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BRIEF REPORT

Building a Home for Family Medicine: Reflections on the Development of a Consultant Clinic at Mangochi District Hospital in Rural Malawi

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ABSTRACT

This article reflects on the establishment of a family medicine consultant clinic at Mangochi District Hospital in rural Malawi, highlighting its significance in enhancing primary health care access and education. Founded under the Department of Family Medicine at Kamuzu University of Health Sciences, which was established in 2008, the clinic aims to address the high disease burden faced by the district's 1.3 million residents, where specialist care is often inaccessible. Since its inception in early 2020, the clinic has provided critical care for patients with complex medical needs, emphasizing a holistic, patient-centered approach to their care. The clinic facilitates continuity of care and coordinates referrals to higher-level facilities, while also functioning as a training platform for medical students and residents. Challenges such as patient overflow, inappropriate referrals, and resource limitations are discussed, alongside strategies for ongoing evaluation and improvement. Early anecdotal evidence indicates a positive impact on patient satisfaction and care quality. The article underscores the importance of integrating family medicine specialists into rural health care settings to strengthen clinical education and improve patient outcomes. This initiative exemplifies a successful model for expanding family medicine influence in other rural districts and will potentially contribute to improved health systems throughout Malawi.

BACKGROUND

The Department of Family Medicine at Kamuzu University of Health Sciences was founded in 2008 with the vision to improve primary health care[1–3] for the more than 85% of Malawians who live in rural areas.[4] Located in Southern Malawi, Mangochi District Hospital has a catchment area of approximately 1.3 million people and serves as one of the primary training sites for both undergraduate and postgraduate trainees in family medicine. The disease burden in the district is high, and the nearest urban central hospital, where specialist care and most medical education have historically been provided, is hours away, resulting in significant barriers to accessing high-quality care for many patients.

Malawian family physicians are trained in the provision of primary health care services with a holistic and patient-centered approach, as well as in the domains of teaching, advocacy, research, both health systems and clinical leadership. Family medicine specialists and trainees are the first physicians to take on primarily clinical roles in the district hospital system in Malawi, which have previously relied on other members of the health care workforce—mainly clinical officers, nurses, and medical assistants—to provide services. Historically, roles for physicians at the rural district level have been largely administrative and allowed for limited direct patient care.

The Family Medicine Department began training postgraduates in the district hospital setting in 2015 and has since graduated eight fully qualified family medicine specialists, all of whom are now working for the academic department or the Ministry of Health (MOH). The vision of the MOH is to eventually see family physicians serving in each of the 28 rural district hospitals as leaders, clinical educators, patient care advocates, and catalysts for improved education and patient care. In the meantime, efforts are underway at the department's training sites to develop the infrastructure through which family physicians can best meet the educational and patient care needs of the district hospital.

Since its founding, the department has envisioned the establishment of a family medicine consultant clinic at Mangochi District Hospital to provide expertise for a wide variety of medically complex patients that seek care at the district level, to provide a platform to teach a variety of learners, and to model patient-centered continuity care including coordination with the wider health care system.

BUILDING THE FAMILY MEDICINE CLINIC

With assistance from nongovernmental organization partners and staffed by departmental trainees and faculty, the family medicine consultant clinic opened to patients in early 2020, where it has been running twice weekly ever since. Prior to opening, an informational session outlining the scope of the clinic was held with colleagues from MOH, who provide the bulk of the clinical care at the district hospital. Appropriate referrals were envisioned as patients with two or more chronic conditions, complicated cases that required clinical support beyond what is normally handled in the district hospital, or those needing close follow-up after hospitalization. The clinic started slowly but has seen a steady increase in its numbers and currently serves about 15 to 25 patients per session.

Conditions commonly seen in the family medicine clinic include, but are not limited to, uncontrolled hypertension, diabetes, chronic obstructive pulmonary disease, erectile dysfunction, psychiatric conditions, heart failure, renal failure, rheumatic heart disease, congenital heart diseases, and sickle cell anemia. The clinic serves as a teaching platform for a patient-centered approach to chronic disease management, and continuity of care is modeled for both undergraduate and postgraduate students alike. The skill transfer extends to diagnostic investigations including point-of-care ultrasound and electrocardiogram, which are otherwise not available in an outpatient setting in district hospitals in Malawi. These investigations often help to change the diagnosis or treatment in real time, without patients having to wait hours or days for results or requiring them to navigate multiple clinical departments to find a way forward.

The family medicine clinic also serves as a platform for coordinating care between the rural district hospitals and urban central hospitals. Common reasons for referral to central hospitals include the necessity of higher-level diagnostics for confirmation of disease (eg, biopsies requiring pathology) or the need for specialty treatments (eg, chemotherapy) that are not available at the district level. Equally important is the coordination of return to the community level of care. Follow-up of subspecialist consultations often fall beyond the scope of day-to-day clinical practice at the district level and require physician input and oversight that the family medicine clinic can provide.

LESSONS LEARNED

While extensive evaluation of the impact and experience of the clinic is just beginning, anecdotal evidence has been promising. For example, one patient shared, "I notice the difference [compared with] other clinics within the hospital, that in this clinic you assess patients holistically and you take your time for patients to ask questions."

Although rollout and growth have generally been fruitful and clinic function is sustainably integrated within the other teaching and clinical care activities of the department, the clinic has had challenges. Patient volume has grown considerably, and while capping the clinic's patient panel is not realistic given the role the clinic plays in the system—seeing the most complex patients in the district—the clinic staffing (and limitation of two clinics weekly) is currently limited by faculty and trainee numbers. The novelty of having a specialist-level integrated clinic within reach has led to many inappropriate referrals (bypassing the normal MOH systems), straining clinic capacity. Overlap with MOH-run noncommunicable disease clinics (large-volume clinics focused on single conditions such as diabetes or hypertension) is another point of continued negotiation. Additionally, sharing a common space with other MOH clinics sometimes requires movement of patients and clinical activities on short notice, leading to many logistical challenges. Finally, despite offering diagnostics such as echocardiograms that are not otherwise available to patients, resource limitations persist; and the clinic relies on the general hospital infrastructure for other point-of-care tests and medications, which are frequently out of stock.

NEXT STEPS

In 2024 the Department of Family Medicine hired a clerk (with prior clinical experience in the local setting) to collect data, take vital signs, and occasionally serve as interpreter. That collected data is intended to provide objective feedback on clinical management of patients to facilitate systematizing continuity of care and patient follow-up. In addition to the collection of clinical metrics, systems to capture patient feedback are being developed that have potential to improve clinical governance. All these initiatives will take place in a dedicated, permanent space for the clinic, which is currently under construction, set to open in 2025.

CONCLUSIONS

Thus far, the presence of the family medicine clinic at Mangochi District Hospital appears to be having a positive impact on patient care and clinical skills of trainees, and enjoys good repute within the hospital system. The goal is to continue improving the clinic in terms of clinical care, teaching excellence, reliable infrastructure, and processes that support continuous self-evaluation and quality improvement. The story of this clinic—from consensus-building and relationship management with local partners to the process of transforming vision into the day-to-day management of human and material resources—will be vital in advocating for expansion of the model to other districts in Malawi as postgraduate trainees fan out across the rural landscape in the coming years.

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