

NEPAL'S GENERAL PRACTITIONERS

WHERE ARE THEY &
WHAT ARE THEY DOING

IN 2006 ?

ABSTRACT

Objectives

This study examined the current location and type of practice of MDGP (family medicine) graduate doctors in Nepal.

Methodology

Questionnaires and personal interviews of MDGP graduates. This repeated a 2001 study.

Results

To date, there are 99 graduates - 90 males and 9 females. Fifty - three worked outside the Kathmandu Valley (30 with government, 12 in private institutions, 8 in medical colleges and 3 in mission institutions), thirty-four in Kathmandu (5 with government, 10 in private institutions/private practice, 12 in medical colleges and 7 in mission institutions), eleven are overseas, and one has died. At least 8 others have worked at some time outside Kathmandu. The major change from 5 years ago is that there are now more MDGP graduates working overseas.

Most MDGPs are doing emergency work but are not using major operative skills - because of either lack of need or lack of facilities and support staff. Most work in private practice to provide for financial needs, offsetting perceived inadequate government salaries. They are hard workers, with an average of 3 days off per month and 4 days weekly on call.

Conclusion

The MDGP programmes continue to be reasonably successful in getting doctors to rural areas, with 62% of those in Nepal working outside the Kathmandu Valley. However, the doctors are still generally not using the wide range of skills provided in their training. MDGPs should be posted in places where they can use their skills and should be provided clear career structures. Authorities should also address other significant retention issues such as income, infrastructure, children's education, and CME.

KEY WORDS

Practice Location, General Practice Training, Work Patterns



INTRODUCTION

The Medical Doctorate in General Practice (MDGP) programme was launched in 1982 as a serious attempt by the Institute of Medicine (IOM), Tribhuvan University and the Ministry of Health (MOH) to reorient the direction of health care and medical education to the needs of the districts. Subsequently BPKIHS started a MD in Family Medicine in 2001 and NAMS started an MDGP programme in 2005

The objectives of the Government's Second Long-term Health Plan (1997-2017) include:

- 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;(1)

Currently in Nepal, there is under-staffing and hence underutilisation of District Hospital beds (60% occupancy). At the same time, there is high utilisation in central hospitals (95% occupancy), and 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). Another problem is the huge difference in doctor/ population ratios between Kathmandu (1/1057) and the hill (1/41,004) and mountain regions (1/43,874) (Ministry of Health figures 2005).

One of the main goals of all three MDGP (family medicine) programmes is 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. Thus, the training programmes remain very much in line with the government's objectives and the needs of the country.

In the 1994 "Process Evaluation of the Nepal Health Development Project" (2), 4 of the 12 MDGP graduates were serving in District Hospitals. In our 2001 evaluation (3), 33 of 45 living graduates had worked at some time outside Kathmandu - and 28 were still working there. We concluded that the MDGP Programme had been reasonably successful in preparing doctors and getting them to rural areas, but once there, they were often not able to use their skills because of lack of facilities and support staff.

With the major security upheavals in the last 5 years and the development of more training programmes, there is a need for further evaluation of how successful the MDGP programmes have been at tackling the rural doctor shortage and equipping doctors for the task.

METHODOLOGY

This study was done by hand delivering or mailing a questionnaire to the MDGP graduates resident in Nepal between June and September 2006. It was the same questionnaire used in 2001.

Information was collected about personal demography and current and previous places of work and work habits. Places of work were classified as within or outside the Kathmandu Valley, since this is the major urban area of Nepal. The data results were compiled and analysed in SPSS programme.

To enhance and supplement this information, a personal interview with graduates was conducted. Mostly, this was done in their place of work but, if this was not possible, in Kathmandu. There were 62 MDGPs who completed the questionnaire - 39 outside Kathmandu and 23 in Kathmandu, which is similar regional distribution to the total number of graduates.

RESULTS

We made contact with 75 of the 87 graduates living in Nepal. One graduate has died and eleven are overseas. At least three of these twelve have worked at some time in rural areas.

Who are Nepal's General Practitioners?

- Among 99 graduates from 1982 till 2006 there are 9 females.
- The mean age of 66 graduates is 45 years with a median age of 46 and range from 32 to 59 years.
- They have a mean of 16.5 years of medical practice (range from 5 to 34 years and median 15) and 6.3 years of MDGP practice (range from 0 to 21 years and median 5).
- All are married except 1 and of 68 married respondents all have children (mean 2.1, median 2 and range from 1 to 4).
- 32 have been Health Assistants, 30 have done ISc, 4 have done both and one female has a nursing background.

Where are Nepal's General Practitioners?

- Fifty-three (62.1% of those in Nepal) work outside of Kathmandu Valley
 - ▶ Thirty in government service
 - ▶ Three with Mission Hospitals
 - ▶ Eight in Medical Colleges
 - ▶ Twelve in Private Institutions/ Practice

Note – there are no females currently working outside Kathmandu.

- Thirty - four (37.9% of those in Nepal) are in the Kathmandu Valley
 - ▶ Five in government service in Valley hospitals
 - ▶ Seven in Mission (6 with Patan UMN/ government hospital and 1 with HDCS)
 - ▶ Twelve in Medical Colleges
 - ▶ Ten in Private Institutions/Practice.

Of these, at least five have at some time worked in rural areas.

- Eleven are overseas.
 - ▶ Of these at least 2 have done some work previously outside Kathmandu.

The location of practice by region is illustrated in Graph 1.

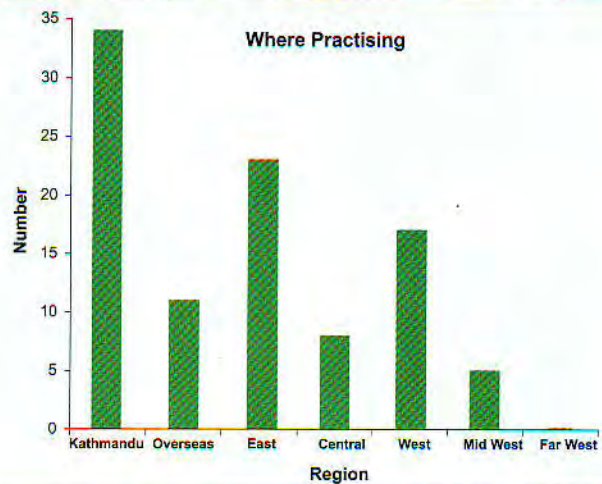
What are Nepal's General Practitioners doing?

From a maximum of 75 respondents,

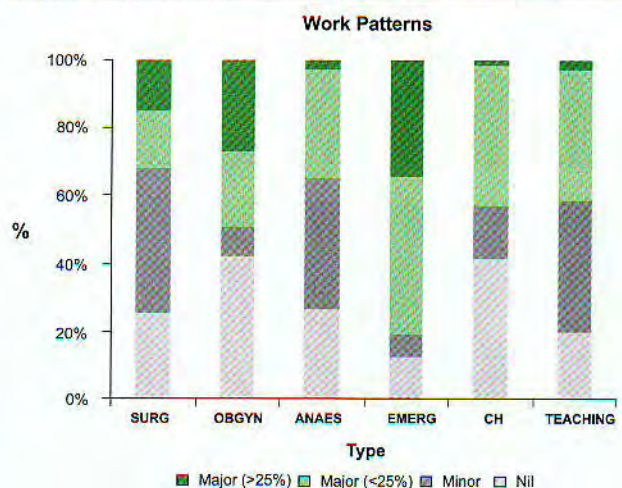
- 13 (17.3%) are doing a mix of surgery some of the time while 32 (42.7%) are only doing minor surgery, 19 (25.3%) are doing none and 11 (14.7%) are doing surgery more than 25% of their working time.
- 19 (26.8%) are doing a mix of obstetrics (all types of deliveries and surgery) while 30 (42.3%) are doing no obstetrics, 6 (8.5%) office care only, 12 (16.9%) doing deliveries and 4 (5.6%) just do operative deliveries.
- 23 (31.9%) were doing a mix of anaesthetics (local, spinals and/or ketamine) while 28 (38.9%) perform local anaesthetics only, 19 (26.4%) do none and 2 (2.8%) do GA's.
- 34 (46.6%) do some emergency medicine while 5 (6.8%) do a small amount, 9 (12.3%) do none and 25 (34.2%) do predominantly (>50% of their time) emergency medicine.
- 21 (41.4%) do some Community Health work while 11 (15.7%) do a small amount, 21 (41.4%) do none and 1 (1.4%) spent more than 50% of his time.
- 27 (38.4%) do a significant amount of Teaching while 27 (38.4%) do a small amount, 14 (20%) do none and 2 (2.9%) do predominantly teaching.
- On average, the MDGPs do 11.5 hours Administration weekly, ranging from 0 to maximum of 35 hours.
- 22 (36.1%) are on-call every day and 20 (31.3%) have no regular days off. 7 (11.5%) do no on-call work. On average, they are on-call 4.0 days weekly with 3 days (range 0-9) off per month.
- 6 (12.5%) do no private practice and 7 (14.6%) - 4 in Kathmandu are fulltime in private practice. Most (35) do regular private practice supplementing their hospital jobs with 13 (27.1%) doing on their days off and 22 (45.8%) doing private practice most days.
- There are insufficient responses about Research and use of Ultrasound.

Graph 2 illustrates these work patterns.

GRAPH 1. LOCATION OF MDGP'S BY DEVELOPMENT REGION



GRAPH 2. MDGP'S WORK PATTERNS



DISCUSSION

Overall, at least 61 of the 99 MDGP graduates have at some time worked outside of the Kathmandu valley. This compares with 33/45 in the 2001 study. Therefore, despite increasing security issues, this remains a much better rural ratio than for doctors overall. There is a similar proportion of doctors currently working in Kathmandu now (34/98 or 34.7%) as 2001 (16/45 or 35.5%) but the main change is the increased number of MDGPs currently overseas (11/98 vs. 1/45). There continues to be relatively little migration of doctors, with only 5 doctors who started rural having come to Kathmandu (compared with 2 in 2001). This highlights the continuing importance of getting doctors out of Kathmandu for their first placement.

From 2001, there has been a slight shift of the rural placements from the three western regions (60% vs. 40%) to a higher number in the Eastern and Central regions (60% vs. 40%). There are now greater non-Government opportunities in rural areas particularly medical colleges as well as private institutions. Also in Kathmandu, there are greater private opportunities than in 2001 though this probably reflects a significant increase in number in Patan Hospital especially since the NAMS programme started there.

Like 2001, though the majority of graduates were out of the Kathmandu Valley, a minority of the graduates was using the full range of clinical skills (particularly surgical and obstetrical) obtained in training. Understandably, no one in large urban practice or in medical colleges was doing any significant surgery or operative obstetrics. In rural areas particularly, the lack of facilities and support staff in many district hospital settings continued to limit opportunities for these surgical interventions. About 1 in 3 MDGPs are doing major surgery and anaesthesia (similar to 2001). The impact of the Safer Motherhood Programme probably contributed to the small increase in MDGPs doing all types of deliveries (1/4

now vs. 1/5 in 2001). It is noted that more MDGPs are doing no obstetrics now (42 vs. 36%), probably reflecting the increase of the number in medical colleges.

Emergency work figures significantly, particularly in those working in urban areas, with 80% MDGPs doing a significant amount of emergency work now. Reflecting the greater number in medical colleges, teaching has become more prominent (40% vs. 20% doing a significant amount). There was more Community Health being done (60% vs. 33% doing some now). There is more administration work being done now (mean of 11.5 hours vs. 7.2 hours weekly).

Most continue to work long hours with much on-call work (average of 4 days weekly with 22/61 on call every day) and little regular time off (average of 3 days monthly with 22/57 having no regular days off). Most (apart from those in Medical Colleges) continue to supplement their income and spend significant amounts of time outside their main working hours in private practice. Its availability remained an important consideration in choice of practice location.

CONCLUSION

The MDGP programmes, despite greater security problems, continue to be reasonably successful in getting doctors to rural areas. However the doctors are still generally not using the wide range of skills from their training. There continues to be a need for greater commitment to appropriately place MDGPs in places where they can use their skills and to provide clear career structures as well as addressing other significant retention issues like income, infrastructure, children's education and CME.

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