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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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.

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 5.2% of annual national budgets was allocated to the health care of an estimated 110 million people in Nigeria.

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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 coordinated 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.

Masters degree in Clinical Pharmacology

Since 1974 the Department of Pharmacology at the Faculty of Medicine, University of Pretoria, has been delivering a very necessary and highly sought service in the medical field in that they provide a singular opportunity for doctors in all spheres of medicine to follow a formal course in Clinical Pharmacology.

This course, which is unique in South Africa, leads to a masters degree in Clinical Pharmacology (M.Pharm.Med) after successful completion of the course. The aim of the course is to guide the study to the acquisition of a critical, analytical approach to Clinical Pharmacology in general, resulting in better therapeutic reasoning and decision making.

During the three years of part time study, all aspects of the field, i.e. pharmacokinetics, pharmacodynamics, toxicology and medical biostatistics are covered. A student must also successfully complete an approved research project in his specific working environment in order to qualify. The popularity of this degree has grown over the years, emphasising the importance of clinical pharmacology in modern medicine.

The next three-year course starts on 4th February 1998.

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