General practice in rural areas

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As a consultant physician in a small town in Maharashtra, I would like to share my thoughts on how general practitioners can best contribute to people's health.

General practitioners form the backbone of health services in rural India. They are available round the clock and take active part in community activities. In remote villages, their dispensaries may have the only emergency medical supplies in the vicinity.

Rural health practitioners must also interact with the *sarpanch, talathi, gramsevek* and primary teacher, the four pillars of rural life, to get their support for public health programmes such as immunisation, chlorination of drinking water, and reporting of notifiable diseases to the primary health centre.

They must also contend with the influence of untrained people offering medical services. In a village community, anyone with a stethoscope who knows how to administer an injection is assumed to be a trained doctor. Unqualified practitioners, or quacks, flourish all over rural India. They provide free services to the local leaders, ensuring that any complaints against them will be quashed. They promote irrational drug therapies and unsterile injection practices, causing more harm than good.

Without the required equipment and proper mind-set, general practitioners can pose health risks of their own. Many times patients come to GPs in a state of acute medical emergency. I have seen doctors injecting the patient with steroids before coming to a conclusion on the nature of the problem. Many times their blood pressure apparatus is not working properly, its cup has not been changed for many years. A doctor once gave me a completely non-functional stethoscope with which to auscultate the patient. Less than two per cent of peripheral doctors maintain an oxygen cylinder, IV stand, ambu bag and other emergency drugs. Some doctors administer IV calcium gluconate, causing an addiction in many patients. The risk of HIV and hepatitis transmission makes it all the more important to avoid the use of injections. General practitioners should charge for examination, but not use routine injection as a way of collecting their fees.

Physicians in rural areas find it difficult to practice because trained staff is not available, putting more pressure on the physician's own resources. In such a situation, they must focus on treating acute cases, handling emergencies until the problem settles and the patient can be sent to a tertiary care centre if necessary. They should study and look for simple solutions to the acute medical emergencies faced by villagers. In this way, I studied scorpion stings, snake bites, thyroid dysfunction, and ischaemic heart disease. They should arrange CMEs in villages to train peripheral doctors to diagnose and treat acute problems. They should never participate in politics.

The concept of the family doctor is disappearing in this era of competition. Commercialisation of medical practice has already damaged the doctor-patient relationship. The educationist Karmvir Bhaurao Patil felt that said unless children from villagers became doctors or engineers the real problems of India could not be solved. Unfortunately, rural medical officers are contributing to unethical practices such as the illegal 'table practice' at the primary health centre's out patient department.

After completing my MD and five years of rural service, I started a consulting practice at Mahad, a town of 20,000 population on the Bombay-Goa high way. Before starting, I purchased a cardiac monitor, defibrillator, ambu bag, suction machine, oxygen cylinder and other emergency medicine. Most patients asked me for injections even after I explained to them that I could diagnose their problem, but that the necessary treatment would be administered by their family doctor. If necessary, I would examine them free and give them a letter for their family doctor. I have always taken an ECG wherever it is necessary, irrespective of payment. I have told doctors in the area that if they felt a patient would benefit by my examination, I would examine them for free if they were not in position to pay. I have never dreamt of participating in the cut practice or of accepting gifts or sponsorship, routine practices today.

I do not advise detailed investigations in my first visit. I make a clinical diagnosis, suggest investigations and revise the diagnosis accordingly. If there is no improvement after the second visit, or if I feel unsure of the problem, I refer the patient to a tertiary care hospital or a senior physician for an opinion. If examining the patient I feel the problem is not of my field, I immediately transfer to the concerned specialist.

I always spend time discussing life-style issues such as smoking, chewing gutkha or betel nut, and the importance of exercise, and of life long treatment for hypertension. Whenever I see a smoker patient, I write on top of my prescription in bold letters: "STOP SMOKING" . For patients with HIV, counselling is important, as are detailed examinations to rule out tuberculosis, and discussions with the patient and spouse, not other relatives. Many times general practitioners see an HIV reactive report and send the patient off saying there is no treatment. Such a response sends many HIV patients to alcohol addiction, some to suicide.

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Those interested in the subject of evidence-based medicine may find the letters in *The Medical Journal of Australia*, February 4, 2002, 176 3: 137-140, interesting. They are in response to an article by Leeder and Rychetnik entitled " Ethics and evidence-based medicine" (*Med J Aust* 2001; 175: 161-164). www.mja.com.au