Original Articles/นิพนธ์ต้นฉบับ

Comparison of Family Medicine Training Programs in the UK and Thailand.

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Abstract

Background: In the UK, modern General Practice has developed over a period of 50 years. By contrast, the specialty of Family Medicine is a new concept in Thailand being promoted recently by the government in response to economic crisis. Despite this perceived need, in Thailand Family Medicine is not fully recognized as a specialty by the public or the medical profession. Through a lack of resources and expertise very few doctors are training as family physicians. This review of training programs in the UK and Thailand looks both for common ground and differences in approach between the two countries.

Methods: Comparison of the characteristics of the two training programs.

Results: Similarities, differences, strengths and weaknesses of each system.

Conclusion: Despite differences between the two health care systems, there are sufficient similarities between FP training programs in the UK and Thailand for successful approaches to be shared.

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Background

In Thailand, hospital-based medicine has dominated the health care system since scientific medicine was introduced in 1886. Access to primary care has been hindered by the increasing specialization of Thailand's physician workforce, most graduate doctors preferring to study in hospital specialties. Although three-year training programs in general practice were established in 1969, few doctors have been trained in this area. In response to an economic crisis in the 1990s, the Thai Government reformed primary health care in an effort to reduce medical costs[1]. However, the lack of professional recognition given to family medicine continued to result in low numbers of doctors choosing this career. In 1998 only 216 (1.7%) of the 12,500 Thai board-certified physicians were general practitioners[2].

In August 1998, in the hope of attracting more doctors to primary care training, doctors completing training programs in family medicine were designated as Family Physicians to distinguish them from general doctors. In the same year, nine residents joined the first year of the nationwide program. The number of trainees joining these programs increased yearly, reaching a peak of 60 in 2002 before declining to 18 trainees in 2006[3]. Currently there are 26 training centers for family medicine education but out of a total 141 training posts, only 12.76 % are filled[4].

The Department of Family Medicine at Ramathibodi Hospital has provided family medicine residency training since 2001 and is one of the most popular programs in Thailand. Despite this, in 2006 only 8 resident positions were available. A comparison between family medicine training programs in the UK and Thailand is intended to give readers a picture of both systems and to consider whether any lessons can be learned. This article is written prior to the Modernising Medical Careers program impacting fully on UK training[5].

Objective

To compare the characteristics and settings of the training programs, board examination requirements, numbers of trainers and trainees, and health care systems at Ramathibodi Hospital with a typical UK scheme

Study design

Cross-sectional analytic qualitative study

Methods

Reviewer 1 (DJ) studied in a primary care setting in the UK from July to August 2004, while she was a 3rd-year Family Medicine resident at Ramathibodi Hospital. After exposure to both training programs, the same reviewer compared and analyzed the similarities and differences between both systems. The analytic data was reviewed independently by reviewer 2 (SH) and reviewer 3 (AD). The article was then developed through e-mail and personal contact between the reviewers.

Results

The similarities, differences, strengths and weaknesses of the two training programs are compared and summarized in Table 1-3.

Discussion

In the UK, GP vocational training programs are spread across the country, but are broadly similar in their approaches. In Thailand, Family Medicine residency training programs are based within teaching hospitals and can differ considerably from one another. In the UK, the value of hospital-based experience for GPs is being questioned but training schemes contain a large component of in-patient care. Community experience occurs in the final year. Family medicine residents at Ramathibodi Hospital develop the skills of ambulatory care in a hospital setting and give

Table 1. Family Medicine training in the UK and Thailand.

	UK	Thailand
Duration of under-graduate training	5 years (average)	6 years
Commitment after graduation	2 Foundation Years	1-3 years of work in government hospitals
Postgraduate program	GP Vocational Training Scheme	Family Medicine Residency training program
Postgraduate position	Foundation Year for first 2 years GP Registrar for 3 year program	Year 1, 2, 3 Resident
Postgraduate training in GP/FP	hospital-based for first 2 years community based for final year	3 years hospital-based and community based, varying across centers
Total number of trainees nationwide	2,000 Registrars / year (UK population = 60 millions)	30-50 residents / year (Thai population = 60 millions)

Table 2. Characteristics of programs at Wycombe and Ramathibodi Hospital

	Wycombe Scheme	Ramathibodi Hospital
Number of trainees	20 Registrars in Hospital posts in the first two years 10 registrars in community health centers	24 residents (8 in each year)
Income (approx)	£ 50,000 / year	£ 2,000 / year
Setting	Suburban	Urban
Trainer	Specialist tutors for the first two years GP trainer in 3rd year	Specialist and FP tutors alternately, depending on the department in which the resident is enrolled
Holiday	5 weeks / year and national holidays	2 weeks / year and national holidays
Rotation	4 six-month posts in a variety of relevant specialty departments, such as Medicine, Surgery, Paediatrics, Obs. & Gyn. and Psychiatry final year in a GP practice	Longitudinal 3 year program based in the Family Medicine out-patient clinic, with the following additional out-patient clinic attachments : Yr. 1 : Medicine, Paediatrics, Obs. & Gyn., Surgery, Orthopaedics Yr. 2 : Geriatrics, Radiation Medicine, Anaesthetics, Physical Medicine & Rehabilitation, Forensic Medicine, Psychiatry, Community Medicine, elective period Yr. 3 : 4 month elective, 8 months in a Family Medicine clinic
Place	Hospital for in-patient experience Health Centers for community-based experience	Hospital out-patient depts. Community hospitals
Program emphasis	first 2 years : hospital-based education final year : community-based education	predominantly University / Hospital-based education, with at least 2 months community-based education

Table 2. Characteristics of programs at Wycombe and Ramathibodi Hospital *(cont.)*

	Wycombe Scheme	Ramathibodi Hospital
Patients seen in a half day	in final year 8-15 patients / half day : 7 half days / week	Yr. 1 : 8 patients / half day 2 half days / week Yr. 2 : 12 patients / half day 2 half days / week Yr. 3 : 16 patients / half day 3 half days / week
Teaching communication skills	Analysis of self-recorded video by trainee and trainer	Video observation and chart-stimulated recall by faculty family physicians
Home visits	daily : 1-2 cases	one half day a week : 1-2 cases
Academic activities	Day release course Residential courses Tutorials with GP trainer once a week Shared clinics Debriefing after clinics	Behavioral medicine series Journal watch Morning report: Case presentations Home care conferences EBM series Academic half-days Chart-stimulated recall of consulting Debriefing after clinics
Board examination requirements	MCQ exam paper Written project (audit) Video-tape of 11 consultations Satisfactory trainer's report (requirements will change in 2008)	MCQ exam paper Oral examination Long-case examination Three home-care case reports Research project: health belief, health services in primary care Three-year evaluation report from trainer
Pass rate of board examinations	98%	98%
Where and how are graduates practising?	the majority enter general practice as salaried or profit-sharing partners	faculty family physicians teaching and practising in university hospitals family physicians working in government primary care units or community hospitals

Table 3. Strengths and Weaknesses of the programs: Learners' perspective

	Wycombe Scheme	Ramathibodi Hospital
Strengths	In-patient skills Emphasis on communication skills and patient-centred care Exploring wide areas (e.g. beliefs and attitudes, career development) 1:1 GP trainer / registrar ratio Training by working and supervision rather than formal teaching	Continuity of patient care (out-patient) for 3 years Emphasis on patient-centred and family-centred interviewing Academic activities Time for electives Research skills development
Weaknesses	GP trainer / registrar relationship (if not matched appropriately) Problem-based learning may be unsystematic and may neglect the acquisition of factual knowledge	1 trainer : 4-6 resident ratio during out-patient sessions No in-patient experience or procedural skills training A new program with unknown reputation among other medical specialties

continuity of care for their regular patients throughout the three year training program. It is noticeable that the service commitment of UK Registrars amounts to seven clinic sessions each week compared to third year residents at Ramathibodi who work for three sessions.

Home visiting is a regular feature of a UK GP Registrar's work but this is rare in Bangkok. At Ramathibodi only fifty percent of patients live in the inner-city, the remainder coming from across the country. Although in recent years home visiting to Bangkok residents has become a feature of FP training at Ramathibodi, this is made difficult by the notorious traffic jams. Visiting is not regarded by older graduates as being cost-effective but this attitude may not be prevalent away from Bangkok.

There are several similarities between the two training programs in teaching methods, such as the use of video-taped consulting, debriefing after clinics and involvement in academic activities. In both programs teachers are comprised of hospital specialists and GP trainers but in the UK there is the advantage of a one-to-one GP trainer-trainee relationship in the final year. Although this allows a trainer to respond to his trainee's individual educational needs, problems might arise if trainer and trainee are inappropriately matched. In Ramathibodi, residents have the benefit of exposure to a variety of feedback styles and role models through having several teachers. However, the high ratio of residents to teachers during out-patient sessions is an obstacle to learning.

In the UK, the impact of the new GP curriculum on training has yet to be assessed. Currently the academic program for GP registrars is largely dependent upon negotiation between the Registrar and his trainer, a tailor-made curriculum. In Ramathibodi the curriculum is structured through a variety of predominantly formal academic activities, such as presentations, weekly journal watch meetings and case conferences. Residents learn from one another and gain experience in teaching. They are also required to complete a primary care research project at Master

level to be eligible for the board examination for Family Medicine. There is no equivalent to this in the UK program.

In the UK about 50% of graduating doctors choose a career in general practice, while in Thailand this figure is less than 1%. This difference is generally attributed to the low status of primary care in Thailand and the poor conditions of service, especially the low salaries compared to other specialties. However, it should be asked whether part of the problem might lie in the structure of the undergraduate and post-graduate training programs themselves. In the UK, professional training for General Practice is becoming increasingly community-based, with most teaching taking place at health centers or being delivered by general practitioners at education centers. A substantial service commitment is required of trainees throughout the three year schemes, a situation that may alter with the introduction of Modernising Medical Careers[5]. At Ramathibodi the majority of residents will complete a predominantly academic program, having had relatively less experience of community primary care but a great deal of experience of teaching and research. This reflects the present need for primary care teachers. More emphasis on learning in the community will be necessary to prepare residents for careers in primary care units, especially those situated away from Bangkok.

Conclusion

Family Medicine in Thailand accepts that it is in urgent need of help. Although health care systems in the two countries differ, there are some similarities between the UK and Thai training programs. Successful components of UK training programs could be considered when reviewing the Thai approach.

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