DEBRIEF OF A

USAID BRITISH PHYSICIAN

VIETNAM

1963 - 1967

No. 306711

Control Code 306711

# PRÉCIS

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This British physician is known to his AID associates as brave, dedicated, outspoken and skillful. He has had considerable experience in nurse training and relates well to them by their own testimony.

He makes the following observations:

a. There is a lot to be said for small medical teams.

b. Vietnamese nursing staffs should be trained and administered under a chief nurse.

c. Vietnamese midwives are quite good, but tend to be very independent.

d. Mosquito nets are useful, but screens are a waste of time and money in a Vietnamese hospital.

e. All Free World Forces medical people worked together splendidly in Vietnam -- military and civilian.

f. Vietnamese nor Montagnards follow medical instructions unless they are closely supervised.

g. Members of the family accompany the patient to the hospital and "live in." Although this creates congestion, relatives serve a necessary role in the nursing process.

h. The Vietnamese and Montagnards are good patients because for the most part they don't know what's going on--there's no Vietnamese Reader's Digest to confuse them. They must be watched as they'll take pills indiscriminately. They also feel that real medical care is provided by an injection.

i. The status of doctors in Vietnam is very high. The intellectual standard of the modern medical student is very high, but there are no facilities for post graduate training. The pay of doctors is very low.

j. Training is in French, but the Vietnamese should be taught in English because most modern technical books are written in English. There is also a grave shortage of teachers.

k. The influence of the Chinese herb doctor is still very strong which means that the modern physician is often a last resort and sees the patient in advanced stages of diseases.

l. The smarter members of the Vietnamese medical team often end up as an administrator--which is sad.

m. There is a problem in the use of drugs. Their origin varies, their nomenclature differs and they have various national proprietary names--American, English, French, etc.

n. The paper work involved in getting supplies is incredible.

o. Americans tend to think in terms of American requirements. They supply big, complicated, expensive equipment that can't be used or maintained. It's better to do things in a practical, small scale way.

p. There is a requirement for an institutional memory and greater continuity of personnel.

q. Aid to Vietnam ought to be specialized by country. For example, only one country should supply automotive equipment and spare parts.

r. Preventive medicine in a country at war is best handled by the schools.

s. Outside of tuberculosis and cholera, there is no unusual amount of communicable diseases in Vietnam. Infection is common and parasitic infestation is almost 100%. Leprosy appears in certain locations more than others. It seems to occur more often in certain longitudes. The Vietnamese, including medical personnel, are superstitiously afraid of it.

t. Nurses should be sent back to the provinces from whence they came, but they would rather serve in the big cities.

u. American doctors could profit from Area and Operations Training such as offered by ATC. It would be costly, but worthwhile.

v. Medical care is available to the people of Vietnam on a scale never seen before and it is far better than in other developing countries.

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## PREFACE

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1. To obtain general information for the indoctrination of ATC overseas trainees that will be of value in their intended area of assignment.

2. To obtain specific information that will be of value to the trainee in performing in his specialty (agriculture, engineering, medicine, etc.).

3. To provide material for understanding the social and cultural framework of a country, and its particular and peculiar dynamics of social change. And, as a correlate, to discover customs, mores, taboos, etc., which affect interpersonal relationships between Americans and members of a host community.

4. To accumulate a bank of new or updated knowledge for fundamental research and application to future development assistance programs.

5. To put on record information on the functions, roles, frustrations, complaints, successes and failures of AID Field Operations Personnel that may not have been made a part of official reports.

6. To extract problem situations of sufficient complexity and significance to construct what is commonly known as a "case study" for use in ATC seminar problem-solving exercises.

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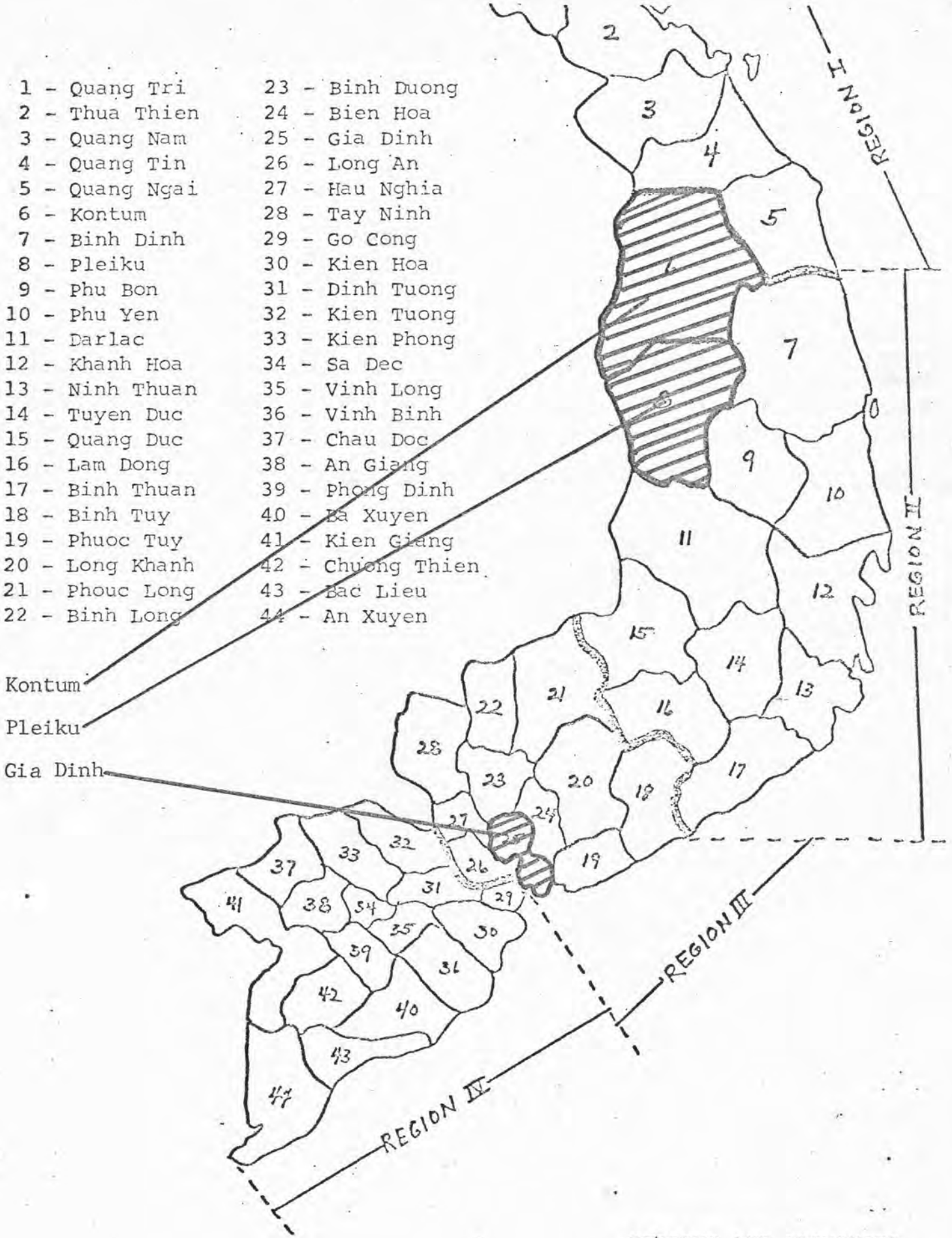




REGIONS AND PROVINCES
OF
SOUTH VIETNAM

Control Code 306711

# DEBRIEF OF A USAID BRITISH PHYSICIAN

# VIETNAM

# 1963 - 1967

## Preparation and Orientation for the Position

I am a British subject and I first went to Vietnam in May, 1963, having had two years experience in the Far East before that. In 1960, I went to Laos with the First British Team under the Colombo Plan to work for the Laotian government in the remote areas. The team consisted of two doctors and the British equivalent of a Peace Corpsman. There would be a team of three living in a small village, running a dispensary, doing surgery and holding out-patient clinics. I was recruited to go to Vietnam when I had been back in England for a few months. I was recruited with a group of British and Malay Montagnard aborigines who were being sent to Vietnam under the auspices of the United States government to help with the development in the Montagnard areas. I was the doctor for this team and medicine was one of the principal areas in which we wished to assist the Bahnar tribe in Kontum province.

I didn't expect very much when I got to Vietnam, but I found that the work was more pleasant, more rewarding and generally easier than I had expected. And I found the Vietnamese were atom bombs compared to working with the Lao people. In Laos we were working in a very, very small Mekong town which only had about eight shops and three large monasteries. A lot of my work consisted of seeing neurotic monks. Also living conditions were particularly ordinary via the Colombo Plan. Under the terms of the Colombo Plan, host governments provide housing. The Lao government doesn't really have any money at all for this sort of thing. In fact, this has now been abolished but in our day we had to get our housing from the Lao government. We lived for two years without electricity and water in our houses or in the hospital, and we managed with pressure stoves, kerosene lamps, etc.

## Working with Montagnards

Our team took several months to get off the ground whilst we were in Vietnam and I spent about three months in Pleiku province working in the provincial hospital, where I substituted temporarily for an entire surgical team which had been there six months. I worked in that hospital by myself until my team assembled in Kontum province. We were located in a camp working with the local Bahnar

people. Whilst I was there we built a small hospital, which was completed the day I left. Due to various political problems after the fall of President Diem, the team withdrew from the country around December of 1963, but I was asked to stay behind. I think probably for political reasons so that something would be left. I then moved down to Kontum and spent the next nine months working by myself--the only foreign doctor--in the provincial hospital there. This was a relatively easy job because we were not very busy, the hospital plant was pretty good and we had a lot of excellent Vietnamese nuns who looked after the patients very well. The chief nurse was a nun.

The local military doctor was in charge of the civilian hospital as well as the military hospital. This meant that he didn't have much time to spend on medicine because he had to administer both hospitals. He was an able man and as far as I know, he's still there. He likes the area up there. I didn't do surgery--my post graduate training was in anesthesiology. I persuaded the Vietnamese military hospital to do all of my major surgery, and I gave all of their major anesthetics. This worked very well. Kontum is a very well-developed town; it's had a very strong French, Catholic influence for 100 years. There was a Catholic mission hospital in Kontum with an American woman doctor, Pat Smith, who is rather famous.

They had a very good orphanage and an excellent leprosarium run by French nuns. There was quite a lot of medical help in quite a small town. We had the usual problems, of course--lack of electricity and water. An X-ray machine was sent to us because the Minister of Health, who was with the then Chief of the Public Health Division of AID, had been impressed with the hospital when he visited it. So, as a sort of present, he sent us a fast X-ray machine and a generator. We managed to get those installed just about the time I left. We also installed a water pump.

There were lots of small things that we could do in that hospital that big teams couldn't do. There's quite a lot to be said for one doctor working by himself who is not particularly busy. I used to run the out-patient department. Patients were screened and about 200 would come to the hospital. I would see about 30 in the morning. The first thing every morning was about ten dental extractions. I would line them up, give them all local anesthesia, and by the time the last one got his injection, the first one was ready to have his tooth pulled. I limited it to ten a day because one could just go on forever. I also ran the male ward and was assisting in developing the hospital. New buildings were planned and going up whilst I was there.

I got acquainted with my environment gradually. Dr. Smith, the missionary doctor, used to send for me occasionally to come do anesthesia when she needed to operate. I gradually got to know

the town and her hospital. The civilian hospital had an old man who was a *medecin ambitionnaire*[1] from Hanoi--he was very ill and very old. The hospital only had about ten or twenty patients and an evil reputation.

I can't remember exactly how I engineered my way in. I know, though, that pressure was put on me to go back to Pleiku where I had been before I worked with the Montagnards. I resisted this pressure very much, partly because Kontum Hospital was an easier one to run and Pleiku Hospital was very difficult. I thought I could do a better job, and I liked Kontum. Also it had Dr. Smith there. It's a great comfort to have another doctor to turn to in times of trouble and I also knew the military there. I think I just more or less moved in on my own and started to work. The old *medecin chef* retired and another Vietnamese doctor, who had been in the States on some public health training course, came to take his place. He was only too glad to have me take half of the load and also as someone to talk to. He was feeling culture shock. Kontum is a place that the Vietnamese consider like Siberia.

At that time I lived in the MACV compound. I had a room there, and the MACV people were extremely kind to me. I helped them to a certain extent when their doctor wasn't there. I used to run their dispensary for them, so it was a symbiotic relationship. After a few months I moved out of MACV, because it was getting very full and as a civilian I had no right to be there. I moved into the province chief's guest house. He had a row of four rooms, each with a small bathroom--just a simple room and a bathroom. I lived in one of those, and the American provincial representative lived in another. The other two were used as guest rooms. This was really very convenient. I had bought a bit of furniture and it was really quite nice. For food I tended to live on bread and tomatoes and things like that. I used to go to MACV occasionally for meals or perhaps with Dr. Smith, if I happened to be working with her.

At the Kontum Hospital they cleared out and painted a room for me. This had been the out-patient area. They fixed it so that I could sit there with my instruments, supplies, equipment, etc. and the patients could be brought in one by one. My idea of hell is a perpetual out-patient clinic in Asia, and this is probably what my end will be. You're exposed to all these clutching hands and a lot of terrible noise going on. I didn't have an interpreter and I didn't speak Vietnamese, but I spoke enough French and the nurse spoke French.

One of the successful things that I was able to accom-

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[1] Medically trained, but not a fully qualified medical doctor.

plish in the hospital was to make one of the nuns chief nurse. She was a very, very remarkable woman--small and very energetic. Because of that, we did manage to advance our patient care quite a lot. I used to inspect the hospital every day. We were not, as I said before, working under great pressure like some of the very busy hospitals. I used to inspect toilets and showers every day to make certain they were clean. I built simple incinerators and was obsessive about burning everything as it was soiled. The chief nurse and her nuns painted the beds and we got the place really tidied up and it began to fill up with patients.

Some of our nurses, of course, were not as good as others. The midwives, although they were quite good, were very independent and the midwifery ward was a place that I tended to avoid. I didn't like some of their practices but you can't change everything. I think that I was probably more impatient then than I would be now. I'm several years older and wiser. I realize there are things that can't be done. The hospital did seem to get quite a bit better--for instance, the kitchen used to be an awful sort of grass hut. We managed to get a new kitchen built and USAID gave tin trays--Army style meal trays--which were handed out every mealtime to the patients. When they finished, these were taken away which meant that all of the scraps of food were then removed and not left lying around anywhere. We kept pigs and the scraps were given to the pigs (the nuns kept the pigs). The trays were washed and put in the sun. This and burning the garbage eliminated flies; we didn't have a fly problem after a time.

The patients slept under mosquito nets, and I even stopped screening altogether. I think screening is a waste of time in Vietnam (it's one of my hobby horses). It's a sort of American visceral reaction to screen any building. It's all very well, but it rots so quickly, especially on the seacoast areas. Patients push their fingers through it, they want to throw things through the window, and if the screen is there the stuff either topples back into the room or they make a hole in the screen, you know. The screen doors never fit and never shut, so it really seems to be an awful waste of time and material for screening. What you should do is make a real attempt to clean things and burn things. We were successful in this.

We sold the pigs eventually and built a very nice school with the money, employed a teacher who taught the children of the staff and any patients' children that were around. This was a very liberal thing. It was the nuns' idea, and it's just that I helped them. We installed a generator and built a generator shed during that year and a water pump. We opened up the surgical suite which was one of 26 which had been built around the country by AID over the preceding couple of years. They're all in use now, but when I was first there, it was just full of supplies and things.

The USAID nurse used to come about every six weeks and spend three or four days with me. We really worked hard in those days, unpacking things and setting things up so that when I left and this team replaced me, the surgical suite would be in operation. We closed down the old surgical room, which was a horror show, and we closed down the old X-ray and installed a new one. I got a lot of support from everybody around. Paint arrived and we had people sewing pajamas for patients and this sort of thing. These are trimmings but they are worth doing.

We had quite a lot of missionaries in the area. We also had 35 French Catholic priests living in villages in the area, and they tended to bring more patients in--their Vietnamese patients. Vietnamese patients tended to come to our hospital and the Montagnards went to Dr. Smith's hospital. She spoke Bahnar and her hospital was really for the Montagnards. I was able to give the priests and the missionaries things like aspirin and simple drugs. They always came with a shopping list. The hospital filled up and when I left I suppose we had about 120 patients as against about 20 when I first arrived.

We grabbed and used anybody who had any expertise. We'd get the MACV doctor to come help sometimes, and the Vietnamese military doctors would help. Once a week I would go with the medecin chef on ward rounds, and he would come around my wards and I'd ask his advice. This was very helpful. Frequently, Dr. Smith would have to send patients to the military hospital for X-rays or surgery and then take them back to her hospital. We tried to work together as much as we could. On one occasion the Special Forces camp was attacked by the Viet Cong; they overran it in fact, five miles away from Kontum. I was flown in with the military and I did the triage.[1] I evacuated 32 patients. The helicopters were landing and taking off all of the time. We had, I think, 39 dead. We just simply had to mobilize the entire province and the province of Pleiku as well. As the helicopters landed, I would sort the patients and say, "Take him to the military hospital in Pleiku," or "Take this one to the civilian hospital in Pleiku," etc. I did this on the basis of the fact that I knew the capabilities of the hospitals. Those that needed urgent surgery I sent to the military hospital either in Pleiku or Kontum. Those who were Montagnard or weren't very badly injured--just shaken up--went to Dr. Smith. Some of the minor things went to my hospital since I wasn't there. We got good cooperation from everybody on this.

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[1]The sorting out and classification of casualties of war or other disaster to determine priority of need and proper place of treatment.

## Vietnamese and Montagnards as Patients

Neither the Vietnamese nor the Montagnards followed instructions as to taking pills when they were supposed to. The Montagnards didn't because they didn't understand. Of course, like most Asian people, they preferred an injection to anything else. They didn't feel as if they'd been treated if they didn't get an injection and they traded the pills amongst themselves. It was a big problem. Say I had a patient on antibiotic pills--tetracycline--I used to bring them back every day to see if they took them. For the town Vietnamese this worked pretty well. They used to come back, but it was very difficult to get patients to come back. They were just not disciplined to coming to the doctor's office as we are and, of course, with the Montagnard people, they probably didn't know the day of the week anyway. It was very difficult to get them on a schedule. Therefore, we tended to hospitalize patients in a place like Vietnam that we would normally not hospitalize.

Invariably the family accompanied the patient to the hospital. Usually this consisted of the wife or mother and two or three children. Mostly the children came if the mother was sick also. It's hard to say how much of the family accompanied the patient, but there usually seemed to be two or three people with the patient, and they slept in wards and in the beds with the patients. They were an essential part of nursing care. In the children's hospital in Saigon, obviously, when children were sick, their mothers came and brought other small children that couldn't be left at home.

This created a bit of a problem of congestion. We were planning to build a day care center for the children and the mothers to give them some occupation during the day just to keep them off the wards and also provide a laundry for the mothers and some simple training in nutrition. I don't know if it's been completed yet, but I think it's a very good idea. We used the time with the families to get them educated about some of the things that would be helpful but, we wouldn't expect really to achieve a lot because it was a shifting population. It's just like telling patients not to spit on the floor and walls. They don't after a few days, but they go out and others come in.

A lot of patients and family members seemed to live in some of the hospitals permanently--almost like refugees. There was very little social work done in Vietnam. Their society wasn't really geared up to it. In the Buddhist-oriented society the family comes first. If you're not a member of their family, the people are not going to be concerned about your welfare. It does mean, of course, that within the family you get very good care. The old people are not neglected and there were very few--I have

seen some, but very few--old people's wards in the hospitals.

In performing charitable deeds, most of the organization was within the Catholic church. It was hard to distribute charity goods easily through Buddhist organizations because they just didn't have the framework. This may come in time. There are very many people with very high motives and money to use who are frustrated because they can't find a reasonable outlet for it. One should use the people in AID working in the provinces to find out what is necessary for real charity work.

We found Vietnamese and Montagnards to be very good patients in many ways. I don't think they realized what was going on most of the time and I think they were always grateful that a procedure was being performed that didn't hurt them. There was no cultural thing you had to overcome. You see, a patient's knowledge of medicine and medical techniques in the East is very much less than in the West. They don't have the Reader's Digest, you know, to tell them all of the latest developments before the doctors have even heard of them. We definitely spent much less time explaining to a Vietnamese patient about what we were going to do to him than we would to one of our own nationals. They didn't ask very much--they had a faith in the doctor.

## Second Country Asians, Philippine Medical Team

In August of 1964 I was asked by the headquarters of the Public Health Division in AID to come to Saigon and work in the main office. Since the Division was about to expand very rapidly, they wanted some people who had experience in the country to start running some programs. I left Kontum and was replaced by a Philippin civilian team consisting of two doctors and two nurses. They were reasonably efficient but not especially effective people. They seemed to get on very well with everybody, but they did seem to have quite a lot of housing and personal problems. The team used to take leave all together. All four of them used to go away at once. Every time one wanted to go away, all the rest went with him. While they were gone the Vietnamese would have to run things. This on again, off again business is very bad.

## Out-of-Country Training for Vietnamese Doctors

The medecin chef in Kontum province and I got along very well. He wasn't a very active man and had been in the States for a year doing public health training in Maryland, which was a year of wasted money actually. He considered it a year of wasted money himself because he said he was taught the wrong things. He was

taught things like air pollution problems in Baltimore, and this sort of thing, which is not really relevant outside of Saigon. There is a lot of air pollution in Saigon, which is mainly due to the vehicles and diesel trucks. I don't think that he was the kind of man to be very keen on government service anyway. He was definitely sent to Kontum as punishment for not having done well in his course.

He could possibly have studied something that would have been more applicable during his year in the States, but I think it's probably true that he didn't try very hard. I think that some people may have gotten some value out of that course, but the last I heard was that he was going back to the States--this was about four years later--for something else, which would have been mad. He eventually was relieved of his post and went back into private practice in Saigon, which is what he really wanted to do. He had a large family to support.

There was one doctor in Saigon with whom I worked who had returned from the United States with his Board in Anesthesiology. He was very, very bright and I was counting on his help in a training program for nurses. He was opposed to this plan to start with because he thought we couldn't give them adequate training in six months. He didn't want to tarnish his academic reputation by getting involved in a project that might fail.

We had a lot of good luck over this just the same. In 1965 I managed to persuade the British government to send him to the European Congress of Anesthesiologists (he'd been back in Vietnam about a year) which was convening in Denmark, and then on to England for three months, where he was to work in special centers which I had selected. I had the great good fortune to be going to London and Washington on TDY for AID so I accompanied him to Copenhagen and he attended the Congress. Of course, since we were from Vietnam, we were very much in the news. Everybody wanted to talk to us, and he did meet a lot of people. Then we sent him to Oxford, where our anesthetic apparatus had been invented, and they thoroughly brainwashed him. They sent him on to another professor and then on to my old teaching hospital in London. He came back quite a different person. He'd already had five years of good training in Canada and the United States but for some reason this short tour seemed to have worked magic with him. He came back full of enthusiasm and was ready to take over the course.

## Medical Training in Vietnam

The rank and status of doctors in Vietnam was very high indeed. It was one of the most prestigious jobs. I would say that it was higher than it probably deserved to be, but they did tend

to respect the doctors and their judgment. The kind of training they had for doctors in Vietnam varied. In the days of the French, the university was in Hanoi. Certain picked students spent three years in Hanoi and then went on to Paris and finished their work there. A few came back to Vietnam. Others took only the three year course and are what is called medecin ambitionnaire. One still meets these in Laos and, I believe, Cambodia. There are fewer of them now in Vietnam as they seem to have died out.

When the country was divided in 1954, about half of the medical faculty in Hanoi moved south to Saigon. Several of the professors then became professors agrégés from the faculty of Paris, and they set up a medical school in Saigon with a six year course. The physical facilities in the past had been very poor indeed and they hadn't been able to do as much experimentation or as much lab work as the medical students do in the West. The intellectual standard was rather high, however, when they finally made it. The system seemed to be that almost anybody could start, but not very many would finish. This has now been changed and there is an entrance examination.

Some still go to France for their training, but with the six year course now in Saigon, if the students get through it, they know a lot. Dr. Edmonds, the leader of the British team which teaches in the Faculty of Medicine in Saigon and at the Childrens' Hospital, thinks that probably the intellectual standard of the Vietnamese medical student is higher than the British.

The problem came in at the postgraduate era because all of the men virtually were drafted into the army for at least four years. They got stuck away in some dismal command post for the first year or two with no intellectual stimulation, and no discussion with their peers during this time or exposure to journals. Their curiosity very often died away. At the same time, though, they would probably be practicing private medicine, but of course their pay was very low indeed. An army doctor got about $120 a month and a civilian medecin chef in the provinces didn't get very much more. The problem was that, in the postgraduate era, there were no facilities for teaching postgraduate medicine in Vietnam. It will take a very long time. Specialty training is the problem.

Every Vietnamese doctor assumed that he was a surgeon on the day of his graduation--with some pretty dire results. Many of the doctors were excellent and well trained, but for the next 20 or 30 years, I think the pattern will be undergraduate training in Vietnam and postgraduate training in another country. One just hopes that we will be able eventually to cover all the specialties. Of course there's a chronic doctor shortage which is getting worse, not better, because of the population increase. This is a worldwide problem. The proportion of doctors to the population leaves

an ever-widening gap throughout the world.

During the six years of training, their work was not all academic. It did include practical training and internship. I think the first three years they did basic sciences. Their anatomy was extremely good, and they had a brilliant anatomy professor. Physiology, I think, was still in the early stages. They didn't have the physical plant and apparatus to be outstanding really. I don't know about physics and chemistry. But in their later years they did intern work. As students they lived in the hospitals and very often night duty was covered only by students. They got much more practical surgery during their studentship than any student in the West, but by the same token, it wasn't as closely supervised. Recently, in the last year, we opened a new basic science building in Saigon. This project was jointly funded by the United States government and the Ministry of Education of Vietnam. It was very, very beautiful. It was better than I've ever seen anywhere else in the world. Certainly it was better than we have in Britain, but there will be tremendous maintenance problems. Other problems they had were in language. Most of the students spoke French. French medical textbooks, though, tend to be rather old-fashioned, even those printed today. They'll have illustrations rather like the ones we had in the early part of this century. The students wanted to be taught in Vietnamese (it's the nationalistic thing). That created problems because the vocabulary doesn't yet exist. We would like for them to teach in English. It would be sensible to switch to English because worldwide an overwhelming proportion of medical textbooks and journals are in English. Also, most international conferences are in English and postgraduate students and senior doctors must go from Vietnam to the international congresses to keep up to date, to be seen, and to talk to and meet people. Therefore, they must have a command of English. Fortunately, Vietnamese are brilliant at learning foreign languages; they have no difficulty. If the students would put nationalism aside and concentrate on learning English in their early youth, I think they would accomplish more.

There was a very grave shortage of teachers in the Faculty of Medicine. I think only about 25% of the slots were filled. Professors are going from the United States under the AMA contract to help at the University. They only stay for a month or two and I don't really think they can do very much in that time. They can deliver lectures, but it's just like any professor coming in only to deliver a lecture and going away again. You need a nucleus of dedicated individuals to stay year after year after year. I don't know what the answer is. There was one Belgian priest who had been in the Faculty for a very long time. It may be that we might have to contract with some religious group or order. I think there is a plan for doctors from medical colleges in the States to teach while on leave for a semester or a year, but I don't know how far it's gone because this is an area that I'm

not very familiar with. Education wasn't my line. I think it would be a good plan, and I think it has been proposed that a given medical faculty take a subject and keep it covered.

## Medical Practice in Vietnam

The influence of the Chinese herb doctors was still very strong throughout the country and it influenced the attitude of the people generally toward modern medicine. We saw more gross pathology in Vietnam than we ever did in the West because people tended to come to the doctor rather late. They would go off and have acupuncture or cupping or scarification or the local herb medicines first. They may, of course, have gone to several doctors at the same time, that is, shopped around and seen several in the same day and took all the pills they were given, often with fatal results.

The Minister of Health under the Diem government tried to limit the influence of the Chinese doctors (the herb doctors). He suppressed them and also controlled the sale of drugs and antibiotics. When the government fell, this group of people turned round on him, and he was in prison for two years. Because this official tried to do what we think would be the right thing, he suffered and was probably way ahead of his time. They had a tremendous influence over there. Of course, a lot of French people believed in acupuncture and things like that. We tended to see people with their diseases in very much more advanced stages than was necessary.

Technically, medicine was free in Vietnam, which means the clinics were often full of old ladies with backaches and things like this. I'm sure they had backaches but there's not much that could be done about this. Patients would, nevertheless, scrape together the money and go to see a doctor in a private clinic. What the free government service consisted of was out-patient service, drugs--limited really because they tended to only give small amounts--and hospitalization. There were paying wards where one could pay a certain amount of money, probably something like one or two dollars a day, for a more comfortable room. X-ray service was free. This was all absorbed by the government. There were additionally certain routine examinations made that were free to civil servants. For example, they had their chests fluoroscoped every year.

Because the government didn't have very much money to spend on medicine, due to the cost of the war, doctors and civil servants were very, very poorly paid and one can't blame them at all for turning to private practice. It was legal. Many of these officials practiced their private medicine early in the morning

and in the evenings. A few didn't have any private practice at all. They had rich wives. I would say probably 50% of the time these officials were in private practice. A hospital's chief doctor, in a province, may have been the only doctor there, and he had to spend a terrific amount of time on routine administration. The solution here is to train hospital administrators, and again this is a 20-year deal, that is, to train them and also give them prestige and power.

## Frustrations of a USAID Doctor

When I first arrived in Vietnam in the spring of 1963, I was confronted with a problem that has not yet really been solved. The U. S. Public Health Service had, through AID, sent four surgical teams to Vietnam prior to my coming. They were to be located at Can Tho, Nha Trang, Pleiku, and Da Nang. These teams actually contributed very little for the first year because the preparations for their arrival were not adequate. A sophisticated surgical team of doctors, nurses, and technicians cannot function without drugs and supplies, electric power, and running water. The team in Pleiku was pulled out for that reason and redistributed among the three other teams. This happened just when I arrived, and as a political sop, more than anything else, I was asked to work in Pleiku for the first few months.

The matter of inadequate supplies of one kind or another was a problem caused by some rather complicated factors. One difficulty that I had, for example, was that there are drugs which the British use and the Americans don't. These are manufactured in Britain and are used for certain anti-parasitic things. I used to get those through charity funds in Saigon. Of course, another problem was that drug names are different. One has to learn French, American, and English names for the drugs. But this wasn't much of a problem really. There are certain things, though, that we still don't carry, certain items which I used a lot of. An example is a drug such as intramuscular iron. There was a lot of anemia in Vietnam. A shot of this intramuscular iron will last a month. It's a very effective way for raising the iron count in the blood, whereas with pills, they had to take them every day, they constipate the patient, they got lost, and they're dangerous if taken by children. They still don't have intramuscular iron. They were still handing out sulphate pills after all these years.

There were not really any particular kind of supplies that I was constantly short of. It varied. It was difficult to say from month to month whether you're going to have a crisis in one thing or another. I believe that the supply system there has been shaken up a lot recently, but three years ago it required a year of lead time from actually ordering materials and having them delivered in

Saigon. Having them delivered from Saigon out to province was another problem. The paper work was quite incredible. I think now they've got a new system coming in where they can get supplies probably in about three months. We did, though, have a crisis over intravenous fluid, but that was nobody's fault. I think one of the firms in the States had some contamination and there was virtually a world-wide shortage.

Vietnam swallowed up an awful lot of supplies that the economy had to be geared up to produce. If the supply in the West lagged behind in a production item, there would be a shortage. There's a world shortage of quinine because a lot of it is being used in Vietnam, and that's one reason, but another reason is that there's a monopoly in its production. I know the price is terrible. It has gone up fivefold in the last few years. It's interesting that the economics in Vietnam are felt all around the world.

I was asked on my return to Saigon from Kontum in August, 1964, to join a new branch in the Public Health Division called Provincial Hospital Development. We were surveying provincial hospitals with the idea of updating them and upgrading them so that we could put in more teams from the United States and so that when we did, the teams could be more effective. As I said before, sophisticated surgical teams can't do very well without a running water supply. Vietnamese hospitals in general were built by the French in a pavilion style, that is, separate buildings started within a compound. Most of them were constructed around the turn of the century. Some had very little electricity. Most provincial towns were short of electricity. If the hospital was located quite a distance from the generating plant, not much electricity got through the wires by the time it reached the hospital.

In provincial hospital development we employed a firm of architects who used our own surveys to draw plans for these particular 15 hospitals. We had approximately $4,000,000 to do this with. The plans were then approved by the Ministry of Health, and we employed the big American construction firm of RMK to do the work. Since RMK in Vietnam operated on contract under the U. S. Navy, the NOICC (Navy Officer in Charge of Construction) was responsible for seeing that the work was performed in a satisfactory manner. It was rather a fiasco.

It took about two years and by the end of that time we found that we could only renovate ten hospitals. By then, the cost had escalated to $10,000,000. What happened was that there were too many people in the act--too many people were involved. We got a lot of very elaborate, expensive equipment shipped from the States which has never been used. I'm thinking of things like oil-fired incinerators, which the Vietnamese not only didn't know how to use, but there were parts missing. There were washing machines, too, for example, that as soon as the belt broke, it was useless because

it was too difficult to get replacement parts, and there was not enough water anyway. In this renovation program we didn't aim to build another Johns Hopkins. We aimed to give them adequate water, power, and sewage disposal. I don't think we have yet achieved that in any of these hospitals.

I think what probably happened is that inexperienced people sent us these things. I feel--and I'm speaking now as a foreigner--that many Americans overseas see things very much in Stateside terms. I don't know whether it's due to a lack of people who have spent a long time abroad in developing countries, but they seem to think that if they have it in the States, then that's what we get. A lot of these things could have been manufactured locally. Possibly the incinerators could have been built locally out of brick. We even had hot water systems in the kitchens, which, of course, was never used because they boil their water on open fires. They didn't have the money to buy the fuel oil.

Of course, the situation has improved vastly. It isn't all bad. We do have sophisticated teams who are able to cope now with what has been provided. I just feel that it could have been provided more expeditiously and cheaper if fewer people had been involved in the planning.

When I first came to Vietnam, I was pretty much cast adrift and forced to improvise. In those days I was not as integrated into AID as I was later. Being independent, in a way, had its good side. I had contacts with the British Embassy, for example, who had charity funds and didn't know how to spend them. This was a big problem and it affected quite a lot of agencies in Vietnam who had funds and didn't know how they could best be used so that they would get something for their money.

For a very small amount of money, about $350, we retiled the entire orphanage floor. Before this, it had brick tiles which were porous and dirty. For very little money we retiled it, which meant that they could keep the entire place clean easier by just hosing it down. A year's supply of condensed milk also came out of these funds, and things like salt, agricultural implements, and blankets for the Montagnard villagers were also provided. If you've got somebody on the spot who knows the needs and can be there to see that the work is done and that the goods are distributed, this is invaluable. Over the years we were able to spend a fair amount of money quite wisely on small projects that worked. It's not always the multimillion project that pays off.

## Requirement for Institutional Memory and Continuity

In order to effect permanent improvements in an under-

developed country, I still think that you need the continuity of a person. This is one of the big, big problems with everything in Vietnam. Tours come to an end very quickly, and people go away. With their departure a lot of accumulated knowledge dies. We can do this type of thing (your interviewing me), but it doesn't mean as much. When I left Vietnam, I had been there longer than anybody in the Public Health Division. I knew stories and problems that the Division had years before that nobody else knew about, and I had only been there four years, which isn't very long.

Of course, it's difficult to get technicians to go over there. They want to take their families. With the country at war, it's a unique situation. You can't compare it with colonial days when British, French, and Dutch administrators or doctors went to a country, lived there for 20, 30 or 40 years, learned the language and taught and built up a system. It's not the same. The situation is totally different in Vietnam. Here is a country at war and also a country emerging from a fairly dismal colonial history.

One thing that I felt I had accomplished was in my specialty, anesthesia. In the standardization of equipment, bringing in more equipment, and in training people to operate and maintain it, we have done a lot. This anesthesia scheme is an example of an idea that was followed through over the years. I'm talking about a span of only three and a half years so far. Really the plan would have to go on for another 20 years. There's no such thing as instant success. You do need somebody to follow it up. A lot of our foreign aid efforts fall by the wayside because people rotate so frequently and other people come in who don't know the history of a particular project or the history of the Division.

Even though accounts of these projects have been written up, I discount their value. Things don't come alive from reports somehow. People very often are so busy writing other reports that they don't have the time to read those that have gone before. The demand for reports seems to be inexhaustible. It's alarming. I don't really remember going back over the history of a certain project. I read the current reports as they came through. It's a rare person who reads back reports. The ultimate success, of course, with any project lies in training enough Vietnamese and motivating them to continue. I maintain that all of these projects need constant follow-up. They need somebody on the spot to follow through on the whole thing. Now, my colleague, the other English doctor, knows all of the problems I had when I left. He's got all of the files and all the letters that have ever been written and hopefully this will go on. But, if he were to leave and there was no one to take over, even after three years, these projects would probably bog down.

## Maintenance of Equipment

Providing equipment and providing the means of supporting and maintaining it are quite different. In my own particular specialty we have an example of both the good and bad aspects of the situation. We now have agreements with the British government to support efforts in anesthesia in Vietnam for some time to come. This, I think, is quite a good way of giving aid. The problem, however, is to stimulate the Ministry of Health into saying exactly what they want and, more important, what they don't want. Then appeals to various governments should be made to get government "A", for example, to take a subject, government "B" to take a subject or a particular project and follow it through. By following it through, I mean not only to provide the apparatus, but what's very important, the spare parts and the personnel to keep the thing going.

We had a Japanese anesthesia apparatus. It's a beautiful thing but the American cylinders didn't fit those machines. We had a British apparatus; we had umpteen types, but most of them couldn't be used. Another sad situation was ambulances. We had Landrovers, Toyotas, Volkswagens--innumerable types but very few spare parts. If government "A" concentrated on ambulances and spare parts and probably a few motor mechanics, that would be a solid aid project.

We managed after a fair amount of persuasion to get the British government to give something like $30,000 worth of Landrover parts. The Landrovers had been brought in during the pre-American era, about 1959. Now the Ministry had a couple hundred of these vehicles that were old and needed spare parts. With a comparatively small capital sum we could have put these back on the road again. This is the sort of thing we need. What is not needed in aid are some of these huge prestige schemes like the atomic energy reactor at Dalat. If there is no one available or able to explain how these things are to be used, or to give the spare parts and the facilities for repairing the apparatus, it's useless. There's no shortage of apparatus in Vietnam; there's just a shortage of people to maintain and repair it.

What is lacking in the Vietnamese is not the ability but the philosophy behind preventive maintenance. Public property never gets adequate preventive maintenance. It would be foolish to say that they're not good at repairing things when you look at the privately owned motor vehicles on the road. There are many, many old French cars, which haven't been made for 15 years, running perfectly well. Obviously they can keep them going. It's the pennyworth of preventive maintenance that's lacking. It's the attitude of living from day to day, which I think is prevalent throughout the East (certainly it was true in Laos) and the inability to look beyond the immediate question.

This is one thing that we tried to drum into and influence our counterparts in, but it's one that doesn't get very much attention. There is lip service but no real effort yet. I think it's a question of education and development, and we're a long way from getting it. There's a tremendous shortage of skilled operatives among the people to run generators, to repair medical machines, military vehicles, and things like this. A lot of the skill is in the military, of course. There's a great manpower shortage in Vietnam.

## Health Education

So far as educational programs that were aimed at preventive medicine were concerned, I had almost no experience and I wasn't very good on this. We used to have posters in various tribal languages on boiling water, killing mosquitoes, and this sort of thing. But health education is a rather difficult thing to tackle. It's very, very important, but it's something that probably should be done in the schools rather than elsewhere. In preventive medicine, you're not able to do a lot. The malaria program was on the go at that time and we had some rural health programs, dispensaries manned by nurses, etc. But, in a country at war, the day to day problems of the wounded and this sort of thing draws most of the medical talent.

## Diseases in Vietnam

I haven't seen very much in the way of communicable diseases in Vietnam apart from tuberculosis and cholera. Somehow, I think the spread of infection is probably not quite as rapid in Vietnam as it would be under similar conditions at home. Many people say they get a lot of post-surgical infection in their patient in Vietnam. When I first arrived and spent most of my time actually in the hospital, we really had very little business as a result of the war. Now, of course, Kontum is surrounded. In those days a fair number of injuries resulted from mines on the roads and this sort of thing, but we didn't have a lot of war injuries then. I don't know what the situation is now. For surgery, we got peritonitis, bowel obstruction, diphtheria, acute abdomens, etc.

Medical problems that seem to be unique to Vietnam by their presence or absence are perhaps significant. They have very, very little cardiac disease--very little indeed. High blood pressure is very rare; coronary thrombosis is very rare; cardiovascular disease just doesn't seem to take to them, and strokes are very rare. Certain cancers are not common. Cancer of the lung is

not as common as it is in the West. Cancer of the breast, I'd say, is less common; cancer of the uterus possibly more common. Ear, nose, and throat cancers are common, particularly in the Chinese population. I think the lack of cardiac condition has to do with their way of life. They have a relatively less stressful life, and the type of food they eat has very little cholesterol and not very much fat in general. On the whole, they have a fairly healthy diet--fruit and vegetables and a small amount of meat, rice, and fish.

One tends to see the sort of things that one saw in the West before the days of antibiotics, that is, very bad ear infections leading to mastoiditis. This is the sort of thing you very rarely see nowadays. Pneumonia is very common. Empyema, which is pus in the chest, is very, very common, particularly amongst the children. The antibiotics are there, but they just don't get to the doctor soon enough. Of course, parasitic infestations are almost 100% (roundworm, hookworm)--just constant debilitation. They have hemoglobin levels which are so low, and they're walking around doing a day's work, that you or I wouldn't be able to stand up if we had it. Over the years they've gotten accustomed to this. It's amazing how they get about.

Vitamins, of course, is a magic word also to the Vietnamese. Everybody wants vitamins, penicillin, cortisone, chloromycetin, and they get them for all sorts of extraordinary purposes. It's not uncommon to find a patient on half a dozen different drugs, three or four antibiotics, at the same time. It's sad but it's just what the doctors often prescribe--"shotgun therapy." It's deplorable medical practice, but in a way we see the same thing in another aspect in the West. When a patient is admitted to the hospital, we do dozens and dozens of laboratory tests on him, most of which are normal. It's a similar type of thing.

The prevalence of leprosy in Vietnam strikes me as very odd. Leprosy seems to occur in certain areas. Naturally, the people are collected into leprosaria mainly by religious groups. Oddly enough, where we were in Laos we saw one case of leprosy in our area while our team in the south saw many every day. Leprosy seems to occur in certain longitudes. The lepers are collected together into leprosaria, run very often by religious groups who tend--and we have been rather appalled by them on this--to treat it as an incurable disease. They provide places for the leprosy patients to live in and probably give them some treatment, but once they're there it's as if they were going to be there for life. Really you can arrest the disease, and they should be leading normal lives. It is probably going to take a hundred years for these people to be treated in their own homes.

Of course, in a place like Vietnam where communications are so poor, it would be very difficult to treat lepers in their

own homes. I think that one should probably bring them in and discharge them when their case is arrested. But they tend to treat them rather paternalistically. I read an interesting book on Thailand recently. A layman who had no knowledge of leprosy felt that he should start a village. He founded a normal village for lepers. The lepers came there and built their own houses, grew things, and lived a normal life with their families while they were being treated. This is how it should be done, but we're a long way from it, not only in Vietnam but all over the world. Also, alarmingly, it's a disease which is probably not decreasing very rapidly but may be increasing. It's a much bigger problem than most people realize. I think it's something that we rather put down into our subconscious.

In many parts of the world, in Africa, India, and Southeast Asia, leprosy has been undetected and is spreading. Tuberculosis is dying out in the States, but it's probably the biggest single medical problem in Vietnam. It's also one of the most difficult to cope with. You can see somebody with leprosy. You can see if he's got it and therefore treat him. He knows he's got to be treated or people will shun him. You can't see tuberculosis. It's a much bigger danger to work with tuberculosis patients than with lepers. We've got to get this across to the general population in some manner.

If we consider the germ theory of disease, I don't know whether the ordinary people in Vietnam understand this. I think the nurses do. You wouldn't think so sometimes from the way they perform. Of course, I think we make them a sacred cow with all this scrubbing up and sterility. I've seen people go to the most ridiculous lengths to insure a sterile operation, and then the patient is nursed in squalor afterwards. There's a limit to what we should try to do. With tuberculosis patients, of course, they are usually isolated, which means they're all huddled together, coughing over each other.

An illustration of the problems we run into was a case where there was a patient from a leprosarium with an acute abdomen. We wanted to open him up, and he had leprosy. I asked the Vietnamese military doctor to do it while I gave the anesthetic and they made no problem about it at all. We took him to the military hospital in the ambulance, about a mile and a half away. I gave the anesthetic and he did the laparotomy and couldn't find anything very much wrong. Of course, he may have had some sort of tuberculous agonitis, or something. We resutured him and then they would not admit him to the hospital because his leprosy was really frightening. We had to put the patient, still unconscious, back into the ambulance and drive back to our hospital, which was really rather dangerous. We put him in a small ward and the Vietnamese nurses wouldn't go near him. They wouldn't even walk across a floor that he'd been across. They have a tremendous superstition about leprosy.

I looked after him, handled him, and touched him all the time until gradually, after a day or two, they saw that it wasn't as bad as all that. But even among the military doctors there is this tremendous superstition and fear that they have about catching leprosy. Nobody really knows how it's transmitted even now. But this is very difficult to get across to them.

## Innovations in Medicine

The main innovation I made in Vietnam was in the field of anesthesia. When I first went to Vietnam, I took with me a portable anesthesia machine. It weighed about 50 pounds and it can be packed into a box with a handle. With it I carried a box of drugs, tubes, and equipment. With this unit one can give an anesthetic for any case anywhere because one is not dependent upon supplies of oxygen, nitrous oxide, or electricity. There is a small powerful foot suction pump with it called an ambu pump, and it is available through American sources. We have them all over the country now. This kit also includes a resuscitating mask with a self-inflating balloon.

I didn't use this equipment a lot to start with, but I began to use it more and more in Kontum. The Secretary General of the Ministry of Health heard about it and asked me to come and see him. I did this, set it up, and demonstrated it in his office. He liked the look of it and said he would ask the British government for 20 of these units under the Colombo Plan. I suggested to him that he should ask the British government for only three of them, and if they were used successfully, we could ask for more. I didn't think we should bring in equipment that possibly would not be used. So we did get three of them and by the greatest good luck we used them with the Australian and New Zealand medical teams. They used them all the time because they had heard of them and knew something about this method. Since it proved successful, we asked for the other 17. Later, we imported another 20 from British aid, making a total of 40. The Australians and New Zealanders also occasionally brought some in, so that I think we have around 45 now throughout the country.

In theory they're indestructible, but a few have gone wrong and we've had to set up a repair system. AID is repairing them with spare parts that come from Britain. I had the manuals sen from the factory on how they work plus one exploded model which we used to teach and to show our repair people how to assemble them. We had problems with a particular valve that was sticking in the hot climate and these, hopefully, are all being replaced by a more modern part.

What they had used before this to give anesthetics in

Vietnam was unbelievable, but I managed to obtain two of these machines that they were using for the museum in Britain. It's a primitive apparatus and consists of a large hollow ball stuffed with something like felt, a mask, and a pig's bladder. You pour ether into this and in theory you can dial certain strengths and the patient rebreathes in and out of this bag so they don't get any oxygen after a very short time. We always called it "anesthesia through asphyxia!" It is a very, very dangerous piece of apparatus.

This anesthesia project was a very, very small thing compared with the whole wide range of medical efforts in Vietnam, but it was something that was relatively easy to do. One reason for this, of course, is that in Vietnam anesthesia is not a controversial subject. It's not a fashionable subject amongst Asian doctors. They can earn more money and enjoy more prestige being the surgeon. Actually, it's only in recent years that anesthesia has become a respectable subject in the West. Anesthesiologists had to fight everything in the past to get their point of view across. As it's developed technically and become a very scientific and interesting subject, so the prestige has gone with it. But all this hasn't yet hit Vietnam.

If you want to get a scheme like this across, there's very little opposition because you're not in the competition one probably would meet in the surgical field. There, if one wanted to develop a particular training in surgery, one would immediately be in competition with the older French-trained doctors. They had their training a long time ago and are pretty old fashioned. They would feel threatened by the young doctors who espoused different methods, regardless of their merit.

## Training of Nurses

After introducing this advanced anesthesia project, the next obvious step that I took was to persuade the Ministry of Health to set up a training program for nurses. We organized a six-month training program for nurses in anesthesia with a stiff test at the end. This course taught them the principles of anesthesia and in particular the operation of this machine I just mentioned. I managed to get some movie films which had been made in Japan and Nigeria on the use of this apparatus, and I also got donations of anesthesia textbooks and copies of a book of instructions.

Each student got two textbooks: One was a very comprehensive synopsis of anesthesia and the other book had many pictures showing the apparatus. Of course, the students' English was not very good, but it improved during the course and they were able to use the books. This was a great thing and a good prestige symbol

for them. The course was run by a Vietnamese thoracic surgeon who had had his training in the United States. I was advising the course, and this surgeon's nurse/anesthetist, who had accompanied him to Boston, did a lot of the teaching. We used other nurses, too, who had had some training in France.

The male nurse/anesthetist who had been trained in Boston was very, very remarkable. He interpreted my lectures and when there were things that I'd either forgotten or left out, he would put them in. I could tell. He also gave a lot of lectures himself. The chest surgeon gave lectures on anatomy and physiology, and we persuaded other anesthesiologists who were in the country to come to Saigon, mainly specialists from New Zealand and Australia to take certain topics and lecture to the course. It went over very well and we graduated 20 of our first 25 students. Of the five we failed, two passed later. The second course that we ran we managed to get the military to take part as well. There was a big military hospital in Saigon and they had two M.D. anesthetists. We incorporated them into the course and also brought in the Ministry of Education doctors who teach in hospitals. We had three elements working: military, Ministry of Education, and Ministry of Health. This in itself was quite unusual.

Once I had this nursing course fairly established, I was able to use the anesthesiologist on the British medical team, who was very well trained, as the main support for the course during the past year. He now has returned to Saigon in my former position with AID, and I hope he will keep the anesthesia course going. There have been problems. My hope would be that they take nurses from the outlying provincial hospitals, bring them to Saigon, train them, and send them back where their homes are so we can get some trained people out all over the country. It hasn't worked that well. I've submitted names, and some certainly have come in, but a lot of them are nurses straight out of nursing school. They do the course quite well, but then they don't want to leave Saigon.

This is a perpetual problem with nurses. They all want to work in the big city, naturally, unless they are from a really remote province. It seems the logical thing to do is to bring them in, train them, and send them back where their roots are, but it doesn't seem to work that way. A lot of the nurses that we trained we've found are not in anesthesia anymore. The medecin chef where they work has found that they've had more training and are a bit brighter so they've put them into administration, which is very sad.

The very good nurse I mentioned earlier, for example, who was trained in Boston, resigned because he wasn't earning enough money to take care of his six children. He went to work for the Americans at Vung Tau as an administrator. I pulled him back to Saigon, and he became the administrator for the British pediatrics

teams. Also, he's continuing now as a sideline to help with the anesthesia training course. He was the saviour of the British pediatrics team and seemed to be able to solve all of their problems for them. He was getting a very good salary also. He was practicing a specialty, to a limited extent, but he was still practicing it, and he got some fringe benefits. That was a happy outcome as far as he was concerned. It is difficult once you start a course to keep it going, to keep the nucleus there, and keep the people concentrated. The instructors and people like that tend to go into other things and drift away.

In setting up a training course like this and keeping it going, all sorts of other support is needed, such as cinema projectors for teaching courses, which they didn't have. We could have borrowed them with great difficulty, but the obvious thing to do was to get British aid to send them cinema projectors, which they did. But once you get into one thing, you've got to follow on and on, bringing in other things so that you get a completely rounded program. My plans for the future are that AID will be able to get a nucleus of about five M.D.s trained with their Boards in Anesthesiology or their English Fellowship as well as a cadre of nurses who would go to the United States for training.

The United States is one of the very few places where you can train nurse/anesthetists. In most of Europe anesthesia has to be given by a doctor. This nucleus of trained personnel would then form the instructors and keep this course going. There was also a long two-year course, which the Vietnamese anesthesiologist ran at his own hospital. One problem was providing enough practice for the nurses. We solved this to a large extent by concentrating the lectures in the first couple of months of the course and then splitting them up into groups. One group would go to the military hospital, one to the teaching hospital, and one to the Saigon hospital. We then put instructors out to supervise them, and assure that they get enough practice.

Another job I assumed after I had been recalled to Saigon was the supervision of what we called the General Practitioner Program. This consisted of six young American doctors who were in the Army but were "seconded" or placed on detached duty in AID. These men had done their interne but nothing much more and were sent to work in Vietnam individually in hospitals, much as I had been working. I was their boss. These doctors were there for one year and were spread out in six different provinces throughout the length of the country. On the whole they did quite well. One or two of them were outstanding. They paved the way for the MILPHAP program, which came later. As they left on completion of their tours, we put MILPHAP teams in to replace them. This buildup was going on all this time. After those six we didn't have anymore come in and do that kind of thing.

## Personal Adjustment - Doctors

In retrospect I feel that placing an American or British MD off by himself in some provincial hospital is not such a good thing. I think it is difficult for a single doctor to work alone. I had recommended earlier that I thought it was a good idea, but I think that I had envisaged a team of probably two doctors working together. Two of them working together, I think, are as useful as probably three working alone. When you're by yourself, you get very close to problems, and perhaps too close. You can sit with a patient for weeks and not make a diagnosis. Then another fresh opinion comes in, and you get the answer straight away. I used to do ward rounds with them all--these six working by themselves--and I used to visit them once a month and always do ward rounds in order to discuss their cases. It was quite valuable for both of us.

## Preparation for American Doctors Going to Vietnam

It would have helped, I think, if some of our American doctors in Vietnam had received rather more of a briefing before they arrived. I think orientation is very valuable. Of course, it is a very expensive process to orient a doctor because he earns such a high salary while it's being done. I was thinking since I've been here that perhaps it would be a good idea to send doctors to ATC for language training. A doctor's tour is normally only a year, however, and since they get the equivalent in salary, a lot of them, of an FSR-2 or -3, it would be a costly business for probably a minimum return. But I think orientation in the political, geographic, and social history of Vietnam is probably very important. They did get some in Washington. I don't know whether the earlier officers ever had this, but now they certainly get some. I don't know whether it's enough or not. I have personally never had any orientation on Vietnam in my life. I had some on Laos when I was in London, but not a word on Vietnam.

I eventually spent a year in Vietnam in still another program which brought American doctors to Vietnam. I ran the Saigon end of the Volunteer Physicians for Vietnam Program. These doctors come into the country for two months as volunteers. They get an honorarium of only $10 per day. They spend 60 days in country and they get a free ticket from the United States and possibly around the world, so that they can do some traveling. On the face of it this sounds like rather a poor scheme but in practice it works much better than you'd expect. We send them to established teams, and we try to match their skills to the needs; for instance, an orthopedic surgeon would go to the large hospitals and possibly travel throughout the region. Provincial hospitals can set him up for two or three days for orthopedic work, that is, get instruments

ready, the patients lined up, etc. so he can just come in and go right to work. It's the same with plastic surgeons. We use general surgeons in the larger hospitals, and we could not have run the Da Nang surgical team without these volunteer physicians. At one stage we had seven over there who have taken permanent positions because they knew we were having recruiting problems.

These are doctors who just volunteer time from vacations and from their own practices in the States. Originally it was Project HOPE that undertook the management of this for the first year. Since then the American Medical Association has taken it on. They are responsible for screening the doctors and a certain amount of orientation. The bio-data is sent to Saigon for concurrence from the Ministry of Health and AID, and then the doctors come in. Now, they're away from their practices for at least two months, but their sacrifice is actually greater than that because it takes time to build a practice back up again once they get back to the United States. Several doctors have, nevertheless, come two or three times, and some of them we recruited under direct hire for AID. Several outstanding people have been hired this way. Not all of them are highly motivated and skillful. We've had a few less than adequate people in this program, but it's very few all things considered. The majority of doctors go back to their communities and try to explain what Vietnam is all about. A few go home angry, but a larger number go home impressed with what the U.S. government is trying to do in Vietnam.

During my last year in Vietnam I served also as the USAID Public Health Division's "Free World Liaison Officer." There were Free World medical teams in the country that were Korean, Filipino, Chinese, Swiss, Spanish, Iranian, British, Australian, and New Zealand teams. These teams were to a greater or lesser extent supported by AID through the Ministry of Health. A lot of the drugs and equipment came from AID, but the personnel themselves were donated in the main by the Free World governments. The agreements between these governments and the U.S. and Vietnamese governments all varied as to how much support was given to the various teams. The Australian teams, for example, were housed by AID but the New Zealand team was not. The British team got drug supplies through the Ministry of Health warehouse, but all other support such as housing, vehicles, interpreters, etc. and quite a lot of other drugs, came from the British government.

This arrangement was done purposely because a sovereign nation, if they can afford to give aid, should give across the board. The Free World teams were pretty successful. Of course, skills vary because of the different types of training and such a broad spectrum of personnel. In the main, they performed admirably. They averaged about 28 people to a team. It was rather like the MILPHAP team except these had 16 on their team. The British team had only ten, but will be expanded to 18 this year (1968). It does vary a lot. The teams consist of M.D.s and nurses, and in some

teams (Australian and Korean) they have lab technicians and X-ray technicians as well. The Australians only stay for three months at a time and rotate. Each of their teams comes from the same hospital back in Australia, which is a very good thing. The Australian nurses can stay six months. The British teams stay for a year. It's difficult for any of these M.D.s to spend more than a year away from their country, unless they join the Foreign Service as a career.

## Overall Assessment

My overall impression of the medical program in Vietnam, having been associated with it for four years, is that medical care is available to the people of Vietnam on a scale never before seen by them. They can get better and more sophisticated medical care than they've ever had. Mind you, they need it more now than they ever did before because of the big buildup in armaments and accidents, etc. The medical care available to the people of Vietnam is probably very much more sophisticated than most of Africa, a lot of India, and certainly Mainland China.

I think we've achieved a lot in four years. One has to know what it was like before and where we've gone. Anybody coming in now can say "My God, what an awful mess!" They don't know what it was like, and most of them haven't seen other parts of the world. The meanest provincial hospital in Vietnam is better than the best hospital in Laos. (I think the situation in Laos probably has improved a lot recently, too.) One's got to look at the overall picture. We have achieved a tremendous amount. We've got a long way to go, but we really can't do it overnight.