# The Family Medicine specialty: buyer's remorse or reluctant seller?

This year, we celebrate the first 10 years since the Health Professions Council of South Africa (HPCSA) approved the specialty of Family Medicine in 2003. It is an opportune time to review the progress made. Elsewhere in this journal, Couper, Fehrsen and Hugo[1] raise concerns about the "state" of family medicine in South Africa at the present time. They postulate that we need to change direction, as we are training the wrong kind of family physician for the needs of the South African population. They argue that we should have shorter postgraduate training that focuses more on "primary care" skills necessary for ambulatory care in clinics, and that we should conduct less training on "procedural and technical" skills required to work in a district hospital, citing the examples of Brazil and Cuba as the models we should follow.

The need for postgraduate training for family doctors in South Africa became clear in the early 1970s, following international trends, and was one of the main reasons why the Academy was founded. Pioneers in family medicine worked hard to establish postgraduate programmes and vocational training at our universities, resulting in the establishment of the category of Family Medicine in 1994, and giving recognition to those trained as family physicians. Let's not forget the ill-fated attempt by the then SAMDC in 1997 to introduce a generalist three-year "vocational training" programme under the control of hospital specialists. In 2003, the approval of Family Medicine as a specialty[2] was the result of a process that spanned more than 40 years, and although it was a compromise (yes, we actually did ask for three years of compulsory vocational training for those wishing to enter into "independent" family/general practice), it provided us the space for specific postgraduate training under the control of family doctors.

During the debate on the specialty in the HPCSA in 2002/2003, there was a proposal that perhaps two separate specialties were needed: the "rural/hospital generalists" (for hospital care) and the "general practitioner" (for ambulatory care). However, the argument prevailed that South Africa's needs and scarce resources dictated that (specialist) generalist doctors must be able to work in any health facility in the district, and that there should only be one specialty catering to both needs, i.e. district hospital/rural care and ambulatory care. In the Western Cape, the Family Medicine departments only managed to get the support of the provincial Department of Health once they agreed to train doctors able to deliver the kind of services that the province needs, i.e. generalists able to work and take the lead in district hospitals and community health centres. I would like to argue that this requirement should even more strongly apply to our more rural provinces.

Are we neglecting personal care, patient-centered care and community-oriented primary care in our training? Absolutely not. If some residency programmes do that, they should correct the situation. Our training programmes need regular evaluation to ensure that we do not neglect important aspects of Family Medicine and that we constantly adapt to the needs of our society.

Do we need four years of training? Becoming a competent family physician is no lesser task than any other specialty. As a matter of fact, the UK is currently looking at extending its vocational training programme to four years, and it does not require the same level of technical skills training that we do because of its particular health system needs. Our family physicians are sought after by other countries because they are trained to function anywhere within a district healthcare system.

Family physicians are not trained to be everything our heath system needs, but to work in teams and be the lead clinician at district level. While I agree that we need many more family physicians, and that we need to vastly expand our registrar numbers, one has to acknowledge that the same applies to primary care nurses and clinical associates. Primary care is a team effort involving many role players.

There are probably some family physicians who have a bad attitude, but a bad attitude is a human trait, not a family medicine trait. It should be corrected through role modelling, counselling and training. We should also recognise that as family physicians become more senior, they fulfill different roles. They deserve recognition for that. The health system must value its senior family physicians.

I am proud of the family physicians whom we train today. They can work and take leadership anywhere in the district health system, working in teams. My only regret is that I never had a similar training opportunity when I was 25 years old!

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## References

1. Couper I, Fehrsen S, Hugo J. Thoughts on the state of family medicine in South Africa. S Afr Fam Pract. 2013;55(3): 208-210.
2. De Villiers PJT. Family medicine as a new specialty in South Africa. S Afr Fam Pract. 2004;46(1):3.