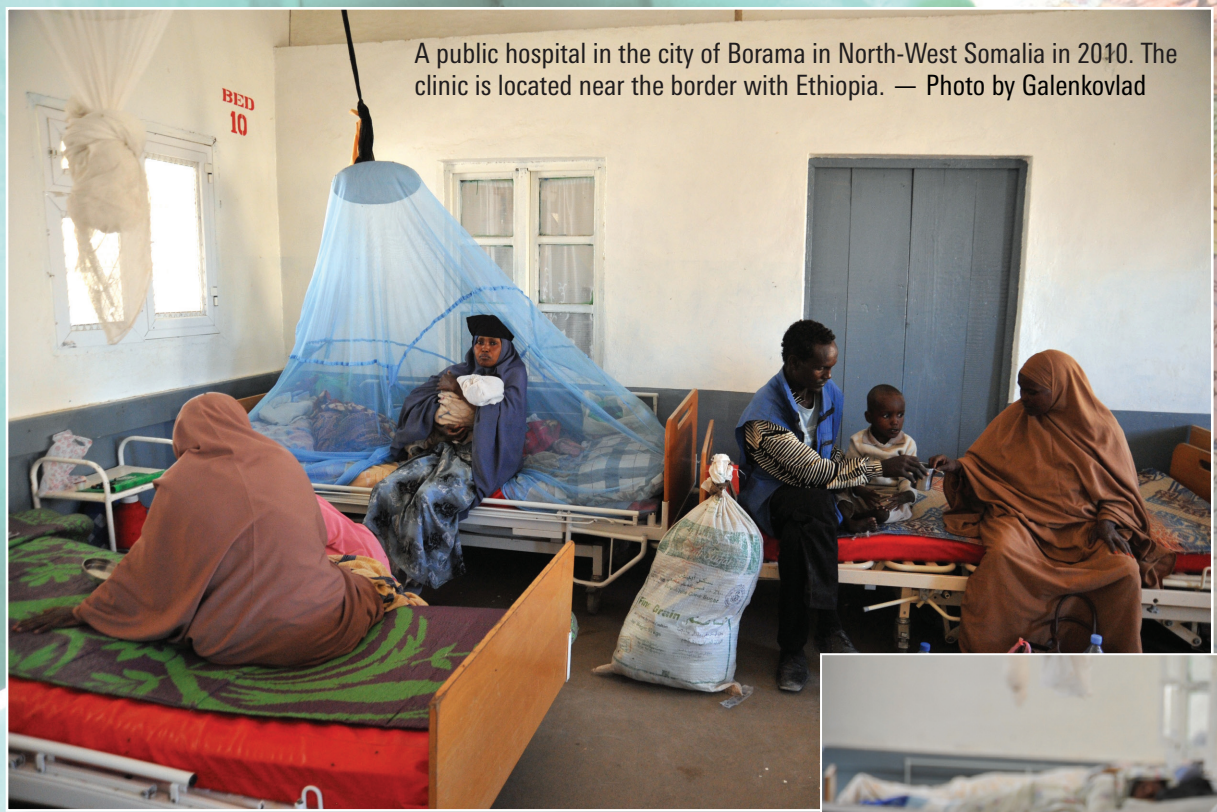


A public hospital in the city of Borama in North-West Somalia in 2010. The clinic is located near the border with Ethiopia. — Photo by Galenkovlad

*Overwhelmed by the "foreign," visiting health care workers miss the common thread of care in international settings.*

# Where the Waiting Rooms Have No Chairs

*Pavitra Krishnamani*

A line forms outside the casualty center at the Institute of Child Health. Photo: Pavitra Krishnamani

For some, the phrase "global health" conjures up images of cracked dirt floors, straw huts and lines of destitute individuals standing in oppressive heat for hours on end to receive basic health care. Yet, in working with supply shortages and less than ideal circumstances, global health leaders have garnered a reputation for being ingenious and entrepreneurial physicians. For the idealistic student, global health work presents the opportunity to venture outside of what is comfortable and face head-on the harsh realities that many individuals in the world have accepted as fate. For the seasoned academician, it provides access to a variety of intriguing diseases that are rare, if not entirely absent, in more-developed nations.

This summer, I had the privilege of working with neonatal patients, their families and physicians in a government hospital in Chennai, a sprawling city located on the coast of the South Indian state of Tamil Nadu. Like most cities around the world, Chennai is home to people living in opulence, juxtaposed with people living in abject poverty. The patients I observed were either of the latter variety or had traveled hours from rural regions to reach the Institute of Child Health (ICH), one of the top referral centers for children all over South India.

The first thing I saw upon arriving at the hospital was a crowd of parents sitting on the ground and standing in line outside of the casualty center with their children.

Mothers had saris draped over their children


to provide shade from the morning sun, and fathers waited patiently nearby with a bag of their children's records in hand. However, the problem of long waiting is certainly not unique to developing nations, with the Hamilton Spectator reporting in 2012 that "one in 10 patients seeking emergency care here [in Canada] will wait eight hours or more."

The most prominent difference between waiting for emergency care in lower resource and higher resource settings is the environment. While lower resource nations often lack the infrastructure to provide sufficient seating for the large numbers of patients health centers must evaluate on a daily basis, higher resource nations are generally able to build waiting rooms that have chairs.

Limited infrastructure is also responsible for the other material challenges that health centers in lower resource nations face. Patient rooms may be nothing more than a hut or tent, and when they do exist with structural integrity, they often contain nothing other than a desk and cot. Several rooms at ICH that were used for patient evaluation in the mornings quickly became spaces for meetings and academic work later in the day. Medical equipment was reserved for active care spaces such as the sick neonatal care unit (SNCU) wards and the neonatal intensive care unit (NICU).

In the best of circumstances, a hospital in a developing nation must decide between being able to provide phototherapy for jaundiced neonates or investing in incubators for sick, premature babies brought to its doorstep. At ICH, the neonatal beds were simply clear crates that had partial films stretched over them to keep pathogens away from the susceptible children inside. In the worst cases, individual crates are not available for babies, and neonates are simply laid next to one another on a large cot padded with blankets.

The comfort and accessibility of medical procedures are also heavily influenced by the availability of equipment. Even in the best case, blood draws are painful events, restricted by a lack of formal medical equipment. I remember cringing when I saw blood squirting out of a hypodermic needle inserted into a screaming child's vein before the flow was manually controlled to a slow drip. The physician I was observing skillfully caught the precious liquid in an open test tube held under the needle.

Those who volunteer abroad will soon find that local physicians and staff are aware of such limitations, and work diligently to compensate in any way within their means. At ICH, physicians avoided recommending blood tests unless they were absolutely necessary, and several policies were in place to maintain a sanitary and hygienic SNCU. Hand sanitizers were attached to every bed in the wards and NICU, and the janitorial staff meticulously washed the floors several times every few hours. Furthermore, no shoes worn outdoors or anywhere else in the hospital were permitted into the SNCU. All footwear either had to be removed entirely, such that employees and patients walked barefoot within the halls of the SNCU, or exchanged for slippers that regular visitors kept in the SNCU for exclusive use there.

Volunteers must also try to contextualize the relationships they observe between local physicians, patients, and other health care workers while abroad. In many developing countries, physicians are almost revered, much as they were during previous generations in the U.S. While interactions informed by this hierarchy may be representative of the majority of relationships in a country's health care space, it is important to avoid generalizing these patterns to every association. After acknowledging that "doctors try to keep their distance from other staff in the hospital," one physician I worked with noted that he "find[s] it freeing not to do that."

While the societal hierarchy in which a physician is considered the primary authority in health care is divisive, it also acts as a quality control measure for health care in these communities. It guarantees that every patient will be evaluated solely by individuals who have received the most formal medical education in their society. On the other hand, this stratification breeds the expectation that patients will be unquestioningly receptive to the care they are provided by physicians. After an encounter with a patient whose mother insisted that babies only see in black and white, the physician I was observing said to me that he finds "those types of parents who pretend to know things they do not [to be] very irritating." He mentioned that he prefers to "not keep talking to them" and others who ask "too many questions" for an extended period of time.

However, the opinion that patients who ask too many questions are difficult and non-adherent patients are rebellious is not limited to the Indian social context. Only recently has this perception been brought to the forefront of medical education in the U.S. Even with the introduction of

relationally oriented classes into medical school curricula, social dynamics in which the physician is thought to be superior still persist. Medicine, as a field, has historically been deeply hierarchical and the paternalistic doctor can as easily be found at home as abroad. Every year, stories about arrogant physicians and subdued medical students surface in countries that are considered "developed." With the democratization of the Internet, patients are able to post reviews on websites like Healthgrades about their experiences with doctors who wouldn't adequately answer their questions and those who made them feel uncomfortable to even ask.

All of this occurs despite the fact that patients in higher resource nations receive a standard of care that is far more comfortable and medically advanced than what is accessible to the patients I met this summer. Internet, social media and other technology-based communications have not yet reached many of the people served in the regions that most global health workers travel to. Local health care professionals and patients have also not had an opportunity to turn their attention to relational aspects of care, for they are still trying to improve the medical services they are able to provide for an ever increasing pool of patients. These patients are underserved in an already "underprivileged" nation. Yet, at government institutions like ICH, they have access to radiology and a reasonable medical standard of care for absolutely free. The medical services provided for these patients are far superior to what underserved individuals can receive free of cost in some "privileged" nations.

With global health work comes an introduction to what is foreign—an introduction to what has traditionally been portrayed as exotic and mystical by the societies from which many volunteer workers originate. Like traditional attire turning into nothing more than mere costumes without a thought to its purpose and value, medical practices and systems abroad can easily come to feel somehow inferior to the processes that volunteers have been accustomed to at home. Yet, when this tendency is abolished, global health work becomes more personal, and the worlds that have been so firmly established as "first" and "third" become no more than "privileged" and "underprivileged" nations within the same world—nations with differing levels of resources, but with individuals who share the same passion for protecting human life.

During my time at ICH, I saw flaws stemming from the reverence of doctors and a lack of infrastructure, but I also saw a group of people who wanted to make sure that every child had equal access to the limited resources available through the hospital. I saw physicians who could not bear to see a child, who could have been helped, come into the hospital too late. And I saw people whose passion to help their patients drove the opening of ICH's new breast milk bank. Every global health experience is a precious exercise in cultural humility and an opportunity for volunteers to consider the context in which they are providing aid. And, in doing so, those who have a chance to travel to a nation with fewer resources may just find that what they see is far more familiar than they would assume—once, of course, they look past the waiting rooms in front of them that don't have chairs.

**Pavitra Krishnamani** is a second-year at Sidney Kimmel Medical College at Thomas Jefferson University and a member of *TNP*'s Editorial Advisory Board. She completed her master's in global medicine at the University of Southern California.