Murmurs of Politics and Economics

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Heat from the sub-Saharan sun bakes the ground beneath my feet into a hot plate. I fan myself with the ill-fitting laboratory coat hanging off me, take a swig of water to quench my thirst after lunch, and stride past the line of patients. It stretches on forever. From the outpatient department, out of the hospital grounds, and around the corner of the dirt road. Somehow, we are going to have to get through that line before 5 p.m.

The patients' stares follow me and the other final-year-medical-student whitecoats all the way to the clinic. The last student in shuts the door as if to keep out the deluge.

"All right," I say. "Let's get rocking." I line up my pen and paper on the desk. The interpreter shuffles in her seat, and then in the patients come.

Malaria, hypertension, worms, lacerations. Old foes and some I have just begun getting acquainted with.

Five p.m. passes. My stomach grumbles. I haven't had any water since starting the afternoon clinic.

Then he comes in: a 12-year-old boy with his father. After waiting all day, they sit down smiling. "Muli bwanji," the father says.

"Muli bwanji." I curve my lips around the foreign words, semi-skilled in forming them at last. The interpreter does the rest for me. "Where have you come from?"

They name a place, but I don't recognize it. "How far away is that?"

"Four-hour walk."

"Oh. How did you get here?"

The boy looks at his father, then at me. "We walked."

I swallow. Hard. I force a smile, and my cheeks burn at the thought of leaving the clinic for a drink. "What's been the matter?"

"I get breathless when I play soccer," the boy says, still smiling.

The walk that morning hadn't been too bad in terms of breathing, he tells me, but when he exerts himself, breathing becomes very difficult. It has been coming on for a couple of years and worsening over time.

Easy, I think: it's got to be asthma. I'll get them inhalers, and they'll be on their way.

I ask the boy to hop up on the examination table, and I pretend we have privacy by pulling makeshift curtains around him. I get my stethoscope out, tap it, and then pop it onto his chest. Clear breath sounds. No hint of wheeze.

I place it on his left parasternum, and the culprit blasts out of the med-school textbooks, through the bell and earpieces, into my ears. A diastolic murmur with a soft presystolic accentuation. Mitral stenosis. Rheumatic heart disease, no doubt.

For a second, I smile, proud that I recognized the diagnosis, and I even call the other whitecoats to come have a listen — none of us have heard a mitral stenosis murmur before.

Then, as the sun sets outside the window, the thought dawns on me: This kid is doomed.

Advanced rheumatic heart disease in sub-Saharan Africa. Translated into normal English, that means "no hope."

The drum in my chest thumps, and I manage to mutter that the boy can go take a seat next to his dad. He jumps up, smiles, and runs back to safety. I stand behind the curtain, in pretend-privacy, and attempt to settle the sympathetic overdrive coursing through me.

The sole attending physician in the hospital, serving 2 million people, comes along and congratulates me on identifying the diagnosis. She offers advice that will not change the prognosis and then leaves to deal with a ward bursting with sick children.

I try to explain to the father and boy as best as I can. They leave still smiling. Patients continue to come in and out, and I know that an equally long line awaits me at sunrise.

Ten years after that experience, the boy has traveled with me everywhere. He has taught me things my medical school professors never could — critical things about the interplay among economics, politics, and health.

In medical school, we were taught about the ways people get sick, how they can be fixed, and rudimentary epidemiology of smoking, alcohol use, and unprotected sex. We were taught biology.

But we were never taught about how the World Health Organization is run. Or how neo-

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liberalism has contributed little to improving the quality of life and health care in sub-Saharan Africa. Or how violent conflict has far-ranging effects, amplifying harm to women and children in particular.

Providing theoretical knowledge to contextualize clinical experience is the goal of medical school. The Krebs cycle and the Cori cycle are deemed fundamental, though I have not found them to be applicable in my day-to-day practice. Yet the theoretical knowledge regarding contributors to vast global inequities in health and suffering is largely absent from medical school curricula.

If medical schools provided global health education as a core component, students would come to appreciate the complexities of health care, not only within the biologic context but also in light of underlying political and economic principles. For example, understanding the methods of governance and funding of the World Bank, the International Monetary Fund, and the World Health Organization would cast light on the reasons why so many low-income countries rely on unilateral aid, such as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), to fund basic health services.

It would also go a long way toward explaining why a 12-year-old boy has to walk 4 hours to hear that nothing can be done for his preventable and treatable disease.

Disclosure forms provided by the author are available at NEJM.org.

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