

GENERAL PRACTICE TRAINING IN WEST AFRICA

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In view of the developments in undergraduate and postgraduate training for general practice which are taking place in Great Britain this account is presented of what has already been done in the very different setting of West Africa, and of the plans for the future.

University College, Ibadan, Nigeria has the only medical school in British speaking West Africa (though another one will shortly be opening in Lagos). It is affiliated to London University and has until now been giving London degrees, though it will soon become an independent university of the Federation of Nigeria. The clinical school opened in October 1957 shortly after the 500-bed teaching hospital opened, before which students were sent abroad, usually to Great Britain or Ireland, to do their clinical course.

The Background

As the general practice teaching has had to fit in to the pattern of medical practice in the area of the teaching hospital and in particular to the service provided by the hospital itself, a brief description of these is necessary to understand the method adopted and its value. There are very few general practitioners in Nigeria and they practice only in the large towns—in the largest, Ibadan itself with a population of over half a million, there are only ten. Each doctor has his own small hospital or nursing home with its own operating theatre, and there he conducts his practice, which is entirely private. There is little or no home visiting. The great majority of the people are dependent for medical care on the government and mission hospitals, at which they attend as outpatients and where they may be admitted when seriously ill or requiring operation, if a bed is available. Here again there is no home visiting, and indeed the demand for Western medicine (as distinct from the unqualified traditional native doctor) precludes at present any possibility of such visiting by the hospital medical staff. In the large hospitals

where there are consultants on the staff there are specialist outpatient clinics as well as the large general clinic. In the smaller hospitals the medical officer has his daily outpatients and is also in charge of the wards and will have to do emergency and some routine surgery (such as hernias) and obstetric emergencies. There are also a number of rural health centres, maternity units and dispensaries, as yet largely without doctors except for occasional visits from a medical officer from the hospital for the area (possibly 50 miles away), and staffed at present by midwives and dispensers.

University College Hospital, the teaching hospital for the medical school, has a full set of consultant and specialist clinics to which entry is limited to patients referred by a doctor. It was considered when planning the hospital that because of the very few general practitioners and the distances to other hospitals it would be necessary to have its own general outpatient clinic, as in other hospitals, to obtain the necessary number and variety of cases for teaching. This consideration has proved to be correct and over half the patients seen in the consultant clinics are referred from the hospital's own general outpatient clinic. The hospital has also a casualty department staffed by the department of surgery, but to prevent duplication of work this is mainly a traumatic unit dealing with injuries of all kinds and also other conditions, such as abscesses, ganglia, and so on which require outpatient surgery. All other emergencies are seen in the general outpatient clinic which maintains a continuous 24 hours a day service.

It is this set-up which has provided the great opportunity for training in dealing with the great variety of cases which are never seen in the wards or clinics of a teaching hospital and which make up the bulk of a general practitioner's work. It is obviously still incomplete training in many aspects, which will be dealt with later, but it does help to fill a big gap in the teaching, especially for medical practice as it is in Nigeria and the tropics generally to-day. This is in fact demonstrated by the amount of supervision and instruction necessary for new medical staff.

Postgraduate Training

The general outpatient clinic (originally the general-practitioner clinic, but changed to its present name because of the opposition of the local practitioners) is in charge of two S.H.M.O's who supervise the six post-registration and senior house officers who do the routine work. These house officers have six or twelve months in the clinic, during which they become experienced in dealing with every variety

of disease, except of course trauma and the surgical conditions, which are passed on to the casualty department, and obstetrics. (They get experience in the casualty department while doing their house surgeon posting).

All patients attending the clinic are given a personal registration number and a card which they have to bring with them on each attendance. A record envelope with notes enclosed, very similar to those used by general practitioners in the National Health Service in Great Britain, is kept for each patient, and when they return, either by appointment as necessary or for any other reason, they are seen by the same doctor as long as he is working in the clinic. Whatever time they return these records are available as they are filed numerically in the department with an alphabetical cross-index.

There is a small laboratory in the clinic where routine chemical and microscopical examinations of urine, microscopical examinations of stools, examinations of stained blood films, haemoglobin estimations, E.S.R., microscopical examinations of skin snips and scrapings can be done. A laboratory attendant is employed to prepare specimens for examination and clean glassware and similar work, but each doctor is expected to examine specimens from his own patients and the laboratory work is limited to what should be done by any general practitioner or in any small country hospital or rural health centre. In addition, however, the clinic has the use of most of the hospital laboratories and of the x-ray department, though with certain limitations which are reasonable in view of the large numbers of patients. It is thus possible to teach discrimination in the use of x-ray and laboratory investigations and at the same time to reach a reasonable standard of diagnosis. Moreover, when referring patients to consultants such investigations as are necessary are carried out first in order to save time at the consultant clinics, and this adds further to the clinical interest of the work.

All patients referred to other clinics are sent with a letter giving details of their case so that the doctors learn the reasons for referral and how to do so adequately. When patients are considered to need admission, the house surgeon or physician on duty is sent for and a letter written in the same way. Reports on these patients (which are incidentally delayed as much as, if not more than, in England) after being seen by the doctors concerned are filed in the patients' record envelopes. The great majority of the patients, however, are treated and followed up solely by the general outpatient clinic staff. Exceptions to this are pregnant women who are sent to an antenatal

clinic, and proved cases of tuberculosis who are treated by the tuberculosis service. The very limited number of hospital beds necessitates outpatient treatment, even at the teaching hospital, of many patients who would in Britain be admitted, and of course all those who would in Britain be treated by their doctor at home or in a cottage hospital are here treated as outpatients. For instance, most of the patients with pneumonia have to be treated in this way—and one of the junior staff is at present preparing a paper on the method and the results.

This work is not easy as the pressure of patients is very great, history and symptoms are frequently quite unreliable, and it is essential to give time to the necessary physical examination. The experience gained in doing this rapidly and coming to decisions quickly is invaluable. Discrimination, however, has to be exercised in the time given to the less serious conditions and unfortunately sufficient time cannot be given to investigating and treating the very common psychiatric complaints arising from ignorance and fear and the stresses of a possibly over-rapidly developing people.

This is a picture of the postgraduate training which is given in University College Hospital at present and which may perhaps be compared with the trainee practitioner period in Great Britain. The clinic has, however, also been used for student teaching at three points in the clinical course.

Undergraduate Teaching

First, during their introductory clinical course the students attend in groups of 8-12 for one morning. An attempt is made to give them some perspective of the sickness in the community compared with the patients they will see in the wards and consultant clinics and to show them why and how this selection operates. They are shown the methods of keeping records of patients and so on, and spend the rest of the morning watching the doctors at work (one or two to each doctor).

Second, during their posting to the Department of Social and Preventive Medicine they attend with a member of the staff of that department for four double sessions. This course is introduced by stressing the vast amount of medical work resulting from common preventable diseases for which curative medicine alone is no help in reducing the pressure. For each session one of the common groups of diseases seen in the clinic is taken—gastro-intestinal disorders, malaria, skin diseases, psychiatric and social problems—a few cases are shown and the problem presented with the aim of

provoking discussion on methods of prevention. To make sure that each student will take part in the discussions, this course also is divided into groups of about eight. I feel that this is a most important part of their training as medical officers of health are as yet only appointed in a few large towns and in rural centres the doctor will have to organize and take part in health education, instruct and supervise sanitary inspectors and so on, in addition to his clinical work—a satisfying assignment.

Third, during his final year each student spends a week in the clinic. He is given his own patients which are selected for him so that he sees as wide a variety of the problems as possible in the time. He examines and writes up each case which is then discussed with him, with regard to diagnosis, the investigations necessary, and the treatment. Those he treats are of course seen by him again, but he is given also some patients to be referred to consultant clinics and some emergencies requiring admission, writes the necessary letters for these and is encouraged to follow them up. A week of this shows the student something of the interesting field lying outside his usual hospital work, the drawback to the short period being that he misses the satisfaction of the follow-up of some of his patients. Until now this posting has been taken out of the time officially spent in the department of medicine, but when the first two sets of students who qualified in Ibadan were asked for comments on the curriculum the majority asked for more time in the general outpatient clinic, and the posting is to become an official part of the course. Whether the period should be increased beyond a week is a matter for discussion. I would say that a fortnight would be adequate to allow for the follow-up of treated cases and to see a better selection, but that really to learn the work requires a postgraduate posting.

It will be evident from this description that while this programme of postgraduate and undergraduate teaching is a help in producing more competent doctors for conditions in Nigeria today, it will do little towards the development of family doctoring with continuous medical care in the homes of the people where it is required so much. Patients have to be able to get to the doctor to get any treatment and nothing can be done to help the aged and the dying. Little preventive medicine can be carried out in the clinic and time is not available to deal properly with social problems.

Future Developments

For over two years I have been trying to get accepted a scheme for a community health centre away from the hospital, which could

serve as a model general practice and be used for postgraduate training and student teaching. Patients could be seen in their homes if necessary and continuous medical care practised with the inclusion of antenatal and obstetric work, preventive measures for children and health education. Such a unit, moreover, gives the opportunity for several other projects to be carried out—(1) The load, personnel required, and the cost of a comprehensive health service can be assessed as well as the buildings required, and the value of medical auxiliaries, (2) a true morbidity survey can be made, previous figures being based on those willing and able to attend hospital, (3) preventive measures can be instituted and their effects determined. (4) The clinical records of the unit would be a help in the investigation of the natural history of endemic disease and could be a basis for additional research projects.

The Board of Clinical Studies approved the scheme in principle but suggested that for the convenience of student posting the centre should be in one of the poorer sectors of the city and should be dependent on the agreement of the private practitioners. No co-operation in running the centre or agreement to it could be obtained. Finally the scheme has now been adopted by the professor of medicine and included in a project for research on endemic diseases in a rural area. On this basis it has been approved by the university and is probably being assisted by the Rockefeller Foundation. This area is isolated and self-contained and very suitable for the project except for its distance (50 miles) from the university and the hospital, which will involve considerable expense in buildings and transport and difficulties in obtaining staff. The population of the area is about 55,000 and it contains a rural health centre, a maternity unit, and several outlying dispensaries and antenatal clinics, all of which will be taken over. It is planned to begin work with a medical staff of four, two senior and two junior, but this will obviously require very considerable expansion for the objects of the scheme to be attained and not lost in the pressure of routine work. The plan includes student teaching—eight students at a time, after they have had, I hope, a preliminary week in the general outpatient clinic, will live in a hostel at the centre for a month in their final year. This unit as it develops will be able to supply trainee practitioner work to a number of doctors each year, and the students will have an excellent opportunity to learn practically the problems and interest of general practice and of social and preventive medicine. Furthermore, much valuable information on the lines planned above can be obtained.

It is a project of considerable magnitude and will require careful development by stages, with the establishment of adequate living conditions for a medical community in a primitive area and the employment of sufficient auxillary staff for the keeping of good records and collection of data. The establishment of such a centre makes use of the actual lack of medical facilities in the country and it should be of value far beyond Nigeria as a model for medical teaching and for research into basic problems.

“ I would invoke the memory of another octogenarian and a member of the same cloud of witnesses in the person of my own father, for fifty years a general practitioner in a north-country mining village. A few months after his eightieth birthday, though for some time retired from practice, he was called out one winter night—all other medical aid being stricken with influenza—to assist a midwife in a difficult confinement. He found himself delivering the granddaughter of a patient whose confinement he had attended fifty years previously. He thus made his acquaintanceship with the fourth generation of that family. In this there was nothing really surprising, except the coincidence, for in those mining villages the tradition of the family doctor was strong on both sides, and the doctor-patient relationship was that of friend to friend. Trust and respect on the one side were reciprocated on the other, where it was joined by a sense of continuing responsibility. I remember the visits paid three or four times a day about the time of the crisis to the patients with lobar pneumonia and the interest in the progress, week by week, of the children with rheumatic fever, until they could safely face the rough-and-tumble of school again ”.

Sir John Charles—*Brit. med. J.*, 1962, 2, 1631.