



Can Family Medicine extricate itself from the shackles of biomedicine?

Towards the close of last year (2003), there was an intensive and healthy debate amongst FAMEC members on the issue of the place of the district hospital in the lives and training of family physicians. The debate continues albeit with reduced intensity. Two strands appear to have emerged from this debate:

- i) Uncritical and over-whelming enthusiasm for the district hospital
- ii) A critical minority welcoming the district hospital but to proceed with caution in defense of the nascent independent status of primary health care physicians.

Both strands appear to be agreed on one fundamental issue, i.e. the training of family physicians in the acquisition and retention of biomedical interventional skills in the management of patients. However, the uncritical enthusiasm for the district hospital demonstrates the latent desire to satisfy ourselves and to prove to our biomedical colleagues that we are still doctors after all. This is somewhat reminiscent of the 19th century when surgeons in Britain were not regarded as doctors. Surgeons responded by undergoing training to become doctors and thereafter in a form of inverted snobbery dropped the title “Dr” and called themselves “Mr.” Inferiority complex negates the many complex skills of primary health care physicians in the community. To deliver effective care in the community, the health professional needs to be a competent counselor, a good listener who is patient centred, a good diagnostician and must have the ability to live with uncertainty. Our biomedical colleagues cannot run such a practice which requires several diverse skills.

Arguably, modern medical practice is heavily concentrated in hospitals in South Africa. It could not be otherwise since the development of the practice of medicine has largely followed and copied the European and North American models of health care. The preoccupation and use of hospitals encourages the dominance of the biomedical or engineering model of medicine. This is clearly demonstrated with respect to research areas from such centers where the focus remains shackled in disease and its causation instead of a focus on: ‘Why do people stay healthy?’¹. In this way, hospital doctors maintain a dominant position in matters of health care both consciously and to a minor extent unconsciously. Hospital doctors are the “experts” consulted by governments and industry and in this way community opinion is rarely represented. Primary health care physicians on the whole are the legitimate representatives of communities since the community is their domain. This physician is not only the advocate of individual patients but of entire communities and is linked through a series of networks to several support services for the benefit of patients.² The greatest drawback of biomedicine is that it is reactive rather than proactive. The emphasis is on waiting for something to go wrong; the sufferer then approaches the medical professional, the problem is

diagnosed and dealt with.³ A primary health care physician who spends a large proportion of his/her practice life in a hospital of whatever description will find it extremely difficult to minimize the dominance of biomedicine in encounters with patients. In the distribution of scarce resources in the advanced countries, it has been shown that this has tended to be skewed in favour of tertiary hospitals. The development of district hospitals in South Africa has to face this reality, and come to terms with it, since these hospitals will come to be seen as junior partners of the established biomedical tertiary hospitals.

Our different skills should not be imprisoned within the narrow confines of a district hospital. Modern primary health care ought to be about skills mix. If we are to move in this direction, as indeed we should, we need to build strong primary health care teams.

‘If shifts in care provision are to continue from tertiary to secondary to primary care, general practitioners will need to rethink their own position vis-à-vis skill mix, and negotiate with other members of the primary care team in order to allocate tasks appropriately.’⁴. In the context of South Africa, such a skills mix might include several primary health care physicians with different skills such as child care, gynecology and obstetrics, cardiovascular diseases, chest medicine, diabetes the list may go on. In addition, the mix would also include primary health care nurses, counselors, traditional practitioners, community pharmacists and social workers. A question might be asked: is there a place for the primary health care physician with surgical skills in such a set-up? The answer is a definite yes, particularly in remote rural areas. However, a large bulk of primary health care interventions can be carried out in community settings such as surgeries, community health centers and primary health care clinics. The district hospital should be assigned the role of skills training for registrars and the care of patients needing shorter periods of hospitalisation. Such a hospital should not be seen as a junior partner of tertiary hospitals but the two should work harmoniously, avoiding disequilibrium if patients and staff are to benefit.

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