North–South exchange and professional development: experience from Mali and France

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Monique Van Dormael participated in the conception and design of the study. She carried out part of the field research, contributed to data analysis and interpretation and drafted the manuscript. Sylvie Dugas participated in the study design and revised the manuscript. Seydou Diarra participated in the study design, carried out part of the field research and contributed to the data analysis and the interpretation.

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Abstract

Background: In developing countries family practice is facing the challenge of developing a medical culture in a context in which clinical practice remains strongly associated with hospital practice. Professional exchange with GPs from the North may fuel novel professional identities in family practice in the South. Still, little is known about the effects of North-South professional exchange.

Objectives: Assess to what extent a North-South professional exchange programme involving rural GPs from Mali and France affected practice development and professional identity formation of Malian GPs.

Methods: Qualitative analysis of 18 exchanges between rural GPs from Mali and France based on (1) interviews; (2) retrospective report analysis; (3) field observation of three exchanges; (4) workshops with Malian and (5) French GPs.

Results: Malian GPs reported increased self-esteem, increased concern for doctor-patient communication, and innovations in practice organization. Although Malian participants considered a transfer of French general practice into Mali irrelevant, the experience was described as thought provoking. The interpersonal and professional interaction between counterparts was crucial. The Malian Rural Doctor's Association provided a platform to

capitalize on individual experiences in a process of collective professional identity construction. Costs of the programme were kept low, limiting possible side expectations of participants.

Conclusions: North–South professional exchange between family practitioners can contribute to professional development. Exchange programmes should be designed as mutual learning processes, rather than unilateral assistance or transfer of practice models. Family practitioners from the South are likely to improve primary care to individuals and families, while Northern GPs can draw lessons from the community perspective of PHC in the South. Recruitment and preparation of participants are crucial, as well as collective reflection upon return.

Keywords: family practice, primary health care, professional development, professional identity, developing countries

INTRODUCTION

In a growing number of developing countries, including Thailand [1], Vietnam, Egypt, Morocco and Tunisia, health care reforms rely on family practice to strengthen health care delivery. Family medicine networks are launched in East and South Africa [2]. A major challenge is the development of a family practice culture in a context in which medicine remains strongly associated with hospital practice. Shifts in medical education are needed, but also field developments for purposes of advocacy, experimentation and role model dissemination [3].

While GPs from "developed" countries can learn fundamental lessons from developing countries [4], the reverse may be true: exposure to family practice in the North could fuel novel professional identities in the South. North-South exchange programmes are rather common in the field of education [5] and health care [6]. Their aims include cultural understanding, exchange of experience and professional development through the acquisition of new skills, knowledge and inspiration. Still, little is known about their effects: do they actually contribute to health in the South or are they varieties of "medical tourism" [7]? This paper analyses the effects of an exchange programme between rural general practitioners from Mali and France.

Primary care in Mali is mostly delivered by nurses and/or auxiliaries. Rural GPs appeared in the 1990's as an indirect consequence of structural adjustment measures imposed by international agencies which left young doctors unemployed in spite of gigantic unmet needs in remote areas. Encouraged by the Faculty of Medicine, a few young graduates pioneered as rural general practitioners [8]. With steady support from Santé Sud, a French NGO, the movement intensified and the Malian *Rural Doctors Association* was created in 1993, counting some 80 members in 2005. Santé Sud provides assistance in the creation of new

rural practices, contributes to continuous training and to the running costs of the association. It also coordinates an exchange programme between Malian and French rural GPs.

The exchange programme is meant to "*support isolated rural doctors in Mali"* and to instigate rewarding professional roles by exposing them to the French "*médecine de campagne"*. An exchange typically starts with a two-week visit by a French rural GP to a Malian rural GP, followed by a two-week return visit of the Malian doctor to his French counterpart. The NGO's financial contribution is limited to transportation since the visiting GP is hosted by the visited GP. Both in France and in Mali participants share professional activities, as well as family and social life. The interpersonal relationship is considered by the NGO as a key for success. Between 1995 and 2003, 19 mutual visits took place.

Our research question was: did exchange contribute to practice development and to professional identity formation among Malian GPs, and if yes, what conditions eased this?

METHODS

Data collection was carried out by two experienced socio anthropologists. We considered each of the 19 exchanges as a case and successively used several sources of information, in an iterative process, to identify patterns of perception.

Two NGO promoters were interviewed about objectives, programme design and case diversity. The three 2003 exchanges, described by the promoters as typical of the variety of previous exchanges, were directly observed through a three-days field visit, both in Mali and

in France. Observation focused on process issues, including the social relation between participants. This was complemented by situational conversations and semi-structured interviews on expectations and perceived contrasts and similarities with the 6 GPs involved,

Emerging themes (reasons for satisfaction or dissatisfaction and comparisons of general practice in Mali and France) were then searched for in visit reports of previous exchanges and written by Malian and French participants shortly after their exchange experience. 17/19 Malian reports and 17/19 French reports were available and analysed. This released significant, though disparate information. Some reports were mainly descriptive, others more analytic.

Preliminary findings from field observation and report analysis were organised around the following themes: exchange process, perceived practice differences, and self reported effects of the exchange. These findings were presented and discussed during a validation workshop in Mali: 8/19 Malian GPs attended and provided valuable additional information from their own experience. Five GPs could not join for logistic reasons, four had started a specialisation abroad, and two were deceased. Final results were eventually discussed during a workshop in France with the promoters and with 8 French participants.

Information sources were coded by the number of the exchange (from 1 to 19), a letter to designate the participant (M: Mali or F: France), and the technique used (int for interview, rep for report, WS for workshop). Available sources of information are presented in Annex. 1

RESULTS

Effects on attitudes

Most exchanges were described as enhancing personal and professional recognition and self-esteem. One participant stated that his French counterpart's attitude strengthened his local reputation: *"People thought that the white doctor came to instruct me. But he told that diseases were different and that it was he who came to learn. Even white doctors come here to learn, they said! This was very rewarding."* (8M WS). In France, the favourable reception by French patients was a source of recognition. So were the encounters with local professional associations or schoolchildren and the interviews by local newspapers or radio. Overall, the exchange legitimized community-based medical practice and supported a professional self image of usefulness to the community.

Exposure to French practice induced comparisons and increased awareness about distinctiveness of their own practice, differentiating them from hospital practice: high reliance on clinical skills, continuity of care and importance of communication skills. These features were found common to general practice in Mali and France.

Differences between care in France and Mali, summarized in Table 1, were also highlighted: *«It is comfort medicine in France against survival medicine in Mali"* (3M rep).

Table 1: Summary of differences mentioned by Malian participants

	Mali	France
Resources	Lack of financial resources Lack of equipment	Opulence, Social Security; Waste of resources
Patient profile	Poor and low educated; patient delay and serious disease	Healthy and overly demanding
Content of primary care	Broader scope, including community-based activities, deliveries and small surgery:	Limited to routine consultations
Relations with patients		Good doctor_patient communication
Organisation		Medical records Referral mechanisms Time management

While the French opulence generated envy among some participants, others condemned the "*waste of resources*" and "*exaggerated the use of technical procedures, making French GPs lazy" (11M WS).* Social Security was described as making French patients overly demanding: *"In France, patients are healthy, in Mali patients delay a lot before seeing the doctor"* (19M int). Malian doctors considered themselves as dealing with more serious disease and having a broader scope of practice. Nevertheless, observation of clinical consultations in France acted as an eye opener, especially with respect to doctor-patient communication (Box 1) and practice organisation.

Box 1: Increased awareness of doctor-patient communication

"*His ability to listen to patients is extraordinary…"* (2M rep).

"What impressed me most was the relation between the patient, the doctor and the family » (13M rep);

«What I learned: the skills of my friend when communicating with patients, his availability and his promptness to answer calls. This will be of great use in my future practice. From now on, I will listen better to elderly people and to the handicapped" (10M rep)

Effects on individual reflection were amplified through discussions within the professional association. Upon return from France, Malian doctors shared their experience with other participants to the programme and discussed it with their peers.

Self reported practice changes

Contextual differences precluded transfer of practice models. : *«It is totally impossible to copy the French model; the socio economic context is too different »* (3M rep). Still, confrontation with the French general practice was described as thought provoking: *"French practice cannot be directly implemented here, but for those who have imagination, exchange brings a lot"* (13 M WS).

Several Malian participants reported increased concern for information supply, communication and privacy during a clinical encounter. Otherwise, no acquisitions were reported in terms of clinical expertise relevant to the Malian epidemiological and socio-economic context: treatment strategies for chronic patients were said to be interesting but economically not transferable.

Most changes described as an outcome of exchange were related to practice organization. Improved procedures and discipline related to hygiene, asepsis and waste management were frequently mentioned. Exchange triggered innovations, such as medical records, home visits, appointment consultations, etc. One participant, inspired by French Social Security, created the first rural "mutuality" in Mali, a model which has since spread throughout the country.

Personal reflective thinking was central for practice changes, amplified by discussions with the French counterpart and with Malian peers. The professional association functioned as an essential forum for debate and for dissemination of ideas and innovations.

Not all participants declared changes. One explicitly stated *"I did not see anything better than what I already did"* (5M WS). The same doctor expressed disappointment with his counterpart who *"was attracted mainly by tourism in Africa"* and with whom *"affective clashes"* occurred.

The challenge of reciprocity within an asymmetric relation

Strong expressions of satisfaction or disappointment were associated with Malian doctors' perception of the interaction with their counterpart. Relations based on reciprocity - one

learning from the other - induced feelings of self-confidence and readiness to conceive improvements. Though only one Malian doctor openly admitted communication problems with his counterpart, it was acknowledged during the workshop in Mali that such difficulties occurred occasionally. They were attributed to personality clashes and to a lack of preparation to Africa: *"some have pre-historical views on Africa"* (11M WS).

Tensions arose when French doctors criticized health care in Mali, and Malian participants denied their capacity to understand the Malian context (Box 2).

Box 2: Some critical assessments refuted by Malian GPs

About cleanness *"How can somebody visiting Africa for the first time really appreciate the level of cleanness?"* (1M rep).

About "lack of privacy": *"Confidentiality is not the same. In France, consulting is individual. Here, if someone is ill, he needs approval from the head of the family, and the family accompanies the patient.."* (8M WS)

About "authoritarian relations with staff": *"The education level of the staff is much lower than in France and requires hierarchic supervision and control"* (7M WS). *"Staff is recruited from the community and is under pressure to privilege relatives; the doctor's authority protects them."* (11M WS)

French GPs had heterogeneous backgrounds in terms of previous exposure to Africa, involvement in general practice associations and commitment to development. The meaning they gave to exchange varied from humanitarian assistance to paternalistic coaching and genuine partnership relations (box 3). French GPs had disparate opinions about practicing under scarce resources: some drew lessons from the Malian GPs' struggle for efficiency, other recommended equipment at odds with the Malian health system development.

Box 3: Heterogeneity of the French GPs' views on exchange:

« It was really an egalitarian exchange, I was not there as a trainer » (13F WS Marseille).

« Some of my experience might make him question his own practice and perhaps modify it …. » (1F rep)

« I still don't grasp the professional interest of this exchange. But, I put him into contact with a French NGO likely to grant him medical equipment… » (19F rep)

Reciprocal relations were facilitated by the French GPs' readiness to let exchange question their own practice: *«with his new and candid eye, he underlined our contradictions: the irrational use of money for useless investigations; doctors drinking and then caring for alcoholic patients; the futility of a life expectancy of 85 when the old spend the rest of their life in a home for elderly…"* (17F rep)

The socio-economic asymmetry of the relation affected reciprocity. Some Malian GPs expressed expectations of material support, describing exchange as a way to respond to *"an almost total material deficit »* (2M rep). Material support within the exchange was not part of the objectives of the NGO and was left to the participants' appraisal. In practice, material support occurred during or after most exchanges, varying from small practice equipment, medical literature or computers to more substantial improvements of the health centre. One exchange even led to a twinning between a French and a Malian municipality. But the meaning of material support fluctuated from a symbol of human and professional solidarity to a process of mere assistance.

DISCUSSION

This study is, to our knowledge, the first one addressing the potential of a North-South professional exchange programme. Malian participants involved in this study reported positive effects on self-esteem, attitudinal changes and improved practice organization. Their confrontation with the French rural general practice stimulated reflection about their professional role in the context of rural Mali.

A limitation of our study was the logistic difficulty to collect systematic data about all cases included in our study, leading us to rely on disparate sources of information. Nevertheless, the iterative process of analysis and the Malian validation workshop strengthened the analytic validity. Besides, Malian participants may have overemphasized their satisfaction to influence the continuation of the programme to the benefit of fellow doctors, even though the researchers' independence from the NGO was underlined. This called for a careful interpretation of the expressed satisfaction, but increased the validity of critical comments.

The complexity of processes underlying such an exchange limits the possibility of generalizing predictable outcomes [9,10]. Our results are affected by contextual characteristics, including attributes of Malian and French health care systems, and the overall design of the programme. In our study, exchange complemented a broader programme focusing on professional development through a professional association. Exchange programmes organised as isolated measures may prove ineffective.

Nevertheless, our study confirms that the mirror effect produced by a North-South exchange can stimulate professional identity formation in general / family practice. Identity formation implies to explore available alternatives and to commit to some choices and goals[11]. In countries lacking a tradition in general practice, international exchange widens the scope of alternatives and helps in the process of "inventing" practice models adapted to the social, cultural and economic context. As practice settings providing role models develop in the South, North-South professional exchange may gradually be replaced by South-South exchange and by peer visits within the same country.

Professional exchange may be considered as a professional development method. The underlying mechanism - exposure to contrasting situations in order to stimulate reflection – is shared with mutual practice visits[12,13] or mutual peer mentoring[14,15]. Another common characteristic of these processes is that the interpersonal relationship is a key issue for success[16]. North-South exchange, however, differs from usual peer mentoring in at least two distinctive features.

First, unlike in peer mentoring within similar environments, the magnitude of contextual differences increases risks of ethnocentric misinterpretations. Furthermore, the asymmetry between rich and poor contexts may induce paternalism and may hamper partnership[17]. The way this relational asymmetry is handled is crucial for professional self-esteem and development.

A second major difference relates to dominant concepts of primary care. Both North and South can learn from each other to develop community-oriented primary care, integrating community and individual approaches in a single practice. The strength of family practice in "developed" countries is the quality of primary medical care for individuals and family, but concern for population health is usually limited[4]. Instead, in developing countries, primary health care concentrates on disease control activities meant to improve population health, but offers unsatisfactory curative responses to individual suffering[18]. Family practice in the North may inspire doctors from the South to develop patient- centred consultation skills characteristic of family practice[19]. Still, this should not occur at the expense of the existing community orientation of primary health care, indispensable for equitable access to care, efficient use of resources, effective disease control at population level, and community involvement,. High quality clinical care to individuals should be integrated within community-oriented services, rather than develop separately.

A consequence is that North-South exchange programmes should be genuinely reciprocal, not only to favour respectful interpersonal relations, but more fundamentally because a family practice model restricted to primary medical care, as is predominantly the case in developed countries, is not adequate for the South. While practitioners from the South can find inspiration in clinical encounters, practitioners from the North can learn from public health

dimensions. This has implications for the design of exchange programmes aimed at stimulating the development of professional roles (Box 4).

Box 4: Tentative recommendations for the design of exchange programmes

- linkage with other strategies contributing to collective professional identity building (professional association, continuous training, quality improvement mechanisms…)
- overall emphasis on mutual learning, rather than assistance
- selection of GPs in the North : dedicated professionals likely to provide exposure to inspiring practice and interested in learning from the South; previous experience with developing countries may reduce prejudice
- selection of GPs from the South : dedicated professionals likely to remain general practitioners in the long run, with potential of professional leadership in their country
- preparation of participants, introducing social, cultural and economic aspects and health care system of the visited country
- limited budget for exchange, preventing participants' individual side expectations (tourism, per diems…); relying on participants' involvement in hosting visitors is one possible strategy

More research may be useful to refine criteria for selection of participants, as well as content of preparation of participants to an exchange.

CONCLUSION

North-South professional exchange between GPs constitutes a method of personal and professional development. Under favourable conditions, the mirror effect of international exchange stimulates reflection and inspires practice innovations. Contextual differences between “developed” and developing countries, however, exclude transfer of practice models. Objectives of North-South exchange should be formulated in terms of mutual inspiration: while practitioners from the South can get useful insights to improve individual clinical care, practitioners from the North can learn about their public health responsibilities. Reciprocity of exchange is crucial for the success of the experience, as well as the selection and preparation of participants. Professional exchange should, however, not be developed as an isolated programme, but rather as part of a broader package of strategies aiming at developing country adapted professional culture and professional roles.

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Annex 1: Available sources of information

Exchange N°	Observation and interviews		Report analysis		Workshop Mali / France	
1 (1995)			1 M rep	1 F rep		2F WS
2 (1995)			2 M rep	2 F rep		
3 (1995)			3 M rep	3 F rep	3M WS	
4 (1996)			4 M rep	4 F rep		
5 (1996)			5 M rep	5 F rep	5M WS	
6 (1996)			6 M rep	6 F rep		6F WS
7 (1998)			7 M rep	7 F rep	7M WS	7F WS
8 (1998)			8 M rep	8 F rep		

9 (1998)			9 M rep			9F WS
10 (1998)			10 M rep	10 F rep	10M WS	
11 (2000)			11 M rep	11 F rep	11M WS	
12 (2000)			12 M rep			
13 (2001)			13 M rep	13 F rep	13M WS	13F WS
14 (2001)			14 M rep	14 F rep	14M WS	14F WS
15 (2002)				15 F rep		
16 (2002)				16 F rep		
17 (2003)	17 M int	17 F int	17 M rep	17 F rep	17M WS	17F WS
18 (2003)	18 M int	18 F int	18 M rep	18 F rep		18F WS
19 (2003)	19 M int	19 F int	19 M rep	19 F rep		