

Midlevel medical worker: Problem or Solution?



Doctors march to parliament.....

Why would family medicine get involved in developing a midlevel medical worker for South Africa? This at the same time when family medicine is developing as the clinical specialty for primary care, general practice, district health and rural health?

Generalists have been working with nurses as midlevel medical workers for many years. We have been involved in developing the training of nurse practitioners or primary health care nurses who are the backbone of care at primary care clinics throughout the country.

Our experience with the nursing profession has not always been easy. Primary care nurses are often frustrated and feel misunderstood by the nursing establishment.

In district hospitals it often depends on the persons involved how much assistance we get from the nurses. The legitimate comment: "Doctor, this is not a nursing duty" is often heard. And the serious shortage of nurses and doctors in district hospitals is making it worse.

The political decision to develop a midlevel medical worker is a reality.

The plan is to place the midlevel medical worker in the district hospital. He or she should have the knowledge and skills to help the doctor with less complicated clinical tasks and procedures in the emergency unit, theatre and the wards. It is hoped that this will give the doctor more time to support the important work in the community and the clinics. Placing the midlevel worker in the district hospital also makes it clear that this person is not meant to replace the primary health care nurse who works mostly in the clinics.

The concept of a midlevel worker called a physician assistant or clinical officer is that of a distinct profession working in the primary care team with the doctor. He or

she reports to the doctor without the intention of working independently. In the USA the registration of a physician assistant with the Medical Board is linked with the name of the supervising physician. We need to ensure that this element is clearly understood, regulated and implemented in South Africa.

Developing family medicine as a speciality means that most doctors in primary care will either be trained family physicians or family medicine registrars. It means at least 4 years of training post graduation. Primary care nurses also have to do at least one year training on top of the 4 years nurse training. The result is that all the clinicians in primary care go through an extended period of training with all the costs involved; financially for the system and time, effort and sacrifice for the professionals. Here is an opportunity to develop a team member who requires less training and all the training is aimed at the knowledge and skills required to assist us in district hospitals.

Family medicine training complexes develop throughout the country. It seems logical that the training of the midlevel medical worker develops within the same training system. Will it demonstrate that family medicine is committed to quality primary care and to the primary care team?

Quality primary care depends on the team. This team includes doctors, nurses, therapists, pharmacists and lay health workers and it is in this team that the midlevel medical worker has to find a place. We as doctors have been criticised that we only work for the doctors and that our extended training makes us more expensive, more mobile (and more arrogant?). The change in direction that I propose is that we as primary care doctors demonstrate our commitment to the primary care team and develop alliances with other primary care workers. We work for this team, ensure that the whole team is accommodated and looked after in the health system. Then we are more legitimate when we say: "We fight for the welfare of the patient and the community".

Let the next march to parliament be the Primary Health Care Workers of South Africa.

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