Developing family practice in Kuwait

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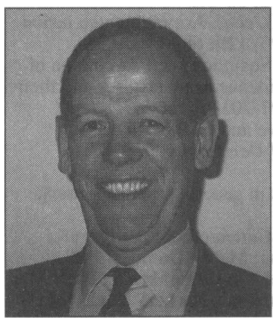

Introduction

SINCE 1984, as the Royal College of General Practitioners Kuwait fellow, I have advised Kuwait on the introduction and development of family practice. It is my intention to highlight some of the key features of the family practice programme in Kuwait.

I have chosen this topic for two main reasons. First, it exemplifies the new and growing role of the RCGP as a focus and resource for countries who wish to develop general or family practice. The second reason is more personal. My involvement with Kuwait has been a uniquely stimulating and absorbing professional challenge. Over a period of 11 years, which includes 39 visits to Kuwait, I have been privileged to work very closely with, and to learn from, many colleagues from both the United Kingdom and Kuwait. I have become familiar with an entirely different culture and made lasting personal and professional relationships. In short, Kuwait has become a major part of my life.

The story began in May 1983, when the Kuwait Ministry of Public Health asked the RCGP for help to improve their primary care services. This was a direct consequence of an earlier visit to Kuwait in February 1981 by the then RCGP president John Horder and chairman of council Alastair Donald. They had indicated that the RCGP was willing and able to assist. The original Kuwaiti intention had been that the RCGP would devise and implement a four-month intensive training programme for their general practitioners, following which participants would sit a local version of the MRCGP examination. The RCGP asked me to be responsible for the training programme, and Professor John Walker, a former chairman of the RCGP examination board, was asked to prepare the assessment. Since I knew very little about Kuwait or its medical services, I made a fact-finding visit to Kuwait in September 1983. It quickly became apparent that more radical measures would be required.

Kuwait and its medical services

Kuwait is a small Muslim country situated in the north-west corner of the Arabian Gulf. The official language is Arabic, although English is widely understood. Following the discovery of oil, some 50 years ago, it has undergone phenomenal change. Its population has expanded rapidly, mainly through immigration (Table 1);[1] only 40% are Kuwaiti, with the remainder mostly from other Arab countries. Its age structure differs markedly from the UK:[2] compared with the UK it has double the proportion of those aged under 15 years and only one 10th the proportion of those aged over 60 years (Table 2). Kuwait has, therefore, a young population and a high birth rate, which have obvious implications for medical services.

Traditional primary health care

The traditional system of primary care in Kuwait is based on local clinics and polyclinics which have separate facilities for males and females. The local clinics serve approximately 9000 people. The clinics provide basic primary health care, with limited dispensing facilities, and are staffed mainly by so-called general practitioners, nurses and ancillary staff. Primary care paediatricians of diploma in child health standard work in approximately half of the clinics. The polyclinics, which serve a catchment population of 30 000 to 90 000, offer the additional services of community obstetricians/gynaecologists of diploma of the Royal College of Obstetricians and Gynaecologists standard, other 'specialoids'[3] (especially in diabetes, dermatology and ophthalmology), more comprehensive dispensing facilities, plus basic laboratory and x-ray services. All clinics open at 07.30 hours; the local clinics close at 21.30 hours and the polyclinics at midnight. After that patients have to attend hospital. Hospitals have a catchment population of 300 000.

Patterns of morbidity and mortality are an amalgam of those of developing and developed countries. Health care is available to all free of charge and most doctors are salaried, shift-working, state employees. Although the structure is basically sound, it does not function well in practice for a variety of reasons.

The so-called general practitioners had received little or no specific general practice training. Most would have preferred to be hospital specialists and many were only too anxious to leave general practice when a hospital post became available. This resulted in a 20% turnover of general practitioners every year. The general practitioners — more aptly described as clinic doctors — provided a limited range of care, since it was the commun-

Table 1. Population of Kuwait.

Year	No. of people
1937	75 000
1957	200 000
1985	1 700 000
2000	2 500 000[a]

[a]Estimated.

Table 2. Age distribution of the population of Kuwait and the UK.

	% of population in 1989	
Age (years)	Kuwait	UK
<5	*20*	*7*
<15	*42*	*20*
>60	*2*	*20*

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ity-based specialoids who mainly looked after young children, diabetic patients, pregnant women, and so on. Medical records were mainly absent and many patients 'shopped around' between clinics and hospitals. The provision of care was fragmented and lacked continuity. Clinical standards were unsatisfactory, with much overprescribing. Professional relationships were poor and morale was low. General practice had a low status in the eyes of hospital specialists, patients and many of the clinic doctors themselves. It was not surprising, therefore, that in 1983 none of the 600 general practitioners was of Kuwaiti nationality.

Identifying a strategy

It thus became apparent early on in my fact-finding visit that general practice, as generally recognized in the UK and elsewhere, simply did not exist in Kuwait. In my report it was made clear that more fundamental changes would be required. Subsequently, Kuwait took the decision to develop family practice as the basis of a comprehensive and patient-centred approach to primary care. The RCGP was asked to help, and on 1 January 1984, I was appointed RCGP/Kuwait fellow with responsibility for advising on and introducing the necessary educational and training programmes within Kuwait. In this way, the first of the RCGP international fellowships was created. At the same time, Dr Mansour Sarkhou was appointed as the local Kuwait coordinator and was soon to become director of the newly instituted Family Practice Training Unit within the Kuwait Ministry of Public Health. From the beginning the two of us worked closely together. Three major aims were formulated.

- The long-term aim was to make family practice the cornerstone of a fully integrated health care system.
- The medium-term aim was: to develop self-sufficient educational and training programmes for family practice within Kuwait.
- The short-term aim was to introduce a postgraduate qualification in family practice in Kuwait, eventually equivalent in standard to the MRCGP diploma.

Since there are many potential models of primary care it was essential that Kuwait first identified its particular preference. The ministry decided that their family practitioner would provide personal, comprehensive and continuing care and act as an integrating force between primary and secondary care. Thus, the family practitioner would be a generalist with a much more extensive set of responsibilities than the general practitioners of the traditional system. Indeed, the name family practitioner was specifically chosen to signify a clear distinction between their respective roles.

The important and inevitable consequence of this decision was that the family practice programme would have to be more than just a new approach to training: it was bound to lead to fundamental changes in the whole system of delivery of health care in Kuwait.

Although there was a recognition that Kuwait would need to rely initially on external help and expertise, it was explicitly acknowledged that a build up of local ability should occur as quickly as possible. Much effort was subsequently directed to this end.

It was felt that the introduction of a postgraduate qualification would help to establish the new specialty of family practice, as it was likely to act as a powerful incentive for potential recruits. A formal qualification would bring status and credibility to family practice, not least because of its link to a respected external body, namely the RCGP. Although the RCGP is sometimes taken for granted within the UK, it is difficult to exaggerate the high regard in which it is held overseas.

Getting started

Although many initiatives were required, two immediate priorities were identified. These were the introduction and development of model centres of family practice in action, and specialist (vocational) training for family practice. These two initiatives were regarded as totally interdependent. Family practice as a service to the people could not be implemented without a specialist training programme, and such training could not happen in the absence of working models of family practice. Thus, the model centres were required not only to pioneer and demonstrate the new concept of family practice, but also to act as the location and resource for training future family practitioners. It is one thing to describe and advocate a new system as a means of gaining support for it. It is likely to have much more impact if a practical demonstration can be set up so that it can be personally experienced by decision makers, the public and potential recruits — and so it proved.

A concurrent task was to identify doctors who might have the special abilities to become the first family practitioners and trainers. In 1984, all 600 doctors working in the clinics were given the opportunity to apply. Of the 120 applicants, 70 underwent a test of competence and an interview; 14 doctors were eventually selected to join the programme and were moved to staff the two model centres. An intensive training programme, lasting 15 months, was then instituted to equip the doctors for their service and teaching roles. This included four full-time courses, each of two weeks' duration and taught by UK tutors, on clinical method, consultation skills, paediatrics and teaching methods. Local potential trainer groups were also formed, and short hospital attachments arranged to fill particular gaps in the clinical knowledge and skills of individual doctors.

In October 1985, formal assessments of the clinical and teaching capabilities of these doctors were carried out. They consisted of direct observation by two UK assessors of each candidate, first consulting for three hours with unselected patients, and then in three different teaching exercises with actual trainees. Following these assessments, 13 doctors were recognized as family practitioners and 10 of them were also formally appointed as trainers. These trainers were to become key assets; at this early stage they were the first practical manifestation of the policy of creating local self-sufficiency.

Changes in the model family practitioner centres

In the two clinics selected to be model centres a number of changes had to be made to facilitate the provision of personal, primary, continuing and comprehensive care. Of course, any changes had to be sensitive to local culture and tradition. For example, teams of doctors, each consisting of one man and one woman were allocated to single consulting rooms and quotas of families allocated to each room (there being no system of personal doctor registration in Kuwait). Although the strict separation of the sexes was discontinued, the patients could still choose between men and women doctors in order to satisfy religious and cultural traditions. Clinical policies were also introduced. These changes facilitated the development of greater continuity and consistency of care and created bonds of trust between doctors and patients, resulting in more personal and comprehensive care along with greater doctor and patient satisfaction compared with the traditional system.[4]

Specialty training programme for family practice

In October 1985, the first trainees entered the newly-created specialty training programme. At first they were unselected, but since 1989 all have had to pass a modified essay questionnaire

and an interview to be admitted. The acceptance rate has averaged 50%.

All trainees undertake an initial period of three months in a designated family practice training centre, followed by two years in rotating hospital posts, with a weekly day release programme organized by the family practitioner trainers, followed by a nine-month attachment in family practice.

In addition, all trainees have to attend five formal, two-week courses resourced by UK tutors (Table 3). The consultation skills courses provide opportunities to conduct systematic assessments of the consulting abilities of trainees. The tutor observes a trainee consulting with patients for a total of five hours. Afterwards the trainee receives verbal and written feedback on strengths and weaknesses, along with suggested strategies for improvement. The whole process is repeated one week later, making a total of 10 hours of direct observation, plus feedback in each course.

The other courses contain a number of common features:

- Explicit aims/objectives
- Problem-based learning
- Small group work
- Formal assessment
- Feedback

They particularly concentrate on developing powers of clinical reasoning and problem-solving as well as trying to ensure that increased knowledge is underpinned by understanding. The courses are also highly interactive, as they are problem-based, mainly conducted in small groups and use a socratic teaching style. Of particular value have been the pre- and post-course formal assessments with verbal and written feedback on performance. This is provided both to trainees and to trainers, so that trainees' weaknesses can be identified, worked on and overcome.

This initially represented a major culture shock as participants had been accustomed to a didactic, lecture-based and passive approach. Indeed, one of the few general practitioner refresher courses to be held in Kuwait prior to the introduction of the family practice programme consisted of eight one-hour lectures daily for six days all given by hospital specialists. Nevertheless, the Kuwaitis adapted quickly and all participants strongly prefer the new approach to courses.

For the first time, Kuwaiti nationals began to be attracted to primary care. Indeed, of the 80 past or current trainees, 90% are Kuwaiti. It is also pleasing that many recruits have been positively influenced in their career choice by exposure to teaching in the family practice centres while undergraduates at Kuwait Medical School.

Diploma in family practice (RCGP/Kuwait)

By early 1986, Dr Sarkhou and I felt enough progress had been made to advise the ministry to invite Professor Sir Michael Drury, then RCGP president, and Professor Walker to visit Kuwait to make an independent assessment of developments. We hoped that they would be able to recommend an early date for the first examination diet for a postgraduate qualification. In their subsequent report they commented on the enthusiasm and commitment of the trainers and trainees alike and stated 'We have been very favourably impressed by the progress which has been made... in such a short time' (report to the Kuwait Minister of Health). They felt that the first diploma examinations could take place in autumn 1987. The qualification was to be known as the diploma in family practice (RCGP/Kuwait) and it was to be a regulatory endpoint assessment. To provide the necessary administrative framework the Kuwait family practice examination board was created with local and RCGP representation.

The components of the examination are set out in Table 4. The written papers are modelled on the MRCGP examination format but modified for local circumstances. The oral examinations are conducted by a pair of examiners and are designed particularly to test the clinical problem-solving ability of candidates. The clinical examination consists of a minimum of three hours of independent observation by two examiners of candidates in consultation with at least 12 unselected patients. For the past five years examiners have used the Leicester assessment package.[5,6] A fail mark in the clinical component results in automatic failure overall.

In September 1987, the first examination diet leading to the diploma in family practice (RCGP/Kuwait) was held. This was an historic occasion since it was the first postgraduate qualification in family practice to be instituted in Kuwait. It was — and still is — the only foreign postgraduate qualification to be given the imprimatur of the RCGP. In the early examination diets all the assessments were conducted by RCGP external examiners, but since 1993 examining duties have been shared equally by internal and external examiners. The pass rate averages 75% and the first pass with distinction was awarded in 1993. There are now 54 diplomates.

In November 1991 a considerable boost was given to the whole programme by the following statement: 'The examination board of the Royal College of General Practitioners recognizes the diploma in family practice (RCGP/Kuwait) as the endpoint assessment of specialist vocational training for family practice within Kuwait. Those who pass the diploma examinations have demonstrated a capability to undertake independent clinical activities in the setting of family practice. The diploma in family practice (RCGP/Kuwait) is the equivalent postgraduate qualification in Kuwait to that of the MRCGP in the United Kingdom' (report to the Kuwait Minister of Health). Although the RCGP had recognized the Kuwait diploma since its inception in 1987, this statement carried that recognition a stage further: it accorded it equivalence in status, thus achieving the third major aim set out in 1984. Soon afterwards, the Kuwait Institute for Medical Specialization, the supreme authority for postgraduate medical training in Kuwait, recognized the diploma as equivalent to the MRCP and FRCS, which meant that for the first time in Kuwait, family practitioners could obtain equivalent career status to hospital consultants.

Table 3. Timing and topics of formal courses during specialty training programme.

Month after entering training	Course subject
2	Diagnosis and patient management (1)
14	Diagnosis and patient management (2)
24	Consultation skills (1)
27	Paediatrics in family practice
33	Consultation skills (2)

Table 4. Components of the diploma in family practice (RCGP/Kuwait).

Component	% of total marks	Examination length (hours)
Multiple choice questionnaire	*10*	1.0
Short answer questionnaire	*15*	1.5
Modified essay questionnaire	*20*	1.5
Oral examination	*25*	0.66
Clinical examination	*30*	3.0

Parallel programme

Recognizing that it would be a lengthy process to provide the total population of Kuwait with care from fully-qualified family practitioners, a parallel training programme was launched in January 1988. It catered for non-Kuwaiti doctors who were unable to enter the three-year specialty training programme. The intention was to equip them to provide more comprehensive care of a higher quality and greater cost-effectiveness than the clinic doctors. The doctors were selected from those working in the traditional system following a formal assessment and interview. The training lasted one year and consisted of two formal courses of two weeks' duration resourced by UK tutors and held some six months apart. Inservice training and formal educational activity under the direction of the local trainers were also incorporated. All selected doctors were brought together to work in the same health centres so that they could apply and develop their new-found skills with mutual support from colleagues. The impact of the parallel programme was dramatic. Following the initial two-week course, overall prescribing frequency dropped by some 50%, and in two of the clinics injection of drugs dropped from pre-course levels of 8000 and 6000 per month to 2000 and 1600, respectively. Patients were more satisfied and doctor status and morale raised. By August 1990 almost 100 doctors had completed this programme.

It also became apparent that many of these doctors had the potential to reach diploma standard. It was decided, therefore, that selected doctors would be enrolled in an inservice training programme of five years, after which they would be permitted to take the diploma examination. Thus, an alternative route of entry to family practice was created to enable more qualified family practitioners to be produced more quickly.

Continuing developments 1989–90

Throughout 1989–90, further developments took place on a variety of fronts. As the number of qualified family practitioners increased, some trainers and service family practitioners were relocated from the original two model centres to three further health centres. This brought a greater balance between training and service provision in all five centres.

Although priority had been given to developing the clinical abilities of the doctors, it was always recognized that much else had to be done. For example, there was a particular need to improve organizational and administrative support within the family practice centres. Because progress was deemed satisfactory on the clinical front, we felt able to lay plans to introduce a new grade of administrator — a health centre manager. The intention was to enrol 15 university graduates in a one-year full-time course and official approval was given for it to start in September 1990.

Efforts were also continuing to increase the number of local trainers. In the UK and elsewhere, doctors are not normally considered as potential trainers until they have acquired several years of clinical experience. In a developing situation, this otherwise sensible requirement had to be waived. As a consequence, in May 1990, 12 diplomates of 1989 attended a two-week course to introduce them to appropriate teaching and assessment techniques. The intention was that these potential trainers would, over the course of the following year, practise their teaching skills with real trainees under the supervision of the established trainers. In May 1991, all would then undergo an assessment of their teaching ability to determine those who would become designated trainers.

Iraqi invasion and occupation

Everything changed on 2 August 1990 when Kuwait was invaded by Iraqi forces. The subsequent occupation was to last until the end of February 1991, but because of the ensuing chaos my first post-liberation visit was delayed until October 1991. Great damage had been done to the infrastructure of Kuwait and many legacies of the war still remained, for example, blazing oil wells, massive oil lakes and damaged buildings. The Iraqi occupation had been brutal and many Kuwaitis were still missing. Nevertheless, throughout the occupation, many family practitioners provided a clandestine medical service to the population from their own homes, often at great risk. I would like to pay tribute to all concerned.

Much population dislocation had also occurred as many previous residents of Kuwait had either chosen or been obliged to leave Kuwait. These included doctors from the specialty and parallel programmes. Of the 34 family practice diplomates prior to August 1990, 25 remained by October 1991; of the 30 trainees, 15 remained; of the original 10 trainers; five remained; and of the 12 potential trainers, nine remained. Having been poised for rapid expansion in 1990, the Iraqi invasion set the programme back by about five years.

Re-launching the family practice programme: 1991 onwards

Following the liberation, Kuwait as a whole had to embark on a period of reconstruction. This was also true for the family practice programme. To make best use of depleted resources, it was decided to suspend the parallel programme as well as the health centre manager initiative in order to concentrate on the core specialty programme. The particular priorities were to restore normality as quickly as possible and to restart the preparation of the potential trainers interrupted by the invasion. The loss of five of our 10 senior trainers had been a particularly hard blow.

Accordingly, in April 1992, annual trainee intakes were resumed and a full quota of courses and examination diets was re-established. Clinical refresher courses were held for trainers, trainees and established family practitioners. Indeed, it is gratifying to report that family practice was the first of the postgraduate medical programmes to be relaunched in Kuwait. The nine remaining potential trainers underwent a refresher course in teaching methods in May 1992. In October 1992, a formal assessment of their teaching abilities was carried out. This involved direct observation by two UK assessors of the potential trainers carrying out problem case and random case tutorials with actual trainees and conducting an analysis of the consultation competence of a trainee. Each assessment lasted two hours, following which seven further doctors were formally approved as trainers.

Meanwhile, the roles and responsibilities of senior trainers were being extended. Since 1989, they had acted as observers on the courses and in the diploma examinations. Since 1993, they have acted as co-examiners in the diploma examinations, having undergone training in methods of assessment. They are now to become co-tutors in all the formal courses planned for 1995.

In January 1994, a series of courses was also launched to enable trainers and family practitioners to develop expertise in practice organization and management. As a follow up, task groups have been set up to bring about improvements within the health centres relating to equipment, availability of drugs, records, chronic disease monitoring and appointment systems. Plans have also been submitted for the re-introduction of the parallel programme and the health centre manager course.

Conclusion

Where does the family practice programme stand now? In May 1994, the RCGP chairman of council Bill Styles and the chairman of the international committee Douglas Garvie visited Kuwait to provide an independent assessment of the state of the family practice programme overall. They observed the traditional system, sat in on consultations by trainees, trainers and family practitioners, attended tutorials and seminars, observed the conduct of the diploma examination and attended an examination board meeting. In their subsequent report they stated: 'We were... particularly pleased to note the successful re-establishment of the programme after the tragic events in 1990–91. That achievement alone reflects the strong foundations on which the programme has been built. We were impressed by the partnership of internal and external examiners, which... reflects the goal of eventual self-sufficiency within Kuwait. We noted particularly at the graduation ceremony the enthusiasm and commitment shown by the graduates, their trainers and all those associated with the family practice programme. Our observation of the examination procedures... and of the training of future candidates makes us confident that this programme is producing family physicians of high quality' (report to the Kuwait Minister of Health).

In conclusion, family practice is now a recognized medical specialty in Kuwait. It is widely acknowledged that family practitioners, who now account for between 10% and 15% of doctors working in primary care, provide a range and quality of care significantly greater than doctors in the traditional system. The programme continues to attract high calibre trainees, a recognized postgraduate qualification has been instituted and local self-sufficiency is increasing. Although severely disrupted by the Iraqi occupation and its aftermath, the family practice programme was the first medical programme to be re-established. Patient satisfaction and doctor morale remain high. Nevertheless, much remains to be done, and those concerned with the programme will not be satisfied until the benefits of family practice can be enjoyed by all the citizens of Kuwait.

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