

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.



## ☼ RURAL HOSPITAL FOCUS - DEBATING POINTS ☼

### ☼ DEFINING RURAL ☼

The issue of defining "rural" is something that has taken up much time at many meetings around the world. Usually it is very difficult to reach agreement, and different groups in different countries come up with and use different definitions. The key is what purpose the definition is used for.

Developed countries tend to define rural (and often remote at the same time) related to the size of communities (population), and, in terms of remoteness, distance. This is less useful in developing countries, where the size of the population bears little relationship to the degree of development, infrastructure and services. It is for this reason, perhaps, that the concept of the "inhospitability index" was introduced by Nicholas Crisp some years ago (report for Deloitte and Touche commissioned by Masa<sup>1</sup>). The USA uses a Physical Quality of Life Index (PQLI), which is a computer-defined index, but this defines disadvantage more than "rural". Factors which need to be included in such indexes include the health service available, geography, demography, primary industry (agriculture), socio-cultural issues, schooling, recreational facilities, general services, etc. Possible employment for doctors' spouses might be included. Academic contact / isolation would be important to include in such

indices. However that is a cumbersome and complicated process to work out and does not actually define rural.

Another possibility is definition in terms of doctor-population ratios. The problem here is that there is not agreement on what ideal ratios are, and issues such as distance and transport infrastructure must affect these ratios – hence Australia has 3 different ratios for urban, rural and remote. The needs of different populations may vary. There are also methodological problems in establishing what the existing ratios are, related to the accuracy of population figures, defining the geographical area and defining the number of doctors.<sup>2</sup> These are thus better used as ideals to be aimed for than as definitions.

Most definitions take issues such as service, access and remoteness (distance) into account. There are differences in definitions related to "rural" versus "rural practice" versus "rural health care" versus "rural development", etc. What is clear is that:

- rural cannot be defined as "non-urban"
- rural and underserved are not interchangeable (some rural areas are not underserved, e.g. well known tourist areas, and some underserved areas may be in inner cities)
- "rurality" is like beauty, which is in the eye of the beholder, and
- defining "rural" is useful as a focus on which to build recommendations and policy, which will

in turn impact on underserved areas.

But rural areas have particular challenges which make them different, beyond the key issue of workforce deficiencies, which is what defines underserved areas. (For this reason one definition proposed relates to the difficulty of evacuating critically ill patients.) Looking at services available is useful, but of course these change very quickly as human resources change, so it is probably better to work with a definition related to people providing the service.

For the purposes of this discussion, Working Party, I have looked at the definition of rural practice. The Royal Australian College of General Practitioners' Faculty of Rural Medicine defines rural practice as "medical practice outside of urban areas where the location of practice obliges some general or family practitioners to have or to acquire procedural or other skills not usually required in urban practice."<sup>3</sup> Jim Rourke from Canada defines rural practice as "practice in non-urban areas, where most medical care is provided by a few GPs or family doctors with limited or distant access to specialist resources and high technology health care facilities."<sup>4</sup>

I thus propose the following definitions, which draw on these and our own particular situation:

- **Rural health care** relates to the provision of health services to areas

outside of metropolitan centres where there is not ready access to specialist, intensive and/or high technology care, and where resources, both human and material, are lacking. This service may be within hospitals, health centres, clinics or independent practices. It is best provided by a team of health care workers and is based on the principles of Primary health care

- **Rural medical practice** is health care provided by generalist medical practitioners whose scope of practice includes care that would be provided by specialists in urban

areas. It is appropriate technology health care, appropriate to the needs of particular communities that are served. It usually includes elements of family/general practice, public health, and extended procedural work, within the context of primary health care and the PHC team.

I would appreciate feedback on these definitions, as well as suggestions on how to define “underserved”, which is possibly an even more difficult task.

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## References

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2. Hays RB, Veitch PC, Franklin L, Crossland L. Methodological Issues in Medical Workforce Analysis: Implications for Regional Australia Aust J Rural health 1998; 6:32-35
3. Working Group on Postgraduate Education for Rural Family Practice. Postgraduate education for rural family practice: Vision and recommendations for the new millenium. Can Fam Phys 1999; 45:2698-2704
4. Rourke J. In search of a definition of rural Can J Rural Med 1997;2(3):113-5

## ☀ IT'S TOUGH OUT HERE, AT THE LIMITS ☀

“Growing up is hard to do”, I seem to remember some crooner belting out on the radio waves of my youth, but boy, oh, boy, did he know what he was talking about. For 24 relatively protected years, I thought that I had life so tough. School everyday, moving to Johannesburg, horror of horrors, for university, medical school at that and the stressful job I had; it was really almost more than I could bear.

Then one Friday, I saw an old man shuffling down the dusty road and it was then that I realised just how privileged I am. To give a little more insight into me; I am a doctor, and am fortunate enough to have worked in the rural Eastern Cape. I grew up in East London, studied at Wits and always thought I was open minded and liberal. My ties to the Eastern Cape have always been strong and my passion lies amongst the people that I find here. It was not an easy decision to move here after my university years, but for want of a job and a change of scenery, I came home and worked in East London for a year, doing my internship, before moving more rural to Queenstown and then Dordrecht for my community service. In Queenstown, I worked at the district hospital, while in Dordrecht I was the rural clinic doctor, travelling to distant

and relatively abandoned clinics, which, until the institution of the community service program, had not had a doctor.

Every move has weighed me down and I have gone with much trepidation and hesitation, only to be pleasantly surprised by what I have found. My rural moves were never part of my life plan, but you know how it goes and they have become defining events in my life. Like the old man.

The old man shuffles down the main road, and you know that he has at least another 5 – 10 kilometres before he gets home, and that at his current pace he is going to be walking for a while. I now know, after working here for six months, that he is probably the breadwinner in his household with that measly pension he gets. He was probably on his way home from the clinic where no doubt the treatment he sought was out of stock and he will have to return the following week, probably still with no success. And slowly watching his cautious shuffle, it dawned again with much greater insight than ever before, just how easy my life is; and I dare to complain.

It is at times like this that I am ever grateful for the opportunity afforded to me by the rural situation. I have

had to quickly and painfully grow up and from this, an intense passion for the circumstantial victims of their situation has developed. Never again will I casually dismiss the patient who tells me she couldn't make her appointment because she had no money (read, the pension officers were late in coming and there was no money in the household since granny is the only breadwinner); because the weather was bad (read, the rains came and washed the road away); because her relative died (mourning is a complex event here, not the clinical process we know); or because her child was sick (being ill in a rural area is hard enough, harder still in the case of a child who will need nursing and extra attention from mom, and the trip to the clinic can take all day.) The glimpse of insight I have gained is invaluable and is changing the way I understand my patients.

The rural option requires sacrifice and there was a lot I lost in my time out there. Friends in bigger cities forget about you and the phone calls dry up, the academics disregard you and your referral hospitals and colleagues begin to view you with resentment. However the reward of seeing the impact that you do have is marvelous and easily counters the negativism of those who have never been where you are. I really

do believe that I am one of the lucky ones who have had a Saul on the road to Damascus kind of experience. It has been a fairly defining event in my life and the people that I encountered have left permanent impressions on my soul: patients, passionate hospital doctors,

committed general practitioners and the community members who welcomed me with open arms.

So I guess despite all my initial misgivings this year of rural work has been a life changing one and I am so very grateful

to have been afforded the opportunity. There is a sense of such fulfillment that I carry with me and a passion that has been evoked to bring about improvements in the lives of these people.

*Robyn Spring, MB ChB*

## ☼ REMEMBER ☼

### ☼ THE 5TH ANNUAL RUDASA CONFERENCE ☼

**...will be held at Hartswater/Taung between 9-11th August.**

The theme is:

**Captain? Goalie? Ref?  
On the bench? - "The Role of the Doctor in the Rural Health Team"**

The congress starts on the evening of Women's Day and the Opening address will address issues common to Women and Rural Medicine. The congress will end on Saturday at lunchtime with a Debate/Forum discussion on "The role of the doctor in the district team. Perspectives from private practice, hospital practice, district management, etc." In between, sessions will focus around teams and programmes.

You will also have an opportunity to participate in discussions around issues

in community paediatrics, community obstetrics, family therapy, essential drugs, maternal and child health, management of HIV related diseases at low cost, management of common dermatological conditions, common ethical issues (confidentiality, consents, etc), hypertension guidelines and many more

The Chairman of the Scientific Programme, Jannie Hugo, would like to invite you to submit abstracts for free papers and posters by 15<sup>th</sup> June 2001: fax (012) 521 4172 or [jh38@mweb.co.za](mailto:jh38@mweb.co.za)

For accommodation, contact Mr William Lock (Manager Hartswater Lodge). Tel & Fax (053) 474 0077

For all other information contact the congress convenor Lino Di Mattia at

[dima@inext.co.za](mailto:dima@inext.co.za) or tel 053-9941917 or fax or 053-9941805

*Where is Hartswater?* Approximately: 450 km from Jhb, 120 km north of Kimberley, 40 km north-west of Christiana. It is easy to reach on good roads or you can fly into Kimberley.

Registration fee includes lunches, suppers and teas; R350 for members, R420 non-members; After 15<sup>th</sup> July, late registration fee will increase to R375 for members and R450 for non-members;

Day registration R200.

Accompanying delegates programme available by request. Children's programme and baby-sitting will be arranged on request.

## ☼ BOOK REVIEWS ☼

### ☼ THE HLABISA HOSPITAL HANDBOOK ☼

**Hlabisa Hospital Handbook**, edited by Dr Gerry Davies. Published by the South African Academy of Family Practice, January 2001.

This is a front-line "how-to-do-it" manual from a typical rural district hospital in KwaZulu-Natal, which will be of great value to a much wider audience in similar situations. Chapters include anaesthesia, O&G, surgery, medicine, psychiatry (a bit thin!), paediatrics, neonates, forensic medicine, a short phrasebook on medical Zulu, and a hospital formulary. Basically, the handbook is a compilation of clinical guidelines and protocols used and

developed at Hlabisa by the editor and his colleagues, but they have been refined and brought together in a comprehensive way that is impressive. Particularly useful are the chapters on anaesthesia, using material from another SAAFP publication, and the guidance on surgery and orthopaedic management in the front line. The only lack of the handbook is in the absence of an approach to the patient with an undifferentiated problem – it is written from a disease-oriented perspective, whereas the clinical dilemmas facing young doctors in the bush are often more complex, in the face of a bewildering array of conflicting clinical

signs, and lack of laboratory and other diagnostic support. However, this does not detract from its usefulness, as one needs to know what to do having made a presumptive or differential diagnosis, when the "normal" course of management is not available in the rural context. Although some of the management suggestions are parochial, the principles of what to do oneself, and when to refer on to regional level, are applicable throughout the country.

Each chapter is written from the Hlabisa perspective, describing what is most common and important to look out for, with interesting notes and local

adaptations, as well as a list of references for further reading at the end of each sub-section. The latter makes this handbook more than just a rural doctor's set of clinical protocols – it consistently provokes the reader into taking a more studied approach to his or her clinical work in the rural situation. Making the most of the

enormous learning opportunities of a rural district hospital in South Africa is something that every generalist doctor should actively pursue, whatever their level of experience, and the handbook contributes admirably to this approach.

I would thoroughly recommend this handbook for every community service

doctor placed in a district hospital, rural or urban, as well as medical students, medical officers and GP's who do sessions in district hospitals. I would endorse the back cover which states: "In the deep end, the Hlabisa Hospital Handbook is a lifeline".

Steve Reid

## SMART HEALTH CHOICES

Judy Irwig, Les Irwig, Melissa Sweet  
**Smart Health Choices: How to make informed health choices**  
St Leonards NSW: Allen & Unwin, 1999.  
226pp.  
ISBN 1-86508-146-9

"Evidence-based medicine for the lay consumer" would be an alternative title for this interesting little book. While its focus is mainly on helping consumers (patients) to assess the health advice they are given, I recommend it highly for any health care professional – not only because if your patients read it and you do not, you will be in a jam, but also because it gives a clear, readable and down-to-earth summary of what evidence-based practice is all about.

The book is divided into 5 parts, and also has a number of appendices. Part 1 looks at the issue of health advice – the problems frequently encountered, and how to assess it. "Just because two events occur together, it does not mean that one event causes the other" (p. 18) Part 2 looks at how to make better decisions, including the choice of health care practitioner (how will you measure up?). It provides 5 critical questions

which can be used in making health decisions, viz.

- What will happen if I do nothing?
- What are the intervention options?
- What are the benefits and harms of these options?
- How do these relate to my situation?
- Do I have enough information to make a decision?
- The issue of guidelines and whether or not they are evidence-based is also addressed in this section.

Part 3 looks at different kinds of evidence that are available, from anecdotal to probabilistic, and other factors which affect outcomes. Part 4 looks at a hierarchy of studies in terms of their usefulness: systematic reviews of randomised controlled trials (RCT's), RCT's, non-randomised studies of various types, opinions and case reports. This section, together with an appendix on appraising research, is, I think, particularly useful for practitioners wanting to improve their ability to assess journal articles. Part 5 gives ideas for finding and evaluating evidence, providing a helpful list of web sites. The appendices cover the usefulness and predictive value of

diagnostic tests, risks and confidence intervals, and provide some exercises in evaluating articles.

Practical examples of issues discussed as well as a summary at the end of each chapter help. Many of the concepts are repeated throughout the book, which I found somewhat irritating, but the authors' rationale is that this allows for modular-style reading of the book – the readers choose the most appropriate sections for their needs rather than reading cover to cover. Amusing cartoons throughout the book help to keep it light – not often something one can say about a book on evidence-based medicine!

I believe this book should be prescribed reading for any course on evidence-based medicine or practice. Those interested in obtaining the book or more details, can visit the Smart Health Choices website <http://www.health.usyd.edu.au/smarthealthchoices/>

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### INVITATION TO ALL COMMUNITY SERVICE DOCTORS

You have received several free copies of S.A. Family Practice over the past few months. If you have found the journal interesting and informative and would like to continue receiving it after your community service has been completed, please contact Penny Bryce at the South African Academy of Family Practice / Primary Care on (011) 807 6605.

**Be Proactive, be Professional, get Involved with your Future!**