Proposal of the Committee for General Practice of the Medical and Dental Professional Board: The future of family medicine.

Proposals for the restructure of general and family practice in South Africa

Summary

In the light of the transformation of the health care services in South Africa with a shift towards primary care and the consequent requirements of change in health care delivery, as well as the changing health care requirements of the population, this committee decided to pursue its mandate of improving general practice in South Africa by initiating a project on how training for general and family practice should be changed to meet these needs.

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The international context for investigating the restructuring of general and Family Practice in South Africa is that WHO and WONCA (the World Organisation of Family Doctors) are jointly, through the publication "Improving Health Systems: The Contribution of Family Medicine. A Guide Book" (Boelen C et al. Singapore, WONCA 2002) and the "Towards Unity for Health (TUFH)" programme, promoting Family Medicine by proposing that:

- "Formal recognition of Family Medicine as a special discipline in medicine – already accepted in many countries – should now become universal", and
- "Every country should aim to establish programs of specific training in family medicine, which should follow basic medical education and which should endeavour to meet the needs of a balanced work force."

In March 2001, the Medical and Dental Professional Board of the Health Professions Council of South Africa appointed Prof. GS Fehrsen as Researcher to investigate and research possible scenarios for the future of education (under- and post-graduate), training, qualifications and the practice of Family Medicine and General Practice in South Africa. This process culminated in a National Consultative Workshop on the future regulation of family medicine and general practice that was held at the Health Professions Council of South Africa on 19 and 20 October 2001. A significant degree of consensus was obtained from all stakeholders present.

The following presuppositions were agreed to:

- Any principles and regulations for family medicine should be congruent with the mission of the HPCSA, which is **"to protect the public and guide the professions"**.
- Generalist doctors play an essential role within the primary health care team.
- Generalist doctors should function within the context of the district health system, whether in public or private practice.
- A satisfactory outcome of training is required for registration to practise independently in both the public and private sectors.
- A long phase-in period is preferred for instituting the above. In the interim, mechanisms such as: 'grandfather' status, practice eligibility and CPD can be used along with the final formal route to gain independent practice status.

It is understood that change should improve the lot of the marginalized and poor in the population; improve matters in the whole system of health care; include a feedback system that needs to be put in place to monitor the impact of changes in the regulations; increase career opportunities, job satisfaction, and morale of family physicians; and contribute to a decrease in the enormous wastage in the present system.

On the basis of the research and consultative processes, the Committee for General Practice, at its meeting in January 2002, agreed on a set of principles that should govern the future of family medicine in South Africa. It was decided that these should be put forward to key stakeholders, and especially to the committees within the Medical and Dental Professional Board in order to obtain broad agreement prior to developing specific action plans and regulations for implementation.

PRINCIPLES

A. There should be only one category of generalist doctor named *Family Physicians*, which is involved in general practice in both the public and private sector

Motivation:

Throughout the developed world the erstwhile scenario where there were two kinds of doctors (i.e. GPs and Family Physicians) in primary care has effectively been dropped in favour of one standard of training and one standard of doctor in primary care. There should be no double standards with general practitioners for the poor and family physicians for the rich.

B. Family Medicine should be *a speciality* on the specialist register of Council

Motivation:
Family Physicians need to be clearly seen by the public and the profession as being specifically trained and skilled to deal with the specific needs and requirements of patients in primary care.

C. Specific *outcomes based training* for family medicine should become *mandatory*, at undergraduate and postgraduate levels.

Motivation:
Our National Health Policy is to give appropriate importance to Primary Health Care and the District Health System. PHC serves a different population in epidemiological terms from specialists and tertiary institutions. This population of patients has illnesses with differing natural histories, risk and prognosis. Training should therefore be done in the PHC context by primary care clinicians. There is evidence that specifically trained primary care clinicians working in a context that enables them to practice the accepted principles of family medicine in a country, make the whole health care system more cost effective in that country or system.

D. Such training should be required before any person is *registered for independent practice* in the public or private sectors.

Motivation:
To maintain a high standard of function in a system it is essential that all be trained, or work under supervision of a trained person. This is presently the case with other disciplines in South Africa, where at times people who do not complete the full requirements for a discipline remain career medical officers in that area of specialisation. To serve the patients of South Africa adequately it is important that the public and private sectors require the same level of skill for registration as independent practitioners.

E. Those in training should be *registrars* with the requisite implications for formal training and supervision within a clearly structured system of approved training sites.

Motivation:
This nomenclature is important to emphasise to colleagues in other disciplines and the public that Family Physicians in training are on a par with other disciplines in terms of content, process and rigour of training.

F. There should be a *long period leading up to* the full implementation of the above, probably 10 years, with accommodation of present practitioners.

Motivation:
In most countries training and registration systems for Family Physicians have been phased in over a long period. This has enabled the present practitioners to come on board in a non-threatening way and the new graduates to have enough time to prepare themselves for the new rules. In this way there has been no major disruption of the system of training and practice as a result of the changes. Doctors presently registered under the category general practitioner (independent practice) will thus become Family Physicians until the new rules come into being.

G. Rural medicine should be seen as a specific discipline within the domain of family medicine, and thus comply with regulations developed for family medicine.

Motivation:
Rural medicine is generalist practice in a specific context and with specific additional skill requirements. To be cost effective and multi-skilled the rural generalist needs to remain a generalist and still have a clear career path. Most rural doctors will practice in a rural area for a limited period of time and then move to a town or city. They need to be able to slot into a career path, and family medicine provides the natural opportunity for that. Rural patients on the other hand also deserve the services of a specifically trained generalist doctor in the same way as any other patient needs one. The speciality of family medicine and its core skills and values need to guide the practice of all generalists and their rural patients in PHC.

H. A separate register medical practitioners will be maintained, who will be required to work under supervision in any discipline, whether practising at primary, secondary or tertiary levels of care, in the public or private sector.

Motivation:
This will identify medical officers who do not hold any post-graduate degree and differentiate them from Family Physicians who are specialists and will be able to practice independently.

TASKS

In order to achieve this, the following tasks require action:

i. development of a national standard endpoint fellowship examination for family medicine, through conclusion of the negotiations between FaMEC, the Colleges of Medicine of South Africa and the SA Academy of Family Practice;
ii. implementation of 4 year M.Med. programmes in family medicine by those universities which do not yet have these in place;
iii. finalisation of the educational outcomes by FaMEC for presentation to SAQA;
iv. development of criteria for the accreditation of training sites and posts;
v. discussion with Department of Health and Department of Public Service Administration regarding post structures and career paths;
vi. identification of potential training posts, in negotiation with the Department of Health and other stakeholders, with a view to the establishment of numbered registrar posts in Family Medicine;
vii. development of regulations by the Board with input from the Committee for General Practice for promulgation on behalf of the HPCSA to set out the different registers, the grandfather clause, training, etc.

APPENDIX

Definitions

Family physician, also known as general practitioner (GP) or family doctor: a medical practitioner who is trained to provide health care services for all individuals regardless of age, sex or type of health problem; provides primary and continuing care for entire families within their communities; addresses physical, psychological and social problems; co-ordinates comprehensive health care services with other specialists as needed.

Family medicine also known as general medicine: the speciality of medicine concerned with providing comprehensive care to individuals and families, that integrates biomedical, behavioural and social sciences; an academic medical discipline that includes comprehensive health care services, education and research; branch of medicine that while broad in scope is a speciality in its own right.

Family practice also known as general practice: the health care services provided by family physicians in the public or private sectors; characterised by comprehensive, continuous, co-ordinated, collaborative, personal, family and community oriented services; comprehensive medical care with a particular emphasis on the family unit.

CORROBORATION AND IMPLICATIONS

There are a number of concepts that underlie the proposals made, as well as issues that need to be addressed once the principles are accepted. It is noted that this process is one that many other countries have already been through, so many lessons can be drawn from the experience of other countries.

1. Family physicians' contributions to primary health care: understanding the family physician as a primary care specialist.

The fundamental characteristics and derivative attributes of family medicine allow family doctors to contribute substantially to systems of primary health care in all countries in spite of differences in the way these systems are planned, organised and managed. They are articulated in the following description from the *Framework for Professional and Administrative Development of General Practice/ Family Medicine in Europe*. This document represents the culmination of almost a decade-long European-wide consultative process initiated by the World Health Organisation Regional Office for Europe.

- **General**

Family practice addresses the unselected health problems of the whole population; it does not exclude certain categories of the population because of age, gender, social class, race or religion, or any category of complaint or health-related problem. It must be easily accessible with a minimum of delay; access to it is not limited by geographical, cultural, administrative or financial barriers.

- **Continuous**

Family practice is primarily person-centred rather than disease-centred. It is based on a longstanding personal relationship between the patient and the doctor, covering individuals' health care longitudinally over substantial periods of their life and not being limited to one particular episode of an illness.

- **Comprehensive**

General/family practice provides integrated health promotion, disease prevention, curative, rehabilitative and supportive care to individuals from the physical, psychological, and social perspectives. It deals with the interface between illness and disease and integrates the humanistic and ethical aspects of the doctor-patient relationship with clinical decision-making.

- **Co-ordinated**

Family practice can deal with many of the health problems presented by individuals at their first contact with their family physician, but whenever necessary, the family physician should ensure appropriate and timely referral of the patient to specialist services or to another health professional. On these occasions, family physicians should inform patients about available services and how best to use them and should be the co-ordinators of the advice and support that the patients receive. They should act as care managers in relation to other health and social care providers, advising their patients on health matters.

- **Collaborative**

Family physicians should be prepared to work with other medical, health and social care providers, delegating to them the care of their patients whenever appropriate, with due regard to the competence of other disciplines. They should contribute to and actively participate in a well functioning multi-disciplinary care team and must be prepared to exercise leadership of the team.

- **Family-oriented**

Family practice addresses the health problems of individuals in the context of their family circumstances, their social and cultural network and the circumstances in which they live and work.

- **Community-oriented**

The patient's problems should be seen in the context of his/her life in the local community. The family physician should be aware of the health needs of the population living in this community and should collaborate with other professionals and agencies from other sectors and with self-help groups to initiate positive changes in local health problems.

(WHO Regional Office for Europe, Draft charter for General Practice in Europe, 1998)

2. Implications for health service delivery systems.

Many of the above mentioned attributes are shared by other physicians and health care providers. Yet, when taken as a whole they define the type of physician whose expertise is remarkably congruent with the requirements for optimal primary health care envisioned in the Alma-Ata Declaration. For instance, distinguishing characteristics such as first contact, accessibility,

person-focused longitudinal care, comprehensiveness and co-ordination define an approach that is unique to primary health care. Health care systems with these characteristics are associated with better outcomes, increased patient satisfaction, less hospitalisation and lower costs. Furthermore, international comparisons of primary health care outcomes suggest that the greatest differences in health between countries are associated with the degree to which the following components of their health services delivery system have been implemented:

- Equitable distribution and financing of health care services.
- Similar level of professional earnings of primary care physicians and specialists.
- Comprehensiveness of primary health care services.
- Absent, or very low, requirements for co-payments for primary health care services.
- Primary care physicians provide first contact care and entry into the health delivery system.
- Person-focused longitudinal care.

Family medicine can play an integral role in helping a country organise its health system to implement these components. In order to achieve these positive outcomes, however, it will be necessary for family doctors to work in unison with community representatives and health workers. Also it will be necessary to develop a system of reimbursement, appropriate incentives, and positive working conditions in order to carry out activities that, although broader than individual patient care, may, nevertheless have even greater impact on the health of individuals. These activities include involvement in analysing the needs of the population, working in teams, and providing medical oversight of health workers.

3. Implications for Regulation

a. How should Training be Regulated?

There are details that need to be regulated in order for the training as envisaged to happen. Once the principles are accepted, council will need to write rules to certify:

- training outcomes for practice competency for family physicians and family practice;
- trainers, who should come from the ranks of registered Family Physicians;
- training sites. To address the issues of the maldistribution of services, training sites may be preferentially approved in disadvantaged areas, within the District Health Service and also in the private sector. i.e. hospitals, health centres, clinics and practices will need to be accredited;
- who may 'host' such training? Universities, recognised academic associations and/or approved service providers for instance.

Examples of these rules abound in many countries. They are entirely feasible, especially if the approach is to implement any rules in a progressive manner over time.

b. How Should Practice be regulated?

Not only training but also practice will need additional regulation. This ensures maintenance of standards of practice, which is so desperately needed in our health care system. Council will need to write rules to regulate:

- practice in the private and public arenas so that only properly certified family physicians may work as independent practitioners in an unsupervised capacity in primary care
- the criteria for the maintenance of certification
- quality assurance at practice level.

Once again the example of may other countries may be followed.

c. The end Point for Practice Competency

Any postgraduate training needs a mechanism to certify practice competency, regulated by the Council. Although an MFamMed or MMed in Family Medicine should be one route to certification of practice competency for Independent Practice there should be an alternate route or routes which will probably the preferred by most potential family physicians.

Worldwide there are two main streams:

- Certification for independent practice after approved training and a 'College type' practice competency examination.
- Certification on satisfactory performance of completion of a period of approved training under supervision. Various forms of assessment are used in these systems such as in the UK and in much of Europe. The examinations in these systems are voluntary.

Other methods of certification are also in use. In most cases they have been used as interim measures while the country is preparing for one of the above two methods. These are:

- *practice eligibility*, which is used for those who have been in unsupervised practice for an agreed number of years. They then call for an inspection of their practice and themselves and go through an audit process in their own practice to gain full certification
- building up an approved *portfolio of CPD points* from an unsupervised practice situation

d. Implications for undergraduate education

Outcomes for undergraduate medical training and internship will also need to be revisited.

4. How Long Should Training be for?

An important question, which will need to be discussed in terms of its implications and feasibility, is the length of postgraduate training for family medicine.

Presently South African vocational training requires two years. In most instances it is three years. There are programmes that are longer.

In ***Holland*** mandatory training to become a "huisarts" started in 1974. The training was for one year, in the '90s it was two years and presently as in the whole of the EU region the training period has become three years.

In the ***UK*** the new system for the training of general practitioners started from October 1973 and compulsory training became effective from the