ORGANIZATIONAL STRUCTURE

The Academy has been structured to achieve the maximum participation of members in its activities and administration. This has been achieved by devolution of responsibility and function to the Regions. At inception there were six Regions, each with its committee which enjoyed significant autonomy. Communication with Council was facilitated by the presence on Regional Committees of Council members from respective Regions. In Natal Midlands the interest and activity of a group led by Dr Neethia Naidoo, together with geographic factors, led to the formation of a sub-Region based in Pietermaritzburg. Another Sub-Region was created in the Border area of the Eastern Cape where Dr Elliot Murray led an active and able group of members in East London. In the new South Africa our Regions are based on the nine Provinces.

The concept of small group learning is central to Academy philosophy. To this end a number of these groups have been set up in Regions to promote interactive learning. The educational material and process involved, is selected by group members but assistance can be gained from the Regional Committees.

The main activity of the Regions has been in the field of continuing education which has taken the form of lectures, journal clubs and skills workshops. In Durban and the Western Cape an annual mini-congress has become a regular feature of the academic calendar.

The introduction of statutory continuing professional development (CPD) in 1999 has added a new dimension to this aspect of our activities. The approval of the Academy as an accreditor body by the Health Professionals Council of South Africa represents profound recognition of the expertise in general/family practice teaching that has been acquired during the first twenty years of existence. In 1998, the Academy appointed a CPD Task Team, chaired by Dr Julia Blitz to look into the requirements of the legislation and to set up guidelines for family practitioners to meet these requirements. In February 1999, the Academy convened a workshop in Johannesburg of all GP Organizations and received widespread support for its role in CPD. A Steering Committee was set up to investigate the formation of an accreditation board to maintain standards in our own discipline.

The Academy Task Team has also produced a brochure entitled "CPD Made Simple". This outlines the scope of CPD activities "that add value to our profession, by improving personal coping and growth, making us aware of ethical issues, facilitating multi-disciplinary learning, increasing managerial and organizational skills" and then stresses the importance of actively participating in the planning and process so that it meets the learner's needs and "thus the ultimate evaluation of CPD is based on whether or not there has been a change in practice, that enhances the quality of care provided to patients". The brochure also indicates the value of small group formation to achieve these objectives.

HUMAN BEHAVIOUR

A study of human behaviour is essential to the practice of holistic (comprehensive) care. Our understanding of the subject has gained much from the advances in the behavioural sciences, particularly psychology. In contrast to the reductionist approach of many medical disciplines, knowledge of the patient and his psyche is integral to the problem-solving process of family medicine and the delivery of personal care. It involves all the life situations, from birth to bereavement, which we share with our patients. It helps us to deal with family problems and the common conditions of depression, sexual dysfunction and loss in its many manifestations. Drs M Silbert and B Sparks[21, 22] have written extensively on these subjects in family practice.

One of the most important contributions to the theory and practice of family medicine has been the work of Michael Balint, a psycho-analyst and his group of general practitioners in London. In discussing problem cases, the participants gain insight into the doctor-patient relationship and learn to understand their own feelings and responses. This work is documented in "The Doctor, His Patient and the Illness"[23], a classic, first published in 1957. Amongst the insights that emerge, is the concept of the doctor himself as the most common 'drug' he prescribes. This work sheds light on that large part of our work that defies traditional diagnostic labels and classification. A great stimulus to this movement was provided by Enid Balint, widow and collaborator of Michael, who was the guest speaker at the 2nd GP Congress in Cape Town in 1980. Over the next decade she returned regularly to conduct weekend workshops.

Dr Stanley Levenstein took the lead in starting the first Balint Group, in Cape Town, in 1974 and subsequently reporting on the experience[24, 25]. He was also Convenor of the Academy Human Behaviour Committee whose main function was to stimulate the formation of these groups in all regions and to serve as a resource for participants. The value of this work was recognised in the training of family practitioners and was incorporated into our vocational training programmes and even undergraduate training[26, 27]. Academy members who were active in convening Balint Groups were Drs FD Dornfest, SN Furman and S Levenstein in Cape Town ; B Michaelides in Port Elizabeth ; P Matthews and H Brathwaite in East London ; C Brock in Durban and N Arnheim in Johannesburg.

The purpose of the Balint training is to promote better patient care and not to produce fledgling psychiatrists. This is neatly illustrated by R Greco of Pittsburgh, USA who describes the beneficial effect of Balint training on his practice in his book "One Man's Practice". He ends the introduction with an anecdote, a patient who was aware that Greco had undergone some form of additional training, asked him "What kind of doctor are you now?" He answered, "I am now a non-psychiatrist", to which the patient replied, "Well, I knew you had something to do with psychiatry"[28].

RESEARCH

Dr Joseph Levenstein continued his work, now as Chairman of the Academy Research Committee. He was involved in many personal projects as well as the organization of collaborative trials and in 1981 he published an overview of the subject of research in general practice[29]. The collaborative third phase drug trials continued - the most notable was on the efficacy of amoxycillin/clavulanic acid combination in common bacterial infections in the community[30]. A different type of project was the screening for colorectal cancer using the 'hemoccult' test. This was a collaborative study, not only of family practitioners, but with specialist disciplines. 94 practitioners from 5 coastal towns in the Western Cape screened 3422 patients over the age of 40, who were asymptomatic. Adeno-carcinoma was found in 12 patients and adenomas in twenty-one[31, 32].

Dr J Levenstein became the second Academy Chairman and held this position for six years - until he left to take up a Chair of