Barriers to T raining Family Physicians in the Caribbean: Distance Education as a Promising Prescription

Tomlin J. Paul and Pauline Williams-Green

Department of Community Health and Psychiatry, the University of the West Indies, Mona

Abstract

Family medicine physicians have been an important part of the primary health care landscape in the Caribbean for many decades. Most of these practitioners have been trained up to the bachelor's level in medicine and surgery at the University of the West Indies (UWI). The UWI with this responsibility for the training of physicians has, over the years, developed a graduate programme to meet the needs for specialist training in family medicine. The initial programme was limited by the problems of cost of training and the competition for hospital training posts with the more favoured traditional medical specialties. The peculiarities of the scattered small states of the Caribbean region call for a model of training practitioners that is effective, relevant and sustainable. Distance education (DE) as an approach offers advantages that meet some of the challenges inherent in training family physicians for the region. Although DE has been used in continuing medical education (CME) programmes in the Caribbean, a complete graduate degree programme for physicians has not been previously offered through this medium. The revised Family Medicine Master's degree programme breaks new ground in this area. This paper examines some of these challenges and shows where DE is being used to structure delivery of the programme. In particular, the need for context-specific training, managing time strictures and the cost issues of training are discussed.

Introduction

Since the inception of the medical school at the University of the West Indies (UWI), hundreds of physicians have graduated with the basic Bachelor of Medicine; Bachelor of Surgery (MB BS) degree. Many of these have worked in the area of general practice, providing primary health care in public and private settings in the Caribbean. The Conference of Caribbean Ministers responsible for health, at a meeting in 1977, requested the UWI to establish, as a matter of priority, a postgraduate training programme in general practice (Caribbean Community Secretariat, 1977). A few years later, a graduate programme in family medicine was established at the UWI with the aid of a Kellogg Foundation grant (Department of Social and Preventive Medicine, 1982). This programme produced Master's and Doctor of Medicine (DM) graduates from full- and part-time options. Started in 1980, it was virtually suspended in 1994 because of the lack of establishment of posts for family medicine residents at the University Hospital of the West Indies. Yet there is

high interest and demand for training in general practice. In a small cross-sectional study, a sample of forty-four Jamaican general practitioners all expressed interest in additional training (Segree and Thompson, 1991).

At a workshop held in 1997 to discuss the redevelopment of graduate training in family medicine, distance education (DE) was proposed as an approach to delivering training. Distance education consists of geographic separation of the learner and the teacher with a high level of educational organization and use of technology for communication with interactivity (Kekes, 1999). This approach is not new to the University of the West Indies nor is it new in the training of family physicians worldwide (Kamien, MacAdam and Grant, 1991; Pieterman, 1992). However, it has not been previously implemented at the UWI in the context of a graduate degree for physicians. This paper outlines some of the challenges faced in graduate education for family medicine in the Caribbean and how the new approach to be taken incorporates distance education in meeting these challenges.

Challenges

The suspension of the initial graduate programme in Family Medicine at the UWI, Mona, brought into focus a number of issues that were limiting the effectiveness and efficiency of training programmes cast within a more traditional structure of teaching. The main issues apparent were:

1. The need to emphasize context and experience-based training
2. Time limitations of practicing physicians
3. Cost of training

Context-Specific and Experience-Based Training

Despite its pervasiveness, the family or general practice setting has not been used frequently for the training of family physicians. In the original training programme, family medicine residents spent a large proportion of their training time in hospitals. Although clinical skills are improved in this setting, the dominant paradigm is not well enough focused on issues relevant to family practice. The preferred context for training is the family medicine setting itself. DE allows for context-specific training, as it facilitates the physician remaining in the office setting, working and studying simultaneously. By being given the opportunity to remain in the office setting, the physician not only sees a relevant stock of clinical case material but has a chance to manage these problems in a setting that is real in relation to his or her post-training encounters. DE moulds the trainer and the apprentice more into one unit where one's own experience becomes an important training resource.

The archipelagic geography of the Caribbean region has been a challenge to the UWI in the delivery of training. This has been addressed through a vibrant network linking campus and noncampus territories and involving use of the UWI distance education technologies. By allowing practicing physicians to remain in their country settings greater access to training is facilitated with these technologies. The former model of Family Medicine training had drawn on use of the UWI Distance Education Training Experiment (UWIDITE) in the delivery of seminars and for holding meetings, but still necessitated students leaving their territories to come in for the bulk of the training experience. This clearly limited flexibility and options.

Time Limitations

All physicians seeking further training in family medicine already have a basic medical qualification and therefore the opportunity to practice medicine.The graduate training is aimed at enhancing knowledge and skills. Many physicians, faced with the pressures of making a living, struggle to find time to proceed for further training. DE, by allowing flexibility in "contact" time, will provide physicians the opportunity to work and study. This point overlaps with the context-specific approach in that time spent with "regular" work overlaps with "training" time.

The flexibility of a DE approach to training for medical education has been highlighted by various authors (Hays and Peterson, 1996; Treloar, 1998; Hovenga, 1999; Overstreet, 2000). Physicians find it more amenable to miss small blocks of time from their offices for training in the DE mode, as opposed to the long periods (three to four years) required for traditional programmes. In addition, time available for studying course material is often limited. Segree and Thompson (1991) found physicians reporting Sundays as the most convenient days for continuing medical education (CME) sessions and late evenings as best for library study. This kind of feedback must be considered in planning training programmes.

Cost of Training

The original graduate programme in family medicine was limited because of the difficulty in obtaining paid posts for residents in the hospital setting. Having the physicians remain in their setting not only enhances the context-specificity of the programme but there is no need to create additional posts. In effect the cost of training is partially subsidized by the physician. The developmental cost of a DE programme may be high, but given coverage and access, the DE approach appears to be cost-beneficial. This comparison of cost approaches in medical education warrants further study as the region moves ahead to develop and implement innovative programmes.

The Revised Family Medicine Programme

The revised family medicine programme, to be started in Jamaica in September 2001, has as its mission to train doctors in general practice in the knowledge, skills and attitudes necessary for the provision of comprehensive and continuous personal medical care in the primary care setting, through the promotion of health and the prevention and treatment of illness and disease.

The programme, which is focused on addressing the health needs of the Caribbean, aims to:

1. Stimulate the professional development of general practitioners based on their existing experience, and enhance their competence and ability to function effectively and efficiently as primary care physicians in the reformed health sector.

2. Make possible access by general practitioners from noncampus island countries to the UWI postgraduate programme in Primary Care.

3. Provide a continuing education base for the development of a career structure for the primary care physicians.

The specific educational objectives of the programme are to help the general practitioners in the Caribbean to:

- Broaden knowledge and understanding of health and illness and their dynamics in the community in relation to the socioeconomic and cultural environment of the community;

- Enhance professional competence, attitudes, values and behaviour that are inherent to the specialty of primary care practice;
- Develop attitudes and skills to allow them to work effectively as members of a health care team in the context of the policy and reality of the health care systems in the Caribbean;
- Enhance the skills of critical reflection and assessment of day to day professional activities, enabling them to meet the often unique and changing health needs of patients and their families, and the changing demands of the health care system;
- Promote skills in effective, continuing, self-directed medical education to revise past knowledge, understanding and skills, and to keep abreast of advances in medical sciences and technology used in primary care practice;
- Enhance clinical skills necessary for the management of common diseases.

These aims and objectives of the programme can be seen as placing emphasis on issues pertinent to graduate education such as "critical reflection" and "self-directed education". The goal of stimulating professional development of general practitioners based on their existing experience also speaks to the priorities inherent in this curriculum revision.

Programme Methodology

The MSc Family Medicine Programme will be delivered in the distance education format. Participants in the programme will complete sixteen courses during the first two years (Phase 1). These courses will be delivered in the print format and the participants will complete the study guide, readings, exercises and assignments included therein. It is expected that there will be significant use of the Internet as a means of course delivery in the near future.

The third year (Phase 2) will consist of three courses, to be delivered by the distance mode, and a research project. This will last a minimum of one year.

The participants are also expected to keep a portfolio in order to record and track their clinical and academic experiences. This is a three-ring binder which will contain written evidence of the participant's attendance at clinic sessions, all corrected assignments with grades displayed, all CME activities attended during the three years, a personal learning diary, and personal observations on readings and courses. This portfolio is weighted 50 percent towards the assessment at the end of each of Phases 1 and 2 of the Master's Programme.

In ensuring a context-specific and experience-based approach, students are expected to complete 960 hours of clinic sessions i.e. 240 clinic sessions lasting four hours each during three years. At least 50 percent of the 960 hours should be spent at an accredited family medicine clinic. If this is not available in the territory, the participant must complete on-going assessment (based on predetermined guidelines), of his or her medical practice (public or private). This must be handed in to his or her supervisor at the ends of Phases 1 and 2, and will form part of the portfolio. The remaining 480 hours (120 four hourly sessions) of the clinic sessions should be spent at accredited specialist clinics.

Completion of Phases 1 and 2 will earn a maximum of 50 percent of the final assessment for the MSc. At the end of Phase 1 of the Master of Science in Family Medicine there will be an Objective Structured Clinical Examination (OSCE) which will contribute to 40 percent of the final mark. Successful completion of a research project in year 3 (twenty credits) is a requisite for obtaining the MSc. An oral examination will account for 10 percent of the final mark.

Summary

There is a felt need for continued training and upgrading of general practitioners in the many small states of the Caribbean region. Graduate training in family medicine in the region has for years been stymied by limited resources and the difficulties of having already practicing physicians from centres far removed from the university setting "come in" for training. The revised programme in family medicine offers an approach using predominantly distance education, which addresses some of the challenges encountered in the earlier course. The dominant exposure for training is now the general practice setting, although exposures in the hospital outpatient department are still being used. DE provides the flexibility needed to allow physicians to access the training programme and to meet specific educational goals within a contemporary training philosophy. Hays and Peterson (1996) have found that advanced training in general practice through distance education and communication technologies can be equivalent to traditional training approaches. The use of the DE medium for delivering specialty training for physicians towards a degree qualification is new to the Caribbean and offers a promising prescription for medical educators faced with traditional challenges.

Bibliography

Caribbean Community Secretariat (1977). Final Report – Third Meeting of the Conference of Ministers Responsible for Health. St Kitts, June 28–30, 1977.

Department of Social and Preventive Medicine (1982). 25th Anniversary Booklet, April 1957–April 1982. Mona: University of the West Indies, Faculty of Medicine.

Hays, R. B. and Peterson, L. (1996). "Options in Education for Advanced Trainees in Isolated General Practice," *Australian Family Physician* 25, no. 3: 362–366.

Hovenga, E. J. (1999). "Using Multimedia to Enhance a Flexible Learning Program: Lessons Learned." *Proceedings of the AMIA Symposium*.

Kamien, M., MacAdam, D., and Grant, J. (1991). "Distance Learning in a Local Setting: A Structured Learning Course for the Introduction of General Practice to Undergraduate Students," *Med Teach* 13, no. 4: 353–361.

Kekes, E. (1999). "Current Status and Possibilities of Distant Education in Medicine," *Orvosi Hetilap* 140, no. 43: 2379–2384.

Overstreet, K. B. (2000). "Public Health Education Opportunities for Physicians in Louisiana," *Journal of the Louisiana State Medical Society* 152, no. 2: 78–82.

Pieterman, L. (1992). "A Graduate Diploma in Family Medicine by Distance Education," *Medical Journal of Australia* 157, no. 3:178–181.

Segree, W. and Thompson, P. (1991). "Report on Continuing Medical Education (CME) for General Practitioners – 1991," *CCFP Bulletin* 3, no. 5: 3–5.

Treloar, C. J. (1998). "Evaluation of a National and International Distance Education Program in Clinical Epidemiology (691)," *Medical Education* 32, no. 10: 70–75.