LETTERS

The Team

Sir,
The title of the article "Towards the reality of the primary health care team: an educational approach" (August *Journal*, pp. 491-495) gave much hope to those anxious to see such a reality. The problem of developing a working primary health care team clearly emerged through the study day's proceedings: it is difficult to envisage the development of a common perspective when all the members of the team have an educational background derived from their experience in their chosen profession.

However, there is now another important issue which warrants consideration by those interested in the future of primary health care and that is, I suggest, an invasion of the community care field by hospital power politics; an issue first raised by Charlotte Kratz. Thus one finds the nursing team vastly expanded to include paediatric home nurses, community psychiatric nurses, stoma care nurses, diabetic care nurses and hospital-based community midwives. These specialist nurses work in a hospital-based team and maintain their professional links accordingly. Not only are the other community nurses bypassed, but also the general practitioner, as direct hospital admission is easily gained through this new avenue. The whole value of community care lies in its attempt to provide total care in an individual's home environment, rather than a piecemeal attempt at condition-orientated hospital medicine. This is not to suggest that hospital care is unimportant—rather, liaison has its place as a means of maintaining expertise of the staff involved while at the same time providing continuity in patient care.

While it is a political truism that it is cheaper to carry out nursing and medical care outside hospitals, the necessity for a plethora of specialist nurses in the community while the general practitioner remains a generalist, would seem open to debate. Perhaps this new development is a method for maintaining power in the hospital environment in a period of financial uncertainty.

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Primary Care Around the World

Sir,
Dr Peppiatt's article (June *Journal*, p.336) about the relevance of 18 months' work in a rural Sierra Leone hospital as a reinforcement of his vocational training, raises some very interesting possibilities.

By the same mail that the *Journal* arrived here I received a letter from a husband and wife, both vocational trainees in the Midlands, seeking a similar opportunity in Nigeria for a year or two "before settling down". I am sure this can be arranged and maybe there are others thinking along the same lines.

Most developing countries have a severe shortage of doctors, with a doctor:patient ratio of 1:25,000, or worse. National governments, and the church-related bodies that run hospitals and primary care services, are still having to recruit overseas to supplement the doctors being trained locally, and doctors are coming to Africa from the Philippines, Egypt, India, Poland, Holland and elsewhere. At the moment not many are coming from the UK, and one constraint has been that much of the British medical training, with its emphasis on hospital-based, high technology medicine, does little to prepare a doctor for the multicompetent skills he has to exercise as a VGP ("very general practitioner") in Africa. Dr Peppiatt has now shown the usefulness of general practice vocational training as a preparation for work in a developing country and as enhancement of skills for the UK.

Nigeria is just embarking on a scheme of general practice training (Pearson *et al.*, 1981), which will prepare young Nigerian doctors for work in general practice clinics and health centres, or the generalist type of hospital of which Dr Peppiatt writes. Three such hospitals have so far been designated as training hospitals, and many more will soon be inspected and approved. The trainees will be on a four-year Fellowship programme. At present Nigeria has no tradition of academic general practice, and the cadre of general practice trainer has yet to be developed. Offers from those who have just completed the vocational training, or even from established trainers who would like a change before retirement, could probably be channelled into these training hospitals, with mutual benefit. I would be happy to facilitate necessary contacts in Nigeria.

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References

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Adverse Drug Reactions

Sir,
While I found the article by Shulman and colleagues on the prevention of adverse drug reactions interesting (July *Journal*, pp. 429-434), it raised several points of apprehension.

The authors are to be congratulated on their efforts to reduce drug side effects but I wonder if their efforts sometimes cause mistrust between them and their local GPs and disbelief between doctor and patient. Of course, they are correct to remind a doctor that he has prescribed penicillin in a patient known to be allergic to it, but I challenge their correctness in the case of the anti-rheumatics and peptic ulcer, and there have been conflicting reports about the effect, if any, of β-blockers on insulin-controlled diabetics.

Unfortunately, I have practised in a country where too many people come between the doctor and his patient. Medicaments are changed without the doctor knowing, and the patient is left confused and not knowing whom to believe.

If the Shulmans' two-card record system serves to remind doctors of drug reactions, I think it can serve a useful function. Medicine is an art and medication has to be tailored to the individual. The pharmacist is not in a position to understand all the interactions which have led to the prescribing of a given drug and sometimes can break down a patient–doctor relationship which has been built up over many years.

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