Care in the community: a conflict of interests?

Scott Murray

John is tired and exhausted. Homeless, he is staying with a friend who says that he is "no bother." His two black eyes suggest, however, that he is a bother to one of the other residents. He has AIDS and occasionally supplements the methadone I prescribe with pills and injections which he finds more to his liking. His wife and 16 month old child have left him. He has no interest in specialist hospital or community services for HIV or drug users. He was not impressed by a local dermatologist who was interested in his atypical psoriasis, or advice to start zidovudine treatment or PCP prophylaxis. What he wants is a small council flat where he can spend the rest of his days. He grudgingly accedes that he would need a social worker and would have to accept a home help and visits from our district nurse.

"Sheltie" is a small council house estate near Edinburgh's Royal Mile. There is a bench half way up the hill from "Sheltie" where residents flop if unable to complete their daily exercise tolerance test on the way to the shops. This area is not suitable for people with physical problems. Many existing resi-

dents think that all the newcomers have either serious social, mental health, alcohol, or drugs related problems. The local psychiatric hospital has confirmed that attendances for serious mental illness and alcohol and drug related problems are five times more frequent than the Edinburgh average. The residents' association believes that a change in housing policy to allocate more "normal families" would be the best way to improve the area.

"How much mental and social ill health can a small community absorb?"

John still needs a flat. Most council flats in central Edinburgh have been sold and there is tremendous demand for those which are left. A flat eventually becomes vacant—but it is in "Sheltie." The housing department telephones to inquire if it is suitable for John. John will not be going out much, so I think to myself that it is suitable for him. But it is the last thing the local residents need—to have drug dealers calling at another house and to have another neighbour who needs more care than he can contribute. The community is already saturated with residents who have complex care needs. Its proximity to the local social work office and psychiatric outpatient clinic has possibly influenced this. The

residents believe that enough is enough. How much mental and social ill health can a small community absorb? Could John be the last straw? But I hear myself saying, "Yes, offer it to him."

As his general practitioner I advised John to take the flat and so organised further strain on the local resources in "Sheltie." But as a general practitioner trying to promote the health of the local community in "Sheltie" this made me reflect. I believe that I have a health advocacy role. I had already been with local residents to the housing department to highlight this cluster of people with mental illness and to consider potential community involvement in housing allocation. But here was I making the problem worse.

By October 1996 general practitioners have to draw up new health promotion plans for their patients, responding to local needs. Should we consider these wider issues for the good health of our patients or stick to what we are trained for and good at?

With John, my fundamental duty to the individual patient prevailed. But if general practitioners do not blow the whistle and vocalise how some of the recent social work, housing, and health service changes are straining local communities who else will? Neither the housing department nor the local psychiatrist knew the extent of this problem. The general practitioner's privileged position carries a responsibility to let providers know of these problems before it is too late.—SCOTT MURRAY is a general practitioner in Edinburgh

Why I became a doctor

Maria Vassallo

There is an art in walking through paddyfields in flip flops and not splattering your clothes with mud. It was an art which I lacked as I splashed through the Indian summer sunshine. I was following at the heels of Prem-ji, a tall man of the Brahmin caste, who had abandoned a life of old-fashioned luxury to work with lepers in one of the poorest parts of India. He enjoyed a simple vanity in his life of simplicity, possessing a wardrobe with only two changes of clothes, all white, always immaculate, the aesthete as well as the ascetic. Prem-ji was working with a project devoted to treating and rehabilitating people with leprosy. I was an English student on holiday and Prem-ji was about to give me my first lesson in examining a patient.

After a good hour and a half's walk we came to a tiny hamlet of ramshackle huts. The welcome we were given was from the heart. Leprosy on the hands or face bears a huge stigma in India. The individual becomes

unemployable, unmarriedable, forced to leave the familiar village, confronted with the ultimate in destitution. In this culture a good welcome is much enjoyed, but lepers, who are stripped almost of the status of human beings, have few visitors, so their welcome is proportionately more enthusiastic.

We went to the hut where the patient lived. Her foster mother explained that her parents both had leprosy but were now dead. They had brought her up as their own, and she had recently, at the age of 14, been married to

"Nothing, I thought, could be more real than illness, except perhaps death."

their 17 year old son. She had developed a pale blotch on her arm, which looked suspiciously like a leprosy lesion, and Prem-ji had come to investigate it. The girl was slight and pretty, full of smiles, with an engaging quality to her. I could imagine her at ease in a Western urban setting. I remembered that she was just five years younger than me.

Prem-ji produced a pin. He told the girl to close her eyes and prodded the back of her forearm with the pin, asking her to say if she

could feel it. This was unsuccessful, as she cheerfully peeped throughout the examination. Prem-ji authoritatively told her to put her hands in front of her eyes. Predictably her fingers parted and she managed to cheat again. Prem-ji was growing impatient, having his time wasted and his authority flouted by all this game playing. For her part, the girl was enjoying the game, which she seemed to be winning. Finally, Prem-ji managed to get her to play by the rules, and, of course, the lesion was hypoanesthetic. The diagnosis of leprosy could be made. It was at this point that she became a patient.

The time for laughter and playfulness had gone, and the girl pulled her sari over her head to form a veil. Perhaps she had not faced up to the purpose of the tests or the gravity of the position until now. She sat devastated, silently weeping, her face invisible, just a few feet away from me but separated by barriers as high and wide as the imagination could entertain. I felt an urge to comfort her, say something, put an arm around her, but I knew that I had nothing to say that would have made any sense to her.

As we walked back across the fields, I turned over in my mind the events of the morning and of the previous days and weeks. I knew that being diagnosed as having leprosy was a catastrophe. I remembered the stories of