Personal Paper

Broaden your mind, narrow your chances? Reflections on short-term medical work in the developing world

J A FAIRCLOUGH, S A SPENCER

It is a wet and cloudy Monday morning in the highlands of southern Uganda. Despite the torrential rain the patients flock to see the Musungu (doctor from overseas) about their many and varied ailments. In the centre of a dingy room the doctor and his colleague sit at a desk while patients parade their symptoms before the waiting crowd. "Actually I've got gonorrhoea, Doctor," whispers the tall African youth in a red cap, knowing that most of the crowd do not speak English. He is slightly embarrassed but not frightened to seek treatment in a church hospital. The next patient, an elderly village woman, complains that her whole body is giving her trouble. Is she tired from overwork? Pained with osteoarthritis? Does she have tuberculosis or malaria? Fruitless avenues of inquiry are pursued as patient histories become obscured in translation. Minutes seem so precious as the crowds build up. A woman clutching a desperately sick child refuses admission because she came only for medicine. Persuasion is of no avail, until one of the local nurses tells her a proverb: "He who refuses advice cannot refuse to die." A man denies his wife the right to much-needed regular antenatal care. Appeals are useless, women are often abused in this way here. A child cries relentlessly in the background and the patients start to crowd the doctors' desk. In the ensuing clamour and chaos the doctor becomes acutely aware of his own inadequacy. Unable to understand the people, unable to cope with the mounting frustration, he shouts at the crowds and peace is restored for a while. Soon he is to be distracted by an even bigger problem, a woman has been in labour for 48 hours and needs urgent attention. The clinic is suspended, perhaps it will be finished later today, perhaps tomorrow. With limited staff and equipment, priority is given to the most urgent need, others will wait. No one is ever in a hurry here, except for the doctor of course, but he has never learnt. Perhaps he will if he stays long enough. . . .

As the sun sets in Uganda, the temperature climbs steadily as the sun rises in Wewak, a coastal town in Papua New Guinea. As the medical officer, already perspiring from the heat, walks slowly down to the wards he wonders how many of his patients have absconded overnight. Despite a well-equipped hospital, the white doctor has no answer to the power of the "Sanguna man" and the call of relatives in the village. If no dramatic improvement is shown in the first days in hospital an empty bed indicates a return to the village for "spirit" medicine. A call arrives by radio and interrupts the ward round: a frantic message demands that he immediately fly to a distant village

where a car driver has been outmanoeuvred by the narrow winding roads of the mountains, and consequently crashed into the river below. Soon the doctor and the mission pilot rise in a single-engine Cessna into the climatic chaos of the mountains. The dangers of flying in Papua are not to be underestimated. A clearing is spotted and, after an initial pass to clear animals and villagers from the makeshift airstrip, the plane lands bumpily on the grass. Meanwhile the casualties wait in the nearby health centre, where a health extension officer (three-year medically trained) has already sited a drip on a child with a ruptured spleen. The health centre, with its dark interior crowded with patients and relatives, carries only the meanest supply of drugs, equipment, and food. A stark contrast to the expensive white doctor and the aeroplane. Back at base a splenectomy is performed: the child lives but another dies. In the children's outpatient department pneumonia has claimed another victim. Again the delay in seeking medical help has resulted in failure. The relatives have another explanation: witchcraft. An old lady may be held responsible; if so another life will be claimed. Their coexistence with Western culture has not displaced traditional beliefs.

Back at home the doctor's wife has endured the steamy coastal heat all day. Alone apart from her child, made fractious by the heat, she longs for the relative cool of the evening and the company of her husband. The evenings seem so short compared with the long isolation of the tropical day.

Value of overseas experience

Two widely different days in different countries are but part of a whole spectrum of medical experience in the developing world. Since returning from overseas we have been asked repeatedly by both students and doctors: "Should I go overseas and, if so, when?" To many, the relevance of the practice of medicine in a developing country seems limited. While it is certainly true that the management of disease is very different in adverse circumstances, is it not relevant to one in a caring profession to learn to care for a poverty-stricken community? Is it not relevant to one in a profession that ought to cut across racial, political, and ideological barriers to learn how to communicate with those from another culture? Is it not relevant to one in a profession that claims the right to make life and death decisions to learn how to be solely responsible for life? It is our contention that these considerations carry far more weight than arguments against overseas experience that are based on the different pattern and management of disease.

What attitude?

What attitudes to the developing world should a prospective candidate have? There is no place for the egoist or the altruist. Visualising oneself as the "great white doctor," or as one

Wewak Hospital, Papua New Guinea

J A FAIRCLOUGH, BM, BS, medical officer (present appointment: surgical registrar, University Hospital of Wales, Cardiff)

Kisili Hospital, Uganda

S A SPENCER, MRCP, medical officer (present appointment: lecturer in child health, University of Nottingham, honorary paediatric registrar, University Hospital)

making the "ultimate sacrifice" is a disappointment both to the candidate and the country. A person entering another culture is an intruder. It is easy to make the mistake of remaining aloof from the local population, demanding respect in exchange for the pearls of wisdom that one deigns to cast before the swine. Easy too to make oneself indispensable by doing all and teaching little. This often has the effect of creating an intolerable situation when expatriate support is ultimately withdrawn. It is even possible to enjoy oneself thoroughly, travelling and sight-seeing, and remain untouched by the human situation.

Another approach is to go in a spirit of friendship. This entails identifying oneself with the needs of the community and sharing the load of their problems. It means listening and learning as well as giving and teaching. How important to realise that as products of a Western technological culture our thinking is biased towards technological solutions. "All Western glitter is not gold," however, and therefore one needs to be able to cast a wider net when searching for solutions to the problems of the developing world. It is a sobering fact that few are wise enough or clever enough to walk into difficult circumstances and bring about a rapid or sustained improvement. How rare it is for medical intervention to alter the statistics favourably; this is why the "great white doctor" makes little sense, whereas friendship and care will always be appreciated. Reading the appropriate reports^{1,2} will help the prospective candidate to learn what type of practice will most benefit his new patients.

The problems

In many narratives of Africa and Papua New Guinea life seems exciting and romantic. Third World experiences, however, are by no means confined to the mountain tops; the valleys are much in evidence. It is easy to appreciate that shortage of food and clean water, troublesome insects, intolerable climate, and basic accommodation may prove taxing to those of us who usually enjoy middle-class comforts. For those working in isolated places, by far the biggest problem is coping with personality clashes, which result from living and working in close proximity to just one or two individuals whom you may well not have naturally chosen as friends. Isolation, when tolerable for the doctor engrossed in his work, may prove too much for the wife and children who have no such diversion. Medical standards will differ from those you are accustomed to, and the continual struggle against overcrowding, dirt, and pilfering will add to your frustrations. Even life may not be esteemed in the way that you think it ought to be.

The practicalities

For those who still feel that short-term work overseas is for them, the question as to when to go is an important one. Obviously it is easier to go before family commitments weigh heavily, and if one is posted to a small rural establishment the experience obtained as a student and house officer will often be sufficient for the basic care these places offer. The larger hospitals with several medical staff members often have a degree of semi-specialisation, in which case postgraduate experience and even diplomas are valuable, if not mandatory. Obstetrics and paediatrics have a wide application in the developing world, but specialists in many different fields can be usefully employed. The doctor with a family will need to take special thought for their needs before leaving: employment for a spouse can make a lot of difference, converting a lonely and miserable experience into a happy and interesting one. Education is another consideration for those with older children. In areas where there is a large expatriate population this is often well catered for, but again the inquiries should be made before leaving. Parents with younger children may need to be prepared to undertake the primary education of their children personally.

Many would-be travellers are concerned about the effect a year or two away will have on their careers. In those specialties requiring a training programme overseas experience will not always be acceptable and the intending emigrant is often in a stronger position to negotiate with the colleges before leaving. On returning to England we both wondered whether a career in a hospital specialty would be possible. In fact we both readily obtained good SHO training posts in the specialty of our choice. Subsequently we have found that our experiences have provided a useful talking point in interviews and in most cases seem to be regarded in a favourable light. Occasionally, such experience is received with less enthusiasm and so one needs to be prepared to reply to penetrating questions regarding not only the value of but also one's motives for working overseas.

Conclusion

Reflections can be misleading; one always remembers the good times rather than the bad, the excitement rather than the frustration, the pleasure rather than the pain. Both sides need to be emphasised because it is in the bad times, in the frustrations, and in the difficulties that we learn the most. We have both had a valuable experience that will always remain with us. We thank our friends in Uganda and Papua New Guinea: without their help we would have made more mistakes and understood less.

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References

- 1 King M. *Medical care in developing countries*. Nairobi: Oxford University Press, 1966.
- 2 Morley D. *Paediatric priorities in the developing world*. London: Butterworths, 1973.

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Why do some people suffer more from cold extremities than others, and what prophylactic advice can be given to patients who do not live in a centrally heated environment?

When people are exposed to a given cold environment with given clothing for a long period the laws of physics ensure that overall skin temperature depends on metabolic heat production. In practice, complaints of cold hands and feet are usually associated with low levels of physical activity, and consequent low heat production. The tendency of old people to feel cold probably results from this. When at rest they have the same preferred environmental temperature as do younger people.¹ During short exposures to cold, the Raynaud phenomenon of digital spasm can cause rapid cooling of one or more digits. Otherwise acclimatisation to heat or cold is the main factor determining the intensity of vasoconstriction and therefore of peripheral cooling during brief exposures to cold. Habitual exposure to cold can greatly reduce the peripheral vasoconstriction induced by brief exposure to cold.² Raynaud phenomenon can be relieved by dibenylamine. Otherwise, cold extremities should not be treated by vasodilators as they are usually ineffective, but if effective they will increase heat loss and risk producing hypothermia. In the absence of central heating an electric blanket is extremely effective and inexpensive for night-time warmth. In the day old-fashioned warm underwear with long arms and legs with warm outer clothing and a wind-proof garment for outdoor use is the most effective measure. Adequate heating of a single small room is more useful and less expensive than low-level heating of an entire house or flat for people who spend long periods sitting at home.

- 1 Fanger PO. *Thermal comfort*. New York and London: McGraw-Hill, 1972: 73-86.
- 2 Nelms JD, Soper DJG. Cold vasodilatation and cold acclimatisation in the hands of British fish filleters. *J Appl Physiol* 1962;17:444-8.