

PROCEEDINGS
of the
FIRST INTERNATIONAL
CONFERENCE
ON GENERAL PRACTICE

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Cairo, Egypt

With Best Regards,
M. S. Shekhar
18/12/83

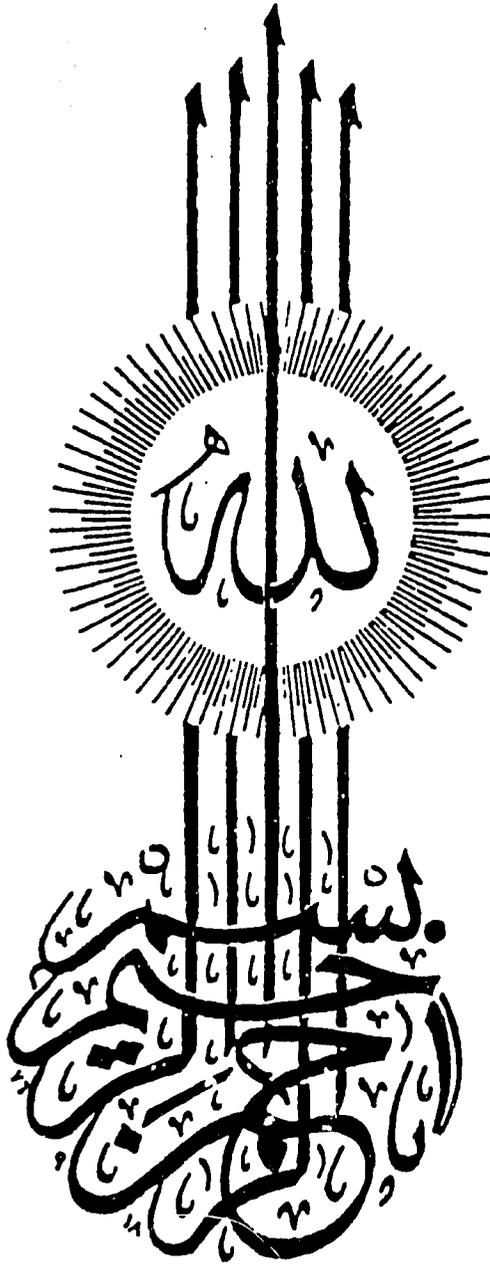


TABLE OF CONTENTS

Opening Session		1
First Panel:	Health, Disease, and Medical Care in Egypt	5
Second Panel:	General Practice in Egypt and Other Countries	13
Third Panel:	General Practice Teaching and Training	25
Workshop A:	Undergraduate Teaching in General Practice	51
Workshop B:	Vocational Teaching and Training in General Practice	71
Workshop C:	Continuing Medical Education in General Practice	85
Fourth Panel:	General Practice Research, Career Structure, and Organization of General Practice Services	105
Workshop D:	Research in General Practice	127
Workshop E:	Career Structure and Organization of GP Services	143
Summary and Recommendations		155
Appendix 1:	Conference Program	163

Editorial Note

These proceedings have been edited to capture the substance of the conference in a brief, readable, and useful document. Portions of the transcript have been translated from Arabic. For purposes of clarity, some changes have been made in the order of remarks within a given session. Repetition has also been minimized. We regret that the technical limitations of the recording precluded transcribing some remarks by participants who spoke at a distance from the microphone. Shortcomings of recording and transcription, as well as the need for a timely document, also made it impossible to identify all the participants. An occasional speaker may be misidentified. Where it was not possible to identify a speaker with reasonable certainty, the terms moderator, panel member, participant, and student have been substituted as appropriate. The reader's tolerance and understanding are appreciated.

Ann V. Goodsell
Editor



WELCOME

Welcome to the first international conference on general practice in Egypt. We hope that this unique gathering will generate a lively and useful exchange of ideas.

Without the efforts of all who contributed to organizing and presenting this program, success would have been impossible. Acknowledgment and appreciation are extended to the individuals and organizations who contributed generously to making this a fruitful and memorable conference.

Dr. Mohamed I. Shehata
Conference Secretary

Dr. Hamdy El Sayed
President, Egyptian
Syndicate of Doctors

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OPENING SESSION

DR. SHEHATA:

This conference coincides with the graduation of the first group of master's degree candidates in general practice in Egypt. It is an unprecedented opportunity to orient and sensitize the medical profession to this new specialty--to its training program and objectives, and to the role of the general practitioner within the Egyptian health-care system and in the medical profession.

We will be talking about achievements and problems in the planning and implementation of general practice training in Egypt, and about the experience of the educators and practitioners attending this conference. We hope that this process will lead to recommendations that will be of benefit to undergraduate, postgraduate, and continuing education, and to research and career opportunities in general practice.

DR. SAMI:

For many years we have been deeply concerned about the situation of the general practitioner in this country. Recently the concept of general practice that is equivalent in stature to any other specialty has been gaining ground in the medical profession, especially among the very young doctors. This change of attitude has been largely due to the untiring efforts of many of our colleagues, particularly Dr. Hamdy El Sayed of the Medical Syndicate, Dr. Shehata, and Dr. Zohair Nooman of Ismailia, who has done truly pioneer work. Other efforts have been less successful, and we must talk about them as well. There is a lot that the Egyptian Medical Association can do on behalf of general practice, and we have already started to cover the country with branches of the Association. I hope that, with the help of our very distinguished visitors and those of us who have had actual

experience in the field, our discussions will point the way toward the next critical steps.

DR. EL SAYED:

It gives me great satisfaction, on behalf of my colleagues at the Syndicate, to address this distinguished gathering organized to discuss general practice and the future of the general practitioner in our country. This has been one of the big preoccupations of the Syndicate since 1970, and the long march has finally come to a successful end with the graduation of the first twelve doctors with master's degrees in general practice from Suez Canal University.

Unfortunately, we are encountering a lot of resistance. Many people predict that this specialty will fail to attract young doctors. I hope that this conference will demonstrate that medical practice in this country will only be upgraded if we take general practice seriously, if we improve the quality of training of our people, and if we can staff our front-line medical services with able doctors, very well trained and highly motivated.

DR. STERN:

What a pleasure it is to be in this marvelous country! On behalf of the foreign visitors who have spent the last two days exploring medical centers in Egypt and learning about your health-care system, allow me to express pleasure at being here with you. I bring you greetings from the Department of Health and Human Resources in the United States, and from the American Academy of Family Physicians, the largest specialty organization in the United States, with 55,000 members.

I would like to clarify the terms general practitioner, family physician, family practice, and primary care. The term general practitioner has been used in the United States since the beginning of medicine; recently, however, the general practitioner evolved into the family physician and became a specialist in the true sense of medical care. The same transition has occurred in Britain. Britain has chosen the term general practitioner, but the two types of physicians are the same in practically every sense in both countries.

The main difference between the old-time general practitioner and the family physician or general practitioner of today is training. There is a basic training course, a core of knowledge, and a discipline that we share with our family physician/general practitioner colleagues. The term family medicine refers to the entire discipline as a field of study, whereas family practice in our country refers to the delivery of health care. Family physicians and general practitioners are among a number of

specialties, including internal medicine and pediatrics, that offer their patients primary care.

Let me close by telling you that general practice family medicine is becoming established throughout the world. I have recently attended meetings of this kind in Spain, Mexico, Venezuela, Brazil and Argentina. Family medicine is being practiced throughout the entire Western Hemisphere, and the British Commonwealth. It is being introduced in several nations in the Middle East, in Japan, Australia, and throughout Asia. I am pleased to see Egypt, a progressive nation, participating in this worldwide movement. I wish you well in your conference, and thank you for your hospitality.

DR. ZAKI:

I want to draw your attention to two important subjects for our agenda: prevention and family planning. Family planning has very recently been introduced in the units of the Health Insurance Organization and in the Cairo Organization for Hospitals. The government employees and factory workers served by the Health Insurance Organization are the most productive sector of our population in terms of birth rate. We consider prevention a very high priority, and family planning is an important form of prevention.

DR. SHEHATA:

I would like to thank the many organizations and agencies that have contributed personally, financially, scientifically, or otherwise to make this conference successful: the faculties of medicine, the Ministry of Health, the Military Medical Services, the Academy of Scientific Research, the Military Academy of Medical Sciences, the Health Insurance Organization, the Egyptian Medical Association, the Egyptian Syndicate of Doctors, branches of the Syndicate of Doctors in different governorates, GP associations, Boston University and Suez Canal University Faculty of Medicine, the British Overseas Development Council, the USAID health office in Cairo, the American Academy of Family Physicians, the Royal College of General Practitioners in the U.K., GPs in the public sector, GP associations and medical schools in other countries, WHO regional office for the East Mediterranean, the Drug Information Committee, public and private drug companies and agencies, the scientific offices of foreign drug companies, and radio, TV and the press.

AMBASSADOR WEIR (U.K.):

It is a great pleasure to be invited to attend this conference, since I have been especially conscious throughout my

four years in Egypt of how strong the links are between our two countries in the medical field. Mutual exchanges date back a long time in history and are continuing, the most recent being the visit of His Excellency the Minister to the United Kingdom only a few weeks ago. As he is well aware, and as we are very conscious in the United Kingdom, our own medical service depends a great deal on Egyptian doctors who have come to work in England, temporarily and in some cases permanently. I hope they are not regarded in Egypt as a brain drain; you clearly have an abundant supply of doctors coming from the universities every year, and they make valuable contributions in all fields of medicine in the United Kingdom, not least in the field of general practice.

It is a great honor and pleasure for us to have been able to contribute to this conference, and I hope you will regard the presence here of several distinguished British doctors as a small return for the great benefit we enjoy in our cooperation with Egypt in the field of medicine. I wish your conference every possible success.

AMBASSADOR ATHERTON (United States):

For at least eight years, the United States and Egypt have been cooperating in support of Egypt's economic development effort. During this time a very close partnership has been forged between our two peoples in support of our common objectives of peace, security, and the economic well-being of all the people in this region. I think there is no area where such cooperation is more important than in the field of health.

There is a long history of cooperation between the Egyptian Ministry of Health and institutions and individuals in my country, dating from long before the activities of our AID program. In particular, I want to mention with pride the exciting community medicine project between Boston University and Suez Canal University; it seems to me that this project is very much a part of what this country is all about, and I wish it a great future.

On behalf of my fellow countrymen here, both those who are living and working in Egypt and those visiting from the United States, I would like to thank the organizers of this conference for the privilege and honor of being invited to share this opening with you. We wish you the very best of success.

FIRST PANEL

HEALTH, DISEASE, AND MEDICAL CARE IN EGYPT

DR. HAMMAMY:

I would like to open this session by describing briefly the development of rural health services in Egypt, and the importance of general practice in the delivery of health services in our rural areas. Egypt's population is about 44 million, 99 percent of whom inhabit only 3.5 percent of the surface area. The population density of the inhabited area is thus about 1,138 per square kilometer, which is very high. Of Egypt's 44 million people, 23 million live in rural areas, in 4,165 villages. The Egyptian village is very unusual in the density of its population, and in its proximity to neighboring villages, which typically does not exceed five or six kilometers.

In 1942 we began building rural health centers to provide basic health services: health education, control of communicable diseases, sanitation, maternal and child health, school health services, control and treatment of parasitic and endemic diseases, and curative and emergency care. Each rural health center was supposed to serve several villages around what we call the mother village.

In 1954, after the revolution, we began to think that health services should go hand in hand with education and socioeconomic development, and we combined our rural health centers with schools and social agencies in what we called combined units. By 1962 we had about 600 rural health centers, both free-standing and combined units. At that time we evaluated our rural health services and found that utilization of services was diluted by distance from the mother village, especially in the areas of preventive medicine, vaccinations, and MCH.

Thus in 1962 we tried another approach, building smaller units in the small villages. At present we have 2,500 units, each serving

8,000 people. Half of our rural health units serve only one village; a few serve two, and far fewer serve three or four. On the average, each unit serves 1.6 villages. In a 1979 study we found that 99 percent of the rural population has a health center within 5 kilometers walking distance. There is one physician for every 6,000 people and one nurse for every 3,000 people. Since 1976 we have been working on making some of the big rural health centers into what we call rural hospitals, for three prime purposes: to make use of the 8,000 beds in the 600 rural health centers, which have been underutilized; to deliver some specialty services to the rural communities; and to utilize these rural hospitals as training tools for the health team in the surrounding units.

The health team in each unit is headed by a physician--at least one in the rural health units, two or more in the rural health centers, and three or more in the rural hospitals--and also includes nurses and sanitarians, an assistant sanitarian, a lab technician, and so on. We have x-ray technicians, lab technicians, and pharmacists in the rural hospitals and rural centers. We are sticking to the basic principle that the health team should always be headed by a physician.

The broad-based infrastructure I have described is the basic tool for our preventive and promotive programs in maternal and child health, family planning, vaccination and control of communicable diseases, malaria control, treatment of TB and control of bilharzia. Recent efforts to control bilharzia in Upper Egypt have succeeded in decreasing its prevalence from 30 percent to about 12-14 percent in some areas. In other words, we utilize the thousands of units scattered all over Egypt to implement any health program that can easily make use of the existing facilities. We have decreased infant mortality from about 400 per thousand in 1942 to about 80 per thousand today. We have also lowered the birth rate from 44 to about 38.

In theory, we have a systematic referral system, but, frankly, it does not function effectively. Some patients bypass the rural hospitals or the rural health center and go directly to the district hospital.

As for the major constraints on the system, we still have the community problems of low income, lack of education, poor sanitation, and disease. With regard to the health system itself, we might say that its anatomy is very good--anyone living in a village can find a nearby health facility--but its physiology is less good. We need some activation, especially in areas of underutilization such as MCH care. The causes of underutilization appear to be lack of adequate training, including basic medical education, pre-service training, and in-service training, and lack of adequate supervision. We need better supervision for these thousands of units and thousands of staff workers. We also have shortcomings in communication between these thousands of scattered

units and the administrative level above them, and lack of motivation for the health teams. For the last four or five years we have been working on finding solutions to these problems, particularly in the project for Strengthening Rural Health Services to which USAID is contributing.

We still have major health problems in our rural communities, especially high infant mortality. Most of the infant mortality is due to diarrhea, gastroenteritis, which is really dehydration. The pilot oral-rehydration program we implemented through the rural health service succeeded in decreasing the infant mortality rate by 50 percent, from 90 to 45 per 1,000; based on this success, we now have an ongoing nationwide oral-rehydration program. We still have a high birth rate, and we are putting emphasis on the family planning program.

DR. GOMAA:

The Health Profile of Egypt Project, which began in 1977 as a research agreement between the Ministry of Health and the U.S. National Center for Health Statistics, is an effort to survey the health status of the Egyptian population by means of interviews and health examinations. The governorates surveyed in the first cycle in 1978-1979 were Cairo, Alexandria, Kafr El-Sheik, Gharbiya, Beni Suef, Red Sea, and Qena. The study categorized the sample into urban areas, rural areas with health centers, and rural areas without health centers.

Literacy differs markedly between urban and rural areas, and between men and women; 73 percent of females are illiterate, compared to 44 percent of males. With respect to the environment, the disposal of excreta was done in open ground in about 28 percent of the regions surveyed. Houses without disposal facilities got rid of their sewage mostly in open land. The frequency of sewage disposal in canals was low--2.9 percent--but is still a serious problem. Among preschool children, the frequency of a positive vaccination history was relatively high in all three regions.

Private doctors were the most frequently utilized health service in urban areas, accounting for 33 percent compared to 18 percent for government hospitals, and 16 percent for maternity and child health centers. Outside of the cities, the rural health units and centers constituted the most frequently used health service at 14 percent, relative to 10 percent for private doctors. A significant association was found between smoking and chronic diseases. Among TB patients, 43 percent were smokers. When people were asked about their awareness of certain chronic diseases, the most frequently mentioned diseases in urban areas were hypertension and diabetes; in rural areas, the most familiar diseases were urinary bilharziasis and intestinal bilharziasis. In terms of regularity of treatment for chronic diseases, diabetes ranked first

at 80 percent, followed by heart disease and hypertension in urban areas. Diabetes also ranked first in rural areas. A high percentage of nontreatment was found among bilharziasis patients, 43 percent and 42 percent for urinary and intestinal bilharziasis respectively.

The main source of financing for treatment of chronic diseases was out-of-pocket money.

In urban areas, two-thirds of pregnancies receive medical care, and delivery was reported normal in 91 percent of the cases. In both urban and rural areas, delivery is mainly at home; home delivery accounted for over 95 percent of deliveries in rural areas. Traditional midwives assisted in 50 percent of urban deliveries, physicians in 26 percent, and nurses in 20 percent. Users of birth-control measures accounted for 28 percent, 4.6 percent, and 9 percent in the three regions respectively, for an overall figure of 11.5 percent. These percentages are very low, calling for close collaboration by the general practitioner with pharmacists, the mass media, field workers and medical institutions, who should all be encouraged to play a more active role in spacing of pregnancies.

The main cause of disability under 15 years of age in urban areas was paralysis of the lower limbs. Proper vaccination against poliomyelitis is one of the crucial jobs of the Egyptian general practitioner. Only 29 percent of the disabled received treatment or rehabilitation.

DR. BRYANT:

In recognition of the need to gather health statistics for planners, policy makers, legislators, and others, the United States in 1956 adopted a law called the National Health Survey Act authorizing a continuing household interview survey, special studies, and methodological studies. A system of surveys and censuses was developed by the National Center for Health Statistics to produce all types of statistics needed by various kinds of users.

The first of these surveys, called the National Health Interview Survey, is a population survey based on a probability sample, which provides estimates of such parameters of interest as the prevalence of particular diseases and number of hospitalizations, as well as information about the entire population that allows us to infer relative rates.

The data are used broadly, for monitoring health and studying relationships. For example, we have made some important contributions to understanding of the relationship between smoking and health. The data are also used widely by health planners; for instance, there has been some effort to introduce national health insurance in the United States, and we have produced data to try to

evaluate the need for such health insurance.

The Health Examination Survey, which is based on physical examinations and tests, enables us to identify otherwise-undiagnosed conditions. The two surveys complement one another. The Health Examination Surveys--we have conducted five since 1959--have collected information on chronic illness, growth and development of children, anthropometrical measurements, and epidemiological research-type information. For example, a recent Health Examination Survey studied blood-lead levels and their association with lead in gasoline. The evidence is very strong that a large portion of the gradual uniform decrease in blood-lead levels that we found between 1975 and 1980 is due to the reduction in the amount of lead in the atmosphere due to gasoline.

The Health Examination Survey also monitors blood pressure, and the findings of three national surveys indicate that--probably as a result of education and other interventions--blood-pressure levels are going down. We also collect information on nutritional status, and review the data to see if there might be a need for food fortification.

The National Center for Health Statistics also has cooperative programs with a number of countries, one of the most prominent and productive of which is the Health Profile of Egypt.

DR. GLASSER:

I would like to comment briefly on the role that the information gathered from the Health Profile of Egypt can play. I have just come from a conference in Zimbabwe that validated Dr. Stern's remarks on the worldwide movement in general practice and family medicine. By and large, the 14 African nations represented at the conference are nowhere near the level of Egypt in the development of their health service systems: they are making the transition from merely building a system of care to beginning to address problems of health. They understand that these systems face competition from other social needs, and they recognize the complexity of the systems they have built. Several problems have emerged, notably the role of primary care vis-a-vis secondary care, the organization of clinical care, and the proper uses of resources and manpower given the economic needs of their populations. They have also learned that they have a scarcity of information with which to make decisions.

I would like to echo the Honorable Dr. Zaki's emphasis on preventive services, the need for family planning, and, most importantly, the need to develop an objective information system to support community medicine and to guide the development of manpower effectively and efficiently. The Health Profile of Egypt is a significant resource to aid in this process within Egypt.

Worldwide, the Health Profile of Egypt is a virtually unique effort to look at the multiple aspects of care that family practice and general practice have emphasized--the relation of the individual to his social context and the relationship of curative and preventive medicine in the treatment of disease. The Health Profile of Egypt has a great deal of pertinence to the clinical practice of medicine.

I think that the Health Profile of Egypt will serve a function similar to that of the growth of general practice in Egypt. Because it is responsive to the complex social, community, family, and clinical factors in morbidity and mortality, it provides us with an information base that can be used over time to understand and unravel the problems and perhaps aid in solutions. Secondly, it can be a useful tool in decisions on manpower development and education of the population, and can also have an impact on the course of medical education and the direction of community services. In these ways the Health Profile of Egypt has lessons for each of us, regardless of our specialty.

Aspects of the Health Profile of Egypt to look at in the future are more detailed analysis of the epidemiology of disease and the relationship of epidemiological patterns to medical-care practice. The Health Profile of Egypt can be a significant contribution to understanding these questions, of extraordinary use to you who are dedicated to the cause of medicine in general and community health in particular.

DR. KHALLAF:

Dr. Hammamy, why do consumers bypass the rural health unit and go directly to the hospitals?

DR. HAMMAMY:

The prevailing attitude in the community is that the district hospital has more facilities. Among the patients who have been admitted directly to the inpatient section, most are difficult labors and emergencies.

DR. GABR:

Dr. Hammamy, how much time do you think is spent on preventive services and how much on curative services by your staff in the primary-care units, and what expenditures of time would you wish to see?

DR. HAMMAMY:

Six of the seven basic health services--health education, infectious diseases, family planning, MCH, school health, and control of endemic diseases--are preventive. But new graduates still have a clinical orientation; curative care is much more attractive to them. We are the first users of the graduates, however, and in pre-service training we are trying to reorient them. We hope that the new direction in medical education will help us.

DR. GABR:

What are the prospects for upgrading Ministry of Health services by accepting modest fees from able patients? The government cannot be asked--and is not able--to provide decent fees for health services for all. Doctors in primary-care units are now allowed private practice in the afternoons, and as you know they have long been allowed to charge a fee for home visits. But this is still an open question, and a very crucial policy problem.

DR. DIAAI:

We in the Health Insurance Organization are trying hard to provide comprehensively planned and convenient medical services, bound by laws and by fixed rates, to workers in the public and private sectors.

The Health Insurance Organization is governed by two laws: one provides for free services and an employee contribution of 1 percent of monthly pay; under the other law, the employee contributes 1/2 percent per month and makes a co-payment for services. The employer pays 1.5 percent and 3 percent respectively.

These percentages were originally determined over 18 years ago, and in both cases they are inadequate. I think we have to raise the contributions of the employer, the employee, and the state as well. The standard of services has suffered due to the pressure of large numbers of beneficiaries and the constraints imposed by limited employer and employee contributions.

The general practitioners in the Health Insurance Organization work in general practitioner clinics and in polyclinics. They have to refer to the specialists in the polyclinic, and only the specialist is allowed to refer to the hospital for admission.

DR. GABR:

Three important points have been raised here today.

The first is Dr. Ramses Gomaa's point that in certain areas of Egypt 33 percent of primary health care services are provided by private doctors. This in itself should motivate those of you who are still hesitant about applying for a masters' degree in general practice.

The second is the constraints on the health insurance system described by Dr. Samir Diaai, and the need for greater contributions from the consumers.

Finally, the point was made that services are now better organized, and that with better organization at the local level, as well as international cooperation, much more can be achieved.

SECOND PANEL

GENERAL PRACTICE IN EGYPT AND OTHER COUNTRIES

DR. SALLAM:

This session is about general practice in Egypt and other countries. We look forward to learning from the experiences of our colleagues in other countries, because specialization in general practice is very new in our country.

DR. BISHOP:

My purpose this afternoon is to consider the role of the physician in primary health care. I am not speaking exclusively about the general practitioner, nor specifically about conditions in Egypt. As you know, it is the view of the world community, as expressed in the Alma Ata Declaration, that the best means of improving the health of the people of the world lies in development of primary health care through a team approach. This policy emphasizes the need to prevent ill health, and recognizes that a great responsibility lies with the people themselves. So this is an approach based on the care of communities, along with vigorous efforts to involve people in looking after their own health.

So the question arises: what is the role of the doctor in this effort? Indeed, is there a role at all for a doctor? As you know, there are people who believe that the doctor has no role to play. We have to take this challenge seriously and examine carefully what our role should be. It will vary with the circumstances in which the doctor finds himself. It will vary with the country he is working in, and whether he is working in a city or a rural area. It will depend upon the quality of communications and many other factors.

The doctor may in certain circumstances be the first person the sick person contacts. In other situations, he may be the person

to whom the first referral is made. He may have the prime responsibility for distinguishing the seriously ill patient from the larger number of people with minor illnesses. He may provide continuity in the care of chronic illness. The doctor should know local circumstances from the health point of view particularly well. He should live in the community, and in consequence he should know its social and economic problems that bear upon health. He should at all times be a health educator, educating the individual patients he encounters--as we all know, illness makes people particularly susceptible to general health advice--but also pursuing a wider responsibility for educating the community. At all times, he should seek ways of emphasizing prevention. Above all, however, the doctor working in the field of primary health care is a person who works as a member of a team. This is a point that can't be overemphasized, because alone he is helpless.

If the doctor is to work on a team, is he to lead it? Most doctors assume that, if they are in a team situation, they will naturally be the leader. I would like to suggest that this is an assumption you should not make, and that only if one has learned how to manage and lead a team does one have the right and capability to do that job. In order to lead a team of health workers, one has to study how to do it--how, in other words, to manage. I think it is the most important function of a doctor in this situation to be a manager. The human resources represented by the other health professionals he collaborates with, and the often-scarce material resources, have to be used to best advantage. His job is to deploy them in the best way possible, and to develop them as best he can. This means continually trying to improve the quality of his work by educating himself and the other members of the team with whom he works.

A very important function of the doctor working in primary health care is to provide what is rather grandly called continuing education for the people he works with. What this really means is to supervise them in their daily work, not in a disciplinary manner but in a way that encourages and continually helps to develop their skills and knowledge. If the doctor does this properly, he is contributing a very great deal to the quality of the care that the team is providing. In order to fulfill these expectations, in addition to his clinical tasks, he has to be a health educator, he has to be an educator of his professional colleagues, and he has to be a manager. We have to develop these skills from an early stage in training; undergraduate medical education has to take these skills into account, and certainly postgraduate education for primary health care has to address them.

I hardly need to convince you that the person I have just described is a specialist. He is every bit as much a specialist as the person who performs operations, gives anesthetics, treats mental illness, and so on. He has to be trained as a specialist, and he needs to be given recognition--which means that a suitable career

structure has to be created.

It is clear that the job I have described is not a job for a young, newly-qualified, inexperienced doctor. But in many countries, that is the kind of doctor who is working in primary health care. I think it is grossly unfair to patients if they can only expect to be looked after by inexperienced doctors. What is needed, really, is that the doctor should be adequately prepared for his task: having been posted to the work station, he needs adequate support and supervision by someone more experienced than himself in the same field. And, as his own career develops and his experience grows, he needs the opportunity to advance in his specialty so that he doesn't have to retrain as a surgeon or a dermatologist in order to gain promotion.

So, as I see it, there are many large challenges to meet as doctors before we can satisfactorily be seen to be playing our part in primary health care. We should not be complacent in thinking that we are doing so at the present time. There is a considerable need for adaptation, and a substantial threat that if we do not adapt, we shall find other health professionals increasingly trying to take over the role of managers and chief providers of primary health care.

DR. RICHMOND:

It is a great pleasure to be back in your midst on the occasion of the first international conference on general practice. This conference symbolizes the very considerable commitment of the members of the Egyptian Medical Association, the Medical Syndicate, and the staff of the Ministry of Health to improving the health of the people of this country, and illustrates the very rapid movement that is taking place in health and medicine here in Egypt.

I had the privilege of attending the World Health Assembly in 1978 when the Director General of the WHO, Dr. Mahler, endorsed the objective of health for all by the year 2000. As Dr. Bishop indicated, this goal was quickly translated into the Alma Ata Conference on primary care. The question we are really addressing in this conference is how general practice or family practice can really move us closer to attaining health for all by the year 2000.

Dr. Mahler, in his historic speech, made the point that health and economic development are indivisible. Without good health, the people of a country cannot achieve sound economic development. When Minister Zaki emphasized prevention this morning, he was expressing the concern of ministers of health all over the world about the very considerable resources that are devoted to curative care rather than prevention. Without prevention, we cannot make significant progress toward reducing infant mortality rates, reducing the rates of infectious and parasitic diseases, and, as a consequence, increasing

life expectancy. And, of course, it is the general practitioner and his or her team who are in the forefront of bringing preventive services to their people.

I would like to describe very briefly some related developments in the United States. After World War Two, we experienced a great increase in specialization in the health professions, and particularly within medicine. Eventually it became quite apparent that the task of integrating all the specialities in the service of the patient had been overlooked. People in our communities began saying, in effect, that we had gone too far in the direction of that kind of specialization, and that we needed to redirect our efforts toward greater integration of our professional skills. This community pressure coincided with growing concern within the health professions, and, fortunately, with increasing student interest in pursuing careers in family practice. The result, as Dr. Stern indicated to you this morning, is that the largest specialty group in the United States is now family medicine, with 55,000 members.

One consequence of this shift of emphasis has been an increase in the financing and availability of services in peripheral areas, outside of the cities. The advent of programs for the elderly and the poor--such as Medicaid, community health centers, and migrant health centers for farm workers who migrate with the crops--has greatly broadened access to primary health services. In 1965, before many of these programs began, our low-income population saw health providers about half as often as more affluent people did. This pattern has largely been reversed: the poor now see providers as frequently as more affluent people. We continue to have problems, as do most countries, in the distribution of services; some rural areas and some of our urban settings are still not as well served by our health professionals as we would like. In a country of about 230 million, we estimate that about 15-18 million people are underserved. Recently we have developed the National Health Service Corps, which provides students an opportunity to practice in underserved areas.

Since we are going to focus rather heavily on teaching and training, I would like to close by posing two questions. What is the integrative task of the primary-care physician? And what is the conceptual task we are placing before the students? In order to assess the total functional capacity of the individual, the primary-care physician must call on biological knowledge, knowledge of society, and sensitivity to psychological issues. It is the conceptual problem of the family physician or general practitioner to bring all of these perspectives together into a coherent whole. The complexity of this task and its potential benefits for the people of Egypt mandate precisely the kind of rigorous scrutiny you are giving to the teaching of general practice and the delivery of services.

DR. COTTER:

The title of this session is "general practice in Egypt and other countries"--not general practice in Egypt and general practice in other countries. I think this is very important, because I am more convinced than ever that the core of general practice is the same throughout the world. It is best learned, however, in the country where you are going to practice, because it is heavily affected by the social, cultural, geographical, and financial realities of that country. Wherever a surgeon goes, he will find the same anatomy of the body, but in primary care there are many major differences. So I am not saying that the subject can be studied anywhere, but that underneath the social, psychological, and geographical factors, there is a common core.

One of the central ways in which general practice differs from hospital medicine is in its distinct patient orientation: we say "Ahmed has an earache again," rather than, "There is a case of cholecystitis coming to my ward." In other words, we are thinking about and treating people we know; the consultant is thinking about a disease that has appeared in his hospital bed.

In orthodox medical schools, undergraduates are taught in departments. The eye specialist teaches eyes; anything other than eyes is someone else's slot.

But the general practitioner's expertise is that he will recognize conditions earlier than the specialist, by virtue of his position. When a shoot first sprouts from a seed, it is very difficult to identify what plant it is. When it has a bud, it is a little easier; by the time flowers appear, it is very easy. The general practitioner sees the shoots and the buds, and he needs far greater diagnostic skill than colleagues whose specialization puts them in a position where they see the disease much later. I now meet doctors who specialize in the retina, doctors who specialize in the cornea; tragically, these are the people who are teaching the general practitioners of the future in hospitals. I think that Egypt, thanks to the Suez Canal University project, is going to be way ahead of many other countries in the training of skilled and capable general practitioners.

DR. McCAULEY:

When we in Canada encountered the problem of specialization that Dr. Richmond just described, we had the advantage, being one-tenth the size of the United States, of seeing the advantages and disadvantages more clearly.

In 1955 we saw that we had too few specialists, and that general practitioners were having to do many things beyond their

scope. Over the next ten years the specialists appropriately doubled in number while the number of general practitioners remained the same. So in 1965 the specialty groups, general-practice groups, the medical schools, and the government met to look at the situation. What happened--and future developments in Egypt are probably going to be similar--was that a plan was developed whereby various groups agreed to work together to increase the numbers and improve the quality of general or family practice. In 1967, the first two departments of family medicine in Canada began at McMaster and the University of Western Ontario.

We began, as you have, very small. The first class to graduate from our specialty program numbered only 13 students, so it seemed very familiar to me today to see your small group of graduates, who are symbolically so important.

We have found that growth will occur if there is an emphasis on quality. The numbers will look after themselves if the product, the graduate of your program, is well trained. Canada now has training programs in all 16 medical schools; there are over 300 full-time academic family physicians. In 1969, when we held our first examination, 13 people took it. By 1982, over 4,000 doctors had taken that examination. I would suggest that growth is partly a matter of quality and partly, as Dr. Richmond pointed out, due to increasing interest on the part of young people coming into medicine today.

In emphasizing the need for high-quality training for the specialty in general practice, let me add that I think it would be wrong for you to--nor do I think you will--adopt the Canadian model, the British model, or the United States model. What you are doing is right, to develop a model which is appropriate for Egypt.

DR. SABRI:

We in Tunisia have a lot in common with our Egyptian brothers. We have the same social background, we face the same problems as developing countries, we have a lot of problems of health status, and we share the same attitude toward medicine and toward health. We also have some differences: we are a small country, we do not have enough physicians or other health personnel, and we are French-speaking.

Tunisia, an Arab country of 170,000 square kilometers and 6 million inhabitants, has 4 medical schools and 15 nursing schools. There is one physician for every 4000 families, most of them concentrated in the eastern part of the country; some rural areas have only one physician for 30,000-40,000 inhabitants. We have a nurse for every 1,000 inhabitants, and one trained midwife for every 6,000 inhabitants. The infant mortality rate is about 80 per thousand. The birth rate is 34 per thousand, and the annual rate of

population increase is 2.6 percent. We are now pursuing a national family planning program to reduce population increase to 2.4 by the end of 1986.

We inherited the French system of training and organization, which is especially curative-oriented. Until 1975, basic medical training took 8 years, 6 years of medical school followed by 2 practice years. Then in 1975 we promulgated some changes in our medical training and in the organization of our health system, reducing the duration of training for basic doctors to 6 1/2 years.

At the same time we introduced the idea of social and preventive medicine, and two years later we started a pilot program of basic health and primary health care. I am personally involved in this program, whose locus is a rural area of 110,000 inhabitants one hour from Tunis. With the support of WHO and the US foreign assistance program, we are using this region as a training ground for future general practitioners. Our third medical school, which opened in 1975 in the town of Sousse in the center of the country, is oriented toward meeting community health needs; it has Tunisia's first department of community medicine, and trains basic doctors to be general practitioners and family practitioners.

There is a very strong link between our activities in the field and the medical college in Tunis, through the social and preventive medicine department of the Ministry of Health. Furthermore, a highly motivated and dedicated member of the medical faculty, Professor Taofik Nacef, has forged a strong link between our general-practitioner training and the medical students. Each year we receive some undergraduate students at the end of their training, and some postgraduate residents in public health. We insist on training them for six months to work in the field of general practice. We don't have a qualification in general practice, but I expect that the experience of our Egyptian brothers at Suez Canal University will encourage us to ask for such training. This is a very interesting lesson for us in Tunisia.

DR. SHEHATA:

Having been involved in the general-practice training program at Suez Canal University for the past two years, and having worked in the area for many years before that, I would like to offer as feedback some recommendations for strengthening general-practice training in the Suez Canal area.

The exposure of our first- and second-year medical students to general-practice settings is still not adequate. Only some of our trainers are wholeheartedly committed to general practice and community medicine; some who have been chosen from other specialities are still specialty-minded. We need to develop a cadre of general-practice trainers; appointing some of the successful M.S.

candidates in general practice to work at our training sites would be of tremendous benefit to our students. Each tutor should be assigned the smallest possible number of students, ideally one-to-one. These trainers should function as preceptors; that is, they should be readily available to the trainees to discuss any health problems they encounter. The conditions the students encounter--infections, chest disease, hypertension, diabetes, family planning, abortion, normal deliveries, and so on--should be recorded in a register book, which should then be made available for studying for the final exam.

I propose that the M.S. thesis be begun earlier, and that students be introduced in the first year to the research concepts and methods they will need to do their theses. This research should address common problems in the Suez Canal area. A financial award should be given for the best thesis at the end of the second year.

Current medical graduates are not adequately exposed to general practice during their training year as house officers. I propose that they at least have the option of being exposed to general-practice settings. They should also be provided with a reference manual on typical problems in general practice.

The lack of diagnostic tools means that primary-care physicians and general practitioners are generally unfamiliar with their use. Primary-care sites are also characterized by lack of adequate recording and statistical awareness.

With regard to continuing medical education, I think that licensure and certification should be based on a satisfactory assessment of knowledge, skills, and attitudes.

In addition to a system of promotions and raises, I would propose that there be a fee for access to the medical services of the Ministry of Health, and that a part of this payment should go to support general practice. Some of the income from curative services should also be used to support preventive measures and community health programs. A fee should be charged for home visits and home deliveries. I would propose an annual subscription for every family.

What are the prospects for a general-practice career? A general-practice organization with branches in every governorate should be created to promote the status of the specialty and to address legal and ethical considerations. The Syndicate should open a GP specialty register and oversee fees and the prestige of the specialty. An M.D. in general practice is a very valuable goal to work toward, in order to enhance the desirability of a general-practice career.

In closing, ladies and gentlemen, let me say that every effort

is worthwhile for our beloved country.

DR. RICHMOND:

Dr. Bishop, the approaches we have heard about this afternoon focus largely on training general physicians to care for the needs of the people. But we know that, in some countries, other kinds of practitioners are also being trained. I wonder if, on the basis of your observations, you could generalize about what kinds of practitioners might be most appropriate?

DR. BISHOP:

Every country, of course, has unique problems, but some countries quite clearly have health problems that are not going to be solved by physicians. I have been very impressed with some of the approaches that train community health workers--people selected by village communities from amongst themselves, who already have the confidence of the community--to provide simple medical treatment for defined conditions, and to recognize when to refer somebody with an illness that is beyond their competence. Their achievements are very striking in terms of improved hygiene in villages, improved water supplies, and mobilizing village people to contribute toward their own health care.

I believe that, looked at on a worldwide basis, efforts devoted to training people like this have greater promise than training more doctors. This movement toward health care based on community health workers is going on throughout the world and I think it is going to grow in strength. The challenge to doctors is to find ways of working with, rather than in competition with, such people. I do believe that this is something that has to be faced.

DR. McCAULEY:

I agree with Dr. Bishop, and I would like to carry the challenge one step further.

Just as a surgeon has an operating room in which he learns, the people we are training need their laboratory, which is the health center. My concern is that the community health workers, the nurses, the sanitation people, are often trained separately from physicians. Our medical students are mostly learning in the hospital wards, and not in the community where the problems are. Our challenge is to bring together not just health workers, nurses, and general practitioners, but our specialists too; they need to move out of the hospital and into the health center to work not only with the general practitioners but also with the community health workers. The focus needs to shift from the hospital to the

community--but this is very hard to do, whether in Canada or Egypt.

DR. ABU ZEID:

Dr. McCauley, general practice or family practice in Canada concentrates mainly on service to individuals and families; the concept of community health is not very prominent in Canada. What efforts are being made to promote this concept there?

DR. McCAULEY:

Many of us who were involved in the beginnings of family medicine in Canada did not have a community background--that is, we had not taken a public-health or preventive-medicine approach before we came into the field of general practice. Also, many of the community problems in Canada are being managed by our health departments, so we don't have problems like contaminated water. Our community problems are things like overcrowding, poverty, industrial pollution, noise. This is why I made the point that the program here must focus on your needs. But a community perspective is also something that we in Canada need to do more about.

DR. SALLAM:

In this country, no more than 10 percent of the doctor population is specialized; 90 percent are general practitioners. I doubt very much that the new measures to create a specialization in general practice will solve our main problem: raising the standard of general practice in this country to render high-quality service to individuals in the communities where they are living.

GPs continuously complain that the 24 hours in the day are not enough to properly carry out the responsibilities assigned to them in their job description. On the other hand, the general population and we as medical practitioners are unconvinced that the existing system of medical training produces doctors who can carry out general practitioners' responsibilities properly. And GPs are also expected to be team leaders, to be managers, to be full of ideas about prevention and caring for the health of the community and so on.

What can we inject into undergraduate and even postgraduate teaching to raise the standard of general practice? Specialization as it is now being introduced requires one or two years full-time, which means leaving one's work. I was expecting a program that would offer the general practitioner additional experience where he is practicing. If we continue to offer only programs that require doctors to leave their work and go to a university, as in other specialties, how many of the 90 percent of doctors will get

that opportunity?

Also, in your countries does the specialized GP earn as much as the other specialists? And is the GP held in high regard in the community after the GP specialty has been introduced?

PARTICIPANT (U.K.):

These are very good questions. As I understand it, Egyptian universities do not aim to produce a doctor who is ready to practice; they provide the basic education, and he then takes further postgraduate years in the field in which he wishes to work. But there remains the problem of doctors who are already working and not in a position to go back to do a residency program. All the foreign GPs here were in the same position when the revolution in general practice happened. We all got in on what we call the "grandfather clause": our experience, plus continuing education, enabled us to pass the examination which younger people passed after their residency program.

I am absolutely convinced that it is essential to have a very strong continuing-education program in primary care in Egypt, because people will not join a group that is not of a high standard. You have got to raise the standard of people already in the field so that others will be willing to join them.

As for your question about relative incomes, certainly in Bahrein the incomes of GPs and specialists are exactly the same. You are considered either a specialist family physician or a specialist in hospital, and you get the same pay and the same privileges.

PARTICIPANT:

The Suez Canal Faculty of Medicine is trying to offer Egypt a good primary-care physician. But if one is a good primary-care physician, why become a specialized general practitioner? There must be some difference, but it has not been made obvious yet. I hope that tomorrow we can clarify exactly what a general practitioner is.

DR. SALLAM:

Several speakers have advocated making the best of the present system by providing opportunities for GPs in the most distant health units to benefit more from the system.

According to the referral system that was introduced when the combined centers were launched 20 years ago, the doctors in the

combined center would refer to the district hospital, and would attend at the hospital one day a week to follow his cases, which would then be referred back to him. Thus he would learn from the specialists in the district hospital. This system needs to be carried out 100 times better than it is now.

PARTICIPANT:

There should be some joint activities between the units and the hospitals, such as joint presentation of difficult cases. I have seen this done in Scotland and Ireland, where the GPs attend conferences and present cases of their own.

Also, the GP is burdened with responsibilities. We don't give him time to concentrate or to express himself as a real practitioner. And this frustrates a lot of doctors. It would help to assign more than one doctor to each unit.

The total dependence on the university for specialty training is a problem for the other specialties too. We have to study two years at the university, and after that we have to drive from our units. I think we should give serious consideration to the possibility of on-the-job training.

DR. RICHMOND:

Some very important and basic questions have been raised, particularly with regard to the large group of practitioners who are already in practice. Dr. McCauley's figures were very interesting about the increasing number in Canada who have become certified. I wonder whether some systematic program of continuing education, perhaps under the auspices of the Egyptian Medical Association and the Medical Syndicate, would ultimately provide opportunities for practicing physicians to upgrade not only their skills but also their status, ultimately leading to some kind of certification. The coming-together in this conference of the Minister of Health, the leadership of the Medical Syndicate, and the leadership of the Egyptian Medical Association seems to me a step that could lead in that direction.

DR. EL SAYED:

Thank you very much, Dr. Richmond. We in the Syndicate sponsor a semiannual week-long conference for continuing education of GPs, but I agree that it is not enough. We should work on an outreach program to send training materials to doctors where they are working, as well as providing some training very near where they work. This would allow them to prepare for the final examination in the specialty.

THIRD PANEL

GENERAL PRACTICE TEACHING AND TRAINING

DR. DOWIDAR:

Good morning, ladies and gentlemen. We are now beginning the second day of the conference. We will spend the entire day discussing the education, teaching, and training of the general practitioner. I want to appeal to the young general practitioners to join in after the members of the panel have finished their remarks; we would like to hear the point of view of the trainees as well as the trainers. Our first speaker will be Dr. Essex from the United Kingdom.

DR. ESSEX:

The specialist skills of the general practitioner are different from those of the hospital doctor. In hospitals, doctors deal with major organic disease; in health-care centers, they deal with both major and minor physical and mental illnesses, and often with problems not seen in hospitals. Diseases in health centers are often seen at the early stage, when diagnosis is more difficult. Hospital patients are highly selected and already assigned to the appropriate specialties, whereas in health centers they are unselected. Tests are available in hospitals but very limited in health centers. These special constraints make the job of the general practitioner more difficult.

In 1976, I was asked by the World Health Organization to develop a problem-oriented method of diagnosis that could be used in outpatient clinics to identify universally prevalent conditions as well as region-specific health problems. It was to be based on questions and clinical observations only. It was to yield acceptable levels of accuracy, and it was to yield the same diagnosis when applied to the same patient by different people. It was to standardize referrals to hospitals and to provide accurate

statistics for health planning and the evaluation of primary care.

This research resulted in 64 flow charts designed to identify about 230 illnesses, each of which can be diagnosed from any one of its presenting symptoms. Figure 1 is a flow chart for diagnosing a patient who develops swelling of the legs. This diagram offers differential diagnoses of 11 different conditions. It identifies more serious conditions before less serious ones, and it specifies treatment in the health center or referral to hospital. Each diagnosis is coded on the right-hand side of the page, for purposes of accurate statistics. The flow chart also allows you to say, "I have excluded most of these conditions, but I am left with a patient whose diagnosis is unknown."

This work was evaluated in many different countries, and interest arose in extending this approach to the field of mental health. In 1978, WHO's Division of Mental Health wanted to develop flow charts that would distinguish between physical and mental illness, and that would be cross-cultural, start with abnormal behavior, yield acceptable levels of accuracy, and indicate effective and appropriate management. This work was undertaken in Egypt, the Sudan, the Philippines, India, Senegal, and Colombia, with my co-worker Professor Gosling of the American University in Cairo. Figure 2 is one of the eight flow charts that were developed for mental health. It outlines management if there is no drug, if no transport is available, and if the patient cannot re-attend or be referred or admitted. Psychiatry is poorly taught all over the world; when it is taught by specialists it has little relevance to the general practitioner. We believe, having evaluated this work in different countries, that this approach is as appropriate for general practitioners trained in London as for general practitioners trained in Cairo.

Effective management plans must indicate the appropriate place of treatment, what to do if transport or drugs or certain skills are not available, which problems should be followed up, where and when to follow up patients, what to ask and look for at each follow-up visit, how to evaluate management outcomes, what to do if treatment fails, and how to prevent recurrence of the problem. We have been working on management plans for midwives, general practitioners, and many other health workers to address the real problems that exist in health centers in the rural areas.

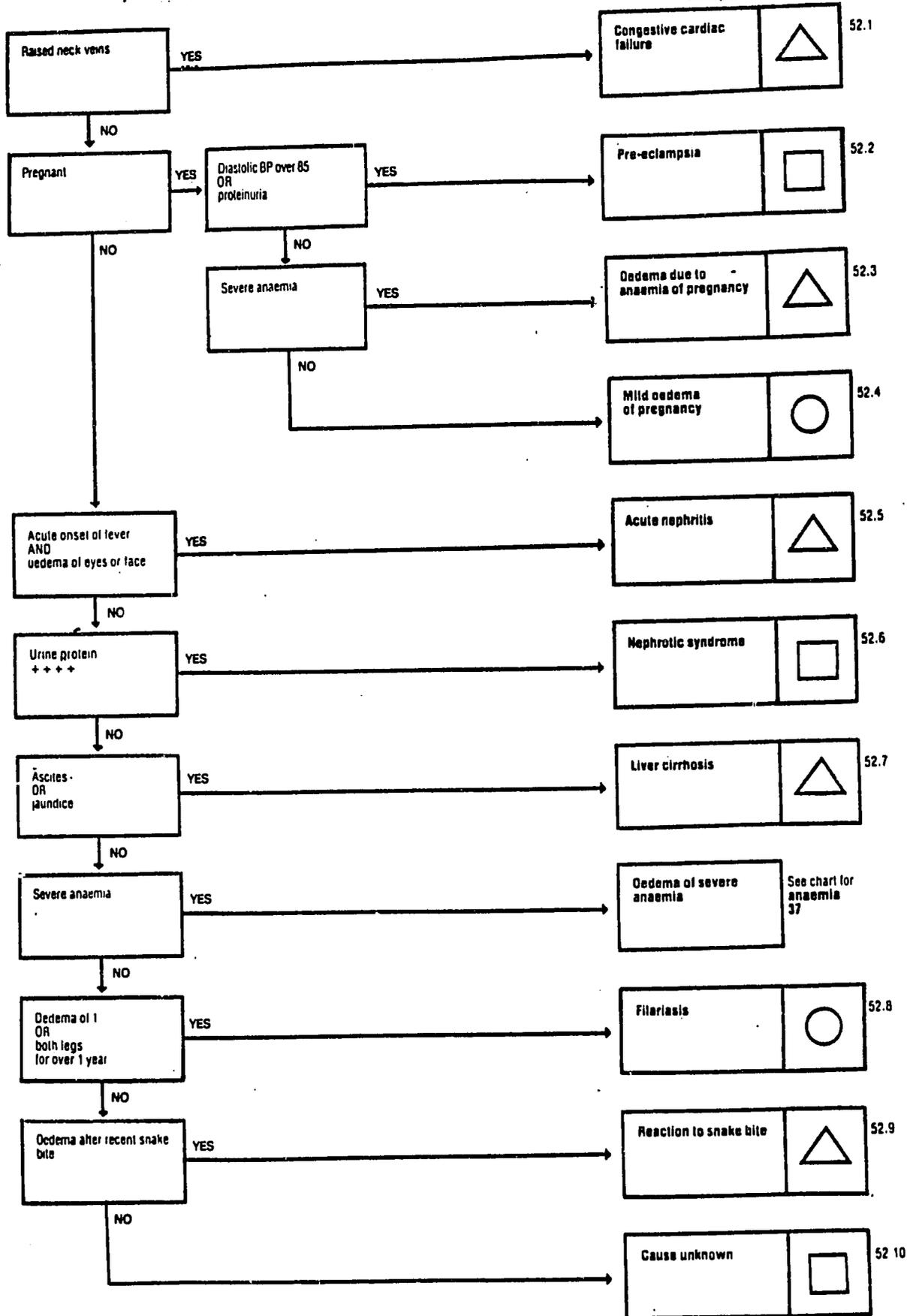
When you have 1,000 medical students a year, lectures can only provide knowledge, not skills. We have been working on methods that would enable the student to develop a series of skills. Compared to disease-oriented methods, flow-chart methods have been shown to increase the skills of all students in a class. They also facilitate rapid transfer of years of experience and reduce the need to learn from one's mistakes.

Effective general practice requires continuity of care, for

FIGURE 1

Swelling of Legs in Adult.

□ Refer to hospital
 △ Admit to the nearest health centre or hospital
 ○ Treat in outpatient clinic



8 Depression

Presenting problem

Immediate actions

Follow-up

Depressed sad, hopeless mood
 OR loss of interest in normal activities
 OR feels he/she has sinned greatly
 OR feels he/she deserves great punishment
 OR specific worries
 OR sleep disturbances
 OR many symptoms no cause found

Thoughts of self-destruction

Yes

8.1

- Constant observation to prevent self injury. **Yes** → REFER
- Transport available → REFER

No

Antidepressant drugs available

Yes

Can attend daily to patient.

- Nurse gives drugs daily to patient.
- Cannot attend daily
- Give one week supply of drugs to relatives.
- Instruct on how many and when to give.
- Record name and address.
- If reaction to specific problem see 8.5.

No

- Relatives told to observe and support patient at home.
- Record name, address and date of next visit to clinic.
- If reaction to specific problem see 8.5.

- Follow-up every week.
- If symptoms improve continue treatment for 12 weeks.
- If no better after 4 weeks REFER.
- If not possible: Consider other support from family, traditional healer, friends or religious leader.

- Do home visit if patient fails to reattend clinic.
- If still has thoughts of self-destruction try to refer again. If not possible try to get drugs to treat patient as above.

No

Follows recent tragic event OR emotional shock

Yes

8.2

- Support patient and family.
- Can religious leader or traditional healer help?

No

- Follow-up in clinic every two weeks.
- If no better in 4 weeks give tranquilliser, but if not available REFER.

22

Best Available Document

Holds incredible beliefs
OR sees or hears things others cannot

Yes

Fever

Yes

Diagnose cause.

No

Smells of alcohol
OR known to be drinking heavily today

Yes

8.3

- Keep under observation.
- Re-examine in 12 hours, if no better record name and address.

No

8.4

- Give tranquilliser if agitated.
- Continuous observation.
- REFER, but if not possible:
- Admit for observation but if not possible, relatives to observe patient at home.
- To reattend in one week
- Record date of next visit.
- Send for drugs.
- Who else may help?

- Start drug treatment in clinic if drugs available.
- Do home visit if patient does not re-attend clinic.
- Refer when possible.
- Inform doctor about patient.

No

Problems in family, community, work:
Conflict between hopes for work or marriage, and achievement.
Number of children in family.
Isolation from relatives or friends.
Behaviour of neighbours.
Sexual problems.
Alcohol drinking problems.
Work or legal problems.
Behaviour of spouse or children.
Infertility.
Other specific worries.

Yes

8.5

- Discuss what patient can do about the problem.
- What can you do to help?
- What can relatives, neighbours, friends do to help?
- Can village headman, religious leader, traditional healer help?

No

Symptoms present for over four weeks
AND preventing normal tasks at home or work

Yes

8.6

- If depressed treat with antidepressant drugs in clinic.
- If drugs not available REFER, but if not possible:
- Support patient and consider who else may be able to help.

- Follow-up as for 8.1.

No

8.7

- Reassure patient and family no serious disease present.
- Tell patient symptoms will improve.

29

which records are essential. I believe that a record card in a health center needs to be only one sheet, possibly carried by the patient, on which name, date of birth, and address are followed by a summary of the problems and space to record events that occur when the patient re-attends.

Yesterday people were talking about the team approach to primary care. We have extended some of these methods to training midwives, traditional birth attendants, and village health workers, all of whom the general practitioner may well be working with.

We have seen that you, our Egyptian colleagues, are prepared to experiment. You are prepared to develop new methods of training for general practice. I hope very much that you will develop an interest in experimenting with some of the new methods of training I have outlined. I look forward to meeting you in the workshops, sharing your ideas and benefiting from your criticisms.

DR. FARLEY:

I am extremely excited about what is being done at Suez Canal University to train physicians appropriately to meet the needs of Egyptian society. Historically, we as educators have trained physicians to meet our own personal needs, regardless of the needs and desires of society. We have developed systems that squeeze inappropriately-trained physicians into working with patients in episodic, divided, scattered, non-integrated ways.

I see general practice and family practice as the integrators of medical care. We cannot segmentalize patients. We should use every contact with a patient to integrate needed care in one visit. We should not send our patients running around to different clinics at different times. Our medical education system encourages us to say, "I am going to be a disease specialist," or "I am going to specialize in a particular age group." General practice and family practice says, "I am responsible for the care of individuals in the context of their families and communities, regardless of age, sex, or condition, and in health as well as disease."

We have to be able to do the very simple basic diagnosis and skills Dr. Essex was just talking about. No matter how skilled we are, if, with simple clinical skills, the stethoscope, otoscope, blood-pressure cuff, our eyes and ears, we cannot identify the problem, we will cripple the whole medical-care system. We need the subspecialists, we need the people with highly technical skills, but if we don't have the appropriate skills to care for most of the problems, highly technical skills will be to no avail. We are the one specialty that has to define problems within the community before we develop our educational objectives. If we don't know what the problems are that the general practitioner/family physicians will be responsible for, they may be inappropriately trained. The

basic simple stuff comes first. It is more important that I be able to recognize the big liver, the big spleen, anemia, heart failure, than that I know the pathophysiology of those conditions. If I know basic physiology and anatomy as I examine, and I learn to relate that to a disease process, then I can learn more and be taught more about the pathophysiology. Traditional medical education, here as in the United States and England, teaches the pathophysiology in extraction. If I pass a test that shows I know the pathophysiology, I begin caring for patients.

I say: show me the patient first, teach me around that patient, use the problem-based approach where I begin by recognizing what the problems are. Then I can apply the pathophysiology to that, and I will be a better student. As general-practice educators, we can't teach preclinical science here and clinical studies there; we can't have epidemiology here and clinical work there. We have to integrate them. In my view the best integrator is the care of the individual patient.

We also have to recognize the social and psychological as well as the organic. If I do not know the culture and beliefs of the patients for whom I care, I cannot bring appropriate care to them. I need to know the other sources of care that they use in the community. All communities have other healers, and we have to be aware of these healers and how they are helping. Some do not seem to help, some help greatly. When I was working among the Navaho people in the 1950s, we American doctors felt that we should never give up the otoscope or the stethoscope to anyone less than a doctor. But we could give only mediocre care at best. Then we trained health visitors--the equivalent of some of our ancillaries--to use the otoscope, the stethoscope, and the blood-pressure cuff. They also knew the culture and traditions. Working with them, we were suddenly able to give very good care. My knowledge base did not change; the eyes, ears, and resources I could draw on improved. All of a sudden, my technical knowledge could be interpreted in a significant way to benefit the community.

So one of the major obstacles in our path is to overcome the tradition of our medical education, the tradition of the systems in which we work, which may inhibit us from using our knowledge well. To do so, we may have to overcome institutional and political restrictions, whether licensure or testing or our own prestige organizations.

If we are to be experimenters, if we are to develop new approaches to care, we also have to keep good data. Dr. Cotter and Dr. Essex have spoken about this. If I see a patient and do not organize my data, if I don't teach my students about data collection and good history-taking abilities, we will just have a lot of loose episodic knowledge that doesn't help us in the care of the patient or help us understand the community.

And as we organize the data, we also have to teach how to analyze it. One of the issues we have had to deal with in the United States and elsewhere is that we cannot afford to train medical students simply to memorize rote knowledge. As I look back on my medical education, much of it has proven wrong, and much of it has been superseded by new knowledge. We must train physicians to think, to look critically, and to make informed decisions--decisions that may or may not be right, but that they can look at and determine which are right. If all we do is teach our students to spew back what is written, we will have many errors.

General practice in every country has to look extremely critically at what it does, collecting and analyzing data so we can think productively about how we give care to the population. There are many different approaches. No two countries are going to use the same method. England and the United States have very different approaches to a common goal, and Egypt will probably take a different road. I came expecting to speak on specifics, but I think it is more important to emphasize that if we collect data appropriately, identify the problems, and organize them so as to be analyzable, then we can start to see which way we should go and how. There will be trial-and-error. The goal everywhere is to look critically at what we do. How do we educate appropriately, and how do we help our doctors force through rational changes to improve the system?

We cannot be passive. We have to be aggressive. Not to protect our own interests, but to respond to the needs of the community responsibly. If we don't do that, if we only pursue our own interests, we are no better than our predecessors. If we don't develop new knowledge, we are no better off than the previous generation. We have to be better at meeting the needs of the population.

We are trying as a group to integrate prevention, health maintenance, and curative care. Our care for the individual is our access to the community. If I do not care for the individual, I have very limited access to the community. Unlike pure preventive medicine, whose access is through the overall needs of the community, we have to work together, we have to work with others. And as Dr. Cotter said yesterday, we have to learn how to work as teams with those around us--despite our pride. Pride can only be satisfied if the patients we serve get good health care. The nurse working next to me may be better at many things than I am; she may have some skills I don't have. If we recognize that and work together, the community will get good health care.

DR. OBENSHAIN:

I wish to talk specifically about a program at one U.S. medical school, the University of New Mexico, aimed at preparing and

motivating individuals to seek careers in general practice, family practice, and primary care.

The problem we were facing in 1970 was that New Mexico ranked 49th out of the 50 U.S. states in the ratio of general-practice physicians to the total population. Our medical-school program was succeeding at preparing specialists, but we were having problems producing primary-care or general-practice physicians. In visiting and looking at the experience of a number of other medical colleges around the United States and Canada, we found that in the traditional curriculum the students learn the sciences basic to medicine in a disintegrated way, outside the context of the patient's need. We decided to try to integrate the basic sciences, clinical skills, and psychosocial skills into the care of the individual patient. The specialization required in doing that is, of course, significantly different from that of other specialists.

The result was what we now call our primary-care curriculum, which is a separate curricular track within a single medical school. We take approximately one-third of the students entering each year-- 20 students out of a class of 73--into the primary-care track. The basic goals of the track are to select and educate physicians who will locate in rural areas and provide competent primary care.

We decided to employ problem-based learning to enhance our students' clinical problem-solving skills and to foster independent life-long learning. We chose the problem-based approach to actively involve the student from the first day of medical school in the clinical problems of patients, to integrate the basic and clinical sciences, to develop self-study skills, and to individualize the learning experience. We felt that it would foster the skills that general practitioners need in order to solve whatever problem is brought to them by the patient. We also decided on a small-group tutorial setting so that the students could serve as resources for one another, since students bring a lot of life experience and knowledge with them to medical school, and also to encourage critical thinking.

Too often, when medical students work only in tertiary care with in-hospital specialists, they do not gain an understanding of the totality of medicine, from the rural clinic to the large-city high-technology hospital. Our students spend four months at the end of the first year of medical school working with rural primary-care physicians, seeing the problems they encounter in their practice and learning how medicine is practiced in a general-practice setting. They become acquainted with community problems, and undertake a community project. The rural preceptors are brought in and educated about the program, and then faculty members visit them. In the second year, students return for more of the same type of learning. Then, as in most medical schools in the United States, they enter into clinical learning with their peers from the other, conventional track.

We will be graduating our first class of nine students next month. Eight of those nine students have elected a primary-care type of postgraduate training program, which is a much higher percentage than we see among the usual graduates of medical school. Four of the eight will be in family-practice residencies. Our residencies in New Mexico will place the students in rural areas to promote their interest in working with our smaller communities.

DEAN NOOMAN:

I would like to express the sense of comradeship I feel in listening to Dr. Obenshain describe his experience in New Mexico. We often feel a sense of isolation when we compare what we are doing with what is happening in our immediate surroundings. Meeting a colleague who has been thinking in a similar way, trying to solve the problems of health-care delivery in his own country by developing an appropriate medical-education model, one feels that one has found a comrade. Let us stick together; otherwise we can suffer in our isolation. Thank you, Dr. Obenshain.

The message I am going to deliver to you is twofold. First I would like to describe the general-practice training program in our Faculty of Medicine at Suez Canal University. The second part of my message will be to explain why we have serious concerns that our efforts will not be as productive and fruitful as we all want unless real changes happen, both organizational and functional, in the health-care delivery system itself.

The basic feature of the Faculty of Medicine at Suez Canal University is that it is a community-oriented medical institution. The educational program has been carefully designed as a prominent component of the nationwide effort to reform Egyptian medical education to make it more responsive to the current and foreseeable health needs of the Egyptian people. Our institutional goals, which we worked out very early in our developmental phase five years ago, and which we have honestly followed throughout our planning and implementation, are as follows:

1. To qualify physicians whose primary objective will be to provide health care in a combined hospital-community system with major emphasis on primary care.
2. To relate medical education to the needs of the society so that the physician will be able to diagnose and manage community health problems.
3. To develop and implement with the Ministry of Health and other health-care delivery bodies an integrated system for comprehensive health-care delivery and health manpower development in the Suez Canal area and Sinai. Such a system

considers the limits of national per-capita health expenditures at present and in the foreseeable future. The regional health-service facilities will be used as the locus for education and training.

4. To develop and provide programs of postgraduate training and continuing education for health personnel.

5. To develop research programs that primarily address the actual health needs of the community.

These are goals that have been guiding all our activities, at the undergraduate and the postgraduate level. As our institutional goals make apparent, our involvement in the general-practice training program is only part of our message. However, our commitment to respond to the major health needs of our people could not be better illustrated than by outlining the role of the Faculty of Medicine at Suez Canal University in the development and implementation of the general-practice training program.

We were asked by the Ministry of Health, the medical profession represented by the Medical Syndicate, and the medical section of the Supreme Council of Universities to respond to the national need to bring the long-desired training program in general practice into existence. Together with two other more senior medical schools in Egypt, we accepted the challenge. In spite of our preoccupation with the development of an innovative undergraduate program, we undertook the additional task of developing and implementing a postgraduate master's degree program in general practice.

The Faculty of Medicine at Suez Canal University has had a Department of General Practice since its inception in 1978; it is the only such department in an Egyptian medical school. Because of the lack of formally trained academic GPs to start our embryonic department, we concluded an agreement with the Royal College of General Practitioners in the United Kingdom for two junior colleagues to pursue the diploma leading to membership in the Royal College of General Practitioners. This agreement, funded by the British Ministry of Overseas Development through the office of the British Council in Egypt, also involved seconding consultants from the Department of General Practice at Guy's Hospital Medical School of the University of London.

Please have a good look at this young man! This is Dr. Maged Khattab, the first Egyptian member of the Royal College of General Practitioners. He passed the membership after studying only two years in the U.K., and he will be back with us next month to assume his responsibilities as an assistant lecturer in our department and to start his M.D. thesis. His colleague Dr. Mohamed Diab will follow after getting his membership as well.

At the same time Dr. Mohamed Shehata, who as all of you know is a distinguished senior general practitioner and administrator, has supervised our general practice department since the advent of the master's degree program. He was joined in October 1982 by Dr. Martin Heshmat, Professor of Family Practice at Howard University in Washington D.C., as a one-year visiting professor. Both Dr. Shehata and Dr. Heshmat, together with Dr. Ron McCauley from McMaster University in Canada and several other visiting consultants, were made available to our department through a generous grant from USAID, acting through Boston University. At present, four other clinical demonstrators and residents are working in the Department of General Practice doing their postgraduate studies.

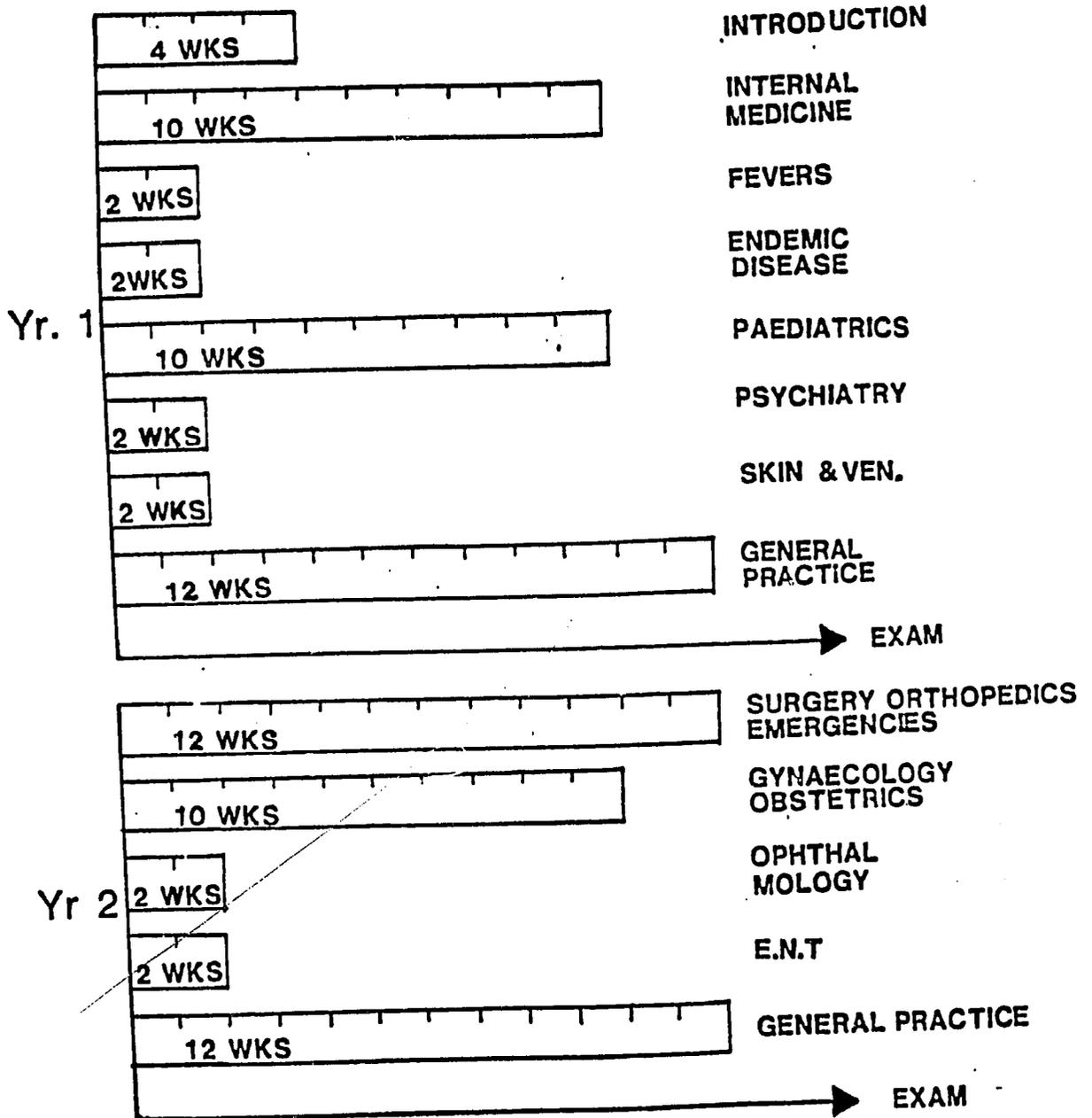
Figure 3 is an outline of the training program in general practice at Suez Canal University. As you can see, it is a two-year program. After a 4-week introduction, first-year students spend 10 weeks on internal medicine, 2 weeks on fevers, 2 weeks on endemic disease, 10 weeks on pediatrics, and so on; the final 12 weeks are devoted to general practice. If the student passes the year-end exam, he or she goes on to Year 2, which also includes 12 weeks of general practice. Before completing Year 2, the student must write and defend a thesis. We divide our students into small batches of four, who rotate among the various clerkships. The first class consisted of 14 students, of whom 12 graduated last month. The second class consisted of 15 students, of whom 9 passed the first-year examination. The third class consists again of 15 students. Most are Ministry of Health primary-care physicians.

We have not yet conducted a meaningful evaluation of the training program in general practice. Our impressions of its shortcomings, however, are as follows. (1) We perceive a need for longer exposure to the major specialties like internal medicine, pediatrics, obstetrics and gynecology, and infectious disease, with opportunities to select from elective clerkships. The present rotation involves too many too-short clerkships to allow for meaningful training. (2) Training at primary-care sites is too brief, and devoid of responsibility for ongoing patient care. (3) Many of the faculty involved in the teaching and training, including myself, are specialists, though we are doing our best to play the role of generalists. (4) Despite a conscious effort to change it, the learning process is still heavily teacher-oriented and didactic, which fosters the already-existing passive tendency in the students.

We are asking ourselves: what are we training general practitioners for? We honestly feel that there is a lack of defined objectives for the training program, and that this lack weakens the program. The reason for this lack of precise objectives, we believe, is that the role of general practitioner in the Egyptian health-care delivery system has not yet been defined. The career structure is not yet defined. Therefore, we feel that we are working in a vacuum. We do not know what we are preparing general practitioners for. To do what? To assume what role in the health-

FIGURE 3

EDUCATIONAL PROGRAM FOR THE MASTERS DEGREE PROGRAM IN GENERAL PRACTICE



- COMMUNITY MEDICINE IN YEAR 1

ONE DAY/ WEEK FOR THEORETICAL

- THESIS DEFENDED BEFORE FINAL EXAM

care delivery system? The reason for this uncertainty is that our delivery system itself is not rationally organized; it is a bit chaotic.

My own view of the health-care delivery system in Egypt in 1983 is that there is a huge problem confronting the unfortunate patient in Egypt. We have primary care, secondary care, and tertiary care; we have Ministry of Health hospitals, university hospitals, rural health units, private practice, insurance, and even something new called five-star hospitals. But there is a complete lack of organization in the delivery system itself, and the patient is at a loss as to where to go and to whom to go--leaving aside the problem of whether he can afford to go anywhere. Figure 4 is a symbolic representation of our health-care delivery system at present.

Unless we rationalize this system, many questions will remain very difficult to answer, including the objectives of the training of general practitioners. Why should a bright young doctor pursue a career in general practice unless he cannot become a cardiologist or a surgeon? There is a growing body of opinion that the master's degree training program, even after its improvement, is not an adequate vehicle for professional training in various areas of medical practice, including general practice. There is a strong rationale for creating professional training programs analogous to the British membership or American board models, tailored to the Egyptian setting. In addressing this question, however, two issues are worthy of consideration.

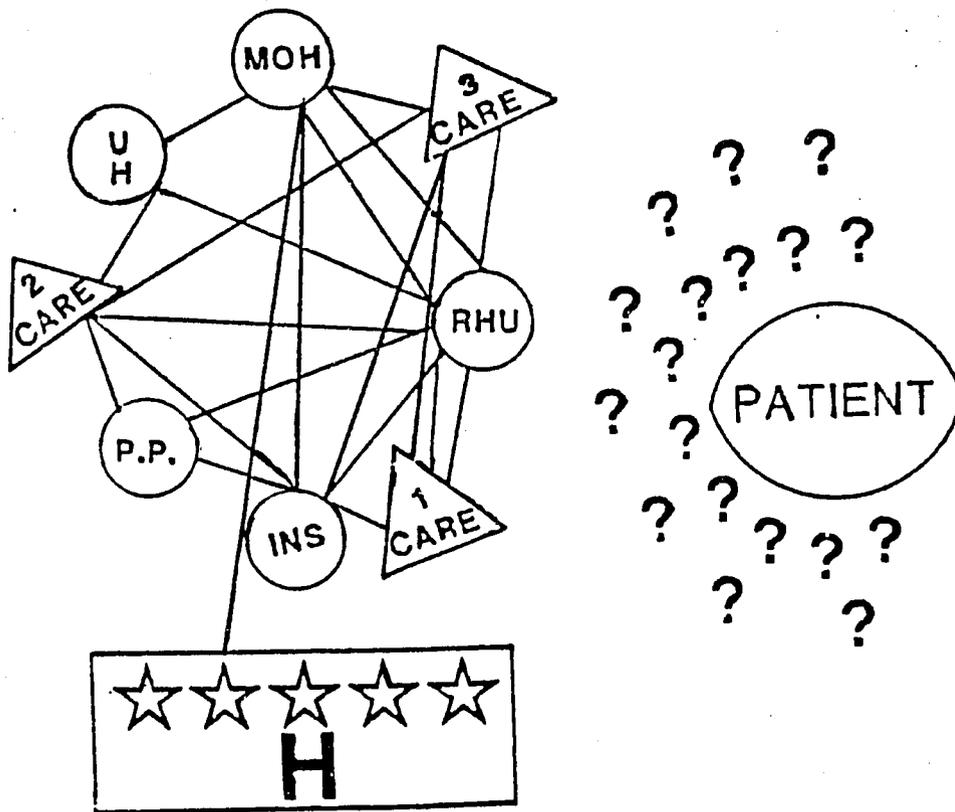
First, we should not confuse the need for formal training programs ending in a diploma or a degree with the continuing education that is desperately needed by the thousands of graduates populating our strained health services. Both are needed, but they are not identical.

The second issue is that a prerequisite for adequate professional training programs is the creation of a suitable organizational structure that would link and integrate health-care delivery institutions and units, regardless of their present affiliations with universities, the Ministry of Health, insurance, etc. A suggested modification of the role of the teaching hospital authority may provide the needed organizational structure.

In conclusion, the Faculty of Medicine at Suez Canal University is committed to its role in implementing and further developing the training program in general practice. This will continue to be a prominent component of our program as a community-oriented medical institution. A beneficial outcome will be doubtful, however, unless there is a rationalization--both organizational and functional--of the total delivery system in Egypt in keeping with the actual health needs of the society.

FIGURE 4

HEALTH CARE DELIVERY SYSTEM EGYPT. 1983



DR. HESHMAT:

In order to orient my colleagues in Egypt to the specialty of general practice or family practice, I would like to share with you some cases I saw with the masters degree students in one day at an urban health center in Ismailia province.

The first case was a 9-year-old boy who came with his 19-year-old sister. He was diagnosed as having mumps parotitis--one of four children with mumps from the same school that day. On examination, the GP student was able to hear a mid-diastolic murmur with late presystolic accentuation over the apex. On further interviewing, we discovered that the child had had two bouts of fever with swollen and painful joints. The two events had not been brought to medical attention.

His sister, prompted by the attention we gave to her brother, requested to be examined. She said that she had had a chest ailment and had taken a course of tablets for one year and streptomycin injections for 3 months. The course had terminated six months earlier, but she complained of weight loss, poor appetite, easy fatigability and occasional night sweats. On examination, the GP heard cavernous breathing over the right lower lobe. On several occasions during the encounter, the patient asked the GP to repeat his questions; finally she admitted that she had been having a hearing problem for several months.

The family concern in this particular case was mumps in a nine-year-old boy, and we could have given him symptomatic treatment and instructions and sent him home. However, the orientation of our students to comprehensive care for patients and their families uncovered more serious problems. They discovered rheumatic heart disease and family contact with pulmonary tuberculosis that necessitated prolonged Isoniazid and penicillin prophylaxis. They discovered active tuberculosis and iatrogenic hearing loss that should modify the choice of further antituberculous medication, as well as possible active tuberculosis or need for TB prophylaxis in other members of the family. To be able to manage this situation effectively, the physician should be able to diagnose and treat mumps parotitis, differentiate between organic and functional heart murmurs, and prevent recurrence of rheumatic fever and occurrence of tuberculosis in children at risk. He should also be able to treat pulmonary tuberculosis, identify signs of toxicity of various antituberculous medications, and protect household contacts of active tuberculosis. In sum, he needs knowledge and skills in pediatrics, cardiology, preventive medicine, and infectious disease in order to handle this situation effectively.

The third case was that of a thirty-five-year-old man diagnosed as having allergic conjunctivitis. As in the second case, the GP student noticed a hearing problem. Using the otoscope, he

discovered a left eardrum perforated in childhood and an external ear canal completely blocked with wax. He prescribed tetrahydrozoline eyedrops and removed the wax from the ear canal. The patient was very happy to hear well again. In this situation, the physician was able to differentiate between various causes of red eye; he was also able to use the otoscope, diagnose perforated eardrum, and remove wax from the ear canal.

The fourth case was that of a fourteen-year-old girl diagnosed as having conjunctival hemorrhage resulting from a fall two days earlier. The girl gave a typical history of grand mal seizure and a family history of epilepsy. She was reassured about her subconjunctival hemorrhage, and Dilantin tablets were prescribed until she could be seen by a neurologist. Here the GP student was able to diagnose and give primary treatment, and decide when to treat and when to refer a case of subconjunctival hemorrhage, calling on knowledge in ophthalmology and neurology.

The fifth case was that of a four-month-old infant whose mother was concerned about his diaper rash, which was getting worse despite three weeks of treatment. This case turned out to be monilial dermatitis that had been diagnosed and treated as irritant dermatitis.

The students chose the sixth case, that of a 49-year-old obese hypertensive female, to practice fundoscopic examination. Her blood pressure was 180 over 110. She carried a bottle of tablets that turned out to be a reserpine-diuretic combination, which she took whenever she did not feel well. She had never been told about the need for periodic checkups, the need to take prescribed medication on a continuing basis, or the need for a modified diet, weight reduction, reduction of salt intake, and exercise. In order to manage such a case properly, the GP should be well oriented to the importance of continuing care.

The last case was that of a 14-year-old girl who came with her mother because of severe vaginal bleeding of one month's duration, in spite of being seen by two private physicians. Bleeding had stopped the second day after taking tablets prescribed by the first physician, which turned out to be 5 mg. norethisterone. However, hemorrhage recurred a couple of days after termination of the course of the progesterone tablets. She went to another physician, who gave her an injection of progesterone. Bleeding again stopped and recurred several days later. Because examination revealed no abnormalities, and pregnancy was ruled out, the GP students made a provisional diagnosis of anovulatory dysfunctional uterine bleeding. They also concluded that the first physician had prescribed the proper medication, the second physician had not obtained an adequate history, and neither had bothered to explain to the patient what she should expect after taking the prescribed medication. In this situation, GPs were able to differentiate between various causes of abnormal vaginal bleeding in a teenage

girl, and understand the sequence of events after the hormonal treatment.

I hope that, after hearing about my experience that day, you agree with me that Egypt is in need of physicians trained in general practice. Physicians who have multidisciplinary skills. Physicians who perceive a given patient as a human being--not as a diseased knee or diseased uterus or diseased liver. Physicians who can diagnose and treat the presenting illness, look for other diseases or risk factors of disease, and deal with them effectively. Physicians who understand the impact of disease on the patient's family and provide them the care they need. Physicians who perceive the doctor-patient encounter not as an event that merely entails writing prescriptions, but as an opportunity for patient education about the illness, about the medication and its anticipated results and possible side effects, and about management of the illness to prevent the progression of disease or complications.

Interested members of the Egyptian Syndicate of Physicians should sit down together with faculty and administrators from the medical schools and administrators in the Ministry of Health to design a comprehensive training program in general practice for all new graduates of medical schools. I think they should also encourage the establishment of postgraduate training programs in general practice that would lead to a master's degree or its equivalent. Moreover, physicians who are already giving care of a general-practice nature in the community should be required to attend occasional short, intensive continuing medical education courses in general practice to catch up with advances in the art of medicine.

DR. FREELING:

How many of you work actively in general practice now? I have been a practicing general practitioner for 25 years. For 20 of those years, I have been trying to teach general practice. For 15 years, I have been trying to teach teachers of general practice, and ten years ago I reached the absurd position of teaching people to teach people to teach general practitioners!

You as a country have 17,000 general practitioners, of whom either all or none are completely trained. I suspect that no doctor can be completely trained, and that is why I intend speaking to you about the teaching of teachers in general practice. When you teach one general practitioner, you benefit a number of his or her patients. When you teach a teacher of general practice, you multiply the possible benefits to patients.

There is a saying about learning and teaching: "If you're not sure where you're going, you may end up someplace else and not even know it." This saying addresses the matter of objectives. Teaching

is the art of helping a learner to manage his own education, and education is the act of trying to change a person's behavior in a desired direction. We all tend to teach others in the way in which we were taught when we were young. Since most of us in general practice were taught by specialists, who themselves had never been taught to teach, it's not surprising that general practitioners find it difficult to teach each other, essential as it is.

I have a couple of other sayings about teaching: "If you're not sure where you're coming from, you're likely to miss the bus." In other words, if you don't understand what you do and why you do it, you can't teach it. And "If you teach someone else about what you do, you will learn a lot yourself."

"If you're not sure where your learners are starting from, they probably won't go with you on your journey." In other words, find out what a learner already knows before trying to help him learn something new. I've been very aware over the last day and a half that I have no idea what the practicing general practitioner in this country knows. I'm looking forward to finding out something about that in the workshops.

Learners are like patients. They want short-term gains and are not very interested in deferred gratification. It is difficult, as all you GPs know, to convince patients to take something now to make them better in five years' time. There's no difficulty convincing them to take something today that will make them better today. Learners are very similar.

There are some general principles that are likely to prove useful to anybody who's involved in adult education--and all medical education deals with adults. Adults like and respond well to a good teacher-learner relationship. Adults want to measure themselves against standards they see as relevant. Adults like to be self-directing and in control of their own activities, and they prefer a problem-oriented approach. Adults also want to apply new knowledge and skills immediately--so courses that take a general practitioner away from his work are likely to be unrewarding unless they are very short and allow him to apply what he is learning immediately, and to bring new problems back to the teacher as he encounters them. Adults want to know how they are progressing. Adults like to teach others, so small-group work is important in adult education. (I do not see how, though, with a thousand entrants in your medical schools, you can offer that.)

When I heard the job description of the Egyptian general practitioner, it sounded remarkably familiar. When I read the broad aims of his training, and of training for the masters degree, it seemed very familiar. We wrote very similar statements in the United Kingdom. The question I am raising is whether that similarity is appropriate. Let me explain. Fifteen features have been identified as characterizing general practice in developed

countries. It seems to me that it is up to you to decide the extent to which Egyptian general practice conforms with what I will describe. To the extent that it differs, you cannot borrow from anywhere else in the world the content of your training. To the extent that your practice is similar, your training can be similar in content.

1. General practice deals with early symptomatic diagnosis and undifferentiated illness. This is the point Dr. Cotter made yesterday in terms of flowers, buds, and leaves.
2. It is a low-technology discipline. It does not employ high technology--although what once was limited to the hospital gradually becomes the province of the general practitioner.
3. General practice depends on informed guesses about illness; a general practitioner is rarely certain what is wrong.
4. Thus the general practitioner makes use of time in both diagnosis and treatment: "That may get better; come back if it doesn't," or "I think this will help; if it doesn't, come back."
5. General practice takes a person-centered approach to the patient.
6. It is sensitive to individuals' needs and wants.
7. It is aware that patients may not comply with advice and treatment, and that GPs may not comply with standards of care.
8. General practice provides continuing care.
9. It takes a preventive attitude.
10. It takes a developmental approach.
11. It makes selective use of resources.
12. General practice has a responsibility to the community at large.
13. It demands that the GP have the ability to tolerate uncertainty; a GP will always leave his office at the end of a day uncertain about the outcome of some of his cases.

14. It requires the GP to understand the functions of many other disciplines.
15. It requires the GP to have a high degree of skill at interviewing.

There are consequences, which you will have to think through, of the degree to which you do or do not conform to these characteristics. What will not change is the philosophy of care and the philosophy of teaching. If you believe in person-centered medicine, if you work one-to-one, then teaching will need to be one-to-one. If you care for small groups like families, then you'll have to learn and teach in small groups.

Let me give you some bad news: very few people other than yourselves will know what you do, and what you need to know and to learn. We know what we know; you know what you know. If you know what you don't know, and I happen to know it, I can tell you. If I don't know either, then we can both go out and look for it. The 17,000 GPs in Egypt should start looking. Then they will feel better, they will have self-respect, their patients will feel better, and their patients will have self-respect.

PARTICIPANT (U.K.):

It is my job this morning to tell you about an experiment in this region to train doctors to be specialists in primary care. About five years ago, I came to King Faisal University in Saudi Arabia to introduce teaching in family medicine or general practice. At the time I arrived, I was told that young Saudi doctors would never opt for primary care; they would only go into primary care--general-practice family medicine--if they failed to get into one of the narrower specialties. We believed that some 45 or 50 percent of them should go into primary care, and we hoped that they would do so intentionally and not because they had failed to get into some other discipline. The problem was how to achieve this.

The first consideration in persuading young doctors to enter a particular discipline is that they must respect it. So our first aim was to go for quality. Numbers, as Dr. McCauley said yesterday, will look after themselves if you have quality. The next thing we had to do was to show the medical students and young doctors some role models who were themselves high-quality doctors. They needed to be very good clinicians; otherwise, they would win less respect than models in other disciplines. They needed to be enthusiasts with a message. And they needed to be people who looked and behaved like physicians of the highest status. If we could achieve those things, we would have a chance of attracting medical students and young doctors to this new discipline. The other thing we had to do was to guarantee that when they came out of their residency programs

they would enjoy real specialist status; that they would have a career structure and salaries and prestige at least comparable to the other specialties.

We also recognized that we must produce doctors who would be suitable for the needs of the region. We decided to go about this by integrating the best features of family medicine in the West with the best features of community medicine in developing countries. We changed the name of the Department of Community Medicine to the Department of Family and Community Medicine, because it seemed to indicate the sort of physician we wanted to produce. To complement the high-quality community-medicine people who were already in the department, we brought in family physicians who already had university status in their own countries, who had American boards in family practice or membership or fellowship in one of the Royal Colleges, who were good clinicians, and who were enthusiasts for the discipline.

Then there was the question of planning the curriculum. The second- and third-year students were already entering their clinical years. The first- and second-year students had already had some biostatistics and epidemiology. So we introduced a fourth-year course on community-medicine topics, which encompassed introductions to primary health care, maternal and child health, environmental and occupational health, practical applications of nutrition, and organization and administration of health services.

We also got the fourth-year students out into the community. Teaching in the second and third years had been mainly didactic, but it's axiomatic that if you're going to be effective in teaching our discipline, you must get your students out into the community as early as possible. We started with field exercises in which all the students descended on a community at once, and surveyed it from the point of view of demography, morbidity status, and so on, covering all the areas they had been taught. They abstracted the data, and drew inferences using the skills they had been taught. Now we're getting them out into the community earlier, in keeping with the principles of teaching this discipline.

We don't teach at all in the fifth year while the students are moving rapidly through rotations in medicine, surgery, ob/gyn, and pediatrics. But in the sixth year we have a six-week family medicine clinical clerkship, and it's here that they come into close contact with the family-medicine role models. It's here too that we seem to be having considerable success at motivating them in the direction that we want to go. We have an elective internship of two months in family and community medicine, and one-third of the first class opted to do the elective internship. At the end of the internship year, one-third, again, of the charter class chose to enter the family and community medicine residency program. We regard this as a very considerable degree of success. For one-third of the class to choose this new discipline--not because they have

failed to do something else--is something that made us very happy.

We're concentrating now on teaching as much as we possibly can in the community. We're bringing the consultants to our primary-care units, where our residents are presenting to the consultants in what one might describe as an old-fashioned type of consultation.

My main message is that the sort of thing that other speakers have been talking about can be undertaken successfully in this region. The aim, of course, must be to meet the needs of the people in the area where the doctors we are training are going to practice. To achieve this, we want a very high-quality primary-care medical service with, of course, all the necessary infrastructure. To achieve this, ideally, we want more applicants for our primary-care residencies than we can accept. If this happens, the prestige of the residency program and of the people who come out of that program will be very high. So we have to aim at quality.

The other thing we must do is ensure that the doctors we produce have specialist status. We had hoped that by the time our current residents were ready, there would be an Arab boards, which would be the qualification that would give them the necessary status. But there has been delay. Just a week ago we brought together all the employers of doctors in Saudi Arabia--the Ministry of Health, the Ministry of Defense and Aviation, the National Guard, the Ministry of the Interior, and all the universities--for the purpose of eliciting approval of our residency program as a model, and approval of any qualification we give to successful candidates at the end of the residency program. We now have an agreement in principle that this type of residency program is appropriate for the training of specialists, and that the qualification we give will confer specialist status, will enter our graduates into the specialist career structure, and will qualify them to receive the same salaries as specialists in the narrower disciplines. We also achieved a preliminary agreement that the people who earn this qualification will be regarded as similarly qualified from the points of view of prestige, salary, and career structure to people with American boards or with Royal College membership. By setting up residency programs in the region in such a way that people will opt for this specialty in preference to others, we can create a base on which the primary-care discipline can really meet the needs of the people of the region.

DR. BISHOP:

The teaching hospitals in Egypt are already overburdened; I don't see how the necessary number of general practitioners could be trained simply through residency programs. For that reason, I think very particular attention needs to be paid to what Dr. Freeling was saying about the training of people who will train general practitioners. No general practitioner really wants to be taken

away from his work for a long time. So, to my mind, the major role of the residency at Suez Canal is to train people whose main job will be to train more general practitioners. We have to bear in mind the realities of numbers.

PARTICIPANT(U.K.):

In many areas where general practitioners work, referral is impossible at certain times of year. Or the patient may not want to be referred. So there is a very great need to identify what the general practitioner can do if referral is impossible. Management Programs have been developed that outline what you can do if you are stuck in a health center with, for example, an obstetric emergency, and referral is not possible. So that is the first thing-- development of management plans for general practitioners when referral or specialist opinion is not available.

The second thing is that, when you do refer to a specialist, you often don't hear from that specialist again. Therefore, the development of a very simple one-piece-of-paper communication to be given to the patient on discharge from hospital, is absolutely essential for you to get the benefit of referring a patient to anybody.

PARTICIPANT:

This question is directed to our guests from the U.K. and U.S.A. Although there is consensus among you about the necessity of the GP's involvement in prevention, general practice in the U.S.A. and U.K. is not very involved in preventive and community medicine.

DR. FARLEY:

There are several aspects to prevention. Sewage disposal, for example, is clearly a public responsibility, as is clearing up malaria or schistosomiasis, whatever the big overall task is. But I, as a GP or family physician, have the responsibility of identifying, in the care of my patients, those problems that should get fed back to the politicians or the public-health people so they can develop methods of responding. I also have the clear responsibility of making sure my patients don't get tetanus or diphtheria, smallpox, measles, polio, whatever we can immunize against.

What disturbs me is that we have often separated prevention at the individual level from doctor care. That is, I see a child for something, but the next day he has to come back to be immunized. To me, it's best to do it while the person is there, unless there is a specific reason not to. It should be structured so that, as the old

saying goes, "a bird in the hand is worth two in the bush." We do personal prevention and education, and we work with those who are providing community prevention--whether it's mosquitoes, sewage, water, whatever. The two kinds of prevention are separate, but not too separate.

DR. FREELING:

The answer for the United Kingdom is very similar. Prevention is a word; preventing is an act. When you talk about prevention you have to work out what you want to prevent. When you have decided what you want to prevent, you then work out the best and most economic way of preventing it. And if the most economic way is a one-to-one contact with the general practitioner, then the general practitioner should do it. If the most economic way is to use radio or TV broadcasts, the general practitioner shouldn't do it. There is strong evidence in the United Kingdom to support Dr. Farley's view that individual immunization in a developed country is best done by the general practitioner. The immunization rate rose from 30 percent to 94 percent in an inner-city practice--our equivalent of your rural problem--when the practice chose to shift from public-health immunization to individual-GP immunization.

However, the notion that an acute-illness doctor should be involved in more than notification of, for instance, an epidemic that is water-borne is absurd. Each country must decide what it wants to prevent and the most economical way of preventing it, and then decide who does it. The GP may not do it, but should always support it.

PARTICIPANT (U.K.):

The future roles of prospective GPs in this region are clearly going to be different from their roles in the United States and the United Kingdom. So we have to teach them--or encourage them to learn, as Dr. Freeling would say--those things that will fit in with their future roles in this region. As Dr. Bishop pointed out, we have to teach our residents, in the first decade or so, in such a way that they can become the teachers and the supervisors in their countries. For this reason, and in particular because of the situation in the rural areas of the region, we have to teach them some things outside the scope of family medicine in Western countries. This is why we feel that the curriculum should consist of a judicious mixture of family medicine and community medicine.

DR. ESSEX:

Dr. Farley and Dr. Freeling said that the general practitioner

should vaccinate children. I totally disagree. I don't think it is possible for a general practitioner to vaccinate a child as he goes through his morning surgery. We don't work like that in the U.K. I would be surprised if Dr. Farley works like that in America, and it certainly wouldn't be practical to do so in Egypt.

We are discussing teamwork; we are training nurses to work with the GP, and these nurses are presumably being trained to do immunizations. I think we should stop asking the GP to do work which is really not possible, and we should encourage him or her to work with other members of the health team to provide preventive services. That does not mean that the GP does not practice preventive medicine. He will do so, but when it comes to immunizing children, the best approach is to work through and with other members of the team.

DR. FARLEY:

I agree 100 percent. What I'm saying is that when the child is there to be seen, the team--the nurse practitioner, the doctor, whoever--should take the responsibility to make sure that the child is immunized. No, don't ask me to immunize everybody.

WORKSHOP A

UNDERGRADUATE TEACHING IN GENERAL PRACTICE

DR. EZZAT:

General practice has existed in our country for years and years, hundreds of years even, but as a specialty it is quite new. So we have many unanswered questions about how to introduce undergraduates to this specialty. I thought we might start with a description of an existing model for training medical students in general practice to give us a sense of how this is done in some of the developed countries. I'd like to ask Dr. Scott Obenshain of the New Mexico School of Medicine to tell us about his experience in training undergraduates in general practice.

DR. OBENSHAIN:

Many models have been developed in medical schools in our country. In recognition of the flourishing of family practice as a specialty over the last 30 years, the government has helped a number of medical schools to start training programs for undergraduate medical students. I discussed our special track in general practice during the Third Panel, so now I'll describe the conventional track in our medical school, and how it imparts the idea that general practice or family practice is a very acceptable specialty to enter.

Our medical school started with the idea that students must begin learning about the patient as a person from the first day of medical school. One of the first things we do is to give the students opportunities to learn how to interview and interact with a patient, so they can get a sense of how patients feel about being ill and being cared for, and so they will gain empathy and understanding for the patient.

One week in the first year is devoted to primary care and its impact on society, and there are approximately four or five more

blocks of a similar nature in the first two years of medical school, mostly a week or two in length. We start early to integrate the biological, psychological, and sociocultural aspects of the patient, and this comprehensive outlook tends to be reinforced by the teaching in psychology and psychiatry.

During the clinical years, we do two things to expose the students to primary care. In the fourth year there is a special clerkship, four weeks in length, that the students may take in family practice; we require that they take either a family-practice clerkship, a general pediatric clerkship, or a general internal medicine clerkship in their fourth year.

And students in the conventional track, who do not have the extended rural experience offered in the special track I spoke of earlier, are also required to do a preceptorship in their fourth year of medical school. They spend four weeks in a rural area working with a general practitioner, a family practitioner, or even a specialist. So the students have opportunities to see and work with out-of-hospital practitioners, sometimes rural and sometimes urban, in all areas of specialty.

DR. EZZAT:

So you have given us two models--one for students being trained in general practice from the beginning, and the other for students being trained in the traditional track.

The term preceptorship is rather new to our people here.

AUDIENCE:

An apprentice.

DR. EZZAT:

Similar. A preceptor is somebody who is teaching you, and you are his young colleague.

We use a similar approach here. Beginning with the first week the students arrive, we expose them to general practice, ideally in the primary-care centers, to learn how to deal with people, how to interview, how to make observations, how to provide sound health education, and some care of the patient in general. This goes on for the first three years. During the clinical years, there will be two clerkships in general practice, in the fourth and fifth years, and eventually, we hope, the sixth. One of our faculty members will give us a broad outline of how it works.

MEMBER OF SUEZ CANAL FACULTY:

The first year is divided into educational blocks of five weeks each. These blocks are organized according to age group: there is a block on infancy, one on childhood, one on prenatal care, and so on. Groups of about eight students go, in the first year, to urban units, where they learn how to communicate with the age group in question, how to take a history, how to diagnose problems, and general measures. For example, in prenatal care, they learn how to analyze urine for sugar and albumin, how to pipette for the fetal level in the uterus, how to listen to fetal sounds, how to weigh the woman, and so on.

In the second year, groups of five students spend one day a week in the urban units and another day in the rural units. They are assigned to a general practitioner, who performs his job in front of his students. Two or three of the students take the history and perform general measures, and then present the history to their tutor. The tutor examines the patient, makes a professional diagnosis, and provides treatment in front of the students. This takes from 9 a.m. to 12 a.m. After that, the tutor and the students choose a particular case for discussion, in which the staff of the unit participates.

In the afternoon we have what we call community projects in the field. The students learn how to identify problems, how to communicate with patients in their homes, how to determine, for example, the prevalence and predisposing factors of gastroenteritis. They may discuss possible control measures. They also learn how to work on a team consisting of their colleagues, the tutor, the lab technician, the nurse, and so on. At the end of the time allotted for the project, each student submits a record of his work.

DR. EZZAT:

Thank you. This is one example of how to use the general practitioner and the setting where he works to teach basic skills and attitudes and patient care.

Is any thought being given to training students in general practice at Alexandria Medical School, and how are your students exposed to general practice?

MEMBER OF ALEXANDRIA FACULTY:

At Alexandria, students can come in the afternoon to the hospital reception room, where they see a wide range of cases. This exposure makes it much easier for them after they graduate; otherwise it would be very difficult for them.

DR. EZZAT:

So students at Alexandria are exposed to the people if they go to the reception room. It's not part of the curriculum; it's just open to anybody who wants to go. But if there are hundreds of students, how can the reception room hold them all? (laughter)

MEMBER OF ALEXANDRIA FACULTY:

Well, not everybody goes every day.

DR. EZZAT:

Now we've heard what's happening in the U.S., what's happening at Suez Canal, and what's happening in Alexandria as illustrative of the rest of the schools all over the country.

Would anyone like to propose another approach to introducing training in general practice, either at Suez Canal Medical School or at the other schools that follow the prototype curriculum of three years in pure basic science, followed by a year spent largely in the hospital, and then two more years almost exclusively in hospitals?

DR. ANAND:

King Faisal University is experimenting with offering its students an elective in general practice, in which they go to a health center for training. This approach could be adapted to the Egyptian situation.

But if the practicing GP is to function as a role model for the students, which the King Faisal experiment emphasizes, the health centers must improve the quality of their care. If the GP is not experienced enough and skillful enough, such an experiment would fail.

DR. EZZAT:

Is it important to train all medical students in general practice? I would like to hear from somebody who says no, it's not required.

PARTICIPANT:

Yes, it is important, because most of them will have to work as general practitioners even if they are going to specialize later. Also, specialists cannot confine themselves to treating cases in their specialty. They are sometimes called upon to function as GPs.

DR. EZZAT:

Such as when?

PARTICIPANT:

Such as if they're working in some remote place, or are asked by their neighbors or family to see a patient. Most specialists in private practice spend about 50 percent of their time treating nonspecialist complaints. So they have to have the basic skills.

When I first graduated, I was confronted with things I had read about and seen other people doing but had never done myself.

DR. EZZAT:

Because they were rare conditions, or had you not been exposed to them because you were trained exclusively in hospitals?

PARTICIPANT:

Because I was trained in hospitals. There are many skills we read about but never learned how to do ourselves. To learn a skill, you have to perform it. And after doing something myself once, I knew how. But at the beginning of my career, I was confronted with very difficult situations for which I was unprepared, such as attending deliveries. I delivered a baby, but there was no one to seek advice from, and I had to do it all by myself. I had seen people doing it, I remembered what my lecturer used to tell me, but it is different now that I have done it myself. Every doctor must be exposed to general practice.

DR. OBENSHAIN:

Part of the reason that family practice departments have wanted equal time in the undergraduate curriculum has to do with the respect that such exposure evokes in students. Surgery gives time to students, medicine gives time to students, pediatrics gives time. Well, if we're a specialty of equal stature to them, we need time in the curriculum to impart the academic discipline of family medicine

to students.

I'm a pediatrician, and I feel rewarded when a student says, "I want to be a pediatrician like you." We must offer students a respected role model in family medicine, so they will have the opportunity to say, "I want to be a family physician, a general practitioner, like you, because I like and respect what you do." A prime reason for trying to get general practice family medicine taught to undergraduate students is to give them an opportunity to see that this is something one can do.

Before I went to New Mexico, a student came to me at the hospital one night. He wanted to go into general practice, but was very worried that other physicians would not respect him if he became a general practitioner. He wanted to know how he could deal with that. One of the reasons we in New Mexico have done as we have is so that this student would now be able to say, "I want to become like one of my respected professors," instead of, "I am going to be different than all of my respected professors," which creates a real tension. Some of you are nodding, agreeing. I have felt in our several days of visits here in Egypt that we have gone through the same kind of experience in America that you are going through in Egypt today.

DR. EZZAT:

Dr. Zohair, would you please describe how and why we started a department of general practice at our school, and how you perceive the role of the department in training the students?

DEAN NOOMAN:

We started our department of general practice, which is one of 15 departments in our school, for the very reasons Dr. Obenshain just mentioned. There is a great lack of role models. We can see professors of surgery, professors of medicine, professors of whatever, but where is a professor of general practice?

If you want to promote a discipline, or a profession, you foster those who will take care of it. If there are no general practitioners watching out for the profession itself, the discipline itself, it will be a no-man's-land. The questions we are facing now, and which we have been facing since we started, are: Who is going to take care of the general practice specialty? Who is going to create a department? So far, we have devised only interim solutions.

DR. MAKLADI:

I would just like to add that another very important consequence of general-practice training in any school is to expose the students to a comprehensive attitude toward patients and their care. The classical approach is to perceive a patient as a pediatric case, or a case of meningitis or heart murmur.

We'd like our students to look at a patient as a comprehensive whole, not only as a diseased person. That is the importance of the general-practice approach in the undergraduate program.

DR. EZZAT:

Yes, it's very important to make every department think in a general-practice way, but can we do it? (laughter) We will ask Dr. Bicknell, who has been a witness to our efforts for five years now.

DR. BICKNELL:

I'd like to refer back to an earlier question about the value of general-practice exposure for people who are definitely going to choose some other specialty. I think there may be two additional benefits for them. They will get to see the diseases of their ultimate professional interest outside the hospital, which will presumably equip them to give better specialist care.

Second, they can learn the strengths of the family practitioner, and how a general practitioner and a specialist might work as a team, referring back and forth as appropriate. There is a lot of fantasy among specialists about what the general practitioner can and cannot do, should and should not do; there's also a lot of fantasy, and a distinct lack of knowledge, at least among specialists in the U.S., about the community and the family. They often make correct diagnoses but very incorrect prescriptions for care and treatment because of lack of knowledge of the patient and the family.

DR. EZZAT:

Would any of our junior colleagues at schools other than Suez Canal tell us his views on training medical students in general practice? Would it be accepted?

DEAN NOOMAN:

We'd also like to hear from our junior colleagues who have

been working in the rural health units. Have you felt prepared for your tasks as a rural health doctor? Has there been something missing in your education, or it has turned out well?

DR. HAMDY (Assyut):

Allow me to offer a point of view from Upper Egypt, where we have a lot of endemic disease. We do a field study with our students, who learn through contacts with the people to identify the problems and recognize the relationships between environmental factors, socioeconomic factors, nutrition, and behavior. Behavior is the most important factor in most of the endemic disease in Upper Egypt. So our point of view is that students must first succeed as general practitioners, and then specialize later.

DR. EZZAT:

So in the Department of Community Medicine at Assyut you send students to survey the problems of the communities, to examine the people, to do various tests, and to detect the health problems there, the major endemic diseases and the socioeconomic factors that lead to such conditions. Do they practice anything?

DR. HAMDY:

They do general physical examinations.

DR. EZZAT:

For how long do you conduct the survey?

DR. HAMDY:

Fourth-year students go every Friday for the whole year.

DR. EZZAT:

How many students go?

DR. HAMDY:

About 40. All the students want to come because they have benefited a lot from doing general examinations and from contact with the people and opportunities to see the environmental causes.

DR. EZZAT:

Have you worked in one of the health units, Dr. Hamdy?

DR. HAMDY:

Yes. One year in the Sohag rural health unit, and one year as a surgical resident.

DR. EZZAT:

Then would you please answer Dr. Zohair's question? (laughter) As a physician in the Sohag health unit, did you feel yourself prepared to serve the people? Did your training match the job you were doing?

DR. HAMDY:

No, I found a lot lacking in my studies. I never thought about the causes of disease. How is the water supply? What about the environment? What about nutrition? I didn't think about statistics at all, or about how to keep records, or notification. I didn't know anything about things like that.

PARTICIPANT:

I am a GP in the Health Insurance Organization. We have a very good referral system, and the easiest thing to do is just to refer. But if I had had better training, I could have spared a lot of referral to specialists when I first began working.

PARTICIPANT:

Dr. Obenshain, is the object of your school to graduate only primary-care physicians, or could this approach be equally appropriate for the future neurosurgeon or cardiologist?

DR. OBENSHAIN:

We believe very strongly that this would be the best way to educate all physicians, whether they're going to be general practitioners, neurosurgeons, or specialists of any type. For two reasons. The job of the physician is knowing how to diagnose and solve a patient's problem. To do that, students must have the opportunity to learn to do it, to practice doing it, to be evaluated

in how well they do it, and then to do it again.

They must also learn how to advance their knowledge. New drugs, new technologies, our abilities to understand patients' problems--so much in medicine is changing rapidly. So doctors must know how to keep on learning. We feel that this is essential to a general practitioner, but it is just as essential to a specialist.

We developed our pilot project to demonstrate to our faculty that there is a different and, we feel, a better way to educate medical students. We hope that there will be crossover--that techniques we are using in our primary-care track will be adopted into the regular track for educating all physicians.

DR. EZZAT:

Among those who feel most urgently that students should be trained in primary-care settings are the people working in endemic diseases. Our next speaker is a professor of endemic medicine at Alexandria School of Medicine, and I'd like to hear his views.

MEMBER OF ALEXANDRIA FACULTY:

Yes, we have some important national health problems, particularly parasitic and endemic diseases, and students should have a basic idea of how to diagnose and manage these cases.

Schistosomiasis is the first priority: nearly 40 percent of our entire population suffers from this disease in both Upper and Lower Egypt. Helmenthic infections are also quite common in this country. I regret to say that more than 50 percent of Egyptians suffer from helmenthic infections solely, and 25 percent from polyparasitism. Undergraduates should learn how to diagnose, how to use a microscope to see the ova, how to treat, and how to use the newly introduced medicines--particularly the broad-spectrum antihelmenthics in mass treatment campaigns. Who will face this?

DR. EZZAT:

If I am going to be a surgeon, should I still be exposed to such a training?

MEMBER OF ALEXANDRIA FACULTY:

Yes, yes. A surgeon will encounter the complications of this disease. He will face patients suffering from hematemesis due to a severe ruptured spleen from advanced hepatic bilharzia; he will face cancer related to bilharzia, and other serious complications.

PARTICIPANT:

What happens after becoming a general practitioner? Here we all assume that eventually we should specialize. In medicine, for example, there is general medicine, and then you may specialize in chest medicine or cardiology or neurology. Now we are even beginning to hear about doctors specializing not just in ENT, but in ear disease. If someone starts as a GP, will he put in all his life as a GP or should he eventually have a specialty?

DR. OBENSHAIN:

In our country, our experience was that young physicians were all going into specialties, and the people were complaining that they had no one to understand their problems. Care was so fragmented that no one was caring for the patient. He had a doctor for his heart; he had a doctor for his eyes; he had a doctor for his head; he had a doctor for his lungs; he had a doctor for his stomach. But he didn't have a doctor for him. (laughter)

Out of this developed our specialty, which grew out of general practice and is now called family practice. If a patient needs some specialty because, for example, his heart problem has become too severe for the GP to manage, or he needs an opinion, then the GP seeks that. But the patient comes back to the GP, and the patient knows there's somebody looking out for him. We're trying to get this the respect it deserves. Rather than saying, "I'm not a specialist; I'm just a general practitioner," we're saying, "I'm a specialist; I determine when you will see my patient, because I know what's best for my patient. You may know what's best for his heart at this point, but I know what's best for him."

Now we are discussing how to prepare the physician to do that. I think there are particular areas of knowledge and skills application that all physicians need, but that the general practitioner must be more expert in understanding the community, the impact of the illness, the complexities of referral, and patient management.

UNDERGRADUATE STUDENT:

Professor Obenshain, what is the best way to evaluate the effectiveness of students' training in general practice?

DR. OBENSHAIN:

That's a very difficult question. It's always the students

who ask the hardest questions. (laughter)

I don't think we know a best way to evaluate that experience. We have to evaluate it by talking with the students, and finding out how they felt the experience benefited them. To give you an example, our students told us that they wanted their rural clinical clerkships, which took place at the end of the first year, to begin earlier. They said the clerkship showed them very forcefully what they need to learn when they returned to school, and they wanted more class time when they came back. So to make that possible, we sent them out two-and-a-half months earlier.

We listen to our students to find out what the value of a particular experience has been to them. We also have them do a community project, and then we observe how this increases their understanding of the patient in the community. These are the best ways we know of finding out what has happened.

The real measure of how successful we are will come years from now when our students have completed their training, and we can see how they practice medicine and how they interact with their community after they've gone into practice. That's a ways in the future--which takes the pressure off me to be able to answer your question. We don't have a full answer yet, but this is something we are very concerned about and are looking at all the time.

DR. EZZAT:

You're throwing a responsibility on the student to advise you. . . .

DR. OBENSHAIN:

Well, sure, he's got to help. That's right.

PARTICIPANT:

When is the best time to start exposing the undergraduate to such experience?

DR. OBENSHAIN:

I think you can't start that exposure too early. Not merely in the first year, but on the first day of the first year. We even try to select students for our program who have worked in the community before. Were they involved in their community when they were growing up? We put a lot of weight on their activities before medical school because we think it tells us a lot about what they

will do later. It give us an idea of what they value. Just as your students have the opportunity of volunteering, which tells you a lot about the students who do volunteer.

PARTICIPANT:

Do you think that all schools in the United States or in any country should follow this new approach, or should some schools remain as they are, and others change their policy in accordance with the needs of the country, or their part of the country?

DR. OBENSHAIN:

I certainly don't expect that all medical schools in our country will eventually be doing things in the same way. There will continue to be traditional schools; there will be some problem-based schools; some schools will put a lot more emphasis on family medicine, partly because the state governments that provide the money say that the state needs more family doctors.

Some schools will say, "Our job is to train specialists." Each country, and in the U.S. each state, will make these decisions based on how the government and the faculties of medicine perceive the needs of the population around them. I think there will continue to be many different systems.

PARTICIPANT:

We have plenty of medical schools, and I think that each school has to decide for itself whether it's going to train family doctors, or traditional doctors, or very specialized doctors.

DR. TAYMOUR:

Are we all agreed now that we have to start exposing students to general practice as early as possible, even in primary school? (laughter) Well then, how are we going to do that? How are we going to formulate it? Is it purely a matter of familiarity with the community, or are we talking about teaching skills--feeling the spleen, giving injections, treating wounds? We have to start to think about what specific form that education will take.

I am speaking as a man who is going to sit down and plan a curriculum for precisely what we are talking about. A general practitioner course. And when I reach the point of deciding on the details of that curriculum, I will stop and ask what specific things are actually needed, which we haven't yet defined.

If we are going to train people who will be working in a variety of settings and circumstances, with different constraints, and who will need different characteristics, perhaps the best approach is a community-oriented problem-solving type of curriculum, which can equip doctors to learn any job in any setting.

DEAN NOOMAN:

Among the issues that have not yet been resolved are the following: Is it enough to provide formal clerkships in general practice, or should the whole curriculum be re-oriented toward community involvement, as in community-oriented medical schools like ours? Or both? Do we need a department of general practice in every medical school?

In England, for example, there is a department of general practice in every medical school, and all of the schools have more or less classical curricula. Medical students are exposed to general practice while attending clerkships in the department of general practice. This is one way of including general practice in the undergraduate curriculum. Another pattern is a so-called community-oriented medical school, where the whole curriculum is oriented in such a way that the student gets a very good exposure to the community and its health problems, and to the role of community physician.

Our school has committed itself to exposing undergraduates to general practice and community medicine. The issue we are facing now is: How and where are we going to do so? In a university hospital? In the rural and urban health units? And if we decide that the university hospital is not a suitable place, how are we going to do it in the rural or urban health units, which are not components of a medical school or a university hospital? How can we organize our relationships with the various health-care delivery sites, including the small rural health units?

DR. FREELING:

Would it be helpful to hear how it works in the U.K.?

DEAN NOOMAN:

Yes, very.

DR. FREELING:

We have a body called the General Medical Council, which is empowered by the government to grant or withhold licenses to

practice medicine. As an outgrowth of this power, the Council also makes recommendations about basic medical education, to ensure that students reach a level at which they may be licensed.

In 1980 the Council recommended that all students be exposed to general practice, and added that this would be more likely to be effective where there were departments of general practice. Before becoming doctors, the Council declared, undergraduates should become familiar with (1) the common diseases not usually seen in hospitals, including their management and treatment and natural history; (2) the prelude and aftermath of hospitalization, including the natural history and effects of management, in conditions that involve episodic hospitalization; and (3) the context of patients' lives outside the hospital, so as to recognize the interaction of environment, family, work, and health.

The Council also pointed out that the purposes of interviewing in general practice tend to differ slightly from the purposes of interviewing in a hospital, and that it would be very difficult to learn the former from a specialist in a hospital, though the same specialist working in the community might take a history of the type more suitable to general practice.

The goal of these efforts was not to produce a future general practitioner, but to produce a doctor qualified for a license to practice medicine. The idea is that doctors should be trained in such a way that they could develop in the direction that (a) society needs and (b) they feel motivated to. Tucked away at the bottom of the recommendation is "so that the student may see general practice as a vocational opportunity." Half the students in our country will end up in general practice whether they like it or not, so they might as well see it before they join it.

One consequence of the Council's recommendation was that we needed to find a great many practices and practitioners to whom we could entrust our delicate flowers, the students. I was asked how I would select the practices. My answer was, "Anybody who can take a student can have one, and anybody who wants a second student is probably quite capable." Of the first 35 practices that we used, we had to give up one because we thought the doctor was unstable. And two others withdrew because they couldn't stand the heat--they couldn't answer the students' questions or tolerate their scrutiny.

In the preclinical years, the students learn interviewing and human behavior, as well as various matters having to do with the environment. In their third and fourth years, when they're also doing obstetrics and gynecology, psychiatry, labs and neurology, they learn about general practice and about the social services--the nursing services and that kind of thing--and about the origins of the cases they're seeing inside the hospital. In the final year, they are assigned to what we consider the better-organized practices and are allowed--within the bounds of legality--to be completely

independent. In other words, they can't write prescriptions, but they are allowed to order investigations without being questioned by what the Americans call their preceptor.

DR. ZIAI:

I would look upon the inclusion of general practice in the curriculum as having another benefit, which is to bring the other disciplines down to earth. I hate to think where the neurosurgeons are going to take our medical-school curricula unless we have people on the faculties who are convinced of the importance of the broader aspects of medical teaching. I personally consider the things we are talking about much more important than learning about the relationship of the messenger RNA to the ribosome.

Medical curricula have had a way of getting completely out of hand. Medical-school teaching has very little to do with the tasks that the student is actually going to be performing in the future. I myself was a dean of a medical school and chairman of a Department of Pediatrics long before I knew how to practice pediatrics. Not until you are really and truly involved in taking care of people, and all of the things that make them tick, will you be able to make some sense out of this profession.

Why do we start with anatomy? Is that really the most proper thing to do? There are a lot of questions like this that we have to ask ourselves. In fact, starting with anatomy may be the worst thing we can do. The student comes to medical school as an idealist, with some respect for humanity. What happens? We confront him with a cadaver, and his last vestige of respect for the dignity of man dissolves. He makes jokes about this poor stiff in front of him. And we should also teach anatomy in a different way: nobody ever taught me the difference between the liver of a 2-day-old and a 70-year-old, which is more important than all the details of the cutaneous nerves that I did learn.

I hope that the departments of general practice will arrange home visits. Many students graduate from medical schools without ever having had an opportunity to visit a patient's home, which is the best opportunity the students and the faculty have to see human beings as human beings. Next best is the outpatient department of a teaching hospital, but that is a very selective population of patients. You see people best in their homes. Problem-solving skill, which was touched upon this morning, and the ability to evaluate the important things--all of this, I feel, comes from exposure to the community. We sometimes get so involved with our biochemistry labs, and our fancy hardware, that we forget about the tremendous laboratory we have out there in the community.

Wouldn't it be wonderful if students could spend a couple of hours a week with a good teacher, talking over their questions and

concerns about the way medicine is practiced, about the way people are treated?

I'd also like to comment on the question of how to find preceptors who are good GPs and good at communicating with students. In a sense, it really doesn't matter how good or how bad he is. I think, in fact, that students learn a great deal from the bad ones. Students are a lot smarter than we as professors give them credit for.

First of all, it is our responsibility as a medical school to keep up the level of medical care, and there is really no better way of teaching physicians than to bring them in contact with students. The student asks questions, which send the practitioner who's not up-to-date back to his books. Meanwhile, the student sees that someone who took the same biochemistry and immunology and pathology that he is taking has forgotten it all ten years later. This scares him, and he says to himself, "How am I going to avoid following in this guy's footsteps?" If he had not had this exposure, the same trap would be waiting for him. I think this is nothing but healthy.

I was delighted, Dr. Obenshain, to hear about the preference you give to students who have done some work in the community. Right now our selection methods are based on who has the highest grades. And grades don't even indicate who is smarter (whether or not that is the most important characteristic for a physician). In terms of selecting students, I think there is nothing comparable to observation of the person out there rolling up his sleeves and doing what he can. This enables you to select the best-motivated individuals. And if you are going to expose the students to the community and let them try to solve some problems, the results will be better if they have already had some experience.

DEAN NOOMAN:

Has anybody else had any experience with starting exposure to the community in the preclinical years? Do you think it's beneficial or not? One of our students points out that because he has been educated as a self-learner at Suez Canal Medical School, he can benefit by going alone to a health unit or hospital to observe, and then going back home to read. But he doubts that preclinical students will benefit as much, because their education is oriented differently.

DR. OBENSHAIN:

I agree with Dr. Freeling that the students are basically very bright. They also come to medical school very highly motivated to help people. It seems to me that one of the best things a medical school can do, from the first day the students arrive, is to start

to harness that energy. To say, "There are people out there who do not understand their problems, who don't understand that children shouldn't swim in the canals, and these sorts of things. Why don't you first find out why they shouldn't, and then think about it from the point of view of the people in the community so that you can communicate with them." Then they can begin learning primary-care general practice from the ground up. It sounds as if some of your medical schools, like most of ours, do things upside-down.

When we visited Alexandria, I had two feelings. Eight hundred new medical students each year would scare me to death. But from the point of view of sheer energy, of an ability to make something happen, that is tremendous power. It is a question of harnessing that power and putting it to work. You could start by just allowing interested students to volunteer. Say to them, "The rural health clinics are open to you; come when you can. We will let you talk to our patients."

I know that your students at Suez Canal talk to patients from the first day, but do students at all the medical schools have that opportunity? They want to be doctors; they want to help people. Let them help people. Don't say, "You can do that six years from now, if you get good enough grades." Let them help people now. That will make them want to do more; that will make them continue to learn. Part of it is just a matter of taking the shackles off. Instead of saying that medical students can't do anything, recognize them as the best and the brightest that you have and turn them loose. Tell them, "Here, Egypt has health problems!"

DR. FREELING:

I don't envy the teachers at a school like Alexandria, with 800 students coming in each year. I share Dr. Obenshain's fear at the prospect of trying to teach 800 people.

Has any thought been given to having a four-term year instead of a three-term year? If, at Cairo or Alexandria, you sent away one-quarter of your students, you could teach the remainder their anatomy and physiology much better. Meanwhile these 200, who are just cluttering up the works in the teaching of physiology and anatomy, could go out to the rural health centers! You will have solved the problem of teaching physiology and anatomy, and the students will get something out of being out in the field. As we drove back from Alexandria, I thought about what I would do with 800 students. And I decided that I'd get rid of them. A four-term year. . . . I think it might work.

DR. OBENSHAIN:

If the marks a student gets in a general-practice course are

considered as important as marks in other courses, the student will try as hard to get a good grade in general practice as in anatomy. When students' futures depend on the grades they get on examinations, it is very hard to interest them in anything that is not directed at that goal. That is why Dr. Freeling's suggestion that you make the 4th term part of the curriculum is so attractive. Have the students be graded in that. Have it be, as Dr. Ziai said, as important as the grade in anatomy, physiology, and biochemistry. But this is going to be very difficult to communicate to your colleagues in the more traditional universities. I am sometimes looked on in my country as some kind of crazy man.

DEAN NOOMAN:

We are too . . . (laughter)

DR. OBENSHAIN:

Much of this depends on the attitude of the school. Another thing to do is to make the dean a general practitioner. That's really the best approach.

DR. MAKLADI:

I would say, judging from our experience at Suez Canal University, that there is a difference between the tutors in the field, at the rural and urban health units, and those trained as GPs at the university. Students complain about the general practitioners at the rural health centers; they say they are not well trained enough to teach the students.

DR. FREELING:

I understand that, but it's still better to see a patient with a doctor who can't teach than not to see a patient with a doctor who can teach. We aren't just talking about clinical skills.

Let me ask a question. Does this country have much accidental self-poisoning by children who drink from bottles they shouldn't drink from?

AUDIENCE:

Yes, absolutely.

DR. FREELING:

We have a lot of that in our country too. I know of one school that said to its students, "We want you to go out, stop people on the street and knock on doors and ask, 'Where do you keep certain poisons?'" So the students had to begin by finding out about poisons and their effects. To their horror, they found, as you might find in Egypt too, that the typical place to keep poisons is in empty soft-drink bottles, because they're less expensive than other bottles. The students learned about a serious pediatric problem, about preventive medicine, about toxicology, about drugs. . . . This is really the kind of thing we are talking about. The students don't have to just be affiliated with a GP; their contacts with the community needn't be limited to his patients.

DEAN NOOMAN:

Thank you, Dr. Freeling. I think your message is very clear that it is the attitude toward general practice that should be the object of our efforts. And let us work with what we have. Your message is clear.

I keep coming back to the problem of the relationship between the medical schools and the other health-care facilities, including hospitals and health units in the urban and rural sectors. The usual pattern is that medical schools have university hospitals; they don't have university rural health units. And there is the usual role division between the university hospitals and the Ministry of Health facilities. Other medical schools have their own hospitals, but they do not have access to--not official access, anyway--or any control over other health units.

What we are trying to do in our area is to work in the Ministry of Health hospitals and health units. We don't have our own facilities. We are trying to devise a way around this difficulty by working together with the Ministry to enlarge the concept of what's called a teaching hospital to include Ministry of Health hospitals and units. This is a very local problem, involving some bureaucracies here, but it is an important issue to solve. If we want universities and other medical schools to train their students in general practice, there needs to be a mechanism and a place to allow this to happen.

WORKSHOP B
VOCATIONAL TEACHING AND TRAINING
IN GENERAL PRACTICE

DR. ESSEX:

For purposes of this discussion, let us define vocational training in general practice as training that begins when the doctor graduates from medical school. Dr. Dowidar?

DR. DOWIDAR:

To train anybody to do anything, it seems to me, you must have several components. There must be a trainer who is himself well-trained. There must be a specific program of training, whose content combines knowledge, skills, and applications. And this training project must be conducted in a certain place--in the hospitals, in the general practice units, or both. What are the pros and cons of each of these locations? And are we able to offer residency training to every junior general practitioner?

PANEL MEMBER:

It's utterly essential, I think, to have a residency program leading to a degree, whether two years or three years in duration, which could be jointly sponsored by the Egyptian Medical Association, the universities, and the Ministry of Health.

But there remains the important question of mobility. Most practicing physicians cannot afford to leave their posts, so training programs should be offered near where they live and work. I dare say most family doctors live in rural areas without universities nearby. The trainers should be senior physicians with extensive clinical experience in general practice, with help from the staff of the universities and specialists from the Ministry of Health on day-release.

PARTICIPANT:

The universities are probably not the most appropriate auspices for general-practice training, because universities are built on a taxonomic system of disciplines and totally independent departments; there is very little interaction between them. And the only department of general practice is at Suez Canal University.

DR. ESSEX:

Are there sufficient trainers? And if not, how can the trainers be increased in numbers?

DR. SHEHATA:

The general feeling is that there are not enough good GP trainers. I think, though, that if we search we can find enough to start with. They will need some orientation and some condensed training courses on how to be trainers. These courses could be offered in different places than are used for training now.

We have to start by deciding on the minimum qualifications we will specify when we advertise for candidates. We also need to figure out how the trainers will be treated financially: what will be their relation to the training agency, whether it is a medical school or the Medical Association or the Ministry of Health?

Meanwhile, we should see if we can find some eminent professors, like Professor Sami and Professor Dowidar, who would be willing to contribute some of their time and effort to teaching the philosophy of general practice.

And if we could persuade some of the younger assistant teachers in different disciplines to change direction and go into the field of general practice, as some of those at Suez Canal have done, we would have more than enough to start with. I think it would take about a year to prepare, say, 50 good GP trainers.

DR. HESHMAT:

Being of Egyptian origin and familiar with the situation in Egypt and the United States, I feel that the trainers in Egypt are very adequate in number.

The concept of general practice is best taught by a general practitioner. But this constitutes only a fraction of the teaching of general practitioners. General practitioners should also be

taught by specialists who are sensitized to the mission of general practice and aware of how much of their specialty to cover. They should be aware of when the GP will treat and when he will refer. Egypt certainly has an adequate number of well-trained, well-qualified experts in the various specialties of medicine. All that is needed is a plan, a well-thought-out plan, to acquaint the specialists with what general practitioners need to know in their respective specialties.

The Egyptian Syndicate of Physicians could recruit specialists who are really interested in teaching general practitioners. I am worried that training of general practitioners will be implemented only by master's-degree graduates in general practice in the training units of the Ministry of Health. Their knowledge is not, I would argue, sufficient to teach surgery, pediatrics, and the other specialties. We need professors, lecturers, and teaching assistants to come one or two days a week to the training centers to offer more sophisticated knowledge.

DR. ESSEX:

If much of the teaching is done by specialists, would it be possible for the trainees to get together in small groups one half-day a week to emphasize how their training applies to general practice? Otherwise it is very difficult in a two- or three-year program to relate hospital training to outside work.

PARTICIPANT:

It should be a two-way street. Candidates should go to a teaching hospital one day a week, and, as Dr. Heshmat said, the staff and trainer should go to the health centers one or two days a week to teach candidates at the center about the kinds of cases they encounter there.

DR. SHEHATA:

General objectives have been defined for all the medical schools, but the specific components of each discipline that GPs need to learn were left up to each university to decide. Our program at Suez Canal is far from perfect. But because we are a new school, we could devote a great deal of attention and support to the general-practice program. And because we are a community-oriented school, the staff is relatively enlightened about general practice. They are mostly specialists, and still disease-oriented, but that attitude is changing.

Perhaps the most important feature of our program is that we have a department and a supervisor. Someone is responsible.

General-practice training draws on many disciplines, and must also work with the health insurance and Ministry of Health units and hospitals and so on. There is a great deal of coordination to be done. Somebody should be responsible; it could be a staff member at the school or a senior GP who could be trained and then devote some or all of his time to the job.

For the time being, most of the training is done by members of the university staff, with the help of visiting professors like Dr. Heshmat. Now that we have graduated our first class, they will be working as GP trainers. We ask the trainers to visit the primary-care units according to a schedule, something like we heard about the Saudi project. According to this schedule, they attend and discuss cases with the trainees in the primary-care units.

Some of the trainers are reluctant to go, but it is working. It helps a lot in reorienting the teachers to the primary-care situation. At the start they complained, "There are no teaching cases in the units; in the university hospital we have big problems to teach them about." But as Dr. Heshmat illustrated this morning, there are teaching cases in the units. Not only that, but the behavioral aspects can't be taught well in theoretical courses. They require an apprenticeship type of teaching: the GP trainee observing and being observed by somebody who has experience in communication skills and behavioral skills. Without good communication, there won't be good diagnosis or management or compliance.

One problem is that the training units are still organizationally unsatisfactory. But I think this is part of the challenge. Part of our objective in training GPs should be to train the whole primary-care team and to upgrade the whole system in these units.

DR. HESHMAT:

I was very pleased to hear one of my colleagues suggest that the general practitioner in the field should go to the district hospital to see what happens to the patients he has referred. We general practitioners sometimes focus exclusively on primary care--that is, care in the clinic--and forget that disease is a continuum. Just as he understands how to manage his case in the clinic, the GP should also understand the entire spectrum of a disease by following cases he referred. When we at Suez Canal University send a patient for consultation, we insist that one of the students meet with the consultant and report back to us the consultant's opinion.

PANEL MEMBER:

We ask a great deal of the general practitioner. He is

responsible for emergency treatment. He screens for diseases. He has to deal with every aspect of medicine that does not need to be referred to a specialized colleague. He needs good training to assess the health status of individuals, to recognize diseases early, and to develop and implement appropriate plans of care. We should bear in mind that continuing education is part and parcel of vocational training.

I have been speaking with Professor McCauley from McMaster University in Canada, who has raised some very important questions which I would like to ask him to share.

DR. McCAULEY:

This morning the young physicians began to discuss some of their questions and concerns. So I would like to raise some of their questions and some of the questions Dr. Zohair Nooman posed in his paper. My first question is whether there is agreement that there should be a specialty of general practice.

DR. EL SHABRAWY:

Let me make the question slightly simpler. All of us are familiar with the FRCS, a general diploma that entitles the bearer to do surgical work. There is an FRCS in neurological surgery, in urogenital surgery, in chest surgery, heart surgery, and so on. The MRCP is similarly specialized. Do we need only a specialty in general practice, or should there be further specialization comparable to the FRCS and MRCP?

DR. SHEHATA:

Professor El Shabrawy has suggested that there could be subspecialties based on the needs of the different locales where general practitioners work--factories, rural areas, urban areas, and so on. Subspecialties could be offered as electives within the regular course or could involve more training.

PANEL MEMBER:

One of our colleagues has asked about the specific causes of absenteeism during study for the master's degree in general practice. His second question was why some universities use the same procedures to teach general practice as they do to teach general medicine or general surgery. Why are there no courses specifically for general practice?

To answer his questions, the main cause of absenteeism is that

the candidate has trouble arranging his life in such a way as to attend courses while working as a general practitioner in one of the primary-care units. We try to schedule the lectures and symposia two days a week; the rest of the week, he is to receive his training in his unit. But we found that concentrating the lectures in two days worked fine on paper but not in reality. The professors would not agree to be concentrated in two days. So the student is in a dilemma: is he going to have his training in his unit, or is he going to attend a lecture at the same time, a time that was not specified on his original schedule? This is a point of dissension between the teaching staff and the candidates. If we can solve this problem, the problem of absenteeism will be largely solved.

The second issue is why master's programs in general practice are lumping their students together with candidates for other master's degrees. It is a question of numbers. For example, at Mansoura Faculty of Medicine there are 100 or 200 candidates for the master's degree in general medicine, and there are also degree courses in other fields. So the professor finds that he has 500 students. Therefore he cannot design a special course for each master's degree program. What happens in practice is that he just collects everyone in a general lecture, or on the ward. This system is bad, but it is going to be changed. And day by day our colleagues on the clinical side are trying to understand what is meant by general practice. It has been somewhat vague in their minds.

DR. McCAULEY:

My second question, stimulated by Dr. Zohair's comments this morning, has to do with the way in which a physician can become a specialist. The three ways that I have heard from speakers are as follows. (1) The master's degree in general practice, which is a university program in which there is clinical training and also a research thesis and examination. (2) Specialty training with an examination but without a research project, as in Australia, North America, and Great Britain. (3) Fellowship or certification, as in Canada and the United States, whereby general practitioners who complete a certain number of study hours every year are allowed to sit the examination. Dr. Shehata has suggested that there could be special condensed courses for general practitioners who want to obtain fellowships, to prepare for the same examination the young doctors take in the masters program.

DR. SHEHATA:

Let me suggest three alternatives that could work in parallel with each other. (1) The master's degree course, mostly to train teachers for the faculties of medicine, with nuclei all over the country as models for training in general practice. (2) A fellowship degree from the Egyptian Medical Association, for which

on-the-job training in different areas in Egypt could be followed by a condensed theoretical course lasting two or three months, and then the examination for the fellowship degree. (3) The Ministry of Health, health insurance, and other employers of doctors could develop their own postgraduate training courses in general practice, which newly graduated doctors would be required to attend before beginning to practice. No certificate or degree would be given. A doctor who wants a degree would attend the three-month theoretical course and take the exam for the fellowship from the Medical Association. If he wants a master's degree, he would not need to repeat the residency; he would just have to write a thesis and then take the examination.

We need all three parallel alternatives, because the numbers are too great--the newly graduated doctors alone number about 2,500 a year. No agency could do it alone. If we adopt this suggestion, there should be a board of representatives from all these agencies to coordinate the different training systems.

Another idea just occurred to me. We have a High Institute of Public Health in Alexandria. Why not have a High Institute for General Practice to train general practitioners and primary-care teams?

PARTICIPANT:

I want to ask about the system in other countries. After the student finishes medical school and is practicing, what next? Is there a master's degree in general practice?

DR. McCAULEY:

The system in Canada and the United States is that everyone who graduates from medical school is required to spend one year as an intern in an approved program run by a university before being awarded a license to practice medicine.

If you want to become a specialist in family practice or general practice in Canada or the United States, you are required to take a training program that provides a lot of supervised office experience plus medicine, pediatrics, surgery, obstetrics and gynecology, psychiatry, and electives. At the end of the program--three years in the United States, a minimum of two years in Canada--you can take the examination. In Canada, 90 percent of the people who have taken the program have passed the examination and become specialists in family practice. The systems in Britain and Australia are somewhat different, but the basic principle is the same.

PANEL MEMBER:

Now we are approaching the core of the problem of vocational training. Dr. Shehata has pointed out very clearly that we have three parallel alternatives: a master's degree offered by the universities, the fellowship under the auspices of the Egyptian Medical Association, and continuing education provided by the various health agencies. His proposal for a High Institute of General Practice is not far-fetched at all. It can be done and it might solve much of the problem.

When we created the system of general practice here in Egypt, we did not do so in a vacuum. We read widely about the various systems, and we visited various schools of medicine in the U.K. and elsewhere. Many features of the English system have been adopted here. The general practitioner is highly respected in the U.K.; most universities there have a vice-dean responsible just for general practice. Our universities are trying hard to produce as many master's degree graduates as they can. However, even two or three years from now we are not going to have more than 30 or 40. In the meantime, the Ministry of Health is in great need of continuing education for general practitioners.

One of our colleagues has asked whether general practice training is really specialty training, or is it a means to correct the weaknesses in undergraduate education? To answer her question, it is not meant primarily for remedial purposes. Undergraduate training focuses on the later stages of disease, not early detection, and the examination always concentrates on very complicated advanced cases. In our practices, 90 percent of what we see is totally different than what we have been taught. The job description is very clear about common conditions, about serious conditions, about emergencies, about chronic conditions, about dying patients. It is totally different from what is taught to a basic doctor who later goes on to become a general practitioner or an internist or a surgeon. So, training in general practice requires a totally different approach, a totally different way of teaching, and a totally different setting. In the process it may correct some of the defects of undergraduate training.

A question was also raised about what will happen during the twenty years or more when there is overlap between GPs with master's degrees or fellowship and GPs who have only had a little continuing education? Every evolution, or revolution, has a transitional phase of this sort. We cannot suddenly transform or forget about the practicing doctors--we will do our best, through continuing education, to upgrade their level. But we have to pay more attention to the thousands who are graduating from the medical schools each year.

DR. STERN:

With regard to graduate education correcting the deficiencies of medical-school education, we in the United States consider medical school a preparation for residency training. We do not consider a graduate of medical school eligible to practice medicine.

The American Academy of Family Physicians has also faced the problem of what to do during the twenty years of transition. What we have done is imperfect, but this is not a perfect world. First of all, we allowed no one to become board-certified unless they took the examination. But for the first eight years after we introduced the certification process, we permitted practicing physicians with enough continuing-education hours to take the examination; if they passed, they became board-certified. After eight years, we no longer allowed physicians who had not had a residency program to take the examination. Physicians who did not pass the examination or did not elect to take it were granted advanced standing in the Academy if they had taken 600 hours of graduate medical education in nine years.

We are the only U.S. specialty to require re-examination every six years in order to retain certification. We made it very tough on ourselves because we wanted to prove to the world that we are a rigorous scientific specialty. This is a subject of great concern to me right now, because I have to take the examination again next year!

DR. McCAULEY:

The third question I would like to pose is: what should be the organizational structure for training and certification in general practice? It seems that you have two alternatives. One is to establish a board composed of representatives of the Ministry of Health, the Syndicate, the Medical Association, and the medical schools. To them would fall the responsibility of establishing standards and planning the various types of training in general practice.

The other way would be for each of those entities to function independently, without coordinating their efforts. My bias is that the second choice is bad, because I think you need to have those groups working together. But it might be decided that the medical schools would have all the responsibility, or the Ministry of Health, or the Egyptian Medical Association, or the Syndicate.

You can find different models in different parts of the world. In Great Britain, it's the Royal College of General Practice; the medical schools have very little involvement. Similarly in Australia, the Royal College of Family Physicians is responsible and

the universities are not much involved. In Canada, it's a joint effort of the universities and the College of Family Practice. The government is involved, in all these countries, because it sets the quotas; the government can decide how many people will be trained, because it pays the universities and the trainees.

This question is an important one in planning for the future: which groups should sit down together to make the plans for general practice?

PANEL MEMBER:

The medical schools are digging into the rock to produce some trainers with master's degrees. The residency that Dr. Stern just spoke of corresponds more or less to our master's degree program--a period of continuous practical training in hospitals and primary care units, hand in hand with courses. But the master's degree program is very ambitious; it is highly condensed and includes a lot of scientific work. Our students complain that it is very difficult, and this is one of the causes of what are called unavoidable failures.

Now we need to address the question of how we are going to train our trainers. And what are your suggestions for modifications of our vocational training in the medical schools?

DR. McCAULEY:

I would like to remind you that this is not the first time this type of problem has occurred in medicine. When pediatrics was a new specialty, it had to fight the same fights we are talking about today.

The other point to remember is that the first generation of teachers are going to be what we in North America call re-treads. These are people like myself who practice for several years, and then become interested in academic medicine, go back to school and teach. We are part of the transition era.

You must start with what you have: good general practitioners in the community who will take the necessary courses to obtain the fellowship. I think you need a large number of re-treads. I don't think you can wait until you have produced enough trainers in master's programs.

PANEL MEMBER:

I sat during lunch with some of our students from Suez Canal University. The graduates who have obtained their master's degrees

in general practice are, as we said, the nucleus of the staff in the Department of General Practice. But the dean is confronted with a very big problem: the university regulations will not allow anybody to be appointed as an administrator, instructor, or assistant lecturer unless he passed his bachelor's degree with good honors.

One of the biggest mistakes of the Ministry of Health has been leaving the choice of specialty up to the master's degree candidates themselves. Of course, most candidates choose clinical fields such as gynecology, surgery, general medicine, or radiology. And those at the bottom of the list study for the master's degree in general practice. Some of them are actually very able, but the dean will not be able to appoint these graduates as demonstrators because they have not fulfilled the university regulations for appointment of demonstrators or instructors. If we want to produce trainers, we should select those who satisfy the university regulations; otherwise we are trying to swim without water.

A solution to this problem is to exploit their capacities as instructors in the MOH units. But they are frustrated by this. They say, "What is the point of studying hard for two years and then be sent back to the same places we came from?" Therefore I think the universities have to select candidates who can be the nucleus of the staff in the future. And if the Ministry of Health will modify its method of selection to make general practice a respectable specialization through incentives after graduation, I think we can provide staff for the universities.

DR. SHEHATA:

In order to have an ample number of GP trainees to start with, we can choose some of the good general practitioners in the community and offer them condensed courses. As for the new graduates with master's degrees who didn't have good honors and thus can't be appointed to the university staff, we can still use them. The medical schools need at least ten GP trainers for each teacher. This is not against regulations. We can pay them while they are working for the Ministry of Health or the health insurance to serve as GP trainers affiliated with the university.

Each year we will see a better grade of doctor applying for the general-practice postgraduate course. Private doctors are now asking to enroll in the course, which means that it is gaining ground.

DR. McCAULEY:

I agree with Dr. Shehata about what happens with good students if you have a good training program. Certainly at McMaster we find

our best students going into the family-practice program. They're excited by the challenge. But it must be a good training program, it must be solidly grounded in reality, and there must be good teachers. It really is exciting to see--and I've seen this at Suez Canal University--that, given the opportunity, students will apply for the program if we as planners do our job properly.

We have time for one last question, which Dean Zohair Nooman already raised: are the objectives of the training program clear and realistic? He also suggested that there is a need to devote more time to various specialty components and to office experience.

DR. SHEHATA:

I agree with Dean Nooman that two years is not enough; it has to be three years. Also, dividing the training in general practice into 12 weeks the first year and 12 weeks the second year does not allow for continuity or ongoing relationship between the GPs and the patients, or for shaping a good recording system. Perhaps we could revise it to three months at the beginning of the course and six months in the second year, as in New Zealand. Alternatively, rather than removing the doctor totally from the primary-care unit during hospital training, we could have him make one-day training visits with the instructor from the hospital, as in Saudi Arabia and Oman.

As for whether the objectives are realistic or not, the problem is that general practice means many things in Egypt. It means a school health doctor, whether curative or preventive or both. It means an MCH doctor, a health-insurance doctor, an occupational-health doctor, a rural doctor who does everything, an urban doctor whose practice is mostly curative. So our program should cover all this. If we extend the length of the course to three years, then we can spare three months or six months for elective training in the subspeciality that a given GP will work in after finishing his postgraduate training.

DR. McCAULEY:

Would some of the doctors in the master's program like to speak? It is important for us to hear your thoughts about the training program.

DR. SHEHATA:

Dr. Mahmoud is one of the students in the master's degree program, so he may be able to comment on Dr. McCauley's questions about whether the objectives of the program are realistic or not.

DR. MAHMOUD:

I think the master's program at Suez Canal University covers what we need from the medical and social points of view. What we need more of is organizational training. For example, how to manage the team we work with, how to work as a team, how to keep records, how to follow up. I was deficient in some basic skills, such as how to use the proctoscope and otoscope. That's why I enrolled in this course at Suez Canal University, which covers about 80 percent of the things I've mentioned.

DR. FARLEY:

Your first group of residents will probably be the ones who are most enthusiastic about looking at systems and creating change. They will become the dynamic leaders of the future. If we do not achieve perfection to begin with, each generation takes us far beyond where we were. You are asking the questions and you are developing answers to those questions. Each generation of graduates will produce something better than we, the originators, produced.

PANEL MEMBER:

I would like to ask our reporter, Dr. Shehata, to summarize what we have discussed today.

DR. SHEHATA:

The majority of us agree that there should be a specialty of general practice or family medicine in Egypt. There will be a transitional phase when we will ask all the GPs who need continuing training to complete a certain number of hours of training to continue being certified.

For the new graduates, three side-by-side approaches have been suggested: the master's degree, the fellowship degree, and training courses offered by the various health agencies. A board would handle coordination among them. There is also a suggestion of developing a High Institute of General Practice and Primary Care.

About the program itself, some suggestions were made about changes in the organization of the terms, and about lengthening the duration of the program.

In order to develop a cadre of trainers, it was suggested that we select some good general practitioners and orient them through condensed courses to serve as trainers, whether under the auspices of the medical schools or the Medical Association or the Ministry of Health. Meanwhile the medical schools will find means of affiliating such GP trainers to work in the training units, and of

giving them incentives and prestige for their work.

DR. McCAULEY:

One of the mistakes often made in planning general practice training is to bring together only general practitioners. I commend your planners for bringing together people from the Syndicate, the Medical Association, the various medical schools, and the Ministry of Health.

I very much hope that the groups represented here today will continue to sit down together and talk about the future plans for general practice in Egypt. We have made a good beginning, but there is much work to be done after this session finishes.

WORKSHOP C
CONTINUING MEDICAL EDUCATION
IN GENERAL PRACTICE

DR. BADRAN:

Why is continuing education a necessity? We know that a physician loses about 10 percent of his knowledge every year due to memory deterioration and aging. It is also calculated that medical knowledge expands by about 10 percent every year. The resulting equation suggests that a physician who is not immersed in the current of knowledge, persistently and continuously, is going to lose 100 percent of his capability and effective knowledge in five years. So any one of us who loses the track for five years will find himself nearly obsolete, which is detrimental to his patients and the country. When I used to visit the units with my colleagues in the Ministry of Health, it was clear that the young doctors in the field felt that their isolation deprived them of exposure to current developments in the science of medicine.

The second question is: Continuing education by whom? Is continuing education the domain of the government? Of the local community? Of physicians? Or of the universities?

Third, what is the definition of continuing education? How large a dose of knowledge must we offer to say that we are running a course of continuing education? For example, does this conference qualify as continuing education?

Continuing education can be defined as the process of maintaining and increasing the skills and knowledge of practicing physicians, in keeping with the growing need of communities for better health care and the need of the practitioner himself to feel alive professionally. The working physician today is likely to encounter problems that medicine was not capable of dealing with at the time of his graduation. Unlike other specialties, which focus on a specific organ or a specific disease, general practice is specialization in the generality of medicine, which means that the

candidate probably should know a bit more of everything. But should continuing education provide a bit more of everything? Or should it be a selective upgrading of the capabilities of the general practitioner? Perhaps it should focus on the health team as a whole--not just the physician but the laboratory people and nurses and midwives and assistants--because general practice depends on a health team concerned with sanitation, water and sewage disposal, food and food protection, and all aspects of preventive and protective medicine. But how to proceed? How to select? How to apply? How to maintain?

Also, when we speak of continuing medical education, we should always think in terms of continuing medical evaluation. If we upgrade, the consumer should be able to recognize that the standard of service is being regularly improved, and the increased effectiveness of health-care expenditures and delivery should also be apparent in curves and studies. Otherwise we will just be preaching in the desert, where there is no audience and no effect.

We shouldn't say that the health-care budget cannot allow for upgrading, because monetary resources are not the most decisive factor in development. In the past, development was largely based on capital and natural resources. Today, however, as James W. Botkin points out in Global Stakes: The Future of High Technology in America, the world's treasure is not so much underground and in banks; it resides in the brain and in the fingers. Human knowledge is its source, and the human hand is the tool by which that knowledge is applied.

DR. FREELING:

There is a story, which I gather is true, that some aeronautical engineers who were studying the bumblebee and the hummingbird--a very large bee with very small wings, and a small bird whose wings move very fast--concluded that neither one of them could possibly fly. Luckily, neither the bumblebee nor the hummingbird knows any aeronautical engineering, so, as they have done for 10,000 years, they continue to fly. My point is that all of the general practitioners in this room have continued in general practice, and there is a plausible argument that what we have forgotten is what we don't need.

In order to define the continuing education of the Egyptian practitioner, we need to know what you who are now in practice found to be your deficiencies when you went into general practice, what you now feel to be your deficiencies, and what you think you've learned from looking after your patients. You must be careful about assuming that what you now know is useless.

I suspect that each of you knows slightly different things, and does things slightly differently. When you get together and

compare experiences, you may well be halfway toward identifying the needs of all of you. When we find we have a deficiency that specialists can rectify, we go to the specialists; when we find a deficiency that the sociologists can remedy, we go to the sociologists; when we find a deficiency that people outside medicine can remedy, we go to them. But we rely on ourselves to identify our own deficiencies. The term continuing education implies that you already know a great deal.

I would like to end with an observation. We've had a chance to see some of the work of general practitioners in public health and in health insurance. A number of us from the United Kingdom had the impression that the new graduates are at a different level of performance than those with whom we are familiar. That's not a criticism, it's an observation. What I would like to know, therefore, is what you have had to learn to do after you have qualified, because that will tell us the first step on the road young doctors will have to take.

DR. TURNER:

I'd like to supplement Dr. Freeling's remarks by saying that, if the job of training a general practitioner is akin to building a house, the house must have firm foundations. This means that we need to know what aspects of the student's education prove useful when the career of the general practitioner begins, and what gaps people think should have been filled when they were students. This is a question we can address not only to those who have been in general practice for some time, but also to those who have taken the master's degree course.

To make one specific observation, we have found that on the whole Egyptian medical students and young general practitioners are uncertain how to handle an otoscope, without which otitis media, for instance, cannot be safely treated, and without which a fair amount of unnecessary chronic ear disease and deafness must occur. It would be interesting to hear from some of our colleagues whether this is the case and what should be done about it. But, more generally, before we make recommendations about continuing education, we need to look at the undergraduate curriculum and see what it consists of.

PANEL MEMBER:

For the last twenty years, our country has been trying to change its basic medical curriculum. This process finally resulted, just two years ago, in a totally new curriculum to correct the defects you just mentioned. We were very concerned about such defects, and sent a mission of three professors to meet with the Royal College of Physicians about the shortcomings of Egyptian

students practicing in England. We took their criticisms to heart, and we also found other defects in our program. Our large numbers of students and limited facilities are continuing problems.

When Professor Badran was the Minister of Health, he asked at least twelve groups to study the problem of continuing education, keeping in mind that continuing education involves more than just courses. The continuing education recognition awards in the United States recognize five types of education: residency programs, traditional courses, audio-visuals, publications, and meetings. When the Ministry of Health brought together interested people in the Ministry, the universities, the Egyptian Medical Syndicate, and the Egyptian Medical Association, as well as young physicians, we concluded that the only way to reach physicians in rural areas is to publish a supplement to one of our journals called the Youth and Science Journal. We could support it through the government, and send it free to all physicians in the rural areas. But this was not sufficient. The Ministry of Health and the Egyptian Medical Syndicate appointed a group of people to study the defects, and Dr. Shehata was nominated by the Syndicate to survey physicians about their needs and gaps in their knowledge through the Journal of Physicians. This was the basis of the curriculum that has been implemented at Suez Canal University and of the continuing education courses that we are running at the Egyptian Medical Syndicate now.

DR. STERN:

Perhaps some of our experience in the United States can be applied to the Egyptian situation. In 1910, when a very searching study of medical education was performed by Dr. Abraham Flexner, the medical schools in the United States were found to be deficient. Continuing medical education in those days was remedial education. It was education designed to continue the medical-school experience, rather than to deepen or expand existing knowledge. Today we look at continuing medical education as the transfer of knowledge to reinforce existing knowledge, to expand the knowledge base of the physician, and to teach new skills.

In concert with that philosophy, the American Academy of Family Physicians requires every member to have 50 hours a year of continuing medical education in order to be re-elected to membership every three years. Some of our states require physicians to report a certain number of hours of accredited continuing medical education every year, in order to renew their medical licenses, and some of our hospitals require it for membership on the hospital staff.

In Egypt I see two problems. I see the need to assess the level of practicing general practitioners, and to provide remedial education based on their needs. These determinations should not be made by medical-school faculty members, but by a coalition of practitioners working with the faculties of medicine.

The second need I see in Egypt is to provide for the acquisition of new knowledge and familiarity with new advances in medicine, and to permit a physician to grow professionally. Prior to 1970 many general practitioners in the United States wished to become specialists in other fields. I recognize this same attitude among Egyptian general practitioners, and I believe this attitude has two sources. The first is lack of respect for the general practitioner on the part of other physicians, because of a perceived deficiency in knowledge. The second is the frustration of the general practitioner who lacks the training to treat many of the problems he encounters. Continuing education can overcome both of these problems, and I hope that you can come up with an overall plan to provide both remedial education and new education.

MASTER'S STUDENT:

The only continuing education available for general practitioners consists of short courses centrally organized in Alexandria or Cairo. There are no criteria for choosing the participants, and because no records are kept to verify that a particular doctor has received this training in a particular subject, there is no continuity of training and no recognition of the skills acquired.

There is a need for a regional center for continuing medical education in the Suez Canal region. There are five such centers in the regions of other medical schools, but none in the Suez Canal area. Now that we who started the experiment have graduated, and are trying to further improve our skills, what training programs are available to us?

DR. BADRAN:

Would one of our colleagues from abroad explain the difference between a general practitioner and a family physician?

DR. STERN:

The family physician uses the family as the base of medical care, and sees all of the members of a family and their complaints. Although the general practitioner in Egypt has not been doing that in the past, it is my impression that the new general practitioners will do so in the future. The general practitioner in the U.K. is the same as the family physician in the U.S.; he sees the entire family.

We need to define what kind of physician we would like to train to give the best care, whether that physician is called a

family physician, a general practitioner, a primary-care physician, or a community physician. The physician that I envision would see all the members of a family over a long period of time, would provide preventive care and comprehensive care, and would see to it that the patient is integrated into the rest of the health-care system by providing timely and appropriate referral to other specialists.

DR. FREELING:

In the U.K. and U.S., the general practitioner is identified by the fact that patients may consult him without restriction. They are not restricted by age, gender, or employment. We can't know the differences between restricted practice and unrestricted practice unless we talk with those who do unrestricted practice. I suspect that, since neither the public health doctors nor the health insurance doctors practice in this way, somewhere among you are doctors in private practice who do jobs very similar to mine. Perhaps, if we want to know about that kind of general practice, we should speak to the private doctor, not the publicly paid doctor. If you want to turn the publicly paid doctor into a general practitioner/family physician in the U.K.-U.S.A. sense, you can't know what extra training to provide until you know what patients are asking the private GP to do.

Is there a private GP in the room who saw patients yesterday? Nobody will admit to it? The day before? Did anybody see a patient this week? (laughter)

You see, I don't know what skills are new to you. When you say "new skills" and you name one, then I can understand.

AUDIENCE:

Otoscope. . . ophthalmoscope.

DR. FREELING:

Anything else?

AUDIENCE:

Proctoscope. Laryngoscope.

DR. FREELING:

At what age?

AUDIENCE:

All ages.

DR. FREELING:

Why do you need a laryngoscope for an adult?

AUDIENCE:

Cancer. . .

DR. FREELING:

How often does cancer of the throat occur in this country? Well, it's very rare. It's a very expensive instrument for a general practitioner. I'm not playing games with you; it's a serious set of questions, and this is the only way I know that you can define continuing education.

There are people here who say they don't know how to use an otoscope. We know, from Dr. Heshmat's presentation, that there are deaf people in the country. So some people need continuing education in use of the otoscope. You also said, quite rightly, proctoscope. It's impossible for outsiders to know what is needed. You really do have to enter into a dialogue. As Dr. Stern said, if you don't ask the learner, you don't know what to teach him. You don't know whether you will need other instruments after you complete the master's degree if you haven't yet completed the master's degree. You may think you'll need them; there are people who may know their needs because they've been working already. That's Dr. Stern's point about a dialogue between the physicians striving to find remedial teaching.

PARTICIPANT FROM THE RURAL HEALTH SERVICE:

General practitioners need a completely new curriculum. This curriculum would not teach, for example, the difference between pontine hemorrhage and subarachnoid hemorrhage; it is enough for the GP to know that a patient has had a cerebrovascular accident and has to be transferred to a suitable hospital. He also needs the necessary first aid. Books designed for general practitioners should concentrate on emergencies and first aid.

PARTICIPANT:

All of us agree that continuing education is very important. What is important now is to figure out the incentives that are needed to promote continuing education.

PARTICIPANT:

In Mansoura, where we have a very good unit of continuing medical education, there are effective incentives in that attending a program of continuing medical education can be required for promotion. It's not a problem of definition, it's not a problem of what we need and don't need, it's a problem of finding an incentive.

DR. ABU ZEID:

Clearly the Ministry of Health and the educators are convinced that we need continuing education. Do we know anything about the needs and preferences of the GPs themselves? If we conducted a survey to ask GPs whether they would participate in a continuing education program, how many would say no? In other words, if we design a program, is it going to be successful? Twenty-five years ago we provided a family-planning program without knowing whether people wanted it. Now we realize that that was a mistake. The feelings of the people involved should be very well understood. So I think we need a survey of physicians' attitudes toward continuing education before implementing a program.

Also, I am convinced that continuing education should be based on motivational incentives; it shouldn't be compulsory. As for requiring a certain number of hours for renewal of the license, I don't think that we should begin it this way in Egypt. In the future we can do so, but it should be voluntary at first.

DR. RICHMOND:

I would like to refer back briefly to Dr. Zohair Nooman's observation earlier today that the delivery system in primary care is unique in this country. There are many physicians delivering primary care, but they are doing so within specific frameworks. For example, the Health Insurance Organization, which I had the privilege of visiting last May, provides health care for its members. When we asked some of the recipients of care whether they would like the system to be expanded into a family care program, they said, "We already pay a certain amount for this care. If it becomes a family service, the costs will increase."

The Ministry of Health clinics provide some care; the maternal and child health clinics provide some care; and--a unique system in

this country--the school health services provide yet another system of care. It will be important to consider how to make a match between the needs of physicians working in these settings and the continuing education programs. If we don't do that, it will be dysfunctional. That is, the educational system will not meet the needs of the people who are working in these settings, each of which is important. This is partly what makes our discussion so complicated. We could say that we would like to convert all of this into a family care system, if that were our bias. But that won't happen readily, if at all, because these systems have grown up for very compelling reasons.

DR. FREELING:

The different delivery systems and different responsibilities make it unlikely that a single job description or a single course will be relevant to all GPs in this country. I think you will find that you need slight variation, if not considerable variation in what you offer the health insurance doctor, the child and maternal health doctor, and the private general practitioner. They're not the same people; they're not doing the same job; they may have the same philosophy.

DR. HAMZA:

In response to Dr. Freeling's question earlier about what the general practitioner doesn't know, I can answer for the general practitioner in the Health Insurance Organization. If you enter his examining room, what does he have? He has a stethoscope, a thermometer, and a sphygmomanometer. These are the only tools he will use. The list of drugs he can prescribe is restricted; he is forbidden to write prescriptions for special drugs unless he is authorized to do so by a specialist. In my opinion, the intimate relationship between the general practitioner and the specialist, and the ease of referral to specialists, has been harmful to the GP. Because it is so easy to refer patients, the GP tends not to bother at all.

Some of our clinics offer special training. For example, some specialists pick cases to discuss with the general practitioners, but this is not organized. There is one organized presentation every two weeks for all the GPs, but very few attend. If we said to the GP, "Increase your skills, and then we can give you more to do as a doctor," I think that would be the necessary first step, an incentive for further training.

DR. BADRAN:

We know the deficiencies in our medical education. The main

gap is hand skills, because, in view of the huge number of medical students, it's very difficult for us to teach hand skills. We teach our students physical science, but we do not have the time or the means or the money to buy the equipment to teach 2000 students per session. It requires a huge lump of money and a huge number of teachers and trainers and educators. So filling this gap is priority number one.

Priority number two is to deal with the fact that the person who begins practicing today will continue until the year 2025. How can we leave him alone in the field to experience deterioration and difficulty and frustration? We should not forget that medical students constitute the elite of the university population. Elites always want to advance; they want more and better; otherwise they will escape or they will shrivel.

We are not at the zero point; the young doctors in the field are not alone 100 percent. Steps have already been taken by the Ministry of Health. There is a system of contact between the rural units, rural hospitals, and municipal hospitals in little towns. There is a system of upgrading lectures and so on, offered by the Egyptian Medical Association. About 3,500 small medical libraries have been distributed to rural health care units by the U.S. Agency for International Development, and there are 3000 films on medical education. There is a center for preparation of materials on medical education. How can we coordinate all this into a system that can challenge young physicians and help them advance and improve their performance?

DR. KHALLAF:

What Dr. Hamza said about the general practitioner in the Health Insurance Organization is true of other GPs. His scope of action is very limited; he has to refer and to depend. The antipathy he expresses toward the specialist is not endemic; it is a result of his dependence on the specialist. In other words, the status of general practice in Egypt is not independent and not free. This is the whole problem. They are not exercising their clinical skills to the best of their ability. And I think that this is why GPs feel frustrated, whether working in rural service or in the health insurance, and why they don't try to pursue job satisfaction.

We have to tackle this problem first, because otherwise some GPs will say, "For heaven's sake, why should I learn more? I am limited to these little jobs. Why learn more?" But he has to learn more if he is to do more advanced work, or to achieve job satisfaction. So I am afraid that, unless we make continuing education compulsory, all levels of service will suffer, because the work of the general practitioner is the foundation of the whole system of health care delivery.

DR. DOWIDAR:

I entirely concur in what Dr. Khallaf has said. If the GPs in the Health Insurance Organization or in the Ministry of Health are not satisfied or happy, it is not their fault at all; it is an outgrowth of the system. These young people are ready to do three times as much as they are doing.

But the resources offered to them are very poor. For purely economic reasons, they are given only two or three drugs to prescribe; the medical insurance is a poor organization. The government wants to treat Egyptians for nothing, you see. The budgets of the MOH and the medical insurance are so low that these GPs are not given adequate facilities to exercise their capacities. And this has a killing effect on incentive. Money is not the only incentive. Achievement is an incentive; promotion is an incentive. These people should be given more resources, and more facilities, and more freedom of action. Then they will be happier, and when they are happier, they will upgrade themselves voluntarily.

DR. FREELING:

As Dr. Richmond pointed out, you cannot offer all the various kinds of general practitioners the same course, because they're going to have different jobs to do. So, yes, there is a need to do a survey. But surveys take time, they cost money, and they take time to analyze. There's another method: if you simply ask any group of GPs who work near each other what they want, you will get a useful answer--and they may also be prompted to do something for themselves.

PARTICIPANT:

I am a basic doctor working in rural health in the Red Sea governorate. I am afraid to become a general practitioner, because the great majority of the people in this country consider the GP an insignificant doctor.

PANEL MEMBER:

Yes. You won't have dignity--

DR. RICHMOND:

As our colleague just mentioned, its perceived status has made general practice less attractive than it may become. I think its status will change here, just as it did in the U.K. and the U.S. When primary-care physicians organized themselves into the Royal College and the Academy of Family Practice, their status and their

performance were elevated and they joined the mainstream of the specialties. That doesn't happen overnight. But it is out of that kind of process that respect ultimately develops. And from respect come status and prestige, and, as Dr. Dowidar indicated, more ample resources.

That process could be set in motion during the course of this conference if the Medical Syndicate, the Egyptian Medical Association, and the Ministry would appoint a planning group, with representation by working physicians, to design programs to meet the needs of doctors in the rural areas, in urban clinics, and in private practice as well. For if the programs aren't designed to meet their needs, they'll fall on very barren soil. Such a group could provide the kind of continuity that is crucial to such a process.

DR. FREELING:

To the young man who was frightened to go into general practice, I would like to say that you are sitting in a meeting which is designing, it hopes, the future of the discipline of general practice. In American they have a phrase, "to get in on the ground floor." (laughter) If you get in on the ground floor, you might get to the top. If your son joins instead of you, he will enter at the bottom and be an unimportant GP in an important discipline.

DR. BADRAN:

I think this phrase is quite pertinent to the field of general practice now. Do you understand what he means? This phrase seems to have aroused some interest in our colleagues (laughter), and we hope very much that the message has reached the MOH...!

Is continuing education to be a requirement or an option? And will it be the domain of the MOH, or will it be shared among the MOH, regional universities, the Medical Syndicate, and the Egyptian Medical Association? If it is diffused, lacking a father, will it be a lost property?

At a conference I attended of the Pan-American Health Organization, they concluded that in South America continuing medical education must be run by the universities, subsidized by the ministries of health, and promoted by the local governorates. If, as mentioned earlier, a conjoint group is appointed by the Syndicate, the Association, the MOH, and the Council on Medical Education of the Supreme Council of Universities, the process can be defined, directed, organized, and subsidized.

PARTICIPANT (U.K.):

Wasn't it agreed that the doctors themselves should be included?

DR. BADRAN:

Sure. By the MOH, I meant the consumers--not the central agency, not the minister.

As for the other question, I think it must be optional, but with rewards for participation. It should be made very worthwhile, useful, and rewarding to attend continuing medical education.

Like family planning, making it compulsory results in revolution and refusal. Optional is preferable; we should discuss incentives and disincentives.

PARTICIPANT:

I think that most continuing medical education should be optional, but it should be made obligatory for some individuals.

PANEL MEMBER:

One more point. I think that optional is far preferable to compulsory, but I think we have to be very clear about what we mean by reward. The terms reward and incentive have both been used. Misunderstanding or misuse of reward or incentive could actually work as a disincentive. Do we mean monetary reward or . . . ?

DR. BADRAN:

Just rewards. Those people who deserve a reward are rewarded.

PANEL MEMBER:

Yes, without bias.

DR. TURNER:

I am sure you all realize that you are at a very significant moment in the history of medicine in Egypt. This is the first conference of its kind that has ever been held; it is the first time that GPs have come together to consider where they can go from here,

how they might make their lives more satisfying, more rewarding, and more useful. There were some things said this morning that I found very encouraging. Some people were expressing dissatisfaction with their lives and with the work they are doing. Some were even quite angry about it, which is a very healthy sign. It reminded me, as Dr. Freeling recounted yesterday, of when I started in general practice in Britain, and we all felt that we were regarded as inferior to doctors who stayed in hospitals. There was a general feeling this morning that continuing education is necessary and that it should be pursued and fought for.

Now we have got to the point of agreeing that it must be a joint effort involving the MOH, the universities, the Medical Association, and the Syndicate. But the initiative, the pressure, must come from the general practitioners themselves. It was only when this happened in Britain that we began to make any progress at all. The 17,000 general practitioners in Egypt represent a very significant pressure group, and if they or their representative were to go to these organizations and say, "We are not satisfied. We need to change," change would follow.

You need the cooperation of these bodies to bring a program of continuing education into being, but most of the hard work will have to be done by you yourselves. Hospital specialists cannot teach you the job; they are not doing the job, and they do not know your difficulties. You know your difficulties. By getting together, by forming groups locally--wherever it is convenient--by discussing topics, by talking about the things that you find difficult, you will approach some answers. It is a slow process, but the starting-point is for you yourselves as representatives of Egypt's general practitioners to take the first steps. Perhaps this is a good time to think about how that might be started.

DR. BADRAN:

It's a wonderful principle that the beneficiaries should look for benefit. This is a splendid suggestion.

I am sure that more than 50 percent of the members of the Egyptian Medical Association committees, both governorate and central committees, have been in practice less than 15 years, and most have less than five years of practice. If we assign them the responsibility of suggesting to the Ministry that their generation needs continuing education, the point could be conveyed.

DR. TURNER:

To repeat myself, only by meeting together and talking about things you find difficult can you discover the things you need to know. And then, having found out what you need to know, you can

begin to look for ways these needs can be met. Is there anyone out there who can help you, or do you have to do a lot of reading, perhaps write your own journals, to communicate with one another, to meet regularly? This is for you to answer.

PARTICIPANT FROM THE RURAL HEALTH SERVICE:

The last group that registered for the master's degree in general practice at Suez Canal University were deeply depressed when they returned to work.

Also, it is well known that people are reluctant to go to Cairo for training rotation. Most physicians, when they receive a letter of acceptance to a training program, try to find any excuse not to attend. Why? The reason is essentially financial: it costs more than 15 pounds to spend a night in a hotel in Cairo.

DR. BADRAN:

Do not expect to have a carpet extended in front of you. In order to accomplish anything, you have to work hard; otherwise it will not be of any value. The governorates are in a coma, and you have to awake them up. Everyone in this world has problems, and the good person is the one who can overcome obstacles.

PARTICIPANT:

But the atmosphere around us is not suitable.

DR. BADRAN:

You can create your own paradise. This whole process is still in an early stage of development, and it is not going to go forward unless we, its owners, carry it forward. We do not have to use foreigners. Whoever wants to learn burns the whole world to get books. And remember that you are very expensive for your country. For every one of us who has been educated and earned an M.D. degree, there are so many others who cannot read or write. In 1980 when I was president of the university it was estimated that it cost as much to educate one physician as to teach 15,000 people to read and write.

DR. DOWIDAR:

There is a big and well-organized group of GPs in Alexandria, most of whom work in the Health Insurance Organization. It is large enough to constitute a critical mass of general practitioners, and it is a completely independent body, which addresses itself to the

scientific interests and the scientific welfare of its members. This association, either on its own, if its members are capable, or in collaboration with the Faculty of Medicine at Alexandria, or at Alexandria and Cairo and Ain Shams, could conduct a program of continuing medical education in which some of the educators would be senior general practitioners. I am convinced that general practitioners can train their own junior people, supported by some people from the medical schools.

Also, within the Alexandria medical insurance organization there is a small scientific group that meets every week for about three hours to hear papers and presentations of clinical material, and to discuss problems of management and organization. And we are trying to establish a clinical side, where we'll see patients. We could expand this and make it a type of continuing medical education for the general practitioner in Alexandria. This could be done in Cairo, it could be done at Assyut. It's very easy, once there is a desire. You don't need to pay much attention to official procedures.

DR. BADRAN:

Leaving the scheduling and coordination of continuing education to the practitioners themselves will mean, in practice, that the teachers deliver their lectures whenever they please, which may not allow most physicians to attend. In Alexandria, only about 20 people out of a few thousand have been able to attend these lectures.

Should there be an agency in the MOH to run continuing education courses with the universities, local syndicates, and local associations? Or should it be run by the MOH alone, or handed to the universities? The University of Alexandria, say, could sponsor the whole thing and be paid by the Ministry of Health. It's open to us to recommend one of these three possibilities.

ADMINISTRATOR FROM THE MINISTRY OF HEALTH:

We have departments for continuing medical education, called training departments, in each governorate.

PARTICIPANT FROM THE RURAL HEALTH SERVICE:

These departments do not function properly. They were designed to serve certain people, not all the general practitioners. They are a tool in the hand of the supervisors.

PARTICIPANT:

University general practice departments.

DR. BADRAN:

Do you mean that you want to initiate a department of general practice in every university? Two universities have them, I think, Mansoura and Suez Canal.

DR. DOWIDAR:

No, no, there is no department in Mansoura. It is a department of community medicine. In Alexandria, unfortunately, there is no department yet, and this is one of the main problems.

DR. BADRAN:

The Department of Community Medicine can sponsor it. One suggestion could be that every department of community medicine appoint a group to develop and maintain a system of continuing medical education in the area.

One of our colleagues has suggested implementation of a continuing education center in each governorate, managed by the health officers of the governorate, to be supplied with materials by the Ministry.

DR. BADRAN:

To summarize, the Ministry is already paying attention to manpower development and regional education. We need to intensify its effectiveness by asking the Ministry to organize an office for continuing education, with outposts in specific governorates or all governorates, to host courses, coordinate teachers and materials, and evaluate and keep track of the development of candidates.

PARTICIPANT:

We should begin with what we have.

DR. BADRAN:

Yes. We are not going to do genuine transformations. As for technology, there are three ways to introduce technology in developing countries: to import a bundle of technology from abroad

and untie it, to get a little fragment of a specific technology and build on it, or to start anew from point zero. We have to choose one of them. We can request educational material from abroad, give it to a group of specialists to adapt it to the Egyptian situation, translate it, and subtract what is irrelevant to practice here. Or we can assign a group of people to adapt a smaller-scale system like that of Suez Canal University for adoption throughout the country. If we decide to build from scratch, we will need a prophet. Professor Dowidar, for example, could gather a group of talented people around him to build up an entirely new curriculum.

PANEL MEMBER:

Actually, a group convened for this purpose met for about 18 months not long ago and produced some recommendations. We could get this material to Professor Dowidar, and he and his committee could work further on it.

DR. BADRAN:

In the meantime, we can ask international agencies to supply us with material that could be gradually injected into the Egyptian material.

DR. DOWIDAR:

There is a well-developed learning resource center in Cairo that could help to produce learning material and to modify existing materials.

DR. EL MENAWY:

So, in conclusion, we have three recommendations. First, continuing education should be optional, with incentives and disincentives. Second, the existing centers in the Ministry can organize a new department of continuing education, with outposts in all the governorates, responsible for coordination and promotion of continuing education. Third, we should ask the MOH to invite Professor Dowidar to head a committee to collect existing material and to draw on the learning resource centers to develop a program for continuing medical education.

DR. BADRAN:

The last point has to do with career opportunities. We should ask the people who are going to be scientifically qualified in general practice to serve as resources of the MOH for future

teaching and development, and probably for future management, of continuing education. Let's say we want the MOH to offer career opportunities for those people who have carried the burden of concentrating on this new specialty. Their spirit is sagging; they feel helpless; they don't know what's coming tomorrow. Are they going to remain status quo ante with no chance of promotion or better careers?

DR. TURNER:

I think you've answered the four questions before us in a very rational way. It's a very good idea to find out what material is already available and to adapt it for your own purposes, but I must point out that many of the problems of general practice are known only to yourselves. Many of the difficulties GPs encounter in their everyday work in Egypt are not met with by anyone else, in hospitals or anywhere else. And the only way you will find out what you need to know is by getting together, pooling your knowledge, finding out what the grounds of common difficulty are, and then devising your best methods of solving these problems.

I presume to speak because this has already happened in my own country. We found there that the specialists were not always able to help us in providing a better service for our patients and doing the job better. We had to go off by ourselves in groups and talk about it, and then we had to try out new methods of organization, new methods of keeping records, new methods of investigating problems. We had to find out what we could do with the facilities we had, and make a great deal of noise and fuss and trouble if we did not have what we needed.

Governments are always reluctant to spend money; they will not give you things unless you complain, unless you go to them and say, "The general practitioners of Egypt cannot do their job properly, because they have not got--whatever it might be." An otoscope was mentioned this morning. It occurred to me that the explanation for why Egyptian medical students are not taught to use an otoscope is that there are too many students. But the numbers are no greater than those who are taught to handle a blood-pressure machine. These are minor skills, but they are needed, and they can make all the difference in the way you do your work. In the last analysis it's up to you to see that you get what you want.

DR. DOWIDAR:

So a last recommendation has been added for GPs to gather together in regional joint meetings to define their needs. I think that this will be very healthy. If each governorate, or a group of qualified GPs in each governorate, sponsors an open meeting for GPs, they can define and pursue their own interests. It's not a

revolution but--evolution.

Manual training is the gap in our medical education. Nobody can deny that. And the reason is clear.

FOURTH PANEL
GENERAL-PRACTICE RESEARCH, CAREER STRUCTURE,
AND ORGANIZATION OF GENERAL-PRACTICE SERVICES

DR. MAHFOUZ:

Let us start by briefly discussing the nomenclature of general practitioners. My own belief is that the term family doctor is more appropriate for the type of medicine we're discussing than general practitioner. It's a humane name rather than a technical name, and it reinforces the message that this kind of doctor takes care of the entire family. So it might be preferable to a more technically oriented name. What do the members of the panel think about this question?

DR. MOBARAK:

In Egypt the job of the general practitioner may be different than in other countries, and the job description probably should be different as well. Most GPs in Egypt are community-oriented and family-oriented. But GPs in the Health Insurance Organization do not treat workers' families, although eventually they too will do so. And private practice also ignores families; private practitioners think in terms of individuals. Then there are the free-standing fragmentary health services: the school health program, which deals only with schoolchildren, and MCH, oriented to mothers and newborns. These programs will be incorporated into an integrated health service for families, but only gradually.

So although the majority of general practitioners in Egypt are definitely family doctors, not all of them are.

DR. COTTER:

What we are talking about is comprehensive patient-oriented medicine. Another way to define what we are talking about is to

invoke the nine parameters of family medicine: it is primary, personal, and continuous care; diagnosis is in therapeutic, social, and psychological terms; and treatment is preventive, educational, and therapeutic.

If we are really going to implement what we have been talking about for the last three days, three requirements must be fulfilled. One is that doctors should apply the philosophy of family medicine in caring for the patient. The second is that there should be continuity of care, by the same doctor or at least by the note system. The third is that, whenever possible, practitioners should work in the same building so that they can communicate readily with one another.

When I say that family medicine is personal, I mean that when patients come to see you, they are coming to see you. You may be aware of social factors affecting why they've come to see you, but the fact remains that they are putting their trust in you personally. The worst possible thing you could do is to communicate information about a patient to other members of the family without the patient's permission. By all means, encourage patients to bring other members of the family who may be affected. But you do not have the right to speak to the other members of the family without permission.

I suspect that a doctor who only does, for example, maternal and child health is liable to become a technician, and to be limited in scope to a hospital department. Furthermore, he is functioning in terms of a particular category of conditions, and we are trying to shift away from disease orientation toward patient orientation. But you have to face the facts of life, and deal with the system as it is at present, while continuing to work toward a future when everybody will be able to practice in a comprehensive manner.

DR. MAHFOUZ:

Thank you, Dr. Cotter. You have given us nine candles to illuminate this very complicated issue. Dr. Bicknell, would you like to speak to this point?

DR. BICKNELL:

I think the main issue is the functions of the physician. What he or she is called will vary from country to country and from culture to culture, but I lean toward your argument in favor of a broader, more socially oriented name, rather than a narrow technical one.

DR. EL SAYED:

I've heard the term general practice family medicine; this combination of the two terms might be very appropriate.

DR. KHALLAF:

The most important questions from my point of view are: What jobs is the general practitioner doing? What is the relationship between the services he is performing and the whole structure of the health-care delivery system?

The community aspect of the GPs duties is particularly important in a country like Egypt. Thirty-six percent of our rural population lacks a clean water supply; only 4 percent of the rural Egyptian population has a tap in the house; only 19 percent of the Egyptian population has an adequate sewage disposal system. The average intake of protein is 91 grams per individual, only 12.5 of which is of animal origin. The rate of illiteracy has been calculated officially as 54 percent; one researcher estimates it to be as high as 70 percent. Per-capita income is 400 Egyptian pounds per year. Such figures demonstrate that the community dimension is highly important in the career and the job of the GP.

DR. MAHFOUZ:

Thank you. You have increased the complexity of the issue by orienting us economically.

Let us proceed to discussing the career structure for family doctors.

DR. MOBARAK:

It might be good to shed some light on the organization of health care before going into the career structure. It's very relevant.

DR. MAHFOUZ:

The ball is in your hands, sir.

DR. MOBARAK:

The 3,000 physicians who work in our 2,500 rural health centers care for whole families. They also have private practices

and can visit patients at home on a private basis. In this sense they are the medical resource for the community.

In urban areas we find two types of services for the family, fragmented and centralized. The family may contact the health bureau for immunization and registrations; they may contact the MCH center for care of the expectant mother and small child; they have to contact the school health unit for care of children, and otherwise they go to hospitals. When they do go to hospitals, they do so without any direction, and typically have to be referred on to a different clinic before they reach the relevant specialist. In some urban areas, all these services are concentrated in what we call the urban health center. We plan to eventually gather all family health services into urban health centers, where the family can get all the services it needs at the same place.

There is a further development, which we have implemented on a pilot basis at four centers, and which we intend to generalize after the pilot experiment is evaluated. Instead of a general-practitioner clinic, a school-health clinic and an MCH clinic within the same center, each physician and his team would be responsible for a number of families who would register in his clinic at the health center and would come there for preventive or curative care. They can also call this doctor to their homes if they need private care. We have tried this at one center in Port Said and three centers in Cairo, and it is a very promising experiment. We will replicate this approach at another 70 urban health centers, and we are also planning to extend the urban health centers throughout our urban areas. As I mentioned earlier, the health insurance general practitioners will eventually become family-oriented as well. Then we will have a backbone of family-oriented general practitioners in the rural health services, in the urban health services, and in the Health Insurance Organization.

We perceive a great deficiency in general-practitioner services in urban areas. The hospitals may begin to offer general-practitioner services in the afternoon; they would screen cases, referring those they cannot treat to specialists in the same hospital. But this idea is still under development.

When we talk about career structure, we must not focus on those few who have their master's degrees in general practice. We must look first at the thousands of practicing general practitioners. What is the best way to encourage young people to specialize in general practice? And how can we best train them in general practice? Should we take them away from their work and send them to a medical school in another governorate, to be trained at a university hospital, where there is no mother department for them and they just shift around from one specialty to another? Or should we try to develop a way whereby they can get their training while they are practicing? This question also has a bearing on the

careers of the specialists who graduated this year and will graduate in the coming years.

I believe that those who have master's degrees in general practice should be directing the training centers all over the country, helping to train GPs in situ. Approximately 200 health centers have been designated as training centers. If the master's graduates in general practice were to run these centers, they could probably be affiliated to the medical schools, acting as instructors in the field for those who will, in the coming years, specialize in general practice.

General practice will continue to have a large base of nonspecialized people. Leadership will be exercised by the specialists in general practice, who will develop these training centers and, eventually, the general practice departments in the medical schools.

Egyptian society does not grant the general practitioner the same socioeconomic standing as the specialist. The question is whether granting degrees can solve this problem. Frankly, I'm very skeptical. The health authorities talk about creating a career structure for the family doctor that will bring him up to the same level socioeconomically as the specialist. But even in the Ministry of Health, specialists are treated differently than general practitioners. Everybody will deny it, but everybody does it.

DR. COTTER:

I think the most worrisome question of all in assessing the government service is why so many people are paying a private service. Because one of the important reasons to maintain a private sector is that it represents a judgment on the Ministry service. And if so many people are prepared to pay instead of using the government health centers, what is the matter with the health centers? I think this is a question that has to be faced. You know the answers better than I do. But I am extremely encouraged, and applaud the proposed developments that Dr. Mobarak mentioned. I think they are all in the right direction.

The universities will not have the capacity to train many people for master's degrees in the near future, and in any case most practicing doctors couldn't go back to do a two-year residency program. So I am absolutely certain that a continuing-education program, with an evaluation assessment test after a reasonable length of time, is essential. Then, after demonstrating mastery by earning a master's degree or by passing the evaluation exam in continuing education, general practitioners would be entitled to call themselves family doctor. Thus the title family doctor, acquired through experience, education, and tests, would elicit respect.

The other very big problem, as I understand it, is that inexperienced doctors are put in health centers all alone, without support. The most difficult task for any doctor is to be all by himself; a person with a lot of experience is needed where there isn't support. This is where the Ministry service will fail. The young doctor should start in a large health center where he has people to consult, people to monitor his work. After a post-internship period as a general practitioner, he would then get a step up and prepare--either through continuing education or an internship--for the master's degree or an equivalent.

The other thing that worries me is that, in the rush, people who have just received master's degrees are being assigned the role of teaching something they have never done themselves. Before people teach or administer, they should have had some service experience to understand the practicalities of the job.

DR. KHALLAF:

In rural areas and in the Health Insurance Organization, general practitioners have to contend with severe limitations on the treatment they can offer. This is why the phenomenon of bypassing the rural health unit and going directly to the hospital is a well-established pattern. The people are aware of the limitations of the units, and bypass them. And in turn the doctors are looked down on socially, as Your Excellency said earlier, as second-class. It isn't their fault; it's the fault of the limitations they are working under.

What can we do about this? I have a proposal (it is mine alone, not that of the Ministry of Health), with several components: First, the duties assigned to the general practitioner have to be community-oriented. Second, we have to end the dichotomy between preventive and curative medicine at that level of service. The third requirement is an efficient and integrated referral system between the GP and the secondary and tertiary levels of service. Fourth, and most important, is independence and a stable and continuous career for the general practitioner. And fifth is a consensus that general practice is a specialty in itself and not a smattering of knowledge from different disciplines of medicine. These are the backbones of the proposal that I hope will prove to be of value.

An intimate relation between the GP and the community he is serving entails thorough knowledge of community characteristics and problems. The services he offers, either directly or through the team, ought to be targeted at improving the health status of that community. To this end, he ought to be accountable to his employers for achieving measurable improvements in the health status of the community, particularly in the control of communicable diseases for which we have standard methods of intervention.

Such efforts require shared responsibility with local community leaders, which cannot be established by temporary or transient methods; it can only work if there is a stable and continuous relationship. This could not be achieved in the present context of transient and salary-scale employment. My suggestion is that the status quo be replaced with a per-capita system of remuneration. A physician, or group of physicians in the case of a group practice, would be assigned to a certain community and paid on a per-capita basis. This proposal would allow for career stability and for a close bond between GPs and the communities they serve. It would also promote the independence of general practice, which would in turn raise its social level. Another benefit is that it allows for differentials in payment for service in remote areas, and hence would attract more physicians to work in these deprived areas.

This proposal cannot work on its own. It would have to be instituted within the framework of upgrading primary health care as a whole. This upgrading has to address the physical facilities and equipment of the health units, particularly methods of diagnosis and laboratory services. The staff has to be sufficient in number and trained to handle the workload required of them. As for drugs, the physician needs a sufficient spectrum and amount to carry on his duties and gain the confidence of his clients. I would advise that the list of essential drugs proposed by the World Health Organization be used as a guide.

I am fully aware this this proposal is not an easy one. The expenses it entails must be seriously considered. I agree that community participation has to be tapped thoroughly, and the approach I favor is extension of health insurance to rural areas. Freedom of mobility from one area to another, and even from general practice to another specialty, also has to be taken into account. In spite of all these questions, I believe that this is the best way of establishing a career for the general practitioner in Egypt. It should be tried in three or four governorates, which would allow us to see any deficiencies and weaknesses, before being adopted on a nationwide scale.

DR. MAHFOUZ:

The linkage you are proposing, Dr. Khallaf, between salary and the per-capita principle is a fundamentally practical way of improving the salary system for doctors--relating their salary to the amount of work they do for the community. This approach has the potential to solve the economic problems related to career structure. Your proposal to integrate family practice with hospital practice would not only promote the more active role in curative care that is essential to upgrading, but would also tend to dissolve inter-professional sensitivities between various types of doctors.

DR. EL SAYED:

I think we need to go back to the root of the problem. You have mentioned that the reason why the general practitioner is not looked upon with great esteem in this country is that he earns less than his colleagues in other specialties and does not have any prospects of promotion.

From the point of view of our foreign guests, we have a very peculiar profession. It is still the most prestigious profession, and we attract the most intelligent, most competitive, and best-motivated young people in the country. When a student enrolls in a faculty of medicine, he has two aims: to improve his financial status and to improve his scientific status.

When he looks around at the various types of doctors, he finds that there is no prestige in working as a GP or running a rural health center. This is why most of those jobs are a transitory phase in the life history of a doctor. Sometimes it is a very unpleasant experience. Sometimes we have to force people to do it, because nobody volunteers to work in a rural health center or other primary health-care unit. It's partly because the job doesn't have any reputation; partly because the unit doesn't have any equipment; partly because the job is limited in terms of functions; partly because few doctors are really prepared to do the job. So the result is that we have a lot of dissatisfied, demoralized people.

Now we want to say to those people, "Come on, this is going to be a very attractive future for you." Well, we must specify how we can make it attractive. We cannot do so except in two ways. One is to make available a full-fledged scientific career, with opportunities for promotion and academic success. The other is to provide for the possibility of financial advancement.

The practice of medicine in this country is facing a crisis whose general outlines are as follows:

Expenditures on health services in this country are constrained by limited funds and by the priorities of the planners. Health services account for only 1.9 percent of the expenditures in the five-year plan, a figure far below the actual needs of the society. One result is that the most effective provider of curative care is private practice. The least effective is the free service, because of its low expenditures on curative care. The second most effective is the Health Insurance Organization, but it only covers about 2.5 million people. We were promised that, within ten years, insurance would cover everybody in this country, but only 5 million will be fully insured by the end of 1987--much less than the expected population growth of 7 million in the same period of time. So private practice is the dream of any doctor.

Per-capita pay doesn't sound very plausible to me, because the

government cannot afford to pay higher salaries than it pays now. We are in a dilemma. We can't pay doctors more, but they can earn more out of their patients' pockets. This is a very bitter fact that we have to accept, whether we like it or not. And unless the practitioner knows that he will have the same opportunity as his colleagues the surgeon and the cardiologist to have a private practice, and to earn a decent living from it, I don't think there is any hope that we will attract people to general practice.

Nevertheless, I would point out to my young colleagues that specializing in general practice offers an unparalleled opportunity to live handsomely and comfortably. About 56 percent of our population lives in rural areas. Meanwhile, urban doctors have to contend with housing problems, competition, and the difficulty of finding a clinic or private office in which to work. The best way for a young doctor to have a prosperous career and a nice flat, and to educate his children, is to go live in a decent village. He can have a private practice, he can be responsible for a primary health care unit, he can practice good medicine, he can be well trained to deal with the problems of the community--and he can build a stable future for himself and his children.

A lot of our young people are dissatisfied with the opportunities available in this country. They would like to go to Saudi Arabia or the Gulf to earn some money. But the golden era of oil prices is ending, and in the future young people will have to make their careers here. So private practice in this country not only does a lot of good for the community, it also makes the difference between a decent career and a demoralized one.

The second point is that physicians are motivated by academic opportunity and by the stature it bestows. Departments of general practice in the various medical faculties would be a very important stimulus to attracting young people into general practice. Such departments would signify that the general practice of family medicine is no less prestigious, no less academically recognized, than the rest of the disciplines.

Suez Canal has shown us the way, and Mansoura is also planning a department. We can begin by appointing graduates with master's degrees from the department of medicine who are sympathetic to the outlook of general practice. We could invite people from the Royal College of General Practitioners or the Academy of Family Medicine to come for six months to preside at the birth of a new department. Departments of general practice would introduce medical students to general practice early in their training, which would convey a message about its importance and help restore its reputation. Without them, we'll never be able to attract anybody with talent or imagination.

On the subject of research, I'd like to point out that general practice is an untapped goldmine for anybody in this country who

wants to do research. Radioimmunoassay and other complicated technologies that the university hospitals are working on are done better in the U.S. and western countries. The thing that cannot be done except by us is research in general practice. It is a mine that should be tapped by the profession, but it cannot be tapped unless we attract doctors motivated by the realistic prospect of a bright scientific career.

DR. MOBARAK:

I would like to thank Professor Hamdy El Sayed for pointing out the attractions of working in rural areas.

I don't want to leave our foreign guests with the impression that physicians are forced to work in rural areas; they are requested to work in the basic health services, either urban or rural, for one year; after that, they can choose any discipline they like. So people don't work in the basic health services more than one year, unless they do not ask to be transferred. When we reassign those who stay on in basic health services, they have the option of choosing an urban or a rural setting. Fully 75 percent of them want to work in the rural areas. We also have specialists in the rural areas, largely in surgery but also in medicine, pediatrics, and gynecology. They are allowed to have their own surgeries and their own private clinics; and the same thing applies to specialists in general practice.

As for allowing all general practitioners in the rural areas to have private clinics, the Ministry of Health does not object, provided the physicians request it and the local authorities agree.

DR. MAHFOUZ:

Would Professor Zohair Nooman like to comment on the experience of Suez Canal Faculty of Medicine with regard to career structure?

DEAN NOOMAN:

What are the bright, motivated young doctors who joined our training program going to do after graduation? What will motivate new students to join? And what will be the effect of what we are trying to do on the overall problem of general practice in this country?

In all honesty, we feel that we can only address the career structure for general practitioners, who represent more than 50 percent of the Egyptian medical profession, by addressing the organization and structure of the health care delivery system in

this country. Professor Dowidar's article on the career structure of general practice lists as a prerequisite the reorganization of the delivery system. A new approach to the delivery system is also implicit in the very intelligent suggestions of Dr. Khallaf, and in Dr. El Sayed's ideas. Whatever system we adopt, the general practitioner will be its mainstay.

We will have to accept the fact that the government is not able, and will not be able, to provide adequate free health care for the community. Therefore other alternatives should be explored. I'm advising everyone to read a recent publication by Dr. Ramses Gomaa about the Health Profile of Egypt Project. It's a summary of the health services in the Arab Republic of Egypt. Read it; read the numbers. The numbers will tell you a great deal.

Then let us sit down together in a conference similar to the Fayyum conferences, to hammer out a reorganization of the delivery system in Egypt. After that, let us implement it at the highest level possible. I'm asking President Mobarak himself to intervene. Only then, after arriving at a structure that responds to the people's needs and the profession's needs, can we design a career structure for the general practitioner, and know the fate of the efforts of Suez Canal University and other medical schools to improve medical practice. Otherwise, I'm afraid that we are acting and talking in a vacuum.

DR. EL SAYED:

Dr. Zohair Nooman is saying that we have to wait for a complete overhaul and reorganization of the health-care system. I think that there's a lot to be done within the present system to encourage people to come and work as general practitioners. If we drop all these problems in front of everybody, they will seem insurmountable. And if we have to reorganize health care and revise the budgeting and reform this and that, it might take us a decade to get anywhere. But within the present system, with a little modification, we can do a lot to attract young general practitioners.

DR. MAHFOUZ:

I believe that there are two different tasks, that of imagining what should be done in the future and that of maximizing what we have now. These are two different exercises.

DR. COTTER:

Why are we here? We are here for the health of the people. If we do not make the people healthier, we lose our credibility.

But what can a doctor in a rural health center really do about installing sewage pipes? What can he really do about illiteracy? We create confusion if we assign the doctor responsibilities that he can't carry out.

These matters fall into the inter-ministerial grey areas. There are grey areas between the Ministry of Education and the Ministry of Health and--I'm not certain of the name of the ministry for sewage and water--that very, very seriously affect health. Progress in such areas depends on the Ministry of Health and the Prime Minister leaning on the other ministries. The other ministries may have more impact on the health of the people than anything the Minister of Health can do: clean water and sewage systems probably do more for health than all the drugs in all the health centers. I think this has to be remembered when one is looking at the total picture.

The number of countries that are able to provide free health service is going down and down and down. The U.K. certainly cannot do so; people pay very heavily for the national health service there. In Bahrein, where the doctors insisted, "We cannot go on providing a free service. We have got to have extra income!" the patients pay if they come after 1 p.m. It may be a token payment, but it's a payment. Are funds so short that the time has come when some extra money must come in from outside?

DR. MAHFOUZ:

Dr. Cotter, you have raised a very important point about the so-called grey areas between the ministries. There is a very important grey area in agricultural technology. Everybody knows that pesticides are injurious to man and life, and many catastrophes are occurring.

The rural doctor has to cope with these medical challenges, yet he cannot do anything to prevent them. You also emphasized that such grey areas should be tackled at the highest level, by ministers and the so-called interministerial committees.

DR. KHALLAF:

Because health expenditures are limited in this country, and because the improvement of sanitary conditions is a long-term process involving huge capital expenditures, the physician and his team have to use the technologies available to them to overcome the resulting hazards. In other words, a good program of immunization is very vital. That's why I want to draw attention to the importance of the tools and technologies in the hands of the physician and his team. If they don't have the tools they need, the adverse effects will be very hazardous indeed.

I agree wholeheartedly with what Professor Hamdy El Sayed said about opportunities for a scientific career. However, in a country of 44 million people, with one general practitioner for every 2,000 inhabitants, we will soon have 22,000 general practitioners, of whom very few will want or be able to pursue academic careers.

My suggestion about methods of remuneration stressed community contribution. I would prefer it to be organized community participation, if possible, ideally through some kind of health insurance. But if this is not workable, I wouldn't hesitate to support Dr. Hamdy El Sayed's ideas about private practice.

Mr. Chairman, when you were Minister of Health in 1972, you tried very hard to integrate the health services. But over the last 11 years, the Ministry of Health has emphasized the secondary and tertiary levels of service--hospitals and so on--and neglected the primary level of service. The first layer of service is the foundation of a health-care delivery system, and if it's not strong enough, if it's not given priority in allocations of resources, the rest of the system will suffer. That's why I am emphasizing strengthening and upgrading that level of service, in terms of equipment, resources, drugs, prestige, everything.

DR. BICKNELL:

It's very true that there is no free service anywhere; it's simply a matter of how one pays. I think it would be very valuable to look at public and private revenues in order to support services--perhaps combining them or using them in a new rationalized way, along with a reallocation of the responsibilities of the public sector and the private sector.

One also has to think about control, because physicians, at least in the United States, are not known for setting fee limits or participating in a meaningful way in cost control. So one has to integrate public and private revenues in a fairly artful way. But the use of private and public revenues in new ways may be very important in improving the level and quality of services at the front line in primary care.

DR. ABU ZEID:

I agree in part with what Professor Zohair Nooman said. There is certainly a lack of understanding of the delivery system, not only on the part of the public but also among the people who work in the system. Many specialists and general practitioners don't know what health resources exist in the community; thus they can't possibly use these resources efficiently. The public is also confused about health-care resources, and often cannot decide where

to take their health problems.

However, these two facts don't necessarily mean that the delivery system is not functioning well. If we look at the past 10 or 15 years, the health profile of Egypt has been improving. The infant mortality rate, for example, has decreased from 140 to 80 per thousand over the past 10 years. The overall mortality rate is approaching that of the developed countries. Coverage is fine, but there are functional problems--which are mainly administrative and attributable to lack of supervision. I don't think we need to wait until we have reorganized the delivery system. In fact, I think the GP program itself has the potential to improve the system.

When we talk about the interaction between public and private, let's not forget that almost 90 percent of private physicians also hold a public job. This situation reflects on the public service in a very negative way, and we need to think hard about it.

DR. MAHFOUZ:

Professor Hamdy El Sayed mentioned that the health sector needs more money. Allow me to voice the position of an economist, to contrast with his position as a health-care delivery specialist and decision maker. The economist is always oriented toward the growth of the economy, which can be promoted by three methods: (1) measures that increase productivity, (2) measures that decrease consumption, and (3) better management and maximization of the revenues of existing production.

The economist looks at health as a second priority, not a first priority, because he is not convinced that giving more money to the health-care delivery system will increase productivity or decrease the loss of manpower productivity.

In the interests of enhancing the status of general practice in the minds of the public and the universities, and of general practitioners themselves, I'm going to propose for purposes of brainstorming that the bachelor's degree in medicine be called a bachelor's degree in the general practice of medicine. That is, all of us would start as general practitioners. After that we would advance scientifically into postgraduate education in general practice or another specialty.

DR. EL SAYED:

Unfortunately, the five-year plan categorizes health services and training as social services; they should be treated as productive services. But there is no point in arguing whether or not health is production; as Professor Mahfouz pointed out, it is a matter of economic constraints. The medical profession should be

somewhat reassured by the sizeable portion of the five-year plan that has been earmarked for sewage plants and a clean-water supply plant, since improvement of the environment directly promotes health.

What we object to is that, although the government cannot allocate enough financial resources for health services, it continues to produce a lot of manpower resources, especially doctors. There is a huge discrepancy between the number of doctors and other medical personnel produced each year, and the resources available for training them.

The other very important problem is that, if you are a poor country and can only invest limited resources in health care, you cannot pretend that you are providing free health services. This is political hypocrisy. When the government tells us that resources are limited, it should be thinking about the priorities for expending those health resources.

When we tell them that we cannot go on treating everybody free, and that the patient has to contribute somehow or other, they tell us to go to the local authorities. When we go to the governorates, they say, "What you are suggesting is unfair to the people. If they have free services, how can you expect them to begin contributing now?" I want them to contribute because it is preferable to no health services at all. If only those who really could not afford to pay received services free, and the rest of the population contributed according to their income, private practice would be incorporated into the strategy of health care.

This nation is committed to public-health preventive medicine, and Dr. Ramses Goma's very good paper on health-care priorities offers some examples of how the network of health-care units really protects the country against epidemics. The poliomyelitis vaccine campaign has reached nearly 95 percent of the target population through this very effective chain. We don't have cholera in this country because of this chain--in spite of the fact that it exists all around us and our water supply and sewage disposal are not the best. We have proved that the medical profession can protect the nation against a lot of epidemic disease.

Promotion of the environment, vaccination, maternity health care and other public-health services could be provided free. But when it comes to curative services, which are the most expensive, only those who are very underprivileged should receive free service; the rest of the population should contribute. When we as a profession act to protect private practice, we are not just protecting our own interests. We are also protecting the interests of the people. We and the government and the local authorities have to act together to incorporate private practice into the overall strategy of health-care delivery in this country.

DR. MAHFOUZ:

We must move on to the last component of our panel discussion, the role of research in general practice. I call on Dr. Bicknell to give an introductory statement.

DR. BICKNELL:

We've been talking about the physician, particularly the general practitioner, primarily as a caregiver in the curative and preventive sense. As we think about undergraduate and postgraduate education, let us keep in mind two additional functions that we have alluded to but not expressly discussed. First, the physician is a manager, in at least three spheres: (1) patient management, which is implicit in the caregiving role; (2) team management, facilitating the working together of the nurse, the sanitarian, the physician, the laboratory technician, the pharmacy clerk, and the other personnel in health centers and clinics; and (3) the mundane but very essential business and administrative side of practice--supplies, equipment ordering, collection and distribution of fees, and the like. Are records kept accurately? Do we know, for purposes of analyzing community needs and the efficiency of service delivery, how many people the health center sees? Management is not a skill we are born with, nor is it a skill that doctors are comfortable with or necessarily enjoy. It needs to be taught.

Second, the physician is also an educator. We've talked at considerable length about his role in educating himself, and some about educating patients, and he also is an educator of the team. Finally, he has a tremendously important role in community education--not only of the members of the community but also of its political leadership. Typically the physician is one of the most educated people in a community. Society has put a great deal of money into his education, and he brings more than patient-management and community-health skills. It is really a tragedy to limit the physician's impact to narrow aspects of patient care.

In Zambia I met a general physician with a broadly based practice, coming out of surgery. He told me that the most important thing he had done over the last several years was working with agricultural committees in the surrounding villages to identify and introduce a higher-yield variety of corn or maize seed. The health-center staff had seen a resulting increase in nutritional status in the community, increased resistance to the adverse affects of diarrhea, and lessened morbidity and mortality associated with infectious disease. The health benefit was also paralleled by an economic benefit. This was a physician acting as an educated person, applying general knowledge. It's true that physicians aren't going to dig sewers and lay sewage pipes, but there are technologies in public-health spheres that physicians can suggest,

such as self-composting privies of the kind developed in North Vietnam. There are other ways: one can talk about the importance of community preventive techniques involving sewage or water, for example.

I want to reinforce the emphasis that Dr. Khallaf and other speakers this morning placed on the role of the community. We've discussed medical students as consumers of medical education, and general practitioners as consumers of education in general practice. Meanwhile the consumers of service delivery need to be involved, not only as payers--whether through the tax mechanism or out-of-pocket--but also as advisors in the design and organization of services. We need to ask them what they want, what they need, and how they perceive the defects, and what would best meet their needs. Though someone may be poorly educated or illiterate, that doesn't signify lack of intelligence. Many insightful lessons can be learned from an open and undefensive inquiry in the community.

Moving on to research, both Dr. Khallaf and Dr. Hamdy El Sayed have made a number of cogent points. It is certainly true that general practice is a rich area for research--in Dr. El Sayed's words, a "goldmine." Research really is problem solving; it introduces critical thinking in a defined way and encourages physicians to question premises. It teaches about inference, causality, and the often subtly confounding effects of variables. Dogmatism and pronouncement are the antithesis of problem solving, and stand in the way of good patient care. Medicine is full of untested hypotheses, belief structures, and values, and research helps develop an intellectual predilection to question the premises, to think twice before just doing what one is told.

The process of research, I would suggest, may be more important than the actual product, particularly as one begins research. How one goes about it, how one defines the question, and the process of thinking through the question and doing the research are really what is of value.

Research also introduces denominator-based thinking. As physicians, we often tend to think in terms of the individual case; "I saw a case of this," "I saw a patient with that." But one should also think in the numerical and quantitative context of the overall community. That sometimes eludes us, and then we leap to convenient conclusions by selecting data comfortable to us. Rigorous research--not elaborate but rigorous--helps us learn how to avoid the traps of numerator-based thinking.

Dr. Zohair Nooman set the stage yesterday for discussing research in general practice when he articulated the goal of "developing research programs that address the actual health needs of the community." The potential benefits of such research are many. The general practitioner learns from the outcome of the research as well as the process. The program or faculty he is

working within accumulates a body of knowledge about community needs and health practices in primary care. This increase in the overall knowledge base can be very useful to the community if it's pursued within a consistent structure, because it can be linked to the improvement of health services.

What are some of the things that a general practitioner should think about in formulating a research question? First, can the question really be answered--not in the abstract, but working on it part-time for two years? Don't ask a question that requires a multi-center trial with thousands of cases. Can you, as an individual general practitioner, answer it with the resources available--basically, your brain, the library, your hands and feet, pencil and paper? If the question's too big, such as how to improve health services in Egypt, it's going to be hard for one general practitioner to answer in two years. On the other hand, one wants to avoid the too trivial or esoteric, which is a waste of the general practitioner's time and intellect. The question should be relevant to his professional interests; because research is hard work, it should be stimulating and have real meaning for the researcher. Will it contribute to better medical practice and, specifically, better primary-care practice? It should be something that the practitioner can see as having real utility in his or her current or future practice, and having relevance to the needs of the country.

Two levels of money have to be considered. First, is there money to pay for the research? If extra funds for research are not available, it may be necessary to modify the research design or even choose a different question. Second, the cost implications of the outcomes of research need to be considered while reviewing one's findings and making suggestions based on one's research. We've heard a lot about cost this morning. Egypt is operating, like most countries, in a resource-constrained environment. So it is not enough merely to develop ways to improve services; we have to ask if a particular improvement is worth the cost. And one must always think in terms of alternative uses of the money--the opportunity cost. The general practitioner at the front line of service delivery should have uppermost in his mind, along with patient care, the cost implications of everything he does.

Let me make some illustrative suggestions of topics that could make a difference, that would be both useful and achievable. The practitioner could survey the 10 most common presenting illnesses at selected health centers, and determine the minimum physician skills and lab tests, if any, needed to make reasonably accurate diagnoses. He could assess the existing degree of diagnostic accuracy--this could be done by a GP trainee--and then review patients, perform his own tests, and determine by personal experience the degree of accuracy that's possible. He could comment on the cost of improving accuracy, the benefits of improved accuracy, and--if it's determined that improved accuracy is desirable--the specific steps that could

be taken to achieve those improvements.

Or one could look at the basic pharmacopeia in selected centers. What are the prevailing illnesses? What drugs does the center have? What drugs does the physician actually prescribe, whether or not they're available at the center? What about the efficacy of those drugs? What is their cost? What is the array of alternative drugs for the same set of illnesses? What are the relative costs of various alternative arrays of drugs?

Or one could look at this question from the patients' perspective: what drugs do patients actually use, where do they get their medications, to what extent do they follow directions? In a nutshell, one could look at health care as it is actually purchased and consumed, rather than from the physician's perspective.

What about diarrhea and oral rehydration? How common is it? In what age groups? What are the actual treatments now? Can or should other treatments, such as oral-rehydration therapy, be substituted? Is there a gap between current knowledge and current practice with regard to oral-rehydration therapy? What actions might be appropriate, in light of the general practitioner's findings?

Or, to look at the community, what are the people's perceptions of Ministry centers? What do the mothers, the fathers, the children think? When do they use them? More importantly, when don't they use them? What are the competing sources of care--traditional, modern, informal, pharmacies? Why? What actions might the community recommend to improve acceptability and utilization? How can the community participate--in services, in cash? What is the basis for people's perceptions, and what kinds of remedial actions, if warranted, might be taken? (Some of these topics may need to be broken down into slightly more digestible bites.)

In the environmental arena, the general practitioner could conduct an environmental assessment of selected rural hamlets or urban neighborhoods, focusing on factors important in disease prevention that can be influenced by community education and the health-center team. Useful research can be disease-specific, it can involve family planning, or emergency medical services, or infectious disease, or it can focus on the laboratory. Such topics--some of which are already being pursued--illuminate real problems. They contribute to the knowledge base of the general practitioner, and to understanding of the community by the Ministry, and they can contribute to the rationalization and improvement of service delivery.

In concluding, I would just like to reiterate three points. (1) In addition to his care-giving function, the general practitioner has a management function as a patient manager, team manager, and business and administrative manager. He is also an educator of patients, the team, and the community, as well as

himself. Both these roles need to be considered in the educational process. (2) The process of research is perhaps as important as the product of research. (3) The people, the consumers, need to be asked what they want and what they suggest. As physicians, we serve the people, and it is only reasonable to ask them how they would like to be served.

DR. MAHFOUZ:

Dr. Bicknell, you did not mention the relationship between an organized health information system and research in general practice. Would one be in a position to do research in general practice without an organized health information system to provide data for analysis?

DR. BICKNELL:

To the extent that there is data available and an organized health information system is functioning, that's wonderful; it can definitely contribute to the conduct of research. But I don't think one needs to depend on that. Certainly it is essential to look at the literature, to know what has gone on elsewhere in the country, elsewhere in the world, as one approaches a specific problem. But even with a very limited data base, one can gather and develop data, within a reasonable time frame, that is reasonably accurate and that will illuminate the question in useful ways. And even if there is existing data to draw on, one has to assess that data to make sure that it is really accurate and focuses on your question usefully.

DR. ABU ZEID:

We don't need to wait for a sophisticated information system to do research. The general practitioners in one district have done a very interesting piece of research on delivery of oral-rehydration therapy. One cell gave oral-rehydration fluid to the mothers; another made it available through the health unit; a third cell put it in shops in the village, and the fourth taught mothers to prepare their own rehydration fluid from household salt and sugar. The outcome of this study was that in the cells where the mothers were trained to identify cases of diarrhea and to start early treatment with oral rehydration, child mortality under five years dropped by 50 percent. This piece of research was the basis of the nationwide rehydration program we are starting now.

In another project, a physician studying for a Ph.D. is working on the role of nurses in identifying and managing acute respiratory infections in rural villages. This piece of research has been very well received here in Cairo. These examples both illustrate that general practitioners, working in their own

communities, can do excellent pieces of research.

DR. EL SAYED:

If we provide the general practitioner with the skills and training to treat the problems he encounters in an efficient way, there's no doubt that he is going to gain the respect and trust of the community. The community doesn't trust the general practitioner at the moment because they believe that he is not able or competent enough to cope with the problems he is likely to face.

The other priority is to convince young doctors that general practice is a prestigious profession in which one can do research, earn an M.S. and a Ph.D., and become a member of the teaching staff of a university. This is the way to attract the most academically talented students.

The experience of the Royal College of General Practitioners is very instructive. General practitioners in the U.K. are very respected members of society, many of them are professors, and they earn more than other specialities. I was told by the people at the Royal College that general practice now attracts the best students. I'm sure this was not the situation 10 or 15 years ago. This isn't something that's going to happen overnight. Change is very slow, and our job now is to take the proper first steps. The departments of general practice at Suez Canal and at Mansoura represent the first step on the road. If we press on as a profession, and if the Syndicate, the universities, and the Ministry of Health care for the general practitioner and cater to him for the next five or ten years, we can bring about quite a drastic change.

WORKSHOP D

RESEARCH IN GENERAL PRACTICE

DR. ABU ZEID:

When we talk about research in general practice, we ought to clarify the need for such research, both during and after the master's program in general practice. Do general practitioners want to participate in research after finishing the master's program, and if so how can we provide them opportunities to do so? Second, who will be responsible for conducting the research training program? Third, what are the priorities when it comes to topics of research in general practice? Fourth, how should the results of these research projects--which will assuredly focus on important practical health problems in the community--be communicated to other people who could make use of them? The information dissemination system is very important.

Dr. Bicknell, would you like to tackle the first point, the need for research?

DR. BICKNELL:

First, Dr. Mahfouz asked me to raise four points for discussion. He wanted to point out that an organized system of care can better promote research; that clinical work always leads to observations, which in turn suggest research topics; and that an information system is the basis--or may be the basis--of a continuing research effort. He also wanted to emphasize opportunities for the general practitioner to do research in the early diagnosis of serious illnesses--how to diagnose at the level of the health center, rather than waiting until later in the natural history of a given disease. I just want to get his comments into the record.

I would very much like to hear the thoughts of the master's

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students on research--its benefits, its difficulties, and how it fits in with the rest of their training. What is their view of the value of research, and how can they be better supported in carrying out research?

MASTER'S STUDENT:

Research is very useful. I live in a rural area, where there are problems I would like to know the answers to. What I learned in the program is how to look for the answers.

I think it is very important, after finishing the master's degree, to continue to do research projects. But the difficulty is that the recording system is very bad. To be a good researcher, you must have a very good recording system, in the health centers and in the hospitals.

DR. BICKNELL:

Does that situation in itself represent a research opportunity, along the lines of designing and testing a simple, effective system for the keeping of data in the center and the outpatient clinic?

If, for example, your real interest is hypertension, but you can't approach it yet because there isn't quite the data you'd like, maybe as an early step you could work on the development of simple record-keeping procedures that will work in the Egyptian context and will improve patient care and facilitate research. Would that be something you would consider?

MASTER'S STUDENT:

Applying a recording system?

DR. BICKNELL:

Developing and testing one. There are many types, and it's not clear which will work best. Dr. Sabri brought an example of the recording system they're using in Tunisia for basic data. Maybe it could be an adaptation of that; or it could be one that you develop; or several alternatives could be tested in different centers.

DR. ABU ZEID:

That's an important question that Dr. Bicknell asked you: could you develop something yourself?

In the master's training program I asked the students to evaluate the record system in the primary-care units, to propose a better system, and to implement it over a three-month period. The problem is continuity--people work on it and then they leave. We may hammer out a very good system for a well-baby clinic, for example, or for a geriatric clinic, but then we face the problem of continuity. So merely by virtue of your continued presence there, you could contribute a great deal to improving the recording system.

A good record system is a very important requirement for evaluating health services in the unit, or at any level. We cannot say anything about whether the health service is effective or not unless we have a reliable record system. It is also important for carrying out research programs. But the first consideration is that it's impossible to get an accurate idea of what's going on in the health-care service without a good record system.

The record system in the primary-care centers is well known not to be good. This is one of the reasons that the Ministry of Health sponsored a national conference to promote a nationwide health information system. The conference discussed the introduction of a microcomputer system for collection, analysis, and dissemination of health information. In fact, it has already been initiated in a number of provinces, and plans are being made to extend it to all the governorates.

Most important, however, is that the people working in a health center should understand how to build up and maintain a good record system. Professionals who want to do research can use other methods of collecting data, such as surveying, prospective studies, and the like.

DR. FARLEY:

I think that the basic purpose of a record system has to do with the care of the patient. If a patient has normal blood pressure today, and high blood pressure when he returns next week, you won't see the connection without a record. So I think the purpose of the basic record is to make you a better doctor. Then we can proceed from there to research. But there have to be records for individual patients, either carried by the patient or kept at the health center.

One of the advantages you have when you begin doing research in general practice is that most things are not prescribed. Research can be descriptive--descriptive of a special experiment, of what you are observing or modifying.

You may have to start, as Dr. Bicknell said, by selecting or designing a record system that will allow you to identify the

problems. We in the United States stole very freely from the Royal College of General Practice--not their charts themselves, but their age-sex registry and their morbidity index. They were way ahead of us; they were doing things that hadn't even entered our heads. So don't hesitate to look at what others are doing, and to steal ideas, or combine ideas. In doing so, you are doing research; you are researching what is available in order to develop some new knowledge.

DR. BICKNELL:

It's true, at least at some of the centers I know around Ismailia, that the records aren't so very good. But there are records available; there are forms available, there are procedures. Why is it that nothing is done with them? What are the underlying behavioral reasons that people aren't collecting data? Until you answer that question, better methods of collection are likely to be better, but ignored, methods of collection.

DR. FREELING:

A record system implies a purpose, and the reason it doesn't get used is that they're devised by people whose purposes are different than those of the people who are supposed to use it. If you want to find a good record system, you'll find it in the place that has to use it.

MASTER'S STUDENT:

Sir, many master's degree students like to do retrospective studies, and that's why the lack of reliable records is such a problem for them.

DR. BICKNELL:

You can also be prospective! This situation may force you to do something even better. You can be prospective; you can randomize on small samples.

In most countries, I've found that although the patient records may be weak, there is usually a register where, when a person comes in, they record the name, the diagnosis, the date, and something about the treatment. It is surprisingly accurate, and it is often the only accurate data. You can really count on it for age, sex, seasonality, and impressionistic diagnoses; it is a rich source of usually quite reliable data. You can validate its reliability fairly well by observing over a period of days how well they record or don't record.

DR. FREELING:

When we talk about good records, the question in my mind is "good for what?" In any organization, the day-log is kept up-to-date by the staff because that's what they're paid to do. And if they don't, they get fired.

DR. BICKNELL:

Well, one problem is that there's not much firing in the public sector here.

DR. FREELING:

If you want to do a study of something, the first thing you want to know is how much of it there is to look at. I know a foolproof way of eradicating any disease: If I design a study of it, it disappears from my practice. (laughter)

So the first step is the very important basic one of making it possible to say, "There are a lot of people in a certain age group, men rather than women, who came for treatment in the morning rather than the afternoon, and who had this sketchy diagnosis." You've got yourself a world's worth of research there.

MASTER'S STUDENT:

When I tried to collect data on the most common indices at the rural and urban health centers, I encountered a big problem: a prospective study of this kind is very time-consuming. I sat in the clinic with every doctor, every day, and skipped classes to collect data. But I couldn't spend all my time at the clinic, and even eight or nine months isn't enough time to determine the most common diseases over the course of a year. So I looked for another topic.

DR. BICKNELL:

Maybe you could do summer and winter, and skip spring and fall. Or just look at the common illnesses that show up during the three months of the summer.

DR. FREELING:

You said that when you tried to get your colleagues to help collect data, it didn't work. Why didn't it work?

MASTER'S STUDENT:

They didn't know the diagnoses.

DR. FREELING:

Well, we've never counted the most common diseases, but we've been able to count the most common symptoms pretty successfully.

DR. BICKNELL:

Yes, if you limited yourself to the ten most common presenting symptom complexes in the summer--just the summer, a short period of time--you could then investigate some of them in terms of diagnoses. You could look at the tests that were done--very few can be done in the health center--and you could perform some yourself as well.

I'd suggest narrowing the topic down to something that's feasible but useful. If you find insufficient data, or inadequate personnel, or whatever, to pursue that topic, it seems you'll have to back up and simplify further. Then you'll start reaching some of the core problems that stand in the way, not only of good research but also of good patient care.

I would like to ask you another question too. Let us say that you were able to find out about hypertension in the Sinai, notwithstanding the accuracy of the measurements. So what? Why would you choose that versus another problem?

MASTER'S STUDENT:

That's the same question I wanted to raise. We master's degree students choose our research topics largely on the basis of what interests us. But are we talking about research to fulfill the requirements of the master's degree, or research to benefit the practicing general practitioner?

If it's a question of the master's degree, there is really no problem: the students are obliged to do research; they will find some to do. (laughter) What about general practitioners who have not studied for master's degrees? Do we want them to do research? If so, what is the purpose of the research? And how can we convince them that research is important, and that you have to do it to know your problems?

DR. BICKNELL:

A very good question.

DR. ZIAI:

Let's be realistic. If we are expecting a very busy practitioner out in the middle of nowhere, with no guidance and no reference library, to devise research on his own, aren't we asking too much?

Perhaps we should give some thought to research as a joint enterprise of the practitioners and the universities. It would keep communication flowing in both directions: devising the experiment, planning, supervising, and then analyzing data would bring the teacher to the community and the practitioner to the university.

DR. FREELING:

If you discuss something with another doctor, and the two of you don't agree, you have just come up with a research project for yourself and the other doctor. Ask him to keep a record, and you do the same, and then compare your data. You're sure to find out something. That is research.

DR. BICKNELL:

Yes, here's an example. This is isuprel, for asthma, made by Breon Laboratories. There's another isuprel made by Riker--same strength, same everything--but the Breon is cheaper. When I was medical director of the United Mine Workers of America, we only paid for Breon. One of our members wrote us that this brand made him cough but the Riker didn't. We had the two brands reviewed, and the person who did the review said that there was absolutely no difference between them. Well, it turns out that I had a little asthma; I usually use Riker, but occasionally I used Breon, and every time I used it I coughed. When we looked into it again, we found that the propellant, the so-called inert ingredient, is different in the two brands.

Chance observations like this are a very valuable way to stimulate research. And the value of research training in general practice is that it sensitizes you to the observation of the worker in the pharmacy, or the nurse. It opens your mind, and then stimulates you to push your colleagues to think in new ways. That's its real value.

DR. FARLEY:

If you select well and are well supervised, the research you do for your master's degree will stimulate your thinking for the rest of your life. As a practitioner, you will constantly be sorting through what you were taught, and you will find that some of it is wrong or outdated or impractical. You may think, "I can't do research, because I don't have access to all the journals, all the books, all the facts." But you are caring for patients, and if you're a good observer--which is what research is all about--and you look at your data, you are coming up with new knowledge. Then you can report back to your former professors, "What you taught does not work in practice. This is what I am doing, and this is why, and this is what I do not understand." This would be a very valuable kind of two-way communication. If a professor says "Nonsense!" or dismisses you, he's in the wrong, not you.

PARTICIPANT:

Is research done by general practitioners in the U.S. and the U.K.?

DR. FARLEY:

Some programs require their residents to do research, and some don't. The program I'm affiliated with now doesn't require research. It's up to the individual program; it's not a national standard.

In Canada and the U.S., we have an annual meeting on primary-care research, at which practitioners from all over present papers. Some are excellent, some are poor; but the purpose is to stimulate, to exchange ideas, not to insist that every paper be as polished as those of lifetime researchers. Practitioners simply present papers of interest, to share their findings with the audience. If they want to take their ideas further, they can do so; if not, they will have stimulated a lot of other people, some of whom may be prompted to do related work.

The natural history of hepatitis was described by a rural English practitioner with no fancy records, just good eyes. He was able to trace the path of the disease, the incubation period, its natural history. All the major scientists in the world lagged behind him.

The exciting thing is to do appropriate research. After my residency in general practice back in the 1950s, I went to work on a Navajo Indian reservation with a group that was, among other things, doing research. All I knew about was hospital research, and I didn't know much about that. I didn't know what questions to ask,

but I was fortunate to be around people who were asking good questions.

DR. BICKNELL:

Most research published in American medical journals is done by people who are primarily practitioners.

MASTER'S STUDENT:

After I graduate, time won't be a problem because I will have two or three years to follow up my patients. But now I only have nine months to do my research.

DR. BICKNELL:

It sounds as if beginning your research projects in the second year of a two-year training program is too late. Because if your first idea doesn't work and the second one is a good topic but can't be done, you may find yourself with only seven months left. So you decide to count the number of angels on the head of the pin just to get your thesis done.

Occasionally people from the Suez faculty who come to visit us in Boston say that they would like to complete their research in two or three months. That's not often possible. One can investigate a problem--gather information, go to the library, talk to people--but to design a study that probes a question and potentially develops a bit of new knowledge is very hard to do in two or three months. I think it's unrealistic.

Maybe it would be a good idea to start discussing research topics early in the first year, so you have a little more time.

DR. ABU ZEID:

I think this is a good suggestion. Students take field training in community medicine and general practice early in the first year, and they could start thinking about research work then. Training in research should really be gradual. You just can't do it in two or three months. I think it should start as early as possible in the first year, with some basic courses and small projects in the field. As students build up their research capabilities over the course of the first year, they could identify appropriate topics to work on the following year. They could also consult people on methodology and design. Then in the second year they could concentrate on the actual design and implementation of the project.

DR. FREELING:

Maybe we should distinguish between learning about research, learning to think in a research mode, and actually doing research. In the medical school where I teach, we ask our students to complete a research project in two weeks. We wouldn't expect to publish many of the results. but the students learn how to pick out a research project, how to approach research questions, how to criticize the results.

DR. ABU ZEID:

You are saying that even in a very short time a student can accomplish something in research. Our undergraduates produce reports, but they are by no means equivalent to a master's degree research thesis. At this level, a longer preparation and exposure to research methodology is needed.

DR. ANAND:

Let me try to summarize our discussion thus far. The research undertaken by postgraduate GP students is intended not only to satisfy academic requirements but also to contribute to the quality of the health-care delivery system. A related goal of such research is to sensitize students' minds to the value of careful observation in all aspects of patient care. The very fact that some of the existing services, like the record system, are unsatisfactory can be an incentive to undertake research. Such examples abound in all aspects of health care. Because postgraduate research in general practice is just starting in Egypt, students have a wide range of methodologies to choose from, including observational and descriptive studies, prospective and retrospective studies, demographic studies, and so forth.

DR. TAYMOUR:

Are we only here to discuss postgraduate research projects for the master's degree, or are we talking about research in general practice?

DR. ABU ZEID:

In general practice.

DR. TAYMOUR:

Then we haven't yet come to the point. We have to insist that the problems of general practice be explored in every department, in every area of medicine, in every project, inside the university and outside.

DR. FARLEY:

That's extremely logical, but I think that the reality of getting more practitioners involved is that you start with a small group, and they stimulate and teach other people, and over the years they get more and more people involved. People in practice will gradually come and say, "I'm interested in some problems; will you help me?"

DR. BICKNELL:

Dr. Taymour's point was that general practitioners have not previously done research in Egypt. Research is traditionally done by specialists with academic affiliations, and there is some resistance to general practice from specialists in Egypt. He was urging that people in the specialties look at general practice, and at the component of their speciality that can reasonably be incorporated into general practice. This would be useful in defining the scope and content of general practice in Egypt, and would also help seduce the specialists to be supportive of general practice.

DR. TAYMOUR:

That's exactly what I'm saying. I'm not really insisting that every GP do research; I'm saying that we have to answer questions in general practice.

DR. ABU ZEID:

Why don't we move to the second point: Who will be responsible for training in research methods? As you know, there is a Department of General Practice, which is in charge of the master's degree program. A number of other departments also offer instruction to the master's students, including internal medicine, pediatrics, ob/gyn, community medicine, and others. The Department of Community Medicine is offering an informal course in research methods, which students like and attend eagerly, but it's not a formal course. We are also offering about eight hours on biostatistics.

DR. FREELING:

Excuse me, are we discussing who should train master's candidates in research, or how practicing GPs will get training in research? We're talking about fourteen people, when there are 17,000 out there. . . .

DR. BICKNELL:

Well, if it's not clear exactly how to go about training fourteen people for research, it's hard to leap to conclusions about 17,000. We can at least talk about the fourteen. Maybe by proceeding from the specific to the general, we can come up with some implementable, plausible, feasible approaches.

DR. FREELING:

If you want to answer a question, though, you have to go out and find the answer. You can't necessarily infer from a different group.

DR. ANAND:

May I summarize? General practice in Egypt provides a broad canvas for research, whether by individuals, specialty groups, or multidisciplinary groups. But we need an information system, so that if a doctor wants to know something, he can go to the university in his region and consult the information system. We also need a publication, edited by a group of doctors--perhaps one in diagnosis, one in surgery, one in medicine--qualified to select good papers from all over the country, and to oversee any revision they might need before publication. Thus one's contributions could be circulated in the information system, which would encourage more doctors to do research. Not just doctors with master's degrees--all the general practitioners in the whole country. For example, if I'm practicing in a rural area, and I notice something, I discuss it with my colleagues and we design some research. When we're finished, we need someplace to send our results for review and for distribution to colleagues in other parts of the country.

DR. FREELING:

When you have a question in your mind, you need guidance on research. After a while you will get good enough at research to do it on your own. But at first, maybe even before a publication system, you need a group of academics willing to advise their practitioner colleagues who want to do research. They probably

wouldn't be swamped with requests from the 17,000, but they wouldn't turn away anybody who requested advice.

DR. BICKNELL:

We might recommend that when the second conference on general practice is held, there would be a scientific session to hear papers by general practitioners.

DR. ABU ZEID:

When we planned this workshop on research in general practice, we wanted it to concentrate on what we can do right now in Egypt, and more specifically in our program in general practice. Our students are required to do some research; what should we concentrate on now? As for promoting research after they graduate, and encouraging general practitioners throughout the nation to do research--that's another question for later on. Are there any other suggestions as to how we could improve the research component of this particular program in general practice?

DR. FREELING:

How much statistical training do the master's students get?

DR. ABU ZEID:

Eight hours in a community medicine program, and eight hours in biostatistics. That's all.

DR. FREELING:

If they are to continue to do research once they graduate, they'll need more statistical support than eight hours in biostatistics.

DR. ABU ZEID:

That's why we offer the research methodology course on a voluntary basis, in addition to the required eight hours in biostatistics.

DR. FREELING:

I suspect that you will need to offer your own graduates more statistical background, if you're not going to formulate that as essential policy for all GPs. Otherwise, they're going to run into problems. General-practice research is usually relatively simple methodologically, but analysis can be complex.

DR. BICKNELL:

Yes, for example, I've been working on the design of a small study of drug stability in primary-care sites. Several of us talked about the sample size and sampling methodology, and we thought it was perfect. But we checked to be certain, and found we had to change the sample size!

DR. FREELING:

That's why they will need that kind of background.

DR. BICKNELL:

Exactly.

PARTICIPANT:

I am taking a course on research methods at the High Institute in Alexandria. The course isn't just for doctors; there are engineers, teachers, doctors. Every university could do this, or every faculty; it need not be limited to GPs, or even to physicians.

DR. ABU ZEID:

So you're proposing that we develop a systematic research course that could also serve people in other master's programs. We started doing that on an informal basis last year, but it needs more development.

DR. BICKNELL:

Dr. Ziai, you looked troubled.

DR. ZIAI:

I'm just thinking that research, more than any other activity,

requires an incentive. It's like exercise. I enjoy doing exercise, but I don't do it unless somebody pushes me. In academic life, the best incentive is promotion; it's amazing how many people stop doing research when they reach full professorship. So to think of general practitioners doing research without any incentive is idealistic. I don't think it's practical.

However, research is badly needed, both for the prestige of the profession and to keep practitioners excited about medicine. So I think we may want to propose certain means of offering incentives. Seeing one's name in print is one; presenting a paper at a conference is another. You get something out of it; the audience gets something out of it; the Ministry derives some benefit. Maybe a person who is performing a research investigation could get a little extra money, I don't know.

There are people who will do research without incentives; they're the ones who make the world go round. But you can't depend on it. Therefore, the more incentives that are built into the system, the better a guarantee you have of results.

WORKSHOP E
CAREER STRUCTURE AND
ORGANIZATION OF GP SERVICES

PANEL MEMBER:

General practice is the backbone of any health service. If we're going to provide a career for everybody who graduates from the faculties of medicine, about 50 percent of our graduates will go into general practice. At the same time, however, with the exception of the general practitioners in the Health Insurance Organization, most general-practitioner posts are transitory.

It's a short phase in the life history of any doctor. He only stays there for a year or two, and then he wants to go on to pursue another specialty. But we cannot base our health services on specialists; primary care is the backbone of health services in a developing country. The cost-benefit of this service is very high, and the reward to the community is very high, but primary care is not very well supported. That's why we are discussing how we should organize the service, and how to make a career attractive to our young graduates. How can we attract the best graduates, those who are really motivated by love of the community, love of the profession, love of the nation, those who want to make a contribution in this specialty?

DEAN NOOMAN:

Suppose I am a junior doctor at the beginning of my career. After I finish my internship, I work for one or two years in a rural health unit or urban equivalent, and then I'm thinking about specializing. What is going to happen to me if I choose to be a general practitioner? This is the question. There is no real career structure.

My hypothesis is that general practice, because it directly involves more than 50 percent of our physicians, is closely tied up

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with the structure of our health-care delivery system. If I ask myself how our delivery system is organized, I find no answer. There is a British system; there is an American system; there is a German system; there is a Russian system; but here in our country, we won't sit down and decide how we want to organize health care. We have the brains; we don't have the guts. But we have to do it. We must decide on the service structure that fits our socioeconomic circumstances and the needs of our physicians, not only now but in the next 10, 20, 30 or 40 years.

DR. SHEHATA:

I urge that we put into practice the system that is supposed to be operating in the Ministry of Health, whereby a GP is assigned to a specific population of individuals or families. We cannot simply leave a unit open for anybody to go. Concurrently, the referral system and a simple record-keeping system should be put into action. The existing recording system is ignored because it is very complicated. We should begin introducing simple records that will be useful in follow-up and in the work of the doctor himself. The referral system should also be strictly followed up. Patients now have the right, except in the Health Insurance Organization, to go to any outpatient unit, any hospital, collecting medicines from here and there. We are overburdened by this abuse of utilization of services. A referral system exists in theory, but it is not followed up.

This morning there was some discussion of a per-capita system. If we devoted the funds of the Ministry of Health to running the units, medicines, consumables, and so on, and collected 10 piasters a month from the 3,000 people assigned to a given GP, we would relieve the Ministry of Health of his salary, and he would earn 300 pounds a month. If it were 5 piasters per person, he would earn 150 pounds. He now earns only about 40 pounds per month. We need not be revolutionary, but at the same time we shouldn't be afraid or stand still. Just this small per-capita payment would mean a better salary for the doctor, and would free the other funds of the MOH to improve services.

The Ministry of Health is now allowing its units to be used in the afternoons for private practice. I am personally opposed to allowing doctors to have private practices in the rural units. The undercurrents are disturbing. If a doctor wants to be a private practitioner, let him do so away from the public system. But the public system needs to provide its doctors an honest way to earn decent monthly incomes. We are compromising their honesty and their behavior by allowing private practice in the units, with the patient moving back and forth between different types of GP-patient relationship. So I suggest a very modest per-capita system and the use of the Ministry of Health funds to improve the services and resources of the units.

DR. EL SAYED:

I don't share with Dr. Zohair Nooman the opinion that we don't exactly know what sort of services we are providing. I think we do know, but that the system is not working right. There is a lot of confusion about implementation of the system. What we need is a rational approach to our health system in the face of our financial, economic, and manpower-development constraints. Egypt has the best health-service chain of any developing country. We are very proud that there is primary health care within walking distance of 95 percent of the population. Even in the western desert, anybody can walk to a doctor. But whether this chain is functioning in the best possible way is another story. This is what we need to discuss, not our philosophy; our philosophy is well known.

Dr. Shehata raised the very important moral question of a double standard of service. It is often said that if you work in a government hospital in the morning and have a clinic in the afternoon, you will have a double loyalty, and the result will be a double standard of practice. Well, this is human; this happens everywhere. The answer, of course, is that we shouldn't allow private practice and we should pay everybody very handsomely. But with the constraints we face, with the cost of living mounting year after year, with the inflation rate above 20 percent, how much can the government pay a doctor?

Dr. Shehata said that we don't need to be revolutionary, but what he's proposing is in fact very revolutionary: to ask the people to pay taxes, and from those taxes to pay the salaries of doctors. He suggested 5 or 10 piasters; this is unthinkable! It would never be accepted! It might be acceptable to ask people to pay five piasters for a comprehensive health service, including drugs, medicines, hospital care, and so forth. It would be more acceptable to charge people for the services they actually use. But people will not tolerate being told, "Pay five piasters for your doctor to look after you."

Private practice is done here out of necessity. For the doctor it's necessary in order to live, and for the people it's necessary to complement the underdeveloped government health service. Among the 90 percent of the population that is not covered by health insurance, about 60 or 70 percent of curative care is provided through private practice. We should not regard private practice as an evil that exploits or undermines free services; we should see it as a necessity.

I urge that we rationalize private practice and incorporate it into the overall strategy of health-care delivery in this country. We could try to find ways to improve the status of private practice, encourage lower fees, and provide more outlets for doctors to

practice privately in their extra time. I can't see any advantage at all in a doctor doing nothing from 2 p.m. when he closes the rural health center until 8 a.m. the next day. Part of that time could be spent in providing a reasonable standard of curative care in exchange for a reasonable financial reward. Doing so improves the doctor's status, improves his financial situation, and at the same time enhances the available health-care facilities and curative services.

PARTICIPANT:

I recognize the financial problem that the government is facing, but I beg to differ with you, Mr. Chairman, that the shortcomings of the health-care delivery system in Egypt can be solved or even partially solved by private practice. If the government is facing financial constraints, that means that the people are also suffering from financial problems. How can we ask them to pay more for their health? That seems to me not only unfair but also illogical. As a young doctor, I don't want to make the error of sucking blood from people who are already anemic.

DR. EL SAYED:

Please don't put words in my mouth. I was talking only about curative services. I did not say that private practice is the only way to treat people or to improve health in the country. In fact, good sanitation improves health status more than prescribing pills or doing surgery.

Vaccinations, maternal and child health care, treatment of endemic diseases, care of school children, emergency services, nutrition--all this is the sole responsibility of the nation. And the government will do more for the nation by allocating all its resources to those areas; cost-benefit to the nation will be doubled or tripled. If, instead of building ten hospitals worth about \$10 million each, the government would spend that amount on improving the environment, sanitation, and nutrition, the people would gain.

If you are saying that the government can afford to support curative services and there is no need for private practice, please tell us how to do it.

PARTICIPANT:

Mr. Chairman, I'm sorry if I misrepresented you, but allow me to disagree that even curative care can be improved by private practice. It is a matter of the attitudes of the doctors. If you instill the attitude in medical students and graduates that the

curative aspect can be solved by private practice, their attention will gravitate toward making money rather than helping people. I know it is possible to help people while earning money, but the people haven't got any money. Even now, how much time are the specialists spending in the hospitals and how much time are they spending in their private practices? Since the government began allowing private practice in the rural units, doctors have been seeing patients privately during regular working hours.

The question is: How can we promote the health-care delivery system without making the people suffer by paying more and more? At the same time, we have to maintain high standards and provide for a comfortable life for doctors. I think the answer lies in the realm of health insurance. As Dr. Shehata and Dr. Khallaf have suggested, it is better to ask a person to pay 5 or 10 piasters than to pay 100 pounds a night in a five-star hospital.

PARTICIPANT:

The problem in our country is that the private practitioners are also the personnel of the public health service. They are one and the same. Even those with high rank in the Ministry of Health have their own private clinics. This means that we cannot control the situation. The income from the private job is much higher than from the public job, so the physician gravitates toward the private job and transfers his patients to his private clinic. I don't think any other country in the world has a similar situation. Whoever works for the public service should be limited to the public service. If the government needs to call on those in private practice, it should do so within a regulated system, such as government reimbursement of patients after they visit a private physician.

DR. EL SAYED:

It is corruption that sucks the blood of the people, not private practice. If we give good service for reasonable fees, we will be helping, not blood-sucking. On the contrary, we will be saving patients the money and effort it takes to rent a car for 5 or 10 pounds, to go to the city to be overcharged by a physician there. But the mayors and village councils like things as they are. If we increased the price of the ticket to 5 piasters, they would say that we are thieves. They want to keep physicians as they are now, weak, worried and under their control. This is the perfect situation for them. They do not like well-trained, educated physicians who can lead the community; they want to keep physicians weak and suffering.

The drugs for each health unit cost about 1500 pounds, which is a waste of money. If an active decision were made tomorrow to stop dispensing drugs in the rural health units, what would happen?

The people like the drugs and there is drug abuse. The chairman of the local council of the village wants vitamin B12 ampules; someone else wants iron, and a third has to have his pockets filled with drugs to keep his mouth shut. If we supplied the rural units only the drugs needed for treatment of bilharziasis and other endemic diseases, in addition to some injections for emergencies, which cannot be sold, and these drugs were to be taken only in the unit, it would be more practical and economic. We must control and regulate general practice. The measures I am talking about would not destroy the free service, and would not infringe on the rights of the people.

PARTICIPANT:

Patients already pay 5 piasters for a 3-piaster ticket to the health unit, due to lack of change, and the physician knows nothing about it. If we charged 5 piasters for the ticket, the extra 2 piasters could be used constructively instead of going into the pocket of the man selling the tickets.

PARTICIPANT:

The fee for immunization of travelers is officially 58 1/2 piasters, but the people actually pay 1 or even 5 pounds; the same thing is true of registration of births and deaths. The rest of the money goes to the clerks and others. I suggest that the 58 piasters be raised to over two pounds, and that some or all of the balance go to the physicians.

DR. EL SAYED:

As we have heard, the Gulf Countries have free medical service. But we have to take relative economic level into account when we compare Egypt's health service with that of other countries. Those countries can do so because of oil. We hope that one day our government will be able to insist that anyone who opens a private clinic has to leave his position in the Ministry of Health. We would expect more than half of the MOH physicians to resign from their government jobs if we did so.

If there is a physician who can live comfortably, operate a car, and give his children a good education on less than 500 pounds, I would like to meet him. But the government cannot pay this much and it cannot help physicians to open clinics, or give them special treatment, because people in other occupations will complain, "Why the physician? Why not the teacher?" Everyone wants to raise his income, and the government simply cannot pay and will not pay until we improve our service and organization.

The only solution to the problem of private treatment in Egypt, and the only way to get rid of the 4- and 5-star hospitals, is to open each government therapeutic facility in the afternoon. If we started this tomorrow, we could get rid of the high fees and the colonies of private practice and clinics, and at the same time give service to the people.

PARTICIPANT (U.K.):

A compromise may be necessary. In New Zealand a reasonably satisfactory compromise has been found, given the economic status of that country. The nature of it is that the government subsidizes a fee-for-service system. In other words, private practice is subsidized by the government. There are two ways of subsidizing. One is that the patient pays the doctor's fee, and the government gives the patient a refund. It's not a total refund; it's a partial refund. The difference constitutes the government subsidy. The other method is that the government pays the doctor a salary--less than enough to support him and compensate him for the work that he does--but also allows him to charge a small fee for his services.

When the patient doesn't have to pay anything, there is no disincentive for him to take his minor complaints to the doctor. And if there's no disincentive, there tends to be overuse of health care. On the other hand, if the patient has to pay the whole fee, the disincentive functions as a barrier to medical services that are really needed.

PANEL MEMBER:

When we talk about private practice in a rural health center, we are talking about very nominal fees of less than one Egyptian pound. If we have a system that exempts from the fee those who really can't pay--those with social security cards, the underprivileged, those who receive pensions, those who have chronic illnesses--and all the rest contribute just a small amount, it would be enough to improve the status of the doctor and the paramedical personnel working with him. They are all severely underpaid, but we simply can't pay them more out of the purse of the government.

If the government can't do it, and private practice shouldn't do it, then who is going to do it? We are not talking about private practice in the sense that the doctor charges whatever fees he likes; we are talking about some form of rationalized private practice that would represent an incentive for the doctor and the people who work with him.

DR. HELMY:

It is commonplace for the rural health units to work at night. This is against the law, but it still happens, and it does not cause any problems for anyone. But it does not solve the problems of the health services in these units at all. From my experience and the experience of my colleagues, I know that most of the rural health units work on a private basis during official working hours, but still this does not solve the problems of the health service in Egypt and is not going to solve it.

Controlling fees for medical care is not going to solve anything. The actual problem is that we have a health system in Egypt that nobody understands. We are the only country in the world to have private service, health insurance, free service, therapeutic organizations, etc. No patient in Egypt knows which physician he is visiting, and no physician knows which patient he is treating. The most important thing is to come up with a well-defined plan for the health service, and to regulate and control it.

If we say that the government cannot do more than is being done now, we will not have a real health service, simply because in every part of the world it is the job of the government to support the health service. So when we discuss the subject of health service, we ought to concentrate more on how to increase its budget. Dr. Mohamed said that he, for one, is ready to work in the health unit in the afternoon and not to open a private clinic. According to the law, the official workday for every person in the country is 6 hours. For every hour the physician works after that, he has to be paid time-and-a-half, and double on weekends and holidays. I believe that this would make a lot of difference in salaries.

PANEL MEMBER:

One of our colleagues who has been working in a rural health center for five years says that, if private practice were legalized, he would spend the whole morning on preventive and promotive services, endemic diseases, family planning, maternal and child welfare, school health, improving hygiene, and so on, and in the afternoon he'd concentrate on curative services at nominal fees. His situation would be much better financially, morally, and psychologically, and he thinks he could produce more and work under less pressure than if he's doing all this in an illegal way.

DR. COTTER:

I feel like Daniel stepping into the lion's den, but I can't understand how you can be so clear in your minds about the distinction between curative and preventive. If you are treating a

patient with hypertension to prevent a stroke, does he come in the morning or the afternoon? I am not against private practice; I think it is very healthy for a country to have private practice, because it serves as a standard against which to compare the health service provided by the government. But distinguishing between curative and preventive is entirely contrary to the whole philosophy of what we've been talking about for the last two days.

On the other hand, there are many differences between primary and secondary care, and this is what I think we are failing to look at. In secondary care, the surgeon must have a hospital in which to operate on the patient he sees at a private consultation; the same principle applies to physicians in secondary care. In primary care, you don't need a hospital. So you could divide your workforce that way. But I think you've got to think of some entirely different device of this nature, because the distinction between curative and preventive is absolute nonsense.

On a different subject, I think there are certain principles for setting out a career pattern. The three factors that need to be considered are years in the service, the quality of patient care, and the level of work assigned. The newly graduated doctors who lack experience should, I think, work only in the larger health centers where they can be supervised and can consult a more experienced colleague if necessary. I think it is perfectly reasonable to limit the types of drugs they can prescribe and the types of investigation they pursue.

After approximately three years, they could progress from grade 1 to grade 2 on the strength of experience and an assessment examination. Grade 3 would follow after another three years or a master's degree or certification. After that, I think you should require a further course to prepare people to teach--in a continuing education program, at a university, or teaching the health center team--or to go into administration or research, or to remain in clinical service. Each of these would require a further course. I'm just outlining a rough pattern, but I recommend that you work out the career structure and pattern in terms of grades. Each grade could have annual steps with annual increments. You either rise through the grades or remain in a given grade, having taken only so many steps.

There is clearly a place for the person who wishes to remain in a clinical service role. I also think that everybody should continue to do clinical work; you can't teach, if you're not doing the job yourself. No surgeon of repute would teach surgery without doing surgery himself.

DR. HAMED:

My experience in the health units has made me concerned about

the scientific level of the new graduates who work as GPs in the rural health units. A group of professors who are committed to the new speciality should develop a curriculum and books for general practitioners. We do not have books that give the general practitioner the information he needs. The books should essentially cover first aid. Many general practitioners now do not even know simple stitches and when to remove them.

PANEL MEMBER:

Our colleagues who visited some of the rural health units were shocked to find these units in very bad condition, with minimal equipment. They were expecting to find, in addition to the stethoscope and the sphygmomanometer, an ophthalmoscope and other diagnostic tools. However, they found many units without even a good sphygmomanometer. Sometimes the physicians were absent. This picture is very disturbing. Supplying these units with simple equipment does not cost much; 1000 pounds for each unit will supply the unit with good equipment. The other major problem is that the physicians working in these units do not know how to use this simple equipment correctly. They could not examine the ear or the fundus of the eye or use a microscope. We have to consider these points.

ADMINISTRATOR FROM THE MINISTRY OF HEALTH:

Sometimes equipment is stored in the health units without being used, out of fear of using it, or because the physician does not know how to use it. We need a well-trained physician who knows how to use the equipment. Also, the Ministry of Health established a small library in each unit, and all the books were absent when we visited the health units, for reasons you know.

DR. EL SAYED:

To sum up, we've had a very hot discussion in this workshop. We've discussed the organization of GP services, and the career structure of the general practitioner. And there has been a lot of discussion of financial woes. It is generally agreed that GPs should be well compensated for their services, and that it is important for general practice to be no less rewarding than other specialties, but the specific means of promoting the financial status of the general practitioner remains to be decided. We appear to be in general agreement on the desirability of offering the option of a master's degree, or a training program ending with a certificate from the Egyptian Medical Association, or further training in whatever skills he requires to promote his status and improve his performance without necessarily receiving a degree.

The advent of departments of general practice represents a

strong incentive, because they put general practice on the same level as other specialties. Any talented practitioner can hope to have an academic career. I think that departments of general practice will also serve other purposes, including exposing undergraduates to general practice, sponsoring research, and sponsoring training units.

We also considered Dr. Cotter's suggestion that the general practitioner have the option of pursuing a career as a research worker, a member of the university, an administrator in the Ministry of Health, or a clinical practitioner.

The last topic we touched on is the creation of professional bodies. Dr. Shehata has made a plea to the general practitioners to band together into a strong professional association to look after their interests in the future. This association is still very young, and is still calling on the support of other disciplines, but once it has enough motivated and dedicated people, I'm confident it will carry on the job of supervising and promoting general practice in this country.

SUMMARY AND RECOMMENDATIONS

DR. EL SAYED:

Dr. Shehata will read for you the recommendations of the various workshops and plenary meetings of this symposium.

DR. SHEHATA:

About the undergraduate program in general practice, the recommendations are as follows:

- Medical students who are being trained as basic doctors should be exposed to the concepts of general practice by dealing with cases that are not seen in hospitals and by looking at individuals in a comprehensive way, with an eye to continuing care and prevention.
- The training of undergraduates in general practice should take place at primary-care sites, rural and urban. Training should start as early as possible.
- Introducing a general-practice program into the existing medical schools cannot be effective unless appropriate changes occur in the prevailing curriculum to incorporate the concept of general practice.
- Students should fulfill an evaluation requirement in general practice before graduation.
- The faculties of medicine should be encouraged to develop general practice departments.

The workshop on vocational training in general practice agreed that general practice should be a specialty, and specified three

routes to specialty qualification: a master's program, fellowship, and residency training. The master's program would be under the auspices of the university, would involve an examination and a research thesis, and would result in a degree. The fellowship program, sponsored by the Egyptian Medical Association, would offer continuing medical education, including coursework and examination, to physicians in practice. Residency training would be offered by the Ministry of Health and other health agencies, with or without examination; participants would have the right to attend the examinations for fellowships.

- The training objectives and the organization of the program should be scrutinized, reviewed, and revised over the next two years.
- The universities are overburdened with training a large number of medical students and postgraduate students in traditional medical specialties. They cannot assume sole responsibility for providing the trainers and training sites for general practitioners. Training should be offered primarily in the field, at accredited training sites, by accredited GP trainers, graduates of the general practice master's program, faculty of local medical schools in various medical specialties, and specialists in the Ministry. The latter two groups should be offered some preliminary orientation to the parameters of general practice.
- Trainers should be trained on how to train others, and oriented to the philosophy and scope of general practice. Trainers should have a clear grasp of the objectives of the general practice program in their respective specialties.
- Communication among general practitioners should be promoted by the establishment of a GP scientific organization, a journal of general practice, and travelling seminars.

The workshop on continuing medical education in general practice agreed on the following recommendations:

- Continuing education for general practitioners has widespread support. It is crucial, however, that the Ministry of Health recognize its importance.
- The Ministry of Health could create an office of continuing education with outposts in rural governorates to host the continuing medical education courses and to follow the candidates and their progress.

- As for the content of continuing medical education, we request that the Ministry of Health collect the teaching materials it has already accumulated, as well as those of the medical resources center in Cairo, and appoint a council to review these materials and develop a curriculum.
- We ask the Ministry of Health to establish a career ladder for specialists in general practice, and to offer certain privileges to those who attend continuing medical education courses.

Dr. Yehya Taher will report the recommendations on career structure and organization of GP services, and Professor Anand will summarize the recommendations on research in general practice.

DR. TAHER:

- It was agreed to convene a meeting to discuss the organization of health services in Egypt, with special stress on the role of the general practitioner.
- We recommend that the Ministry of Health implement the existing policy of accepting at general and provincial hospitals only patients referred by general practitioners.
- It was agreed that the financial status of general practitioners needs to be improved, either through modification of the salary scale and/or some paid services.
- In the interests of improving the scientific status of general practitioners, they should have the option of applying to a master's degree program, a residency training program leading to a certificate from the Egyptian Medical Association, or a continuing medical education program leading to some form of recognition of improved skills and knowledge. In this context, we must stress the recommendations of the continuing medical education workshop.
- The creation of departments of general practice in the faculties of medicine would also stimulate scientific activity by putting general practice on an equal footing with the rest of the specialties. Such departments would also expose undergraduates to general practice early in their educations, and would sponsor research in general practice.

- As for the future careers of general practitioners, after finishing their certifying degree they would either join a university or a research program, take an administrative post, or remain in general practice.
- General practitioners should be urged to join the association of general practitioners, which will look after the interests of the specialty and maintain the standard and quality of training.
- It is important to provide suitable medical equipment and drugs in the health centers and rural areas.

DR. ANAND:

The recommendations of the group on research in general practice are as follows:

- The research undertaken by postgraduate general practitioner students not only satisfies their academic requirements, but can also contribute to enhancing the quality of the health-care delivery system. The very inadequacy or incompleteness of some services, such as the record system, can be an incentive to research. An example would be research on a system of record-keeping maintenance and utilization; there are many such examples in all aspects of health care.
- Because research in general practice is just beginning in Egypt, the students have a wide range of methodologies to choose from, including observational and descriptive studies, prospective and retrospective studies, and clinical epidemiological studies.
- The postgraduate students will find it advantageous to become familiar with research methodologies early in the first year, and to attempt to identify a topic during field work or group assignments. Postgraduate students should be given a course in research methodology before starting their research activities.
- The next conference on general practice in Egypt should include a scientific session to present research papers in general practice. The topics investigated by the postgraduate GP students may thus be screened and followed up, either with further investigation or with such action as the findings may indicate and local conditions may provide.
- Because research involves expenditures for collection of data, secretarial assistance, typing, and the like, the

university in collaboration with the government and pharmaceutical firms may consider providing incentives for research in general practice.

- Considering the newness of the specialty in general practice, there is a wide range of possible topics to be investigated. We should give priority to those that will help improve the quality of the health-care delivery system, such as utilization of health services, cost-benefit studies related to drug use, morbidity patterns, and drug supply, people's perceptions of existing health services, and similar topics.

DR. SHEHATA:

There is also one general recommendation, that an executive committee composed of representatives of responsible agencies and bodies be founded to do detailed planning for the implementation and follow-up of the conference's recommendations.

DR. RICHMOND:

Mr. Chairman, I speak for my colleagues in expressing our deep appreciation to you and to Dr. Shehata for your leadership in organizing this conference and for the opportunity to be present during these deliberations. I view the process that is being initiated during the course of this conference as an important symbolic event, but more importantly as a very significant practical event in the development of educational training and service programs in Egypt.

Mr. Chairman, I would be inclined to compare the process of these sessions to a high-risk pregnancy. We went into the conference with high risk. I didn't know what kind of delivery there would be, but clearly we have a very viable baby. The recommendations reveal that we're launched in a very effective way. The very last recommendation, for a consortium of the Medical Syndicate, the Egyptian Medical Association, and the Ministry to work collaboratively with the Committee on Medical Education of the Supreme Council of Universities, can, if implemented, have far-reaching consequences for moving this whole development forward.

At times our discussion seemed to be going in all directions, but it is apparent from the recommendations of the various work groups that there is a clear direction, and it seems to me to be a highly appropriate one.

I will close, Mr. Chairman, by noting that your leadership in bringing the Medical Syndicate to the point of recognizing this

problem and collaborating with the other organizations is one of the most significant occurrences that I'm aware of for the future of health services and the quality of health care in this country. You are developing a process whereby high standards are going to be established and implemented for general practice, and family practice, as a specialty in this country.

And if this implementation takes place, if such standards can indeed be maintained, if there is an evolutionary upgrading of the quality of health services, this would be our best assurance that the health of the Egyptian people will continue to improve at an accelerated rate. Thank you very much, Mr. Chairman.

DR. FREELING:

Mr. Chairman, my colleagues from the United Kingdom join me in thanking not only the organizing committee and the participants in this conference, but the people of Egypt for their goodwill, good nature, and the welcome they have given us since we've been here.

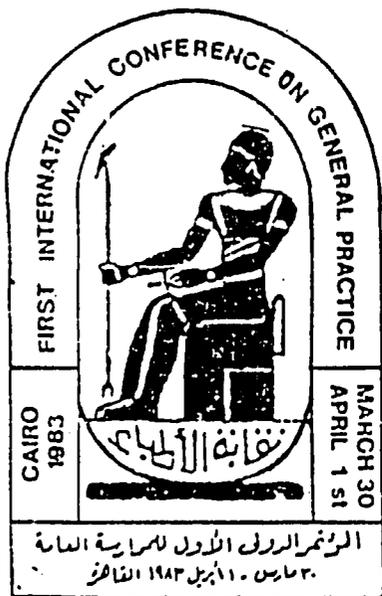
The conference was very much like general practice itself. General practitioners are accustomed to dealing with disorganized problems that turn out well in the end. What seemed to be a confused and conflicting set of statements has resulted in a set of proposals that have the potential to benefit the health of the people and the practice of the doctors of Egypt.

The Royal College of General Practitioners will welcome the news of the progress you are making, and of your resolve to form an association of general practitioners. I'm sure the College will be pleased to support that association, and all your efforts, as it can and as it is asked to. In my second capacity as a representative of the Overseas Development Administration of the United Kingdom, I shall, of course, urge their support of the efforts that have been forwarded by this conference. And finally, I'm here as the head of a department of general practice in the United Kingdom. Departments of general practice in the United Kingdom aren't very prosperous, but we do have what Dr. Badran called "hands and heads." Any help that my department can give to any forming department in this country, or to any academic or working general practitioner, is freely on offer. That's the one thing I can personally promise-- that and my personal gratitude to all of you.

DR. EL SAYED:

In the name of the Egyptian Medical Syndicate, and of my colleagues here today, I would like to extend our gratitude and sincerest thanks to our distinguished guests who have shared in our deliberations over the last three days. In particular, I would like to thank Boston University for its support and help. Thanks are

also due to the British Council and the Royal College of General Practitioners for their continued support. When we first began to think about a degree program, a delegation from the Royal College of General Practitioners, headed by the president himself and supported by the British Overseas Development Administration, visited us and issued a very comprehensive report that served as a foundation of our subsequent work. We would also like to thank the American Academy of Family Physicians and WHO for their support and contributions. Finally, let me thank Dr. Mohamed Shehata for his dedication and continuous effort, which have brought this conference to a successful conclusion. Thank you all very much for attending.



CONFERENCE

PROGRAM

Previous Page Blank

HONORARY CHAIRMEN

His Excellency Dr. M. SABRI ZAKI, Minister of Health .

His Excellency Mr. ALFRED ATHERTON Ambassador of U.S.A.

His Excellency Mr. MICHAEL WEIR , Ambassador of U.K.

**Hjs Excellency Dr. HIUSSEIN A. GEZAIKY, Director of WHO
Regional Office for the Eastern Mediterranean**

CHAIRMEN

Prof. Dr. HAMDY EL SAYED. President. Egyptian Syndicate of Doctors.

Prof. Dr. ABD EL AZIZ SAMI. Acting President, Egyptian Medical Association.

Prof. Dr. M. LOTFI DOWIDAR Chairman. Medical Education Committee, Supreme Council of Universities.

Prof. Dr. WILLIAM BICKNELL Director, Research Institute, Boston University.

VICE CHAIRMEN

Prof. Dr. M. EL ZAWAHRI Secretary General, Egyptian Medical Association.

Prof. Dr. ZOHAIR NOOMAN, Dean, Suez Canal Faculty of Medicine.

SECRETARY

Dr. MOHAMED I. SHEHATA Vice Chairman, National Health Insurance Org., Supervisor, Dept. of General Practice, Suez Canal Univ. Faculty of Medicine.

ORGANIZING COMMITTEE

From the Syndicate of Doctors, Egyptian Medical Association
and Ministry of Health (In alphabetic order).

Dr. Abdul Ghaffar Khallof	Dr. Mamdouh Saleh.
Dr. Alaa El Engebawy	(Prof)Dr. M. El Zawahri
Dr. Ezz eldin Hashish	Dr. M. Habib.
Dr. Galal Battoti	(Prob)Dr. Mohamed I, Shehata
(Prof.)Dr. Hamdy El Sayed	Dr. M. Safwat
Dr. Hamza El Bassioni.	Dr. Mootaz Bellah Mubarak
Dr. Hani Kora	Dr. Mostafa Hammany
(Prof.)Dr. Khahll El Diwani	(Prof)Dr. Osama Abd El Aziz
(Prof.)Dr. Khalil El Lamic	(Prof.)Dr. Yehya Taher
(Prof.)Dr. Mahmoud El Menawy	Dr. Yehya Tomoum

From Boston University & Suez Canal Faculty of Medicine :

- Dr Zohair Nooman(Prof.)
- Dr W. Bicknell (Prof.)
- Dr. M. Heshmat(Prof.)
- Dr.L.Delliguadri
- Dr. Abdul Rahman Bassioni.

From the British Council :

- Dr. Ian Simm

**CONTRIBUTING, PARTICIPATING AND
SUPPORTING AGENCIES AND ORGANIZATIONS**

- Faculties of Medicine.
- Ministry of Health.
- Military Medical Services.
- Academy of Scientific Research.
- Military Academy for Medical Sciences.
- National Health Insurance Organization.
- Egyptian Medical Association.
- Egyptian Syndicate of Doctors.
- Branches of Syndicate of Doctors.
- G P Associations.
- Boston University and Suez Canal Faculty of Medicine.
- British Council — Overseas Development Agency:
- AID Health Office in Cairo.
- American Academy of Family Physicians.
- Royal College of G. Ps. (U.K.).
- G.P. Associations and Medical Schools in Freind Countries.
- WHO Regional office for the East Mediterranean.
- Drug Information Committee.
- Public and Private Drug Companies and Agencies.
- Scientific Offices for Foreign Drug Companies, (with special consideration to : Merk -Sharp- Dhome-Ciba/ Geigi-Wander.
- Radio - T.V. —Press.
- G.Ps. in Governmental and Public Sectors.

The Conference organizers gratefully acknowledge the support, contributions and participation from all organizations, agencies and persons.

**FIELD VISITS FOR INTERNATIONAL
GUEST PARTICIPANTS**

From Sunday, March 27—Tuesday March 29

Sunday March 27 : Giza and Cairo

- 8:30 a.m Dep. by Conference bus from Conference Site.
- 10:00 a.m. Visit to Om-khanan Rural Health Unit.
- 11:30 a.m Visit to Abu El Sauood Urban Health Centre.
- 12:30 p.m Basket lunch
- 1:30 p.m Visit to Old Cairo Mother-Child Care Centre.
- 2:30 p.m Back to residence.

Monday March 28 : Ismailia

- 7:30 a.m Dep. by Conf. bus from Conf. Site.
- 10:00 a.m Visit to Sabaa Abar Health Unit .
- 11:00 a.m Visit to El Shuhada Urban Health Centre .
- 11:30 a.m Meeting with Staff members. Local Health Authorities,
g.p. Master graduates and students. and undergradu-
ates in Seuz Canal Faculty of Medicine .
- 1:30 p.m. Lunch in Suez Canal Beach Club .
- 3:00 p.m Cruise in Suez Canal.
- 5:00 p.m Back to residence in Cairo.

Tuesday, March 29 : Alexandria

- 7:00 a.m Dep. by Conf. bus from Conf. Site.
- 10:00 a.m Visit to Abis Rural Unit.
- 11:00 a.m Visit to Alexandria Faculty of Medicine.
- 12:00 noon Visit to G.p. Company clinic.
- 1:00 p.m Visit to El Nasr Polyclinic.
- 2:30 p.m Lunch in San Giovanni Restaurant.
- 4:00 p.m Meeting with G.Ps. in Alexandria in Gamal Abd EL-
Nasser Health Insurance Hospital.
- 6:00 p.m Back to residence in Cairo (with basket dinner).

CONFERENCE SCHEDULE

30 March — 4 st April

FIRST DAY

Wednesday, March 30, 1983:

8:30—10:30 a.m : **REGISTRATION**
10:30—11:30 a.m : **OPENING SESSION**

SPEAKERS :

- **Dr. Mohamed I. Shehata**, Conference Secretary, ViceChairman, National Health Insurance Org. Acting Head. General Practice Dept., Suez Canal Faculty of Medicine.
- **Dr. Hamdy El Sayed**, Prof., President, Egyptian Syndicate of Doctors.
- **Dr. Abd El Aziz Sami**, Prof., Acting President, Egyptian Medical Association.

Dr. THOMAS L. STERN, Prof, vice CHAIRMAN, AMERICAN ACADEMY of Family Physicians, Conference. Guests word.

- **Dr. Mohamed Sabry Zaki**, Minister of Health.

Introducing First Batch of Master—Degree graduates in General Practice .

11:30—12:00 noon : **Tea Reception**

12:00—2:00 p.m. : FIRTS PANNEL

HEALTH, DISEASE, AND MEDICAL CARE IN EGYPT (WITH EMPHASIS ON PRIMARY CARE).

Chairman :—

— Dr. Mamdouh Gabr, Prof., Former Minister of Health.

Co Chairman :—

— Dr. W. Oldham, Director, Health Office, AID, Egypt.

Moderator:—

— Dr. Ramses Gomaa, Head of Sector, Ministry of Health.

Speakers:—

— Dr. Saad Fouad., Undersecretary. Ministry of Health.

— Dr. Mootaz Bellah Mubarak, Head. Rural Health Sector, Ministry of Health.

— Dr. Ramses Gomaa, Head of Sector, Egyptian Principal Investigator, Health Profile of Egypt Project.

— Dr. Samir Diaai, Chair man, National Health Insurance Organization.

— Dr. E. Bryant, Project officer, Health Profile of Egypt Project.

Film :—

Health Profile of Egypt.

2:00—3:00 p.m Lunch.

3:00—5:00 p.m SECOND PANNEL

GENERAL PRACTICE IN EGYPT AND OTHER COUNTRIES

Chairman : —

— Dr. Abdu Sallam, Former Minister of Health .

CoChairman : —

— Dr. Julius Richmond, (U.S.A.)

Moderator : —

**— Dr. Hassan Abu Zeid, Prof. Community Medicine.Sucz Canal
Faculty of Med.**

Speakers : —

— Dr. J.M. Bishop (WHO).

— Dr. J. Richmond (U.S.A.).

— Dr. E.H.J. Cotter (U.K.)

— Dr. Ronald McCauley, Prof (Canada).

— Dr. Sabri, Prof. (Tunisia).

— Dr. M.I. Shehata (Egypt).

(Other Speakers to be announced).

SECOND DAY

Thursday March 31, 1983 :

9:30—11:30 a.m. : **THIRD PANNEL**

GENERAL PRACTICE TEACHING AND TRAINING.

Chairman : —

— **Dr. Lotfi Dowidar**, Prof. Chairman. Medical Education Committee; Supreme Council of Universities. Egypt.

CoChairman : —

Dr. Eugene Farley, Chairman and Prof of Family Medicine. Wisconsin, U.S.A.

Moderator : —

— **Dr. Khalil El Lamie**, Prof., Sydicate Board Member.

Speakers : —

- **Dr. B.J. Essex** (U.K.).
- **Dr. E. Farley** (U.S.A.).
- **Dr. Scott Obenshain** (U.S.A.).
- **Dr. Zohair Nooman** (EGYPT).
- **Dr. M.Y. Heshmat** (U.S.A. / EGYPT)
- **Dr. Hosny El Rawady** (EGYPT).

(Other Speakers to be announced).

11:30—12:00 noon : **TEA BREAK**

12:00— 2:00 p m.

Workshop A (First Session)
Undergraduate Teaching in General Practice

Chairman : —

- Dr. Esmat El. Shehata, Prof. Assoc. Dean. Faculty of Medicine. Suez Canal. Univ.
- Dr. Essam Fikry, Prof., Head. Int. Med. Dept., Alex. Faculty of Medicine.

CoChairman : —

- Dr. Scott Obenshain, Assoc. Dean for Undergrad. Med. Ed., University of New Mexico. U.S.A.

Reporters : —

- Dr. Taymour. — Dr. F. Makladdy (EGYPT).

Participants : *Elective* .

Workshop B (First Session)

VOCATIONAL TEACHING AND TRAINING IN GENERAL PRACTICE.

Chairman : —

- Dr. Abd El Aziz Sami Prof., President, Egypt. Medical Association/Prof Dr. M.El Zawahri, Secretary General

CoChairman : —

- Dr. B J. Essex (U.K.)

Reporter : —

- Dr. M.Y. Heshmat, Prof. / Dr. M I. Shehata (EGYPT).

Participants : *Elective*.

Workshop C (First Session).

CONTINUING MEDICAL EDUCATION IN GENERAL PRACTICE

Chairman :—

- Dr. Ibrahim Badran, Prof., President, Academy of Scientific Research.

CoChairman :

- Dr. Freeling Paul (U.K.)

Reporter : —

- Dr. Mahmoud El Menawy, Prof., Syndicate Board Member.
- Dr. M. Awad Osman G.P. Master. (EGYPT).

Participants : Elective.

2:00—3:00 P.m. Lunch

3:00—5:00 p.m.

Workshop A (Second Session)

Chairman : —

- Dr. Zohair Nooman, Dean, Prof. Suez Canal Faculty of Medicine.

CoChairman : —

- Dr. Mohsen Zial, Prof., Former Dean in IRAN.

Reporter : —

- Dr. F. Maklady/Dr. Taymour (EGYPT) Suez Canal Faculty of Medicine.

Participants : Elective.

Workshop B (Second Session)

Chairman . —

- **Dr. M. El Shabrawy, Dean & Prof. Mansoura Faculty of Medicine.**

CoChairman : —

- **Dr. Ronald Mc Cauley, Prof. of Family Medicine. Mc Master Medical School. .CANADA**

Reporter : —

- **Dr. M.I. Shehata,/ Dr. M. Heshmat (EGYPT).**

Participants : Elective

Workshop C (Second Session)

Chairman : —

- **Dr. Hashem Fouad, Dean & Prof., Kasr El Aini Faculty of Medicine.**

CoChairman : —

Dr. Rodny Turner (U.K.)

Reporter :—

- **Dr. Mahmoud El Menawy, Prof (EGYPT).**

- **Dr. M. Awad Osman (EGYPT)**

Participants : Elective

THIRD DAY

Friday April 1 st

9:30—12 a.m. : **FOURTH PANNEL**

**RESEARCH IN GENERAL PRACTICE. CAREER STRUCTURE FOR
GENERAL PRACTITIONERS. ORGANIZATION OF G.P. SERVICES.**

Chairman : —

— Dr. Mahmoud Mahfoz, Prof., Former Minister of Health.

CoChairman :

— Dr. E.H.J. Cotter (U.K.)

Moderator : —

— Dr. Abdu ElMagid Lotfi, President. Cairo Syndicate of
Doctors.

Speakers: —

— Dr. W. Bicknell, Prof. Direct., Research Institute, Boston
Univ. U.S.A.

— Dr. Hamdy El Sayed, Prof., President, Egyptian Syndicate of
Doctors.

— Dr. Saad Fouad, Undersecretary, Ministry of Health.

— Dr. Mootaz Bellah Mubarak, Head. Rural Health Sector, Mi-
nistry of Health.

— Dr. E.H.J. Cotter (U.K.).

— Dr. Hassan Abu Zeid, (EGYPT).

— Dr. Abdu El Ghaffar Khallaf, Head., International Relations
and Man power Develop Sector, M.OH.

12:00—2:00 p.m. : Lunch

2:00—4:00 p.m. : Film about Arthritis : Epidemiology
& Treat.

Workshop D

RESEARCH IN GENERAL PRACTICE.

Chairman : —

- **Dr. Hassan Hamdy**, Prof., President, Cairo University.
- **Dr. Hussein M, Bdr El Din**, Director, Military Academy of Medical Sciences.

CoChairman :

- **Dr. W. Bichennel**, Director, Research Institute, Boston University, U.S.A.

Reporter :

- **Dr. D. Anand**, Visiting Prof., Suez Canal, Faculty of Medicine
- Participants : Elective.

Workshop E

CAREER STRUCTURE FOR GENERAL PROCTITIONERS.

Chairman : —

- **Dr. Sami Kurayem**, Director, Medical Services, Army Forces.

CoChairman : —

- **Dr. Mootoz Bellah Mubarak**, Head, Rural Health Sector, M.O.H.

Reporter :—

- **Dr. Yehya Tomoum**, Director, Canal & Eastern Delta Branch, Health Insurance Org.

Participarts : Elective.

Workshop F

ORGANIZATION OF G.P. SERVICES

Chairman : —

- **Dr. Saad Foud**, Undersecretary, Ministry of Health.

CoChairman : —

- **Dr. Samir Diaai**, Chairman, National Health Insurance Organization.

Reporter : —

- **Dr. Mostafa Hammany**, Director general, Rural Health Dept., Ministry of Health.

Participants : Elective.

**4:00 — 4:30p.m: MODERATORS AND REPORTERS MEETING
PREPARING SUMMARY AND RECOMMENDATIONS**

Chairman : —

— Dr. M. El Zawahry, Prof., Secretary General, Egyptian Medical Association.

Cochairman : —

— Dr. Yehya Taher, Prof., Vice President, Egyptian Syndicate of Doctors.

Reporter :—

— Dr. M.I. Shehata. Dr. Ezz Eddin Hashish

Participants : —

CoChairmans, Moderators, and Reporters of Pannels and workshops.

4:30—5:00p.m. : CLOSING SESSION

**DECLARING CONFERENCE SUMMARY
AND RECOMMENDATIONS**

Chairman : —

— Dr. Hamdi El Sayed, Prof., President, Egyptian Syndicate of Doctors.

CoChairmans: —

— Dr. J. Richmond, (U.S.A.).

— Dr. Freeling Paul (U.K).

Reporter :—

— Dr. M.I. Shehata, (EGYPT).

Participants : All Conference members.

- اأءب الأءللمى لمنظمة الصءة العالمة
 - لءنة الأعلام الءوائى
 - شرءء الأءومىة بالءقءاع العام والءاص
 - المءاءب العلممة لشرءاء الأءومىة الأءنبمة
 - (ونءص بالءءر شرءاء مرءء شارب ءوم – سبما ءبءى – وانءر)
 - الإءاعة – التلفزيون – الصءافة
 - الأءباء الممارسبن العنمبن من كائفة القءاعاء العامة والءاصة
- وءءوءه الهبئة المنظمة لئمؤءمر لبءه الءهءء والمساءهمبن من أءراءها
بءالء الشءرء والءءءببر لما ءءموءه من ءهء علمى أو ماءى أو اعلامى أو
ءءظبمى •

الجهات والهيئات المشاركة والمساهمة والمعاونة

- كليات الطب
- وزارة الصحة
- الخدمات الطبية بالقوات المسلحة
- أكاديمية البحث العلمي
- الأكاديمية الطبية العسكرية
- الهيئة العامة للتأمين الصحى
- الجمعية الطبية المصرية
- النقابة العامة للأطباء
- النقابات الفرعية للأطباء
- جمعيات الممارسين العامين
- جامعة بوسطن وكلية طب جامعة قناة السويس
- المجلس البريطانى وهيئة التنمية لـما وراء أعلى البحار •
- المكتب الصحى لوکالة التنمية الأمريكية الدولية بالقاهرة
- الأكاديمية الايريكية لأطباء العائلة
- الكلية الملكية للممارسين العامين بانجلترا
- جمعيات الممارسين وكليات الطب بمختلف الدول الصديقة
والشقيقة •

من جامعة بوسطن وكلية طب جامعة قناة السويس

— أ . دكتور وليام بيكنيل

— أ.د. محمد حشمت

— دكتور لارى دليكوادري

— دكتور عبد الرحمن بسيوني

من المجلس البريطانى

— دكتور أيان سيم

اللجنة المنظمة

من النقابة العامة للأطباء والجمعية الطبية المصرية ووزارة الصحة :

(مرتبة أ بجديا)

أ.د. أسامة عبد العزيز

د. المعتز بالله مبارك

د. جلال البيطوى

أ.د. حمدى السيد

د. حمزة البسيونى

أ.د. خليل الديوانى

أ.د. خليل اللمى

د. عبد الغفار خلاف

د. عز الدين حشيش

د. علاء الدين الانجباوى

د. محمد ابراهيم شحاته

أ.د. محمد الظواهرى

د. محمد حبيب

د. محمد صفوت عبد الفتاح

أ.د. محمود المناوى

د. مصطفى حمامى

د. ممدوح سالم

د. هانى قورة

أ.د. يحيى طاهر

د. يحيى طوموم

هيئة المؤتمر

رؤساء المؤتمر

- السيد الأستاذ الدكتور حمدي السيد
نقيب الأطباء
- السيد الأستاذ الدكتور عبد العزيز سامي
رئيس الجمعية الطبية المصرية بالانابة
- السيد الأستاذ الدكتور لطفى دويدار
رئيس لجنة قطاع التعليم الطبى
- السيد الأستاذ الدكتور وليام بيكنيل
مدير معهد السياسة الصحية بجامعة بوسطن

نواب رئيس المؤتمر

- السيد الأستاذ الدكتور محمد الظواهرى
سكرتير عام الجمعية الطبية المصرية
- السيد الأستاذ الدكتور زهير نعمان
عميد كلية طب جامعة قناة السويس

سكرتير المؤتمر

- السيد الدكتور محمد ابراهيم شحاته
نائب رئيس الهيئة العامة للتأمين الصحى
ومشرف قسم الممارسة العامة بكلية طب
جامعة قناة السويس

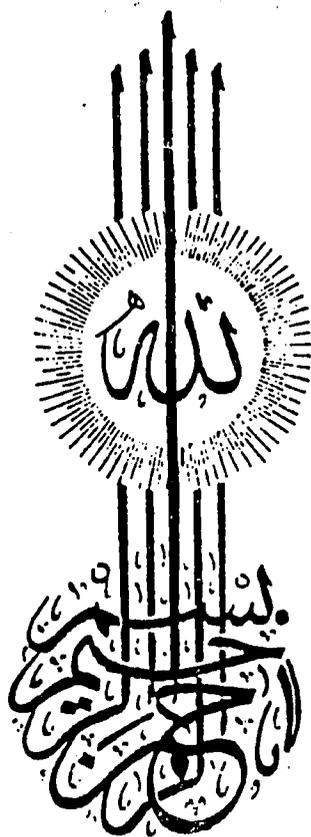
رؤساء شرف المؤتمر

– السيد الدكتور محمد صبرى زكى
وزير الصحة

– السيد ألفريد آثرتون
سفير الولايات المتحدة الأمريكية

– السيد مايكل وير
سفير المملكة المتحدة

– السيد الدكتور حسين الجزيرى
مدير المكتب الاقليمى لمنظمة الصحة العالمية



برنامج المؤتمر

