Proc. R. Coll. Physicians Edinb. 1995; **25:** 260–262

OPPORTUNITIES, PROBLEMS AND SOLUTIONS OF WORKING IN DEVELOPING COUNTRIES: THE TRADITION AND THE ROLE OF THE SCOTTISH ROYAL COLLEGES*

W. A. M. Cutting†, Department of Child Life and Health, University of Edinburgh

Past, present and future of Scottish medicine in the tropics

With regard to service and research in tropical countries, Scotland has a rich tradition, interesting present activities and a hopeful future.

James Lind was apprentice to an Edinburgh doctor at the age of 15. He joined the naval medical service at the age of 23, served mainly in the tropics and nine years later, in 1753, published his *Treatise on scurvy*. He was for some years Treasurer of the Royal College of Physicians of Edinburgh. His finding about the importance of vegetables and fruit for the treatment and prevention of scurvy was accepted slowly, but in the year of his death, 1794, lemon juice was supplied as standard to the ships of the British Navy. There were dramatic decreases in mortality and morbidity and British sailors have been known as 'limeies' ever since. From that time until the present, Scotland has had a rich tradition of doctors providing medical service and performing research in tropical countries, and they include Mungo Park, David Livingstone, Patrick Manson, David Bruce and William Leishman. There have been 11 Scottish Presidents of the Royal Society of Tropical Medicine and Hygiene.

Lest you think the tradition of work and research in Africa has ended, the work of two Fellows of the Edinburgh College in the last decade has been of considerable importance. Donald McLarty, Professor of Medicine in Dar es Salam, is still in Tanzania where his work has laid the foundation of our understanding of diabetes and hypertension in African populations. Harry Campbell with the MRC in the Gambia, researched acute respiratory infection in children and his work has been fundamental to the current WHO policy on the management of pneumonia in children in tropical countries.

Except for London, Edinburgh still attracts more medical trainees from tropical countries than any other centre in UK.

In 1993 almost one quarter of the Fellows of the Edinburgh College resided in either India, Pakistan, Africa or the Far East.

Current international activities of the Royal College of Physicians of Edinburgh

In the last two years there have been 'Visiting Faculties' from the College to Egypt, Kenya, India, Nepal and Romania. Visits are planned to Sri Lanka, Malawi and Jamaica. The 'Faculties' are groups of active physicians and paediatricians who hold seminars and establish teaching, service and research links with medical institutions in tropical and developing countries. The major activity last year was the joint meeting of the College with the Colleges of Physicians and Paediatricians of Hong Kong and a similar venture with the Medical University of Shanghai in the People's Republic of China, which should strengthen links with that important part of the world.

*Based on a paper delivered to the Royal Society of Medicine in London in May 1994.
†Overseas Postgraduate Director of the Royal College of Physicians of Edinburgh.

The Myre Sim Fellowships, of the College, were established by a donation from a Fellow and Edinburgh graduate now retired in Canada. This enables Fellows or Members from UK to visit other countries and physicians and paediatricians from different countries around the world to visit Britain. The Myre Sim Medical Student Fellowships are particularly important since they encourage trainees to spend their elective period in overseas countries and report back to the College. This is a formative experience for many young doctors and a number who are captivated by this challenge go on to provide international service or research during their careers.

The 'Faculty' visits sometimes lead to link programmes betwen UK and overseas countries. The most recent example is the programme between Edinburgh and the University of Medicine and Pharmacy in the Romanian city of Cluj-Napoca. Although not tropical, Romania is a developing country. The College is proud to be able to help, through the good offices of the Senior Fellows' Club and in conjunction with the Scottish–Romanian MedicAid. We will contribute to a programme tailored to the needs of training and services in Cluj.

The College is heavily committed to the Overseas Doctors Training Scheme or the Double Sponsorship Scheme as it is sometimes known. This programme assists doctors, particularly those who have passed the Part I MRCP, to come to UK to gain clinical experience in preparation for the MRCP UK Part II examination. There are new opportunities under this and associated programmes. The MRCP II is also being exported, at the request of the profession in several countries. The whole Part II examination is already being held in Hong Kong at the same time as their own higher qualification. There is the possibility of expanding this concept to other overseas countries, giving young physicians and paediatricians the opportunity to obtain two qualifications at once. As the MRCP (UK) is accepted internationally, they can then come to the UK for specialist training.

There are important changes in service and training in the National Health Service (NHS). The current 'Visiting Registrar' appointments funded by the NHS appear to provide a valuable post-membership training opportunity for overseas doctors. The scheme suits some specialities better than others and has not yet received wide acceptance in medicine and paediatrics. The resources are available and the College is attempting to match the requirements of overseas trainees.

Career structures for UK doctors in international service

In the era of the British colonial empire, and to some extent during its succeeding commonwealth period there were opportunities for UK doctors to work long term in civil, military, missionary or other charitable service in tropical countries. A number of these returned to teach and research at the influential schools of Tropical Medicine in London, Liverpool and Edinburgh. As the number of overseas posts, trainees and the demand fell, the Edinburgh tropical course closed.

For many years the Overseas Development Administration (ODA) of the British Government provided 'top-up' funding for UK clinicians in service and teaching appointments in many developing countries. ODA also supported a programme of Senior Lecturers at the Schools of Tropical Medicine in UK. In the last 5 years, as the Government has pursued a market model of health care

provision, career posts have been cut and the focus is on shorter-term contracts open to competitive tendering. This is producing intensive activity for the achievement of short term goals, but it has largely destroyed the career structure for young doctors who would like to provide longer periods of service to developing countries. There is however, still scope for the most able in the new situation. (For example important contributions are being made by David Nabarro, David Morley, David Bradley and David Warrell.) However, it is certainly more difficult for physicians who have sincere commitment, but not necessarily the highest academic ability, to make long term contributions through overseas work. The ODA has focused on 'development issues', including the improvement of health care management and cost effectiveness in health services for developing countries. Idealistic young UK doctors still want to serve in tropical countries but the prospects are now more precarious and problematical. This is unfortunate since UK doctors have provided innovation and have identified the ways in which scientifically and socio-economically appropriate health services can be established and sustained. A classical example was *Medical Care in Developing Countries—a primer on the medicine of poverty* by Maurice King and colleagues, Oxford University Press, 1966. This both identified the basic problem and suggested a range of practical interventions.

The ODA needs to continue its battle to strengthen health infrastructures and managerial systems in developing countries, but it also needs to recognise that British medical personnel have played, and can still play, a vital role in giving such programmes both direction and credibility.

College contributions in the changing context of international medical service

There is still a great need for international service, accredited training for such work and professional interchange. These can be encouraged and supported by the Colleges. Young trainees need advice about how to use the opportunities, how to prepare themselves for overseas work and how to re-enter the UK medical market place. The Colleges and also the NHS need to give appropriate recognition to work done in developing countries, accepting a significant amount of the time and experience for accreditation. The Scottish Royal Colleges have always had international dimensions. I believe they must still take a lead, innovate, motivate and be supportive at this time of change when inequalities abound.

Proc. R. Coll. Physicians Edinb. 1995; **25:** 263–266

Health Care Worldwide

HEALTH SERVICES IN SAUDI ARABIA

Y. Y. Al-Mazrou, T. Khoja,** and M. Rao†, Ministry of Health, Riyadh, Saudi Arabia*

BACKGROUND

With an area of 2,240,000 sq. km, the Kingdom of Saudi Arabia occupies the major part of the Arabian Peninsula. The estimated population of 16·9 million (1993) are scattered on the basis of topographic favourables concentrated mainly in the cities of Riyadh, Jeddah and Dammam, less than 5 per cent being semi-settled and nomadic. Accordingly, the population density varies from 1–30 persons per sq. km with an average of 7·5 persons/sq. km.

The rapid socio-economic development which has taken place in recent decades has made visible impact on the health status of the population, increasing life expectancy, decreasing mortality rates, changing the morbidity pattern and improving the quality of life in addition to achieving self sufficiency in food production as could be gathered from Table 1.

TABLE 1

Health indices improvement in Saudi Arabia

Indicator	*1960*	*1989*
Crude birth rate	49/1,000	42/1,000
Crude death rate	23/1,000	8/1,000
Growth rate	–	3·8%
Life expectancy	44	70
Infant mortality rate	170	30[1]
Under-five mortality	–	34[1]
Maternal mortality rate	–	16·7/100,000[2] (1993)
Male literacy	15%	70%
Female literacy	2%	38%
Potable water: urban	–	100%
: rural	–	68%

Saudi Arabia is a welfare state wherein the citizen's right to health is taken care of through the development of relevant socio-economic policies in general and health policies in particular. While the state is committed to provide free of cost services to all the citizens, increased involvement of private sector is actively promoted.

Thus, the health services in Saudi Arabia are provided by three distinct sources, viz: (i) Ministry of Health (MOH), (ii) other Government Sectors and (iii) Private Sector. Ninety-eight per cent of the population have access to health services delivered exclusively through the MOH.

*Assistant Deputy Minister, Preventive Medicine.
**Director General, Health Centres.
†PHC Consultant.