



**Pierre JT de Villiers**

The new specialty of family medicine is vibrant and actively developing, but there is an underlying tension caused by the pulling effect of two “opposing” viewpoints: namely, ambulatory care and district hospital care. This became evident to me whilst attending two recent conferences, the 14th National Family Practitioners’ Conference in Rustenburg (8-10 August 2008), hosted by the SA Academy of Family Practice/Primary Care, and the 12th National Rural Health Conference in Beaufort West (18-20 September 2008), hosted by the Rural Doctors’ Association of Southern Africa.

Specialty training for family medicine is based on nationally approved outcomes and will be measured by a unitary end point examination starting in 2010. In designing these outcomes there were two main points of departure, namely: (a) Family medicine is the specialty of the district health service and the district must be the main context of training, and (b) the family medicine specialist must be able to function independently as a clinician at the district level of care, which includes the district hospital.

Part of these training outcomes was the formulation of a clinical procedural skills list, consisting of a set of core and elective skills. The list of skills was compiled by conducting local research.<sup>1</sup> Further research confirmed that family medicine in Africa differs from the traditional “western” model,<sup>2</sup> the main difference being the procedural skills required and being the leader, and sometimes educator and supporter, for a team of primary health care workers.

Family medicine started as a distinct discipline in South Africa during the early eighties with the formation of the South African Academy of Family Practice/Primary Care. The philosophy upon which this new discipline was formed was based on the four principles of family medicine as formulated by McWhinney.<sup>3</sup> These principles are still applicable to the family physician in Africa, but differs in the way those principles are expressed in practice.<sup>2</sup>

We need a way to join together the “ambulatory care/urban health” and “district hospital/rural health” requirements, because the last thing we can afford at this stage of the development of the specialty is a splitting up into two separate disciplines/specialties, competing for the same resources to reach the same goal. At Rustenburg an attempt was made in a symposium on “**making a success of specialist family medicine training**”. A consensus statement was drafted afterwards, and I place this complete consensus statement in order to give more clarity about the context of training and in particular the relationship between family medicine and rural health:

#### Importance of context

The task of family medicine as the primary health care discipline differs markedly from that of other disciplines. Comprehensive care including ambulatory care in the context of the district health service is important. Family medicine as a discipline is mainly tasked with chronic illness care, preventative care and ambulatory care. Rural health and care in the district hospital are included in the scope of family medicine. Private general practice is an important specific context.

Training should take place in the same context where that family physician should function.

The concept of the Academic Health Complex that spans all levels of the health service has been implemented by HPCSA since 1994 and is entrenched in the National Health Act. It is therefore expected that family medicine will define and develop training complexes that represent the work place of family physicians.

## A Tale of Two Conferences

District clinics, health centres, NGO’s, home-based care, hospices, private general practice and district hospitals are crucial parts of family medicine training complexes. Regional hospitals are included in training complexes as a temporary measure because of resource constraints and also as a place where specific skills can be learned. Regional hospital rotations per se are not a compulsory part of the training program but should be focused on specific skills learning, where there is a lack of competency in both the learner and the district.

Rural training complexes are critical to address the future needs of rural people and to learn the skills needed for rural health and service in district hospitals.

#### Training outcomes and skills list

The learning outcomes as developed by the university departments of family medicine and accepted by HPCSA and the HEQC are the basis of the curriculum. The skills list is an important part of one of the outcomes. The skills list is not meant to define the curriculum. The focus of all programs should be on meeting the agreed-upon outcomes and not specific rotations or skills.

#### Supervision

Supervision is an important cornerstone of specialist training. Each training complex needs to have at least one full time family physician whose main task is to supervise the registrars. The creation of these trainer posts is essential for the development of training complexes. Within these training complexes, registrars may rotate through hospitals, health centres, clinics, etc. which may not have a family physician physically present at all times. In a developing situation and with a shortage of trainers, specific arrangements for the accreditation of sites can be considered, for example, utilising senior clinicians such as principal/chief medical officers working in district hospitals and community health centres as clinical supervisors and mentors to assist the supervising family physician. In regional hospitals specialists in other disciplines can supervise registrars for the learning of specific skills.

#### Flexibility

Because there are such vastly different situations in districts in SA, flexibility in the development of training sites and training will be necessary. National training outcomes can be reached within different contexts, and family physicians should be able to function anywhere in SA on completion of training.

#### Consensus statement

Family Medicine specialist registrar training should primarily be based in the district. The focus should be on training complexes, under specialist family physicians, within which registrars are enabled to meet the nationally agreed outcomes in a flexible manner related to the particular district context.

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#### Reference

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2. Mash B. The definition of family medicine in sub-Saharan Africa. *SA Fam Pract* 2008; 50(3):58
3. McWhinney IR. *A Textbook of family medicine*. 2nd ed. Oxford University Press, USA. 1989.