Reflections on the development of family medicine in the Western Cape: a 15-year review

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Abstract

This article reviews how the model of family medicine has developed over the last 15 years in the Western Cape. It is based on a series of in-depth interviews with key role players. This period coincides with the immediate post-apartheid era, in which both the health system and health science education experienced rapid transformation. The new focus on primary health care, the district health system and community-based education provided an opportunity for the disciplines of family medicine and in primary care to develop. The model that emerged required the family physician to work at both the district hospital and in primary care, and to have a number of different roles: care provider, consultant, capacity builder, supervisor, manager and community leader. Family medicine was accepted as a new speciality in 2007. The first specialist family physicians will qualify in 2011, and start to consolidate the model that has been developed. Although the model shows promise, a number of challenges still remain, in relation to the health system, the relationship between universities and the province, the discipline of family medicine, research, and training programmes. It is hoped that these reflections will be of value to other provinces in South Africa, and other countries in the region, that are also thinking of including family physicians in their health systems.

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Introduction

Defining the role of the family physician in the South African healthcare system remains an important topic for several reasons. Firstly the National Department of Health is considering major changes that would create ward-based primary healthcare teams, enhance school-based health promotion, and district specialist teams to improve maternal and child health. The role of the specialist family physician in these initiatives is being actively debated. In the long term, similar questions will arise in relation to the proposed National Health Insurance.

Secondly, this debate is set in the context in which provinces have had differing positive and negative experiences of family physicians, trained under a variety of older programmes. Many other specialists remain poorly informed, or openly skeptical, of the role of family physicians. Provincial and district managers have differing perceptions of what family medicine contributes. The new speciality of family medicine and associated registrar training programmes will only deliver its first graduates from 2011 onwards. While this means that the country will have an expanding cadre of new family physicians over the next few years, it also means that the contribution of these new specialists is yet to be fully realised.

Over the last 15 years, the Western Cape has gradually committed itself to establishing the central role of family physicians in the district health system. This open-forum article discusses how this model developed, what the model currently comprises, and its strengths and ongoing challenges. In preparing these reflections, five in-depth interviews were held with key stakeholders from the Department of Health, Stellenbosch University and University of Cape Town (see acknowledgements). Interviewees were purposefully selected because of their significant contributions to the development of the family medicine model over the last 15 years. The interviews were recorded, transcribed and analysed using ATLAS-ti and the Framework method. Quotations from these interviews are used to illustrate key points in the article.

It is hoped that this article will be of value to the broader debate, and even to other countries in sub-Saharan Africa that are considering whether or not to train specialist family physicians.

Background

Since 1994, and the end of the apartheid system, there has been a simultaneous transformation of health services and health sciences education in the Western Cape province.

The new government committed itself to a unified district health system (DHS) and the primary healthcare approach. President Mandela's announcement, making primary health care free to all children under six years of age and to pregnant women, immediately opened the doors to a flood of new patients. At the time, curative services were only being provided by doctors, and the new managers realised that they did not have enough to provide services equitably. A move to a nurse-based primary care service was also supported by an evaluation of the part-time district surgeons.[1] These clinical nurse practitioners were rapidly trained to be the first line of contact with patients.

At the time of this transition, family medicine had moved away from a focus on continuing professional development and private general practice in the 1980s, to training family physicians within full-time vocational training posts in the public sector. The development of this vocational training also required the development of an academic framework for family medicine.[2] Canadian principles of family medicine were especially influential. However, these assumed that the family physician would be the first-line primary care provider.[3]

This led to a conflict of vision between the discipline of family medicine, the representatives of which viewed themselves as trainers of doctors for first-contact primary care, and the province, the representatives of which did not see the feasibility of delivering primary care through family physicians.

At the same time, the health science faculties placed an emphasis on community-based education, and a desire to increase the exposure of undergraduates to family medicine and primary care.[4] Both institutions revised their undergraduate curricula to align more with the new political priorities, the needs of the whole community, and the latest thinking in health science education. Despite some opposition from other specialist disciplines, both universities created departments of family medicine and primary care, and appointed associate professors. By the late 1990s, both institutions had introduced formal rotations in family medicine for medical students in primary care settings, and this exposure continued to expand in subsequent years.

These academic changes were enabled by the appointment, for the first time, of a handful of specialist family physicians in the public sector. In the health services, these family physicians were frequently met with suspicion, hostility or misunderstanding, and had no clear role or authority within the district health system itself.

At a national level, the departments of family medicine at each of the eight medical schools created a Family Medicine Education Consortium, with support and inspiration from Belgian family physicians and the Flemish Interuniversity Council. This enabled a national dialogue and a co-ordinated advocacy at the Health Professions Council of South Africa (HPCSA) for family medicine as a speciality.

A breakthrough in understanding the role of the family physician started to emerge around the needs of district hospitals. Between 1997-1998, two workshops were hosted by the Department of Health which explored the scope of practice of the district hospital, and the team of health workers needed to deliver this. Later, research also highlighted the knowledge and skills gaps of doctors at district hospitals in the Western Cape.[5]

The key role players began to agree on the need for a well-trained generalist who could improve the scope of practice and quality of care at these hospitals. This new understanding was in line with thinking at a national level, which was that rural medicine was a part of family medicine, and which placed emphasis on the need to train family physicians for rural hospitals.

The emergence of this common ground between the needs of the health system and the role of the family physician, led to completely new training programmes. Nationally, the clinical skills needed for this were identified, and new training outcomes were defined.[6] From 2005 onwards, graduates from these new programmes were employed, and by 2008, the number of family physicians in the province had risen to 20, and their contribution was beginning to be recognised. By this time, they had a clearer job description within the district health services, but still experienced friction when dealing with the new cadre of facility managers.

The HPCSA finally promulgated the regulations in 2007 that created a new speciality of family medicine. This landmark decision enabled all the universities to change their degree programmes to Master of Medicine (MMed), in line with all specialist training. It also required the Department of Health to create registrar posts for structured full-time training under the supervision of family physicians.

In the Western Cape, the DHS and the universities entered into a new partnership to train specialist family physicians. Five training complexes were established, and the DHS committed to fund 80 registrar posts over a four-year period, with the first intake of 20 registrars in 2008.

The current model

The training programme

Family physicians are trained according to the unit standards outlined in Table I.[7] Under each of these unit standards, there is a detailed list of specific training outcomes.

First and foremost, the family physician is a clinician, and clinical family medicine has been divided into 10 domains (see Figure 1). Each domain has a set of outcomes, associated clinical skills and knowledge base.

Each training complex has an academic training complex coordinator and associated district manager, who both sit on a provincial operational management team. The team also includes the postgraduate programme managers for family

Table I: Summary of the unit standards for family medicine[7]

The candidate will be able to:

- Effectively manage him/herself, his/her team and his/her practice, in any sector, with visionary leadership and self-awareness, in order to ensure the provision of high-quality, evidence-based care.
- Evaluate and manage patients with both undifferentiated and specific problems cost-effectively, according to the bio-psycho-social approach.
- Facilitate the health and quality of life of the community.
- Facilitate the learning of others regarding the discipline of family medicine, primary health care, and other health-related matters.
- Conduct all aspects of health care in an ethical and professional manner.

medicine from each university, and reports to a higher-level strategic management team. The strategic team includes the heads of family medicine and DHS in the province. The training complex coordinator ensures that registrars receive adequate clinical training and supervision. These structures enable good communication, planning and resolution of issues.

Within each training complex, the registrars rotate between the regional hospital, district hospital, and primary care facilities. Usually they will rotate for four months through six specialist departments: internal medicine, paediatrics, obstetrics and gynaecology, orthopaedics, general surgery, and anaesthetics. These rotations are seen as important for the learning of clinical skills, and also for building credibility and relationships between future family physicians and Level 2 specialists.

During the four years, they will also have short exposures to ear, nose, and throat; dermatology; ophthalmology; and dedicated human immunodeficiency virus and tuberculosis services. All these competencies are reinforced and contextualised during their work at the district hospital and primary care.

The training programme also addresses important principles and competencies such as:

- Consultation and communication skills
- Ethics, professionalism and human rights
- Evidence-based practice
- Family-orientated care
- Personal and human growth and development
- Community-orientated care
- Chronic care
- Health promotion and disease prevention
- Management and administration

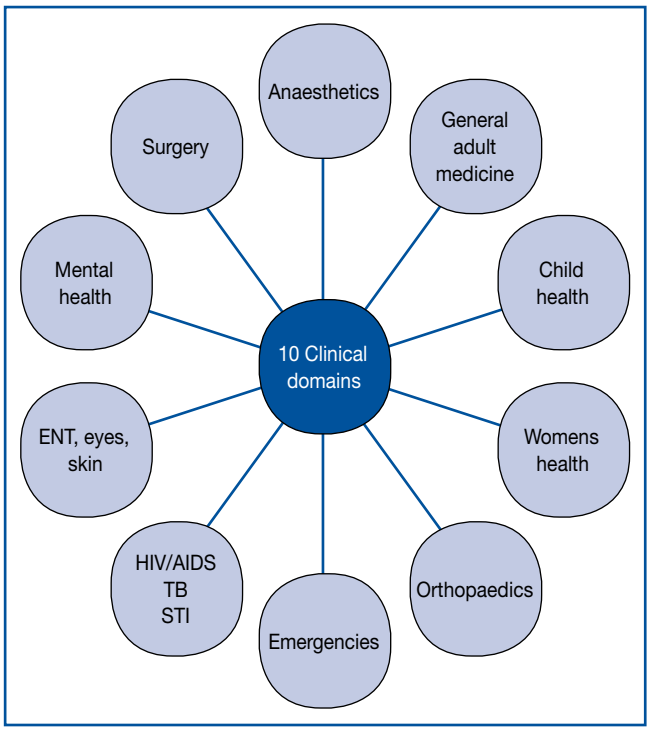
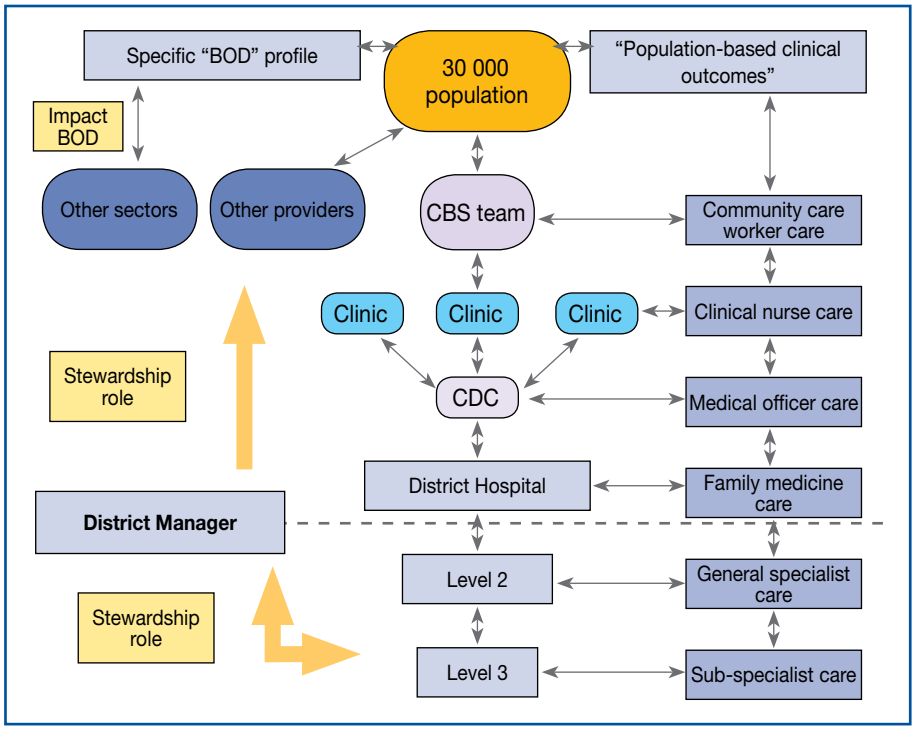


Figure 1: The 10 clinical domains for family medicine training

- Teaching and education
- Research.

The district health system

Within the DHS, the family physician is employed at district hospitals and community health centres as shown in Figure 2.



Source: Dr K Cloete, Director, Metropolitan District Health Services

Figure 2: The place of family physicians in the district health system

The role of the family physician

Apart from being a clinician, who is able to manage the majority of patients presenting to the district hospital, the family physician is also a consultant, who sees patients with more complex cases who have been referred by the primary care team (see Figure 3).[8]

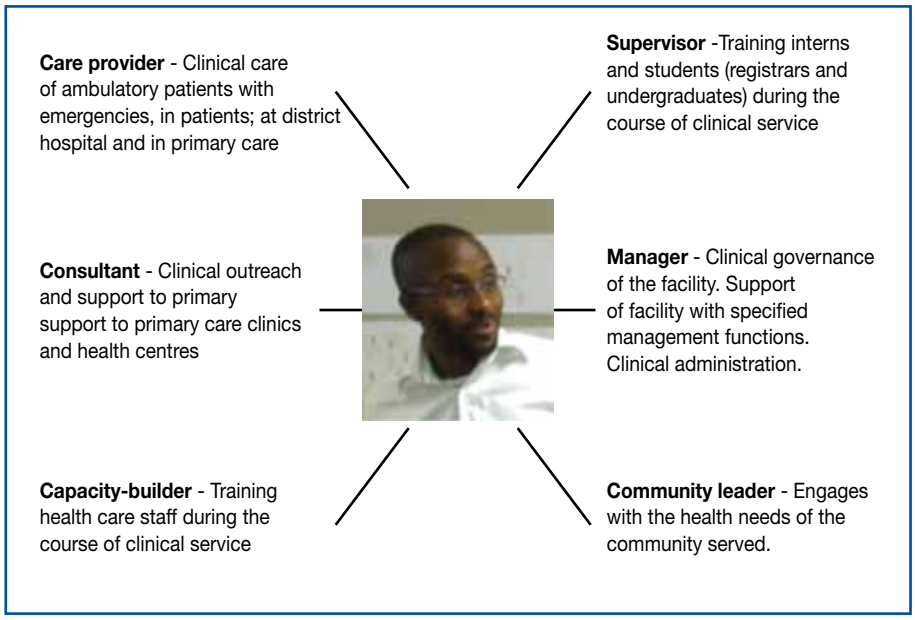


Figure 3: The roles of the family physician[8]

He or she must also mentor and provide in-service clinical training to junior colleagues and the primary health care team as explained by one interviewee:

"I think that if we need to work in Africa, we need to understand that the family physician is not the first point of contact, but has other roles. You know, my pet subject is for family physicians to be good teachers and learners." (University)

With some colleagues, such as registrars and interns, there may be a more formal role as supervisor. This may also extend to medical students during their family medicine rotations.

Another important role is that of a manager, with a specific focus on clinical governance and the quality of clinical care:

"So if I have to describe it, it is quite an interesting description. We have taken a very significant decision in this province to almost 'lock' family medicine into a speciality in the DHS, as the bedrock of the DHS, and to locate the prominence of family physicians as the custodians of clinical governance." [Department of Health (DOH)]

Finally, they have a role in helping the sub-district or facility to be mindful of the community served, and the broader health needs of the community (see Figure 3). This focus on the population at risk includes attention to health promotion and disease prevention.

This community orientation was explained by one interviewee:

"Knowing where the people live, how many are there, knowing what is wrong with them, and having population outcomes attached to them; and gearing a whole range of people across the continuum of care to contribute toward the outcomes. We see that the family physician is pivotal in terms of its sub-district team or the DHS-based team, to achieve these population outcomes." (DOH)

At present, the majority of family physicians are involved in both academic work and service delivery. This is because the total pool is small, relative to the number of students and registrars. Within a few years, it is expected that there will be sufficient family physicians in the system, and that most will only be involved in service delivery, while others will be committed to academic work at universities.

Strengths of the current model

The creation of specialist family physician posts within the public sector has established a career pathway with the same salary scale as other specialists in the academic teaching hospitals. This has enabled family medicine to attract good candidates, and to start to transform the perception that only people without academic ability or ambition are attracted to careers in district health services.

The district health services have seen family physicians make a strong contribution in the area of clinical governance. Family physicians need to be strong clinically in order to offer this kind of leadership.

There is a clear perception that family physicians are already making an impact on quality of care, and even health status:

"I think the level or quality of the clinical interventions of the teams of people who work in those specific centres has dramatically improved."(DOH)

In instances where family physicians have functioned well, the primary health care team has begun to function more coherently:

"The second thing here is a sense of coherence involved in a system response. It is getting a sense of a clinical team, which I think did not exist in primary health care services in

any tangible form prior to family physicians coming in: that sense of a clinical team." (DOH)

Family physicians have the potential to develop a sense of responsibility for specific communities, and to connect higher management with local community needs:

"Starting to orientate, not just themselves, but the team, towards population reasoning … I think a guy like xxxx has very quietly also been doing that. And I think a lot of this stuff that he has done is beneficial." (DOH)

Family physicians have been able to broaden the scope of practice on offer because they have been trained across the whole spectrum of district health care:

"They are able to service patients with a wider range of medical problems than was previously the case." (DOH)

In some situations, the family physician could possibly achieve even more with the necessary support and equipment.

As a result of the improved quality and scope of practice, family physicians may have impacted on referral rates, and enabled more patients to be managed in the district, saving money at other levels. This also saves patients time and money, as previously, they would have had to travel to a referral hospital.

Family medicine has been introduced to the district health system at a critical time in its development, and is a key component in the final vision.

It is also assisting with the process of achieving that vision:

"Family medicine is part of a strategic vision of an entire system. It actually plays quite a pivotal role in the evolution of an entire system, which doesn't get assessed. Maybe I don't know enough about other systems. It is almost like family medicine is developing despite the system, or parallel to the system." (DOH)

Challenges for the model now, and in the future

The current family physicians have to be competent specialists, as well as contend with a system that is constantly evolving. This requires a certain type of leadership, beyond what might be expected in a more mature system. The need for such agents of change has implications as to who should be selected for training, as high-calibre applicants are needed. They have to be able to cope with uncertainty, and be motivated by the concept of making a difference, rather than just being a specialist. Through their exposure to medical students and junior doctors, the initial cohort of family physicians in the system will also serve as role models, who either attract or repel future generations.

Family physicians must also build credibility, and define their role with respect to other specialists. At level 2 hospitals, the specialists have overlapping responsibility for clinical governance and outreach within their specific disciplines. Emergency medicine specialists are also new in the system, and are trying to find their place simultaneously. It is anticipated that many districts will employ public health specialists in future. Again the interface with family physicians will require clarification.

Universities want to secure joint staff posts so that the academic activities of teaching, training and research can continue on a solid foundation. The province wants the attention of family physicians to focus on clinical governance and service delivery. There are concerns that the existing pool of family physicians cannot deliver on all the expectations regarding clinical competence, mentoring, training, teaching, management, research and stewardship.

The formalisation of joint posts among the pool of family physicians will enable universities and district managers to define roles pertaining to academic activities. It will also give appropriate recognition and privileges to family physicians on the joint staff at the university, and will enable academic capacity building to be clearly determined. However, the creation of joint posts has currently been put on hold.

Another challenge for the discipline is the development of a strong identity as a specialist grouping, and to make sense of what it means to be a specialist vs. a general practitioner or career medical officer. The Academy of Family Practice and Primary Care has been transformed into the Academy of Family Physicians in order to focus on this issue.

It may be that as more family physicians enter the system, there will be an opportunity for people to concentrate on activities that best suit their interests. Some family physicians may be more academic, while others may prefer to work in primary care, or in the district hospital. Even within these compartments there may be room for preferences, and the discipline may even have to cater for the concept of sub-specialisation later on.

Another challenge for the discipline is whether all doctors entering a career in the DHS should be trained in family medicine in the future. The HPCSA did not support this viewpoint at the time of creating the speciality, but the issue remains open for further deliberation.

As family physicians are employed in larger numbers within the system, there will be a need to research the impact that this might have on the burden of disease, quality of care and functioning of the health system. Establishing an evidence base for the impact of specialist family physicians in an African context is a priority for the discipline. Ongoing educational research will also be needed to ensure the quality of the training programmes. Registrars and family physicians should continue to contribute to research

projects across the whole spectrum of the burden of disease. The universities must also make certain that an increasing amount of research is performed at a doctoral and post-doctoral level.

It is anticipated that as family medicine becomes more established, more of the training will be performed by family physicians in district hospitals and health centres, and less in the Level 2 hospitals. As a principle, it is important for registrars to be trained as much as possible in a context relevant to their future practice. As increasing numbers of family physicians qualify and take up posts, they will need to stay up to date, and continuing professional development, tailored to their needs, will be required.

A more fundamental challenge is the potential negative consequence of training that meets the needs of the province for technically competent family physicians at the district hospital, but which could underprepare them for primary care:

"We have claimed the district hospitals for family medicine, with tension between primary health care and the district hospitals. I still think the risk is very high in terms of solely training people in district hospitals, and just turning them into mini-surgeons." (University)

Some core family medicine principles are misunderstood, or regarded as impractical and irrelevant by the province. For example, there is a perception that general practitioners' primary competence lies in "soft" skills such as counselling, and that they do not possess important clinical skills.

There is also the belief that in general, family medicine concerns working with families, and that this is not practical:

"We had to make compromises on both sides. I think you probably saw that, plainly, I'm not too respectful of the philosophy of family medicine, in terms of treating the whole family as a unit. I am not against it. It is just that it is not possible at this stage of our country's history." (DOH)

However, there is some agreement that family medicine needs to share its approach with the broader primary care team, particularly the clinical nurse practitioner:

"Obviously, there are still people who struggle with the tension of being a family doctor, who are in the front line, looking after families, and so on. And the values behind that, the values around caring and thinking of the family, and being patient centred, are still really important. This is because even if the family physician is not doing all of that, they need to fuse those values and train the other people in the team: the nurse, the practitioner and the other doctors. So that would be the first part for me." (University)

A combination of technical competence and family medicine principles can be seen as the goal:

"We need well trained generalists with strong clinical skills, who are also well versed in the principles of family medicine, continuity of care, and holistic care. A combination of that in one clinician: I think that is what the country needs. That is really what I think our district hospitals and primary care services need." (University)

Conclusion

The DHS in the Western Cape, and the departments of family medicine, have journeyed together over the last 15 years to create a model of family medicine that is embedded in district hospitals and primary care. The model will continue to mature as more family physicians enter the system from 2012 onwards, and to adapt to ongoing changes in the broader health system, and to the needs of the community. The Western Cape model should be of interest to other provinces in South Africa and countries in the region that are considering the inclusion of family medicine in their own health systems.

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