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A Proposal For The Training Of Physicians In Primary Care For The Rural Areas Of Malaysia

Rajakumar MK. A proposal for the training of physicians in primary care for the rural areas of Malaysia. Family Practitioner. 1984;7(1):58-61

Introduction

The majority of the population in developing countries live in rural areas, and they are not only economically but also culturally deprived. This is true also in Malaysia although our higher national income makes it less excusable.

There is an internal brain drain that deprives the rural areas of all trained people, their most promising children, and even their young men and women with the most initiative. Urban industry and schools are a powerful magnet to the young people of the rural areas. As a result, cultural life in the rural areas is impoverished and retrogressive attitudes, superstition and obscurantisms add to the burdens of rural life. Young people find the climate in the villages and estates to be oppressive and flee to the freer and better quality of life they see in the urban areas.

In health, a parallel process is reflected in the very small numbers of physicians in the rural areas. Not even the children of rural people go back to work in the rural areas. The government sends the most inexperienced physicians to the rural health centres and the brightest of these young men and women are in a desperate hurry to resume their careers on a specialty ladder back in the urban hospitals.

Whatever the official pronouncements regarding the high priorities of rural health care, rural health service is, in reality, an unrewarding and unsatisfying career for the physician.

I present my proposals to encourage physicians to serve in the rural areas as part of a vision to see more trained people live and work there. If good health care is available, then this is one factor to encourage others to follow. This proposal concentrates on the training of primary physicians as a prelude to the training of the entire health care team.

If government is willing to divert a relatively small amount of money, it is possible to make a satisfying and rewarding career for all members of a health care team in the rural areas and to improve the quality of health care at the point where it touches the lives of the greatest number of people.

These ideas are offered in all humility to all those in the community who share a concern for the welfare of our rural people and to those decision-makers who have great personal knowledge and experience regarding these problems.

Malaysia

Malaysia has subscribed to the Declaration of Alma Ata which makes 'Health for All by the Year 2000' a universal target and identifies Primary Health Care as the strategy to achieve it. To achieve the ambitious target of health for all by the year 2000, Malaysia will need to give a high priority to primary care and this has to be translated into objectives in a succession of Five-Year Plans.

The concepts of primary care

The term 'primary care' is used with different meanings. In the United Kingdom, it is synonymous with general practice, and in the US, it refers to primary medical care given by any type of physician. Over recent years there has been much original and innovative thinking directed towards a sophisticated form of primary care that is described as 'family practice'.

Family practice aims at comprehensive and continuing care that is directed at the family as a unit, with emphasis on the preventive approach. This complements

the emphasis placed by the WHO on primary health care that meets total health needs in contrast to episodic medical care, and aims at the whole community and not just the individual sick person. A similar parallel exists with the Ministry of Health's own programme of Family Health Care which addresses the family as a unit for health care, identifying within it the pregnant mother and the infant as the target group for special attention.

The Malaysian programme is distinguished by the use of the concept of 'Family Health' and by the development of rural health centres intended for use by health teams led by physicians. This is in contrast to the situation in many developing countries where the majority of the population living in the rural areas is denied modern health care in comparison to the urban areas; a double standard in health is accepted as a political fact in life. Such a double standard should be unacceptable in Malaysia as it would be in conflict with the objectives of the New Economic Policy.

The gap in Malaysia in primary health care has been the absence of a grade of physician dedicated to its success and trained specifically in the skills necessary for primary health care.

The place of the primary care physician

A new type of general practitioner has to be created to meet national needs. Such a physician would differ from the traditional general practitioner in that he or she is specifically trained for his task by receiving general clinical training as well as specialised vocational training, by passing a qualifying examination, by undertaking continuing education and by making service in primary care his or her life-long vocation. The new general practitioner emphasises the preventive approach and is trained to work as the leader of a health care team. The appropriate designation for such a physician would be Family Physician or Primary Physician. These trained family physicians would also serve in casualty and out-patient departments but their principal area of practice would be the Rural Health Centres. They will be attracted to a service that provides them with excellent training, the status of a postgraduate diploma, the reward of a career in specialist grades, and the satisfaction of service in modern health centres. Many will continue to leave the service of the Ministry of Health, but private practice too would benefit from a new standard of skills and a new calibre of physicians.

Training family physicians for the ministry of health

The postgraduate training of any physician consists of housemanship, general clinical experience and specialised vocational training. Under the Medical Act, a three-year service term with the Ministry of Health after provisional registration is required by law. This provides an opportunity for postgraduate training of all young doctors which would make this period in their lives both valuable and professionally satisfying.

Some assumptions can be made regarding this period of service. Firstly, we may assume that two of these three years will be spent in the rural areas. Secondly, young doctors in the traditional hospital specialities will want to proceed to specialist units of their choice as quickly as possible in order to fulfil the requirements for their diploma whereas doctors intending to specialise in primary care will wish to obtain experience in a variety of specialty departments. Finally, we may safely assume that doctors pursuing traditional specialities will spend most of their practising life in urban hospitals whilst primary physicians must be persuaded to settle in the rural areas.

Housemanship and general clinical experience

It is essential that young doctors preparing for primary care should receive training during housemanship and general clinical experience that is as comprehensive as possible. The following recommendations are made with a view to ensuring this.

The Outpatient and Casualty Department should be part of the primary care service and during the period of general clinical experience in hospital, the young doctor should have that department as the base: the four months in this department should be broken into four one-month periods, interposed between postings to specialist departments so that the trainee will be able to apply his experience in an outpatient setting and retain his orientation in primary care.

There should be a training committee in each hospital to ensure that every young doctor receives the experience that is appropriate to his speciality of choice and each specialist department must accept responsibility to ensure that trainees on rotation are adequately prepared during their posting in that speciality.

Further clinical experience in Public Health, Internal Medicine, Paediatrics, Obstetrics and Surgery will be obtained by rotation from the rural health centre posting to an affiliated district hospital.

Specialised vocational training

Training in primary health care as a speciality should take place at selected health centres. The rural health centres of Malaysia provide an ideal environment for the training of family physicians and selected centres should be upgraded to teaching health centres. The teaching health centres will function in conjunction with the local district hospitals. These teaching centres will provide vocational training in primary care as well as provide housemanship and general clinical experience for those doctors pursuing other specialities. These health centres will provide a model of primary care integrating, prevention and treatment, cooperating with the hospital services and with the public health services.

The period of specialised vocational training including periods of rotation to the affiliated district hospital should be three years after a general clinical experience of two years. This should be a requirement for postgraduate certification examinations which will be taken usually four years after housemanship.

The teaching health centres

Teaching health centres should be selected for their relative isolation and proximity to a small district hospital which can be integrated with the teaching programme of the teaching health centre. The centre and sub-centres should cover a population of about 15,000 - 30,000.

Each training health centre should have two senior physicians; one with experience in administration and one with teaching skills. Two trainees will be posted to the teaching health centre each year up to a total of six trainees.

The teaching health centre will serve as a model for the continuing and comprehensive care of the whole community under its care, directed to the family unit and orientated to the community, emphasising the preventive approach. The teaching health centre will have the following functions, in addition to health and medical care of the community: Training of the health care team including

primary physicians, housemanship and general clinical experience for young doctors who intend to enter one of the hospital specialities, continuing medical education and research.

The upgrading of rural health centres to become teaching health centres is emphasised as the high standards necessary of a teaching centre must be met. Together with a full complement of staff, there should be a clinical diagnostic laboratory, radiology, operating theatre and library.

The key to the success of rural health care is the rural health centre. If these are given the fullest support in terms of funds and staff, then a posting to a rural health centre will be an exciting and professionally satisfying event for a young doctor.

The Institute of Primary Health Care

There should be a primary health care institute in Kuala Lumpur, incorporating the outpatient department and casualty at the General Hospital, Kuala Lumpur. This institute will be the support organisation to the teaching health centres and will have the following functions: Teach ambulatory care based on the outpatient department; teach emergency care based on the casualty department; teach the concepts and approaches of family practice in a health care team; train teachers for the teaching health centres; teach diagnostic and therapeutic procedures appropriate to primary care; organise continuing medical education; develop diagnostic and treatment protocols, computer programmes, etc., needed in primary health care; assist and coordinate operational and clinical research at teaching health centres; develop a medical records system for use at health centres and organise a health information system for primary health care; evaluate and report on the progress and experience of the rural health centre programme.

If the rural centre is the key to good rural health care, then the Institute of Primary Health Care is the key to the success of the rural health centres.

A plan

In this part of the proposal, an outline plan is given for the implementation of a training scheme for primary physicians as part of a national rural primary health

care programme. It is proposed that the plan be implemented over the next two Five-Year Plans. It is proposed that:

- The national primary health care programme becomes a special project under its own director, with representatives from the Prime Minister's department and treasury.
- The Institute of Primary Health Care be created early and given responsibility to make plans for implementation.
- Rural health centres should be selected, on the basis of defined criteria, to be upgraded into teaching health centres. It is suggested that five new teaching centres be established each year for the first three years, then 10 new teaching centres in the fourth year. The numbers needed should then be reviewed.
- Initially, young doctors with two years experience in rural postings should be sent abroad for training. They will become teachers at teaching centres and their programme abroad must enable them to acquire teaching skills as well as family practice skills.
- The first batch must be selected and sent quickly because the commencement of the programme must await their return. It is proposed that 30 young doctors be sent for periods of 12-24 months to carefully designated programmes that will match their individual talents and interests. At the same time, experienced officers in the Ministry who wish to turn to primary care can be sent abroad for 6-12 months orientation courses to University Departments of Family Practice.
- A detailed plan should be drawn to increase the number of teaching centres until approximately half the entry of doctors into the Ministry of Health can receive training. The first trained primary physicians should come out three years later after the acceptance of the programme and they should be put in charge of other rural health centres to upgrade them, as well as to sub-centres of the rural health centre.

Conclusion

These proposals will enable the majority of the rural population of West Malaysia to have access to modern health care by 1990. Well-equipped rural health centres, staffed by trained health care teams led by qualified specialists in family practice

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will transform the quality of health care in rural Malaysia. The introduction of family practice into the rural areas will provide a qualitatively new level of service, improving health care at the point where it touches the lives of the largest number of our people.

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[Editors' Note: Table I and Table II have been omitted]