
Editorial

Rural doctors- do we need a separate entity?

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There is unanimous agreement that the health care delivery in rural India is not up to the mark. The health care institutions in rural areas are poorly staffed primarily due to the shortage of doctors. Why doctors are unwilling to serve in rural India? There are many reasons. Primarily the diagnostic facilities in the remote rural clinics are much below average and the lone doctor will have to treat sick patients on clinical judgement alone. This is not what he has learnt from the urban medical colleges which have most of the latest diagnostic facilities. The work load in rural clinic is unimaginable with more than 500 patients queuing up daily for outpatient treatment alone. The nearest hospital worth its name is usually 200-300 km away. Hence the patients and their family are often unwilling to go the hospital in the next town where also the facilities may not be up to the mark. If something goes wrong, the doctor will have to face the irate and angry rural mob and many times doctors have flung from these places for their life. The local quacks are notorious to add enough spice to the rumours of mismanagement of patients. The living standards in rural areas are nothing compared to urban areas where the doctors have undergone medical training. Being new to the locality, it takes quite some time for the doctors to win the trust of the villagers even if they want to work sincerely in that village.

The government of India has been trying to solve the problem of inadequate health care delivery in rural India for quite some time. The National Rural Health Mission (NRHM) project of the Government of India has been afloat for the last five years in most of the states. This programme has ushered a new energy level to various activities of rural hospitals and health centres in India. However this programme could succeed only in states where rural health delivery was already successful. The NRHM programme provided the much needed funds for infrastructure development in the form of construction of new wards, purchase of equipments and also supported payment of salary to newly appointed staff. In states like Kerala, where there is compulsory one year posting in government service after MBBS, the young and fresh graduates were posted mostly to the village clinics. These new doctors helped the regular doctors in those localities and the young doctors as well as the villagers benefitted out of this arrangement.

However there is no such compulsory government service in most of the states in India. Compulsory rural medical service is being planned by the central government; however no legislation to this effect has been passed yet. There is a tendency for fresh graduates to get into post graduate training immediately after MBBS. Such doctors lack clinical skills and knowledge in general practice and finally develop a highly focussed speciality approach. They refuse to work in rural hospitals where there are less facilities. There should be compulsory posting in rural clinics for at least one year for all fresh medical graduates and only after this they should be given full medical registration. During the one year period of rural posting, they should be given only temporary registration which should be converted to full registration only on completion of rural service and production of certificate to this effect. It is ironic to note that the government spends considerable amount of money to train plus 2 students into doctors and sooner or later they go abroad looking for better pastures. This is a colossal waste of national resources and should be looked into seriously.

The rural area service after MBBS course should be encouraged immediately to tide over the shortage of doctors in these areas. Incentives in the form of grace marks for post graduate admissions are to be given to those who work in difficult rural areas and very difficult rural areas. However the grace marks should not be given indiscriminately for all courses, but for post graduate courses in general practice, general medicine, geriatrics, community medicine etc. The government should encourage those who opt for family practice in rural areas and their salary should be more than that of specialist doctors in urban areas.

Another approach will be to change the policy regarding new medical colleges which can be started only in rural areas both by public and private sector. Minimum infrastructure will be guaranteed in a medical college hospital including residential facilities. Soon a township will develop around this new medical college and the government can have more professional institutions in these demarcated areas. Attractive incentives should be given to private sector for starting professional institutions in rural settings. The government should demarcate Special Education Zones (SEZ) in rural areas for starting professional institutions and provide the entrepreneurs with tax holidays and incentives. At least 25% of seats in these institutions should be reserved for students belonging to rural areas and they should be given subsidies in fees also. We can develop a new breed of doctors trained in rural settings and there will be less resistance among these doctors to serve rural areas. Post graduate course in family practice should be started in rural medical colleges and seats should be reserved for those who complete five years of rural service.

There are many quacks who practice various systems of medicine in rural areas. These people should be identified and given appropriate training in preventive aspects of health sciences, nutrition, immunisation and absorbed into the health sector as health care assistants in rural clinics. They should be working under the guidance of the medical officers in rural clinics. A government sponsored job will boost their ego and they will be more acceptable to the community during implementation of preventive health care. A lot of thrust is to be given to preventive health in the rural community in terms of environmental sanitation, nutrition, immunisation and family planning. Health education is extremely important in the success of any health programme and female literacy is an important factor in such a scenario. Along with establishment of rural health care delivery system, there should be schools in rural areas giving free education at least up to 12 years of schooling.

The plan of the MCI and the central government of India to have a separate and condensed medical course named BRMS (Bachelor of Rural Medicine and Surgery) for rural areas is a hasty step without far sight. Who can say that the villagers do not require the services of properly trained doctors? Experience of yester years have shown that such half baked doctors will agitate to get parity with their urban counterparts and government will be compelled politically to allow these rural doctors to practice in urban areas thus defeating the very purpose of the new course. Another foreseeable possibility is that the government will allow these doctors to complete MBBS through lateral entry. The end result will be the same. Not enough doctors to serve the rural community. Collective wisdom should prevail over myopic ideas and we fervently hope that the medical council of India and the government of India will think positively for the improvement of rural health care in India.

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