Americans Are Learning Medicine the Cuban Way

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Melissa Rose Mitchell was discouraged. After taking the Medical College Admission Test, she was uneasy about applying to medical schools. In prep courses for the exams, she had glimpsed her future as a doctor, and she didn't like the environment she saw. "People were like, 'What kind of doctor do you want to be?' and it was all based on how much money you make," the Oakland resident recalled. "It was a really scary moment, because this thing that all my life I had wanted to do without question, all of a sudden I'm thinking, 'I don't know if I want to do this.'"

Mitchell had scraped together the money to prepare for and take the med-school admissions test, but even as she studied, she had begun to waver. "It had taken me over a year to save the $1,400 for the test and prep course and they said, 'We recommend that you apply to no less than twenty schools,' at about $200 each." And there were still the costs of plane tickets and a proper suit to interview at schools. She did well on the exams, but Mitchell was spending a lot of money to fulfill her goal of serving the poor.

But then her boyfriend saw a blurb in a church newsletter that appeared to assuage her growing worries. It was a unique offer to study in Cuba, the impoverished nation 90 miles from Florida that is internationally known for its training and use of doctors. She applied through the Interreligious Foundation for Community Organization in New York, a group whose mission is to "increase minority participation in medicine" and therefore increase the doctor-patient ratio for underserved areas.

Cuba began educating American medical students after members of the Congressional Black Caucus met with Fidel Castro in 2000. Congressman Bennie Thompson of Mississippi told Castro about areas in his district that suffer from extreme doctor shortages. The Cuban president responded by promising scholarships for 500 Americans to attend medical school in Cuba, under the umbrella of the Latin America School of Medicine. To qualify, the students would have to show aptitude and a commitment to work in underserved communities in the United States. Since then, 34 have graduated, and more than 160 are currently enrolled.

The Bay Area, it turns out, is something of a hub for the Cuba school of thought, where Cuba-trained students, unencumbered by the massive debt that plagues grads from US medical schools, have the luxury to do the kind of medicine that Cuba instructs — family medicine. The island's medical schools focus on nutrition and other preventative approaches. Cuba also is well known for its focus on the "social determinants of health."

The Cuban experience also may provide important lessons for our current health-care crisis. With a fifth of our per capita GDP, Cuba has health statistics comparable to those of industrialized nations. In the shabby, eroding, and commodity-deprived neighborhoods of Old Havana, Cubans also enjoy a better doctor-patient ratio than Americans: 59 doctors per 10,000 people compared to 26 for us.

Cuban life expectancy also matches that of the United States, its infant mortality rate is lower, and the island's HIV/AIDS transmission is among the lowest worldwide. Cuba's aggressive health-care delivery system also costs much less — around $200 per capita annually, compared to our $7,000. And it provides timely and primary care for every citizen — near universal accessibility. To the Cuban government, health care is a right.

This fact highlights a gap in the health-care reform initiative proposed by Congress and President Obama. Those currently without insurance, who will receive coverage with the bill, will feel the lack of family practitioners as basic care continues to be undervalued in favor of more profitable types of medicine.

At a White House forum early last year, the president spelled out the problem bluntly: "We're not producing enough primary-care physicians," he said, pointing to a daunting chain of obstacles. "The costs of medical education are so high that people feel that they've got to specialize."

According to the Association of American Medical Colleges, the average debt for a US medical school graduate in 2008 was $154,607. American doctors, as a result, feel forced to take up specialized practice, because ultimately the higher pay will ease their enormous student debt. Yet without enough primary care doctors, experts say, health-care costs grow exorbitant, end-stage care increases, and thousands of family practice residence positions go unfilled every year.

Doctors graduating in Cuba have no such excuse to specialize, and the island does not graduate members of an elite profession. Instead, it's a veritable doctor-producing machine with more than 70,000 physicians for a population of just 11 million.

And after medical school in Havana, Mitchell would return to the United States debt free.

Many students enter American medical schools wanting to do family care but get discouraged, said Dr. Richard Quint, retired faculty at UC San Francisco and a medical consultant to the Oakland nonprofit group Medical Education Cooperation with Cuba. American medical schools deem primary care as having secondary import, he contends. "The overall structure of our 'non-health system' is fragmented and skewed toward specialty practices," he said. "Faculty in medical schools make comments suggesting you shouldn't go into primary care because it's not stimulating or high-achieving enough." It also no secret that physicians are reimbursed highly for procedures and surgeries rather than for preventive medicine and diagnoses. And the need for primary care in underserved areas often doesn't make it into the textbooks or the classroom.

When it comes to preventative care, the shortcomings in American medical education mirror the failings in our health-care system as a whole. "There's nothing the Cubans are doing that people couldn't think of here — it's just they are looking upstream" at prevention, explained Dr. Lynn Berry, chronic disease program manager at Oakland's Highland Hospital, who has conducted research in Cuba.

Berry pointed out that Alameda County has "pretty strong" community health care. "We have La Clínica de La Raza, the Ethnic Health Institute, Native American Health Services," which emphasize prevention and education to avoid the costs, medical and financial, of end-stage care. But "ours is a market system," Berry said, a system "organized around insurance and payer source, not necessarily the long-term health of the patient."

Cuba redesigned its medical system out of financial necessity following the collapse of the Soviet Union. Faced with a supply crisis brought on by the lack of Soviet funding, Cuba revamped its medical education system towards primary care. By the mid-Nineties, they had established a comprehensive neighborhood-based family medicine standard: a *consultario* (neighborhood clinic) in every locale, and a revised medical school curriculum to embed family care into the model.

The island's health care starts with a top-down mandate for a "bottom-up" approach to health care. Too poor to rely on high-tech equipment or expensive, invasive procedures, the Cuban model stresses prevention and spreads health-care responsibility beyond doctors — into schools, work sites, and neighborhoods. A national network of polyclinics ensures the mandate. People in all walks of life are expected to cooperate in health publicity campaigns and other measures to prevent disease.

The United States' fifty-year-old embargo on goods to the island also has played a role in shaping Cuba's medical care system. The embargo prohibits or restricts the sale of some medical equipment and punishes other countries that deliver essential cargo. Drugs and medical supplies are sporadic, especially in Cuba's rural areas, where clinics work with outdated X-ray machines. And because US pharmaceutical companies develop most major new drugs, Cuban physicians don't have access to many new medicines on the world market. Countries like Spain and Venezuela donate, but routine medical supplies remain scarce or absent from some Cuban clinics.

Still, Dr. Davida Flattery, an internist at Highland Hospital, was struck by Cuba's "bottom-up" approach when she observed their health system last year. "What really impressed me about Cuba was their focus on the non-medical determinants of health," she said. It's standard in Cuba, she added, to engage the psycho-social factors of a patient — level of sanitation, presence of abuse or addiction, and food habits. Doctors and nurses, in fact, make home visits to evaluate these things personally.

Americans trained in Cuba see firsthand the glaring differences between the two medical education systems. Melissa Rose Mitchell learned, for example, that Cuba highlights rural medicine. "In lots of situations the professor will ask, 'What's the best test?' We'll say 'CT scan, ultrasound.' They'll say 'Well you don't have ultrasound, you're in the middle of nowhere, in the mountains, you have no electricity or phone. ... What are you going to do?'"

Many past and current students of the Latin American School of Medicine in Havana, where Mitchell attended, had lived or worked in poor and underserved neighborhoods in the United States, and were chosen to study in Cuba so they could take what they learned back home. And their Cuban education equipped them to deal with health problems of the poorest communities in the United States far better than if they had gone to Harvard.

Havana medical students, for example, are trained to stabilize people in places with no electricity or potable water. One might think those skills irrelevant in the wealthy United States, but a number of poor American communities have come to resemble sections of Third World countries — especially after a disaster (see Hurricane Katrina).

The lack of doctors in America's neediest communities is exactly what the Interreligious Foundation for Community Organization wanted to remedy as they began recruiting for the Cuban scholarships. The resulting program also is quite diverse — far more diverse group than any US med school. The majority of students in Latin American School of Medicine in Havana are African Americans from New York or California, 85 percent are minorities, and 73 percent are women.

And most of the students are trained as "médicos de la familia," or family practitioners. But, as the students saw, medical supply shortages plague the system, and despite diabetes intervention and screening programs in schools and workplaces across the country, the Cuban national diet remains high in fat and sugar. Like the US poor, Cubans don't have easy access to fresh fruits and vegetables — or the habit of eating them — and this hinders their health. Cuba's food distribution system from the countryside to the cities is substandard. The nation imports more than 50 percent of its food.

Mitchell said the training and experience suited her. "They train us just like they train Cubans," she said. "Every Cuban, regardless of specialty, has to do two years of family medicine. Until you can deal with basic, vital situations, you are not allowed to mess with other parts of the body."

After graduating last summer, Mitchell settled in Oakland to work and prepare for the boards, but she says her calling is rural medicine. She used her summer breaks from medical school, in fact, to work in a mobile health-care clinic serving rural populations outside of Birmingham, Alabama, a conservative city with stark wealth disparities. "Every two weeks or once a month, this clinic on wheels visited parts of the state where some of the houses did not have electricity or indoor plumbing. Not because it couldn't be gotten, but because people didn't have the money to invest in it." When asked if the poverty compared to that of rural Cuba, she responded: "The poverty was more intense" in some areas of rural Alabama than in rural Cuba, she said, "because there were no social services."

Yet back home Mitchell faced disapproval — even hostility — for deciding on a nonspecialized practice. "My first experience going home, my aunt and I had a heated argument — me saying I didn't want to specialize and if I did it would be family medicine or rural medicine. Her argument was anybody who had any sense would become a neurosurgeon or a cardiologist. But my image of a doctor is someone who can handle any situation that comes up."

And having witnessed the obstacles facing Cuba, the returning American doctors are scandalized with the state of health care at home. Mitchell works as a part-time medical assistant at a Bay Area clinic and doesn't have insurance herself. "There have definitely been a couple of times I've been sick and couldn't afford to see a doctor," she said.

"A friend did me a favor by seeing me, but I had to pay $60 for antibiotics — that was with the clinic's discount."

Before moving to Oakland as a teen, Pasha Jackson saw firsthand on the streets of South Central Los Angeles the power of nonmedical, psychosocial factors to spread disease — both physical and mental. Violence, joblessness, and addiction merge with poverty to leave many residents out of the health-care system. "What does primary care mean for the people around me?" he said. "It's self-medication. Junk and drinking. These people really need attention, and insurance will deny them for a list of reasons."

But Jackson didn't know he wanted to study medicine until he sustained a football injury. Recruited from City College of San Francisco by the University of Oklahoma, he went on to play for the San Francisco 49ers and Oakland Raiders. But academic advisors throughout high school and college, he said, actively discouraged his interest in science. "They said it was too hard," and that his best chances were with football.

Reassigned by the Raiders to NFL Europe, Jackson tore his left pectoral — "a huge injury for a linebacker," he noted. "Once I left the NFL my health care ended, and to go to Cuba I needed shots and checkups to travel internationally. I couldn't believe what I had to go through. After calling around to public clinics, I had to wait for weeks and miss a day of work to see a doctor that didn't want to see me."

Jackson spent a year recuperating and getting physical therapy. And during that time, the effects of Hurricane Katrina reminded him of the deep connection between poverty and disease. "I knew I didn't want to play football anymore," Jackson said. "In the NFL there's so much waste, the playing with the money and power. I saw how much a part it was of the capitalist system."

Disgusted with professional football, Jackson went to the Interreligious Foundation for Community Organization's web site and applied. The Cuba program "had me in Cuba, where I could learn Spanish; covered me financially; and got me back to science." With that, Pasha Jackson went socialist.

On summer break from his studies in Cuba, Jackson and more than a dozen other students from the Latin American School of Medicine visited deprived American communities to deliver basic health services and expand their own cultural competency. Los Angeles' Skid Row, a place with "ridiculous numbers of homeless people," was one stop on the trip, Jackson recalled. "Mora County [New Mexico] has hardly any doctors." They stopped at Pajarito Mesa, "where the Pueblo Indians live, with no potable water and no electricity. It shows you," Jackson said. "There's the Third World — right here. There are no national boundaries."

<"When the earthquake hit in Haiti, over 400 Cuban medical personnel were already there - they've been there for years," said Dr. Nelson Valdez, Professor Emeritus of Sociology at the University of New Mexico and Director of Cuba-L, which monitors news related to Cuba. According to Medical Education Cooperation with Cuba, some 700 Haitian medical students in Cuba study at the Santiago de Cuba campus of the Latin American Medical School. Cuba is sending doctors and students in droves to treat tens of thousands Haitians lying wounded in hospitals with zero or few doctors. "No one is reporting on the Cuban presence in Haiti," commented Valdez, though he said he wasn't surprised. "The additional doctors being sent are part of the same team that was offered to the United States by Cuba when hurricane Katrina hit." The assistance was refused. Valdez also said the Cuban doctors, solidly trained in disaster medicine, provide psychological as well as physical attention to victims.

The State Department announced that U.S. aid workers would cooperate with Cubans on the ground in Haiti. Those who've observed what we can learn from the Cuban medical approach -- scholars and physicians, new and veteran -- all agree that cooperation and conversation with Cuba, at least in this respect, might bring us all some relief.

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