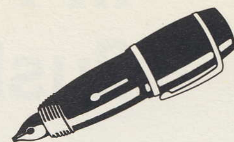

From the editor • Van die redakteur

Why do doctors congregate in the cities?

This question concerns most governments and should also be a concern of medical educationists and medical associations. There are real dangers for our patients and for ourselves in the overpopulation of doctors in the cities.

The first temptation, often at a subconscious level, is to overservice the fewer patients one cares for to maintain one's standard of living. Thus the market forces do not drive doctors out into the periphery, as there is a large margin of earning capacity between what is acceptable practice and what is malpractice. No country, however, can afford the maximum possible 'standard' of health care for all citizens. More and more governments are thus intervening in the affairs of medicine. In July doctors in Ontario, Canada were out on strike due to a further step in control taken by government.

I recently came across another example of 'interference' by government, which has been associated with a very good outcome for family practice and the repopulation of a rural area with doctors[1].

Dr John Verby met us at the airport at Minneapolis, Minnesota, USA and with great enthusiasm explained and showed us the Rural Physician Associate Program (RPAP).

Fourteen years ago the Minnesota legislators came to the University of Minnesota Medical School and said, 'We do not have enough doctors in the remote and rural areas of the state. If you guys in the medical school cannot make a plan with this, we'll take away your subsidy.'

It took a while for the medical school to hear what they were saying. A faculty committee then sat over a period of a year to plan an intervention. This multidisciplinary group decided on the following scheme:

Students are given the option of doing nine months minimum to a amximum of twelve months training during their clinical years in a rural community practice, instead of at the medical school. For this they get credit for six months only.

The group or doctor who takes the student into their practice, pays the student $2 500 for every three months after the first six months, and the state pays the student $7 000 for the whole period. The student in turn has to move house (with family and all, if married) and live in the local community. The aim is that they will be there long enough to take part in village or town life and feel what it is like to live there.

The local practitioner undertakes to give a certain amount of time to the student. The practice gets a computer that is linked via a modem to the medical school library. Literature searches are done by doctors and students and the library posts free reprints on request. They can also call up other teaching programs on the screen. University lecturers from many disciplines visit the practices a few times during this elective and teach both student and doctors. They also do free consultations for the practice.

The success of this program is recorded[2,3,4]. Suffice it to report that each year enough students (from 25 to 40) have enrolled for the RPAP. So far 500 have completed the program and of them, 60% have returned to rural communities!

There is now no area in Minnesota with less than one doctor for every 2 500 people, and the students are doing as well as their counterparts who remain at the medical school for the whole period.

Miskien moet ons ook aan so iets dink in Suid-Afrika. Sekere stede is al so oorbevolk met huisartse dat ons eersdaags die lelike sy van mededinging sal begin sien. Ons omstandighede is nie dieselfde as in Minnesota nie, maar daar moet tog lesse wees wat ons by hulle kan leer.

Sam Fehrsen

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