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FAM 505

PRIVATE PRACTICE ORGANISATION/ETHICS OF MEDICAL PRACTICE

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Course code: FAM 505

Course title: Private Practice Organisation/Ethics of Medical Practice

Course credit load: 1 Unit

Series 1: Medical Services, Voluntary Agencies, and Private Organisations

- **Part 1.1: The Structure of Medical Services**
    - Sub Part 1.1.1: Overview of medical services structure
    - Sub Part 1.1.2: Government medical services
    - Sub Part 1.1.3: Non-governmental components of medical services
- **Part 1.2: Voluntary Agencies**
    - Sub Part 1.2.1: Concept and role of voluntary agencies in health
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    - Sub Part 1.2.3: Contribution of voluntary agencies to health service delivery
- **Part 1.3: Private Organisations and Their Inter-Related Nature**
    - Sub Part 1.3.1: Private organisations in health service delivery
    - Sub Part 1.3.2: Inter-relationship between government, voluntary, and private services
    - Sub Part 1.3.3: Challenges and opportunities in inter-agency collaboration

Introduction

No private family practice operates in complete isolation, but rather exists as one component within a much wider **structure** of medical services, alongside government facilities, voluntary agencies, and other private organisations, each playing a distinct, often interconnected, role. Picture a private family physician referring a patient to a government teaching hospital for specialist investigation, while simultaneously partnering with a local voluntary agency running a community outreach programme, illustrating the genuinely interrelated nature of the wider medical services landscape within which private practice operates. Understanding this broader structure is the essential foundation for everything that follows in this course.

The aim of this Series is to equip you with a clear understanding of the structure of medical services, voluntary agencies, and private organisations, and their inter-related nature.

This Series begins with the **structure of medical services**, before turning to **voluntary agencies**. It concludes with **private organisations and their inter-related nature**.

Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 1.1:** describe the overall structure of medical services, including government components
- **SLO 1.2:** describe the non-governmental components of medical services
- **SLO 1.3:** describe the concept and role of voluntary agencies in health
- **SLO 1.4:** give examples of voluntary agencies in Nigeria and their contribution to health service delivery
- **SLO 1.5:** describe private organisations in health service delivery, and
- **SLO 1.6:** describe the inter-relationship between government, voluntary, and private services.

1.1 The Structure of Medical Services

1.1.1 overview of medical services structure

A layered landscape of providers serving a shared population

Medical services within Nigeria are delivered through a layered structure comprising **government** facilities, discussed in relation to the Nigerian health system in an earlier related course, **voluntary agencies**, discussed further later in this Series, and **private organisations**, discussed in the final Part of this Series, each contributing distinct capacity to overall health service provision.

Understanding this overall structure is particularly important for the private family physician, discussed in an earlier related course, since effective private practice generally requires an accurate appreciation of where the practice sits within, and how it relates to, this considerably broader medical services **landscape**.

Fill in the blank: Medical services within Nigeria are delivered through a layered structure comprising government facilities, voluntary agencies, and private _____.

1.1.2 government medical services

Government medical services are organised across the three tiers of government discussed in an earlier related course, federal, state, and local government, providing the largest single component of formal health service delivery within Nigeria, and generally bearing principal responsibility for public health functions, discussed in an earlier related course, benefiting the wider **population**.

Government medical services additionally include specialised **regulatory** and standard-setting bodies, discussed in relation to the Medical and Dental Council of Nigeria in an earlier related course, responsible for maintaining professional standards across the entire medical services structure, including its voluntary and private components discussed later in this Series.

Fill in the blank: Government medical services additionally include specialised regulatory and standard-setting bodies responsible for maintaining professional _____ across the entire medical services structure.

1.1.3 non-governmental components of medical services

Beyond government provision, Nigeria's medical services structure includes a substantial **non-governmental** component, encompassing both voluntary agencies, discussed further later in this Series, and private organisations, discussed in the final Part of this Series, collectively delivering a considerable proportion of overall health services, particularly within urban areas.

This non-governmental component frequently fills important **gaps** in government provision, discussed in relation to public and private sector roles in an earlier related course, whether through specialised services, geographic coverage in underserved areas, or simply additional overall service **capacity** supplementing an otherwise stretched government system.

Fill in the blank: The non-governmental component of medical services frequently fills important gaps in government provision, providing additional overall service _____.

Figure 1.1: A wide view of a hospital complex alongside a smaller private clinic within the same neighbourhood.

Pilot questions 1.1

1. Describe the overall layered structure of medical services in Nigeria. (Linked to SLO 1.1)
2. Explain why understanding this structure is particularly important for private family physicians. (Linked to SLO 1.1)
3. Describe the organisation of government medical services across the three tiers of government. (Linked to SLO 1.1)
4. Describe the role of regulatory and standard-setting bodies within government medical services. (Linked to SLO 1.1)
5. Describe the non-governmental component of medical services and the gaps it typically fills. (Linked to SLO 1.2)

1.2 Voluntary Agencies

1.2.1 concept and role of voluntary agencies in health

Non-profit organisations supporting health service delivery

Voluntary agencies are non-profit organisations, generally operating independently of direct government control, that contribute to health service delivery, health education, or related **support** activities, often relying substantially on charitable donations, external grants, or volunteer **contribution**.

Voluntary agencies frequently focus on specific health issues or particularly underserved **populations**, discussed in relation to poverty and health in an earlier related course, allowing them to develop particular expertise and sustained commitment to areas that might otherwise receive relatively limited attention within broader government health system **priorities**.

Fill in the blank: Voluntary agencies often rely substantially on charitable donations, external grants, or volunteer _____.

1.2.2 examples of voluntary agencies in nigeria

Voluntary agencies active within Nigeria's health sector include the **Nigerian Red Cross Society**, discussed in relation to the Red Cross and Red Crescent Movement in an earlier related course, providing humanitarian and emergency health support, and various faith-based organisations operating hospitals, clinics, and community health **programmes**.

Further examples include international and local non-governmental organisations supporting specific disease control programmes, discussed in relation to disease control in an earlier related course, and professional or philanthropic **associations** providing targeted health support, such as free surgical outreach camps or medical equipment donation programmes.

Fill in the blank: Voluntary agencies active in Nigeria include the Nigerian Red Cross Society, providing humanitarian and emergency health _____.

1.2.3 contribution of voluntary agencies to health service delivery

Voluntary agencies make substantial practical contributions to overall health service delivery, including direct service **provision** in underserved areas, discussed earlier in this Series, and supplementary funding and resources supporting government health programmes, discussed in relation to healthcare financing in an earlier related course.

Voluntary agencies additionally frequently contribute specific technical **expertise** and innovative approaches, discussed in relation to disease control programmes in an earlier related course, that can subsequently inform and strengthen broader government health system practice, illustrating a genuinely collaborative, mutually reinforcing relationship rather than entirely separate, parallel **activity**.

Fill in the blank: Voluntary agencies frequently contribute specific technical expertise and innovative approaches that can inform and strengthen broader government health system _____.

Table 1.2: Comparing government, voluntary, and private components of medical services.

Component	Main funding source	Typical focus
Government	Public taxation and budget allocation	Broad population coverage and public health
Voluntary	Donations, grants, and volunteer support	Specific health issues or underserved populations
Private	Direct patient payment or insurance	Personalised, fee-based service provision

Pilot questions 1.2

1. Define a voluntary agency. (Linked to SLO 1.3)
2. Explain why voluntary agencies often focus on specific health issues or underserved populations. (Linked to SLO 1.3)
3. Give two examples of voluntary agencies active in Nigeria's health sector. (Linked to SLO 1.4)
4. Describe two ways voluntary agencies contribute to health service delivery. (Linked to SLO 1.4)
5. Explain how voluntary agency innovation can strengthen broader government health system practice. (Linked to SLO 1.4)

1.3 Private Organisations and Their Inter-Related Nature

1.3.1 private organisations in health service delivery

Fee-based provision complementing government and voluntary services

Private organisations in health service delivery include private hospitals, clinics, and individual private practices, discussed in an earlier related course, generally funded through direct patient

payment or private health **insurance**, discussed in relation to healthcare financing in an earlier related course, rather than public budget allocation or charitable funding.

Private organisations range considerably in scale, from large private hospital groups to small individual family practices, discussed throughout this course, each contributing to overall health service **capacity**, particularly in urban areas where private organisations frequently represent a substantial proportion of total available health service provision.

Fill in the blank: Private organisations in health service delivery are generally funded through direct patient payment or private health _____.

1.3.2 inter-relationship between government, voluntary, and private services

Government, voluntary, and private medical services do not operate in complete **isolation**, discussed earlier in this Series, but rather interact continuously through mechanisms including patient referral between different providers, discussed in relation to the two-way referral system in an earlier related course, and, at times, formal partnership arrangements supporting shared health **programmes**.

This inter-relationship additionally extends to shared professional **regulation**, discussed in relation to the Medical and Dental Council of Nigeria in an earlier related course, since practitioners across all three components remain subject to the same overarching professional standards regardless of their specific employment or practice **setting**.

Fill in the blank: Government, voluntary, and private medical services interact continuously through mechanisms including patient referral and, at times, formal partnership _____.

1.3.3 challenges and opportunities in inter-agency collaboration

Inter-agency collaboration between government, voluntary, and private medical services faces practical **challenges**, including differing organisational priorities and funding **structures**, discussed earlier in this Series, and, at times, limited formal communication mechanisms connecting practitioners across different components of the overall medical services structure.

Despite these challenges, meaningful **opportunities** exist for strengthened collaboration, including more consistent, coordinated referral pathways, discussed in an earlier related course, and shared participation in health planning and disease surveillance activities, discussed in earlier related courses, ultimately benefiting the shared population all three components collectively **serve**.

Fill in the blank: Meaningful opportunities exist for strengthened collaboration, ultimately benefiting the shared population all three components of medical services collectively _____.

Figure 1.3: Representatives from a government hospital, a voluntary agency, and a private clinic meeting to discuss collaboration.

Pilot questions 1.3

1. Define private organisations in health service delivery and describe their typical funding source. (Linked to SLO 1.5)
2. Describe the scale range of private organisations in Nigeria's health sector. (Linked to SLO 1.5)
3. Explain how government, voluntary, and private medical services interact rather than operating in isolation. (Linked to SLO 1.6)
4. Describe two challenges facing inter-agency collaboration. (Linked to SLO 1.6)
5. Describe two opportunities for strengthened collaboration between the three components of medical services. (Linked to SLO 1.6)

Series Summary

This opening Series introduced **medical services, voluntary agencies, and private organisations**, beginning with the **structure of medical services**, its overall layered composition, government medical services organised across the three tiers of government, and the substantial non-governmental component supplementing government provision, before examining **voluntary agencies**, their concept and role, examples active within Nigeria, and their meaningful contribution to overall health service delivery.

We concluded with **private organisations and their inter-related nature**, private organisations' role and funding, and the genuine, continuous interaction between government, voluntary, and private medical services, together with the challenges and opportunities facing inter-agency collaboration. Having worked through this Series, you should now possess the conceptual foundation needed to understand medical administration in hospitals and private practice management examined in the next Series of this course.

Glossary of Terms

- **Medical services structure:** the overall layered composition of government, voluntary, and private health service provision.
- **Government medical services:** health services organised and funded across the federal, state, and local government tiers.
- **Voluntary agency:** a non-profit organisation contributing to health service delivery, often reliant on donations or volunteers.
- **Non-governmental component:** the voluntary and private organisations supplementing government health service provision.
- **Nigerian Red Cross Society:** a voluntary agency providing humanitarian and emergency health support in Nigeria.
- **Faith-based organisation:** a religious organisation operating hospitals, clinics, or community health programmes.
- **Private organisation:** a fee-based health service provider funded through patient payment or private insurance.
- **Inter-agency collaboration:** coordinated interaction between government, voluntary, and private health service providers.
- **Patient referral:** the process of directing a patient from one health provider to another for further care.
- **Professional regulation:** the oversight and standard-setting applying to all practitioners regardless of practice setting.

- **Partnership arrangement:** a formal agreement supporting shared health programmes between different organisations.
- **Health service capacity:** the overall ability of a health system to deliver services to its population.

Concept Check Questions [Series 1]

Objective questions

1. Medical services in Nigeria are delivered through a layered structure comprising government, voluntary, and private _____.
2. Government medical services include regulatory bodies responsible for maintaining professional _____.
3. Voluntary agencies often rely substantially on charitable donations, grants, or volunteer _____.
4. Private organisations are generally funded through direct patient payment or private health _____.
5. Government, voluntary, and private medical services interact through mechanisms including patient referral and formal partnership _____.

Short-answer questions

6. Describe the overall layered structure of medical services in Nigeria.
7. Explain why voluntary agencies often focus on specific health issues or underserved populations.
8. Give two examples of voluntary agencies active in Nigeria's health sector.
9. Describe the scale range of private organisations in Nigeria's health sector.
10. Describe two challenges facing inter-agency collaboration.

Long-answer questions

11. Discuss the structure of medical services, including government and non-governmental components. (Linked to SLO 1.1, SLO 1.2)
12. Discuss the concept and role of voluntary agencies in health. (Linked to SLO 1.3)
13. Discuss examples of voluntary agencies in Nigeria and their contribution to health service delivery. (Linked to SLO 1.4)
14. Discuss private organisations in health service delivery. (Linked to SLO 1.5)
15. Discuss the inter-relationship, challenges, and opportunities between government, voluntary, and private services. (Linked to SLO 1.6)

Answers to Concept Check Questions [Series 1]

Objective questions

1. Organisations.
2. Standards.
3. Support.
4. Insurance.
5. Arrangements.

Short-answer questions

6. Government facilities, voluntary agencies, and private organisations, each contributing distinct capacity to overall provision.
7. Because it allows them to develop particular expertise and sustained commitment to areas that might otherwise receive limited attention.
8. The Nigerian Red Cross Society, and faith-based organisations operating hospitals and clinics.
9. From large private hospital groups to small individual family practices.
10. Differing organisational priorities and funding structures, and limited formal communication mechanisms.

Long-answer questions

11. **Basic response:** Medical services are delivered through a layered structure of government, voluntary, and private components, with government services organised across federal, state, and local government tiers.

Value-added response: The non-governmental component, comprising voluntary agencies and private organisations, frequently fills important gaps in government provision, particularly through geographic coverage and additional service capacity.

12. **Basic response:** Voluntary agencies are non-profit organisations contributing to health service delivery, health education, or support activities, relying substantially on donations, grants, or volunteers.

Value-added response: They frequently focus on specific health issues or underserved populations, allowing sustained commitment and expertise in areas that might otherwise receive limited government attention.

13. **Basic response:** Voluntary agencies active in Nigeria include the Nigerian Red Cross Society, providing humanitarian and emergency support, and faith-based organisations operating hospitals and clinics.

Value-added response: They contribute through direct service provision, supplementary funding, and technical expertise and innovation that can inform and strengthen broader government health system practice.

14. **Basic response:** Private organisations, ranging from large private hospitals to small individual family practices, are generally funded through direct patient payment or private insurance rather than public budgets.

Value-added response: They contribute substantially to overall health service capacity, particularly in urban areas where they often represent a significant proportion of total provision.

15. **Basic response:** Government, voluntary, and private medical services interact continuously through patient referral, formal partnership arrangements, and shared professional regulation.

Value-added response: Despite challenges such as differing organisational priorities and limited communication, opportunities exist for stronger collaboration through coordinated referral pathways and shared health planning activities.

Answers to Pilot Questions [Series 1]

Part 1.1

1. A structure comprising government facilities, voluntary agencies, and private organisations, each contributing distinct capacity.
2. Because effective private practice requires an accurate appreciation of where the practice sits within, and relates to, this broader landscape.
3. Organised across federal, state, and local government tiers, providing the largest single component of formal health service delivery.
4. They maintain professional standards across the entire medical services structure, including its voluntary and private components.
5. Voluntary agencies and private organisations; they typically fill gaps such as specialised services and geographic coverage in underserved areas.

Part 1.2

1. A non-profit organisation contributing to health service delivery, health education, or support activities.
2. Because focusing allows development of particular expertise and sustained commitment to areas that might otherwise be under-prioritised.
3. The Nigerian Red Cross Society, and faith-based organisations operating hospitals and clinics.
4. Direct service provision in underserved areas, and supplementary funding and resources supporting government programmes.
5. Voluntary agency approaches can subsequently inform and strengthen broader government health system practice.

Part 1.3

1. Fee-based health service providers, generally funded through direct patient payment or private health insurance.
2. From large private hospital groups to small individual family practices.
3. Through patient referral, formal partnership arrangements, and shared professional regulation applying across all three components.
4. Differing organisational priorities and funding structures, and limited formal communication mechanisms.
5. More consistent, coordinated referral pathways, and shared participation in health planning and surveillance activities.

References and Attributions [Series 1]

- Park, K. (2021). Park's Textbook of Preventive and Social Medicine (26th ed.). Banarsidas Bhanot.
- World Health Organization (2000). The World Health Report 2000: Health Systems, Improving Performance.
- Federal Ministry of Health, Nigeria (2004). Revised National Health Policy.
- Nigerian Red Cross Society. Overview of humanitarian health services in Nigeria.

Figures, Plates, Tables, and Boxes

- Figure 1.1: A wide view of a hospital complex alongside a smaller private clinic within the same neighbourhood. AI-generated using the prompt: "A single clean, realistic illustration of a large hospital building and a smaller nearby clinic building within the same street scene, calm daytime setting, natural lighting, no text overlays, no multiple panels, accurate and professional depiction, no graphic detail."
- Table 1.2: Comparing government, voluntary, and private components of medical services. AI-generated using the prompt: "Create a clean reference table titled Comparing Government, Voluntary, and Private Medical Services, listing component, main funding source, and typical focus. Simple clinical reference table style with outside border."
- Figure 1.3: Representatives from a government hospital, a voluntary agency, and a private clinic meeting to discuss collaboration. AI-generated using the prompt: "A single clean, realistic illustration of three representatives from different organisations seated together around a meeting table, calm professional setting, soft indoor lighting, no text overlays, no multiple panels, accurate and professional depiction, no graphic detail."

Series 2: Hospital Administration and Private Practice Management

- **Part 2.1: Medical Administration in Hospitals**
    - Sub Part 2.1.1: Concept and functions of hospital administration
    - Sub Part 2.1.2: Organisational structure of a hospital
    - Sub Part 2.1.3: Administration of other health services
- **Part 2.2: Concept and Scope of Private Practice Management**
    - Sub Part 2.2.1: Defining private practice management
    - Sub Part 2.2.2: Establishing a private practice
    - Sub Part 2.2.3: Day-to-day management of a private practice
- **Part 2.3: Comparing Hospital Administration and Private Practice Management**
    - Sub Part 2.3.1: Similarities between hospital and private practice administration
    - Sub Part 2.3.2: Differences between hospital and private practice administration
    - Sub Part 2.3.3: Lessons private practice can draw from hospital administration

Introduction

In the last Series, we explored medical services, voluntary agencies, and private organisations. We now turn to **medical administration in hospitals**, the large-scale organisational structures underpinning hospital-based care, and **private practice management**, the corresponding, though considerably smaller scale, administrative discipline required to run a successful private family practice. Picture a large teaching hospital's dedicated administrative department managing hundreds of staff and multiple departments, alongside a solo private family physician personally handling every administrative decision for their own small practice, illustrating the same underlying administrative principles applied at very different scales. Understanding both is the focus of this Series.

The aim of this Series is to equip you with a clear understanding of medical administration in hospitals and other health services, and private practice management.

This Series begins with **medical administration in hospitals**, before turning to the **concept and scope of private practice management**. It concludes by **comparing hospital administration and private practice management**.

Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 2.1:** describe the concept, functions, and organisational structure of hospital administration
- **SLO 2.2:** describe the administration of other health services
- **SLO 2.3:** define private practice management and describe how a private practice is established
- **SLO 2.4:** describe the day-to-day management of a private practice
- **SLO 2.5:** compare the similarities and differences between hospital and private practice administration, and
- **SLO 2.6:** describe lessons private practice can draw from hospital administration.

2.1 Medical Administration in Hospitals

2.1.1 concept and functions of hospital administration

Coordinating a large, complex clinical organisation

Hospital administration refers to the management functions, discussed in relation to general management concepts in an earlier related course, required to coordinate a hospital's substantial **resources**, staff, and clinical activity toward the shared goal of delivering safe, effective patient care.

Core functions of hospital administration include overall strategic **planning**, discussed in relation to health planning in an earlier related course, financial and resource management, discussed further in a later Series of this course, and human resource management across the hospital's typically diverse, multidisciplinary **workforce**, discussed in relation to the health team in an earlier related course.

Fill in the blank: Hospital administration refers to the management functions required to coordinate a hospital's substantial resources, staff, and clinical _____.

2.1.2 organisational structure of a hospital

A hospital's organisational **structure** generally includes a senior administrative leadership team, clinical department heads responsible for specific specialities, and, importantly, dedicated support departments such as medical records, discussed further in a later Series of this course, and **pharmacy**, each contributing to overall hospital functioning.

This structure additionally generally includes formal **governance** arrangements, discussed in relation to hospital management boards in an earlier related course, providing oversight of hospital performance and major decisions, reflecting the genuinely substantial organisational complexity characteristic of hospital-based care compared with smaller health service settings.

Fill in the blank: A hospital's organisational structure generally includes formal governance arrangements providing oversight of hospital performance and major _____.

2.1.3 administration of other health services

Beyond hospitals themselves, medical administration additionally applies to other health services, including primary health centres, discussed in relation to the Nigerian health system in an earlier related course, and specialised services such as public health laboratories, discussed in an earlier related course, each requiring administrative arrangements appropriately scaled to their specific **size** and function.

Effective administration of these other health services generally requires the same underlying principles applied to hospital administration, discussed earlier in this Series, adapted to the considerably smaller **scale** and, often, more limited resources characteristic of these settings, meaning administrative principles remain broadly consistent even as their practical scale varies considerably.

Fill in the blank: Effective administration of other health services generally requires the same underlying principles applied to hospital administration, adapted to their smaller _____.

Figure 2.1: Senior hospital administrators reviewing an organisational chart in a boardroom.

Pilot questions 2.1

- Define hospital administration. (Linked to SLO 2.1)
- List three core functions of hospital administration. (Linked to SLO 2.1)
- Describe the typical organisational structure of a hospital. (Linked to SLO 2.1)
- Describe the role of formal governance arrangements within a hospital's structure. (Linked to SLO 2.1)
- Explain how administrative principles apply to other health services beyond hospitals. (Linked to SLO 2.2)

2.2 Concept and Scope of Private Practice Management

2.2.1 defining private practice management

Applying management principles at the scale of a small practice

Private practice management refers to the specific application of management principles, discussed in relation to general management concepts in an earlier related course, to the particular context of a small, independently owned family practice, generally involving a

considerably smaller **scale** of operation than the hospital administration discussed earlier in this Series.

Despite this smaller scale, private practice management requires attention to the same fundamental management **functions**, discussed in an earlier related course, planning, organising, directing, staffing, controlling, and coordinating, though generally undertaken personally by the practising physician rather than delegated to dedicated administrative **staff**.

Fill in the blank: Private practice management requires attention to the same fundamental management functions, though generally undertaken personally by the practising _____.

2.2.2 establishing a private practice

Establishing a private practice generally requires careful attention to appropriate **location** selection, discussed in relation to community-oriented care in an earlier related course, securing adequate premises and equipment, and completing necessary regulatory **registration** and licensing requirements, discussed in relation to the Medical and Dental Council of Nigeria in an earlier related course.

Further essential establishment considerations include initial financial **planning**, discussed further in a later Series of this course, and recruitment of any necessary support **staff**, discussed in relation to the health team in an earlier related course, each representing a necessary practical step before a new private practice can begin seeing patients.

Fill in the blank: Establishing a private practice requires initial financial planning and recruitment of any necessary support _____.

2.2.3 day-to-day management of a private practice

Day-to-day management of a private practice includes appointment scheduling and patient flow, discussed in relation to family medicine tools in an earlier related course, ongoing supervision of any employed staff, and routine financial **management**, discussed further in the next Series of this course, ensuring the practice's ongoing operational **sustainability**.

Effective day-to-day management additionally requires ongoing attention to maintaining clinical **quality** and patient satisfaction, discussed in relation to the patient-centred approach in an earlier related course, since a private practice's long-term success ultimately depends on sustained patient trust and reputation within its local **community**.

Fill in the blank: Effective day-to-day management requires ongoing attention to maintaining clinical quality, since a private practice's success depends on sustained patient trust and reputation within its local _____.

Table 2.2: Comparing hospital and private practice management responsibilities.

Responsibility	Hospital administration	Private practice management
Who typically performs it	Dedicated administrative staff and departments	The practising physician personally
Scale of resources managed	Large, multidisciplinary workforce and facilities	Small team and single premises
Governance	Formal boards and committees	Direct physician oversight

Pilot questions 2.2

1. Define private practice management. (Linked to SLO 2.3)
2. List the six management functions relevant to private practice management. (Linked to SLO 2.3)
3. Describe two considerations in establishing a private practice. (Linked to SLO 2.3)
4. Describe the components of day-to-day management of a private practice. (Linked to SLO 2.4)
5. Explain why maintaining clinical quality is essential to a private practice's long-term success. (Linked to SLO 2.4)

2.3 Comparing Hospital Administration and Private Practice Management

2.3.1 similarities between hospital and private practice administration

Shared underlying management principles despite differing scale

Both hospital administration and private practice management, discussed throughout this Series, rest on the same underlying **management principles**, discussed in an earlier related course, planning, organising, and controlling resources, whether those resources span an entire hospital or a single small practice.

Both settings additionally share a common ultimate **objective**, delivering safe, effective, patient-centred care, discussed in an earlier related course, meaning the fundamental purpose underlying administrative activity remains consistent even as the specific practical scale and complexity vary considerably between a large hospital and a small private **practice**.

Fill in the blank: Both hospital administration and private practice management share a common ultimate objective, delivering safe, effective, patient-centred _____.

2.3.2 differences between hospital and private practice administration

Key differences include the considerably larger **scale** of resources and workforce managed within a hospital setting, discussed earlier in this Series, compared with the typically much smaller scale characteristic of private practice, and the presence of dedicated administrative staff and formal governance structures within hospitals, generally **absent** from smaller private practices.

Further differences include the private practice physician's typically **direct**, personal involvement in nearly every administrative decision, discussed earlier in this Series, compared with the more **delegated**, layered decision-making structure characteristic of larger hospital administration, reflecting the fundamentally different scale at which each operates.

Fill in the blank: A key difference is the private practice physician's typically direct, personal involvement in nearly every administrative _____.

2.3.3 lessons private practice can draw from hospital administration

Private practice management can usefully draw several practical **lessons** from hospital administration, including the value of clear organisational **structure**, discussed earlier in this Series, even at a small scale, and the importance of systematic quality **monitoring**, discussed in relation to health service evaluation in an earlier related course, rather than relying on informal assumption alone.

Further useful lessons include the value of appropriate **delegation**, discussed in relation to management principles in an earlier related course, of specific administrative tasks to trained support staff where the practice's scale genuinely permits this, allowing the private practice physician to devote proportionately more attention to direct clinical **care**.

Fill in the blank: Private practice management can draw practical lessons from hospital administration, including the value of appropriate delegation of specific administrative _____.

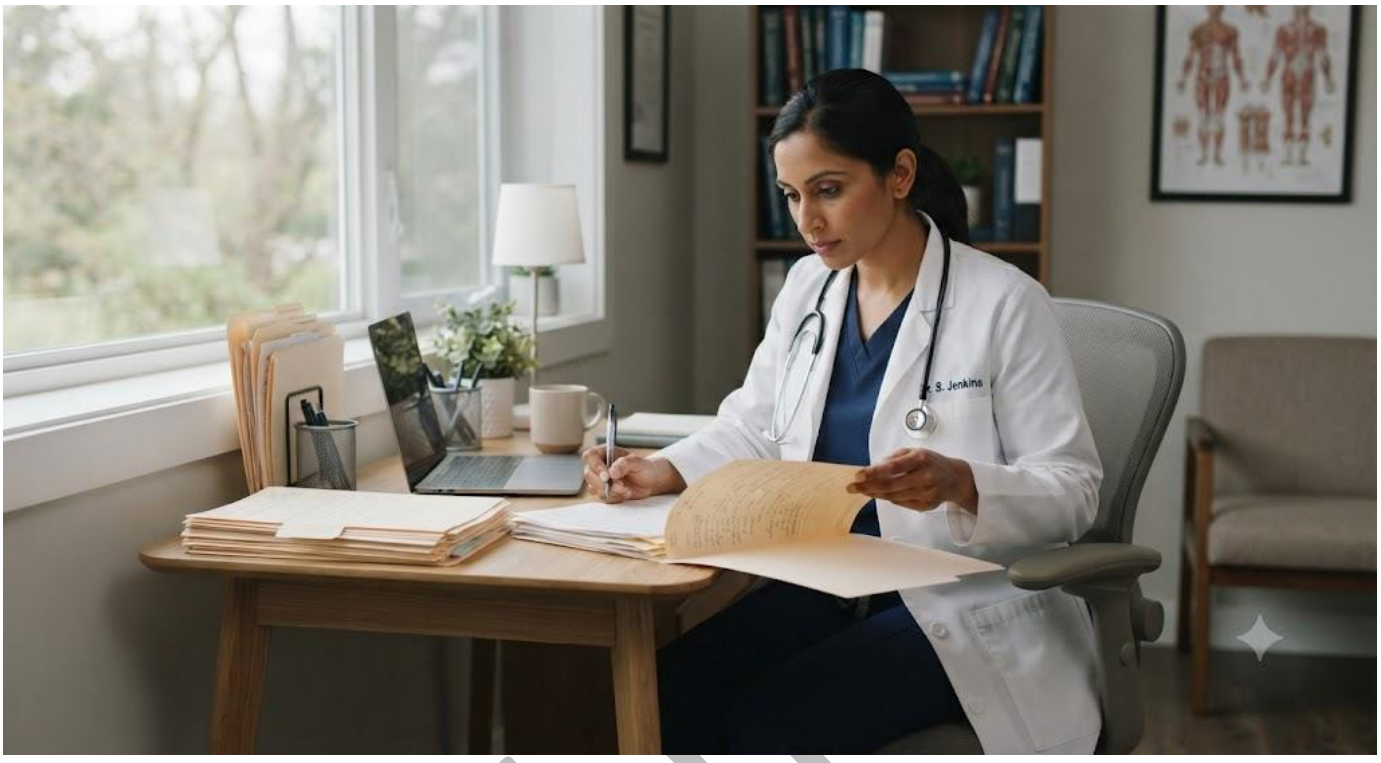

Figure 2.3: A solo private practice physician managing patient records alongside clinical duties.

Pilot questions 2.3

1. Describe the shared underlying management principles common to both hospital and private practice settings. (Linked to SLO 2.5)
2. Describe the common ultimate objective shared by hospital administration and private practice management. (Linked to SLO 2.5)
3. Describe two differences between hospital administration and private practice management. (Linked to SLO 2.5)
4. Describe two lessons private practice can draw from hospital administration. (Linked to SLO 2.6)
5. Explain how appropriate delegation can benefit a private practice as it grows. (Linked to SLO 2.6)

Series Summary

This Series examined **hospital administration and private practice management**, beginning with **medical administration in hospitals**, its concept and core functions, organisational structure, and application to other health services, before turning to the **concept and scope of private practice management**, its definition, the practical steps of establishing a practice, and the components of day-to-day management.

We concluded by **comparing hospital administration and private practice management**, their shared underlying management principles and common objective, the key differences in scale and structure between them, and the practical lessons private practice can draw from hospital administration. Having worked through this Series, you should now be equipped to understand budgeting, financing, and personnel management examined in the next Series of this course.

Glossary of Terms

1. **Hospital administration:** the management functions required to coordinate a hospital's resources, staff, and clinical activity.
2. **Hospital governance:** formal oversight arrangements, such as boards, providing accountability for hospital performance.
3. **Private practice management:** the application of management principles to a small, independently owned family practice.
4. **Practice establishment:** the process of setting up a new private practice, including location, licensing, and staffing.
5. **Day-to-day management:** the routine operational tasks required to run a practice on an ongoing basis.
6. **Delegation:** the transfer of specific tasks or decisions to another appropriately trained individual.
7. **Organisational structure:** the formal arrangement of roles, departments, and reporting relationships within an organisation.
8. **Clinical department:** a hospital unit responsible for a specific area of clinical speciality.
9. **Support department:** a hospital unit, such as pharmacy or medical records, supporting overall clinical operations.
10. **Practice reputation:** the standing and trust a private practice holds among its patients and community.
11. **Regulatory registration:** the formal process of licensing a health facility to legally operate.

12. **Quality monitoring:** the systematic assessment of whether care meets expected standards.

Concept Check Questions [Series 2]

Objective questions

1. Hospital administration coordinates a hospital's substantial resources, staff, and clinical _____.
2. A hospital's organisational structure includes formal governance arrangements providing oversight of major _____.
3. Private practice management requires attention to the same fundamental management functions, though generally undertaken personally by the practising _____.
4. Both hospital administration and private practice management share a common ultimate objective, delivering safe, effective, patient-centred _____.
5. Private practice can draw lessons from hospital administration, including the value of appropriate _____ of specific administrative tasks.

Short-answer questions

- List three core functions of hospital administration.
- Describe the typical organisational structure of a hospital.
- Define private practice management.
- Describe two considerations in establishing a private practice.
- Describe two differences between hospital administration and private practice management.

Long-answer questions

1. Discuss the concept, functions, and organisational structure of hospital administration. (Linked to SLO 2.1, SLO 2.2)
2. Discuss the definition and establishment of private practice management. (Linked to SLO 2.3)
3. Discuss the day-to-day management of a private practice. (Linked to SLO 2.4)
4. Discuss the similarities and differences between hospital and private practice administration. (Linked to SLO 2.5)
5. Discuss lessons private practice can draw from hospital administration. (Linked to SLO 2.6)

Answers to Concept Check Questions [Series 2]

Objective questions

6. Activity.
7. Decisions.
8. Physician.
9. Care.
10. Delegation.

Short-answer questions

11. Strategic planning, financial and resource management, and human resource management.
12. Senior administrative leadership, clinical department heads, and dedicated support departments such as medical records and pharmacy.
13. The application of management principles to a small, independently owned family practice.
14. Appropriate location selection, and completing regulatory registration and licensing requirements.
15. Hospitals have dedicated administrative staff and formal governance; private practices generally lack these, with the physician personally handling most decisions.

Long-answer questions

16. **Basic response:** Hospital administration coordinates substantial resources, staff, and clinical activity through strategic planning, financial management, and human resource management.

Value-added response: Its organisational structure generally includes senior leadership, clinical department heads, dedicated support departments, and formal governance arrangements providing oversight.

17. **Basic response:** Private practice management applies general management principles to a small, independently owned family practice, generally undertaken personally by the practising physician.

Value-added response: Establishing a practice requires location selection, securing premises and equipment, completing registration and licensing, and initial financial planning and staff recruitment.

18. **Basic response:** Day-to-day management includes appointment scheduling, patient flow, staff supervision, and routine financial management supporting operational sustainability.

Value-added response: Maintaining clinical quality and patient satisfaction remains essential, since long-term success depends on sustained patient trust and community reputation.

19. **Basic response:** Both settings share underlying management principles and the common objective of safe, effective, patient-centred care, despite differing considerably in scale.

Value-added response: Key differences include the larger scale and dedicated administrative staff of hospitals compared with the direct, personal administrative involvement typical of private practice.

20. **Basic response:** Private practice can draw lessons including the value of clear organisational structure and systematic quality monitoring, even at a small scale.

Value-added response: Appropriate delegation of specific administrative tasks, where practice scale permits, can allow the physician to devote proportionately more attention to direct clinical care.

Answers to Pilot Questions [Series 2]

Part 2.1

11. The management functions required to coordinate a hospital's substantial resources, staff, and clinical activity.
12. Strategic planning, financial and resource management, and human resource management.
13. Senior administrative leadership, clinical department heads, and dedicated support departments.
14. They provide oversight of hospital performance and major decisions.
15. The same underlying principles apply, adapted to the considerably smaller scale and resources of these settings.

Part 2.2

1. The application of management principles to a small, independently owned family practice.
2. Planning, organising, directing, staffing, controlling, and coordinating.
3. Location selection, and completing regulatory registration and licensing requirements.
4. Appointment scheduling, patient flow, staff supervision, and routine financial management.
5. Because a practice's long-term success ultimately depends on sustained patient trust and reputation.

Part 2.3

6. Both rest on planning, organising, and controlling resources, regardless of scale.
7. Delivering safe, effective, patient-centred care.
8. Hospitals have larger scale and dedicated administrative staff; private practices have direct, personal physician involvement in most decisions.
9. The value of clear organisational structure, and systematic quality monitoring.
10. It allows the physician to devote proportionately more attention to direct clinical care as the practice grows.

References and Attributions [Series 2]

11. Koontz, H., & Weihrich, H. (2015). Essentials of Management (10th ed.). McGraw-Hill.
12. McWhinney, I. R., & Freeman, T. (2016). Textbook of Family Medicine (4th ed.). Oxford University Press.
13. Park, K. (2021). Park's Textbook of Preventive and Social Medicine (26th ed.). Banarsidas Bhanot.
14. Rakel, R. E., & Rakel, D. P. (2019). Textbook of Family Medicine (9th ed.). Elsevier.

Figures, Plates, Tables, and Boxes

1. Figure 2.1: Senior hospital administrators reviewing an organisational chart in a boardroom. AI-generated using the prompt: "A single clean, realistic illustration of administrators reviewing a chart together around a boardroom table, calm professional

setting, soft indoor lighting, no text overlays, no multiple panels, accurate and professional depiction, no graphic detail."

2. Table 2.2: Comparing hospital and private practice management responsibilities. AI-generated using the prompt: "Create a clean reference table titled Comparing Hospital and Private Practice Management, listing responsibility, hospital administration, and private practice management. Simple clinical reference table style with outside border."
3. Figure 2.3: A solo private practice physician managing patient records alongside clinical duties. AI-generated using the prompt: "A single clean, realistic illustration of a physician managing files and paperwork at a small clinic desk, calm professional setting, natural lighting, no text overlays, no multiple panels, accurate and professional depiction, no graphic detail."

Series 3: Budgeting, Financing, and Personnel Management

- **Part 3.1: Budgeting and Accounting in Private Practice**
    - Sub Part 3.1.1: Principles of budgeting in private practice
    - Sub Part 3.1.2: Basic accounting practices
    - Sub Part 3.1.3: Financial record keeping
- **Part 3.2: Health Financing in Private Practice**
    - Sub Part 3.2.1: Sources of income for a private practice
    - Sub Part 3.2.2: Managing NHIS and insurance-related financing
    - Sub Part 3.2.3: Financial sustainability of a private practice
- **Part 3.3: Personnel Management and the Health Team**
    - Sub Part 3.3.1: Recruiting and managing practice staff
    - Sub Part 3.3.2: The health team within a private practice
    - Sub Part 3.3.3: Performance management and staff development

Introduction

In the last Series, we explored hospital administration and private practice management. We now turn to the specific financial and personnel functions underlying a sustainable private practice, **budgeting, accounting, and health financing**, and **personnel management**, including the practice's own small **health team**. Picture a private practice owner carefully tracking monthly income and expenses, navigating NHIS reimbursement paperwork, and simultaneously supervising a small team of nurses and support staff, each activity essential to keeping the practice financially viable and well run. Understanding these practical financial and personnel functions is the focus of this Series.

The aim of this Series is to equip you with a clear understanding of budgeting, accounting, and health financing, and personnel management, including the health team, within private practice.

This Series begins with **budgeting and accounting** in private practice, before turning to **health financing** in private practice. It concludes with **personnel management and the health team**.

Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 3.1:** describe the principles of budgeting and basic accounting practices in private practice
- **SLO 3.2:** describe financial record keeping in private practice
- **SLO 3.3:** describe sources of income and the management of NHIS and insurance-related financing
- **SLO 3.4:** describe the financial sustainability of a private practice
- **SLO 3.5:** describe recruiting and managing practice staff, and the health team within a private practice, and
- **SLO 3.6:** describe performance management and staff development in private practice.

3.1 Budgeting and Accounting in Private Practice

3.1.1 principles of budgeting in private practice

Planning income and expenditure with realistic discipline

Budgeting in private practice involves systematically planning anticipated income and expenditure over a defined future period, discussed in relation to health services budgeting in an earlier related course, allowing the practice owner to make informed decisions regarding staffing, equipment purchase, and other significant financial **commitments**.

Effective private practice budgeting requires realistic **estimation** of likely patient volume and corresponding income, discussed in relation to demand for healthcare in an earlier related course, together with careful attention to both fixed costs, such as rent, and variable costs, such as medical **supplies**, that fluctuate with practice activity.

Fill in the blank: Budgeting in private practice involves systematically planning anticipated income and expenditure over a defined future _____.

3.1.2 basic accounting practices

Basic **accounting** practices in private practice include systematic recording of all income received and expenses incurred, generally organised into a simple, consistent **format** allowing the practice owner to track overall financial performance over time.

Sound accounting additionally requires maintaining a clear separation between practice **finances** and the physician's own personal finances, and, particularly as a practice grows in scale, may benefit from professional accounting **support**, ensuring accurate, compliant financial record keeping, discussed further in the next sub-Part.

Fill in the blank: Sound accounting requires maintaining a clear separation between practice finances and the physician's own personal _____.

3.1.3 financial record keeping

Systematic **financial record keeping** provides the essential evidence base supporting both accurate budgeting, discussed earlier in this Part, and appropriate compliance with tax and other regulatory **obligations**, discussed in relation to regulatory registration in an earlier related course, applicable to any legally operating private practice.

Good financial record keeping additionally supports timely identification of emerging financial **difficulties**, allowing the practice owner to take corrective action before a manageable problem develops into a genuinely serious threat to the practice's ongoing financial **viability**, discussed further later in this Series.

Fill in the blank: Good financial record keeping supports timely identification of emerging financial difficulties, allowing corrective action before problems threaten the practice's ongoing financial _____.

Figure 3.1: A private practice owner reviewing income and expense records on a laptop.

Pilot questions 3.1

- Define budgeting as it applies to private practice. (Linked to SLO 3.1)
- Distinguish fixed costs from variable costs in a private practice. (Linked to SLO 3.1)
- Describe basic accounting practices relevant to private practice. (Linked to SLO 3.1)
- Explain why practice finances should be kept separate from personal finances. (Linked to SLO 3.1)
- Describe the purpose of systematic financial record keeping. (Linked to SLO 3.2)

3.2 Health Financing in Private Practice

3.2.1 sources of income for a private practice

Diverse revenue streams supporting practice operation

A private practice's **income** generally derives from several sources, including direct **out-of-pocket** patient payment, discussed in relation to healthcare financing in an earlier related course, and reimbursement from health insurance schemes, including the **NHIS**, discussed in relation to health insurance in an earlier related course.

Additional income sources may include corporate or organisational health service contracts, and, in some practices, specific ancillary services such as diagnostic testing or minor procedures, discussed in relation to family medicine tools in an earlier related course, each contributing to the practice's overall **revenue** base.

Fill in the blank: A private practice's income generally derives from several sources, including direct out-of-pocket payment and reimbursement from health insurance schemes, including the _____.

3.2.2 managing nhis and insurance-related financing

Managing NHIS and insurance-related financing requires the practice to maintain accurate **documentation** of services delivered, discussed in relation to medical records in a later Series of this course, supporting timely and accurate insurance claim **submission**.

Effective management additionally requires understanding the specific **reimbursement** rates and coverage limitations applicable under NHIS and other insurance arrangements, discussed in relation to cost implications in an earlier related course, and planning practice finances **realistically** around these known constraints rather than assuming unlimited insurance coverage.

Fill in the blank: Effective management of NHIS and insurance-related financing requires understanding specific reimbursement rates and coverage _____.

3.2.3 financial sustainability of a private practice

Financial sustainability refers to a private practice's ongoing ability to generate sufficient **revenue** to cover its operating costs and provide the physician a reasonable, sustainable livelihood over the long term, discussed in relation to budgeting earlier in this Series.

Achieving genuine financial sustainability generally requires a balanced income **strategy**, drawing on multiple income sources discussed earlier in this Part, careful ongoing cost management, and periodic review of the practice's overall financial **performance** to identify and address any emerging sustainability concerns proactively.

Fill in the blank: Achieving genuine financial sustainability generally requires a balanced income strategy and periodic review of the practice's overall financial _____.

Table 3.2: Comparing out-of-pocket payment and insurance-based income for a private practice.

Feature	Out-of-pocket payment	Insurance-based income (e.g. NHIS)

Payment timing	Immediate, at point of service	Delayed, following claims processing
Predictability	Variable, depends on patient volume	Governed by fixed reimbursement rates
Administrative burden	Minimal	Requires documentation and claims submission

Pilot questions 3.2

1. List three sources of income for a private practice. (Linked to SLO 3.3)
2. Describe the documentation requirements for managing NHIS and insurance-related financing. (Linked to SLO 3.3)
3. Explain why understanding reimbursement rates and coverage limitations is important. (Linked to SLO 3.3)
4. Define financial sustainability as it applies to a private practice. (Linked to SLO 3.4)
5. Describe the components of a balanced income strategy supporting financial sustainability. (Linked to SLO 3.4)

3.3 Personnel Management and the Health Team

3.3.1 recruiting and managing practice staff

Building a small, effective, and trustworthy team

Recruiting practice staff, discussed in relation to human resource management in an earlier related course, requires the private practice owner to identify appropriate candidates for roles such as reception, nursing support, and, where relevant, other clinical or administrative **positions**, matched to the specific needs of the individual practice.

Managing practice staff additionally requires clear communication of expected **responsibilities**, discussed in relation to management functions in an earlier Series of this course, fair, consistent treatment, and appropriate attention to relevant employment **regulations** applicable to small private practice employers.

Fill in the blank: Recruiting practice staff requires the private practice owner to identify appropriate candidates matched to the specific needs of the individual _____.

3.3.2 the health team within a private practice

The **health team** within a private practice, discussed in relation to the health team more broadly in an earlier related course, generally comprises a considerably smaller group than a hospital-based team, often including the physician, one or more nurses, and reception or administrative **support**, each contributing to the practice's overall functioning.

Even at this smaller scale, effective functioning of the private practice health team requires genuine **teamwork** and clear role definition, discussed in relation to the health team in an earlier related course, since each team member's contribution remains essential to the practice's overall patient **experience** and clinical quality.

Fill in the blank: Even at a smaller scale, effective functioning of the private practice health team requires genuine teamwork and clear role _____.

3.3.3 performance management and staff development

Performance management of practice staff, discussed in relation to health worker performance management in an earlier related course, involves setting clear expectations, providing regular constructive **feedback**, and addressing any performance concerns promptly and fairly, supporting consistent practice quality.

Staff development additionally supports ongoing improvement in practice **quality**, providing relevant training opportunities for practice staff, discussed in relation to continuing professional development in an earlier related course, and recognising good performance, contributing to staff **retention** and overall practice stability over time.

Fill in the blank: Staff development supports ongoing improvement in practice quality and contributes to staff _____ and overall practice stability.

Figure 3.3: A private practice physician and small support team discussing daily operations together.

Pilot questions 3.3

1. Describe the considerations relevant to recruiting practice staff. (Linked to SLO 3.5)
2. Describe the typical composition of the health team within a private practice. (Linked to SLO 3.5)
3. Explain why teamwork remains important even in a small private practice health team. (Linked to SLO 3.5)
4. Describe the components of effective performance management for practice staff. (Linked to SLO 3.6)
5. Explain how staff development contributes to staff retention and practice stability. (Linked to SLO 3.6)

Series Summary

This Series examined **budgeting, financing, and personnel management** within private practice, beginning with **budgeting and accounting**, the principles of realistic budgeting, basic accounting practices, and systematic financial record keeping, before turning to **health financing**, sources of practice income, managing NHIS and insurance-related financing, and achieving genuine financial sustainability.

We concluded with **personnel management and the health team**, recruiting and managing practice staff, the composition and teamwork of the private practice health team, and performance management and staff development supporting practice quality and stability. Having worked through this Series, you should now be equipped to understand medical records, family transitions, and computers in primary care examined in the next Series of this course.

Glossary of Terms

1. **Budgeting:** systematically planning anticipated income and expenditure over a defined future period.
2. **Fixed cost:** an expense, such as rent, that does not vary with practice activity.
3. **Variable cost:** an expense, such as medical supplies, that fluctuates with practice activity.
4. **Accounting:** the systematic recording and tracking of income and expenses over time.
5. **Financial record keeping:** the ongoing documentation supporting budgeting and regulatory compliance.
6. **Out-of-pocket payment:** direct payment by a patient for health services at the point of use.
7. **Reimbursement rate:** the agreed payment a provider receives for services delivered under an insurance scheme.
8. **Financial sustainability:** a practice's ongoing ability to generate sufficient revenue to cover costs and provide a livelihood.
9. **Personnel management:** the recruitment, supervision, and development of a practice's employed staff.
10. **Health team:** the group of professionals working together to deliver health services within a practice.
11. **Performance management:** setting expectations, providing feedback, and addressing performance concerns among staff.
12. **Staff development:** training and recognition activities supporting staff growth and retention.

Concept Check Questions [Series 3]

Objective questions

1. Budgeting in private practice involves planning anticipated income and expenditure over a defined future _____.
2. Sound accounting requires maintaining a clear separation between practice finances and the physician's own personal _____.
3. A private practice's income generally derives from out-of-pocket payment and reimbursement from insurance schemes, including the _____.
4. Financial sustainability refers to a practice's ongoing ability to generate sufficient revenue to cover costs and provide a reasonable _____.
5. Staff development supports ongoing improvement in practice quality and contributes to staff _____ and stability.

Short-answer questions

- Distinguish fixed costs from variable costs in a private practice.
- Describe the purpose of systematic financial record keeping.
- Describe the documentation requirements for managing NHIS and insurance-related financing.
- Describe the typical composition of the health team within a private practice.
- Describe the components of effective performance management for practice staff.

Long-answer questions

1. Discuss the principles of budgeting and basic accounting practices in private practice. (Linked to SLO 3.1)
2. Discuss financial record keeping in private practice. (Linked to SLO 3.2)
3. Discuss sources of income and the management of NHIS and insurance-related financing. (Linked to SLO 3.3)
4. Discuss the financial sustainability of a private practice. (Linked to SLO 3.4)
5. Discuss recruiting and managing practice staff, the health team, and performance management and staff development. (Linked to SLO 3.5, SLO 3.6)

Answers to Concept Check Questions [Series 3]

Objective questions

6. Period.
7. Finances.
8. NHIS.
9. Livelihood.
10. Retention.

Short-answer questions

11. Fixed costs, such as rent, do not vary with activity; variable costs, such as supplies, fluctuate with practice activity.
12. It provides the evidence base for accurate budgeting and compliance with tax and regulatory obligations.
13. Accurate documentation of services delivered, supporting timely and accurate insurance claim submission.
14. The physician, one or more nurses, and reception or administrative support.
15. Setting clear expectations, providing regular constructive feedback, and addressing performance concerns promptly and fairly.

Long-answer questions

16. **Basic response:** Budgeting involves realistically planning anticipated income and expenditure, distinguishing fixed and variable costs, to inform staffing and equipment decisions.

Value-added response: Basic accounting practices involve systematic recording of income and expenses, kept separate from personal finances, supported by professional accounting help as the practice grows.

17. **Basic response:** Financial record keeping provides the essential evidence base for accurate budgeting and regulatory compliance.

Value-added response: It also supports timely identification of emerging financial difficulties, allowing corrective action before problems threaten the practice's viability.

18. **Basic response:** Private practice income derives from out-of-pocket payment, insurance reimbursement including NHIS, and other sources such as corporate contracts or ancillary services.

Value-added response: Managing NHIS and insurance financing requires accurate documentation supporting claims and realistic planning around known reimbursement rates and coverage limitations.

19. **Basic response:** Financial sustainability is a practice's ongoing ability to generate sufficient revenue to cover costs and provide a livelihood.

Value-added response: Achieving it requires a balanced income strategy drawing on multiple sources, careful cost management, and periodic review of financial performance.

20. **Basic response:** Recruiting and managing staff requires identifying candidates matched to practice needs and clear communication of responsibilities, with the small health team requiring genuine teamwork despite its scale.

Value-added response: Performance management and staff development, through feedback, training, and recognition, support consistent quality and contribute to staff retention and practice stability.

Answers to Pilot Questions [Series 3]

Part 3.1

11. Systematically planning anticipated income and expenditure over a defined future period.
12. Fixed costs, such as rent, do not vary with activity; variable costs, such as supplies, fluctuate with practice activity.
13. Systematic recording of income and expenses in a consistent format.
14. To avoid confusing practice performance with personal financial matters and support accurate tracking.
15. To support accurate budgeting and compliance with tax and regulatory obligations.

Part 3.2

1. Out-of-pocket payment, NHIS or insurance reimbursement, and corporate contracts or ancillary services.
2. Accurate documentation of services delivered supporting timely, accurate claims submission.
3. Because it allows realistic financial planning around known constraints rather than assuming unlimited coverage.
4. A practice's ongoing ability to generate sufficient revenue to cover costs and provide a sustainable livelihood.

5. Drawing on multiple income sources, careful cost management, and periodic financial performance review.

Part 3.3

6. Identifying candidates matched to the specific needs of the individual practice.
7. The physician, one or more nurses, and reception or administrative support.
8. Because each team member's contribution remains essential to overall patient experience and clinical quality.
9. Setting clear expectations, providing regular feedback, and addressing concerns promptly and fairly.
10. Training and recognition support staff growth and satisfaction, contributing to retention and stability.

References and Attributions [Series 3]

11. Koontz, H., & Weihrich, H. (2015). Essentials of Management (10th ed.). McGraw-Hill.
12. National Health Insurance Authority, Nigeria (2022). NHIA Act and operational guidelines.
13. McWhinney, I. R., & Freeman, T. (2016). Textbook of Family Medicine (4th ed.). Oxford University Press.
14. Rakel, R. E., & Rakel, D. P. (2019). Textbook of Family Medicine (9th ed.). Elsevier.

Figures, Plates, Tables, and Boxes

1. Figure 3.1: A private practice owner reviewing income and expense records on a laptop. AI-generated using the prompt: "A single clean, realistic illustration of a practice owner reviewing financial records on a laptop at an office desk, calm professional setting, soft indoor lighting, no text overlays, no multiple panels, accurate and professional depiction, no graphic detail."
2. Table 3.2: Comparing out-of-pocket payment and insurance-based income for a private practice. AI-generated using the prompt: "Create a clean reference table titled Comparing Out-of-Pocket and Insurance-Based Income, listing feature, out-of-pocket payment, and insurance-based income. Simple clinical reference table style with outside border."
3. Figure 3.3: A private practice physician and small support team discussing daily operations together. AI-generated using the prompt: "A single clean, realistic illustration of a physician and small support team discussing operations together at a clinic, calm professional setting, natural lighting, no text overlays, no multiple panels, accurate and professional depiction, no graphic detail."

Series 4: Medical Records, Family Transitions, and Computers in Primary Care

- **Part 4.1: Medical Records and Family Life Cycle Transitions**
    - Sub Part 4.1.1: The medical record in private practice
    - Sub Part 4.1.2: Concept of family life cycle transitions
    - Sub Part 4.1.3: The family in different cultural contexts
- **Part 4.2: Computers in Primary Care**
    - Sub Part 4.2.1: Introduction to computers in primary care
    - Sub Part 4.2.2: Electronic medical records
    - Sub Part 4.2.3: Benefits and challenges of computerisation in private practice
- **Part 4.3: Medical Problem Solving Algorithm**
    - Sub Part 4.3.1: Concept of a medical problem solving algorithm
    - Sub Part 4.3.2: Steps in the medical problem solving algorithm
    - Sub Part 4.3.3: Applying the algorithm in private practice

Introduction

In the last Series, we explored budgeting, financing, and personnel management. We now turn to the **medical record** and **family life cycle transitions**, including how the family is understood across different **cultural contexts**, and the growing role of **computers in primary care**, together with the structured **medical problem solving algorithm** many family physicians use to organise their clinical reasoning. Picture a private family physician reviewing a patient's electronic medical record before a consultation, noting that the patient's family is currently navigating the transition of an adult child leaving home, all while applying a structured problem solving approach to a new, undifferentiated complaint. Understanding these practical tools and concepts is the focus of this Series.

The aim of this Series is to equip you with a clear understanding of medical records, family life cycle transitions and the family in different cultural contexts, computers in primary care, and the medical problem solving algorithm.

This Series begins with **medical records and family life cycle transitions**, before turning to **computers in primary care**. It concludes with the **medical problem solving algorithm**.

Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 4.1:** describe the medical record in private practice and the concept of family life cycle transitions
- **SLO 4.2:** describe the family in different cultural contexts
- **SLO 4.3:** describe the introduction and use of electronic medical records in primary care
- **SLO 4.4:** describe the benefits and challenges of computerisation in private practice
- **SLO 4.5:** describe the concept and steps of the medical problem solving algorithm, and
- **SLO 4.6:** describe the application of the medical problem solving algorithm in private practice.

4.1 Medical Records and Family Life Cycle Transitions

4.1.1 the medical record in private practice

A structured, evolving record of a patient's care over time

The **medical record** in private practice, discussed in relation to family medicine tools in an earlier related course, systematically documents a patient's history, examination findings, investigations, and management over successive **consultations**, providing the essential factual foundation supporting continuity of care, discussed in an earlier related course.

A well maintained medical record additionally supports appropriate clinical, legal, and administrative **functions**, discussed in relation to financial record keeping in the previous Series of this course, meaning careful record keeping represents an essential, non-negotiable component of responsible private practice, regardless of practice **scale**.

Fill in the blank: The medical record systematically documents a patient's history, examination findings, investigations, and management over successive _____.

4.1.2 concept of family life cycle transitions

Family life cycle transitions refer to predictable stages of change a family typically experiences over time, discussed in relation to family dynamics in an earlier related course, including

marriage, the birth of children, children leaving home, and, eventually, the death of an ageing family **member**.

Each transition carries specific health-relevant **implications**, since periods of significant family change frequently coincide with increased stress and altered health-related needs, discussed in relation to the impact of family on health in an earlier related course, meaning the family physician should remain attentive to a patient's current position within this broader family **cycle**.

Fill in the blank: Family life cycle transitions carry specific health-relevant implications, since periods of significant family change frequently coincide with increased stress and altered health-related _____.

4.1.3 the family in different cultural contexts

The specific expression of family structure and life cycle transitions, discussed earlier in this Part, varies considerably across different **cultural contexts**, meaning family types and expectations common in one Nigerian community may differ meaningfully from those in another, discussed in relation to types of family in an earlier related course.

The family physician must remain genuinely attentive to this cultural **diversity**, avoiding assumptions regarding family structure or expected transitions based on a single cultural framework alone, and instead directly enquiring about each individual patient's own specific family and cultural **context**.

Fill in the blank: The family physician must remain genuinely attentive to cultural diversity, avoiding assumptions and instead directly enquiring about each patient's own specific family and cultural _____.

Figure 4.1: A family physician reviewing a patient's medical record alongside notes on family life stage.

Pilot questions 4.1

- Define the medical record and describe its role in private practice. (Linked to SLO 4.1)
- List two important functions supported by a well maintained medical record. (Linked to SLO 4.1)
- Define family life cycle transitions and give two examples. (Linked to SLO 4.1)
- Explain why family physicians should remain attentive to a patient's family life cycle stage. (Linked to SLO 4.1)
- Explain why the family physician must remain attentive to cultural diversity in family structure. (Linked to SLO 4.2)

4.2 Computers in Primary Care

4.2.1 introduction to computers in primary care

Digital tools supporting modern practice operation

Computers are increasingly used within primary care, discussed in an earlier related course, to support practice **organisation**, discussed in relation to family medicine tools in an earlier related

course, including appointment scheduling, patient records, and communication with other health providers, discussed in relation to the two-way referral system in an earlier related course.

Even relatively modest computerisation can meaningfully improve a private practice's overall efficiency and organisational **capability**, discussed in relation to practice organisation tools earlier in this course, allowing the physician and staff to manage information more systematically than paper-based systems alone typically **permit**.

Fill in the blank: Even relatively modest computerisation can meaningfully improve a private practice's overall efficiency and organisational _____.

4.2.2 electronic medical records

Electronic medical records, or **EMR**, digitise the medical record discussed earlier in this Series, generally offering advantages including easier information **retrieval**, improved legibility compared with handwritten records, and, where appropriately configured, automated reminders supporting preventive care and chronic disease **follow-up**.

Implementing an EMR system in a private practice requires appropriate attention to data **security** and patient confidentiality, discussed in relation to medical documentation in an earlier related course, and adequate staff training to ensure the system is used effectively and consistently rather than **partially** or inconsistently adopted.

Fill in the blank: Implementing an EMR system requires appropriate attention to data security and patient _____.

4.2.3 benefits and challenges of computerisation in private practice

Benefits of computerisation in private practice include improved efficiency in appointment scheduling and record retrieval, discussed earlier in this Series, and enhanced ability to systematically track preventive care needs, discussed in relation to family medicine tools in an earlier related course, across the entire practice patient **population**.

Challenges of computerisation include the initial financial **cost** of appropriate hardware and software, discussed in relation to budgeting in the previous Series of this course, the learning curve required for effective staff use, and, at times, unreliable electricity or internet **infrastructure**, particularly relevant within certain Nigerian practice settings.

Fill in the blank: Challenges of computerisation include initial financial cost, staff learning curve, and, at times, unreliable electricity or internet _____.

Table 4.2: Comparing paper-based and electronic medical records.

Feature	Paper-based records	Electronic medical records
Information retrieval	Manual searching through physical files	Rapid digital search and retrieval
Legibility	Dependent on handwriting quality	Consistently legible typed entries
Initial cost and requirements	Low initial cost	Requires hardware, software, and training investment

Pilot questions 4.2

1. Describe how computers support practice organisation in primary care. (Linked to SLO 4.3)
2. Define electronic medical records and list two advantages they offer. (Linked to SLO 4.3)
3. Describe the data security considerations relevant to implementing an EMR system. (Linked to SLO 4.3)
4. Describe two benefits of computerisation in private practice. (Linked to SLO 4.4)
5. Describe two challenges of computerisation relevant to the Nigerian practice context. (Linked to SLO 4.4)

4.3 Medical Problem Solving Algorithm

4.3.1 concept of a medical problem solving algorithm

A structured pathway supporting consistent clinical reasoning

A **medical problem solving algorithm** is a structured, step-by-step pathway guiding clinical **reasoning** from an initial presenting complaint, discussed in relation to patterns of illness in an earlier related course, through assessment and investigation, to an appropriate management plan, supporting consistent, systematic clinical decision making.

Such algorithms are particularly valuable in primary care, discussed in relation to primary care management in an earlier related course, given the genuinely broad, unselected range of presenting complaints a family physician regularly encounters, providing a reliable structural **framework** even for unfamiliar or unusual clinical presentations.

Fill in the blank: A medical problem solving algorithm is a structured, step-by-step pathway guiding clinical reasoning from an initial presenting complaint to an appropriate management _____.

4.3.2 steps in the medical problem solving algorithm

A typical medical problem solving algorithm begins with clearly defining the presenting **problem**, discussed in relation to interview structuring in an earlier related course, followed by systematic **data gathering** through history, examination, and, where indicated, investigation, discussed in an earlier related course.

Subsequent steps generally include formulating a differential **diagnosis**, selecting and implementing an appropriate management plan, discussed in relation to primary care decision making in an earlier related course, and, importantly, planning appropriate **follow-up** to reassess the problem's evolution over time, consistent with the longitudinal approach discussed in an earlier related course.

Fill in the blank: Subsequent steps in the algorithm generally include formulating a differential diagnosis, implementing a management plan, and planning appropriate _____.

4.3.3 applying the algorithm in private practice

Applying the medical problem solving algorithm within private practice provides a genuinely valuable structural discipline supporting consistent, thorough clinical assessment, discussed throughout this course, even within the time constraints of a typical private practice **consultation**, discussed in an earlier related course.

Consistent application of this structured approach additionally supports appropriate documentation, discussed earlier in this Series, since each step of the algorithm naturally corresponds to a correspondingly organised section of the medical **record**, reinforcing the connection between systematic clinical reasoning and systematic record keeping within a well run private practice.

Fill in the blank: Consistent application of the medical problem solving algorithm supports appropriate documentation, since each step naturally corresponds to a correspondingly organised section of the medical _____.

Figure 4.3: A family physician working through a structured clinical assessment sequence with a patient.

Pilot questions 4.3

1. Define a medical problem solving algorithm. (Linked to SLO 4.5)
2. Explain why such algorithms are particularly valuable in primary care. (Linked to SLO 4.5)
3. List the typical steps of a medical problem solving algorithm. (Linked to SLO 4.5)
4. Explain the value of applying the algorithm within the time constraints of private practice. (Linked to SLO 4.6)
5. Explain how the algorithm's steps correspond to organised medical record documentation. (Linked to SLO 4.6)

Series Summary

This Series examined **medical records, family transitions, and computers in primary care**, beginning with **medical records and family life cycle transitions**, the role of the medical record, family life cycle stages and their health implications, and the family in different cultural

contexts, before turning to **computers in primary care**, electronic medical records, and their benefits and challenges.

We concluded with the **medical problem solving algorithm**, its concept, typical steps, and practical application within private practice, reinforcing the connection between systematic clinical reasoning and organised documentation. Having worked through this Series, you should now be equipped to understand palliative care, alternative medical practice, and medico-legal ethics examined in the final Series of this course.

Glossary of Terms

1. **Medical record:** the systematic documentation of a patient's history, findings, investigations, and management.
2. **Family life cycle transitions:** predictable stages of family change over time, such as marriage or children leaving home.
3. **Cultural context:** the specific cultural background shaping a family's structure and expectations.
4. **Electronic medical record (EMR):** a digitised version of a patient's medical record.
5. **Data security:** measures protecting patient information from unauthorised access or loss.
6. **Computerisation:** the introduction of computer systems to support practice organisation and record keeping.
7. **Medical problem solving algorithm:** a structured, step-by-step pathway guiding clinical reasoning.
8. **Differential diagnosis:** a list of possible conditions that could explain a patient's presentation.
9. **Data gathering:** the systematic collection of history, examination, and investigation findings.
10. **Follow-up planning:** arranging appropriate reassessment of a clinical problem over time.
11. **Practice efficiency:** the effectiveness with which a practice uses its resources and time.
12. **Infrastructure reliability:** the consistency of essential services, such as electricity or internet, supporting practice operations.

Concept Check Questions [Series 4]

Objective questions

1. The medical record documents a patient's history, findings, investigations, and management over successive _____.

2. Family life cycle transitions carry health-relevant implications, since family change often coincides with increased stress and altered health-related _____.
3. Implementing an EMR system requires appropriate attention to data security and patient _____.
4. Challenges of computerisation include cost, staff learning curve, and unreliable electricity or internet _____.
5. A medical problem solving algorithm guides clinical reasoning from a presenting complaint to an appropriate management _____.

Short-answer questions

- List two important functions supported by a well maintained medical record.
- Define family life cycle transitions and give two examples.
- Explain why the family physician must remain attentive to cultural diversity in family structure.
- List two advantages electronic medical records offer over paper-based records.
- List the typical steps of a medical problem solving algorithm.

Long-answer questions

1. Discuss the medical record in private practice and the concept of family life cycle transitions. (Linked to SLO 4.1)
2. Discuss the family in different cultural contexts. (Linked to SLO 4.2)
3. Discuss electronic medical records in primary care. (Linked to SLO 4.3)
4. Discuss the benefits and challenges of computerisation in private practice. (Linked to SLO 4.4)
5. Discuss the concept, steps, and application of the medical problem solving algorithm in private practice. (Linked to SLO 4.5, SLO 4.6)

Answers to Concept Check Questions [Series 4]

Objective questions

6. Consultations.
7. Needs.
8. Confidentiality.
9. Infrastructure.
10. Plan.

Short-answer questions

11. Supporting continuity of care, and appropriate clinical, legal, and administrative functions.
12. Predictable stages of family change over time; marriage and children leaving home are examples.
13. Because family types and expectations differ across communities, so assumptions based on one cultural framework may be inaccurate.
14. Easier information retrieval, and improved legibility compared with handwritten records.
15. Defining the problem, systematic data gathering, formulating a differential diagnosis, implementing a management plan, and planning follow-up.

Long-answer questions

16. **Basic response:** The medical record systematically documents a patient's history, findings, investigations, and management, supporting continuity of care and legal and administrative functions.

Value-added response: Family life cycle transitions, such as marriage or children leaving home, carry health-relevant implications given the stress and altered needs often accompanying family change.

17. **Basic response:** Family structure and life cycle transitions vary considerably across cultural contexts, meaning expectations common in one community may differ meaningfully from another.

Value-added response: The family physician must avoid assumptions based on a single cultural framework and instead directly enquire about each patient's own specific family and cultural context.

18. **Basic response:** Electronic medical records digitise the patient record, offering easier retrieval, improved legibility, and automated reminders supporting preventive care.

Value-added response: Implementation requires appropriate attention to data security and confidentiality, and adequate staff training for effective, consistent use.

19. **Basic response:** Computerisation offers benefits including improved scheduling and record retrieval efficiency and systematic tracking of preventive care needs.

Value-added response: Challenges include initial financial cost, staff learning curve, and unreliable electricity or internet infrastructure in certain settings.

20. **Basic response:** A medical problem solving algorithm guides clinical reasoning through defining the problem, data gathering, differential diagnosis, management planning, and follow-up.

Value-added response: Applying this structure within private practice supports consistent, thorough assessment even under time constraints, and naturally reinforces organised medical record documentation.

Answers to Pilot Questions [Series 4]

Part 4.1

11. The systematic documentation of a patient's history, findings, investigations, and management over time; it supports continuity of care.
12. Continuity of care, and clinical, legal, and administrative functions.
13. Predictable stages of family change over time; marriage and children leaving home are examples.
14. Because periods of family change often coincide with increased stress and altered health-related needs.
15. Because family structure and expectations vary meaningfully across communities, requiring individual enquiry rather than assumption.

Part 4.2

1. Through appointment scheduling, patient records, and communication with other health providers.
2. A digitised version of the medical record; advantages include easier retrieval and improved legibility.
3. Protecting patient information from unauthorised access, alongside adequate staff training.
4. Improved efficiency in scheduling and record retrieval, and systematic tracking of preventive care needs.
5. Initial financial cost, and unreliable electricity or internet infrastructure.

Part 4.3

6. A structured, step-by-step pathway guiding clinical reasoning from a presenting complaint to a management plan.
7. Because primary care involves a genuinely broad, unselected range of presenting complaints requiring a reliable structural framework.
8. Defining the problem, data gathering, differential diagnosis, management planning, and follow-up.
9. It supports consistent, thorough clinical assessment even within limited consultation time.
10. Each step naturally corresponds to a correspondingly organised section of the medical record.

References and Attributions [Series 4]

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14. Duckworth, A. D. (2018). Clinical reasoning in primary care: an algorithmic approach (overview).

Figures, Plates, Tables, and Boxes

1. Figure 4.1: A family physician reviewing a patient's medical record alongside notes on family life stage. AI-generated using the prompt: "A single clean, realistic illustration of a physician reviewing a patient file with handwritten notes at an office desk, calm professional setting, soft indoor lighting, no text overlays, no multiple panels, respectful and accurate depiction, no graphic medical detail."
2. Table 4.2: Comparing paper-based and electronic medical records. AI-generated using the prompt: "Create a clean reference table titled Comparing Paper-Based and Electronic Medical Records, listing feature, paper-based records, and electronic medical records. Simple clinical reference table style with outside border."
3. Figure 4.3: A family physician working through a structured clinical assessment sequence with a patient. AI-generated using the prompt: "A single clean, realistic clinical illustration of a physician working through an assessment with a seated patient in a calm clinic room, soft natural lighting, no text overlays, no multiple panels, respectful and accurate depiction, no graphic medical detail."

Series 5: Palliative Care, Alternative Practice, and Medico-Legal Ethics

- **Part 5.1: Palliative Care Services in Nigeria and Abroad**
    - Sub Part 5.1.1: Concept and principles of palliative care
    - Sub Part 5.1.2: Palliative care services available in Nigeria
    - Sub Part 5.1.3: Palliative care services abroad: a comparative view
- **Part 5.2: Alternative Medical Practice: A Critical Review**
    - Sub Part 5.2.1: Concept and scope of alternative medical practice
    - Sub Part 5.2.2: Common forms of alternative medical practice in Nigeria
    - Sub Part 5.2.3: Critical evaluation of alternative medical practice
- **Part 5.3: Attachment to an Accredited GP and Medico-Legal Ethics**
    - Sub Part 5.3.1: Purpose and value of attachment to an accredited GP
    - Sub Part 5.3.2: Medico-legal matters in private practice
    - Sub Part 5.3.3: Code of ethics governing medical practice

Introduction

In the last Series, we explored medical records, family life cycle transitions, and computers in primary care. We now conclude this course with **palliative care** services available in Nigeria and abroad, a critical review of **alternative medical practice**, the value of **attachment to an accredited GP**, and the essential **medico-legal matters and code of ethics** governing every physician's practice. Picture a private family physician arranging palliative care support for a patient with advanced illness, carefully discussing a patient's interest in an alternative remedy with appropriate critical balance, and conducting their own practice within clear medico-legal and ethical boundaries throughout. Understanding these final topics completes the foundation this course has built.

The aim of this Series is to equip you with a clear understanding of palliative care services in Nigeria and abroad, alternative medical practice, attachment to an accredited GP, and medico-legal matters and the code of ethics.

This Series begins with **palliative care services in Nigeria and abroad**, before turning to **alternative medical practice**. It concludes with **attachment to an accredited GP and medico-legal ethics**.

Series Learning Outcomes

At the end of this Series, you should be able to:

- **SLO 5.1:** describe the concept and principles of palliative care
- **SLO 5.2:** identify palliative care services available in Nigeria and abroad
- **SLO 5.3:** describe the concept, scope, and common forms of alternative medical practice in Nigeria
- **SLO 5.4:** critically evaluate alternative medical practice
- **SLO 5.5:** describe the purpose and value of attachment to an accredited GP, and
- **SLO 5.6:** explain medico-legal matters and the code of ethics governing medical practice.

5.1 Palliative Care Services in Nigeria and Abroad

5.1.1 concept and principles of palliative care

Focusing on comfort and quality of life

Palliative care is an approach focused on improving the quality of life of patients facing **life-limiting** illness, addressing pain and other distressing symptoms, discussed in relation to chronic disease management in an earlier related course, together with genuine psychological, social, and spiritual **support**.

Core principles of palliative care include a holistic, patient-centred approach, discussed in relation to holistic care in an earlier related course, extending support to the patient's family, discussed in relation to the effect of illness on the family in an earlier related course, and, importantly, treating palliative care as complementary to, rather than necessarily replacing, active disease-directed **treatment**.

Fill in the blank: Core principles of palliative care include treating it as complementary to, rather than necessarily replacing, active disease-directed _____.

5.1.2 palliative care services available in nigeria

Palliative care services within Nigeria remain relatively **limited** compared with overall health service capacity, discussed in relation to healthcare financing in an earlier related course, generally concentrated within a small number of specialist units based at select teaching **hospitals**, though growing awareness and investment continue to expand this capacity gradually.

Community-based and hospice-style palliative care initiatives, often supported by voluntary agencies, discussed in an earlier related course, additionally provide important supplementary capacity, particularly for patients unable to access specialist hospital-based palliative care **services** directly.

Fill in the blank: Palliative care services within Nigeria remain relatively limited, generally concentrated within a small number of specialist units based at select teaching _____.

5.1.3 palliative care services abroad: a comparative view

Many high-income countries have developed considerably more extensive palliative care **infrastructure**, discussed in relation to comparative health systems in an earlier related course, including dedicated hospice facilities, structured home-based palliative care teams, and formal integration of palliative care into broader oncology and chronic disease management **pathways**.

Comparing Nigerian and international palliative care provision highlights both the considerable **gap** in current Nigerian capacity and the potential value of adapting proven international models, discussed in relation to lessons for Nigeria in an earlier related course, to the specific resource constraints and cultural context of Nigerian palliative care **development**.

Fill in the blank: Comparing Nigerian and international palliative care provision highlights the considerable gap in current Nigerian capacity and the potential value of adapting proven international _____.

Figure 5.1: A palliative care team providing comfort and support to a patient and family member.

Pilot questions 5.1

- Define palliative care. (Linked to SLO 5.1)
- List two core principles of palliative care. (Linked to SLO 5.1)
- Describe the current state of palliative care services in Nigeria. (Linked to SLO 5.2)
- Describe the role of voluntary agencies in Nigerian palliative care provision. (Linked to SLO 5.2)
- Describe a feature of more extensive palliative care infrastructure found in many high-income countries. (Linked to SLO 5.2)

5.2 Alternative Medical Practice: A Critical Review

5.2.1 concept and scope of alternative medical practice

Approaches falling outside conventional biomedical practice

Alternative medical practice refers to health-related approaches falling outside conventional, evidence-based biomedical practice, discussed throughout this course, encompassing a

considerably broad range of practices, from traditional herbal remedies, discussed in relation to traditional medicine in an earlier related course, to various other unconventional therapeutic **approaches**.

The scope of alternative medical practice within Nigeria specifically reflects the country's diverse cultural and religious **context**, discussed in relation to family health beliefs in an earlier related course, with many patients continuing to consult alternative practitioners alongside, or sometimes instead of, conventional medical **care**.

Fill in the blank: Alternative medical practice refers to health-related approaches falling outside conventional, evidence-based biomedical _____.

5.2.2 common forms of alternative medical practice in nigeria

Common forms of alternative medical practice in Nigeria include traditional herbal **medicine**, discussed in relation to traditional healers in an earlier related course, spiritual or faith-based healing practices, and various forms of traditional bone setting and other unconventional physical therapeutic **approaches**.

These practices vary considerably in their specific claims and underlying **rationale**, ranging from approaches with some genuine, evidence-supported therapeutic benefit to others lacking any credible scientific **basis**, meaning a genuinely critical, individualised evaluation, discussed further in the next sub-Part, is essential rather than uniform acceptance or rejection.

Fill in the blank: Alternative medical practices vary considerably in their specific claims and underlying rationale, requiring a genuinely critical, individualised _____ rather than uniform acceptance or rejection.

5.2.3 critical evaluation of alternative medical practice

Critically evaluating alternative medical practice requires the family physician to assess available **evidence** for a given practice's claimed benefit, discussed in relation to evidence-based practice throughout this course, while remaining genuinely respectful of patient beliefs, discussed in relation to family health beliefs in an earlier related course, rather than dismissively rejecting all such practices without consideration.

Critical evaluation additionally requires particular attention to potential **harm**, including delay of necessary conventional treatment, discussed in relation to curative care in an earlier related course, or direct toxicity from certain herbal preparations, meaning the family physician's role generally involves open, non-judgemental discussion rather than either uncritical endorsement or outright **dismissal**.

Fill in the blank: Critical evaluation of alternative medical practice requires attention to potential harm, including delay of necessary conventional _____.

Table 5.2: Comparing conventional and alternative medical practice.

Feature	Conventional medical practice	Alternative medical practice
Basis	Evidence-based biomedical science	Varies; ranges from traditional knowledge to unsupported claims
Regulation	Formally regulated (e.g. MDCN)	Often informally organised or unregulated
Physician approach	Standard clinical practice	Requires respectful, critical, individualised evaluation

Pilot questions 5.2

1. Define alternative medical practice. (Linked to SLO 5.3)
2. List two common forms of alternative medical practice in Nigeria. (Linked to SLO 5.3)
3. Explain why alternative medical practices require individualised rather than uniform evaluation. (Linked to SLO 5.3)
4. Describe the components of a critical evaluation of alternative medical practice. (Linked to SLO 5.4)
5. Describe two potential harms relevant to alternative medical practice. (Linked to SLO 5.4)

5.3 Attachment to an Accredited GP and Medico-Legal Ethics

5.3.1 purpose and value of attachment to an accredited gp

Learning private practice directly from an experienced mentor

Attachment to an accredited GP, a general practitioner formally recognised as suitable for supervising trainee attachment, provides direct, practical exposure to the genuine day-to-day operation of a well run private practice, discussed throughout this course, complementing the theoretical treatment of private practice organisation examined in earlier Series.

This attachment offers valuable opportunity to observe an experienced practitioner's approach to the practical topics examined throughout this course, budgeting, personnel management, discussed in an earlier Series of this course, and medico-legal and ethical practice, discussed further later in this Series, within a genuine, functioning private practice **environment**.

Fill in the blank: Attachment to an accredited GP provides direct, practical exposure to the genuine day-to-day operation of a well run private practice _____.

5.3.2 medico-legal matters in private practice

Medico-legal matters relevant to private practice include the legal requirements surrounding informed consent, discussed in an earlier related course, appropriate medical documentation, discussed earlier in this course, and clear understanding of the physician's legal liability in the event of an adverse clinical **outcome**.

Effective management of medico-legal risk generally requires diligent adherence to recognised clinical **standards**, discussed throughout this course, maintenance of appropriate professional indemnity insurance, and prompt, honest communication with patients and families when adverse outcomes do occur, discussed in relation to honesty in clinical communication in an earlier related course.

Fill in the blank: Effective management of medico-legal risk requires diligent adherence to recognised clinical standards and maintenance of appropriate professional indemnity _____.

5.3.3 code of ethics governing medical practice

The **code of ethics** governing medical practice, discussed in relation to the Medical and Dental Council of Nigeria in an earlier related course, sets out the fundamental professional and ethical standards every physician, whether in private or public practice, must observe, encompassing confidentiality, discussed in an earlier related course, and honest professional conduct.

Consistent adherence to this code of ethics represents the essential foundation upon which patient trust and the entire profession's public **standing** ultimately rest, meaning the private family physician's day-to-day ethical conduct, discussed throughout this course, remains inseparable from the broader, genuinely successful practical operation of their private **practice**.

Fill in the blank: Consistent adherence to the code of ethics represents the essential foundation upon which patient trust and the entire profession's public _____ ultimately rest.

Figure 5.3: A trainee physician observing an experienced accredited GP conducting a consultation.

Pilot questions 5.3

1. Define attachment to an accredited GP and describe its purpose. (Linked to SLO 5.5)
2. Describe two topics a trainee can observe an accredited GP handling during attachment. (Linked to SLO 5.5)
3. List three medico-legal matters relevant to private practice. (Linked to SLO 5.6)
4. Describe two measures supporting effective management of medico-legal risk. (Linked to SLO 5.6)
5. Explain why consistent adherence to the code of ethics is essential to a private practice's success. (Linked to SLO 5.6)

Series Summary

This final Series examined **palliative care, alternative medical practice, and medico-legal ethics**, beginning with **palliative care services in Nigeria and abroad**, its concept and principles, current Nigerian service availability, and a comparative view of more extensive

international provision, before turning to **alternative medical practice**, its concept and common forms in Nigeria, and the balanced, critical evaluation such practices require.

We concluded with **attachment to an accredited GP and medico-legal ethics**, the practical value of learning directly from an experienced practitioner, the key medico-legal matters facing private practice, and the fundamental code of ethics underpinning all medical practice. Having worked through this Series, and indeed this entire course, you should now possess a comprehensive, practically grounded foundation in private practice organisation and the ethics of medical practice, from medical services structure and hospital administration introduced in earlier Series through budgeting, records, and, finally, palliative care and medico-legal ethics addressed throughout FAM 505.

Glossary of Terms

1. **Palliative care:** an approach focused on improving quality of life for patients facing life-limiting illness.
2. **Hospice:** a facility or service providing specialised palliative and end-of-life care.
3. **Alternative medical practice:** health-related approaches falling outside conventional, evidence-based biomedical practice.
4. **Traditional herbal medicine:** the use of plant-based remedies rooted in traditional healing practice.
5. **Critical evaluation:** a balanced assessment weighing evidence, patient beliefs, and potential harm.
6. **Accredited GP:** a general practitioner formally recognised as suitable for supervising trainee attachment.
7. **Medico-legal matters:** legal issues, such as consent and liability, arising in the practice of medicine.
8. **Professional indemnity insurance:** insurance protecting a physician against claims arising from their professional practice.
9. **Code of ethics:** the set of professional and ethical standards governing medical practice.
10. **Informed consent:** a patient's voluntary agreement to treatment based on adequate understanding of relevant information.
11. **Adverse outcome:** an unintended, harmful result arising from medical care.
12. **Professional standing:** the reputation and trust a profession holds within society.

Concept Check Questions [Series 5]

Objective questions

1. Palliative care is complementary to, rather than necessarily replacing, active disease-directed _____.
2. Palliative care services in Nigeria are generally concentrated within a small number of specialist units at select teaching _____.
3. Alternative medical practice refers to approaches falling outside conventional, evidence-based biomedical _____.
4. Effective management of medico-legal risk requires diligent adherence to clinical standards and appropriate professional indemnity _____.
5. Consistent adherence to the code of ethics is the foundation upon which patient trust and professional _____ ultimately rest.

Short-answer questions

- Define palliative care.
- Describe the current state of palliative care services in Nigeria.
- List two common forms of alternative medical practice in Nigeria.
- Describe two potential harms relevant to alternative medical practice.
- List three medico-legal matters relevant to private practice.

Long-answer questions

1. Discuss the concept and principles of palliative care. (Linked to SLO 5.1)
2. Discuss palliative care services available in Nigeria and abroad. (Linked to SLO 5.2)
3. Discuss the concept, scope, and common forms of alternative medical practice in Nigeria. (Linked to SLO 5.3)
4. Discuss the critical evaluation of alternative medical practice. (Linked to SLO 5.4)
5. Discuss attachment to an accredited GP and medico-legal matters and the code of ethics governing medical practice. (Linked to SLO 5.5, SLO 5.6)

Answers to Concept Check Questions [Series 5]

Objective questions

6. Treatment.
7. Hospitals.
8. Practice.

9. Insurance.
10. Standing.

Short-answer questions

11. An approach focused on improving quality of life for patients facing life-limiting illness.
12. Relatively limited, generally concentrated in a small number of specialist units at select teaching hospitals.
13. Traditional herbal medicine, and spiritual or faith-based healing practices.
14. Delay of necessary conventional treatment, and direct toxicity from certain herbal preparations.
15. Informed consent, medical documentation, and legal liability for adverse clinical outcomes.

Long-answer questions

16. **Basic response:** Palliative care improves quality of life for patients facing life-limiting illness, addressing pain and distressing symptoms alongside psychological, social, and spiritual support.

Value-added response: It is holistic and patient-centred, extends support to the family, and is complementary to, rather than a replacement for, active disease-directed treatment.

17. **Basic response:** Palliative care services in Nigeria remain relatively limited, concentrated in select teaching hospitals, supplemented by community-based and hospice-style initiatives often supported by voluntary agencies.

Value-added response: Many high-income countries have more extensive infrastructure, including dedicated hospices and structured home-based teams, highlighting a gap and potential lessons for Nigerian development.

18. **Basic response:** Alternative medical practice encompasses approaches outside conventional biomedical practice, including traditional herbal medicine, spiritual healing, and traditional bone setting.

Value-added response: These practices vary considerably in their claims and rationale, reflecting Nigeria's diverse cultural and religious context and requiring individualised rather than uniform evaluation.

19. **Basic response:** Critical evaluation requires assessing available evidence for claimed benefit while remaining respectful of patient beliefs, rather than uncritical endorsement or outright dismissal.

Value-added response: It also requires attention to potential harm, including delayed conventional treatment or direct toxicity, guiding the physician toward open, non-judgemental discussion.

20. **Basic response:** Attachment to an accredited GP provides direct exposure to the practical operation of a well run practice, complementing theoretical learning throughout this course.

Value-added response: Medico-legal matters, including consent, documentation, and liability, are managed through adherence to clinical standards, indemnity insurance, and honest communication, all underpinned by the code of ethics essential to patient trust and professional standing.

Answers to Pilot Questions [Series 5]

Part 5.1

11. An approach focused on improving quality of life for patients facing life-limiting illness.
12. Holistic, patient-centred care, and extending support to the patient's family.
13. Relatively limited, generally concentrated within select teaching hospitals, though gradually expanding.
14. They provide important supplementary capacity, particularly for patients unable to access specialist hospital-based services.
15. Dedicated hospice facilities and structured home-based palliative care teams.

Part 5.2

1. Health-related approaches falling outside conventional, evidence-based biomedical practice.
2. Traditional herbal medicine, and spiritual or faith-based healing.
3. Because they vary considerably in their claims and underlying rationale, from evidence-supported benefit to no credible basis.
4. Assessing available evidence for claimed benefit while remaining respectful of patient beliefs.
5. Delay of necessary conventional treatment, and direct toxicity from certain herbal preparations.

Part 5.3

6. Supervised placement with a recognised general practitioner; it provides direct exposure to genuine private practice operation.
7. Budgeting and personnel management, and medico-legal and ethical practice.
8. Informed consent, medical documentation, and legal liability for adverse outcomes.
9. Diligent adherence to clinical standards, and maintenance of professional indemnity insurance.
10. Because patient trust and the profession's public standing ultimately rest on consistent ethical conduct.

References and Attributions [Series 5]

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13. Medical and Dental Council of Nigeria (2008). Code of Medical Ethics in Nigeria.
14. McWhinney, I. R., & Freeman, T. (2016). Textbook of Family Medicine (4th ed.). Oxford University Press.

Figures, Plates, Tables, and Boxes

1. Figure 5.1: A palliative care team providing comfort and support to a patient and family member. AI-generated using the prompt: "A single clean, realistic clinical illustration of a care team supporting a patient and family member together in a calm setting, soft natural lighting, no text overlays, no multiple panels, respectful and accurate depiction, no graphic medical detail."
2. Table 5.2: Comparing conventional and alternative medical practice. AI-generated using the prompt: "Create a clean reference table titled Comparing Conventional and Alternative Medical Practice, listing feature, conventional medical practice, and alternative medical practice. Simple clinical reference table style with outside border."
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