OVERSEAS EXPERIENCE

'They sailed away for a year and a day to the land where the Bong-tree grows'[1]

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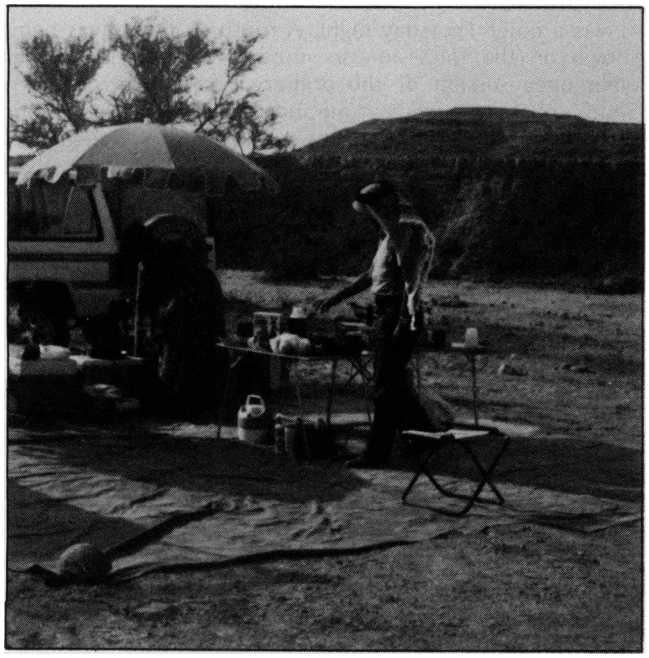
Many doctors recognize the rigidity of thought that sets in after a few years in practice.[2] As an attempt to counteract this our partnership allows members to take occasional sabbatical periods away from the practice. We would agree that 'a modicum of wayfaring makes a better doctor'.[3]

BETWEEN January 1982 and April 1983 I left my practice and worked as a consultant primary care physician at the Riyadh Armed Forces Hospital in Saudi Arabia. This break was taken as an extra partner was being employed in the practice.

The administrator of the family practitioner committee advised me that all he required me to do was to inform him who would be looking after my patients—in my case my new partner. Jobs in many Middle Eastern countries are advertised in the *British Medical Journal,* and the BMA often has information relevant to the job or can put doctors in touch with members already working in an area.

Many doctors leaving their practices for a sabbatical have found that on return their partners have not been prepared to accept them back. Despite the fact that I trusted my partners we had a legal and financial agreement drawn up by the practice solicitor. Before leaving for Saudi Arabia the consultancy group who recruited me sent us some rather inaccurate background information on life in Riyadh. I also had some more accurate personal knowledge as I had previously worked a four week locum in Riyadh. I also reread Davidson, including the tropical medicine chapter to brush up my rather rusty medicine. We found to our surprise that the most accurate books on life in Saudi Arabia are banned in that country.[4,5] In the final few weeks we were occupied with boarding the children at school and letting our house—it was finally let only two days before we left the country.



The author camping in the desert.

Arrival

Saudi culture is religious, conservative and rigid. Many westerners find living in the country—particularly living with the totally different roles and perceived worth of women[6] very difficult. The role of women also affects expatriate families. An expatriate woman may not go out alone even to the shops. When going out accompanied she must be covered totally from her neck to the floor. Had my wife not been given a work permit before we left the UK she would have found life very difficult. Religious freedom and religious worship even in private groups is not countenanced, and to partake is to invite repatriation. This is a problem for a Christian family. The weather varies between extremes of frost and 48°C, but this is not uncomfortable due to the excellent accomodation and air conditioning in homes, shops, offices and cars. Riyadh is surrounded by desert which is surprisingly beautiful. One of the highlights of a time in Saudi Arabia is a camping trip into the desert.

Work

The primary care department is housed in a wing of the main Armed Forces Hospital. It consists of four groups of three rooms arranged around a central reception and waiting area—the male and female waiting areas being segregated. A team of six doctors, three of whom would be career grade, and three in training grades worked from each set of rooms. The unit operated from 7.30 until 19.00 with emergency cover from 19.00 until 23.00.

Between 23.00 and 7.00 all patients attended the accident and emergency department. No home visits were allowed. Some patients attending for a repeat consultation were given appointments, but most patients just walked in. Patients were encouraged always to consult with the same team. There was a morning and an afternoon surge of attendances. This, together with the fact that the record department was slow at producing notes, led to very long waiting times for some patients. A further problem was that all primary care notes were interleaved with hospital consultations. This made continuity of primary care consultation difficult. The notes were partly computerized. Towards the end of our year in Riyadh computer printouts of some aspects of patients' notes and VDU displays of pathology results were available. This made the frequent unavailability of the notes less of a problem.

The consultation rate of patients was very high.[7] Also there were many health services in Riyadh with no central coordination, most of them not keeping notes. Many patients were eligible to use several of these services and did so all at the same time. 75 per cent of patients attending our unit had consulted another doctor for the same disease and 53 per cent of patients were already taking treatment for the illness.[7] Thus the first task on seeing any patient was to find who they had consulted about their illness and what medicine they were already taking. Most of the hospital investigative facilities were open to the primary care teams except during the emergency session. However, many patients attended in the emergency session for non emergency problems.[8] A wide range of clinical problems were met with ranging from the trivial to the life threatening.

Primary care consultants were not permitted to carry out even minor procedures such as opening abscesses and giving intravenous aminophylline: this all had to be done in the accident and emergency department.

In theory the department was an equal member of the hospital structure with all the other departments. In fact consultants in the primary care department had a lower status, and were only paid at the level of senior registrars in other departments, still an extremely good salary. The situation was similar to that in this country in the 1950s. One consequence of this was that the better junior doctors avoided primary care as a career choice.

The job description of the primary care physician in Riyadh was similar to that of the general practitioner in England. He was to provide curative and preventive care to people and families and to teach junior doctors.

This was a very different aim to the one I was given when I was working in Fiji. The aims of the health services in Lau province were firstly the eradication of filariasis, tuberculosis and leprosy; secondly the provision of clean water and prevention of diarrhoeal diseases and thirdly the treatment of disease. In Saudi Arabia there was not even a system of following family members of patients with open tuberculosis on our arrival.

Agitation for change was discouraged in a hierarchical system and at times led to repatriation as happened with the course organizer of the primary care teaching unit and the professor of one of the major hospital departments.

Dr Martin at a farm with a male nurse and a baby.

Positive features

There were many unsatisfactory features about the primary care unit, however the department was a stimulating place to work. The staff included many well read, articulate, independent doctors. There were regular weekly journal club meetings and clinical presentations.

The restrictions led to much discussion and often definition of what individual members felt were the basic principles of good primary care. Both junior doctors—equivalent to trainees in the UK, and students from King Saud University medical school were taught in the department. Usually they arrived with the preconception that primary care was a dull sorting job but several—particularly students, left with a completely new vision of the possible range and effectiveness of this speciality.

There were formal teaching sessions with the juniors twice weekly. Once a week the junior doctors had a joint consultation session with their tutors. The teachers met weekly for two hours in a trainer's workshop. Various methods of teaching were experimented with and assessed. The teaching sessions and consultations were recorded using videotape and were reviewed. The hospital would not provide the money for the video equipment, nor would they allow the teaching group to use the equipment from the medical illustration department, so we used the camera and recorder which belonged to a member of the teacher's group.

The juniors and the teachers took the same assessment exams each quarter and the teaching programme was reviewed. The hospital authorities encouraged research programmes and several research projects were completed and have been accepted for publication.[7,8,9] Even some of the juniors who had failed in several of the departments before 'making a mature decision to find their career in primary care', started to find medicine interesting, and their performance and enthusiasm improved.

One further major advantage of working in Riyadh was the very generous travel allowance given by the Saudi Government. During the year we visited Cyprus, Turkey, Thailand, Malaysia, Singapore and the USA at the Saudis' expense.

Conclusion

It was a quiet Thursday night. A football match was being shown on the television so nobody was coming to the emergency session of the primary care department. My Saudi colleague quietly came into the room, sat down and expounded at length about the weakness of British general practice, and how it failed to provide for the major needs of the British people.

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