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 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.

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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.

Most clinicians and health policy-makers overlook the importance of preventive and community health services. Traditional medical education and practice tend to be disease-oriented, organ-system-centred, hospital-based and disconnected from public health activities. Successive governments have paid most attention to expensive hospital medicine, which is limited to a few urban settlements.

Equity is one of the four goals for health services established by WHO. In Nigeria, the health system is inaccessible, unaffordable and inappropriate to the needs of the majority — particularly the rural poor. Politicians pay more attention to the development of expensive, permanent structures than the establishment of efficient health service structures which would benefit the majority of the population.

It is essential for governments to determine the appropriate number, types and distribution of health professionals and facilities to provide equitable, quality health care for the population. In developing countries the limited supply of physicians and facilities is disproportionately clustered in cities, contributing to serious regional imbalances.

The need for post-graduate training in general practice/family medicine

It is widely recognised that basic medical education is insufficient for family doctors. At the first international conference on training for general medical practitioners in Nigeria in 1980, it was recognised that family physicians required a structured, competency-based, post-graduate, vocational training.

In developing countries family doctors need to be trained to integrate universal primary, promotive and curative care with many aspects of public health. Extra incentives are needed to retain general practitioners in rural areas. The roles of the various organisations in the health care delivery system need to be properly defined and co-ordinated for efficient management and allocation of resources.

The Core Training Curriculum can be summarised under two headings: Essential Public Health Services and Essential Clinical Services.

ESSENTIAL PUBLIC HEALTH SERVICES:

Health promotion

- Nutrition education • Education on common local diseases
- Education on environmental protection, sanitation, food safety, water purification, etc • AIDS prevention

Disease prevention

- Immunisation • Health screening • Health counselling

School-based health services

ESSENTIAL CLINICAL SERVICES:

Surgical, medical emergencies
Pre- and post-natal care
Common serious childhood diseases such as measles and malaria

Management of common acute and chronic conditions

- Ambulatory continuing personal care • Simple hospital care
- Simple routine, basic surgery • Identification and appropriate use of referral services • Building up patients for referral

Infection control, case-finding and treatment of patients with TB and STD

Family planning services

A relatively large percentage of medical school graduates should have this training. Orientation towards a generalist vocation should begin early in the pre-clinical undergraduate years and continue throughout the clinical years. Following WHO and WONCA recommendations, all medical schools should establish a department of general practice.

General practice training in Nigeria

General practice training started in Nigeria in 1981, following the ratification of the proposed training curriculum. Between 1981 and 1997, 189 doctors entered the programme, 62 have graduated and 117 are currently training. The curriculum is broad-based and structured to meet the demands of health care today.

To ensure high standards and relevant courses, trainers and training centres are inspected regularly and the curriculum is reviewed as necessary. Training itself is divided into two parts and takes place in typically high-volume, low-technology, low-cost hospitals. Part II consolidates and expands on skills and experience acquired in Part I and both parts offer experience in community-based medicine.

Of the 62 graduates from this programme, 20 are in GP training centres, 11 in peri-urban and rural general practice, 13 in urban private practice and six in occupational health services.

Recommendations

I can make a number of recommendations from the Nigerian experience. These include:

- National planning of health workforce training, including physician training in response to community needs;
- Each country should plan for the necessary health personnel, so that doctors and health professionals are trained and available in the right numbers to meet national needs;
- Undergraduate training should include general practice and rural health care;
- Post-graduate training is important to provide doctors with appropriate skills for general practice, especially in rural areas;
- Each country should offer incentives to increase the number of health care professionals in rural areas;
- General practice should be recognised nationally as a medical discipline and family physicians should have appropriate status.

When these recommendations are implemented, only then will the ideal of Health for All be attainable. This is particularly true in developing countries in Africa, where the distribution of health care resources is particularly inequitable. ●