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.

The Netherlands

Continuity: What Do Patients Want?

Continuity of care matters. It is associated with increased patient satisfaction and trust. Seeing the same doctor may exert its benefit by the doctor’s use of accumulated knowledge about the patient and may increase the personal responsibility of the physician toward the patient. Thorough identification and discussion of patient beliefs is considered important for quality of health care. However, little is known about patients’ views and expectations regarding continuity.

In June 2000, 875 questionnaires were sent out to patients from 35 participating general practices across The Netherlands. Each practice gave one questionnaire to 25 consecutive patients who were seen on a specific day. The questionnaire asked them to rate the need for and importance of seeing their personal doctor for nine different scenarios (ranging from a sprained ankle to abdominal symptoms).

Of 644 respondents, more than 75% felt it was important to see their personal general practitioner (GP) for most of the presented situations. Patients preferred their personal doctor because she/he was believed to have the best medical and personal knowledge of the patient and that better communication was possible with their GP. Patients particularly wanted to see their personal doctor for potentially serious medical conditions and emotional problems. Two personal factors were mildly related with the perceived need for continuity: having children and having experienced a serious life event in the past 5 years. Surprisingly, no significant relationship was found by regression analysis with age, gender, marital status, chronic illness, psychosocial problems, practice area, and practice type.

The authors conclude that patients value a personal relationship for serious and emotional problems. Patients appear to value personal continuity because they think that this will be beneficial to their health. Prior knowledge of the medical condition, as well as knowledge of the personal and family background, is considered important by most patients.

Comment: This report from The Netherlands agrees with similar patient reports from the United Kingdom and the United States. If doctors and patients attach such importance to continuity, why, in the United States, do we tolerate so many administrative threats to the disruption of continuity? What would a similar questionnaire sent to managers and payors of the medical care show? Family physician pleas to value continuity must join with those from the patients who want and need it—people with chronic medical and emotional problems.

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Europe

An Example of Country to Country Collaboration

In September 2000, family physician delegates from Italy, Israel, Greece, Malta, Portugal, Spain, and Turkey met to promote the development of general practice/family
medicine (GP/FM) in the Mediterranean region.

These countries share many similarities in morbidity and mortality statistics. They have the lowest mortality rates from coronary artery disease (the Mediterranean “paradox”) in Europe, as well as low mortality rates from malignant neoplasms. The people of the Mediterranean countries share many similar lifestyles and illness behaviors. For example, nonverbal “affective” behavior is most important in determining patient satisfaction.

Many countries of the region share similar approaches to delivering medical care. Greece, Israel, Malta, Portugal, Slovenia, and Spain have emphasized the development of primary health care (PHC) teams who work in health centers. These PHC teams integrate community and personal care. The total expenditure on health as a percentage of gross domestic product in Greece, Italy, Israel, Portugal, and Spain is similar to the Western European average of 8.5% (and about two thirds the level of the United States).

At an academic level, general practice is recognized as a distinct discipline in all medical universities in Portugal, two thirds of those in Turkey, and one each in Greece and Malta. The Mediterranean GP/FM Group proposes a network to promote research and act as a central source of information and support to doctors practicing and developing the practice of family medicine in the Mediterranean.

Comment: Comparisons of health statistics, medical care delivery organization, and medical care financing across countries and regions has the potential to identify best practices and offer insights into what works and what doesn’t. These comparisons may be particularly helpful where countries share a number of important historical, cultural, and epidemiological factors—such as in the Mediterranean region and between the United States and Canada.

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United Kingdom

Is There a Culture of General Practice, and Can It (Should It) Be Changed?


Culture represents shared beliefs and values within an organization. These, in turn, influence norms, attitudes, and behavior of members of that organization. Clinical governance is a term used both here and abroad to mean a framework for accountability, continuous quality improvement, setting of practice standards, and the creation of an environment to provide high-quality care. It is commonly claimed that there needs to be a change in the culture of general practice to implement clinical governance.

To understand the culture of general practice, Marshall et al chose to look at primary care groups (geographically defined groups of 75–100 general practitioners (GPs) in the United Kingdom called primary care groups and trusts (PCG/Ts). Marshall et al conducted semi-structured interviews with 50 senior managers of 12 PCG/Ts in England. The managers concurred with policy rhetoric that cultural change in general practice is a fundamental part of the implementation of clinical governance. They were able to identify cultural traits that they thought would facilitate change and ones that would inhibit it.

The managers felt that the most desirable cultural trait was the value placed on public accountability by the practice. The desire of practices to work together and learn from each other was also an important trait. The main barriers to cultural change were a high level of practice autonomy and perceived pressure to deliver rapid, measurable results. The managers saw their role as facilitators of exchange between practices and a buffer between the demands of politicians and the capability of providing services to deliver on those demands.

In an accompanying editorial, Helman questions if there is a uniform culture of general practice. A key characteristic of general practice is its enormous diversity—for example, practices vary widely in their practices, social, and gender composition of their patients and staff. Helman identifies five different modern practice cultures: efficiency and accountability, litigiousness and suspiciousness (defensive medicine), measurement and statistics (evidence-based medicine), patient expectations and preoccupation with the medicalization of everyday life, and computers and technology. The GPs have multiple and contradictory roles—as educator, priest, researcher, psychotherapist, technician, friend, pharmacist, and anthropologist. Helman feels that there is a basic incompatibility between some of the attitudes of managers (especially the controlling and homogenizing tendencies) and the realities of general practice, which are based on relationships between doctors and patients but influenced by the local community.

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