OBSERVATIONS ON THE TROSKIE MEMORANDUM BY THE CAPE OF GOOD HOPE FACULTY OF THE COLLEGE OF GENERAL PRACTITIONERS

The College of General Practitioners is an academic body which aims to encourage and maintain the highest standards of general practice and to improve the status of the GP. Our observations on the Troskie memorandum are based on our experience in the Western Cape through our various activities. Thus we have come into contact with colleagues in town and country through refresher courses organized by our post-graduate committee.

Through our undergraduate committee we have been in contact with students of the University of Cape Town. We have run a yearly students' *attachment scheme* whereby students have obtained a glimpse of the atmosphere and work of general practice. We have been teaching aspects of general practice at the evening clinics run by the students in under-privileged areas. We have been in contact with the teaching staff of the medical school. One of our members has been taking part in a weekly comprehensive medicine ward round. Others have been invited to discuss a typical day in their working lives. Yet others have appeared on a yearly panel on medical ethics. Our College provides a great stimulus to its members who aspire to greater knowledge and better practice. It also creates a fine spirit among its members who enjoy the experience of working with colleagues who are similarly motivated.

At the outset it must be said that we do not agree that the standard of general practice is declining in our area. The nature of our work has, to some extent, changed and this will be discussed more fully later. We do not agree that the competence of the family doctor has in any sense declined. Moreover, his working conditions have improved as a result of partnerships, off-duty arrangements and the most significant development of group practice.

We do agree, on the other hand, that fewer graduates are entering general practice. Herein lies the great danger to the whole medical structure in this country. We have seen the eclipse of the *family doctor* in the United States and Sweden and the serious effects that resulted. It has led to an expensive medical system—costly to the patient and wasteful to

society. The unfortunate patient is passed along the 'conveyor-belt' from specialist to specialist without anyone to guide him or to take responsibility for his welfare. Thus side by side with the remarkable advances in medicine, we have the paradox of a deterioration in the quality of medical care. The relationship between doctor and patient has suffered and there is a heightened anxiety about becoming ill.

In this respect South Africa is at the crossroads. Something must urgently be done to encourage the university graduate to enter general practice in greater numbers.

We accept that the expansion of medical knowledge has created the need for more specialists. Indeed we welcome the skilled technical help that their special training has given them.

Naturally we deprecate the abuses that spring from an excessive number of specialists, i.e. the usurping of the general practitioners' work, seeing patients who are not referred and continuing to see them without the knowledge of their family doctor. We agree that a patient should always be referred to a specialist where necessary and that a full report should always be sent to the doctor who referred him. This we regard as rudimentary ethics—anything short of this acts to the detriment of the patient and the medical profession. Where this basic rule is infringed the GP concerned must make his views perfectly clear to errant patient and specialist alike. It must be said that the situation in our area is in this respect not as bad as that depicted in the Troskie memorandum.

We have referred to the changing nature of our work. Certainly in urban practice we have relinquished much of the technical aspects of treatment, e.g. major surgery and abnormal obstetrics, to those who are better skilled. We have become more dependent on the use of newer diagnostic tools which we cannot handle ourselves.

On the other hand we have been able to define our role and function more clearly as follows:

1. The general practitioner is *the first contact doctor*. He has an important—a key diagnostic role to play. For this he must be adequately trained. It has been said with much truth that the general practitioner must justify special investigation by his diagnosis whereas the specialist justifies his diagnosis by special investigation. Thus the GP remains a clinician in a profession that is becoming increasingly technical.
2. He sees a large number of unselected and undifferentiated problems. Thus he maintains perspective towards illness.
3. He sees and treats his patient, not as a clinical process, but as an individual in relation to his family and his community. Thus he provides comprehensive care.
4. He provides continuing care, guiding his patient through what has been aptly called the 'medical jungle'.
5. He takes responsibility for his patient, for both his health and welfare.
6. The GP has an important role to play in preventive medicine.
7. A well-run practice with good note-taking offers scope for research into early symptomatology, epidemiology and the natural history of disease.
8. The general practitioner has a special function in relation to the mental health of his patient. He will encounter a great deal of emotional disturbance, some the product of the environment, and some due to neurotic personalities. He is specially suited for this role because of the relationship which has developed through the years of continuing care. This doctor-patient relationship is one of the most interesting and satisfying aspects of general practice and has been the subject of much recent research.

The above-stated features of general practice emphasize the practitioner's essential role in the medical system. They also point the direction of the training of the future general practitioner for this role. It has become clear that postgraduate training has become as essential for the family doctor as it is for any of the specialties.

Why the Declining Numbers Entering General Practice?

Status in the eyes of the public. The term 'specialist' has a certain magic for the layman. This is a 20th century phenomenon and applies to all aspects of human endeavour. It is partly a tribute to his years of extra study. However, there are welcome signs that the public is becoming aware of the loss of the personal physician.

The attitude of the doctor. The general practitioner appears to have an inferiority complex about his place in medicine. This is largely due to ignorance of his true function, failure to appreciate his essential role as the first contact, personal, family doctor—indeed as the *real doctor*.

The attitude of the medical school. It is quite apparent to us that the basic problem lies in the medical school. The students with whom we have discussed the subject are unanimous in the observation that *the image of general practice is badly presented in the medical school.* This is hardly surprising when we realize that few of our medical teachers have ever been in general practice and have little understanding of its nature and problems.

Each subject is dealt with by specialists in a specialized way. The emphasis is on pathology as opposed to medical care. Students are learning too many facts, to the detriment of understanding and broad perspective. Furthermore, students tend to identify themselves with their medical teachers who are all specialists.

Students have told us of their apprehension about going into practice because they are unprepared for this type of work.

It may well be that the criteria of selection of students for the medical faculty are at fault. Perhaps our present criteria tend to turn out doctors who are too technically orientated. We can only agree with the British College which states that much research must be undertaken into this aspect of the problem.

What are our Practical Proposals?

The College of General Practitioners must be strengthened and expanded as the academic body of general practice. We have ample evidence that it has stimulated its members to further study; it has given them an insight into their vital role in medical society and a vision and philosophy of medicine. It is to be hoped that the impending formation of an independent South African College will increase our strength. In this way we shall extend our activities among our colleagues in general practice and our influence in the profession as a whole.

The growth of group practice offers a solution to the problem of working conditions. Rotation of off-duties allows time for relaxation, continuing study and holidays. It is important that each doctor retains his own patients, performing all the functions of a family doctor. However, it is possible for each member of a group to indulge his special interest within the group whether it be paediatrics, midwifery, anaesthetics or cardiology—at least one member should be skilled in electrocardiography. In this way consultation can take place within a group and avoid unnecessary reference to specialists.

It is here that the Medical Council must issue a clear directive. *Each medical school must establish a Department of General Practice.* This department must be staffed by general practitioners and it must be represented on a curriculum committee. Initially the department may consist of part-time men but it must expand to include several full-time general practitioners. It may start off as a department within a department, but it must ultimately be autonomous.

The department will undertake: (*a*) undergraduate training in general practice; (*b*) vocational training for general practice; (*c*) continuing education for general practice; and (*d*) research into the problems of general practice.

Undergraduate Training

Each medical school should run a group practice staffed by full-time general practitioners. This practice must be conducted in the best traditions of a family practice. There must naturally be domiciliary visiting and each doctor must have his own patients. The number of patients must be limited so that there is adequate time for teaching and research. Students must be attached to the university practice—full-time for a specific period—and they must live in.

Students may undertake a period of voluntary attachment to private practices, both urban and rural. In this way they will encounter a different atmosphere which will complement

their experience in the university practice. There will be a limited number of lectures, symposia and discussion groups with panels of general practitioners. We do not contemplate any examinations but university examination papers on all subjects should include questions on practical problems met with in general practice.

Vocational Training

It has become obvious that the prescribed period of undergraduate training inadequately equips the graduate for general practice as it does for any specialty.

After the period of compulsory internship, the prospective general practitioner should spend at least 2 years as a registrar in various hospital departments. Because of his important clinical role, a substantial portion of this time should be spent in the Department of Medicine. It has been calculated that 40% of our work is concerned with children so that a paediatric appointment is essential. A shorter period can be spent in those departments, e.g. dermatology, ophthalmology, ENT, which are important in general practice.

If the prospective GP has any particular leaning, e.g. anaesthetics or cardiology, he should spend additional time in these departments.

Because of the great importance of the doctor-patient relationship and the extent of psychological illness encountered, there should be psychiatric instruction as well. This should be undertaken by a psychiatrist who is particularly interested in this aspect and should take the form of group discussions. There should be a series of lectures on medical ethics and preventive medicine.

One year should then be spent as an assistant to an experienced general practitioner.

The medical school may consider it desirable to offer a diploma or honours degree in general practice.

Continuing Education

Here the Department of General Practice would collaborate with the College of General Practitioners in organizing symposia and refresher courses in both town and country.

There should also be facilities for doctors in practice to come back to the teaching hospital and the general university practice for a period of full-time instruction.

Research

The department should undertake research in its own practice. It should also help doctors in private practice to organize research. It could request aid from those members of other departments who are engaged in research.

These suggestions that have been made with reference to a Department of General Practice are by no means rigid. We appreciate that this department may start in a small way, but we feel most strongly that a department must be started in each medical school. It is only in this way that we shall avoid the extinction of the family doctor.