Urbanisation and Family Practice: Challenges for Family Practitioners

One of the main differences between rural family practitioners and their urban counterparts is the environment in which they practise their professions. The strong influence of the local conditions on the practice of family medicine has been identified and described by McWhinney [1]; a situation which this article explores further.

The essence of this article is to focus on the need to emphasize the role of family practice in the cities, where in most cases family practice is taken to be synonymous with clinic and community health centre practice, rather than hospital practice. It is becoming important to emphasise and enhance the roles played by family practitioners in the urbanised communities.

Urbanisation [2] refers to the transition from a rural society to one in which a growing number of the world's population lives in cities. Between 1900 and 1999 the proportion of the world's population living in the cities has increased by about 40%; that is, from about 150 million to 2.2 billion this century. This urban explosion could not go unnoticed by family practitioners, since it will definitely impact on their practices within these urban environments.

Perhaps it is time that urban practitioners reassessed themselves, how they fit into these rapidly-urbanising world communities as individuals and as healthcare providers, without compromising caring services to their patients and the communities. This obviously involves some challenges.

My understanding and perception of these challenges is based on personal experience from observation of urban family practice in community health centres and clinics.

In my view, the main challenges faced by an urban family practitioner are:

Over-dependence on hospital secondary and tertiary care:

As a result of relatively closer secondary and tertiary hospital services in urban areas, family practitioners tend to seek this level of care for their patient too soon. Family practitioners cannot be held totally responsible for this, since, in many cases, patients themselves request hospital referral. This situation suggests that most patients who should be cared for at the primary care level are then exposed to expensive and unnecessary investigations at secondary and tertiary level care.

Loss of surgical skills:

Rural doctors, are, in most cases, prepared for appropriate surgical interventions in healthcare delivery. In urban practice less surgical intervention occurs, primarily because practices are mostly clinic based and secondarily because higher levels of care are easily available. The impression here is not that urban practitioners lack surgical skills, but how quickly they can lose these skills in the context of the environment in which they practise.

"Competition" with hospital doctors/ specialists:

Family physicians coexist with specialists in the urban areas to complement each other's services. In the process, family physicians refer necessary cases to specialists. Unfortunately, most of the urban hospital specialists erroneously perceive doctors in community health centres and clinics as less competent and subservient to them. For a variety of reasons a substantial number of urban doctors prefer to work in hospitals rather than clinics or community health centres. The apparent claim to superiority by one or the other level of care in urban areas presents a situation akin to competition between community health centre based family physicians and hospital doctors.

Distraction of family physicians from some fundamental principles of family medicine:

In urban areas today it is becoming less common for a family physician to share the same habitat with his or her patient. Reasons for this include difference in socio-economic status in some cases, the location of health facilities, plus the convenience and safety for doctors. In many cases, an urban family physician,

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might only see his patient at the office, since home visits could be very risky in some areas due to escalating crime.

Patients in urban areas tend to overload most clinics and community health centres. This leaves family physicians to manage scarce human resources, at the expense of some other important services such as opportunistic preventive care/ health education that deserve the doctor's time.

A family physician needs to be involved in community-based support networks to the benefit of his patient. This could easily be ignored in an urban practice due to the peculiar and complex socio-cultural elements of an urban community network.

Healthcare service delivery has become a huge challenge for family physicians in less developed countries; a situation made more difficult in the face of various political dictates that often limit the ability of practitioners as good resource managers.

Workload pressure:

The continuing influx of people to the urban areas remains a source of higher demand for the services of family physicians in these communities. These increasing loads are a source of work stress and could compromise all aspects of important healthcare functions.

Training and development:

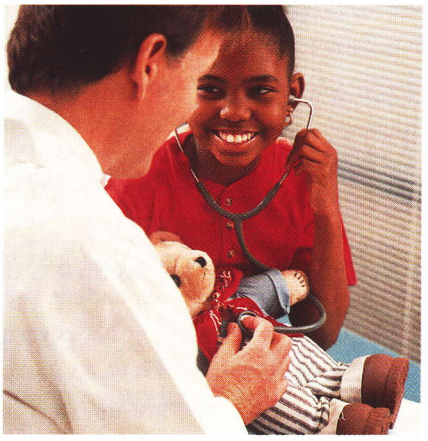
Continuing Professional Development is essential, and now obligatory, for family practitioners. It is also very beneficial to all health care providers. Primary healthcare approaches to learning such as self-directed learning, peer review programmes and in-service programmes, among others, need to be further emphasized. An interesting trend in the cities is the movement of doctors to the hospitals from clinics and community health centres for jobs and further specialist training. Perhaps most of these doctors do not understand the important role they could play in urban primary healthcare service.

Doctor-patient relationship:

Continuity of care could be undermined in the cities, since most of the patients are lost as a result of patient hopping from one health facility to the other. In urban areas, some patients simply cannot afford to visit a private family practitioner. Family physicians in urban areas need to be aware of this socio-economic situation and see patients' problems in this context.

The quality of care:

Two emerging factors impacting on the quality of care in urban practices are the increasing load of patients mentioned above and the apparent low level of quality improvement activities among urban family physicians. Because of the patient load, there is decreasing consulting time per patient. This situation might not particularly compromise quality of care, but some aspects of patient-centred care could suffer, as this might serve as a constraint to some doctors' addressing patients' own agendas.



How can we cope with these challenges?

Urbanisation is a reality and family physicians need to design ways and means of coping with this. Some of the challenges posed by urbanisation could be met in various ways.

Firstly, urban family practitioners will have to strengthen their individual and collective relationships, which could be organized in defined groups. Hopefully, such relationships would enhance interaction both professionally and otherwise among practitioners in order to keep in focus what family practice stands for. This will also serve as a common strategic approach to other problems and challenges facing family practice in the urban areas.

Secondly, there is a need to encourage ongoing self learning by each practitioner, based on his or her daily experience with his or her patients.

Thirdly, emphasis on quality improvement activities should be made a prerequisite for defined, acceptable quality primary care for the urban communities.

Conclusion:

The views on the challenges facing an urban doctor outlined above are far from exhaustive, as the challenges are defined by each doctor's unique circumstances. Meeting these challenges would require the joint effort of all urban practitioners in a particular community.

Finally, it is important to realize that the time has come for every family physician practising in the cities to be supported, recognised and encouraged with equal emphasis on the urban doctor as there is on the rural doctor.

References.

1. McWhinney IR. A textbook of family medicine: A profile of family medicine. New York: Oxford University Press, 1989: 35-42
2. Polese M. Urban research as a tool for international development; urbanization and development. www.unesco.org/most/wien/polese.htm, 7 May 1999: 1-8

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