

## Caring for the poor: A family physician's experience



### Curriculum Vitae

Marietjie was born in Paarl and after matriculating at the Paarl Gymnasium, she spent a year at the South African Defence Force Women's college at George. She qualified as a medical doctor in 1980 at the University of Stellenbosch and then worked for three years at Tygerberg Hospital as intern and medical officer. Marietjie then joined the practice of Dr CG de Villiers and partners in Kuils River where she worked as full partner in the practice from 1983 until 1988. She obtained her post-graduate qualification in Family Medicine/Primary Care (MFamMed) cum laude at the University of Stellenbosch in 1988. In July 1988 she started a solo-practice in Mfuleni which is a black township in the Eerste River area. During this time she was involved with several community initiatives including Sacla clinics in Kbayelitsba, Masigcine Children's Home, Noluthando School for the deaf, and many others. She is currently appointed as Senior Family Physician/Lecturer at the Department of Family Medicine and Primary Care of the University of Stellenbosch responsible for the initiation and development of a vocational training programme for Family Medicine and Primary Care. She is also the co-ordinator of the Bishop Lavis Primary Health care project for the establishment of multi-professional community-based education for health personnel and including the development of community participation in health. Marietjie is the organiser and co-founder of the CME-group of the Academy of Family Practice/Primary Care for general practitioners of Cape Town's northern suburbs and also co-ordinates CME for the medical personnel of surrounding Community Health Centres at Tygerberg Hospital. She serves on the Hospital Board for the Community Health Centres Organisation of the Cape Metropole and the Board of the Tygerberg-Boland branch of MASA. Marietjie has special interests in the field of community involvement in health, community-based education for health personnel, the development of primary health care personnel and medical care for the indigent. She is married to Pieter Fourie and they have one son.

### Summary

*Poverty remains a threat to health even in our modern society. The poor have major problems, but people in the helping professions who respond to their duty to care for the poor also suffer unique difficulties. Albert Nolan aptly describes these dilemmas as four stages of development that such people can undergo. In this article a family physician describes her experience in working with the poor in accordance with these four stages.*

### Introduction

Poverty is the most fundamental assault on the ability of people to remain healthy. It is one of the supreme ironies of the 1990s that the most needy people are denied access to basic health care at a time when health technology is more advanced than at any other time in history.<sup>1,2</sup>

Not only do poor people suffer from higher rates of ill health, they also have major problems in accessing health care.<sup>3-6</sup> Once they do enter the health system, the poor are more prone to receive sub-standard medical care than their middle-class peers.<sup>7,8</sup>

However, those of us in the helping professions who choose to care for the poor, have our own set of problems.

Our attitude to the poor can grow, develop and mature over the years. On

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**S Afr Fam Pract**  
1995;16:244-249

### KEYWORDS

Primary Health Care;  
Poverty;  
Case Report.

Not easy for the poor to  
stay healthy.

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the other hand it can equally well get stuck and we can become stagnant in our relationship to the very people we try to serve.

Albert Nolan describes four stages of development that people working with the poor can experience:<sup>9</sup>

1. Compassion and relief work.
2. Discovering structures: the importance of anger.
3. Discovering the strength of the poor.
4. From romanticism to real solidarity.

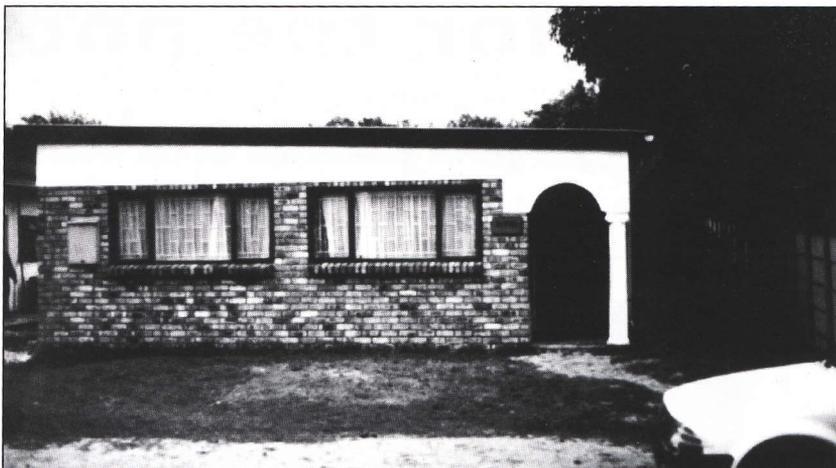
I chose to work as a family physician in a poor black township near Cape Town. For five years I lived through these stages, and I hope that by sharing my story it can be of value to others who also serve the poor.

## Background of Mfuleni

Mfuleni is a black township which came into existence in the 1980s through the clearing of "black spots" in the Kuils River and Eerste River areas. It has an estimated current population of 25 000 people.

The township consists of several different types of housing, including the familiar matchbox houses, grossly overpopulated hostels, a few middle class houses for private ownership only, and a vast and growing informal housing sector.

In 1988 the health services of the community consisted of a temporary clinic which provided only preventative services. A private practitioner visited the township for two hours twice a week. For curative and other services people had to travel to Kuils River or to Tygerberg Hospital 30 kilometres away.



The surgery (and half of the bakkie!)

## I. Compassion and relief work

*The experience of compassion is the starting point. The more we are exposed to the sufferings of the poor, the deeper and more lasting our compassion becomes. Nothing can replace immediate and personal contact with pain and hunger, seeing people in the cold and rain after their houses have been bulldozed, seeing what children look like when they are suffering from malnutrition.<sup>9</sup>*

I was working in Kuils River when I became aware of the lack of medical services in the local township. We were five partners in a mainly white, middle class practice. We had a cash practice "at the back" for poorer patients of colour. One day I asked a patient where he lived and discovered that he had to travel 10km from Mfuleni to see a medical practitioner. At that time I was not even aware of the existence of such a place.

*At this stage it is necessary that there is a willingness to allow compassion to develop. We can put obstacles in the way of this development by becoming more callous, denying our own responsibility, and blunting our natural compassion.<sup>9</sup>*

The strength of the poor.

Doctors, caring for the poor, have specific problems.

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This is the defence mechanism that most medical students develop in their clinical years to escape the personal pain of dealing with suffering and death of such a magnitude - in the absence of support systems from their mentors.

*Compassion then leads to action which can take the form of relief work, or a simplification of our lifestyles in solidarity with the poor.<sup>9</sup>*

In October 1987 I visited the town clerk of Mfuleni to discuss the possibility of starting a medical practice in the township. He was a conservative white man who initially actively tried to discourage me. By this time I had had so many white people trying to dissuade me that it only made me even more determined to go ahead. He suggested that I had to see the mayor of the township.

I had an unusual interview in the mayor's dusty shop. He was a big, bosomy, patriarchal old man who to this day calls me "my kind" (my child).

As a white, I was not allowed to own land in the township, so I had to rent the plot on which the surgery was to be built. I then sold my house, car and other luxury belongings to finance the building and set up a medical practice. At this stage I was labelled as being out of my mind, urged by my family and the church to reconsider my decision, and even admonished not to interpret the Bible literally.

The building was eventually completed in July 1988. The first day I had one patient; the second day, none. It took nine months before the practice became financially viable.

## 2. Discovering structures: the importance of anger

*The second stage begins with the gradual discovery that poverty is a structural problem. It is not merely misfortune or bad luck, but the direct result of political and economic policies. We find ourselves getting angry with the rich, with politicians and with governments.<sup>9</sup>*

Feeling compassion is the starting point.



The doctor doing home visits

Nothing can replace immediate and personal contact with the poor.

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This period had a major effect on my conscience. Going into the previously forbidden black townships, witnessing institutionalised poverty and suffering, meeting real people behind demonised black faces, hearing many tales of indescribable humiliation and suffering.

*Relief work is like curative medicine as opposed to preventive medicine. What is the point of trying to relieve suffering while the structures that perpetuate the suffering are left untouched?*<sup>9</sup>



A regular patient in her house

The discovery that family medicine is as relevant in Mfuleni as in Kuils River, I had to make on my own. I obtained a post-graduate degree in Family Medicine six months prior to my change of practice; however, this was so much orientated towards first world private practice that it did not at all prepare me for the crucial issues around community-oriented primary care.

### 3. Discovering the strength of the poor

*This is the discovery that the poor must save themselves and that the poor will save themselves and that the poor do not really need you and me to save them. We have to come to grips with humility in the service of the poor. We are faced with the need to learn from the poor instead of teaching them.*<sup>9</sup>

The first contact with a family would usually be a sick child and concerned mother. Later the mother would present herself and other children, then the grandparents, then the adolescents, and lastly the father came and dared to entrust himself to a woman doctor. Then the workers came, always just before closing time, or on Saturdays as they could not afford to lose a day's wages. Eventually patients came from many other townships in the Peninsula. It seemed as if they were starving for simple kindness and understanding.

The fees were kept to a minimum and were generally about 30% lower than the fees of medical practitioners in the surrounding areas. Each time the fees had to be raised, I spent hours agonising about it, only to be told by my patients that it is a universally accepted practice.

There is a saying amongst some doctors that black people will pay anything for a good service; but does it serve us to exploit the trust of another? Has any one of these doctors ever been to the homes of these people to see what they sacrifice in order to afford the treatment of this "wonderful" doctor?

The house calls were always a surprise. I could never predict what kind of living conditions I would find. The woman battling terminal colon cancer on a makeshift bed in a two by

We can grow, or blunt our natural compassion.

Poverty is a structural problem, not merely bad luck!

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two metre "hokkie" within a hostel inhabited by 20 other people. The kitsch of the poor proudly displayed on cheap furniture. The horrible stench of seeping sewage around the hostel where a young girl was slowly dying of systemic sclerosis. The troubled eyes and awkwardly gloved hands of the mother of my first AIDS patient.

*Having crossed this hurdle we open ourselves to a particular kind of romanticism: romanticising the poor. We feel that anything that has been said by someone who is poor and oppressed must be true.<sup>9</sup>*

And of course there were the visits to the dead and the prayer meetings held for them. The mourners were always there before me, overflowing from the minute front rooms into the dusty streets, displaying that remarkable ability of the poor to accept their fate.

## 4. From romanticism to real solidarity

*This is the crisis of our disillusionment and disappointment with the poor. We discover that the poor are human beings like any of us. They are sometimes selfish, sometimes lacking in commitment, sometimes manipulative; they have more middle-class aspirations than we have and are less conscientious than we are. The poor are not saints and the rich sinners.<sup>9</sup>*

Sharing a neighbourhood with a poor community has distinct drawbacks. The constant unexplained electricity cuts, the flooding of streets and dampness of buildings, the lack of maintenance services due to political

turmoil. People wanting to borrow money, having no money to pay for consultations, needing money for bare essentials: "A'ndi nayo imali": I have no money - the cry of the township.

At first I felt responsible and treated almost anyone on credit; eventually I was able to distinguish between the trustworthy and the others, with fewer guilt feelings! It was humanity all over: the universal homo *un-sapiens*.

We had three burglaries in five years and a robbery at knifepoint. During this last occasion we were robbed of the cash takings as well as my car, which was discovered in Khayelitsha within an hour by one of my patients. After all these incidents the community rallied around me and showed remarkable solidarity. For the first time I realised how many innocent people have to live with the constant assault of crime in the course of their everyday lives.

*Solidarity with the poor means taking up their cause, not ours. But we need to do this **with** them. Real solidarity begins when we recognise **together** the advantages and disadvantages of our different social backgrounds and*



Community initiated health promotion

We need to learn about humility in serving the poor.

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*present realities and quite different roles.*<sup>9</sup>

Looking back, it was the **poor** who empowered **me** and not the other way round. It was the poor who taught me humility, wisdom and acceptance of life.

## The duty to care for the poor

The strength of a society is judged by its treatment of the poor, therefore we have a duty to care for those less fortunate than us.<sup>4</sup>

Further, the objective of the medical profession is to care for the sick. That simple notion is the essence of the physician: to treat the ill, without concern for who they may be, what their diseases are, or whether they can afford to pay.<sup>10</sup>

Also, a doctor is a person with acknowledged skills helping another person. In contrast to scientific knowledge, which is always improving and is required to be up to date, **caritas** (kindness) is unchanging. Kindness and understanding are perhaps the most important tools in caring for sick people.<sup>11</sup>

Lastly, by drawing on the physician's mercy, compassion and empathy, charity care strengthens the emotional bonds between patient and physician that are too often weakened by the commercialisation of medicine.<sup>10</sup>

To make that choice, we need something we do not yet have - something that goes beyond professional codes or the analysis of ethical puzzles: a moral philosophy of medicine.<sup>12</sup>

## Post script

A new Community Health Centre was

built in 1991 and Mfuleni now boasts a comprehensive curative and preventive health service. Due to an enterprising primary health care nursing sister, a centre for old people was built and other community programmes started. The University of the Western Cape is currently involved in a community project with Kellogg's funding, and a community-based education initiative. Mfuleni now also has a well-functioning community health committee and a growing community health worker contingent.

I often long for my own people.

## References

1. Burstin HR, Lipsitz SR, Brennan TA. Socio-economic status and risk for substandard medical care. *JAMA* 1992;268:2383-7.
2. Martin J, Macdonald J, Fustukian S. Co-operation is the key. *Health Action* 1993;6:2.
3. Blendon RJ. What should be done about the uninsured poor? *JAMA* 1988;260:3176-7.
4. Hilfiker D. Are we comfortable with homelessness? *JAMA* 1989; 262:1375-6.
5. Harpham T. Health and the urban poor. *Health Policy and Planning* 1986;1(1):5-18.
6. Gelberg L, Linn LS, Usatine RP, Smith MH. Health, homelessness, and poverty. A study of clinic users. *Arch Int Med* 1990;150:2325-30.
7. Hafner-Eaton C. Physician utilisation disparities between the uninsured and insured. *JAMA* 1993;269:787-92.
8. Brooks DD, Smith DR, Anderson RJ. Medical apartheid: an American perspective. *JAMA* 1991;266:2746-9.
9. Nolan A. The Service of the poor and spiritual growth. *Justice Papers* No. 6, Nottingham: Russel Press, 1985.
10. Council on Ethical and Judicial Affairs, American Medical Association. Caring for the poor. *JAMA* 1993;269:2533-7.
11. Clarke PS. General practice as a caring discipline. *Med J of Aust* 1992;157:325-6.
12. Levenstein JH. The South African general practitioner - an overview. *S Afr Med J* 1981;59:309-10.