Historical evolution and present status of general practice in Nepal

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BACKGROUND

In 1981, in the face of no post-graduate training programs, health policy makers realized that Nepal needed "generalist" physicians who could cope with the wide range of preventive and curative medicine required in rural areas. From discussions between His Majesty's Government (HMG) and the University of Calgary, the Medical Doctorate in General Practice (MDGP) programme was launched in 1982 by the Institute of Medicine (IOM), Tribhuvan University and the Ministry of Health (MOH).

Phase 1 was from 1982-1987 when half the training (18 months) was in Calgary, Canada with the rest in Nepal, including 6 months in Surkhet in mid-western Nepal. A total of 11 doctors undertook at least part of the training programme, with 7 completing the training and 6 passing the final examination, receiving a Postgraduate Diploma in General Practice.

Phase 2 was from 1987-1988 with 3 months training in Malaysia. A further six doctors successfully completed training to receive the MD (GP) degree. During 1989 and 1990, the program accepted no new intake of trainees while the University re-evaluated the feasibility and requirements of the programme.

Phase 3 started in 1991 continues to the current time with all training in Nepal. In a 1994 evaluation, it was recommended to establish linkages between the IOM and Patan Hospital to supplement weaknesses in the curriculum, provide resources for facility development and provide the basis for future collaboration. In 1994, the IOM programme officially accepted Patan Hospital general practice residents into the MDGP programme. In 1998, the IOM programme also included residents in BP Koirala Institute of Health Sciences (BPKIHS) but this ceased after BPKIHS established its own programme.

Subsequently BP Koirala Institute of Health Sciences (BPKIHS) started its own MD in Family Medicine in 2002.The National Academy of Medical Sciences (NAMS) approached Patan Hospital and its Department of General Practice and a 3rd MDGP course based in Patan was started from 2005.

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CHALLENGES

The MDGP programme has been the one postgraduate programme specifically seeking to address the rural doctor shortage by training doctors for district hospitals. An important goal of the MDGP programmes continues to be to enable doctors to provide comprehensive and effective management of common health problems encountered in rural Nepal, including timely emergency and life-saving surgical and obstetric interventions in the district hospitals of Nepal. The programme's objectives attempt to address the needs of Nepali people, 83% of whom live in rural areas[1] and are deprived of basic and primary health care services with no access to a doctor of any sort. In 1999, it was estimated, there was a ratio of 1 doctor/850 people in the Kathmandu Valley compared to 1/30,000 outside the Valley.[2] In 2009, of the 8,118 doctors working in Nepal, Kathmandu's doctor density was still estimated to be 25 times more than rural Nepal's.[3]

This goal has remained in line with Government policies. HMG's 8th Plan (1992-1997) emphasized the improved health status of rural people and the objectives of the Second Long-term Health Plan (1997-2017) included

•To extend to all districts cost-effective public health measures and essential curative services for the appropriate treatment of common diseases and injuries;
•To provide technically competent and socially responsible health personnel in appropriate numbers for quality health care throughout the country, particularly in the underserved areas;

In Nepal there is under-staffing and hence underutilization of District Hospital beds (60%) with high utilization in central hospitals (95%). Many of these patients could be managed at lower level institutions. Improving access to basic primary and secondary care across the country requires significant increase in staff and beds at district (213%) and zonal level (100%). (Human Resource Report 2003)

In an evaluation in 1994 as part of a Process Evaluation of the Nepal Health Development Project [4], four of twelve graduates (Phase 1 and 2 of the programme) were serving in District Hospitals. In this 1994 evaluation, it was found that MDGP residents were generally willing to serve in districts if certain basic criteria were met – operating theatre with minimal support staff, residential facilities, available schooling, assurance of future postings in less remote areas, equitable HMG policies for posting and transfer and opportunities for private practice.

A study in 2001 of the 46 graduates to date, found Twenty-eight outside Kathmandu Valley (twenty-two in government service), sixteen in Kathmandu (three with government), one overseas and one had died. Only one rural doctor started in urban practice and two Kathmandu doctors started MDGP practice outside Kathmandu. Place of growing up appeared significant in determining location of work. Health assistant background and undergraduate rural exposure appeared non-significant. Lack of support staff and facilities were the greatest difficulties working in rural areas. Government policy, particularly frequent transfers and lack of clear career path and family factors, particularly children's education were identified as major issues. Lack of specialist support, lifestyle issues and Continuing Medical Education appeared non-significant. Most were doing emergency work

but were not using major operative skills. Few were doing research and outside the University Departments did little teaching. Only those working as District Health Officers were doing significant community health. Most had private practice that provided for financial needs, offsetting perceived inadequate government salaries. This study concluded that although the MDGP programme had been reasonably successful in getting doctors to rural areas they were generally not in District Hospitals as DHOs and not using the wide range of skills from their training and greater cooperation with government to encourage, place and appropriately use the operative and community skills of MDGPs was needed, especially in more remote areas where there was no viable private practice.[5]

A RAY OF HOPE

General Practitioners' Association of Nepal (GPAN) was established in 1990 as a chapter of Nepal Medical Association. The major aim of GPAN is to support general practitioners of Nepal in various ways. It has been conducting CME's, national and international conferences. The journal is yet another endeavor undertaken by GPAN to help develop academic activities of general practitioners. GPAN is operated by elected members from General Practitioners through a democratic way of voting. Each committee has a term, and after finishing, it will hand over the responsibility to the newly elected members.

The establishment of the Nick Simons Institute (NSI) in 2006 with a mission to support and train rural health care workers with a focus on MDGPs as the captain of the team in a district hospital has given great support to Nepal's GPs.

A symposium in March 2006 with international and national participants sponsored by General Practice Association of Nepal (GPAN) and NSI was important for the development of MDGPs in Nepal.[6] It encouraged

- A common name (MD in General Practice has been adopted by all institutions now)
- A need for an advocacy group for GPs that can go to the government and lobby for key changes in career structure. There has been significant progress in this with recognition in 2012 of MDGPs going to Level 11 as Specialists;
- Developing GPAN into a supervisory body for GPs (this continues to develop);
- Coordination of the three current academic bodies for training GPs (there are good relationships and sharing of some resources though not yet a common exam as initially proposed);
- Furthering research to build up a Nepal evidence base for proposed changes to enhance GP recruitment and retention (see below);
- Raising awareness of GPs in the public arena (a radio programme was developed by NSI to highlight the role of the GP);
- Continuing professional development (Nepal CME has been established with Volume 2 soon to be released after Volume 1 was well received) and
- GP input to undergraduate training which has happened in 2 medical colleges (BPKIHS and PAHS) and currently work is going on in collaboration with NMC to make a compulsory General practice component for all medical schools.

A follow-up study in 2006 investigated all MDGPs trained in Nepal between 1982 and

2005 (n=99) and found 87 working in Nepal (11 overseas and 1 died) of whom 53 (61%) were outside Kathmandu and 30 (35%) were working in government. The major change from 5 years earlier was that there were more MDGP graduates overseas. Again, most were doing emergency work but not using major operative skills either because of lack of need or lack of facilities and support staff. Most had private practice to provide for financial needs, offsetting perceived inadequate government salaries. There continued to be a need for greater commitment to appropriately place MDGPs in places where they could use their skills. [7]

This study also found that the spouse growing up outside Kathmandu and whether the doctor had ever been a Health Assistant were the statistically significant factors in whether currently working outside Kathmandu.[8]

The main themes arising with regard to improving retention of GPs in rural areas were[9]:

- Addressing the career/promotion prospects of GPs in the government system – a key area
- Improving the status of GPs at government, community and peer level
- Adequate hospital and local infrastructure
- Addressing professional isolation
- Providing continuing medical education
- Adequate financial remuneration
- Provision of education for children
- Political stability and security

In 2007, NSI conducted a retrospective study of Nepal government district hospitals where an MDGP doctor was present for five or more years during the period 2053 – 62. 19 district hospitals were identified and in 12 of these district hospitals, MoHP Annual Reports showed that the presence of an MDGP doctor was associated with more deliveries, more OPD visits and more operations – both by comparing years before and after an MDGP arrived in post and over the course of a continuous period when MDGP(s) worked in that hospital. Though other factors likely played a role, it is suggestive of the value of an MDGP.[10]

In a 2010 review of NSI's Rural Staff Support Programme (RSSP), where there was an MDGP doctor, the patient utilization and comprehensive emergency obstetric care (CEOC) rose dramatically. In Gulmi, where an MDGP had been posted for 1.5 years at the time of this assessment, the number of OPD patients increased by almost 3 fold, the number of deliveries by over 2 fold and the number of admissions by approximately 1.4 fold. Where the GP had yet to come, the results were modest. From community member interviews, the availability of the MDGP made a tremendous difference in the service provided to patients and they were appreciated.

JOURNAL OF GENERAL PRACTICE AND EMERGENCY MEDICINE OF NEPAL

Journal of General Practice and Emergency Medicine was started by General Practice Association. The first issue was published in December 2010. The aim of this journal is to help General Practitioners working in rural areas to upgrade their knowledge, increase the skill of writing and to practice evidence based medicine. As general practitioners are isolated socially and educationally, [9] this is an initiative

to make a social and intellectual circle. In a long run this journal will also help to increase public awareness. As general practitioners are covering the wide areas from rural health to emergencies, emergency medicine has also been incorporated in this journal.

The journal provides technical support to the MDGPs in helping them to conduct research or writing articles. It is also a platform for MDGPs to discuss what they are facing in rural areas, their challenges and the way they are managing. Despite all these efforts, the journal is facing challenges of resources and motivation.

FUTURE OF MDGPs

The strength of General Practitioners is increasing in Nepal with the help of organizations like Nick Simons institute and General Practice Association of Nepal. There is still a need to train general practitioners for rural health. There is also empirical evidence that training family physicians in rural areas increases the likelihood that residency graduates will choose to settle in rural places.[11-14] So, one of the upcoming institutes, "Patan Academy of Health Science", building on the long service history of Patan Hospital has already taken initiatives to train undergraduate students in rural areas. It has further plans to extend its educational activities with its own MDGP residency program.

The future of MDGPs in Nepal is very promising and the model of General practitioners in Nepal can be taken as an example to promote rural health in any part of the world.

CONCLUSION

"Primary health care also offers the best way of coping with the ills of life in the 21st century: the globalization of unhealthy lifestyles, rapid unplanned urbanization, and the ageing of populations." (Dr Margaret Chan, Director General, WHO – 2008)[15] The World Health Assembly adopted a resolution urging member states to "accelerate action towards universal access to primary health care" and "to train and retain adequate numbers of health workers including family physicians."[16]

The people in Nepal, particularly the majority rural folk should be able to meet a doctor who has a broad background of training, who understands them and knows how best to meet their need in a comprehensive way, recognizing what is possible and affordable in that context. Primary care is not just about treating common diseases, nor is it acceptable that primary care be synonymous with low-tech, non-professional care for the rural poor who cannot afford any better. Good primary care is good for everybody. It requires a team of health care professionals with sophisticated medical and social skills. The generalist specialist or the MDGP is a vital part of this team. It is often said of generalists "Jack of all trades, Master of none" without the rest of the saying "But oft times better, than master of one".

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