Letter from . . . the Himalayas

Health for the people or cash for the clever?

T E LANKESTER

Doctors, of course, know that their prime task is to unearth and treat the "real" needs of their patients. Patients, of course, know, not least those who are poor and oppressed, that the doctor's job is to treat immediately and effectively the "felt" needs they show him. If teeth ache they should be pulled out, if coughs tickle they should be soothed with some medicine, and if a child is thin he must be given a tonic. The ignorance and stupidity of new style health workers is amply confirmed when they give injections to well children, sputum tests for grandfather's cough, and family planning advice to the mothers of thin children.

Instant remedies

After a particularly taxing day of trying to integrate care for real and felt needs in a distant clinic we started talking in the jeep. I suggested that what would give our patients greatest consumer satisfaction would be a week's supply of red capsules; a daily, coloured injection of vitamin B; and steroids to improve well being. To this my colleague added some fashionable handouts: tonics for the toddlers, dried milk for the infants, and patent medicines for all. In this way we would certainly earn our salaams and be rewarded by ever growing queues of contented patients.

Such a caricature is fast becoming the norm in many Third World countries. It suits the drug companies—galloping sales proudly displayed on full page advertisements in the *Economist*—and it suits the private practitioner—greater throughput of medicine and input of cash. It also suits the patients, who are fortified by modern, tasty medicines and a feeling of identification with the brave new world of flashy clinics and instant remedies.

It is not surprising that a system bringing such tangible benefit to all three parties is such a spectacular success throughout the developing (and indeed the developed) world. It is not surprising, either, that the initial qualms of many health providers are quickly washed downstream in the surging current of grateful patients and flowing revenue. What is the net result? Two deadly new addictions—to drugs and to doctors. In the face of all this who can stand?

Patients' real needs

Though belatedly, the primary health care lobby is at last developing its own latter day strategy for trying to stem this onslaught. The resolutions of the 1978 Alma Ata conference on primary health care are now being brought into practice by the World Health Organisation, UNICEF, and more enlightened governments, who realise that only a radical new health policy can hope to win the day. Concerned with this process are certain

voluntary and non-government organisations, alerted to what is happening, which have access to sources of idealism and skill. India, which has its own nationwide primary health care network, has been among the first to welcome and integrate voluntary programmes which can help deliver the goods.

Yet it is difficult to know who will be the eventual winners in this health dialectic. Will the combined effects of the more unscrupulous drug companies and the more mercenary practitioners, fed by wrongly sensitised urban and rural masses clamouring for remedies, win the battle for the pockets and stomachs of the poor in the Third World? Or will common sense and true professionalism win the day? This is today's key question in primary health.

At the grass roots or "diarrhoea and dengue" level the real answer lies in the determined persistence of the front line health workers. Will they have the commitment and the patience to alert people to their real needs, or will they capitulate before the clamour of sick and needy masses, wrongly sensitised to want pretty, instant remedies? The ultimate test of the primary health worker is his courage and ability to break through this barrier and re-educate the population to its real needs and how they can be met by the people themselves. This is both the heartache and the reward of Health for All.

Running an immunisation programme

Just as people have been wrongly sensitised to want what they do not need, so there is an apparent perverseness in not accepting what they do need. This process is bewildering to the health worker, who is tempted to brand such people as stupid and naughty, but has its own simple logic for the villagers. Our attempts at running an immunisation programme illustrate this point.

Shortly after setting up our own clinic in the community we planned a village to village programme for immunisation against diphtheria, pertussis, and tetanus and polio. The pressure on health workers to do this is considerable and to delay such an apparently simple community health practice takes much courage. Armed with flasks, needles, and vaccines our team set off for round one. Virtually no villager knew what diphtheria, pertussis, or tetanus were, but there was an archetypal sense of rightness that a medical team should descend, or in our case ascend, with needles and syringes. Any reluctance on the part of either victims or parents was quickly dispelled by the cunning strategy of the new village health worker, who lured the children into her house and showed them a sweet which would soon be theirs if they first bared their thighs. This plan worked a treat and great was the rejoicing of the health team, who recorded a 95% uptake on their first field trip.

The pyrrhic victory of round one was devastatingly exposed on round two. The very sound of the health workers' feet sent children flying for hay lofts, and all but the most disloyal mothers were accomplices to the acts. Tempting, cajoling, and threatening were about as effective as dew in watering the desert.

Our mistake lay in trying to inflict our own correct but unimaginative health inputs on a village population unaware of

North India

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the purpose of our programme. Our attitude reflected the health workers' classic, clumsy mistake: "You need this so I will give it to you."

The villagers' response reflected their own pastoral logic. "We don't often see the diseases you talk about, so we don't see why we need special injections to prevent them. Last time you gave injections our children got sore legs and fevers and, although you warned us this would happen, it didn't make it any less painful for the children. Moreover, it was harvest time and many of us had to stay in from the fields to care for the children when we could ill afford the time." Game and first set to the villagers.

Sensitising the people

The missing ingredients in the health workers were the gift of sensitivity and the process of sensitisation. We had been insensitive to the priorities of the villagers' lives and to the way in which they viewed our health programme. More importantly, we had omitted the prior step of sensitisation. This, the definitive art of community health, means informing and alerting a person and community about its real needs and how they can be met. A person sensitised on the subject of immunisation will say: "I understand the need for them, I want my children to have them, and I will bring them for you to administer the injections." In this way the request comes

from the people, cooperation is assured, everyone is satisfied, and coverage is complete.

As a result of failure to sensitise the people many immunisation teams are squeezed between seniors demanding returns and children reluctant to bare their bottoms. It is no wonder that the numbers of immunisations recorded often bears little relation to the numbers actually given.

Priorities of Health for All

Such is the double dilemma of primary health care: on the one hand wrongly sensitised villagers falling prey to the therapeutic imperative of the salesman and on the other hand those same villagers, unsensitised to their real needs and suspicious of the technically correct but insensitive advances of the health worker.

A sinister twist in the health care process easily follows. The unscrupulous practitioner exchanges service for exploitation, maintaining a vested interest in a pool of ready disease. The illiterate patient, confused and gullible, falls easy prey to capricious treatments. It is only by arming people with the power of understanding that they can be protected from the consequences of a sometimes corrupt and insensitive health care system. Whether in the developing world or in the West, correcting this betrayal of trust is one of Health for All's most daunting priorities.

Lesson of the Week

Backache and the Guillain-Barré syndrome: a diagnostic problem

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Backache is one of the most common presenting symptoms in general practice and is estimated to cause the loss of 33 million working days a year in Britain.¹ By contrast, Guillain-Barré syndrome is rare, with an incidence of about $1.7/10^5$.² The mortality associated with backache is low, while that from Guillain-Barré syndrome may reach 20%, being greatest if ventilatory support is needed.³

The diagnosis of Guillain-Barré syndrome rests on finding a symmetrical polyneuropathy associated with a raised protein concentration in the cerebrospinal fluid.^{4,5} Muscle pain is a recognised feature and may be severe; importantly, it may precede the onset of neurological symptoms and signs. We describe two patients whose presenting complaint was back pain and who were initially referred to the orthopaedic department. Later they required the monitoring and support that are provided by an intensive care unit.

Guillain-Barré syndrome should be considered in the differential diagnosis of backache

Case 1

A 61 year old man requested a visit from his general practitioner complaining of severe lumbar and interscapular pain. He was admitted to hospital after a domiciliary consultation by an orthopaedic surgeon.

The patient complained of sudden onset of back pain three days before his admission and, though he did not admit to any weakness of his legs, said that the pain prevented him from moving his legs fully. Initial examination showed no neurological deficit other than a loss of vibration sense at ankle level bilaterally.

Two days after admission he complained of difficulty in breathing and had difficulty swallowing. He developed paraesthesias in both legs and was incontinent of urine. A medical opinion was sought and the patient was found to have developed generalised weakness in all limbs, grade 4 in all muscle groups. There was no detectable loss of sensation to pinprick or soft touch. Reflexes were absent and the loss of vibration sense had extended to his arms. The provisional diagnosis was Guillain-Barré syndrome, which was supported by a cerebrospinal fluid protein concentration of 0.8 g/l. He was transferred to our intensive care unit for further monitoring of his ventilatory reserve. Twenty four hours after transfer his forced vital capacity was 1.0 litre and he was therefore ventilated. He required 22 days of

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