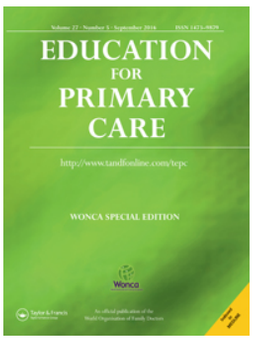

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LEADING ARTICLE

Primary care education: medical student and young doctors' perspective from Brazil, India and Portugal

Raman Kumar[a], Ana Nunes Barata[b] and Mayara Floss[c]

[a]Academy of Family Physicians of India, New Delhi, India; [b]UCSP Buraca, ACES Amadora, Lisbon, Portugal; [c]Faculdade de Medicina, Universidade Federal do Rio Grande, Rio Grande, Brazil

ABSTRACT

This opinion paper is a collaborative effort describing recent developments in primary care education in three different countries; representing diverse socioeconomic and political systems. The authors describe their respective perspectives from the point of student (Brazil), trainee (Portugal) and young doctor (India). The section on Brazil focuses on the response of the medical education system to the developments before and after political reforms, leading to creation of the Unified Health System. The Indian experience focuses on the challenges faced by recently qualified doctors and ongoing debates about the medical education system in a highly populated but rapidly growing economy. The Portuguese section presents an evolving primary care education system for family doctors and describes the detail of the training programme. Education in primary care is an ever-evolving process that needs to be adequate for each country's health care system. Reading and learning from other experiences may highlight education strategies that may be adopted by peers from other countries. Medical students, doctors in training and recently qualified doctors are the key stakeholders in this process.

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India; Portugal; Brazil; primary care; education; family medicine; general practice

Global collaboration: medical students, trainees and recently qualified primary care doctors

Globally we see an increased effort to improve primary care. Momentum is building up for reforms in medical education systems to meet future healthcare challenges. With rapid advancement of information technology, the process of globalisation is spiraling faster than ever; various global networks of professionals are facilitating intercultural peer learning.

The seven young doctors' movements (YDMs) of WONCA (World Organisation of Family Doctors) have developed a global exchange programme for young general practitioners and family physicians called FM360°.[1] The aim of the FM360° programme is to promote worldwide intercultural exchanges to give primary care doctors an opportunity to learn from each other in different cultural and socioeconomic contexts. Medical students are also actively involved with this process through various other initiatives such as (a) Rural Family Medicine Café (b) World Rural Medicine Student Network and (c) Rural Health Success Stories.

Brazil, India and Portugal: developments in primary care education

This opinion paper is a collaborative effort describing recent developments in primary care education in three different countries; representing diverse socioeconomic and political systems. The authors describe their respective perspectives from the point of student (Brazil), trainee (Portugal) and young doctor (India). The section on Brazil focuses on the response of the medical education system to the developments before and after political reforms, leading to creation and strengthen of the Unified Health System. The Indian experience focuses on the challenges faced by recently qualified doctors and ongoing debates about the medical education system in a highly populated but rapidly growing economy. The Portuguese section presents an evolving primary care education system for family doctors and describes the detail of the training programme.

Medical education for primary care in Brazil: a student perspective

Since the 1970s Brazil's approach to medical education can be described as a mosaic of experiences of changing paradigms. Since the establishment of the first two medical courses in Brazil in 1808, medical education has remained hospital-centric.[2] A challenge remains in Brazil to change disease-oriented, hospital-centric, dehumanised medical training to an approach that is

CONTACT Raman Kumar dr_raman@hotmail.com

more comprehensive, humanistic, socially-committed and focused on primary care.

In 1976, residency programmes in Community General Medicine (CGM) in Recife, Porto Alegre and Rio de Janeiro were initiated, however their impact remained localised.[3] The democratisation of the Brazilian Health System took place in 1990, with the creation of the Unified Health System (Sistema Único de Saúde, SUS) with underpinning principles of social accountability, equity, equality, decentralisation, integrality and health promotion.[4] The Comissão Interinstitucional Nacional de Avaliação do Ensino Médico, which was composed of representatives of groups of medical educationalists, recommended comprehensive transformation of medical schools, with the development of curricula to prepare medical students to meet the major health needs of Brazilians.[5] Since 2001, the National Curriculum Guidelines for Medical Schools (DCNs) has changed the training paradigm; rendering it more oriented to the needs of primary care.[6,7] It was marked by the creation of three programmes that aimed to improve Primary Care;

(1) The Life Experience and Elective on the Reality of SUS (Vivência e Estágios na Realidade do Sistema Único de Saúde – VER-SUS) a Ministry of Health programme created in 2002 to give to students an immersion experience of the SUS for one to two weeks.
(2) The President's Support Programme for the Restructuring and Expansion of Federal Universities (REUNI), created in 2007 to consolidate a national policy to expand the higher education system, within a decade, to at least 30% of those aged 18–24 years.
(3) Pró-Saúde (translated as 'Pro-Health'), a national programme created by the Ministries of Health and Education in 2005 to re-orientate healthcare professional training.[5]

CGM residency programmes were further strengthened in 2002 by the creation of the Family Health Programme (Programa Saúde da Família, PSF). The PSF structure consists of Primary Care teams generally comprising of one doctor, one nurse, one auxiliary nurse, and four to six community agents, and has been demonstrated to have a positive impact on the health system.[3] Subsequently the CGM name was changed to 'Family and Community Medicine' which now plays a key role in Primary Care in Brazil.[3] However despite these achievements, primary care still faces an uneven distribution of professionals among the poorest, rural and isolated populations. To address inequitable access to primary care the 'Mais médicos' (More Doctors) project was introduced in 2013. This involved contracting more doctors (mainly from other countries) in a context of infrastructural improvements, primary care oriented changes in DCNs, and increasing the number of medical courses and residency programmes, including increasing the value of residency grants.[7]

Challenges remain relating to hospital-centric care, underfinancing and privatisation of healthcare, privatisation of medical education and universities; lack of professional role models working and teaching in primary care; and the impact of market forces regulating the health system rather than population needs.[8,9]

It is interesting to note the crucial role of undergraduate students while these developments were happening, with representation through local and national organisations like DENEM (National Executive of Medical Students). In a context of political crisis which threatened to dismantle the SUS, the impact was immense.[10] These local student initiatives were organised through community projects based on popular education and family health leagues. Since the 1970's, 'Freirean', or popular education has a central role in developing community empowerment; this is based on the idea of 'constructing knowledge' and not 'imposing knowledge', leading to mutual empowerment of students and communities.[11] The family health leagues were groups organised by students, through the forum of the Brazilian Association of Leagues of Academic Family Health and Community (ALASF), which has more than 50 registered leagues.[12]

Medical education in India: perspective from young medical professionals

Several political, social and economic changes have taken place during past three decades in India; which in turn also have impacted on the healthcare delivery system, medical education and the medical profession as a whole. A career in medicine has always been considered a respected and lucrative profession. Indian doctors have contributed to the workforce of developed countries such as the USA and the UK. This period has also been marked by the rise of specialty and subspecialty health facilities, few of which are of international standards. Due to rapid economic development, these healthcare facilities are concentrated in the urban and metropolitan areas. India has emerged as a popular destination for medical tourism. As an industry, healthcare is booming and is considered a billion-dollar industry.[13] However the industrial growth in the health sector has not translated into better prospects and prosperity for all medical doctors, especially those that have recently qualified. Gone are the days when doctors were the top earning professionals of society – their positions have been replaced by corporate managers and IT professionals.[14] Medicine is also now considered a

tedious, time-consuming career path taking up long years of youthful lives and professional income comes very late when compared the other professions.

The toughest challenge that today's medical students and young doctors face is a lack of career development after MBBS (undergraduate training). By default the numbers of postgraduate residency positions are very limited. For 53,330 MBBS graduates, less than 25,000 post graduate positions are available for postgraduate training.[15] Due to recent trends in society, industry and peer-recognition, most new medical graduates would wish to enter into a clinical postgraduate specialty programme, which are few in number. As a result, thousands of fresh medical graduates stagnate and prepare for postgraduate entrance tests instead of fruitfully engaging with the health system.

There is an assumption that surplus MBBS graduates (surplus to the number of available specialist training posts) would by default become generalist primary care doctors, however this is not happening due to intrinsic problems in the design of the medical education system. Traditionally public health and primary care domains are not strong within mainstream medical education. Academic general practice or family medicine (FM) does not figure in the MBBS curriculum, although it is a recognised postgraduate medical qualification in India. Family physicians and primary care doctors cannot become medical teachers due to regulatory restrictions.[16] The phenomenon of postgraduate residency training in FM is a recent development and has been gradually gaining ground due to a push from government policies, such as the National Health Policy in 2002, however implementation is slow. A few hundred postgraduate residency training positions in FM now exist.[17]

Opening departments of family medicine/general practice will provide a mechanism to let young medical professionals shift to community-based health system instead for facing the bottleneck of progression in a tertiary care system. Reforms in the medical education system are currently under heated debate, and many of the senior agencies such as supreme court of India, the Indian parliament and the policy commission deliberating upon the matter.[18]

Family medicine education and training in Portugal

Education in primary care in Portugal has been under development in recent decades. It is established as an assignment in medical schools and includes clinical rotations in family medicine. After medical school, in order to be a family doctor, applicants need to enroll in a FM residency training programme.

The national FM residency training programme was established in 1987 and currently there are seven regional coordinators who manage residents' training throughout the country.[19] Training in FM in Portugal is over four years and is constructed in a way that the resident attains progressive autonomy when doing consultations. On completion of training, the trainee should be able to do consultations autonomously, within the expected time of a senior family doctor. The programme follows a specific structure that is organised into timeframes during which trainees work on Primary Care-related activity and rotate through secondary care settings. Secondary care rotations include compulsory rotations (Paediatrics, Obstetrics and Gynecology, Emergency Medicine and Psychiatry) and elective rotations. The electives are chosen by the trainee, allowing them to build their own residency training programme, tailored to their interests. In some circumstances, trainees are allowed to organise an elective rotation as an exchange in Primary Care in a different country.[20]

Compulsory rotations have outlined specific learning objectives and the trainee needs to make sure that he or she complies with all of them. For elective rotations trainees list their learning objectives prior to their rotation. After every rotation, trainees are expected to write a report on their activities and be assessed on their attained knowledge. These assessments are a condition of progression in the training programme. A failed assessment will result in an inability to progress in the programme until it is successfully retaken. At the end of the programme, all residents take a national exam which has three parts: a theoretical exam, a practical exam and a curricular exam. The marks obtained in all three results in a final mark for residency training. This mark allows ranking of candidates at a national level when it comes to choice of placement.

Following placement for some years, family doctors may opt to take a further exam that will allow them to progress in their career. In this assessment, family doctors have to present an updated curriculum, containing all their scientific activity up to that point.[21] One may therefore conclude that curricular activity has a strong significance in Portugal. Consequently, it promotes participation in relevant scientific events as well as the extensive production of scientific material (be it in the form of posters, articles, oral communications, etc.).

Furthermore, we are also seeing the rise of family doctors who seek elective post-graduate training provided by Universities in the form of courses and higher degrees (M.Sc. and Ph.D.). This phenomenon is supporting the development of family doctors in Portugal, allowing them to provide better care to the population.

Conclusion

Medical education in each of the described countries is in a dynamic state. In spite of the structural challenges, there is a global trend to shift from the existing model of disease-focused, organ-based and hospital-centric care and its associated educational system, towards a more comprehensive, person-centered and community-based approach. Education in primary care is an ever-evolving process that needs to be adequate for each country's healthcare system. Reading and learning from other experiences may highlight education strategies that may be adopted by peers from other countries. Medical students, doctors in training, and recently qualified doctors are the key stakeholders in this process.

Disclosure statement

No potential conflict of interest was reported by the authors.

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