

# The roles and competencies required of the future primary care doctor: Summary of a national stakeholders workshop

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## 1. Introduction

This workshop was held as part of the project “Strengthening primary health care through primary care doctors and family physicians”, which is funded by a grant from the European Union in collaboration with the Department of Health. Stellenbosch University is the main applicant in this project and partners include: Pretoria University, University of Witwatersrand, University of Limpopo (Medunsa), University of Kwa-Zulu Natal, Free State University, University of Cape Town, Walter Sisulu University, SA Academy of Family Physicians, SA College of Family Physicians, University of Ghent, Royal College of General Practitioners.



Some members of the project team – Dr Zelra Malan, Dr Klaus von Pressentin and Ms Talitha Schutte.

## 2. Attendance

1. Prof Bob Mash – SU
2. Prof Julia Blitz – SU
3. Dr Klaus von Pressentin – SU
4. Dr Zelra Malan – SU
5. Ms Talitha Schutte – SU
6. Dr Mergan Naidoo – UKZN

7. Dr Clive Rangiah – UKZN
8. Dr Hendrik Hanekom – Intercare
9. Prof Nathaniel Mofolo – UFS
10. Dr Gerhard Botha – UP
11. Prof Marina Clarke – Health matters
12. Prof Cyril Naidoo – UKZN
13. Dr Shabir Moosa – WITS
14. Dr Pierre de Villiers – SAAFP
15. Dr Vivienne Maginqua – UP
16. Prof Tessa Marcus – UP
17. Dr Desmond Kegakilwe – Rudasa
18. Prof Yogi Yogeswaran – WSU
19. Dr Hannes Steinberg – UFS
20. Prof Jannie Hugo – UP
21. Prof Jimmy Chandia – WSU
22. Prof Stephen Reid – UCT
23. Dr Sarie Oosthuizen – UP
24. Dr Beverley Schweitzer – UCT
25. Prof Laurel Baldwin-Rigaven – WITS
26. Dr L Matela - FPD
27. Dr Henru Kruger – ASAIPA
28. Dr Anton Prinsloo – ASAIPA
29. Dr Gio Perez – OR Tambo Health District
30. Ms Jeanette Hunter – Primary Health Care: National DDG
31. Dr Richard Cooke – WITS
32. Dr Tony Behrman - NIPA

### **3. Rationale and background**

The purpose of this workshop was to define the future roles and competencies expected of primary care doctors in South Africa. The envisioning of these roles and competencies would then guide the development of learning outcomes and the design of a national level Diploma over the next year.

Currently a number of universities offer a 2-year Diploma programme, but the learning outcomes and directions of these programmes are diverse and not aligned. The College of Family Physicians is also about to start an assessment that can lead to a Diploma – its learning outcomes are also different to the universities. Defining a national set of outcomes for such a Diploma, based on what the country needs at this time, will enable these programmes to re-align themselves to the same relevant outcomes.

In addition the need to offer training at-scale should lead to other higher education institutions developing Diploma programmes, also aligned to the same outcomes.

Primary care doctors in this discussion are seen as doctors who have made a career in primary care, in either the public or private sector, but who have not trained as family physicians. The Diploma will therefore be developed for primary care doctors in both the public and private sectors.

South Africa is in the process of re-vitalising its primary health care system through initiatives such as the development of ward-based outreach teams, the ideal primary care clinic, school health services and district clinical specialist teams. Improving the quality and effectiveness of care is a central priority.

There are currently thousands of primary care doctors in both the private and public health system that due to the stage of their career will not go back to becoming registrars and training as family physicians. This pool of primary care doctors will be an important resource for the health system over the next 10 years and the proposed Diploma is aimed at re-orientating them and up-skilling them for their contribution to a re-vitalised primary health care system. In the long term such a system will be incorporated into a national health insurance scheme.

The roles and competencies below are therefore imagined in terms of an emerging and revitalised primary health care system over the next few years and what will be required of the primary care doctor. Although this is “shooting in the dark” to some extent we feel it is necessary to try and align training opportunities with this new policy direction.

The intention is not to develop an alternative career pathway to that of the family physician. In the long term young doctors intending to pursue a career in primary care or district health services would be expected to become registrars and train as family physicians. The Diploma is aimed at the pool of existing older primary care doctors who will not become registrars. It is of course possible that the Diploma could be a stepping stone on the career path towards becoming a registrar for some.

Primary care doctors can make a significant contribution, but may need re-orientating to an approach to primary health care that is collaborative, multi-disciplinary, community-orientated and which includes roles beyond the purely clinical. They will therefore also need up-skilling to ensure they are familiar with the latest national guidelines across the whole burden of disease, are refreshed of all the clinical skills required and are strengthened to perform roles beyond the purely clinical.

#### **4. Programme**

As background and preparation for the workshop the following people gave presentations:

- Prof Bob Mash (Family Medicine and Primary Care, Stellenbosch University) – The background to and purpose of the workshop
- Ms Jeanette Hunter (National DDG: Primary Health Care) – The role of the primary care doctor in the future PHC system

- Dr Richard Cooke (Family Medicine, University of Witwatersrand and National Department of health) – Reflections on the project to contract GPs into the PHC system in the NHI pilot districts
- Dr Tessa Marcus (Family Medicine, Pretoria University) – Experiences with community orientated primary care and ward-based outreach teams in the City of Tshwane
- Dr Tony Behrman (National Independent Practitioners Association) – The perspective of the private sector on the role of the primary care doctor in the future PHC system



Ms Jeanette Hunter with her banner on the ideal PHC clinic and Prof Bob Mash co-ordinator of the project team.

The talks are available as podcasts at: <http://www.sun.ac.za/fammed>

Following the initial presentations the participants followed a process of small group snowballing to reach consensus on the required roles and competencies – initially 4 groups, then 2 groups and finally 1 group as a plenary.

Following this consensus building process the plenary session discussed broader issues of concern, further comments or questions.

## 5. General comments and recommendations



Tony Behrman answers questions during the workshop

A model based on primary care doctors as visitors to the primary health care platform to do sessions and just see complicated patients does not do justice to the contribution that they should make and which is outlined below. The model should eventually enable primary care doctors to be more fully a part of the team. The roles and competencies described below that will inform the design of the Diploma must be accompanied by a model of the health system that enables them to take on these roles.

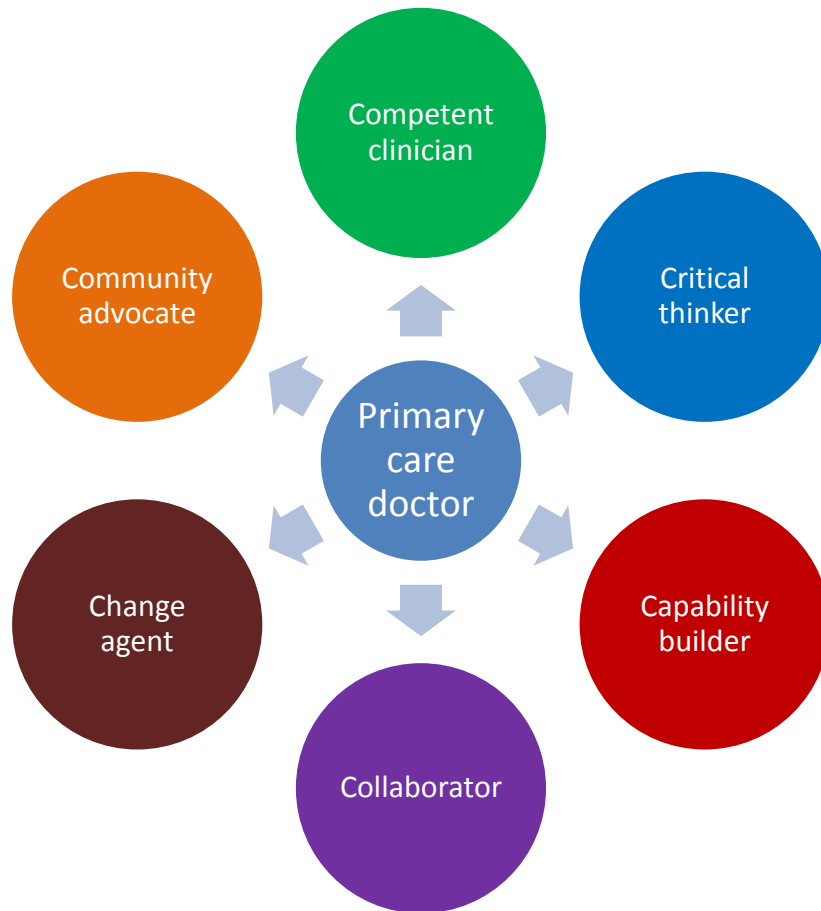
A part time 2-year Diploma aimed at re-orientating and up-skilling existing primary care doctors must have modest and targeted goals and cannot aim to deliver the equivalent of a full time 4-year MMed degree, which is provided for the training of a family physician. The curriculum developed for the roles below must keep this in mind and not be too intense. The system should also aim to employ family physicians in primary care.

Primary care doctors are able to offer leadership within a nurse-driven system. Ideally ward-based outreach teams and primary care should be doctor-led and nurse-driven.

Primary health care has a number of different contexts (e.g. community based teams, clinics, community health centres and midwife obstetric units) which require different mixes of competencies.

## 6. Consensus on roles and competencies

The overarching role of the primary care doctor is to be an **expert generalist**. The workshop envisaged such an expert generalist as having the following roles to play in the future primary health care system. The six roles can be thought of as the 6 Cs as described below.



### 6.1 Competent clinician

The primary care doctor should be able to practice competently across the whole quadruple burden of disease (HIV/AIDS, TB, maternal and child care, non-communicable diseases, trauma and violence) and in terms of the morbidity profile of primary care in South Africa. This includes acute (emergency) care, chronic care and in some cases care provided in the midwife obstetric unit. In this respect they should be aware of the key national guidelines and be able to assist with their implementation in primary care.

They should have the clinical and procedural skills to fulfil this role in primary care.

They should be a role model for holistic patient-centred care with the accompanying communication and counselling skills.

They should be able to offer care to the more complicated patients that primary care nurses refer to them.

They should support continuity of care, integration of care and a family –orientated approach.

They should be able to offer or support appropriate health promotion and disease prevention activities in primary care.

## **6.2 Capability builder**

The primary care doctor should be able to engage in learning conversations with other primary care providers to mentor them and build their capability.

They should be able to offer or support continuing professional development activities.

They should help to foster a culture of inter-professional learning in the work-place.

As part of a culture of learning they should attend to their own learning and development.

## **6.3 Critical thinker**

The primary care doctor is one of the most highly educated/trained members of the primary care team and as such should be able to offer a level of critical thinking to the team that also sees the bigger picture.

They should be able to help the team analyse and interpret data or evidence that has been collected from the community, facility or derived from research projects.

They should be able to help the team with rational planning and action.

They should have IT and data management skills and the ability to make use of basic statistics.

## **6.4 Community advocate**

The primary care doctor should exhibit a community-orientated mind-set that supports the ward-based outreach teams, understands the community's health needs and social determinants of health in the community and thinks about equity and the population at risk.

They should be able to perform home visits in the community when necessary.

## **6.5 Change agent**

The primary care doctor should be a champion for improving quality of care and performance of the local health system in line with policy and guidelines.

They should be a role model for change – people need to see change in action.

They should know how to conduct a quality improvement cycle and partake in other clinical governance activities.

They should provide vision, leadership, innovation and critical thinking.

They may need to support some aspects of corporate governance.

They may need to assist with clinically related administration e.g. occupational health issues, medical record keeping, medico-legal forms

## **6.6 Collaborator**

The primary care doctor should champion collaborative practice and teamwork.

The primary care doctor should use their credibility and authority to assist the team with solving problems across levels of care (referrals up and down) or within the community network of resources and organisations.

They should help develop a network of stakeholders and resources within the community.

## **7. Questions and concerns regarding the development of a new national Diploma for primary care doctors**



Participants during tea break

The outcome of this workshop should be circulated for discussion to the participants who can also take it to their broader constituencies and give feedback.

This is an opportunity to start bringing primary care doctors from the public and private sectors back together and bridging the gap.

Representatives of the IPA expressed interest in being contracted to support WBOTs and not just see patients at the clinic and to explore other models of contracting such as provision of chronic medication.

The national policy needs to give more recognition to the role of the doctor in the primary care team.

GPs with the mindset of a miner (just digging out one consult after another) may be less attracted to this Diploma than those who have a broader view (the shift bosses in this mining analogy) – need to focus on the “shift bosses” initially.



Once the Diploma is created it will only be successful at-scale if the vision for the primary care doctor in the re-vitalisation of PHC is congruent with the learning outcomes of the Diploma.

The Diploma should be incentivised to encourage primary care doctors to do it and to make a contribution to the re-vitalisation of PHC. It must have a perceived value to the doctors and they must feel that they want to do it. In essence it should become more compulsory as we move towards NHI. For example some suggestions:

- Maybe link to the Certificate of Need (private sector)
- Accreditation of practices or people for NHI takes Diploma into account (private sector)
- Career progression for MO grades requires completion of the Diploma (public sector)
- Private HCP organisations could require that their primary health care providers do the diploma

## **Acknowledgement**

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## **Contact details**

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