International Family Medicine Education

Jonathan E. Rodnick, MD
Feature Editor

The goal of the International Family Medicine Education column is to bring our readers information about developments in family medicine education in countries outside the United States. We will abstract relevant literature from journals published throughout the world that address issues relevant to medical student education and graduate training in family and general practice. The issues may relate to changes in medical education or in medical care organization or delivery. Topics may also address health and illness issues relevant to family physicians throughout the world. To help abstract literature, I have asked a few “foreign correspondents” to identify relevant articles from the medical literature in their region. I hope this column will become an important resource for those interested in what’s happening in family medicine education outside the United States. Contact me at 415-476-3409. E-mail: rodnick@itsa.ucsf.edu. University of California, San Francisco, Department of Family and Community Medicine, UCSF Box 0900, San Francisco, CA 94143-0900. Your comments regarding this column are welcome.

Ireland

Irish GPs Are on the Web
(The ICGP leaps into new frontiers on the Internet. Journal of the Irish College of General Practitioners 1999;16:14-6.)

Prompted by WONCA’s Internet venture last year, the 2-year-old National General Practice Information Technology Working Group (GPIT) of Ireland introduced its own Web page (www.gpit.ie) in October 1999. According to the Irish College of General Practitioners (ICGP), only 270 general practitioners (GPs) were on-line last fall, although 85% of GPs had access to a computer. ICGP officials envision that within 5 years, patients will book appointments via the Internet. Piloted for personal use as a practice information leaflet on-line, the GPIT Web page is expected to develop into a sophisticated and tailor-made means by which doctors interact with one another, patients, medical agencies, and the ICGP for educational purposes. Currently, the site has links to hospitals and governmental and training organizations in Ireland, as well as health information on the Internet. 

Eduardo Pena Dolhun

New Zealand

The Ups and Downs of Being Married to a GP
(Cunningham W, Dovey S. Being the spouse of a general practitioner. New Zealand Family Physician 1999;26:41-6.)

What do spouses of general practitioners (GPs) think of their significant others’ work? In a small study conducted in New Zealand, letters were sent to randomly chosen spouses of GPs who were members of the Royal New Zealand College of General Practitioners. The letter asked for a reply, in any format, explaining “the nature of being a spouse of a general practitioner.” The authors received replies from 13 spouses (10 females and 3 males). The spouses had been married from 10–35 years to a GP. Themes identified from the responses included a much greater burden of responsibility that fell on the spouse for the care of children, suppression and realignment of the spouse’s own career, and the effect of expectations from the communities where they found themselves living.

According to the authors, most spouses wrote that they had not expected the unequal extent to which they would have to shoulder responsibility for the care of their families. Letter writers were keenly aware of the conflicting demands of patients and family that doctors had to balance. However, they felt that they and their children often lost out to patients. The nature of family/general practice impacted directly on the respondents’ lives, such as nighttime interruptions from phone calls or when the spouse had to leave to go to the hospital. The community expectations of the spouse of a GP also were noted by some of the writers. In the face of strongly felt community expectations, most respondents expressed their need to forge a separate identity for themselves. Some respondents were aware that their acquain-
tances and friends were patients of their partner, and sometimes this placed them in an awkward position. The authors conclude that:

The replies showed that the spouses were not only aware of the impact of general practice on themselves and their families but also its effect on their doctor partners.

The authors felt that:

The quest for realistic solutions to the issues starts with the acknowledgment of the special nature of the GP-spouse relationship. We cannot significantly change the nature of general practice . . . we can bear witness to the pressures placed on both partners and respond by putting in place support systems that minimize them. These will vary with the life cycle and individual circumstances but should seek to maximize the amount and quality of time that doctors and spouses can spend together and apart. The pressures of living in a community need to be addressed, recognizing that the urban environment does not always provide anonymity, nor the rural community, support. The concept of self-sacrifice seems inevitable for both doctors and their spouses but must be negotiated and monitored to minimize its intrusion into their relationship.

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The Electronic Medical Record as the Basis of a Practice-based Research Network (Dovey S, Tilyard M. RNZCGP computer research network: an update. New Zealand Family Physician 1999;26:36-9.)

The Royal New Zealand College of General Practitioners (RNZCGP) research network was begun in 1984. The college recognized that a general practice research unit must be part of its strategic development of the discipline. A university-based academic unit, based at the University of Otago, was established with a small seed grant. Pharmaceutical companies funded most research conducted in the new unit. The early projects crystallized a problem: data collection tools that were used were intrusive and external to general practice. These tools collected data that researchers wanted rather than data important to general practice. Therefore, 10 years ago, the RNZCGP Computer Research Network was started by general practitioners (GPs), who use their computers to record all patients’ notes. The network began with a group of approximately 20 GPs who were clustered around Auckland and Otago. Two hundred practices now contribute to the research network and are distributed throughout the country. All studies to date have involved different subsets of these 200 practices.

Questions that the research network has addressed include: Who receives general practice care? What sort of care do they receive? What is the outcome of care? Specific issues addressed include the range of public health services used by general practice patients, care of patients who have a cold or an ear infection, trends in the prescription of anti-hypertensive drugs, and estimation of the health costs associated with smoking. The network has also studied adverse reactions from prescribed medicines and conducted drug trials on asthma therapy. The questions addressed sometimes come from the GPs and sometimes from those in health policy positions. Government departments and agencies have been regular users of network data. The authors predict that the computer network will soon be an integral part of an interwoven network of health information about New Zealand.

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Nigeria

Organizations Seeking to Outlaw Female Circumcision

(Would you do this to your daughter? Nigerian Journal of General Practice 1999;3:11-4.)

Approximately two million girls are mutilated every year in Africa by the traditional practice of female genital circumcision. Egypt, Ethiopia, Kenya, Nigeria, Somalia, and Sudan account for more than 75% of all mutilated women. Usually inflicted on girls ages 4–12, the consequences include bleeding, infection, scarring and keloid formation, infertility, and death. Chronic urinary infections and fistulas also result. Long-term psychological problems of anxiety, fear, and depression can result. For those who suffer infibulation—the severest form in which all external sexual organs are cut away—the trauma is repeated with each birth to allow passage of the baby. These women approach childbirth knowing that an attendant must be present to cut open the vaginal opening. If this is not done, the second stage of labor is prolonged with serious consequences for both mother and baby.

Mutilation is not required by any religion. It is traditionally done to preserve virginity and ensure marriageability. Several African governments have begun to move against the practice. So far, Ghana has translated policy into law. There have also been growing pressures against the practice from women’s groups, human rights organizations, child welfare groups, and medical organizations.

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