

RURAL HEALTH ISSUES

The South African Academy of Family Practice's Rural Health Initiative (RHI) is proud to be able to bring you the following section of the journal, that will concentrate on issues pertaining to rural health in South Africa. We hope to provoke discussion on these issues and would encourage anyone interested in rural health to offer contributions to future issues.



WORKING IN A RURAL HOSPITAL FOR THE FIRST TIME

In the previous Rural Hospital focus column¹, I looked at the issue of the Culture Shock new doctors face in moving to work in rural hospitals. This time the focus is on preparing for or dealing with this culture shock.

I have reflected on my own personal experience of nine years working at Manguzi Hospital during which I had to orientate dozens of new doctors. Arising from this, I wish to offer some suggestions for consideration by any doctors planning to work in a rural hospital. I hope it will be especially useful to community service doctors posted to such hospitals.

Most doctors will undergo "culture shock", which has been well described in the non-medical literature. There are 4 distinct phases of culture shock, or the ongoing response to a new cultural milieu. As in any human process, people do not necessarily experience these in the same sequence and may move in and out of the different steps. They are usually more easily noticed by those on the outside, but an awareness of them helps the new arrival to deal with them as they arise. Even if there is not a cultural adjustment required in terms of ethnicity, there may be other adjustments related to rural versus urban differences, or to hospital cultures, as noted previously¹.

The stages are as follows:

1. Fascination. The newcomer is excited by the novelty of the experience. The differences in the host culture arouse interest, fascination or amusement. These may be remarked on at length and repeatedly, sometimes inappropriately, to the irritation of the hosts. For example, there may be comments

regarding the friendliness of the staff, or the appreciation shown by patients, or the speed at which laboratory test results are obtained. In any new situation, we adapt by comparing what we are experiencing to what we know in order to assimilate it, and this is simply part of that process.

2. Irritation. The differences that initially inspire wide-eyed excitement become repetitive experiences, which wear the newcomer down because they are so consistently unfamiliar. This leads to negative comparisons with "home" in which nothing in the host culture is seen to be as good as the situation we have come from. On a simple level, this might mean longing for the food that one is used to and distaste for what one has to eat, or dissatisfaction with the types of entertainment available. The very things that initially fascinated can become a source of irritation (e.g. the "friendly staff" are "only interested in chatting and drinking tea") In the health care context, practices and procedures are usually compared to the standards we are used to and found wanting. Hosts have to exercise much patience to cope with constant comments starting, "at our medical school we would ..." (give this drug /do this operation/offer this specialist intervention/take this blood test, etc.) Doctors who become stuck in this stage often leave because they cannot cope with the way things are done locally, and will forever remember that health service for its "inferior standards" and "incompetent staff", judgments made on the basis of difference and not appropriateness.

Finding ways to channel this irritation into working positively for change and making a contribution to the system can prevent progression to the next stage.

3. Depression. At some stage, the irritation becomes focussed inwards, i.e. the newcomer feels there is something wrong with him that he cannot cope in the situation and becomes depressed. Where the previous stage can have negative repercussions for the host hospital if the doctor returns home without moving out of it, this stage can leave the doctor with permanent negative feelings about himself, of inadequacy and incompetence, if not dealt with. In this stage the new doctor struggles to make a contribution to the work, needs much care and support which drains the energy and resources of the hosts, and talks constantly of leaving, which creates unwelcome uncertainty. Good emotional preparation, understanding colleagues, and outside support from home can make a big difference at this stage.

4. Adaptation. Most people are able to come to a symbiotic relationship with the host culture so that they can function effectively and sensitively in the new situation, though they may at times revert to a previous stage. The problems often occur on returning home, when a very similar process of re-entry culture shock may occur – sometimes worse than the original process. (This is exacerbated by relating to people who, having continued in their normal routines, do not understand the life-changing experience the returnee has had.)

One form of negative adaptation, which often does occur, must be guarded against. Arising from comparisons with previous experiences, the doctor might mistakenly decide that the differences that exist relate to inferior standards or, worse still, a lack of concern for local people, leading to a feeling that "anything goes", i.e. that he can practice any sort of medicine or perform any sort of procedure without concern for possible untoward consequences - third-rate medicine for the 'third' world, as the rural context is often described. This is the result of mistaking culturally- and contextually-appropriate responses by health workers to people's needs and problems for lack of care and concern. This is particularly problematic where training has happened entirely within academic ivory towers - fortunately increasingly less common in South Africa. Ultimately, those who have adapted will become balanced ambassadors for the host culture (hospital), able to express how they have grown and been enriched, and to share what they have learnt, thus inspiring others to go through the same process.

It should be noted that doctors with families are not protected from culture shock. While a partner can be a support in coping with this process, each person in the partnership or family may be in a different stage at the same time, which can lead to great conflict.

An attitude that doctors from the cities, who could be living more comfortably back home, or doctors who have been forced to work in a rural hospital, often communicate to their hosts is that they expect gratitude for the "sacrifice" they have made, and the hardships they have to endure. If things are not as they expect them to be, the hosts are told, directly or indirectly, that they are ungrateful. Such an attitude quickly creates resentment and damages working relationships.

A similar attitude amongst new doctors, who with the best intentions want to make a significant contribution to the work, is the unintended arrogance of the reformer or expert

who is going to show the ignorant locals a better way of doing things. New ideas are always welcomed, but such gifts need to be shared sensitively and humbly if they are to be well-received. A wise person will also examine the long-term impact of any changes suggested, especially if she is not going to be in the context for very long. Doctors need to be realistic in matching any changes proposed to the extent of their own commitment, and to their own willingness to see through the changes.

In terms of length of stay, it is wise for a doctor going to a rural area not to commit himself for longer than he may be able to cope with. In the constant struggle to staff their hospitals, medical superintendents may offer vacancies to doctors both on the basis of their experience and their expected length of stay. A doctor who indicates she is willing to commit herself for a year and then leaves after 6 months lets the local service badly down - just as one who puts off her arrival at the last minute. In a small team it has a huge impact on morale. It is better to promise a minimum commitment and mention any doubts at the outset. The stay can then be lengthened by mutual agreement. Similarly, it is not wise to make decisions about departure when in the throes of culture shock; many doctors who make fixed plans to move on because they are not coping, later regret these as they adapt to their new situation.

It is of course reasonable to expect a commitment from the receiving hospital too regarding any position or appointment. Also, the local hospital should provide answers to the most commonly asked questions. However, it is difficult for doctors working in the frontline to be objective. Thus it is useful to ask for contact names and details of people who have worked there in the past: most rural hospitals will have former doctors who can be contacted and who can provide a wealth of useful information. This information should of course always be checked out with the local contact, both because things change and because, as noted above, culture shock will have affected the other

person's memories and perceptions of his experience.

As part of one's preparation it is worth finding out about cultural norms and expectations, especially where there is an ethnic difference. Never assume what is okay in the city will go down well in a rural area, even if you are familiar with the ethnic group you will be working with. Rural people are frequently more conservative than their urban counterparts. The area in which this is often most noticeable is dress. Doctors should NOT assume they can wear what they do at home - locals may be more or less formal. Even the simple process of greeting can be fraught with difficulties.

Finally, it is vital to go with a willingness to learn - not only about medicine and healthcare, but also about language and culture, and not only from doctors but also from other health workers and from patients. The doctor who is not open to learn quickly finds he is not suited to a rural hospital. Learning the local language is an important ingredient in this. No one can be expected to be fluent in a few months, but the simple ability to greet another person in his or her own language goes a long way to being accepted.

Ultimately, there is a two-way process required, as in any relationship: just as the incoming doctors need to accept the locals, so these "visitors" need to be accepted by local colleagues and patients if their stay is to have any meaning.

Reference:

1. Couper, Ian. Culture Shock among New Doctors (Column) SA Fam Pract 2002; 25(1): 17-18

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Note: We welcome contributions to this column, particularly any personal experiences readers may have of this issue.