Response to discussion paper: thoughts on the state of Family Medicine training in South Africa

To the Editor: The following views are my own, and are not necessarily the views of any university department. I am responding to the discussion paper handed out on *Thoughts on the state of Family Medicine in South Africa* at the 16th National Family Practitioners Conference recently held in Cape Town.

Family physicians are indeed guardians and custodians of the district health system (DHS), which includes level 1 district hospitals, community health centres and primary healthcare clinics. The DHS is part of state health services, and this is where we belong, as family physicians. In many instances, family physicians also play an important role in providing quality private healthcare services in this country.

The registrar Family Medicine training programme is aimed at providing optimal, high-standard care at all levels within the DHS of state health services. Some of our graduates also play an important role in the private health sector, but the registrar training of our universities is largely aimed at state health services.

Firstly, the Family Medicine training programme focuses on providing optimal, safe and appropriate primary healthcare services. Primary healthcare services can take place at district hospital, community health centre, or primary healthcare clinic level. Great emphasis is placed on the so-called "golden threads" of family medicine, which include consultation and communication skills, patient centredness, family- and community-orientated primary health care, health promotion, disease prevention and ethics. These are all important and core aspects of the new training programme.

Secondly, the Family Medicine training programme has an emphasis on the knowledge, skills and attitudes which enable district hospitals to provide optimal, safe and appropriate health care. These hospitals need to provide care for those who are too ill to be managed at community clinics, and some of these patients need to undergo procedures and surgical interventions where indicated.

In addition to providing quality clinical service delivery, family physicians also play an important role in clinical governance, administration and teaching at all levels within the DHS.

The national hospital packages of care define the services that need to be provided at all levels by identifying the clinical conditions and procedures that are appropriate for each level of care. The defining requirement for the provision of level 1 services is the availability of a family physician; that of level 2 services is the availability of a general specialist, and that of a level 3, a subspecialist. The packages-of-care document is further subdivided into different sections. These include clinical conditions, competencies and equipment needs. All levels of hospital care need to function effectively, and certainly level 1 district hospitals need to function optimally, with the family physician in the leadership role. Specialists from other disciplines will never play a significant role at district hospital level. They may supply episodic outreach at most. District hospitals need doctors who can function effectively across all specialties, and this is where family physicians play a vital role. Neither the ambulance transport system, nor the level 2 hospitals, would be able to function optimally without good district hospitals.

Stellenbosch University runs a distance-based two-year modular Family Medicine diploma course for those doctors who choose not to carry out the four-year registrar training programme. Ideally, this would meet the needs of those generalists who would prefer to work at community-based clinics.

Family medicine cannot absolve and distance itself from the challenges, demands and requirements of district hospitals. "Hospitalists and generalists", as stated in the discussion paper, may well form part of the teams working at district hospitals, but lack of a career path and job satisfaction for these medical officers generally makes this career choice unsustainable and unpopular in the long term.

The graduates of our registrar training programmes have every reason to be proud of their achievements and qualifications. They are registered as specialists by the Health Professions Council of South Africa and have a right to be treated with the respect afforded to specialists in other disciplines.

Our graduates should have the freedom to make their own choices regarding the type of after-hour calls they choose to carry out. It is not unreasonable for a family physician to perform after-hour calls on a more senior basis where this is possible. However, choices may not always be possible, depending on local circumstances. Many family physicians find it unsustainable to perform after-hour duties at medical officer level over the long term. Please consider your own feelings and how you personally handled these issues after you moved into more senior positions in family medicine. It may also be inappropriate for family physicians to perform after-hour duties at medical officer (junior) level, and then

go off duty early (post call) the next day. This may impact negatively on important issues like clinical governance and teaching and administrative duties, which are largely daytime activities.

It would be disappointing if family physicians were reluctance to see patients with minor ailments. This sort of thing should be discussed during the training programme and should certainly be addressed on an individual basis wherever it occurs, even after qualifying. The Brazilian model of health care is something with which I am unfamiliar. However, I am going to quote an extract from the *Sunday Times* (12 May 2013), as this is food for thought, and also impacts on health.

I quote:

"The cars roll off the local assembly lines in Brazil, more than 10 000 per day, into the eager hands of Brazil's new middle class. The economy is in full bloom in the world's fourth largest car market. What happens once these cars hit the streets is becoming a national tragedy, as thousands of Brazilians die every year in accidents, that in many cases should not have been fatal.

"The culprits are the cars, which are produced with weaker welds, scant safety features and inferior materials, compared with similar models made for USA and European consumers. Four of Brazil's best-selling cars failed their independent crash tests. Unsafe cars, coupled with often unsafe driving conditions, have resulted in a Brazilian death rate that is nearly four times that of the USA, according to an analysis of Brazilian Health Ministry data. The USA recorded 40% fewer fatalities from car crashes in 2010 than it did a decade before. In Brazil, the number killed rose by 72%".

The moral of the story is to ensure that you don't hire or travel in a car in Brazil when you go and investigate the Brazilian healthcare model! They may have the quantity in health care in Brazil, but what about the quality? Same as the cars?

Probably much the same can be said for Cuba when quality versus quantity issues are considered. For many years, I have been involved in assisting with "re-training" of South African students who have undergone their undergraduate training in Cuba. There are certainly massive quality issues there.

I have no knowledge of healthcare quality in Ethiopia and the Sudan.

In conclusion, family physicians need to function effectively at all levels within the DHS. Our registrar training programme should reflect this need and we should direct our training in order to achieve this. The district hospital is pivotal to the service. The family physician's presence in a leadership role at this level, and in fact at all levels within the DHS is vital, and in my opinion, non-negotiable.

I was involved in the initial planning and subsequent implementation of the new postgraduate Family Medicine programme at Stellenbosch University until I retired in 2012. During the past few months, I have been assisting Family Medicine at UCT. During these years, I have never seen the training and principles of primary health care being compromised at either university, even though adaptations have had to be made in order to accommodate the extended knowledge and skills training required for district hospitals. I was, and still am, very enthusiastic about the new programme. It has been an absolute pleasure and a privilege to have been part of it.

For those who have misgivings about the new curriculum, I am sure that you will continue to confer and have dialogue with your colleagues. Perhaps you should also engage with graduates and registrars of the new programme. But there are so many role players with whom one can liaise: the Minister of Health, the National Health Insurance, the Provincial Departments of Health and the eight universities. At the end of the day, what probably matters most is what is in the best interests of the patients who access the DHS.

Regards,
Paul Hill