Forum

Vocational Training

FOR may years voices have gone up in favour of Vocational Training for General Practice from individuals, groups in the Medical Association and others. The most recent events are presented here. Readers of *SA Family Practice* are invited to respond so that the matter can be more generally debated.

Present Position

Any person who has completed a recognised internship may set up in solo General Practice the next day. More and more people are now saying that this is undesirable as today's medical school training and subsequent internship in South Africa does not equip the graduates for any form of Primary Care.

Various negotiations have been taking place to remedy this.

Calendar of recent events

- 1981, April 11 - Academy held a one-day workshop on Vocational Training at Jan Smuts Airport
- 1981, July 17 - The Medical Education Committee of the SA Medical Council discussed memoranda from The University of Cape Town and the Academy asking for Vocational Training. A 4-man delegation from the Academy was also received. The Medical Council wrote to the Medical Association, Medical Schools and The College of Medicine for their opinions with regard to Vocational Training.
- 1983, March 21-22 - Academy Workshop in Pretoria resolved to promote vocational training in and for the underdoctored areas of the country.
- 1983, May 10 - Federal Council of MASA passed the following resolution :

(a) that a basic doctor who had completed his year of internship could not be regarded a general practitioner;

(b) that a period of definitive training should elapse before such a practitioner should be permitted to enter general practice;

(c) that a register for general practitioners should be established.

- 1983, November 25 - The Academy had an interview with The Browne Commission of Enquiry into Health Services and presented the memorandum reproduced below.

- 1983, December 1 - Appointment of Dr J A Smith as Co-ordinating Director for Vocational Training for the Academy. ■

Present status of Family Medicine in SA Medical Schools

1. Universiteit van Pretoria

Die U P bied al meer as 15 jaar vanuit 'n volwaardige Departement Huisartskunde 'n drie-jaar deeltydse kursus aan vir die M Prax Med-graad. Verskeie mense doen ook die graad terwyl hulle werksaam is in diensposte binne die Departement.

2. Medunsa

Medunsa has a full department of Family Medicine which offers a three year part-time M Prax Med Course as well as a two-year full-time Vocational Training Course. The latter is made up of one year in the Dept of Family Medicine, and one year in various specialities, according to the trainees' needs. Rotation occurs every three months. There is half day per week release to the Department of Family Medicine for seminars. There are ten trainee posts.

3. Universiteit van die Oranje-Vrystaat

In Bloemfontein is daar 'n deeltydse M Fam Med en voltydse Beroepsopleidingskursus. Daar is 'n tydperk van ses maande in die Huisartskunde-departement. In die tyd besoek die kliniese assistente ook die departemente van Oor, Neus en Keel-geneeskunde, Oftalmologie, Radiologie en Dermatologie. Vir agtien maande roteer hulle elke twee maande na ander dissiplines met 'n sekere mate van eie keuse. Daar is 'n weeklikse kliniese bespreking vir die hele groep. Daar is agt poste vir hierdie opleiding.

4. University of Witwatersrand

At Wits they have advertised a Chair in Family Health and are in the process of making an appointment.

5. Stellenbosch

Die Universiteit van Stellenbosch het onlangs 'n persoon as senior lektor in Huisartskunde aangestel.

6. University of Cape Town

UCT has part-time appointments in a General Practice Unit within the Department of Community Health.

7. University of Natal

The Faculty of Medicine in Durban has approved the establishment of a Chair in Family Practice.

Memorandum on Vocational Training in South Africa for General Practitioners/Primary Care Doctors

1. Introduction

The SA Academy of Family Practice /Primary Care considers it desirable and feasible that Vocational Training and a Register for Family Practitioners be instituted in South Africa It is suggested that this be done on a voluntary basis. Where applicable, certain points in this document will be discussed which will only apply if registration was mandatory.

1.1 *Purpose of Vocational Training*

Vocational Training has been shown in studies in Australia and Canada[1] to *raise the quality of Primary Care.* To achieve and maintain high standards in Primary Care, it is considered important that all General Practitioners/Primary Care Doctors should receive Vocational Training [2] as in other fields of clinical practice.

1.2 *Cost Effectivity*

At present, studies are showing that doctors who have been vocationally trained are more *cost-effective* than those who have not been trained.[3] This is quite apart from the fact that the cost of medical care in the Primary Care sector is cheaper than that provided in Consultant practice. This is especially so in that less special investigations are performed and more rational and cost-effective prescribing habits are inculcated. On the other side of the coin, health promotion activities result from adequate Vocational Training.

1.3 *The Distribution of Manpower*

It is furthermore likely that a *better spread* of doctors might arise due to Vocational Training[4]- as shown by the American experience since introducing Vocational Training

1.4 *Aims of Training*

The aims and objectives of such a training programme is to produce a practitioner who :

- thinks and behaves in terms of health, as well as disease, and who can apply techniques of prevention and health promotion as well as disease, as well as cure and rehabilitation.
- thinks and behaves in terms of membership of a health team consisting of doctors, nurses and other health workers.
- thinks and behaves in terms of making the best and most effective use of the financial and material resources available.
- thinks and behaves in terms of the country's patterns of health and disease, and its relevant priorities.

2. Method of Training

It is suggested that two forms of training be offered :

2.1.1 *Full time Vocational Training*

This should be offered in a University Department of Family Practice, or equivalent. The trainee should be in a *Family Practice service post* in the Department, or *on rotation* with other disciplines. While out of the Department of Family Practice, there should be at least a *half-day/week release* back to Family Practice for continuity of training. We feel that we should start with a *two-year* period - though some overseas experience suggest *three years* are necessary.

2.1.2 *Part-time Vocational Training*

This can take place over a period of *three years* post-internship, while the trainee is working in an approved post outside a University Department. For at least *six months* of this period, the trainee should work in a University Family Practice post. These may be satellite posts of the University in health centres or non-University hospital Primary Care Departments.

The approved posts for the cumulative non-University period of 2½ years may be from any Primary Care situation (i.e. peripheral public hospitals, health centres, private practice, or mine and other private hospitals) and satisfactory multi-disciplinary experience in specialist Departments for not more than half the time.

The posts would have to be approved *by the Medical Council* for this purpose. A *minimum period* of not less than three months should be spent in any particular Primary Care post. Shorter periods may be allowed in sub-specialities.

2.2 *Examination and Registration*

By whatever method practical training was achieved under supervision, the following *methods of evaluation* will be necessary before being able to register as a Family Practitioner :

2.2.1 An appropriate qualification in Family Practice, such as Master in Family Practice from a University or MFGP of the College of Medicine of South Africa.

2.2.2 Any other appropriate evaluation approved by the Medical Council.

3. Feasibility

3.1 *Number of Trainees and Posts*

The following calculations are based on the premise that all people going into Primary Care would undertake Vocational Training. If training was voluntary however it should be organised in such a way that the request for training does not outstrip the provision of training opportunities (as is unfortunately the case in the USA)

- If it is assumed that 50% of all graduates will undertake training, 500 trainees a year should be catered for.
- Assuming that the Universities will accept between them 50 trainees per year for full-time training, they would need 100 posts for this.
- For the 6-month period of the

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remaining 450 trainees entering the system per year, who will have to undertake part-time training over three years, a further 225 posts will be necessary.

- This total of 325, divided by 7 Faculties, will give each a total of 46 training posts to manage. This is certainly an attainable goal for the present Departments of Family Practice, considering the service loads they have to manage.
- For the remaining part-time trainees, 1 125 approved posts can be selected from the Private and Public Primary Care sector spread across the country. It should be noted that this would bring many into peripheral situations to alleviate the maldistribution of Primary Care provided.

3.2 ***Regional Directors***

The Academy proposes to appoint a system of Regional Directors to co-ordinate with a National Director (as in the Australian system). Their duties will be to supervise the extra-University practical experience of Vocational Trainees by :

3.2.1 assisting them to plan their rotation to various jobs and their learning programmes; and

3.2.2 scrutinising the contracts they undertake with hospitals and practices, who take trainees into approved posts. They will, by so doing, make sure that the trainees are given sufficient time for study and attendance of courses.

To qualify for a post as Regional Director, a doctor will :

3.2.3 have to be in possession of a recognised post-graduate qualification in Family Medicine; and

3.2.4 have taken an appropriate course in the training of Family Practitioners. (This could be offered as a series of week courses, over three months, at a University Department).

3.2.5 have to be in active Family Practice, preferably a Group Practice, or Primary Care Practice, enabling the person to take a 3/4 appointment as Regional Director.

To start with, six Regional Directors should be appointed to coincide with the Regions of the Academy covering the whole country.

3.2.6. The post should be in an environment in which an acceptable standard of practice is maintained. Sufficient time should be provided for in the contract to cater for the study-leave needed to attend University, and other continuing education programmes.

3.2.7. Just as the case is with the University Departments, the Academy and the Regional Directors should be *inspected by the Medical Council*, with regard to standards and quality of supervision of trainees.

3.3 ***Financial Implications***

3.3.1 *Public Sector*

3.3.1.1 **ADDITIONAL TEACHING POSTS**

If one accepts the ratio of five full-time trainees to each teacher[5] then 65 teaching posts will be established for the 325 trainees in full-time training.

These same people would probably be sufficient to carry the part-time students, being an additional load of about 20 part-time students per staff member (1 125 students at any one time).

Divided between the 7 Faculties, this would mean 9 posts each.

These are already available at the three existing Faculties with full Departments of Family Practice.

In practice then, this would mean providing a further 36 to 40 posts at the 4 remaining Faculties. In many cases, these will not be new posts but posts presently serving as service posts - being converted to joint University posts. Presently, there is some difficulty in filling posts in Outpatient and Casualty sections, outside teaching units.

3.3.1.2 **TRAINEE POSTS**

In the majority of cases, trainees will be able to enter present service posts.

3.3.2 *Private Sector*

3.3.2.1 **VOCATIONAL TRAINING FUND**

Both the trainee and the trainer will have to be paid, where Vocational Training takes place in the Private sector. Additional training posts in the Public sector will also need funding.

We propose the establishment of a Fund for this purpose which will get its monies from a percentage of all monies spent in Private Practice and Public sector/Primary Care. This could be a levy on the gross income from Private Practice for Practitioners and monies spent in the Public sector. A similar system operates for the training of specialist surgeons in the Netherlands.

3.3.2.2 **ADVANTAGES**

3.3.2.2.1 This investment in improved Primary Health Care will bring dividends back to the patient who made the initial investment.

3.3.2.2.2 British experience has shown that being a trainer is a sought-after position, and has contributed to improving standards.[6]

3.3.2.2.3 The fund will not be dependent on the vagaries of budgeting procedures.

3.3.2.2.4 It will allow for localisation of training into the areas from which the funds were raised to contribute to the distribution of medical manpower throughout the country.

3.4 ***Register and Possible Timetable***

3.4.1 *'Grandfather' Clause*

All doctors who entered General Practice, prior to the institution of the Register should be allowed to register without having undergone the Vocational Training.

They should be given adequate prior warning of the last day of registering without Vocational Training.

To register, one should have been in active Primary Care for at least one year in the 3 years prior to registration.

3.4.2. *New Registrants*

All doctors wishing to register as Family Practitioners who complete their internship two years prior to the date of instituting the Register will have to complete a programme of Vocational Training to be eligible

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for registration.

3.4.3 *Remaining on the Register*
Doctors who wish to remain on the Register will have to give proof of at least 'X' hours of continuing medical education annually, or give satisfactory proof on practice audit.

Their registration will lapse if they are out of active Primary Care for more than 'X' years.

3.4.4.*Re-entry to the Register*
Anyone whose registration has lapsed would have to spend at least 3 months in a full-time training post before being allowed to re-register.

3.4.5 *Unregistered Doctors*
(This would only apply if the Register were mandatory)
Those doctors who are neither on the Family Practice nor Specialist Registers will only be able to work as assistants under supervision of registered doctors in Private Practice, or in full-time Medical Officer posts under supervision of registered persons.

3.4.6 *Registration from Other Countries*
The Medical Council can register people from Vocational Training Schemes in other countries, if they judge their standards to be adequate.

3.4.7 *Benefits of Doing Vocational Training on a Voluntary Basis*

3.4.7.1 Those on the Register will be called Family Practitioners and not General Practitioners. This will hopefully become a mark of good quality Health Care.

3.4.7.2 Registration could be a requirement for more senior Academic and other State Provincial posts in the Primary Care sector.

3.4.7.3 Hospital privileges in Public and Private sectors could be allocated in preference to those who are on the Register.

3.4.7.4 Registration could be made compulsory for all those wishing to leave Specialist Practice for General Practice.

3.4.8. *Possible Timetable*
With the institution of a Register for Family Practitioners and a universally available possibility of Vocational Training, a growth period is envisaged. It is anticipated that there will be no dramatic change in the quality of Primary Care after the Register opens, but that steady improvement will take place. A significant effect will probably only be measurable in the Primary Care sector, in general, after a period of 10 years or so. To get the scheme functioning on a compulsory basis would probably take longer.

PROFESSOR G S FEHRSEN
DR JA SMITH

	TIMESPAN	NUMBER OF YEARS Compulsory	Voluntary
3.4.8.1	For consideration and the formulation of regulations by the Medical Council, State Departments, and other bodies	2	2
3.4.8.2	For creation and filling of posts for Regional Directors, teachers at Universities and trainee posts	3	1
3.4.8.3	First group of medical students in their 6th year, up to the time for Vocational Training being required before registration as a Family Practitioner	3	3
		8	6

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Dr. V. I. McCusker: Presidensiële Uittreerede

HAVING grown up in a medical family I often wonder about the changing status and stature of the medical practitioner in the community. The older practitioner had less academic knowledge at his disposal and was scientifically able to do less for his patients and yet was valued more highly than the modern practitioner who is able to do so much more and possibly is tempted to do too much too often. There are a number of questions which may explain this discrepancy.

Is daar op die huidige stadium te veel of te min dokters? en waar lê die probleem met die getalle? **(Tafel 1)**

Dit is duidelik dat ons as ontwikkelende land geen globale tekort aan dokters het nie en dat daar waarskynlik ten opsigte van die blanke bevolking 'n ooraanbod aan me-

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TAFEL 1:

Jaar	Totale Bevolking	Blankes	Dokters	Bevolking/ Dokters	Blanke Bevolking/ Dokters
1935	9 435 000	1 970 000	2 746	3 436	767
1955	14 665 000	2 840 000	6 987	2 099	406
1975	25 343 000	4 256 000	13 347	1 899	319
1981		4 674 000	17 261		270

diese dienste bestaan. Dit is net so duidelik dat die verdubbeling van blanke mediese skole deur die owerhede nie die probleem van desentralisasie en wandistribusie oorbrug nie. Die blanke mediese skole behoort ingeperk te word en die oprigting van mediese skole in die areas en bevolkingsgroepe waar dokters benodig word is al logiese manier om konstruktiewe vordering te maak. Desentralisasie van die opleiding sal lei tot herdistribusie van mediese dienste.

Are doctors now too clever? The present criteria for selection of medical students place such emphasis on academic results that selection for a medical course has almost become a status symbol for recognition of academic achievements. As a service profession we should guard against having too many practitioners whose academic ambitions are not adequately stimulated or satisfied by the often mundane work of clinical practice and whose decreasing enthusiasm can lead to less than optimum treatment.

The country can afford and support only a limited of number of research projects and the vast majority of medical graduates should be trained with the aim of producing a practitioner orientated to rendering service with available medical knowledge. The tendency to extend the scope of the course to exceed the cerebral capacity of the students is not constructive. There is a danger in having too many facts and too little knowledge, experience and insight.

'n Groot en belangrike deel van mediese onderrig ten opsigte van praktykvoering berus steeds op die vakleering beginsel en ons moet waak teen die proliferasie van departemente of dosente waar akademiese prestasie so hoog geag word dat basiese dienslewering as minderwaardig beskou word. Om hierdie beginsil te behou is dit noodsaaklik dat 'n belangrike deel in die opleiding van studente deur deeltydse dosente wat aktief in kliniese praktyk betrokke is waargeneem moet word. Dit is meer belangrik vir die pasient se welvaart om 'n deeglike as briljante dokter te hê en ook om 'n dokter te hê wat tyd het en bereid is om die moeite te doen met basiese kliniese medisyne, as 'n akademikus wat meer belangstel in eksotiese navorsing.

No country can afford to follow the American example where the cost of health care is absorbing an increasing percentage of the Gross National Product. At present almost ten percent of the American GNP is spent on health care services. Cost effective medical care should start in medical schools with practical instruction to students given an insight into the relevancy or redundancy of special investigations, rather than showing by example just how many investigative procedures can be done on each individual patient.

The greater the safety of an operative or invasive investigative procedure, the greater the chance that it may be applied on inadequate indications.

In earlier times a doctor rendered a single account for professional services. At present the account is rendered according to an extensive and bewildering list of tariff items where careful use and possible abuse can significantly increase the income of a practitioner. In the present situation of maldistribution of available medical services to the private sector we must guard against the situation where a doctor, faced with a decreasing number of patients, provides an increasing number of service items to maintain a constant income. Simplification of the present tariff is urgent and essential.

Uitgediende en ondoeltreffende operasies en ondersoek metodes moet van die tarieflys verwyder word. Statistieke is nou beskikbaar ten opsigte van betekenisvolle verskille onder praktisyns in die gebruik en misbruik van prosedures. Nie alle afwykings berus op die winsmotief nie.

Die Mediese Vereniging moet die leidende rol neem om hierdie kollegas in te lig oor doeltreffende en koste effektiewe mediese praktyk. Waar misbruik aangetoon word kan die Mediese Vereniging nie bekostig om die swart skape te beskerm ten koste van die oorweldigende meerderheid van eerlike mediese praktesyns nie.

The high standard of medical practice in this country owes a debt to the competence of the traditional general practitioner. Just as a surgeon who can not operate or a physician who lacks basic clinical competence is undesirable, we are now producing a graduate who is not adequately equipped to enter unsupervised clinical practice.

Serious thought should be given to supervised post-graduate training for general practice. Taking into account the financial loss of extended studies and the shortened years of the specialist in clinical practice, the tariff structure should be such that the stimulus to specialise is interest in the subject and not the promise of increased financial gains. The general practitioner should remain the cornerstone of medical practice and the patient's guide through consultant specialist practice when indicated.

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