"VILLAGE (BED?) SIDE MANNERS"

- suggestion for the development

of an appropriate rural

Primary Health Care "style"

by

DAVID DRUCKER

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As the concepts of Primary Health Care are gradually being examined, and even enunciated in policy statements by governments, there are healthy signs of a growing embarrassment in medical circles, that medical schools are not set up to adequately prepare their students and the profession for work in rural areas. At the same time the medical profession and the medical schools have every intention of maintaining firm control over PHC developments and naturally wish to play a major contributory part in programmes which are of such potential importance.

One response has been to send students "to the field to receive experience in serving the rural population." Let me tell you some of the things I observed recently at a Health Centre where medical students were receiving rural training.

The "village" was on a first class road at the end of the fairly frequent bus route - perhaps twenty kilometres and ten cents away from the centre of the capital city. The Health Centre is surrounded by a very high wall, forbiddingly topped with broken glass and the compound is entered through substantial iron gates. Unlike the mud walls of the surrounding villages, the building is of brick and concrete. One enters a large room with a small pharmacy in one corner and a small laboratory facility in another. To the left in another fairly large space, on this occasion a health education exhibition had been set up. To the right in the smallest room, a square of tables had been made taking up most of the available space. At each side of this square sat a doctor and someone keeping a register. In one corner there was a raised examination plinth and the walls were hung with charts which in English gave

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limited and relatively undifferentiating information regarding different villages thereabouts.

The initial impression is of large numbers of people milling about, pressing their way into the doctor's room and beseiging the pharmacy enclosure. The patients, largely women with children, but some men, crowd the door to where the doctors sit and are projected forward by the crush when they are beckoned to receive attention. On this particular occasion I thought that these patients were inspected in a rather more attentive way than I have been familiar with elsewhere. (However, it is not unusual for doctors to claim that they see over two hundred patients in three or four hours). One girl was examined on the plinth - a simple curtain hung precariously on a piece of string but this was not pulled. Nevertheless the major activity within the room appeared to be writing on pieces of paper and filling up the registers. This paper work is perhaps the most striking message that is communicated to the observer, despite the flow of patients who are busy unwinding their own crude dressings and hopping about when legs and feet are involved. Most of the complaints seemed to be of skin eruptions and small wounds although stomachs and chests were frequently inspected. Almost all patients clutched very insanitary looking bottles they had brought with them and clearly the prescribing of medicine was a very important feature in the proceedings. A community health worker was being shown various physical conditions by the medical students. He was the son of the local headman and lived very close to the centre itself.

Meanwhile very neatly turned out student nurses were rounding up groups of women and children and propelling them past the health education exhibits. Much of the exhibition material was painstakingly, and probably locally executed but

seemed very conventional. Noticeable was the carefully made model of house, kitchen garden, well pump, latrine, animal enclosure etc., which had little relationship to the type of housing and landholding of the surrounding villages. The full range of birth control equipment was on display and provided a somewhat overwhelming prospect.

A mobile unit arrived and the patients squeezed into the darkened and airless main room to see a film on nutrition. Fish as an item of diet was commended, it had been stressed also in the exhibit - but is virtually unobtainable in the vicinity, and apparently there are some religious taboos about it. Milk was always portrayed in bottles although milk bottles are not common even in the city nearby. We were taken on a rather aimless tour of a village beyond the high walls of the Centre. As visitors werwere soon the objects of curiosity by children and youths, who were shooed away as we made our progress and expected calls upon village dignitaries. Why we had called seemed to be explained to nobody.

Discussion brought out a number of serious matters. For example it became apparent that there was no clear set of educational aims, social and clinical, to be derived from this village experience that the medical students were able to spell out.

The responsibility for formulating these aims certainly did not reside with the staff providing the experience and responsible for the centre. Complaint came from the staff that the students did not stay at the centre but left on the bus for the ten cent ride back into the city each evening. As far as our informants were concerned the students came with no fixed set of commitments. The responsibility for supervising the

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students did not reside anywhere clearly and tension and conflict between the resident nurses and the fly-by-night young doctors emerged. This confusion could be seen in the implied (if not actually openly exercised) air of authority displayed by the student doctors vis-a-vis the nurses. An interesting aspect of this was that the centre's staff disagreed with the student's practice of prescribing for a week's supply of medicine. They argued that village people did not maintain the appropriate regime and this was both wasteful in supplies and did not encourage frequent return of the patient for follow up!

By and large there existed only a very general belief that "village work was a good thing" and that fifteen days at the centre met this need in the young doctors' training.

Here I would like to focus upon the fact that neither the doctors under training nor the centre itself in any way seem to have accomodated their knowledge or their "style" (bedside - or - outpatient - city - clinic - side - manner) to the conditions of village life. The whole atmosphere is strikingly doctor - centred rather than patient - centred. Health workers of all kinds unknowingly adopt this stance also, for much is irresistably "caught" even where it is not consciously "taught"! In a very compelling sense the "institutional" ambience and the relationships set up in the centre are indistinguishable from those in the crowded clinics in the towns. The villagers can either take it or leave it. One suspects that many leave it!*

The relationship between healer and patient is an important and subtle one, this everyone knows, and it is always stressed in the literature and by teachers. However, everyone also knows that except in exceptional cases, whether

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* See D Drucker "Mantras and Medicine for Development."

in developed or developing countries, doctors are very busy, increasingly difficult to approach, and in practice very little time and care is taken for a "healing relationship" to be established. Medicine, is to the sufferer increasingly a bewildering technology rather than an intimate and personal human service. There is rarely time even under the most excellent circumstances, for doctors to even listen to what patients have to say or for them to talk in a way that the patient can comprehend.* In the context of PHC with its accent on health rather than disease, on the unreached rural masses rather than the urban elites, and on active community participation rather than passive patient (!) acceptance, the time has come for restructuring our institutions, and the style and relationship they impose upon both the medical professional and those whom he serves. Much exploration is called for. How might the following approach fit our new objectives?

Instead of the medical professional perceiving himself as addressing patients (or separate organs!) one to one, examining, treating and advising, somewhat secretively, with the crowd held back to allow him to get on with his work and get things down on pieces of paper so that the patient can receive medicines as has been described - why should he not conduct himself as a group leader with the crowd as participating members and "audience"?

The "audience" becomes the prime target and the examination and curative aspects of patient care are withdrawn to the background and become the takeoff point for a public performance which is given pride of place by the health team. All patients and those with them are received and expected

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* For a truly fascinating account see "Doctors talking to Patients." P S Byrne - B E Long
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to be the audience for group medicine. Patients (especially those suffering from the common ailments scabies, wounds, diarrhoea, etc. etc.) are selected from the audience and the professional examines the patient in full view, explaining to the audience as he does so, in a very simple and appropriate language what is being done and what the signs and symptoms are. The questions to the patient and his replies, along with the whole procedure will be conducted in the nature of a public case-conference discussion in a terminology that the villagers are likely to understand. A simple explanation of the problem will be given, followed by appropriate information regarding how such conditions come about and what action can be taken to prevent or minimise such conditions. The treatment and management of the condition will also be explained. The preventive and management aspects should be emphasised. The audience will be asked if there are others among them who have come with similar complaints and the professional will briefly examine and confirm (or separate for more extensive examination), the patients who have diagnosed themselves as also having the problems similar to those of the demonstrated case.

As small groups are formed this way - the health message and instruction can be reinforced by another member of the team. Treatment can then be communally provided and regimes and management gone over in detail, with demonstration as appropriate. For example cleansing of wounds, the boiling water, preparation of dressings, etc. can be followed and practiced by those accompanying the patient or by one patient assisting another. Questions will be invited and answered. Experience will show us how far we can go in this "do - it - yourself" caring. I suspect that we can go much further than

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is currently believed. Of course not all patients need be dealt with in this way, although this should be the major "visible" style of practice. It will appeal to the curiosity and even entertainment qualities of village life and against the mystification and "confidentiality" of western middle class medical ethics. Even so, according to village values one must be careful fo avoid public display of matters which may affect social life chances, such as acceptability in marriage and so on. A village oriented health care will soon become sensitive to what these are. Experienced practitioners will have to pioneer the way but standards could soon be set for students to meet. These standards can be achieved by having a student assigned to conduct a session or part of a session of this kind. He can be easily observed by his peers and discussion of the student's performance and presentation could take place after every session. This way he will be helped to learn the skills of a village - side - manner.

Developments of this kind and the relationship established by this method between Health Team and villagers is only the beginning. The doctor or health worker could choose his moment and proceed along the following lines : Addressing his audience of sufferers with diarrhoea, (scabies, or whatever,) he says "Look there are 70 (?) of you here this morning, 22 (?) from the same village . . . You come to me for medicines. Every day there is a large number with the same problem, last week so and so came too late for us to help, and all the time, children especially, are dying of diarrhoea. How long are you going to put up with it? You know what some of the causes are for diarrhoea, we have been talking about this, this morning. Why don't you go home, talk to your neighbours about it, and ask your (headman?) (councillor?)

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(health committee?) to call a meeting and one of us will join you and we can inspect the village all together and see what might be done about this problem. Who will take the responsibility for getting this started and for letting me know when the meeting is to be called?

At such a meeting, the specific extent of the medical problem should be conveyed to the village . . . "In your village there have been at least . . . so many cases, and so many deaths in the last . . . months. The reason for this situation is . . . . and it can be prevented or at least cut down by . . . (preventive actions to be spelled out) and if the condition does occur . . . (management actions to be spelled out.) Let us have a quick look round the village and see what we can see . . . A brief tour of inspection takes place and items of risk are pointed out . . . "Why don't we have a full scale inspection of your village, you can do it yourselves." The health worker produces a specially developed "How to . . guide." In this case "How to inspect your village to find out the risks and conditions which lead to diarrhoea." guide? ? Such guides can be developed as "Look and See" games that children (an unacknowledged developmental work force, witness the crowds of kids who appear to gaze at any stranger) can play.* Information should always be thought of as information for use by the village and should be so displayed. Its utility for those outside the local situation is obvious and can be shared but whose information it is, is a crucial matter. Information charts, in health centres should be for the community and not specially directed at sophisticated (and statistically literate?) visitors.

The point, is to begin with an actual condition which the village is concerned with now (at the health centre) and to

*I have discussed these as "I Spy" games in "Commentary Notes" on "Keep your Village Clean" - a handbook for community workers.

move into health education and preventive action, from the point at which people in the village recognise the immediate need. The worker dramatises this and works towards establishing a realistic village-made plan of action. The success of this will depend on the level of established or potential planning skills within the community and the ability to support with technical advice (in simple village-oriented terms) and technical inputs as required. The need for a village health worker should grow out of these discussion and planning attempts, and as this need emerges from village involvement, understanding of the PHC approach; criteria for selection of workers; social control requirements; and the necessary village contributions towards his work; will become clear. To begin with, simple single tasks should be undertaken by those wishing to volunteer. - "OK, why don't you become the SCABIES lady. Here is the lotion your village will need. Lets go over and write down all the things you have to do. (How to "Scabies" guide.) Everyone must hear that you can help when this happens . . . We will teach you to look out for conditions which can be mistaken for scabies and for which different help should be sought . . . etc. etc. A village worker, or workers, thereby becomes an obvious asset to the village. Too many programmes rush over this element of village people being actively introduced to understanding the why and wherefore of PHC workers. Selection of workers, is commonly precipitous and somewhat arbitrary, (in terms of who is well connected rather than he who connects well.) In one project in India, I know that a period of nine months passed with profit, before the need and value of a PHC worker was understood and satisfactorily selected. The pressure to fill training places at a time determined by remote administrative convenience, rather that determined by a community's readiness is to be avoided. Incidentally much more thought needs

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to be given to job description and task assignment which will differentiate between workers whose community is located geographically close to health posts or centres (where the PHC workers will be bypassed for many services) and those workers who will have to work in isloated situations. Ranges of responsibility and training should be differentiated accordingly. Training of such workers should be on an item-by-item basis which is clearly required by the community and in which the worker can demonstrate his utility and skill before responsibilities are increasingly piled upon him. The training investment becomes a heavy loss if he fails to perform. His training and responsibilities should be cumulative. Underlying all this is the principle that services must be made-to-measure (measure up to the local community that is) and not be rigidly uniform. This goes for matters of prevention, and health education too. Nutrition for example. Actual eating patterns of each village need to be documented and <u>specific</u> nutritional improvements promoted according to the <u>known</u> deficiencies of that village and the known-to-be-available resources. The same is true for wells, pumps, latrines, etc. First find out (the village finds out, not the centre) what are the specific conditions and what are specific improvements which can be made. Who, when, what with, how much, etc. must be properly spelled out for <u>each</u> village and fully involve people in finding out, understanding, and suggesting how. (More "How to . ." guides.)

The implications of all this is that PHC as community medicine, must be specifically community related and this requires local knowledge, sensitivity and skills related to the community, and community conceived plans. Medical Science, with the help of the social sciences and the involvement of

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social service personnel, must devise ways of contributing the increasingly sophisticated medical technology through simple delivery systems mediated through the community. Such systems must be based on appropriate relationships and institutional forms which stimulate and reinforce cmmmunity participation, step - by - step. action - by - action. In community matters the golden rule is that the community will know best, if pains are taken to involve them in their own problem solving processes and we are prepared to take time and energy and develop the skills in assisting them with gathering and considering information they can use and in offering realistic methods for planning and harnessing their full potential.

The latter part of this paper gets into complex community participatory methods which are as important for all development programmes as they are for PHC. However, I have not at this time done this, much talked of and obscure area of concern, full justice. I have merely sketched it in, as the context and outcome of starting with restructuring the skills and relationships of the health personnel vis-a-vis patients in the health centre and the community. Can we give this group medicine element a try; see whether it really works; is indeed and improvement on what we have presently got; and is a viable contribution towards a true village - side - manner in PHC?

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