

The Review

Medical care:

elitism or social commitment?

INTRODUCTION

As a director of a family medicine programme at the American University of Beirut Medical Center, Beirut, I have to make sure that residents receive proper training. The programme I work on is based in a tertiary care hospital. This has its pluses and minuses. Our paediatrics load is minimal, and the number of deliveries requested by the Accreditation Committee for Graduate Medical Education in the US is difficult if not impossible to attain in my setting. Having a satellite clinic in a marginalised community may overcome these barriers.

With the help of a resident, I identified a non-governmental organisation (NGO) that runs a clinic in Sabra Camp in Beirut. After listening to a presentation by a doctor who worked in that clinic I visited the place. The road to the clinic is narrow and barely allows the passage of two cars. This puts the cars of residents and faculty at risk of accidents. If an accident happens, neither the NGO nor the institution we work in will cover that. One of our faculty members was against sending our residents to this clinic as it will give an impression that family medicine is a specialty for the poor! After reviewing the website of the NGO, I realised that occasionally there are armed clashes between two clans in the area, which puts the residents and me in danger. In this situation lives are at risk.

Why then send the residents to this set-up? My visit included the clinic and the 'houses' of three families in the community. The clinic consisted of three rooms, a kitchen, one bathroom, and a terrace. The doctor's room occupied less than 9m² area; but it serves the purpose. The other two rooms were bigger and are around 12m² each. One room is used to educate the women of the community about health issues and the other is the reception area. The doctor examines on average 12 patients, the majority of whom are women and children, over a 3-hour period. This would increase the paediatrics load from less than 7% in our hospital-based setting to 25% in this community setup.

The visits to three families were big eye openers. In all instances we received a warm welcome. Though it was Ramadan (the fasting month for Muslims), we were asked if we were fasting to determine if they could offer us a cold drink. All the homes we

visited consisted of one room with sponge mattresses and a few utensils on the ground; there is no kitchen. The first visit was to an older person who was crippled by what seemed to be severe osteoarthritis. She lived on a cement ground of a room covered with a tin roof and walls. If heat helps this condition she should have reported that, as it was August with the temperature outside the tin roofed 'house' exceeding 35 degrees Celsius. I was impressed by the caring attitude of the nurse who checked her polypharmacy and promised to refill her pain medication.

The second house call in the company of the nurse was to a family with a 1-month-old twin who had an upper respiratory tract infection. The twin was lying on a blanket over a cement ground. One of the twins was sleeping, the other was sluggish. Next to them was an uncapped milk bottle. When the mother stood up to receive us the bottle teat hit the ground. The father who was there in the morning is unemployed. He makes a musical instrument called *Rababa* (a one string violin). He is willing to sell the piece for around £6.5 Sterling (US\$ 10). Some may argue that it may be more important to help the father sell the musical instruments rather than provide him and his family with health care.

The third visit was to a couple who had four children. Here I listened to the mother who is in her mid-30s. She had been suffering from cholelithiasis for several months which requires intramuscular injections to control the pain. She cannot afford an operation as she is not Lebanese and poor.

Concerning the ethnicity of the people living in that community, there are Kurds, Turkmen, Palestinians, Syrians, Gypsies, and others. Many are in Lebanon without legal papers. This is why they cannot benefit from the services of governmental hospitals. The good news is that these people are not deported: Hail to Lebanon!

On our way back to the clinic the nurse indicated to a house inhabited by prostitutes (prostitution is illegal in Lebanon). When



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asked about the prevalence of sexually transmitted diseases she confirmed that this is not uncommon. Other social problems encountered in the clinic are domestic violence and illiteracy. The NGO also has a school one block from the clinic where they educate children who usually earn money by begging in the streets.

I left the clinic with many questions ringing in my head:

- How will the residents view this new experience?
- Do the NGO and our programme have hidden agendas?
- How to contain poverty?
- Will we make a difference?

Each of these questions deserves some examination.

HOW WILL THE RESIDENTS VIEW THIS NEW EXPERIENCE?

My residents came from different backgrounds. There are the rich ones with their own drivers and those who need to change vehicles at three sites to reach the clinic. Their expectations also vary; on graduation some residents plan to offer their services to those who can afford paying while others are willing to serve the poor at a nominal fee. When I was a resident I imagined myself working in a marginalised area, in fact I ended up looking mainly after the rich in one of the most expensive private teaching hospitals in the country. It is hoped

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"... containing poverty is the most important step to improve health."

that this experience in Beirut will alter the attitude and the behaviour of the residents. In the hospital setup, the majority of patients have health insurance that covers the requested investigations and medications prescribed. Once they start going to the NGO clinic they have to rely more on their clinical sense and prescribe rationally.

DO THE NGOS AND OUR PROGRAMME HAVE HIDDEN AGENDAS?

I was involved with several NGOs. The majority of people who started an NGO meant well. With time they become 'kings/queens' — presidents for life (the director/president of the NGO remains the same over a stretched period of more than 10 years — as the presidents in the Middle East). The source of the bread they put on their tables and much more is the NGO that they lead. Another problem is that many NGOs have a political agenda, for example, indoctrinating others. This may be easier in a marginalised community. As for the programme I direct, we are interested in increasing our paediatrics service as well as the obstetrics and gynaecology load. This clinic also gives us a huge opportunity to practice community medicine.

HOW TO CONTAIN POVERTY/ARE WE MAKING A DIFFERENCE?

As mentioned earlier, containing poverty is the most important step to improving health. I am sceptical about our ability to make a difference in the health of this community. The World Health Organization (WHO) Millennium Development Goals calls for containing poverty and hunger as well as educating people.¹ These two issues may be the most important prerequisites for improving health; however, the WHO does not provide a feasible recipe for doing that. Ending poverty with the slogan 'Health for all by 2000'² looks to me unrealistic. Che Guevara, a medical doctor and a guerilla leader, dropped his medical bag, realising that abolishing poverty by changing political regimes is more important than treating individuals. Statistics prove that he was right. Today Cuba enjoys high standards of health. When hurricanes hit this island the death toll is almost zero. This is made possible by abolishing illiteracy, almost eliminating the gender gap, replacing the huts with concrete

homes, as well as other achievements. The Cubans who are suffering from a long-lived embargo imposed by the US have a higher GDP-real growth rate (GDP growth adjusted for inflation) than the Mexicans who are 'blessed' by being a member of the North American Free Trade Agreement.^{3,4} In a trip to Cuba in May 2010 I did not note signs of richness that I observed in Cancun, Mexico, during the World Organisation for Family Doctors conference that was held in the same month (Cancun has a lot of fancy hotels but also many poor people on the streets, some of whom are children). I realised that in Cuba there is one certified family physician for 400 inhabitants and family physicians constitute 50% of the medical doctors. The infant mortality rate in Cuba is 5.7/1000 compared to 17.8/1000 in Mexico.³ Cuba spends 13.6% of its GDP on education which places it in the second rank worldwide, while Mexico's rank is 82.³ There are clinics in all Cuban villages that provide comprehensive and free primary health services.

Democracy is a better option, when possible, to put the right people in the right place and improve the life of human beings. This is what several countries in Latin America have experienced over the last decade. WHO is not expected to recommend Guevara's method to abolish poverty but it needs to at least take a harder line with corrupt governments.

THE CLINIC

Back to the clinic, after reassurance that armed clashes are rare and occur outside the clinic time, a decision was made to send our third-year post-graduate residents to the clinic. It was also agreed to close the clinic at the first sign of tension in the community. We are convinced that medical care is a social commitment and a right for all human beings. This motivated us to:

- introduce minor surgery;
- work on three quality improvement projects;
- plan for replacing paper files with electronic health records; and
- set international standards for procedures.

Now after 2 months of signing the

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agreement, the three residents manning the clinic have given a positive feedback regarding the workload and the variety of conditions they are encountering. One weakness surfaced in such a setting; it is the inability of the residents to handle social issues in a community with meagre resources.

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