or head injury is a good example. Also, medicolegal worries may dictate excessive prescribing in the belief that liability can be avoided by a positive act.

DR MACARA: The Ipswich doctors who cut out amphetamine prescribing showed what can be done by local initiative.

DR A J SMITH: We must be careful in assessing the results of such economies—they may prove more expensive. It's Catch 22.

MR KLEIN: As a layman I see no reason why the medical profession should lay down health priorities for the public, though I want any decisions to be well informed. It is disappointing that the priorities document has not spelt out the options at ground level, but this gives doctors an opportunity to demonstrate with specific examples what the choices are. It is for them to point out that if cardiac pacemakers are to be generally available they can be paid for only by, say, cutting all patients' stay in hospital by a day. People can understand that language. We badly need a vigorous, informed debate on these priorities and the medical profession is admirably placed to start it.

Appointments of speakers

- (1) Dr Stephen Lock, MB, FRCP, editor, *British Medical Journal*
- (2) Dr L Zander, MB, DOBstRCOG, senior lecturer, Department of Social Medicine and Epidemiology, St Thomas's Hospital, London
- (3) Dr I J T Davies, MB, MRCP, regional director of post-graduate medical education, Raigmore Hospital, Inverness
- (4) Dr R B Hopkinson, MB, FFA RCS, senior registrar in anaesthetics, Birmingham

- (5) Mr A P J Ross, MB, FRCS, consultant surgeon, Royal Hants County Hospital
- (6) Dr A W Macara, MB, FFCM, acting head of Department of Community Health, Bristol University
- (7) Dr Andrew Smith, MB, FRCGP, general practitioner, Whickham, Newcastle upon Tyne
- (8) Professor C C Booth, MB, FRCP, professor of medicine, Royal Postgraduate School of Medicine, London
- (9) Mr Rudolf Klein, MA, senior fellow, Centre for Studies in Social Policy, London
- (10) Dr Gordon Macpherson, MB, BS, assistant editor, *BMJ*
- (11) Dr A J Smith, MA, BM, assistant editor, *BMJ*

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Outside Europe

Management of psychiatric problems in a Kenyan mission hospital

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British Medical Journal, 1976, **1**, 1454-1456

Summary

Many psychiatric conditions are found in the rural general hospital in Kenya and are recognisable and manageable along standard Western lines. An essential element in management is the training of the nursing staff. The psychiatric patient should be actively managed and can benefit from the unsophisticated treatment possible at the mission hospital.

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Introduction

Mental ill-health is a major problem in Africa. The nature and extent of the problem is still not clear and reports are contradictory. The emerging consensus is that the prevalence of mental illness, in Africa is comparable with that in Europe, and the clinical entities are fundamentally the same.^{1 2} The simplicity of this is obscured by the strong cultural component in mental illness, which is shown in the symptoms and the way the patient presents. Furthermore, the health care structures in Africa are fundamentally different from those in Europe, with different priorities and methods of practice. The populations on which they act bear little resemblance to one another, so that standardisation is difficult and the same phenomenon is often seen and described in different terms. Epidemiological and cross-cultural studies show that the differences that exist between psychiatry in the developed and in the underdeveloped countries are more apparent than real.^{3 4}

In response to the plea of Lambo² that "clinicians in the 'back of beyond' should marshal their experience and set down their observations with as much care and exactness as possible," we report our experiences in one rural general hospital in Kenya.

The hospital

In the rural general hospital it is usually impracticable to refer cases to specialist psychiatric care since this is only available in the capital city. The rural doctor has many conflicting demands on his time. He is running an understaffed and underfinanced hospital providing a broad spectrum of curative treatment and a community health service. He is responsible for the administration and for training the whole medical and nursing team. He is busy, and sees his time as being enormously valuable. Furthermore, he may have little confidence in his knowledge of psychiatry, which traditionally has been only a small portion of his undergraduate training. Inevitably, however, discontented and fearful nurses will expect him to help and support them with the nursing problems. The reality is that he cannot avoid the psychiatric patient who is disrupting the wards or presenting repeatedly. He has to devote some time to such patients and it is better to manage them actively. Intensive psychotherapy is as inappropriate in the mission hospital as cardiac surgery, but crisis management will benefit most cases. The simple, short, problem-orientated interview is usually sufficient to reveal the nature and extent of the problem. Often interest alone is beneficial.

In an 18-month period we studied 102 psychiatric cases in the inpatient population—that is, 1.7% of all inpatients.⁵ These cases had to be managed within the limitations of the mission hospital. Using simple psychotherapy and a limited range of physical methods we found that 54% improved as assessed by the patient and ourselves. On discharge 15% showed no change and 11% were referred elsewhere: 7% to a Government hospital/welfare agency, and 4% to the traditional healer. Contact was lost with 20% of psychiatric patients through unauthorised discharge, discharge against medical advice, and default at outpatient clinic.

The "mad" patient

There was a policy of admission on demand to avoid the risk of unnecessary violence to the acutely disturbed patient who was often an object of fear to the family and community. The traditional practice of binding the patient hand and foot had, in the past, carried over to the ward. Sedation to the patient, encouragement to the nursing staff, and untying the patient interrupted the cycle of mutual aggression which had previously led to uproar and the other patients discharging themselves. A close relative was encouraged to remain in hospital with the patient to provide a focus of familiarity in this alien environment.

This approach usually succeeded in calming the patient down so that assessment, diagnosis, and treatment could be undertaken. It was essential to train all the staff in a confident reassuring approach to the disturbed patient.

Cultural-linguistic problems

With three major language groups in addition to Swahili and English, no one person, African or European, could communicate in depth with every patient. The use of an interpreter is essential.⁶ This introduces a potent source of error through mistranslation and filtering of information by the interpreter. For this reason the interpreter must be trained and should, where possible, be concerned with the treatment. Nursing students and medical auxiliaries are ideal for this purpose since translating at a psychiatric interview is an excellent educational exercise. For the expatriate doctor too, the presence of a local person is valuable in evaluating cultural norms and understanding the local customs and beliefs. There is also the possibility of collaboration with a local traditional healer.⁷

Cultural differences raise considerable problems in evaluating the history and examination findings. We found, however, that after several cases the local patterns emerged—for example, what expressions denoted depression, what somatic complaints had psychiatric significance, what were the local superstitions, taboos, and religious beliefs.

Relatives were frequently difficult to contact since the mentally ill patient was often greatly feared, or his illness believed to have a spiritual significance: a curse, a devil, a contagion (for example, certain forms of epilepsy). Their co-operation, however, was valuable in the assessment, treatment, and disposal of the patient.

The attitude of the nursing staff to the mentally ill had to be transformed from one of fear and suspicion to one of acceptance and interest. This was achieved by including psychiatry as a subject in the nursing-school curriculum, through continuous in-service training to

all grades of staff, and through the consistent example of the attitude and approach exhibited by the senior staff.

Problems of management

Deficiencies of plant and equipment were problems. There was no secure place in the hospital, so sedative drugs had at times to be used in quantities which would have been undesirable in other circumstances. There was no electric convulsion therapy machine, but in the few cases in which electric convulsion therapy was strongly indicated it was possible to send the patient to the provincial hospital for each treatment session. The supply of drugs was frequently precarious, but a small formulary was found to be sufficient. This comprised oral and injectable forms of a phenothiazine (chlorpromazine), a barbiturate (phenobarbitone), and a tranquilliser (diazepam). Antidepressant drugs were used infrequently since prolonged medication was expensive and tablets were liable to be sold or taken inappropriately. Tricyclic antidepressants were found to be preferable to monoamine oxidase inhibitors.

Facilities for social rehabilitation within the hospital were rudimentary, and mainly consisted of domestic work. Community resources for rehabilitation and aftercare were absent, but limited manipulation of the environment was possible if the problem was related to work, school, or family.

The existing medical records system made it difficult to establish an efficient system of outpatient management and follow-up. A special psychiatric file was established which provided full information on each psychiatric case, cross-referenced with the general files. It safeguarded the particularly confidential information essential for psychiatric evaluation. This was thought to be important, though the patients in general did not appear to value confidentiality as highly as would their European counterparts.

In-service education helped to mitigate the lack of trained psychiatric aides. Simple, regular observations on sleep, appetite, and behaviour were soon being recorded adequately and became useful aids to diagnosis and a monitor of progress. Medical auxiliaries can be trained to recognise and deal with the more common types of mental disturbance, so eventually the doctor is relieved of most routine psychiatric work.

Patient problems

The cost of a one-week stay in hospital (in 1973) was about KSh100, which is roughly equivalent to one month's salary for an unskilled labourer. Thus economic pressure caused anxiety to the patient and his family, often resulting in premature discharge against medical advice. Pressures for discharge mounted when the patient showed the first signs of improvement, especially at the times of crop sowing and harvesting, or where there were heavy family responsibilities. The therapeutic regimen therefore had to be built round a brief stay in hospital for intensive evaluation followed by outpatient treatment. There was a considerable default rate at follow-up at the outpatient clinic. This was not surprising on account of social and economic pressures and relative deficiency of postal, telephone, and public transport services. A high default rate at outpatient clinics is, of course, not unusual in other countries.

By contrast, many patients were over-demanding, presenting repeatedly to the outpatient department with somatic complaints. This type of neurotic presentation is very common, and has been interpreted as an attempt by the patient to present a problem in a way which he feels acceptable to practitioners of Western medicine.⁸ Such patients are often treated symptomatically with polypharmacy—a serious drain on the hospital's stocks of drugs and the patient's finances—and his real need may remain unrecognised. Some may be helped by a brief inquiry about stresses and by suggestion, but often little can be done for them, so that there is no point in pretending that conventional medicine is of value. There is something to be said for the suggestion by German¹ that such patients may derive more benefit from the traditional healer, whose ministrations have a strong psychotherapeutic component.^{2 9}

Many patients, in any case, present to both the hospital and the traditional healer without any feeling of contradiction. It is difficult for the hospital doctor to break through the barrier of mutual suspicion and distrust to make contact with the traditional healers, but their easy coexistence is possible, as in the village hospital at Aro, Nigeria,⁷ and the concept of using the pre-existing healing structures is being

exploited by health planners to the benefit of the patient in many parts of the developing world.

Conclusions

At the end of the period we had reached the following conclusions: (1) Doctors in rural general hospitals in Africa cannot avoid dealing with psychiatric patients. (2) Psychiatric problems of many kinds present and most can be managed and helped even in the unsophisticated setting of the mission hospital, with little extra effort on the part of the doctor. (3) An essential prerequisite is educating the whole hospital staff in the elements of psychiatric nursing and management. (4) It is essential to use a local person as linguistic and cultural interpreter. If this role can be combined with therapeutic skills it would be advantageous to all concerned. Thus medical auxiliaries can be trained to deal with most of the problems presenting. (5) There is much to be said for seeking the co-operation of a

local traditional healer. (6) The co-operation of the patient's relatives should be encouraged throughout the therapeutic process. (7) Outpatient treatment may be difficult to organise, but should be the aim.

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Personal Paper

A question of conscience

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It was indeed a surprise to be informed by an eminent professor, after a hospital interview, that as a Roman Catholic gynaecologist "there is no place for you to practise within the National Health Service." One had always assumed, quite naively it seems, that the British "system" is based on fair play and, above all, respect for the individual conscience. It soon became quite obvious that in order to stay in the specialty in Britain I would have had to change a conscientiously held abhorrence to the direct taking of human life. I chose to leave country, home, and family in order to practise medicine in full freedom of conscience.

Rights of physicians

Much has been written about the rights of women to obtain abortions and also the rights of physicians to provide this service within the law. The 1967 Abortion Act protected this right. Little has been written, however, about the rights of physicians who might have conscientious objections to the termination of pregnancy. I shall describe a particular experience in Britain and argue for the place of conscience within the practice of medicine.

All obstetricians and gynaecologists are now faced with the terrible decision as to whether to terminate a human life. For

many this decision in conscience is possible. For others, equally in conscience, this decision is impossible. This view is based on a fundamental respect for life from the moment of conception. The conscientious objection clause was included in the 1967 Abortion Act to respect this view. My own experience, and that of others, and recent directives from the Department of Health have made this conscience clause largely a mockery and raise fundamental ethical questions concerning the practice of medicine in the National Health Service.

Personal experience

The method for side-stepping the conscientious objection clause is illustrated by my own experience. I had started specialising in obstetrics and gynaecology in 1965 after pre-registration house appointments. At that time terminations of pregnancy were performed in teaching hospitals, more or less on the grounds laid down by the present Act. The rights of the junior doctors to object to these procedures were fully respected. The explanation given at that time was that all terminations should be done by a member of the consultant staff as the procedure was technically illegal and prosecution was always a possibility. In the next years I completed the junior house appointments and obtained the required postgraduate qualifications. Discrimination began once the Abortion Act was passed and I began applying for senior house appointments.

At one University Appointments Board the interview went as follows:

PROFESSOR: Doctor, what are your views on sterilisation?

WALLEY: Well, sir, when there is a good medical or moral indication, I have no problems in recommending this procedure.

PROFESSOR: In taking this a little further, what are your views on termination of pregnancy?

WALLEY: I have a conscientious objection to abortion.

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