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

since we are individualists, it is difficult to persuade any group of doctors to agree to standardize their record-keeping. In Mansfield we agreed to adopt 'family folders', the advantages of which I enumerated in my paper (June, p. 341), but beyond this it has not so far been possible to standardize record-keeping. Case summaries are important but we don't have much spare time to compile them. I used to think they should be kept on the back of the medical record envelope as suggested by Walford, (*Journal of the College of General Practitioners*, 1962, **5**, 265) but with further experience of tattered MRE's I am sure a separate summary card is required. The College summary card is not used much, following the introduction of forms EC 7A and 8A. Perhaps a similar card without the immunization section should be introduced by the College or by the Department of Health.

There are four essential tools for tidying records: A roll of Sellotape for MRE's, a stapler (and "unstapler") for the continuation cards, a pair of scissors and a packet of paper clips for the correspondence. It is unrealistic, however, to think that Dr Kendall or I could persuade or coerce a group of ten or more general practitioners to tidy up their own records when these arrive from the executive council. For this reason, and because I agree that it is so important and should be done, the tidying and summarization of records should be in the hands of well-trained receptionist or clerical staff. With a local authority employer and with suitable supervision from an administrator, there may be some friendly competition between receptionists to see who can produce the best records—and the doctors allowed extra time to listen to their patients.

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Correction

Due to an error in the review of 'Some implications of steroid hormones in cancer', August *Journal*, p. 554, column 2, line 13, should read "The epidemiologist should *now* collect data".

Book reviews

Migraine. Evolution of a common disorder. OLIVER W. SACKS, B.M., B.Ch. London. Faber & Faber. 1971. Pp. 298. Price £2·50.

One-subject books are sometimes a disappointment. To fill his pages an author may accumulate reports and accounts of the work of others and incorporate them in extenso and sometimes uncritically. The really successful one-subject, one-author book is an extreme rarity, but this is one of those.

Migraine is something with which every doctor is familiar. Its frequency of occurrence ensures that any patients consult with the condition and that a proportion of these will themselves be scientists or doctors able to describe their own symptom-patterns with accuracy. The subject is well documented and Dr Sacks has immersed himself in the history of migraine from classical and mediaeval times. He considers definitions and descriptions through the centuries and goes on to dissect the components of the migraine attack from the experience of his own clinical practice. The resultant blend of critical analysis and observed recording is both satisfying and convincing.

Though the occurrence of an attack of migraine is an event which can be described in isolation the condition is recognized as one of a group including cyclical vomiting, biliousness, periodic fever (the pyrexia psychogenica of the older teachers?) and menstrual tension states. Its exchange—and substitution—conditions are discussed fully with clear examples both from the literature and the case-notes of the author. No matter what aspect of migraine is examined the presentation of material is logical, clear and readable. Of how few books can this be said?

Inasmuch as many doctors themselves experience migraine they will wish to obtain this book to see reflected in it their own symptom-constellations as well as those of others. Much that is not at first sight immediately relatable to migraine is found to fit into the syndrome and the diagnosis may well be made more often after reading the second part of the work, and the reader will have a fuller understanding of the basis of the condition, its psychological mechanisms, its biological significance and its psychological aspects after study of part three.

The fourth part relates to treatment, though this features in earlier chapters where it is relevant. The place of the physician, the way of life advised for the patient, as well as specific therapies are all discussed, including castration as reported by Gowers in 1881. The relative merits of drug treatment and psychotherapy are balanced in the admission that there is an element of magic in the successful treatment of migraine. Dr Sacks has given us the standard textbook for contemporary magicians and for those of the generation to come.

Parkinson's disease: A new approach to treatment. First edition. Edited by G. F. B. BIRDWOOD, S. S. B. GILDER AND C. A. S. WINK. Academic Press Inc. London. Pp. 115. Price £1·75.

This report of an international clinical sym-