continuous dealing with minor problems, which enables us to do this because it is taken over by the renal unit. They do it well, but I would like to make a plea for the greater involvement of the general practitioner with the renal unit and with long-term illness in our practices.

Is there a common ground, on a teaching and learning level, which renal units and general practitioners share, a ground which is not primarily an understanding of the disease process, but an understanding of how patients react to their disease process?

DR. OGG: I am delighted that Dr. Baker has said this. It took me two weekends to go through the notes, and when I saw what we had done to this poor girl I was horrified. The notes are a monument to her suffering. She had 34 admissions, 27 operations (including 18 for shunts), and 136 pints of blood (including 50 in the last few days). But I don't think we would make all these mistakes again. We have better access to the circulation, better and larger dialysers, better understanding of nutrition, less anaemia, and much less metastatic calcification.

We haven't yet solved the problem of menorrhagia, which crops up every day. But this woman did carry on as a housewife, and she had a little bit to spare because she also worked part time and contributed to local village life. And perhaps most important, her son had his mother's company for an extra seven years.

PROFESSOR LESSOF: Thank you. We have presented this case in a way that presents problems and sometimes our own inability to solve them.

This conference was recorded and edited by Dr. W. F. Whimster.

APPOINTMENTS OF SPEAKERS

- (1) Dr. W. Cattell, M.D., F.R.C.P., Consultant Nephrologist, St. Bartholomew's Hospital, London.
- (2) Dr. G. A. K. Missen, D.M., F.R.C.PATH., Consultant Morbid Anatomist, Guy's Hospital, London.
- (3) Mr. T. M. Coltart, Ph.D., M.R.C.O.G., Senior Lecturer in Gynaecology, Guy's Hospital, London.
- (4) Dr. C. S. Ogg, M.D., F.R.C.P., Renal Physician, Guy's Hospital, London.
- (5) Dr. A. J. W. Hilson, M.B., M.R.C.P., Senior Registrar in Nuclear Medicine, Guy's Hospital, London.
- (6) Dr. H. M. Saxton, F.R.C.P., F.F.R., Consultant Radiologist, Guy's Hospital, London.
- (7) Professor M. H. Lessof, M.D., F.R.C.P., Professor of Medicine, Guy's Hospital Medical School, London.
- (8) Dr. W. L. Brander, M.R.C.PATH., Lecturer in Histopathology, Guy's Hospital, London.
- (9) Dr. R. Williams, M.D., F.R.C.P., Director, Liver Research Unit, King's College Hospital Medical School, London.
- (10) Dr. J. W. Baker, M.R.C.G.P., D.OBST.R.C.O.G., General Practitioner, Addington Health Centre, Paddock Wood, Tonbridge, Kent.

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Medical Education

Postgraduate and Continuing Medical Education in a Developing Country

BRIAN SENEWIRATNE, M. KANAGARAJAH

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A major cause of frustration in young doctors in many developing countries is the lack of continuing medical education. This results in the emigration of many bright and enthusiastic students and is an important cause of the "brain drain."¹ Recently representatives from several developing countries claimed that the main reason for their doctors leaving was to seek higher education.²

Postgraduate education costs several times more than undergraduate education,³ but can developing countries afford *not* to provide such an essential facility and almost certainly lose the best of their young doctors? If such countries, which are among the poorest in the world, are to get the best of the considerable investment they have made in training their own doctors some form of postgraduate instruction must be provided.

We outline the present system of postgraduate education (or lack of it) in Sri Lanka and suggest ways of improving it within the finances available. Any such programme must be implemented within the framework of the existing hospital system rather than by the establishment of a separate institute of postgraduate medicine, which would cost more than many developing countries can afford. Our observations are relevant to all developing countries.

Present Hospital System

Sri Lanka has an area of some 25 000 square miles (64 750 sq km) and a population of 14 million. The hospital service is a tiered structure (fig. 1), with the Colombo group of 10 hospitals, which includes a teaching hospital, at the top. Then come the provincial hospitals (10), the one in Kandy being the second teaching hospital. Well-equipped libraries and well-qualified teaching staff in all the important specialties are available in the teaching hospitals. The provincial hospitals other than that in Kandy have similar specialized staff but no library facilities. Next come the base hospitals (12), where specialist staff are limited to a physician, surgeon, obstetrician, and, possibly, a paediatrician. Then come the district hospitals (96), which are run by a district medical officer (with no specialist qualification).

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Lastly, come the peripheral hospitals (94), which are staffed either by a single doctor working alone or assisted by an apothecary or by an apothecary alone, who receives only partial medical training. The distribution of the larger hospitals in Sri Lanka is shown in fig. 2. The north and south east, which have few large hospitals, are sparsely populated.

FIG. 1—The tiered hospital structure in Sri Lanka.

FIG. 2—Distribution of teaching, provincial, and base hospitals in Sri Lanka.

The Service Load

About 70% of the population live in rural areas where the smaller hospitals are located. These hospitals, therefore, carry the major service load. In 1970, of 28.4 million people seen in all outpatient departments 76.6% were seen in the district hospitals and smaller units. These centres also contained 52.8% of the 32 885 available beds. The major problem in Sri Lanka, as in many other countries, is the employment and retention of doctors in the smaller hospitals, the vast majority of which have only a single doctor. Any programme for continuing medical education must provide some form of training and "contact with medicine" for the doctors in these small, isolated units.

Existing Programme

The newly qualified intern is compelled to join the Government

Health Service.⁴ He is offered a resident appointment in one of the teaching hospitals or in a provincial hospital, this being determined by his preference and his position on the "merit list" (compiled according to his performance in the final M.B., B.S. examination). There is no organized course of instruction for the interns, even in the teaching hospitals. At the end of the year of internship all except a few at the top of the original merit list are sent to peripheral hospitals. This is an anomalous procedure not peculiar to Sri Lanka, in which it is considered necessary to keep those who have gained distinction under the further guidance of senior staff, and satisfactory to send those who have barely "scraped" through the final examination to fend for themselves in a place where what little knowledge they have is rapidly lost in the isolation in which they find themselves. Any suggested scheme must correct this.

A major defect is the importance attached to the performance in a single examination (the final M.B., B.S.) in determining the career of a doctor, especially with regard to specialization. For one who fails to "shine" in this examination, which may be determined entirely by chance, the possibility of obtaining a postgraduate degree is irretrievably lost, however competent he may become.

A second major defect is that what little postgraduate instruction there is, is available only in the teaching hospital in Colombo, resulting in a reluctance to work outside the city, frustration in the peripheral hospitals, and attempts to "escape" from the periphery by any means. This again is common to many developing countries. A proposed scheme must attempt some form of decentralization of available postgraduate instruction, so that doctors in the peripheral hospitals do not feel isolated and have some access to postgraduate instruction. One way to escape from the small peripheral hospital is by emigrating to a developed country. The inability to further one's education is a major factor responsible for emigration¹ and far outweighs any other consideration. Of 197 young immigrant doctors in Canada 74% claimed that they had gone there to acquire advanced training.⁵ Those unable to escape lead a life of frustration and disinterest in their work, thus contributing to the inefficiency of the health service.

The door to postgraduate medicine abroad is open only to those who pass either the Ceylon M.D. (an examination on the same lines and of the same standard as the M.R.C.P.(U.K.)) or one of the primary examinations for a British diploma which are held in Sri Lanka. As would be expected, most of those who succeed do so from appointments held in the larger hospitals, where facilities for study are available. Despite success in these examinations no doctor is allowed to leave Sri Lanka for five years after qualification.⁴ In such a situation, where the young doctors are virtually incarcerated, it is mandatory for some form of postgraduate instruction to be available during the most receptive period (the few years after the qualifying examination).

Those who go abroad are usually sent to Britain to complete the examination that they have partially passed. They are sent for the examination rather than for training. The result is that as soon as they pass they are recalled to Sri Lanka as "specialists." There is little doubt that doctors from developing countries benefit from a period in a developed country, but it should be spent in specialist training—for example, as a registrar and senior registrar—rather than in attending a series of postgraduate courses specifically aimed at success in an examination.

Basis of Suggested Scheme

Any new scheme must not only provide for postgraduate instruction but must do so in relation to the service requirements of the country, the available talent (both teaching and taught), and the budget of the country. The major service requirement in Sri Lanka is the staffing of the peripheral and district hospitals. Small hospitals, especially those staffed by a single doctor, should be manned by the more experienced rather than by the

less experienced. It is unrealistic to suggest that each of these small hospitals should have a programme of postgraduate instruction. Nevertheless, unless there is some access to such instruction all but the most unenthusiastic will be reluctant to staff them.

Specialist staff who work outside the larger hospitals (in both developed and developing countries) are relatively under-utilized from the point of view of teaching. Developing countries, already victims of the brain drain, cannot afford this waste of talent. A scheme aimed at decentralizing postgraduate training will not only utilize this talent but will also tap the considerable amount of trainable talent outside the larger hospitals and ensure that working in a small hospital is compatible with continuing one's education.

The cost of the scheme must be weighed against the financial loss caused by doctors emigrating. It is false economy to save a few thousand rupees on books and journals and lose one's best doctors trained at a colossal cost to the State.

The Scheme (fig. 3)

INTERNSHIP

Generally the intern appointment as it now stands is satisfactory. Nevertheless, some form of evaluation of the suitability of consultants and the nature of their work for the training of interns is desirable. Appointments with not enough supervision or too much would be better manned by a post-intern than an intern. Hospitals to which interns are sent should be the large hospitals where there are enough consultants to enable a reasonable programme of postgraduate instruction to be organized.

FIG. 3—Proposed scheme for postgraduate appointments.

POST-INTERN PERIOD

At the end of the internship all the newly registered doctors irrespective of their performance in the final M.B., B.S. examination should be sent to a base hospital staffed by a physician, surgeon, and obstetrician. They should be encouraged (but not compelled) to rotate among these specialties. The base hospital should have a basic library and provide some organized teaching, which, because of the shortages of staff in these hospitals, could be supplemented by visiting staff from the nearest provincial hospital. The period at the base hospital would not only provide time for basic training but would also provide an opportunity for assessing the suitability of the doctor for further training. After two or three years at the base hospital the doctor should be given a choice of (1) moving to a smaller hospital—that is, a district or peripheral hospital (2) moving into preventive medicine; (3) going into general practice; or (4)

specialization, which would mean moving back to a larger hospital. These who opted to specialize should have a consultant opinion on their suitability based on their two or three years at the base hospital, which would afford ample opportunity for such an assessment. Most would go to the smaller peripheral hospitals, where there would be no organized teaching. These units should be “tied” to the nearest base hospital, and the doctors sent to these small units should be encouraged to continue their association with the teaching programme at the base hospital which they have just left. Sri Lanka has a good system of roads, even to remote areas. Transport for the doctor could be provided, say, once a week, by the hospital ambulance, which would also provide an excellent opportunity for the transport to the larger hospitals of problem cases for consultation with more senior staff. This would also decrease the inpatient load on the larger hospitals and effect better utilization of the peripheral hospitals.

After two years in the peripheral unit the doctor should be given the choice either to continue in a small unit or revert to a larger hospital—for example, a provincial or teaching hospital—and continue his education. Some doctors are quite happy to continue working in a small peripheral hospital so long as they do not feel “trapped.” The suggested scheme ensures that those who remain at the periphery do so by election, which would result in a satisfied profession, which in turn would make a positive contribution to health care.

The provincial hospitals should have a more advanced course of postgraduate instruction than would be available in the base hospital, assisted when necessary by members of the teaching staff of the two university teaching hospitals. But however good the course and however excellent the teaching, postgraduate medicine cannot be learnt unless such medicine is practised on the wards. It is, for example, futile to teach that a woman of 20 years with a diastolic blood pressure of 140 mm Hg needs investigations to exclude an underlying cause, if all that is actually done on the ward is stabilization of her blood pressure. During May 1971 to April 1972 Sri Lanka lost more than 100 doctors, which is more than the entire output of one medical school.⁶ The financial loss must be several times the cost of providing a reasonable course of instruction in postgraduate medicine.

During their stay in the provincial hospitals doctors should be encouraged to sit the local postgraduate examination, on the results of which they would be selected for further training abroad.

Training Abroad

A certain amount of postgraduate training can be done in some developing countries such as Sri Lanka which still have some well-trained doctors left. Nevertheless, they have neither the men nor the resources to have a comprehensive course of instruction as is available in developed countries. The question often asked is whether such advanced instruction is necessary for those who work in these countries. An important point in favour of such instruction is that unless there are some doctors who are aware of the ideal we shall never know how far away from this we are, and as a consequence no improvement in the health service will occur. Against giving such instruction is the possibility that acquiring such knowledge results in frustration and, possibly, an increased desire to emigrate. Despite this risk we are strongly opposed to the lowering of the standards of medicine which would undoubtedly result if Sri Lanka were to become more insular than it is geographically. There is little doubt that doctors from developing countries benefit from a period (of training) in a developed country just as much as doctors from developed countries benefit from a period (of experience) in a developing one. The primary purpose of such an exchange must not be lost sight of or confused with success in an examination.

If Britain and other developed countries are to make a real contribution to medicine in developing countries they can do no better than accept some of the doctors from these countries, if

possible on an exchange basis, where the accent is on work rather than an examination. At the end of three or four years of such work in a developed country, part of which could be spent in a specialized unit, the doctor would return home a true specialist, rather than one who has specialized in the art of passing an examination. On his return the specialist could be sent to the larger hospitals, where he could join in the postgraduate training programme and undertake the training of others.

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Hospital Topics

Excessive Use of Psychiatric Services by Suicidal Patients

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Summary

The use of psychiatric services by patients with a suicidal history was examined to see if they placed a greater long-term burden on these services than other types of patient. Suicidal patients spent significantly more days in hospital and made more outpatient attendances; suicide attemptors in particular not only needed more emergency consultations but also spent more days in hospital. A more economical yet more effective treatment policy for the suicidal patient is needed.

Introduction

The increasing numbers of admissions due to self-poisoning or self-injury ("attempted suicide") represent a considerable work load for general hospitals.¹⁻⁴ Less attention has been paid, however, to their effect on the psychiatric services; these are required to provide screening for all such admissions⁵ and two-thirds of the patients are subsequently referred for psychiatric treatment.⁶⁻⁹ A survey of an American state psychiatric hospital¹⁰ showed that 6.5% of patients had attempted suicide shortly before admission and Woodruff *et al.*¹¹ noted a history of attempted suicide in 14.2% of a psychiatric clinic sample. A more recent survey in Oxford¹² showed that one in every 11 inpatients or day-patients had attempted suicide over a six-

month period—a rate of 8800 per 100 000 patient population. General population surveys, on the other hand, show a much lower rate of attempted suicide—364-600 per 100 000 per year.^{13 14}

Though many would consider most suicide attempts to represent an appeal for help^{15 16} or care¹⁷ it has not been conclusively established whether those who do attempt suicide actually seek or require more psychiatric "help" than those who do not. Evidence from follow-up studies confined to relatively short periods after a suicide attempt¹⁸⁻²⁰ shows that about 27-64% of attemptors fail to make further contact with a psychiatrist. On the other hand, psychiatric patients with a history of attempted suicide have had more previous psychiatric illnesses²¹ or hospital admissions¹¹ than those without.

By using patient contacts obtained through a cumulative psychiatric case register we attempted to test more directly whether suicidal history was associated with a greater burden on psychiatric services. We confined the study to patient contacts over a defined period, considered only those service contacts which were systematically recorded, appraised comprehensively the use of services by including not only inpatient care but also outpatient and emergency contacts, and examined groups which were comparable on several important variables.

Method

The original sample, from which our sample was derived, comprised 6795 referrals from 1963 to 1967 aged 20 or over obtained from the north east of Scotland psychiatric case register.²² A subsample of 575 patients, for whom additional psychological test data were available, had been extracted to examine the personality characteristics of suicidal patients.²³ This smaller sample was comparable to the original one in age, sex, and social class. While reviewing the case records of this subsample for evidence of suicidal acts or communications certain clinical items were also noted, which formed the material for our study. This investigation resulted from the fortuitous observation that the suicide attemptors seemed to have the bulkiest case records. This additional information was collected in 1974, thus providing the opportunity to include data from a further period ranging from seven to 11 years.

Evidence of suicidal acts or suicidal communications recorded at any

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