International Family Medicine Education

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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 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.

South Korea and Norway

What Do Doctors Think of Requiring Patients to Choose a Primary Care Physician?

A few countries, including the United Kingdom, The Netherlands, and Denmark require all patients to “register” with a family physician/general practitioner (FP/GP) who will serve as their first-contact physician and provide continuity and coordination of care. Many HMOs in the United States do likewise. Such programs may help increase continuity and control costs of care by making referrals more appropriate. However, GPs are often reluctant to embrace required patient registration, fearing more administrative burdens, too large a workload (list size), and changes in the doctor-patient relationship.

In early 2001, the authors sent a written survey to 300 FP/GPs in two countries who were considering a patient registration program. Their aim was to explore FP/GP attitudes toward mandatory patient registration. Norway, where GPs have a long tradition of being exclusive providers of primary care, was implementing a mandatory system later that year. South Korea, where primary care is delivered by both FPs and specialists, was making plans to introduce a registration system in the future. The authors received 205 completed surveys from Korean FPs and 251 from Norwegian GPs.

More than 85% of the physicians in both countries felt that continuity of care was important, and 65% of Norwegian GPs and 78% of Korean FPs thought that a registration program would increase continuity. Likewise, 62% of Norwegian GPs and 77% of Korean FPs thought it would increase comprehensiveness of care. But, 60% of Norwegian GPs and 75% of Korean FPs thought it would increase their workload. Overall, a similar number in both countries, about 73%, would like to participate in a patient registration system, if it provided satisfactory income.

The authors note that Korean physicians have more-widespread dissatisfaction with their system (they perceive problems with doctor shopping and average 388 patient visits a week, compared to 83 for Norwegian GPs), and this may explain Korean doctors’ more-positive attitudes to a registration program. They conclude that physicians in both countries favor a registration program, primarily because it will increase continuity. In both countries, dissatisfaction with the present system is a strong predictor of being in favor of the change. In Korea, a positive attitude toward registration is also related to being in favor of gatekeeping and believing it will make their practice more comprehensive. Norwegian GPs favor registration on the assumption that it will increase their responsibility but not their workload.
**Comment:** The great majority of FPs/GPs in two completely different systems of care think that a patient registration system will improve continuity and is a step in the right direction to improve medical care. What do patients think? If it's portrayed as a way to limit choice, it will likely fail, as it has in many US HMOs. Improving continuity and comprehensiveness must be seen as important both by patients and physicians for a registration system to be accepted.

**The Netherlands**

**Should You Share the Problem List With the Patient?**

(Lauteslager M, Brouwer HJJ, Mohrs J, Bindels PJE, Grundmeijer HGLM. The patient as a source to improve the medical record. *Fam Pract* 2002;19:167-71.)

A good problem list is at the core of the problem-oriented medical record and ambulatory electronic medical records. Incomplete or inaccurate problem lists may lead to inappropriate care, underestimation of disease prevalence, and insufficient prevention activities.

The authors wished to explore two questions: (1) Can the patient be an information source to improve the completeness and accuracy of the problem list? 2) Why do patients and doctors disagree about the patient’s problem list?

The authors chose a three-person general practice in a suburb of Amsterdam that had computerized medical records. The general practitioners (GPs) had made an extensive, manual effort to update the problem and medication lists of their 3,600 patients. Over a 7-week period, a medical student researcher interviewed all willing patients (n=437) who had just seen their GP and asked them about their chronic diseases, operations, and allergies or intolerance to drugs. The researcher then compared these to the problem list and asked the patient about any discrepancies. The physicians were later asked if they agreed with the patient suggestions.

The problem lists of these patients contained 910 problems. The patients spontaneously mentioned 55% of them and, when shown their problem list, agreed with another 33% of the problems, for an overall agreement of 88%. The patients disagreed with 12% of the problems listed by their GP. Common disagreements included anxiety, depression, irritable bowel syndrome, musculoskeletal problems, and hypertension. The reason most often given for disagreeing was that the problem had not given the patient any trouble for many years. In about one third of the disagreements, the GP accepted the patient’s view, but in two thirds, they decided not to remove the problem from the list. Patients also mentioned 411 problems not on the problem list. Most frequent were past surgeries, such as appendectomy or hysterectomy, and allergic rhinitis. The GPs added 255 (62%) of the patient-mentioned problems to the problem list but chose not to add 38% because they were of a minor nature, such as tiredness or mild headache. Ultimately, there was a net gain of 24% in the number of problems on the problem list.

The authors note that patients most frequently disagreed about psychological problems, and this may reflect that the patient sees these as stigmatizing and does not want to be reminded once the problem no longer needs medical attention. When doctors consider a problem to be temporary or without consequences, patients sometimes think otherwise; this may be especially true of old operations or respiratory allergies. The authors conclude that the patient is important in improving the quality of the medical record.

**Comment:** This study reinforces what I think should be common practice, giving patients a copy of their problem and medication lists. It improves communication.

**United Kingdom**

**Do Teaching Patients Feel Grateful or Exploited?**

(Coleman K, Murray E. Patients’ views and feelings on the community-based teaching of undergraduate medical students: a qualitative study. *Fam Pract* 2002;19:183-8.)

Most medical schools around the world are increasing the amount of community-based teaching. Patients previously managed in the hospital are now being cared for in a wide variety of community settings. Indeed, many medical schools now teach basic interviewing and clinical skills in non-hospital settings.

At University College London, the basic clinical skills course is taught in general practitioners’ (GPs) offices. One aspect of this course is that students are assigned a patient to interview and examine in a session that usually lasts about 2 hours. This is repeated with new students every 5 weeks for 20–40 weeks a year. Patients were recruited by the GP tutors from their practice. Although a popular course with the students, the course directors and the GP tutors were concerned about patient fatigue with so many repetitive sessions.

One of the authors conducted qualitative semi-structured interviews of 15 patients (14 in the patient’s home) to address concerns about whether patients could sustain this level of involvement. Interviews were audiotaped and transcribed, and themes were identified.

The overwhelming theme was that the patients’ experiences of community-based teaching was extremely positive and, given the opportunity, they would be willing to participate indefinitely. The reason for participating was usually altu-
ism—providing a service to the community through training better doctors. Patients saw it as a way of repaying the system. They also felt there was some personal gain—through improved knowledge, relief from social isolation, and the reassurance of well-being from a “good going over.” A few patients expressed concerns that might cause them to be less involved—the teaching session could be a source of anxiety and reinforce feelings of ill health. Interestingly, patients did not feel pressure to do the teaching session, but some did not feel comfortable with the student having access to their medical record. Lastly, the GP tutors, whose patients they were, had a concern that the teaching sessions might make patients feel that they had a special relationship with their doctor that entitled them to out-of-ordinary care. The general consensus from the respondents was that this would not happen, but the potential was there.

The authors concluded that patients saw themselves as making a specific contribution to medical education and deriving a number of personal benefits from this involvement.

Comment: I expect many US family doctors have also recruited a group of loyal, usually not employed, patients with chronic medical problems who have volunteered time and again to be interviewed or participate in student education. Its nice to know that in the United Kingdom, they like their “job.”