

## General Practice Specialist in Nepal

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General Practice is perhaps the most important, but least recognised specialist discipline of medicine in Nepal. It is important because the majority of Nepali people live in rural areas and have no access to a doctor of any sort. They 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, recognising what is possible and affordable in that context. It has been demonstrated that General Practitioners (GPs) are the most effective doctors for providing primary health care.

The current observed trend in Nepal and in the world towards specialization and super specialization is particularly concerning when you look at the evidence in the literature about the effect this has on the health care of populations as well as individuals.

Countries with a strong primary health care system have lower premature mortality and better health care outcomes than those with a specialist focus (such as the USA). Research in the US has found that increasing the number of General Practitioners by 1 per 10,000 (33%) decreases mortality by 70 per 100,000 (9% fewer deaths). In the same study they found that increasing the number of specialists by 1 per 10,000 (8%) increases mortality by 16 per 100,000 (2% more deaths).<sup>1</sup>

Other studies have confirmed this. Patients with a GP as their personal physician rather than a specialist have 33% lower costs of care and are 19% less likely to die prematurely.<sup>2</sup>

Why is this? Why do people do worse under the care of a specialist? There are a number of possible reasons. A patient doesn't usually know exactly what is wrong with them, and so when they approach a specialist,

the doctor may easily be working outside of his field of expertise.<sup>3</sup>

Primary care is complex, with patients on an average visit bringing between 1.4 to 8 problems. The GP needs to deal with a broad range of problems. When the practice of a specialist is examined, the top five conditions in that area make up 90% of the case workload. For a GP the top twenty five conditions commonly seen make up only 60% of the total workload.<sup>4</sup>

Specialists tend to over investigate and over treat.<sup>5</sup> A systematic review of the literature found that adverse drug events accounted for 2.4% to 4.1% of admissions to inpatient facilities.<sup>6</sup>

In addition, there is evidence that specialists tend to be less good at communicating with their patients leading to more errors.<sup>7</sup>

Care by a General Practitioner reduces disparities in health (the gap between rich and poor), reduces the effect of income inequality and improves self-rated health.<sup>8</sup>

The excessive specialization of health-care providers and the narrow focus of many disease control programmes discourage a holistic approach to the individuals and the families they deal with and do not appreciate the need for continuity in care. "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".<sup>9</sup>

It is with this evidence in mind that the World Health Assembly adopted a resolution urging member states to "accelerate action towards universal access to primary

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health care" and "to train and retain adequate numbers of health workers . . . including . . . *family physicians*. . ." <sup>10</sup>

General Practice should be recognized for the vital role it can play in the health care system of a country. The evidence is clear. The world needs General Practitioners, working in a functioning primary health care system. Nepal, as a nation with limited resources and a large number of poor people needs far more well-trained, committed General Practitioners.

The objectives of the Second Long-term Health Plan<sup>11</sup> 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;

In Nepal there is under-staffing and hence underutilisation of District Hospital beds (60%) with high utilisation 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) There is a huge difference in doctor staffing levels between Kathmandu (1doctor /1057 population) and the hill (1/41,004) and mountain regions (1/43,874) (Ministry of Health figures 2005)

When district hospitals are understaffed, patients must travel long distances into cities to find competent medical care. Junior MBBS doctors in rural areas find themselves "in over their heads" while handling difficult cases alone, and they are more likely than other staff to be absent from their posts. In 2006, a Nick Simons Institute (NSI) study <sup>12</sup> found that only 56% of doctors and 81% of nurses were present in their posting in government district hospitals.

General Practice doctors (MDGPs), on the other hand, are fully trained to handle a range of cases including difficult deliveries and operations. An NSI study in 2006 <sup>13</sup> investigated all MDGPs trained in Nepal between 1982 – 2005 (n=99) and found 87 currently working in Nepal (11 overseas and 1 died) of whom 53 (61%) were outside Kathmandu and 30 (35%) were working in government.

In 2007, NSI conducted a retrospective study<sup>14</sup> 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.

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.

As of 2007, only 19 of the 65 government district hospitals (30%) provided comprehensive emergency obstetric care (CEOC).<sup>15</sup> These services fluctuate over time, and currently it is estimated that CEOC is in only 12 district hospitals, of which MDGPs are the service providers in 9 of them. (personal communication through NSI) The MoHP's goal by 2017 is that all Districts would have CEOC. This will significantly depend on the presence of MDGPs.

One or two fully trained GPs placed in the Primary Health Centre and District Hospital, are able to provide the sort of comprehensive holistic service that the people need. As the service builds up, visiting specialists may also come. There are appropriate and complementary roles for Primary Care and Specialist Physicians.

Primary care should be person-focused care over time, first-contact access, ongoing care of all but uncommon problems and coordination of care. The GP can make the best decision about which patients require specialist services. Specialist care should include short-term consultation for diagnosis or initiation of management;

recurrent consultation for advice on continuing management and long-term referral for management of unusual conditions.<sup>16</sup> This model is the most efficient way to use specialists to benefit the greatest number. An adequate network of fully functional district and zonal hospitals will enable a more effective referral network with reduction in inappropriate cases presenting to tertiary hospitals.



While the people in greatest need of service are those living in isolated rural areas, the other reality is that the towns and cities of Nepal are growing very quickly. As they develop, the need for primary medical service grows too. Currently there is random or market driven growth of specialist services with direct access by the public. This leads to fragmented patient care and inappropriate investigation which is less cost effective. The GP has much more to offer as the first point of call for town people. He/She will become known for continuous care of the family over a length of time. The GP can help the family to make wise choices about the use of their savings to restore, maintain and build the health of the family.

The GP can recognize the deficiencies in health services and advocate for their improvement with community members. He/She can see patterns of community health problems and work together with counterparts in that discipline to improve the health of the population as a whole. They are an important key to integrating curative and preventive services. There is wide agreement that strengthening district health systems is the most appropriate way to promote primary health care.

The case for General Practitioners in Nepal is strong and backed by the international literature. Why is it then that so few doctors choose this as a career pathway?

One key reason is that there must be an integrated career pathway of education and training for rural generalist practice. The government, as recognized in the 2003 Ministry of Health 15-year human resource plan<sup>11</sup> must provide posts and manage the support of those on the job.

Many doctors in Nepal have no clear idea about what General Practice is. All medical schools in Nepal need departments of General Practice to provide appropriate role models and influence undergraduates to choose this needed specialty. "General Practice with its dual emphasis on patient-centred care and population-based health care can add value to the medical school curriculum by providing all students with a solid foundation of generalist physician skills....".<sup>17</sup> The need for General Practice teaching in the undergraduate setting has recently been recognized by the Nepal Medical Council.

There needs to be 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 Continuing Medical Education (CME).<sup>18</sup>

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"

We call for a fresh look at the educational and medical system in Nepal, so that more doctors choose this vital specialty of General Practice, in order to meet the health care needs of the people of Nepal.

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## बर्ड फ्लु रोगको जोखिमबाट आफू बच्न र समुदायलाई बचाऔं

वर्डफ्लु रोग विशेषत हाँस, कुखुरा जस्ता पंक्षीहरूमा लाग्ने घातक संक्रामक रोग हो। यो रोग सङ्क्रमित पंक्षीहरूबाट मानिसमा पनि सर्न सक्छ। तसर्थ निम्न लक्षणहरू मानिसमा देखिएमा वर्डफ्लु रोग लागेको शंका गर्न सकिन्छ।

- ज्वरो आउने,
- घाँटी दुख्ने,
- खोकी लाग्ने,
- श्वास फेर्न कठिनाई हुने
- टाउको दुख्ने,
- नकबाट सिँगान बग्ने,
- कसै कसैमा भाडा पखाला र बान्ता हुने समेत पाएको छ।

उक्त लक्षणहरूको आधारमा मात्र यो रोगको निदान गर्न नसकिने भएकोले यो रोगको निदानको लागि शंकास्पद रोगीको घाँटीको नमूना प्रयोगशाला परिक्षण गर्न जरुरी हुन्छ। त्यसकारण नजिकको स्वास्थ्य संस्थामा सम्पर्क गरी स्वास्थ्य जाँच र सल्लाह लिनुपर्छ।

### वर्डफ्लु रोग लागेमा पंक्षीमा देखिने रोगका लक्षणहरू

- अकस्मात् र अस्वाभाविक रूपमा एकै चोटि धेरै पंक्षीहरू मरेको देखिन्छ।
- पंक्षीले स्वाँस्वाँ गरेको, खाँकेको र सिँगान र ज्याल बगाएको देखिन्छ।
- टाउको सुनिने, सिर र लोती नीलो रङको हुने हुन्छ।
- फुल पार्न बन्द हुने वा कमजोर बोक्रा भएको फुल पार्ने गर्छ।
- दाना नखाने, तिर्खाउने र छर्ने गर्छ।
- पक्षपात हुन सक्छ।

उक्त लक्षणहरूको आधारमा मात्र यो रोगको निदान गर्न नसकिने भएकोले रोगको निदानको लागि शंकास्पद रोगी पंक्षीको घाँटीको नमूना प्रयोगशाला परिक्षण गर्न जरुरी हुन्छ।

### वर्डफ्लु रोग लाग्नबाट बच्ने तथा बचाउने उपायहरू:

- कुखुरा, हाँसको स्याहार सुसार गरेपछि र पंक्षी जन्य पदार्थको प्रयोग गरिसकेपछि साबुन पानीले राम्ररी हात, खुट्टा धुनुपर्छ।
- खोक्दा, हाँचिछुँ गर्दा सधैं सफा रुमालले नाक र मुख छोप्ने गर्नुपर्छ।
- कुखुरा, हाँसको मासु र अण्डालाई राम्ररी पकाएर मात्र खानुपर्छ।
- हाँस, कुखुरालाई छुट्टै छुट्टै खोरमा राखी पाल्ने गर्नुपर्छ र बाह्य पंक्षीका संसर्ग हुनुबाट पनि बचाउनु पर्छ।
- कुखुरा, हाँसको खोरको वरीपरि निसंक्रमण गर्नुपर्छ।
- पंक्षीजन्य पदार्थको अवैध ओसार पसार गर्नु हुदैन र गर्न दिनु पनि हुदैन।
- अकस्मात् धेरै कुखुरा वा हाँस विरामी परेमा वा मरेमा पशु सेवा कार्यालय वा पशु सेवा केन्द्रमा तुरुन्त खबर गर्नु पर्छ।

नेपाल सरकार

कृषि तथा सहकारी मन्त्रालय पशु सेवा विभाग  
एभियन इनफ्लुएन्जा नियन्त्रण आयोग/जना  
बुटानिलकण्ठ, काठमाडौं।



नेपाल सरकार

स्वास्थ्य तथा जनसंख्या मन्त्रालय  
राष्ट्रिय स्वास्थ्य शिक्षा सूचना तथा संचार केन्द्र  
टेकु, काठमाण्डौं