SIMPLE SOLUTIONS TO COMPLEX PROBLEMS

Dear Editor,

While going through the Indian Express (Pune Edition) of Feb 5, 1999, I read with interest an article on milestones in Science wherein the writer Dr Bal Phondke mentions about simple techniques in solving complex science problems. He gives the example of a Noble laureate Alfred Hershey who used a very simple equipment, the blender which we use in our kitchen, to unravel the mystery of genetic material in propagation of virus.

Thus it disproves the often repeated sentiments of our research scholars regarding the lack of sophisticated instruments for research. Hershey was awarded the Noble prize in 1969 for his brilliant experiment.

I am reminded of a similar episode which I would like to share with the readers of your esteemed Journal. In 1997 while posted to Arunachal Pradesh, I had gone to investigate an outbreak of scrub typhus which had claimed 13 lives amongst the civilians in a remote border hamlet.

The place located ahead of Tawang in high altitude area could only be reached after 10-12 hrs of march on foot, and required carrying the food and other essentials on our back. On reaching this

border outpost, the area was surveyed and remaining population was administered with prophylactic doxycycline. However the raging epidemic and subsequent transmission could only be checked once the infected ticks larvae and eggs had been taken care of. There was no insecticide available to do this job. While checking up with the local units I found a spirit blow lamp and the idea of using the same flashed in my mind.

I incinerated the ticks, larvae and the eggs by carefully blowing the flames of blow lamp in all the crevices found in the hutments which effectively controlled the outbreak. Similarly occurrence of falciparum malaria amongst the unprotected troops participating in counter-insurgency operations in the forests of Assam in 1997 was contained by impregnating the uniforms with Deltamethrin. This breakthrough was achieved at a very low cost and without using any sophisticated equipment and fetched "Air Marshal Ajit Nath Gurushanti Devi Award". Thus when the ideas are clear, simple equipment may sometimes be sufficient.

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PORTRAITS OF A MEDICAL STAFF

Dear Editor,

On 10th Nov 1997, Ex Hav/ORa Om Prakash appeared for an interview for employment as a nursing staff in a civil establishment. The interview went on as under:-

"What is your trade?"

"Operation Room Assistant"

"What is it? "We are looking for a Nursing staff".

"My job is to help the Surgeon and Anaesthetist in Operation Room. It is a specialisation after the basic nursing training. I can work as a nursing staff as well."

"Have you got any diploma or certificate equitable to civil qualification?"

"No"

"Thank you"

We have a mixed menu for staffing in the Armed Forces Medical Services. There are Amb Assts, Psychiatric nursing assts, Special treatment Assts, Operation Room Assts and Dental Operation Room Assts, who are unheard anywhere else and without an equivalent qualification or certificate in civil. The result is cruel unemployment after middle aged retirement. It is interesting to note that just about four categories like Nursing Technician, Dental Technician, Dental Hygienist and Pharmacist (totalling to only 3% of the total medical manpower below officers) are awarded with diplomas. There are also people in the "middle road" like Radiographer, X-Ray Asst, Lab Technician, Lab Asst, Blood Transfusion Asst and so on who may get away with vaguely equated civil certificates.

Youngmen join the medical services after matriculation and above to become para-medics (Nursing Assts, Special Technical Staff or Amb Asst). Their fragmented training stretching to 5 to 12 years will take them close to their exit. By then, they would have

undergone training from a modest 50 weeks to a stupendous 300 greying weeks depending upon the speciality. Such trained personnel with their practical experience in peace and field fade out in the wilderness on retirement.

It is amazing that Army Medical Corps manages to train an annual intake of about 1300 para medical personnel without authorisation of instructors, training aids and class room at all phases. They are trained for the same course at different places by different untrained staff and tested by still divergent teams. Yet, curiously a uniform standard is expected. It is also a unique feature for an AMC personnel to come for a centralised course only after 8 to 16 years of basic technical course. By then, the personnel in other Arms and Services would have completed two or three centralised courses. That system helps them for uniformity in training, advancement and selection of suitable instructors. It is estimated that in AMC, about 4500 training weeks in a year are conducted by staff authorised for patient care related jobs and not by trained instructors. It, thus alongwith jobs like Station duties, recruiting duties etc takes away millions of patient care seconds and quality. The quality is further lowered many times by the effective functional deficiency of about 40% manpower. In spite of all the above odds, if a satisfactory standard is maintained, there is reason for self compliment.

AMC can certainly be proud of a Corps accepting unending commitments while systematically loosing the manpower. It is a shocking fact that AMC has lost a manpower of about 6000 since 1970 while there is additional commitment of ex servicemen at the rate of 50,000 per year and there is mushrooming of specialised trades, allied specialities and diversified equipments warranting extra working hands.

Comparative studies show that an average paramedic in AMC is much more dedicated, knowledgeable, dependent and systematic