

EXPERIENCE REPORT

Pushing Medical Education Forward: Emphasizing Community-Based Approaches for Health Success

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We are blessed to live in a time in which modernized medicine has significantly increased our lifespans. Nowadays, we have not only vaccines to immunize us against the myriad bacteria and viruses that probably would have killed us mere centuries ago but also CT-guided radiation surgery against dangerously located cancers. Yet, despite all our medical advances, disease is still rampant throughout all our communities throughout the world. Multidrug-resistant TB runs rampant throughout South Africa and India, obesity and diabetes are progressively impacting not only adults but children in the Middle East and “Western” countries like the USA, and maternal-child transmission of HIV and HBV continue to compromise individuals’ health from the moment they are born into this world. Essentially, we continue to live in a paradoxical world; despite cutting-edge medical advances, the overall health of the world is still extremely compromised.

A slightly closer observation quickly reveals that medicine is not just about medical practitioners giving

patients vaccines and medication. Providing healthcare requires that medicine is available and affordable for both clinics and patients. Providing healthcare requires not only training doctors and nurses in pathology but encouraging them to provide healthcare in areas where access to medical help is virtually unavailable. But stopping at the financial and geographical obstacles for effective healthcare is not enough; though difficult, we must go beyond these concrete constraints and seriously consider social, political, and cultural barriers to providing effective healthcare. More importantly, we must completely challenge our current understanding of the power-dynamic between trained healthcare professionals and patients; instead of assuming doctors are always superior, we must shift our healthcare to community-based approaches in order provide not only medicine to communities but also address the systemic barriers to quality healthcare.

Considering all these aspects can be overwhelming. Simply considering financial and geographical obstacles can cause one to conclude that solving the mismatch

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of medical service supply and demand is impossible. Adding on the consideration of how social, political, and cultural systems affect people's health quickly shatters any notion of developing a universal healthcare system. Furthermore, considering that healthcare experts (like doctors, nurses, and public health experts who have dedicated years of their lives to medical training) are not necessarily superior to patient communities but rather their equals in designing effective treatments challenges millennia-long understanding of power dynamics in medicine and, at the core, doctors' assumed superiority and egos. Unsurprisingly, even if one is willing to accept all these considerations, recreating even just one health care system so that it will be effective and efficient, seems absolutely impossible. How can we ever create a universal healthcare system that will optimize the health of every human individual?

The simple answer is that we cannot. Our concept of a "universal healthcare system" is flawed from the beginning. For most of us, the term "universal healthcare" conjures up the idea of a single system that will provide perfect healthcare to every human being; this does not and never will exist. Instead, we must conjure up malleable healthcare systems tailored to individuals' and communities' specific needs so that every human being receives, at the very least, basic "universal healthcare".

Defining "universal healthcare" was only the introduction to the Disease Prevention, Health Promotion, and Vulnerability Reduction course led by Dr. Ana Claudia Germani, Dr. André Mota, and Dr. José Ricardo Ayres during the first International Winter School Program hosted by the *Faculdade de Medicina da Universidade de São Paulo* (FMUSP). Eight medical students and I were extremely privileged to create such a priceless learning environment even if only for two weeks. Representing Colombia, Hungary, Mexico, Peru, South Africa, the United Kingdom, and the United States, my classmates and I brought together knowledge about the political, social, economic, and healthcare situations in each of our countries. We could not have asked for a better forum for discussing burdens of disease and healthcare systems throughout the world.

Inspired by the history of medicine in Brazil and the

recent movements towards more humanized healthcare, we collectively reflected upon the most pressing healthcare not only in our respective countries but throughout the world. We discussed the nearly non-existent healthcare systems of extremely isolated Columbian communities in the Andes while considering geographical barriers. We discussed the recent exponential growth of designer drug abuse in Hungary causing unprecedented physical and mental disabilities that the general population is largely unaware of and the healthcare community is just beginning to understand. We discussed the huge burden of multidrug-resistant tuberculosis (MDR-TB) in South Africa, the corrosive 9+-month antibiotic regimens most people cannot afford let alone comply to, the lack of incentive for pharmaceutical companies to develop better drugs, and the fact that a person's "race" quite literally colors whether they will live or die. As each student would bring up a healthcare issue, the rest of us chimed in our experiences and the state of those issues in our respective countries. We went beyond pathologies and molecular drug design to discussing socioeconomic barriers, cultural taboos, and political inefficiencies.

Despite all the pressing, and perhaps depressing, healthcare burdens discussed, we did not dwell only on problems. As our course continued and we started reshaping our understanding of "universal healthcare," we unknowingly began brainstorming solutions with a more "humanized" mindset. We discussed how better incentivizing healthcare professionals to serve in isolated Columbian populations might result in more continuous care. We discussed how more research and public awareness efforts from the Hungarian government and medical community might better inform the population about the truly devastating risks associated with novel designer drugs. We discussed how medical professionals, including doctors, in South Africa might save more people's lives if they sympathize with patients who physically cannot comply with intense MDR-TB drug regimens and if they destigmatize simple preventive measures like wearing a face mask.

As we continued our discussions, Dr. Ana Claudia challenged us to consider where these solutions were coming from. Without realizing it, we had proposed

most solutions from a “top-down” mindset, assuming that people with higher authority have the expertise and power to implement solutions based on what they deem most important. Most alarmingly, we had ignored the most important component of these healthcare systems: the target communities. Paradoxically, this kind of community-less decision making and healthcare policy implementation is what most of us are used to.

When considering the current state of medical education and how we should develop it moving forward, one glaring realization should be prioritized. As Mary Eddy Baker wrote, we must “give patients credit for sometimes knowing more than their doctors”. While our biomolecular understandings of disease and novel technologies grow at unprecedented rates, the healthcare we provide will always be compromised unless we acknowledge this simple truth. Who else better understands the pain, suffering, and obstacles patients experience while trying to get better than the patients themselves? Mary Eddy Baker was in fact one of these patients driven to create a new form of spiritually-based medicine out of her frustrations with the mid-19th century healthcare system that often worsened rather than restored patients’ health. Though we need not necessarily create new forms of medicine, we must seriously reconsider our current forms.

The most fundamental aspect of medical training in our current century and beyond is the acknowledgment

that community-driven healthcare is the foundation for “universal health”. As modeled in the Ottawa Charter for Health Promotion of 1986, we must strengthen communities and engage them when building public health policies in order to advocate on their behalf, thereby mediating meaningful solutions. If, like young medical students, we fixate on a particular problem (ex. a trauma patient’s broken leg) we might miss the bigger problem burdening a patient (ex. the heart attack the patient is having due to stress). Instead, we must teach our medical students how critical engaging our patient communities is for providing relevant, effective, and sustainable healthcare.

However, in order to strengthen our ties with patient communities we must strengthen our ties within healthcare environments, making them more dynamic, respectful, and supportive for every healthcare professional, ranging from cleaning staff and patient transporters to the chief physician and business administrators. Regardless of all the amazing medical advances that are to come, we will never be able to effectively eradicate disease or achieve optimal health among our global population unless we understand the concept of “universal healthcare”. “Universal healthcare” is not one healthcare system tailored for all but rather a healthcare system that we must perfectly tailor for each community in our global population.