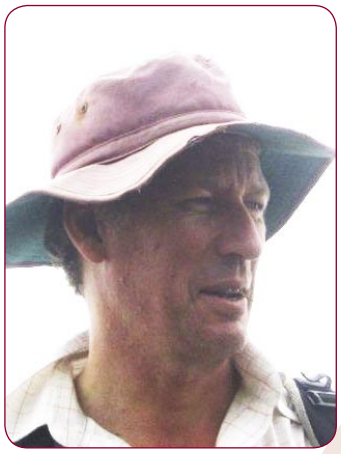

The African Family Physician

A group of 8 South African academics in Family Medicine met recently at a workshop in Kampala, Uganda, with some 20 colleagues from a number of sub-Saharan African countries in order to promote the development of Family Medicine throughout the continent. While this seems a lofty goal, the practitioner on the ground may ask: "What for?" Well, this is one response.

One of the key foundational issues for our discipline is the development of a home-grown and locally owned concept of what Family Medicine means in an African context. We have borrowed the principles and the theories, and to some extent the practice as well, from North America and Europe, and these serve us well up to a point. When a colleague of mine moved from public service in a rural district hospital to private general practice in a town, his comment was that the McWhinney principles "fit perfectly, like a glove" – his experience was that the "northern" principles are entirely appropriate for private practice in South Africa. So why doesn't the glove fit in the public service? Is it just that our public health service is not up to scratch? Alternatively, could it be that we are using the wrong glove?

Now when we meet our colleagues from countries to the north of us, we find them desperately enthusiastic to introduce Family Medicine training into their undergraduate and postgraduate programmes, and to produce Family Physicians. But when we ask them about their health systems, we find that they are similar to our public health service – understaffed, overburdened with preventable illness, and poorly managed. We find doctor-to-population ratios of 1:10 000 and much worse, very few specialists, and the few doctors that there are, swamped by surgical and obstetric emergencies.

So we have to carefully consider, with our African colleagues, exactly what the role and focus of the Family Physician in Africa is. While the "northern" model assumes a personal one-to-one relationship of doctor to patient, with a defined list of between 1000 and 2000 patients, it is clearly impossible for one doctor to personally provide primary care to 10 000 or more people. So the primary health care (PHC) team becomes a sine qua non. The Family Physician's role in this team needs to be clearly defined: what amounts of teaching, management, support, consulting, monitoring and evaluation are appropriate, in addition to the generalist clinical role.

Then there is the issue of the surgical and obstetric care at the district hospitals, with which the generalist medical practitioners are particularly busy all over Africa. What is the ideal balance of public health, ambulatory care, and surgical or emergency medicine skills for the Family Physician in Africa? Discussing with our sub-Sahara African colleagues, we find huge variations – in Tanzania, for example, virtually all anaesthetics are given by clinical assistants, so there is no need for doctors to have these skills. In urban areas in South Africa, there are enough obstetricians to do all the Caesarean sections, so there is no need for urban Family Physicians to practice this. So too at the Public Health end of the scale - in Malawi for instance where there is an active Masters programme in Public Health that area is well catered for. So the answer must be that the scope of practice is dependent on the context of the health system. However, while scopes of practice may vary, are there still some principles or values that we find in common in Africa, that are more appropriate for our context? In discussion, we found indeed that there is significant common ground, and that the similarities far outweigh the differences.

Maybe we need a different set of principles to work by in the African context, so that the "glove can fit". We need to create a discourse around the balances and relative weighting of each part of that common ground. We need to decide on the fulcrum around which the balance of priorities is made, as well as the criteria on which we should base the balance. Achieving some consensus is a work in progress, and a number of projects and meetings will pursue this agenda over the next 2 years, culminating in the WONCA Africa conference in March 2009 in Gauteng. The theme is "Family Medicine in an African Context". As chairman of the scientific committee that is planning the conference, I would like to invite your participation in the process.

So here are some ideas, to start the debate. Maybe they could look something like this:

Twelve Principles of African Family Medicine

1. The African Family Physician is committed to the Primary Health Care team, and is its clinical leader.
2. The African Family Physician provides clinical consultation, teaching, encouragement, management, monitoring and evaluation to other members of the Primary Health Care team in order to improve the quality of primary care.
3. The African Family Physician provides clinical diagnostic and management services for a pre-selected minority of patients who have been screened by other members of the Primary Health Care team.
4. The scope of practice of the African Family Physician is sensitive to and dependent on the context of the health system in which the Primary Health Care team operates.
5. The African Family Physician strives to use the most appropriate evidence to address the highest priority clinical, family and community issues.
6. The African Family Physician is competent in surgical, anesthetic, and procedural obstetric care at the district hospital level, i.e. in the absence of other specialists.
7. The African Family Physician knows his or her limitations, and identifies and refers patients who present with clinical problems beyond the scope of practice, to appropriate levels of care.
8. The African Family Physician supports members of the Primary Health Care team in the community, in the facilities where they work, as well as at the district hospital.
9. The Primary Health Care team including the African Family Physician is patient & family-centered and community-oriented. This means that people who are ill and those who are at risk, are always managed in the context of their families and communities. The Family Physician as the link between family care, facility/hospital-based care and primary/community-based care.
10. The Primary Health Care team including the African Family Physician engages with the community in which it operates as a population at risk, by defining its boundaries and acting on its health priorities.
11. The African Family Physician is dedicated to life-long learning and provides leadership in continuing professional development for the whole team.
12. As a manager of resources, the African Family Physician is primarily concerned with the reduction of disparity, and equal access to health services of all sectors of the community.

How does this fit with your situation? I hope you will feel free to disagree with some of the points above. I look forward to debating this, and meeting you in 18 months' time in Gauteng!

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Note: The contributions of my colleagues at the VLIR workshop in Kampala, Uganda, September 2007, are gratefully acknowledged. In particular I want to acknowledge the research: "A definition of Family Medicine" by Mash R, Moosa S, Downing R and De Maeseneer J." a poster presented at the The Network: Towards Unity for Health International Conference, Kampala. September 2007.

However the above draft principles are my personal interpretation, proposed here for the purpose of stimulating debate, and were not officially endorsed by the workshop participants.