

The Central African Journal of Medicine



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Volume Eighteen
JANUARY - DECEMBER
1972



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The Central African Journal of Medicine

Volume 18

JANUARY, 1972

No. 1

Broadening the Horizon* A Glimpse of General Practice in Rhodesia

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The term general practice is familiar to everyone in the medical profession who has been brought up in the British tradition of medicine. Nevertheless, there are a number of other terms which have been used to cover this branch of medicine. We are familiar with the family doctor, family physician, personal physician and others, but for the sake of definition we are considering in this paper the doctor who makes first contact on a personal basis with a person, be he seeking advice for an ailment from which he is already suffering or, perhaps more important, seeking advice whereby he might prevent an ailment occurring in the future.

It must be obvious that the scope of general practice varies widely from one country to another, and even within a country the variation may be considerable. When considering a country such as Rhodesia, where there are few towns of any considerable size and a population scattered widely throughout an area of 150,000 square miles, it does not take much imagination to see that there will be considerable variation in the types of general practice from that found in the more densely populated countries of Western Europe. The work of the general practitioner in Rhodesia varies from the relatively sophisticated type of practice found in the large towns such as Salisbury, where the doctor is rendering a personal care service for two or three thousand people, to that of a practitioner in the more remote rural areas where he may be rendering the only medical care to 60 to 100,000 people, having primary contact with a few but medical responsibility through para-medical personnel for the many.

An address read at the General Practice Section of the 1969 South African Medical Congress in Pretoria.

Ross and Rittey (1969), when considering ways and means of providing "a glimpse at general practice" to undergraduates, considered there were seven different types of general practice in Rhodesia. These were—

- (1) General practice in a large town among a sophisticated type of patient, with easy availability of hospitalisation, consultant services and diagnostic aids such as X-rays and laboratory services.
- (2) General practice in a small country town, among sophisticated patients, with a small hospital, limited X-ray and laboratory services and no readily available consultant services.
- (3) General practice on a mission station among less sophisticated people, with large numbers of patients, few ancillary services, limited hospitalisation, but fairly easy access to a large centre.
- (4) General practice similar to (3) above, but in a remote area with difficulty of access, sometimes completely cut off in the rainy weather.
- (5) General practice in a mining community with good facilities, both European and African patients to be looked after, and the challenge of occupational medicine to be met.
- (6) General practice on an agricultural estate, with problems not dissimilar to those of the mining community, but with medical hazards associated with irrigation, e.g., bilharziasis and hookworm.
- (7) General practice as carried out by a Government medical officer, usually in rural Rhodesia, with responsibility for a large area, probably a base hospital and several rural hospitals and the need to provide personal physician care for a few fairly demanding Europeans, and community care for what may be many thousands of African people.

It will be seen, therefore, that the qualities and skills required of the general practitioners in these varying practice situations are widely dif-

ferent in some ways and yet very similar in others. The more remote the doctor from his colleagues, the more resourceful he will have to be and the more important will it be to ensure that his skills are kept up to date because of his less informal opportunity to have constant contact with colleagues. The myth of the clever doctor being associated with urban practice and the professional dead-beat being rusticated to the rural area must be buried forever when the enormity of the task and the responsibilities of a rural area are considered in the hard light of day.

I believe that during the undergraduate training an opportunity must be afforded to the medical student to become aware or familiar with the world of medical practice beyond the walls of the teaching hospital. Although I believe the teaching hospital should have no walls, nevertheless we seem to have to accept that in the eyes of many colleagues it is the be all and end all of medical practice. To overcome this, various schemes of general practice attachments have been devised in different parts of the world. Some are voluntary and arranged by the student in a vacation, while in others attachment is compulsory and arranged by the faculty. In some the attachment is for as little as a week and in others for a longer period up to four to six weeks. In some medical schools a department of general practice has been established in which the student spends "formal teaching time", while in others no effort at all is made to acquaint the student with this type of practice. In some parts of the world the attachment of a student to a rural health service, frequently run by the department of social and preventive medicine, is seen as being a type of general practice attachment.

At the University of Rhodesia the department of social and preventive medicine has undertaken, on behalf of the faculty of medicine, the task of providing what we call "a glimpse at the practice of medicine *outwith* the teaching hospital." To this end we attach our students for a period of two weeks, at the end of the fifth year, to one of the seven types of practice listed previously, the arrangements being made by the Department.

As the number of students in each year is still small, being of the order of 20 to 35, and we have only had two years' experience, it is perhaps too early to be able to come to any major conclusions. On the other hand, the opportunity of close personal contact with students allows me to say that this has been a *most popular scheme and more than one student* has already taken steps to revisit the doctor with whom he spent his attachment. In many cases the student has stayed in the home of

his mentor and has thus shared fully in the trials and tribulations of the practice. I believe that this attachment scheme has certainly given the undergraduate the opportunity to familiarise himself with the problems of general practice and not a few have said how much they welcomed this chance to broaden their horizons. It must be emphasised that this attachment is designed to "broaden the horizons" and not to actively recruit in any military sense.

It would seem to be a truism to say that any medical school should produce graduates fitted to the practice of medicine in the country in which it is situated. However, it is now generally agreed that at the time of graduation the young graduate still has to undergo a period of vocational training before he is fitted to take his rightful place in the medical community, no matter what his choice of career may be. In the light of my earlier description of the varieties of general practice in Rhodesia, it will be readily agreed that the need for vocational training in general practice, and more particularly for those in the more remote areas, is very real. If the school of medicine is to take its rightful part in such training there must be a good liaison with and understanding of the needs of the practitioners throughout the length and breadth of the country.

Ross (1967), as a result of a study of the register of medical practitioners at the end of 1965, was able to establish some idea of the future medical manpower requirements of Rhodesia. At the time of the investigation there were only 504 registered doctors living in Rhodesia, of whom 473 were in full- or part-time practice. In this survey it was found that 78 per cent. of those doctors practising were to be found in six towns, leaving 22 per cent. to serve the rest of the country. It can be appreciated, therefore, that the doctors working in the less urbanised and rural areas carry an enormous medical responsibility, bearing in mind that they care for 84 per cent. of the population. While in the six towns referred to there are a goodly number of general practitioners of what we might call the conventional type, it seems to me that it is those who are caring for the 84 per cent. of the population to whom we must particularly direct our attention.

In making this statement I wish to make it clear I am in no way derogating the skills of the general practitioner in the urban areas, the standard of which, I believe, is above average in Rhodesia, but I am merely emphasising the problems which fall on those in the more remote areas. By establishing our medical practitioner attachment scheme, this has allowed us to be in close touch with a variety of practitioners in various parts of

the country. Furthermore, as an effort is made by members of staff of the Department of Social Medicine to visit as many of the students as possible during their attachment, this brings in its wake the possibility of the faculty being informed of the varying problems of practice throughout the country.

When the survey of Rhodesian doctors was carried out it was found that 47 per cent. of the registered medical practitioners were over 45 years of age. When it is borne in mind that many of the younger doctors were those who were working in the larger hospitals as interns and registrars, it will be seen that there is cause for concern at the age structure of those who are rendering general practitioner care, either in urban or rural areas.

When any new faculty of medicine comes into being the question must be asked about the provision of postgraduate facilities. It might well be argued that teaching should start at postgraduate level and then later venture into undergraduate training. It may be easier in the first instance in a small community to attempt to refresh those who have already been taught rather than to attempt the production of a whole graduate from scratch. Fortunately in Rhodesia, for a number of years before the establishment of the faculty of medicine in 1962, efforts had been made to cater in a small way for the needs of the profession by the establishment of libraries, clinical meetings, teaching rounds and in other ways. These were supported by general and specialist practitioners alike and it might be said that these were the beginning of postgraduate facilities.

In view of the fact that the greatest need in Rhodesia is for well-trained general practitioners, it seems obvious to me that this is one area in particular where the young faculty of medicine should spread its wings in the postgraduate field. In 1966 the faculty established a Postgraduate Medical Education Committee, and under its auspices a number of one-day symposia have been arranged. These have catered primarily for the general practitioner in rural practice, but nursing staff have also been encouraged to come.

Sight must not be lost of the value of bringing together doctors who in their daily work may not have much opportunity of professional contact. When we remember the distances which many of these men (and women) had to travel to attend these one-day courses and the enthusiasm with which they were received, the organisers have been encouraged to extend their interests to the possibility of arranging clinical meetings and dis-

cussions in smaller centres even if only a few people could attend.

It is hoped that suitable training courses can be established in the teaching hospital in association with the Ministry of Health. Following the compulsory pre-registration year in medicine and surgery, it is the hope of the faculty of medicine that for those doctors wishing to take up general practice a further two-year programme of training may be instituted. We would envisage a further year in the teaching hospital or similar major hospital, where six months would be spent in obstetrics and six months covering subjects such as dermatology, ear, nose and throat diseases and ophthalmology, with opportunity at this time to obtain further experience in anaesthesiology, community medicine and the like. The second year would be spent obtaining a wider experience in a smaller general hospital working with an experienced general practitioner, where opportunity would be available to broaden the experience already gained and also to exercise increasingly the individual responsibility which is so essential in general practice.

Although many would wish to make a career in private practice as a family physician, it is considered that the experience which would be gained in a training programme as outlined above would be invaluable in providing a sound basis for any of the types of general practice which were described previously. The essence of being a good general practitioner is to be a sound doctor, and this can be best achieved by an environment in which the young doctor can have the chance to develop and broaden his skills in an atmosphere of medicine well practised and adequately supervised. There must, however, be scope for the development of personal initiative.

In a country like Rhodesia I believe it is essential to develop ways and means of encouraging doctors to keep in contact with facilities which will allow them not only to have the opportunity to acquire new knowledge, but to share with each other personal experiences. For this reason I have no doubt that the day of single-handed practice is gone. No longer can we expect a doctor to bury himself in a rural area providing a total health service on his own. In future, group practices must be developed where particular skills may be encouraged within the general background and where opportunity exists for a regular division of work and leisure.

SUMMARY

The scope of general practice varies from one country to another, and even within the same country the types of general practice may vary. The various patterns of general practice in Rho-

desia are considered and the qualities and skills required to undertake the differing types of practice are described.

Methods whereby undergraduates can be given some insight into the opportunities of general practice are discussed and a programme to demonstrate the professional requirements of the types of general practice met with in Rhodesia is presented.

It is important for a school of medicine constantly to keep under review the structure of general practice in the country it serves, not only in relation to the teaching of the necessary skills, but also in relation to the present and future medical manpower requirements. Efforts to make such a survey of medical needs of this nature in Rhodesia are presented.

The place of a young faculty of medicine in providing facilities for training in general practice is reviewed and the point is made that this may be the most important postgraduate service which can be provided in the early years of the faculty in a developing country. Opportunity is also taken to discuss ways and means of arranging facilities to encourage practitioners to remain in general practice.

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