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Ukrainian general practitioners; the next steps

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The Eastern European block frequently looks to its western neighbours to help develop its medical faculties through the creation of exchanges supported by charitable organisations or through the development of International Exchange Fellowships. Such fellowships allow a unique opportunity to encourage observation, exchange and debate in the field of healthcare and medical education. This paper describes the Royal College of General Practitioners Ukraine Fellowship Programme (1993-1997), which has created two unique opportunities to explore healthcare delivery in a new primary care setting and discuss university curriculum design. The authors use these observations to discuss the possible reasons behind Ukraine's poor health statistics and what is needed at both primary care and university levels in an attempt to improve these figures.

Introduction

The breakup of the Former Soviet Union (FSU) in 1991 transferred the responsibility for healthcare from a central office to individual republics. As a consequence, Ukraine, representing 36% of the population of the FSU, suffered heavily. The rapid collapse of the economy resulted in drastic cuts in funding for health, contributing to the present poor state of the Republic's health, and demonstrated by some of the worst morbidity and mortality figures in Eastern Europe.

Despite having three times the number of physicians and at least two and a half times the number of beds per capita than the United Kingdom, Ukraine continues to show a falling life expectancy rate. Sixty percent of deaths in Ukraine are due to diseases of the cardiovascular system, whilst cancer accounts for 13% of all deaths. Some 4500 people died in 1990 from tuberculosis, and the figure continues to rise. The standardised death rate (SDR) from infectious diseases is three times that for the United Kingdom.[1]

Ukraine's morbidity rates are high when compared with other European countries. Circulatory disease accounts for 20% of all adult illness, whilst respiratory morbidity accounts for over 60% of all childhood illness.[1]

Obtaining accurate figures that reflect lifestyle in Ukraine is difficult, although they probably reflect those of their Russian neighbours, where alcohol, poor diet, obesity, poor sexual health and smoking play an increasing role in a falling life expectancy.[2,3] The suggestion from others working in Russia that an increased awareness in health and health education could bring about an improvement in the country's health could also apply to Ukraine.[4]

By the early 1980s the Ukraine government had begun to recognise the health problems that the present system was not addressing, and in 1988 the first proposal for the introduction of a primary care-led system of healthcare was suggested (personal communication with RCGP International Committee). In 1993, post Soviet reform, the Royal College of General Practitioners entered into an agreement with Ukraine to facilitate the development of primary care, through the use of a fellowship scheme which is described in detail elsewhere.[5]

Ukraine's decision to institute a system of primary care based upon the European model of family medicine is relatively unique in that it preceded any change in training; indeed the new breed of family doctors occupied the first seats in their surgeries with very little or no training in family medicine. This scenario was mirrored by very little initial change in both undergraduate and postgraduate medical education. This situation has provided the opportunity to observe the new family doctors in consultation and recognise their learning needs prior to development of any family medicine training.

At the same time opportunity has arisen to explore the various medical institutes' curricula as to a potential link between the subject matter and Ukraine's poor standard of health.

General practice observed

In order to begin an assessment programme for training needs, a series of observation of family medicine consult-

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ations was commenced, in particular observing for clinical content, style of consultation and evidence of health promotion.
Four practices were chosen, two in Lviv, and two in Kiev. Four practising physicians were observed, one from each practice. These practitioners were working within a group environment of several independent practitioners.
The two Kiev practices and one Lviv practice had an average doctor/patient ratio of 1:2700. The other Lviv practice had a higher number, 1:6500, because of its old style polyclinic environment.
Features of typical Ukrainian consultations are the presence of a nurse in the consulting room, and the frequent interruptions by other members of staff or even patients. In these conditions, the presence of an observer did not appear to add significant artificiality. One of the observers was fluent in Ukrainian, so the disruption of continuous translation and/or the potential lack of objectiveness of end of consultation summaries by the doctor were avoided. A Ukrainian medical translator accompanied the other observer. The observer recorded the salient points of the consultation in a notebook, with particular reference to the three areas previously described. There was a debriefing with the family doctor at the end of the session. No form of electronic recording was used. A total of 255 consultations were observed. The age of patients ranged from six months to 84 years, average age being 43 years. Seventy-six percent of consultations occurred in patients between the ages of 20 and 50 years. The gender distribution was 61% males, 39% females.

Clinical content

In the majority of consultations (86%) there was only one presenting complaint or problem. In just over 10% of consultations, there was an initial clinical problem plus a request for certification. A high proportion of consultations (51%) was for certification of illness alone. This was a bureaucratic process and was not explored by the doctor. The other reasons for consultation are listed below:

URTI, viral and bacterial	(20%)
Musculoskeletal disorder	(16%)
Chest pain	(6%)
Abdominal pain/disorder	(5%)
Headache	(1%)
Other	(1%)

Prescribing was frequent. Out of those patients who had come for a reason other than a sick certification, a prescription was issued to 85%. Multiple prescribing was common. Thirty percent of prescriptions issued were for one item, 40% for two items and 30% for three or more. Common additions to antibiotics were other antibiotics, vitamins and tonics.

Investigations were carried out on 44% of patients. Fifteen investigations in the form of urine examination were carried out in-house, the rest were referrals. Common investigations were blood tests (n=32), chest X- ray (26), ultrasound scan (15), stool examination (12), and echocardiography (7). There was little apparent relationship or logic between clinical presentation and investigation, e.g. chest pain and stool examination, or URTI and echocardiography.
The referral rate was high. Including those referred for investigations, it totalled 64%. Excluding this group, referred patients totalled 26%. Again there was little logic or reasoning applied to the reason for referral.
A surprising diagnosis was 'hypertensive crisis' found in 11% of clinical cases. This was based on a finding of a variable degree of raised blood pressure, together with other vague symptoms of headache or nondescript chest pain. There was no consensus of what constituted a raised blood pressure, and the measurement was usually taken only once. On no occasion was the optic fundus examined.

Style of consultation

Consultations were conducted in an unhurried manner, with times ranging from 2 to 20 minutes. Average consulting time was 10.3 minutes. There were frequent interruptions from the nurse, and in some cases, patients walking into the consulting room. These interruptions appeared to be accepted by all parties and were part of normal practice. Patient's expectations appeared to be matched by the treatment or advice given by the practitioner, with no adverse comments given by the patient. No evidence was seen of any other than a clinical reason for illness. To the observer, the consultations appeared to be handled in a sensitive and unhurried manner. The doctors appeared to show good communication skills. They were polite, showed good eye-to-eye contact, did not interrupt their patients and the consultations appeared unhurried. However there was little attempt to explore the patients' underlying psyche or any psychological components of somatic disease.

Opportunities for health promotion

Sixty-six patients (26%) had their blood pressures taken, the reason not always related to their presentation. In only 4% of consultations was the patient asked about smoking. Similarly, in 4% of consultations, the subject of alcohol was raised. Diet was enquired about in only 2% of consultations. There was no evidence of true health interventions; discussion was at an enquiry level only. It was difficult to estimate the true numbers of how many patients smoked or drank alcohol, although it was estimated that this figure was high, as seen through observation. There was no evidence of health promotion in the areas of exercise, sexual health, contraception or cervical cytology. Childhood immunisation was discussed in only two cases.

Curriculum content

During the month of November 1997, an exchange visit by one of the fellows (TG) coincided with an annual meeting of the Rectors (cf Dean in the UK) of all the Ukraine undergraduate and postgraduate medical faculties. This

created an opportunity to explore the teaching of health education and promotion within their parent organisations, in the belief that Ukraine's health figures may be due to poor medical education in these areas. The group consisted of 20 delegates representing the 15 undergraduate medical schools in Ukraine and ten delegates representing the seven postgraduate medical institutions. The postgraduate institutions consisted of two Institutes of Advanced Training for Physicians, one Medical Academy (Kiev Medical Academy for Postgraduate Medical Education) and four Faculties of Postgraduate Education and Training. These organisations represented medical training for all specialities, including family medicine. Most of the communication was conducted in English, with interpreter facilities if required. After an initial discussion that raised people's awareness and understanding of the concepts in question, each of the medical institutes presented their curricula.

It was clear that there was little evidence of any depth of understanding concerning the wider aspects of the determinants of health. Concerning the extent to which the issues of health promotion and related topics are covered within the educational organisations represented: of the 15 undergraduate schools, only one said that the topics discussed were present in their curriculum. In this Faculty, the topics were integrated into the teaching of individual subjects, were not stand-alone concepts and occupied a small amount of student teaching time. Of the seven postgraduate schools, three could give examples of teaching activities related to health education. However these were narrow, concerned specifically with diet and heart disease and related to physicians only, and did not involve any other professional groups.

When asked specifically whether health education featured in expected areas such as obstetrics, gynaecology and paediatrics, there was some acceptance amongst the postgraduate group that health issues were discussed, but were of low importance.

When the obstacles to including health education into the curriculum were discussed several interesting theories were put forward. Most curricula had been in place for many years, without change. There were no specific plans to change these curricula. Very few had a defined curriculum management group.

Curricula were very clinically driven and orientated. The need to pass examinations, which focussed on a specific core clinical method and had been derived at a central government level, often drove the curriculum content.

The style of teaching did not lend itself to explore topics such as health education and its effects. Teaching style was very much of a didactic lecture format, often to very large groups (50-300 students) and with very little opportunity for discussion.

None of the schools had a recognised individual responsible for health education. Public health specialists in Ukraine deal mainly with hygiene and sanitary issues. Lack of teaching resources, and teaching large groups and in poor surroundings were given as common reasons for not including health education in a curriculum. An inability to obtain up-to-date literature and educational material was expressed as an important inhibitory factor by most of the participants.

Discussion

The provision of primary care is the accepted norm in many developing countries and organisations are now prepared to financially support individuals and professional bodies in developing primary care in Eastern Europe, along European and United Kingdom guidelines.[6] The ability to explore the provision of healthcare in the Soviet and Former Soviet Union is relatively new but is becoming possible through the introduction of various support and development agencies. The development of a primary care-led family health system has occurred over a very short time in Ukraine. The opening of five Departments of Family Medicine, the establishment of two chairs in Family Medicine, the roll out of vocational and reaccredidation schemes, and the early establishment of training practices have all been achieved in a relatively short period of time. The declaration in late 1997 by the President of Ukraine that there would be an effective primary care system operational by the year 2000 further enhanced these developments. But what will the product of change be and how can it be influenced?

Observations are often flawed by a need to respect and observe others' values in terms of hierarchical status and cultural differences. This paper demonstrates this in its tentative approach to observing consultations, and understanding and exploring curricula through discussion with faculty officials. A more meaningful approach would be through the teachers themselves. However the ability to discuss and explore these issues with the 'shapers and formers' of Ukraine medical education has its advantages and is reflected through the eagerness of the Rectors to take ideas back to their own faculties. Despite these reservations, the results suggest that the lack of health education input into patient care, particularly when observed in family practice, may be a reflection of its absence in medical teaching institutions. Of particular importance is the free admission that health education information is learned at a continuing medical education (CME) level, although not clearly demonstrated through consultation observation. The heavy reliance upon a clinical approach and pharmacological management with distinct lack of desire to explore other health issues such as societal effects and individual responsibility must certainly contribute to Ukraine's poor morbidity and mortality figures. The concept of CME is not new to Ukraine; indeed a process of statutory reaccreditation for all doctors has existed for many years. However the content is very clinically orientated and lacks innovation (personal observation). It is important to note that the university participants in this study were the few to which literature from the other European States was available. Until very recently this group was also the few to which foreign travel was possible.

These luxuries are not open to those providing day-to-day care for patients. However it is also a possibility that although this group may appear to be the 'shapers and formers' they may not be a true reflection of the university, but more of the old Soviet hierarchical organisation with little true input.
Somatisation of symptoms is apparent in patients and doctors alike when consultations are observed, possibly reflecting a 'clinical cloak', hiding inadequacy and uncertainty. Ukraine citizens talk of 'zdoroviy sposib zhyttia', a healthy lifestyle, usually when discussing the more affluent Western Europe and not their own health. It is possible that the medical fraternity do not embark upon a discussion about health education either through their ignorance of the subject or through an inability to deal with the concept because of their poorly directed medical education. However upon these observations can be built a vocational training programme for family doctors which will attempt to concentrate on those major areas of deficit.

It is correct to question that if health promotion were better taught and understood by doctors and patients alike, would this alone be sufficient to improve Ukraine's health, when financial instability is probably the root cause of the country's demise?

Conclusion

The appalling life expectancies in Russia and the Former Soviet Union can be improved by preventing alcohol abuse, discouraging smoking and encouraging a healthy diet and lifestyle.
As the West continues to support the East in its socioeconomic reforms, developing healthcare is high on the agenda. Although the importance of finance must not be lessened, effective educational activities, based on sound educational method, evaluation and outcome measures, should be improved. ■

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