Providing proper generalist care during compulsory service as Medical Officer*

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Training, coaching and teaching Family Medicine to starting Medical Officers

Compulsory service programmes have been used worldwide as a way to deploy and retain a professional health workforce within countries.[1] After finishing their medical training Medical Officers in many countries around the world have to do at least two years of hardship or public duty. The setting is usually in less attractive areas or health facilities.
Yet they usually offer generalist medical care to their patients in difficult circumstances and have to learn relevant and responsible medical caring the hard way. Cut off from their university, with no supplementary training and with no other role model than specialists they may develop a cynical and detached attitude towards patients and simply wait out this period.
A report by the WHO (2009) on "Increasing access to health workers in remote and rural areas through improved retention" highlights these problems[2] and their recommendations are also relevant for Medical Officers and Family Practitioners. (Box 1)

The rural hospitals that need Family Practitioners were formerly served by tropical doctors from abroad, who for years helped to relieve the more or less permanent medical disaster in many rural areas in Africa. The choice of the Dutch government to stop Technical Assistance and only give aid in case of disaster is an absurdity. There will be a lack of competent doctors for many more years to come.
What can Family Medicine contribute to the retaining and motivating of doctors in remote areas?

Retention of doctors in remote areas seems nearly hopeless in Low Income Countries. Developed countries had Family Practitioners (FP) years before they had specialists. In Low Income Countries, Family Medicine competencies need to be learned without that tradition of Family Medicine. These competencies are about contextual integral compassionate care, requiring communication skills, a community approach, managerial skills, knowledge of simple every day diseases and their treatment, teamwork & delegation, leadership and organization, addressing mental problems with somatic presentation, etc.
To provide these competencies Family Medicine training departments are starting in many sub-Saharan countries. The former tropical doctor - a generalist in a hospital and predecessor of the Family Practitioner - still is a much needed specialty in Africa.
African doctors cannot enter training for the specialty of generalist or Family Medicine. Up to now they have often chosen to leave their country, because their perspective was to stay Medical Officer (access to specialty training is limited).
The Family Medicine training at Moi University in

Box 1. How to increase health workers' retention in rural and remote areas

- Locate health professional schools, campuses and family medicine residency programmes outside of capitals and other major cities.
- Expose undergraduate students to rural community experiences.
- Revise curricula to include rural health topics.
- Design continuing education and professional development programmes that meet the needs of rural health workers and are accessible locally.
- Introduce and regulate enhanced scopes of practice in rural areas.
- Ensure that compulsory service requirements in rural and remote areas are accompanied with appropriate support and incentives.
- Provide scholarships, bursaries or other education subsidies.
- Use a combination of fiscally sustainable financial incentives, such as hardship allowances, grants for housing, free transportation, paid vacations, etc.
- Improve living conditions for health workers and their families.
- Provide a good and safe working environment.
- Use telehealth.
- Develop career development programmes and provide senior posts in rural areas so that health workers can move up the career path.
- Support the development of professional networks, rural health journals, etc.

Family Medicine is quickly becoming an accepted specialty

Eldoret, Kenya[3] is a training for all-round doctors in sub-district hospitals and health centres. (Box 2)

The Family Medicine Programmes are to prepare competent, caring, compassionate Family Physicians committed to serving their community by providing leadership in their communities, to addressing the broad range of health needs, rendering comprehensive clinical services (including acute surgery & Gyn/obstetrics).

It takes many years for a developing country to reach a sufficient body of knowledge and culture of Family Health. Yet, Family Medicine is quickly becoming an accepted specialty. The necessity of an adequately trained generalist doctor is becoming more established.[4]

In an African context, the Family Practitioner is a clinical leader and consultant in the primary health care team, ensuring continuing, comprehensive, holistic and personalized care of high quality to individuals, families and communities.[5] He serves as a role model, teaching the skills that could make regular or general care more rewarding.

Box 2. The FM-training programme at Moi University, Eldoret, Kenya

The first FM-training programme in Kenya at Moi University School of Medicine is a cooperation between a public university (Moi), a local faith-based organization (INFAMED) and the General Practitioner-division of the Dutch Society of Tropical medicine and International Health (WHIG) jointly with Maastricht University (MUNDO). The principal founding father is Prof. Khwa-Otsyula, the former dean. Eight Family Practitioners have finished the training and five will follow this year. The rural Webuye District Hospital is the main training center for FM. The FM-training has greatly improved the quality of care and attracts many patients from a large area. This success is critical for the reputation of Family Medicine as a discipline that can make a difference in the care provided to patients.

MOs, clinical officers and nurses also offer generalist care, but do not get training in the basic skills. It would be in the interest of patients and MOs to offer these doctors a follow-up programme in their starting years in order to give them some feeling of belonging, to teach the relevant skills and knowledge as well as to keep them motivated.

The benefits of such training are potentially enormous. Strategies and programmes to serve rural doctors to be adequate and motivated are used in Australia[6], New Zealand, Canada, Zambia, South Africa, Norway and a number of other countries. WONCA** even has a working party for rural FPs and developed teaching materials. Such programmes are rare in sub-Saharan Africa, probably because of lack of faculty, lack of FM departments that could host a training program, lack of means but primarily because there is no clear owner of this problem.

Teaching and coaching should be done by local staff of various departments

Yet, a study in Mali of such training for postgraduate students was highly successful. Out of the 65 trained doctors between 2003 and 2007, 55 were still engaged in rural practice at the end of 2007, suggesting high retention for the Malian context.[7] The Malian participants viewed the training as crucial to face technical and social problems related to rural practice. The conclusion was that training, increasing self-confidence and self esteem of rural practitioners may contribute to retention of skilled professionals in rural areas. Other types of professional support are also needed (follow-up visits, continuing training, mentoring). This experience suggests that professional associations can contribute significantly to rural practitioners' morale.

Such a success was also reported by Koot et al. in Zambia, in addition using financial and other benefits as an incentive for working in a rural area.[8]

The WHIG[9] (Working party for FM and International Health) proposes a pilot for a simple and low-budget training programme for starting MOs that could give an answer to the cost-effectiveness of such programmes and could result in more MOs entering FM-training.

What programme could be offered to MOs in their compulsory service period?

Our suggestion is to make a programme consisting of

1 An introduction course of 2 weeks to create a group (groups) of MOs. The course will focus on basic FM-principles, communication and management skills etc. In the introduction course MOs will also be introduced to distance learning.
2 A one - two year curriculum after the introduction course + (5-7) follow-up training courses (approx. 1 week) and a fixed set of modules to be done by distance learning. A Personal Digital Assistant should support them in problem-based learning and on the spot assistance.

It is essential that the trainee should not be hindered in getting permission to attend the training. The students should be stimulated to contribute to the lecturing themselves in collaboration with the assigned teachers and staff.

Teaching and coaching should be done by local staff of various departments supplemented with expertise from experienced FM-trainers/ consultants.

Conclusion

The WHIG wants to support both the development of FM training centers in LIC as well as contribute with ideas and manpower to motivate and train doctors in acquiring the competencies of FM. This article is a call to experiment with training MOs in their compulsory service years. Many stakeholders should be involved (Ministry of Health (MoH), Moi University, Infamed, Primafamed, WONCA). WHIG has made a project plan to be proposed to the Kenyan MoH Family Medicine Coordinating Committee.