Correspondence

The Association of Rural Surgeons of India

In the early 1980s several members of the Association of Surgeons of India (ASI) who were practising in rural areas requested the parent association to permit them to form a separate section. They wanted to be able to discuss among themselves the unusual problems faced by those who sought to serve 70% of India’s population living in rural areas while 80% of our surgeons live and work in urban locations. This request was not considered since rural surgery chiefly consisted of general surgery and could not be recognized as a specialty by the ASI, which itself was started in 1938 by the then general surgeons.

It was pointed out that the different sociocultural and economic conditions of the rural masses together with the difficult terrain, transportation facilities and lack of specialists required an entirely different approach to what superficially seemed the same surgical problems in urban areas. Even if trained in a specialty in an urban or semi-urban medical college, surgeons practising in rural areas were forced to tackle all problems including life-threatening medical problems in the absence of any other medical facility. Even the surgical problems had to be tackled under improvised conditions due to lack of basic facilities such as the availability of oxygen, electricity, an anaesthetist, a qualified nurse, pathologists, radiologists and blood transfusion services. They had to learn to acquire new knowledge and skills. Also, they had to use many techniques devised by previous generations of surgeons not only in India but also abroad, especially under conditions of warfare, and adapt them. This required considerable ingenuity, originality and adaptability to save the lives of their less fortunate countrymen, which in itself was a challenge.

After three years of failure to persuade the ASI, a new Association of Rural Surgeons of India (ARSI) was formed at Shimoga in March 1992. Its first annual conference was held in October 1992 at the Mahatma Gandhi Institute of Medical Sciences, Wardha. Starting with 7 founder-members, ARSI presently has 250 full as well as 50 associate members from allied disciplines. Annual conferences have been held at various places in rural and semi-urban areas; the camaraderie and exchange of ideas more than made up for the simple conditions under which we met.

Several week-long, hands-on training courses for ARSI members have been held in medical colleges to keep them abreast of recent advances which are applicable under rural conditions. The members of ARSI have demonstrated how effective surgical care can be provided to all citizens at a fraction of the cost incurred even in our government hospitals, leave aside the exorbitant expenses incurred in private urban nursing homes and five-star hospitals. This demands a new approach to surgical care especially in ‘need-based’ countries such as India rather than blind adoption of what emerges from a country such as the USA where medical care has been converted into a lucrative business to which the medical profession has been co-opted.

To promote this new approach to medicine in the discipline of surgery, which has been highly mystified, ARSI seeks to train younger surgeons to provide services to their less fortunate brethren as well as to update their knowledge and technical expertise. The Indira Gandhi National Open University (IGNOU) was approached to utilize its facilities of distance education to serve the above purpose. As a result, a one-year certificate course in Rural Surgery has been evolved by IGNOU with the help of ARSI. It has 18 modules providing 30 credits. The course imparts basic knowledge in a variety of surgical fields suitable for those who wish to practise in rural and semi-rural areas, including how to establish a cost-effective rural hospital infrastructure. This course includes the use of two-way tele-conferencing facilities for discussion of experiences of ‘rural surgeons’ and specialists in allied fields. IGNOU provides audio and video facilities besides the published booklet modules for learning at home. The course also provides hands-on training and experience at various regional centres located in hospitals. Being a course developed by ARSI to suit the conditions prevalent in rural areas of India, it will also be suited for surgeons working in the SAARC countries using the distance education facilities of IGNOU.

This is not a high-tech course developed by a high-tech institution but has a philosophical approach which addresses itself to the care of the less fortunate billions in ‘need-based’ countries. No western university can provide this, as both the concept and practice are alien to their highly technical approach to medicine and health. This certificate course, which is a new and original concept, will have to be widely promoted not only in India but also in other countries with similar problems if Health for All is to become a reality rather than a mere cliche.

15 December 2001

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It’s time the twain meets


Seemingly, both these concepts have nothing in common—if anything, they present diagonally opposite viewpoints. Telemedicine invokes the god of high technology, astronomical expense and vindicates the thrust of the ‘haves’ to impart their standards of medical care everywhere. Health and medical care: A people’s movement, by contrast, emphasizes the concept of a panchayat healthcare system—from the grassroots up with integration of various systems of medicine—that healthcare is more the maintenance of good health, not only the treatment of disease. The more I read and re-read both these articles (as also the book itself) the more I kept asking myself is it not possible for the twain to meet? Can we harness the high technology of telemedicine to activate and kick-start a people’s movement? The only people’s movements I know of in India were started at the grassroots level by the likes of Gandhiji and Vinoba Bhave. In this century, which is sadly devoid of Gandhis and Bhaves, could motivated technology breathe life into a people’s healthcare movement—a concept of healthcare advocated over 60 years ago by Gandhiji?

Could it be possible for those of the technological mindset who participated in the first national conference on telemedicine to get...
together for meaningful discussion with those of the mindset of panchayat health, with both groups removing their blinkered rigidity and seeing the Indian health scenario (or should it be termed fiasco?) as a sad yet urgent challenge—a challenge worthy of the total effort of every means of succour—technology, resources, various healthcare modalities, awakening of the people that their health is their business and not largesse but their birthright.

17 January 2002
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Communal riots: a deja vu

During the recent communal riots of Gujarat, we witnessed a replay of the inhuman acts of violence seen in Mumbai 10 years ago. The data presented below are the break-up of 359 casualties received in the emergency department of the L.T.M. General Hospital, Sion, Mumbai over 3 days of rioting in December 1992. This is a gruesome reminder that mindless mob frenzy causes damage to both sides and leaves the whole world blind. The average age of those affected was 26 years. There were innocent bystanders which included 5 children and 6 elderly persons caught in the crossfire. The youngest was a 3-year-old girl who was attacked with acid and the oldest was a 77-year-old man attacked with fist blows. The victims (and perhaps the attackers) were all men, except for 13 women (3.6%).

As in the recent riots, the weapons used then were stones, bricks, tiles, broken tube-lights, broken glass bottles, sticks and bamboo, iron rods and metal pipes, hot oil and acid, choppers, swords, sickles and knives, and cycle chains, guns and bullets.

The experience at the K.E.M. Hospital, Mumbai was similar. Despite the proliferation of the private sector, the onus of treating the large number of casualties of major disasters always falls on public hospitals which are overwhelmed at these times of crises.

Unfortunately, such calamities have not been a consideration for any disaster management or health budget planning. This year’s health allocation has been around 1% of the GDP, whereas it should have been at least 3%–4%.

6 March 2002
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