

Where Shall John Go?

Transkei

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Transkei is becoming headline news. Until recently this corner of South Africa was known in Britain only to a few tourists for its rolling hills dotted with huts; its "red blanket" tribespeople; and its click-language—recently heard over here in the African musical *Ipi Tombi*. On 26 October it became the Republic of Transkei—the first "independent African homeland" of South Africa.

Like any developing country, Transkei faces considerable health problems. The Government aims to provide a comprehensive health service, responsible for preventing as well as curing disease. It runs all the Transkei hospitals, and needs doctors to staff them. Medical care in the Transkei was pioneered by the mission hospitals, founded in the nineteenth century mainly by British and South African missionary societies. They staffed the hospitals when they could, starting a long tradition of British doctors practising British-style medicine in the Transkei. Although the Transkei Government has now taken over all the mission hospitals, the tradition persists, and only the pattern of staffing is changing—there are now even fewer of the old-style "medical superintendents" devoting their professional lifetime to a hospital. More and more of the medical staff are young doctors contracting to spend a few years in the Transkei. Their help is welcomed, and they themselves gain useful and unusual clinical experience before returning to their careers at home. In describing some of the conditions encountered and medicine practised, I write from my own experience of a year spent as a medical officer in a small rural hospital in Pondoland, on the Transkei coast—probably fairly typical, but obviously varying in detail from other areas.

The country

The Great Kei River forms the southern boundary of an area the size of Switzerland, extending eastwards from the Drakensberg Mountains to the Indian Ocean. Cross it, and you are "trans-Kei," in a country of vast expanses of bare, undulating grassy hillside, green in summer and brown in winter. Rivers wind through deep valleys down to the coast, where the vegetation is more tropical and exotic. Umtata, the capital, is one of the few towns, which are linked by long tarred roads. Otherwise dirt tracks, mud in summer and dust in winter, join the scattered small villages. The rocky Wild Coast has magnificent beaches with thundering surf—very popular for holidays and sea fishing. Dry sunny winters and wet summers (average summer temperature 22°C) make for a pleasant climate.

Of the three million inhabitants, most are Xhosas, varying from educated professional people, mostly urban, to primitive peasant tribespeople in the countryside. It is the latter who live in the round grass-thatched mud huts that dot the hillsides; who wear the distinctive red blankets with finery of beads and bangles; and who make up the vast majority of the "practice population" of most Transkei hospitals.

Country families are large and usually poor, living crowded in one hut. Wealth is measured in cattle, so that meat is rarely eaten. Maize is the staple diet, grown at subsistence level. Infants stay on the breast until supplanted by the next child—they are then weaned on watery maize porridge. As soon as possible, children are put to work minding cattle. Education is rudimentary and by no means universal, but opportunities are increasing—most hospitals have a school nearby, usually started by the same mission. Of the few who complete secondary education, most become teachers, nurses, traders, or government officers; some may go on to university. Most men, however, leave the Transkei in search of work—as lads, in the sugar plantations of Natal; and, once circumcised, in the mines of industrial South Africa, returning only between jobs, or when too ill or old to work. Witch doctor medicine and tribal customs (even such as abducting a wife) still obtain in many places, but are gradually being eroded by "European" urban influences and lifestyle. Cattle theft and "faction-fighting" are popular rural pastimes.

Pathology

Tuberculosis is endemic, and protean in its manifestations, affecting lungs, meninges, spine, joints, peritoneum, and pericardium, in all age groups. Chemotherapy has now changed its grim prognosis, and screening, immunisation, and health education schemes are aiming at its prevention. Malnutrition is widespread, with kwashiorkor common and often fatal among infants. Its cause is ignorance of a suitable diet as often as sheer poverty, and most hospitals have schemes whereby mothers can come in with their sick children and be shown how to grow, prepare, and use higher-protein foods.

Much of the medicine is paediatrics. As well as tuberculosis and malnutrition, gastroenteritis is common. Dehydrated babies may die quickly, but may recover equally quickly with intravenous fluid and electrolyte replacement. If at the same time their mothers can be taught the elements of hygiene and feeding, their chances for the future are greatly improved. Common bacterial illnesses—for example, pneumonia, croup, meningitis, and abscesses—respond rewardingly to timely intervention. Chickenpox can kill among malnourished children; polio is sometimes seen; and bilharzia too in the lower-lying areas. Obstetrics is a busy specialty, though birth control is encouraged. Many women have small abnormal flat-brimmed pelvises, so that prolonged labour is common, and many come to caesarean section. Ectopic pregnancies are often met with, and incomplete abortion is common. Venereal diseases are seen regularly. Most

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of the surgery performed, other than for obstetrics, is for trauma—fights, stabbings, and road accidents. The commonest bone injuries are Colles's and supracondylar fractures. There is great demand for dental extractions.

There are, therefore, excellent opportunities for experience in general medicine and surgery, paediatrics, and anaesthetics. With maximum clinical work and minimum paperwork, it is general practice at its best.

The hospitals

There are about 30 Transkei hospitals, of various shapes and sizes. My hospital had 260 beds, and about 400 inpatients—a conundrum common to most hospitals, and solved by putting less ill patients under the beds, and less ill babies in the same cot. Our area had a population of 160 000. The number of doctors varies from hospital to hospital, and on it will depend the scope of the work done. We had five doctors, and could thus split the work according to our own experience and interests—we usually arranged our time and responsibilities so that there was always one "surgeon" and one "anaesthetist" on duty in the hospital. Some hospitals, however, are virtually singlehanded. There are few African doctors, but there is a plentiful supply of well-trained African nurses (who also act as interpreters). Most are hard-working, capable, and possessed of a vast sense of humour. Some senior sisters are resident at out-station clinics—satellites of the hospital, visited weekly by a doctor. These nurses are, in effect, the "barefoot doctor" of their locality, diagnosing and treating minor ailments, referring more serious cases, and teaching the local people.

All the hospitals have adequate modern pharmacies, and basic x-ray facilities. Pathology facilities vary—we were well-equipped with microscopes, and could estimate haemoglobin, and do cell counts and ESRs. More complicated investigations and microbiology could be done through Umtata Hospital. Our operating theatre was adequately equipped for general surgery (which was limited by our own knowledge)—if patients we could not manage were fit enough they could be transferred to Umtata by road or air.

Most hospitals have at least one senior doctor, highly experienced and competent in the vast range of Transkei medicine, who will willingly teach. Newcomers quickly learn and accept much clinical responsibility. Of the few consultants resident in Transkei, most live in Umtata and are keen to teach. The hospital there is being built up into a teaching and referral centre, with quarterly teaching sessions, organised by the College of Medicine of South Africa, and occasional short courses. In-service clinical attachments can sometimes be arranged, as required, in Johannesburg. Some hospitals receive visits from "Harry's Angels"—a group of teaching hospital specialists who give up their weekends to fly to rural hospitals to operate and advise. So you're not entirely on your own. The Transkei and Ciskei Research Society, actively supported by leading South African medical scientists, encourages and advises on original research, for which there is every opportunity, among a people rapidly changing in circumstances, diet, and lifestyle, and whose patterns of disease are also changing.

A day in the life of . . .

The Transkei day starts early. From dawn the hospital compound is a cacophony of crying children, with garden and laundry workers calling to each other across the hillside, the clatter of utensils as mealie porridge is served in the long, single-storeyed wards, and the resident mothers singing and dancing on their way down to the health huts. After a quick visit to the wards to see the problems of the previous night, it is time to talk to the clinic sisters' course about, say, meningitis. Then comes outpatients, the brunt of the day's work.

A rapidly-vanishing dust cloud marks the departure of the clinic ambulance, laden with medicines and returning patients. One of the doctors is driving it, by way of a village antenatal clinic, to a clinic near the sea—a mud shack beside a trading store. Already a queue will be forming there. Not all will be ill: the clinic day is something of a social event, with a family visit to the store followed by a visit to the doctor, and perhaps even the chance of a magical "injection." The clinic doctor will see about 100 patients today, some of whom will have walked miles, or been dragged in on ox-sledges.

Already outpatients is crowded, largely with pipe-smoking mothers and screaming babies. Sister has written a history on record cards—"waistache and pain between the shoulders," is a favourite presenting complaint—the Xhosa equivalent of flu or depression. Throughout the morning we work through a seemingly endless flow of varying pathology. Many diagnosed as having pulmonary TB will be started on chemotherapy, which they will pick up from a "dropping point" nearer their home. Sister explains the need for continuing treatment with the analogy of cattle-dipping to prevent tick infection: most understand, but many will default from treatment once they feel better.

After lunching together, we finish seeing the outpatients and then do our own minor surgery that may have accrued during the day—fractures, suturing, D and Cs, circumcisions, abscesses, and aspiration of fluid from every imaginable body cavity. Later there is time for the wards—a full round, or new admissions; or perhaps some elective surgery; or a lecture to the student nurses. There will be some more admissions when the clinic ambulance returns, but by the evening there is usually time for a drink and a break. Each doctor will be on call for his own wards tonight. One will be responsible for casualty, and his phone will ring several times, for, perhaps, a "gasping" baby, a stabbing, or an impacted fetal head. Someone may have an evening off, and make the bumpy journey into Umtata and back to see an old film at the "bioscope."

Conditions and leisure

Most hospitals have comfortable furnished or unfurnished houses for their staff, with electricity and running water. Rent is low (and will probably be based on 2.5% of salary). Umtata has shops where all the comforts of home can be bought—and more: fresh meat, exotic fruits, and Cape wine are plentiful and relatively cheap. For doctors, the standard of living is probably higher and the cost of living lower than in Britain. Salaries for Medical Officers are adequate, being R7740 × 360 (£5340 × 248)—9900 × 450 (£6830 × 311)—11 700 (£8073) + 10%, depending on experience. Specialists receive R12 600 (£8694) + 10%. Additional allowances total R1010 (£697) a year. Contracts are for one to three years, the latter being standard. For a three year contract the costs of the outward journey will probably be paid. Regulations may change after independence, probably to become more generous. Unless they are doctors themselves, wives will find it very difficult to get jobs. Suitable schools for European children are available in towns not too far away from most hospitals.

Recreational facilities vary from hospital to hospital, but tennis, riding, and golf are usually possible, and sometimes river or dam fishing. The Wild Coast offers superb surfing and fishing. Artists, photographers, botanists, ornithologists, and sunbathers will find plenty to do. Time off will depend on staffing—ours was probably unusually generous, as we worked alternate weekends. My wife and I bought an old van, and spent most of our weekends off camping at the coast, where avocados cost about ½p each and fresh crayfish can be caught and barbecued on the beach. Medical Officers get four weeks' annual leave, and then Southern Africa is your oyster—peoples, cities, gameparks, beaches, mountains, forests, and deserts. Most doctors take the opportunity to travel at the end of their contract, and some brave spirits return to the United Kingdom overland. To reach

Transkei, any travel agent will advise on flights to Johannesburg and their cost. Some of the lesser-known flights—for example, Luxavia—are good value, or it might be worth becoming, for instance, a Friend of the Springboks for their charter flights. If there's time, the sea voyage is enjoyable. Rail or coach or both take you on to Umtata.

Pros and cons

If you're thinking seriously of a short time in a developing country, you would probably enjoy this sort of job. Patients get better, and seem to enjoy doing so, so it is immensely rewarding in terms of job satisfaction. There is excellent clinical experience to be had, and the chance to become clinically more self-reliant. The medicine, however, is probably relatively elementary, and facilities for definitive investigation are limited. Also, demand on scarce medical resources is enormous—at times the resources seem so thinly spread as to be depressingly ineffective. Rural hospitals are very isolated, and doctors and their families are thrown very much on their own social resources. There are all the

disadvantages of leaving the NHS for a while, in terms of superannuation, salary increments, and so on, and the posts are not officially recognised by the Royal Colleges as suitable for vocational training experience. Many will not like the political climate of Southern Africa, although Transkei's paramount chief promises a "non-racial society in which race, creed, or colour will not be the criteria of a man's worth." This has certainly been the philosophy of the mission hospitals throughout their history.

Transkei has immense potential. It is a land of stark contrasts—wealth and poverty, health and disease, wisdom and ignorance. I marvelled as one evening a white-gloved waiter served wine at a dinner party under the chandeliers of Umtata's Imperial Hotel—four hours and 40 miles away I had been among the flies and smells of a ramshackle mud hut in the bush examining a marasmic infant, poisoned by a witch doctor's herbal medicine. Worlds apart, but perhaps the gulfs that divide them are gradually closing.

Doctors wishing to work in Transkei should apply to the Secretary for Health, Department of Health, Private Bag, Umtata 5100, Transkei. Further information before applying may be had from Dr Guy Daynes CBE, Umzimkulu Hospital, Private Bag 514, Umzimkulu 4660, Transkei, whose help I gratefully acknowledge.

For Debate . . .

Monitoring adverse reactions to drugs

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The number of patients and the duration of treatment that can be included in controlled clinical trials before a drug is marketed make it impracticable to detect any save the most common adverse effects of drugs. To minimise the hazard of toxic effects under conditions of general use some kind of monitoring and early warning system is needed. In Britain the Committee on Safety of Medicines (CSM) pioneered the use of a voluntary system of spontaneous reporting by doctors on prepaid addressed postcards (yellow cards). These cards have proved valuable in several investigations when adverse reactions were known or suspected, but they are of little use in relation to their main purpose: the detection of previously unrecognised adverse drug effects. Moreover, they give no indication of the incidence of adverse reactions. Those who use yellow cards mainly report toxic effects that are already known.

The deficiencies of the yellow-card system are highlighted by their failure to detect the serious toxicity to eye and peritoneum caused by the beta-receptor-blocking drug practolol. It was only after Mr Peter Wright, an ophthalmic surgeon at Moor-

fields Eye Hospital, published his findings that large numbers of reports of damage to the eye caused by practolol were made to the CSM. A different type of monitoring system is therefore required: one that achieves a higher reporting rate and identifies previously unknown reactions and estimates their incidence. An arrangement of this sort is often referred to as monitored release.

Monitored release

The basic concept of monitored release is that the pharmaceutical company marketing a new drug should have a duty to obtain reports on all patients treated up to an agreed number. In early experiments using this idea the individual companies were left to devise their own methods of collecting information. They found great difficulties in persuading doctors to complete report forms, and the information obtained was of limited value. The problem became even worse when the promotional side of some leading pharmaceutical companies debased the concept of monitored release to something that resembled buying prescriptions. Doctors were promised new stethoscopes, medical bags, calculators, etc in return for completing "report forms." These forms did not seem to be seriously intended for monitoring drug toxicity, and the whole exercise fell into the category known in the industry as a "promotional trial."

The concept of positive monitoring is so important that it cannot be allowed to slide into ignominy in this way. Our proposals are designed to overcome some objections to existing schemes and to ensure that data are collected in a valid and usable manner.

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