

Vocational Training - Revisited

Very few issues caused such uproar amongst doctors and medical students in recent times, as the debacle of Vocational Training in 1997/8. The Interim National Medical and Dental Council of South Africa (the Council) at the time decided that doctors were not properly prepared for independent (read "private") practice at the end of their intern year. It then decided to introduce a 3-year period of "vocational training", which would replace the intern year, as proper preparation for independent practice.

The proposed system was 3 years of rotation in hospital posts through the main "domains" (read "specialities") in medicine. Family Practice was thrown together with mental health as a single rotation of 4-6 months. In the end completing the College of Medicine diplomas during this period was to be encouraged and even a 6-month research rotation was to be allowed.

It is now history that the introduction of the system was blocked by the uproar amongst medical students who refused to do longer training, supported by the senior hospital doctors who refused to supervise this training in addition to their normal clinical duties. Dr. Zuma stepped in amongst the confusion and introduced one year of community service for newly qualified doctors to fill one thousand empty posts in her understaffed hospitals - indeed the stroke of a master! In the shocked silence that followed the Council introduced a two-year internship during 1999. This will only start in 2005 in order to avoid a new medical student revolt. This year's new intake of medical students will therefore do 2 years internship plus one year of community service. Some of them are still doing a six-year undergraduate

curriculum, which means that they will have to do 9 years before being allowed into independent practice.

What is not well known is the fact that Council's own Subcommittee for Family Medicine, and the academic departments of Family Medicine, also rejected the proposed system at the time. Their reasons were: (1) The whole system of vocational training was introduced in total disregard for the "other" system of vocational training for family physicians that was introduced scarcely four years earlier by the same Council. (2) The proposed system of hospital rotations would amount to completely inappropriate training for most practitioners who would be going into private family practice.

The newly proposed system would have wiped out 20 years of hard work by family doctors that realised back in the early seventies that young doctors were not ready for independent family practice. They started small vocational training programs and the universities introduced master's in family medicine courses. After many years of appealing to Council to make such further training compulsory before entering independent family practice, Council in 1994 introduced a new category of practitioner, the "Family Physician". Registration in this category and the required vocational training were however completely voluntary. The reason given by Council at the time was that there were just not enough resources to make it compulsory.

And then came "Vocational training" in 1997! Family Practice was caught by surprise like everybody else. Other disciplines decided on its behalf what extra training was needed to become

a family doctor - because "it takes a village to raise a child" - meaning that family practice was just not capable enough to organise their own training ("raise their own child"). Many appeals were made to the Council from academic and organised family practice, but to no avail. It could only be interpreted as a massive snub for family practice.

Fortunately the system was halted, if only for other (the wrong we may say) reasons. But what are the lessons to be learned from this traumatic episode in the development of Family Practice in South Africa?

1. Family Practice needs unity and a strong organisation to speak on its behalf.
2. Family Practice needs to be proactive and get its own house in order by developing well-run vocational training programs that are outcomes-based and have nationally agreed minimum standards of content and supervision.
3. Family Practice needs to win and keep the support from their friends in government circles and amongst academic specialists who are decision-makers.
4. Any new system of training needs to fit in with the realities of the South African health care system and needs to be introduced in a fair way to prospective medical practitioners.
5. Maybe most of all, Family Practice needs a clear vision of how it sees the future family doctor in South Africa and to articulate that vision clearly to decision-makers and the public.

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