

It's all changed

In conversation with colleagues at the 2012 Family Practitioners Conference, I learned that in South Africa, family medicine has been completely transformed and is now aligned with the needs of the people of sub-Saharan Africa. The family physician is now the African family physician (AFP)¹ and has a job description in accordance with the primary healthcare approach. My colleagues were keen to impress on me just how different things are now: "It's all changed," said one. "It's different now," said another, referring to registrar training, while in a workshop, a third declared that "Family medicine got it wrong". Affronted by such summary relegation to family medicine's Jurassic Park, I looked into some of these changes.²

It seems to me that the AFP is essentially the district medical officer (DMO), reinvented for postcolonial Africa. The DMO was a generalist based in a district hospital that was responsible for supplying preventive and curative health care for large populations. The DMO did this with teams of auxiliaries that they both trained and led. Generations of doctors in Africa over the past century, including Albert Schweitzer, Cicely Williams, Anthony Barker and Pierre Jaques, would all have recognised the AFP's responsibilities because they had been their responsibilities too.

I think my colleagues were as insistent as they were because there is still tension between proponents of family medicine as practised by the individual general practitioner and those who support the primary healthcare approach. There is an ideological divide between those who are primarily concerned with the individual patient and those who view their responsibility as being towards an underserved majority of patients. The tension between these standpoints reflects a false antithesis, but of course it's right for academics to work away at such knotty problems. Charles Boelen convinced me, at a meeting in Cape Town in 1995 (1995, personal communication), that those of us who work with individual patients, while advocating the primary healthcare approach, can bridge the gap between these divergent ideologies.

I was one of a group who met in 2000 under the auspices of the World Health Organization (WHO) Global Programme on Evidence for Health Policy to consider the responsiveness of health systems to community needs. AFPs will find our guidelines helpful in determining the needs of the communities that they serve.³

These guidelines concern patients' views on their experience of their health system with respect to the following domains:

- Autonomy
- Confidentiality
- Dignity
- Prompt attention
- Basic amenities
- Communication
- Choice of provider
- Social support.

The AFP's emergence is a welcome expression of our deliberations at the WHO Towards Unity for Health Conference,⁴ where, through the "Phuket Consensus", we agreed that:

- Each person has the right to health environments and equitable, effective, humane and ethical health services.
- Policies and practices that affect health must be evidence-based, rational and sustainable, and must aim at achieving both individual and societal good.

Though clearly much has changed in the interpretation and application of family medicine in Africa, what will never change is the need that any one of us might have, when sick or sad, to seek the help of a doctor or nurse who we trust. This need goes straight to the heart of health care, whether we are rich or poor, in an urban or rural setting, or insured or not. But paramount here, above and beyond our racketsy academic discourse, are the needs of South Africa's majority for care against the effects of noncommunicable diseases, as examined at a United Nations' meeting in New York in 2011.⁵

In the event that the AFP is trained, rewarded and fully enabled to provide care to South Africa's underserved majority, especially to her woefully neglected children,⁶ then more strength to her elbow.

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