

Strengthening General Practice Training in Nepal

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Postgraduate training in General Practice at the Institute of Medicine of Tribhuvan University in Nepal has undergone three phases of development. Phase I training was begun in 1982 with the collaboration of the Institute of Medicine and the University of Calgary, Canada. Nepali doctors were trained for 1 1/2 years in Canada, followed by 1 1/2 years in Nepal, including 6 months in Surkhet District Hospital. A newly established General Practice Faculty began Phase II, with repatriation of the training to Nepal in 1987. However, in 1988, after two intake of residents, the programme was frozen, while the Ministry of Health and the Institute of Medicine examined alternatives for training. Following a two year hiatus, the re-establishment of the three year General Practice training programme in 1991 marked the beginning of Phase III.

The aim of the MD (GP) Programme, since its inception has been to provide a broadbased training to enable doctors to function effectively in district hospitals and thus meet the needs of the people of rural Nepal for primary health care services and first referral centres.

The phases of development of the programme, the problems encountered and the lessons learned are discussed.

Keywords: General practice; district health services; postgraduate education; curriculum development.

INTRODUCTION

General Practice is a term which means different things to different people. To some it simply means the non-specialized, office-based form of health care delivery which many doctors undertake immediately after internship. To other it is synonymous with

Family Medicine, a comprehensive, professionally accredited form of primary medical care which emphasizes continuity of care and management of the patient in the context of his family environment, with an important coordinating role for the doctor as the interface with the various speciality services. Some understand it as the kind of

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practice which predominated in North America until 50 years ago, when increasing levels of knowledge and technology forced the development of specialized services in progressively more centralized hospitals.

As the Tribhuvan University Institute of Medicine, 'General Practice' has multiple connotations as it often does elsewhere. However, more and more, it is coming to refer to the kind of skills required for doctors to perform well in the district hospitals of Nepal. Here it is envisioned that hospital-based general practitioners represent the apex of the Primary Health Care system. As such they need to demonstrate a wide range of skills, particularly in surgery and obstetrics, to serve people referred by lower level health workers in the communities and health posts.

In December 1991 a post-graduate training programme was re-established at the Institute of Medicine (IOM) to train doctors in General Practice. The goal of the Medical Doctorate in General Practice Programme or MD (GP) Programme is to train doctors in the

"...comprehensive and effective management of common health problems encountered in rural Nepal, including timely emergency and lifesaving surgical and obstetrical intervention. The graduate will be capable of functioning as a District Medical Superintendent."¹

This paper will document the evolution of the MD (GP) Programme to date, noting some of the problems encountered and the lessons learned.

Phase I - The Calgary-Nepal Project - 1982 to 1987

The concept that general practitioners with a broad base of skills were needed to staff district hospitals had its origin in 1974, with the development of Nepal's Long Term health Plan. As it was approved in 1976, Section 5.1.2 on Hospital Services states "In our country there is a need for more GPs than specialists and hence more General Services Hospital will be opened in the country." Section 5.1.2.1 goes

on to say "General Services will be provided to patients in these hospitals. Generalists with training in more than one subject will be posted. Arrangements for this type of training will be made in Nepal".² In 1981 the Ministry of Health indicated readiness to proceed. The training of doctors in general practice was initiated with the assistance of the University of Calgary, Canada in 1982. This represented the first postgraduate programme at the Institute of Medicine where a medical school had been established in 1978.

Looking back over the ten years since the training of general practitioners began it is clear that the programme has undergone considerable evolution. Although not initially planned in this way, there have been three stages or phases of development to date. The first phase began in 1982 when pairs of trainees travelled to Calgary, Canada, to begin 1 1/2 years of training in the Canadian health system. The trainees were initially assigned to hospital settings in the teaching hospitals of the University of Calgary but spent the last six months of the programme associated with Canadian general practitioners working in rural settings.³ Trainees then returned to Nepal where they completed one year in Kathmandu hospitals; a final six months was undertaken at Surkhet District Hospital under the guidance of a Canadian preceptor.⁴

Until the establishment of the Phase I of General Practice training, specialist training had been conducted outside of the country and had been dependant on foreign scholarships. The usual track for postgraduate training tended to produce specialists in medicine or surgery, but neglected the role of the general practitioner and created other imbalances within the medical profession.⁵ At this early stage in the 1980s, teachers at the Institute of Medicine were fully occupied dealing with a new undergraduate medical programme as well as with the development of other cadres of health workers.³ The Calgary-Nepal Project assisted in several ways. Several government practitioners were given a broad based training to facilitate their role in district hospitals; several doctors from the Institute of Medicine received similar training to establish a core of

teaching faculty in the Department of General Practice; additionally, assistance was provided to develop teaching capabilities in physiology and anaesthesia at the IOM and to create a rural training site at Surkhet District Hospital.

In 1986, key individuals from the Ministry of Health, the Institute of Medicine and the University of Calgary were brought together in a workshop to scrutinize the progress of the Calgary-Nepal Project in the training of general practitioners. It was apparent that there were problems in curriculum content, the selection of suitably motivated doctors, career options for graduates and the general organization of the programme.⁶ Several participants expressed concern that the medical community as a whole had not voiced support. In fact, some felt that many doctors seemed negatively disposed towards the concept of general practice as conceived by the Institute of Medicine. The workshop attempted to analyze these problems.

With respect to curriculum content, it was felt that if graduates were to function as Senior Medical Officers of district hospitals, training had to include not only clinical medicine but also training in administration and management, disease prevention and health promotion. Along the same line, there was discussion about locations for the training programme. Proposed sites for training included Surkhet Hospital and other district hospitals, zonal hospitals, non-governmental agencies and other Asian centres in addition to the Kathmandu valley hospitals. Use of any alternative training sites, it was recognized, would require an evaluation of staffing, facilities and other needs.

Criteria for selection were debated with most attention being paid to the requirement that doctors serve for five years before nomination by government as candidates for the programme. As well, the eligibility of non-government doctors was discussed.

A major concern was about career opportunities for graduates. The need for a degree qualification (as opposed to a diploma) to provide status equivalent to other trained

specialists was expressed. It was also stated that career opportunities had to be specifically defined and the hospitals to which graduates would be posted had to be well equipped.

Although a committee constituted by the Dean of the Institute of Medicine recommended in May 1986 that repatriation of the programme occur in 1991, this workshop concluded that Nepal-based training should begin as soon as possible. This decision was made apparently on the basis of the difficulties in selection of candidates and the perceived inappropriateness of the technology to which trainees were exposed in Canada.

The health care system continued to lack adequately trained manpower and the lack of adequate resources, logistic support and managerial skill contributed to the ongoing ineffectiveness of district hospitals. The workshop concluded that the training of generalist physicians was a priority and induced a sense of optimism; unresolved issues were referred to a task force, a proposal for funding was developed and planning for a 1987 start-up commenced.

Altogether, eleven doctors participated in Phase I. Four of seven individuals nominated by the Ministry of Health remain active in district hospitals and three of the four Institute of Medicine candidates continue to serve as members of the Department of General Practice.

Phase II - Transition - 1987 to 1991

Funding for the second phase of the programme was secured from the Canadian International Development Agency, through the University of Calgary, similar to arrangements for Phase I. Several important differences should be noted. The MD (GP) programme became part of the broader-based Health Development Project, which focuses on community development and management support for district health activities in Surkhet District, in addition to the training of post-graduate doctors. During Phase I, coordination of the programme had been primarily in the hands of Canadian physicians; preceptors were

appointed for Surkhet Hospital for short terms (6 months) only. With Phase II, the coordination of the programme was handed over to Nepali doctors. Two long term Canadian preceptors were hired, one to assist with activities in Kathmandu and another to continue support for Surkhet Hospital.

The 'repatriated' MD (GP) programme initiated the activities of Phase II with the intake of four trainees in November 1987 and another four in May 1988. (Two candidates dropped out shortly after admission to the second batch).

The revised curriculum for this phase provided for two years of training in Kathmandu. During the third year residents were permitted to undertake a three month rotation in Malaysia, where they had the opportunity to see general practice organization in another Asian context. The key to the programme was felt to be a six month placement in Surkhet District Hospital, where it was hoped that the important elements of training could be integrated in a realistic setting.

The foundation for Nepal-based general practice training appeared secure - but was it?

Unfortunately, the areas of contention and controversy documented in 1986 continued to be unresolved. High level support, expressed by King Birendra during his tour of the Mid-Western Development Region in 1984, began to fade. Concerns were voiced that not enough trained doctors were being produced fast enough. Indecision about the classification of graduates and the absence of a clear career path for them continued to be problems.

Then, in September 1988, shortly after the second Phase II batch was taken in, instructions were received from His Majesty's Government to suspend the programme. The reasons for this change in direction were unclear. The Canadian preceptors associated with the programme at the time tried to analyze the situation. Ministry of Health officials indicated to them that the training programme was too long; had a high attrition rate; had no

support from the medical community, particularly doctors employed by the government; furthermore, it was still not possible to place doctors into district hospitals.⁷ Arguments and rationale to counter these reasons were presented to the Health Development Project Steering Committee, where the Ministry was represented by a number of senior officials. The programme could be shortened if necessary; attrition could be shown to be limited; support was lacking from the medical community because there was no clear understanding of the MD (GP) objectives and difficulty envisioning a role for the general practitioner; finally, to a great extent the difficulty in recruiting doctors for district hospitals lay in the Ministry's inability to provide a satisfactory working environment and compensation package to attract doctors to remote parts of the country. Despite the rationale presented there was no change in policy. No new trainees were brought into the programme, but fortunately those already accepted were permitted to continue.

Thus in 1988, morale was low and the future of general practice training within the Institute of Medicine appeared quite tenuous. Convinced of the continuing need for skilled district hospital doctors, however, key figures within the Institute of Medicine continued to press for the training programme. Different models and possible solutions to the problems raised by the Ministry of Health were proposed and considered.⁸⁻⁹

Throughout this difficult period, Phase I and Phase II trainees completed their requirements for examination. An external examiner, Dr MK Rajakumar from Malaysia provided a report on the MD (GP) programme as he perceived it in 1988 and 1989, when he was asked to assist in examinations of the Phase I candidates. He reinforced the need for further faculty development and effort in teaching activities, building the programme to fit the Nepali cultural context. He also pointed out many strengths of the existing faculty and offered his support for the objective of training general practitioners for rural Nepal, with a number of suggestions for improvement.¹⁰ Dr L De A Karunaratne, who participated in the

November 1990 as external examiner for several Phase II candidates commented that the examination process reflected a reliable and valid measure of "..... the outcome of a training program for General Practice in rural Nepal, the content of which seemed to be relevant to the health needs of the people."¹¹ These comments bear witness to the effort which the Institute of Medicine continued to put into the programme in spite of the adverse climate of confidence.

The steps towards democracy in Nepal in 1990 hindered progress to a certain extent - the interim government had difficulty moving ahead on policy matters - but in November 1990, at a meeting of senior officials of the Institute of Medicine, the Ministry of Health and the Health Development Project concurrence was again achieved. It was accepted that a three year training schedule leading to an academic qualification was required to provide adequate experience and to confer a degree of status on graduates. The rotation outside of Nepal was dropped for a variety of reasons, including the cost, the question of its applicability to the Nepali context and because of the difficulty in monitoring student activity. The needs to train doctors as much as possible outside of the Kathmandu valley, for appropriate peripheral training sites and for the development of appropriate management skills were echoed. The need to define medical and surgical skill requirements carefully was stressed.

Some career path definition began to occur around this time with the promotion of MD (GP), graduates to Second Class status by the Public Service Commission.

Phase III - The Present - 1990 to 1992

The present phase began with renewed efforts in the planning of training activities. From past experiences it was clear that planning had to be focussed on several areas before curriculum revision could be attempted or trainees brought into a revitalized programme.^{12,13}

The definition of general practice and the

objectives of the programme were carefully and concisely laid out. The perceived future role of the graduates of the programme in health care delivery were clarified with general practice faculty at the Institute of Medicine, Ministry of Health officials and advisors from the Health Development Project.

The goal stated in the opening paragraphs of this paper was adopted. This goal acknowledges the need for highly skilled rural doctors but differs somewhat from previously in that it is not implied that the leadership can not automatically be conferred on graduates but has to be earned.

Once the general practitioner's role was agreed upon, specific job or skill requirements needed to be identified in preparation for curriculum review. As utilization of regional, zonal and district hospitals away from Kathmandu had to be considered, site visits had to be conducted. The essential task of consultation with the medical profession (and education of doctors about the potential scope of general practice at the district level) was a third requirement which had to be incorporated with the tasks of skill analysis and site appraisal. These three tasks were carried out simultaneously over a period of about nine months of 1991.

A survey of doctors was prepared.¹⁴ A list of potential skills required was assembled based on the previous curriculum and the cumulated experience of the General Practice faculty. Open-ended questions regarding the medical problems which doctors perceive to require referral from district hospitals to larger centres and the in-service training requirements of nursing and health post staff were included to assist in the identification of skills. As well, questions about other factors affecting the work life of doctors in a district hospital were asked.

The survey questionnaire served two purposes. Firstly, data on opinions about training requirements for the proposed revised MD (GP) programme were collected. Secondly, the questionnaire served as a vehicle for promoting discussion, often heated, among

groups of doctors. Doctors were approached at the Nepal Medical Association Biennial meeting in Biratnagar in February, 1991, and at the principal hospitals in Kathmandu - Teaching, Kanti, Patan, Bir and Maternity Hospitals. All together about 120 written responses were received with many more (uncounted) individuals providing verbal input.

The conclusions of these efforts to document skill requirements provided support for the programme's objectives, with the need for basic life-saving skills emphasized. As well, there was good support for including components of public health, management and administration and laboratory medicine. Concerns about potential flaws in the proposed training programme were also brought out in the course of discussions, with perhaps the most important being that a model practice setting does not exist for General Practice within the university setting. Many comments described the lack of facilities, manpower and equipment in district hospital settings which the MD (GP) program is not in a position to address, although future graduates should be able to demand and encourage the development of these aspects of the health care system.

Consultation with practising doctors continued during visits to potential training sites. A team representing the Ministry of Health, the Institute of Medicine and the Health Development Project visited a total of 12 hospitals looking at various options.¹² Clearly, none of the district hospitals visited (Dang, Bhairahawa, Taulihawa, Tansen and Bharatpur) could easily serve, principally because of the high mobility of medical staff. Patients often bypass these smaller hospitals en route to larger hospitals where doctors, treatment capabilities and other facilities tend to be more available. Zonal hospitals similarly have a tendency towards instability in staffing patterns, but might be suitable to consider in the future. The conclusion was reached that some parts of the training cycle could occur in peripheral sites, with the preference being for the larger hospitals with stable staffing and existing continuing medical education activities.

Based on the findings of this consultative process the curriculum was revised. The most important change has been to increase the time residents spend in Surgery and Obstetrics/Gynaecology to six months total in each area. Additional attention has also been paid to sub-specialty areas (Dermatology, Dentistry, ENT, Ophthalmology and Psychiatry), with the time allocation increased from two weeks to one month in each to improve resident's opportunities for skill development. A one month rotation in Family Planning (based at the Family Planning Association of Nepal) has been added to ensure that trainees at least become certified in performing vasectomies and possibly the minilap procedure. Components of epidemiology, management and administration, health education and other aspects of community health are areas in which many people feel doctors at district hospitals should be competent. These topics have also been included and are described in more detail in the new curriculum.

Inclusion of district level experiences in the training is essential if the programme is to be successful. Doctors must learn how to perform with reduced resources and become attuned to rural needs and society. Primary Health Care concepts must be emphasized. Surkhet District Hospital was previously upgraded with this in mind,³ although in the past two years, as a result of the suspension of the programme, the Canadian preceptor based there was withdrawn. Subsequently the hospital itself has suffered from problems similar to other district hospitals - staff mobility and lack of direction. Under the revised curriculum, it is intended that residents will spend up to six months in district hospitals or related primary health care settings. This will be augmented by ensuring that part of the surgical rotation (and possibly part of anaesthesia and obstetrics rotations) occur in peripheral training sites. The curriculum and actual site selection for adequate exposure to problems in the districts are presently being discussed. It will take time and concerted effort to rebuild a site such as Surkhet District Hospital to the point where postgraduate training is feasible.

A deliberate attempt has been made to make the curriculum one based on competency. The need for residents to become skilled in certain basic procedures in each rotation had been emphasized. Experience will help in determining how many Caesarean sections or appendicectomies a resident may need to undertake before being considered competent. For the present, numerical targets have been avoided, but residents have been asked to maintain logbooks listing their experiences with different procedures. This hopefully will be a useful tool in monitoring their progress.

Eight residents entered the revised programme on December 1, 1991, re-establishing general practice training at the Institute of Medicine and in Nepal. With six of the eight trainees being graduates of the Institute of Medicine, they should be starting out with a fairly common level of knowledge. As well several of the trainees have also served as Health Assistants and should be well aware of rural needs and be able to integrate their past experiences with their present training.

Conclusion: The Future of General Practice Training

One concern that has been raised time and again is that Ministry of Health nominees to the programme have to be permanent, experienced (now a minimum three years) employees. This presents the very tangible problem that those selected are mature students and may be set in their habits, may have considerable distracting influences from young families and may well have difficulty maintaining good study habits. Their motivation for entry into the programme may not be that they wish to return to a district setting, but rather that they wish to remain in Kathmandu, then on completion, find a suitable promotion by virtue of their postgraduate training to urban rather than rural settings. Ideally candidates should be relatively fresh medical school graduates and lengthy government service requirements should not be necessary before undertaking MD (GP) training. One would expect these candidates to be capable of gaining more from the training experience and be more amenable to posting in

remote districts after graduation.

Graduates of the programme will no doubt be posted to district hospitals for at least the first few years after training, where they will be able to apply the skills they acquire during the residency. Their increased awareness of the art and science of medicine should help them to stimulate staff and improve hospital environments. Skills in the area of community health should assist them to participate meaningfully in the development of the communities to which they are posted.

The later career path for graduates is still not clear. Much will depend on the quality of output of the programme; furthermore, graduates will always have a number of personal choices to make about where they might like to live or work. No one expects graduates of the MD (GP) programme to replace specialists, although specialists should consider whether they can delegate the performance of certain routine or emergency procedures to the general practitioner to reduce the burden of work. It is possible to visualize graduates as Chief Casualty Officers in zonal, regional or central hospitals, or contributing to significantly to District or Regional Management. Graduates should be able to assume a role (perhaps as 'District Health Director') in the management of curative services for the district with additional responsibilities for working with the district public health office to coordinate primary health care and referral services. Even in private practice, graduates should be able to function well in a variety of capacities. Many issues may remain unresolved until such time as there are sufficient numbers of trained general practitioners to make representations to the medical profession as a whole or to policy makers in government.

The number of of general practice faculty members at the Institute of Medicine will need to be increased as the number of trainees swells in the next few years. A model practice setting must be created and developed to secure a teaching base and an environment of common understanding which will in turn lead to achievement of programme goals.

These are some of the challenges the Institute of Medicine and the Ministry of Health must overcome in order to improve the quality of training, raise the standard of practice of

general practitioners and improve health services in the districts. Developments to occur in the next few years will be interesting to observe.

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