elected to the Health Professions Council and became a member of the SA Medical and Dental Professional Board. She is now on the Executive Committee and chairs or sits on a number of committees of the Board. Her main task as Academy Chairman has been to oversee the introduction of CPD for family practitioners. Dr de Villiers has also led the Academy delegation in talks with the Colleges of Medicine of South Africa to achieve unification of the Academy and the College of Family Practitioners. In addition to the CPD Task Team chaired by Julia Blitz, an Information Technology Task Team has been set up under the chairmanship of Dr Leon Geffen.

COMMENTARY

When requested to write the history of the first twenty years of the Academy, it seemed essential to commence with the first academic organizations of general practitioners, some two decades earlier. Thus, in summary, we have dealt with:

- 1958-1969 The formation of six South African faculties of the (British) College later the Royal College of General Practitioners.
- 1969-1970 The South African College of General Practitioners.
- 1970-2000 The Faculty of General Practice of the College of Medicine of South Africa later named the College of Family Practitioners (CMSA).
- 1980-2000 The SA Academy of Family Practice/Primary Care.

Perhaps one of the most important aims of all these organizations has been to raise the self-esteem of the general practitioner by demonstrating that his/her field is as intellectually demanding, as emotionally taxing (and rewarding), as socially necessary and, requiring a training as rigorous as for any other medical field or discipline. This has led to the somewhat irreverent reference to our organizations as the "GP consciousness movement".

The nomenclature adopted in this history has been all-embracing. Thus the terms general practitioner, family practitioner and primary care physician have been used interchangeably as have the terms general practice and family medicine to denote our discipline. It is interesting to note that the term general

practitioner originated in Britain in 1820 and, true to tradition, the British have retained the name and its affectionate acronym GP. In the United States, the condition of general practice had deteriorated to the point that a new image was deemed necessary. Thus the new speciality of family medicine came into existence, a term that has gained widespread acceptance to describe our discipline. Because of our close ties to British medicine, the terms general practitioner and GP are still widely used in this country.

In writing this history some significant events and names have been omitted. Important questions and issues have been raised including our relationship with other medical bodies and with government old and new. Perhaps the greatest omission is failure to record the names of many fine doctors, who by their example, teaching and support for our objectives, made a major contribution to the establishment of family medicine as an academic discipline in South Africa. To have recorded all their names and achievements would have necessitated a much larger work.

Mention must be made of the fellowships funded by a pharmaceutical company, to mark the contribution of Dr BM Fehler to general practice, when he left this country in 1986. Known as the Lennon-Boz Fehler Fellowship, it involved the presentation of a paper to be delivered in at least three centres. This offered some of our leading members an opportunity to present aspects of family medicine of their choice, which they did with originality and erudition. The names of the Fellows and the title of their papers are listed chronologically below:

- 1987 Dr JH Levenstein: Family Medicine and the New Science
- 1988 Dr S Levenstein: The Ecology of General Practice in South Africa
- 1989 Prof BLW Sparks: "Doctor your family is waiting"
- 1990 Prof GS Fehrsen : In Search of Excellence - Practical Advances in the Consultation Process
- 1991 Dr SN Furman: Research in General Practice - Is it Necessary?
- 1992 Dr N Naidoo: The Role of the Family Practitioner in Primary Health Care
- 1993 Prof GJ Pistorius: Family Practice - A Living Organism

Scant reference has been made to the role of Academy President. This is essentially a ceremonial position, to which Council elects someone who is deemed to have made a major contribution to academic general practice and whom it wishes to thus recognise. There have been four Academy Presidents - Drs Boz Fehler elected in 1980, Basil Jaffe in 1984, Profs Howard Botha in 1988 and Sam Fehrsen in 1993. There has been no incumbent during the past three years, possibly because of the intention to amalgamate Academy and College, creating a body with its own structure.

Collaboration between family practitioner and community physician in the delivery of primary health care has been alluded to and is particularly valuable in the rural situation. Unfortunately the term community medicine has led to some confusion in the minds of legislators and some medical educators. Perhaps the older terms public health or social medicine more appropriately describe this field of medicine which deals with populations, in contrast to family medicine which is patient-centred and clinical. One of the most useful tools in general practitioner research is epidemiology, the basic science of community medicine.

In considering the interface of community and family medicine, mention must be made of the community-orientated primary care movement which started in Natal in the early 1940's. It was based on the health centre set up by Sidney and Emily Kark in the rural setting of Pholela, which provided curative, preventive and promotive services for individuals and the community. The health centre was staffed by medical practitioners, nurses and health assistants, the latter being involved with health education and the collection of statistics which measured the outcome of the health programmes. Pholela was a highly successful venture[49, 50] funded by the government of the time which proposed that it should be the model for a comprehensive health service (Gluckman Report 1945). By 1948, 44 health centres had been set up but very few approached the standard attained by Pholela.

In 1945 Dr Sidney Kark established the Institute of Family and Community Health at Clairwood, Durban to train health personnel for the health centres. However, the academic discipline of family medicine was still in its infancy and constituted a minor aspect of the Institute's philosophy and

work. In 1948 the change in government led to the reversal of health policy, no new health centres were created and the scheme was allowed to run down. Dr George Gale, Secretary of Health (1946-1955), was a great supporter of Kark and his Institute and, as Dean of the newly created Natal University Medical School (1952-1955), was instrumental in incorporating the Institute into the Department of Preventive Family and Community Medicine. This was a temporary arrangement because the Karks and their leading co-workers emigrated to countries where their ideas were more acceptable.

Dr Shula Marks gives some valuable insights into this period of medical history[51]. She shows that, apart from political opposition, there were structural and other factors which led to the failure of the health centre movement. These should be carefully examined by our Department of Health in giving practical expression to its commitment to primary health care.

There were other innovative health initiatives in South Africa, notably that of Dr Halley Stott in the Valley of a Thousand Hills in Kwa Zulu Natal. Here, in 1951, he founded with his own funds the Botha's Hill Health Centre which became the governmental component of Stott's project. This was linked to the Valley Trust, a non-governmental organization set up in 1953. Stott described the project as a "socio-medical experiment focussed on the promotion of health with particular emphasis on raising nutrition standards". Patients were referred from the Health Centre to the Valley Trust Education Unit to learn about issues such as diet, infant feeding, cooking methods and vegetable gardening. Over the years the Trust broadened the scope of its activities by the promotion of improved agricultural methods; self-help housing and building block production; the building of schools and crèches and the provision of educational resources; creating access to water by the building of dams and pipelines. All this has been undertaken with the participation of the community which has now taken over many of these activities.

Valley Trust has a special significance for us as family practitioners. Stott remained a clinician who regarded the primary health care unit as central to his project which embraced the principals of Alma Ata many years before the Declaration in 1978. Of added interest is the fact that Dr Stott's son Nigel

became Professor of General Practice in the Welsh National School of Medicine, Cardiff.

The Academy has existed during a momentous period of South African history which has witnessed the transition from apartheid to a democratic society. Where did the organization stand in relation to the socio-political issues which affected the health of the population? In 1997 a submission by the Academy to the Truth and Reconciliation Committee deals with this issue (available from Academy Cape Town office). A summary of the submission was published in SA Family Practice under the name of Dr Stanley Levenstein[52]. He points out that the membership of the Academy varied in political viewpoint from far left to far right. Nevertheless the organization steadfastly maintained its non-racial membership, its belief in non-discrimination and its commitment to improving primary health care for all.

The submission then makes its central point that the Academy tended to avoid taking positions which could be regarded as politically controversial. There were exceptions, e.g. the motion passed by Council in November 1985 - "That the Academy of Family Practice....., notes with concern, reports about the care of detainees currently held under security legislation and affirms the Tokyo Declaration (guidelines for medical doctors, concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment).....and pledges itself to do all in its power to ensure that necessary and appropriate health care is provided to all concerned, in accordance with the Academy's beliefs and philosophy".

In April 1986 Council passed a motion admonishing the Minister of Health who, at the opening of the 5th GP Congress, made a statement that was politically propagandist and offensive to many members.

Yet there remained those who believed "that the Academy was obligated to make its voice heard on the social injustices which prevailed in South Africa, particularly as it affected health". There were others, as strongly opposed to the prevailing political system who worked in other organizations, medical and non-medical, to oppose the social injustices inherent in government policy. The Academy policy of regional autonomy permitted

regions like the Western Cape, to take a strong stand against detention without trial and apartheid in the health services. Yet Council was reluctant to provoke political conflict that could undermine the Academy, its fine objectives and its achievements. The Academy had in its short existence demonstrated its social commitment by the provision of primary health care in under doctored areas, to the poorest of communities.

Indeed, one of the important achievements of the Academy was to bring together family practitioners of all races, language groups and political persuasions, to work for common humane and progressive objectives. This does not entirely accord with the view expressed by Williams and Reid in their article "Family Practice in the New South Africa"[53], that family practice in South Africa today (1998) is highly fragmented both organizationally and philosophically. This difference in perception is due mainly to regional variation. Whilst the authors are correct in their observation that apartheid had a fragmenting effect on medicine and medical organizations, the Academy leadership strived to promote non-racialism and a common philosophy and ethos of family medicine, this being regarded as integral to our academic function.

Historical factors were responsible for previously disadvantaged doctors forming their own groups, notably the guilds in Natal which deal with medico-political, economic and continuing educational aspects of general practice, independent of the Academy. The Transvaal Study Circle, by contrast became closely linked to the Academy from our inception and Drs A Nana and AJ Kgomo played a leading role in both organizations. Furthermore, the Transvaal Study Circle donated the presidential chain to the Academy in 1981.

Williams and Reid make a number of other observations in their article, notably that the impetus for the development of academic family/general practice has come from the practitioners themselves and not from government and societal pressures as in the United States. Nor has it come from an enlightened academic medical establishment -"Indeed, in academic centres and medical governing bodies, there remains a lack of understanding of family practice and its value, and often, a resistance to its development and growth". The gist of the article is that the planned changes in health care in the New South Africa presents

the discipline with a great opportunity for development and growth. Whether this will happen "will depend on whether, as a discipline, it can project a vision of how it can meet the country's health care needs". It goes on to state that the current government appears to consider family practice irrelevant to its efforts to provide primary care for all.

The Academy for its part, has always maintained that primary care that is not personal, continuing and comprehensive, is second rate care and will not satisfy the needs of the patient or the doctor. The Academy, with its limited resources, has set up a limited number of models that embrace these features of care. Most of our academic departments of family medicine have likewise demonstrated these principles in their practical teaching in the community. It remains for the government of this country to make available the resources to provide our previously disadvantaged and deprived citizens with first rate primary care.

It seems appropriate at this point to quote the words of Julian Tudor Hart, one of the pioneers of general practice research. He practised in Glyncorrwg, a small isolated industrial village in South Wales - "Primary Care is a good place to learn real rather than formal respect for patients, the many ways in which doctors must be subordinate to patients and the sick must become the subject rather than the object of care" (personal communication 1977). Dr Hart, who would not accept an invitation to visit South Africa during the academic boycott, thus eloquently describes personal care in a way that has a special resonance for us in South Africa.

Other important issues remain, such as the independence of the Academy from the medico-political and economic organizations that abound in South Africa. This goes back to the first academic organization of general practice in 1958 that came about through the initiative of members of MASA (now SAMA) and the support of that body. It was agreed that the National General Practitioners Group (NGPG) of MASA would deal with medico-political/economic issues and the College/Academy would confine itself to academic activities.

This division of function has to a large extent been maintained but there has been a significant degree of co-operation. The NGPG has attended most of our major workshops and has been

represented on the organizing committee of all our national biennial congresses. In February 1999 the Academy convened a workshop on CPD at which all the academic and medico-political organizations of general/family practice were represented. It was a successful meeting at which the Academy received wide support for its initiative and prospective role in CPD.

The Academy has, for its part made frequent representation to governments, old and new, and has in recent years sat on committees of the Department of National Health. We have also made frequent submissions to the SAMDC (now the Health Professions Council), on mainly educational matters affecting the future of general practice.

An interesting debate developed in the Academy in 1985-86 over the traditional right of doctors to dispense, which was under threat by the SAMDC. This was a particularly important issue for colleagues who worked in lower socio-economic areas where the medicine was usually supplied by the doctor and included in the consultation fee. Some of our members felt that the Academy was not doing enough to defend the rights of the dispensing doctor, others that this was not an academic issue. Ultimately there was a unanimous acceptance of the motion "That this General Meeting of the Academy of Family Practice reiterates the right of the doctor to dispense to his own patients and that this Academy notes with concern the possible effect of the removal of this right of the dispensing doctor might have on the standards of primary care in South Africa and therefore reaffirms its offer to conduct appropriate research in this area" (Johannesburg April 1984).

In the past few years it has become progressively more difficult to avoid the impact of medico-political/economic factors on the standards and quality of family practice that the Academy has sought to promote. We have witnessed the intrusion of big business into the relationship between patient and doctor. This is an issue mainly affecting the private sector but it must be remembered that it was the private (independent) practitioners who initiated the development of academic family medicine and its organization in this country.

The medical aid system which started so promisingly, providing patients with a sense of security, has largely fallen into the hands of corporations. We have become part of the "health industry" comprised of suppliers, managers, providers and consumers. The growth of the so-called health maintenance organizations (HMO) has provided a further avenue of commercial encroachment into primary care. The HMO is a corporate body employing general practitioners together with a number of other health professionals to whom they inter-refer their patients.

The cost of medical care has certainly increased over the years but personal care, by its nature, implies that we make our services affordable and accessible to our patients. Our diagnostic system of "making hypotheses on partial information"[13] restricts special investigation to the essential. Moreover the **well-trained** family practitioner can competently deal with the vast majority of problems presenting to him/her.

It is the opinion of senior Academy members in independent practice that the commercialization of medicine threatens the very fabric of family medicine. When profits, rather than patients become the raison d'etre of medicine, we stand to lose something precious to our patients and ourselves. I believe that access to a caring and well-trained family doctor is one of the great benefits a society can offer its citizens. This right must be defended by our patients and our selves.

Thus we welcome the efforts of Academy leadership to unify academic organizations on the one hand and the numerous medico-political bodies on the other and for the two groups to work together to preserve family practice and extend it to all the people of South Africa.

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