

The role of clinic visits: perceptions of doctors

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Abstract

Background: The aim of this study was to ascertain what doctors perceive to be their role in visiting district clinics.

Methods: Individual and focus group interviews were conducted with hospital doctors of different seniority and with doctors who work solely in the clinics.

Results: A range of important themes emerged from the interviews, relating to the intended function of the clinics and their resources, the operationalisation of doctors' visits, the varied roles that doctors play in clinics and the importance of teamwork and support. Doctors working full time in the clinics shared a more positive view.

Conclusions: There is a need for clear consensus policy and guidelines on the role of the doctor in primary care clinics, the involvement of the doctor in the management of clinics, structuring doctors' visits to ensure continuity, facilitating transport for doctors, and ensuring that dedicated doctors are available to visit clinics, to support community service doctors visiting the clinics and to train clinic nurses.
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Introduction

Primary care clinics are the backbone of the district-based health service in South Africa. They are run mainly by primary health care nurses, who perform a wide range of functions, including the diagnosis and treatment of the patients.

It is intended that doctors should play a supportive role through regular visits to these clinics. However, there is great variation in the roles played and frequency of visits by doctors in different provinces and districts. The National Department of Health's Primary Health Care Package states the norm that "Doctors and other specialised professionals are accessible by communication for consultation, support and referral and provide periodic visits", but does not indicate the frequency or function of these visits.¹

The Eastern Cape Provincial

Department of Health developed a helpful guide for doctors visiting clinics, but it is not known whether this guide is used at all.²

Another issue that is not clear is that of which doctors should visit clinics. The concept of the district medical officer is accepted in principle, but such personnel are few and far between. In some places, district family physicians are utilised to support these functions (Dr G Marincowitz, Limpopo, personal communication). In other provinces, such as the Eastern Cape, visits are mainly done by part-time medical officers. North West Province has also made use of local private general practitioners in some districts, and this is the subject of other research.³ In most cases, hospital-based doctors are responsible for these visits – a phenomenon which creates its own problems.

Recent research has highlighted how nurses, particularly in the North West Province, respond to and experience doctors' visits to clinics.⁴ It is clear from this research that a doctor's visit is very useful and an important part of the running of a primary health care clinic, if it is constructive. However, poor co-operation and negative attitudes by doctors can render such visits non-functional and often useless.

A knowledge of doctors' views on their roles during clinic visits will help to develop a structure for these visits, and to guide education and management interventions.

Methods

Aim: The aim was to understand how doctors in the public health service perceive their role in visiting primary care clinics.

Study design: A qualitative study was done using a phenomenological approach through focus group and individual in-depth interviews.

Sample: The sample was from two North West Province districts. Doctors working in the former Odi district and in Brits Hospital were invited to participate in focus groups. These two areas were chosen because it was there that the research on how nurses experience doctors' visits had been done. Two doctors from Odi district who are involved full time in visiting clinics formed one group, and six of the eight Brits Hospital doctors who are involved in visiting clinics in the district, formed the other. Individual interviews were conducted with six specially selected doctors working in the Klerksdorp and Potchefstroom hospitals, including a community service doctor, a clinical manager and experimental medical officers.

Data collection: Data was collected both through focus group and individual interviews, with cross-validation. The exploratory question was "What do you think of the role of the visiting doctor in primary care

clinics in your district?" The individual interviews allowed for in-depth exploration of the doctors' thoughts and feelings on the issue. Reflection and summarising were used to obtain as much information as possible from the interviewees, and the interviews were continued until saturation had been achieved. The focus groups allowed for an exploration of some of the interactional issues and for differences of opinion to be expressed and debated. The interviews were audio-taped and transcribed.

Analysis: The researchers involved in each arm (IC and WvD) identified themes and created a baseline summary through content analysis. The third researcher (JH) did cross-checking of the analysis and validated the themes. The two arms were then combined for reporting.

The themes identified in the focus groups were validated by the participants. The results and recommendations were shared with two of the interviewees and with one participant in the focus groups for further validation.

Ethical considerations: Participation was voluntary and informed

consent was obtained. The protocol was approved by the North West Province Department of Health and Medunsa Research and Ethics Committee.

Results

The identified themes were grouped into five main areas (see Table I).

A. Health service issues

1. *The place and importance of clinics*
Doctors recognise that primary care clinics are fundamental to the functioning of the whole health service, because they are the "backbone of the system". "I feel the clinic is actually the entrance of the health system for the patient and it is a very important place."

Clinics are seen to be "taking the service to the patient", instead of making patients come to the service. The work that the doctor does at the clinic ensures continuity of care for the patients.

Working at clinics in a poor community is also educational for the doctor, because it exposes him or her to "the poverty, unemployment and high prevalence of infectious diseases in the poor community".

Table I: Themes that were identified

Area	Related to	Themes
A. Health service issues	the intended function of clinics	1. The place and importance of clinics 2. The environment of the clinic 3. Resources and equipment
B. Organisational issues	how the system of doctors' visits is operationalised	4. Senior doctors needed with experience 5. The allocation and rotation of the doctors 6. The structure of the visits
C. Specific roles of doctors	what doctors should do or are doing	7. Clinical role (seeing problems, referrals, etc.) 8. Teaching and training of nurses 9. Administration: a burden 10. Good clinic management – what role?
D. Human issues	relationships and attitudes	11. Teamwork and relationships 12. Attitudes to clinic visits 13. The role of clinic nurses 14. Support of the doctors and communication
E. Doctors working full time at the clinics	a different experience of clinic visits	15. Doctors working full time at the clinics

2. The environment of the clinic

Clinics vary a lot in terms of their environments and physical working conditions, which affect the doctor's experience and perceptions of the clinic. "I think it depends in my experience on which clinic you go to."

The conditions in the clinics have a direct effect on the quality of care, because they influence how the doctors work, and also influence their attitudes. "The whole environment. [X clinic], when you walk in there it looks like a private clinic. It looks like you don't expect this. We are not used to that. You know there's toilet paper and towels to dry your hands and it's very good. And in [Y clinic] not even the door to the toilet works and stuff like that and you are lucky if there is water."

3. Resources and equipment

The availability of resources at clinics varies. Doctors often feel frustrated by the lack of equipment and facilities, without which they are limited in what they can do. "The problem ... is lack of facilities for what they think they can provide in the clinic; for example if they have much more equipment for minor surgical procedures they could have done that. ... if primary health care clinics can provide a little more of those services in line with the epidemiology of the diseases that we have, probably you know patients would not have to run around in different places to get the total service."

Transport arrangements to the clinic are often a problem, with some doctors using their own cars at their own cost to get to the clinics in order to keep the service running.

Drug stocks are limited in the clinics, and this is experienced as being for budgetary reasons. "There is always a shortage of stock, especially anti-inflammatories, pain medication is virtually non-existent. ... The impression I get with all due

respect it is often not just the supply or ordering problem it is a monetary problem, it's a budget problem."

B. Organisational issues

4. Senior doctors needed with experience

The level of experience of the doctors visiting the clinics was raised frequently. It was clearly expressed that more senior doctors should visit clinics. "But I doubt very much whether doctors at junior levels are able to comprehend what they can do at this level."

Junior doctors are seen to need supervision. "There should be a senior doctor at clinic level who should be co-ordinating these functions and monitoring these junior doctors." The junior doctors may also be exploited by colleagues, nurses and patients. "[As] a woman being so junior I was sometimes exploited ... [the nurses] feel I am also a woman, I am also young, I can just do the same as them."

5. The allocation and rotation of doctors

The commitment of doctors rotating through the clinics can be problematic. "We are using community service doctors ... so I am not too sure how much they are committed to improving the service at the clinic level because ... they know it's only for a year of which three months of it is in clinics." Short rotations also make it difficult for doctors to fit in and therefore also limit their impact. "[The nurses] sometimes see the doctors as intruders and it's difficult to have relations because the doctor comes there one month and then another one ... every time the new doctor has a month to spend or two weeks to spend just to figure out how the system is working and by then there is a new doctor."

Doctors find it difficult to do clinic visits in addition to having hospital responsibilities. "I do think the clinics

should be part of the doctors' rotation, it should be an entity. It shouldn't be attached to the surgical department or the medicine department or whatever department because I mean those guys are quite busy."

A rotation system makes it difficult for the doctors to become part of the team at the clinic, to know their role and make a contribution. Many doctors go to the clinic for part of the day and work at the hospital for the other part, which makes the visit to the clinic rushed. "The community service doctors they see it as a waste of time and just get the clinic time over as soon as possible ... so that they can come back to the hospital and that's not right."

A doctor who works full time in the clinics explained that previously, as a hospital doctor visiting the clinics, her experience was a "rushed affair with superficial relationships", while as a full-time clinic doctor she can focus on the work and make a success of it.

The involvement of private general practitioners was suggested as a possible solution, as they may be more able to build up relationships over time.

6. The structure of the visits

Clinics must be organised to receive doctors in order to get the full value out of the visit. "I expect something from that side as well, that they must be prepared to receive me there, they mustn't run around and waste my time. ... And I am not there to push a line for them and just to finish their amount of patients quicker."

The actual visits must be properly structured, which is an aspect that relates to how the clinic functions generally. "If there was somebody working with me and helping me do all that administrative work I could have seen six times more patients and more effectively. ... My biggest frustration in the clinics was about the

structure and the management, not so much the work and the patients.”

As part of this, the particular expertise and function of the doctor needs to be recognised. “*It is much more expensive to have me there than to have one of the sisters there and to have me just doing exactly the same as one of the sisters, it’s a waste of resources.*” Patients should be booked for the doctor in order for him or her to fulfil this role. “*We said the sisters must first screen the patients before the doctor sees them otherwise the doctor would sit and see cases which could have been managed by the nurse practitioner.*” Booking also ensures that certain problems do not swamp the doctor; disability grant assessments in particular must not crowd out other work.

C. Specific roles of doctors

7. Clinical role

The most important role of the doctor is that of attending to clinical problems. “*In the first instance concerning patients that the doctor can be used to assess people that sisters don’t feel adequate or experienced enough to handle themselves.*”

The doctor provides a link between the clinic and the hospital. “*The doctors ... are often a more effective link between the rest of the health system because I have been working in the hospital also for a long time and then it was much easier for me to get patients from the clinic to the hospital, to the right places and it saves time.*” The doctor can also determine whether or not patients need referral to hospital. “*If there is a doctor there they will only be referred if they need more facilities than the clinic has.*”

8. Teaching and training of nurses

Training of staff in the clinics, and particularly of the primary care nurses, is essential, and doctors should play a role in this. “*The doctor must be*

involved with the training of personnel ... because in the end that will lead to the bettering of the doctor and of the sister.”

The work in the clinic is seen to be difficult and complex because of the wide range of conditions that may be seen. Practical, patient-based training is important for this. “*Should they see a sister do something and it is not correct they can say, ‘sister please do this or that, add this extra’.*” At the same time, formal teaching also has a place. “*Say today we are speaking about this subject, next week about that ... It does not need to be a big lecture, just a short thing, five minutes.*”

The nurses also recognise a need for training. “*The clinic sisters ... want to start a training programme more formally.*” “*The sisters are very eager to still learn so there are a few practical things that I can teach them.*”

9. Administration: a burden

The administrative work associated with clinic visits is seen to be a time-wasting burden. “*I have been a little bit frustrated in a way in the clinics that I felt I end up doing a lot of administration work.*” A balance is therefore needed.

Medico-legal work is certainly seen as an important part of the doctor’s role. “*Say a patient applies for a disability grant – where does he go to get it completed? He cannot go to a private doctor; he must go to the clinic. ... I think that is the role of the doctor, to complete those forms. ... I know that they do not want to do that. But it is important.*”

However, the problem of disability grant assessments is that the numbers are so large that they dominate the work at the clinic.

10. Good clinic management – what role?

The structure and the management of the clinic have an important effect on the experience and effectiveness of

doctors at the clinics. The frustrations with management issues, including difficulties with transport and equipment, make the work less fulfilling for the doctors.

There was a feeling that doctors need to be involved in clinic management. “*I think it would be good to have some doctors working in the management of the clinic as well, structuring things better than they are at the moment ... I have often felt that if they would just invite me to the management meeting or whatever I can give very important input into the problem because often the people managing the clinics are never inside the clinic.*” Doctors can also assist with quality improvement initiatives.

A fundamental question that must be addressed, however, is who is in charge. “*I was not really sure where I fitted into the structure because now I felt that I was working under the sister in control, because they are actually managing the clinic and I am only like a visitor there so I felt that they were in control ... And I also find that the sisters also don’t know quite how to handle where we exactly fit in.*”

D. Human issues

11. Teamwork and relationships

The relationship between the doctor and the staff at the clinic has an important effect on the experience and effectiveness of the doctor. Clinics at which good relationships exist were identified as the places where they enjoy going and where they find the work meaningful and fulfilling.

A team approach clearly benefits the patients. “*I think if there develops an attitude or rather a team approach than sort of a separate approach it will lead to the best thing for the patient.*” In order to develop such an approach, the negative attitudes related to the past must be dealt with, especially in

terms of the way doctors and nurses interact. *“Something that needs to be said to one another that we are trying to work together and not trying to work against one another.”*

The knowledge and skills of clinic nurses should be recognised. *“There are about four or five of the sisters who are primary care practitioners and I think of them as GPs sitting there and seeing the patients. I really have a lot of respect for them because they know far more than me about the drugs they dispense.”*

Obstacles to teamwork that were mentioned, and that were also highlighted in other themes, included the absence of continuity, lack of time, lack of commitment from the doctor because it is seen as a short-term task, the doctor's superior attitude, the doctor feeling excluded from the clinic team as an outsider, and doctors feeling abused.

12. Attitudes to clinic visits

The attitude communicated by other hospital doctors is often that clinic visits are not important, and that they (the doctors) do more important work in the hospital. *“In the minds of many of the doctors, the clinics are the not important part. Nobody wants to go to the clinic. The doctors were pitying me very much because I had to work such a long time in the clinic.”* Part of this is because doctors often see themselves as superior. *“I've been working in the hospital for periods of time and I have also seen a lot of doctors come and go ... they don't always see themselves as a team player. I've learnt a lot from nurses in my life ... you must be prepared to learn from the whole spectrum.”*

Doctors who work full time in the clinics feel that the hospital doctors do not have insight into the service provided by the clinics and its importance, as well as the difficulties and challenges. The full-time doctors

experience an attitude of superiority which corresponds with *“the attitude of superiority on the part of specialists towards family medicine and general practice”*.

13. The role of clinic nurses

The nurses are viewed as knowing their patients. *“They know absolutely everything about everyone.”* They are seen to be very dedicated. *“They all really enjoy what they are doing; it's not like us who keep on moaning about the work. They really have extremely good relationships with all their patients. They are available to their patients the whole time and it's not as if it's work.”*

The clinic nurses work differently from hospital nurses. *“They are working very differently than any one of the sisters in the hospital because they are seeing the patients themselves from A to Z and they are making their own decisions.”* Because of this, the range of things they need to do sometimes overloads them.

At the same time, some doctors feel that the nurses tend to relax when the doctor comes and leave the doctor to do the work, indicating a lack of collaboration and teamwork.

14. Support of the doctors and communication

Feedback is important for learning. Reply letters for patients referred to the hospital are seldom received. This adds to the feeling of isolation and stagnation, and highlights the need for linking services and information between the hospital and the clinic. *“I do feel like I am not learning there.” “I felt a bit isolated there as the only doctor in the clinic.”*

Regular meetings are needed. *“I am not a great meeting person but I think one should get together on a fairly regular basis with the other doctors and nurses working at the clinic.”*

E. Doctors working full time at the clinics: A different experience

The doctors who work full time at the clinic sketched a significantly different picture of their work. The issues of resources, equipment and transport were the same, but the doctors complained less about management issues at the clinics and were not unsure of their role. They also reported good relationships with the staff and the patients.

The following sub-themes were reported by these doctors:

- There was initial boredom with the work in the clinics, but that changed quickly.
- The doctor has more time to build “deeper relationships” with staff and patients.
- There is a strong sense of belonging to a team, where the clinic, staff and patients talk about “our doctor”.
- Staff and patients phone the doctor in the evenings and on weekends for advice.
- The doctor gets involved with the socio-economic situation of the patients and the community, and also does home visits.
- Their clinics are becoming increasingly busy. This was reported in a positive manner, with a sense of pride; the doctors said that they cope with the workload. In contrast, hospital doctors who also visit the clinics felt too busy and overburdened by the patient load.
- The lack of resources and equipment at the clinic is reported in terms that the doctors feel sad that they have to refer the patient while treatment could have been given at the clinic. It breaks the continuity between the patient and the doctor.
- More interaction is needed between the clinic doctors and hospital doctors for the sharing of information and joint learning.

Discussion

On the whole, the doctors appreciate the importance of primary health care and the involvement of the doctor at clinic level. This involvement makes them more aware of the needs of the patients and the community.

The doctors view the district hospital and the services it renders as an integral part of the broader district primary health care system.

The doctors demonstrated an understanding of their tasks at the clinics related to patient care, networking and referral, training and management. They also seem to appreciate the difficulties of primary care and the extended tasks of the primary care nurses in these clinics.

The major issue is that the role of the doctor in the clinic and in the district health system is not clear. This leads to different expectations from doctors and nurses, and different experiences of the situation in the clinics, resulting in poor teamwork. In instances where doctors visit the clinics full time, the situation is better as it is built on good relationships.

Another issue is the challenge of the ineffective management of clinics. Basic organisational problems, such as a shortage of drugs and a lack of standard equipment, lead to much frustration and dysfunction. It is in this area that the role of the doctor is most unclear and where he or she can make an important contribution.

Lack of transport is a critical weakness for doctors visiting clinics. It is commendable but not sustainable that some doctors use their own vehicles without compensation.

The lack of continuity caused by the frequent rotation of doctors, often involving community service doctors, is another weakness. This feeds frustration and non-commitment. Without continuity in a specific clinic, the doctor can only offer episodic technical input on individual patients. Furthermore, there is no opportunity

to establish relationships, work through difficulties and contribute towards the development of the service. Doctors doing clinic visits while carrying normal hospital responsibilities almost invariably sacrifice the clinics when there are pressing needs in the wards.

Doctors working only at the clinics seem to be good for effective functioning and for the satisfaction of the doctor, staff and patients. The problem is that this is not good for the integration of the hospital and the clinics as equal partners in the same district primary health care system and for interaction between the two entities.

Recommendations

National consensus is needed on the role of the doctor in primary care. This consensus should be expressed in a policy document and should form the basis of medical training and service delivery.

Building on this, clear guidelines outlining the role and functions of doctors visiting clinics need to be developed for the doctors involved, for the managers who monitor their performance and for the clinic nurses with whom they work.

In the management of primary care clinics, doctors should be included as members of the management teams. This will ensure more commitment and less frustration on the side of the doctor and will utilise the knowledge, skills and connections of the doctor.

Continuity in clinic visits needs to be prioritised. This requires clear strategies for the deployment and rotation of doctors, with an effective means of transport as a basis. Further work is needed to look at models of clinic work that provide both continuity and integration, based on the understanding that this work requires committed senior doctors.

Clinic work in districts should be structured under a clinical department of primary care or family medicine.

This should ensure a mixture of experienced and young doctors working in the clinics, better supervision and training, continuity, and the further development of the doctor's role as part of the clinic team. This department should also support the training and development of clinic nurses, interns and community service doctors. It could also manage the integration of services between district and hospital, as interactive partners, and assist ongoing quality improvement.

Districts must ensure that the essential drugs and equipment are available in the clinics, utilising doctors to achieve this if necessary, and that there is an organised system that caters for doctors' transport to the clinics, whether by government vehicle or by reimbursement for the use of private vehicles. Clear standards and measurable outcomes will help to address these concerns.

District managers should facilitate regular meetings between clinic doctors and nurses at the level of the sub-district for the purposes of training and development, sharing ideas, and dealing with problems. This facilitation will also contribute towards the building of teamwork.

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The full research report is available from the authors.

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