

Physician review thyself

Leaving doctors to practise in isolation is unfair to both doctor and patient. City doctors have a role, urges Shima Gyoh



Performance in health systems was originally assessed by dividing the population of the country by the number of doctors available within it. The average number of population per doctor gives an approximate idea but does not reflect the true situation anywhere in the country. Maldistribution of health workers is a particularly serious problem in rural areas.

Towns have a higher concentration of health workers because they have higher populations with wealthier people, medical colleges, and teaching hospitals. In Nigeria, the number of doctors in one teaching hospital on a conservative guestimate would be more than those serving the rural areas of over ten states! To make matters worse, it is the young and less experienced doctors that are deployed to rural areas.

Technically, the education of doctors at medical college up to the stage of internship constitutes the foundation on which the acquisition of professional skills will be subsequently built under a residency programme. There is no longer any room for non-specialists, for even general medical practice is now a specialty. Residency is a period of apprenticeship to consultants during which the professional character of the medical graduate grows and matures. He is guided to acquire the knowledge and skills that would enable him safely manage most of the conditions he will meet during his professional life, and to internalise principles that would enable him competently unravel any unfamiliar ones that might crop up in the future.

Most developing countries are unable to afford a training that may delay the deployment of the doctor to needy areas for another 3–5 years after graduation. The new doctor is sent to a rural hospital where he or she is obliged to practise without supervision, libraries, or even the internet. Power and water supply are at best intermittent and available equipment badly needs replacing. Basic essential diagnostic aids and laboratory back-up are often unavailable. The argument is that, no matter how badly the graduate doctor performs, he is better than any quack! This is very true.

Pressure of work is high. Emergencies beyond the doctor's skill cannot be referred elsewhere because there may be no ambulance, the nearest competent hospital may be too far, or the patients might not be able

to afford the journey or the fees at the other end. Even where referral is possible, some of the emergencies, such as acute abdomens and obstetric complications, might not be able to survive further delay as they often arrive at the late advanced stages. The new graduate might not have had the opportunity of being first assistant at an operation which he or she must simply do, or even that slim chance of survival will slip away. These frightening exposures lead some of the practitioners to develop some unorthodox methods of management. Where they succeed, he shares the praise with God; where they fail, it is God's will to which all must submit.

The doctor does not receive frequent supervisory or solidarity visits from the employer. The quality of service he gives now depends entirely on his conscience. The majority leave for private practice, while others simply combine the two in a formula of their choice.

In Benue State of Nigeria, the British Department for International Development funded an excellent programme for training and supervising doctors in rural areas.¹ The doctors attended a 5-day workshop in one of the rural hospitals where they received lectures and participated in clinical and academic activities under a senior visiting resource expert. At the end, they had a comprehension test and returned to their stations. Between the workshops, a senior clinician visited their individual hospitals and conducted similar activities with the staff, giving each doctor more individual attention. Although there was no formal evaluation, the boost in the morale of clinical staff and the improvement of the quality of clinical care was as obvious as an elephant on a football field.

Where there is a high concentration of doctors in our countries, there is often insufficient time and space to keep each fully occupied. Their services should be extended to rural hospitals. Each consultant could take a tour of two or more rural hospitals at suitable intervals – perhaps once every 3 or 4 months. Over a 2 or 3-day period, the consultant would see outpatients specially selected by the resident doctor, do a teaching ward round, conduct clinical and mortality conferences, and, for surgeons, a session in the operating theatre. The benefits would be a boost in the morale of health staff in rural hospitals, upgrading of the quality of clinical practice throughout the state, and provide planners with a better handle on their responsibilities.

Reference

1. Continuing Medical Education in Benue State of Nigeria. *Afr Health* 2001: 4–5.

Prof Shima Gyoh has held many posts ranging from village doctor to DG of Nigeria's Federal Ministry of Health and Chair of the Medical and Dental Council of Nigeria.