Opportunities and challenges for GPs in the developing world

Australia has a well developed system of general practice and can be proud of the quality of its generalists. In many developing countries however, the idea of a trained generalist is not well understood. The global situation creates many opportunities and challenges for Australian general practitioners. Most of us know Australian GPs who have worked in the United Kingdom or Canada. This article outlines my experiences of working in a hospital in Nepal.

Malcolm Moore
MBBS, FRACGP, GradDipIntHealth, is a general practitioner, Albury, New South Wales. malmoore@iprimus.com.au

General practice is a discipline that is still struggling for acceptance in many parts of the world. The drive to sub-specialisation has spread to most countries, even where medical resources are scarce. Nepal is a country that could be expected to produce generalist doctors to manage its heavy burden of ill health. In fact, although family medicine (general practice) was an early feature of its medical training, it has low prestige and struggles to attract trainees. Resources are put into training sub-specialists and competition is fierce to get into the more highly remunerated programs. There are public health programs across the country but they are under-resourced and suffer from the effects of the ongoing Maoist insurgency.

Nepal is developing its medical workforce against a backdrop of dire health indicators. The average life expectancy at birth is 60 years. The under 5 years mortality rate is 91 per 1000 live births. It is estimated that 50 000 people develop active tuberculosis every year and 15 000 die from it. In 2004 there were 4838 registered doctors – or one doctor for every 5732 people. However, half of the doctors live in the capital, Kathmandu. Therefore the ratio in rural areas is closer to 1:100 000.[1]

The urge to promote family medicine in Nepal is supported by an understanding of the workforce needs of the developing world. The World Health Organisation (WHO) regularly estimates the top 10 causes of global disease burden.[2] All are conditions in which generalists should be central to management and prevention efforts. The WHO list of top 10 risk factors for disease highlights the need for broad public health interventions, meshing with the generalist's expertise in health education and disease prevention. Further, an analysis of disease management according to 'broad care needs' showed that 86% of 'disability adjusted life years' (DALYs) were from conditions requiring long term care and management.[3] The family doctor clearly has a central role and this role has been shown to be an important contributor to better health outcomes.[4] While this might seem obvious to the generalist, the forces that drive the health system are often moving in the opposite direction.

Medical migration

We are very familiar in Australia with the phenomenon of medical migration. Australia is currently reliant on overseas medical graduates to assist with its medical workforce crisis. This comes at a high cost to the countries that are training those graduates. India is thought to lose 4–5000 doctors a year to western countries. It is estimated that training these doctors costs US$160 million.[5] The situation is similar in Nepal. Doctors aspire to train to a level where they can leave their country to work in the USA and Europe. If doctors remain in Nepal, they generally prefer to work in the Kathmandu valley, home to only 5–10% of the population. The majority of the population – generally subsistence farmers – remain without adequate medical services. Some aspects of this problem are also very familiar to Australians. There is no system in place for western nations to compensate these countries for the doctors that they poach.

I have spent two short stints in the department of family medicine in a teaching hospital in eastern Nepal. I plan to go back for a longer period. This is not driven by

'western guilt' over inequity. After all, Australia has its own workforce shortage and indigenous health problems that shade many developing countries. But what can look like altruistic decisions often have a healthy dose of self interest inside them.

We all see problems with Australian general practice so it is easy to take its overall high quality for granted. We have been through comprehensive training programs and have an emphasis on continuing education. Overseas experience can help us value this more. In Nepal, the culture of referral and communication is in its infancy: there is no expectation that doctors will communicate and pass on information; practice tends to be competitive; and record keeping is often scanty or nonexistent. Patients may not be given information about their illness and its treatment. Few doctors are trained in rational prescribing and ordering of investigations. Simple active listening and counselling may not occur with the management of psychological problems often not extending beyond a prescription for amitriptyline. In any case, patients may be unable to pay for the prescribed drugs and tests.

BP Koirala Institute of Health Sciences

At BP Koirala Institute of Health Sciences (BPKIHS) in eastern Nepal there is a 700 bed teaching hospital with a Department of Family Medicine, largely run by Australians, teaching general practice along The Royal Australian College of General Practitioners lines. BPKIHS is a joint development between the governments of India and Nepal and struggles to maintain staff across all departments. For this reason, there is the opportunity for foreign staff to be accommodated and to receive a local salary.

At BPKIHS, the family medicine faculty teaches undergraduate students and runs the general outpatient and emergency departments (emergency medicine is not yet a specialty in Nepal). Training is extending to the smaller district hospitals in the region. Work in this setting requires a change of mindset! In outpatients there are two doctors working in each room from the same table, along with medical students seeing other patients. Patients will often give advice about the symptoms and management of others in the room. The waiting throng frequently tries to push into the room if the person on 'crowd control' has stepped away. In the middle of this a doctor might be giving the result of an HIV test. And we are here teaching patient centred communication skills!

The change in mindset extends to clinical work. While consulting with house officers on a visit to a district hospital, I was using my Australian experience to help manage patients in emergency. The first case was Bishnu, a teenager presenting after his first seizure. Unfortunately, my competence did not extend to thinking of a tuberculoma of the brain as the cause (later confirmed on CT). Within an hour another young man had arrived, with back pain. The wise Australian doctor didn't think of tuberculosis of the spine. It takes a while to re-program a middle aged brain!

Opportunities

An Australian GP has much to contribute, even while catching up on the different spectrum of local disease. Fortunately (for English speakers) all medical education is taught in English. There is a full teaching program of lectures and case discussions with undergraduates and postgraduate doctors. The BPKIHS bases its style on case based teaching and problem solving. Non-Nepali speakers can treat patients in conjunction with medical students. There is also an increasing opportunity to undertake research as the institute seeks to build its academic base. We can be part of the development of the Nepalese health system and be an important voice advocating the training of generalist doctors.

What we can get from this may be far more. We are continually learning and adapting to the local situation. There are opportunities to experience a range of unfamiliar and challenging scenarios – and also to marvel at the similarities in primary care presentations. There is the chance to develop a fledgling research career. And there are the delights of crossing cultures and getting to know people in hugely different social structures, and learning a new language. On days off you can walk in the hills, through villages that have barely changed over a century.

For doctors who are considering the possibility of working in a developing country it can be hard to know where to start. It is important to consider the type of experience you want. You might be drawn by a particular country or by the different nature of the work. Recognise that countries are not looking for well meaning amateurs or people who want to save the world. They generally want people who can help them build their own capacity and become self reliant. You may need to think about what further training you might need: public health qualification, up-skilling in emergency medicine, or experience in teaching. I can recommend international public health study as an important part of preparation. The FRACGP is often mandatory. Preparation can take years and countries might require extra qualifications for certain positions.

There will always be reasons for not making a work change such as this. Families and money will inevitably be big issues and dealing with bureaucracy will require stoicism. Deciding what to do about your practice is sure to be complicated. But once you start asking, you will find that there are many people out there thinking about similar possibilities. You can also be sure that there will be no problem getting work back in Australia any time soon!

Conflict of interest: none declared.

References

1. Dixit H. Nepal's quest for health. Kathmandu, Nepal: Educational Publishing House, 2005.
2. WHO. Global burden of disease report, 2002. Available at www.who.int/healthinfo/bodgbd2002revised/en/index.html
3. Setel P, Saker L, Unwin N, et al. Is it time to reassess the categorisation of disease burdens in low income countries? Am J Public Health 2004;94;384–8.
4. Starfield B. Is primary care essential? Lancet 1994;344;1129–33.
5. Hastings A, Rao M. Doctoring deprived areas. BMJ 2001;323:409–10.

afp CORRESPONDENCE email: afp@racgp.org.au