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CONTENTS

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FACTORS AFFECTING THE OUTCOME OF TREATMENT OF PULMONARY TUBERCULOSIS IN SUB-OPTIMAL CONDITIONS:

An 18-month Follow-up of 224 Patients

By

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Science Assisted Medicine and the Future of General Practice and Public Health

BY

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"There is new interest in the total quality of life rather than in disease and infirmity."
—Forest Linder.

Our profession has been slow to recognise disease in society as a whole in contrast to its skill in caring for individual sickness. The cost of medical and surgical treatment has risen from year to year and there is an increasing demand for specialised care with more hospital beds, an indication that the overall health of communities improves slowly, if at all. During the last 100 years social and economic progress alone may be credited with having played a large part in improved mortality rates. Individual doctors have made efforts in the past towards advancing preventive medicine throughout the world, while research in psychiatry and sociology indicates there is need for a new approach with man again regarded by his doctors as a whole human being both in health and disease.

It may be assumed that clinicians and the public are ill-prepared for this "holistic" view of illness. Examples are the tentative treatment of alcoholism or drug addiction and crime which require psychiatric care combined with social medical research. A physician's training includes little consideration of morals, aesthetics and study in the field of inner self-fulfilment, since this is assumed to form part of traditional education at home or at school. His function, therefore, is largely confined to treating and relieving disease in individuals, while each social group is itself left to decide what constitutes health or illness worthy of treatment. Divisions of medicine into preventive medicine, general practice and specialisation (now frequently superspecialisation) have resulted in inequalities of status without true co-operation between doctors or medical auxiliaries.

Medical doctors are now less respected in a changing world where younger age groups live an almost tribalised existence in contrast to their ordered life in the nation states of recent history. An urban medical practice today is an integrated collection of individuals with differing approaches to work, family life and recreation. Some oppose and others support traditional culture, but are at all times subject to thought control through the "mass communications" media.

In the past, more especially in rural practice, a physician, as a member of a community, was consulted on matters outside treatment and cure of disease. This is seldom so in "modern" society and in cities where doctors become involved at times in what amounts to an "ego game," a struggle to achieve wealth and influence with or without concern for the health of the community as a whole. What of the public health physician? In general less well paid than clinicians, their status suffers in State Health Services, yet they are vital to the defence of a nation's health through active involvement in social medicine. Their opportunities to practise clinical medicine are reduced. The World Health Organisation Technical Report Series No. 355[1] recognises, however, physicians practising outside a hospital (general practitioners) as first line public health workers in daily practice; seeing patients in their own environment; first to observe the occurrence of disease or infection, and able to play a part in mass screening or in health education with surveillance of groups at special centres and in immunisation programmes. It is suggested that specialist physicians and surgeons practising in hospitals should now consider their work as part of a broader picture and know how and when to work with agencies concerned with various aspects of public health. Traditional divisions in medicine may therefore hinder programmes aimed at all-round improvement in the health of a people.

Sociomedical problems such as alcoholism and drug addiction in urban areas and the increasing incidence of psychiatric illness and crime will require further applications of the techniques of preventive medicine to a wider field which in-

volves the community and its physicians, general practitioners, hospitals, consultants or "polyclinic" personnel in total co-operation with medical auxiliaries, health workers, psychiatrists and sociologists. However, those who are interested in such schemes will recognise the existence of a double standard in our society, the modern ethos, predominantly "scientific" and humanist and the remains of a traditional orthodox or mainly Christian culture.

The determining influence within society is no longer the church or even an all-powerful rationalistic, humanistic State, but "public opinion" managed and manipulated by a confusion of interests in politics, commerce, the universities and the "Establishment," or by vaguely socialist-liberal theorists, while the depleted and more easily understood "isms" continue their appeals by suggesting to the masses a well-defined goal and a manageable design for healthy living.

The State has always been considered non-moral. There are no elements of natural goodness in it. Like science, its morality depends on the morality of those who control it.[3] Power may corrupt, and ever-increasing control over the medical profession, with an easy promise of "health" for all through treatment of disease at slight cost to the individual, should alert medical and allied workers to dangers inherent in such views. A medical profession without independence, unity and equality of status among members is unlikely to remain a creative minority within modern government. A confusion of interests manipulate government policy with moral or immoral purpose (always concealed in altruistic statements), yet moral superiority in a small group can, and often does, exert decisive control. The medical profession has a great history, strong philosophical roots, and should be in a position to exert such an influence at a time of change. Our services should therefore become more firmly established within the community and not only at "city hall" or through pressure groups in associations, universities or "colleges." As a first step, a democratically constituted profession in communities of the future could well reconsider its attitude towards "closed" hospitals and to colleagues now excessively privileged.

In a society subject to medical care orientated towards the attainment of health rather than sickness, the need for institutionalised treatment may even diminish with successful mass programmes in screening out disease. At times this has been shown by reductions in the incidence of such "social" diseases as tuberculosis or venereal disease, yet even here defective liaison between social services, sociologists and doctors leads to recrudescence.

There are many ways of looking at illness, but we are largely concerned with western man's emphasis on a voluntary contract between doctor and patient where the client does not seek help unless his normal activities are hindered. The decision to seek help may be a highly complex and sophisticated decision, as when an adult recognises that he is ill in the sense that his own society recognises illness, that there is something wrong and that a medical doctor is the appropriate person to consult, not a popular medical book, a spiritualist or a chiropractor. A religious component exists in this relationship on account of remaining uncertainties in "medical science" and a physician's ability to relieve anxieties regarding health.

There is ample evidence to show that wide divisions of scientific medicine are not warranted when applied to health care. Medicine as part of the science of life has lagged behind natural philosophy,[4] especially when we consider the significance of nineteenth century achievements and discoveries in wave theory of light, diffraction and polarisation, measurement of light velocity, spectrum analysis, wave length measurements, atomic theory or thermodynamics. These discoveries influenced humanity and medical science at least as much as the work of medical leaders, discoveries which though applied in the twentieth century were ignored at times by supporters of the institutionalised and traditional art of clinical medicine.

At a time when we are seeing changes in social organisation and teaching and when man is probing the secrets of survival and longevity along with attainment of a healthy mind and body, world overpopulation and social disease threaten civilisation itself. Two world wars, a shortage of medical practitioners and some disarray have moved family practice away from its leisurely function of bygone days when the physician was a family friend in time of sickness, an amateur psychologist and an opinion leader in each community. The harassed doctor of today, working in an office or surgery overflowing with patients who seek relief from anxiety and tension or minor ailments, spends little time studying his community and the aetiology of disease. Medical traditionalists hold the stage and usually clinicians at that. There is strong support for team or group approaches in resolving problems and in organising primary care. We are advised to

reject ideas that disease may not be what it seems to be by clinicians who may not have appreciated the biosocial aspects of man in his community. A practical solution is favoured.

Workers in public health and social medicine do not as a rule regard health and disease in the tradition of hospital clinicians. Having been divorced from their once active role in treatment of disease, they form a speciality in medicine less well equipped to deal in primary medical care. It is difficult to visualise a role for public health physicians in group clinical practice, at health centres or at polyclinics where numbers of clinicians work in diagnostic treatment centres of referral and re-referral. However, such health centres or group practices may in the end prove self-defeating, at best an expensive outgrowth of hospital specialist services, while family practice could continue to stagnate in the shadow of institutionalised medicine.

"Free" medical treatment does not necessarily lead to improved community health, and fragmentation continues in our State-supported treatment of emotional disorders, mental illness and crime.

Although aware that changes are required in medical education in order to meet conditions in practice today, many universities continue to train doctors in more exacting scientific disciplines, possibly without seriously considering whether this does in fact lead to the creation of a good doctor, a cultured man, a man concerned with the health of his community. More recently medical faculties have undertaken training of general practitioners, which training may be given a place beside specialism and social medicine. Another speciality? Is it possible that our teaching colleagues hope to be absolved of responsibility for family practice in this way? Dr. Van Es of Utrecht says, "being a family doctor is not practising a specialism, it is exercising a function in a certain way."[5] Today the problem of health in a community is certainly a practical problem, a problem of administration, finance, deployment of paramedical workers, social welfare workers and psychiatrists. Town planning, slum dwellings, pollution and industrial waste, together with housing and conditions of work or recreation, are surely the concern of general and family practice?

The institution of State medicine and sick funds or medical aid societies combined with increasing affluence among the urban industrialised peoples has led to misuse or overuse of specialists in widely divergent fields of medical care. The enormous cost to the community or State re-emphasises the need for general practitioner and public health services which provide direct accessibility to family doctors along with paramedical workers and field workers in social medicine and psychiatry. Without presymptomatic diagnosis, active preventive medicine and screening programmes[2] working outwards into each community, family practice will be unlikely to influence the health of people who are at present hospital and specialist dependent, or suffering from psychosomatic and social disease.

Primary health care could not therefore be regarded as satisfactory without providing—

(a) adequate diagnostic screening and referral services;

(b) accurate and updated record keeping, storage and retrieval of information;

(c) a continuing role in research into community development and social disease.

This envisages the creation of an instrument, a team or group in general practice rather than polyclinics or an extension of hospital outpatient departments into primary health care, but does not preclude a function within a hospital building or adjacent to a hospital or in association with a university or group of specialists, since direct access to advice and consultations with hospital specialists is mandatory. Specialist co-operation is required for successful programmes of presymptomatic diagnosis and continuing education along with exchanges of information, record keeping and storage with retrieval for purposes of research.

Autonomy has been stressed, however, since the status of practitioners in family care or in community practice units suffers if made subject to direction by specialists in clinical disciplines. Health team or unit or group leaders are required for primary care rather than individual practitioners; physicians working in practice and trained in psychiatry and in social medicine for a continuing role as directors and in research. Otherwise primary care falls behind advances in science-assisted medicine. A move outwards into the community in presymptomatic diagnosis and preventive medicine results in a merging of general or family practice and public health in community health care. Is it too much to insist that primary care units include all the functions of (a), (b) and (c), along with responsibility for the overall health needs of the people? Fragmentation is unnecessary in what is essentially the social psychosomatic disease pattern of family practice. Advances in science and tech-

nology are as well applied to family practice units and public health as they are today in hospital and specialist practice.

Earlier it was emphasised that our profession has a great history, strong philosophical roots and should always be in a position to exert influence at a time of change. Many individuals have made contributions towards improved community health. It is unlikely, however, that a Jenner or a general practitioner of the calibre of Mackenzie could work out with a team of paramedical and sociomedical workers in practice today.

Voluntary contracts between doctors and patients reduce the possibility of general acceptance of group or health unit practice as outlined above. The ideal would appear to be unattainable at this time, yet general practitioners and public health officers should give some thought to these concepts since remaining uncertainties in "medical science" become fewer. As the clinical specialists reduce the role of general practitioners in institutional medicine, so the work of health educators, sanitary engineers, obstetricians, paediatricians and sociologists[6] reduce the role of public health physicians in social medicine. Urban society today as much as the rural society of old is in need of a helping, supporting relationship from the profession of medicine in each community directed by practitioners who seek consciously to control and to integrate the means for maintaining a healthy community. It would be a considerable advance if proposed specialities in family practice and the speciality of public health could be merged into a function as family health units in our communities. Group medical practice is therefore considered to be ineffective without public health physicians playing an active role in primary medical care.

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