Correspondence

Primary medical care in Africa

Sir,

Having worked for some years in West Africa helping to provide primary medical care and teaching this subject to medical students and house officers, I was very interested to read in the June issue of the *Journal* Dr John Fry's excellent article on his visit to Kenya, Tanzania and Zambia. While most of his observations are very true I think that some comment is required.

First, though this is now perhaps a minor point, while the deficiencies in administrative experience are only too true they are hardly due in the ex-British colonies to independence being "thrust upon them too quickly". Education in the colonial days could not be made compulsory, as it is in this country, but had to await on demand. When this came it was explosive—as indeed was the demand also for modern medical care. It then takes time to provide schools and teachers and even more time to provide universities and graduates (and hospitals and doctors). Independence undoubtedly came too quickly, but could hardly be resisted, only delayed as far as possible. As a consequence experience of administration and of responsibility was inadequate.

Common diseases

It is true that the common diseases of this country, especially the respiratory infections, are also common in the tropics, and indeed one must expect to see most of the diseases of the developed countries, including some not now occurring so frequently, eg, tetanus and tuberculosis. (In one year, out of 25,000 new patients at the General Practice Clinic in Ibadan there were 2,250 cases of tuberculosis). But some of the tropical diseases are also common, and acute as they often are, especially malaria in children, cannot be relegated to the background. In general there is far more serious acute medicine than in Britain; multiple diagnosis is not infrequently necessary, and one must be prepared to treat as outpatients many who would in this country be visited at home or admitted to hospital. Emotional disorders are very common as a result of the changing social structure that Dr Fry describes. The symptomatology is naturally different from that in Great Britain, but the symptoms of physical diseases are often exaggerated and picturesque too, and the distinction may sometimes be difficult.

Medical care

In Ghana and Nigeria (and, I think, in Uganda) the need for training in community or primary medical care is appreciated by the medical schools and steps have been taken to implement this. It is after all a comparatively recent development even in Britain. In Africa I think it is even more important. The biggest problem is vocational training as owing to the shortage of doctors governments are unfortunately reluctant to delay their deployment. Unfortunately also, many of the African doctors set up in private practice in the large towns where they can earn high fees.

Medical assistants, as Dr Fry has seen, play a vital part in providing primary medical care and I think must continue to do so. Even when more doctors are available it would not be economic to employ them in rural areas with the scattered population and difficult communications because their expensively acquired skills would not be fully utilized. It is, however, essential that medical assistants working in these areas should have adequate contact with and supervision by doctors.

Finally I think that a period of up to six months for secondment of general practitioners from this country is too short. It takes time to become "acclimatized" medically and to become really useful. I would suggest 12 months, with six months as a minimum.

Peebles, Scotland. K. COBBAN.

Health centre practice

Sir,

A new building should encourage doctors to improve their standard of work; this does not always happen, as some general practitioners are either too conservative or too individualistic.

Although there are some advantages to the general practitioner in employing his own receptionists, as Dr M. Thompson (August, p. 496) suggests, I consider there are more advantages in having them employed by the local authority. This way, the general practitioner is saved much trouble and the receptionist is likely to receive a fairer deal—we are not interested in which is cheaper. The receptionists certainly remain responsible to their general practitioners, and show them the greatest loyalty. When a new appointment is to be made the general practitioner will see all the application forms and will attend the interviews of the candidates.

There is a standard rate of pay, increasing according to age and years of service, which is more generous than that of most privately-employed receptionists. Dismissal is never easy, and some privately-employed receptionists are retained longer than they should be because the doctor hasn't the heart to dismiss them—perhaps long after the normal retiring age. It is usually possible for a local authority to find alternative employment for unsuitable receptionists.

Dr E. J. C. Kendall (August, p. 496) comments upon methods of improving general practitioners' records. I agree with most of what he says, but