

The new rural doctor: qualified quack or appropriate healthcare provider?

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The recent decision of the Medical Council of India (MCI) to initiate the training of an exclusive cadre for the healthcare needs of rural areas has provoked intense debate. Groups as well as individual experts have raised several points while arguing on either side of the debate (1-3). This short comment discusses here two such debates, one on the "level of skills" with which the new cadre would put its profession into practice and the other about the need for basic practitioners.

There have been several questions, some with ethical overtones (why should there be substandard care for the rural population?) and some on practical matters (will the cadre be able to handle the population's healthcare needs?). These are based on the notion that what we have today (the current medical graduation programme) is the gold standard, and what we are considering as a new cadre is nothing but a compromise and a short-term solution to the problem of non-availability of doctors. This position can be challenged because the issue of health human resources in rural areas is not limited to their non-availability. Another important question relates to their appropriateness to work in the rural context, especially for primary level care.

The need for social physicians

Many experts have pointed to the urban-centred training of the present cadre of doctors, and the focus on biomedicine without consideration of the socioeconomic context of healthcare, which makes them inappropriate to work in most rural areas and rural health institutions. For example, the recently submitted Government of India Task Force report has commented on the nature of the problems with medical graduates that are produced by the existing educational system (4).

By and large they carry the values of the urban middle class. Even those from a rural background are unwittingly co-opted into the urban milieu, discarding their social roots. As a result, fresh graduate doctors have no concept of broad community healthcare needs. Their professional world-view, regardless of whether they pursue a career in the public or in the private sector, is of providing curative services with considerable high-tech backup. Professionally they aspire to specialise in one or the other clinical disciplines, and their skills are organically linked to the back-up infrastructure of a tertiary care hospital. The Task Force sees the lack of an understanding of broad community health needs in the fresh medical graduates as a critical deficiency. This results in a misconceived approach to primary healthcare, whether in the public or in the private sectors.

This is not an isolated comment. Almost every such commission and committee that has studied various aspects of the Indian health system after the Bhore committee report has pointed to this aspect. In fact, the Bhore committee itself had envisaged a qualitatively different kind of medical cadre, which the report called "social physicians" (5). By calling them social physicians the report envisaged that the doctors of the future should be guiding people to a healthier life and recommended that students of medicine be brought into contact with the environmental and social conditions which largely influence the health and disease of people. Fifteen years later, the Mudaliar Committee (1961) reiterated the need for the "social physician" (6). Other important reports like the Srivastava Report of 1975 (on the family and community-oriented practitioner) and the Bajaj committee report (1989) on the community physician also described the ideal medical cadre in similar lines (7, 8).

The recent report of yet another high power committee, the subgroup on medical education set up by the National Knowledge Commission (2007), has pointed the finger at the Medical Council of India for the failures which led to the progressive decline of medical education in the country (9). The commission argues that the shortcomings of new medical graduates are principally the outcome of their urban orientation and the skewed pattern of their aspirations. "Most of them have only lived and trained in the urban setting. The few with a rural background acquire an urban mindset in the course of their training that is focused around a tertiary care hospital."

A historic opportunity

Of course this can lead to the argument that what we need is a revamping of medical education, and not a new cadre. This notion can be challenged because I believe that the present cadre survived because there was a market for it in the "powerful" curative services in the secondary and tertiary care sectors. Any attempt to reorient the training of medical graduates to primary level care, or to create "social physicians", would be politically unviable, no matter how desirable it is. It is here that the option of a new cadre offers us a historic opportunity. Surely this is neither a quality compromise nor a short term solution. It is in fact an opportunity for providing appropriate care at the primary level.

An alternate policy option that is being increasingly debated in this context is the compulsion – as a strategy – to deploy more doctors in rural institutions, even though the mechanism applied so far to deploy medical personnel in such underserved areas

has been a losing battle (3). Even if we succeed in forcing a certain percentage of medical personnel to work in rural areas, how would such a reluctant cadre serve the purpose? I quote again from the National Knowledge Commission report (9):

Compulsion fills up vacancies – much more at the apparent level than at the real level. It also provides a poor quality person for these jobs, and with very short term commitments to working there. After all, one can force a horse to the water, but one cannot make it drink.

Another incorrect assumption in this entire debate is that the present curative care needs in the rural areas of the country can be addressed if all vacant positions of medical officers in primary health centres (PHCs) are filled. An epidemiological profile based on available morbidity data will throw more light on the inadequacy of present norms for human resources for curative services in rural India. The 60th round of the National Sample Survey Organisation morbidity survey identifies 53 morbid persons for every 1,000 population on the previous day of the survey (10). This amounts to about 1,590 morbid persons in a day for a PHC area population of 30,000. This, along with clinical examination related to maternity and family planning services and medical screening for certain public health programmes such as immunisation services and disease control programmes, forms a sizeable caseload for clinical management through inpatient and outpatient services which is difficult for one or two doctors at PHCs to handle. Today, this unfulfilled gap is dealt with by a range of less than qualified providers, or by self medication, or no treatment. With the increasing prevalence of non-communicable diseases, the requirement for such services is only going to increase in the future. Ideally, it is time for us to think of having medical practitioners placed at the level of sub-centres to attend to curative care needs.

Recognition of the new cadre

I have used the initial part of this article to defend the policy of a new health human resource cadre for primary level care. However, let me also state some of my concerns as the new policy is implemented. At the outset, the MCI has made it clear that practitioners in this new cadre should not be allowed to call themselves doctors. This is definitely a step backward and an attempt towards disempowering the cadre. It is important that people recognise these providers as their primary level physicians who have the mandate and capacity to diagnose and prescribe appropriate treatment for their ailments. Based on past experience, the MCI's capacity to govern the new cadre in terms of professional practice and education can be called into question. The regulatory concern should be more in terms of avoiding medical malpractice, especially the interference of commercial interests in their professional practice; for this the MCI has been a bad governor for the current cadre of medical practitioners. Similarly, the MCI's inability to revamp current medical education to meet the needs of the country has been repeatedly noted by several high powered committees and commissions. This calls for different institutional mechanisms outside the purview of the MCI for governance of this new cadre.

It is also important that we have a balanced approach to the new cadre when we consider their career path against the country's present health human resource requirement. Having the title "rural" attached to their degree will permanently tie them down to rural areas, which is not desirable. In fact, their services should be also made available for primary level care in the entire country (even though they can be deployed exclusively for rural areas, in the initial years). It is unfortunate that while considering the entry requirements for training of the new cadre, the potential of other health professionals like nurses and nurse auxiliaries to switch to the new cadre was not considered. The training of nurses has a strategic advantage as they are already trained in the allopathic stream and also have gained patient management skills at the end of their training.

A matter of equity

Those who raise ethical arguments based on notions of inequality – that the new cadre will result in sub-standard care for the rural population – should also understand that one of the principles of healthcare ethics is the principle of justice and an important expression of justice is equity (11). The provision of a primary level of care to all sections of society according to their need is crucial in achieving equity in healthcare provision. Nevertheless, there is a danger if we approach the present initiative in health human resources as a stopgap arrangement which can be reversed when enough of the present cadre of medical personnel are trained and made available for the rural areas. Our health system would only benefit if we approach them as an important type of healthcare provider and use their potential in providing universal primary level care.

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I, Dr Sanjay Nagral, hereby declare that the particulars given above are true to the best of my knowledge and belief.
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