Primary care in Transkei

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SUMMARY. A period of ten weeks working in an African hospital is described. The quality of service that can be given by British general practitioners in rural African hospitals is discussed and the educational aims of such a venture are explored. It is concluded that there is scope for such arrangements and that considerable mutual benefits may result.

Introduction

GENERAL practice in Britain is currently enjoying a renaissance. There have been searching enquiries into the content of primary care in the home, surgery or health centre, and the hospital (Barber, 1972; Cavanagh, 1976; DHSS, 1974; Kyle, 1971; RCGP, 1972). This lively debate reveals that general practice is concerned with *caring* for people. To care effectively the doctor must understand how the patient thinks and what to him are the meanings and consequences of disease. To grasp fully the depth of this concept it is helpful to work among people with a cultural and educational background very different from our own.

We have both experienced the new concept of vocational training since graduation in 1968. A proposition had been made to the Royal College of General Practitioners that a period of six months in a hospital post in the Transkei in South Africa be included in a three-year vocational training scheme for general practice in Britain. To test the viability of this proposition we therefore arranged to exchange lives, including practices, homes, and cars, for three months. The following information and opinions are culled from our collective experience and from the observations of one of us during a three-week tour visiting seven mission hospitals in the Bantu homelands and in Lesotho.

Aims

At the outset we saw the educational aims of this venture as follows:

1. To observe different patterns of morbidity and to revise certain practical skills, particularly in obstetrics.
2. To compare and contrast contemporary attitudes to disease, death, and childbearing in communities of widely differing cultures.
3. To explore the place of the British general practitioner working for a short time in a developing country.

The settings

The Transkei

The Transkei was an African territory in South Africa, known as Bantustan, which became an independent nation in October 1976. It lies between Durban and East London, bounded to the east by the Indian Ocean and to the west by the Drakensberg Mountains and Lesotho. It covers an area of 16,500 square miles (Wales has 8,000 square miles) and has a population of one and a half million people, including a diminishing white population of 15,000. The climate is pleasant: in summer rainfall is plentiful but not excessive, and winter is dry and sunny with snowfalls over the higher ground.

Most of the Transkei is rural and poorly developed; African communities are grouped into small villages each with a small shop or larger trading store. There are 24 hospitals, 22 being ex-mission hospitals which have now been taken over by the Transkei Department of Health. The hospitals form natural centres of a comprehensive health service with responsibility for the preventive aspects of health as well as the curative.

There are many well-trained and capable African nurses, but few doctors. The doctor/population ratio is approximately 1/14,000, which compares with a figure of 1/20,000 for the whole of black Africa. Many of the doctors are British and few are black.

St Lucy's Anglican Mission Hospital was established in 1906 and taken over by the State in 1975. It is situated in the beautiful foothills of the Drakensberg Mountains, 3,500 feet above sea level and 40 miles from Umtata, the capital of Transkei. The hospital serves a population of about 100,000, has an establishment for seven doctors (seldom enjoyed), and employs 160 nurses with a further 170 ancillary staff. It is a training school for registered nurses, midwives, enrolled nurses and nursing assistants, all of whom become registrable with the South African Nursing Council when they have passed their examinations. In addition, a course for nurse practitioners is held.

The hospital is equipped with a small laboratory manned by two part-trained technicians who can perform most basic tests. There is a busy x-ray department and a modern operating theatre. There are two trained and well-equipped physiotherapists. There is an occupational therapy department and a small hospital school. The outpatient department of the hospital acts as a clearing house for admissions and also serves as a casualty and general-practice unit. There is a daily antenatal clinic and a children's clinic as well as the usual curative services. There are four district clinics run by resident nurse practitioners, and eight comprehensive clinics visited fortnightly by a mobile team, sometimes including a doctor. The number of these district clinics is increasing and the aim of the Transkei Department of Health is to build a district clinic within walking distance of every citizen. In addition to this there are many treatment points visited weekly by two other mobile teams of nurses, mostly to distribute antituberculosis drugs. Health education at the hospital and in the district is provided by a team of health educators which has its own transport.

British setting

In Lichfield we work from a small health centre which accommodates three principals in partnership and a trainee. We also work from a village branch surgery. We employ a practice nurse, dispenser, and practice manager, as well as the usual reception and secretarial staff. We have attached health visitors and district nurses, but not social workers. There is a total of 11 general practitioners in town all of whom take part in running a 64-bed general practitioner hospital which includes a maternity unit. This is a lively centre which combines acute medicine for young and old, cold surgery, with about four operating lists per week performed by visiting consulting surgeons, and a busy casualty department. There is a physiotherapy department and a well-equipped x-ray department. The nearest district general hospital is about ten miles away.

Objectives achieved

1. Clinical comparisons

a) Disease patterns. Tuberculosis and malnutrition are the major causes of morbidity and mortality in Transkei. The whole range of general medicine is encountered but there is very little tropical disease. Some diseases are much more common here than in Britain, for example cirrhosis, hepatoma, cardiomyopathy, rheumatic heart disease, and carcinoma of the oesophagus. Conversely appendicitis, tumours of the bowel, varicose veins and ischaemic heart disease are very rare. The absence of asthma in children is the subject of current research. Some effort is made to deal with psychiatric disease and there is a small alcoholic rehabilitation unit. Most surgery is in association with trauma, craniotomy being a not infrequent procedure.

The pattern of morbidity seen in general practice in Lichfield is unremarkable compared to Britain as a whole, except that we have a small proportion of old people.

In order to make an objective comparison we have recorded 400 consecutive new cases (that is, first attendance for a disease episode) in both Lichfield and Transkei. In Lichfield patients were seen either in the health centre, branch surgery, patient's home, antenatal clinic, or casualty department. In Transkei they were seen either in the outpatient department or district clinic. Many of the babies and children in Transkei were seen first by nursing staff in the children's clinic: this is reflected in the high mean age (Table 1) and the false low incidence of nutritional disease (Table 2). The disease classification of the Royal College of General Practitioners was used. A diagnostic census of the hospital inpatients was taken from 293 patients on 6 November 1975.

African practice is shown to have an absence of home visits, high prescribing and hospital admission rates, and a low rate of referral for consultant opinion (Table 1). A high incidence of communicable disease

Table 1. Some operational comparisons: 400 consecutive patients.

	Lichfield	*St Lucy's*
Mean age	29	33
Sex ratio F/M	1.6	1.7
New case/old case ratio	2.7	2.9
Consultation/visit ratio	14.4	(no visits)
Referred to consultant	17	2
Admitted to hospital	4	94
Drugs prescribed per patient not admitted	0.85	1.30
Antibiotics prescribed	0.17	0.26

and tuberculosis and a low diagnosis of mental disorders were also recorded in Transkei (Table 2).

b) Workload. Longer hours were worked in Transkei than in Lichfield general practice. Workload in Transkei was broadly equivalent to that of a British houseman. There was adequate time off and free weekends were spent visiting the Drakensberg Mountains or the beautiful Wild Coast beaches. A full day in the outpatient department (seldom achieved because of inpatient responsibilities) would require one to see about 60 patients.

c) Procedures. Having charge of the obstetrics enabled one of us to revise or learn many practical procedures, including active management of labour, forceps deliveries, vacuum extraction, symphysiotomy, and Caesarean section (some of which are relevant to obstetric practice in Lichfield). Having to cope with emergencies fostered a confidence which tends to wither when very few abnormalities are seen.

d) Health education. The primary health care team is the idiom of modern British general practice. Health education and disease prevention are assuming an ever-increasing importance in the western world (DHSS, 1976). This was well understood at St Lucy's. Nurse practitioners, trained by the medical staff of the hospital, ran residential district clinics where they functioned as primary care physicians, midwives, district nurses, and health visitors combined. As well as performing ordinary medical tasks they gave talks to the people on nutrition, hygiene, immunization, and disease prevention. In this they were assisted by a mobile team of nursing and lay people based at the hospital and trained there.

e) Research. Research in British general practice has become almost fashionable, but there have been some important contributions to medical knowledge. It is widely recognized that there are unique opportunities for the study of the natural history of disease and for epidemiological investigation. In this respect St Lucy's Hospital has been no sloth and, of numerous papers published, some have been of considerable importance (Daynes, 1974a and b). The description of Transkei silicosis (Daynes, 1973; Palmer and Daynes, 1967) demonstrates the reward of intelligent observation and lively wit.

2. Some cultural comparisons

An understanding of the significance and consequences of, for example, death (Daynes, 1974c), disease, and child-bearing to the individual, are integral to a valuable therapeutic relationship. By observing pat-

Table 2. New episodes of illness presenting in 400 consecutive patients in Lichfield and Transkei.

Diagnosis	*RCGP Classification*	*Lichfield*	*St Lucy's*	*St Lucy's hospital census from 293 patients*
Tuberculosis	1—2	0	28	164
Communicable disease	3—43	6	39	15
Neoplasms	50—82	3	2	5
Nutrition and endocrine	85—105	8	5	13
Blood disorders	110—122	1	2	0
Mental and personality	124—151	22	6	5
CNS	155—207	44	31	26
Circulatory	209—237	7	13	15
Respiratory	240—272	64	76	10
Digestion	274—308	11	30	2
Genitourinary	310—344	18	28	9
Pregnancy and childbirth	345—366	18	10	32
Skin disease	368—399	23	13	5
Bones and joints	404—427	24	12	8
Congenital malformations	429—439	0	0	1
Diseases of infancy	440—451	0	1	0
Vague symptoms	454—464	12	3	0
Trauma	467—496	18	21	20
Prophylaxis and administrative	500—586	33	11	0
Total		312	331	330

terns of behaviour widely different from those of western cultures, our awareness of the vitality of this concept is heightened.

We have observed in the Transkei how death is accepted as a natural process; how the family will take the dying patient home from hospital to die, how a mother copes with the death of a child or a stillbirth, and how African nursing staff cope with these common events. We have learned how to deal with our own emotions when the seemingly unnecessary death of a child occurs through ignorance or stubbornness of the parent or, more often, the grandparent. We have observed how often disease is thought to be the consequence of wrongdoing or bewitchment, and how important it is to understand this. We have seen the value of children to parents, and how a high birth rate cannot effectively be tackled until the huge infant mortality is seen to be reduced. We saw what a tragedy infertility is to a woman.

There is little employment for men in Transkei, so many go to work in the mines in Johannesburg, returning home only once a year. We observed only too easily the dynamics of the fatherless family. Finally we saw how education leads to social isolation and its consequences: alcoholism was euphemistically known as 'teacher's syndrome', a disease which also occurred among priests.

3. The British general practitioner in Africa

The requirement of a post in the Transkei, which would form part of a three-year vocational training programme for a British trainee general practitioner, is that properly supervised and planned training should be available:

a) The range of clinical experience and responsibility should be adequate.

b) Competent and comprehensive supervision should be available.

c) Employment should be in a single designated clinical discipline or at most two, e.g. general medicine, paediatrics, or paediatrics with medicine.

d) The post must be kept open for a series of trainees in this predetermined specialty.

For St Lucy's, and probably for most other similar hospitals, we think there are difficulties in meeting these four criteria successfully. The number of medical staff employed is not always up to the full complement. This leads to difficulty in providing a post in a fixed discipline or disciplines. In a rural hospital such as St Lucy's all doctors are inevitably required to give service in areas of greatest need. Only those with specialized skills, such as obstetrics or paediatrics, can be guaranteed employment in fixed areas of medical care. We are therefore of the opinion that a combined post in general medicine and casualty surgery would be the most suitable.

The variable and frequently transitory nature of the medical staffing means that adequate supervision cannot always be guaranteed, and indeed will frequently be lacking. Supervision will seldom be of the quality expected by discerning trainees in British hospitals.

It may be argued that local patterns of morbidity differ markedly from those in Britain and that the clinical experience offered is therefore inadequate. We feel that this nebulous disadvantage is more than offset by the frequency of gross pathology with a plethora of physical signs. This, together with the difficulty in obtaining a history, makes careful physical examination mandatory and rewarding.

It is most unlikely that the colleges of physicians, surgeons, or obstetricians and gynaecologists will recognize African mission hospitals for official training purposes. Therefore time spent there will not qualify for taking the DCH or DRCOG examinations.

Our opinion is that St Lucy's, and other similar hospitals, could provide valuable training and experience for British general practitioners. That value lies not simply in the observation of pathology or even in the acquisition of new skills, both of which may be irrelevant in British general practice. More important is the value of learning about other methods of delivering health care and observing different attitudes to disease and death. The British general practitioner is now trained not only to make a physical diagnosis, but also to assess each case in social and psychological terms. The importance of this concept to the *caring* doctor in developing countries is inestimable. Some may be encouraged to add a spiritual dimension to their diagnoses.

We believe that St Lucy's, and some other rural homeland hospitals, could provide part of the preliminary three-year training of future British general practitioners in a combined post in general medicine and casualty surgery. Only if the trainee had previous house-officer experience in obstetrics or paediatrics would training in these subjects be appropriate. We would not recommend that a trainee be sent to St Lucy's during his first post-registration year.

There are two other ways in which the Royal College of General Practitioners could encourage doctors to work in developing countries:

1. A period of six months, or preferably one year, could be offered as an extension to a three-year scheme. We believe that such experience would create a better doctor and a wiser person, able to give more mature care to British patients. The African people are still dependent on medical manpower from overseas, without which there would be much more suffering.

2. Established principals in British general practice can be encouraged and assisted to take sabbatical leave to work in Africa; in some instances an exchange of doctors between British general practice and African rural hospitals may be possible. The College could keep a register of such opportunities.

The doctor's family in Africa

Many doctors going to work in Africa will be married and some will have children. We both have pre-school children and found that this provided no obstacle, but lack of educational facilities may exclude older children. Wives with experience of nursing or other hospital disciplines, such as teaching or typing, may be able to do valuable work in an honorary capacity, but a paid job is difficult to obtain. There is no shortage of African servants to entertain the children, and the climate is for enjoyment! A year's salary and the relatively low cost of living will more than take care of travelling expenses.

Conclusion

We both enjoyed our experiment enormously. We learned a great deal about people and caring for them. We think that well chosen employment in a developing country could be of great benefit to the British general practitioner, trainee or principal, in helping him to care more effectively for his patients in Britain.

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Addendum

This paper describes work in South Africa. For political reasons some doctors may be unwilling to work in that country. The authors will be pleased to discuss the implications of working in the African homelands with anyone so interested.