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Perspectivas

Being a resident of family medicine in Africa in 2019: a picture from the 6th WONCA Africa Conference in Kampala

Ser residente em medicina de família na África em 2019: um retrato da sexta conferência WONCA África em Kampala

Ser residente en medicina familiar en África en 2019: un retrato de la sexta conferencia WONCA África en Kampala

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Abstract

Training young doctors in family medicine is challenging in any setting and many variables can influence the success or failure of a residency program. This article is the end result of a collaborative work that started in June 2019 at the WONCA Africa Regional Conference in Kampala, during a workshop lead by the Besrour Centre for Global Family Medicine at the College of Family Physicians of Canada. We present here the perspective of a small group of young African family physicians on the experience of being a resident in family medicine in Africa in 2019, hoping that the picture we depict here helps to promote the necessary improvements in the training programs in Africa for the near future.

Keywords: Family Medicine; Medical Education; Internship and Residency.

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Resumo

Formar novos médicos de família é um desafio em qualquer cenário e muitas variáveis podem influenciar o sucesso ou o fracasso de um programa de residência. Este artigo é o resultado final de um trabalho colaborativo iniciado em junho de 2019, na Conferência Regional WONCA África em Kampala, Uganda, durante um workshop liderado pelo Centro Besrour do Colégio Canadense de Medicina de Família. Apresentamos aqui a perspectiva de um pequeno grupo de jovens médicos de família africanos sobre a experiência de ser residente em medicina de família na África em 2019, esperando que a imagem que representamos aqui ajude a promover as melhorias necessárias nos programas de residência na África em um futuro próximo.

Palavras-chave: Medicina de Família; Educação Médica; Internato e Residência.

Resumen

La formación de nuevos médicos de familia es un desafío en cualquier lugar y muchas variables pueden influir en el éxito o el fracaso de un programa de residencia. Este artículo es el resultado final del trabajo colaborativo iniciado en junio de 2019 en la Conferencia Regional de África WONCA en Kampala, Uganda, durante un taller dirigido por el Centro Besrour del Colegio Canadiense de Medicina Familiar. Presentamos aquí la perspectiva de un pequeño grupo de jóvenes médicos de familia africanos sobre la experiencia de ser residente en medicina familiar en África en 2019, con la esperanza de que la imagen que representamos aquí ayude a promover mejoras en los programas de residencia en África en un futuro próximo.

Palabras clave: Medicina Familiar; Educación Médica; Internado y Residencia.

INTRODUCTION

From June 6 to 8, 2019, the WONCA Africa Regional Conference was held in Kampala, Uganda. 181 Family Physicians (FP) from Africa, Europe, South and North America shared experiences, knowledge, and projects to further the growth of Family Medicine (FM) on the African continent, during three days of activities. Approximately 20% of the participants were residents in FM or young FPs, presenting a very optimistic picture of the future of FM in Africa.

The African continent cannot be described as homogenous in any sense, neither in FM nor in primary care (PC). Overall, sub-Saharan countries face a shortage of any kind of trained health workers, especially in countries like Sudan, Mali and Uganda.[1] South Africa was the first country to establish a residency training program in FM, followed by Nigeria, Uganda, the Democratic Republic of the Congo, Sudan, Ghana, Tanzania, Kenya, Lesotho and Botswana, and most recently in Somaliland, Ethiopia, Mali and Malawi.[2] Today, not every African country has FM as a medical specialty though, and some countries like Mozambique and Ethiopia are currently graduating their first trained FP.[3]

As part of its mandate to foster global collaborations in FM, the Besrour Centre for Global Family Medicine at the College of Family Physicians of Canada ran a workshop during the WONCA conference for residents in FM and young FP with the objective of getting feedback about their experiences during their years of training in FM. The Besrour Centre[4] is a hub of international collaboration dedicated to advancing *family medicine* as a pathway to health equity. Since its inception in 2015, the Besrour community has gathered partners from 22 low- and middle-income countries (LMICs) worldwide. Through colearning and collaboration of these partners, the Centre flexibly supports a diverse set of emerging FM systems through research, education and advocacy.

The workshop was facilitated by three members of the Besrour Centre (one Brazilian and two Canadians). It lasted 90 minutes and the following three key questions were used to guide the personal reflection and the group discussion: (1) “What made you decide to become a FP?”; (2) “What were the most positive aspects you experienced during your training?” and; (3) “If you were the director of the training program, what would you make different or would like improved for the next generation?”.

This article is an experience report of this process and aims to share with fellow professionals the perspective of a small group of young African FP on the experience of being a FM resident in Africa in 2019.

METHODS

Building on the discussion from the workshop, a focus group was created using an online survey and email group to allow each participant of the workshop to delve deeper into the same three questions and share their experiences with everyone. Seven young FP from Somaliland, Kenya, South Africa, the Democratic Republic of the Congo, Nigeria, Ghana and Mozambique took part in this work. All authors took part in all phases of this process. The CanMeds - Family Medicine 2017[5] and the EURACT Educational Agenda for Family Medicine and General Practice[6] frameworks were used to organize and categorized the responses from the participants. Writing was a collaborative process and the final version was discussed and approved by all authors.

RESULTS AND DISCUSSION

The results are presented according to the responses of the participants and three different tables summarize the responses linking them to their respective competencies from the CanMeds-FM and the EURACT educational agenda frameworks.

Why did we choose FM?

We (the participants) decided to become FPs because we wanted to build strong relationships with patients, treating them not as cases or file numbers but as individuals with their own experiences.[7] The notion of comprehensive care and the ability to develop longitudinal relationships, following our patients throughout their lives, coordinating and sharing health care with other health care providers, were the first aspects of FM that captivated us.

We have a common vision of ourselves as generalists,[8] feeling that our practice would not be complete if it was more limited in scope. By training as FPs in several clinical environments, we do not want to choose between seeing babies and elderly people, or being limited to either mental health conditions or surgical procedures.[9]

Having a role model[10] during our medical training made us see how trained and skilled FPs can routinely do their work, using different skills to manage different patients and treat a variety of conditions, often helping several patients at the same time. Being socially accountable[11] for the health care of the people - including health care in rural areas and underserved communities - has been a driving factor in choosing FM, as is being a young leader in the growth of a new discipline.

Finally, personal choices and preferences, such as having a more flexible work schedule and having time for other interests in life, including our families, also played an important role in our decision to become FPs.[12] Table 1 summarizes the responses to the first question.

What are/were the most positive aspects of your training in FM?

Fortunately, most of our training happened in the welcoming environment of a PC clinic in the community and we know that this is more an exception than the norm in many African countries. Nonetheless, shifting from a hospital-based environment to a community-based setting allowed us to live and experience a wide variety of clinical and professional experiences, making us more confident to face the challenges in the communities where we will eventually work.

Table 1. Responses and respective CanMEDS-FM and EURACT competencies to the question "Why did we choose FM?"

Participants responses	EURACT educational agenda	CanMEDS-FM roles and competences
We wanted to build strong relationships with patients, treating them not as cases or file numbers but as individuals with their own experiences.	Person-Centred Care – ability to adopt a person-centred approach in dealing with patients and problems in the context of the patient's circumstances.	Develops rapport, trust, and ethical therapeutic relationships with patients and their families.
Longitudinal relationships, following our patients throughout their lives.	Person-Centred Care – ability to provide longitudinal continuity of care as determined by the needs of the patient, referring to continuing and coordinated care management.	Establishes plans for ongoing care and timely consultation when appropriate.
Coordinating and sharing health care with other health care providers.	Comprehensive Approach - ability to manage and coordinate health promotion, prevention, cure, care and palliation and rehabilitation	Collaborator - Works effectively with others in a collaborative team-based mode.
A common vision of ourselves as generalists.	Primary Care Management – ability to manage primary contact with patients, dealing with unselected problems.	Practises generalist medicine within their defined scope of professional activity.
Using different skills to manage different patients and treat a variety of conditions, often helping several patients at the same time. Working in the community allowed us to develop clinical reasoning skills, critical thinking and evidence-based medicine (EBM).	Specific Problem-Solving Skills – ability to relate specific decision-making processes to the prevalence and incidence of illness in the community.	Integrates best available evidence into practice considering context, epidemiology of disease, comorbidity, and the complexity of patients.
Having a more flexible work schedule and having time for other interests in life.	Attitudinal Aspects - Being aware of the mutual interaction of work and private life and striving for a good balance between them.	Manages career planning, finances, and health human resources in a practice.

These unique settings allowed us to focus on clinical reasoning skills, critical thinking and evidence-based medicine (EBM). We could better understand the population and clinical aspects of our community while learning about the available resources and developing the skills to effectively use EBM in our practice. Working side by side and learning from more experienced FPs, sometimes from different countries, allowed us to appreciate different ways of practicing and incorporate innovations and best practices to contexts of limited resources.

By the end of our training, we can see that the progressive exposure to different levels of responsibility in the clinic and with our patients is the result of our preceptors and directors' efforts to guarantee a safe environment for our training while preparing us to practice in the real world. Being challenged as adult learners to find solutions in our daily practice and becoming gradually entrusted with greater responsibilities, such as supervising undergraduate students or undertaking other academic activities, we were provided with multiple learning opportunities to understand the process of achieving clinical competencies and have become better equipped to start teaching undergraduate students and young doctors in the future.

Interaction with our peers in class or in preparation for exams fostered a positive academic environment and helped us to bring innovations to our practices. These relationships as well as with those with all the providers in our clinics helped us realize that we need each other's support to get ahead in our work and in our careers.

None of that would be possible without the support we had from our preceptors.[10] They were inspiring role models, teachers and friends that tried to optimize our learning experience during our years of training.

In summary, by being treated with a well-deserved respect in a community-based PC setting, we have learned the core competencies of FM and how to provide person-centred care to our patients. A comprehensive and respectful environment made us have a clearer vision of the importance of improving the quality of PC in our countries and the key role that residency training in FM plays to achieve this goal. Table 2 summarizes the responses to the second question.

Table 2. Responses and respective CanMEDS-FM and EURACT competencies to the question "What are/were the most positive aspects of your training in FM?"

Participants responses	EURACT educational agenda	CanMEDS roles and competences
Shifting from a hospital-based environment to a community-based setting allowed us to live and experience a wide variety of clinical and professional experiences.	Contextual Aspects - Having an understanding of the impact of the local community, including socio-economic factors, geography and culture, on the workplace and patient care.	Contributes generalist abilities to address complex, unmet patient or community needs, and emerging health issues, demonstrating community-adaptive expertise.
Being challenged as adult learners to find solutions in our daily practice and becoming gradually entrusted with greater responsibilities.	Specific Problem-Solving Skills - to adopt appropriate working principles. e.g. incremental investigation, using time as a tool and to tolerate uncertainty; Scientific Aspects - Developing and maintaining continuing learning and quality improvement.	Family physicians take responsibility for the development and delivery of comprehensive, continuity-based, and patient-centred health care.
We have become better equipped to start teaching undergraduate students and young doctors in the future.	Scientific Aspects - Developing and maintaining continuing learning and quality improvement.	Teaches students, residents, the public and other health care professionals.
Our preceptors were inspiring role models, teachers and friends that tried to optimize our learning experience during our years of training.	Attitudinal Aspects - Having an awareness of self: an understanding that one's own attitudes and feelings are important determinants of how they practice.	Demonstrates role flexibility; for example, changing from team member to team leader as necessary based on context, team composition, and patient needs.

If we were the Directors of the Residency Program, what would we do differently and what would we like to change to provide a better training program for future generations?

Community-based PC is a reality for some residents in Africa (as it was in our experience) but for the vast majority, FM practice and teaching are predominantly urban and hospital-based. If we want to see our countries achieving universal and comprehensive primary health care, we should work to move FM from the hospital where it is confined today to where in fact it should be: in the communities and close to the patients.[13]

Some areas of FM training still deserve more investments. For example, all residents must be trained in surgical skills regardless of their training site. Research skills should be developed to improve clinical reasoning and help us to address the challenges we face in PC.[14] One suggested initiative is the creation of FM learning video libraries and networks, with video-recorded consultations to be used as an educational resource for training communication skills.

How to give and receive feedback is a big issue that must be addressed urgently. There is a consensus in our group that the way we received information about our learning process and performance was usually vague, often unscheduled and unannounced, sometimes perceived as threatening and discouraging. Feedback should not be filled with disapproval and threats but should provide constructive information in a safe and supportive environment to help and guide learners to develop their full potential. It is our duty to surpass this hurdle and develop the skills to provide timely, objective, and constructive feedback to future generations of learners.

Another big challenge FM training programs in Africa must address is the need to delineate learning objectives for the residents. If they are clearly described, preceptors will have more realistic expectations of the learners' progress and residents will also have a better idea about the educational requirements to become a FP.[5,15,16] We know that every training program will be unique, but they need to share the core attributes of PC and the core competencies of FM. In a vast continent with young institutions representing FM, it is reasonable to believe that it will not be easy to close this gap of heterogeneity.[17]

Exchange elective opportunities must be encouraged so that residents can share knowledge and experiences with colleagues from different programs and contexts, especially via sustainable and symmetrical international collaborations.

A greater importance must be given to expand training in FM beyond the biomedical aspects of practice, exploring the learning opportunities we can have from advocating for our patients' health care, dealing with complex and vulnerable patients, and working with the community.[18]

Finally, we must not forget about our own medical community, which remains a setting where FM and PC is still an exception, disjointed from the health care system. We need to promote the teaching of PC and FM in medical schools and the interaction with other medical specialties by advocating for the discipline in the curricula.[19] Medical students should spend more time in PC to experience it the same way they do with other medical specialties. Showcasing the richness of PC as a learning environment will help more young doctors to see FM as a viable career and a rewarding medical specialty. Table 3 summarizes the responses to the third question.

Table 3. Responses and respective CanMEDS-FM and EURACT competencies to the question "If we were the Directors of the Residency Program, what would we do differently and what would we like to change to provide a better training program for future generations?"

	EURACT educational agenda	CanMEDS roles and competences
All residents must be trained in surgical skills regardless of their training site.	Specific Problem-Solving Skills - ability to make effective and efficient use of diagnostic and therapeutic interventions.	Performs a procedure in a skillful and safe manner, adapting to unanticipated findings or changing clinical circumstances.
Research skills should be developed to improve clinical reasoning and help us to address the challenges we face in PC.	Scientific Aspects - Being familiar with the general principles, methods, concepts of scientific research, and the fundamentals of statistics (incidence, prevalence, predicted value etc.).	Critically evaluates the integrity, reliability, and applicability of health-related research and literature that is relevant to settings where family physicians work.
The creation of FM learning video libraries and networks, with video-recorded consultations to be used as an educational resource for training communication skills.	Holistic Approach - ability to use a bio-psycho-social model taking into account cultural and existential dimensions; Person-centred Care - ability to develop and apply the general practice consultation to bring about an effective doctor-patient relationship, with respect for the patient's autonomy.	Adapts communication to the unique needs and preferences of each patient and to their clinical condition and circumstances ensuring that care is inclusive and culturally safe.
How to give and receive feedback is a big issue that must be addressed urgently.	Attitudinal Aspects - Having an awareness of self: an understanding that one's own attitudes and feelings are important determinants of how they practice.	Provides feedback to enhance learning and performance.
The need to delineate learning objectives for the residents.	Scientific Aspects - Developing and maintaining continuing learning and quality improvement.	Engages in the continuous enhancement of their professional activities through ongoing learning.
If we want to see our countries achieving universal and comprehensive primary health care, we should be in the communities and close to the patients. A greater importance must be given to expand training in FM beyond the biomedical aspects of practice, exploring the learning opportunities we can have from advocating for our patients' health care, dealing with complex and vulnerable patients, and working with the community. We need to promote the teaching of PC and FM in medical schools and the interaction with other medical specialties by advocating for the discipline in the curricula.	Community Orientation - ability to reconcile the health needs of individual patients and the health needs of the community in which they live in balance with available resources.	Contributes generalist abilities to address complex, unmet patient or community needs, and emerging health issues, demonstrating community-adaptive expertise.

DISCUSSION

FM training in Africa has made great strides and its many achievements need to be acknowledged and celebrated. However, advances and innovations need to be sought in order to create and develop further training programs in FM, fostering advances in PC and creating a more sustainable environment for future generations.[1] Efforts should be made to generate interest in the specialty at the undergraduate level. With more medical students being exposed to FM and PC, it might boost enrolment in postgraduate residency training.[20] Furthermore, by having more residents in FM, it will make the specialty more popular for the new generations that will start to see FM as a viable career to be pursued.

FM training should aim to produce competent, knowledgeable and highly-skilled FP[21] who would make a positive impact in the delivery of holistic research-driven PC services in their communities. These would enhance advocacy to promote investments not only in FM training but to invest in training to advance the skills of every professional working in PC.

The views expressed here, though diverse, define our commonalities in terms of expectations, experiences and desires for the future. However, some limitations must be highlighted. We tried to depict our impressions in a way to help the training programs to improve, leaving aside complaints that could not lead to change or benefit the discussion. If the reader ends up having an overall positive impression about FM in Africa, it may be because of our optimism about the topic and our desire to build a better future for the next generations. We were also limited to a small number of young FPs (only nine of the almost 30 attending the conference) and we are sure that our opinions do not represent the whole continent. Nonetheless, we are quite aware that this opinion comes from a group concerned with the quality of training received and engaged with the Young Doctors Movement (YDM) of WONCA Africa movement – AfriWon Renaissance. Lastly, it is important to remember that this article is not a formal research, but a structured report of our experience from our training years. Further in-depth research with rigorous methodology should be conducted to describe in more detail the current state of the training programs in Africa.

CONCLUSIONS

Despite being exposed to good training experiences, many improvements would make our residency programs better and we are aware that the responsibility of making them happen is on us, the next generation of trainers. Patient-centred care, community-based practice and comprehensive care are essential to address the healthcare needs of Africa. This will not be feasible if training programs and medical societies do not start to design learning objectives that are clear, achievable and possible to be translated to every environment.

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