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TEACHING FAMILY MEDICINE - WHAT, WHY AND WHERE

PROFESSOR J BLITZ

PROFESSORIAL INAUGURAL ADDRESS
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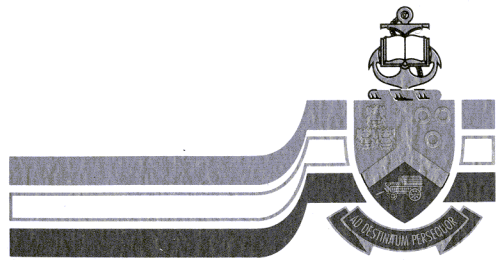


University of Pretoria

TEACHING FAMILY MEDICINE – WHAT, WHY AND WHERE

Professorial Inaugural Address

Delivered on

28 May 2002

by

PROFESSOR J BLITZ

CURRICULUM VITAE
JULIA BLITZ

Julia Blitz matriculated from Brescia House, Sandton in 1975. She gained a BSc with majors in Anatomy and Physiology from WITS University in 1979 and then completed her MBBCh at the same university in 1982.

She completed her internship at Baragwanath Hospital and followed this by doing two medical officer jobs in Paediatrics at Windhoek State Hospital, Namibia and Livingstone Hospital, Port Elizabeth. Realising that she wanted to pursue a career in Family Medicine she then began the South African Academy of Family Practice's Vocational Training Scheme, which consisted of 18 months at Edendale Hospital, Pietermaritzburg and 12 months at Benedictine Hospital, Nongoma. She then went into private family practice in Pietermaritzburg in 1987. While in practice she completed her M Prax Med degree with MEDUNSA in 1990 and subsequently became a part-time lecturer in their Department of Family Medicine.

In 1997, she moved to Pretoria to join the Department of Family Medicine as a Senior Family Physician at Mamelodi and Pretoria Academic Hospitals. For eighteen months she also took on the task of Acting Medical Superintendent at Mamelodi Hospital. In June 2001, she was appointed as Professor and Head of the Department of Family Medicine.

During the period of her academic career, she has supervised 16 Masters students research projects, published 8 articles in peer-reviewed journals, written 1 chapter in *"The Handbook of Family Medicine"*, peer reviewed articles submitted for publication to *"Medical Education"* and *"British Journal of General Practice"*, served on the Editorial Board of *"CME – journal of Continuing Medical Education"* and currently serves as the Associate Editor of *"SA Family Practice"*. She has presented papers and posters at National and International Congresses.

She has also been an external examiner for undergraduate and post-graduate exams of other South African Departments of Family Medicine and the College of Family Practitioners exams, as well as for 7 theses for Masters in Family Medicine research projects.

She has served on the organising committee of National and International congresses and convened the Scientific Programme of National Congresses.

In the School of Medicine, she has been the Chairman of Special Activity 5 of MBChB curriculum and is currently the Chairman of Block 16 of MBChB curriculum, the Chairman of the MBChB Progress Test committee and the Family medicine representative on Undergraduate Curriculum Committee.

Professor Blitz has previously been the Director of the SA Academy of Family Practice's Rural Health Initiative. She is currently the Vice-Chairman GP Committee, Medical and Dental Professional Board, Health Professions Council of South Africa, the Chairman SA Academy of Family Practice Task Team on Continuing Professional Development and the Chairman of Family Medicine Education Consortium (FaMEC).

She is married to Professor Gerhard Lindeque and between them they have four children. Three are studying at the University of Pretoria, but none display any interest in the field of medicine!

INAUGURAL ADDRESS

Mr. Vice-Chancellor and Rector, Dean of the Faculty of Health Sciences, other dignitaries, colleagues, family and friends, it is a great honour to be able to deliver this inaugural address to you tonight.

I would like to speak to you about

Teaching Family Medicine – what, why and where

Although Family Medicine has a strong presence in the undergraduate curriculum of **this** Medical School, there are currently limitations to reaching all the goals of teaching Family Medicine when it is based largely in tertiary academic teaching hospitals.

In my talk tonight, I would like to
explore the **characteristics** of Family Medicine (the what),
the **teaching objectives** that we have (the why) and on that basis
motivate why we need to look for **sites** for the teaching of Family Medicine in addition to those that we already have (the where).

Family Medicine is the discipline that focuses on a commitment to the person, their family and their community rather than their disease.

This slide graphically depicts the difference between family medicine and other disciplines. This difference is that family physicians become experts in seeing different illnesses in the same person, whereas specialists are experts in seeing the same diseases in different people.

		Specialist		
		GIT	Dermatology	Gynaecology
	Person		X	
Generalist	Person	X	X	X
	Person		X	

Boland 2002

This different perspective requires specific exposure to the characteristics of Family Medicine in the teaching of the discipline.

I would like to tell you about the Characteristics of Family Medicine (the what) and the unique contribution that Family Medicine makes to medical care

In order to achieve the abovementioned focus on the person, there are five characteristics that need to be identified in order to establish the teaching objectives for Family Medicine:

i. The first of these is contextualised care
This is **the** defining characteristic of Family Medicine.
The implications of this are that

- health care problems are seen in a biological, psychological **and** social (biopsychosocial) context (in other words, it is as important to be concerned about the effects of the patient's symptoms as you are about the cause of the symptom),

Biological pathophysiological deviation Psychological individual's thoughts, fears, feelings and expectation Social family, work and environment

and that

- general systems theory (which takes account of chaos and complexity in the real world) is medically applied (in other words, that causation is **not** linear and that the different parts of a phenomenon interact in relationships with each other to produce an outcome).

Contextualised care allows us to help patients to define the meaning of their medical problems in terms that are of meaning to **them** in **their** context. This facilitates the development of a collaborative plan that factors patient and family values into a strategy for managing the problem in each of the biopsychosocial contexts. The objective of contextualised care is to initiate and foster an effective therapeutic partnership by understanding the household and social, functional, financial, dependency and cultural contexts that the patient exists in.

Ransom and Vandervoort 1985
Family Medicine is an emerging discipline concerned with the relationship of life in small groups, to illness and care. Its focus is on the ecology of relations among individuals in families, and between families and their surrounding environment. Family medicine aims toward *understanding* and *changing* health problems that **cannot** be managed successfully by dealing exclusively with the individual and his or her illness, abstracted from the pattern of *recurrent interpersonal situations* that shape and transform a human life.

McDaniel 1990 outlined the following aspects of contextual care in Family Medicine
Family-oriented care is based on the **biopsychosocial** model.
The **primary focus** of medical care is the patient in the context of the family, because:
a) The family is the primary source of many health beliefs and behaviours.
b) The stress that a family feels when going through developmental transitions can become manifest in physical symptoms.
c) Somatic symptoms can serve an adaptive function within the family and be maintained by family patterns.
d) Families are a valuable resource, and source of support, for the management of illness.
The patient, family and physician are **partners** in medical care.
The physician is seen as **part of**, rather than apart from, the treatment system.

ii. The second characteristic of Family Medicine is continuity of care
This is the fundamental value of Family Medicine.
The concept covers continuity of both the doctor-patient relationship and of the transfer of medical information on a number of different levels:

- chronological level

This is a responsibility over time. Knowing patients when they are well provides the family physician with powerful information about their personalities and character that can be drawn upon and used to advantage when the patient becomes ill. Caring for patients through a series of illnesses can help the physician to understand the patient's coping mechanisms, tolerance of symptoms and personal resources.

- geographical level

This continuity is assured when a single provider is responsible for the co-ordination of care and is accessible to the patient no matter where the care is provided. This ensures continuity of information to and from the family physician when other health care providers become involved in the patient's care.

- family-oriented level

For this level of continuity to be a reality, all of the members of a family unit should identify with and seek care from the same primary care provider. Caring for families makes it easier to recognize and treat illnesses or conditions that occur more commonly in families. Illnesses invariably have an impact on all members of the family, and the course of an illness can be dramatically affected by family factors. Many patients value family care.

Providing continuity of care has the outcome of improved patient satisfaction, doctor satisfaction, cost of care and quality of care

iii. The third characteristic of Family Medicine is accessing care;
Access to health care does not guarantee that care will be utilized appropriately. There are a number of factors that contribute to patients seeking health care – what makes **people** become **patients**! There is a highly complex process by which a person evolves from thinking of themselves as healthy to thinking of themselves as sick. This is greatly influenced by social, family and cultural expectations and beliefs. Access to care occurs when perceived needs outweigh barriers.

It is essential that family physicians have the skills to identify and overcome these barriers to access, as well as to identify patients who overuse the system. The family physician needs to establish the underlying reason why the patient chooses to consult.

- Some of the factors that patients consider in deciding to access care are:

Seriousness or severity of symptom e.g. coughing may be acceptable until the sputum contains blood
Degree to which the symptom causes anxiety or fear e.g. sudden weakness in a limb
The opinion of the family "health authority" e.g. the grandmother
Previous personal or family experience with the symptom
The degree of inconvenience involved in accessing care e.g. no transport to clinic
Economic impact of missing work or school e.g. no work, no pay
Degree to which the patient, or family, values continuity of care with their own provider e.g. not wanting to access an off-the-street walk-in facility
Personal or family experience with health care e.g. ability to self-treat
Economic costs of accessing care e.g. user fees

So, barriers to access can be financial, geographical, cultural, family-based, health system, gender-related or educational.

- Reasons for patterns of overuse are now listed on the next two slides. These include

Patient has an undiagnosed mental illness, such as depression or anxiety disorder, eating disorder
Patient has a drug or alcohol abuse problem
Patient is living in a dysfunctional family or marriage
Patient is seeking care to obtain safety from a situation of family violence or intimidation
Patient is lonely or emotionally needy and utilizes care as a social outlet
Patient is obtaining secondary gain from utilizing care, such as an excuse to miss work, or for disability
Previous physicians may have implicitly or explicitly encouraged the patient to overuse care
Patient has had a prior traumatic experience leading to excessive worry about health e.g. surgery that was complicated, remission phase of cancer

These are not things that patients usually present with directly, but overuse patterns should alert the physician to the possibilities of such "hidden" problems.

A confusing or unusual complaint from the patient often precipitates a quest for the "holy grail" of the rare diagnosis without any attention to the underlying and important problems that exist within the contexts of care other than the biomedical.

iv. The fourth characteristic of Family Medicine is the provision of comprehensive services;
Family medicine needs to be aware of which services are most essential to the health of the community being served and to ensure competent management of the common problems. This needs to include

- the scope and extent of services required by members of the community (that is whether the service should be performed at the site of care or whether the patient would be better served by being referred to another health care centre). For instance, it may not make sense to develop an expert service in the management of pulmonary tuberculosis in a community where this is uncommon – it may be more effective to refer these patients to a center that develops the relevant expertise. Equally if the community that you work in has a high prevalence of hypercholesterolaemia, it may be appropriate to develop a full range of risk factor assessment and lifestyle and disease modification services.

Comprehensiveness of services also includes the concept of

- methods of evaluation and improvement of service provision (this would include competence of practitioners and assessment of the scope of services). This concept is served by the carrying out of quality improvement exercises as an integral part of practice. This is the constant assessment against a pre-determined standard, of the services provided by you and your team in your practice.

v. The last characteristic of Family Medicine is co-ordinated care;
Family physicians need to attend to all aspects of each unique patient's health care needs:

- health promotion and patient education,
- preventive services and screening,
- formation, organization and leadership of health care teams,
- referral process to other health care providers in the community with effective transfer of information,
- chronic illness management,
- patients with special needs (geriatric patients, disabled)

The success of Family Medicine revolves around the success of the consultation in discovering the reasons why the patient has sought care on that particular occasion, and

knowing what within the health care system and that patient's context of care will be available to promote or return health.

Stott summarized the potential of every Family Medicine consultation in the following way: The Family Physician needs to pay attention to medical problems, but we need to remember that these may be of two types - the presenting problem (maybe an ingrown toenail), but also the continuing problems (such as an alcoholic spouse). However, attention also needs to be paid to the health behaviour of patients. Here there are again two areas – that of modification of help-seeking behaviour (understanding why the patient chose to come at that time, including an understanding of barriers to seeking health care and overuse of health care systems) and opportunistic health promotion (the obligation to consider ways of maintaining health or minimizing complications that may result as a consequence of risk factors or disease).

Attention to medical problems	**Attention to health behaviour**
A	B
Management of the presenting problems	Modification of help-seeking behaviour (health care utilization patterns and resources)
C	D
Management of continuing problems	Opportunistic health promotion (disease prevention and health education)

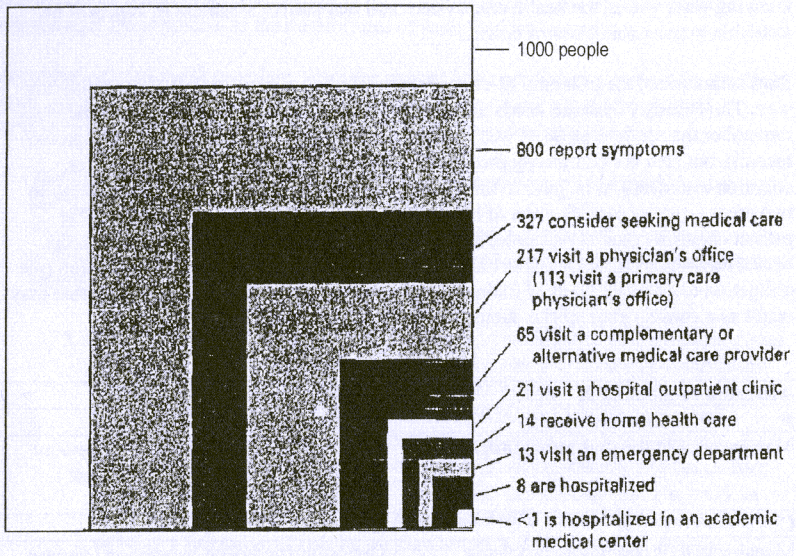
Stott and Davis 1979

In the light of these five characteristics of Family Medicine, I would now like to move on to why we think that Family Medicine has a place in the medical curriculum

What are our Objectives in teaching Family Medicine to medical students?

In order to enable students to deal with undifferentiated patients seen at the first point of care, we need to expose students to the case mix that is seen at community level in addition to that seen at academic hospital level.

The following diagram is from an article that describes the ecology of medical care in the United States in 1996.



It can be seen that of 1000 men, women and children in the United States, on average each month, 800 experience symptoms, 327 consider seeking medical care, 217 visit a physician in the office (113 to a primary care physician), 65 visit a professional provider of complimentary or alternative care, 21 visit a hospital-based outpatient clinic, 14 receive professional health services at home, 13 receive care in an emergency department, 8 are hospitalized and less than 1 is admitted to an academic medical centre. Please note that these results are not subgroups of one another; they are all based on the denominator of 1000. The researchers confirmed that the number of persons receiving care each month in different settings varies according to age, sex and race. This shows that each month a large proportion of the population has symptoms. Almost 25% visit a physician's office, but less than 0,1% are admitted to an academic medical centre.

Interestingly this study confirmed the stability of the relationships of forms of care first presented by White in Britain in 1961. There is probably no reason to think that the proportions should be greatly different in this country!

There are various objectives in terms of knowledge, attitudes and skills that result from the characteristics mentioned above in terms of what Family Medicine strives to achieve within a curriculum.

The contextual model of Family Medicine means that students need to establish, understand and know how to use, the patient's context in developing a health care plan, within a health care system.

Competencies needed for this are:

- Communication and inter-personal skills to build a relationship of trust and respect between patient and doctor
- Cultural competency to understand the social and family aspects of the culture of which the patient is a part
- Preventive care competency to determine when appropriate measures should be taken to prevent progression of risk factors to disease, or to prevent progression or complication of disease
- Competency to continuously evaluate and educate oneself in terms of the services that one is required to provide to the community in which one works
- Competency in systems thinking to take into account the multi-factorial relationships between the bio, psycho and social contexts of each individual patient
- Competency to assess community needs in an attempt to provide services relevant to their particular needs
- Competency to care for common, acute, chronic and behavioral problems in a way that is cost-effective and provides as much care as possible within the community
- Competency to recognize uncommon problems and to deal with them appropriately
- Competency to organize and co-ordinate the health care team of colleagues, other health care professionals, community organizations, etc

A significant part of South Africa's health care plan revolves around the effective functioning of the district health system. This is the level of the system at which Family Medicine finds its home. The district health system includes an effective inter-relationship between private sector primary care physicians as well as public sector primary health care services. This means that we have an obligation to train South African generalist medical graduates how to work in this system - not just from an understanding of policy and theory, but to have the skills to be able to practice in that system. It is also crucial for the effective provision of health care in South Africa that there is an effective primary health care system which ensures quality care of patients with appropriate referral further up the system and competent dealing with patients when they are referred back down the system. In terms of life-long learning and continuous quality improvement, it is important to understand what you are referring for (up referral) and to have the opportunity to learn from what happened when the patient was referred. The importance of working in relationship with specialists is crucial for this. Training to work in a low technology environment, where referral for further investigations and specialist opinions is not as easily accessible as within secondary and tertiary hospitals, is also important to ensure that the future graduate is comfortable working in this sort of

environment. The needs of the management of the patient need to be weighed against the logistical difficulties of obtaining these investigations as well as the logistical difficulties of the ambulatory patient returning for the results.

Training needs to place great emphasis on the development of self-sufficient practitioners with a deeper understanding of the impact that illness and disease have on a patient and their family, as well as an obligation to be aware of one's own limitations and a commitment to life-long relevant learning.

The educational motive for exposing all students to the Family Medicine care model is that it useful for all health care practitioners, although the nature of some disciplines will preclude incorporation of these concepts to any large extent. Being taught in the context of where you will be practicing is likely to ensure that the knowledge, skills and attitudes are learnt and practiced, because they are requirements of providing service in that context, not merely theoretical constructs.

Teaching students how to respond to the needs of their practice (patients and community) is a locally relevant and internationally competitive skill.

This table is a comparison of the most common reasons for visits to Family Physicians at the Mathibestad clinic near Hammanskraal and the American National Ambulatory Medical Care Survey. It is evident that different communities present with different reasons for visits. It can be seen that while hypertension is the commonest reason for visiting Mathibestad, it is only the 4th most common reason for visits in the United States. Antenatal care is a much more common reason for visits to Mathibestad than it is in the NAMC survey. Most significant though are the nine reasons in pink on the Mathibestad list, which do not even appear on the NAMCS list! It would appear that practicing in the Mathibestad community requires different knowledge skills in terms of the ability to deal even with common problems.

This illustrates the necessity of understanding the particular health needs of the community in which one is working.

Mathibestad clinic 2002	**NAMCS survey 1993**
Hypertension	General medical exam
Contraception	Throat or neck symptoms
Upper & lower respiratory infections	Cough
Antenatal	Hypertension
Pain	Upper respiratory tract congestion or infection
Skin conditions	Back symptoms
Immunizations	Earache
Diarrhoea & Vomiting	Abdominal pain
STDs	Headache
Asthma	Well child care
Well baby examination	Skin rash
Urinary Tract Infections	Fever
Diabetes	Prenatal care
Psychiatric conditions	Chest pain
Eye problems/ Conjunctivitis	Pap smear
Osteoarthritis	Medication follow-up

Lastly, I would like to propose why we need to look for additional sites for the teaching of Family Medicine in addition to those that we already have. In other words, where and how these teaching objectives would best be met

Because all patients arriving at academic hospitals are referred by another health care worker, these patients are essentially no longer "undifferentiated" patients. Students are seeing a selected group of patients, with an already predetermined notion of what the problem might be. However, it is important for students to experience in this tertiary setting, the role of ambulatory care and the relationship with specialists and other members of the health care team. This allows them to see how the different health care professionals at different levels of the health care system can effectively work together in the provision of seamless health care services to patients. It gives students an opportunity to learn skills more regularly performed in the larger hospitals.

Distancing (or dislocation) of the academic hospital from a specific community that it serves, makes it difficult for students to see and understand the patient's social context and habitat. Therefore, it is also important to balance the academic hospital site of training with sites where there are opportunities to meet some of the other teaching objectives, for example cultural competency, systems thinking and assessing community needs.

Training sites that provide only ambulatory care, with no access to investigations other than those that can be done at the bedside and logistically difficult access to hospital care, and with truly undifferentiated patients, provide a more accurate perspective on the

practice of Family Medicine. It is more closely allied to the sort of practice that many of our undergraduates are likely to experience in smaller hospitals and their associated clinics where they will spend time during their community service, as well as to the type of private generalist practice where many of them may practice in the future. There is evidence that providing sites of medical academic excellence in communities adds value in terms of improving the health care of those communities.

Training in parallel with other disciplines such as nursing and allied health professionals, and the ability to interact with community structures enables greater competency to assess community needs and to work in a team

The role of senior mentors who have a long-term commitment to their practice cannot be overlooked. These members of staff illustrate the value of continuity of care and of understanding community resources (both other health professionals in the community and community agencies and organisations).

I would like to conclude with the following five recommendations, which need to be in place in order to reach the objectives of teaching Family Medicine:

1. Teaching practices (in central and satellite locations, in hospital and community-based sites) need to include sites providing all levels of care in order for students to be exposed to the full spectrum of diseases as well as potential levels of care with each one's benefits and constraints. Each site needs to develop the concept of it being a practice with an awareness of patients' contexts and a sense of responsibility for the practice population. The site needs to have a dedicated team of health care professionals who will strive to provide the best possible quality of care of relevance to the problems that its patients present. These sites should be seen as an integral part of the academic teaching complex. The apartheid of hospital and district health care systems should be abolished.

2. Joint appointment teaching staff should also be appointed to sites outside the academic hospitals, in the district. These appointments should be within the private sector and the public sector. This would have the advantage of providing academically minded mentors on site. These members of staff could be not only Family Physicians, but also nursing staff and possibly allied health professionals, to facilitate the parallel training of students from different disciplines.

3. Model training facilities would be created at which all the competency objectives mentioned previously could be achieved. This would result in the provision of excellent quality of care to the communities served. This would require the staff to have a sense of long-term commitment to the community being served and to interact with community structures and across the barriers between private and public sectors. These facilities would represent the ideal at which the District Health System is aimed.

4. Mastering the outlined knowledge, skills and attitudes will enrich our graduates' ability to practice comfortably in the future at sites outside of the large hospitals where most of their training has occurred. It is hoped that this degree of comfort would allow them to consider as a viable option the return to such practices after they have graduated. This would increase the pool of graduates looking at practicing as a generalist in South Africa as an acceptable career path.

5. We, in the Department of Family Medicine, would like to support the University's vision of producing an "Innovation Generation of medical graduates", by providing our students with the opportunity of broadening their experience from the current largely hospital based one to an experience that in addition embraces providing care to people in the context of their communities, over time and with an understanding of the systems (social, family and health care systems) in which they find themselves working.

Thank you all for being here this evening and for allowing me the opportunity to address you on this subject. I would particularly like to thank those of you who played a role in my training and development. But, most of all I would like to thank my husband, my daughter and all the other members of my families (the basis of **my** context) for their support of my career and for all their love and encouragement.

Thank you