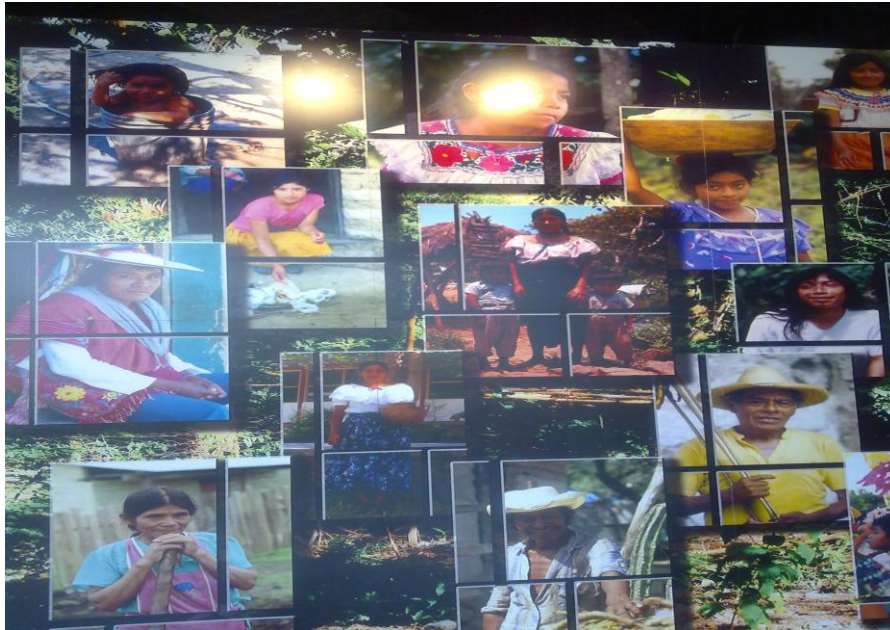


London to Mexico State Worlds apart—A brief comparison of Family Medicine Practice through a 2 week shadowing exchange trip



Dates of Exchange:

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Introduction and Exchange Organisation

I was first introduced to WONCA Europe, the Vasco de Gama Movement and the Hippokrates Exchange Programme, by a fellow GP trainee. I found it both exciting and intriguing about being able to share and compare family medicine practice with other trainees and early family practitioners across Europe. As I came to the end of my training I thought it would be a good time to organise the exchange, however, having already completed my undergraduate elective in Europe, I was hoping to go and experience healthcare outside of Europe. After researching, I thought Mexico, with its vibrant history, culture, size and population density, would be an ideal choice. With the help of many individuals within WONCA Europe, WONCA World and WONCA Iberoamerica, we were able to organise the first Hippokrates Exchange outside of Europe. This involved a 2 week period of shadowing a 2nd Year Family Medicine Trainee (Resident) whilst travelling through various medical faculties, as well as experiencing Mexico City and its people.

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Initial thoughts:

Having recently completed by vocational training I was both excited and a little anxious about visiting and experiencing medicine in one of the busiest cities in the world. I love traveling and experiencing different cultures and was excited to see how medical practice differed. My main anxieties were with personal safety and crime and also concerns about language and cultural barriers.

After fifteen hours of air travel, one stop and seven hours in three airports, I was met by my friendly driver who was anxiously clutching to my name board, hoping that I was indeed arriving in Mexico. We then travelled for 90 minutes through the heavily congested streets of Mexico to arrive at my hotel. As we travelled, I was briefly acquainted to Mexico City, its driving and some of its many monuments. I was informed that Mexico was not a poor city and reminded that the richest man in the World (Carlos Slim) was Mexican and she also allayed some of my anxieties about personal safety and crime.

Undergraduate Training:

Although variations exist, most undergraduate medical degrees in Mexico last for 6 years as in England. They enter at around 18 years and similarly the first 2 years are clinical, following which they have 3 years of clinical speciality rotations. They do not appear to have an intercalated research BSc option and their final year involves a year long internship within a hospital, which I suspect is equivalent to the first year house job of our foundation training.

Medical Career Route to Family Medicine :

Following completion of their undergraduate medical training, newly qualified doctors, have many routes of progression. Without further training, they can apply and work as General practitioners, within primary care, but with limited competencies and experience. They can nevertheless, do the same things as family medicine doctors, but cannot deal with for example family therapy and some of the emergency room treatments.

Unlike the British Medical Career progression, where newly qualified doctors must complete 2 years of foundation training prior to entering speciality training, newly qualified Mexican doctors, can apply for speciality training immediately. This involves another exam (sat by all the different speciality candidates) after which all are provided with a ranking. Based on this you then apply for the various specialities. Most speciality trainings last three to four years, but exceptions include the sub-medical specialties such as cardiology which require a few years in internal medicine before entering further specialist training.

General Practice Training:

Family Medicine training is 3 years long and the first 2 years are structured to involve many short speciality rotations (including paediatrics, gynaecology, cardiology, respiratory medicine and family medicine and more specialities in the second year). All of these are within the morning and involve shadowing and participating in clinical practice. Daily afternoon sessions involve attending the Primary Care clinic for teaching. They also have weekly oncalls at the local Emergency Department which involves clerking for 12 hour night shifts as the A+E junior and for 24 hours on weekend and public holidays. Assessments include exams, and coursework. The final year is divided into 2 blocks with a 6 month period of social service which involves leading in the running of a small rural hospital's primary care department and 6 months (with oncall commitments) to complete a research protocol. Interestingly although qualified, they are not paid a wage, but awarded a monthly scholarship of around \$11,000 pesos, per month and this is probably as they are still in training and treated very much like students, but with oncall commitments! They do also have 6 weeks of annual leave which is fixed and all the trainees have this together.

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A Brief overview of the Mexican Healthcare System.

Unlike the uniform NHS in the UK, the Mexican (non private) healthcare system has four main branches, and the service provider is determined by your work. Each has its own primary care clinics, and secondary/tertiary hospitals and patients affiliated to one institute cannot use the other, unless, rarely, there is a reciprocal agreement.

The first (the largest, accounting for 60% of healthcare and which I was attached to during my stay) is the **IMSS** (Instituto Mexicano del Seguro Social). Everbody who works in Mexico and pays social security is affiliated to this, apart from a few exceptions (which i will cover later). The second is **ISSSTE** (Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado), this provides medical care for all government workers such as government office workers and teachers. The third is **PEMEX** (Petroleos Mexicanos). PEMEX is the sole provider of petrol in Mexico and is owned by the government. As it monopolizes the petrol industry within Mexico, its powerful union has demanded and obtained a separate and well funded healthcare system for all its workers. Finally this leaves **Secretaria De Salud**. This is the the healthcare for the poor, unemployed and medically unaffiliated Mexican population. This is a resource limited service and has lots of gaps in service provision, which is most apparent within primary care, especially outside of the city centres. Positively the Secrearia De Salud does have access to the National Institutes' hospitals, which are the most specialized and have access to the most up to date clinical and research facilities. The finances for all hospitals and clinics within each healthcare is managed by itself and it is funded partly (solely in the case of Secretaris de Salud) by the government with employer and employee contributions.

Primary Care and the Role of the Family Medicine Doctor

As I have already pointed out, the Mexican Health Care System differentiates between general practitioners and family medicine practitioners, with the former being untrained medical graduates and both provide primary medical attention. As with primary care within the UK, Primary Care Clinics are the first point of entry into the healthcare system. They provide all of the first line acute and chronic medical treatment and also act as a gateway for referral into secondary and tertiary care.

Unlike surgeries in the UK, primary care clinics are large and often have many doctors consulting simultaneously, each covering its own designated patch of around 7000 patients to ensure some continuity of care. The layout of the room is similar, with a couch, a table, computer and additional facilites, although resources seem limited. Outside the consulting room a healthcare worker who books in patients (usually covering 2 consulting rooms) and also does the weight and height. Each day the family doctor works a six hour shift with a 30 minute break in between. The shift is either all morning or all afternoon. They see up to 30 patients, spending between 10-15 minutes with each patient. They can have additional spontaneous patients, which will need to be seen as extras. If however, too many arrive, they are directed to, the on-call doctor who is managing the emergency room, or to the local accident and emergency department (although this is avoided). Home visits are again performed by the doctor covering the patch, but an hour of clinic time is freed and any walk in patients or appointments are covered by the on-call doctor.

Intrestingly primary care within the IMSS has a very limited prescribing formulary with access to only certain cheaper medications and only certain antibiotics. For example until recently proton pump inhibitors were only available in secondary and tertiary care. Insulin, as another example, can only be initiated in secondary care, although once initiated, they can be repeat prescribed for the specified duration in primary care. I have also learned that they too, work from Evidence Based Practice and have access (although more on secondary and tertiary levels) to expensive and novel drug therapies, for example DMARDs, Anti-retrovirals and Chemotherapeutics. Also of note, all prescribed medication is dispensed freely to all patients.

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Some additional services which are offered:

The IMSS Mexican healthcare system provide a comprehensive primary prevention (Preventative Medicine) run by the social workers and nurse with occasional support from the doctors, where everyone has annual blood pressures, BMI, glucose and lipids monitoring (SODMHI), as the population is deemed at high risk with its high prevalence of cardiovascular disease and risk factors. Sexually active women have free access to all forms of contraception including the morning after pill and are offered annual cervical screening from teenage years and also breast screening from 18-50 years. They also offer pregnancy, breast feeding and child care advice.

Culture & Religion:

Mexico is a predominantly Catholic country which is very culturally diverse with many festivities, beliefs and customs remaining from the civilisations which had once lived there. For example, even today, the Day of the Dead is celebrated a month before Christmas. The population is, as a whole very hospitable and although it may remain quite conservative in smaller more rural communities the cities are becoming more Western and less conservative. Doctors are still respected very much and patients are happy for doctors to adopt a more paternalistic approach to practice, although holistic medicine and ethics and communication skills do exist, the population in general prefers the current approach at present.

Conclusion:

In summary, I feel that these 2 busy capital cities have very differing populations and subsequently have different health care systems in place to deal with this. Although on the surface of it we deal with very similar medical problems, the incidence is different and subsequently better health surveillance and prevention mechanisms are in place in Mexico, although these do need to be developed further to increase efficiency. I suspect with large socio-economic divide, is further emphasised and translated into healthcare with the differing healthcare systems in place for differing occupations. I have thoroughly enjoyed my stay and although it may seem that compared to London, Mexico City is less culturally diverse (and indeed it is), Mexico's own culture is so vibrant and diverse that it remains very interesting nevertheless. I hope that experiencing Mexico will enable me to understand Mexicans much more in the future and I will always remember their generous hospitality and hope to remain friends with many of those whom I have met during this short, but very pleasant and memorable trip. I will definitely recommend this exchange to all GP trainees and newly qualified GPs.

