

Children in Crisis: A Role for the Physician in Caring for the Poor

Some Personal Observations

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THE United Nations Children's Fund offers statistics which indicate that worldwide 40 thousand children die each week as a result of poverty. The vast majority of those deaths occur in developing nations. But one does not have to look beyond our borders to find children ravaged by poverty.

I am stirred by what I see. As a pediatrician at an urban community health center, I witness daily the pain which poverty inflicts upon children and their families. I share the incomprehension of the 14-year-old rape victim who struggles to understand how to cope with a one-year-old son, the product of that rape. I sympathize with the reasoning of family after family who will not report health violations in their apartments for fear that to do so would leave them homeless.

As a young physician searching for role models of physicians dedicated to the service of those in need, I have noticed that physicians vary greatly in how they approach the poor. Many physicians do make significant contributions by trying to decrease the suffering of all their patients. For example, Dr. Philip Porter created a system of school-based clinics which serve the children of Cambridge, Massachusetts, including many who previously had not had access to health care; his system has become a model for other cities across the country. In fact, the American Academy of Pediatrics is now using his Healthy Children program as part of its efforts to improve access for children to health care in communities across the country. This is an excellent example of how local activism can have far reaching benefits; the Academy provides the role model of an established medical society lending its weight and its prestige trying to improve the public health by advocating for the needs

of the poor.

I am saddened that there are other physicians who dismiss their poor patients as being somehow lesser human beings: I have heard the terms "dirt bag" and "dirt ball" used to describe destitute patients or substance abusers at medical centers in various regions of our country. The dichotomy between "service" and "private" patients is being translated into different attitudes towards each class. We must demonstrate by our behavior—and our graduate educational system must reinforce—that such thinking is not acceptable.

Other physicians withhold their professional services from patients who are unable to afford necessary medical care. I recently called a surgical specialist's office to refer a child in need of his services. The child was on Medicaid. I was informed that the doctor would consider taking the case only if he found the "pathology" of interest! While I sympathize with the needs of the physician as a small businessman, this physician is a member of a high-paying specialty. Indeed almost all physicians are members of a financial and educational elite. Public funds have supplemented the education of all of us. It is our responsibility as professionals to serve; we need to lead by our example. It is our privilege to be remunerated as we are for our services; it is not society's obligation.

The poor are often thought of as comprising a homogeneous group—people who have chosen to be on welfare rather than to work. They are perceived to be guilty of missing some vital element or quality that would make them appropriate for general society. The statistics belie this perception. *The Changing World of Connecticut's Children* (Connecticut Commission on Children, 1987) is a government publication which describes the outlook for children in our wealthiest state: it points out how the economic and demographic changes which our society is undergoing have created a bleak outlook for the future of children which can only worsen unless we reprioritize

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public policy in favor of children, families, and human services. Increasing numbers of the poor and the homeless are children. Many heads of households are working full time but not earning enough to feed, clothe, and house their children, not to mention to obtain appropriate medical services. Nationwide, one third of the homeless are families with children. Government figures indicate that over 37 million people do not have health insurance. Many of these are working families; regardless of their income, these families are within one illness of complete poverty. I will try to illustrate the impact of poverty on three children who were seen during a single week of my practice in Bridgeport, Connecticut. Then, I will suggest how we as physicians can attempt to interrupt the cycle of poverty.

First, I would like to describe the case of Roberto. Roberto was a two-year-old boy who lived with his mother, his five siblings, his aunt, and her three children in a four-room apartment. The two mothers were overwhelmed by the task of caring for nine children under six years of age in an apartment designed for two adults only. Also living in this apartment were many rats, each about a foot in length. Unlike the children, the rats seemed comfortable in this environment. They did not run when approached. They sauntered through the kitchen or the bedroom at their pleasure. They climbed the skirts of Roberto's mother. She slept with Jonathan, her two-month-old son, in her bed to protect him from the rats. Unfortunately, she was not able to protect Roberto as well. Roberto was bitten by rats on his ankle, both hands, his ear, and his left eyelid. Three of his fingers were so infected that he was required to be in the hospital receiving intravenous antibiotics for more than a week. The city's health and housing departments offered to fine the landlord if he would not fumigate within a week; that is the extent of their authority. The social workers informed me that they were searching for alternative housing, but that the market was very tight. They also confirmed what Roberto's mother had told me: the landlord owned a refurbished building in the neighborhood. It remained empty because he had not found the "type" of tenants he was looking for. Pressure was brought to bear to have him make an apartment available to Roberto's family. In the mean time, Roberto sat in the hospital and his family fought the rats for control of the apartment. Currently, Roberto and his immediate family live in another of their landlord's buildings. His aunt and cousins were turned out of the apartment by the landlord. In addition, Roberto and three of his siblings required treatment for iron-deficiency anemia. The rats in this apartment are smaller and less aggressive than those in the previous one.

My second case is that of Anna, a four-year-old girl who came to my office for a routine physical exam. As part of the examination, I noticed that she had a bruise at

the entrance to her vagina; this almost certainly means that she had suffered sexual abuse. I spoke with Anna and her mother in some detail. Her mother explained that about one month earlier Anna had complained that a fifteen-year-old girl, a neighbor, had touched her sexually. Mother thought the genitalia looked unmolested and thus dismissed the complaint. I explained that sexual abuse often left no physical evidence and that children do not just make up these complaints. She burst into tears. She had wanted to believe her daughter; she was concerned about Anna's welfare. But the fifteen-year-old was the landlord's daughter; Anna's mother dared not say anything to anyone. Instead, she had tried to keep the older girl away from Anna. Anna confided that she thought the fifteen-year-old was nice to her, even though she molested her. "She gives me candy," explained Anna. When I asked her when she last had been molested, she replied simply, "Yesterday."

Six months later, I again found Anna to have fresh vaginal trauma. It appeared that this was inflicted upon her by her stepfather. It is now not clear whether he was the actual perpetrator of the initial sexual assault on this four-year-old child.

The third case has a happier ending. Iris is the mother of three school-aged sons. They live in the same neighborhood as Roberto and Anna; I had helped her in the past to obtain needed food and clothing. Iris brought her son, Joseph, to see me. Joseph had returned home from school six days earlier with bruises all over his body. He could not or would not explain to his mother how he had gotten them. She took him to school the next day to demand an explanation for the bruises from the principal. Not satisfied with his answers she reported the school to protective services. The principal, upon seeing the boy, had reported Iris to the same agency. They, in turn, suggested that she see me. Joseph did appear badly beaten. However, laboratory tests revealed that Joseph was recovering from a benign, disease idiopathic thrombocytopenic purpura. In fact, he had not been beaten: the bruises came from normal activities. The delay in seeking medical attention actually had spared Joseph the need for a bone marrow examination, a test which is expensive, very painful, and would have required a referral to a pediatric hematologist. Thus, on the basis of a simple blood count (and follow-up counts), I was able to reassure Iris, the school system, and protective services. And Iris and her sons returned to the poverty in which they live.

This last is as happy a tale as I can tell about my patients. For these children, this is as well as the system works. The families of children like Joseph, Roberto, and Anna remain anonymous victims—until they become statistics.

As physicians we are among the few in our socioeconomic class to be directly exposed to the suffering which poverty inflicts upon our fellow human beings. I call upon my fellow health-care professionals to become

involved with this suffering. Provide service to those who need it. Don't leave your patients' pain at the office, but rather share it with your spouse, your colleagues, your friends, and your elected representatives. Tell of the real people who suffer as a result of misdirected budget cuts and failed social and economic policies. If you become involved, I am convinced that you will grow incensed that our affluent society produces such poverty. Give outlet to that rage in the form of political and social action.

It is only through a concerted advocacy effort that we can hope to offer young parents an environment in which they can nurture their children. If we want these children to grow to be productive members of our society then we must see that these families have safe and clean housing, adequate food, and a decent education. We are not as insulated from the effects of institutionalized poverty as we let ourselves believe: the brutal and senseless slaying of a vital pathologist in her office at Bellvue, and the equally atrocious rape and attempted murder of an investment banker as she jogged in Central Park can both be traced to the failure of society to provide for its underclass. These crimes are not excusable; they are part of an epidemic of violence which is one result

of a devaluation of life on the streets. We treat the victims of drug related shootings in adult and pediatric emergency rooms every day. We are frightened by reports of teenage gangs terrorizing the urban landscape. As physicians we are able to recognize that this violence is not random, that it has a definable epidemiology. These types of attacks are predictable; they are also preventable. Tragedy will continue to be added to tragedy until we improve the fundamental quality of life for society's poorest. Physicians can play an important role in improving the quality of all our lives.

I call upon my fellow physicians to lead the struggle to make this a kinder and gentler nation in the reality of the ghetto and in the barrio. Let us not permit poverty-dependent deaths of children or of anyone in these United States. We physicians are in a unique position to be able to lead such advocacy efforts. We are at the interface between society and its underclass: our patients trust us and we have access to the power centers of our communities. Let us be advocates for those patients who need our help the most; our efforts in our communities can be the difference between life and death. The need is manifest. The time is now. The opportunity is ours.