

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 and the April issue of Family Medicine were the last he wrote before he died. We will miss you, Jack.

Australia

Principles of General Practice

(Kidd MR, Watts I. Primary care is the answer: the role of general practice in Australia. Asia Pacific Family Medicine 2006 (available at www.apfmj.com/afm5_2/afm40.htm).

General practice is alive and well in Australia. There are more than 20,000 general practitioners (GPs) to serve their population of 20 million. Each year there are more than 100 million consultations between Australians and their GP and 1 million home visits by GPs to their patients over age 75. The Royal Australian College of General Practitioners (RACGP) is the largest specialty organization in Australia, with 14,500 members. Each year more than 1,000 candidates who have finished postgraduate training take the RACGP's exam (a passing grade is needed to do unsupervised general practice anywhere in Australia). The RACGP has recently conducted an extensive review of the curriculum of general practice and has announced a number of principles to ensure that sustainable, high-quality general practice is available to all. These principles aim to:

(1) Attract the "brightest" and the best of medical school graduates to a career in general practice.

(2) Ensure a curriculum that addresses communication skills and the doctor-patient relationship,

population health, professional and ethical roles, organizational and legal dimensions of practice, and applied professional knowledge and skills.

(3) Support lifelong learning including online CME and special programs for rural doctors.

(4) Provide standards for excellent practice that are realistic, affordable, and achievable. Standards for the use of information technology are an important part of this principle.

(5) Provide ready access to the best available evidence and to produce guidelines to support high-quality preventive care, care of the elderly, and care of indigenous Australians.

(6) Value the generalist tradition. This includes having the government recognize and value generalist approach to high-quality primary care.

(7) Maintain morale and a yearning for excellence. Happy doctors are better doctors. It is the context of general practice, rather than the content, that results in reduced morale among some family doctors. The RACGP has developed a structured program of peer support for all medical practitioners and is committed to ensuring general practice remains a satisfying and rewarding vocation for all GPs.

Comment: These principles are likely shared by family medicine professional organizations throughout the world. Valuing the generalist approach and maintaining morale are two that should be articulated more clearly in the United States.

England

Who Works Long and Hard?

(Gravelle H, Hole AR. The work hours of GPs: survey of English GPs. Br J Gen Pract 2007;57:96-100.)

There have been a number of recent changes in the work life of general practitioners (GPs) in England, such as more part-time practice, more women physicians, call centers, and an expanded range of services to deliver. The last major survey of GPs' work load and hours was conducted in 1998. The authors were interested in comparing current GP work hours with other professional and managerial groups in the UK.

The authors mailed a questionnaire to a random sample of 4,200 GPs (both full and part time) and received usable responses from 51.5%. The questionnaire asked about hours worked and hours on call in a typical week as well as personal and practical characteristics. The study did not use work diaries, which may be more reliable.

They found that full-time male GPs worked a mean of 49.6 hours a week and had 14.9 hours a week on call. Full-time female GPs worked a mean of 43.2 hours and had 12.7 hours on call. Part-time GPs worked an average 13.5 hours a week less and spent 6.7 hours less on call.

Full-time male GPs work more hours than males in other professional occupations and managers (as determined by a separate, but

comparable, labor force survey), whereas female GPs work fewer hours than females in other professional occupations and managers.

With regression analysis, the authors found the probability of working part time increases with age and previous experience in both sexes and with the number of children under age 18 for females but not for males. Hours worked per week reached a maximum at 17 years of experience and then declined. Hours worked a week also increased with increasing list (panel) size, increasing age of patients and doing nursing home work. Having children reduced the hours on call for both sexes.

Comment: The difference in hours worked between male and female GPs was mainly due to the differential impact of children and is unlikely to go away. It is also interesting that older physicians of both sexes work fewer hours. Enlightened work policies should take these variables into account.

Kenya

Coordinating Contributions

(Oman K, Khwa-Otsyula B, Majoor G, Einterz R, Wasteson A. *Working collaboratively to support medical education in developing countries: The case of the friends of Moi University Faculty of Health Sciences. Educ Health 2007;20:1-9 (available at www.educationforhealth.net/).*

Medical schools in developing countries are frequently challenged by low levels of funding and shortages of academic staff. "Twinning," the establishment of a formal link between a department/institution in a developed country with a corresponding department/institution in the developing world, is promoted as a way to facilitate contact between developing country institutions and appropriate donor insti-

tutions. However, medical schools in developing countries remain vulnerable to the possibility that their partners will withdraw their support and funding. To reduce this likelihood, as well as increase their global support, medical schools in developing countries often participate in a number of parallel, independent twinning prospects. These multiple efforts pose challenges including overlap and duplication of efforts and conflicting advice.

Moi University Faculty of Health Sciences was established in Eldoret, Kenya, in 1989. During the initial start-up phase, the dean approached and received support from the University of Maastricht in The Netherlands, Linköping University in Sweden, and Ben-Gurion University in Israel. Representatives of each first became aware of support from other universities at a chance meeting. Faculty from general internal medicine at the University of Indiana soon established their own ongoing relationship with Moi. The four partners, working with The Network: Towards Unity for Health and decided to establish the "Friends of Moi" to coordinate their support of medical education. In 2004, Indiana obtained a large (\$15 million) grant to help Moi develop its HIV services, supported by work faculty from Brown University and the University of Utah.

The Friends of Moi now meet annually. The dean of Moi oversees the meeting and presents the school's current needs. The partners review the activities of the previous year and plan for the upcoming year, paying particular attention to avoid overlaps. The funding available at each institution is discussed, as well as when grant or external funding might be available and what shortfalls need to be met.

The authors note that the joining of the partners happened by serendipity and had no precedent. The success has required open collaboration. At present, Linköping primarily helps with community-based

educational endeavors, Maastricht with problem-based learning in the preclinical years, Ben-Gurion with physical therapy and occupational medicine programs, and Indiana with clinical education and HIV care.

There have been difficulties, since at each institution there is only a small pool of interested faculty. Grant-related funding is uncertain and affects continuity of projects. And, although there is collaboration in the meetings, this is sometimes not reflected "on the ground."

Comment: The need for support of medical schools in developing countries is acute. Faculty at many institutions in the developed world want to contribute but also want to make sure their projects address real needs and are coordinated with others. This model has a great deal of potential to make these contributions more effective.

Mali

A Real Exchange Program

(Van Dormael M, Dugas S, Diarra S. *North South exchange and professional development: experience from Mali and France. Fam Pract 2007;24:102-7.*)

Mali, a country on the Atlantic coast of Africa, has historical ties with France. It also has rural general practitioners (GPs) whose continuing training is partially supported by Sante Sud, a French non-governmental organization (NGO). Sante Sud provides assistance for an exchange program, for establishing new rural practices, and for the Malian Rural Doctors Association.

The exchange program supports isolated rural doctors in Mali by exposing them to rural French GPs. An exchange typically starts with a 2-week visit by a French GP to a Malian rural GP, followed by a return visit by the Malian doctor to

his French rural counterpart. The NGO funds transportation, but each visiting GP is hosted by the visited GP. Social and cultural activities were encouraged.

This report is a qualitative analysis of 19 exchanges that took place between 1995 and 2003 and is based on interviews of the participants, retrospective report analysis, field observation of three exchanges, and separate workshops with the Malian and French GPs. The report primarily reflects the Malian doctors' experiences.

Most Malian GPs felt the exchange enhanced their personal and professional recognition and self-esteem. They felt a favorable reception by French patients and media. Common themes of GPs' practices in both countries were a reliance on clinical skills, communication skills, and continuity of care. However, differences were summed up in one comment: "It is comfort medicine in France and survival medicine in Mali."

The Mali GPs felt there was a waste of resources in France and overuse of technical procedures. They felt the French patients were overly demanding, but they were impressed with the doctor-patient communication skills of the French GPs. They also felt that treatment strategies for patients with chronic illness were interesting but not economically feasible in Mali. Changes in practice that resulted from the exchange were related to practice organization—better asepsis and hygiene techniques and improved medical records. Material support for the Malian doctors' practice by French GPs, for example, sending practice equipment or computers, although not one of the objectives of the program, was often subsequently provided.

The authors conclude that this type of exchange stimulated professional identity in general/family practice, particularly since Mali lacked a general practice tradition. It can also stimulate reflection and inspire practice innovations. GPs

from poorer countries can get useful insights on improving individual clinical care, while those from richer countries can learn about their population and public health responsibilities.

Comment: Despite dramatic differences in culture and medical resources, this exchange program had many positive outcomes. The globalization of our specialty offers each of us the chance to stand in the shoes of our colleagues. This is real continuing professional development.

Mozambique

Not the Easiest Place to Go to Medical School

(Sousa F Jr, Schwalbach J, Adam Y, Gonçalves L, Ferrinho P. *The training and expectations of medical students in Mozambique. Human Resources for Health 2007;5:11.* (Available at www.human-resources-health.com/content/5/1/11.)

Mozambique, previously a Portuguese colony on the southeast coast of Africa, has a population of more than 19 million people. In 1999 there were only 406 medical doctors in Mozambique and of these, 298 were specialists and 58% practiced in the capital city, Maputo. There are two medical schools, the largest being a public institution; the University Eduardo Mondlane is located in the capital of Maputo. The authors, all from Portugal, were interested in understanding the demographics, expectations, and difficulties faced by medical students there.

The authors distributed a questionnaire in 1999 to all 441 registered medical students at the university, and 51% returned completed ones. The students had a mean age of 23, and 61% were women. Although Maputo city and province has only 6% of the country's population, almost two thirds finished their high school education

in Maputo. Ninety percent reported that their parents were in health care as doctors, nurses, pharmacists, or other health sector personnel. The two main reasons for choosing medicine as a profession were "to contribute toward the welfare of the public" and "self-realization." Only 25% received financial support to go to medical school; most were "self-financing" their medical school education. Almost three fifths reported financial difficulties. Sixty-six percent reported that the lack of available reference books caused difficulties. Many students had to repeat one or more years of medical school. Only 44% were satisfied or partially satisfied with the lectures, and 52% felt the training was adequate. Eighty-two percent hoped to work full time or part time in the public sector. After graduating they hoped to earn, on average, about \$1,200 a month, although the authors report the average salary in the public sector is only about \$350/month for new doctors.

The authors note that this sets the scene for dual practice (public/private) to improve earnings. The authors conclude that most students migrated to the capital city before entering medical school and will likely return to the capital once their term of compulsory rural service is completed. Their level of academic performance was poor, probably related to lack of library facilities and financial support. The students know they will be needed in the public sector but will likely do private practice to improve their earnings.

Comment: Although their report uses data from an old survey, it highlights many of the problems of medical education in developing countries—poor facilities, little support, and limited opportunities. The article doesn't mention if students are considering careers in family medicine, but given these facts, it seems unlikely that many will choose it.