Non-allopathic doctors form the backbone of rural health

H. S. Bawaskar

Introduction

India is a country of villages. Most villagers are illiterate, innocent farmers who are busy round the clock all through the year. They are unaware of medical facilities in or around the village till they fall sick. They do not plan for measures to be taken if and when they are ill, nor do they participate in any medical insurance schemes. They are entirely dependent for medical care on the practitioner in or near their village. They call any person giving drugs and injections 'Doctor'. When facing him, they are interested only in getting well and not in the qualification of the doctor or what '-pathy' he follows.

Health pattern in rural areas

Government Health Service	Location	Private health service
Civil Hospital	District headquarter	Nursing homes Specialists, GPs Visiting specialists Few non-allopaths
Rural hospital or cottage hospital	Taluka headquarter	Nursing homes GPs, surgeon, physician, Few non-allopaths
Primary health centre	Peth	Non-allopaths Occasional MBBS doctor Visiting MBBS doctor
Health visitors Malaria workers SEW, SW centre	Village	Non-allopaths Visiting MBBS doctor
Visiting health worker?	Kond or wadi	Quacks, mantriks, village healer, visiting non-allopath

Villagers usually seek medical help when they are seriously ill or when illness disallows work. The common problems one encounters in villages are acute dysentery, gastroenteritis, malaria, hyperpyrexia, convulsions, hepatitis, bronchopneumonia, fevers, infected scabies, conjunctivitis and bites (snake, scorpion, fox, dog). Of course, one also has to deal with pregnancies and difficulties in labour.

Due to non-availability of public transport, when a person falls sick in the dead of night and is seriously ill (snake bite, scorpion sting, obstructed labour, eclampsia, acute gastroenteritis...) the patient is placed in a wicker basket and carried to the nearest public health centre or to a private practitioner at the taluka headquarters.

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Government health service

Civil Hospital This is located at the district headquarters, is well equipped and has a consultant physician with ancillary staff. Patients are referred there from the primary health centre, cottage or rural hospital, or private nursing homes. The Civil Hospital of Raigadh District is located at one corner of the district headquarters at Alibag. Patients prefer to go to Bombay instead of the Civil Hospital there.

The civil hospital should be sited in a centrally located place, which can easily be approached. As matters stand, the consultant at the civil hospital, its medical officers and others are often busy with their private practices. What little time they do spend at the hospital is often spent in issuing medical certificates, conducting medical board examinations and attending to VIPs.

Cottage and rural hospitals These are located at taluka headquarters and are supposed to possess indoor beds, staff and radiology and laboratory facilities for investigations, These machines are often out of order. Technicians are rarely to be found there. Xray films or chemicals for developing them are usually out of stock. The medical superintendent possesses a postgraduate qualification. Other medical officers are diploma holders. The nursing staff is inadequate.

The environment in and around the hospital is filthy and not conducive to health. Bedside lockers are broken, the mattresses stink, bedsheets soiled and toilets dirty beyond imagination. Few are willing to get admitted to these hospitals. The abjectly poor must, perforce, seek help here and lie on these beds. They are made to feel highly obliged to the staff. The doctors are busy attending calls in private nursing homes. Soon after they join the hospital, they start building their own nursing homes and once these are ready, resign.

Primary health centre This is located at the *peth* or large village and is intended to cater to the medical needs of a population of fifteen to thirty thousand. Here the conditions can only be compared to those in cow sheds. The centre is spick and span only on the auspicious day of its inaugural by a VIP. The medical officer is rarely available. He may visit just for a few hours to conduct an outpatient clinic. The rest of the time is spent in private practice or 'table practice' (charging patients examined at the centre). When I stopped this practice, I was harassed by all authorities

including the local politician when I compelled these medical officers to work - as they are supposed to - without charging their patients.

These medical officers are supposed to collect data on immunisation, ante-natal care and family planning. Their sincerity and awareness can be judged from the fact that they claim to have inserted more copper-Ts than the number received by the'centre. .The consequence: population storm.

The only person available at the centre all the time is the humble servant who informs anyone who calls that the doctor is not in. Even victims of snake-bites have to move from centre to centre, ultimately landing up in a nursing home.

The total absence of rational and ethical therapy is especially evident in the case of a pregnant primary teacher who was brought to a government dispensary soon after a dog-bite. The person in charge refused to administer anti-rabies injections for fear of teratogenic consequences. The woman died of rabies. It did not occur to this person that an abnormal foetus can always be identified and terminated but a dead mother cannot be brought to life.

Adivasis, other tribals and all except the most poor shun government services.,

Government hospitals serve but two purposes: 1. To register medico-legal cases - who are transferred elsewhere once the first aid has been offered. 2. Stepping stones for their doctors who flourish and soon start their own nursing homes in the same area. Sick government hospitals and clinics have permitted allopaths and non-allopathic medical practitioners to flourish in rural India.

Private health services

Allopathic doctors They crowd in district and taluka headquarters where multi-storied nursing homes mushroom. Radiology, sonography, endoscopy and cardiac monitoring are easily available. The staff watching the cardiac monitor may not be able to identify abnormalities on the oscilloscope or use the defibrillator.

Whilst sophisticated gadgets are freely available, their usage is questionable. A patient with a renal colic will be subjected to plain xrays of the abdomen, intravenous pyelography and sonography. Examination of the urine will be done only after these have been completed. Xrays and ECG are carried out on requests by patients and their families rather then on referral by consultants. Patients move from doctor to doctor. If one consultant advises against an investigation demanded by the patient, they will go next door to a more obliging doctor.

Surgeons claim that there are few patients in rural areas for them to operate upon. They thus add midwifery to their trade and diagnose obstructed labour that necessitates Caesarian section.

Allopathic doctors are unwilling to move to the villages because of personal or family compulsions. The key factors cited are lack of facilities for the education of their children and paucity of outlets for recreation.

Non-allopathic doctors This group comprises of those who have qualifications such as BAM&S, BHMS, DHB, LCEH, GFAM and those who are registered medical practitioners (RMP), vaidyas professing ayurveda and unani practitioners. They include village healers (mantriks) and quacks. They reside in the villages, participate in all the activities of the community and are available to patients round the clock. They are truly family physicians and villagers repose confidence and trust in them. They treat all acute illnesses with commonly used allopathic drugs, give intravenous fluids and injections. Their poor understanding of the science of modern medicine leads to grave errors as when injecting atropine or digoxin, administering corticosteroids and prescribing chloroquin, quinine and diuretics. Leeches are frequently used.

I must refer to retired vaccinators, malaria workers, operation theatre assistants, wardboys and compounders serving as non-allopathic doctors without any additional training. They prescribe allopathic drugs and give injections to villagers.

Non-allopathic doctors and allopathic therapy

Non-allopathic doctors are sincere and eager to learn allopathy. Let me provide some examples. In the villages where I work, scorpion stings are not uncommon. Many victims died of pulmonary oedema. I was able to reduce mortality from this complication by using prazosin. I have travelled throughout this region and have done my best to spread this knowledge through talks, slides and demonstrations to all doctors, regardless of their background. I later carried out a postal survey!

Results of postal survey to assess effects of training on treatment of victims of scorpion-stings

Reporter	Number	Total cases	Systemic involvement	Treatment given	Fatal	Mortality
Physian - M D	7	287	166	Prazosin	2	1.2
MD (Ped)	3	67	33	Prazosin	4	12
MBBS	35	2971	251	Prazosin	5	1.9
Non-allopath	6	197	79	Prazosin	2	2.5
Physician — MD*	2	24	13	Conventional therapy	5	38

*= consultant not aware of the utility of prazosin
Conventional therapy= digoxin, frusemide, atropine, corticosteroids

I found that these non-allopathic doctors were now diagnosing and treating these victims of scorpion stings effectively with a low mortality whilst a postgraduate allopathic doctor was unaware of the use of prazosin and reported a high mortality whilst using convention1 therapy.

The second example is from Gadchiroli.[2] Villagers were trained to record the respiratory rate of children with bronchopneumonia and estimate the severity of the disease. Excellent results were obtained using co-trimoxazole.

The third example is that of an ayurvedic doctor who was trained in the administration of general anaesthesia. From 1978 to 1994 -he was the only anaesthetist in Mahad. He provided excellent anaesthesia for patients operated upon by seven surgeons in Mahad, Mangaon, Shrivardhan and Poladpur talukas. He was even able to demonstrate the ideal technique for cardiac resuscitation to the cardiologists in the region.

Health care can thus be provided to villagers without a single allopathic doctor. It will be necessary for the authorities to help the non-allopathic doctors. Each of them must be provided training at a functioning civil hospital where instruction on drugs and their usage should be imparted. Special care must be taken to emphasise side effects and complications and caution them against drugs beyond their competence. They should also be made to undergo annual training programmes to update their knowledge. (Such continuing education is equally necessary for allopathic doctors.)

Irrational practices

Farmers and labourers in villages develop an irrational faith in the potency of intravenous injections in the treatment of *vat* (illnesses such as myalgia and paresthesiae supposed to result from imbalance of the four humours). Calcium gluconate is their drug of choice and is routinely administered by allopathic and non-allopathic doctors on demand. The consumption of this drug jumps during the pre-monsoon season and in October when there is a lot of work to be done on the farms.

The treatment of tuberculosis also invites criticism. In many cases a few injections of streptomycin and tablets for a few days is all the patient receives. In clinics run by the government, only patients with positive sputum are given bactericidal treatment.

Patients with severe anaemia are given blood transfusion without determining the cause or continuing long-term medication to prevent recurrence.

The unkindest cut of all is when the terminally ill, brought in gasping, are sent home so that the hospitalor nursing home does not have a death on its premises. At times, lack of transport is used as an excuse by relatives to take such patients or even the corpse home.

Dilemmas consequent to Supreme Court ruling

Confronted with the recent ruling by the Supreme Court disallowing non-allopathic doctors from using allopathic drugs, I am in a quandry.

Suppose a villager suffers severe angina1 pain and the only medical attendant in his vicinity is a non-allopathic doctor who has often used nitroglycerine successfully in such patients, should the doctor be allowed to prescribe this drug or not? This question becomes even more relevant when the non-allopathic doctor later learns that a consultant cardiologist has prescribed the same drug in the same dose for his patient.

I have taught non-allopathic doctors to treat the victims of scorpion stings with prazosin. Several lives have been saved thus. Should these doctors now be disallowed to administer this drug in the absence of any other medical attendant?

Conclusion

The Supreme Court decision needs review if the health care system in our villages is not to collapse. There is no dispute over the need to ensure adequate training of non-allopathic doctors with provision for continuing education programmes and certification. We need to ensure that the medical practitioner does not deteriorate into a drug pusher.

Allopathic doctors need to be cautioned against disparaging their non-allopathic colleagues. We are well aware of the fact that most Indian medical colleges are of low standard. Our journals are full of shoddy papers with little or no peer review. The medical profession consisting of allopathic doctors is no more respectable or noble. The practice of medicine has degenerated into commerce.

Whilst the allopath demands huge sums from the patient, the non-allopathic doctor in the village is content with poultry, lemons, coconuts and clothes from his patients. As I ponder these facts, it occurs to me that Mahatma Gandhi would have been greatly saddened at the sight of the educated in the medical profession deceiving the illiterates whilst approaching the 21st century.

References

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