More “medical tourists” needed, not fewer

To the Editors:

Reading the editorial, “Medical tourism as medical harm to the third world: why? for whom?,” I was dismayed by the negative tone of this editorial—or did I misunderstand the message? I have been involved in health care projects, both clinical and educational, in the countries of sub-Africa for over 43 years. What began as a modest project of “surgical tourism” with three western, ex-patriot surgeons planning a volunteer program to bring reconstructive surgery to needy patients in rural East Africa quite naturally evolved into the largest non-governmental health organization in Africa whose goal is to help the people of Africa to achieve medical self-sufficiency through education, public health, training, and clinical outreach programs. We are on the way to reaching that goal, although we have far to go, with a full-time staff of over 700, of whom 95% are African (including top management), many of whom came up through our ranks.

“Medical tourism” introduces, by professionals to recipients of the third world, modern techniques and treatment modalities (flawed as they may be) which, in most cases, have a positive impact on health care. Mere exposure to the techniques and knowledge that medical tourists provide creates a powerful incentive for the hosts to learn more. “Go and do thou likewise?” Such projects do much to alleviate the isolation experienced by many health care workers who live and work in the field.

Medical tourists also gain tremendously from their experience, often completely changing their perspective on what medicine is all about. I have known many such medical tourists who started out to have an adventure and ended up devoting their careers to helping people in the developing world. Such programs are especially rewarding for medical students who gain a whole new insight into their chosen careers.

While not everyone can take a few weeks or months out of their lives to bring their skills to a third world country, the few who can and do are richly rewarded by such an experience, meeting at first hand the challenge of treating and teaching where often there are only primitive facilities available. Such experiences often kindle a true desire to do more about the suffering people of the developing world than simply giving lip service. They also learn that much can be accomplished with simple and limited tools and without all of the expensive medical paraphernalia that surrounds our modern medical centers.

Of course, the state of our health care systems in many

of the so-called developed countries chagrins us all, but it is absurd to imply that we should totally clean up our act before attempting to help the third world through people-to-people programs rather than relying entirely on massive US Agency for International Development, World Bank, or International Monetary Fund programs. Such programs all too often go astray or line the pockets of corruption.

We need more “medical tourists,” not fewer. Both the recipients and the tourists benefit from such human interpersonal contact. This type of human communication often eclipses the more apparent value of the medical tourist project.

Thomas D. Rees, MD, FACS
*Co-founder and Chairman Emeritus
 African Medical and Research Foundation
 New York, NY 10086*

Response of Dr Bezruchka in reference to letters from Drs Lluberas and Rees

Drs. Lluberas and Rees raise important perspectives in response to my editorial on medical tourism. After 25 years of working on the problems of health and health care in both rich and poor countries, I have “come out” with the thoughts stated in the editorial. My experience reflects public health and clinical work as well as countless discussions with others, including teaching in the International Health Program at the University of Washington. I made two major points in that editorial, centering around the idea that we who supposedly work for better health in the United States do not seem to be very effective in that quest. The United States is the least healthy of all the rich countries, despite being the richest, and harm caused by medical care is a major cause of death here. The other point is that health is best obtained by structuring a society so everyone shares more equitably in the wealth, what I call structural medicine. For poor countries this involves ensuring that everyone has access to basic needs with the fruits of development shared equitably, and for rich countries, limiting structural benefits to those most in need. Our national and foreign policies work against those ends, and endless data support these observations.

Dr Lluberas does missionary work. The dictionary defines a missionary as someone who is “sent to do religious or charitable work in a territory or foreign country” and also “one who attempts to persuade or convert others to a particular program, doctrine, or set of principles.” I would suggest the dictionary definitions could apply to both Dr. Lluberas and myself. Lluberas focuses