Scaling up changes in doctors' education for rural retention: a comment on World Health Organization recommendations

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In July 2010, the World Health Organization (WHO) published recommendations on *Increasing access to health workers in remote and rural areas through improved retention*.[1] The report outlines principles and evidence-based recommendations to improve rural retention. It targets medical education, regulatory interventions, financial incentives, and personal and professional support for rural practitioners. This rigorous examination of in-country maldistributions, an often-neglected obstacle to accessing health workers, will hopefully foster efforts to reduce a key barrier to health delivery around the world.

An especially important recommendation, "Match curricula with rural health needs" (3.1.4), focuses on medical education. It supports designing medical curricula to improve graduate retention in rural areas, presumably only in regions with severe shortages in rural practitioners. This ingenious idea has immediate face validity. While it may be tempting to maintain the status quo, the ethical imperative is surely to align health education more closely with the unmet needs of underserved populations.

In the light of this, however, the phrasing of the actual recommendation is unnecessarily weak. More fundamental changes to medical education are needed than this somewhat cautious report suggests.

The actual recommendation is surprisingly limited: "to include rural health topics" in curricula – a modest recommendation that can be met by merely adding a few classes on rural health. The urgency of providing doctors for underserved populations demands more fundamental change. In sub-Saharan Africa and south Asia, in particular, critical doctor shortages have a direct effect on maternal, child and infant mortality and hinder HIV care.[2] The resulting net harm is clearer in the case of doctors than in the cases of nurses and mid-level health workers, because the latter more often send remittances to rural families, offsetting some of the harms to rural populations.[3]

In regions where shortages in rural doctors are at critical levels, educators ought to transform, rather than merely supplement, the status quo. The stated primary goal of most medical education in those regions should be to prepare doctors for assisting the underserved, typically in local rural and public-sector practice. Core classes, central cases and role models should reflect this commitment, as should the admissions policy. A considerable portion of training should take place in underserved rural settings. From an ethical standpoint, public and donor-funded medical education in such regions ought to implement a near-complete focus on preparing doctors for practice in underserved settings, until the shortages abate.

Such commitment to the underserved requires more than the potentially cosmetic addition of rural content on top of pre-existing curricula. While core disciplines such as anatomy and physiology are identical everywhere, some materials and skills are currently more distracting than helpful, scarcely relevant for practice in underserved settings, and may even exacerbate doctor shortages. Other materials and skills, such as mastery of diagnostic skills based on clinical signs, safe surgical, obstetric and emergency interventions, and preparation for early-career management of community health workers, are more relevant to the needs of underserved populations. These and other rural integration skills should form the core of the medical curriculum. Such specialization in rural patients' needs could improve both the quality of rural care and the availability of rural physicians.[1,3]

These fundamental changes to many countries' public and donor-funded medical education would be consistent with other sections of the WHO report, which endorses social accountability in medical education, meaning that "health and social needs of targeted communities guide education, research and service".[1] Indeed, recommendation 3.1.4 is associated elsewhere in the report with a "primary-care orientation in the production of rural health workers", again suggesting a stronger recommendation than the current one.[1]

WHO's new policy recommendations rigorously analyse a key bottleneck to medical delivery in the remote and rural areas of many countries. However, the changes needed in medical training may be more fundamental than recommendation 3.1.4 currently suggests. A more dramatic shift in many countries, towards a near-exclusive focus on rural care in public and donor-funded medical education, would strengthen health systems that, ethically, ought to command first priority. While closer examination of all available evidence remains necessary, giving medical curricula a truly rural orientation does seem to increase rural retention.[4] ■

References

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