

A look at the future of Family Practice in South Africa

This month we take a look at the future with the publication of two thought-provoking articles. Many changes are taking place within the South African health care scene, which will determine the role of the generalist doctor in our health services and the future nature of medical education.

As the world is becoming more and more a global village, we discover that much the same is happening in other parts of the world. The first

article by Schneider and Freeman paints a picture of what the issues are that the Americans are grappling with - increasing specialisation within family practice and how to accommodate that within the educational sector! We are experiencing much the same, as testified to by the emergence of "rural medicine" as a growing issue in our country. We shall also have to deal with these matters.

The second article by Hugo deals with the unfolding of the district health

system in South Africa, and the role of the generalist doctor within that. Will family practice find its rightful role at last after so many decades of increasing specialisation, spiralling health care costs and neglect of the person in our health care system?

Read and decide for yourself, and put your thoughts in writing, we would like to hear from you!

Pierre de Villiers
Editor

What is the future of our speciality?

As faculty members in three different programs in the last decade, we have noticed changes in the privileges sought by our graduates entering practice. Many do not want to deliver babies, do procedures for which they were trained, work in the ICU, or even have hospital practices at all. Some choose to limit their practices to children over age 2 or over age 12 and some do not want to care for children at all.

Why is this? Is family practice as a specialty becoming increasingly narrow? Are we training doctors who really want to - or will be able to - practice *family practice*? To the extent that practices are narrow and limited, are these true choices made by our graduates or made by their employers? If they are choices, are they the result of who we have taken into our family practice training programs or how we train them?

AFMO Strategic Plan

Recently, the Academic Family Medicine Organizations (AFMO)

Subcommittee on Residency Education,* developed a draft strategic plan for family practice residency education for the next decade. This plan looks at the continuum of education from medical school through residency but is inadequate in examining where our discipline and its educational mission are headed. There has been a great deal of concern about the shrinking pool of applicants to family practice, and many potential explanations have been offered.

These explanations include the pay levels of graduating residents, the characteristics of students selected for admission to medical school, and uncertainty about what we are as a specialty, what defines us, and from that, what sort of practice a physician entering our ranks might reasonably expect.

One idea proposed is to develop different kinds of residency programs for different kinds of family physicians: ruralists ('classical' FP), urbanists (limited FP), and hospitalists (inpatient FP). Programs that train urbanists may,

for example, teach little or no inpatient care. For this to happen, our generic Residency Review Committee criteria would have to be altered to reflect exactly what we wanted our program to be. We would need to carefully select our residents based on a commitment to practice a certain kind of family medicine. We are not sure how many of us would be willing to make our stated mission as limited as, say, caring for only patients over age 12. There are many who would argue that the definition of the family physician is not simply in the procedures that he or she performs. In fact, one of the basic tenets of family medicine is care for all patients regardless of age.

Another idea has been to increase the time of training from 3 to 4 years, or to alter the traditional time-based training to a competency-based training of variable length. This concept is certainly intriguing. It would insure that all those who completed a family practice training program attained the competencies that would allow them

to practice the full range of family medicine. Scheduling and funding issues involved in a training of indeterminate time would be significant, but the outcome may be a better quality family physician.

We would suggest that the continuing strategic planning process of AFMO and its constituent organizations focus on the areas where we can influence this trend. This includes defining who we are and what we stand for as family physicians. For those of us in medical schools as well as residencies, the characteristics of family physicians that we value should be criteria for entrance into our specialty. We feel that many of these are ingrained attitudes that may

not be taught. It also means we want our future family physicians to continue to be trained in, and to continue to receive privileges for, the skills for which they are trained: hospitalized patients, intensive care, obstetrical care, and specific procedures, such as endoscopy and cesarean sections, if the training is appropriate.

Family practice is, however, more than that. It is, at its base, about doctors who care not for diseases or organ systems, but for people - people in the context of their families and communities. It is about training physicians for whom the basis of the doctor-patient relationship is the relationship, not the age or disease or the procedure being

performed. This is what we, as family physicians, can offer our trainees, our society, and our future.

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* The AFMO Subcommittee on Residency Education consists of the Association of Family Practice Residency Directors, which led this effort, the American Academy of Family Physicians, the Association of Departments of Family Medicine, and the Society of Teachers of Family Medicine.

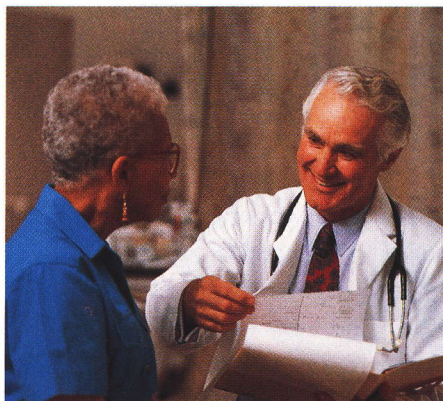
What is the future of our discipline?

Painting and the Painter”

The health care milieu is ripe for an increasing input and influence from General / Family Practice. Implementation of government policy for public and private health care, as well as changes at medical schools, creates an interesting picture. And the shape, colour and place of the generalist doctor are being drawn in at this time.

Whose hand is holding the brush and what is on the palette?

The government’s policy of basing health care on a district health system is being implemented throughout the country. This creates a context in which family medicine / general practice finds its logical place. The district includes clinics, health centres and hospitals. Doctors work in teams with other health professionals; they see patients



at clinics, in patient’s homes, and in the hospital. They can practice comprehensive, continuous care making use of hospital facilities and undertaking appropriate procedures themselves.

As the clinician with the more advanced training, the doctor plays an important role in supporting nurse clinicians, and becomes the first point of referral. In some districts a functional collaboration with private practitioners may develop. It is government

policy to appoint family physicians as the **only** specialists at the district level. Other specialists are appointed in regional (secondary care) hospitals.

A clear space in the picture has been created for the well-formed generalist doctor.

The new Medical Schemes Act is aimed at making health insurance accessible to more people. Whether it will work out remains to be seen. Health care inflation is well beyond general inflation and makes private health care and health insurance less affordable and to fewer people. One way of addressing the spiralling health care costs is to clarify and reward the appropriate role of generalists. Not only is their traditional gatekeeper role important, but continuous care, comprehensive care, and home care are all incorporated.

Core values such as

- the primacy of the person;
- the importance of relationships;
- the role of the family; and
- participation of patients in their own care are all components of cost effectiveness.

What picture is presently filling this space?

I see medical aid schemes appointing general practitioners and specialists to “manage” and “control” costs with

protocols and reviews. In their advertisements, family medicine training is not even mentioned!

What new picture is being drawn here?

Several medical schools are implementing new integrated curricula with a major emphasis on community-based education. Where will this take place? Who will create the appropriate context, and who will do the teaching? It will have to be generalists working in districts!

A five-year curriculum with a two-year internship is on the cards. Part of this internship will probably have to be done in districts.

Family physicians will have to be present to make training possible. Doctors in community service are also being placed all over the country. Support and training is needed for them as well.

Another space? Another picture?

Rural doctors are more

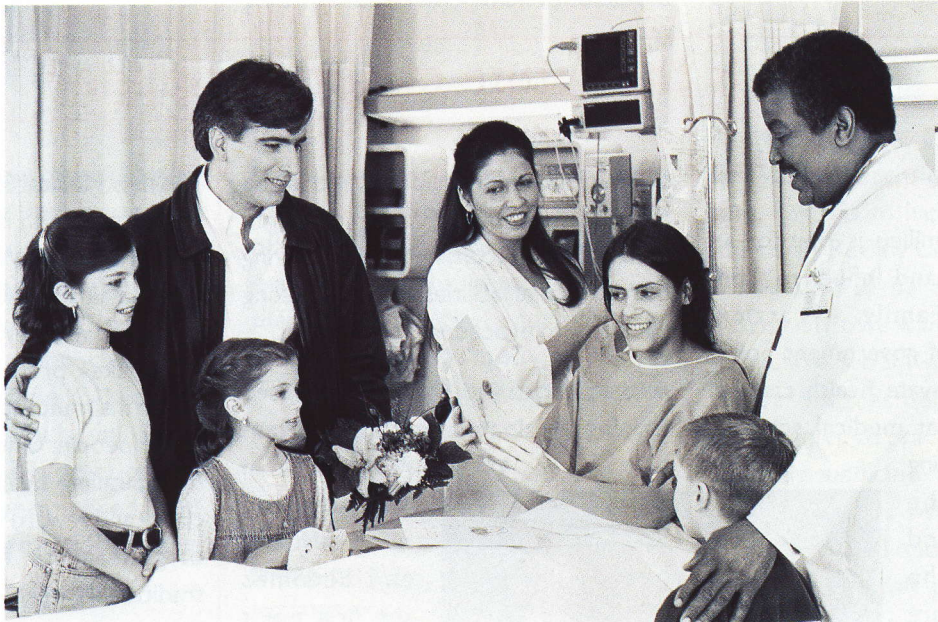
organised and are clearly defining their issues. Where does family medicine fit in?

Another space? Another figure?

My opinion: We need to clearly identify Family Practice as **the** discipline that will take responsibility in making a meaningful contribution to these situations. The values and principles, as well as the skills and experience of generalists need to be applied in all these areas. Whether we call ourselves General Practitioners, Family Practitioners or Family Physicians;

whether we work for self, state, or a company, we all need to focus on these tasks.

- Doctors groups, IPA's and co-operatives could explicitly involve Family Medicine values and skills in working out a future for the private sector. (Academic departments of family medicine could well participate in working out sustainable solutions with these groups.)
- Academic bodies such as the Academy/College, FaMEC (Family Medicine Education Consortium) and the individual departments of Family



Medicine should continue working towards a common set of educational outcomes in the training of generalists for these situations. The envisaged national examination has to reflect something of this picture.

- Departments of Family Medicine at each medical school have to take leadership in the new undergraduate curricula. Students are supposed to be trained in an integrated way in the community, but their training is designed and carried out mainly by specialists in hospitals; a contradiction

in terms.

- Rudasa (Rural Doctors Association of SA) should continue to challenge our discipline to be relevant in rural health care in terms of service, skills, training and research.
- Generalists involved in the processes of (establishing?) the new Medical and Dental Professional Board will have to make meaningful contributions in the shaping of health care as a whole, through this regulating body.
- Generalists and other people in government positions, working groups

and task teams can contribute to policy discussions and decisions from a secure foundation of the body of knowledge that defines our discipline.

We need to become reliable partners – prepared to take on responsibility and deliver in

the whole health care scene.

Visualise the picture, choose the appropriate brush, hold the brush firmly, make the stroke with just the right amount of firmness – and lightness... allowing your hand to follow your mind.

“So whose hand is holding the brush and what is on the palette?”

Hugo, J

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Chairman of the Family Medicine Subcommittee of the Medical and Dental Professional Board.