MEDICAL CARE PROVIDERS

SHUFFLING & STUMBLING

or

FORGING FORWARDS

Effie Schultz

CURRENT GLOBAL POSITION

- medical care paradigm not meeting needs and expectations
- patient satisfaction and trust ratings low
- job satisfaction low especially in primary care
- increase in prevalence of chronic diseases including TB & AIDS
- time-consuming needs of an increasing number of sick elderly
- increased dependency on medical care and medicines
- high medical workload at all levels of care
- long waiting lists for non-emergency care
- overuse of emergency departments
- insufficient attention to health promotion and disease prevention
- little time for talking and listening - for patient empowerment
- mismatch between supply and demand of medical workforce*
- blurring of medical workforce roles
- appropriation by the medical sector of other sectors' responsibility for health

* shortage especially of nurses and doctors + maldistribution (least where need is greatest)

WHO's ESSENTIAL ELEMENTS FOR CORRECTIVE ACTION

- building integrated rather than fragmented health services
- encouraging a team approach
- supporting the shift towards chronic care
- emphasising prevention
- centring care on the patient and family
- providing services and support in the community
- using an evidence based methodology
- focusing on health implications in other sectors
- securing political commitment and consensus

BMJ 2002;324:1237

CHRONIC DISEASE CARE MODEL AS RECOMMENDED BY WHO

Because managing chronic conditions involves behavioural and lifestyle changes, patients must be empowered to take a central role in their own care

- there should be a partnership between:
  - patients and their families
  - healthcare teams
  - supporters in the community
- staff should be skilled in:
  - counselling and behavioural change techniques

BUT IN REAL LIFE

We referred many patients to an exercise scheme, had a dietician working in the practice, and organised health groups … where dietician and doctor would weigh, encourage, motivate, and educate patients. Almost all of these patients required a continuous personal input to maintain their weight loss, regular exercise, or healthy eating, and it simply became unsustainable.

In the end I realised that it is not patients who don't understand but we doctors who don't. For how we behave, what we eat, what opportunities we have to exercise, are all shaped by what confronts us in our environment.

The prevention of obesity and type 2 diabetes (and many other diseases) is an environmental problem and not a medical one. Clinical and community based health promotion strategies would simply waste enormous amounts of limited resources and end up being demoralising for both medical workers and patients alike. A healthy population requires a healthy environment where all have the ability and opportunity to follow a healthy lifestyle.

Letter from Colin Guthrie, a GP in Glasgow. BMJ 2001. 323.997

POSITIONING RECOMMENDATIONS ON THE CONTINUUM OF HEALTH AND DISEASE

not on the left health side:

the protection and promotion of health

but on the medical right side:

the prevention and management of distress, disease, disability, and death

THE CHALLENGE FOR MEDICAL PRACTICE

- Many countries need to enhance, re-orientate, and integrate their workforce planning capacity across occupations and disciplines to identify the skills and roles needed to meet identified service needs.
- A wider perspective is needed to achieve clarity of roles and a better balance of registered nurses, physicians, other health professionals, and support workers.
- (Staff) shortages are ... portrayed as a problem only for (staff). They are not; they are a health system problem, which undermines health system effectiveness and requires health system solutions.
- Why have ... wider reaching interventions not been more systematically implemented? The very fact that they have a wider reach means that they often challenge current practice, health system inertia, and vested interests.

James Buchan, professor, social science and health care. BMJ 2002;324:751-752

WHAT ARE THE OPTIONS ?

more of the same with more staff and buildings

or

- a community oriented, neighbourhood-based, patient-centred, one-stop, primary and secondary medical care service with continuity of care, patient autonomy and mutual respect
- cooperative team work at all levels of care
- networks between levels of care and disciplines
- an integrated, real-time medical information system
- a new framework for medical service providers

AN INSTITUTION'S COMMITMENT TO ITS COMMUNITY

- work with local authorities and other local organisations to provide childcare schemes etc rather than buying in services
- increase local recruitment by offering training and enabling local people to apply for jobs especially in areas of high unemployment
- buy goods locally rather than just from national suppliers, thereby boosting the local economy and reducing transportation
- improve the standard of food so that less of it is wasted and buy from local outlets to ensure that local jobs are maintained
- manage waste more carefully, so that the use of landfill sites is reduced and energy consumption is cut
- reduce the use of cars by opting for good public transport links and cycle schemes and by building on easily accessible sites
- upgrade existing units to incorporate energy saving measures

modified from the King's Fund Report on the NHS in the UK. (BMJ 2002;324:1178)

PERSONAL & ORGANISATIONAL CONTINUITY OF CARE

at the personal level: (compared with a walk-in service)

- It is more effective and safer and increases the potential for patient and service provider satisfaction and a good outcome

in hospital care, referral systems and group practice:

- should be embedded in organisational structures
- must reflect behind the scenes continuity at a systems level
- should be based on structured patient records and team-work
- there should be: staff stability
  collective competence
  consistent care
  a shared ethos of commitment

PERSONAL ATTENTION WITHIN A TEAM STRUCTURE

Medical service providers in primary care trusts in the UK “could share administrative, computing, prescribing, audit, and educational support with each other within service units but would offer a more personal and individual service. The evidence is that patients prefer this kind of organisation and would probably have better medical outcomes from it.

BMJ April 2000;321:734-736

A NEW FRAMEWORK FOR MEDICAL SERVICE PROVIDERS AT ALL LEVELS OF CARE

predicated on

- rationalising the role, scope of practice, competencies, training, accountability, responsibility and registration of all categories of medical service providers*
- service providers working together in a team
- stopping the proliferation of poorly-trained, professionally restricted, under-paid, low status, dependent assistants
- training and deploying a category of health educator with general skills, flexibility and options for specialisation

* defined broadly to include us all – doctors, nurses, pharmacists, OTs, psychologists, the lot

WHY GROUP OCCUPATIONS INTO CATEGORIES?

staff considerations:

- occupational boundaries
- separate career paths
- scope of practice determined by grade*
- specialisation and up-grading within occupations
- opportunities and credits for switching between occupations

service considerations:

- individuals from different occupational groups to work as a team
- single administrative chain of command for team as a whole

* grade determined by level of training and qualifications; not by competence or experience

CATEGORIES OF MEDICAL SERVICES

basic services: diagnosis and treatment

supplementary services: supplementing basic services

support services: supporting basic and supplementary services

- administration and management
- data management
- house-keeping – cleaning, cooking, …
- nursing care – personal care such as washing, feeding, comforting
- public health – water and sanitation, housing, transport, …
- research – pursuit of knowledge
- teaching and training – all categories

MEDICAL OCCUPATIONS IN BASIC AND SUPPLEMENTARY SERVICE CATEGORIES

basic services

- doctors
- midwives
- para-medics

  providing first aid and

  emergency services

supplementary services

- nurses
- therapists
- pharmacists
- dieticians
- diagnostic technicians
- health educators

BUT CATEGORIES ARE BLURRED ESPECIALLY IN POOR COMMUNITIES

by the deployment as mini-doctors and other forms of proxy doctors of:

- professional nurses
- all sorts of assistants
- so-called mid-level, multi-tasked Jacks of all trades …
- community health workers and a host of others

trained in IMCI and IMAI* and other minimalist stop-gap short-term programmes

* IMCI = integrated management of childhood illness; AMAI = integrated management of adolescent and adult illness

PROBLEMS WITH PHCN MINI-DOCTORS*

- lack of autonomy - accountable to a supervising doctor
- providing possibly a second-rate, low quality service
- threatening doctors' income and employment
- conflict with nurses and misunderstanding of roles
- nursing model and not medical model
- loss of identity, insecurity, isolation, vulnerability
- low job satisfaction and high rate of attrition
- depleted general nursing pool
- long and expensive training period
- no career ladder nor academic credits for up-grading

* some reservations apply also to nurse practitioners, advanced nurses, medical auxiliaries, assistants & orderlies …

ASSISTANTS ARE EXCLUDED

because:

- since assistants are not allowed to act independently and need to be supervised, service work-load is increased
- patient satisfaction and efficacy have not been demonstrated

examples of assistants:

- medicine: physician assistant, medical orderly, medical auxiliary, ...
- nursing: nurse aid, assistant nurse, auxiliary nurse, ...
- neither medicine nor nursing: PHCN*, nurse practitioner, …
- physiotherapy: physiotherapy assistant, HBRW*, HBGW*, …

* PHCN = primary health care nurse, HBR/GW = home-based rehabilitation/geriatric worker

ROLE OF HEALTH EDUCATORS

- mediate* between patients and care providers
- advise and assist individual patients in out-patient and in-patient settings and in patients' homes
- provide appropriate general non-drug medical care
- initiate and conduct group discussions in medical institutions, work-sites, places of learning, churches – wherever people gather
- organise health and screening campaigns
- prepare and submit media material
- plan, monitor and evaluate health education programmes and practice

* includes interpreting languages - body and other

EXPANDED ROLE OF HEs

with additional training replacing/incorporating all current assistants to work in

- nursing (personal) in hospital wards and homes
- emergency departments (ombudsman, liaison)
- supporting doctors in ambulatory care
- extending the role of therapists
- monitoring convalescence and rehabilitation
- monitoring the health of adolescents, the elderly, mentally ill, disabled, distressed and the dying, …
- case management (with in-patients and out-patients)
- diagnosis and management of disease

HEALTH EDUCATORS IN PRIMARY CARE

- child growth monitoring and immunisation
- ante-natal and post-natal monitoring
- chronic disease care and exercise monitoring
- supervising prescribed drug treatment
- psycho-social, substance abuse and disease counselling
- family diagnosis, home nursing
- personal care of the elderly and disabled
- case management*
- dressing wounds, performing selected tests
- first-aid and epi-demography
- diagnosis and treatment of common endemic infections
- IMCI and IMAI – temporarily if necessary

* planning, co-ordinating, managing, and reviewing care of an individual

NON-MEDICAL CARE PROVIDERS

providing social and psychological support

- social workers
- psychologists
- health inspectors
- birth attendants
- care givers
- traditional healers
- religious leaders
- agricultural officers
- police officers
- school teachers
- community workers
- beauticians

OBJECTIVES OF MEDICAL EDUCATION FOR DOCTORS

to equip doctors with the skills and knowledge to be able to provide:

appropriate, safe and cost-effective medical care to individual patients

at the level/grade to which they have been trained and certified as competent

THREE GRADES OF DOCTORS GENERAL DEFINITIONS

- primary care doctor – working ONLY in primary care
- general medical doctor or generalist – working in primary and secondary care but NOT in tertiary care – equivalent to medical practitioner with MB BCh
- specialised medical doctor or specialist – working in all three levels of care but principally in tertiary care

WHAT IS PRIMARY MEDICAL CARE

first contact ambulatory care between a patient and a team of personal medical care providers to:

- promote and protect health
- prevent disease
- offer first aid and emergency care
- cure or control of common conditions
- support convalescence and rehabilitation
- alleviate pain, discomfort and distress

OTHER FEATURES OF PRIMARY MEDICAL CARE

- gate-keeper and coordinator for other levels of medical care
- team-based with multi-disciplinary referral network
- continuity of care, one-stop service, not walk-in supermarket style
- person-centred and socially contextualised
- neighbourhood-based and family/household oriented

NO

- in-patient care
- care of patients with complicated conditions
- genetic counselling, deliveries and abortions

AND DEFINITELY NOT

- some amalgam of medical care, social work and community activism

MEMBERS OF A PRIMARY MEDICAL CARE TEAM

in small, single public or private service sites:

primary care doctor + midwife and health educator/s
assisted by relevant medical support staff
± out-sourced supplementary and non-medical services

in urban and rural clinics or group practices:

as above
± dedicated, in-house, shared or contracted therapists, diagnostic technicians, pharmacists, dieticians, …
and non-medical service providers

no nurses, but definitely a doctor

and not some sort of multi-skilled, mid-level proxy or mini-doctor

SCOPE OF PRACTICE OF PRIMARY MEDICAL CARE

- first aid and emergency care
- health promotion and protection
- primary and secondary disease prevention
- diagnosis and treatment of uncomplicated common conditions
- prescription and dispensing of medicines
- minor surgical procedures appropriate to an out-patient setting
- point of care tests, specimen collection and referral for tests
- monitoring normal pregnancies and advising on contraception
- child and adolescent growth and development
- chronic disease care, rehabilitation, and geriatric health

NON-MEDICAL COMPETENCIES NEEDED BY PRIMARY CARE DOCTORS

- language and mathematics
- understanding people and society*
- collection and evaluation of data
- communication and patient counselling
- nutrition, dietetics, and home budgeting
- achieving and maintaining own health

* social and family dynamics, the psychology and sociology of sexuality, violence and substance abuse, the social and economic determinants of health and disease

MEDICAL COMPETENCIES NEEDED BY PRIMARY CARE DOCTORS

- first aid and emergency care
- health promotion and protection
- primary and secondary disease prevention
- diagnosing and treating common conditions
- performing, ordering and interpreting special tests
- prescribing and dispensing medicines
- pain and distress alleviation
- referring patients to other levels of medical care

NON-MEDICAL CURRICULUM

- English language and mathematics
- social anthropology and local history
- medical sociology, demography and ecology
- epidemiology, biostatistics and medical informatics
- nutrition, dietetics and home economics
- psychology and sociology of violence and substance abuse
- family dynamics and parenting
- counselling and communication skills
- administration and management
- medical ethics and law
- physical fitness training and relaxation techniques

MEDICAL CURRICULUM

- first aid and emergency care
- anatomy, physiology and pathology
- pharmacology and drug supply management
- medical care* of common diseases and mental disorders
- infant, child and adolescent growth and development
- genetics and sexuality
- contraception and midwifery
- geriatric care
- environmental and occupational health
- intermediate medical technology
- selected surgical procedures
- dental health and hygiene
- psychotherapy and physiotherapy

* medical care is here used comprehensively to refer to diagnosis and management

EXAMPLES OF COMMON CONDITIONS TO BE MANAGED IN PRIMARY CARE

acute conditions:

respiratory tract infections, gastro-enteritis, intestinal parasitic infestations, dyspepsia, STDs, other genito-urinary tract infections, conjunctivitis, skin infections, locally endemic infections such as malaria, joint and muscle strain, minor cuts and abrasions, ...

chronic conditions:

asthma and chronic bronchitis, diabetes mellitus, epilepsy, hypertension, obesity, under-nutrition, osteo-arthritis, PTB, HIV/AIDS, substance abuse, depression, schizophrenia, mental retardation and dementia, ...

ENTRY CRITERIA AND TRAINING OF PRIMARY CARE DOCTORS

- entry criteria: English language proficiency and a grade 12 certificate
- selection criteria: academic, social and personal
- course duration: 3 years full-time
- curriculum: scientific, experiential, outcomes-based and community-oriented
- training sites:
  - theoretical: medical schools
  - practical: accredited primary care service sites
- qualification: bachelor degree

RECRUITMENT FOR TRAINING AS PRIMARY CARE DOCTOR

Selective recruitment to direct post-graduate deployment to areas in need

- applicants from rural and under-served areas to be preferentially recruited
- sponsorship, bursaries and social contracts from the state, the community, NGOs and the private sector conditional on post-graduate placement in pre-determined, contracted areas

SECONDARY MEDICAL CARE TEAM MEMBERS

ambulatory out-patient care:

generalist doctor/s + rest as for primary medical care

in-patient care:

generalist doctor/s + nurses, therapists, dieticians, pharmacists, diagnostic technicians, …

house-keepers, administrators, data managers, …

SCOPE OF PRACTICE OF GENERALIST DOCTORS

- emergency care
- ambulatory and home-based medical care at a level mid-way between primary and tertiary medical care
- non-specialist in-patient hospital services
- general surgical care
- maternity services including genetic counselling, home deliveries, termination of pregnancy, and Caesarian section
- common investigations eg scans, ECGs, CXRs and point of care tests
- prescribing and dispensing of medicines

doctor-based team with multi-disciplinary referral networks

ENTRY CRITERIA AND TRAINING OF GENERALIST DRs

entry criteria:

- registration as a primary care doctor
- at least 2 years work as a primary care doctor
  at least 1 year in the public sector in an under-served area
- a prescribed number of CPD credits/points

training (3 years):

- paid supervised in-patient and ambulatory clinical work
  in accredited secondary medical care service sites
  at least 1 year in the public sector in an under-served area
- structured lectures and course work in medical schools
  divided into 9 x 4 months blocks/modules
  last block: part-time work, dissertation, final examinations

TERTIARY MEDICAL CARE TEAM MEMBERS

ambulatory care:

specialist doctor/s, specialist nurse/s +

rest as for primary care

in-patient care:

specialist doctor/s, specialist nurse/s +

rest as for secondary care

FEATURES OF TERTIARY MEDICAL CARE

- specialist in-patient hospital and ambulatory services
- customised per speciality
- organ or system-centred, not person-centred
- doctor-based with multi-disciplinary referral networks
- no direct referral from other tertiary care doctors
- all referrals via primary care or generalist doctors
- continuity of care via referring doctors
- no home-based care

ENTRY CRITERIA AND TRAINING OF SPECIALISTS

entry criteria:

- registration as a generalist doctor with MB BCh degree
- at least 1 year as a generalist doctor
  at least 8 months in the public sector in an under-served area
- a prescribed number of CPD credits/points

training (3 years):

- paid supervised clinical work in accredited tertiary care service sites
  at least 8 months in the public sector in an under-served area
  at least 480 hours in the public sector in rural under-served area in last year*
- structured lectures and course work in medical schools
  divided into 9 x 4 months blocks/modules
  last block: part-time work, dissertation, final examinations

* not necessarily under supervision

INTERNSHIP FOR ALL THREE GRADES OF DOCTORS

primary care doctor:

1 year internship in primary care units ONLY

in accredited public or private sector institutions under supervision

secondary care doctor:

1 year public sector in-patient and out-patient hospital work

with at least 4 months in an under-served area*

tertiary care doctor: NIL required

* not necessarily under supervision

ACADEMIC MEDICINE
(research, teaching, training, learning)

for whom and what:

all disciplines, categories and grades
every level of care

by whom and where:

dedicated, ad hoc contracted; paid or voluntary
service sites, institutions, long-distance, electronic, ...

how:

full-time or part-time, modular, mentoring, experiential, in-service,
participatory, outcomes-based, interactive, integrated, …

outcome:

under and post-graduate qualification, CPD credit, publication, …

JOB OPPORTUNITIES FOR PRIMARY CARE DOCTORS

- public and private health centres and clinics
- hospital primary care “polyclinics”
- private primary care practices

CAREER DEVELOPMENT OF PC DRs

within primary care:

specialisation with diplomas for example in:

- paediatrics and reproductive health
- mental health and geriatric care
- occupational health and chronic disease care

beyond primary care:

in addition to generalist and specialist doctor, post-graduate qualification for example as:

- MPH Master in Public Health
- MSc Master of Science

POSSIBLE OUTCOMES

in the medical sector:

- a new service paradigm with continuity of care and team work
- rationalisation of categories of medical service providers
- increase in the number and competency of primary medical care providers
- more professional nurses and their appropriate deployment
- deployment of regulated and appropriately trained supplementary personnel
- more time for medical consultations in primary care
- lower work-load for doctors and nurses in secondary and tertiary care
- less burn-out, more job satisfaction and higher morale among staff

in the country as a whole:

- improvement in the quality of medical care
- lower doctor and nurse attrition and emigration rates
- less doctor poaching
- extra and affordable career options with opportunities for up-grading

COST-EFFECTIVENESS OF PC DRs COMPARED TO GENERALIST DRs & PHCNs

- PC Drs cheaper to train than generalist Drs
  - shorter training period
  - practical training in primary care and not in hospitals
  - almost two for the price of one
- PC Drs longer potential working life than PHCNs
  - because they will be younger on graduation
- nurses will not be lost to PHCN ranks
- PC Drs less attractive to poachers than generalist doctors

OTHER ADVANTAGES OF PC DRs COMPARED TO PHCNs

because qualifications will be accredited, PC Drs will be obliged to:

- maintain high standards
- follow a strict code of professional ethics
- comply with CPD requirements
- account formally for their acts and omissions

because the status of PC Drs will be secure, there could/will be:

- good reciprocal relations with other care providers
- explicitly defined public sector remuneration
- career ladders
- job opportunities

UPGRADING OF PHCNs TO PC DR STATUS

- PHCN training to be discontinued
- PHCNs to have the option to continue as is until "the end" or to upgrade to PC Dr status provided that they meet prescribed standards in respect of:
  - professional qualifications
  - recognised prior learning
  - duration, content, and relevance of experience
  - the successful completion of bridging courses and challenge examinations

UPGRADING OF OTHER MEDICAL PROFESSIONALS TO PC DR STATUS

the following also to have the option to upgrade:

- foreign trained general medical doctors*
- medical auxiliaries and orderlies, physician assistants
- South African homeopaths and USA osteopaths
- advanced nurses and nurse practitioners

provided that they meet the
same prescribed standards as the PHCNs

* MB BCh equivalents

IF THERE IS SUPPORT FOR WHAT IS PROPOSED

WHERE TO FROM HERE?

FROM THEORY INTO PRACTICE