# Family Medicine as a New Speciality in South Africa

Every creature on earth, whether man, beast or insect, is constantly looking for a space in the sun. A new medical professional creature has evolved form the general practitioner, the doctor all medical students previously became if they opted not to specialise. The Health Professions Council of South Africa (HPCSA) late in 2003 approved a new speciality, namely "Family Medicine", and the practitioner will be called a "family physician". This move was received very positively [1], but what does the decision actually mean and what will this new specialist be doing different from the present general practitioner or medical officer?

Being a medical speciality implies two things: (1) the professional has a very specific field or scope of practice, and (2) underwent a specific training program, including assessment, to become a specialist. The recognition that family medicine is a specific field of practice, very different from that of other medical specialists, was the key factor that paved the way for the HPCSA decision. The onus now rests on the profession to develop the training programs needed to train the specialists of the future. The university departments of family medicine have been involved since over the past 20 years in postgraduate masters programs in family medicine and the Colleges of Medicine has offered its membership examination (MCFP) for even longer. These will definitely form the building blocks of the new training programs. The joint initiative of the Family Medicine Education Consortium (FaMEC) and the Interuniversitary Consortium about Training for Family Medicine in Flanders, Belgium (ISHO) [2], to develop appropriate vocational training programs in family medicine for South Africa could also not have come at a more opportune time.

However, now that we are rolling up the sleeves to develop these family medicine training programs, we first have to tackle 2 major issues: (1) What would be relevant training for family medicine (content, context, scope and duration), and (2) how can we convince government to give family medicine training programs the necessary resources (facilities, trainers, trainee posts)?

With regard to the first: the development of family medicine in South Africa has mainly followed the so-called "McWhinney" (developed world) model, i.e. amongst others the emphasis on consultation skills, continuity of care, ambulatory primary care skills, and the management of resources. This may have been the direct consequence of the marginalization of the discipline within the academic complexes, with the other specialties claiming hospital based-care as their domain, but also the main line of thinking and the literature in family medicine came from the developed world, acting as a major influence on thinking in South Africa.

Circumstances in South Africa however beg for a well trained generalist, not only able to perform the "western type" of family medicine, but also able to perform many practical/procedural clinical skills regarded by some as the domain of other specialties. The argument goes that ambulatory care can be well catered for by primary health care nurses, but who is going to perform the clinical services in the district hospitals? In line with this thinking the government has decided to introduce "doctor assistants" as mid-level health workers to mainly take the place of primary health care nurses. If one talks to health care service managers one often hears the concern that academic family medicine is neglecting training in practical and procedural skills. This is an important argument and universities need to take note. Further training in practical/procedural clinical skills should therefore be an integral part and parcel of any family medicine specialty program.

As far as the resources issue goes, there are two important opportunities at hand: (1) the government plan to provide anti retroviral treatment (ART) to all in need, and (2) the further development of the district health system (DHS) in the provinces. The ART programme will not only need medicines but also doctors to administer and supervise the application of these medications, and the roll-out can only happen in a well structured and resourced health care system. The challenge for family medicine is to ensure that government understand this and that the new posts will be mostly family medicine trainer and trainee posts [3]. The family physician should be positioned by the discipline as the key professional in the DHS, functioning mainly at the district hospital level, but also be in support of the clinics and community health centers.

We are indeed living in exciting times and to many of us striving over many years for the full development of family medicine the current events and opportunities are almost "too much to bear" *Carpe diem*!

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1. Family medicine gets the specialist tag. The Cape Times, 21 October 2003.
2. Derese A, Blitz-Lindeque J, De Maeseneer J. From Flanders with Love. SA Fam Pract 2003;45(4):3
3. Hugo J, Vintges M, Marincowitz G, Blitz-Lindeque J. The roll-out of Antiretrovira (ARV) treatment and the contribution of Family Medicine – let's take up the gauntlet. SA fam Pract 2003;45(8):3