INTERNATIONAL NEWS

Letter from the Himalayas 1: Mountain Clinics

TED LANKESTER

Community Health Physician, Mussoorie, India.

Ted Lankester trained at Cambridge and St Thomas's Hospital. After seven years as a principal in general practice in Twickenham he moved to North India where he is currently implementing a three year community health programme. He is married with three young daughters.

MEDICAL emergencies are of various hues. On this particular day my mountain clinic was interrupted by a cacophany from the concrete verandah above. Clutching my stethoscope I tore past non-queues of waiting patients to be greeted by an amalgam of amusement and panic. Two barely clad female patients were fleeing from the injection room. The cause for this was fear, neither of the nurse nor of the needle. A swarm of excited bees had chosen this inauspicious time to emerge from their hidden home under the nurse's injection shelf. Later in the year a different surprise was in store for us: the dynasty of this errant queen would provide us with sweet Himalayan honey.

Each Monday we hold a clinic in this hill village-cum-trading centre. In summer it basks in pre-monsoon thermals wafting up from the valley below; in winter it is lashed by harsh winds, hail and snow. At such times all but a hardy few retreat to warmer climes at lower levels.

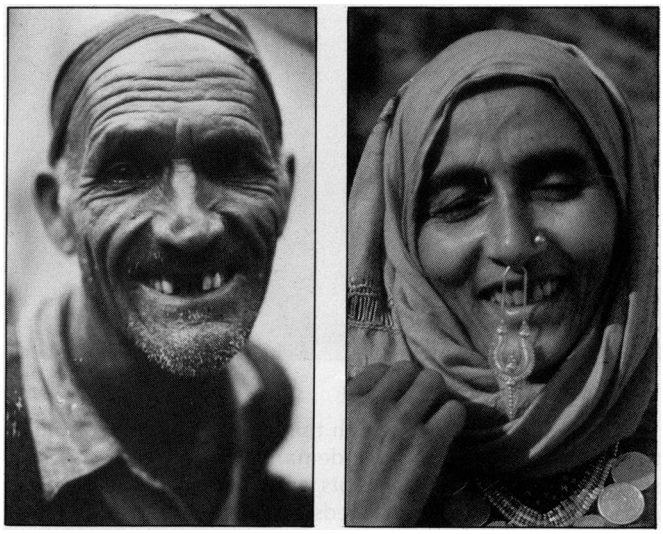
We reach this clinic by a superb mountain road, which, climbing to 8,000 feet, affords glimpses of the mighty Himalaya to our north. If we leave sufficiently early, the enshrouded outlines of lower hills to the east are lit by the rising sun. According to season we may see the rare wall-creeper beaking for insects in crevices, or admire a soaring lammergeir scavenging for the bones of erstwhile mountain goats.

Our six subcentres in this moutainous district provide an embryonic medical service for more than 50,000 people scattered in over 200 villages. Four days each week a doctor or health worker, laboratory technician, dispenser and nurse make the journey by Landrover to each in turn. Often in the snows or rains we have to trek many miles, clear landslides or even construct our own piece of road.

Queues of patients

In our different clinics we see a good mix of the Himalayan equivalent of those who throng general practitioners' waiting rooms in the west. To these are added the queues of patients clutching Amoeba and Giardia-sodden intestines, children plagued with scabies and fungus infections and the coughing, emaciated mountain men innocently showering AFB charged aerosols over their waiting friends.

The most popular symptom, even if not the most serious, is *dant-may-darad*—toothache. Here my colleague has a unique approach. He will lie all the patients down on parallel benches and inject each in turn. The first to volunteer adequate anaesthesia is then relieved of his rotting teeth. The painfree extraction coupled with onlookers' cheers provides effective psychotherapy for any prostrate victims whose courage may have failed them.



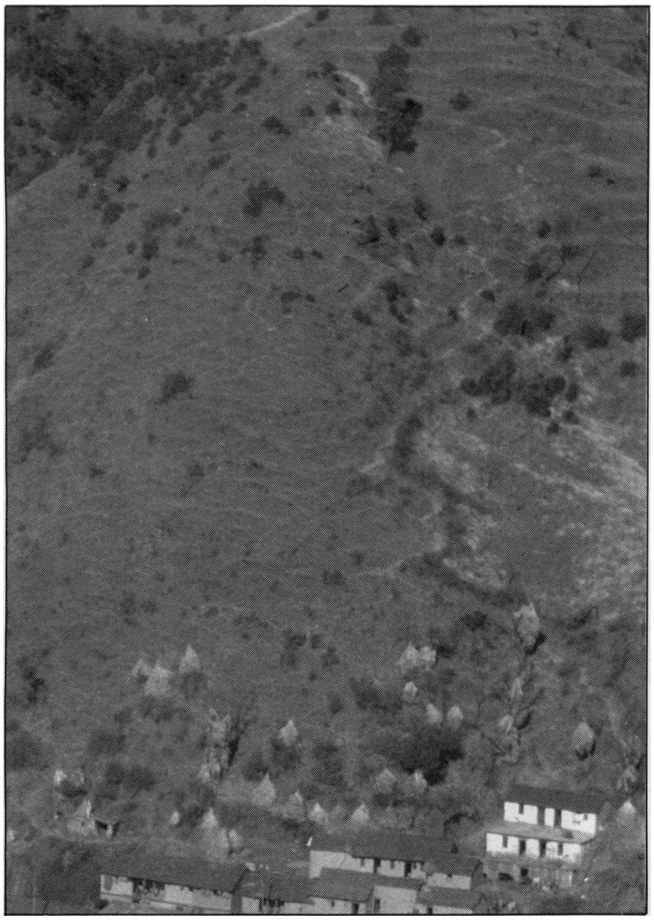
Village people

Differences and similarities

At the end of a busy clinic when I have seen the 32nd patient with 'And Here' syndrome and pulled the 20th tooth I start to compare medical practice here with my seven years as a principal in general practice in suburban London. It is not the differences I muse upon as much as the similarities. The differences after all are superficial: converted potato stores and shops acting as clinics, rather than health centres constructed with the aid of expert architects and the latest design guide: dangling three inch nose rings, which first must be detached and handed to waiting relatives before the pharnyx can be visualized.

Similarities however abound: the shy young man who by demeanour and furtive glance tells me of a recent urethral discharge: the young woman with her medical passport of stomach ache coming to unload her feelings about her petulant mother-in-law: the old man racked by pain and sporting an abdominal mass who whispers with his eyes and in his mountain dialect, 'Doctor-sahib, is it serious?'

For all the abounding human and medical interest we often question the value of the facilities we offer. It has been said after all that providing curative services for the rural poor is like trying to empty the Atlantic Ocean with a teaspoon; that the main beneficiary of the exercise is the doctor's sense of service, while the patient, cured only briefly, soon reattends with the same problem and for the same pills.



A steep climb to the road

Although I sympathize with this view, the doctor's role in the care and cure of the sick demands no apology. Also, in a society where health concepts are poorly understood, it is essential to meet the felt needs of patients before they will mount sufficient trust to accept such exotic theories as prevention and self-help.

This is nowhere more important than in areas such as these where many factors conspire to make the provision of health care difficult and its acceptance poor. Villages and hamlets lie scattered over hundreds of square miles, linked only by rough tracks and dizzy paths. Monsoon rains and winter snows isolate whole communities for weeks or months each year. Patients may live hours' or even a full day's walk from the nearest road or subcentre. Such remoteness has in turn bred suspicion of outside aid so that help provided is often spurned. Even state medical services, despite well laid plans of providing primary health centres, dispensaries and basic village health worker training, find it hard to recruit personnel prepared to give consistent service.

The net result is this: villagers falling sick are most likely to attend a local priest, healer or midwife. Whereas this group undoubtedly includes an untapped resource of appropriate care, its integration into a health care system has yet to be realized.

Such varying factors make it imperative to set up effective curative services. These alone can establish bridgeheads into communities so that appropriate care at village level can be developed.

Bottoms up or trickle down?

It is helpful at this stage to distinguish between two apparently conflicting models of health care provision, the village-based or 'bottoms up', and the hospital-based or 'trickle down.'[1]

Trickle down health care is seen at its most classical and inappropirate in the unmodified western style health model, originally bequeathed to many excolonial countries. Here the centres of excellence were saturated, district general hospitals doused, primary health centres sprinkled, leaving but few drops of distilled medical wisdom and expertise for the needy periphery.

The bottoms up approach, in contrast, starts with the villager himself. On falling ill he is trained first to draw on his own resources. In this he may be guided or even treated by a locally elected village healthworker. In turn she may refer him to the subcentre or hospital if his problem is beyond her competence. Twinned with this curative service is an emphasis on health promotion and prevention at all levels. Time, effort and money are therefore invested at the periphery, although not to the exclusion of other tiers in the health system.

Bypassing the needs of the village

In implementing such a bottoms up model it is tempting, in remote areas, to emphasize the subcentres at the expense of the village itself. How such an emphasis bypasses the needs of the village was graphically shown to me by an experience I had shortly after joining the programme.

The baker who faithfully deposits loaves of steaming bread on our verandah twice a week invited me and my family to visit his village. This happened to be well outside our practice area, one and half hours by road followed by a 3,000 ft scramble downhill, through pine and paddy.

As we slaked our thirst on overbrewed Himalayan tea an assemblage of patients gathered from their crowded, smoky homes. I was instantly struck by the greater degree of ill health shown by these patients as compared to those in a typical roadside subcentre. The reason was not hard to find. How many of those I saw this day would be fit enough to climb 3,000 ft to the road? How many in this village could afford the fees charged by the private practitioner who runs a weekly clinic at the roadside?

A vital truth began to dawn. Subcentre clinics cater only for the nearest, the fittest and the richest. The poorest, the sickest and the most distant rarely leave their villages.

I became convinced at this time that the only way of meeting the real and felt needs of villagers was at the village level. Our attempts to convert our pre-existing subcentres into components of a genuine bottoms up village-based health care system will be described in a future article. The principle underlying this approach is aptly summarized in the lyrical wisdom of this old Chinese proverb.

Go in search of your people
Love them, learn from them,
Plan with them, serve them.
Begin with what they have,
Build on what they know.
But of the best leaders, when their
task is accomplished, their work done,
The people all remark
'We have done it ourselves'.[2]

References and Futher Reading

1. Joint study group of the Indian Council of Social Science Research and the Indian Council of Medical Research. *Health for All—an alternative strategy*. Pune: Indian Institute of Education, 1981.

This book gives an excellent analysis of these two health care models in the Indian context.

2. Quoted in: Werner D, Bower B. *Helping Health Workers Learn* Palo Alto: Hesperian Foundation, 1982 First edn.

This book outlines methods, aids and ideas for instructors at the village level.