Faysal Saab, M.D. ’12 is a resident physician in his third year of training in Internal Medicine and Pediatrics at UCLA. He is a member of the UCLA Department of Medicine Global Health Track, and later this year he will travel to Lilongwe, Malawi, to work at Partners in Hope (PIH) for the third time since he became a medical student. Over the last decade, he has served as a medical volunteer in Costa Rica, Nicaragua, and in the Palestinian refugee camps in Beirut, Lebanon. He has a passion for providing medical care to the underserved and wishes to continue his global health activities throughout his career.

“Why do you go?” It is a question I hear frequently from coworkers, friends and family when they learn that I will be traveling to work in Malawi. At first, it may not make much sense: I am a resident physician training in the United States—how does Malawi fit into that?

I traveled to Lilongwe, the capital city, earlier this year through the UCLA Internal Medicine Residency Program: Global Health Track. The track operates within the UCLA Center for World Health, which collaborates with several international clinical sites to provide global health education for medical students and residents. My initial visit was three years ago as a medical student, and both times I have spent three weeks working at PIH, a nonprofit organization operating a joint clinic and hospital in Lilongwe. The clinic relies on private donations and grants from organizations like USAID and has very limited resources, compared to a clinic in the United States.

At PIH, I learn to manage patients with HIV/AIDS and the opportunistic infections that often complicate their course. During my visits, I have noted that Malawi is the poorest country in the world, according to the World Health Organization; that its healthcare budget is $77 per person per year, compared to $85,000 per person per year in the US; that the life expectancy is 55 years; and that one in 10 people have HIV. It is absolutely jolting to witness such devastating disease in the context of devastating poverty.

In the depths of this tragedy, for a UCLA resident there is much to be learned. When I work in a place like Malawi, I frequently face manifestations of diseases I otherwise may never encounter. I see Kaposi’s sarcoma, a very rare cancer in the US but the most common one there. I see malaria, a mosquito-borne infectious disease, in its most severe forms. I see disseminated tuberculosis, an exceedingly unusual case in the US. I see the adverse effects of antiretroviral medications, rare forms of meningitis, and uncontrolled warts caused by HPV. The sheer volume of these diseases trains my eyes to recognize them in an instant.
In addition to learning from such cases, working in Malawi has shaped the way I practice medicine. Given the paucity of labs and imaging modalities at my disposal, I rely almost exclusively on my patient’s history and lean more heavily on my physical exam skills in order to build a differential diagnosis. Before I order a test, my mind scans through a checklist: Is a test crucial to obtaining this information? Will the result change my patient’s management? Can my patient even afford it? I am forced to adopt a mindset that considers the limited resources around me and I am able to return to UCLA carrying that mentality with me. Despite the seemingly limitless resources we have in the US, we lead the world in healthcare spending with 17 percent of our gross domestic product spent on healthcare. Maybe we stand to learn a thing or two from Malawi about resource conservation.

Residents also have much to contribute to hospitals like PIH. Because there is only one doctor for every 65,000 people in Malawi, most of the healthcare is delivered by clinical officers, individuals with three years of health education followed by a year of internship. Although they do not attend medical school, they are trained to practice a mostly successful strategy of pattern recognition. They rely on the fact that certain diseases are very common in Malawi—if a patient’s symptoms appear consistent with tuberculosis, they likely have tuberculosis, for instance, and treatment can empirically be initiated. They see thousands of these cases that often present similarly and their experience begins to guide them. On a public health level they are playing the odds, doing the most good for the most number of people. However, every so often one disease can mimic another. As residents, we are trained to consider a wider variety of diagnostic possibilities. In one instance, upon performing a more thorough history and physical exam we showed that a presumptive diagnosis of tuberculosis was actually lung cancer, radically changing the patient’s medical treatment and prognosis. It was an educational opportunity for the clinical officers who are not typically trained to recognize such a case.

Beyond medicine, my work in Malawi allows me to peer into the often forgotten walks of life. My visits ground me and remind me of the dire conditions that exist outside my bubble—that access to clean water is not guaranteed, that electricity is a luxury, and that transportation often consists of only two legs. These visits give me a strong sense of appreciation for what I have and a valuable perspective. They help me remember that if we all threw our problems into a pile and saw everyone else’s, we would quickly grab ours back.

That is why I go to Malawi.

To donate to the UCLA Global Medical Education Fund: giving.ucla.edu/globalmedfund
To learn more about Partners in Hope: pihmalawi.com

Saab teaches his patient about selfies, who poses for one after overcoming malaria.