

International Family Medicine Education

Jonathan E. Rodnick, MD
Feature Editor

The goal of the International Family Medicine Education column is to bring our readers information about developments in family medicine education in countries outside the United States. We will abstract literature from journals published throughout the world that address issues relevant to medical student education and graduate training in family medicine and general practice. The issues may relate to changes in medical education or in medical care organization or delivery. Topics may also address health and illness issues relevant to family physicians throughout the world. To help abstract literature, I have asked a few "foreign correspondents" to identify relevant articles from the medical literature in their region. I hope this column will become an important resource for those interested in what's happening in family medicine education outside the United States. Contact me at 415-597-9370. E-mail: jrodnick@psg.ucsf.edu. University of California, San Francisco, Department of Family and Community Medicine, UCSF Box 0886, San Francisco, CA 94143. Your comments regarding this column are welcome.

Brazil

Family Medicine in Brazil— Establishing the Specialty

There are many parallels between Brazil and the United States—the countries are large, primarily urban, and ethnically diverse, and they have much social inequality. Both countries have complicated medical care systems made up of both public and private institutions that are specialty and hospital dominated. However, in the last decade, Brazil has addressed many of its inequalities in health care by enacting universal access to care and a plan to provide primary care to all its citizens.

Brazil has approximately 180 million people, who live in 26 states. Based on economic variables, Brazil can be divided into three parts, with standards of living and health care statistics similar to those found in Belgium (the South and Southeast), Bulgaria (Center-West and North), and India (Northeast). Overall, 3.3% of the gross domestic product (GDP) is spent on health, and life expectancy is 68.4 years. Many areas have a triple

burden of disease (high prevalence of infectious diseases, chronic diseases, and accidents/violence). Brazil is the world's leader in offering free antiretroviral treatment to those infected with HIV.

In 1988, a law was enacted that guaranteed universal access to medical care. Since then, many reforms have worked to combine the public and private medical systems with the government as the single payer. However, urban/rural income disparities and inequities in medical care access and quality persisted. In 1996 a Family Health Programme (PSF) was created. It encouraged the formation of primary care teams with family doctors. Each team is to be responsible for 3,000 people and live in the communities they serve. Significant efforts are being made to train this new cadre of health care workers.

An organization with the initials SOBRAMFA (the Brazilian Society of Family Medicine) was founded in 1992 and has developed many activities to encourage medical students to consider a family medicine career. Brazil has 102 medical schools, none of which currently has a department of family medicine. But 18 schools now have

family medicine interest groups. Currently most generalists have had little formal postgraduate training. The number of family medicine residencies, although too few, is increasing. It is hoped that, based on a family medicine model, Brazil will expand basic medical services, improve access, reduce inequities, and create a medical care system that will be the model for Central and South America.

Jonathan Rodnick, MD
University of California,
San Francisco
Pablo Blasco, MD, PhD
SOBRAMFA
Sao Paulo, Brazil

Scotland

Determining the Prevalence and Treatment of Disease by Surveying Those in the Community, an Underused Approach

(Hannaford PC, Simpson JA, Bisset AF, Davis A, McKerrow W, Mills R. The prevalence of ear, nose, and throat problems in the community: results from a national cross-sectional postal survey in Scotland. Fam Pract 2005;22:227-33.)

Ear, nose and/or throat (ENT) symptoms are common reasons for seeing a family doctor. The authors of this paper were interested in the prevalence of ENT symptoms in Scottish people as well as their use of their general practitioner (GP) for diagnosing and treating these problems.

The authors sent a questionnaire to a random sample of 1,000 residents in each of 12 areas of Scotland. Individuals were identified from computer files of people of all ages “registered” with a GP. The questionnaire asked about ENT symptoms experienced by each member of the household in the past 12 months. A subgroup was asked if the researchers could examine their medical records at their GP’s office. The authors ended up with completed and usable questionnaires from 15,788 individuals whose age and gender distributions were similar to that of the whole of Scotland.

More than one fifth reported hearing difficulties, including tinnitus, and/or it was very difficult to follow conversations with background noise. Of those with hearing difficulties, 77% did not usually wear a hearing aid. Older people, those who were or had been manual workers, and those who were less affluent reported more hearing problems.

Between 13% and 18% of respondents reported having a blocked or runny nose for more than 2 weeks in the past year. Nearly one third experienced at least one episode of severe sore throat in the past year. Students and more-affluent individuals had a higher prevalence of nose and throat complaints. Nearly 21% had experienced dizziness in which things seemed to spin, 13% in which they seemed to move, and 29% experienced lightheadedness or feeling faint.

The portion of individuals who consulted their GP varied by symp-

toms—30% of those with a severe sore throat, 43% of those with dizziness or lightheadedness, to 17% of those with tinnitus. Overall, 24% of those with symptoms visited their GP, and 4.8% were referred on to a specialist or hospital.

The authors conclude that ENT problems are common, and most manage them without going to their GP.

Comment: Community-based surveys on the prevalence (or incidence) of disease show that people have a lot of symptoms. In the United States, we often use billing or fiscal intermediary records to gather data on frequency of disease. This misses lots of people and problems. Like Kerr White’s classic study, this one showed that only about one in four of those with symptoms go to see a doctor, and less than one in 20 go to a specialist. The challenge is to decrease the number of physician visits for self-limited conditions, while making sure those with serious or troubling symptoms get seen quickly.

The Netherlands

The Comorbidity Conundrum: Patients With Psychological and Medical Problems Are More Work for Physicians

(Zantinge EM, Verhaak PFM, Bensing JM. The workload of GPs: patients with psychological and somatic problems compared. Fam Pract 2005;22:293-7.)

Family doctors throughout the world handle the diagnosis and treatment of many patients with both medical and psychological problems. However, doctors are sometimes reluctant to take responsibility for their patients’ mental health care because of a perceived

lack of support from the mental health system and the time needed to adequately take care of patients with mental problems.

The authors wanted to quantify the increase in GPs’ workload from patients with psychological or social problems. During a 1-year period, a stratified sample of 195 GPs kept an electronic record of all patient contacts, including diagnosis, prescriptions, and referrals.

The authors found that patients with psychological problems (divided further into categories of depression, anxiety, stress problems, sleeping problems, relationship or work problems, and other psychological problems) were significantly older, female, and unemployed than those without psychological problems. Patients with psychological problems visited their GP almost twice as often (7.5 versus 4.1 times a year). This higher contact rate is from both visits for psychological problems as well as visits for medical problems. Patients with sleeping problems, depression, or anxiety consult their GP most frequently.

The authors conclude that these results support GPs’ claims that dealing with patients with mental problems is more time consuming, especially due to the increase in visits for medical problems from these patients.

Comment: Patients with comorbidities, especially combined medical and psychological, are often difficult patients and not only seem to see us more frequently, they really do. It is important to realize that this is partially because they also come in more frequently for their medical problems. The need for better training, support systems, and remuneration to address these issues is worldwide.