

building will provide a health centre, day-care unit, 17 general beds, and 17 maternity beds; the second phase will provide a further 34-bed general ward unit. The whole development is regarded as an experiment and will be made the subject of critical evaluation.

Initially, a pilot experiment was mounted. A small pavilion ward of 15 beds was reopened in a peripheral hospital to serve as a community hospital for the patients of three general practitioners. Experience from this has shown the size of the contribution that can be made to the care of the acutely ill elderly patient, to the care of patients transferred from specialist units, and to the rehabilitation and support of elderly and disabled patients.

The methods of the Oxford Community Health Project have been used for recording data on the population of the catchment area of the new hospital. Use of primary services is being recorded by general practitioners on mark-sense cards; data on in-patient care are available from the Oxford Record Linkage Study. Definition of the three main care groups of patients poses the key questions that are being studied in determining the effectiveness and efficiency of care provided. Three randomized controlled trials are in progress or planned to evaluate the outcome of direct admission of acutely ill patients to the community hospital, a policy of early postoperative transfer of patients from the district general hospital, and a programme of continuing surveillance and treatment in the elderly.

As the results of these studies become available, evidence on effectiveness of care of patients treated in the community hospital may be viewed in the context of knowledge of the population at risk, their demand and use of medical care services, attitudes of patients and the community, resources deployed, and costs.

The Patients of Traditional Doctors. JOYCE LEESON and R. FRANKENBERG (*Department of Social and Preventive Medicine, University of Manchester*)

When a patient seeks the aid of a doctor he wants a cure but he may have other felt needs such as for a convincing explanation of why he is suffering, and these secondary wants may increase in importance if a quick cure is not obtained.

A study of 1,123 patients consulting traditional doctors in an urban setting in Central Africa examined factors in the choice of this particular medical agent in a town where clinics, hospital, and private 'western' doctors were also available. Diseases and symptoms of every body system were found, but the commonest single group was that of infertility and impotence and other urogenital troubles. Many patients had been

troubled for a long time, 40% of them for more than one year. Two-thirds of them had consulted 'western medicine' as their first source of professional advice, and only one-sixth were seeing their first adviser when interviewed.

The reasons for consulting the traditional doctors were sought, and the answers were grouped into four categories (some gave more than one answer). First, the traditionalists who 'believe in traditional medicine' (31%) or 'are against western medicine' (11%): nearly half of them had gone to a ng'anga before consulting anyone else, and 40% of them had been ill for less than three weeks. They had a rather lower educational level than their fellow patients. It seems they had been satisfied in the past with their experience of the traditional medicine of their forefathers and saw no need to try anything else.

At the other extreme were those (38%) who had come because others had failed to cure them. This was a better educated group, and almost all had gone first to a 'western' medical agency, but they had found no quick cure. 57% had been ill for more than three months, and they had had time to wonder if others might not be able to help where western medicine apparently could not. This group included all the known cases of tuberculosis; western medicine had failed to cure them as surely as if there was no such thing as streptomycin, PAS, and INH, because no one had communicated effectively with them.

A rather similar category were those (just under one quarter) who were seeking an explanation for their illnesses. 45% had been ill for more than three months and two-thirds had been first to a 'western agency', and when after all this time and effort they were still ill, they were wondering why. The ng'anga rarely fails to offer an explanation, often of a general nature such as breaking a taboo, and to advise how to put the situation right, giving great relief to patients, whatever the effect of his other remedies.

The last category, also about one quarter, rated convenience highly. As one put it, 'they are all doctors, so I went to one where there are no queues, and it is private'. Two-thirds had recently fallen ill, and of those who had gone to a western agency at first the majority had consulted a private doctor.

It is suggested that effectiveness of medical agencies depends not only on the possession of effective therapeutic agents but also on how far other criteria are met. One of these is convenience, and others, which increase in importance in chronic illness, involve communicating with the patient, attempting to answer his queries, and winning his co-operation for the treatment regime. These criteria may well apply in other parts of the world.