each other. While there may be some good practical and administrative reasons for this state of affairs, the effects have often been unfavourable. Instead of a co-operative working together between different specialties, we have all too



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often seen a competitive attitude, with each discipline aggressively asserting its territorial claims. The result has been evident in much of the fragmentary care which has been administered within the specialties and super-specialties. General Practice has sought to avoid this approach, and to move towards holistic patient care. To some extent we have been successful in this endeavour, but can we honestly say we have done everything possible to work in a truly inter-disciplinary way in the best interests of medical

knowledge and our patients? I will cite one instance, without apportioning blame to either party, where I feel the degree of co-operation has left much to be desired.⁶ I refer now to the relationship between the disciplines of General Practice and that of Community Health.

It has indeed to be said that the history of the relationship between General Practice and Community Health in South Africa has not been a particularly happy one. On the face of

it this may seem surprising, as the two disciplines would logically appear to be natural allies. Both are particularly concerned with preventive and promotive health care, as well as attaching great importance to primary (as opposed to secondary and tertiary) health care. Why, then, the animosities which have arisen, the allegations and counter-allegations about the legitimacy of each others' area of work? The answer to this question is partly an historical one. General Practice (or Family Medicine) has had to fight an uphill



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struggle to gain recognition as a separate discipline in its own right. It has particularly resented being tucked away within various departments at Medical Schools, particularly Departments of Community Health, where the perception has arisen that General Practice has been regarded as a mere appendage to, or small subdivision of, the wider discipline of Community Health (or in some cases, Internal Medicine). This perception, whether fully justified or not, tended to spill over into the wider medical community, with GPs

and community physicians to a large extent becoming split into opposing camps, each ridiculing and belittling the other. The GPs charged that while they were concerned with people, the community physicians were mainly concerned with pit privies and abattoirs. The latter in their turn alleged that GPs spent a lot of their time dealing with "trivial" complaints and that most of them were in any case mainly interested in making money!

An impartial observer, asked to

arbitrate on this unedifying and unproductive dispute, could fairly have pronounced that both sides had failed to understand the other's point of view. More seriously, he might have concluded that while there may have been good reasons for the misunderstandings which had arisen, both disciplines had missed the opportunity to work together and thereby make a greater contribution to medicine as a whole.

The truth is that the fields of General Practice and Community Health have



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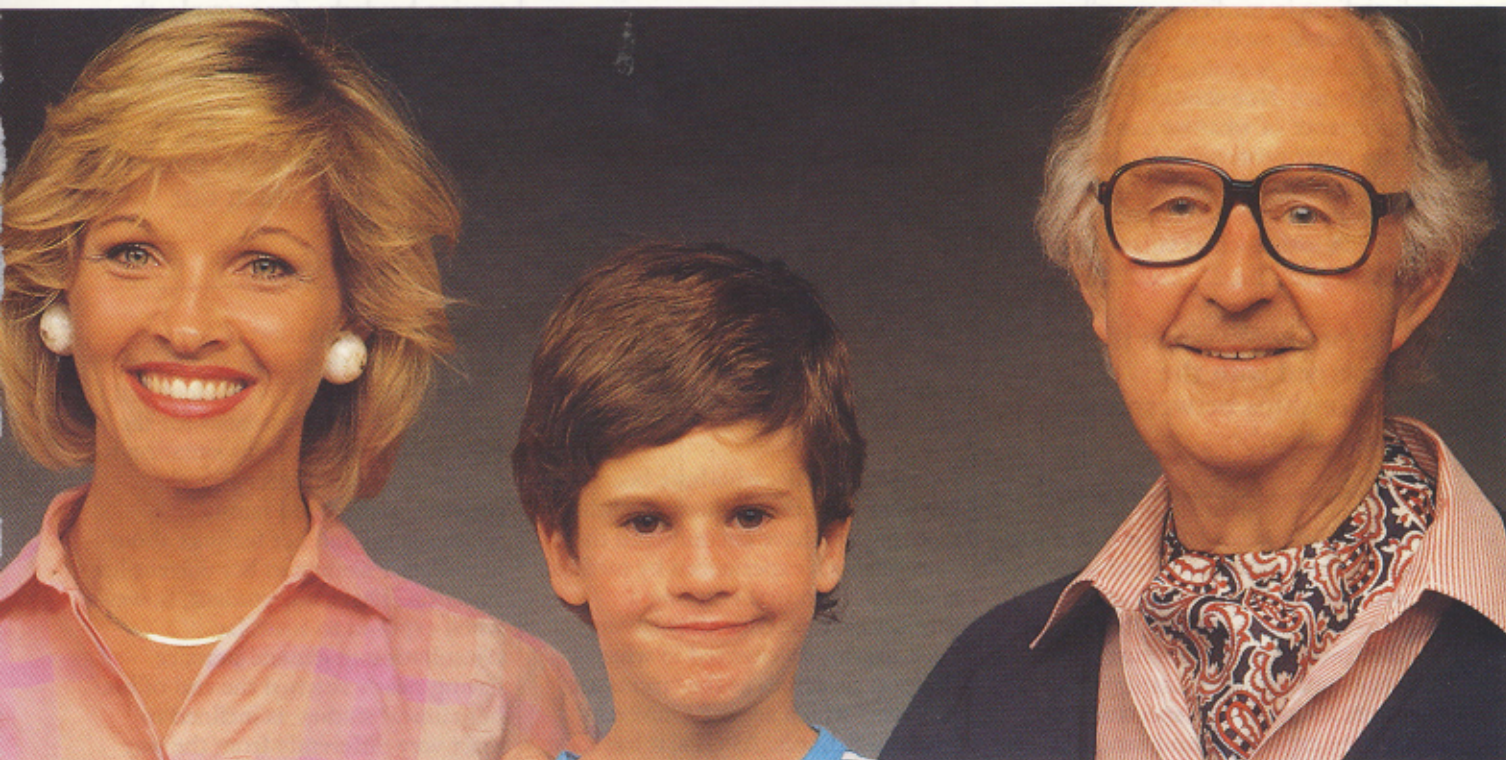
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much to offer each other.⁷ General Practice and Community Health could be regarded as being at different ends of a spectrum, with General Practice laying its emphasis on personal patient care and Community Health being more concerned with whole communities. In between these two ends of the spectrum is a large middle-area, of great importance to both disciplines. It includes such areas as the incidence of various conditions in the community and the ways in which they manifest in individual patients;

occupational health; school health; the health expectations and needs which exist in the community, etc, etc. How fruitfully could GPs and Community physicians not work together to explore these areas more profitably! The community physician could bring to bear his/her skills in epidemiology etc, while the GPs' understanding of the unique expression which each individual gives to the wider environment, could help to shed more light on the complex inter-action between the health of communities and that of

individuals. Instead of this, we have unfortunately seen a lamentable ignorance within the ranks of both disciplines of what the other discipline is all about. To my mind it will serve no useful purpose for this state of affairs to continue. The time has come for us to stop shouting at each other and to start listening to each other - in an atmosphere of mutual respect and sincere willingness to learn.⁸ Failure to do this would be like considering a rainbow as though only certain of its colours were important, and would in



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its own way be an example of the reductionistic approach to medicine of which Joseph Levenstein² spoke in his Boz Fehler dissertation in 1987. It is an attitude which is not only unscientific but also anti-scientific in that it mitigates against greater knowledge and understanding. It can only redound to the detriment of both disciplines and all our patients.

I have made specific mention of the relationship between general practice and community health, but my comments apply equally to other disciplines in medicine as well as many *outside* medicine, such as Psychology, Sociology and Economics. Nor should we forget the importance of what we can learn from other professionals, such as nurses, physiotherapists and social workers, as well as from non-professionals such as village health

The family physician is also concerned with the relationships between the family members

workers. And, not least, is that much-quoted but much neglected source of learning which is our patients themselves. The point is that we can learn most through continual interaction and cross-pollination with others across a wide spectrum of areas of experience and expertise. The more cut-off we are, the less viable we will be.

The state of affairs which I have described regarding the lack of understanding between disciplines cannot be seen in isolation from the tertiary institutions of education where our health professionals train.⁹

Professor Hugh Philpott³ in a paper on medical education points out that our medical schools in the universities:

- (a) keep, and are kept separate from other disciplines that are vital to health care, eg agriculture, education, economics, etc;
- (b) that the various disciplines within the health profession are disconnected and
- (c) that within the Faculty of Medicine, even, we set up isolated Departments that practice and teach as though their specialties were more important than the whole.

Philpott describes this state of affairs as one of "pathological disconnectedness", and says that the layered curriculum encourages the development of departmentalised specialty interests and forgets about the holistic needs of the sick, and for that matter the healthy. He adds that "we have institutionalised our specialty Departments and forgotten that the people live out in communities".

Certainly all GPs who have been involved in undergraduate medical teaching will have encountered the culture shock experienced by medical students when first entering a primary care practice after having been previously closeted in what Philpott describes as the "monastic enclaves" which are the University Medical Schools. As GPs, it has long been our contention that the traditional medical school training, with its bias towards the specialties and specialised technology, has left its graduates ill-prepared for patient care in the community. In fact, there is evidence that traditional methods of medical training are not only inadequate, but actually result in

trainees becoming *less* empathetic and able to relate to patients effectively than they were to begin with - in other words, it is not only un-educational but anti-educational! Confirmation of this can be obtained from any GP who has witnessed the negative attitudinal transformation of a medical student from the beginning of his/her clinical years of study to the end. At the beginning of this period, most students will be found to be receptive to learning about psycho-social aspects of patients care - when a woman presents with a tension headache, for example, the student will appreciate the fact that the GP takes into account the part

Always remember the tense atmosphere in which our patients live

played in the causation of her symptoms by emotional and social stresses in her life. The student will recognise that it is essential for the GP's management of this situation to take into account, inter alia, the patient's marital and family relationships and her feelings about herself as a woman in her current life situation. That same student, however when exposed to a similar consultation in general practice having nearly reached the end of his/her clinical studies, is inclined to react very differently from the way he/she did a couple of years earlier. Now the student can no longer be bothered with trifles like tension headaches and chastises the GP for failing to order computerised axial tomography to exclude a brain tumour immediately! The bewildered GP could not be blamed for wondering what happened to his/her

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erstwhile sensitive medical student since last he/she attended the practice.

Perhaps a large part of the answer to the question in the GP's mind lies in the teaching process at the medical schools.¹¹ As Philpott³ puts it "the teachers do not consult the community or the students and in their didactic isolationism, they unwittingly (or perhaps wittingly) become authoritarian and rigid and oppressive. The students become dependent on their teachers and find it difficult to cut the umbilical cord"

Philpott also argues¹² that as far as examinations are concerned, the content of the curriculum tends to bear no relation to educational objectives, if ever such were set. Consequently examinations tend to be loaded with methods that are easy to set and mark, such as MCQs. They call for rote learning of facts rather than the ability to solve problems.

Harmful competitive attitude between the different specialities resulting in fragmentary care

This latter point requires further comment, because I believe that the teaching process at the medical schools has an important bearing on the later conduct of medical students during their professional lives. I am referring now to the reluctance and perhaps to some extent the inability of most medical graduates to become involved in thinking about, debating and contributing towards the resolution of health issues in their country. I am going to cite two

illustrative examples in support of this view.

I referred earlier in this paper to the tense atmosphere in which all our patients currently live.¹³ One manifestation of this is that since the declaration of a State of Emergency by the Government in June 1986, an estimated 30,000 people have been detained under security legislation. The effects of this type of confinement, physical and psychological, have been well documented by, amongst others, Foster and Sandler⁴ and a Namda study⁵. Less well documented, but abundantly clear to all those who have worked with them in a medical and/or counselling capacity, are the devastating effects of these detentions on the families and friends of the detainees. Apart from the separation from their loved ones (some for more than two years now) and in many cases the loss of a breadwinner (most employers refuse to pay the wages of employees while in detention and often refuse to re-employ them after their release), the detention process plays havoc with the physical and mental health of family members. While many have exhibited almost super-human strength and fortitude, the family members of detainees are, after all, only human. They are inclined to experience irrational feelings of guilt and resentment about the detained family member, the resentment in turn giving rise to more guilt feelings. Feelings of intense anxiety and depression are common, as well as psychosomatic symptomatology and problems such as sleep disorders and enuresis amongst the children of detainees.¹⁴ The detention process disturbs and distorts the normal relationship pattern within such families. The constant tensions can reflect in

irritability and quarrels over apparently trivial issues. A child might also, for example, adopt a parental role in order to protect a depressed spouse of a detainee whom the child fears may break down through failure to cope with the stress of the situation.

When the detainee is released, the family understandably, but unrealistically, expect things to return to normal immediately. They often do not realise that the detention process (even if short) makes it extremely difficult for the detainee to re-adjust to the outside environment for some time. The ex-detainee is often inclined

General Practice and Community Health have failed to understand each other

to be withdrawn and irritable, as well as being mistrustful and fearful of close, intimate personal contact, including sexual intimacy. Even after a measure of re-adjustment has taken place, the ex-detainee still has to live with the real fear of re-detention, harassment, personal injury or worse.

Some simple arithmetic: if every detainee is regarded as having a mother and a father, a brother and sister, a spouse or lover, and a son and daughter, this means that eight people (including the detainee) will be directly and immediately affected by each detention (the real figure is of course very much higher than this). Multiplying 8 by 30 000, we arrive at a figure of 240 000 ie nearly 1/4 million people whose physical and mental health has been directly affected by the fact of detentions without trial in the past two years or so.

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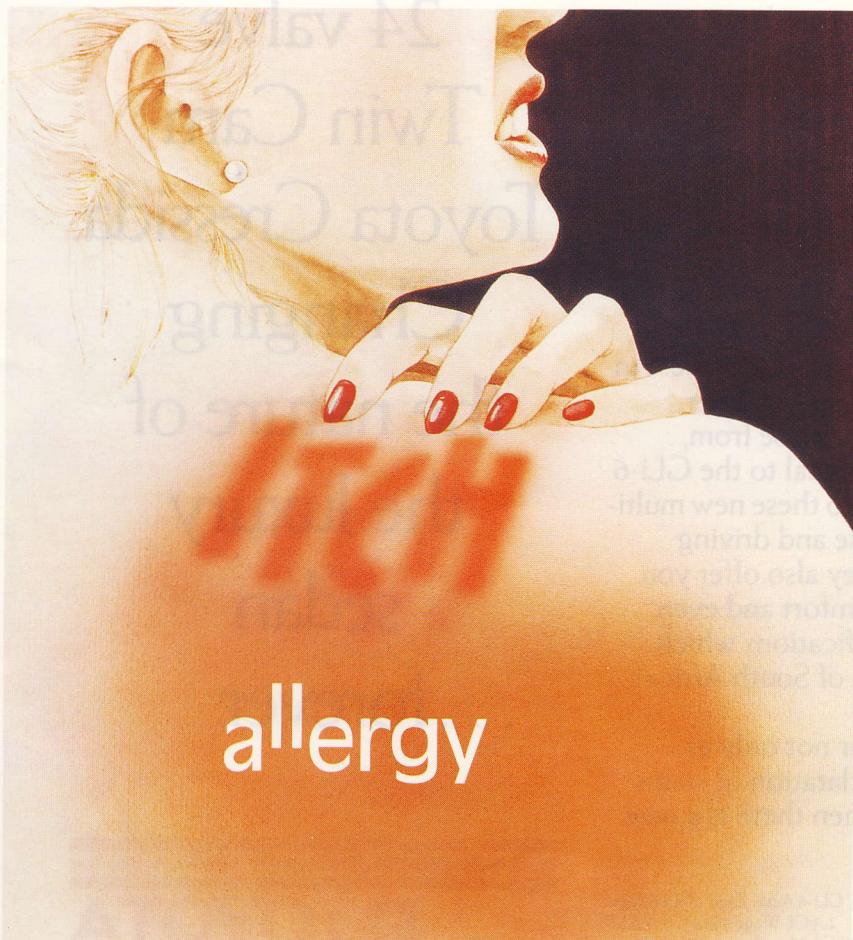
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Let us look at this figure of 1/4 million people coldly and objectively for a moment. What could happen if a medical condition affecting the lives of 1/4 million people over the past two years were to be identified in South Africa? I think we know the answer: the media, (lay and medical) would be full of screaming headlines about this new "epidemic" which was ravaging our country like a veld fire. There would be editorials and public information campaigns aplenty to inform people about this condition and to advise them how to cope with it. This public

health problem is an unmistakable part of the ecology of General Practice in South Africa, and what is the response of the "mainstream" medical press? An incredible silence. The question must now be asked: why has the literature on this topic been almost exclusively confined to "alternative" medical publications? Where is the regard for the knowledge, which is supposed to be unselective and without prejudice? Where is the concern for truth, which is supposed to be the object of all scientific endeavour? And what about "the good of our patients", the catch

phrase which is always being self-righteously touted particularly by those who are anxious to shy away from any topic which might vaguely be construed as being controversial? We, however, have a kind of selective blindness and disregard for reality which seems to flow out of the training process at our medical schools.

I would like to cite a second example of the phenomenon I have been describing.¹⁶ The SA Family Practice Journal, which is the official journal of The South African Academy of



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Family Practice/Primary Care published a letter⁶ written by myself to the editor in its September 1987 edition. The letter began by referring to an editorial⁷ in the April 1987 edition entitled "Truth is Difficult" in which the editor commented that "A National Health service is seen by many as the only means of achieving greater equity". The letter continued by stating "Since SA Family Practice is the official journal of the SA Academy of Family Practice/Primary Care, it seems both appropriate and necessary that the question of which system of health care is best suited to the needs of the people of our country, should be addressed in this publication."

The content of medical examinations tend to bear no relation to educational objectives

The last part of the letter is quoted here verbatim. "It is true that many GPs may balk at the idea of a NHS in our country, fearing as they do an incursion into their professional freedom, loss of income, etc. The experience of GPs in the UK (and other nationalised health systems) however, appears to indicate that many of these fears are misplaced or exaggerated and are in any case counter-balanced by a greatly reduced burden of responsibility for the running costs of their practices, as well as the advantages of a relationship with patients which is unencumbered by concerns about the patient's financial status".

"Whatever one's opinion on this question may be, I feel it is vitally

important that SA Family Practice be available as a forum for serious discussion of the issues concerned. In this way the Academy can make a meaningful contribution to what could be regarded as the most crucial issue in medicine in South Africa today and in the future."

The letter ended with the words "Let the debate proceed!"

I wish that I were able to report on the progress of that suggested debate in the fourteen months since that letter was published. Sadly, however, the truth is that the editor has not received a single reply in response to it, whether in favour of, or against the introduction of a NHS in South Africa, or to make any comments or suggestions on the topic whatsoever.

I have wondered long and hard as to what could account for this silence on the part of my colleagues.¹⁷ Could it be that very few people bother to read letters to the editor, but if that is the case then one wonders why it is so? Perhaps a more likely explanation is that people are reluctant to express their views in writing for fear of antagonising people and/or having their own ideas subjected to attack. The one possibility I find impossible to accept is that the readers of SA Family Practice are *indifferent* to the question of what kind of health system they practice medicine within. I have been forced to conclude that it is not that doctors have necessarily not wanted to correspond on this issue, nor yet that they were not capable of doing so, but rather that they did not feel *safe* enough to do so.

If there is a feeling of lack of safety amongst our colleagues, if we do not feel safe enough to tolerate criticism and disagreement from each other,

then we as an Academy must take some of the blame for this state of affairs. However, one is again forced to call to account a process of medical education which produces doctors who lack the confidence in themselves and their colleagues to be able to participate meaningfully in debates on vital health issues in their society. Surely this state of affairs would be different if medical students were encouraged to question and debate issues from the start of their studies, rather than being forced to ingest and regurgitate millions of facts, most of which are forgotten soon after examinations have been undertaken.

References will appear after Part 2, next month