## 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 literature from journals published throughout the world that address issues relevant to medical student education and graduate training in family medicine 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. If you have seen something published in the non-US literature about the development of family medicine education and research that could be shared with your colleagues, please contact me at 415-597-9370. E-mail: jrodnick@psg.ucsf.edu. University of California, San Francisco, Department of Family and Community Medicine, UCSF Box 0886, San Francisco, CA 94143. Your comments regarding this column are welcome.*

# Laos

### How a New Family Medicine Residency Was Developed (With the Help of Canadians)

*(Kanashiro J, Hollaar G, Wright B, Nammavongmixay K, Roff S. Setting priorities for teaching and learning: an innovative needs assessment for a new family medicine program in Lao PDR. Acad Med 2007;82:231-7.)*

Successful health care system change in a country requires adequate understanding of local health care needs and local politics, plus successful engagement of local health care institutions and other stakeholders. Kanashiro and colleagues describe the process that they used in consultation with the National University of Laos, the Lao Ministries of Health and Education, and the University of Calgary to develop a Family Medicine Specialist Program (FMSP) for training family physicians in the Lao People's Democratic Republic (Lao PDR).

The 2-year curriculum was divided into a first year of hospital-based rotations and a second year of community medicine experiences in provincial hospitals and rural villages. This article describes use of a "modified Delphi technique" to develop an appropriate and feasible first-year curriculum. An expert panel of key leaders from government ministries, the medical school, and medical institutions developed a list of recommended clinical objectives that were divided into four content areas: internal medicine, surgery, pediatrics, and obstetrics-gynecology. Next, a questionnaire based on the objectives was administered in small-group or individual interviews to clinicians representing specialists, emergency physicians, and family medicine teachers with prior rural experience. Finally, results from the questionnaire interviews were used to rank objectives in terms of overall perceived importance. The final priority lists were reviewed with clinical specialists and FMSP leaders to confirm consensus on the objectives for the curriculum.

The authors note several areas of divergence among participants in priority objectives. Teachers with rural experience rated certain objectives higher than did pediatricians (eg, managing neonatal resuscitation, severe dehydration, and trauma and burns). The emergency physicians rated some surgical skill objectives lower than did the surgeons (eg, anoscopy, regional blocks, reducing joint dislocations). The authors speculate that these divergences in priority ratings were due to differing willingness or ability to teach, differing clinical experiences, or differing perceptions of local health care needs among participants.

While Kanashiro and colleagues feel that their process made for a robust, "made in Laos" approach to developing primary care, they identify several challenges that had to be faced in developing the curriculum: polarity between teaching what "ought to be taught" versus what "can be practiced," difficulty in developing attitudinal objectives, language equivalency for translation of materials, and difficulty involving rural practitioners. They note, however, that a significant benefit of the process was the way it served a dual role of identifying health priorities and providing faculty development for the medical education leaders who participated.

*Comment:* Family medicine may seem ideally positioned to help establish primary care throughout

the world, but the solutions cannot be "one size fits all." This article gives some excellent insights into the particular primary health care needs in Laos but also illustrates successful adaptation of a consultation process to a resource-poor setting to help develop a locally relevant training program. The challenge for those who seek to help develop primary care in developing countries is to develop local solutions to local problems, and this description of the consultative process provides a helpful model.

*Bill Cayley, MD*
*University of Wisconsin*

## United Kingdom

### Should Residents Spend More Time in the Office and Less in the Hospital?

*(McNaughton E. General practice specialty training: an innovative programme. Br J Gen Pract 2006; 56:740-2.)*

In an editorial, the author reviews the recent restructuring of postgraduate—residency—training in the United Kingdom. These changes are partially driven by a widely read report: "Modernizing Medical Careers: The Next Steps," published by the Department of Health, London, in 2004. Replacing a year of being a junior house officer (rotating intern), there is now a 2-year requirement for all doctors for "foundation training," which includes 4 months in general practice. The graduates of these foundation programs then go into specialties, including general practice. This training has historically consisted of 2 years as a senior health officer (SHO) in hospital services and 1 year as a general practitioner (GP) registrar working and learning in a teaching general practice. This traditional training is now being reexamined in many countries. The European Academy of Teachers of General Practice (EURACT) supports a more unified program and acknowledges that current 3-year programs (as in the United Kingdom) have too little time in general practice to prepare for independent practice.

In Denmark, GP postgraduate training has been extended from 3.5 to 5 years, with 2.5 years in general practice. Australia has new GP training standards that there be 3 years postgraduate training and 2 of these years must be spent in general practice. Currently in the United Kingdom, there are trials of redesigned programs, particularly involving the first 2 years as senior health officer. In Scotland, one innovative program, described in this article, the GP trainees have a 3-month attachment to a general practice in year 1 of the SHO, year 2 SHO trainees have 1 day a week in the practice, and year 3 have most of their time in the practice. The goal is to have GP training programs be practice (rather than hospital) based with an appropriate balance of secondary care supported by a GP trainer to facilitate relevant and focused learning. The author notes that implementation of these types of programs with more training in practices has resource implications of increased funding for trainees in the practice setting, for GP trainers, and for practice infrastructure.

*Comment:* Most countries with family medicine postgraduate training programs do not follow the US model of a hospital-based family medicine clinic for trainees. Instead, trainees are assigned for varying periods to be a "junior partner" in a highly functioning office. This type of experience is the most relevant experience a trainee can have. As this editorial notes, many countries are now increasing the time spent and knowledge and skills learned in the office. We need international P4 projects.

*Jonathan E. Rodnick, MD*
*University of California, San Francisco*

### Does Having Longer Visits Make Any Difference?

*(Wilson A, Childs S. The effect of interventions to alter the consultation length of family physicians: a systematic review. Br J Gen Pract 2006;56:876-85.)*

In a previous systematic review of observational studies, the authors found that withlonger consultation (visit) lengths to primary care doctors, the physicians were more likely to discuss prevention activities, give lifestyle advice, and generate fewer prescriptions. However, there are confounding factors, and visit length may be a marker for physician style. Further, increasing the length of the visit may not improve care.

The authors conducted a Cochrane-style review to address the later issue: they wanted to assess the effectiveness of interventions that alter primary care physicians' visit length. They searched the literature for any intervention that altered visit length in primary care and had one or more process or outcome measures. They found six articles describing four trials, all of which took place in the United Kingdom. Three trials assigned patients to appointments of varying length (such as 5, 10, or 15 minutes) and one that increased appointments from 5 or 7.5 minutes to 10 minutes. All trials had methodological weaknesses, such as non-random allocation of patients. The studies found no consistent differences in problem recognition, examination, and prescribing or referral rates with different length appointments. Blood pressure was checked more frequently, and there was some evidence that health prevention activities such as smoking were discussed more often when more time was available. Patient satisfaction showed a trend favoring longer appointments, but validated instruments were not used. One study measured physician stress and found that after a 10-minute

visit (compared to 5 or 7.5 minutes) stress scores were significantly lower.

The authors conclude that their review provided insufficient evidence to support or resist a policy of increasing visit (consultation) lengths in the United Kingdom. They note that the average visit length to the general practitioner in the United Kingdom is now 9 minutes, and the Royal College of General Practitioners had advocated for longer consultations to coordinate care and explain treatment options to patients.

*Comment:* These (the effect of visit length on process or outcomes of care as well as patient and doctor satisfaction) are important issues, and it's concerning that they have not been examined more often. It's tough to argue for smaller patient panels or longer visits to improve quality of care if there is no data.

*Jonathan E. Rodnick, MD*
*University of California, San Francisco*