"Too many doctors?"

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When the Voluntary Services Overseas (VSO) office informed me that a placement had been found at a district hospital in Malawi, I quickly started my research into the health care situation there. The statistics were grim, reflecting everything you think of when you think of Africa: 1 million AIDS orphans, under-five mortality of 133 per 1000 live births, malaria taking the lives of thousands of children every year, $5 per capita spent annually on health care.

Among the many shocking statistics I unearthed was one that caused me to hesitate: a doctor:patient ratio of 1:60 000! This, apparently, was why they were recruiting doctors. I wasn't sure I was up to the task.

Clinging to the faint hope that this statistic was somehow in error — a typo perhaps or out of date, at least — my husband and I packed up our 2 children and all the medical supplies we could carry and boarded a plane headed for the "Warm Heart of Africa."

As it turned out, the number *was* wrong. When I met my Malawian counterpart, I learned that there would be just the 2 of us at our district hospital. Trying to look unperturbed, I ventured another question, "And our district has a population of … ?" "Oh, about 500 000 …" he replied casually with a big Malawian smile.

Arriving at the hospital for the first time I braced myself for the worst. To my amazement I found a functional, bustling place with hundreds of patients lined up outside antenatal and under-5 clinics, outpatient departments, vaccination clinics, tuberculosis program offices, and HIV testing and antiretroviral distribution clinics. So many people, all of them very alive and colourful — a scene more festive than funereal. Every morning there would be singing, dancing and theatre put on by the hospital staff (many of whom were the equivalent of janitors who just happened to like performing!) with messages about health topics to entertain and educate patients while they waited.

The wards revealed scenes more consistent with my expectations. Many were full to overflowing. The beds were old and the bedding a bit dodgy, but generally they were clean and bright. The patients were mostly young and many looked very ill, almost all suffering from infectious diseases.

Over time, I learned the secrets of running a hospital without doctors and very few nurses (40 for a 250-bed hospital with usually 350 patients.) Behind the shockingly low numbers of reported "health care professionals" hides an army of relatively low-paid medical assistants, clinical officers, patient attendants, ward aides, cleaners, environmental health workers, health surveillance assistants, community health workers, laboratory technologists, drivers, porters, and on and on. In addition, each patient is expected to be accompanied by a "guardian," usually a female family member who is responsible for feeding and cleaning the patient, and generally monitoring their condition, reporting to the nurses when something seems wrong.

The Malawian Ministry of Health has figured out that the way to fix a health care system is not to just train more doctors. One health policy expert, when asked what to do about the 3:150 000 doctor:patient ratio in Malawi,

suggested, "Can we get it down to two? Or one?"[1]

The problem with doctors is that many use their privileged position to cluster in big centres (sound familiar?), demand high wages and focus large amounts of time on small numbers of patients, most often the ones who can pay. Many doctors, whether they are Malawian or foreign, get tired of the difficult life in Malawi and move on (or back) to greener pastures. When most Malawians are still dying of simple, preventable diseases like diarrhea and malaria, doctors are simply not cost-effective. All of the other cadres of health care workers have less freedom to move and so continue on in the trenches, doing the work that needs to be done, much of it in the field of public health.

In Malawi, the front-line equivalents of Canadian rural general practitioners are medical assistants and clinical officers. With 2 or 3 years of very specific training focused on the most common conditions they are likely to face, they manage inpatients, outpatients, emergency and maternity, even doing cesarean deliveries and the odd bowel resection! An impressive scope of practice. They do an extremely good job considering their limited training, and they consulted me on only the most complicated cases (which made my practice extremely interesting, challenging and rewarding!). The main focus of my work involved "capacity building" with this team — filling in the knowledge gaps created by training your front-line "doctors" for only 2 or 3 years. I helped with policy and protocol development, shared skills as I saw patients and did training so my colleagues could do even more. To further maximize their time, they have long ago embraced the concept of group counselling for antenatal, postpartum, well-baby, HIV testing and antiretroviral, family planning and many other patients.

Is this a perfect system? Absolutely not. There are still far too many preventable deaths. Despite all of the innovative ways the Malawians are trying to make the most of what they have, they simply don't have enough — not enough staff, not enough supplies (or at least, not enough of the right supplies at the right time) and not enough training, and that leads to not enough good care. Examples of malpractice that would make headlines in Canada were routine in our hospital and barely provoked any discussion. A baby stillborn because there was no one to check the fetal heart for hours during second stage. A man asphyxiated because the junior clinical officer didn't recognize the neck abscess as a threat to his airway. The many apnoeic babies who were never resuscitated because some of the midwives just assumed them to be already dead. No human being anywhere in the world should have to settle for this kind of care. It is just plain wrong. Clearly much, much more needs to be done.

Surprisingly though, one of the worst health care systems in the world still offers many things that can be learned. The VSO logo "Sharing Skills, Changing Lives" might be assumed to mean that we, the volunteers from the developed world, come in, share our skills and knowledge, and change the lives of the people we work with for the better. As anyone who has had any cross-cultural experience knows, it is never so straightforward. The learning, sharing and changing always happen on both ends, with the volunteers often going home shaking their heads in amazement at how much they have "taken away" and gained, hoping they were able to leave at least as much behind.

Perhaps there is something to be learned from countries like Malawi who have found ways to deal with a doctor crisis much worse than our own. Group counselling visits could be much more widely used here in Canada. More nurse practitioners and physician assistants could go a long way toward lightening our load if they were given the chance. Many of the routine problems we see could easily and competently be dealt with by nonphysicians. We should be sure it is not professional arrogance, greed or simply resistance to change that is hindering this much-needed transition. From what I have seen both in Malawi and Canada, with good training these professionals perform their delegated functions to a very high standard — to the benefit of the patient. We still need doctors and lots of them for the system to work and for our patients to get the best possible care, but we must also continue to look at other options.

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Dr. Ilona Hale is a family physician from Kimberley, BC, who has recently spent 2 years with her family volunteering at a district hospital in Malawi, Africa, with Voluntary Services Overseas (VSO).

For more information on volunteering overseas with CUSO-VSO (Canadian University Services Overseas–Voluntary Services Overseas) visit www.cuso-vso.org.

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