Thoughts on the state of family medicine in South Africa

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Sometimes it feels to us that, as family physicians in South Africa, we are like the dog that is chasing the bus. Now that we have finally caught it, we aren't quite sure what to do with it. At times, it feels that it would have been better if we had never caught this bus of family medicine becoming a specialty, and all that this brings with it. This may seem like heresy to many colleagues. However, we have many questions as to the state of things in this country of ours, specifically in terms of family medicine and the future of health care. What is the role that we are going to play? What is the role that we are already playing?

Some of the questions that arise for us include the following:

- Why do we have a need to be equal to other specialties?
- Why do we want to be valued by specialist colleagues more than by patients or communities?
- Why have we appointed ourselves as the guardians or saviours of the district hospital?
- Why is our training so focused on skills and procedures?
- What is our role in primary healthcare re-engineering in South Africa?
- What is our role in the districts?

We have had many of these questions for some time. They have been brought to a head by watching events unfold in recent times, but also by learning what is going on in other countries. We have learnt how Brazil has established family health teams throughout the country, led by family physicians, and with a focus on family and community health. When they created these teams, they did not have enough family physicians, so they set up a vast training programme throughout the country to train doctors who are placed in these teams and then trained in family medicine, in addition to two-year residency programmes. Why have we not been able to be relevant in that kind of way, or to have taken that sort of approach to training? Our very exclusive small four-year intensive training programmes will never have that degree of impact on the country.

We have known for some time how Cuba developed community-based family physicians as the cornerstone of its highly regarded healthcare system, with one family physician per 200 families. We heard at the Wonca Africa Regional Conference in November 2012 about the Sudan, where they placed people in rural areas throughout the country, and put them through a distance-based, two-year diploma course training programme in family medicine. This allowed them to train a large number of family physicians at once (approximately 240). This is more than we will probably train in 10 years in South Africa. We have also seen how Ethiopia scaled up medical training in that country, establishing something like 20 medical schools over five years. One can argue about the quality of the doctors that will be produced, but that is the type of radical solution that is needed to address the human resource needs of Africa. Have we not missed the importance of scale and impact in favour of exclusivity and perceived quality?

Instead, what have we achieved here in South Africa? We have established MMed registrar training programmes that, at the very best, produce a family physician after four years, but in most cases, after five or six years. The graduates are perhaps academically sound in the sense that they have passed rigorous exams and are able to conduct research, but do they really address the needs of our country? We believe we need to take careful stock of this and think through the issues. We also need to consider the time that it takes to produce a specialist. One of our major concerns is the amount of time that we spend focusing on skill and procedures. This does not necessarily mean that our graduates are competent clinicians (though one does hope that they are) because the procedures are specialist-focused around particular domains, and not necessarily what is needed in everyday primary care practice. However, we worry that, with the focus on skills and procedures, we may lose some of the core that is family medicine, such as

person-centred care, community-orientated primary care, the central importance of the doctor-patient relationship, the role of the doctor as a therapeutic agent, as well as the role of the family physician in terms of disease prevention and health promotion. Do we say that these are inappropriate for the African family physician? We hope not.

At the same time, is focusing considerable time and attention during training on procedures that may or not be used the best use of precious training time? Are procedures not best learnt in the practice environment when they are needed? If that is so, we need to ensure that the graduates have the foundational skills on which to build, the requisite knowledge, and most importantly, the ability to learn and to continue as lifelong learners.

We are saying this in the context of having been family physicians in rural hospitals ourselves. We enjoyed procedures and still think that it is essential for a doctor to be both a generalist and a proceduralist in a rural hospital, or at least to have a number of those on the team. However, we learnt most of those procedures in the rural hospital, or through focused periods of time in referral hospitals to gain specific skills. In addition, the hospitals in which we worked were always very anchored in the community. We were very actively involved in community development activities and community outreach. We worked in clinics and we engaged in community-oriented primary care. That must not be lost in this process.

This raises the question as to who decided that as family physicians, we are the people who need to save the district hospitals? We worry about anchoring family medicine to the district hospital because we do not believe that family medicine is ultimately a hospital-based specialty. Some countries are moving towards developing hospitalists, or generalists who focus on hospital work. Is that really the role that we want for ourselves as family physicians? As we develop the cadre of clinical associates, who can play a greater and greater role in district hospitals, we see them taking on many of these responsibilities. Procedures are technical tasks. In many instances, one does not need to be a highly trained specialist to perform procedures, and yet we want to give our time and attention to these tasks. Yes, we need to be supporting, guiding and leading much of this, but should that really be our focus? We worry that we are truly becoming medical specialists in the sense of being highly trained technicians skilled in a particular field, rather than generalists who are specialists in primary care.

Let us then pick up on our concern about being registered as specialists. We are very worried and disappointed to hear colleagues, as we did in Victoria Falls and on other occasions, standing up and proclaiming that they are equal to any other specialist, that they need to be treated in the same way, and are as good as them. We understand where this is coming from. However, we believe that respect is something that is earned and that it is earned by what that we do, rather than by a title. Recognition and status are attributed by society and become a mockery when claimed for oneself. This striving for recognition and equality contains the seeds of our downfall.

Furthermore, we need to be very clear that we are different from other specialties, and not try to be the same. We think that some of our problems derive from the fact that we try to be the same as other specialties and to be seen in the same way, instead of making it very clear that we are completely different, because primary care is different from any other specialty; because our role is in the community, and not in the hospital like other specialists; because our focus is on all patients and not types of diseases or specific groups of patients; and because our approach is holistic, rather than specific. We are generalists who need to coordinate patient care in balance with specialists, who each have their own unique way of making clinical decisions. We need to be experts in health, and to say to our patients that their illnesses are but one part of them as whole people, while the specialist is an expert in saying which sicknesses they do or do not have, in a narrow field.

We are extremely worried by reports of family physician specialists who consider themselves to be too important to see patients with so-called minor ailments. We are deeply disappointed to hear students reporting on family physician colleagues saying: “I am a specialist family physician” with great pride, as they strut around and do not see the patients that the other doctors and nurses see, because they are specialists. We feel pain when we hear that our colleagues will not carry out the normal first contact calls, but want instead to perform “consultant calls”, where they sit at home and are only called out on the odd occasion, while still being paid the full amount for overtime. Is that what being a specialist really means? Are we selling ourselves out? This is definitely not the way to gain the respect of our colleagues, the public, or the powers that be that run the health service. We do not think it is the way to gain self-respect either.

What is our role in primary health care re-engineering then? We ask this question, not because we believe we should be following the vagaries of every change that is implemented by successive governments, but because we believe that primary care is where our focus should be, and primary care re-engineering allows us to rethink our focus. Much is said about models on which our current system of primary healthcare re-engineering are based, with comments about Brazilian and Cuban models. We do not believe the model that is being followed is a Cuban or Brazilian model, but it is sad that it is not, because in the Brazilian and Cuban models, the family physician is central. That is the role we should

be having. We should be part of the ward-based outreach teams. We should be part of initiatives at community level. We should be leading community-orientated primary care. We should be ensuring that true primary health care is being developed. There is a great danger that the district clinical specialist teams are going to entrench a silo-based approach to health care, instead of the holistic integrated care that we need. As family physicians, we should be ensuring that we have the right kind of broad-based primary care, yet we seem to have been bypassed by primary care re-engineering. We think that we have fitted into this specialist-driven understanding that primary care is something which is too simple for doctors to be involved in, and can be left to midlevel workers or primary health care nurses. Nothing could be further from the truth. We know, from the evidence of Barbara Starfield and others, that primary care is where we can really make a difference and we should be playing a leading role.

Yet what is the situation? If we have doctors who are interested in primary care who want to become family medicine specialists, but only want to be involved in primary care, we have to tell them that that is not possible because they have to pass exams that require them to be skilled in all sorts of hospital-based procedures, and that they have to conduct rotations in hospitals, which means that they cannot thus be focused on primary care. Clearly, we have lost our way.

One of us raised some of these issues with a senior colleague. The response was that surely we cannot now, when we have just put everything in place, go back and re-think what we have fought so hard for. We are among those who fought for change, but not for what we now have. We did not imagine the unintended consequences. We campaigned for all independently practising primary care doctors to be family physicians, and that the bulk of general practitioners would qualify through a grandfather system. We have now ended up with a two-tier system of family physicians and general practitioners, which we were trying to avoid. The gaps between specialist family physicians and general practitioners, and between public and private practice, have seemingly widened. It is better to review and re-campaign now, than in five or 10 years' time when the problem will be greater, and the consequences even more toxic to society, with an absence of appropriate generalists at the coal face.

We do not claim to have a clear answer in terms of the way forward. However, we need to think seriously about what we can do differently. We need to recapture our focus on primary care. We need to reconsider how we can train doctors for primary care better. If that means that we need to have two kinds of primary care doctors, then so be it. We need to discuss whether or not we should have a generic family medicine training programme which allows for some specialisation in certain areas. We also need to move away from our current hierarchical model and incorporate primary health care nurses and clinical associates into the family medicine team, and to include them as genuine partners in our organisations and our training. We need to look at how we relate to public health medicine, and work more closely with our community medicine colleagues, for the sake of communities. (Brazil's national equivalent of the Academy of Family Physicians is the Society of Family and Community Medicine [our emphasis].) We need to consider primary health care re-engineering, get fully involved in it and see how we can contribute to making it work in this country.

We think that we have taken the wrong path, but we believe it is not too late for us to change direction and to find the right way forward for our own sake, and, even more, for the sake of health care in this country.

Note: This paper reflects the personal views of the three authors, and not the views of the organisations or the university departments to which they are affiliated.

We welcome your comments and criticisms. A draft of this paper was circulated at the 16th National Family Practitioners Conference in Cape Town, in May 2013. We appreciate the mostly positive responses we received to it. There were a number of colleagues who gave detailed feedback. We decided not to try to include those comments in this article, but rather encourage you to share these in the form of letters to this journal, so that they will stimulate wider debate.