Perceptions of medical students, faculty and private GPs towards the utilisation of private GPs in the teaching of undergraduate medical students in Malawi

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Through institutions in the region, EQUINET has been involved since 2000 in a range of capacity building activities, from formal modular training in masters courses, specific skills courses, student grants and mentoring. The capacity building activities in EQUINET are integrated within the existing areas of work of the network or build cross cutting skills demanded across themes by institutions in the network. The papers and reports produced in these training activities are products that are used to support or target mentoring. This report has been produced within the student grant programme and is disseminated in this context. It is not a formal EQUINET discussion or policy paper.

1. Abstract

A qualitative study was conducted in Malawi to describe the perceptions of medical students, recent medical graduates, faculty members of the Malawi College of Medicine and private general practitioners (GPs) towards a proposed utilization of GPs in the teaching of undergraduate medical students. General Practitioners welcomed these proposed changes whilst the majority of students, recent graduates and faculty were opposed to this idea. General practitioners were perceived not to be able to adapt to the culture of public teaching hospitals.

2. Introduction

Malawi's health system suffers from inadequate health workers. The Malawi government has over the years failed to take human resources for health seriously, choosing to only increase financial and material resources to the health sector without attempting to address the needs of its health workers. In addition the bulk of clinical care is provided by medical assistants, clinical officers and nurses (Adeloye, 1993; Fenton et al, 2003). Most of Malawi's 250 medical doctors are working in urban areas. The few medical doctors in rural areas work in denominational hospitals and as district health officers. The public sector provides 61% of the formal health services, whilst denominational health facilities under the Christian Health Association of Malawi, CHAM provides 37%. Other formal health providers include non-governmental organizations, firms/ companies, private hospitals, local government and the uniformed forces (MoHP, 1999). The private sector is largely serviced by medical assistants and clinical officers, with medical doctors in the minority.

In a UK study students reported that patients enjoyed interaction with students attached to general practice (Mathers et al, 2004). In another study, Fraser (2003) reported that learning in the general practice setting is limited by the fact that private GPs may not perform as many procedures as compared to those performed in a teaching hospital setting. It is not clear if patients being seen by students provide consent under private practice settings. Kljakvic and Parkin (2002), however, reported high consent rates among patients in a New Zealand setting. In Malawi private medical practitioners mainly operate in urban areas and their case load is mainly of ailments of the Malawi well to do.

A cross sectional qualitative study was conducted to explore the perceptions of medical students, doctors in both public and private practice on the involvement of private medical practitioners in teaching medical students in Malawi. For the purposes of this study, private medical practitioners were defined as individuals that are self-employed. In Malawi, the basic medical degree e.g. MB BS or MB ChB and completion of an approved internship program are adequate for one to be registered as a private general practitioner and for one to run a private practice.

3. Materials and methods

This report records the findings of a qualitative cross sectional study utilizing key informant in-depth interviews. Content analysis was used to identify themes and statements that were considered pertinent. The study was conducted in Blantyre (for medical students, faculty and some GPs) and Limbe (one private GP). The categories of

medical personnel recruited into the study were as follows: 14 medical students, 65 medical interns, 5 medical faculty members and 6 doctors in private practice.

4. Ethical considerations

Ethical clearance 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.

5. Results

Generally, the idea to involve private GPs in the teaching of undergraduate medical students at the Malawi College of Medicine was perceived as favourable by the GPs, whilst, there were mixed feelings from medical students, intern medical doctors and faculty at the College of Medicine. Most of the medical students were not in favour of the involvement of GPs in teaching of medical students. The reasons mostly provided were that the quality of teaching and the knowledge, skills and attitudes to be obtained by medical students would be compromised.

5.1. Fear of compromising standards

An intern medical doctor said:

> *Assuming there is a need to involve them [GPs] and that they are well qualified to teach, it would be a good idea. However, Malawi has very few well qualified private GPs who are well [informed] updated to teach students based on current knowledge.*

Medical students and interns also reported that the main focus of private GPs was to make money even at the expense of quality of care. Students were likely to learn this bad habit. An intern doctor said:

> *Most of the GPs 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 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 by GPs was seen as a result of lack of continued medical education.

The GPs, 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 of acceptable standard.

A GP 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 matter. But*

you still tell them this is still effective. Well, it really depends on the practitioner.

GPs also indicated that the perception that they [GPs] do not have current knowledge was not factual. One GP 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 different for you to teach.

It was also reported that the knowledge of GPs in Blantyre might not be as outdated as perceived by faculty, medical students and intern doctors. All the private GPs interviewed reported involvement in continued professional development (CPD) or continued medical education (CME) with most of them reporting involvement at CME sessions at a large private hospital, the Malawi College of Medicine and Ministry of Health workshops for private medical practitioners. A few GPs showed evidence of CME refresher courses they had attended in South Africa.

5.2. Benefits of using private GPs

There were several perceived benefits of utilizing private GPs:

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 GP 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 doctor should know how to treat different types of patients.

The involvement of GPs would also reduce the load of teaching by the current numbers of staff at the Medical school in Malawi. However, although the Medical school in Malawi was planning to increase its teaching sites, a previous dean 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.

Private GPs 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 they may be involved to teach students.

5.3. Patient unwillingness to have students at clinics

A professor at the Medical School 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 of patients, teaching wing where those patients who can accept exposure to students and the non-teaching wing as the opposite.

A GP commented:

Private practice is something 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 GP 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 GPs want their privacy, unlike at [The Medical School] Queens (QECH).

5.4. Lack of appropriate clinical exposure

It was suggested by some faculty members and students that the GPs attachment would not provide the requisite clinical exposure. 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 situations of the patients as well as the range and severity of conditions that students are likely to meet. At Medical School, students mostly have exposure to non-ambulatory cases, unlike in private practice where most cases are likely to be ambulatory. There was also suggestion by students that some private clinics have fewer patients than the Medical School and therefore students would not have adequate exposure to cases. It was also suggested that the non-use of Medical School by medical students at some stage of their training could lead to inadequate human resources at the public institution as students provide limited care to patients.

5.5. Compensation to GPs

One GP 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 as may be the current practice at the Medical School for part-time staff. Availability of postgraduate certificate and diploma courses would also be one way o compensating the GPs. A faculty member of the Medical School suggested that GPs could be recruited as honorary lecturers. Honorary lecturers are only reimbursed for direct expenses related to their work.

You see in the past long time back there were a number of doctors who were doing part-time work at [Medical School] QECH. There would do every afternoon in the hospital, 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.

There were also suggestions that GPs involved in the teaching could be awarded honorary status within the university.

6. Limitations of the study

This study was limited to obtaining perceptions of faculty members, students and intern doctors but missed out from seeking perceptions of patients.

7. Discussion

This study aimed to describe the perceptions of medical students, recent graduates and faculty members of the University of Malawi and private general practitioners in Blantyre, Malawi on the idea on using the private GPs in the training of medical students in Malawi. In general, most of medical students, recent graduates and faculty members were not in favour of incorporating private practice in the teaching of medical students citing fear of compromising standards of teaching. Margolis et al (2005) 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 such as internet connectivity, regular visits by medical specialists was provided. The lack of a formal continuing professional development program for re-registration of medical practitioners in Malawi has been described before (Muula et al, 2004). The fact that in Malawi, there is no requirement for postgraduate training for GPs for recognition as a GP is an impediment for acceptability of this cadre of health professionals in the teaching of medical students. The perception by medical students and some faculty that respect for patient privacy should be an issue in a private care setting, but not in a public teaching hospital, is interesting. This need not be the case though as privacy and confidentiality ought to be respected all the times and in all settings in the care of patients. Of course, in a designated teaching hospital, patients need to be aware that they may be requested to be involved in the teaching of students at all levels.

It may be true that the socio-economic conditions, the range and severity of cases seen at the Medical School may be different from those seen in the private GP clinics. While students and faculty perceived this in the negative sense, we believe should be all the more reason attachment to a private GP 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 also practice in the private sector, and among

a different sector of the community.

That some private clinics are not so busy is indeed true and only few patients can be seen. But this can also be an advantage, unlike at Medical School where the practice is just to spend a few minutes on a patient as the clinical workload is so heavy. Fewer patients may provide opportunity to provide holistic care but also provide critical time to reflection of cases between clinical teachers and students.
It would seem that although the Malawi College of Medicine medical curriculum has been designed as community-oriented and based (Broadhead, 1998), 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 public health sector, serving the poor. Of course this could be understandable as the public health serves the majority of the population. But we believe medical doctors should be skilled and comfortable in taking care of both the poor as well as the non-poor.

Barrit et al (1997) reported that rural GPs 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.
Finally, we believe the brain drain that the country is facing in case of medical doctors could, in part be reduced in medical graduates from Malawi College of Medicine could have clinical exposure to private practice and would possibly choose a career in private practice, earn more than in the public sector, obtain job satisfaction and be retained in the country.

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Equity in health *implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.*

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
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- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

This report is produced under a training programme as part of a skills building exercise. It does not reflect the views of EQUINET and is not a formal EQUINET discussion or policy paper.

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