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During the twelve month period beginning November, 1971, I worked as a volunteer physician in Kontum, South Vietnam, at Minh-Quy Hospital, Pat Smith's facility for indigent Montagnards. The hospital is ostensibly one of about 100 beds, but the usual inpatient census is closer to 130, at times reaching 170. Staffing is from two sources, Westerners and Montagnard tribesmen. The Western complement is usually comprised of two physicians, three to five nurses, and various ancillary personnel — a handyman, an administrator, a lab advisor, and a village health worker instructor. The Westerners are a truly international group, with representatives from China, Switzerland, New Zealand, Korea, Germany, France, Australia, and Great Britain. The Montagnard payroll numbers roughly 100 employees of various occupations, and the bulk of the actual work of the hospital is done by the local people, with the Westerners advising. Supplies are from varied sources, and adequate stocks prove a continuous challenge. The bulk of medical materiel is provided by USAID funds and distributed by the Ministry of Health.

The population served is roughly 90% Montagnard, the rest being ethnic Vietnamese. The setting is a city of 30,000, though most of the Montagnards come from hamlets in poorer areas outside of town. Most of the urban Vietnamese get their care from the Kontum Province Hospital, run by the government.

The climate is tropical, but the standard of living is somewhat better than is found in India, Haiti, and parts of Africa. The war, however, greatly affects, both directly and indirectly, the health of the area, and provides many additional challenges to the provision of medical care. For example, primary malnutrition is not seen, except in those persons under siege, or forced to live in the jungle for several months while fleeing hostile forces. Malaria is rampant, including chloroquine-resistant strains; and, of course, tuberculosis in all forms is highly prevalent. Plague is endemic in our Central Highlands location, and is, fortunately, as curable as it is deadly and swift. Respiratory infections and diarrheal diseases are two other major categories of pathology seen; and the types and incidence of trauma vary widely with the tides of war.

The needs of the population served by Minh-Quy, from a medical standpoint, are several. Of highest priority should be the introduction of public health concepts and training in specific measures for combatting certain target problems (Malaria, TB, childhood diarrheas, plague, for a start.) Secondly, decentralization of preventive and curative resources (already begun quite successfully at Minh-Quy) would decrease the lag between onset of symptoms and initiation of treatment. Common and fundamental to both the above

goals is an effort to improve the basic level of education of the Montagnards, a formidable task, given the current social and political climate.

The past year in Kontum has been an eventful one. It was a year in which new situations continually forced reevaluation of some concepts long taken for granted. Kontum was relatively quiet until April, though the Communist build-up and intentions were obvious long before. With the onset of the push for Kontum, though, most of the Western staff was forced to leave, the hospital was divided physically between two cities, supply lines were cut, and the patient population doubled, virtually overnight. Furthermore, the proportion of surgical type cases quickly rose to the 80% level, requiring a greater degree of attention for the individual patient.

The adaptations forced by these new stresses provided a valuable education to the Minh Quy staff. Of primary importance, the experience forced the Montagnards to perform the more complicated functions, to accept the roles of higher complexity and responsibility that they were accustomed to leaving to the Westerners. This was a painful transition, but I don't think patient care suffered significantly. This upgrading of responsibility was extended all the way down the line, and formerly custodial workers rapidly developed into quite competent dressers, etc. With the drop in available supplies, and the need to provide food and shelter for patients, staff, and families in a strange city, the Western staff was forced more and more into administrative roles. Hard as this was at the time, this shift in responsibilities seems to have increased the effectiveness and survival value of the hospital, and "Montagnardization" is still the practice at the time of this writing, even though the stresses have diminished considerably.

Without doubt, this has been a difficult year. The rewards, however, are easily worth it. Professionally, though the experience is nil with respect to ischemic heart disease, diabetes, and the like, the exposure to the management of bizarre trauma and exotic infectious disease was well worth the time. Even the more common problems provided a challenge, as their presentation is usually quite severe, and diagnostic facilities are quite limited. The experience in Kontum highlighted for me the value of reliable paramedical personnel as well as non-medical administrative and logistics workers. The main drawback is the lack of adequate time and facilities for reading. This time, though, can be made up.

The cultural aspects of the experience, I feel, are by far the most rewarding. An encounter with the Third World can be of considerable value to anyone truly interested in people. One gets an inkling of what is essential for civilization, what traits are common to all humanity. Moreover, one is provided with a different perspective from which to view our American life. For example, working almost solely with Montagnards,

a dignified, humble, grateful people; simple, yet quite capable, I have been able to view racial oppression (on a scale probably not seen in the US since the South of a generation or two ago) through the eyes of one oppressed. Politically, by working with civilians directly, one is given a closer view of the significance of the war.

The VPVN program offers the physician a vehicle for providing medical services in Vietnam with a minimum commitment on his part. The efficacy of the program in achieving its goals is a function, I think, of the suitablity of the individual physicians for the tour. From my admittedly limited experience, I feel that applicants could be more closely screened. In the remaining months of the program, the emphasis, as it has been to some degree all along, should be on training and public health activities, with de-emphasis of solely curative services. This is a lesson we learned the hard way in Kontum.

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