MULTIRACIAL GENERAL PRACTICE IN NAIROBI

BY

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Multiracial general practice in Nairobi can be quite a difficult affair for any newcomer not acquainted with Africa and the Orient; for, apart from knowledge of general medicine and even specialized tropical medicine, there are many factors which govern the healing art. The chief of these factors in a multiracial society is the knowledge of the peoples themselves in relation to disease. In Nairobi, poverty, ignorance, and superstition play a very important part, in contrast to England, where they are practically negligible.

In the practice of medicine in a multiracial city, among peoples of diverse races and creeds, with cultures of different social and economic strata, one has not only to know these patients of different races and tribes as individuals, but also to know them in relation to their tribal and racial background. Mere expert medical knowledge will not suffice.

The European Community

The European population, consisting of people from the United Kingdom and the rest of Europe, are more or less in a privileged position both economically and medically. They have a medical system which is as good as any in Europe, and there is no poverty, because there is practically no unemployment and wages are high. With them, therefore, medical practice is the same as in Europe.

A Complex Community

The Asians form a very complex group of peoples, consisting of Hindus, Mohammedans, Goans, Arabs, Seychellois, and Somalis. The Hindus make up 52% of this group, and are subdivided into Sikhs, Punjabis, Marathas, Cutchis, Banniahs, and Patels. With the exception of the Sikhs, they are generally vegetarians, and much of the disease among them is due to poor nutrition, particularly among the women, whose diet is totally inadequate, thus producing avitaminosis and anaemia.

Overcrowding is general. I have often seen a family of six, eight, or even ten living in one room, using tiered beds like bunks in a ship. It is not to be wondered that members of the family are constantly ill. I was once called to attend a case of obstructed labour. The patient was in a little tin shed, which consisted of a single room where 14 people had been living. The woman in labour was not 30 years old, and she had already had six children. This was her seventh baby. I had to rotate and apply forceps with the aid of two small electric torches and an open-flame nightlight while my wife gave chloroform.

The Patels, Banniahs, and Cutchis, although sometimes quite well off, are particularly guilty of living in overcrowded premises, because they love to amass money. They are vegetarian, and even in the severest cases of anaemia they refuse liver injections and any form of meat or fish extract by injection or orally.

The Sikhs are very fond of drinking milk and sometimes, in contrast, brandy, each drink of which consists of four to five fingerbreadths at a time and as much as over a bottle a day, with the inevitable consequences.

The Mohammedans can be divided into the Orthodox Muslims and the Khojas, who are the followers of His Highness the Aga Khan. The latter group is very well off both economically and medically. This is due to a very

wise economy in the community, with highly organized business, and also extensive free medical services among themselves.

The Orthodox Mohammedans are not so advanced as the Khojas and their economic standard is lower. Their women-folk suffer from lack of air and exercise, because, owing to the custom of purdah, they are mostly confined indoors. Some of them wear garments like huge tents, called birlahs, when they step out of their homes, so that no man may see their face or figure. These birlahs are cumbersome and shut out the light and air, causing these women to have an unhealthy pallor. These people are very fond of extremely greasy and rich food, which is apt to produce dyspepsia and obesity. They prefer Christian doctors to any others, sometimes even in preference to one of their own faith.

The Goans are a unique group. They are devout Roman Catholics and have been so for the last four centuries. With Roman Catholicism they have assimilated some Portuguese culture, and so are more westernized in their ways and outlook than the other Asians here. Medical practice among them is mostly confined, apart from the usual common ailments, to nutritional disorders due to their limited diet. This consists of rice, curry, fish, and overcooked meat, which is very oily and highly spiced; it causes dyspepsia and poor development of children, who tend to be undersized and rachitic, sometimes showing extensive dental caries. I have seen one case of acute pancreatitis following a heavy drinking bout on a saint's feast day. Venereal disease is very rare, and I have treated only one case in eight years.

The Arabs and Swahilis live mainly in the coastal areas, but sometimes settle in Nairobi. They are Mohammedans who deal in skins and hides. Consequently one sees anthrax and a variety of skin diseases among them. They are very susceptible to venereal diseases. I have seen them with chancres and gonococcal discharges as well as other venereal granulomatous diseases of the genitals, anus, rectum, the armpit, groin, and even the navel. It seems that male and female prostitution is quite the accepted thing.

The Somalis are the most backward of this group of peoples, because they have no written language of their own, and very few of them can read or write any language at all. They are mostly cattle-herding nomads in the country, and garage hands when living in the city. They are notoriously addicted to the drug myrrha, which helps them to live on a very meagre diet. They are very quarrelsome, and often inflict injuries on one another which need medical attention. Jealousy, combined with hallucinations from too much myrrha, is a potent factor for crime, such as cutting the nose and ears, or slitting the genitals of a wife who is suspected of unfaithfulness. They are strict Mohammedans. I had a woman brought to me from a district 30 miles away for tooth extraction, when she was very ill from haemorrhage due to difficult labour caused by locked twins. When I suggested to the relations that I would like to treat her for this condition first, they declined emphatically and told me that midwifery was not a man's business at all, even if he was a qualified doctor. I was told later that the woman died, and that her relations shrugged their shoulders and said that it was the will of Allah.

Because they are Mohammedans, the Somalis often ask the doctor to circumcise both males and females. In the case of the females this is done by either removing the labia minora alone or the labia minora together with the clitoris. I always advise them to have only the labia minora removed and to leave the clitoris alone.

Since they are a turbulent people, they will sometimes commit murder with knife or poison. The seeds of *Datura stramonium* ground and mixed with coffee are often used. Therefore one has to be particularly careful when they state that a patient has died at home miles away from Nairobi, or even in Nairobi sometimes, and that they need a death certificate. I had a Somali come to me for a certificate of death for a man I did not remember treating within a month. He insisted that I had treated him for this last

illness, and as proof produced a bottle of medicine with my label on it. The date on the label showed that the medicine had been dispensed three years before. It was just as well that he was illiterate.

The Seychellois come from the Seychelle Islands, in the centre of the Indian Ocean. They are of mixed European and Indian Oceanic descent. They are generally poor. The males work in the garages and the females as nannies during the day. At night they supplement their income by other means. One often sees congenital syphilis among them.

Asian Languages Spoken.—It will be seen from the above description that one must know more than English to treat these peoples. The other languages required are Hindustani, Gujarati, French for the Seychellois, Portuguese and Konkani for the Goans, and Swahili for the Arabs and Somalis.

The African Community

A large proportion of a multiracial practice in Nairobi must needs be African. It is in this group that one really sees disease at its worst. Any medical student who has the chance to see this aspect of general practice for only a few weeks would acquire knowledge and experience he would never forget.

These patients sometimes travel hundreds of miles to see their chosen doctor, and, in his absence, will wait patiently for him, refusing to see any other doctor even if supplied free by the Government. They will sometimes walk into my surgery with a double pneumonia or a septic abortion *in extremis*, and to one's surprise recover against all odds.

There are many African tribes. The lingua franca of all the tribes is Swahili. The largest group is composed of the Kikuyu, Meru, Embu, and Wakamba tribes. All of them speak Kikuyu or a variation of Kikuyu with their tribal dialects.

They are Bantu-Hamitic and so practise circumcision of both men and women, the same as the Somalis, although they are not Mohammedans. The important thing is that circumcision is always performed by the elders, male and female circumcisers; never by anybody else, not even a qualified doctor. It is only when the wound becomes septic or refuses to heal that they will consult a doctor; but sometimes they come for trimming or repair because of excessive mutilation.

All these people are extremely superstitious and addicted to witchcraft. It is only when the witchdoctor has failed with his tricks—and one of them consists of making tiny cuts with a small sharp knife on the skin of the part he thinks diseased—that they come to the city for treatment. If the patient is cured then all is well. If not, then they will blame the doctor's injection and medicine for any trouble that may occur.

The Wakamba are a tribe who use poisoned arrows when hunting game. The poison is a decoction of the leaves, flowers, and twigs of a shrub called *accacanthera*, which grows wild in great abundance, and contains a very lethal cardiac glucoside. These people file their teeth into fine sharp points. Eventually caries invariably destroys these teeth, leaving only the stumps, which become septic. The Wakamba will go only to a qualified doctor for removal of these stumps, and to no one else, because, since their witch doctor, who is called a "Muganga," originally filed these teeth, only another Muganga, although a foreign one, has the right to take them out and treat them.

This also applies to the Jaluo, a Bantu-Nilotic tribe inhabiting an area round Lake Victoria, with Kisumu as its main town. They do not practise circumcision, but they remove the lower incisors and canines. Removal of their teeth is not easy, because these are large and very strong, much stronger than those of any other people whose teeth I have removed.

The Baganda are from Uganda, and among them venereal disease is very extensive, because sex is their greatest cult. So much is this so that the women enlarge

their labia minora to four or five times their normal size by stretching them regularly from childhood onwards. These people often need special treatment to the labia minora, which become infected.

The Masai, who are a cattle-herding tribe, are very susceptible to pneumonia because they do not adjust themselves to the variations of temperature, which sometimes amount to as much as 30 to 33° in 24 hours. The Masai women are very fond of ornaments. They will cover both arms with bangles of different varieties. I had a woman come to me for treatment of severe burns of the whole of the right forearm, caused by celluloid bangles which had caught fire when she was cooking on a charcoal brazier.

All tribes invariably suffer from malaria, and it is quite common to see small children with enlarged spleens, sometimes occupying quite a large part of the abdominal cavity. The Wakamba suffer from kala-azar, which also produces enlargement of the liver and spleen. They get pneumonia and secondary anaemias quite easily, and it is not uncommon to see them with deep chronic ulcers on their legs. The children are pot-bellied owing either to helminthic disease or to the maize diet.

Factors Governing Treatment

As I have said, these people will travel enormous distances to consult their doctor. They arrive in the city in the morning and leave by 4 o'clock in the afternoon. One has therefore to do as much as one can for them, in the minimum of time and for very little money, for the average African cannot afford the fare for frequent visits, and can pay for only one or two consultations. He must have treatment that will either cure the disease or tide him over till his next pay-day. As a rule, they will not take any medicine which did not come from the surgery of the doctor himself, and will often demand that he administers the first dose with his own hands.

Poverty, ignorance, and superstition hinder and limit treatment. A Sikh child whose arm had been burnt over a charcoal brazier was brought to me. The family have been my patients for many years, but on that particular day I was not available, so the father rushed to another doctor. This doctor called in a surgeon, and between them they decided that the burns needed skin-grafting. They explained this to the father, and told him that they would have to cut the skin from the back of the child. The father immediately picked up the child and ran out of the surgery. He contacted me later, and told me that he could not understand treatment which made one injury into two. This shows that one must know one's patient and his mentality.

Superstition can be a very strong factor in hindering treatment. An example of this is the belief that the uvula is the seat of all illness—a belief that will make them refuse treatment for pneumonia or any other disease if the uvula is not cut first. Again owing to belief in magic, the African is very reluctant to give blood for examination, especially if drawn from a vein, lest it be used against him for black magic.

Ignorance affects treatment at the moment, as the African is very easily taken in by anti-European political propaganda. At present the Kikuyu are very averse to being injected, because they have been told that the Europeans are trying to exterminate them and their cattle with injections, and also that the foreign doctors may give them either poison or mere water, according to the instructions received by them from the Government.

Poverty is the cause of spread of venereal disease due to prostitution. It is responsible, too, for disease due to a diet of unsupplemented maize. Poverty is also responsible for helminthic diseases, which are due to lack of hygienic amenities and of finances for treatment.

Discussion

It will be seen that a multiracial practice in Nairobi is quite different from a practice in Britain, where everything

is homogeneous and organized in a welfare State, and where patients have not to worry about paying their doctors. Besides, superstition and ignorance as a hindrance to treatment are practically negligible.

One must know something about Eastern peoples if they are to be treated successfully, because, in the East, truth is regarded as an eccentricity and the process of thought is diametrically opposite to that of the West.

The African medical practice is generally run solely on the clinical acumen of the doctor, with little use of modern accessory aids, for the simple reason that finance, time, and distance make laborious investigations involving highly technical apparatus an impossibility. An African is unable at the moment to cope with the expense of x-ray examination and chemical and pathological tests, since he can barely afford to pay the small fee of the doctor, and also because he comes into the city only once in several weeks for his affairs, which usually have to be completed in a single day.

Because of these factors, a practitioner's surgery is simplified into an office, a sitting-room, an examination-room, and a dispensary. Some practitioners keep a separate room for Africans, because their children soil the floor, and because some of the women, especially the Masai, use mud and castor oil on their clothes, according to ancient custom.

Summary and Conclusions

Multiracial general practice in Nairobi is described and compared with general practice in England.

Factors controlling multiracial general practice in relation to the patient's environment, mentality, and economic status are described and analysed.

Stress is laid on the fact that medical knowledge *per se* would not suffice to handle a large multiracial general practice.

FIFTH INTERNATIONAL CONGRESS ON GEOGRAPHICAL PATHOLOGY

WASHINGTON, D.C., SEPTEMBER 6-10

[FROM A SPECIAL CORRESPONDENT]

The International Society of Geographical Pathology, taking cancer as its subject for study on this occasion, held a successful conference at Washington in the second week of September. The International Congress of Clinical Pathology and the International Association of Medical Museums met at the same time, and the joint organization dealt admirably with some 1,400 registrants. For the preparatory work much credit is due to Professor Robert A. Moore, of St. Louis, and Professor C. Roulet, of Basle, the president and secretary of the executive committee.

There had been some misgivings over the choice of cancer on the grounds of insufficient data, but work had been done in preparation for the conference by national committees in 36 countries, and the 74 papers submitted proved that the decision was justified. Some of the communications set upon a firmer statistical basis geographical peculiarities of incidence and relationships with social and environmental factors which had previously been only suspected. There were also pathological studies from parts of the world where certain uncommon types of cancer seem to occur with unusual frequency, and a few experimental studies and philosophical dissertations.

Gastric and Hepatic Carcinoma

It had been decided to concentrate attention upon cancers of the stomach, liver, breast, uterus, and bronchus, and to each of these was devoted a session at which the papers included a rapporteur's summary of the answers received from national committees to a questionnaire which had been

circulated early in 1953. In the case of stomach cancer the papers did little more than emphasize the great mortality from this cause in most countries and the curious facts that it tends to be higher in northern than southern parts, to be strongly related to socio-economic factors, and to be peculiarly high in certain geographical districts. Although opinions were expressed that dietary differences must account in some measure for these variations, no evidence for this was produced; but from the Netherlands some new statistical evidence was presented for a relationship between stomach mortality and type of soil.

Primary liver cancer in parts of Africa and in Hong Kong was thought to be related with cirrhosis, nutritional syndromes, and clonorchis infestation. In the opinion of the rapporteur it is scarcely possible yet to obtain reliable measures of the frequency of this disease in any country, but careful geographical studies in Africa offer the best prospects of increasing our knowledge of its aetiology.

Mammary and Cervical Carcinoma

Breast cancer was shown to have extremely low morbidity and mortality rates in Japan, and the removal of any doubt about this curious phenomenon was an important step forward to further research. The contrast with frequencies in Western Europe and North America seems much greater than can be accounted for by the higher fertility in Japan, and the prolongation of breast-feeding which is customary there has to be considered as a probable protective factor. Calculations from death rates and statistical researches in England and Wales indicated that the post-menopausal mortality risk tends to be greater among single and infertile married women than among those with children, and to be smaller in mothers of large families than in mothers with few children. Some experimental evidence was submitted that restricting family size in mice, by continuing only a first and second litter descent, increased susceptibility to fibrosarcoma and also increased the time of survival.

Cancer of the uterine cervix was shown by a careful study of the records of nuns in Quebec to be practically non-existent amongst virgins; and further evidence for a low incidence amongst Jewish women was also given. Statistical studies from several countries indicated that the married state in itself, apart from number of confinements, tends to increase the mortality risk from this form of cancer, and also that early sex relations and absence of circumcision of the husband are significant factors.

Bronchial Carcinoma

In the discussion on lung cancer a real and rapid increase amongst men and a statistical relationship with cigarette-smoking were generally accepted; but experimental evidence concerning the latter was admitted to be inconclusive as yet. It was stated that, so far, the only evidence that air pollution may be another important factor came from England and Wales, but nevertheless it was considered that the indications for its importance there could not be discounted.

Little time was allowed for formal comments on the papers, but there was plenty of informal discussion outside the conference rooms, leading in some instances to combined planning of future research with several countries working together. The answers to the questions sent to national committees certainly revealed a profundity of ignorance about real incidence, and the need for a histological classification and clear definition of malignancy. Sufficient good work was produced, however, to encourage those who are trying to remove these defects, to improve cancer registration and death certification, and to pursue *ad hoc* inquiries into relations with genetical and environmental factors in human populations. Scepticism as to the possibilities of endemiological study of cancer received a hard knock, and this perhaps was the most important achievement of the conference.