# *Retention of General Practitioners in rural Nepal – a qualitative study*

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## ABSTRACT

***Objectives***

To explore the key issues that influence General Practitioner (MDGP) retention in rural areas of Nepal.

***Methods***

Design: A qualitative study using triangulation of data from one postal questionnaire, one hand delivered questionnaire with semi-structured interview and focus group discussions. Data from a small community survey from 13 rural districts also included.

Participants: Sixty two Nepali MDGPs, 25 doctors in General Practice (GP) training programmes, 11 individuals involved in policy development and rural health care.

***Results***

The key issues identified by this study as critical to the retention of Nepali MDGPs in rural areas were:

1. Career/promotion prospects
2. Status/recognition
3. Financial incentives
4. Working conditions
5. Education for children
6. Continuing medical education
7. Political stability and security

***Conclusions***

The strongest theme was that of career development. This must be addressed by the government of Nepal if there is to be any hope of improving retention of MDGPs in rural areas. MDGPs need to have a clear career ladder, with recognition of the value of service in rural areas.

There is, however, no one single answer to the complex interacting factors that impact on MDGP retention in rural Nepal. A multi-faceted, holistic response is necessary. From the level of community awareness, a career structure and financial remuneration to adequately set up hospitals, functional teams, family support, continuing professional development and a safe secure working environment - each area must be addressed for the whole to function.

## INTRODUCTION

In Nepal, as in many parts of the world, there is a major problem providing health care to those living in rural areas. There is a huge rural to urban disparity reflected in the physician to population ration of 1:850 in Kathmandu and 1:30,000 outside of the capital [1]. In many areas of Nepal, the General Practitioner (MDGP) is the only doctor in the hospital, specialists being confined to urban centres. The MDGP is skilled in providing medical, surgical, obstetric and managerial services. The first postgraduate course in MDGP was started in 1982, with the specific vision of improving the health care available to people in rural Nepal. There are now three postgraduate training courses, the Institute of Medicine (IOM), BP Koirala Institute (BPKIHS) and the National Academy of Medical Science (NAMS).

Studies from developed countries notably USA, Canada, New Zealand and Australia [2] suggest a number of significant factors that can improve retention of doctors in rural practice. These include an adequate income, appropriate workload, locum provision, access to specialists for advice [3] and continuing medical education, spouse career opportunities and children's education [4,5,6,7].

The aim of this qualitative study was to define the factors impacting on Nepali doctors decisions regarding practice location, and to explore how these factors might be addressed to improve rural retention rates.

This study is a follow-up to a previous study done in 2001 [8] and was initiated at the request of the Nick Simons Institute a charitable organization that aims to build up the health care system of rural Nepal.

## METHODS

### *Study design*

The initial study looked at both recruitment and retention issues for MDGPs in Nepal, using qualitative and quantitative methods. Here we report just the results of the qualitative part of the study, looking specifically at MDGP retention. For the qualitative arm of the study we used triangulation of data from one postal or hand delivered questionnaire, semi-structured interviews and focus group discussions during a national symposium on General Practice [9]. Data collected from interviews of randomly selected community members in thirteen rural districts is also included.

### *Sampling strategy*

The aim was to survey all 99 MDGPs who had graduated from the GP training schemes in Nepal at the time of the study, as well as all MDGP resident doctors currently in training (33) in the three GP training centres of Nepal (IOM, BPKIHS and NAMS). We found Nepal contact details

for 87 of the fully qualified MDGPs (11 were overseas and one had died) and questionnaires were either emailed or sent by post to their hospital address. Follow-up visits to each doctor in their place of work were carried out, using the same questionnaire as a framework for semi-structured interviews.

Questionnaires were distributed by hand at the MDGP weekly training sessions for the IOM and NAMS courses (which are based in Kathmandu), and were sent by email to BPKIHS (which is in the south of Nepal).

In addition there was purposive sampling by questionnaire of 11 individuals involved in rural health policy development and rural health care. These included the deans of IOM, BPKIHS and NAMS, representatives of major aid organizations (GTZ, Nepal Safer Motherhood Programme and UNICEF), government officials and expatriates from mission hospitals providing training and clinical services.

***Instruments and data collection***

A questionnaire was designed and piloted amongst MDGPs working in Patan Hospital, Kathmandu. The finalized questionnaire (see appendix one) was sent by email or using the local postal system. The poor response rate from rural doctors sent postal questionnaires led researchers to personally visit each doctor, taking the same questionnaire and delivering it by hand. This questionnaire was also used as the framework for semi-structured interviews.

Those individuals (excluding students) who responded to the initial emailed or postal questionnaire were invited to attend a national symposium on "Building up General Practice in Nepal", jointly organised by the Nick Simons Institute and the General Practice Association of Nepal (GPAN) [9]. During this symposium, focus group discussions were held looking in more depth at the recruitment and retention issues for MDGPs in Nepal, and also brainstorming possible solutions. Two of the researchers, and two others chosen for their experience in such work, were facilitators for the four small groups. A written record was kept of the discussions and notes were also taken during plenary sessions.

***Data processing and analysis***

Two authors independently read and transcribed each of the questionnaire responses, identifying main themes emerging and performing initial coding. The themes were refined in discussion with all authors and then the questionnaire responses were re-read and coded according to the thematic framework developed. The themes arising from the interviews were analysed by the third author and checked against questionnaire responses by all authors to look for any discrepancies. There were no significant outlying data.

The written transcripts of focus group discussions and plenary notes were also independently read and transcribed by two authors, defining concepts and looking for recurrent patterns. Discussion with all authors lead to consensus on emergent themes and then the transcripts were re-read and coded accordingly. The final analysis was developed in discussion with all authors.

## RESULTS AND DISCUSSION

Responses were received from 62 doctors, 39 from outside of Kathmandu valley and 23 from within, an overall response rate of 71%. Of the MDGPs currently in training, the 12 students in BPKIHS chose to respond as a group, and 13/21 responses were received from students at the other two training institutes (IOM and NAMS)

The key issues identified by this study as critical to the retention of Nepali MDGPs in rural areas were:

- Career/promotion prospects
- Status/recognition
- Financial incentives
- Working conditions
- Education for children
- Continuing medical education
- Political stability and security

### *Career/promotion prospects*

The lack of a clear career ladder was one of the commonest themes in this study. Within the government system there is no real opportunity for significant career development, nor clear promotion criteria.

Some specific suggestions were made that could address this issue.

- Create more MDGP posts in each level of institution with clear, transparent promotion criteria.
- Create a senior position of “Chief of Emergency Room” in zonal hospitals
- Senior MDGP doctors should be allowed to move into senior government positions.
- Allow “GPs with a special expertise”. Many doctors commented on the prevailing public desire to be seen by “specialists”. Further study in a particular area of interest such as surgery, use of ultrasound or endoscopy might allow an MDGP to expand his or her knowledge in a smaller field, while still retaining their generalist knowledge and skills. It might also provide MDGPs with an extra income in their private practice.

***Rural MDGP*** *O "Future career attraction will definitely inspire doctors to take up MDGP. Specialties like emergency medicine or GP surgery will benefit not only the MDGPs but the nation as a whole."*

Many respondents criticized the government system of frequent transfers to other remote areas. All agreed that there should be some sort of rotation between urban and rural areas, in consultation with the doctor. Many were willing to serve in a rural area, but don't want to become trapped there.

***Rural MDGP*** *N1 "Always working in rural area so no future."*

***Status/recognition***

Many doctors expressed frustration at the low status and poor recognition of General Practice, reflected in the lack of career structure.

***Urban MDGP (government service)*** *C "MDGP in Nepal may be good but the career in this field does not seem promising. Unless definite system of Family Care will exist this career is dark."*

The lack of recognition is at three important levels.

Firstly the public is not aware of what General Practice is. This was confirmed in the community interviews, where most people were unaware of the surgical and obstetric skills of MDGP doctors. The public wanted doctors with good communication skills, able to deal with a variety of cases, particularly emergencies, obstetrics and surgery – precisely the areas in which MDGP doctors are trained.

The next level is lack of recognition by medical colleagues and peers. Finally MDGPs feel that the government pays lip service only to the importance of General Practice in providing good health care to the nation.

Work needs to be done on how to boost the morale of MDGPs [7,10,11]. This needs to look at each of the three levels described above. Respondents suggested a number of tactics:

- Use the media (radio, TV and newspapers) to raise the awareness of General Practice and recognize their service to society.
- GPs should be involved in undergraduate education teaching the particular skills of a family physician.
- Most importantly, the government needs to recognize and help raise the status of General Practitioners. An essential part of this would be to provide a good career structure.
- Develop a MDGP support agency to act as an advocacy group

***Rural MDGP (mission hospital**) O1 "Unless we do something to lift up the status of MDGP doctors, all our efforts to influence young doctor to consider MDGP as a career will be futile."*

***Financial incentives***

The desire for an adequate and fair pay scale came over particularly strongly in the semi-structured interviews, although it was expressed by almost all. During semi-structured interviews, the researcher was able to probe more deeply into this issue. Those doctors working in rural areas have less opportunity for private practice, the normal way for doctors in Nepal to supplement their government salary.

***Working conditions***

*Professional isolation:* Many respondents commented on the importance of sufficient numbers of staff to form a viable team. Professional isolation was a key factor discouraging GPs from working in rural areas. The community survey also confirmed this desire for two or more doctors to provide clinical cover while one doctor was away.

***MDGP student I1** " there should be good cooperative team so can work easily and build good working environment. At least 2-3 doctors to work encourage the good decisions in many cases."*

In addition, suggested ways to address this issue included:

- Developing a locum service to allow rural doctors to take annual leave and sabbaticals.
- Providing facilities for phone or email contact with seniors or specialist colleagues for advice.

Social isolation is also important. Most rural district general hospitals are in poor areas, with minimal facilities. Respondents specifically mentioned as concerns, the absence of phone networks and other forms of communication even post, reliable transport, lack of opportunities for a social life [6] and inadequate food.

*Hospital infrastructure:* While a good team of doctors and support staff is necessary for the running of a good health care system, there also needs to be a reasonable level of infrastructure. Discouraging factors for MDGPs trained in surgical techniques were the lack of operating room facilities, equipment and blood transfusion services or even basic essential drugs.

Many respondents commented on the mismatch between doctors' skills and hospital facilities. In the community survey, respondents were unaware that the reason surgical facilities were not available was due to lack of facilities rather than lack of a skilled doctor.

***Family Factors - particularly children's education***

The issue of children's education was the number one priority for all those who mentioned family factors. At present the vast majority of district general hospitals do not have what most doctors would consider adequate local schooling options for their children. Generally these doctors feel they need to pay to send their children to boarding schools in the city.

Proposed incentives for doctors to work in rural areas often included the provision of adequate schooling for their children or scholarships for boarding school.

Studies elsewhere [6,12 found opportunities for spouse employment were important, but this was not mentioned in our Nepal study. This may be because it is common in Nepali culture for husbands and wives to live separately because of conflicting work and family commitments.

At the time of this study, only nine of the ninety-nine General practitioners qualified in Nepal were women, and all were working in Kathmandu valley.

***Continuing medical education (CME)***

Professional isolation meant that CME was particularly important to rural doctors. They are unable to attend central conferences due to heavy workload, lack of locum cover and cost of travel. Proposed solutions included the provision of books, journal, email/internet access and opportunities for distance learning. Periodic meetings with colleagues for both professional and social refreshment could involve organizing conferences in rural areas, or "on the job" updates.

***Political stability and security***

The final major issue identified by all doctors, but particularly those working in rural areas, was the need for political stability and security.

## LIMITATIONS

Focus group discussions were held in Kathmandu and many of the rural doctors were unable to attend due to the previously discussed problems associated with isolated practice in rural areas. This may have lead to an over- representation of more urban-based physicians.

The focus of this study was how to improve retention of General Practitioners in rural Nepal. Many doctors expressed the opinion that General Practitioners should not be seen purely as rural physicians.

## CONCLUSIONS

General Practice in Nepal remains poorly recognized by both the public and the medical profession. There have been just 99 graduates from the country's three MDGP training schemes, since the first course started in 1982. Worryingly there has been an increasing trend in the last few years for MDGP doctors to complete their training and then move overseas.

There was a high level of agreement regarding the key issues facing MDGPs in rural Nepal from the questionnaire and semi-structured interviews. Focus group discussions further validated the questionnaire findings. The results of this qualitative study resonate with previous studies done in Nepal [8,13] and also internationally [3,10,14,15].

The strongest theme was that of career development. This is a key issue that must be addressed by the government of Nepal. General Practitioners need to have a clear career ladder, with recognition of the value of service in rural areas.

There is, however, no one single answer to the complex interacting factors that impact on MDGP retention in rural Nepal. A multi-faceted, holistic response is necessary. From the level of community awareness, a career structure and financial remuneration to adequately set up hospitals, functional teams, family support, continuing professional development and a safe secure working environment - each area must be addressed for the whole to function.

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