Family Medicine, Medical Bureaucracies and Society

— Joseph Levenstein

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Summary

The progress of Family Practice in South Africa over the last few decades is examined and evaluated. It is done in the context of the history of modern medicine world-wide and put into South African perspective by explaining the different government and other professional agencies and bureaucracies in society which decide on or influence medical care. It concludes with future opportunities for Family Practice as they exist today.

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Curriculum vitae

Dr Joseph H Levenstein graduated from the University of Cape Town in 1963 and joined his father in general practice in Milnerton. He has been actively involved in Academic Family Medicine for the past twenty years and is a foundation member of the Academy of Family Practice and is currently the National Chairman of the Academy. He is also Head of the Unit of General Practice at UCT and is convenor of the Faculty of General Practice of the College of Medicine of South Africa. He has published widely on many subjects relating to general practice which range from the management of ischeamic heart disease to the use of antibiotics in general practice and detection of colonic cancer. He has held visiting professorships at several universities in the United States and in South Africa and has been visiting Professor at the University of Western Ontario, Canada, on three occasions. In 1984 he was visiting Professor at the University of Hong Kong.

Dr Levenstein was Vice-President of Wonca from 1978 until 1980 and actively represented South Africa on this body. He has received numerous academic awards, including the Louis Leipoldt Medal, Noristan Gold Medal and is the first recipient of the Lennon Boz Fehler Fellowship.

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Family Medicine/General Practice or Generalist Primary Care — call it what you will, has had a universal resurgence over the past three decades. Depending on how you view the outcome of this phenomenon, its progress can be regarded as spectacular or abysmal. In particular, we must examine this resurgence in the South African context.

History of Modern Medicine

In analysing the rebirth of Family Medicine we have to view it in the context of the history of modern medicine. Medicine and its position and role in society, as we understand it, is not even a century old. Only since the turn of the century has there been a determined effort to get rid of the charlatans and quacks and legislatively to enshrine our monopoly over health care. In the USA this followed the Flexner report, (1910), which laid down the requirements and standards that were expected of doctors. Only as recently as 1928, the South African Medical & Dental Council was instituted with its statutory powers over

the educational standards that were needed to practice medicine in South Africa.

Within sixty years medical education has transformed the incompetent empiric physician or health care worker into a highly trained scientific professional. The process was accompanied with the creation of more and more specialist disciplines. Furthermore, modern medicine, at its zenith was accorded total autonomy and sovereignty in deciding what society's medical needs were and what services they would provide to meet them.

Standard modern medical training produced the so-called "undifferentiated" doctor who was thought fit only to be a general practitioner. The latter left the medical schools never to be heard of again. Their vocation had no academic discipline. It was believed, that they required less training than their specialist colleagues. It was thus understandable that the administrative and economic power of the profession would be concentrated in the hands of the medical

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school specialists. They would control the training of doctors, the allocation of resources and therefore the health care services of a community and even directly or indirectly the fees that would be paid for various types of services in the community. It is therefore no co-incidence that by far the greatest share of society's medical bill goes to activities related to tertiary care hospitals. This is true irrespective of the health care system that is in existence. It is evident in countries where there is predominantly "private" practice as well as those where health care is nationalised or socialised. In a dual system such as in South Africa, the largest slice of the private health care bill is for hospitals and specialists, mirroring the allocations of the public sector. How else could we understand how a cardiac surgeon receives R1 500 for 3 hours work, the hospital theatre with its technologies about R10 000 and the Family Physician R180?

The establishment of family medicine

It was in such an economic and medico-political climate that general practice/family medicine made its bid for institutionalisation towards the end of the seventh decade of this century. Their leaders steadfastly maintained that general practice was not only a vocation but an academic discipline in its own right with its own body of knowledge and skills peculiar to its area of activity. The cardinal principles of the discipline included breadth as opposed to depth, viewing the patient as a whole rather than as ever-diminishing fragments and recognising relationships between doctor and patient, patient and family and patient with environment as having an influence on the aetiology, outcome and therapeutic management of illness. Furthermore, the areas of prevention of disease and the management of chronic illness, the two major medical challenges of our time, regardless

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of the politico-economic status of a community, fell squarely within the job definition of the primary care generalist.

To effect these activities as well as the appropriately modified knowledge and skills of specialist disciplines, one needed a trusting, ongoing relationship with each unique patient. It was argued that there was a sound scientific basis for this approach and it was not "hit or miss", "experience", "bedside manner" or "waffle" for example. It was based on Einsteinian theories of Relativity and Quantum Physics.

It was also maintained that traditional Newtonian fragmented specialist medicine had failed in the areas that Family Medicine laid claim to. These attempts, based on principles of fragmentation and specialisation, had made no impact on the incidence of Tuberculosis, the increasing number of unwanted pregnancies, the compliance rate in chronic disease and the high so-called "sudden death" rate from acute heart attacks, to mention just a few activities that have been tackled on specialist principles in the community. Family Medicine also claimed to be cost-effective in the provision of several service needs for one patient, thereby avoiding endless referalls, as well as in its preventive role.

In making these claims, Family Medicine insisted that its discipline required additional postgraduate training, termed "vocational training" as well as undergraduate

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training. It therefore required the infrastructure for teaching, service commitments and research. Needless to say this required money and undergraduate teaching time — money which is never readily available, and teaching time which is always shrinking under the burden of the ever increasing number of specialities

and sub-specialities and the vast increase in specialised knowledge within these disciplines.

Family Medicine differed from the other newer disciplines that had evolved over the past 50 years. These had evolved from isolating an activity that was already being undertaken in the tertiary care hospital environment. Thus, for example, children would fall under the aegis of the paediatricians, mental diseases would be cared for by the psychiatrists and radiotherapy by the radiotherapists. All these were hospital activities already and were based either on a distinct group of patients, a specific disease entity or on advancing technology.

Family Medicine had no powerbase within the medical school as the discipline evolved from the community and not the hospital. Its activities appeared to have no boundaries. These activities appeared by definition to involve "trivia" or at least patients not ill enough to be admitted to hospital.

Finally, to add to family medicine's difficult task, many medical schools believed that they were the arbiters of what knowledge and skills general practitioners should have. They were entrusted with maintaining standards and consequently with deciding on what knowledge the undifferentiated doctor should be in possession of.

The objective of the medical profession should be to meet the medical needs of society.

It thus stands to reason that few, if any, medical schools, voluntarily embraced Family Medicine as a full participating discipline. Ultimately the objective of the medical profession should be to meet the medical needs of society. I hope to be able to indicate how the realisation of this latter objective is intrinsically bound up with the activities of the medical school.

The Bureaucracy of Medicine

The bureaucracy of medicine in South Africa consists of:

The University medical schools which control undergraduate education and the issuing of degrees. They are also responsible for the training of postgraduate specialist degrees and are permitted to issue these;

The College of Medicine of South Africa, which is responsible for conducting and certifying specialist examinations and postgraduate degrees and diplomas;

The South African Medical & Dental Council is the statutory licensing body. They ultimately register degrees, accepting that the appropriate degree of proficiency has been obtained according to the standards they have formulated;

The professional bodies which embrace medical practitioners and in some instances other health care professionals;

The governmental authorities at all levels, ie. central, provincial and local. The Southern African situation is further complicated by having separate medical infrastructures for the homelands, whether they are independent or not. Yet another set of bureaucracies have recently been added in the form of the Indian and Coloured Health authorities as an outcome of the tricameral system of parliament. The effect of the latter cannot be gauged as they are not really been involved in the system as yet. Governmental authorities are the link between society and their perceived medical needs and the medical establishment. They provide financing directly via health care services and indirectly through subsidies to medical schools;

Family Medicine Departments increased in the USA from 18 (in 1968) to over 400 (in 1980).

Medical corporations, private hospitals and medical insurance companies are the final component of medical bureaucracies in South Africa. We will hear more about these in the future should "privatisation" be allowed to run its full course.

Governmental agencies and society

Governmental authorities have been the singular most important factor in the institutionalisation of Family Medicine in other countries. The number of Family Medicine Departments in the USA increased from 18 in 1968 to well over 400 by 1980. This was as a direct result of state legislation linking grants to the medical schools on the proviso that departments of Family Medicine be created. In Australia, postgraduate general practice training is financed directly by the Australian government and administered by the College of General Practitioners. The latter obviously impressed them more than the universities as the appropriate vehicle for this operation, either as a result of the Medical Schools' lack of expertise in the area or unwillingness to embrace Family Medicine. In the United Kingdom the formation of the National Health Service resulted in the basis for general practice training. Payment for the trainee and trainer have all been built into the system. It is interesting to note that the recent Thatcher cutbacks in the British National Health System do not affect General Practice.

. . . the desire of the population to have a personal doctor.

Presumably, the rationale of governmental agencies in acting in this unprecedented manner, in interfering with the autonomy of medicine, was as a response to their constituencies' priorities. These have been labelled as being the cost effectiveness of general practice, the desire of the population to have a personal doctor and the ever increasing cost of high technological medicine with a perceived low return. A further reason often stated is the dehumanising effect this high technology has had on medical care and a desire by medical students in particular, for more humanised involved commitment.

The late Pat Byrne, the first Professor of General Practice in the United Kingdom and a President of the Royal College of General Practitioners, told me this story in relation to the establishment of vocational training in the United Kingdom. Whether it is apocrophyl or not, is not relevant. He maintained that the British Government were persuaded to finance vocational training on the basis of one calculation — "if the general practitioner, by the prevention of a stroke, early intervention in the treatment of

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pneumonia, good antenatal care or the prevention of an attempted suicide, for example, saved the state 20 hospital days from all his patients, throughout his career, he would have paid for his training!"

In the USA societal opinion was reflected in the 1966 Citizen's Commission on Graduate Education where the Chairman stated "If there had not been a general practitioner in the past, we would have to invent one and then educate the primary physician for the future".

It is also salutory to reflect on the quiet revolution taking place in the USA in relation to medical care. Medical Corporations, generically referred to as HMOs are springing up like mushrooms. They are at present strongest in the South, mid-West and Western coast. These work on the principle that a Primary Care Doctor is given approximately 800 dollars per patient per year for total patient care. This includes referrals, hospital admission and operations for example. Various estimates quote up to 50% of the American population having membership of these organisations where the patient is contracted to a single doctor for this care. This is taking place in an environment where hospitals are closing down by the day. A member of the American Medical Association has been quoted as saying "The capitalists have done to us what the socialists would not have dreamed of!"

So it is evident that society and their representatives are intervening in the once strictly medical preserve of health care. While society apparently wills the doctors on to giddier and giddier technological feats, they appear more and more unable to pay for them or accept the emotional isolation that they bring.

What of southern Africa? The medical establishment here has had very little if any, governmental or societal intervention into their activities. While the central government has been extremely strong on rhetoric it has been unable or unwilling to influence our medical priorities. The National Department of Health seems

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helpless to reverse this emphasis which appears to be contrary to their Health Service Facilities Plan for the Republic of South Africa. The latter advocates inter alia, the following principles:

- The accent moves from the sick person to the healthy person;
- Services will be more community orientated with the emphasis on promotive and preventive care rather than on curative care;
- The total need of the individual is now of importance.

Furthermore, they list six levels of care which should be achieved progressively:

1. Providing of basic subsistence needs, water, food, sewerage and wastage disposal and housing;
2. Health Education;
3. Primary Health Care;
4. The Community Hospital;
5. The Regional Hospital;
6. The Academic Hospital.

It is ironic that in spite of this, within a space of a few years, the Cape followed the Transvaal example by erecting a new academic hospital which is supposedly lowest down on the priority list, at a

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building cost of R200 million, let alone all the other costs involved. And yet another teaching hospital has been planned for Pretoria. I am not going to indulge further in questioning these decisions, but in the light of the Government Health Services Plan, the economic recession and the urgent Primary Care needs, it appears

that whatever the policy may be, what money there is, still seems to be being spent on the traditional curative services related to the teaching hospitals.

It could be argued that in South Africa, the State only controls about 10% of the health care budget, (the Provinces about 80% and local authorities approximately 10%), so therefore they really have no say. Whatever the allocations are, only 5% of this total budget is spent on preventive care.

This bizarre fragmentation, (which extends even further as previously mentioned), is combined with another type of fragmentation in the delivery of primary care health services. The latter fragmentation is based on hospital specialist care type facilities which are extended into the public sector community.

By way of an example, let us look at the current status of public primary care and see how, the little money that is spent there, is utilised.

A twenty three year old young woman brings her eight month old baby with the problem of persistent "colds", (Health Provider 1). His assessment is that the baby has asthma and he refers him to the asthma clinic (Health Provider 2). He also decides that he is behind in his immunisations and refers him to the Well Baby Clinic (Health Provider 3). The mother says that she has had a persistent blood stained discharge since her pregnancy (Health Provider 4 — Gynaecology OPD) and that she wants to go back on the contraceptive pill (Health Provider 5 — Family Planning Clinic). Somewhere along the line she says she can't cope and life isn't worth living since she's had the baby, (Health Provider 6 — Psychiatric OPD). There is no one in this setup to contact the husband who is drinking too much, who should need (Health Provider 7) and to check up whether he is taking his anti-hypertensive tablets (Health Provider 8 — Hypertension Clinic).

Although society still demands technological feats, it appears more and more unable to accept the emotional isolation that they bring.

This is a very simple everyday example of a non-differentiated primary care contact which results in many patients and many problems! In a fragmented depersonalised system the initial contact could result in eight health care contacts provided directly or indirectly by 3 government agencies. The scenario could be managed more efficiently by any competent family physician at far less cost, anxiety and time with

all the advantage of a personal physician who is acting as the patient's manager of health.

University medical schools

As is already evident, South African medical schools are not unique in their failure to embrace Family Medicine as a discipline worthy of major resources. With a few notable exceptions, (which include Charleston in South Carolina, Case Western in Cleveland, Monashe in Sydney, Australia, Belfast and Manchester in the United Kingdom, Western Ontario and McMaster in Canada), those that initially had general practice foist upon them, did not respond with enthusiasm.

. . . the accent moves from the sick person to the healthy person.

The Private Medical Schools in the USA have no departments of Family Medicine. The one program started at Harvard did not meet up with the standards set by the credentials committee of the American Family Physicians.

The reason I mention this is to refer to another phenomenon which medical schools, if unchecked, are able to affect when they are forced or pressurised, to set up Family Medicine Departments. These then function in the fashion of a private club, rather than public institutions. Their appointments are not recognised academic leaders of general practice but "fit-in" well with the university's perception of Family medicine and the facilities offered are woefully inappropriate for a legitimate discipline.

Not that Family Medicine has been without friends in Medical Schools. In South Africa, for example, the late Professor Hennie Snyman, was directly responsible for the establishment of two departments of Family Medicine.

It is sobering to reflect on the Medical School's influence in South Africa on the Health Care Budget. It will be remembered that the Provinces get 80% of the allocation. In the Cape about half is allocated to the University Teaching Hospitals. In 1986 the total

Provincial Budget for Hospital Services and Public Health was R777 000 000. Of this R105 000 was allocated to ambulance service facilities and pension funds. Of the remainder, R312 000 000 was allocated to 2 teaching hospitals; R367 000 000 was allocated for hospital services and public health for the Western Cape, Eastern Cape, and Border. (These figures do not include the costs of the new teaching hospitals). In the apportionment of these funds the Province must obviously be heavily reliant on the Universities which act as their health care experts. Thus, they will directly and indirectly influence health care facilities. Let us observe by way of a hypothetical example, how the medical school might directly influence health care facilities:

Within the medical school, a previously weak department, let us say orthopaedics, finally obtains a strong charismatic academic leader. He attempts to convince his colleagues that a priority is to double his number of interns, registrars and consultants. Unlike his predecessor, his status and political clout within the medical school is such that he is successful in persuading his colleagues. In representations to the joint appointment board with the Province or medical superintendent or whatever, the medical school representatives argue his case for additional

General Practice has so far taken little part in the bureaucracy of medicine in the RSA.

appointments and for vacant posts to be given to this department.

An independent observer from Mars observing the health care needs of the Cape could assume that the orthopaedic needs of the community have doubled!

My next hypothetical example is a bit more fanciful: A new Head of Family Medicine is appointed. He convinces his colleagues that in South Africa, Primary care is a priority. He needs approximately 100 appointments for the Cape and although he appreciates that some of his colleagues in other departments are at a stretch, he will need some of their junior appointments as well. He will need more undergraduate time, a 3 month block at least, even though that is not enough to balance the influence of the other specialist disciplines.

Needless to say, his colleagues are convinced by his rational arguments and support his claim to the hilt!

Thus it can be seen that the Medical Schools with their large influence over the allocation of the health care budget, ipso facto, exercise an extraordinary large influence on the health care services in South Africa. What they deem as priorities in their teaching programs have far-reaching effects on health care in the community both in the public and private sectors.

We have seen how their influence persists, even in areas beyond their direct control in the fragmentation of the services of primary care, for example.

The medical schools are, however, subject to and/or influenced by the other medical bureaucracies: the SAMDC, The College of Medicine and the Medical Professional Bodies.

Family Medicine has indeed made great strides since the formation of the SA Academy of Family Practice/Primary Care.

The South African Medical & Dental Council

The SAMDC is the ultimate arbitor of the standards, the requirements and the licencing of medical practitioners in South Africa. Its decisions are legal and binding. The key commiteee with regard to the training of physicians is the Medical Education Committee. Understandably, the Universities' 5 representatives on the Council must play a key role in that area.

Most recently the education commiteee took a decision to support compulsory Family Physician Vocational Training in principle. If this decision were to be carried through, the SAMDC would not be involved in the content, the process and the form of the training. This would be left to the Universities themselves.

The College of Medicine in South Africa

This body is constituted predominantly by the self-same Medical School specialist leaders. The examiners, the content and the form of the examinations are all subject to the decisions of the Examinations & Credentials Committee, a body made up almost totally of specialists. The College of Medicine must be aware of the potential political power that GPs might have when appropriate training and compulsory examinations are instituted. Their constitution only

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allows for 2 general practitioners to be elected on to their governing council.

It is not entirely surprising that the Faculty of General Practice within the College of Medicine has fought for 12 years to have instituted what they considered to be an appropriate examination for the Membership

of General Practice. On numerous occasions they were vetoed. What this has meant is that members of other disciplines decide on the content of general practice and how it should be examined.

Professional medical bodies

Professional medical bodies play an extremely important role in the industrialisation of medicine. In all countries they have agitated for, (and usually preceded) educational, examining and licencing institutions. They are intensely involved in standards as well as their legitimate trade union functions in the protection of their members' interests, professionally and economically. They are also inevitably involved in issues which impinge on these activities.

. . . never lifted a stethoscope in anger!

The SA Medical Association, for example, was strongly supportive of the establishment of the first Medical School in South Africa, the University of Cape Town and the SAMDC. On all matters, educational and otherwise, their opinions are sought after by that body and are regarded as representative of the profession. However, with the best will in the world, these bodies cannot represent general practice.

Universally, those higher up in the medical hierarchical establishment, ie the specialists, particularly the specialist academics have dominated. This, in spite of efforts, even within organisations, to do otherwise. Where there are subsidiary GP groups within the organisation, they must be subject to the governing body's approval.

It makes sense that medical academics will be more able to serve on these and other bodies. They are salaried and their involvement does not involve a loss of income. Unless a professional body makes a determined effort to compensate the involvement of those in such organisations, the position becomes untenable.

Professional bodies of the individual disciplines are designed to meet the needs of their own area of activity and to formulate policy relating to it. It is a matter of record that Family Medicine has made great strides since the formation of the South African Academy of Family Practice/Primary Care. Its principle aims are the raising and maintenance of standards of Family Practice/Primary Care for the benefit of all the peoples of South Africa. It has addressed itself to the urgent medical problems of this country, making its top priorities vocational training and the doctoring and health care of underdoctored areas. It is firm in its belief that there should be only one standard of primary care based on universally accepted principles. There cannot be two standards of Primary Care — one for the public and another for the private sector, anymore than there can be two standards of surgery or internal medicine. Patient care is the Academy's most important objective and while it realises that members might have widely differing opinions and that patient care cannot exist in a vacuum, it must steadfastly stick to its task. This does not mean that it will shirk from expressing opinions in issues which impinge on these objectives. Furthermore, it has as its stated policy, co-operation in joint ventures with any organisation in projects where the objectives are similar.

However, for reasons which are obvious, we cannot and will not align ourselves with any one particular organisation exclusively. History has shown us that our major strength is our independence. We no longer require permission to hold meetings, publish a journal, setup vocational training projects in underdoctored areas, make representations, and issue policy statements as to what we believe the health care structure of this country should be.

However, it is evident that General Practice has taken little part in the bureaucracy that has made an industry of medicine in this country. In the USA John Millis, in 1970, in his Citizen's investigation into Graduate Medical Education, maintained that General Practice had failed to date, because it had no place within the organisations of medical education and medical care. The same can be said of this country resulting, I believe, in a heavy cost to the health care structure and the health of its people. This places an extremely heavy burden on the Academy to undertake and finance projects until Family Medicine eventually finds a place in that bureaucracy.

Primary Care

As society becomes more and more aware of the importance of medical care in the community, more and more interest groups become involved in what had been previously disparagingly left to the general practitioner. The term Primary Care is used to denote the services which would emanate from medical services in the community. This term has served as a convenient ragbag for all and sundry, to define what is needed for health care in the community. The viewpoints have ranged from those which believe that Primary Care is simplistic and the province of nurses and other health care workers to those regarding it as a highly complex activity suited only to Primary Care Specialists.

The individual sick patient is not a number or a disease entity – he is a whole person and the meaning of his illness is unique to him.

Most destructive, yet persuasive due to the apparent

logic, are the attempts by the medical social engineers to impose untried medical solutions to the problem. Most, who have never lifted a stethoscope in anger, presume to define boundaries, design block diagrams, and juggle with numbers ad nauseam without the slightest idea of the complexities and the psyche of an ill patient. Often these solutions are designed to fit into one or other theory and to the practicing community doctor they would appear laughable if they were not taken so seriously by health administrators and politicians. Often the solutions do not even include Primary Care Generalists. These are supposedly superfluous and only for the rich and the private sector. Ironically, Somers has maintained that this type of most personalised care is most urgently needed by the poor and the deprived.

There can be little debate on the view that Primary Care involves a team approach. However, the essence of it is personal comprehensive and continuing care. Anything else is second rate, and is doomed to failure because it fails to take into account the individual sick patient. The latter is not a number or a disease entity who fits into one or other category. He does not fall ill in terms of any political or sociological theory. His illness and the meaning of it is unique to him or her.

Family Medicine has a contribution to make in the teaching, research and service needs of both medicine and community.

The future

I cannot seriously believe that major change will come from within the medical establishment. Bureaucracies with unfettered power rarely make changes that radically alter the status quo. Moreover, none can deny the achievements of modern medicine, thus strengthening their belief that they are right and we are wrong. At present the very departments who are being accused of having a disproportionate portion of the resources are stretched to the limit with frozen posts and cutbacks. It is difficult to persuade anyone that if resources were appropriately utilised, their wards might not be full of "tuberculotics" and "strokes" when they are full with patients who have tuberculosis and have been afflicted by strokes.

Sadly, however, their very failure to adjust may well take the decision making process out of their hands. Not only is the failure to place resources in the community illogical, it is patently obvious that society can no longer afford to pay limitless money for limitless medical, sometimes inappropriate esoteric advances. How society will effect this change, is not certain. How long it will take is equally uncertain.

There are strong trends abroad challenging the sovereignty of the medical establishment. Practitioners

of all sorts are gaining legitimacy. There is little doubt that the time is ripe for the medical establishment to reassess its role in society. A far more equitable balance is needed with regard to its resources. Family Medicine, while a firm adherent to sound scientific principles, stands on the interface between society and traditional medicine. It has a contribution to make in the teaching, research and service needs of both medicine and the community.

Spectacular or abysmal?

Well, do we adjudge Family Medicine's progress in the past 3 decades as spectacular or abysmal? Compared to the progress of the specialist disciplines,

For 3 hours' work:
Cardiac surgeon: R1 500,00
Theatre with its technologies:
R10 000,00
GP: R180,00

it is indeed abysmal. Fragmented, specialised medicine has further entrenched itself within the medical establishment and maintained its influence on societies' health care priorities. Our progress in establishing ourselves as an integral part of the infrastructure of the medical bureaucracies and thereby making our contribution in research, service and teaching, has been by contrast minimal.

However, if we in South Africa, look at our achievements without the advantages of a secure academic base, they could indeed be regarded as spectacular. Every advance has been tedious and painstaking, yet we have established a professional body, voluntarily initiated training programs in underdoctored areas, and undertaken research projects. The SAMDC has accepted vocational training albeit only in principle and the College of Medicine is in the process of accepting our recommendations for an examination. We have established a Health Foundation which will help us with the health care of underdeveloped communities and further vocational training as well. The Medical Research Council is seriously looking at research programs in the community. There are academic presences in all but one of our universities albeit on a low key level. In conclusion, medicine has to serve society. While, like any professional activity, it needs autonomy with regard to how it sets about its functions and how it regulates its activities, it cannot operate in a vaccuum. I submit that South African medicine has not responded to the challenges of medical care over the last quarter of this century. While there is also little doubt that a greater percentage of the GNP should be spent on medicine, the teaching hospital still saps a large percentage of resources and dominates health care. In spite of policy to the contrary, newer and better teaching hospitals are being built. This is medicine of the 50's and the 60's.

We have an incredible opportunity in our situation to make major strides in caring for patients in the community. In the 1950's and 1960's we capitalised on our unique situation of first world medicine in a third world environment to blaze an unenviable trail of progress. The same opportunity exists again. This time we must focus our attention on the community with all that this implies. It will be of everlasting benefit to our profession but more importantly to our patients, all the peoples of South Africa.

From the journals

A study of headache in North American primary care

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Abstract Headache is a common symptom in primary care about which surprisingly little is known. Over a 14-month period 3 847 patients making 4 940 consecutive visits for headache to 38 primary care practices in the USA and Canada were studied. The clinical characteristics of patients, as well as the diagnostic and therapeutic strategies employed by their doctors, were examined. Visits for headache represented 1.5% of all visits during this period. Most patients (72.0%) made only one visit, and nearly half of the headaches reported were new. Only a small number of patients (3.0%) received a computerised tomographic scan; other investigations were used sparingly, as were referrals to consultants (5.0%) and hospitalisations (2.2%). Drugs (75.2%) and advice (64.5%) were commonly employed, although formal psychotherapy was recommended infrequently (4.5%). It is concluded from this large series that most patients with headache visit primary care practitioners only once; their headaches frequently defy usual diagnostic categorisation and often change in character from visit to visit. Moreover, headaches in this series were frequently associated with a variety of causes not often included in discussions of headache aetiology. These findings suggest that the strategies which doctors in primary care devise to diagnose, investigate and manage this common symptom, require further study.