A Different View of the Middle East

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During the time between the last rotation of medical school and the start of residency, many graduates relax and let loose; others move to their new location and learn the lay of the land. For me, I used the time to volunteer overseas. In April 2013, I was awarded the Rossnick Humanitarian Grant from the American Osteopathic Foundation. My mission was to provide volunteer medical care for 2 extremely diverse populations in Israel: the Bedouin people in the South of Israel, who are of the Islamic faith, and the Jewish people in the West Bank.

My friends and family were incredulous when I told them that I would be spending half of my time caring for the Bedouin people. I am an Orthodox Jew. Jewish individuals and Muslim individuals are not thought to get along at all—at least not in the Middle East. My response was 2 pronged: (1) as a physician whose focus has been on public health, I have the ability and responsibility to advocate for and provide health care to all those who need it, regardless of race, religion, and gender, and (2) as an Orthodox Jew, I also have the responsibility of *Tikun Olam*, or "fixing the world." In other words, I have the responsibility to fix, or heal, what I can in the world. My experiences in Israel brought my responsibilities as a physician and as a Jew together in many poignant and wonderful encounters.

My first day of volunteering was in the Negev region of southern Israel, under the capable leadership of Yoram Singer, MD. Dr Singer is the director of the Home Palliative Care Unit of the Clalit Health Services health fund and chairman of the Israeli Association of Palliative Care. Dr Singer leads a group of physicians, nurses, and social workers who travel to the dwelling places of the Bedouin people in the desert to provide home-based medical care for cancer patients, including various medications, social support, and nursing care. We traveled with a Muslim social worker and translator, as our ability to communicate in Arabic was limited. Both Dr Singer and the nurse I worked with were barely fluent; my Arabic was nonexistent.

The first day, I saw patients with just the nurse and the social worker. Our first patient was a Syrian Bedouin with gastric cancer who had undergone a Whipple procedure. To get to his home, we headed toward Dimona from Be'er Sheva and took a dirt road exit off the highway. At our destination, there were 4 shacks approximately 25 by 20 ft, each with walls made of random pieces of wood and a tin roof. The 1-room home of our patient contained just a few dressers, a very old refrigerator, and a hot plate. The appliances were not plugged in, as there was no electricity. The patient lived in this village of 4 shacks with his family, along with his 110-year-old father (who was still ambulatory and had no mental decline), brothers, sisters, children, nieces, and nephews.

When we first walked in, the patient was sitting on a small, 3-in thick mattress on the floor with a wool blanket. I felt slightly awkward and tense. I was walking into the patient's bedroom, which was part of a small familial community where I felt I was intruding, and I was wearing a yarmulke, the skull cap that religious Jewish individuals wear as a symbol of faith. By wearing this cap, I made it clear to everybody, even in this area where Jewish people were generally not welcomed, that I was Jewish. My feelings of trepidation, however, were quickly quelled. Our patient invited us to sit on the floor next to him, as he did not have the energy to get up. We gave him medications and performed a physical examination. His mood was pretty bland; he seemed quite tired, probably because of the fact that he had not been eating much and had very little energy to move about. We addressed some of his social issues and just sat and talked for a while. He was very nice and spoke fluent Hebrew, so I understood what was happening during the entire visit. We made sure that he understood the medication regimen before we left to attend the next patient.

Our next patient was in her late 20s. She had thyroid cancer. Her thyroid had been removed, but the cancer had metastasized to her abdomen and ovaries. To get to her home, we had to travel through a

village much larger than the last that was very poorly developed but—in stark contrast from our last home visit—was filled with large villas. As we pulled up to a villa that in the United States would be viewed as beautiful, I saw a BMW sports utility vehicle in the driveway and was somewhat confused. I had always imagined that all Bedouin people live a poor or nomadic lifestyle, but I learned that day that some Bedouin people live in secluded cities. The woman we were visiting was the third wife of her husband and had 2 young children with him. Her husband was upset that his young wife was now "broken," so he took all of her money and gave her only enough for food for herself and for her children.

Walking into a house in a Muslim-only town, I could feel and see the many stares that we were getting. I knew that the stares were likely aimed at me because of my appearance. Once inside, we met our patient and her husband's sister. She and her sister-in-law were extremely friendly, welcoming, and appreciative of our coming to help. They gave us drinks, cakes, and fruit. Once again, my nerves were calmed, and I thought, "How beautiful it is that when we get to know each other and understand that we have a similar goal of health, we can get along beautifully."

Our patient had multiple problems from her cancer. Her abdomen was extremely swollen, and she was sensitive to the air conditioner even though the weather was extremely hot. Her clothes were tattered and those of her children had not been washed in weeks. We gave our patient the pain medications that she needed. She told us that for the past few days she had been experiencing terrible neck pain and headaches and that the pain medications had not helped. I asked the translator to explain to her that I was trained as an osteopathic physician and that I might be able to ease her pain with manipulative techniques. As osteopathic physicians are not common in the Middle East, it was difficult for her to understand, so I offered her "massage therapy." She was very willing to accept my help, as her pain was unbearable. I performed some osteopathic manipulative treatment (OMT) to help her with some of her head and neck pain, and she felt some relief.

After receiving the treatment, the patient told us about her financial difficulties. As it was a long walk from the patient's house to the bank, we drove the patient to the bank so she could withdraw money from her Israeli government stipend before her husband could transfer it. With this money, the patient could buy the medications that she needed that were not fully covered by the government's health care plan. I was told that some of the husbands in these communities hoard their governmental stipends to buy nice houses, cars, and vacations as opposed to helping their second and third wives and their children. It is also a common practice for the men to disconnect the electricity when they are not around to save money. The women and children are then left without money to live in the cold and dark houses.

Later that week, we followed up with these patients. These visits and the relationships I realized I had developed with these patients reminded me of why I went into medicine, and specifically osteopathic medicine. When Dr Singer, the social worker, and I went to see the woman with thyroid cancer, she complained of a headache and arm pain. It was clear that the headache was a result of anxiety from the patient's upcoming follow-up computed tomography, which could show that her disease had irreversibly progressed. Dr Singer told her to take acetaminophen for the headache. He explained to me that the patient's pain was likely due to anxiety and that if he prescribed a medication for anxiety, the patient would think that she was going crazy. Rather than add to the patient's stress by making her think that she was crazy, Dr Singer prescribed this common over-the-counter drug to act as a placebo to calm her down and perhaps help her headache.

The patient also told us that the OMT that I had performed during the previous visit was amazing. She explained that she was on many pain medications, but that the OMT that I performed was the

only treatment that relieved her pain. She wanted to know where to go to get more of that kind of treatment. Unfortunately, there are only a few osteopathic physicians in Israel, and the government does not pay for OMT. We told the patient to have a family member or a friend give her light massages, if possible.

Next, we revisited the Syrian Bedouin man. Dr Singer explained that the first time he saw this patient, the patient could barely move and was quite upset throughout the visit. I told Dr Singer that when I saw the patient the previous week, he still was not moving much, but he no longer appeared upset. When we arrived, the patient stood up for us and gave us a huge smile. He was terminally ill but was feeling much better, probably because of the pain medications and corticosteroids that were prescribed. He had his daughter bring us tea, which was the best I had ever had. She had a lovely smile, and I could see that we were now considered part of their family. We then discussed a feasible treatment plan.

Our last patient visit of the day was an emergency. The patient was an elderly woman with a metastatic, rare cancer. She was having frequent episodes of vomiting and was very dehydrated. When we got to her village, her entire extended family was present and waiting for us; this was an overwhelming sight, as it included approximately 10 people of all ages. As we walked to the patient's house, the entire family, as well as many other people in the community, was glaring at me. This unwelcome feeling, once again, made the beginning of the patient encounter extremely stressful for me.

When we entered the home, the patient was sitting on her bed and looked extremely weak. Her sodium level had been abnormally low when checked 2 days earlier, so she needed some fluids. We then started what I thought was going to be an intravenous line. However, instead of placing the catheter into a vein, Dr Singer inserted it subcutaneously into the patient's upper arm. Throughout my 11 years volunteering on ambulances and attending medical school, I had never seen the administration of fluids started this way. Dr Singer explained that because we were going to start a line that would remain in place for at least a day or 2, we were going to have to place it in a way that would not cause many complications for the patient. This patient would not have medical personnel available throughout the treatment to fix any problems; the subcutaneous line was less likely than an intravenous line to become infected, would not cause flash pulmonary edema as a result of the slow uptake of the fluids from the subcutaneous fat, and would not cause bleeding if accidentally or purposefully removed. We worked out the patient's medication regimen to streamline the medications she was taking. We left an extra bag of saline with medication inside for the family to hang after the initial bag was finished. She and her family were extremely grateful. There was an excess of smiles and delicious tea to go around, as well as handshakes and hugs.

The second part of my trip took place in the West Bank. My time was spent with Simcha Shapiro, DO, a family physician who also works with Dr Singer's organization and moved to Israel from the United States. Dr Shapiro calls what he does rural community medicine. The way that Dr Shapiro describes rural community medicine is that it requires that a physician do everything within his or her power and knowledge to take care of the patients in his or her community without making them travel far to get medical care. For many of these patients, getting into a larger city to see a specialist is extremely difficult. Additionally, these patients may require a specialist, but the waiting period could be months.

The days that I spent with Dr Shapiro were divided between working in a few clinics, making house calls for his regular patients, and making house calls for his palliative care patients. The majority of his patients were Jewish. Working in the primary care clinic was quite a change from the primary care offices that I worked in during medical school. Instead of seeing patients primarily with

diabetes mellitus, high blood pressure, and high cholesterol, I saw children and adults with acute infections, hernias, extremity numbness, and even a young girl with her earring stuck inside her ear lobe (which we removed). We also cared for some patients with neck pain and other musculoskeletal disorders, which we managed with OMT.

One day after we finished at the clinic, we made a house call to an elderly, wheelchair- and home-bound woman. Dr Shapiro explained that the patient had diabetes mellitus and a very resistant urinary tract infection being managed with daily oral antibiotics. However, this treatment was not working. The patient needed intravenous antibiotics. She refused to go to the hospital to get the intravenous antibiotics because of a prior terrible experience at a hospital. The type and amount of medication she needed was not available for home care. The clinic was collecting, albeit very slowly, single doses of the necessary drug, imipenem, from around the country until they had enough to treat the woman for her infection.

The reason for the house call was because of a chest radiograph that had shown possible pneumonia. Her daughter had come to us earlier in the day with the radiograph, but she explained to us that her mother looked and felt well. While at the patient's home, we listened to her lungs and sat and spoke with her to see how she was feeling. She showed no signs of pulmonary infections and told us that she was feeling really well, so we did not treat her for her pneumonia. Her daughter then told us that her mother was depressed, as it was difficult for her to read books with her dwindling eyesight. We gave them different options of how to make it easier and plausible for the mother to read, including using a tablet that can magnify the words or using a magnifying glass. Before we left, we were profusely thanked and left the patient and her family with smiles and a feeling of unity. It felt like déjà vu from my time with the Bedouin people. I felt the same love after my patient encounter here as I felt after my patient encounters there.

In a country with a tremendous amount of tension between religions, as well as factions within the religions, it was nice to see a different side of these individuals' lives. Over the course of 3 weeks in Israel I met people of many religions, and in each patient encounter the outcome was the same: At the end of each visit, there was, at the very least, a sense of camaraderie. I believe that there was a realization from the patients that there are people in the world who do not care about the politics and who are there just to help. From my perspective, every patient was, in a way, the same. They were people who needed help. It did not matter where they came from or what their beliefs were. Each one needed to be treated equally, as an individual, and with the same loving care that I would treat any member of my own family.

I have a medical background of working in ambulances in the United States and Israel and in different public health positions during and after my education in public health and training to become an osteopathic physician. None of that experience can compare with the volunteer encounters I had in Israel; this mission was 1 of the most amazing experiences of my life and definitely the most amazing experience of my medical career. Up until this point in my career, I have not had the opportunity to enter any of my patients' lives by visiting their homes and meeting their families. Rather than the religious tension that I felt from my friends and family in the United States, I felt welcomed in a community that previously I would never have contemplated entering. This trip made me realize how connected all people are, no matter their background, beliefs, and station in life. I hope that I was able to put a little spark of hope and love into the lives of each of my patients and their families—just as they did to me—that they can spread throughout the country and, with optimism, the world. (doi:10.7556/jaoa.2014.041)