Procedural skills in rural practice – a practice profile

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S Afr Fam Pract
1995;16:674-677

Physicians, family;
Rural health;
Education, medical, graduate.

Curriculum Vitae

Paul qualified at UCT with an MB ChB in 1967 and subsequently obtained the Dip Mid in 1971 and the MFGP in 1974. After four and a half years at Edendale Hospital, Pietermaritzburg he spent two and a half years in private general practice in the same city. This was followed in 1974 by general practice combined with hospital sessional work in Kokstad, southern Natal. He has now completed 21 years in this position. He is group Academy leader for southern Natal and on the rural health committee of the Academy of Family Practice. He is married to Jan, previously medical superintendent at Kokstad Hospital and since January 1995 a member of the medical practice P V Hill and Partners. They have two children, Mark and Lisa.

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Summary

An overview of a GP practice in a rural area is given to illustrate the skills required of those doctors. More organised and appropriate training is needed to equip doctors for this task. The authorities governing medical planning are urged to appreciate this aspect and provide the necessary training programmes; especially as medico-legal threats are facing doctors more and more these days.

Introduction

Kokstad is a town located in southern Natal, bordering on the old Transkei. It has a population of some 10 000 blacks, 5 500 whites and 5 000 coloureds. In addition to this, the medical services drain a large part of Northern Transkei, where medical care standards are unfortunately dropping alarmingly.

The local hospital has 198 official beds. During 1994 a total of 3 276 operations were performed, including 248 Caesarean sections, thus averaging some 20 Caesarean sections per month. These procedures were performed by a complement of seven part time medical officers with assistance from the hospital superintendent, the only full time doctor.

The seven part time doctors all belonged to the same medical partnership. We have since reduced our number to six as the hospital has acquired the services of an additional full time medical officer.

Typical examples of the type of surgery we perform are:

General surgery:

– Stab abdomens, and more recently gun shot wounds

- Herniorrhaphies
- Haemorrhoidectomies
- Appendectomies
- Limb amputations

Orthopedics:
- Simple and compound fractures
- Internal fixations of certain fractures

Gynaecology:
Ectopic pregnancies
- Abdominal hysterectomies

ENT:
- Tonsillectomies

In addition we provide an ultrasound, gastroscopy and epidural service for private and hospital patients. We are also part time district surgeons for the magisterial district of Kokstad. Not all procedures are performed by all doctors, given the wide range of operations required. We encourage doctors to perform only those operations with which they are comfortable, also bearing in mind the medico legal implications involved, with the exception of emergencies.

Our practice is thus extremely varied and multi facetted. In private practice we see both first and third world patients, in addition to performing hospital sessional work which includes twenty four hour emergency cover and also part time district surgeon duties.

A great sadness to us during the past eighteen months has been the continuing political unrest at our hospital. If Kokstad Hospital is a microcosm of Union (NEHAWU) agenda elsewhere, the ANC Health Policy of close co-operation between private and state sectors of health must be under threat. We sincerely hope that this is not the case, but we have our doubts.

Our doctors all have higher qualifications, with a mix of MFGPs, DAs, DCHs, and DIP Obstetrics. We have weekly academic meetings within the practice and monthly meetings with visiting speakers, usually specialists. It is also compulsory for each doctor to spend one week annually in some form of CME programme.

All doctors are expected to perform "basic" procedures such as Caesarean sections, appendicectomies etc. Appropriate procedural skills are an essential prerequisite for any doctor joining our practice. There are several reasons for this. As we are 250 kilometres from our nearest referral hospital, it is obviously a necessity that emergency and elective surgery be performed at the local hospital. Our state referral hospitals are over loaded and we often have great difficulty in getting patients transferred. It can on occasions be exasperating and time consuming trying to convince the registrar at the other end of the line that the referral is in fact essential.

Generalists will be responsible for basic surgical care but need appropriate training.

Transport is a major problem, as in Kwazulu Natal there are only ninety available ambulances for emergency services. We have a weekly state shuttle service to Durban, totally inadequate to cater for the referred patients' needs. Thus many patients have to provide their own transport to Durban or be issued with a rail warrant, to find thereafter their own way to the referral hospital. One can just imagine the difficulties involved with that system.

Will primary health care *per se* attract doctors to make this a career?

Discussion

Primary health care is obviously necessary and essential, but one wonders whether the bulk of these services is not being handled (or hijacked) by primary health care nursing services.

One doubts whether primary health care *per se* will attract doctors into making this a full time career. Will the addition of structured and necessary procedural skills provide the interest in primary health care as a career? Another problem that needs to be addressed is the progressive de-skilling of family practitioners in urban areas in recent years, although that is not the subject of this article. Fortunately they

Will new procedural skills help to get doctors into primary health care?

are at least involved with family medicine which is somewhat different from primary health care as practiced in state institutions. Family medicine could certainly be attractive as a career option for young doctors. One doubts whether the same applies to primary health care in state institutions, unless appropriate procedural skills are added to their curriculum, in addition to vocational training in primary health care.

I quote from a recent article by Dr Graham White (Principal Medical Officer, City Health Department, Port Elizabeth) "very few doctors consider primary health care as a career option and consequently the present PHC/OPD doctor complement is often made up of the retired, the transient (on his or her way to some other speciality) and those who are not interested in PHC and for some reason cannot get a job anywhere else".[1]

Perhaps a policy of reacquisition of clinical skills as advocated by Prof Mac Millen Rodney[2] of the Department of Family Medicine University of Tennessee Memphis, should be implemented in this country. A group of family physician educators supported by the American Academy of Family Physicians, has constructed a series of technologically assisted projects leading to the propagation of diagnostic and therapeutic skills in family medicine. Although some perceived this as "proceduralism" it represented the desire of family physicians to remain clinically excellent in pursuit of serving their patients. No amount of psychosocial expertise can overcome the credibility lost when a physician cannot pursue basic clinical skills on behalf of his or her patient. Australians have also recognised this need, where in addition to the Royal Australian College of General Practice three year training programme, a further one year of procedural skills has been introduced to equip doctors for rural practice.[3] Similar programs exist in Canada[4] and elsewhere. The World Health Organisation, together with WONCA has recently aligned itself with efforts to improve the delivery of health care at family physician level.[5,6]

Recently the training of community specialists for this country has been proposed.[7,8,9,10] This would contribute to improved health care and provide a new career for young qualified doctors.[11] Medical faculties could, and perhaps should, institute a four year community course, leading to a registerable higher degree, to train doctors in the fields of medicine, paediatrics, anaesthetics, orthopaedics, obstetric and gynaecology. Much more exciting and appropriate than pure primary health care without much academic and professional satisfaction don't you think! One hears so much about primary and tertiary health care, yet so little about secondary health care. The reasons for this appear to be obscure, perhaps nobody appears at this stage to know who should fulfil this vital role. The main purpose of this article is to highlight the importance of this neglected aspect of health care, and to urge the relevant authorities to give recognition and direction to secondary health care. All indications at present are that generalists will largely be involved with and responsible for secondary health care. If not, then who will?

GPs have gone through a period of progressive de-skilling in urban areas.

Conclusion

An overview has been given of a rural practice in a country town in Southern Natal. Emphasis has been placed on the absolute necessity for appropriate procedural skills required of rural doctors. More major operative and anaesthetic skills would require appropriate training and experience with the doctor always being mindful of his or her limitations and the ever present medico-legal threats facing doctors today. An appeal is made to all generalists in both urban and rural practice to obtain and maintain the necessary procedural skills pertaining to their type of practice and for the authorities governing

A special training programme of procedural skills to equip our doctors for rural practice.

medical planning in this country to appreciate the absolute necessity of this "generalist" discipline.

References

1. White G. Primary Health Care – Where are we going? SA Fam Pract 16(6);419-21.
2. Rodney M. Reacquisitions of Clinical Skills by Family Practitioners 1973-1998. Address to WONCA, Hong Kong, June 1995.
3. Strasser R. Education and Training for Rural Practice in Australia. Address to WONCA, Hong Kong, June 1995.
4. Babey K. The Nature of Rural Practice in The Canadian Perspective. Address to WONCA, Hong Kong, June 1995.
5. WONCA Policy on Training for Rural Practice. Adopted at WONCA Conference, June 1995.
6. World Health Organisation and WONCA. Making Medical Practice and Education more relevant to people's needs: The contribution of Family Doctors, February 1995.
7. Naidoo N. Rural and Remote Health Care – Guest Editorial, SA Fam Pract 1995;16: 382.
8. Jaques PH. Developing a Career Structure for Rural Practitioners. Address to WONCA, Hong Kong, June 1995.
9. Jaques PH. Editorial: Rural Medicine – a Speciality in its own right? S Afr Med J 1992;81:589-91.
10. The Rural Practice Task Force of the SA Acad of Fam Practice/Primary Care. Neethia Naidoo. (Unpublished).
11. Jaques PH. Recruitment and Retainment of Staff in Rural Areas. SA Fam Pract 1994;15: 398-400.