SHORTAGE OF MEDICAL OFFICERS IN THE GOLD COAST

BY

IAN FRASER, D.S.O., O.B.E., M.D., M.Ch., F.R.C.S.

Earlier this year Mr. Fraser visited the Gold Coast at the request of the Council of the B.M.A., which had been considering the desirability of forming a Gold Coast Branch. In this article he describes the medical problems of the colony.

The present shortage of medical officers in the Gold Coast is causing anxiety, both in the colony itself and at home. There is a shortage of men in all branches of medical practice—shortage of medical officers for out-stations and for the medical field units, and shortage of specialists. These posts have in the past been filled partly by Africans trained in the medical schools in the United Kingdom, and the cost of this has been borne mostly by the Gold Coast Government, with the understanding that when qualified they would return either as junior medical officers, or, possessing higher qualifications, to fill some of the many specialist posts available. The result has been a little disappointing. Some of the men who have qualified in the United Kingdom have decided to stay here. Others have returned to the Gold Coast, but have soon left the service to take up the more lucrative private practice; and so the colony as a whole has not benefited to the extent that was hoped for. Very few have become specialists, because few of the senior specialists have the time or the facilities to introduce the young men returning to the colony to more advanced surgery or medicine, and so give them the basic training in a specialty that would later require only a short postgraduate course in the United Kingdom to enable them to obtain a higher degree.

Help in Qualification

Since 1948, with an increase in trainee specialists in the United Kingdom, as many as 400 candidates at a time may have attempted to pass higher examinations like the F.R.C.S. and M.R.C.P., with the possibility of 40 to 50 of them getting through. Obviously the chances of passing for young medical officers trained in the colony were diminished in the face of such stiff competition, though this state of affairs may be passing off now. I feel that something must be done to help the African student and doctor to become well qualified. There should be no question of lowering standards, but facilities should be improved. In England the facilities remain constant and are always available; but they are expensive and demand time. Therefore teaching in the colony itself must improve, and this means more teachers and more specialists, and hospitals which cater for a wider range of specialties.

The average hospital in the colony to-day consists of surgical wards, medical wards, a maternity ward, and a children's ward. The medical staff varies in quantity and quality. In some instances there may be only one medical officer capable of doing routine surgery, and he may be also responsible for dealing with gynaecology and complicated midwifery. The average list includes such cases as hernia, hydrocele, trauma, sepsis, ectopic pregnancy, hysterectomy, etc., and one surgeon has just completed a series of 150 operations for vesico-vaginal fistula. Another, a young African, had performed 97 caesarean sections within a few months. In one area two extrauterine pregnancies have to be dealt with every week. It will thus be seen that there is ample opportunity for practical experience.

The European or expatriate doctor starts at an advantage. He has found the examination in the United Kingdom easier and begins at a younger age. It is also easier for him to return on study leave and work for higher

qualifications. Therefore up to now the majority of the specialist posts have been filled by expatriates. Even so, there have always been too few of them; they have been so busy with routine work that teaching and organization of a department have been impossible, and, with the shortage of junior staff, no young doctor is left long enough in a potential teaching centre to get trained. After a brief stay he is hurried off to a district station where the need for his services is great; once there, his chances of specialization are increasingly difficult.

The expatriate specialist becomes more valuable to the colony the longer he stays there. He may in time have to maintain a home in the United Kingdom so that his children may be educated there; and this is costly. With the increased cost of living in the Gold Coast, these senior medical officers and specialists are finding their salaries insufficient, and many are tending to leave the service. It is most important something should be done to halt this tendency, and immediate replacement must be found when they do go.

In the next ten years the Gold Coast will experience one of the most interesting and dramatic expansions in its history. Money is being spent lavishly in many necessary projects—a new town, a new harbour, the Volta scheme, a new university, and a new hospital costing £5,000,000 for its 510 beds. These and other schemes will cost in the region of £144,000,000. This gives some idea of the expansion. Yet at the moment there are three surgeons for 4,500,000 people, one gynaecologist, no eye specialist, no ear, nose, and throat specialist, no dermatologist, no tuberculosis specialist (tuberculosis is very prevalent), no anaesthetist, no paediatrician, no orthopaedic specialist (yet injury is becoming increasingly more frequent, and will become still more so with the new mechanization). Yet at home here in Britain there are some 60 to 70 candidates for every hospital appointment; at a recent appointment there were two applicants—specialists—actually drawing unemployment benefit. What a contrast! And what wasted opportunity!

In a letter to the *Lancet* of April 11 this year a registrar wrote this: "There must be many hundreds of us throughout the country, growing yearly more hopeless, a stagnant pool of cheap specialists, deliberately created by the National Health Service. A great many of us have been qualified for ten to fourteen years, but we are paid less than a newly settled general practitioner. We are liable to dismissal at short notice and at regular intervals. We can settle nowhere and we can plan nothing. It is obvious that we cannot all become consultants overnight." But there are parts of the world where opportunities and vacancies are waiting, and the Gold Coast offers these to-day. Though one may sympathize with these young men it is difficult to understand the attitude of those who would rather do nothing and starve at home than go abroad and practise real medicine, with unrivalled opportunities for experience.

The man willing to do this must be of the right type; his integrity must be beyond question; he must be able to improvise, to turn his hand to anything. As a surgeon he may in the course of an afternoon have to remove a ruptured spleen, deal with an ectopic pregnancy, sew up or amputate a leg bitten by a crocodile, and perhaps repair a deep stab wound. An elephantiasis of the scrotum touching the ground may be thrown in for good measure. If he has a wife with the pioneering spirit—one who is a good companion as well as a wife—he will be doubly fortunate.

Reasons for the Shortage

Why are not enough British doctors going to places like the Gold Coast? One reason is that Africanization is going to exclude them from some of the higher positions. Certainly this will happen in time, but at the moment the question does not arise. It will be long before there are enough senior Africans of experience to take all the jobs in the various specialties and also fill the higher adminis-

trative posts. The obvious need in the Gold Coast is to increase the number of specialist posts and fill them with people of integrity and ability, with the skill to teach the younger generation and so build up a lasting service—the specialist at the top, the medical officers below, in training to become specialists, and dispensers, sisters, nurses, etc., all trained to a higher level. The standard of work in hospitals will rise, and the hospitals become recognized as suitable for the training of medical students. Only when all this happens should the Gold Coast consider forming a medical faculty. Certain back-benchers, with little knowledge of facts, may press for the early formation of such a faculty. It would be just as valuable as a Rolls-Royce car with no one able to drive it properly.

In the Gold Coast, therefore, the specialist service is priority No. 1. In the United Kingdom the men are available, but the colony must make the conditions attractive. In every country there is always the difficulty of paying for one service more than for another. Why should the doctor get more than the engineer? It is clear, I think, that he should. He spends himself more, his daily responsibilities are greater, he gives a 24-hour service, and he is doing more than curing an individual life—he is making a permanent service.

As I have pointed out, when the specialist is at an age to give his best to the colony his home commitments are unfortunately at their heaviest, and often that is the stage when he retires, as many are threatening to do at the moment. Some attraction must be offered these men, especially during the next ten years. If the present service deteriorates further it will be difficult to build it up again with new people. Better pay and some security of tenure, or compensation, would attract better men and women.

Appointments Available

The appointments in the Gold Coast are very varied: a medical officer of health to a port authority; a doctor to a bauxite mine, a diamond mine, or a gold mine; a specialist in every branch of medicine; a practitioner in a town; a practitioner in a country station; or, best of all, a bush doctor, with a shot-gun and the midwifery forceps both kept at the "ready" in the back seat of the car. At the moment there are many attractive short-time contracts whereby one can see the country. Having recently revisited the colony after an absence of ten years, I found that in the interval progress has been equivalent to that of 50 years at home.

But the shortage of doctors is being made good in a makeshift manner. Many areas are without a qualified doctor, and dispensers and dressers are doing the work, with perhaps a call every few weeks from the medical officer at the nearest station. This is a sad state of affairs. It is bad medicine and is dangerous: it is putting power into the hands of untrained and sometimes unscrupulous, greedy people. It is hard to be critical, as the gaps have to be filled. Some are allowed to practise with degrees of doubtful validity, and, finally, there is a tendency for the foreign doctor to infiltrate—Poles, Swiss, Germans, some stateless. One is not in a position in all cases to criticize their medical ability, but most of them have not the same interest in the Gold Coast as has the British doctor, with his long connexion with the colony: the interest of the former in the colony is that it affords a good living, but they give little in return in the way of teaching or in building up a service.

Conclusion

The next few years will be critical. The future of the medical service of the colony will depend upon whom we send out. The present service, its link with teaching, and its improvement in hospital work, will make up the foundation of the medical school. With the eventual formation of a medical school real Africanization of the service can be envisaged. Till then, promotion, if it is to be fair and if the appointments are to carry respect, must be made through merit and experience, and by no other way.

NOBEL PRIZE

(Walter Stoneman, London)

Professor H. A. Krebs, director of the Medical Research Council's Cell Metabolism Unit at Sheffield, who has been awarded the Nobel Prize for Medicine jointly with Professor F. A. Lipmann, of Harvard (see p. 984).

SEVENTH INTERNATIONAL PAEDIATRIC CONGRESS

[FROM A SPECIAL CORRESPONDENT]

The Seventh International Paediatric Congress was held in Havana from October 12 to 17 under the presidency of Professor Felix Hurtado. The opening ceremony was performed in the House of Representatives in the beautiful National Capitol Building on Columbus Day by President Batista, who gave a moving address on the need for child care. The British delegation of twelve was led by Dr. Bernard Schlesinger, President of the British Paediatric Association; Professor Alan Moncrieff represented H.M. Government. Nearly 50 countries were represented, and altogether nearly 2,000 registrations were made.

Epilepsy in Childhood

The first plenary session was devoted to epilepsy in infancy and childhood. Professor C. H. ALSTRÖM (Sweden) dealt with genetic problems, stressing the fact that acquired causes were more important than heredity factors. He emphasized that the risks in marriage as regards transmitting epilepsy were of the same order as for the majority of the population, provided that the affected parent was of normal mentality. Professor I. MCQUARRIE (U.S.A.) traced the story of water balance in relation to epilepsy from the discovery that dehydration reduced the number of fits, to the modern use of deoxycortone acetate as an adjuvant to drug therapy. Professor M. A. PERLSTEIN (U.S.A.), in a review of drug treatment, gave much wise advice. There was "more to it" than drugs in treating epilepsy. It was better