

# REDISCOVERING MEDICINE IN RURAL PRACTICE

It would appear that, even in the most troubled societies, the physician is seen as the one non-threatening figure — the only reliable source of caring and compassion. The modern city is an environment that is hostile to this sort of physician.

The unique combination of art, science and craft that constitutes the practice of medicine, is fragmenting under the pathological stresses of an industrialised urban society. The individual is mistrustful of, and estranged from, society, as family values disintegrate in the artificial environment of the modern city.

The rural area remains the last haven of stable communities, where the family flourishes and the individual can sustain personal relationships. The doctor in the countryside is enmeshed in a network of relationships that keeps the doctor honest to his vows. In rural practice, the opportunity exists to place the interests of the patient above costing and narrow professional interests. This movement of family physicians must lobby the cause of rural health and now is the best time to start.

Consider the state of cities worldwide. Megacities are emerging with populations greater than some nations represented here. A vast underclass forms the bulk of inhabitants and crime is a significant way of life. Until urban drift is reversed, the stability of society will be threatened by urban chaos.

## Information technology

There is also the great information technology explosion. Swift electronic communication, and infinite global access to information, have enabled people to work from home or from remote offices. Thus it is possible for highly skilled people to live away from the horrors of the city. They bring with them the means to sustain the quality of life, as well as a reversal of the detrimental urban spread, but they want the assurance that established medical care is also available there.

The other advantage of the information explosion is ready access to the latest medical information and expertise from around the globe. This means that the good standard of rural medical care, once established, can easily be improved.

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Our cause is truly important. The majority of the peoples in the world live in rural areas, and even in developed countries, about a third of the population lives outside the cities. Globally, although the majority of the population lives in the countryside, the bulk of health funds is spent in the cities.

The diseases that afflict rural people are neglected; their mortality is an invisible statistic. There are few doctors in rural areas, in contrast to the oversupply of doctors in cities. Rural doctors accept heavier responsibilities and face greater clinical challenges, yet they are poorly rewarded, unrecognised and unappreciated except by the people they serve. The system is unfair and politicians only pay lip service to the importance of rural health. We must do something about it.

## Proposal

I propose two tasks for our united efforts. We must get our own house in order by improving the quality of care, and we have to launch a global campaign to put rural health at the top of the international agenda.

For the first part, we have to build up our organisations and to develop our networks. We need common global standards so that trained rural physicians are equipped to be effective, wherever in the world they are needed. To this end, we need to strengthen our training programmes. Medical schools have to be nudged into a recasting of medical education to make them relevant to a greatly changed global environment.

## Health for All

For the second part, the programme initiated by the World Health Organisation, to achieve Health For All by the Year 2000, has fallen short of the targets. This is due, not only to a lack of commitment from governments, but to a lack of commitment from the medical profession as well. That programme is currently under review by WHO and rural doctors and their organisations must play a leading role in the search for new approaches and strategies.

Organisations such as WHO, UNESCO, as well as WONCA and its associated groups and committees can help us. We have the historic opportunity to advance the welfare of the majority of the human race and, at the same time, to rediscover our vocation in the practice of medicine. ●

## THE RURAL GENERAL PRACTITIONER: AN AFRICAN PERSPECTIVE

In 1991 WONCA defined the general practitioner as "the physician who is primarily responsible for providing comprehensive health care to every individual seeking medical care". The World Health Organisation defines general practice as "the front line of care".

These definitions were confirmed at an international conference on training for general medical practice in Nigeria in 1980. The training programme that was developed provides advanced general practice training which has proved to be appropriate for the care of the 80% of Nigeria's population who live in rural or peri-urban shanty settlements.

## Developing countries

In rural and peri-urban areas of developing countries child mortality is ten times higher than in industrialised countries. Life expectancy is shorter, sanitation is poorer and there is a high incidence of communicable diseases and malnutrition. Poverty, illiteracy, lack of potable water, limited access to health care services and

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inequitable distribution of nationally-available resources all contribute to an unhealthy and unequal situation.

The major causes of morbidity in rural areas are malaria, diarrhoeal diseases, ARI, measles, tuberculosis, typhoid, yellow fever, genito-urinary infections and ecto- and endo-parasitosis.

In sub-Saharan Africa, health and the number of health care providers have improved dramatically since independence. The infant mortality rate has been reduced by a third and life expectancy increased by ten years. However, health outcomes in Africa still fall below those in other developing countries. Most medical schools and governments in sub-Saharan Africa still do not recognise the need for post-graduate training to produce doctors relevant to national needs.

## Nigeria

Nigeria's population density is twice that of Africa as a whole and less than 40% of the population live in urban areas. The general physician to population ratio in 1991 was 9:100 000. Of an average of 950 doctors graduating annually from 19 medical schools, only 20 (2.1%) enrolled for general practice training. In 1992, a paltry 3.2% of annual national budgets was allocated to the health care of an estimated 110 million people in Nigeria.