

Development of Family Practice Specialty Training Program over a 20-year period (1983-2002) in Kuwait

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Objectives The study examined the evolution of the Family Practice Post graduate Training Program (FPSTP) in Kuwait during the period 1983 to 2002 and identified the main changes and achievements as well as limitations in order to identify ways to improve the program for the future.

Methods In a review of the main records of the FPSTP and manpower statistics in Qadsia, Kuwait Institute for Medical Specialization (KIMS) and Ministry of Health (MOH) covering the last 20 years, three years were selected for observational comparisons. These were 1987, the year of graduation of the first batch of Family Medicine Graduates (FMG), 1995 when the program was reactivated after the Iraqi invasion, and 2002. Data reviewed included numbers of graduates, year of graduation, sex and nationality.

Results The study showed that the number of FMG has increased tremendously over the 20 year period, from 13 in 1987 to 152 in 2002, with the percentages of Kuwaitis increasing from 7.7% to 77%. The percentage of females also changed from 38.5% to 62%. This increase was also accompanied by the loss of

FMG to attachments or posts other than clinical general primary care work. Steps have been taken to make the program local, with decreasing Royal College of General Practitioners (RCGP) participation in the courses and examinations. Training centers, however, have not increased since 1995, despite the rise in the numbers of trainers and examiners.

Conclusion The study revealed that FPSTP has expanded, with an increase in the number of FMG, in spite of the substantial shift away from family practice as a career for some graduates. There have also been improvements and additions to the curriculum in conformity with international postgraduate (PG) programs.

Key words: Family Practice Specialty Training Program, vocational training, Royal College of General Practitioners

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Introduction

Family Practice is a distinct medical discipline; doctors who intend to become family practitioners require a period of special professional preparation. Specialist Vocational Training (V.T.) is just one phase; it builds on and complements undergraduate education and general professional training.¹⁻³ The objectives of the training program are to produce a safe doctor who is not only sound in his/her clinical judgment and in the way his or her practice is organized, but is also sensitive to patients' needs and able to communicate effectively with patients in addition to being self aware and critical in his/her professional standards.^{2,3}

The Family Practitioner is a medical graduate with specific training to give personal, primary and continuing care to individuals, families and a practice population, irrespective of age, sex and illness.¹⁻⁴ The FPSTP is a four year residency program in Kuwait. Doctors who have completed the first year internship are eligible to apply for training. It provides supervised learning opportunities and clinical experience in both hospital and family practice. All trainees are required to complete rotations in general medicine, pediatrics, obstetrics & gynecology, psychiatry, dermatology, ear, nose and throat, general surgery, ophthalmology, orthopedics, casualty and emergency.²

The program started officially in 1983 under the close supervision of RCGP with 13 general practitioners who were selected after written and oral assessments. They joined the program in 1984 and received intensive training, lasting 15 months. Four full time courses were offered on developing consultation clinical skills, teaching and assessment techniques. These

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were completely run by UK tutors.⁵ The group received additional hospital attachments to fill in certain gaps of knowledge and clinical experience,⁵ and 10 were formally selected and appointed as trainers in October 1985.⁵ The first training centers were in Qadsia and Midan Hawalli.⁵ Later, the training centers increased to six, which were: Qadsia Training Center, Abdullah Al-Salem, Shamiya, Mishref, Yarmouk and Hadiya. The number of FMG has increased considerably during this 20 year period, and the program duration has changed from 3 years to 4 years in 2000. A trainee audit project was introduced to the program in 2002 after intensive preparation of the trainers for supervision and assessment.

This paper examines the main changes that have occurred in the FPSTP, (one of the well recognized postgraduate training programs of KIMS) by studying the changes in manpower over the last 20 years.

Methods

The study method involved a review of all records of FPSTP in its department in Qadsia, at KIMS and in the MOH, and covered the last 20 years (1983-2002). Three time point limits were studied namely: 1987 (when the first batch graduated), 1995 (when the program was re-activated after the Iraqi invasion) and 2002. We consider that these three years were the most representative stages of major development in the program regarding the number of graduates, number of years of residency and the recent changes in the program. Information extracted from records included: the total number of graduates in each batch, the year of graduation, sex and nationality of graduates.

Results

The main changes in the FPSTP at the three points (1987, 1995, 2002) were as follows:

1. CHANGES IN MANPOWER

The number of graduates had significantly increased from 13/600 (2% of the total number of general practitioners) in 1987, to 60/514 (11.6%) in 1995, to 152/584 (26%) in 2002. Kuwaiti graduates accounted for 7.7% of the total number of FMG in 1987 and 77% in 2002, with female graduates increasing from 38.5 % in 1987 to 62.0% in 2002 (Table 1).

2. CHANGES IN TEACHING STAFF AND EXAMINERS

In 1987 there were 10 local trainers. The number of trainers remained at 10 in 1995, but increased to 20 in 2002. The number of examiners also doubled in 2002. (Table 1).

3. LOSS OF FMGS

Around 34 (22.4 % of all graduates) were lost during this period, mainly due to resignation and shift to administrative positions (Fig. 1).

Figure 1. Loss of FM personnel to other services and resignations

4. FAMILY PRACTICE AND TRAINING CENTERS

The number of FP centers increased from no designated center in 1987 to 21 centers

Table 1. Distribution of the main characteristics of the FPSTP over the three times point estimates

Year	Numbers GR:GP	Nationality K:NK	Gender F:M	Number of Trainers	Number of Examiners	V.T. Years	Centers FM:GPC	Training Centers:GPC	RCGP:Local Sharing Exam	RCGP:Local Sharing Courses
1987	13:600 2%	1:12	5:8	10	0	3	0:60 0%	2:60 3.3 %	100%:0%	100%:0%
1995	60:514 11.6%	44:12	38:22	10	5	3	9:68 13.2%	6:68 8.8%	50%:50%	50%:50%
2002	152:584 26%	117:35	94:58	20	10	4	21:77 27.2%	6:77 7.8%	50%:50%	0%:100%

in 2002. There had been no corresponding increase in training centers since 1995, the number remaining at 6 (Qadsia, Abdullah Al Salem, Shamiya, Hadiya, Mishref and Yarmouk) (Table 1).

Table 2 shows the main international standardized features required for training centers.

Table 2. International standardized features of a Training Center

<ul style="list-style-type: none"> • Adequate clinical records and registration system • The Practice should be a family practice center providing comprehensive care irrespective of age, sex or ethnic group • Computerization system • An integrated practice team • Library with online access to Evidence Based Medicine • Sufficient workload that is not light yet not overloaded clinic • The Practice has morning and afternoon shifts • Night and weekend duties • Adequate staff, equipment and organization • Preventive medicine and performance review (audit) • Overall arrangements for service and teaching

5. CHANGES IN THE STRUCTURE AND CONTENT OF FPSTP CURRICULUM

The program was changed from 3 to 4 years vocational training in 2000, with the addition of a trainee's project (the audit) in 2002. The RCGP's role as external examiners in the Diploma and as course tutors had declined from 100% in 1987 to 0% sharing in courses and 50% sharing as external examiners.

Discussion

The recognition of the FPSTP as a post-graduate program at KIMS in 1987 and of its certificate as an equivalent to MRCGP/UK by the Examination Board of RCGP in 1991 are important factors leading to increasing choice of FM as a career by Kuwaiti graduates.⁵ There had been an increase in the number of FMG especially females. This can be explained by the fact that general practice is more suited to the needs of females with regards to childcare and other family commitments.^{4,6}

The increasing number of FMG is an encouraging sign, reflecting the stability and strength of the program. Studies reported suggest that vocationally trained GPs are better in terms of the quality of patient care, confidence and self-perception as GPs as well as in knowledge,

practice skills and attitudes.⁷⁻¹² The switch of manpower from primary care clinical work to administrative duties or to other specialties is a phenomenon that has been observed in many other countries as well. Kelly and Murray⁶ reported on the experiences of 600 doctors who had completed their training in the west of Scotland over a period of 20 years and found that only 85% were still working in GP at the time of the study. Osler¹³ also studied the experiences of trainees from one region of England (East Anglia) who had completed their training between 1981 and 1987 and found that only 89% of men and 71% of women were still serving in general practice posts. This important problem was addressed recently by the Faculty of Primary Health Care, which recommended that FMG should spend a sufficient number of years working in primary care general practice clinics before they can be moved to an administrative or other specialty branch, such as diabetic clinic. This was supported by a decision from the Ministry of Health in 2002.

Training centers have special requirements for trainers and teachers to cater for teaching as well as service (Table 2).¹⁴⁻¹⁶ There has been an increase in Family Medicine Centers to accommodate the graduates but there has been no corresponding increase in FM training centers, a problem that should be taken into consideration. The number of trainers had increased (it had nearly doubled), and another batch of potential new trainers is currently being prepared locally. Contributory factors to this state of affairs include the destruction caused by the Iraqi invasion leading to the loss of some senior trainers, and the lack of enthusiasm towards FM, because the concept had not been well understood. This has made the importance of FM to be underestimated. This should be the starting point for the MOH, to widen the scope of FM by preparing training centers in accordance with standardized international criteria (Table 2).

The increase in V.T. years from 3 to 4 is also a healthy one. There is substantial variation in the duration of training among European states, ranging from 2 years in Iceland, Belgium and Italy to five years in Norway. In Australia and Holland, the duration of the program is three years. The duration of training for the Arab Board of Family Medicine is 4 years.^{4,15-17} The introduction of CME programs

by KIMS is one of its strongest credits, as the provision of CME is one of the most important roles of many academic organizations. Many studies have shown that participation in CME programs could affect the doctor's prescribing habits, test ordering habits and other decision activities of the practice.¹⁸⁻²⁰ The vocation of a Family Physician is one that calls for a lifetime of learning, continuous acquisition of new skills and the constant renewal of one's intellectual capacities⁴, which coincide with the objectives of the FPSTP.^{2,3}

Many aspects of our FM curriculum have been revised, and the teaching staff have introduced many suggestions and additions. Traditionally, teachers have been asked what a teacher needs to do to enable students to learn, but the new trend is to focus on what students need to learn.^{4,18,21-23} The introduction of a trainee project was an important addition to our program. An Audit project is required for the purposes of summative assessment. It aids in continuing medical education, identifying learning needs and in developing individual knowledge. There are many educational benefits from Audit. Firstly, a critical review of current practice and the setting of standards encourage updating in a wide variety of areas. Secondly, audit highlights the need of special knowledge and information, the acquisition of new skills and the development of existing ones as well as the need to undertake research. Thirdly, self evaluation, which is at the heart of continuing professional development, is made possible through audit.^{18,19,21,22,24,25}

Conclusion

The study has highlighted the main changes in the quality and quantity measures of the FPSTP, which reflect the active roles of teachers and examiners in the program as well as the support of KIMS and the MOH. Regular evaluation of the training and educational process can identify specific needs and requirements for program quality assurance aspects.

RECOMMENDATIONS

- Encourage the medical school graduates to join the FPSTP in Kuwait, as primary care is in need of qualified personnel.
- Encourage the setting up of more training centers.

- Encourage the accreditation process of training centers to meet international criteria and to facilitate measurements of quality assurance of the training process.
- Encourage the preparation of new trainers and new examiners to meet the increasing need for educating general practitioners all over Kuwait.

References

1. Fraser R. *Clinical method*. 2nd ed. London: Butterworth Heinemann Publishing; 1992.
2. Kuwait Institute for Medical Specialization. *Family Practice Specialty Training Program curriculum*. Kuwait: Kuwait Institute for Medical Specialization; 2002.
3. Kuwait Institute for Medical Specialization. *Educational guide*. Kuwait: Kuwait Institute for Medical Specialization; 2002.
4. Wonca Asia Pacific Working Party on Education and the Philippine Academy of Family Medicine. *Workshop Report, Family Medicine Education in the Asia Pacific Region*: 1993; [3 screens]. Available from: URL: www.globalfamilydoctor.com/publications/core_curriculum.htm
5. Frazer RC. Developing Family Practice in Kuwait. *Br J Gen Pract* 1995;45:102-6.
6. Johnson N, Hasler J, Mant D, Randall T, Jones L, Yudkin P. General Practice careers: changing experience of men and women vocational trainees between 1974 and 1989. *Br J Gen Pract* 1993;43:141-5.
7. Hindmarsh J, Coster G, Gilbert C. Are vocationally trained general practitioners better GPs? a review of research designs and outcomes. *Med Educ* 1998;32:244-54.
8. Borgiel AE, Williams JI, Bass MJ, Dunn EV, Evensen MK, Lamont CT, et al. Quality of care in Family Practice: does residency training make a difference? *J Can Med Ass* 1989;1:1035-43.
9. Coffey G. Medical Services performed by vocationally registered and non-vocationally registered medical practitioners in Australia. In: *General Practice Evaluation Programme: The 1992 work-in-progress conference*. Commonwealth of Australia, Canberra: 1996; p.23-38.
10. Duncan P. Evaluation of the GPVTP. *N Z Fam Physician* 1994;21:186-8.
11. Freeman F, Byrne PS. The assessment of vocational training for general practice. *Reports from General Practice 17*. London: Royal College of General Practitioners; 1976.

12. van Leeuwen YD, Mol SSL, Pollemans MC, Drop MJ, Grol R, van der Vleuten CPM. Change in knowledge of general practice during their professional career. *Fam Prac* 1995;12:313-7.
13. Osler K. Employment experiences of vocationally trained doctors. *Br Med J* 1991;303:762-4.
14. Schofield T, Hasler J. Approval of trainers and training practices in the Oxford region: criteria. *Br Med J* 1984;288:538-40.
15. Gray DJP. *Training for General Practice*. 1st ed. Plymouth: Macdonald and Evans Limited; 1982.
16. Arab Board for Medical Specializations. *Arab Board of Family Medicine Booklet*. Damascus: Arab Board for Medical Specialization; 2001.
17. Steinunn J. Vocational training in Europe. *Br J Gen Prac* (letter 2) 2001;51:1013.
18. Beaudry J. The effectiveness of continuing medical education: a quantitative synthesis. *J Contin Educ Health Prof* 1989;9:286-307.
19. Gehlbach SH, Wilkinson WE, Hammond WE, Clapp NE, Finn AL, Taylor WJ, Rodell M. Improving drug prescribing in primary care practice. *Med Care* 1984;22:193-201.
20. Stein L. The effectiveness of continuing education: eight research reports. *J Med Educ* 1981;56:103-10.
21. Richard H. *Practice-based teaching: A guide for General Practitioners*. 1st ed. Victoria: Eruditions Publishing; 1999.
22. Hall MS, Dwyer D, Lewis T. *The G.P training handbook*. 3rd ed. Great Britain: MPG Books Publisher; 1999.
23. Chambers R, Wall D. *Teaching made easy: a manual for health professionals*. 1st ed. Oxford: Radcliffe Medical Press Ltd.; 2000.
24. Havelock P, Hasler J, Flew R, McIntyre D, Schofield T, Toby J. *Professional education for General Practice*. 1st ed. New York: Oxford University Press; 1995.
25. Keighly B, Murray S. *Guide to postgraduate medical education*. 1st ed. London: BMJ Publishing Group; 1996.

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On-line Sites for Education in Family Practice

A selection of web sites that offer learning opportunities in Family Practice or links to CPD providers in the specialty appear below. Additional details are available in *Bratton RL, editors. Mayo Clinic's complete guide for family physicians and residents in training*. New York: McGraw Hill; 2000, and in the CME Center website www.kims.org.kw/cme.

<http://www.aafp.org>

Information related to AAFP American Family Physician Family Practice Management, American Academy of Family Practice

<http://www.abfp.org>

Information related to American Board of Family Practice, certification. Link to journal of the American Board of Family Practice (via <http://www.medscape.com>)

<http://www.ama-assn.org>

Information related to American Medical Association, JAMA, Archives of Family Medicine, Links to Journal of the American Board of Family Practice and to NEJM

<http://www.cdc.gov>

Centers for Disease Control MMWR, Travel information, Immunization guidelines, Public health information

<http://www.mayo.edu>

Mayo Clinic Proceedings (table of contents)

<http://www.mms.org>

Massachusetts Medical Society; Information on Journal Watch, NEJM

<http://www.nejm.org/content>

New England Journal of Medicine Table of contents

<http://www.mayohealth.org>

Mayo Health Oasis patient education

<http://www.aamc.org>

Association of American Medical Colleges

<http://www.census.gov>

United States Bureau of Census

<http://www.hcfa.gov>

Health Care Financing Administration

<http://www.ahcpr.gov>

Agency for Health Care Policy and Research

<http://www.dhhs.gov>

Department of Health and Human services

<http://diversityRx.org>

Diversity Rx

<http://www.ncsl.org>

National Conference of State Legislatures

<http://www.aafp.org/members.html>

AAFP Online; Requires membership identification to access comprehensive CME listings

<http://www.aafp.org/residencies>

Directory of Family Practice Residency Programs - A source of information on Family Practice Training Programs, including faculty, administration, accreditation, size and salaries

<http://www.aafp.org/fellowships>

Fellowship Directory for Family Physicians - Information on fellowships in Adolescent Medicine, Family Medicine Research, Rural Medicine, Sports Medicine, Substance Abuse, and other fellowships

<http://www.aafp.org/catalog>

AAFP Catalog - Various educational services and products, including AAFP Home study Self-Assessment and American Family Physician CD ROM collections

<http://www.aafp.org/careers/index.html>

Career Opportunities Online - Listing of career openings for primary care physicians