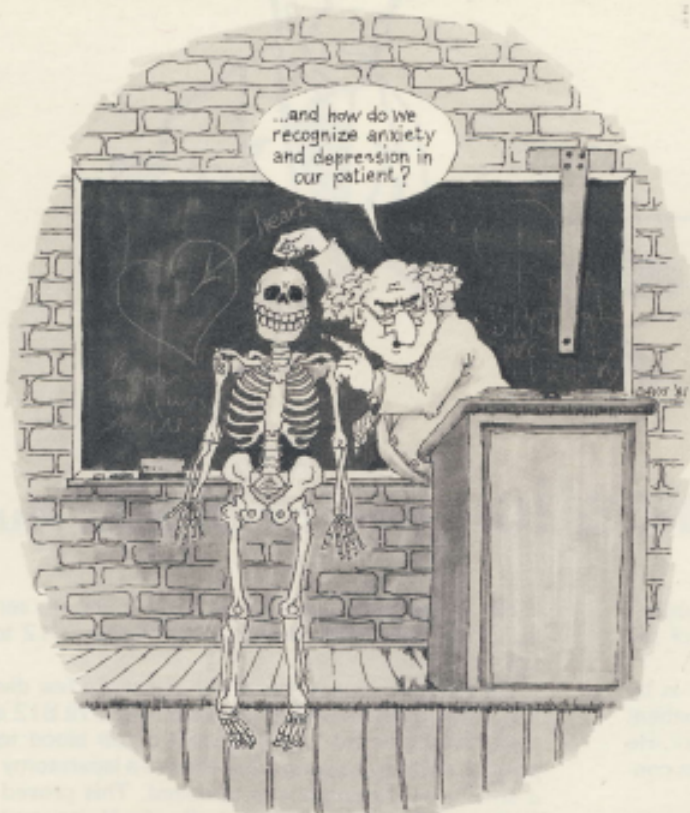


# Comment Komentaar

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In planning medical training one must start with the needs of the community and the patients from it. There is no doubt that there is a great need for G.P.'s./Family Practitioners/Primary Health Care workers who deliver a curative service within an holistic approach in which health promotion has a high priority. There is a shortage of G.P.'s. in the developed and in the underdeveloped communities in S.A. To solve this problem one solution would be to have a Medical School whose graduates are G.P.'s. on qualification.

It is theoretically possible to produce a G.P. after six years training and one year's internship in General Practice. This is being done in Holland. To do this the major part of training and teaching should take place in General Practice and be done by G.P.'s. There will have to be a deemphasis in the teaching of Anatomy and many other disciplines and a much greater input from other disciplines as Psychology, ENT, Der-

matology and Epidemiology.

The consequences of this approach will be several. The present S.A. Medical Schools will basically become post graduate schools for specialist training. New or parallel G.P. Schools will have to be established. We will need new S.A. Medical Council Regulations.

Specialist training will have to start at an earlier stage in the undergraduate curriculum or be of longer duration post graduate than at present. South African G.P.s. will become less multipotential and all-rounders and less internationally acceptable than at present.

It seems that these requirements are medico/politically unattainable in the South African context.

Even with ideal undergraduate training some things in medicine can only be learnt when you have full responsibility for the patient. General Practice is also no longer the normoblast or blob Dr. for differentiation into specialities and subspecialities.

Family Practice has become a separate discipline with a particular frame of reference, subject matter and approach.

We hesitate in the S.A. context to call it a specialty for:

- we are not Consultants
- we are not confined to any aspect of medicine but are generalists limited by our own training and competence.
- we do not charge specialist fees.

The pragmatic and politically possible avenue open to us in South Africa is thus to:

- state specifically that the basic Doctor of our Medical Schools is not equivalent to a G.P. He is an undifferentiated blob and a good one at that.

- institute sufficient Family Practice teaching by Family Practitioners in the undergraduate programme alongside the specialties to give students the opportunity to choose their own careers in an informed way.

- institute post graduate vocational training for Family Practice to provide Primary Care Doctors from the stem doctors who have been initiated into the principles of Family Practice in the undergraduate curriculum.

- To link this back with community needs one has to accept that this approach is not going to provide a G.P. accessible to each person in South Africa in a short time.

These doctors will therefore have to learn as undergraduates and as G.P.s. in training to work in teams in which much of their task is accomplished by delegation to other members of the health team such as Advanced Clinical Nurses.

We can no longer discuss end product without reference to these new relationships to the health care team.

- Concisely, we should aim at producing a graduate that is a multi-potential stem Doctor who will need vocational training in whatever career is selected; can solve medical and medically related problems without knowing everything beforehand; has started a habit of lifelong learning; can understand people and make himself understood; thinks in epidemiological and health promotion terms as well as clinically can function within the team context and possess the necessary management skills.

Acceptance of such a statement by Faculty will have radical consequences for our teaching programme if taken seriously. □