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After my first tour with VPVN, 13 months(1971-1972), I was impressed that the primary service that Western physicians could render the people of Vietnam was not so much in the area of direct patient service, but in guiding local efforts where possible, within the context of the culture, teaching where possible, helping with organization of health services, and influencing attitudes toward delivery of health services, should the opportunity present. It is extremely difficult to divorce oneself from the immediate pressing need for direct patient-oriented curative service, but, in order to accomplish anything of more permanent benefit, it is important to clearly define the objectives of any input of effort, and to ~~never~~ avoid sacrificing long range improvement in favor of immediate, though temporary ~~and~~ palliation of an extremely difficult overall problem.

Toward this end, my most recent two months in Vietnam were again spent at Minh-Quy Hospital, Kontum; a facility with only Western doctors, and Montagnard nurses. Fortunately, sufficient physician staffing was present, so that the pressures for immediate patient care were minimal. The two month period was spent in training four of the most advanced of the nursing staff to function as nurse practitioners, screening all presenting patients, taking care of those within their range of ability, and referring the rest after ordering appropriate laboratory studies. The training consisted of overall evaluation of the patient (history and physical), an approach to intelligent evaluation of infectious illness, use and misuse of diagnostic laboratory facilities, record keeping, and diagnosis and treatment of those diseases most commonly seen in the area. The workers were supervised in an on-the-job setting as well as given didactic sessions (1 or 2 hours per day). At the end of the training period, the trainees were performing quite satisfactorily evaluating newly arrived clinic patients, prescribing treatment according to standardized treatment regimes, and deciding with a refreshing degree of accuracy which patients were in need of referral, and which were not.

Should, as happened last year, security no longer permit a Western presence at Minh-Quy, I feel that these trainees can provide a necessary first approximation to satisfying the medical needs of the Montagnards of the area. The hospital death rate will rise, but the bulk of the serious illness, the diarrheas, the pneumonias, malaria, TB, can be handled without a fully-trained physician. If security remains satisfactory, these persons will be used in their screening function, thereby freeing the physicians for more attention to the very sick, surgery, and hopefully, preventive efforts.

In a recent letter to the editor of the J.A.M.A., a Thailand-based American physician wrote of the needs of health care in Indochina, and warned that any effort should be based on the local culture, avoiding where necessary some of the impracticalities of a Western model for the government health care system. He also emphasized the overwhelming importance of a preventive approach. My sentiments are in full agreement. Any future programs for health assistance in this area, in my opinion, should follow these general guidelines:

1. Objectives should be clearly-defined, limited in time and scope, and attainable.

a. Without a clear idea, stated in detail, and never lost sight of, of what your money and effort is trying to do, the vast needs of this area can easily dilute any input into a number of ineffective channels. For example, is the objective to provide X number of health personnel or medical facilities (looks good on paper and politically), or is the idea to improve the health of the people? Which people? What is the yardstick by which their health is measured? (Not reliably measured by number of health personnel, etc.).

b. Health care is a long-term effort, but open-ended projects can easily lose direction. A series of short-range objectives should be defined, and long term projects be accomplished in well-defined stages.

c. Whatever the objectives defined, they should be compatible with the needs of the people, with attention to a realistic schedule of priorities. In this vein, preventive efforts, well-structured to ensure long-term continuity, will provide more value per dollar than the highly specialized hospital. The muchy current National TB Control Programme is a well conceived, practical effort, but it needs to be implemented where the people are.

2. Some attempt should be made to evaluate the effectiveness of whatever inputs are being made, on a continuing basis. If the effort is not succeeding in approaching the desired goal, why not? What can be done to correct the course? Is it worth it?

3. Personnel should, with few exceptions, be long term (My usefulness in effecting any more or less long-term (though minor) changes did not begin until I had been in country at least six months.) A two-year period of service should be minimum, I think. New personnel should be well-oriented in the US before they are inundated with the immediacy of the problems here.

a. They should attain a thorough understanding of what they are coming here to do.

b. They should receive as much orientation to Vietnamese culture and medical realities as possible. This includes basic language training.

c. They should be oriented somewhat toward Third World medicine. Maurice King's Medical Care in Developing Countries is a useful start.

In planning any future medical assistance for Indochina, the experience of the VFVN program should be thoroughly evaluated. What was the state of health of the people of Vietnam when the program started? What is it now? How much of the difference is due to VFVN, and how much to other factors? What has it costed? I strongly feel that assistance to the people of Vietnam is a worthwhile endeavor, and that progress is achievable only with a clear definition of target problems, coupled with a rigorous evaluation of results in relation to cost.