Editorial

Basil Jaffe at the Vocational Training Launch

The Academy was formed in 1980 with three main objectives:

1. To raise the standard of general practice in South Africa;
2. To achieve recognition of family medicine as an academic discipline and to achieve equality for our discipline in all spheres of medical education and practice;
3. To help provide a system of good primary care for all the people of this country.

We called ourselves the SA Academy of Family Practice/Primary Care, because we wished to state categorically that family medicine is integral to the delivery of primary care and is certainly its intellectual source and its philosophical basis.

I would like to reiterate our respect for the community physician in defining health priorities, but in the matter of dealing with patients at the first contact level, the skills and knowledge of the family physician are paramount.

We draw no distinction between the principles of primary care in the private or public sector, between different population groups or between urban and rural situations.

The practical application may vary with local conditions, availability of trained personnel and the deployment of national resources, but the basic principles remain the same.

Let me briefly state that these principles rest on the four cornerstones of family practice. If any element is missing the quality of care will suffer.

1. Primary care is the first contact care of patients of all ages and sexes presenting with undifferentiated symptoms as opposed to defined diseases.
2. Continuing care permits us to build a data base and a total health profile of each patient. It also fosters the relationship of trust and mutual respect, which is essential for the therapeutic doctor/patient relationship.
3. Holistic or Comprehensive care. This means that we assess our patient in psychological and social as well as organic dimensions: that our management be promotive and preventive as well as curative; that we recognise the effect of illness in the family.
4. Personal care implies the recognition of each patient as a unique individual and that everything which troubles the patient is important to the doctor.

It is readily apparent that the skills of the family physician are complex, that the knowledge required of his own and other disciplines is great and that additional technical skills are necessary for the doctor practising in a rural setting.

This all points to the need for post-graduate vocational training for the doctor who wishes to enter the field of primary care. This has been recognised in North America, Britain and Australia where intensive training programmes exist for aspirant family physicians.

In South Africa we have lagged behind:

Primary care has been neglected both in the allocation of resources and in the field of medical education.

Vocational training for family physicians is virtually non-existent.

Geographical maldistribution of doctors is an added major problem.

In seeking solutions to these problems, I would like to restate certain principles:

- Valuable as the specialist may be in secondary and tertiary care and in teaching, he has no part to play in the delivery of primary care either in the public or the private sector.
- The primary health care nurse is a valuable complement to, but not a substitute for the family physician.
- The most effective and economical medical service is one based on the well-trained family physician.

Tonight we are launching our first vocational training programme. This has been brought about by the foresight and vision of the KwaZulu Health Authority.

We owe a deep debt of gratitude to the KwaZulu government, who have given the Academy the opportunity of making an important contribution to the health problems of South Africa. We hope that this scheme will be the model and the forerunner of many more, and that this will lead to better health care for all our patients.

Address given on the 13 March 1985 at the launching of the joint Academy/KwaZulu Vocational Training Scheme.