

Perceptions towards private medical practitioners' attachments for undergraduate medical students in Malawi

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Abstract

Objective To describe perceptions of medical students, recent medical graduates, faculty of the College of Medicine, University of Malawi and private medical practitioners (PMPs) towards an attachment of undergraduate medical students in private medical doctors' offices.

Method Qualitative cross sectional study conducted in Blantyre, Malawi in 2004 using in-depth key informant interviews and content analysis.

Results In general, private medical practitioners were favourable to the idea of having medical students within their consulting offices while the majority of students, recent graduates and faculty opposed, fearing compromising teaching standards. The lack of formal post-graduate qualifications by most private medical practitioners, and nationally-approved continued medical education programs were mentioned as reasons to suspect that private medical practitioners (PMPs) could be outdated in skills and knowledge. Private medical practitioners however reported participation in credible continued professional development (CPD) programs although these were not necessary for re-registration. Students and faculty suggested that the need for privacy in private institutions unlike in the public teaching hospitals as one reason why patients may not be willing to participate in the teaching in PMPs facilities. The fact that the patients profiles with regard to disease presentation (mostly ambulatory) and higher socio-economic status may be different from patients attending the public, free for service teaching hospital was not seen as a desirable attribute to allocate students to PMPs clinics.

Conclusion Faculty, medical students and recent graduates of the Malawi College of Medicine do not perceive PMPs as a resource to be tapped for the training of medical students.

Introduction

Malawi's health system suffers from inadequate health human resources. The bulk of clinical care services is provided by medical assistants, clinical officers and nurses^{1,2}. The majority of medical doctors in the country work in urban areas. The few medical doctors in rural districts, medical doctors mostly work in denominational hospitals or as district health officers providing administrative and some clinical services.

Formal health services in Malawi are largely provided by the public sector (61%) and denominational health facilities under the Christian Health Association of Malawi, CHAM (37%). Other formal health providers include non-governmental organizations (NGOs), firms/companies, private hospitals, local government and the uniformed forces, thus contributing about 2% of the care³. The private sector is also largely

serviced by medical assistants and clinical officers; medical doctors are in the minority.

Mathers et al⁴ in their study in the UK reported that patients enjoyed interaction with students attached to general practice offices. The authors however, also highlighted the resource implications of students' attachments to PMP facilities which may act as a disincentive to effecting such a program. Betham et al, 1999⁵ have reported that 98% of patients perceived no disadvantage of being seen by a student, 35% reported an advantage and 98% were willing to be seen again by a student when within a private medical practice. Whether patients provide consent or not is another concern when private practice settings are used for teaching and exposure of students. Kljakovic and Parkin⁶ however report high consent rates among patients in a New Zealand setting.

Fraser⁷ reported that student learning in private medical practice setting may be limited by the fact that PMPs may not perform as many procedures as may be required for student training. However, mentoring of students by PMPs in practice has been found to be useful for trainees⁸, as students may be exposed to useful skills that may not normally be the case in hospital-based clinical training. The benefits, dos and don'ts of mentoring between faculty and medical students have been described by Rose et al⁹. These includes the need for mentors to focus on the mentee's professional development rather than perceiving the latter (mentee) just like cheap labour. The student should also recognize that they are under the supervision of the mentor to meet professional development goals and are subordinate to the mentor. Mentees who are overly dependent may also tax the mentor-mentee relationship heavily.

Although the curriculum of the College of Medicine (COM) is community-oriented as has been reported by Broadhead¹⁰, experience by students within private medical practice has not been part of their training. Practical community experience is achieved through clinical attachments to rural district hospitals and health centres, living with rural communities and conducting community research¹¹. Private medical practices mostly operate in the urban areas, run by medical doctors, the majority of whom are non-Malawian trained. They serve an important niche within the country where they provide care to a growing proportion of Malawians in the middle and upper socio-economic classes. Clinical officers and medical assistants, although they can operate private practice are not legally defined as medical practitioners, but rather paramedical health workers.

Among the medical doctors who have graduated from the University of Malawi, College of Medicine, less than five have gone into sole private medical practice. The rest are either in postgraduate training within the country and abroad or employed by organizations within the country. There are also only a few other specialist doctors that have ventured into self-employment. Studies are required to explore why medical graduates of the College of Medicine (Malawi) do

not readily join the private health sector as self-employed medical practitioners, as sole or in group practices. The Ministry of Health and the College of Medicine continue to be the largest employers of medical doctors in Malawi.

A cross sectional qualitative study was conducted to explore the perceptions of medical students, doctors (interns, senior house officers, specialists, and private medical practitioners) towards involving private medical practitioners in the training of medical students in Malawi. Most of the clinical teaching of medical students occurs at the Queen Elizabeth Central Hospital (QECH) in Blantyre. Community training is provided in district and community health centres run by the Ministry of Health. For the purposes of this study, private medical practitioners were as defined by the Medical Council of Malawi, who are medical doctors having registered themselves as private medical practitioners. In Malawi, the basic medical degree i.e. Bachelor of Medicine, Bachelor of Surgery (MBBS), and completion of an approved internship program are adequate for one to be registered as a private general practitioner. This is unlike elsewhere, for instance the UK for example where general practice is a specialty requiring formal postgraduate training^{12,13}.

Materials and Methods

This was a qualitative cross sectional study utilizing key informant semi-structured in-depth interviews. Interviews, lasting about 60 minutes, and were audio-taped and transcribed. Content analysis¹⁴ was used to identify themes and statements that were considered pertinent. The study included medical students, faculty and some PMPs (from Limbe and Blantyre). Limbe is situated about 6 kilometres from the College of Medicine. The following groups participated in the study: 14 medical students, 6 medical interns, 5 medical faculty members and 6 doctors in private practice and 6 graduates of the COM living outside the country. After the collection and analysis of data collected from study participants within the country, the major themes were presented to six medical graduates of the COM, not resident in the country at the time of the study for them to comment on the interim findings. Study participants were identified purposively for all categories except medical students who were identified randomly. Among the faculty, one was current dean and 3 previous deans, and one head of department. The interns were those available in Blantyre at Queen Elizabeth Central Hospital during the period of the study. All PMPs in Blantyre were eligible for study, but eventually three were not available to participate.

Clinical attachment within the private medical practitioners consulting officers was defined as having a medical student “shadowing” or doing clerkship responsibilities within the private practice for training purposes. Our definition of private medical practitioners excluded specialist doctors in private medical practice.

Ethical Considerations

Ethical review and clearance for our research proposal was obtained from the University of Malawi College of Medicine Research and Ethics Committee (COMREC). Verbal informed consent was obtained from each of the participants. Each of the study participants was interviewed in private.

Results

Generally, the idea to involve PMPs in the teaching of undergraduate medical students at the College of Medicine was perceived favourably by the PMPs. While there were mixed feelings from medical students, intern medical doctors and faculty, the majority was not in favour of incorporating private medical practitioners in the teaching of medical students. The reason mostly provided was that the quality of teaching and knowledge, skills and attitudes to be provided to medical students by private medical practitioners would be compromised. Although the six medical graduates living abroad were more accommodating of the idea, they still expressed reservations of concern about lowering standards.

In the case of fear of compromising teaching standards, an intern medical doctor said:

Assuming there was need to involve them and that they are well qualified to teach, it would be a good idea. However, Malawi has very few well qualified private medical practitioners who are well updated to teach students based on current knowledge.

12 of 14 medical students and 4 of the 5 interns also reported that PMPs were mostly motivated to maximise profits at the expense of high quality medical care. This was viewed as compromising the quality of teaching as students are likely to copy poor clinical practices. There was also perception that the need to make more money would mean that private GPs would not be dedicated to the teaching of medical students, as this responsibility would not likely bring them high financial returns.

An intern doctor said:

Most of the private medical practitioners are aimed at making money than teaching and it would be difficult to dedicate their teaching at the expenses of making money.

A faculty member said:

Most GPs (general practitioners) in Malawi are purely business-oriented, to make money. They can prescribe as many drugs as the patient can buy.

The perceived lack of adequate current knowledge for PMPs was explained as due to the lack of mandatory continued medical education (CME) or continued professional development (CPD) for re-registration by the Medical Council of Malawi at the time of the study.

The PMPs, while accepting that they have to make money as compensation for their services to the community, argued that the quality of care within their practices was not of low standards.

A private medical practitioner reported:

Well, yes patients may demand a certain drug because they know the name of the drug they have heard about or they have been told that it is effective. But as a practitioner you try to convince them, try this one it is still effective. But if they insist, you may give it to them because they have the money. But you still tell them this is still effective. Well, it really depends on the practitioner.

GPs also indicated that the perception that they (the private medical practitioners) are not updated with knowledge was not representative of all PMPs. One PMP said:

It depends on the individual. If the person is not interested to update their knowledge then they can not impart anything. What you learned twenty years ago may not be current on the market. If somebody is not interested in reading, I have my doubts that person will be interested in teaching. You don't attend clinical meetings, conferences,

you don't get updated, it will be difficult for you to teach.

Private medical practitioners reported that may not be as outdated as perceived by faculty, medical students and intern doctors. All the private PMPs interviewed reported involvement in CME activities with most of them reporting involvement at sessions at a reputable large private hospital in Blantyre. The COM and Ministry of Health were also reported to offer workshops for private medical practitioners, which the private medical practitioners had attended. In addition, a few PMPs showed evidence of CME refresher courses they had attended in South Africa.

A graduate of the COM, but living abroad while highlighting the need to maintain high standards also reported that the COM was already using tutors who were not specialist medical doctors in the teaching of medical students. He said:

The issue is at what level of teaching should the GPs be involved? I can recall at QECH (without student consent) being taught some skills by a Clinical Officer in anaesthesia, dermatology, orthopedics. These COs (clinical officers) were chosen because they demonstrated enthusiasm, interest and practical knowledge in these subjects. Having said this, the bottom line was there was a shortage of qualified medical teachers! If there are still COs involved in sub-specialty clinical teaching, then there should be no argument against letting local private medical practitioners be involved.

Another medical graduate living abroad however felt otherwise. He reported:

My view is that in any academic institution, teaching must be done by academics! That's why they are there. In the case of the College of Medicine, it depends on what area you are talking about. For instance, internal medicine must be taught by specialists in Internal medicine etc. If there is a private medical practitioner who is a specialist in Internal medicine, then he must apply to the college.....

I mean it's the same thing here, a medical consultant in a teaching hospital no matter how senior cannot supervise a PhD student if he doesn't have a PhD. So really we must be very careful on who teaches who, lest we lower our standards!

A faculty member reported:

Basically specialists think private medical practitioners are simply generic low level doctors whereas private medical practitioners have themselves developed a specialty of their own with skills and competencies which other specialty doctors do not have. Family Medicine does indeed require a whole set of skills, attitudes values and knowledge. This is true anywhere including Malawi, although it is not a priority specialty here yet.

Benefits of using private medical practitioners

There were several perceived benefits of using PMPs in the teaching of medical students. A private medical practitioner said:

It will be beneficial to both the private medical practitioners and students. Medical practitioners have vast experience and we have practical experience than many of the faculty at the College. We would also like to brush up our knowledge.

Another PMP said:

The approach of the patients in the private sector is slightly different from the approach to the patients that are seen in the hospitals. Secondly, we do not see as many very sick patients and a doctor should know how to treat different types of patients.

The involvement of PMPs was seen as a way to reduce the

load of teaching by the current numbers of staff at the COM. However, although the COM was planning to increase the number of teaching sites for senior clinical students, a previous dean, referring to a possible involvement of private medical practitioners said:

It was discussed during my time as dean but the idea was shelved because we had very few students and enough members of staff such that there was no need to do that. However, looking at the student intake now, the shortage of staff in the college is planning to have another teaching place but not the private sector.

Private medical practitioners also indicated that if they could obtain some certified post-graduate qualifications, then it would be a motivation for them to participate in any proposed program of teaching medical students.

Patients' unwillingness to have students at private clinics

A professor at the COM said:

Some patients can not allow exposure to students for teaching, while some might probably accept hence the need to carefully look into this and come up with probably two wings for patients; teaching wing where those patients who can accept exposure to students and the non-teaching wing as the opposite.

A private medical practitioner commented:

Private practice is something different that is why it is called private practice because of the confidentiality that we keep all the time. The patients will not be comfortable with the medical students sitting by my side watching him or watching her because they come with various problems which they can not even disclose to each and every one. Privacy is the biggest factor in the private practice.

However, the need for utmost privacy that may lead to students to be excluded was not universally accepted. A PMP commented:

My practice is mainly paediatric practice and I doubt there will be many patients who will mind. But if it is the case, then we have to work something around that.

Interestingly, faculty members and medical students interviewed almost always suggested that while privacy was essential at a private clinic, it was not so at the teaching hospital. A student suggested:

People who go to private medical practitioners want their privacy, unlike at Queens (QECH).

Lack of appropriate clinical exposure

It was suggested by 3 faculty members of the COM and some students that the private medical practitioners' attachment would not provide the requisite clinical exposure for medical students. A student reported:

Public practice will not prepare us on what we are likely to face in the future as most of us are likely to work in public institutions.

Private practice was described as different in terms of the socio-economic characteristics of the patients as well as the range and severity of conditions that students are likely to meet. At QECH, students mostly have exposure to non-ambulatory cases unlike in private practice where the majority of cases are likely to be ambulatory. There was also suggestion by medical students that some private clinics have fewer patients than the QECH and therefore students would not have adequate exposure to a diversity of cases.

It was also suggested by 2 students that when students are

attached to private medical practice, there would be inadequate human resources at the public institution as students provide much needed, but limited care to patients.

Compensation to private medical practitioners

One private medical practitioner suggested that he would not require any compensation in order to participate in the teaching of medical students. Others suggested that they would need to be paid according to whatever the current compensation practice at the COM for part-time staff. Postgraduate certificate and diploma courses would also be one way of compensating the PMPs. A faculty member of the COM suggested that GPs could be recruited as honorary lecturers. Honorary lecturers are only reimbursed for direct expenses related to their work. A PMP reported:

You see in the past long time back there were a number of doctors who were doing part-time work at QECH. There would do every afternoon in the hospital and I do clinics in the morning. Then the government brought it a rule that the doctors either get employed in government or concentrate solely in private practice. They were doing that not for the sake of earning anything. In fact there were not earning anything. They were doing that just for contribution to the community.

Discussion

This study aimed to describe the perceptions of medical students, graduates and faculty members of the Malawi College of Medicine and private general practitioners in Blantyre, Malawi on the idea of using private medical practitioners in the training of medical students in Malawi. In general, the majority of medical students, graduates and faculty members were not in favour of incorporating PMPs in the teaching of medical students citing fear of compromising standards of teaching. Private medical practitioners however, were more likely to support such an initiative.

Margolis et al¹⁵ reported that in Queensland, Australia, there was no statistical difference in core clinical knowledge and skills between students attached to large teaching hospitals and those attached to private general practitioners. This was possible when particular attention was given towards internet connectivity for access to CME and regular visits by medical specialists for supervision.

The lack of a formal requirement of CPD or CME for re-registration of medical practitioners in Malawi has been described before¹⁶. The fact that there is no requirement for postgraduate training of private medical practitioners for their recognition and registration was a hindrance towards their acceptability in the teaching of medical students. Since the completion of the study, the Medical Council of Malawi has introduced CME or CPD requirements for re-registration of medical practitioners in the country. It remains to be explored if such CPD requirements have reduced the concern among faculty and students at the COM that the knowledge and skills of private medical practitioners were outdated.

The concern for upholding the standards of teaching of medical students is a legitimate concern. However, the view that PMPs were outdated seemed to arise out of lack of interaction and therefore knowledge about what is going on in the private health sector by some members of the COM. During the study, we were shown schedules of CME programs, certificate of attendance to training

courses/workshops, medical journals and recent books by the private medical practitioners. Although these were not required for registration, the PMPs reported attending meetings, including in South Africa at significant financial cost to themselves. It was also interesting to note that there was medical college faculty resistance to involving PMPs in the teaching of medical students even without the study participants being told what was it that the PMPs would be teaching the students.

The perception by medical students and faculty that respect for patients' privacy should be an issue in a private care setting but not in a public teaching hospital is interesting. Ideally, this need not be the case though as privacy and confidentiality ought to be respected at all times and in all settings in the care of patients. Public teaching hospitals ought not to be associated with diminished sense of privacy or confidentiality. In a designated public teaching hospital, patients need to be aware that they may be requested to be involved in the teaching of students. However, this can also be done in a designated private care setting where students may be attached to.

It may be true that the socio-economic conditions, the range and severity of clinical cases seen at the QECH, the main clinical teaching facility of the COM may be different from those seen in the PMP clinics. The QECH, although also serving as a district hospital for Blantyre, is essentially a tertiary care level facility. While students and faculty perceived the difference between QECH and PMP facilities in the negative sense, we believe it should be all the more reason that attachment to a PMP clinic may be useful for medical students. Medical students in Malawi continue to be exposed to, mostly in-patients and the low socio-economic groups of society. While this is usually the situations they may work in upon graduation, things need not remain the same. Medical students in Malawi need to broaden their horizon and feel confident to practice in the private sector, and among a different socio-economic group of the community than there are normally exposed to at the QECH. In addition, clinical attachments at private medical facilities should not replace, but rather complement the training that they are already receiving at the QECH.

That some private clinics may not so busy is possible.. But this can also be an advantage, unlike at QECH where the practice is just to spend a few minutes on a patient as the clinical workload is so heavy, fewer patients in the private sector may provide opportunity to not only provide holistic care but also provide critical time to reflect on cases between clinical teachers and students.

It would seem that although the College of Medicine's medical curriculum has been designed as community-oriented and based¹⁰, experience within the community-based primary private health care facilities has been neglected. The spirit of primary health care (PHC) has been limited to some experience in the public health sector, serving the poor. Of course this could be understandable as the public health sector serves the majority of the population. We believe however that medical doctors should be skilled and comfortable in taking care of both the poor as well as the not so-poor, in public as well as private health facilities.

It was also interesting to note that some PMPs were even

suggesting rendering a service at little or no pay. Barrit et al¹⁷ reported that rural PMPs in Australia were willing to participate in the teaching of medical students if accorded academic status, quality assurance points of their clinics and limited financial reimbursements. Some of the PMP participants reported altruistic tendency and search for knowledge and intellectual pursuit as possible motivation for teaching medical students. Dahlstrom et al¹⁹ have also documented these motivations among senior clinicians teaching medical students. Private medical practitioners, if well trained and supervised by medical school faculty, can be a useful, less expensive way of training students in skills that may not be possible or effectively done at the public teaching facility.

We believe the brain drain of medical doctors that the country is facing¹⁸ could, in part be reduced if medical graduates from College of Medicine could have clinical exposure to private practice. This would possibly encourage graduates from the COM to choose a career in private practice, earn more than in the public sector, obtain job satisfaction if this is the setting they would rather practice and be retained in the country. Of course this suggestion is speculative but seems plausible.

If private medical practitioners were to be involved in the teaching of medical students, there is need to formulate clear guidelines for their selection, including academic and professional qualifications and experience. Training and supervision and clear job descriptions must be provided. The introduction of a mandatory CME requirement for re-registration of doctors in Malawi which was long overdue, will also help to improve the knowledge and skills of medical practitioners in the country, but much more so those involved in student teaching. In addition, not all PMP facilities could be suitable for teaching medical students. Clear criteria for private medical facilities to be used for teaching also need to be discussed.

The Malawi health sector should consider seriously on how to provide specific training above that of the general medical degree to enhance the quality of care for patients. It is of particular interest that while the COM offers limited specialist programs in Internal Medicine, Paediatrics, General Surgery, and Obstetrics and Gynaecology, the same attention has not been paid towards specialist general or family practice programs. The reasons why specialist general practice training has not been developed in the country are unknown to us. However, the COM has probably prioritized its specialist training programs within the available limited resources²⁰. The career prospects of a general practitioner specialist doctor within the Ministry of Health are unclear. This may act as a disincentive for the creation of postgraduate training programs for doctors in Malawi. In addition, general practice training may not be the perceived immediate need for the country's health system. There is need however for the establishment of specialist general practice training in Malawi. Finally, role models which are crucial in the shaping of medical students' careers will only be created if student interaction with private medical practitioners is improved²¹.

Limitations of the study

This study was limited to obtaining perceptions of faculty members, students and intern doctors and a selection

of graduates of the COM living abroad. The views of patients who are important stakeholders in this discussion are missing. Future studies on this topic need to incorporate collection of patients and the general community's perceptions. In addition, the choice of faculty members and medical graduates interviews was convenient. To the extent that those interviewed were not representative enough, our results could be biased. However, the fact that a diversity of opinions were obtained, suggests perhaps that many constituencies were interviewed.

Conclusions

In general, other than the private medical practitioners themselves, medical students, medical graduates and faculty of the College of Medicine did not support involving private medical practitioners in the teaching of medical students. There is need to explore the provision of graduate training for private medical practice so that their role in the teaching and mentoring of medical students can be harnessed. Medical students and faculty have misconceptions about private medical practitioners' level and access to continued medical education, and this probably shaped their overall perceptions.

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He further explained that doctors decide which patients need an MRI and once the decision is made, the patient comes to the MRI unit in person to be booked, and during this time, they make sure the MRI is safe for the patient in question.

Patients who have metallic materials within the body are advised to notify the MRI staff because this can significantly distort the images obtained by the MRI scanner. Similarly patients with artificial heart valves, metallic ear implants, insulin pumps are advised not to have an MRI according to www.medicinenet.com.

The advantages of the MRI compared to x-rays, ultrasound or CT scan (other imaging methods) available at QECH, Dr Kampondeni explained are that MRI shows better soft tissue characterization and that its accurate in detecting structural abnormalities of the body and further still the patient avoids X-ray radiation exposure.

The MRI machine is owned by the College of Medicine, University of Malawi but will also help Michigan State University physicians who are doing research on cerebral malaria in Malawi where the vast majority of malaria patients are children. This will enable them to get a closer look at the damage malaria does to a child's brain, something that, before the coming of the MRI was only done in an autopsy.

Not only will the MRI machine be the first in Malawi, it will also serve the neighbouring countries of Mozambique and Zambia, neither of which has an MRI. The total value of the donation was more than \$1.3 million which included transportation costs, various hardware, software and other MRI necessities.

