IFMSA

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The mission

of IFMSA is to offer future physicians a comprehensive introduction to global health issues. Through our programs and opportunities, we develop culturally sensitive students of medicine, intent on influencing the transnational inequalities that shape the health of our planet.
CONTENTS

Editorials 4

Conflicts and Health: From the President 5

Abortion: The worldwide ethical conflict 6

Abortion in South America: The case of Peru 8

Access to Family Planning: The Importance of Meeting the Unmet Need 9

Keeping Your Promises 11

Beyond the Science: The Art of Patient Doctor Communication 12

Medical World and Ensuing Conflicts 15

What if the Patient Knows More than Me 17

The Inner Conflict in Health: What does a clown has to do with a doctor? 19

“Free-for-All” Healthcare: The costs are rising, but who will pay? 20

Should organ sale be legal? 22

Terrorism and Medicine: an Indian perspective 24

Dr. Brahma 26

Bedouin 30
Medical Students International (MSI) is a biannual publication released to coincide with the biannual general assembly of International Federation of Medical Student Organizations (IFMSA). It helps to create a foundation and focus for the general assembly in the form of something tangible i.e. a themed journal.

Each issue has a topical theme which focus on global issues in health (for example, ‘conflict in health’). The journal aims to provide veritable student comment on the issue at hand. Fundamental to the journal is representation of diverse international experiences and perspectives.

MSI first encourages students to analyze and interpret the world which they find themselves in. It then encourages medical students to contribute informed discussion and share their views. MSI aims to provide a platform and vehicle for medical students to interact and hopefully, create a common beneficent purpose.

The first consideration of any medical student is to do no harm. MSI aims first to achieve this, and then, through understanding the world around us, maybe we can encourage medical students to make better decisions. Through the propagation of the experiences, opinions, and ideas of medical students from any country, MSI aims to promote the ideals of optimum health for all.

notes

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Text in frames on pages 6, 7 and 8 are taken from Facts on Induced Abortion Worldwide. Most data in this fact sheet are from research conducted by the Guttmacher Institute and the World Health Organization. Additional sources are notes in the fully annotated version, available at www.guttmacher.org and at www.who.int/reproductive-health.
Conflicts and Health

It will not provide a major surprise for most of you if I state that life is full of conflicts. If you look at the short stretch of time that we spend on this earth, or better, if you look at the time that you have subsisted so far, you will notice that it has been marked with personal, social, cultural, religious, political, national, international and many other forms of conflicts. We are compelled, therefore, to carefully study and try to minimize the impact of those conflicts on our daily lives, and strive to enhance our conflict resolution skills, or coping mechanisms to deal with conflicts that are beyond the scope of our control.

We, as medical students and future physicians fighting for healthier and safer communities can classify the conflicts that stand in our way into two main categories, external and internal. Obstacles emerging from the external environment are usually easier to realize and more difficult to handle. These conflicts whether political, social, cultural or financial stop us, in a way or another, from fulfilling our ultimate mission as healers and saviors of human life. Human nature, however, while allowing us to miraculously interpret barriers being imposed on us from outside, keeps us blind to conflicts arising from within our personalities. I will try to shed some light on a few of the latter problems that we have more control over, but unfortunately seldom realize.

Our journey through medical school, when compared to our careers as medical professional is short. However, this journey includes many firsts. We first get to encounter patients in medical school, we initiate our sensitization to pain and suffering in medical school, we start to value human life and see ourselves as the guardians of this asset in medical school, we reach within ourselves and discover our potential to instate comfort and relieve distress in medical school, and most importantly of all, in medical school, we take our first oath to never inflict harm and prioritize the welfare of our patients to everything else. Unfortunately, with time, we get absorbed in our careers so much that those occurrences which made us think for long hours when they first happened, become redundant. We find ourselves, consciously or unconsciously moving away from all the promises we made to ourselves as medical students striving to save the world. The counter argument is always that people mature and realize their potential and their limitations, and it is very valid. However, as we grow older and “wiser” we should be able to maximize our potential to fit into the old priorities we had and the oaths we took as students.

Being IFMSA members, I am sure that most of you have already taken oaths and promises not to fall into this well-woven trap of life. I sincerely hope that we are able to conquer our internal demons and work together to try and minimize the impact of the external forces that we sometimes feel helpless towards. Let us make an effort to free ourselves from our personal conflicts and to remember the things that make us a unique group of medical students from all over the world working for a healthier tomorrow.
Abortion is the termination of a pregnancy before 22 weeks of gestation, with the weight less than 500 grams (WHO, 1977). Can occur spontaneously (miscarriage) or can be induced. The legality, prevalence, and cultural views on abortion varies around the world, and there are two movements in many parts of the world that debate ethical and legal aspects of abortion, the pro-life and pro-choice movements. These differences of opinion affect the woman's choice by considering abortion a right or a murder. But the major issues are the consequences of this choice on women's health.

Legal restrictions on abortion do not affect its incidence. For example, the abortion rate is 29 in Africa, where abortion is illegal in many circumstances in most countries, and it is 28 in Europe, where abortion is generally permitted on broad grounds. The lowest rates in the world are in Western and Northern Europe, where abortion is accessible with few restrictions.*

Abortion is one of the most common medical procedures performed in the United States each year. More than 40% of all women will end a pregnancy by abortion at some time in their reproductive lives. While women of every social class seek terminations, the typical woman who ends her pregnancy still is young, white, unmarried, poor or over age 40. Despite dramatically increased use of contraception over the past three decades, an estimated 40-50 million abortions occur annually, nearly half of them in circumstances that are unsafe. Globally, approximately 13% of all maternal deaths are due to complications of unsafe abortion. In addition to some 70,000 women who die each year, tens of thousands suffer long-term health consequences including infertility. Even where family planning is widely accessible, pregnancies occur due to contraceptive failure, difficulties with use, non use or as a result of incest or rape. Pregnancy may pose a threat to the woman's life or to her physical and mental health. In recognition of such circumstances, almost all countries in the world have passed laws that permit termination of pregnancy under specified conditions. In some settings, abortion is legal only to save the woman's life; in others, abortion is allowed upon request by the woman.

Women's can choose if the life inside them will fail just because it's an undesired life? We have the right to kill a child just because it's an undesired life? We have the right to kill a child just because we don't have planned the pregnancy? The main question about the ethical and legal aspects that surround abortion is the viability of life, and when the abortion can be considered a murder. Some pro-choice advocates argue that a woman has the right to control her own body, and thus is under no moral obligation to give birth and should have self-determination in all reproductive matters. Those who are pro-life might argue that the sanctity of life
Worldwide, 48% of all induced abortions are unsafe. However, in developed regions, nearly all abortions (92%) are safe, whereas in developing countries, more than half (55%) are unsafe. *

extends to all humans. The right to life of the fetus would thus overrule the woman’s right to choose abortion since abortion would be equivalent to murder. It is also argued that the right to life is an inalienable right that logically supersedes all other rights.

There are a plenty of consequences on woman’s health, even in a safe abortion. There are not only physically, but especially psychological and moral consequences, like diminished respect for human life; a sense of relief followed by repressed guilt, sadness, and grieving at the death of the aborted baby that would be a women’s natural and feminine feelings and emotions; more than 100 different psychological reactions including alcoholism, smoking, drug abuse, eating disorders, sexual addictions, and self-destructive behavior; post abortion syndrome – a series of psychological effects experienced by 19% to 60% of women, ranging from mild depression to suicide or attempted suicide; overwhelming feelings of regret or guilt during later pregnancies; and destruction of trust between men and women.

Governments around the world may invest more on family planning assistance and public healthcare systems, increasing information about birth control on reproductive health, advising about contraceptives and other birth control methods, and making the women population become more aware of the consequences of an unsafe abortion. Even the safe abortion can affect seriously the woman’s physical and psychological health. This act is an aggression to life, and cannot be considered like a birth control method. Abortion may be a choice when the pregnancy put a risk on women’s or baby’s health, or in cases of rape. Making the abortion legal may reduce the rate of maternal death resulted from the unsafe abortion. But if the governments invest on information about the misdeed that abortion cause, maybe the population acquire more knowledge about it and take more precautions making the right use on contraceptives methods.

More than one-third of the approximately 205 million pregnancies that occur worldwide annually are unintended, and about 20% of all pregnancies end in induced abortion. *

Where abortion is legal and permitted on broad grounds, it is generally safe, and where it is illegal in many circumstances, it is often unsafe. For example, in South Africa, the incidence of infection resulting from abortion decreased by 52% after the abortion law was liberalized in 1996. *

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... a woman’s likelihood of having an abortion is similar whether she lives in a developed or developing region; in 2003, there were 26 abortions per 1,000 women aged 15–44 in developed countries compared with 29 per 1,000 in developing countries *
Abortion is not legal in our country, unless specific circumstances. And even in those specific circumstances, religious influence in our society can lead to violation of this women right. Actually, legal situation of abortion in Peru is the clearest example of the levels hypocrisy can reach in a society developing in a modern era but with a legal framework that hasn’t change significantly since 1924.

Sexual and reproductive human rights section is probably the one that most urgently needs to be reviewed. Specifically in the abortion field legal framework and reality are as dissociated as they can be before a major tragedy take place. Not that abortion-related complication are uncommon all over the country: our statistics are screaming, journalist denounces are in television every week and we, as medical students, are obligated frustrated witnesses of these tragic cases in our emergencies.

The women in Peru that are predominantly affected by this dissociation between sexual health reality and sexual health legal framework are poor women with deficient education and without any knowledge of their human rights or any possibility of exercising them, due to this social or geographic reality. Unfortunately, I’m describing the majority of women in my country and in many latin american realities. These are the women we have to work for. These women that have to face not only the desperation of an unplanned pregnancy, the iatrogenic procedures facilitated by the illegal situation of abortion but even, prison if the doctor in charge decides to report them.

What about the circumstances when abortion is legal? Peruvian law only allows abortion in the context of sexual assault (ethic abortion), when pregnancy is a threat to the live of the mother or attempt her health (therapeutic abortion) or when the product will result with physical anomalies that are not compatible with live (eugenesic abortion). Of these three exceptions, the only one that is “always” respected by our doctors is the one referred to therapeutic abortion. And you may consider the “always” if you always exclude mental health from all the medical cases.

But how will you ask, can a doctor not respect the law? In this case our legal framework does con-
Any doctor has the right to conscious and religion liberty, this means he or she can reject an abortion procedure even when legal, if abortion doesn't fit their beliefs. However, this doctor has to make sure that there is actually some other professional that can take charge of the patient, as the patient has also got her own rights. What is happening in my country? Well some doctors, often responding to social and religious influence, decide to prioritize their right above any patient right. The 2003 WHO report about Induced Abortion, affirms that abortion is a problem in Peru but that “In Peru and the Philippines the rate of hospitalization for abortion-related complications has declined, even as abortion law remained restrictive and the abortion rate remained constant. Access to safer abortion methods (particularly misoprostol-only abortions) and to better-trained providers has made abortions safer to some degree in these countries”. Even when the report succeeds in pointing out our poor sexual health reality, it is still too optimistic for us. Truth is that these safer abortion methods are only available in urban areas. And rural areas in Peru constitute more than 60% of its territory. We better continue working.

RESOURCES

Access to Family Planning Services: The Importance of Meeting the Unmet Need.
Jessica E. Rush, University of Leeds, U.K.

The World Health Organisation (WHO) estimates that sexual and reproductive health accounted for 22% of the global disease burden amongst women (15-44 years) compared with 3% for men. The high unmet need for family planning (commonly expressed as the percentage of married women who are wishing to limit or space childbearing but are not using contraception) indicates that FP is neglected. Attention must be drawn to improving access to FP and reproductive health services in order to reach Millennium Development Goal (MDG) 5: reducing maternal mortality by 75% from 1990 to 2015. West Africa in particular has high levels of unmet need for family planning services: in Ghana, for example, unmet need is 34%. This unmet need is unacceptable, not just because of the high rates of morbidity and mortality associated with unwanted pregnancy, but because women should have a right to choose if and when to have children. Having a lack of control over reproduction has wider impacts on development: unintended pregnancy contributes to the cycle of early childrearing and poverty; factors which contribute to women remaining unequal to men.

At the 4th International Conference on Population and Development in Cairo (IPDC) in 1994, sexual and reproductive health was crucially omitted from the original MDGs, despite the call for universal access to reproductive health. This means governments have been under less pressure to improve FP services as no MDG is specifically focused on FP. The importance of family planning to maternal health was only recently highlighted by the United Nations (UN) in its decision to include unmet need for family planning in the framework for meeting MDG 54. Clearly, if a woman does not become pregnant, then she will not die of pregnancy-related causes; an estimated 90% of deaths from unsafe abortions and 20% of obstetric mortality could be averted by access to effective contraception.

Alongside political neglect, international donor funds have fallen for family planning. The Mexico City Policy, reinstated in 2001 by the previous US government, has had implications for the provision of family planning services. This policy removes or drastically cuts US funding from any organisation that provides legal abortion, counselling, post abortion care, or lobbying for legalisation of abortion. This means organisations have had less funding available for family planning, and decreased access to family planning services actually increases numbers of unwanted pregnancies and abortions.
Against scientific evidence, conservative opinions interpret the IPCD Programme of Action's call for information and services for young people as promoting promiscuity and irresponsible behaviour.6

These arguments for the Mexico City Policy and promotion of abstinence as a birth control measure are at best unrealistic. At worst, they fail to acknowledge a woman's right over her own body, and go against the WHO's working definition of Sexual Rights (which includes the right of an individual to decide whether or not to have children, and to pursue a safe and pleasurable sexual life.)7

Globally, women still receive lower levels of education, less pay for the same work, and carry greater burden of morbidity than males and are far less likely to have any control over finance and decision making, and as the United Nations Family Planning Association (UNFPA) has written, women's health is often “pushed off the agenda” in favour of other health priorities8.

Empowering women is clearly important in family planning and in reducing the spread of HIV – this will only really be possible with the cooperation of men, so it is important to involve them in programmes which aim to improve the position of women in society, and address the unmet need of FP. The President's Emergency Plan for AIDS Relief (PEPFAR) does acknowledge the need for family planning services to work with or to 'wrap around' the HIV/AIDS prevention programmes, but funding for FP programmes through PEPFAR has not increased in recent years and looks like it is set to fall.9 Funding for HIV/AIDS projects can be very narrow, and this encourages vertical programmes that draw human resources away from other core functions of reproductive and sexual health facilities. PEPFAR also requires one third of all funding which goes towards prevention of HIV/AIDS to be spent on promoting abstinence until marriage as the lead strategy to prevent HIV. All groups receiving PEPFAR funding must also sign a pledge opposing prostitution.9 Making family planning and contraception services unavailable to female groups at high risk of unintended pregnancy and STDs including HIV, such as sexually active unmarried adolescents and sex workers, further increases the stigma and difficulty these groups face in accessing FP services. To promote abstinence as the main way to prevent HIV and pregnancy ignores the social, cultural, or economic pressures on women in many low- and middle-income countries.

In summary, evidence already shows that there is an unmet need for family planning services in many countries, and that the reduction of unmet need can have positive benefits for the health and socioeconomic status of women. In order to improve services, the characteristics of women with an unmet need for FP services need to be known, and the factors limiting service provision need to be understood. Knowing where the barriers to family planning lie (whether they are due to a lack of access, cultural factors, or personal beliefs or attitudes) would help improve provision, but only if this knowledge can be translated into action. Removing barriers to contraception is vital to decrease rates of unwanted pregnancy, and meet the unmet need for contraception. Advocating for reproductive choice for women; simply, the ability for a woman to decide if and when she wishes to conceive, is vital if we are to improve the chances of equality for women in social and economic terms. This needs to be done not just by making contraceptives more available, but also by family planning promotion and education, together with programmes to improve the status of women. For this to happen, a drastic increase in political will and support is needed both nationally and internationally, to improve funding and to bring the rights of women back onto the agenda.


Stepping forward is not the main idea should see both sides of the path as well; Long steps may be the dangerous ones-they don’t let the eyes discover what your soul should feel.

Great hopes and ideals brought us together On this challenging experience of life, But paths forthwith divide And the earlier promises scatter afar... among duties and borrowed ambitions.

Untie the mystery of this inner change, ...and discover that No angel did come from paradise expecting everything to be easy.

...for us, human beings, in faith and patience is the key.

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Beyond the Science:
The Art of Patient-Doctor Communication

Research has shown that when it comes to communicating with patients, what doctors say is every bit as important as how it is said.

Some time ago, during teaching rounds, I informed a patient that his episodic abdominal pain was caused by multiple gallstones and that he required an operation. The patient responded, “Ok, Doc, but I would like to talk with my doctor,” pointing to the third-year medical student who had been assigned to my service. I, of course, agreed, and the patient subsequently underwent a successful cholecystectomy. Before he left the hospital, I asked why he had chosen the medical student as his “doctor.” “Doc,” he replied, “he visited me every evening; asked about my family, what I did for a living, about things that might be bothering me. He was the only one who talked to me, explained everything, and encouraged me. He’s a real doctor.” I agreed.

“The most fundamental attraction in medicine is still this unique patient-physician relationship… This is the fundamental reason why anybody should become a physician.”

For better or worse, nearly everyone has had some experience with a doctor in his or her life. Most people, no doubt, can recall being called into a dimly-lit office where a grim, unsmiling doctor in a white coat was perched behind an enormous desk, shuffling through your file. You are nervous, waiting to be told that you are terribly sick or perfectly healthy – it is often a fine line between the two. How the information is conveyed may make all the difference in the world to you. There is an art to medicine that cannot be taught in books or by dissecting cadavers. It is the art of communication with a patient or a patient’s family. Not only is good communication essential for a patient’s understanding, it is also essential for establishing a rapport with the patient that will set the tone for subsequent interactions. It is not only the patient that benefits. By successfully communicating with a patient, a doctor can gain a better understanding of the patient’s perspective on his or her illness as well as begin to see the patient as a person, not simply a conglomerate of symptoms. It is during this interaction that the patient opens up to the physician and begins to disclose the symptoms that may not seem obvious. Furthermore, if the interaction is successful, as the doctor and patient continue to talk, the patient will start to trust the physician and confide in him in other ways. Although it may seem intuitive that good communication breeds trust and mutual understanding, the story does not end here. Studies have shown that physician-patient communication is one of the most important factors in determining patient satisfaction with overall medical care. More important, the relationship between doctor and patient is even critical when it comes to health-related outcomes. A good relationship was found to have a profound effect on treatment compliance, problem resolution, and actual patient well-being. In other words, even though the science behind medicine is continually advancing and the technology is improving, we cannot overlook the most fundamental human aspects of medicine: the relationships that are forged between doctors and patients.
Yet only recently has there been much interest in the interpersonal relationships that pervade the medical practice. Researchers have begun to talk about what they refer to as different “styles” of care. Although researchers differ in their classification of these styles and the number of classifications they think there should be, Flocke et al. focused on four physician interactions styles – person focused, biopsychosocial, biomedical and high physician control -- all categorized under a Mutual Participation model of patient-physician interactions in which physician and patient are thought of as partners working towards the same goal. Their results showed that a person-focused interaction style, where the physician is more friendly, more open to a patient’s agenda and more willing to negotiate options with a patient, is perhaps the best way to facilitate good communication and convey a sense of understanding. In a similar study, Roter et al. also identified four distinct communication patterns that were found to be very similar to those studied by other researchers.

More than simply observing physicians and beginning to identify those existing behaviors that may impact a patient’s outcomes, physicians and researchers alike are starting to investigate how to change, teach and sculpt doctors’ interpersonal behaviors into those that are most desirable. Several physicians have devised handbooks or manuals that outline the necessary ingredients of a good patient-physician interaction no matter what the circumstances of the case. Many of these books are simply laundry lists of do’s and don’ts. Other books deal more specifically with outlining necessary patient consultation or interview procedures that a doctor can follow in order to deal with a difficult situation, such as informing a patient about his impending death.

Although these tools do not tell the doctors exactly what to say, they do give the physicians suggestions about how to say it. In fact, a few studies have shown that while patients may be unable to pick up on the content of what is said, they are often able to pick up on the tone, amplitude or speech rate of the physician. What matters more to the patient’s hospital experience, then, is not so much what is said to them, but how it is said – the vocal component of speech. The study showed that patients perceive rapid speech as more dominant and less friendly, and female vocal cues as being more empathic and calm.

In addition to taking into account vocal cues, the literature also suggests that when it comes to doctor-patient consultations, the physician must also be aware of non-verbal cues that can help strengthen a strong and mutualistic relationship. One study showed that patients have the ability to pick up on the non-verbal behavior of their physical therapists, and this in turn can both change their perceptions of their relationship with their doctor and also impact their physical health outcomes. While this particular article dealt with certain classes of behaviors that can be categorized as distancing behaviors, positive affect, professional behaviors or nervous behaviors, other articles have suggested more specific non-verbal behaviors that may help to cultivate stronger, more satisfying relationships with patients. Among those suggestions are making eye contact, shaking hands with the patient, touching the patient to show care, smiling or nodding.

But despite a long and useful list of behaviors for physicians to be aware of in their interactions, there has been very little empirical evidence collected in this area regarding the effectiveness of these non-verbal behaviors in practice. In other words, are physicians who exhibit more of these recommended behaviors better at getting patients to trust them and their treatment methods? Are they more capable of making patients feel comfortable and at ease? These issues are still unresolved.

What has been studied in more of an empirical way, though, is the content of the interview itself – the verbal component of speech. Most patients want their doctors to be honest with them and tell them all the details of their prognoses, diagnoses and treatment plans. This helps them come to terms with their illness and know what to expect as their illness or treatment progresses. Understanding one’s diagnosis is not as easy as it may seem. Oftentimes, doctors speak in ways that are not accessible to patients, using medical jargon that only further opens the patient-physician divide. Studies have shown that doctors can close that divide and improve patient satisfaction by focusing on using positive language, making sure to acknowledge the patient’s emotions and letting the patient...
tient’s emotions and letting the patient voice his/her questions or concerns.

As one can see, there are many ways to break down and analyze doctor-patient interactions, but it is nearly impossible to draw up a formula for what constitutes the perfect bedside manner. After all, there is no one type of doctor. Each doctor has his or her own specialty and his or her own patient group. While most of the existing research tends to focus on general practitioners and what for them is the most important physician interaction – the medical interview with a patient – the research leaves out most of the medical interactions that are not directly with patients, namely those of ICU doctors who frequently communicate with families about a patient’s prognosis, because most of the patients are either unconscious or incapable of making their own decisions regarding treatment. Studies have shown that the fundamental concerns of family members when dealing with their sick relatives are slightly different than those of the patient themselves. Do these differences in expectation, then, warrant a different type of communication or do those behaviors that apply to making a patient feel most comfortable and satisfied also apply to a family being told about the prognosis of their relative?

Communication with patients and families are skills that are not always easy to teach. The science of medicine can be learned, but what about the art of how doctors interact with patients? So, ideal medicine is both science and art – not only what doctors say, but how they say it and to whom.

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Although the stereotype of the powerful doctor that commands his patients has mostly been surpassed, the latter group’s complaints of violation of their autonomy remain. This article briefly examines the usual reasons for this behavior, while countering them with the proposal that modern medicine’s world view plays a greater role. This Weltanschaung has implications both to the medical education curricula and the public’s interaction and expectations from the doctors.

A scenario common to many will be the following one, quoted by Wilson, HJ, which concerns a woman which has been just diagnosed with breast cancer: “His management of my crisis consisted of a pat on the hand and the assurance that he was very sorry. [...] My medical team were dealing with a diagnosis as a physical problem in terms of their personal and technological resources, [...] it seemed incredible that whatever attention had been afforded to me generally was now withdrawn, and instead focused exclusively on my left breast. Doctors, studiously avoiding eye contact, came, examined me and left. [...] However my refusal to accept the preferred mastectomy so infuriated the doctor that he terminated our discussion by sweeping away the curtains that surrounded my bed, firing as his parting shot over his shoulder: “The decision will obviously have to be taken out of your hands”.”

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The case above may be interpreted as an extreme one, but it definitely makes its point clear – that this was not just lack of bedside manners, which can be ameliorated by careful coaching, but something more profound. Indeed, the most frequent reasons for such alienating behavior, which affects both patients and doctors, fall into three categories: financial structures: the act of conversation between patient and doctor is more time consuming, and therefore less profitable, than a quick look-over, mumbling and the handing of a prescription to be filled, health structures: insurance institutions, whether public funds or private companies, require a definite diagnosis that can be supported by concrete evidence; insofar the state of the patient himself is of little importance and educational attitudes: through exhaustive learning, medical students acquire the skills to fill in a diagnosis into a piece of paper, but not the ones to show empathy and compassion to the patient, regarding him as a byproduct of the whole process. The latter should be further stressed, for it is a often cited target of medical school reform; through a humanistic education, it is supported, we can attain to understand, interpret and mirror the emotions of an anxious or furious patient, therefore reducing his stress levels.

While this may hold true, it acts only in a superficial way: if on the aforementioned example we substituted the doctor’s reaction with “and he stopped on his feet, sat with me, and we discussed on what troubled my mind at the moment”, this would be more humane, but it would not nevertheless question the validity of the operation as the desired method of healing; the doctor would still try to get the patient’s consent.

Therefore, a range of patterns can be surmised when carefully studying the case: first, the focusing on the affected body part, with the simultaneous ignorance of the patient, and the power struggle between the patient and the doctor. As we will see, these two patterns originate from a common stem, namely, the biomedical model and its clinical application.

Contrary to popular belief that this model comes from the biological sciences boom of the 19th century, the seeds of it were sown with Descartes, who proposed the dichotomy between mind and body. The res cogitans (the conscious subject of thinking) is impenetrable, whereas the res extensa (the objects that belong to the external, extended world) can be seen, and therefore perceived, by all outside observers. Therefore, diseases affecting the body, which belongs to this world, can be observed like all natural phenomena; the signs can be perceived by sight, the various changes in bodily structures can be realized by clini-
With the lion’s share of money going into quantitative research and the impressive results that it brings, the place of biomedical models is secured. But what one can hope for is a more fundamental change in curricula than the sole addition of medical humanities as another course (the influence, and the constant reminding that medicine itself is not a science in the narrow sense, but adhering to a broader paradigm, encompassing the patient himself.

**Struggle for power**

This distinction between biomedicine and its clinical application arises also in more quotidian situations; when a patient visits a doctor’s private practice or clinic, there is a conflict a priori; the doctor is a position where he has social (coming from his status as a doctor) and Aesculapian power, i.e. the power to heal. The patient, eager to benefit from the latter, defers to the negligence of his personal identity, or struggles to minimize it, with the success depending on the open-mindedness of the physician - whether he allows questions during the examination, the active participation of the patient in the decision-making process etc.

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**Conclusion: any solution?**

The attachment to this biomedical model is evident in the structure of the medical school curricula; they are divided into clinical and pre-clinical years. Therefore, the student is educated on the basic principles of physiology, biochemistry, anatomy, histology etc., learning the hard core of bioscience, and then he is progressing to its application to the clinical situation, bearing in mind this divorce of the disease itself and its “carrier”. Ethics, patient-doctor relationship strategies etc. belong to the soft outside of the curriculum, not playing a vital role in the educational process, and consequently easily dismissed on difficult situations, such as the one presented in the beginning of the article.
Dr. W is a surgery resident who is too arrogant to admit that he knows less than his educated patient who is coming for a first opinion concerning the management of her varicose veins. He decided to abuse the physician-patient relationship to dismiss the patient's claims. This behavior breaches all the ethical principles of autonomy, beneficence, non-maleficence and justice. The below article discusses the dilemma of admitting the lack of knowledge to a patient from different philosophical perspectives. Such incidents are not uncommon in the modern world with the advance of knowledge in medicine, and we will expect them to be on the rise. It is critical for medical education to focus on patient care to train future physicians how to deal with the ethical challenges of our modern world.

Management of Varicose Veins
Laser therapy and sclerotherapy by injecting a sclerosing agent to small varicosities are two well-known and practiced modalities of treatment for varicose veins. Surgery is reserved for large varicose veins and is coupled very frequently with these two modalities for the treatment of the smaller varicosities. In these cases, sclerotherapy is done on an outpatient basis after recovery from the varicose stripping surgery. A surgery resident rotating in Vascular Surgery is expected to know about these modalities. Whether Dr. X knew about them or not, his behavior depicted above is unethical. If he knew about them and behaved the way he did, this is an unquestionably unethical behavior of arrogance and maleficence. But for the sake of argument we will assume that Dr. X did not know about these modalities of treatment.

The Dilemma
This case depicts a dilemma of a physician who is encountering an educated patient who might know something more than he does. Should the physician admit his lack of knowledge? Should he blindly refute the patient's claims? Or are there other solutions? These situations are becoming more frequent with the advance and spread of knowledge and the
availability of knowledge via the media. It is becoming possible that knowledge reaches patients before their physicians, who should be ready to deal with these situations in an ethical manner.

The Unethical Behavior

Dr. X clearly breaches all ethical principles by his behavior. He caused harm to a patient who is respectfully seeking medical advice. He took her polite inquiry personally since it lies beyond his knowledge. In return he punished the patient by using his status as a physician in order to belittle the patient’s concern and dismiss her. The patient’s autonomy was not respected and she was indeed paternalized by Dr. X who insists that what he knows is sacred, infallible, and unquestionable. Dr. X does not show a care for the patient, but rather a care for his ego. Furthermore, justice is nonexistent to this patient who could have received proper medical care had she been by an attending or by another senior resident who is more properly educated.

Encountering a patient who knows more than the physician is expected in this new era of medicine and should be of no surprise to us. The physician is a philosopher. He/she should be a moral agent with a sense of right and wrong. He should be able to judge how to deal with these situations. The physician should be honest in admitting that this information that the patient holds might be true and lies beyond the physician’s knowledge, and that this has to be checked. Obviously the proper course of action that Dr. X should have followed in this scenario is not belittling the patient’s quest, but rather acknowledging it and double-checking on it with another colleague before dismissing it. This would have been very feasible in the OPD setting and there is no excuse for not doing it. The OPD clinics are a free service for underprivileged patients who could not afford medical care otherwise. The OPD patient realizes many times that students are examining them and that there are issues they confirm with others as part of a hierarchical team. The OPD rooms are numerous and there is always the Chief resident and an attending present. Approaching them with a question should not have been at all problematic. It seems that the resident was worried about his image in front of his chief and attending or in front of his patient, so he opted for the easy way out by abusing his position, belittling the patient’s knowledge, and dismissing her. This is yet another sad case that teaches us that the focus of education should first and foremost be patient care, otherwise we will be only graduating scientists but not physicians.

Her destiny was to be seen by a resident in an institution that does not properly educate its medical trainees on the very core of the profession, patient care, but rather limits medical training to a competition of knowledge recall from short-term memory and hands-on experience in surgical skills.

Dr. X’s arrogance pushed him to lie to his patient and deny her medical rights so that he does not reveal his lack of knowledge. This kind of behavior satisfies any ethical theory. If this was a universal rule on the Kantian way, medical care would be nonexistent and anarchy would rule Medicine. From a utilitarian perspective, by no way do the consequences of this act also justify it, for the only positive consequence is the pleasure of the resident. Many negative consequences are seen, and are harmful to the patient; from deceiving her and denying her opportunities of treatment that might be less invasive, to insulting her by indirectly accusing her of challenging the physician. More importantly, Dr. X lacks the virtues of a real physician who exists for the beneficence of the patient first and not for himself.
Of the many activities that NEM/AAC (my local medical students association) did this past year, there is one that comes immediately to my mind when thinking about Health and Conflict. The local Committee On Human Rights and Peace, pioneer in our country, started with some workshops on which I had the opportunity to participate in one – a doctor clown workshop. The workshop was based on an experience sharing by a clown that is part of a movement that visits paediatric units in order to bring some joy to ill children.

But let me be more specific, because it was a particular point of this workshop that marked me. At a certain point, Pedro, the clown (in a positive sense), talked about the “grey” days he has. Those days where even him felt down. Those days when even him needed a hug during his work. And this made me wonder… Even a clown felt down sometimes… He explained that a clown doesn’t have to be happy every time, because the true clown is the one that is completely honest about his feelings and that has a great resilience. However, this idea didn’t come out of my mind. Even clowns – the messengers of laugh, smiles and happiness – get sad!

But what does this has to do with the topic you wonder… Well, to me, it has a lot, because doctors have to deal with misery, unhappiness, disappointment, frustration, long hours of work, and so on. No body likes to have the need to be seen by a doctor… (OK, let’s rule out hypochondriacs…) Doctors have to work almost everyday, it doesn’t matter if they are up or down, happy or sad… They just have to do it. They have to be there. They have to transmit security. They have to personify hope. They have to comfort even when there is no way out. They have to continue. And very soon… the THEY becomes a WE… I don’t know about us, but I don’t feel ready yet… Will I ever be? Will I ever be ready to give up on someone’s life? Will I ever be ready to forget the misery of my previous patient, the one that just got out of my office by his own foot and that will be dead within the next 2 months? Will I be ready to accept the fact that I will, at some point, screw or finish someone’s life? How can we be ready for this?

There is a comedy about hospital life – Scrubs – where in one of the episodes this topic is the theme. Just to give you a spoiler (don’t read this next line if you haven’t seen it yet!), the best intern quits being a doctor after being unable to cure a sick children that wasn’t responding to any of the treatments that were administrated. Can you see now why do I think that this is a big conflict in health? It is such a big conflict that can even make you want to give up on your life’s dream!

I know that we all dream of saving lives, and that we will save many, but remember: “To cure sometimes, to relieve often, to comfort always”. And what about ourselves? How do we comfort ourselves? How do we learn it? With time? Because many doctors just seem to solve the problem by not caring about the patients, and I don’t consider that an option… I know that I will wake up from that indifference some day if I go that way…

But hey… I still got some time before “they” becomes a “we”; and after all… I already know that even clowns get sad… And I like hugs… Maybe I’m not that lost after all.
The Western and other developing countries’ governments play an important role in the respective country’s healthcare system where they structure, fund and manage it to some degree or another. The idea has its roots in late nineteenth century Germany, when Otto von Bismarck introduced a mandatory health insurance to provide a medical service for a large segment of the population (1). The British National Health Service, launched on July 5th 1948 by Nye Bevan, was the most comprehensive healthcare program implemented nationally at the time (1, 2). It is considered to be the world’s first universal healthcare system (1).

Although healthcare systems vary widely from country to country, the essential idea of providing free care to everyone needing it, prevailed. This improved the general well-being of a large number of people that otherwise would have preferred to remain untreated rather than turn up at a doctor’s clinic and suffer the humiliation of being unable to pay (2). These ideas soon gained popularity and citizens started to expect governments not only to provide top-quality service but also expand it where possible. A political party vying to win an election not only had to promise the continuation of free healthcare but also pledge to channel more money to it.

The notable exception to the above is the United States, which is the only industrialized country that does not provide universal healthcare (1).

Healthcare has dramatically expanded over the past few decades. Pharmaceutical companies are always producing new and better drugs to treat any ailment one can think of. The application of engineering and electronics to healthcare resulted in the design and production of highly advanced equipment, that in turn ameliorated the services available. This is epitomized by computer-assisted surgery, commonly known as robotic surgery, which enhances all aspects of a surgical intervention: the surgeon's view of the patient's body, precision during the intervention, the risk of bleeding and the length of the patient's hospital stay (3). However, this progress also caused healthcare to become more intensive and demanding, putting more pressures on the various professions involved in its running. The ultimate effect was an unprecedented surge in costs. As an example one can mention the global expenses on prescribed drugs: it exceeded $600 billion for the first time in 2006 (4).
Developed countries are seeing their populations ageing. Projections show that by 2015 the number of deaths in all member states of the European Union will exceed that of births and the share of the population aged 65 years or over is expected to reach the 30% mark by 2060 (5). Unless there are migratory influxes, a corresponding drop in the workforce would transpire, which would also be replicated in the number of people paying taxes. So while the expenditure in healthcare might have to expand enough to cater for more people with age-related diseases, the source from where governments draw much of their money is shrinking.

As one can see, the problem in financing healthcare is three-pronged: a long-standing mindset strongly in favour of free healthcare, an ever-increasing cost to run the system and demographic changes that are bound to further stretch the need for medical resources. It is reasonable to ask how sustainable it is for governments to foot the whole bill.

The solution is not in privatizing healthcare. Apart from the fact that in most countries it would be an alien idea that would be fiercely resisted, it is likely to aggravate the problem. As people compete with one another in trying to obtain a medical service, those on lower incomes are easily outpriced and remain empty-handed. If the government had to hand free vouchers to be redeemed on services rendered to these people, where would the demarcating line be? How feasible and accurate would means-testing be?

Some of the pressure on public healthcare would be relieved if more people start using private services. Governments are expected to provide free healthcare for those who are truly in need. Thus, the solution possibly lies in making those people who can afford private care, use it. This could be achieved if governments convince private corporations to invest more in medical services through tax concessions, soft loans and the like. As competition in the health market stiffens, prices go down and more people would be able to afford it. Hence, while the government is relieved from the responsibility of taking care of a number of people, more of its funds go to the healthcare of those on lower incomes.

Another possible way of reducing government expenditure on healthcare is by fielding certain aspects of the system to the private sector, such as food catering and cleaning services. This could also serve as a way of improving the quality of the services offered as the government can easily check on what private companies are delivering and simultaneously keeping costs low.

It is evident that financing public healthcare is indeed becoming problematic and needs to be addressed. However, the possible solution does not lie in handing over the responsibility to the private sector but rather work in conjunction with it in order to aptly improve healthcare services.

References:
Should organ sale be legal?

Erica Pool, UK

Introduction and The Problem

There is conflict in the medical world as to whether organ sale, or ‘financial compensation for organ donation’ as it is commonly referred to, should be allowed.

Receiving an organ transplant can transform a life of constant pain and regular hospital visits to a life of hope, health and independence. However, last year 1000 patients in UK and 5000 in USA2, were not so lucky; they died or were removed from the waiting list after becoming too ill, primarily due to the deficit of suitable organs [1].

The problem is clear: the deficit of organs. The solution, however, is less obvious. The cases of liver and kidney transplantation are unique in that the donor may be living, compared to cadaveric donation for all other organs. Recent advances in immunosuppression have also eliminated the need to exclude non-family members from donation [2]. This has led some to propose that organ sale, or ‘financial reward for organ donation’ as some prefer to call it, may be the answer. There is little doubt this would lead to an increase in number of donors, however it raises many ethical questions.

Who benefits?

In countries such as the UK where it is illegal to give money to the organ donor, the main beneficiaries from an organ transplant are the recipient and the health professionals working on the case. The organ recipient gains health, quality of life and earning potential. The health professionals involved gain new skills, job satisfaction and income [3]. Some argue that the donor deserves to benefit too. They may consider financial rewards justified for the sacrifice they make by donating an organ.

The Black Market, Blood and Sperm

The presence of a black market of organ sale is cited by some as justification for the legalisation of payment for organs [3], [4]. Whilst on a surgical rotation in Leeds, UK, last year I saw a number of patients who had paid for organs and undergone the transplant abroad. The organ trade flourishes with donors from many countries in most continents including Russia, South Africa, Jordan and Peru and recipients in areas as diverse as New York and Iraq.

The current system of a black market for organ sale is acknowledged as exploitative and ethically dubious for many reasons. The money exchanged is often small since the donor is often, if not always, extremely poor and unable to negotiate a higher price. Evidence suggests that the amounts exchanged often do not even cover the donor’s medical care for the organ removal, never mind lost income during the recovery period [3]. Some suggest that this provides an argument for the creation of an open, legal market for organs, which would ensure a fair price. However attempts to regulate the system of kidney sale in Iran proved problematic [5] and regulation does not address the many other ethical problems.

Some people compare payments for organs with payment for blood or sperm donation, which although illegal in the UK are commonplace in coun-
tries such as the USA. Although, there are many ethical issues with payment for these fluids, which may be extended to payment for organs. These ethical issues will now be addressed.

Ethical issues

Whilst blood and semen are akin to the liver in their capacity to regenerate they differ in the risk associated in the method needed to procure the organ, and so the analogy is not appropriate. The donor undergoes considerable risk in order to donate the organ and could suffer serious health problems or even death. There is acceptance that the system of payments for blood and semen in the USA results in most donors being from low-income groups [3]. This may be because to donate blood or semen is not significantly harmful. Whereas the donation of a liver or kidney carries significant risk and so society may not accept most donor’s being of low income, as it appears exploitative.

If donors are paid for their organs it is likely that the majority of donors would be motivated by financial incentive, since to donate an organ to a stranger without care for financial reward would be altruism in the extreme. The leads to the logical conclusion that most donors in a system of payment would be amongst the poorest people in society and likely living in poverty. Any system of financial reward for organ donation, however regulated, would lead to extreme exploitation of already vulnerable groups. Organ trade exacerbates preexisting inequities as organs are donated primarily from poor to rich, from women to men and from black to white people [5].

The German Medical Council argued that even having the debate about payment for organs threatened society’s trust in the medical profession [4]. This trust is necessary to ensure commitment to cadaveric donation, the maintenance of which is vital since most organs; heart, lungs, etc., can only be transplanted following death of the donor. Therefore, the debate and potential legalisation of financial reward for organs, would threaten the lives of the millions of patients in need of organs only donateable after death, perhaps threatening more lives than would be saved by the system.

At present health professionals dominate the debate about whether organ sale should be allowed [5]. If organ sale were allowed the quantity of available organs would significantly increase, thus increasing the health workers’ workload and therefore their income. Since they would benefit so significantly from organ sale, some question whether their input can be objective [4]. However since it is a debate on a health issue it cannot be held without them.

Conclusion

The question of financial reward for organ donation is highly controversial, and will remain so even if legalised. The extension of acceptance monetary reward for, semen and blood is flawed since they are associated with far less risk. It also assumes that the existence of such systems means that they are ethically sound, which is itself debatable. The associated mistrust to the medical profession a scheme of financial rewards would bring is also a significant justification to look elsewhere for the resolution of the organ shortfall. The problem of the organ deficit is large, however the evidence points to the conclusion that payment for organs is not the answer.

References

An area of 3.28 million square kilometers, a population that’s second only to China’s, with a natural population increase of 1.4% per annum and population density of approximately 324 people per square kilometer – India is one of the most successful democracies in the world. A nation just over 62 years old, India has come a long way from being a colonial country to a superpower in its own right. From only a few major hospitals in the country at the time of independence, India had about 22,400 primary health centers, 11,200 hospitals, and 27,400 clinics in 1991A.

Even with the tremendous growth India has exhibited as a country, India has had to face its share of troubles. Some of these were the conventional problems of population explosion, illiteracy, unemployment and so on. In recent times, India had to face the evil of TERRORISM. Though defined in many ways, terrorism in this article encompasses the wide spectrum of issues such as the Kashmir conflict, India Pakistan wars and the separation movements in India such as the Naxalite movements, the Punjab riots, Godhra Massacre and the most fresh in our memories - the horrific series of blasts in the Indian cities – latest being the one in MUMBAI.

How has this state of heightened unsocial and traumatic activity affected medicine in India?

THE CARNAGE and THE AFTERMATH

But obviously, the most evident damage has always been in the form of the causalities and destruction of property. Many families are destroyed and people injured even while the under prepared medical setup is overwhelmed in face of such an unfortunate situation. The medical system as of now does not even have a proper contingency plan in place and the inadequacy is often manifest in form of shortage of blood or essential medicines such as anti gas gangrene serum. The affected region’s essential services sometimes don’t even have enough ambulances to report to the site and people have to use personal cars, and a shortage of stretchers is a common sight. Such acute stresses placed on the already over burdened setup can be a challenge to any country!!

PSYCHOLOGICAL TRAUMA and terrorism

One of the most well known sequelae to terrorism is the growing depression in today’s times leading to increased mental illnesses. The most common of these is the Post Traumatic Stress Disorder which may manifest in a multitude of ways but can be devastating for the survivors and causes significant morbidity. With extremely gruesome attacks on the rise, India may have to seriously consider dealing with the same on a much larger scale. With the media helping in wider dissemination of disturbing images, the children are at a serious risk of developing phobia of death or a paranoid fear of the same. The violent images create an unhealthy environment for the impressionable mind. Some psychiatrists even believe that such children may suffer from behavioral problems in the long run. Of grave consequence is the problem of “survivor guilt”, which may cripple the survivor and even make him mentally handicapped. Such survivors show increased suicidal tendencies and psychiatrists believe that unless all such post trauma and terrorism syndromes are not addressed they may be a cause of unforeseen morbidity. The latest example of such unfortunate post traumatic depressions was the increased rate of fear or phobias in children living around the Nariman Point area in Mumbai which was attacked by terrorists recently.

GOVERNMENTAL POLICIES and Health during these times
The recent events have even prompted a change in the government policies specially the budgetary reallocation. This is evident by the fact that in the year 2000, while the allocation to the Reproductive and Child health programme was increased by approximately Rs. 375 crore, the defense allocation increased by a whopping Rs. 12,893 crores. Similarly, the allocation increase of capital expenditure between the 2007 and 2008 union budgets Rs. 7085 partment only had an increment crores. This disparity is sure to have a profound effect on the creaking edges of the health set up in India, even while India needs to invest increasingly in the same to provide adequate level of quality care especially the emergency critical care as required during the crisis situations.

SUFFERING MEDICAL TOURISM

India has in recent times been hailed as the hub for medical tourism with the economy and the field of medicine immensely benefiting from the same. Unfortunately, due to the recent situations, most countries have issued warning notices to all its citizens alerting them against travel to India and specifically to some cities in India. These cities happen to be the most advanced in medical care. Terrorism has thus effectively quelled the excitement brought in by the concept of medical tourism and the industry is suffering tremendously.

Lastly, but definitely not the least, it was very unfortunate when in the recent blasts in Gujarat, in western India, bombs were planted in the triages of hospitals and they went off as the injured of the other blasts were being bought in. This ushered in a zenith in the lowliness of the cowardliness since it has been assumed since times immemorial that essential services should be left unscathed but this time round the hospitals were made primary targets even as they tried bearing the tragedy of the injured. This is an unacceptable happening and the future of terrorism affected nations maybe bleak unless the problem is curbed in the bud.

But........... YES!!! We CAN, We HAVE, and We WILL!!!

Despite these down falls and shortcomings, the health system in India has shown an unprecedented resolve and that its capable of coming strong, past any situation, the people of India have shown their commitment to the nation and to their fellow country men repeatedly. With the government taking notice and constituting contingency plans and rapid action forces, the situation is expected to turn for the better soon. But the time has come for citizens to take more responsibility and during such trying times, help the unfortunate and help the government in providing relief. This mentioned, even we must keep the faith in ourselves as DOCTORS and the country in itself and the world will come out strong. As someone rightly said “they can shake the foundations of our tallest buildings, but they can not shake the foundations of our resolve!!”

REFERENCES and related reading:

Dr. Brahma grew up in the Netherlands, but spent considerable time in his father’s native country of India. The discrepancy between the rich and the poor bothered him even at a young age, and this is when he first became interested in becoming a doctor and working with impoverished persons. He earned his MD from Vrije Universiteit in 1999, and went on to obtain his Masters in Science in Tropical Medicine from the London School of Hygiene & Tropical Medicine in 2002. Dr. Brahma has worked around the world as an Infectious Disease specialist. He started his career in India, and soon moved to Nepal. He began work with Médecins Sans Frontières (MSF) in 2002 as a Medical Doctor in Burundi, Sudan, Chad, and Ethiopia, and after a brief stint back in the Netherlands from 2004-2005, he returned to Chad with the International Rescue Committee as the Health Manager of the Bahai/Oure Cassoni refugee camp with a population of 27,000 people, and a staff of only 93. Since 2007, Dr. Brahma has been traveling around the Americas giving lectures and raising public awareness for the Sudanese refugees from Darfur and for the Phoenix Global Humanitarian Foundation (www.pghf.org). Dr. Brahma is returning to the USA for a speaking tour in October 2009, and is always happy to receive communication or questions concerning his work. This interview addresses some of the experiences he has had in working with refugees.
So tell me about your first experience working with refugees in Burundi.

I always wanted to go to Africa. I remembered the genocide in 1994 in Rwanda, so I finished my Masters degree and I went to Doctors without Borders, and I said I wanna work. They came up with a profile in Burundi. I didn't even read the job book, I just took the job. And it was a great experience. It was kind of a bit tense. Cause the country still had active rebel movements going on, and refugees and internally displaced people. People from Rwanda hiding in Burundi, Burundi people hiding in Burundi. But there was a health care system in place for them. It was a time when there was an outbreak of malaria, 2 million out of 6 million got malaria. It's a country where ten to fifteen percent of people have HIV/AIDS, without treatment. All the hospital beds were taken up by HIV patients. Where basic things like vaccinations are not in place, there are no drugs to treat malaria, or diarrheal illnesses. The basic cups of tea, the bread and butter you can't even treat. Because either there are rebels running around and shooting at the people, are making the doctors and the nurses go away. Or there were doctors and nurses but there was no medication. So in the short period I worked there, I was evacuated four times back to the capital. And then our village got attacked and fourteen soldiers got killed about an hour’s drive from us; between Christmas and New Years when I was there. And the work I did was monitoring a hospital, actually two and eight health posts. Like ensuring that they had drug supplies, giving consultancy as a doctor and training of all kinds of Health Staff.

Wow, that’s intense. Where did you go from there?

From there I moved into Sudan. I worked in a field hospital bordering Ethiopia. And these were people in the northern part of Sudan. And the government didn’t care about them. They had about 700,000 patients with HIV/AIDS (a rough estimate), many co-infected with Kala-azar; which is the topic of my Master’s thesis. After Sudan I went to Lira, Uganda where the North Uganda Lord’s Resistance Army worked and again saw a situation where there were displaced people. I heard horrible stories of girls coming to the hospital while having lost their entire family, carrying a baby on their back. And the story becomes an even bigger nightmare because their relatives can’t take them in because they already have too many children. And you know that the six year old will end up as a sex slave, before the age of ten in an IDP camp. And there’s nobody who can do anything about it, because there’s so many HIV orphans in Uganda. It’s a mockery again to humanity that we allow these things to happen. So I aided MSF in setting up a therapeutic feeding center. I went to Ethiopia. I went and worked in another few hospitals fighting kala-azar. Same story, Ethiopian government taking people from the higher lands, and they were pushing up refugees, they were forced to move to an area where there’s lots of land and lots of malaria, tuberculosis, kala-azar, TB,
diarrheal disease, crocodile bites…. And after Ethiopia I guess I lost it for a while. Too much violence. So I returned to Europe. I returned to the Netherlands and worked in forensic medicine, social medicine, and infectious disease control for a year in the government Public Health Services. But I decided I couldn’t live in Europe, and longed to return to Africa. So I went to Chad. And I started working in refugee camps. And since then I was working in that camp, I have thousands of stories about the people there. I’ve become an advocate for the position of refugees. And I talk especially about the refugees in Darfur. As a vehicle to tell people that, look at these people, they still have their resilience, their humor, their dignity. That’s very remarkable. They had dreams and they had ambitions for peace. And they see a solution to their problems. Because working in a refugee camp definitely…it was a fantastic year. I also began lecturing at University of N’Djamena in Chad in 2007, but was evacuated due to violence. So I traveled around the world, wrote a book about my work in Chad, and now work for Phoenix Global Humanitarian Foundation, but would like to return to Uganda, hopefully to teach in one of the smaller universities.

When working with refugees or IDP’s, what are the biggest problems that you see in your patients, as far as physically and mentally?

I think common things are common. They have diarrheal diseases, they have respiratory tract infections, they have skin diseases. What is an added component which you won’t see in developed countries is malnutrition. Depending upon which region you work, you see malaria & HIV/AIDS in Africa. But those are the basic things. What you’re worried about obviously are those common diseases. Like most children who died in the camp, died of diarrheal diseases, respiratory tract infections. What you worry about besides that, people need to come to your health care center early. Which is one of the main concerns, because people go to traditional healers. And the collaboration between western medicine and the traditional healer is always skewed to the western medicine people, they think they know it all, but actually they get the patients very late. So the dialogue is lacking. The reality is that most people go to traditional healers first. So unless you start a dialogue with those traditional healers you’ll not get to your patients on time. So another thing would be typical women problems in the sense that pregnancy is not something you could let go without monitoring. And specifically in a population where female genital mutilation is common. So that is a specific issue for women. Then there’s a potential for outbreaks of meningitis. There’s a potential for an outbreak of cholera. There’s a potential for an outbreak of many medical diseases. Even very simple things like ringworm. So you need to have all those ends covered as well.

And then finally I would say on the mental field, imagine that you and your family have lost half of your members. All the women have been raped and all the guys above fifty have been killed. How traumatized would you be. And post-traumatic stress disorder would be very common amongst children and women. That survivors are raped and children have seen their parents being killed. And then finally despite being in a refugee camp, currently the World Food Programme is giving 1,100 kilocalories to several refugee camps in Darfur and in Chad. It does not always meet the requirements for humans since we need 2,200 kilocalories a day according to international convention. So they’re getting half of what is needed. So there’s a plethora of issues. But the remarkable thing is that the simple things are the most dangerous ones. Diarrheal diseases, upper respiratory tract infections. That’s what children die of. They don’t die of fancy stuff. Simple stuff.

As a physician working in such tough conditions, would you say your biggest barrier to care was your lack of supplies or lack of compliance and trust from your patients. Or a combination of both?

There were several issues. First of all the level of education of staff. So that’s where I put my time and effort in. And I would say, at the end of the day, the biggest problem is of access. Access to health by having confidence in the health care system, confidence in the specific physician, confidence in the system as a whole. Supplies, yes we ran out of drugs sometimes. We just wing it. But in the end I wouldn’t say that the supply of drugs would be a problem. More so the quality and quantity of expatriates finally, but first of all of local and refugee staff. And however much time and effort you put into training people, that is still a point of worry.

What do you see as the biggest rewards and the biggest challenges in your line of work?
I think the biggest reward is the smile of a mother that gets a healthy child. Or the dad who is crying out loud because he has a newborn. Or to see a child that comes in your clinic floppy, almost dead. But like a day or two day later and walking out the clinic with the biggest smile on their face, forgetting that they were sick and still playing again. That’s the biggest reward that you can ever get. And the biggest obstacle, that it has an enormous impact on your social and private life. I lived in a jail for six months, we were not allowed to leave the compound, before seven in the morning, come back at five in the evening, getting locked down. We lost five jeeps in the time I was there. I was personally mugged and attacked twice. And hit with a stick. Threatened with an AK47. There were gunshots fired next to our compound on a daily basis. My driver got shot in the liver and his legs.

I guess those are the obstacles. For me I do it because I believe in what I’m doing. It sounds heroic but it’s not. I do this because this is actually what I need to do in life.
In 2006 I headed into the desert south of Be’er Sheva with some peers from my medical school to learn about the plight of the Bedouin tribes. We met the chairman of the Bedouin tribal counsel of the Negev, a village sheik, a local kibbutz physician, and several social workers and NGO personnel with Physicians for Human Rights. We stopped along a barren stretch of highway and started walking south on a faint gravel track. The heat was oppressive. We passed a woman draped in black leading three donkeys. The last was a colt that stood puzzled with his large, furry ears pricked for any sound from our group. The desert haze did not blow away with the scorching breeze. After a half mile, a dilapidated Subaru Brat drove past. The dark-faced driver stared at the white girls but continued to rattle over the hill. On the other side, collections of shacks, pens of dry brush, vehicles, rusty heaps of junk and litter were scattered over a square mile. A few dusty camels and sheep watched our group walk by with little interest. We met the middle-aged sheik at a traditional goat hair tent built for council meetings and visitors. In the shade of the tent, we were offered sweet tea that had been heated on a small fire at one end of the tent.

After we were seated on rugs, an environmental justice activist discussed the history of the Bedouin in the region, their troublesome history with the state of Israel, and the current land issues. Very similar to the American Indians, these historically semi-nomadic people have been dispossessed from their herding land and are now relegated to a small patch of desert. Even though they are full Israeli citizens, the state refuses to provide water and electricity even though the unrecognized village lies in the shadow of the nearby water and electrical plants that provide services to distant Be’er Sheva. Only recently, after years of requests and a ruling of the high court, the state of Israel built a small clinic and primary school in the village. The activist went on to tell us about how the incidence of cancer rose after the tribe was resettled here, near an agriculture chemical plant. A second aid worker detailed her thesis work on Bedouin women and their access to healthcare. Access is hampered by lack of transportation into Be’er Sheva, the cultural limitations of women in an Islamic community, economic limitations, embarrassment and communication barriers when consulting with medical staff, and the inability to leave chores and children at home. The stories of individual women were heart-breaking and frustrating. Solutions seemed so easy, but here in the midst of abject poverty and in the shadow of an oppressive culture and an even more unjust state, quick fixes prove elusive.

During a discussion led by a second year MSIH student working with Physicians for Human Rights, we glanced up from our thick tea. Across a mile of sand and scrub brush to the east laid a lush kibbutz fed by irrigation canals, a paved road, and electrical power. Irrigated fields surrounded the fenced community that had some of the only green lawns I’ve noticed in the Negev. It was striking to see green crops transition to desert as if someone had drawn a line in the sand. After hearing the struggles and injustices done to the Bedouin and then seeing their tedious situation contrasted with the kibbutz, it remained unclear what this
Bedouin tribe really wanted. Someone asked. The sheik talked around the subject for a while. He knew they did not want to move from their traditional grounds to government-planned settlements that are recognized by the state. These settlements would provide water, power, services, and housing. They did not want to live in Be’er Sheva. One of the Jewish students asked, “Do you want a village like a kibbutz?” The man looked unsure, but then agreed that the farming and grazing aspects of a kibbutz were appealing although the Bedouin seem to be less socialistically inclined. Another observation of this community in transition is the awkward mix of traditional and modern life. Even though we were meeting in a traditional tent, most dwellings were made of corrugated tin, not the coolest under the sun. Speakers drove up in new trucks and discussions with the villagers were interrupted by calls to their cell phones. They seemed to maintain livestock, and camels and sheep were kept in traditional brush pens.

I see many parallels to the struggle of the American Indians. They have transitioned from a proud, indigenous people through the process of war, dispossession, and displacement, to a people living on reservations stripped of motivation through federal entitlement. The transformation forced on the Native Americans over the last two hundred years is occurring in the Bedouin tribes at a much faster pace. In the fifty years since the formation of the state of Israel, the Bédouin have transitioned from nomadic tribes to the majority being displaced to Jordan, Syria, Lebanon, and Egypt. The eleven thousand that remained after the formation of the state were either ignored or patronized. For the most part content to be left alone, the tribes stayed out of the settler’s way. With David Ben Gurion’s mandate to, “Make the desert bloom” the tribal residents of the Negev became a liability. And in the resulting push to settle they were requested and often coerced to yield prime agricultural land to the kibbutzim. Recent development of kibbutzim and industrial plants has further marginalized the tribes.

This brings the discussion to their current status. The Bedouin are full citizens of Israel, yet their traditional property rights are not recognized. Israel entices families to move to planned villages or offers to buy their land (which the state does not admit the tribe owns) for a fraction of its worth. Once a family is relocated, their house is destroyed. Periodically the government, which sees the families as squatters, destroys occupied homes. In fact, we were cautioned against taking photos because two weeks ago the government had destroyed two houses in the village. The people might think we were scouting for other homes to level. Even while these tribes are being relegated to reservation-like villages, a few sympathetic Jewish Israelis, NGOs, and a Bedouin council struggle for the full rights of the tribes through community awareness and appeals to the High Court. But the court throws the cases out on the grounds that these unrecognized villages do not even exist. Despite this deaf ear, the state has recognized several of the villages. However, this was only after years of bureaucratic stalling.

This is only an outsider’s observation. I am uneasy drawing any definite conclusions. And I doubt my understanding is free of naive notions or a one-sided view. It is my hope, however, that both the state of Israel and the Bedouin tribes look to the story of the American Indian to avoid repeating the blunders of history. In the meantime however, these Bedouin women and their families continue to suffer.
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