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 relevant 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.

Hong Kong

Can Family and Emergency Physicians Work Together?

(Chung C. Interface between family medicine and emergency medicine. Hong Kong Practitioner 2000;22:273-6.)

There is considerable overlap between family practice and emergency medicine. Both provide patient-demanded, broadly available primary care for patients with undifferentiated illnesses. Worldwide, a high percentage of family physicians provide emergency services, especially those in rural areas. With the development of family practice and emergency medicine as independent specialties, an enlarging gap in training and practice between the two specialties can occur.

In Hong Kong, there is severe overcrowding of the emergency departments (ED). ED visits have almost doubled in the past decade, from 1.3 million in 1991 to 2.4 million visits in 1999, even with a dramatic increase in patient charges. Interestingly, only 24% of the visits were classified as urgent. There, as in the United States, EDs function as large safety-net outpatient clinics.

To help solve the increasing problems of access, cost, and quality in EDs, the author proposes strengthening the interface between emergency medicine and family practice.

The author recommends establishing walk-in clinics next to EDs, with extended hours and staffed by family physicians. He recommends improving the quality and availability of primary care, especially in the public system and in hospital outpatient departments. He also recommends improving communication by giving patients who are seen and discharged from an ED a formal written (hopefully computer-generated) summary of the findings, diagnosis, and medications that can be shared with their family physicians. He also recommends that not only should family practice residents have training in EDs but also that emergency medicine residents have rotations in family practice and a combination of clinical rotations for trainees in both specialties.

Jonathan E. Rodnick

Ireland

More Women GPs Equals Improved Lifestyle for All GPs

(O'Connell A. Wanted: GPs with an interest in women's health. Forum: Journal of the Irish College of General Practitioners 2000;17:29-32.)

In 1993,women comprised just 15% of the general practitioners (GPs) in Ireland. Today, women account for one third of the total GP workforce, almost half of the GPs under age 40, and more than two thirds of the applicants to and graduates of general practice residencies (also known as training schemes).

Although many GPs in practice consider themselves to be very stressed, the author, herself a medical student, cites a number of reasons why women are interested in becoming GPs. These reasons include (1) more emphasis than other specialities on the doctor-patient relationship and a caring rather than curing philosophy, (2) greater practice autonomy than hospital medicine, (3) flexible working hours and

more opportunities to work part-time, (4) a "glass ceiling" that limits womens' abilities to become more highly paid and prestigious consultants, and (5) career prospects in general practice have never been better.

A perceived difficulty of general practice is providing round-the-clock coverage for all patients. The feminization of general practice has resulted in changes in how after-hours (or on-call) care is provided in Ireland. Many women GPs have challenged the traditional and time-demanding way that small practices or individual GPs provide round-the-clock coverage. This led to the development of GP cooperatives that provide universal after-hours coverage for a larger region. For example, in Northern Ireland, a cooperative of 480 GPs has reduced being on call to once every 60 nights, and exemptions from this out-of-hours work can be purchased. The benefits in lifestyle and GPs' mental health have been uncalculable.

Jonathan E. Rodnick

United Kingdom

What Should Our Priority Areas in Research Be?

(Robinson G, Gould M. What are the attitudes of general practitioners toward research? Br J Gen Pract 2000;50:390-2.)

It is widely acknowledged that there is an urgent need for high-quality primary care research. In 1997, the British Medical Research Council published *Topic Review: Primary Health Care,*[1] which identified several research needs and opportunities, such as chronic illness and health-seeking behavior. This was followed by the National Working Party Report on R&D in Primary Care (The Mant Report),[2] which laid out, in practical terms, how the expansion of the primary care knowledge base should be achieved.

In 1997, Robinson and Gould sent a questionnaire to all 295 general practitioners (GPs) in two areas of the United Kingdom. They had an 84% response rate. The majority of respondents were full-time, male, and urban GPs.

Ninety percent of the respondents felt that primary care research was either important or very important for the specialty. Only 9% stated that research was either unimportant or not at all important. A majority (68%) said that research findings directly influence their clinical practice.

Training in research was reported by 38% of the respondents. Five percent reported participation in collaborative research projects; only 4% had published within the last 3 years. Fifty-three percent expressed an interest in doing future research.

Perceived priority areas for future primary care research were chronic illness (22%), primary care organization (19%), patient behavior (18%), prescribing and treatment (17%), outcome measurement (10%), and health promotion/disease prevention (9%).

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References

1. Medical Research Council. Topic review: primary health care. London: MRC, 1997.
2. Mant D. R&D in primary care: an NHS priority. Br J Gen Pract 1998;48:871.