International Family Medicine Education

We are sad to report the death of Jonathan (Jack) Rodnick, MD, the editor of the International Family Medicine Education column. The abstracts published in this issue of Family Medicine *were the last he wrote/edited before he died. We will miss you, Jack.*

South Africa

Principles for the Scope and Practice of Family Medicine in Africa

(Reid S. The African family physician. SA Fam Pract 2007;49(9):3.)

In this editorial, the author reviews the uniqueness of African family medicine. The northern model (from North America and Europe) assumes a personal one-to-one relationship of doctor and patient with one doctor taking care of 1,000 to 2,000 patients. However, in Africa there are doctor-to-population rates of 1:10,000 and much worse, with few specialists or other resources, and the few doctors that are there are swamped with surgical and obstetrical emergencies. The primary health care team becomes the cornerstone of care in Africa.

The family physician, then, must more clearly define relationships with other team members in terms of responsibilities such as teaching, management, support, and evaluation in addition to the generalist's clinical role. What is the right balance of public health, ambulatory care, surgical, obstetrical, and emergency medicine skills for the family physician in Africa? Skill sets needed for successful practice also vary both by setting (anesthesia skills are not needed in Tanzania since anesthetics are given by clinical assistants) and by the level of training of other health professionals (clinical assistants, public health officers, etc). In the editorial, the author proposes 12 "principles" for African family medicine (Table 1), which he hopes will start a dialog about the practice of family medicine in Africa.

Table 1

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, ie, 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 and 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 is the link between family care, facility/hospital-based care, and primary/community-based care.
10. The primary care health 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 lifelong 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.

Table published in Reid S. The African family physician. SA Fam Pract 2007;49(9):3.

Comment: Many of the principles described by Dr Reid sound similar to characteristics of family medicine as it is envisioned in the United States. Despite these similarities, however, this editorial emphasizes the qualitative uniqueness of African family medicine. It provides a useful external perspective for reflecting on where we are and where we are going on American family medicine. It also provides a good perspective for American students, residents, and faculty who want to contribute to African family medicine.

Bill Cayley, MD
University of Wisconsin

Students' Attitudes Toward Primary Health Care

(Draper CE, Louw G. Medical students' attitudes towards the primary health care approach—what are they and how do they change? SA Fam Pract 2007;49(2):17.)

What happens when a medical school curriculum is changed to emphasize primary health care (PHC)? What do students think? This paper describes a qualitative approach, using focus groups and interviews, about the opinions of 82 second- to fourth-year medical students at the University of Cape Town (UCT) after the school responded in 2002 to a South African

governmental white paper on the needed transformation and commitment of South Africa's health system to PHC.

The authors found that most students had positive attitudes toward what PHC stands for. Many also reported that the new PHC exposure had broadened their perspectives, provided a foundation for future learning, and raised awareness of situations they would face. Students were also generally positive about the PHC emphasis at UCT and felt it would better prepare them for work in South Africa. Some were concerned that "other approaches" and the "hard sciences" were neglected and that their degree would not be internationally relevant. Attitudinal change toward PHC ranged from increased understanding of its value to resigned acceptance. A number of students felt that the way PHC was taught, the force with which it was presented, the lack of organization, repetition, and excessive time had a negative influence in their attitudes.

Students indentified a range of things that influenced their attitudes toward PHC, including personality, background, clinical exposure, and the medical school environment. Some students felt the ambiguity and uncertainty of PHC led to negative attitudes, while others noted that some students had values inconsistent with those implicit in PHC. Finally, many students described PHC as idealistic and identified tensions between the theory of PHC as taught and the reality of South African medical practice.

Comment: What is the best way to educate physicians about primary health care? Should primary care education be shaped by student demand or government policy? Which students are best suited for primary care? Despite the quantitative and qualitative differences between primary care education in South Africa, the United States, and other countries, this study provides insights on these and other questions and contributes to the continuing global discussion on the best ways to educate doctors in primary care and primary health care.

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A Consensus of Skills and Procedures That Residents Need to Learn in South Africa

(Mash B, Couper I, Hugo J. Building consensus on clinical procedural skills for South African family medicine training using the Delphi technique. SA Fam Pract 2006:48(10):14.)

South Africa recently started formal postgraduate training in family medicine. Previously, graduate training programs undertaken by family doctors had been perceived as relatively strong academically but weak in clinical skills training. Family physicians in South Africa work in diverse settings and need to be competent in many environments. In an effort to standardize and improve training, the South African university departments of Family Medicine established a national consensus on the core clinical skills needed for graduates of family medicine postgraduate training programs.

They undertook a Delphi process to achieve a consensus. This technique uses a panel of experts who anonymously rate items on a series of questionnaires with controlled feedback. The authors identified 35 expert participants who were either responsible for training family physicians, family physicians working in typical primary care environments, or who were employed in district or private health systems. They then drew up a list of 258 possible clinical skills from existing curricula, the literature, or their experience. The participants were asked to rate each as either a skill that could be confidently done and taught by a family physician (a teaching skill), a skill that could be performed independently at the end of training (a routine skill), a skill that the trainee should have performed under supervision during training and could perform it if they had to (an apply/perform skill), or a skill that they might decide to master electively (an elective skill).

After three rounds of the process, they came up with 214 core clinical skills (those included in the teach, routine, and apply/perform categories), 23 elective skills, and an additional 21 skills where no consensus could be reached about their necessity (defined as 70% or more of the participants agreeing on one of the four categories for the skill). These lists are available at www.safpj.com.za. Examples of core skills include perform a pregnancy test, conduct a Mini Mental States exam, do a D&C, interpret an electrocardiogram, insert a chest tube, resuscitate a newborn, and perform a survey. Examples of elective skills include perform an abdominal ultrasound, drill burr holes, and repair a hernia. Examples of skills where consensus could not be reached were rubber-banding hemorrhoids, perform a slit lamp exam, and remove a cervical polyp.

The authors conclude that these sets of procedural skills will serve as a benchmark for training of family physicians. They can be used as a guide for curriculum planning, a way of monitoring training, and as an indication to trainees of the skills they need to achieve.

Comment: Take a look at the full list. To the American eye, it seems overwhelming and goes far beyond what even residents at the most surgically oriented family medicine programs learn. The list reflects the incredibly broad scope of practice in South Africa as well as the necessity to master many emergency procedures. For the researchers, it's a good example of the use of the Delphi method to achieve a consensus document.

Jonathan Rodnick, MD