Outside Europe

Mission hospital medicine

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The egrets, wearing their immaculate plumage, sit on the eucalyptus trees in the evening sun. The nurses, white uniforms surprisingly unblemished, walk slowly back to the locations, and the white cross on the mountain shines down on the mission hospital in the Transkei. In OPD (outpatients' department) all is quiet and our overnight guests wrap their blankets round them and settle down to sleep on the benches.

Yes—all true. But there's another side to the coin. For the third time that night you slosh, torchlit, through the mud to the hospital. Some fearful problem has just arrived in maternity; the lights have gone out; you've had no mail for a fortnight; and aspirin is out of stock.

Both images are familiar. The truth usually lies somewhere between them, yet there must be something about "mission hospital medicine" that is intensely satisfying: nostalgic letters are written from all parts of the world; and a substantial number of those who originally came as students for their electives return for a longer period. Not every hospital suits everyone, of course. Where the medical staff numbers a mere handful or less, and contact between them is necessarily close, personality differences may be volcanic; better move than murder, and usually a transfer can be arranged and the square peg dropped into its square hole.

The 40 or so mission hospitals in the Transkei were taken over by the State about four years ago. The high cost of medicine meant that for many years they had been financed almost entirely from State funds, and the change was a logical one, but it left some problems and little pockets of nostalgia. Letters of supplication that were once written to faithful congregations in the mother countries are now addressed in more formal language to the Department of Health in Umtata, with the same unpredictable response. Grave problems, particularly of supply, do exist, and it is easy to throw up one's hands and shout when no one can find any soap, or a long list of O/S (out of stock) drugs is chalked up on the ward blackboard. It is even easier, alas, to take it out on the wretched unqualified girl in the dispensary when she fails to find what you want. I count myself a sinner here, and a brief spell helping to sort out the drug store has given me a new respect for those who keep the endless stream of supplies flowing through the wards in Britain. It is large-scale housekeeping, made all the more difficult because our hospital supplies are also used for about 30 outclinics. One raid by those red-bereted sisters and the analgesics completely disappear. Fortunately, we are all generalists here, so the medical

superintendent counts the contraceptives, while matron condemns the mouldy bread.

Jacks and Jills of all trades

This willingness and ability to turn one's hand to anything must be the one common characteristic of those who go to work in developing countries; the advantages are clear. Firstly, in enthusiasm. I have long thought that some of the dissatisfaction in Western medicine (which usually finds its outlet in demands for better pay) is partly due to doing the same job, in the same hospital, with the same bored and boring colleagues for the greater part of one's working life. (Lest I lose all my British friends, I hasten to add that not everyone is thus afflicted, but there are enough to keep the lunch table rumbling with a bass continuo of discontent.) No chance for the chest physician to liven up his life with a tonsillectomy list—he would most certainly not be supported by the defence societies if he did—but, out here, the unthinkable becomes the normal. Our medical superintendent does the neatest caesarean section I have seen in any country, and laparotomies or craniotomies whenever necessary—yet, strictly speaking, he is a physiologist, with a PhD in renal haemodynamics. The Swiss doctor, much of whose training was in child psychiatry, does the cataracts, and our orthopaedic and ENT surgeon has built his considerable skill on a basis of house jobs.

In the past five years even I, an ordinary middle-aged suburban housewife and GP, have learnt to give anaesthetics, vacuum extract babies, and aspirate from various cavities. This year I added tooth pulling to my repertoire—I had to. Given the necessity, and enough enthusiasm, new techniques and specialties can be learnt. "See one, do one, teach one," is said to be the motto about sections of one famous ex-mission hospital. Well, that is rather shortening the course, but it is a better attitude, to my mind, than the rigid parochial system developing in Britain. Specialist or GP the ambitious candidate finds that his best way up the ladder is to decide early and stick round his teaching hospital as much as possible, keeping his face in sight and his mind closed.

Take anaesthetics, for example: I have worked briefly in quite a few departments in various parts of the UK, and each has its own preferred technique—anything other than the locally accepted one being eschewed. In one hospital, this means full relaxation for a simple change of plaster cast, while halothane is used in miniscule dosage (furtively, if at all). Another department regards the controversial halothane as the only safe anaesthetic, however often it is administered. Chacun à son goût—but it is individual taste that dictates rather than the needs of the patient. Here, chronic doctor shortage has led to the routine use of epidural anaesthetic for caesarean sections—but once adopted the advantages are compelling. Nevertheless, we had one total failure (partial failures may be supplemented with pethidine or

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diazepam): she was given ketamine, with equally good results. The lady, who filled her bed, suddenly, with blood clots from a placenta previa—in the middle of the night—was clearly unsuitable for either, so had a straightforward endotracheal anaesthetic. Horses for courses, in fact, and apart from being better suited than an invariable routine to the patients' needs, it is much better practical training for anaesthetists than perfection in one method alone.

A place for specialists

Not that I have anything against specialists: we need them—oh, how much we need them. As I looked into the fire before Christmas (we had a cold spell then, too) I found myself wondering childishly if I asked him nicely would Father Christmas send us an orthopaedic surgeon. The present local—and from all accounts excellent—incumbent is ill and his absence sorely felt. It is the surgeons, of course, who are most needed. Given a good textbook, preferably 30 years out of date, and every man is his own emergency physician. In addition, the almost complete absence of any reliable pathology would frustrate anyone, but it is heartbreaking to have patients rotting in their beds with ununited fractures, and bony infections, and be able to do so little for them.

We had a visit from the local specialist surgeon the other day. We dealt him a rotten hand: six carcinoma of the oesophagus in different stages of debility and decay, an unknown theatre and anaesthetist. I'm afraid he got home very late, but I hope he knew how his effort was appreciated by everyone. It made me realise that there is a real place for a peripatetic teacher. Books are helpful up to a point, but silent beyond it. Lectures and meetings deal only with cases where the loose ends have all been tidied up and the red herrings thrown back. The true education (to which all apprentice surgeons should be exposed) is to see the expert at work and his reaction when the trouble starts.

Almost all the hospitals in the Transkei were started within the last hundred years, and most have grown from one small clinic hut with a single nurse in charge, to become relatively complex structures. The courage, hardihood, and faith of those early pioneers, the reverends (revs), and especially the rev/docs were truly remarkable. Most made it their life's work, and their names are still remembered with affectionate respect because, with the help of their African colleagues, they laid the foundations for the only true national health service in Southern Africa. It seems a sad betrayal of their ideals that these hospitals, which are increasingly used and valued by the local population, should be allowed to atrophy. Eventually, I hope and believe, there will be sufficient indigenous graduates to run them, but that time is not yet, and in the meantime crisis is threatening. Not only is a doctorless hospital severely limited in the treatment it can offer, but the whole complex structure of nurse and ancillary training starts to crumble. Is there a solution? I believe there is.

An uncertain future

The problems of the Transkeian hospitals are not simply little local difficulties. They reflect a worldwide concern. The number of recruits to mission work is decreasing, and few, especially those married and with children, envisage a lifetime overseas. Quite rightly, there is little security of tenure and it becomes increasingly difficult to re-establish oneself on the appropriate rung of the professional ladder after the age of 40. But it is their children's education that drives most expatriates home. Boarding schools are expensive, and the long months of separation not as acceptable as they were before the war. The war brought other differences too. Fewer are impelled to redeem the heathen, when the heathen turn out to be so much nicer and have more of Christian virtue than many of us. Indeed, one is constantly humbled by the dignity, stoicism, and cheerfulness of one's patients, especially when you consider that their diet—grossly

inadequate by European standards—is also regularly shared with a variety of intestinal parasites.

There is a shortage of doctors in the developing countries, but there are worries about a surplus in Europe. Rumours reach us of surgical registrars elbowing each other out of the way to get an appendicectomy, and population changes may make it difficult for a trainee in a declining area to gain enough experience. Mr Innes Williams has pointed out the difference between the number of registrars in relation to senior registrars, and the desirability of some of them changing specialties if they are to improve their chances of a consultant post. He might have added that some, especially in surgery where manual dexterity is important, may find themselves no longer suited to the career they embarked on so enthusiastically in their mid-20s. In the present rigid English career structure it is extremely difficult to change direction, and almost impossible to do so without losing face. For those who find themselves on the wrong ladder, a couple of years overseas might enable them to discover where their true talents lie, and would give them an opportunity for retraining. For the others, it would be a superb finishing school. For years, the BTA (been to America) was essential for some consultant posts, because it was thought to imply proficiency in research. Now, perhaps, we should have a BTAf (been to Africa) as the kite mark of thorough practical experience; if I had abdominal pain of undiagnosed origin it is the BTAf surgeon I should prefer.

Advantages of overseas experience

Some overseas schemes do exist, but they are more in the nature of training posts, an extension of the teaching hospital/district general hospital rotations that are now the norm. I should like to see a three-year training programme—one year to be spent in the teaching hospital; one in a district general hospital, as now; and the whole, or part, of the third year overseas. I have mentioned the advantages to the individual, but I'm sure it would also benefit the NHS. No one who has been deprived of almost all the pathological and a proportion of the x-ray services he has taken so much for granted can ever use them again with such abandon. He will discover that some plastic syringes may safely be autoclaved up to 10 times—think of the saving there. Drugs are prescribed with much more care when they are scarce—our usual amount dispensed is between 12 and 30 tablets rather than the 50 to 100 that are customary in Britain, but I could multiply these examples ad infinitum. (Thrift is a hardy plant, and once well established difficult to eradicate, but it needs a poor soil at the start.)

Further benefit would result from the opportunity given to recognise other people's difficulties and needs. At present, with early choice of specialty, a surgeon may well understand little of his medical colleagues' problems and vice versa. Taking one's turn "on duty" for all the disciplines—obstetric, as well as medical and surgical emergencies—is very good training, and well within most people's competence—as the present staff of the mission hospitals testify.

Were such a scheme of integrating overseas experience into specialist training (and that could well include general practice) adopted, some points remain for discussion. The most important is the attitude of the profession in general. I have suggested that the travellers should be registrars rather than senior registrars for two reasons. Firstly, if someone wants to change course he should do so before his allegiances are too fixed, and, secondly, because, as senior registrar, he will be applying for consultant posts, and cannot be expected to travel back and forth for interviews. In some specialist hearts there is a feeling that the registrar who goes abroad is somehow letting the side down, or falling into bad company and habits—possibly both. Parochialism is prevalent and powerful; it is also pernicious. Those who take up the challenge of overseas work must be assured that out of sight will not be out of mind, and that their career prospects will not suffer. The whole-hearted backing of the royal colleges would go a long way to combat this.

Some sort of central register would then be needed. At the moment, almost everything relies on that tender plant, the grapevine, which is unreliable and slow. Where it should be sited is debatable—the Postgraduate Medical Federation, perhaps, one of the royal colleges, or the BMA? Appointment could either be long-term (two to three years and prearranged), or emergency and short-term (three to six months). There is a real need for the latter, for doctors do get ill, and must have some leave, and the absence of half the medical staff in a two-doctor hospital puts an intolerable burden on the survivor. At the moment, it may take months to find a locum, and a further prolonged period before all the red tape is dealt with. A work permit may take as long as a year. One hopes that, if the candidate comes from a recognised source and is sponsored by his college or hospital, this time might be considerably shortened.

Coupled with such a register should go an information service. It takes some courage to set off into the unknown, even for a short while, and there is a tremendous amount of detail available, especially from those intrepid travellers, the students. If everyone who returned could supply his telephone number, together with the name of the hospital and the date of his visit, then a substantial information bank could be assembled in quite a short time. Thus an orthopaedic registrar, with his second year just completed, might get in touch with the register and find that Umtata desperately needed an orthopaedic surgeon. A couple of telephone calls would give him an uninhibited and

probably forthright view of Umtata, its hospital, staff, and facilities. He might well find himself on the way to a profitable and enjoyable six months, and some Transkeians on the road to recovery.

Lest anyone should now be muttering about impractical fools, I have *not* forgotten about money. The Transkei Health Department pays well at present, but many countries, and I think at this particular time about Uganda, are desperately poor. The open ticket to almost anywhere is beyond the pocket of most registrars, and few funds exist elsewhere. Some students persuade firms or organisations to subsidise them, but no one seems to have thought of approaching the airlines themselves. Every time I have travelled to or from Johannesburg, and on whichever airline, the plane has been at least one-third empty. It would cost little, and might bring them some favourable publicity, if the airlines were to designate so many seats a year or month at 10% of the fare for such "flying doctors." How about it, BA? If travelling expenses were thus reduced it should be possible for the NHS and the host country to come to some arrangement about salaries.

The future of medicine in any country is almost impossible to prophesy. Who would have thought 10 years ago that the gates to the research departments in North America would have been so firmly closed? Yet, as one door shuts another opens. I hope that for some it will be the embarkation gate at Terminal Three.

STRANGE ENCOUNTERS

Distributing references

It is important to consider some of the means by which the content of referees' letters becomes known today, if it does become known, to the appointments committee. I will mention only practices that I have seen in use while serving as a member of such committees (and I must add that my service in that capacity has been infrequent of late, since the college that I belong to ceased to represent the specialty that I practise).

The malpractices and other shortcomings that I have experienced personally may now be of the past. And in making that point I would make another, perhaps rather belatedly, by emphasising that most appointments in the NHS and in British universities are conscientiously and efficiently dealt with by people who, with good humour and courtesy, do their best to see that all goes well. As so often, it is the exceptional that makes news and attracts comment.

Sometimes, the request for a referee's opinion includes a statement that his reply will not be copied or circulated in any form, but will be read out, in strict confidence, to the committee. This should warn the referee of the need to concentrate his reply lest what is important be lost. It has to be asked, too, if reading aloud is a good way to present referees' views. Remarkably few committee secretaries (or chairmen) have the accomplishment of being able to read aloud intelligibly and accurately. Monotony, misplaced pauses, faulty emphasis, arrhythmia, gabbling, mumbling, and stumbling over technical words and eponyms, all may contribute to the listeners' failure to take in what was written.

Even when the reading is passably done, concentration on its content may be interrupted by a neighbour's untimely cough or spoken aside, by a sound from the street below or by any other distraction: when the thread of meaning is broken, the meaning itself can be lost, and it is seldom practicable to have each fractured passage read out again.

I have been at meetings of selection committees at which the chairman, pressed for time, has ruled against reading any referee's

letter that is more than a page long. One might sympathise with his view if it did not victimise the candidate for a fault that is not his but his referee's—if fault it is that the letter is long. A dean, representing his school at such a meeting, protested at the impropriety of the one-page rule by asking the chairman how many words make a page. The chairman told him not to be impertinent. . . . The referees' letters were read in full when the business of the meeting was resumed.

Preparing and circulating copies of referees' letters have the disadvantageous consequence that the confidentiality of the documents cannot be so well protected. Nowadays it is comparatively unusual to find them dealt with in this manner. I had a chief once who always wrote references in longhand, keeping only a barely legible carbon copy as a record of what he had written. One of his assistants applied for a job in a university. The published advertisement had stipulated that candidates must submit 20 copies of their application and the names of three referees. The advertisement did not state that the university, to reduce further the expense of appointing staff, had made it a policy when writing to referees to require them to provide 20 copies of their reply. Our chief's indignation is still remembered well. That university revised its policy toward referees soon after his remarks were received.—WILL MACREDIE.

Correction

How to pass the DCH

We regret that in the bibliography of this article (30 June, p 1776) the publisher of *Practical Paediatric Problems* by J H Hutchison was wrongly given. The book is published by Lloyd-Luke Ltd.