Country Cousins

BY DR RONALD F INGLE

THE EXPERIENCE of going to a Workshop on Medicine among Black People in South Africa has made me realise that many of the things that I have come to believe in regarding the future of medicine really needs to be expressed pretty forcibly.

I know that I went, I admit that I went, expecting to learn about the topics that were to be presented. I went accepting that.

But as I sat there and experienced what was really going on, I realised that these themes regarding medicine as a whole emerged so clearly that they dominated my experience more than the learning. So I made my notes, and I listened to the scientific aspects of what was being said, and that was O.K., but for me that was only a part of it.

It was called a "workshop" for medicine for black people in South Africa, but in fact it was very much a teaching programme based on the medical work on black people in that University hospital.

It was said that there would be ample time for discussion. In fact, as in so many of these programmes, people over-ran their time, and there were five or seven minutes left at the end for questions, and this isn't actually a workshop.

I don't think they should borrow the term and apply it just because it's a current popular term and sounds, perhaps, attractive to people; because a workshop as I see it allows full participation by everybody.

The timetable should provide for the emergence of subjects which might be more pressing for discussion; it allows for people to express directions that they think should be taken; the leadership should identify these problems, and the structure should allow for the coming to conclusions about them before it's over.

At first, on the first day of the thing, some of us tried to ask some of the questions that concerned us in the field concerned, but we found that our questions weren't readily understood. Whereas the academics asked questions that were understood and taken up.

Our questions were not understood because they were not expressing the type of things they were used to hearing as questions, and were used to answering.

Now it may be that our questions are new kinds of questions, and we are not very good at formulating them, and therefore they need to be LISTENED to, and this is one of the things in a workshop, and amongst teachers — that they must be prepared to LISTEN to the questions that the students ask, the learners try to ask, and try to identify what they are actually getting at.

A bad question shouldn't necessarily be dismissed. So you get left with the feeling that your questions are freak questions.

And so as we went into the second day, some of us wondered what would happen to our reactions to some of these things. But of course this is where the group psychology of the whole thing works.

We are in a minority, and so it's hard work to put forward a point of view where it's not readily understood; it may involve embarrassment to people who are the hosts.

By the third day we really succumbed, were anaesthetised, by this practised exhibition of the way they are used to talking, and discussing, and counterarguing, and our voices became quiet.

But the outcome of it was that we were feeling left out, we were left feeling this is not really talking about medicine in South Africa, because we see a different context altogether from them.

And so the very term "medicine amongst black people in South Africa" means different things to us.

This we weren't able to discuss. So I crystallised this in the expression "country cousins".

People are very kind — country cousins is a term I am using to describe what people think of as "mission hospital doctors".

They are very kind to you, they welcome you, but the fact is that they think of you as people who are working very hard, yes, making extraordinary efforts, under very difficult circumstances, but they think of you as people who are trying to do what they do, trying to create hospitals in way out places which by hook or by crook you will try to imitate, try to develop into little models of what they have.

I believe that if you provide an acceptable regime of treatment to all the patients with a certain condition, you know that a pretty high proportion will do fairly well.

Now in the circumstances in which we are working that should be an acceptable standard. The time spent trying to raise that result to nearly a hundred percent cannot be afforded. If you try to you are likely to precipitate a breakdown in the situation.

Now if you talk like this in an academic situation, people will regard you as being a second-rate doctor, with lowered standards, lowered ideals, who is betraying his professional values, and they don't really want to listen to you seriously.

They are surprised that you are willing to talk like that, whereas, if you talk like that in the company of men who have to work in these situations, who are thinking in terms of the vast need, the way you are saying these things is acceptable.

One point I want to make is that it seems to me an obligation of those people who have the depth of clinical experience, of scientific knowledge, supported by research work that it should be their obligation, provided it is accepted that we are working together in this TOTAL field of health care, to provide the distillation of sound, acceptable regimes.

You'll see the result of this in any small institution which can ill afford to have varying regimes, changing of drugs, and fluctuation of dosages.

We all know what happens then. And yet the profession regards this as the glory of free independent medical practice. Whereas in the context I am talking about, it can't be afforded, and it's a sort of licence, not freedom.

Where research, and computers, and statistical facilities are now being directed towards solving certain questions that institutional medicine throws up, it seems to me possibly, that these are the very sort of resources which can be used to resolve this kind of dilemma.

The medical profession is not used to answering this kind of question. It is a new kind of question. It's not regarded as a necessary question. But we believe that it is a necessary question.

We want the skill and know-how and resources of medical science to master these new kinds of questions. We believe that it is an obligation of all the scientific assets to be directed, not in developing vertically to finer and finer solutions of restricted problems; but to work laterally and solve the questions and situations that those of us that work in the greater areas of need are faced with.

It seems strange with the growing awareness of the problems of rural practice in this country that there is such a divergence of attitude. It is clear to me that this is because we are from different cultures.

We know how difficult it is to talk to people from another culture. It's not easy to converse, because you don't have a common language; if you do use a language, you use it differently.

We realise that all the acquired experience and inherited characteristics and circumstances in which you live make you see

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things differently. This isn't just a question of an intellectual game, it's not just a case of questions and answers, it's a question of a different medical culture. No wonder they don't understand us. If you talk about working without a laboratory, for example, they will think: well, that is a terrible temporary handicap which presumably you will overcome, but meanwhile without it you can't really practice the kind of medicine which we are talking about, and, if you will forgive us, if you ask questions against that kind of background.

These are the kind of questions they will tend to regard as unanswerable, questions that shouldn't really have to be asked.

If you point out that this is not possible, and that is not possible, they will regard it as kind of invalidating the situation. So this is the kind of image they have of their country cousins, the mission hospital doctors. And some years ago this really is how we looked at ourselves also — I know it.

But in fact, now we have changed, and we have confidence that in our change of view, and in our change of thinking, we have support, because we happen to move in a different circle.

Many of us read international literature which links us with prominent people with experience of what is called third world medicine. We are encouraged by this to re-identify ourselves as people who perceive that this situation which they regard as an unfortunate temporary situation, which progress and facilities will eliminate, we regard as by no means temporary, but as being a fairly world-wide fact, which calls us to reassess what medicine is all about, and how it should serve the majority of people.

They are not in touch with this opinion, which is why, when we speak in their milieu, in their environment, it's not acceptable.

The difference is that we think that the people in these institutions still think, as we used to, in terms of those people who are fortunate enough to come under their care, and be given proper medical care on their terms.

Sure, they've got difficulties of overcrowding, and shortage of staff, and accommodation and so on; they battle with that.

But their sights are still the same kind of medicine that we were trained in. Now this is the same experience that we used to have. We tried to, as I have said before, improve our model in these circumstances, and apply those criteria of medical care to the people who were fortunate enough to come to us.

But we have this awareness that we have got to devote some kind of care to far more people, whereas we don't think that they really think like that. And this is why we re-examine our assets, in terms of medically trained people, paramedical assistance, and others.

One of the elements of the change required among us is that we feel that the elements of sound medical care must be distilled down to basics, which can be applied to people's care, say, in a hospital, with not necessarily a minimum, but a reduced amount of case-supervision.

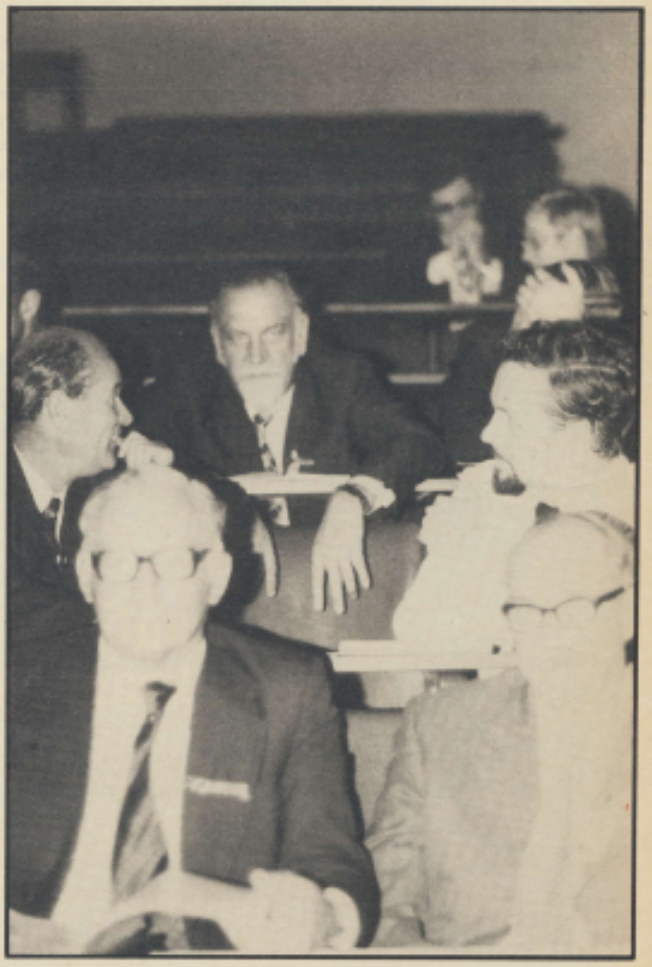
This means that the time spent in tailoring, and modifying, and adjusting actual therapeutic regimes will be reduced.

This is where you will find, that in a place like this, where doctors come in from that graduate background, we spend an awful lot of time discussing variations in regimes, choices of drugs, dosage problems, and so on.

This is designed to improve the quality of care of a smaller proportion of patients.

If they were trying to help us, and that was the object of the course, they should have devoted some time at the beginning getting themselves orientated to us.

They THOUGHT they were trying to help us by talking of the medical subjects. And I went there knowing that I would learn about the subjects. But I ratted on that. It is not medicine's purpose to know more and more — it's a luxury to know more and more about a myopathy.



Medicine's purpose is to reach out and do something about all those people who **have** myopathy. I don't forget for a moment that academics will say: It's only by exploring the details of this myopathy that we can come up with the answers. My answer to that is: O.K., but I also feel that we have accumulated a vast amount of knowledge about most things, and we may have to be content with what is serviceable for the time being. Because we are on a sinking ship — this needs to be acknowledged.

The main bones of what I want to say has to do with the consolidation of basic treatments which can then be delegated. There are two levels — the rural hospital, and the clinic level.

Then there's the point that instead of trying to produce this simplification, as it is at the

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moment, I think that it should be the clever people who do it, because they know far more about it.

Then their institutions may be able to go on with the experimental approach. But our trouble is that we are inheriting this experimental individual freedom business in these situations.

We feel that we are pioneering into the necessary revolution in medicine. We've got to become more respectable. I'm saying the plea depends on what we call medical standards. And pleading that we've got new kinds of standards, which are not necessarily a disgrace.

But when our voices are raised on these terms in academic circles, instead of being regarded as second-rate questions, they must be heard as being real questions.

A workshop provides for the working out of what the subject ought to be. You can start with a field, or a problem, or a theme, but with the contribution of members, who may not be specialists, there may be different levels of contribution. But it provides for the discovery of unsuspected aspects or problems.

It would have been less misleading, perhaps, had the workshop I attended been called a Symposium on African Medicine.

At it, I was aware of how conferences may be taken over by people. You've heard of students taking over a conference, and throwing the panel off the platform, and how people have more or less told other people: Look, you're talking rubbish.

We are accustomed to saying: Look, you can't take over somebody's thing, and yet if there is an urgency about it, you may feel that it's part of your prophetic function to tell people that they need their eyes opened.

This was our dilemna. This is what we did in the end. We

accepted it on their terms.

We didn't collectively form a strong enough voice to even say at the end: Look, we haven't said anything up to now; we've taken it as you've given it to us.

But now we would like to say a few things, we thank you for having us, and for all we've heard, but we would like you to listen to what it has made us want to say, because we don't often get a chance to say these things, we country cousins. We don't want you to get the wrong idea about us.

I've been asked why don't we ever do dialysis here. We could have said: Yes, we've seen the need for it, we've tried to find out methods for doing it, we understand there are ways, but, in fact, it needs someone to pursue the very practical business of what are you going to do?

And the nearest we have got to it has been: Brother, it'll be just a little bit beyond you. I mean we can't estimate a blood urea. Why? Because we haven't got continuing laboratory assistance. We haven't got the continuing presence of doctors who can turn it into a routine function.

This is not just an unfortunate accident. It's a more or less

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inevitable fact of existence. Therefore it's no good talking as if it were a misfortune.
This is why, when the doctors throw up bright ideas, my reaction is, but, Brother, would you put it into practice, and put it into such a practice that we can carry on with it when even you, with your brightness, are no longer here.

I'm convinced that no matter how fervently I may have tried to express myself, it's extremely difficult when a gulf of experience separates you. I don't mean just experience in the sense of making you better at it; I mean just experience in the sense of what you've experienced.

No matter how fervently you express it, you know that the guys, because of the background they have come from, because of the extent of the status-identity problem.

You know, like we unfortunately, attribute to the African with his qualification, that we can smile about the qualification, can smile at the way it doesn't really qualify him for this and that; but to him it means a lot more than it actually is.

It's rather like that with these chaps. This is what they have learned and the way they have learned it, it's what has got them to where they are, and it's integrated with their assurance, and their commanding outlook. They need to live by what they have been introduced to, Otherwise they don't know where they are.

Then there is the plea for the redirection of research towards answering the kind of questions we ask. And you see, people will say: Oh my God, this is what happens in communist regimes, in state-controlled set-ups, the totalitarian approach. This is the present reaction of our free-enterprise school.

And again, we feel that this is where you have to say NOT HOW do the medical profesion WANT it to be, and how they want to preserve how it has been, more for the sake of their idea of what medical integrity and practice can be like.

We say medicine is a serving profession, and we have to be prepared to change, and respond in the way that circumstances demand.

If the medical profession found itself pitch-forked into a full-scale war, then they know jolly well that they've got to make do.

When they worked in the desert, they worked as circumstances allowed them to work, and out of that they discovered lots of things.

But they didn't question the circumstances. A doctor who worked in a prisoner of war camp couldn't question the circumstances, and used his knowledge as best he could.

We are saying that these circumstances which we should try to make clear to people, are GIVEN circumstances, that have to be accepted, and worked in. They must not be seen as undesirable circumstances, that we don't want to know about, and shouldn't have to work in, and the State should pay, or find the doctors, or it's not our business, or something.
Although they think we should change, we think that it is THEY who should do the changing.

We think also, that when we have learnt within our experience as country cousins, to work within limited resources, we have therefore learnt something about priorities.

We are really AHEAD in our experience of priorities, compared with the profession in developed countries which haven't had to ask these questions, because their ceilings have been much higher.

But in many of those countries now they have been hitting those ceilings. It's most interesting to observe that they are beginning to battle with the priority question.
Whereas we used to consider who could get ampicillin, they are discussing who is entitled to renal dialysis — the same kind of question. And we have had more experience of thinking and working like that. To us it's a real, live, honest problem.

To many of them it has for a long time been a kind of infliction of the bureaucacy. They have regarded it as a kind of dirty trick played on them by the administration.

The average young doctor does regard limitation in choice, say, of antibiotics, as being some dirty trick played on him by an administrator, whereas many of us regard it as an honest use of a country's resources.

We have met people, we have read literature, in which this kind of thought is vividly and forcefully presented. When we read those things, we KNOW we are on the right track. It is only when you get into the other situation that you get an inferiority complex.

It is difficult to put across these views, although they are held by many, without sounding fanatical, churlish, and lacking both taste and manners.

I couldn't say it at the close of the "workshop", when they asked for people to comment. This was the moment when I had thought up a speech in my mind, which went: Look, I am going to say what I know is hard for you to accept; and I think that it is so important that I am willing to try and say it, and then carry on: I have enjoyed it, I have been anaesthetised by the presentation.

I think back to my old medical school days, it was a pleasure to listen to people speaking with such precision, and clarity, and inventivenes.

Sure, it WAS a pleasure of its kind; like going to play a game of squash once, after not having played it for some time (provided you're fit enough) and revelling in the excercise and flexing of unused muscles. But it's not the game we're actually playing.

Let us briefly look at the meanings of those words, workshop and seminar. I don't think workshop has yet got an acceptable definition. It hasn't got to the point of needing to have one. It soon will.

A Seminar: In German Universities (hence in certain British and American Universities), a select group of advanced students associated for advanced studies and original research under a Professor's guidance. Also a class that meets for systematic study under the direction of a teacher. The other word used is Symposium. These words are used rather indiscrimately.

Symposia, seminars, workshops.

Symposium: A drinking party, the convivial meeting for drinking, conversation and intellectual entertainment. An account of such a meeting or the conversation at it.
A meeting or conference for the discussion of some subject, hence a collection of opinion delivered or a series of articles contributed by a number of persons on a special topic. That's what I understand by a Symposium.

In a Symposium, the presentation has been determined by the speakers beforehand, in a seminar there is, I think, more the idea of off the cuff contributions, but still the selected subject. Whereas, the workshop ... I'll look up the meaning of workshop.

It really won't have this word ... Workhouse. (My mother once called this place a workhouse). Workhouse: a house, shop, or room in which work is regularly performed. A house established for the provision of work, for the employed poor of a parish. Later, an institution administered by the Guardians of the poor in which Paupers are lodged, and the able-bodied set to work.

Workshop ... a room, apartment or building, in which manual or industrial work is carried on!

ABOUT THE AUTHOR

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1927 Born in North China. Son of Baptist Missionary & Professor of Surgery, Cheeloo University (who first translated Gray's Anatomy and Rose and Carless Surgery into Chinese).

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1955 - 57 Surgical Division, Royal Air Force, U.K.

1958 - 76 Medical Officer and Superintendent, All Saints Mission Hospital, Transkei.

1970 - 76 Member and Vice-Chairman, Consultative Committee for South African Medical Missions.

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1977 - Executive Committee, South African National Council for Health Education.

1978 - Council Member, Transkei and Ciskei Research Society.