Monks enact a ceremony at the Ganden monastery in Ulan Bator. A resurgence of Buddism has revived interest in traditional treatment

Another possile factor is swaddling. Mongolians tend to swaddle newborn infants from head to toe for the first few months or weeks, exposing only the face, and then from waist down for a few more months. The infant is often swaddled quite tightly with two or three layers of cloth, with or without blankets or a sheep skin, and a rope tied round to keep the child in place. For the first few weeks, every two to five hours the child is unwrapped for only up to half an hour and cleaned. The period of being unwrapped increases as the child grows until swaddling is practised only for sleeping hours.

Keeping the child warm, the excreta in one place and the legs straight are the most popular reasons for swaddling, so swaddling is a form of "nappy" in Mongolia. Sadly, swaddling has been shown to contribute to rickets by blocking the sun's rays. In the countryside a high proportion of the mothers see swaddling as a means of keeping the baby warm in winter, and generally in the cold winter months children are swaddled longer. Literature from other countries reports an increased incidence of pneumonia in swaddled children due to restricted total lung capacity, reduced lung compliance, and the loss of an insulating layer of air around the skin. In Mongolia swaddling is tight and particularly prevalent in winter months; changes in this practice may reduce acute respiratory infections and hence child mortality.

More changes to come

There is an international recognition that many problems of primary health care programmes are due to lack of knowledge of local practices and lack of sensitivity to economic and cultural factors. Mongolians have a relatively positive view towards conventional medicine. Before the reforms of 1990, traditional medicine had been severely condemned by communism and conventional medical treatment was greatly encouraged. Even now, most people consider a visit to the doctor before or in conjunction with the traditional healer. Public education programmes therefore have some hope of success, especially if local beliefs and practices are taken into consideration.

There is much that the rest of the world can learn from Mongolia, as with many other remote cultures. It was a privilege to be able to have a glimpse of the culture and life of Mongolians at a time of such transformation. Much hardship is created at these periods, and the future is uncertain for many. It will be interesting to observe how, if at all, Mongolia manages to establish a balance between its Eastern roots and Western development, even though it already has a foot in both worlds. In terms of health care, the challenges facing it are shared by many developed and developing countries—the example of Mongolia's response to these challenges could be of benefit to many.

Travelling as a doctor

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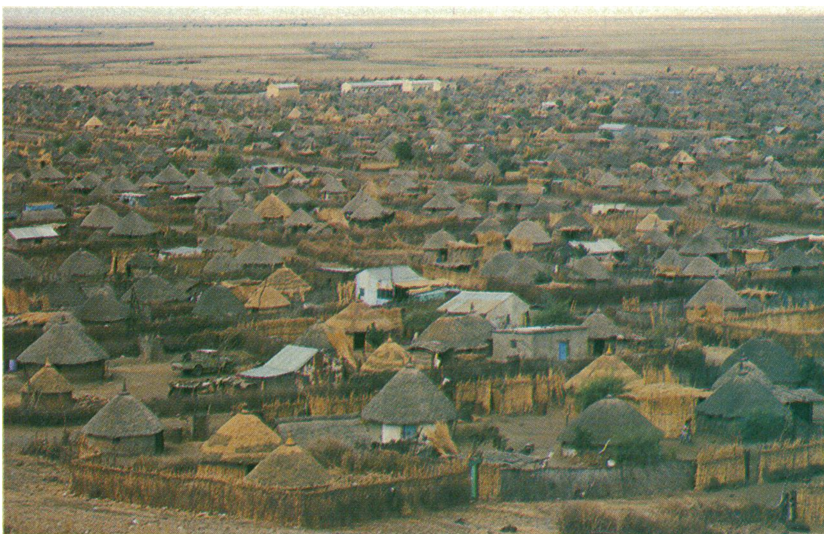
When you applied to read medicine, were you asked at interviews why you wanted to read medicine? If so, I wonder what answer you gave. My reason, pure and simple, was that I wanted to travel, and medicine seemed to me a ticket to go anywhere in the world. Somehow I never got round to mentioning that reason at interviews, but still, after all those years of medical training, I was desperate to travel. I was strongly advised against doing preregistration jobs abroad because of the difficulty of getting them recognised. Sadly, I listened to that advice and missed the opportunity of doing a house job in Zimbabwe. But that was the last advice I did listen to. Everyone said that a newly qualified doctor in the Third World is useless. That is true. They then went on to say that you must do an accident and emergency job, an obstetrics and gynaecology job, a paediatrics job, a surgical job, a dental job, etc, before you are likely to be any use. That is not true. At the end of that set of jobs, not only are you likely to be no use but you are also probably not going to go either. The clutter of responsibilities accumulates rapidly after you qualify, and for most doctors the only time to travel will be straight after registration.

Lesson one: if you have got to travel, do it as soon as possible.

The next problem was who to work for. Missionaries hold a near monopoly of medical jobs in the Third World. Making people better is a cheap and quick way of gaining converts, so medical and surgical clinics are a well recognised annex to many mission stations. My own view is close to that of the Nepalese, who I understand have banned proselytism. I am not religious and have no objections to others being religious but would be obliged if they would keep it to themselves. But a doctor who is not prepared to work at a mission station will find very few openings.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First job overseas: in a Sudanesse refugee camp

Two of us doctors had decided to team up to provide each other with moral support, and together with my wife we decided to set out freelance and see if we could find work. We had been told that there was a tremendous need for medical care for the Ethiopian refugees in Sudan but had no money to support us. Our first port of call was therefore Geneva, where we visited the various United Nations agencies, each of which is housed in an extremely tall skyscraper (denoting wealth and power) with an extremely large tree (denoting longevity) in the forecourt. Agencies that provide aid for the Third World may give money but do not want to know what happens to it. The World Council of Churches was sending tens of thousands of pounds each time a disaster occurred, with a promise of hundreds of thousands on receipt of a request for aid, but no effort was made to find out what happened to

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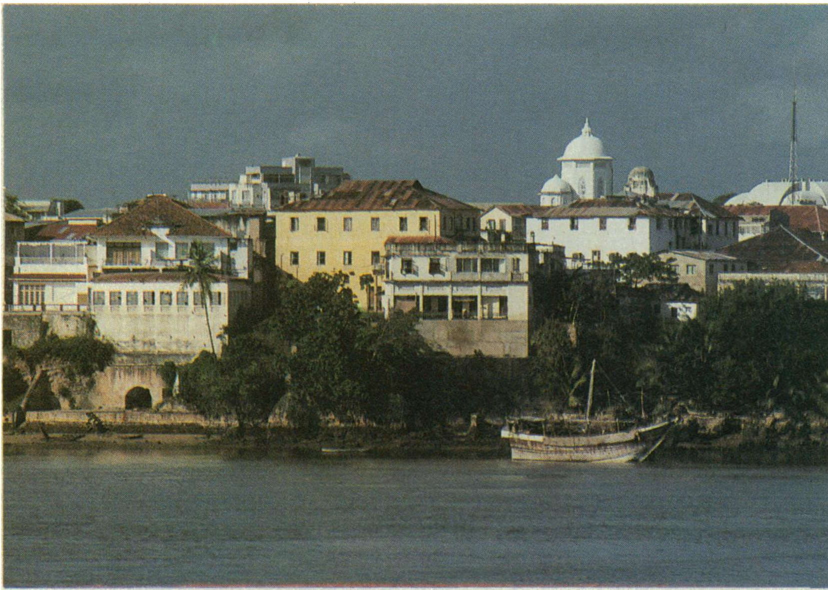

Next job: as a GP in Kenya, with hospital beds overlooking Mombasa harbour

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the money, and no bid was ever received for the even larger grants. It was all rather depressing.

We eventually gathered enough money to travel on, driving over the Nubian desert to our respective camps, where, although Oxfam was paying our salary, we were administered by a local church organisation that I think was trying to get a Christian foothold in a Muslim area. At the camps, over 50 miles apart, we both felt medically very isolated. In the first two weeks I saw no patient with a condition that I had ever seen or been taught about in medical school. Presumably, if you are deeply religious you can put this down to God's will. If you are not then a good friend who can share the problems is vital.

Lesson two: unless you've got God on your side, don't travel alone.

The conditions we met in the refugee camps were far beyond our wildest imagination. We had brought nearly half a ton of medicines with us, and I had brought a broad set of surgical instruments. The drugs we had brought were mostly irrelevant and were far more expensive than those which could be bought locally. Surgery was a complete waste of time. Although I had an operating theatre in the small hospital where I worked, there was no anaesthetist, nor were there any theatre staff. It took a whole day to set up a theatre, to do an operation, and then to clear away afterwards. I had to give the anaesthetic at the same time as doing the surgery, and as the result of exceptionally poor judgment in choosing patients for surgery, combined with precious little competence in surgery and anaesthesia, my mortality rate for surgery was 100%. I rapidly took the hint and stopped operating.

Lesson three: don't try and do Western medicine in the Third World.

The first need in my camp was food. I have to admit that I had never thought in the cosy confines of an English medical school that people in fact never die of starvation. They die of intercurrent illness secondary to malnutrition. When I arrived and started treating people for malaria, kala-azar, and typhoid all I succeeded in doing was saving their lives so that they could die a second or even a third time. What I needed in my camp was food and clean water. My colleague, who subsequently went into public health, recognised this early and acted accordingly. I did not. His camp prospered, mine did not.

Lesson four: it is no good doing what you want to do; you must do what is needed, and if you don't like it you are probably better off leaving.

Learning the language was obviously an early priority. Although I am no linguist, it is surprisingly not half as difficult as you might think. Most people in Africa speak two or three languages (a local tribal language, perhaps a second tribal language, and a lingua franca). They are also quite used to communicating with people who speak very different dialects or completely different languages. They are therefore very patient with people who do not speak their language. In my case, it was the local policeman, who spoke no English, who was the greatest help. He sat down each day and taught me 10 phrases. Within a few weeks I had enough grasp of the language to be able to communicate and to learn the language spontaneously. All that was required was a couple of weeks of very hard work to break the barrier so that I could at least start using the language.

Lesson five: start learning the language immediately from a local person, not from a book.

My bible at this time was *Medicine in Developing Countries* by Maurice King, a book written by a man who has worked in difficult conditions and knows what he is talking about. Time after time this book provided the information I needed on public health measures, or the common sense that made it possible to continue the work.

No one is indispensable, but once again I had to learn this the hard way. During my time I trained five barefoot doctors to recognise five diagnoses and institute five simple treatments. I finally caught typhoid myself, and for reasons that are not clear to me now, diagnosed myself as having stage four Hodgkin's disease. The clinics actually went better than they had when I was in charge of them. This was intensely galling, but really I was needed only to ensure that salaries were paid, that drugs and fuel were ordered, and that standards were maintained. The Swahili word for white man is m'zungu. It is also the word for a bureaucrat, presumably because of our passion for paperwork.

Lesson six: if you think you are going to the Third World to be a doctor, forget it; what is really needed is a bureaucrat.

The fate of the refugee camp really turned round when my wife succeeded in getting some cottage industry going. This led to money coming into the camp, which in turn led to food coming into the camp. Quite suddenly the clinics were no longer crowded by a mass of apathetic folk hoping to see the doctor, and the people literally started to live again.

Lesson seven: medicine without the infrastructure to provide people with dignity and food is a complete waste of time.

When we left the camps I had lost over 25 kg, there was a cholera epidemic coming, and the drugs and drips that we needed to treat the epidemic had been impounded for use by the army. One of the barefoot doctors succinctly put to me: if you do not go now you will surely die, and for what? I had always wondered what kind of doctors they were, those who ran away from London in the face of the Black Death. Well, now I know. I suppose the final lesson learnt from the refugee camps was that you can't save the world. The same principle applies in the NHS, but Africa has a special way of demonstrating this particular truism.

My next job was in Kenya, as a general practitioner with beds in a hospital overlooking Mombassa harbour. As a junior partner I had the job of looking after the staff and families of many of the hotels and factories. I suppose this was really the perfect job. I had the resources and permission to treat Africans to the best of my ability. I loved the work and lived life to the full. The dream ended abruptly when I realised that I was slowly becoming an idle colonial lout. If I didn't move soon, my standards of medicine would gradually deteriorate until I would be a disgrace to my profession.

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Off we went again, to the People's Republic of Tanzania, which was at that time a true socialist state. There I met racial prejudice for the first time. Many young Tanzanians had been taught that a white man was wicked, colonialist, and never to be trusted. It was at first depressing and then infuriating, having to carry this awful stigma. My feelings then seemed very similar to those of some of my coloured colleagues in Britain. It did not make for a happy life.

So what did I learn from my travels? As T H Lawrence says in the *Seven Pillars of Wisdom*, "just because you can't cope in your own society, there's no reason to believe that by escaping to another you will solve those problems. The problem lies with you, not with your society." I learnt that I could not be an Albert Schweitzer and, without religion, working in the Third World is pretty useless, apart from the learning experience for you. That in itself is important, but don't think that you are going to the Third World to help the Third World: you are going to try to help yourself. I learnt that the highly praised skills of the Western world are largely irrelevant to the other 90% of the world's population. I also tasted the bitter pill of being on the receiving end of racial prejudice.

Would I do it again? Yes, of course I would. I would try to do it differently, but I don't suppose I would succeed. Should you do it? Yes, of course you should. You should go full of optimism and determination to try and do some good and have a good time. You won't succeed, but you'll learn a lot in the trying.

Gumboots at the Christmas party

Duncan Curr

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Duncan Curr, *medical officer*

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The dining room is humming with activity. Even with two sittings for lunch, the queues at the servery are daunting, and there are not many free spaces on the long wooden benches. Extra chairs have been drafted in for the occasion and squeezed in at the end of the tables. A large, rather dusty plastic Christmas tree has been set up just inside the door, ousting the hand-washing bowl from its usual place. And the tablecloths have even been ironed.

Anyone who's anybody is here today. It's the last working day before Christmas, and more importantly, the day of the Christmas party. All the nursing sisters are wearing their frilliest white blouses, and the male nurses' uniforms are almost rigid with starch. The off duty nurses are all here too, outshining each other in their Sunday-best polyester. But more impressive are the hats, real wedding and funeral hats in all shapes and sizes. Matron has the most spectacular hat of all: an incredible towering creation which seems to be made from several metres of mosquito net.

I must say the kitchen has done us proud. No sign of the ubiquitous Spam-like "polony" which issues forth from the servery almost every other day, thinly disguised as something else. Instead today we have a real Christmas lunch: roast chicken with gravy, roast potatoes, cabbage, carrots, and even something that looks rather like stuffing. And none of the staple mealie-meal to be seen. Unfortunately, by the time we reach dessert, supplies of cutlery are beginning to run short, but it's amazing how, given enough time, even custard can be eaten with a fish knife.

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The real thing—Zulu gumboot dance

But time to stop eating: Matron is standing up and calling for quiet. The tables must be cleared and pushed to the wall to make room for the rest of the proceedings. A flurry of activity, quite unlike anything I have seen before at Mosvold, and the room is transformed in a matter of minutes.

The master of ceremonies, one of our most vocal student nurses, is installed at the front of the hall. More banging of cutlery on the table, and the hubbub dies down. He would like to welcome us all to the Mosvold Hospital Christmas party, and asks the pastor if he will kindly lead the opening prayer. The chairs scrape, and everyone is standing for a seemingly endless prayer in Zulu. "Amen" comes often, but I am not so naive now as to think that it means the end is in sight. And then a hymn, a familiar tune from the constant singing on the wards, but I still don't understand all the words. Now it's the medical superintendent's turn to welcome us and thank all and sundry for their contributions to the life of the hospital over the past year, and especially for bearing with it when staffing levels were even worse than usual. His speech is mainly in English, and is translated phrase by phrase by the student. Only one more prayer and hymn before Matron stands to give her speech, politely spoken in very formal English, and unfortunately rather drowned by the sound of vigorous washing up in the kitchen.

The room is getting crowded now, and it's standing room only at the back as more staff and a few curious patients squeeze in through the doors. Still the prayers and speeches continue. But then a high woman's voice from the front of the hall sings the first line of another favourite hymn, and the room is suddenly full of song. Everybody is up on their feet and swinging in a tremendous rush of exuberant energy. Over behind the servery, the three kitchen women are holding up their huge spoons and swaying together in rhythm with the music, and the whole room seems to have become as unreal as a scene from *Sarafina!*

But the introductions are over, and the entertainment must begin. First a poem read by one of the staff nurses, then a couple of songs sung in rather incongruous American accents by the third year students. But these items, however long, cannot postpone our agony indefinitely; sooner or later the doctors must perform.

Why have we chosen to do a Zulu gumboot dance yet again? As usual, the old cohort of doctors has

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