

## Duffle Bag Medicine

**W**HILE THE SELF-STYLED MEDICAL MISSIONARIES ARE piling into the back of the truck, I spot a young man, at most 19, wearing a cowboy hat, smoking a cigarette, and leaning against the makeshift frame that converts the backs of pickups into the primary form of public transportation here in Guatemala. He is not a licensed medical professional; he is an American on vacation and he is about to distribute medication to patients.

I do not think he is aware of the power he radiates in this community. We are in a modest-sized village in the temperate green midlands of Guatemala, the coffee region. The most substantial source of income here is from day labor on the plantations, during the November-to-March harvesting season. Clean bottled water and fresh produce can be purchased at a lively outdoor market on Tuesdays and Fridays. However, for most families, these are luxuries that agricultural day labor cannot consistently support.

This impoverished community has been home to a religious mission for 30 years. The mission orchestrates various projects, including coffee production for export, a reforestation initiative, and a permanent medical clinic. The mission also sponsors transient field clinics: groups of visiting physicians and nonmedical volunteers travel to various remote satellites of this village and deliver medical care for the day.

While conducting nutritional research here, I have watched groups arrive, travel to deliver care at transient day clinics, and depart after a week. The main goal of these clinics is for the volunteers to listen to medical concerns and to dispense medication to all who arrive. Some missionary groups have only one physician for every dozen or so volunteers. The physicians traveling with the group are responsible for delivering the care and for supervising the others, in an unavoidably hectic makeshift clinic. Some of the missionaries speak Spanish, but most do not. I have not come across a missionary who speaks Kaqchiquel, which is the only language spoken by many people in the remote areas. One volunteer I spoke with translates Spanish for a group. This interpreter tells me that they all bring heavy duffle bags full of drugs, and by the end of the trip they hand out whatever is left, whatever they can, whatever the illness.

The teenager I spotted wears ripped jeans while working in the midst of a prevailing culture where even the poorest tuck in their shirts. He has confidently slung a stethoscope around his neck, proclaiming an ability to provide medical care, an assertion that is at best questionable. He is from a small US town; all he needs to do to be part of this transient medical team is to finance his flight to Guatemala. He

freely donates his time and energy, but he delivers “care” without the appropriate training, without knowledge of the predominant language, and without any clear accountability.

For many volunteers, this is not just about a mission, religious or medical. The mission’s administration ensures that this project also provides a wholesome family vacation destination. These missionaries bring donated pills—vitamins, acetaminophen, antibiotics. They also bring their stylishly sloppy jeans, their teenagers, and their hunger for their homeland’s cuisine, served three times a day in the mission’s cafeteria. This young man and his group are genuinely proud that they spend their vacation here and are especially proud of their contribution. But I worry that this pride prevents them from acknowledging that their actions may actually be harmful and do not necessarily address the complex needs of this community. Their short-term work is not integrated into a local infrastructure. Health promoters—local men and women trained to recognize serious ailments and to treat minor ones—are not introduced to these groups. Public health and preventive measures are not part of the overarching goals for the transient clinics; this inhibits the project’s long-term potential and puts the community at risk of receiving inappropriate care.

An expatriate friend of mine living in this community suggested this mental exercise:

A foreigner sets up a clinic in your city. He does not speak much English, he will leave after a week or so, and he is not very likely to ever return. This foreigner tells you that he is a physician in his home country, but that he has never been to your community before and is not going to be working with your family physician or with other health professionals in your local health care structure. Would you take your children to see him if you had any other choice?

The people in this area do not have many options for medical care. Their community is rife with hunger, poverty, malnutrition, and high infant mortality. This community has severe medical needs and meager options for how to address them; it has become a practicing ground for first-year medical students and a venue where well-meaning missionaries can feel good about a one-time contribution without ultimately being responsible for their actions. These day clinics focus on treating as many patients as possible. “First do no harm,” which could serve as a point of reflection and perhaps as one safeguard, has not been incorporated into the ideology.

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Let us explore a very simple example: vitamins.

A shipment of donated vitamins arrives to help this malnourished community. Missionaries load it into the pickup trucks, set up clinic, and give a bottle of vitamins to every parent who arrives. The volunteers emphasize to the parent that the vitamins are important and that they help children grow healthy and strong.

There are a number of possible outcomes from this gift:

1. The child eats the vitamins, but, like many children, eats most of the bottle in one sitting and gets constipated. The vitamins do not eliminate the parasites, which continue to inhabit his gut, and the child now has the unenviable combination of persistent parasitic infection and vitamin-induced constipation.

2. The child takes the vitamins and also happens to feel better. The next time an illness occurs, the mother drags the child down to the permanent clinic, because there is no field clinic that day, and tells the physician she needs vitamins. The physician explains that what the child really needs is metronidazole. She explains that she will give her child both. The physician writes both prescriptions, assuming that the vitamins will not harm the patient. The mother heads to the pharmacy, where she is told that the metronidazole is 14Q (*quetales*), and the vitamins are 50Q. She has enough for the previously suggested vitamins but decides to skip the unfamiliar drug.

3. Many Guatemalan-produced vitamins are not in chewable form; they are injectables. Local health promoters tell me that vitamin B<sub>12</sub> is thought to give a high upon injection. Following the volunteers' encouragement of vitamin use, there is a subsequent increase in complications from the nonsterile injections.

There are serious risks associated with eager distribution and inappropriate use of antibiotics. This is indeed an issue for the transient clinics. However, when volunteers follow neither their home country's guidelines nor those of the local system, even the distribution of seemingly innocuous pills, like vitamins, can be frankly dangerous.

The use of untrained volunteers to deliver care and medication is not acceptable in the United States and should not be considered acceptable elsewhere. The inability to follow up with patients and the lack of long-term responsibility for medical care is a serious and largely ignored problem. This community does offer a legitimate opportunity for physicians to evaluate people who are ill, but no one can ultimately benefit from medical care that has no accountability.

Instead of trying to fine-tune this type of missionary involvement, I would like to propose restructuring how the volunteers interact with the community. First, volunteers should reflect on how their specific strengths can address the prevailing medical needs of the community. Non-medically trained missionaries can still address health issues, perhaps through the collaborative creation of a culturally sensitive teaching program. Some programs can run almost entirely on the energy and human companionship that all volunteers can bring. They can gather up children to draw a Guatemalan version of the food pyramid with chalk on one of the few paved roads in town. They can spend the afternoon cooking and cleaning with various families, observing the Guatemalans' practices and reflecting on their own culture's similarities and differences. Volunteers who want to donate money or supplies can refill local health promoters' medical kits.

Finally, missionaries with genuine medical experience can reinforce the local medical infrastructure. They can review and revise local medical kits with the health promoters, teaching about medicine in the process. Clinicians should strive to integrate with the local staff and existing medical system. They should not enable or support nonmedical volunteers delivering poorly controlled care. Honest acknowledgment of limitations permits volunteers to work more effectively and to provide prudent care with a lasting, positive impact.

The young man on the back of the pickup truck neither demonstrated adequate respect for the standards of this community, nor exhibited insight into the consequences of his actions. Instead, he was fearlessly confident in his ability to help the local population, limited only by the number of vitamins and antibiotics he carried.

There is profound need in this community, but right now the vast amount of donated time, energy, and money does more to stoke the egos of the Americans sojourning here than it does to improve the lives of these *Guatemaltecas*. We need to respect the cultural setting and the local health care infrastructure while we are volunteering our services. We need to take long-term responsibility for our actions and for those we oversee. We must begin by acknowledging our own social history because recognizing the attitude we bring to our patients enables us to deliver effective care.

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