Technicians in Reconstructive Surgery

Sir,

This has reference to the suggestion of Dr N. H. Antia, on the floor of the XI International Leprosy Congress at Mexico City (13–18 November 1978), that "Technicians should be trained to do reconstructive surgery in leprosy because of the paucity of doctors available for this work".

It was surprising that this suggestion came from India's finest and most well-known plastic surgeon. We in leprosy seldom make attempts to analyse and evaluate the quality of our work. For a good 30 years we have tried to take several short-cuts, without stopping to think whether some of these short-cuts would contribute to the postponement of leprosy control. Dr Antia has added one more weapon to the following existing ones:

(1) Paramedical workers with an education ranging anything from IV grade to school final, being responsible for the care of the vast majority of leprosy patients. From the number of responsibilities assumed by these workers, we tend to assume and give the impression that leprosy is the most simple and uncomplicated of all diseases.
(2) We have leprosy physiotherapy technicians and leprosy shoe-workers who do not know or understand (many of them never capable of understanding) the anatomy and the complex mechanisms in the normal or leprosy hands and feet, yet they give physiotherapy in a mechanical fashion and produce shoes in a stereotype fashion.

Even the most qualified and experienced physiotherapist or shoe-maker will find his greatest challenges in leprosy but we seem to have simplified the gravity of the situation.

Of course these situations have evolved in leprosy programmes due to several constraints including financial but what is dangerous is the fact that these are accepted as "ideal" or at least "sufficient" by most leprosy workers and all government and funding agencies.

"To reach as many patients as possible and do as much as possible with as little money and personnel (as little qualified) as possible" has been our slogan but *Mycobacterium leprae* seems not to get affected by our mass-scale quantitative approach.

Perhaps a more vigorous qualitative approach is called for. It's time we did some genuine stock-taking before setting up more of our "low cost, large numbered, impressive statistics" projects. Just as we have now started to pay the price for giving dapsone the monotherapy "crown", I would hazard the guess that we shall pay the price for every one of our short-cuts including the one suggested by Dr Antia if implemented, by taking a much longer time to reach our final destination—the eradication of leprosy.

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