

# A Visiting Student Views His Stay in Pakistan

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I came to Pakistan in February, 1981, for about ten weeks when I was a final year medical student from Bristol, England. I was at the Memorial Christian Hospital, Sialkot, and worked partly on day to day clinical work and partly on a project looking at the prevalence of malnutrition in surgical patients. Language was the first hurdle I had to meet. The nursing staff patiently translated for me and I slowly learnt to ask some simple useful questions. Communication, though, involves more than just words and many times I felt that I had not understood the real complaint. Phrases like "pain all over my body" and "gas in my blood" must have meanings that escaped me. A deeper understanding of cultural values and expectations is needed, particularly in psychiatric and gynaecological problems. Good medicine must surely involve more than just symptoms and signs.

There were many, mainly infective, diseases common in Pakistan of which I had never seen cases in the U.K. I was glad to learn a little about these diseases before I left. Disease prevalence in a community tends to be geographically and socially determined. It does seem to me inappropriate for the West to try to export its medical education wholesale to developing countries. While clinical skills may be universally applicable, much of the emphasis on particular diseases is not. At home our wards are full of the diseases associated with a society whose diet is low in fibre and high in animal fat, and whose cigarette consumption is high. The commonest of these are ischaemic heart disease, cerebrovascular disease and cancer of lung and bowel. In Pakistan, the prevalence of insect-vectors and the means for faecal-oral spread of disease go hand in hand with malaria, intestinal parasitic disease and gastritis.

Working in a hospital with fewer diagnostic facilities than at home, I found it an exciting challenge to have to rely heavily on clinical judgement. Although there are times when the lack of facilities is frustrating, there can be dangers when we have full access to these facilities. There is the temptation to do every available and conceivably relevant test. These are usually expensive, often cause discomfort and sometimes danger to the patient. At the end of the investigation we expect the diagnosis to be presented neatly to us. Clinical medicine loses a great deal when we try to operate with preset decision making processes and fail to think independently.

At home, the government is trying to cut back on public spending, including spending on the health service. This has led to much discussion as to the priorities of resource allocation. Although both the resources (manpower and materials) and the needs to be met are quite different in Pakistan compared to the U.K., there are similarities. In both countries we must think clearly and objectively where the available resources would do most good. Research is sometimes accused of being an expensive luxury in medicine. However, if health care needs are to be identified and met, then appropriately directed research is essential.

I feel that I learnt a good deal during my stay in Pakistan and I thank those who made my stay so enjoyable.