

A personal and professional retrospective of an exemplary family doctor who works at the very heart of his profession and his community

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Introduction

This retrospective highlights the activities of an exemplary family doctor, Dr Manzoor Butt from Rawalpindi, Pakistan, whose life's work extends far beyond the confines of his clinic and out into the community where he has initiated many projects in the fields of public health, public safety and poverty appeasement in the local community. This work also operates on what could readily be seen as evidence based medicine for impoverished communities and is also based on sound scientific principles.

Background

Dr Butt was born in Rawalpindi, Pakistan in, 1960 and received all formal education from School to Medical degree within Rawalpindi.

Dr Butt's work, as a family doctor, and trainer and educator is both textbook and enlightened. Additional to his clinical work he has trained male and female health workers from many parts of Pakistan as well as Rescue workers, called Emergency First Responders.

He has committed his life to his patients and community often to the detriment of his own health and is currently recovering from an above the knee amputation and getting ready to resume his practice. Both authors have met and worked with Dr Butt in various ways and have been moved by his commitment to true family medicine and to his community and wish to showcase his work as both a model and an ideal.

Dr Butt's Maqbool Clinic, is in Shamsabad, an impoverished area of Pakistan.

Dr. Manzoor Butt has an exemplar practice in terms of what he has done and is doing in the context of his community. Quality must be context dependent. The waiting room has two areas, one for men and one for women which is important for the culture in this area. This is a very rare amenity for his patients. He has a tiny, very private, room with a table for doing gynaecological examinations – again a rarity. He has a computer in his practice, and he has high-speed internet access so he can get the latest information. And, he is very careful to avoid the incentives so available to less ethical physicians (kick-backs from laboratories as an example). He is very careful about sterility. (Hepatitis C is epidemic in Pakistan – mainly from the re-use of needles and unsafe injections). He sees about 60 to 100 patients a day and the average charge is less than \$1.00. Many pay nothing and he gives them free medicine. He has one boy, perhaps 12 years old who helps some around the office – so that the money he gives him for school is not just a “gift”.

But the most important part of his practice is what he does in his community. He pulls together community walks for traffic safety. He has organized formal teaching sessions for homeopathic physicians. (He doesn't think homeopathy does anything, but points out that they are out there in the community treating people so they should have some knowledge). He has organized community groups and teams of volunteers (some from well-to-do families) to address issues of clean water, sanitation, mosquito control, medical care for of the poor and education for women. He has sponsored art contests to provide some income for women. Because of the lack of ambulance services, he has also organized a Rapid Response Team to deal with accidents and injuries in the community.

Many of the facilities most of us take for granted are not available in this area and medical students are seeing patients – patients with multiple problems including a very heavy load of psychological problems (many of these are displaced from the area near the Afghanistan border or the earthquake area). The patients generally do not have even a few Rupees for medicine. The students take up collections so they can buy some medicines, get needed tests and on occasion use their own cars (if they have one) to drive patients for needed treatment.

Right from the beginning of his career, Dr Butt had very strong intention to organize the primary health care system in his area and to make his clinic a model for others. Towards this end, he became involved with willing international people and organisations throughout his working life. Dr Christopher Rose, PhD, Ex. Executive Director, Action in International Medicine (AIM) , London, UK and Dr Barry H. Smith, MD, PhD, Director of Dreyfus Health Foundation (DHF) , New York, USA were early collaborators. The two organizations were jointly operating the renowned CCI-Programme.

Dr Rose visited Pakistan twice, in 1998 and 1999, at DR Butt's request. They identified the Top Ten Health Problems of Shamsabad List during the last visit. Women's health problems were on the top of the list. They decided to address these problems through the CCI-Approach, but this was not possible due to lack of funds and the collapse of AIM.

Dr Butt was left with three choices:

- a) Continue searching for the funds from other sources
- b) Quit the mission
- c) Continue the mission with his own personal resources at a very small scale through my clinic.

The first two were not possible so he decided to act on the third option and hence started to follow the PSBH1 - approach in his clinic.

Before starting the work, it was necessary to have some insight into the prevalence and magnitude of the most pressing health problems of women living in Shamsabad. Therefore, all the women attending his clinic for any reason were questioned about their (women's) health problems for one month and the most pressing women's health problems were identified.

Later, some conclusions were drawn, from this data.

The main problems were:

- 1) Vaginal discharge
- 2) Unwanted pregnancies in married women
- 3) Breast Problems
- 4) Malnutrition
- 5) Menstrual disorders

Strangely, only a few indicated the lack of facilities for Antenatal care and problems caused by childbirth by traditional birth attendants who are uneducated and lack

training. To make the list more real and practical, the problems were re-numbered as follows:

- 1) Lack of facilities for antenatal care and childbirth
- 2) Vaginal discharge
- 3) Unwanted pregnancies in married women
- 4) Breast Problems
- 5) Malnutrition
- 6) Menstrual disorders

The women's health problems were discussed during different workshops in Shamsabad which were attended by a cross section of the community and the following were identified as aggravating factors:

Lack of medical facilities,
 Ignorance,
 Lack of nutritional facilities,
 Prevalent social environment,
 Psychological factors,
 Unemployment and Poverty

Mrs. Rahila Manzoor (Dr Butt's remarkable wife) is a locally trained health technician who can perform vaginal examination and take HVS and Pap smears. She plays a vital role in this work. The clinic always has at least one nurse capable of dealing with women. It was decided that Mrs. Rahila would first examine the patients and if she found something they were followed up.

How the problems were overcome

First of all, Dr Butt established a help line (from 06 am to 01 am) which provided free advice and guidance for medical and social problems of patients. He is proud to inform us that he has saved lives of many innocent girls who were at the point of committing suicide because of their social circumstances. The clinic is also a social welfare office and available for everyone regardless of faith and religion. Dr Butt advises right from the start, I referred to patients as relatives, such as sister, daughter, and aunt so that they understood I do not have any evil intent. To overcome other difficulties, he undertook the following steps:

- 1) The examination room of the clinic permits complete privacy
- 2) During examination, his wife or a female nurse is always present
- 3) The Patient is allowed to bring in one of her relatives or friend into examination room during check-up, if she likes.
- 4) All information regarding a patient's examination and disease is kept fully confidential, even from the husband if the woman demands. If she is suffering from some serious problem, she is encouraged to take her husband into confidence.

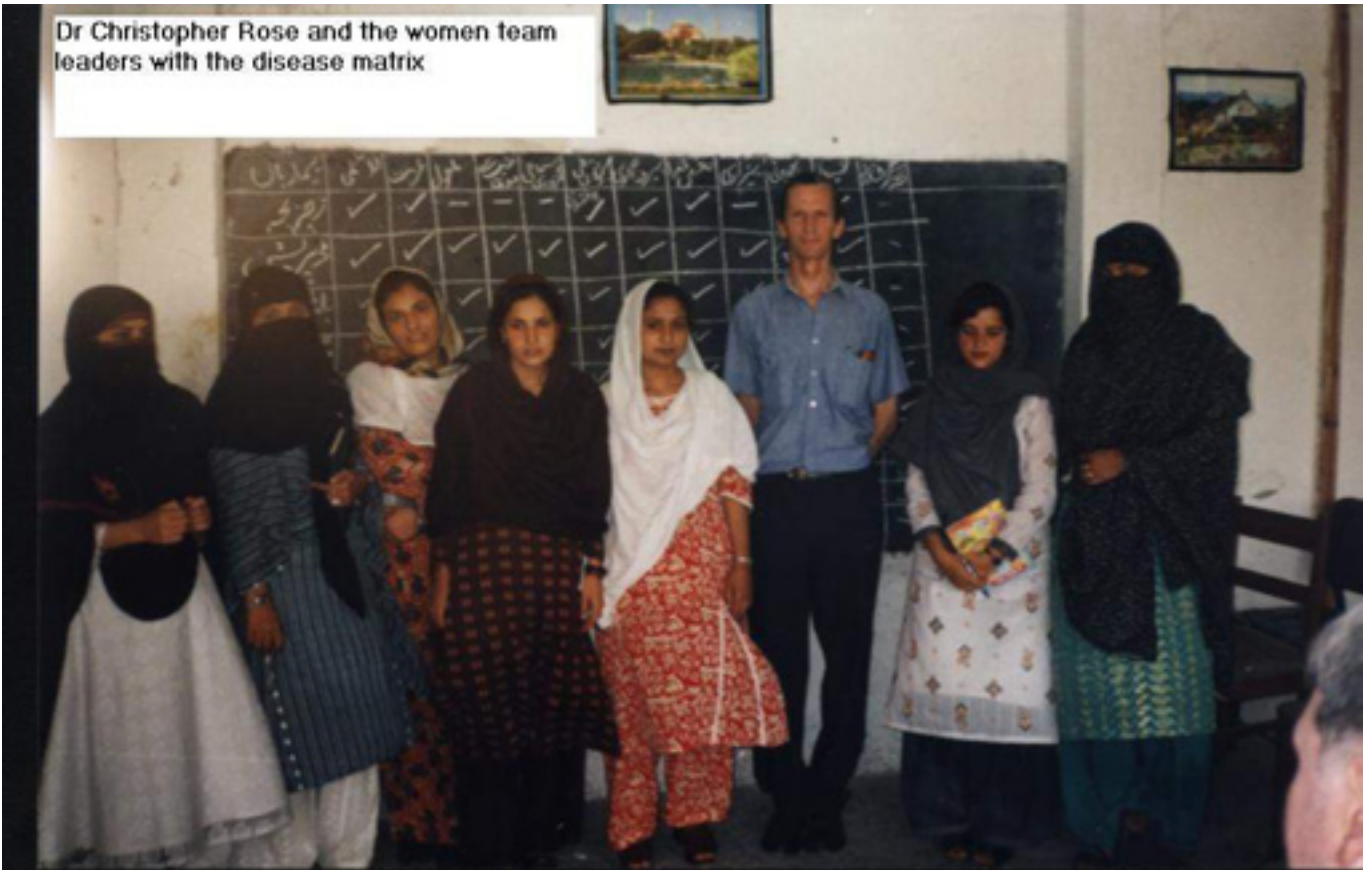
Training Women's Health workers



Dr Christopher Rose & Dr Manzoor



Dr Christopher Rose and the women team leaders with the disease matrix



Women group leaders are standing by the disease matrix of the area. They have acted as facilitators for its development



The activity was initiated formally in year 2000. All pregnant women attending the clinic were informed about the presence of Antenatal centres in the city and they were encouraged to visit such free government centres for antenatal booking and delivery. They were informed about the importance of:

- (a) Diet during Pregnancy
- (b) Regular Blood pressure check-ups
- (c) Regular weight measurements
- (d) Regular fundal height check-ups
- (e) Hb % determination
- (f) Blood /Urine Sugar determination
- (g) Blood group determination
- (h) Determination of foetal wellbeing through ultrasound examination
- (i) Immunisation against Tetanus and Hepatitis

During 2001, this activity was performed with about 700 women. The outcome was greater than expected. Many women now come to the clinic for antenatal check-ups. Their number is at least five times more than those who were coming previously.

It was realized that the following activities are urgently needed to augment this effort:

- a) More organised Antenatal check-up facilities including basic relevant tests at his clinic
- b) More advocacies for ultrasound examinations and hospital delivery
- c) The most important of all is the availability of resources for training of local midwives who are already popular among women. Requiring examination by a doctor, the patient would be given a choice to either have a pelvic examination in the clinic but if she refused a referral to hospital with a female doctor with a full personal reference from us. Dr Butt had already trained and upgraded his skills in obstetrics and gynaecology. The necessary skills were then taught to Mrs. Rahila. It was decided that expenses for the women's health project would be met from income of his clinic's other routine activities and all income from this project would be utilized to add facilities for enhancement of the activities.

There was no pathology laboratory nearby. There was a great need for a laboratory that could provide quality results at low price for his "Women's Health Project", especially those essential during antenatal period. He was already doing blood sugar testing, urine sugar testing and pregnancy tests in the clinic from his own resources; but there was an immense need to initiate the following very important tests: Blood grouping, Haemoglobin Estimation, ESR, urine screening for sugar and albuminuria, urine routine examination, screenings for Hepatitis-B, Hepatitis-C and HIV/AIDS.

Dr Butt used some savings from the clinic's income for this purpose. The money was used to buy the essentials. He has a part time laboratory technician and he refreshed his pathology knowledge and skills and undertook training in these tests. He has been performing these tests since 2002 and has kept the rates at a level which is affordable

for all patients and does them free for the very poor. He uses Standard Control Technique to prevent false results. His patients have benefited not only via the affordable costs, but also get quality results without going very far. To keep it self sustainable, all income from the laboratory is being reinvested to buy the diagnostic reagents and material.

The main obstacle for providing such services

The main obstacle was that no-one could imagine that women would have an examination by a GP who is operating a clinic right near their homes. The following were identified as restraining factors:

- * The concern as to how they could face this person again
- * What if my husband finds out?
- * The fear that someone may peep in during examination
- * The fear that the staff of clinic would disclose this information to my neighbours/relatives.

Dr Butt advises - I respect every patient, especially women.

Working in the community

Dr Butt has initiated many community projects and some have already been mentioned. We would like to highlight a few.

Blind girl's school

An outstanding area of both Dr and Mrs Butt's work was with the Blind Girls school in Rawalpindi where some of the students had been abandoned and were at great risk on the streets and in some cases when found and brought to the school covered in lice. Initial work was to provide them with a safe clean place to live as so many students board at the school.

Medical focus was on practical lessons in hygiene and health, (including provision of proper toilets and bathroom at the school, and education on menstruation). The running of the school has now been taken on by the government and the status of the girls has risen from being marginalised and at risk – to now being called 'the angels'. The photos opposite show the girls receiving gifts for Eid.

Emergency assistance and Emergency Response

This chapter focuses on the aftermath of the Earthquake in the northern regions of Pakistan on October 8, 2005 and much of the following data comes from a paper by Lesley Pocock (1) with input from Professor John Beasley and Professor Qidwai of AKU Karachi Pakistan. In October 08, 2005 a major earthquake struck northern parts of the country, killing tens of thousands of people and injuring manifold more. Hundreds of thousands of residents lost their houses and were rendered homeless (1).

The region is under developed with lack of proper housing, roads and basic infrastructure including schools and hospitals. The people already live a very hard life with poor housing, lack of proper water supply and heating during severe winters.

Rawalpindi Blind Girl's school - celebrating Eid. Mrs Manzoor handing out gifts to the girls



Emergency Response after the 2005 earthquake



The earthquake struck one of the most vulnerable populations. The lack of food, water, warm blankets, clothes and shelter made life extremely hard for those who survived the natural disaster but lost close family members, neighbours and friends.

The medical issues were innumerable and rehabilitation of the injured the foremost tasks.

The lack of food and clean water supply facilitated spread of infectious diseases and gastroenteritis in particular. The exposure to severe cold with inadequate clothing and shelter will lead to frost bite and respiratory infections. A lot of people simply die due to exposure to cold.

The authors were intimately caught up in the disaster through existing relationships with family doctors in the region, and Emeritus Professor Beasley observed: "There are three phases to responding to a catastrophe such as that of the disaster of the Pakistan earthquake. (1) The first is the initial emergency response. Inevitably this was inadequate - No country, even one with wealth and a robust infrastructure, can cope well with an unexpected event on that scale. Witness, for example, the limitations of the response to hurricane Katrina in the US even though this was a far small disaster in terms of scope and lives lost. (Not only that, but it was one which was predictable -- at least for a matter of some days.) During this time the lives that are lost are due to the direct trauma and immediate effects of the earthquake.

The second phase is the response to the immediate aftermath which involves caring for the surviving injured, the hungry and those without shelter. In this phase more resources, governmental, international and local as well as international philanthropy are brought to bear. Interest and support for the response tends to be high and is heightened by a sense of continuing crisis. The lives that are lost are more due to hunger, disease and exposure in the weeks to a few months following the disaster.

The third phase is that of prolonged and sustained physical and social deprivation. New and continuing problems including general malnutrition, continued exposure, stress reactions and eventually the loss of such institutions as power, education, sanitation, public health systems, and medical care take their toll. Compounding the situation is the loss of the philanthropic and other support that is essential for the alleviation of the continuing suffering and the rebuilding of the physical and social infrastructure. Support dwindles as the event moves off the front pages (as it already has!) and new international situations erupt. Dr Tariq Aziz, at the time General Secretary of the Pakistan Society of Family Physicians reported on the medical issues surrounding the relief and rescue effort: "Relief workers are experiencing severe depressive illness on their return to base camps and later to their homes. Now the Rehabilitation phase is on. Relief workers and people stranded in the area have severe logistic problems due to snowfall. Illnesses like pneumonia and gastro enteritis have also increased suddenly. Requirements of artificial limbs have suddenly become apparent. Some low cost

material may be required, so that local manufactures can be encouraged to produce such on a mass scale. Besides big cities like Muzaffarabad (Capital of Azad Kashmir) all other towns and villages are located at variable height and distance, with difficult terrain in between and steep roads. Some cities and towns had really disappeared as the mountains separated and colonies or habitations caved in the big crevices formed, which almost closed in the end. Even dead bodies of thousands of people and buildings could not be traced as if they did not exist at all. The jolts of earthquake were so severe that within 2 minutes everything came to the ground or disappeared between mountains. Due to heavy landslides almost all roads disappeared. Total deaths exceeded 100 thousand and injured were about ten times of this."

Dr Manzoor Butt, travelled to the region and somehow got through. He sent these reports to international colleagues and they were outlined in an article called "Reaching the Unreachable (1).

"...All of you have watched the role of various organizations on TV. I have personally visited major affected areas with my team and I want to share the following observations with you.

1. The most tragic part of this disaster is the death of school children throughout the affected areas. In many schools, no one could be rescued. The main reason was poor quality of infrastructure in government buildings.
2. There was no Disaster Management Policy to follow and no Disaster Management Committee in Pakistan before this tragedy.
3. Lack of co-ordination between government, volunteers and NGOs was very evident
4. There was lack of initial interest and responsibility in most of government institutions- a large quantity of food and drugs are still at airports and there is no system to prevent their loss.
5. Most of people did not trust relief agencies [because of lack of transparency]. They personally took relief essentials with them to affected areas. The result was an increase in transportation charges, roadblocks and repetition of efforts in many areas.
6. All aid went to areas where roads were accessible. The result was absolute absence of Rescue and Relief work in really damaged areas.
7. Absolute failure in rescue efforts - only one building got damaged in our capital city but we were totally unable to rescue the sufferers.

There was an urgent need for a Rapid Response Team in all communities. Towards this end, I have established "Shamsabad Rapid Response" with its headquarters at my clinic. I have temporarily suspended "Under -5 General Health Screening Project" and have initiated work on training of volunteers in Rapid Response.

The founder members of this team are staff at my clinic, my students and interested members from the immediate community. Medical aspects would be covered by me and the rescue work would be covered by Mr. Pervaiz Sheikh - who is a renowned civil defence trainer. He started this

work in 1958 and got First Gold Medal in Rawalpindi district in social work. He has worked during major disasters of Pakistan, namely 1965 & 1970 wars, many floods, Rawalpindi Bomb blast tragedy in 1988 and in this recent event.

And then regarding the journey itself Dr Butt sent the following report:

Day 1 - Camps are everywhere in the valley - it is difficult to reach these

Day 2 - A car of relief workers fell in the river.

Day 3 - Heavy landslides while we were passing through

Day 4 - A woman playing with her children outside of a camp

Day 5 - People crossing a river on a trolley

Day 6 - Base camp of Mules [army property] for areas where nothing else could go

Day 7 - Pakistan army at work.

Day 8 - Water Filtration plant set up by army. See the young "Lt. Faisal" of Pakistan army

Day 9 - Sabit Qadam Hospital at Sawan, set up by army

Day 10 - CHINNARI, once a busy town - now, one whole side of it has gone into river

Day 11 - Two mountains collapsed to block the river. Army had to blast the obstacles to give way to river again

Day 12 - Relief truck snatched by angry people in the dark of night.

Rocky Martial Arts Academy

Dr Butt works with many committed people from the area, both young and old. Dr Manzoor Butt contributed this article to the MEJB on Mr Zahid Bhatti, who operates the Rocky Martial Arts School in Rawalpindi, Pakistan.

Mr Zahid Bhatti, 23, is a highly distinguished Martial Arts Trainer who has a Black belt - Third Dawn (Black Belt 2nd Degree) in Muay Thai Kick Boxing.

He is a Martial Arts Master, Social Reformer, Human Rights Activist & Youth Worker at his own training facility the Rocky Kick Boxing Martial Arts Academy, which teaches approximately 150 students.

Among the students there are three girls, who are perhaps between 6 and 10 in the otherwise male class who range in ages from perhaps 10 to 20. Their mother, who has no husband and is very poor, was in despair – what to do with three girls and no husband? Mr Bhatti took them into the course so that they could get off the streets and perhaps have some opportunity to make something of themselves. No fee. No charge. Uniforms provided.

We feature some photos below of Mr Zahid Bhatti and students and further photos of one of the authors, Prof Beasley attending an awards session with Dr Butt.



Mr Zahid Bhatti



Using the internet

Community education continues via the internet. Dr Butt provides 'public/patient education in Urdu and English from his Facebook page and on You Tube.

YouTube :

<https://youtube.com/c/DrManzoorAhmedButt>

Facebook

<https://facebook.com/drmanzoorbutt>

Twitter

<https://twitter.com/drmanzoorbutt>

Conclusion

There are uncountable references we can make that show Dr Manzoor's endeavour and ingenuity in finding pragmatic ways to assist his community in both healthcare and life but none of this would have occurred without the most genuine and committed heart.

Dr Manzoor's community may be impoverished in financial terms but in terms of true humanity and human decency it must be one of the richest communities in the world.

References

(1) Lesley Pocock. REACHING THE UNREACHABLE. MEJB Volume 1, Issue 2