You are on your own, Doctor!

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Summary

A survey amongst country practitioners in Natal done in 1981 is reported on. The doctors were mostly between 30 and 50 years of age, a large number had moved to country practice since 1975 and most were in solus practice. The joys, challenges and problems of country practice are also discussed, giving ideas of how it can be made fully comprehensive in its scope.

KEYWORDS: Rural Health; Physicians, Family; Health Services Research; Community Medicine; Practice Management, Medical.

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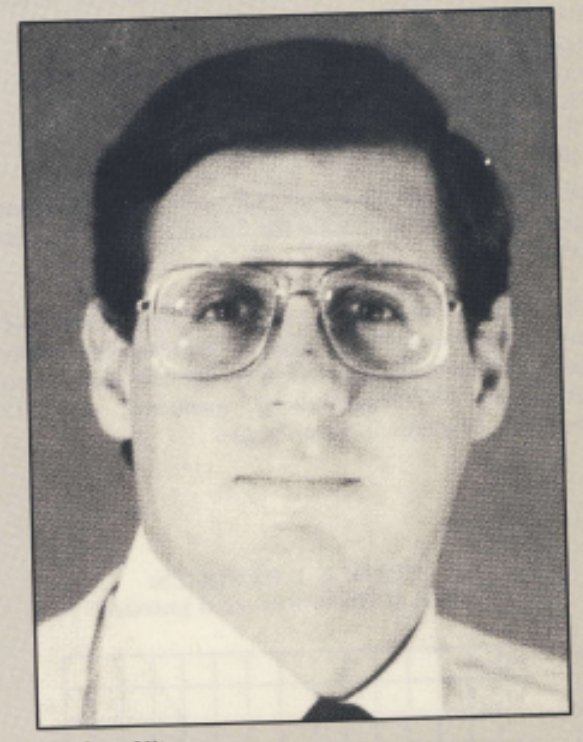


Curriculum Vitae

Dr Chris van Selm obtained his BSc (Med) at the University of Stellenbosch in 1965, and his MB ChB in 1969. He obtained the Diploma Mid CO&G and the MFGP of the College of Medicine of South Africa in 1974 and 1981, respectively. His houseman year was served at the Pelonomi Hospital, Bloemfontein in 1970. He was registrar in O&G at Greys Hospital and Witwatersrand Medical School in 1971-1973. In 1974 he was in general practice in Pietermaritzburg followed by country practice in Dalton from 1977/1983. He became Medical Officer of the Tongaat/Hulett Group Kearsney Hospital in 1984. He has several publications with particular reference to country practice to his credit.

Country practice, and in particular, rural medical practice involves features of lifestyle and challenges to upgrade medical care services. This awaits the doctor who is geared to coping with a responsible and complicated type of practice to which is added the wonderful existence and challenges that he or she would find hard to implement within the boundaries of the city.

Surveys were done in the Natal Midlands region, to establish what the problems and difficulties of country practitioners were, being out on their own. Family medicine in country and rural settings is managed

somewhat differently. It is necessary to emphasize these management areas, and the significant features allied to country practice alone.

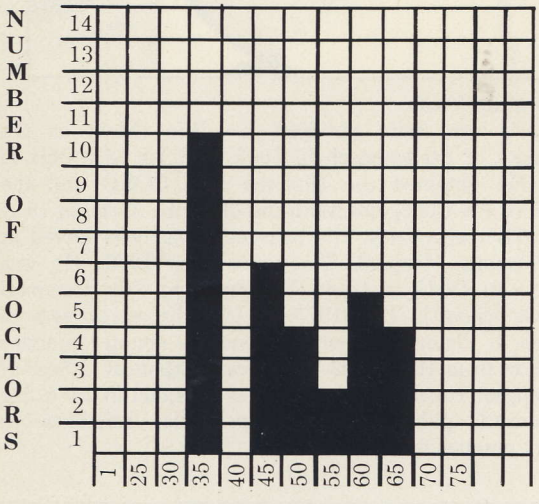
Country areas do not accommodate the faint-hearted, and the doctor who lives in these regions must be highly motivated and well experienced, and, it would appear, academically qualified as well. The surveys indicated five major areas of conflict:

COMMUNICATION
FACILITIES
TRANSPORT
FINANCE
TIME

All these will be discussed fully and further expanded upon to include proposals for future implementation as well.

The survey was done in 1981 by means of a questionnaire sent to 67 doctors who were members of the Natal Inland Branch of the Medical Association of SA, with Pietermaritzburg excluded; 49 (73%) answered, of whom 3 were females.

TABLE 1 RESULTS:
Age of Doctors in rural practice



60% of the 40 country practitioners were between 30 and 50 years of age.

Table 2 shows a large number of doctors moving into this country area from 1975 onwards.

Looking at **Table 2** and **Table 3** it would appear that the majority of the country practitioners were firmly established in their practices from the third year after qualifying from medical school.

TABLE 2
Year of entry into Natal Midlands practice of 43 doctors' (6 did not answer the question)

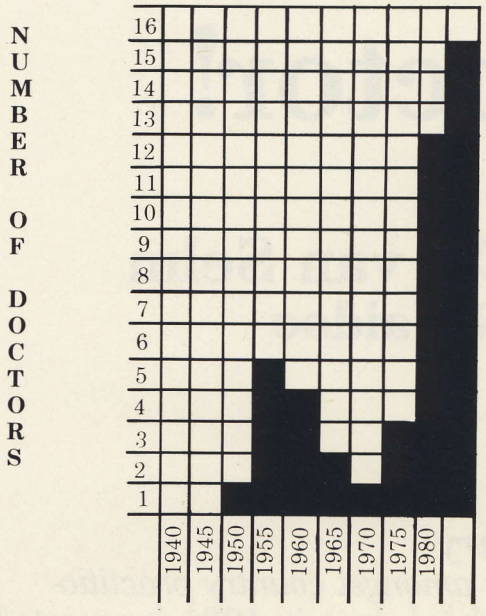
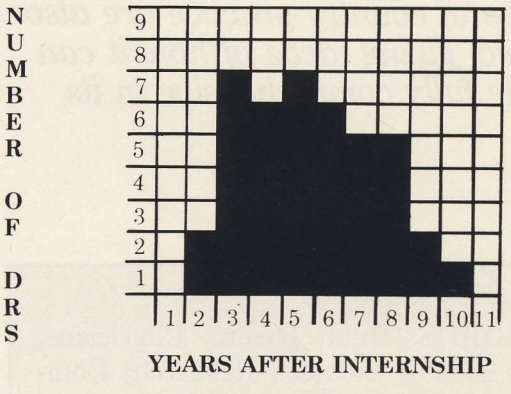


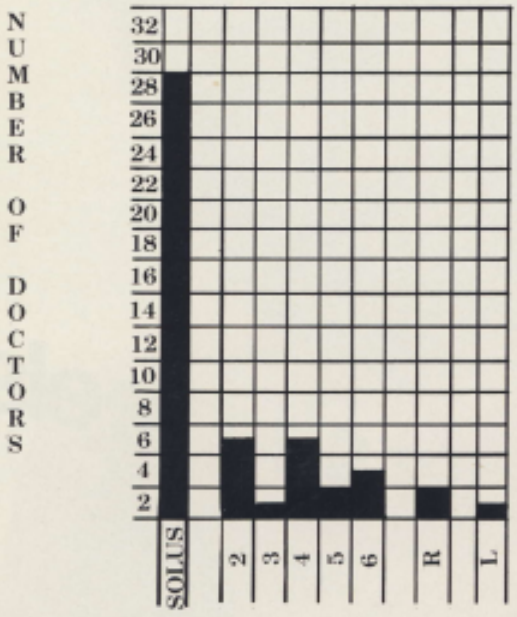
TABLE 3
Years after internship on entering country practice, of 42 doctors (7 did not answer the question)



The greater majority (88%) started in the country within the first eight years after leaving internship.

Doctors who work out on their own, have a distinct preference for SOLUS practice. Many and conflicting reasons were given for this, but it will suffice to suggest that these doctors work on their own for personal reasons, or for the type of work they do (practice personality), or simply the workload would not justify a partnership arrangement.

TABLE 4
Practice Preference of 47 doctors (2 did not respond)



Added or extra qualifications was a further important finding in TABLE 5. These findings give some idea of the necessity for country doctors to extend their education because of their isolation and the type of medicine they practice.

TABLE 5
Added Qualifications

BSc (various faculties)	12%
MFGP (SA) + MRCGP (UK)	8%
DIP FOR MED (SA)	4%
DIP MID CO&G (SA)	4%
DIP ANAES (SA)	4%
M PRAX MED (PRET)	2%
DIP CHILD HEALTH (SA)	2%
DIP AVIATION MED	2%

Of all the practitioners surveyed, 38% had added qualifications.

What then are the problems facing country practice and being out on one's own?

COMMUNICATION: Several distinct areas of lack of communication were identified.

(a) ***Colleague contact:*** Practitioners found that the day to day contact between their city counterparts was sorely missed; they felt left out. Some distress would inevitably develop if the situation was ignored, and most of the doctors out on their own, have devised a system of linking themselves to a city colleague, based either on verbal or even on formal association for the benefit of patients who possibly required referral or another reason for investigation, not requiring specialist attention. This system has been facetiously called 'ADOPT-A-DOC' by some, and the discussion has extended the theory by many of the country practitioners who feel that some recognition should be given them by the academic institutions themselves, in which country practice can be more effectively utilised and planned, channelling both material and pathology through an intergral departmental avenue for both teaching and practice. This liaison could be established for both patients' welfare as well as encouraging country doctors to continually upgrade their own standards.

(b) ***Correspondence:*** The second communication breakdown is the frustrating encounter that takes place when practitioners refer patients to hospital. Correspondence between doctors is generally of a poor standard. Both practitioners and their hospital counterparts appear reluctant to use correspondence as a means of improving management of patients, with few exceptions. This problem will hopefully receive more attention and improve in the future. Techniques in correspondence and referral of patients should be an integral part of a doctor's training.

(c) ***Patient communication:*** Patients themselves are a third source of communication problems, and these might be created either by a language or a cultural barrier, both of which must be suitably approached. To understand and accommodate patients and their customs and manners, must be learned by the doctor as well, particularly within the confines of his consulting rooms.

FACILITIES

Laboratories and other investigative facilities are always a problem in the country areas, but hopefully with the modern usage of mini-type procedural techniques, some of the difficulties of the country doctor will be relieved. Side-room tests play a very significant part in the country practice. There is a distinct trend at present for the private laboratories to play an increasing role by offering daily shuttle services to the doctors. But most of the country doctors within our own region are conscious of the enormous costs involved with private laboratory procedures, and fight shy of utilising these services for patients who do not have Medical Aid cover.

X-ray facilities would be welcomed by many practitioners, but costs and registration make the investment unjustifiable, particularly for the young doctor starting out on his own. Some liaison between country doctors might be feasible in which a shared investment could be considered. In-patient facilities would be well received by all country doctors, especially those without hospitals available, and again costs would have to be carried by the patients and possibly to a large extent by the doctor himself, making the exercise completely uneconomical. Perhaps as the concept of Community Centres develops and extends in the future, some consideration might be given towards accomodating the costs involved with assistance from the various State Health Departments.

TRANSPORT

The costs involved in transport in the country are high. Vast distances between clinics, or emergency calls, make travelling costly and uneconomical as well. In addition roads and weather conditions are poor and ambulance facilities are often not available, especially in the rural areas. This can lead to tremendous problems when moving patients, or attending to accidents, injuries or other problems requiring ambulance transport. Practitioners who were fortunate enough to have such facilities found that they would inevitably bear much of the basic cost-structure themselves anyway, as patients were often reluctant to settle accounts for the ambulance or accept responsibility.

FINANCE

Cost-awareness and cost-effectiveness play a vital and increasingly significant part in any medical practice today. In the country, the doctor is faced with costs unrelated to any city practice, particularly because of his isolation. These include:

(a) Having a dispensary stocked with adequate quantities of essential medicines.
(b) Adequate stocks of bandages, dressing materials, plasters and other medical equipment.
(c) The staff must meet with the regulations of the Medical and Dental Council Act. They require trained staff, which increases the costs considerably.
(d) Catering for outlying clinics and storage facilities together with rental for clinic buildings etc.
(e) Coping with the high cost of purchasing drugs and materials.
(f) Fee structures which allow for medical-aid patients' attendance are not geared per se for country practice. Consultative and counselling techniques are adjusted to a slower lifestyle, benefiting the patient maybe, but the doctor will find the exercise costly. Operative procedures that could compensate for higher costs are often lost to the bigger centres, because of lack of facilities. The country doctor must, however, to some extent justify costs involved in order that he might receive some remuneration for his own personal needs. These additional costs all increase the financial burden when patients default payment.

Country doctors should realise that a wealth of valuable information lies locked up in their own practices.

TIME

Dividing time into areas so that the organisation of the practice becomes more evenly distributed is essential with particular regard to the country doctor. Country areas do not allow the doctor to have 'off-duty' periods in which he can feel free from the responsibility of his work. The doctor being on his own within the country area, patients in the community are dependant on him and he must cater for calls and work after-hours on a continuous basis. The doctor is in effect never off-duty.

Disciplining patients to observe rules, and planning the day to day running of the practice is also important to instill some measure of control, as, in the country, people are inclined to be casual about arrangements. The other very relevant aspect is the vital programming of outlying clinic arrangements, and the reliability of visits to these clinics. Patients attach great significance to the day of visit and will walk or make complex travelling arrangements to meet the doctor on his clinic day. It is always a valuable arrangement to discuss and detail all duties with staff in writing in the form of a contract, setting out the type of duties required. Confusion and complications can best be avoided if all arrangements are made in consultation with the staff in consensus.

Managing a country practice is facilitated if a POLICY is clearly established, and adhered to.

Country practice can be managed by identifying three areas: Policy, Administration and Performance.

Management = Policy + Administration + Performance

A policy is essential; incorporating concepts of self, time, staff and planning programmes, and is distributed by administration, which in itself must be dependant on an adequate policy. Administration must include satisfactory record-keeping, a filing system which must incorporate planned notes, dove-tailing with outlying clinics, and adequate monitoring. Communication with patients themselves about administration can also avoid confusion and frustration, especially with farmers and their labour accounts. Workmen's compensation plays a significant part in country practice, and filing and records must be carefully maintained.

What then are the factors involved in the performance of a country practice?

Performance is actually a reflection of management. This therefore means that the better the management, the better the performance. Judging performance is unique in country practice because of two feedback mechanisms which play a highly significant role within the boundaries of the district and the isolated community. It is important to realise that because of the singular community within the smaller villages and rural areas, the effects of the community will be felt by the doctor, in his practice performance.

Communal Replay, by definition means an awareness of the inter-related forces between doctor and community, by which a feedback mechanism can be established in order that the performance of his practice may be judged. It means essentially that the efforts the doctor has made will be rewarded by the response of the community towards him. The community will make efforts to look after the doctor as well as his family, and as such this becomes an area in which his practice

performance can be measured. Examples of communal replay are a telephone exchange operator, or the local store, or other small businesses within the village; transport, and willing hands becoming available when needed, often without asking. Doctor-concern by the community will be manifested by gifts, cards, greetings and efforts to show appreciation, especially on days of celebration.

Promotive Contingency Planning (PCP). By definition PCP means maintaining efforts by the doctor to upgrade his standards on a continuous basis including study, refresher courses, or CME congresses, self-audit systems and colleague contact as has already been mentioned.

Research programmes also play a vital role in all these aspects of PCP and the doctor who lives out in the country needs this effort because of his isolation, and also because of the type of medicine he practices. Hopefully research will play an increasing role in the future as doctors realise that a wealth of information which would be valuable to the concept of continuing medical education lies locked up in their own practices.

Techniques in correspondence and referral of patients should be an integral part of a doctor's training.

In expanding on the master plan, the divisions incorporate aspects of country practice which could be added to or removed depending on the type of practice, the personality of the doctor and other factors related to his environment.

Community care is the goal of country practice, and to get to this, some form of management is essential, but the basic 'unit' of Community Care is in effect 'the family'. Family medicine is in itself complex enough, and added to by the overall communal approach. The two feedback mechanisms of communal replay and promotive contingency planning, play an essential role in the performance of the practice as has already been mentioned. Dividing Community Care into the various aspects makes identity and programming of each section much easier.

The country doctor is faced with costs unrelated to any city practice because of his isolation.

In the ***clinical*** section, mention is made of the primary health care concept, simply because it is a basic part of any country practice and needs no further explanation.

The ***operative part*** of community care incorporates particularly trauma, and the surgical resuscitative ability of the country doctor is usually of a high standard. The work situation lends itself to this because of the agricultural labour force, or motor-vehicle accidents and other day to day contingencies.

The methods of resuscitation also apply to orthopaedic problems, and as such, the practice is equipped to cope with this type of trauma as well.

The other two areas of performance within the country practice concept, are the financial rewards, and some long term objectives as well.

The financial rewards in any practice make common sense. These rewards are attractive enough only if the management of the practice is satisfactory, and clearly defined. It would be quite realistic to say that the financial rewards are well within the comparative

COMMUNITY CARE PROGRAMME

COMMUNAL REPLAY — **PROMOTIVE CONTINGENCY PLANNING**

DOCTOR

FAMILY — **MANAGEMENT**

COMMUNITY CARE

CLINICAL	OPERATIVE	THERAPEUTIC	ANALYTICAL	AUXILLIARY
PHC	Trauma	Dispensing	Side-room	State Health
Consult	Orthopaedic	Compliance	Lab. Proced.	Civil Defence
Counselling	Obstetric	Co-ord. therapy	X-rays	Blood Trans.
Liaison	Dental	Control	Library	Social
Hospital sessions		Cost-effective	Other	Other
District Surgeon		Paramed.		
Other		Resuscitative		

rewards of the city type practice. But many factors play an important part in the financial planning of any practice, with country practice having the added financial burdens of capital investment initially and more complex subsequent systems of accounting and book-keeping.

Long-term objectives should be an integral part in the life of any doctor who lives out in the country. These objectives need not necessarily be medical, and good examples are hobbies, or farming perhaps, or some other project. The idea behind this is that the doctor must find some personal interest to engage his free time, and this must be significant enough to add to the attraction of remaining within the confines of the community in which he lives. His interests and motivations must not come into conflict with his work situation however, and possibly communal replay could just be a highly significant aspect in coping with these objectives of the doctor.

Patients should be trained to adhere to the rules and times of their doctor's practice.

Obstetrics does not play a significant part in any small solus type practice, particularly in the rural setting, and the efforts and time involved do not allow the doctor on his own to cope beyond the limits of the odd emergency. If facilities (or a maternity unit) are available, the inference is that the patient must be carefully monitored and adequately attended to by qualified midwives.

Dental work is part of the country practitioner's daily workload. This aspect of practice is unfortunately a problem area because of the fact that no doctor is taught or trained to cope with extraction techniques and dental block procedures. However, these are relatively simple to learn.

Therapeutics play a further role in the problems outlined by being complicated by regulation and rule through the Pharmacy Act. Dispensing is an integral part of country practice, and this facility plays an important role within the context of the country doctor's approach towards his community care. Patients themselves attach great significance to the medication issued by the doctor, and identity with the doctor in their trust and confidence in the medication given by their own doctor.

Dispensing medicines within the overall communal approach is important because of the close contact between patient and doctor within the community. Compliance is therefore high, with co-ordinative therapy carefully controlled as well. Distribution and control of serious and dangerous drugs is also carefully monitored, and all these significant aspects of the therapeutics within the community work together towards the ultimate reality of cost-effective medicine. Abuse of this facility is unfortunately topical only through the offices of those practitioners with whom no good country doctor would associate, nor would they feel comfortable defending this abuse.

Analytical details of country practice are worth repeating, considering the importance country doctors attach to their side-room tests, and the utilisation of these quick and easily executed procedures. Familiarisation with the use of microscopic analyses play a significant part in diagnostic approach, and in particular, the simple but accurate urine and blood tests available with minimal difficulty, are extensively used. X-ray facilities can be effected if the capital outlay justifies the expenditure, and the necessary adjustments for installation can be made at the doctor's consulting rooms.

Auxilliary aspects of community care must include features in which liaison with State Health and other Provincial bodies can facilitate an overall health programme for the community. Well-baby clinics, family planning, immunisation and nutrition programmes can all play a part in assisting the doctor to implement his approach to the communal cover required.

Further communal involvement would be linked to other examples such as Civil Defence, Blood Transfusion Services, or social commitments (eg school committee).

It is important for the rural doctor to establish contact with a city colleague.

Finally, the FUTURE

All the doctors in the Natal Midlands region who participated in the surveys, indicated that they were both clear about their objectives, and in identifying their problems. They were surprisingly well qualified, and motivated to accept the challenges and problems, with some confusion as to the solutions. Solus Practice appears to be increasing, but the isolation does create problems.

Increased effort is required both by themselves, but to a significant extent by everybody, to recognise and acknowledge country practice as an entity to be reckoned with in the future. University education can have an important influence on the undergraduate to help him identify with the concept of country practice, seeking a lifestyle and an existence which is far more challenging than city-type practice.