Slow Progress: Predoctoral Education in Family Medicine in Four Latin American Countries

Lyndee Knox, PhD; Julio Céitlin, MD, DPH; Ricardo G. Hahn, MD

Background: Many countries in Latin America are seeking to expand primary care services provided through their health care systems. Family physicians are an essential component of an effective primary care workforce, but we know little about the status of family practice training in Latin America. This study examines predoctoral training in family practice in four Latin American countries and identifies factors affecting its incorporation into medical training institutions. Methods: A Spanish language survey was mailed to the heads of all medical schools in Argentina, Colombia, Mexico, and Panama (n=100), asking about the status of family practice training at the school and factors perceived as facilitating or impeding its acceptance by the institution. Quantitative data were analyzed for frequency, and qualitative data were analyzed for content and theme. Results: Sixty-five of the 100 schools responded to the survey. Of these, only 34 (52%) provide training in family practice at the predoctoral level, and only nine (14%) have established departments of family medicine. Barriers to inclusion of family medicine include lack of financial and human resources, definition of family practice as a subject rather than a specialty, and a perceived lack of interest among students. Discussion: Inclusion of family medicine into medical education in Latin America has been slow. Unless strategies can be developed to increase training for family physicians in Latin American countries, governments in the region will have difficulty expanding primary health care services in their systems. Support is needed from governments, public health officials, funding agencies and organizations, and the academic community to increase training of family physicians in Latin America.

(Fam Med 2003;35(8):591-5.)

The introduction of family practice into Latin America began in earnest in the 1980s, stimulated by efforts of Latin American governments to develop cost-effective and efficient systems of care for their predominantly poor populations. Efforts to expand the family practice workforce were further stimulated by the World Health Organization’s advocacy for primary care service models as a main strategy for delivering health services in developing nations.1 Activism by individual family physicians has also played an important role in advancing the specialty. Individuals such as Julio Céitlin, MD, DPH (Argentina), Pedro Iturbe, MD (Venezuela), and Thomas Owens, MD (Panama) have done much to advocate for the specialty not only in their countries but also in the region at large. The introduction of the specialty in Canada and the United States served as an additional stimulus.

Building an adequate health care workforce in family practice will be necessary to ensure the success of both the Latin American governments’ efforts to expand primary health care services and the survival of family practice in the region. Development of this workforce will depend in large part on the availability of training.

Similar to their US counterparts, family physicians in Latin America complete 5 to 7 years of medical school, followed by a 3-year residency in family practice. Emphasis is placed on preparing physicians to work in ambulatory care settings, training them to be capable of responding to the majority of problems presented by patients in the office. However, we know little about the degree to which family practice training has been incorporated into medical training in Latin America.

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In January 2000, family physician leaders in Latin America established a task force known as the Grupo de Panamá to monitor the progress of academic family medicine in Latin America. The group met again in December 2000 with support from the AQUUS Foundation. This paper, written by two members of the task force and a third researcher from the United States, reports the findings of the task force’s evaluation of predoctoral training in family medicine in the region.

Methods

Samples in four Latin American countries—Argentina, Colombia, Mexico, and Panama—were used in the study. The countries were selected based on task force members’ ability to identify and contact top administrators in medical education in each country.

The Grupo de Panama research team (Julio Ceitlin, Argentina; Miguel Angel Fernandez, Mexico; Arnoldo Bromet, Colombia; Thomas Owens, Panama; and Ricardo Hahn, United States) constructed a 14-item Spanish language survey that contained questions on the existence and characteristics of family practice training in medical schools and factors that may have affected inclusion of the training in the schools’ curricula. Members of the task force reviewed the survey for face validity and relevance of terms and concepts to their particular country.

Next, the team mailed the survey to all medical schools (n=100) in the four countries selected for the study, along with a cover letter requesting that the dean or the dean’s designate complete and return the survey within 3 weeks by mail or fax. No effort was made to collect surveys from nonrespondents.

Quantitative survey data were entered into an Excel database and analyzed for frequency using SPSS. Qualitative survey data were analyzed by three reviewers. One member of the review team was an experienced qualitative researcher from the United States, and the remaining two were practicing family physicians from Latin America. Two of the reviewers coded the qualitative data for content and theme using methods recommended by Miles and Hubberman. Disagreements between the two reviewers were resolved by the third reviewer.

Results

Deans at 65 of the 100 medical schools responded to the survey, for an overall response rate of 65%. Deans at 13 (62%) schools surveyed in Argentina responded, 18 (75%) in Colombia, 31 (60%) in Mexico, and 3 (100%) in Panama.

Table 1

<table>
<thead>
<tr>
<th># of Medical Schools With FP Training at Any Level</th>
<th># Providing Training at Predoctoral Level</th>
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<tbody>
<tr>
<td>Argentina (13)</td>
<td>8 (62%)</td>
</tr>
<tr>
<td>Colombia (18)</td>
<td>11 (61%)</td>
</tr>
<tr>
<td>Mexico (31)</td>
<td>19 (61%)</td>
</tr>
<tr>
<td>Panama (3)</td>
<td>3 (100%)</td>
</tr>
<tr>
<td>Total (65)</td>
<td>41 (63%)</td>
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</tbody>
</table>

FP—family practice
Organization of Predoctoral Training in Family Practice in Medical Schools

Respondents were asked to identify the organizational structures supporting family practice training at their institution. They were provided with the options of “department” (eg, the institution supports a department dedicated to the discipline—considered the highest level of organization within an institution), “professorship” (eg, the institution supports faculty positions specifically designated for family practice specialists but does not have a department of family medicine), “course work” (eg, the institution provides courses in family medicine that may or may not be taught by specialists in the discipline but does not have faculty positions designated for the specialty or a department of family medicine), or “none” (eg, training in family practice occurs as part of other courses or curricula in the institution but has no formal structure of its own). Using these criteria, 30 (88%) of the 34 schools with predoctoral training in family practice report some type of formal organizational structure at their institution supporting the training. Of these, however, only nine (27%) have established departments of family medicine. Twelve (35%) have formed professorships in family medicine, and a few (4/12%) report no formal organizational structure for family medicine beyond providing a course dedicated to the topic (Table 2).

In Argentina, only one (17%) of the schools offering predoctoral training in family practice has established a department of family medicine. Four (67%) have professorships in family medicine. In Colombia, four schools (36%) have established departments of family medicine, two (18%) have formed professorships, and three (27%) support family medicine at the course level.

In Mexico, only three (21%) schools have established departments of family medicine. Four (29%) have formed professorships in family medicine, and one (7%) is organized only at the course level. In Panama, one (33%) school has established a department of family medicine, and two (67%) have established professorships in family medicine (Table 2).

Factors Affecting Inclusion of Training in Family Practice in Medical Schools

Qualitative responses from the surveys were analyzed for content concerning barriers/facilitators to the inclusion of family practice at the respective institutions. The majority (89%) of respondents reported substantial barriers to the inclusion of training in family practice at their institution (Table 3).

Lack of Resources for Teaching Family Medicine

Respondents reported a lack of financial support from their institutions for family medicine. Many also described difficulty finding appropriate sites for clinical training in the specialty, indicating that most sites associated with their institutions were designed for subspecialty training and were unable to support the continuity experiences central to effective family practice training. Respondents also cited a lack of skilled teachers of family medicine and limited curricular resources as barriers.

Failure to Define Family Practice

As a Legitimate Medical Specialty

Subspecialists’ and academics’ perceptions and definitions of family practice created a significant barrier to the specialty’s inclusion. These professionals often defined family practice as a set of “basic skills” learned by all specialists and subspecialists, rather than as a specialty in its own right. In its most extreme form, respondents reported that their schools did not need to include family medicine in their curriculum because it “was already [being] taught in their medical sociology and epidemiology” courses. Others reported that “family practice” was the domain of mid-level practitioners and not of physicians.

Lack of Demand for the Specialty by Students

Several respondents reported a lack of demand for training in family medicine among the students. They attributed this to student perceptions of limited job opportunities for family physicians and low prestige relative to other specialties. Respondents indicated that their schools decided not to offer training in the specialty because of this limited demand.

**Table 2**

<table>
<thead>
<tr>
<th></th>
<th>Mandatory Training</th>
<th>FP Specialists on Faculty</th>
<th>Departments</th>
<th>Professorships</th>
<th>Course</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina (6)</td>
<td>4 (67%)</td>
<td>5 (83%)</td>
<td>1 (17%)</td>
<td>4 (67%)</td>
<td>0</td>
</tr>
<tr>
<td>Columbia (11)</td>
<td>11 (100%)</td>
<td>9 (82%)</td>
<td>4 (36%)</td>
<td>2 (18%)</td>
<td>3 (27%)</td>
</tr>
<tr>
<td>Mexico (14)</td>
<td>7 (50%)</td>
<td>13 (93%)</td>
<td>3 (21%)</td>
<td>4 (29%)</td>
<td>1 (7%)</td>
</tr>
<tr>
<td>Panama (3)</td>
<td>3 (100%)</td>
<td>3 (100%)</td>
<td>1 (33%)</td>
<td>2 (67%)</td>
<td>0</td>
</tr>
<tr>
<td>Total (34)</td>
<td>25 (74%)</td>
<td>30 (88%)</td>
<td>9 (26%)</td>
<td>12 (35%)</td>
<td>4 (12%)</td>
</tr>
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</table>

FP—family practice
Discussion

In Latin America, health care services are delivered through three separate systems: the public health services, funded by the government and open to all citizens; social security programs, which provide health care to the employed; and private health services, which includes prepaid medical care and services purchased from insurance companies. The public health services and social security systems provide health services for the vast majority of the population, with private care providing service for less than 10% of individuals in the region. In three of the countries studied in this report—Colombia, Mexico, and Panama—family practice has been designated as the main provider of primary care services in the social security system.

Despite the central role that family practice has been assigned in these systems, and despite the potential that family practice holds for improving health care in the countries surveyed, progress incorporating predoctoral training in family practice into academic institutions in these countries has been slow. In Argentina, Colombia, and Mexico, only half (31) of the institutions responding offer predoctoral-level training in family practice. Of these, only eight (26%) have established departments of family medicine. Although the smaller country of Panama has made more rapid progress in including training in family medicine in its medical schools (3/100%), similar to the larger countries, only one school has organized family medicine at the department level.

Stages of Development of Family Practice in Latin America

In 1982, Gayle Stephens, a prominent scholar in family medicine, outlined three stages in the inclusion of family medicine training into medical schools. He suggested that the first, or political stage, is characterized by power struggles between the newcomer (family medicine) and established disciplines to acquire basic recognition of the specialty and the contributions it can make to medicine. The second, or administrative stage, is characterized by negotiations of conditions under which the new specialty will function in the medical school and the acquisition of the basic resources needed to educate students, including time, money, space, and human resources. Finally, the third, or academic stage, involves the establishment of academic boundaries, including the definition of how the new discipline is distinct from and similar to existing disciplines and developing the methods and styles of training for the specialty. It is during this stage that classroom- and clinic-based instruction begins in earnest.

Based on this model, predoctoral training in family practice in the countries surveyed remains in the early political and administrative stages of incorporation.

It is discouraging and even disturbing to observe that 20 years after the Declaration of Alma Ata, and in contrast to the progress family practice has made in other parts of the world, such limited progress has been made in Latin America.

Why Has Progress Been Limited?

A number of factors may be contributing to this slow rate of progress. Most significantly, in its call to strengthen primary health care services in developing nations, the Alma Ata Declaration fails to address development of physician specialists in primary care, emphasizing instead the development of mid-level providers. Consistent with this, the governments of the countries surveyed have failed to develop incentives or regulations that stimulate development of a primary care physician workforce.

What Needs to Be Done

Government support, both financial and regulatory, will be central to the expansion of training in family medicine and to the development of a competent primary care physician workforce. For this to happen, however, internal advocates for family medicine must be developed. Future leaders in family medicine must be identified and provided with training in political advocacy, in medical education, and in the curriculum change process. This training might occur through seminars held at well-established predoctoral training programs in family practice in Canada, the United States, the United Kingdom, and Europe.

Similarly, leaders in family medicine in Latin America must work to convince governments, public health officials, and the academic community of the contributions that family physicians can make to their health care systems and of the need for specialized training in family medicine at all levels. This could be

<table>
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<th>Table 3</th>
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<tr>
<td>Barriers to Incorporation of Family Medicine Into Medical Education</td>
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</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Barrier</th>
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<tbody>
<tr>
<td>Definitions/perceptions of specialty</td>
<td>• Failure to see need or academic value   • Belief that content is already adequately incorporated into subspecialty training—family practice as subject versus specialty   • Rigid rules for curriculum change</td>
</tr>
<tr>
<td>Resources</td>
<td>• Lack of money   • Lack of time to provide continuity experience   • Lack of clinical training sites   • Lack of specialists to teach   • Lack of curriculum</td>
</tr>
<tr>
<td>Demand/student interest</td>
<td>• Perception of limited job opportunities in specialty   • Low level of interest among students</td>
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accomplished by physician leaders in the different Latin American countries partnering with international associations such as the World Organization of Family Doctors (WONCA), Pan American Health Organization (PAHO), and the Inter-American Development Bank (IDB), to convene meetings of political and health systems and medical education leaders. Topics of these meetings should include discussion of the role and potential contributions of family medicine and other primary care disciplines in reformed health systems in Latin America.

Models of how primary care can work together with other specialties and subspecialties also should be developed and disseminated as part of national health reform efforts, which will decrease subspecialist opposition to the discipline. Similar efforts should be made to identify and develop mechanisms to encourage collaboration rather than fighting within the primary care disciplines.

Finally, an advisory group of leaders in academic family medicine, such as the Grupo de Panama, should be formed to assist medical schools in identifying, lobbying for, and obtaining funding to support the incorporation of family practice training into medical education in their countries. One existing source for this is the IDB, which currently provides funding for curriculum change in medical schools in Latin America. Argentina’s Programa de Reforma de la Atencion Primaria de la Salud en la Argentina (PROAPS) uses IDB funding to train physicians in family practice/general practice in four provinces in the country.

Curricula specific to predoctoral training in family practice in Latin America should also be developed and made easily available to educators from the region. Partnerships between professional associations in Latin America and associations such as the Society of Teachers of Family Medicine (STFM) and WONCA can facilitate the sharing of these resources and their modification for use in Latin America. Training fellowships for faculty members could be developed through collaboration among medical schools in North America, Europe, and Latin America. An Internet-based clearinghouse for training resources for family medicine could be established to provide easy access to the materials.

The Need for More Information

While this study provides information on four countries in Latin America, it is not possible to generalize its findings to all the countries of the region. A comprehensive survey of family medicine training in all Latin American and Caribbean countries should be carried out to identify “best practices” in the diffusion of predoctoral and other levels of training in family practice that can inform incorporation of training throughout the region.

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References


