

## A Journey into Solitude

Trevor Turner, Medical Student III

UT Southwestern Medical Center at Dallas

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*Africa*. In the Western world, we hear the word and conjure up images of children with bloated bellies and flies around their faces. We think of corruption and civil wars, of diamonds and natural resources, of languages with clicks and tribal rites of passage, of beautiful animals and perilous terrain, all bound up in a certain mystery in which this foreign land is shrouded. And so naturally the most curious of travelers must get to the bottom of all this business surrounding the unknown. Yet many who return from such a place do so not merely with satisfied curiosity but with descriptions of “life-changing experiences,” and it is my assertion that for those of whom these accounts ring true, they are awed less by the differences of the place and more by the commonness they discover between themselves and the fundamental human condition.

However, it is difficult for those of us accustomed to life in the first or second world to obtain any kind of frame of reference in which we can relate our own lives or even the lives of our countries’ poor to the absolute poverty illustrated in the lives of the destitute in sub-Saharan Africa. Therefore, it becomes essential for us to radically exit the environment in which we are comfortable so that we may examine the self from an outside perspective. By this I mean, “God speaks to us in the desert,” as a mentor of mine named John S Dunne used to say. On the one hand, he spoke of a literal desert into which mystics and holy men of history would travel to root out the source of their temptation and rely ever more fully on God in their quest for a life of joy. On the other hand, the desert is a metaphor for the isolation and the loneliness through which all must pass if they are to strip away their familiar mechanisms of support and to find deliverance in an insight and wisdom stronger than they had known in the past. As Professor Dunne writes in his *Reasons of the Heart*,

“Nevertheless, one must pass through pain, the pain of aloneness that appears in each of the situations that make up the human condition. One comes to ecstasy, a joy of loving and knowing that carries one outside oneself, and yet one comes to selfhood.”<sup>1</sup>

Thus it is that the witness of the suffering of the poor tears us away from our selfishness when we become overwhelmed by the plight of another, but after this original separation from the self, we come paradoxically closer to our true self in the end.

*Swaziland* was the locale of my desert. In the summer of 2008, I packed my bags for the long trip to the southeastern part of the Dark Continent to the tiny country bordered by South Africa and Mozambique. The Swazis sported the world’s worst HIV infection rate estimated at 40% of the close to 1,000,000 people, and this was compounded by the highest ratio of Tuberculosis per capita despite more abundant resources than some of its neighboring countries. The statistics became real to me even by my first day in the Baylor International Pediatric AIDS Initiative Clinical Center of Excellence in the capital city of Mbabane. I started by going to see how HIV testing was performed, and three mothers walked into the room with their children to obtain rapid testing for HIV antibodies in their blood streams. As a few drops of blood were inked from each patient onto their respective testing strips, I could not resist the temptation to cast a furtive glance at each result. The magnitude of the AIDS epidemic in Swaziland then confronted me squarely. As the women politely sat there listening to Pax, our counselor, I knew already that 3/6 were presently ignorant of the fact that at any moment, they or the person beloved most by them in the world would be told that a malady which had befuddled the greatest of all mankind’s science and brilliance more than any other in history currently inhabited the outwardly very normal and perfectly ordinary human figure that had strolled so plainly into the clinic that day. After the small group had left

and a couple had returned, Pax began to chatter away in SiSwati. I could only hope I had not given anything away to the young girl by studying her every movement. When the news finally broke, no language barrier could mask the pain the girl suffered. Her countenance started with shame and avoidance. Next, she stared unblinkingly out of the window as if Pax's words fell on deaf ears. Finally, the tears started to come, and Pax passed a paper towel over the desk. The mother sobbed a little as well, and Pax extended her the same courtesy after which he explained the services that the clinic would offer them. I thanked Pax and told him how excellently he performed his challenging work, particularly with having to fight not only the sorrows of positive diagnosis but also the frustrating refusal of those in denial.

My next encounter would stand in stark contrast to the grief of the previous one. The next patient I saw was a 27 month old boy who was HIV+. Three months ago, he could not even walk at his initial clinic visit, but he was started on Anti-Retroviral drugs. On this day, he toddled up to me with a big smile on his face and insisted that I share one of his peanuts with him! It brought me such joy to see the recovery of one simple developmental milestone in this child's life. After using this example, the medical director, Dr. Joyce, described the awful state of the clinics before the arrival of antiretroviral medications to Africa in 2004. Even in the first month of the clinic's opening in 2006, the trauma of AIDS had so devastated the people that the waiting room, always so regularly packed, was completely and utterly **silent**. Imagine the human condition so deprived of its normality.... And then ever so slowly, the children began to cry. A response. And as time went on, Dr. Joyce began to hear them run, play, and finally **laugh**.

However, it was not until I traveled to our outreach clinics that I began to comprehend how over 2/3 of the people lived in absolute poverty, defined as making less than the equivalent of \$2 US per day. The famine-swept homesteads in the rural region of Lubombo presented the cruel blight of drought in all of its fullness. To paint a picture, Swazi homesteads were small 1-2 room huts built of concrete for the more fortunate but made of mud and straw for those less so. Nearly all had dirt floors upon which a woman and her throng of children routinely slept. The men were often gone in search of work as only a few could find employment in the nearby corporately owned and lushly irrigated sugar plantations. There was usually another smaller building with a few bricks for the kitchen which housed some iron pots for cooking over an open fire. For those who were not entirely dependent on monthly fortified porridge disbursements from the World Food Program, chickens were a precious commodity in the stricken land where few subsistence crops could survive. But it was the dogs that were the drabest metaphor for life among the poorest of the poor. Most Swazi's have at least one dog to help guard their property, but these were so emaciated that the threat of attack to an intruder was utterly laughable. It was in this sense, how the complete lack of nutrition rendered these canines unable to carry out their inherent purpose, that human beings afflicted by starvation were so well portrayed. Perhaps this was where we as physicians faced our greatest ethical dilemma... When children were born to mothers with HIV, they were still exposed to the virus through breast milk while they nursed. However, the risk for dying from malnutrition before the age of 5 was even higher than that of living with HIV on HAART therapy, and so the question of whether or not a baby should be nursing in the face of contracting a terminal disease became immensely complicated. The WHO criteria for starting formula feeding included Affordable, Feasible, Acceptable, Sustainable, and Safe means. Clearly the affordability measure eliminated nearly everyone in the rural areas, and feasibility was even less likely without sources of clean water or ways of storing any formula without power for a refrigerator. Acceptability brought an entirely different realm of social issues into our sphere. If a woman was living with HIV in secret and if she avoided telling her family for fear of being thrown out of the home, then what excuse could she give to her husband or elders for wanting to feed her baby formula all the time? After all, it was the death of its women that was crippling the basic unit of society in Africa, but a woman could be beaten or exiled for refusing sex with her husband. Then the issue of polygamy, which had been entertained for centuries and which was still in practice even by the king whom all Swazis deeply admired, threw an enormous wrench into the healthcare prevention machine. On top of this, most Swazi men left home to find work, and the added temptation of living without their wives for long periods of time did nothing to aid their desire to be faithful. It was then I realized the definition of true poverty: It is the absolute inability to change one's life circumstances in any possible way for the better.

My newfound insight into the plight of the poor would be both a blessing and a curse. Even my peers who worked in many of the Non-Governmental Organizations in the area were extremely skeptical of change, but if they were the ones supposedly leading the charge, how was there ever going to be improvement? This was nowhere more evident than at the Mbabane Government Hospital where I had started a project to assess why the ward mortality rate was so high. I felt we had a stake in the well being of the patients there since our clinic was not equipped to deal with patients that needed ICU care. The sickest patients were funneled to the government hospital, and I would never forget my first day. During morning rounds, we came upon a child who had a feeding tube and an intrathecal IV line. Her stomach was very distended, and her chest x-ray showed an enlarged heart. My attending, Dr. Richardson, tried to stick the miniscule veins of the toddler at multiple sites, and I knew the child had to be in bad sorts when the child barely changed its behavior in response to the repeated needle sticks. I went off to find some help, and when I returned, Dr. Richardson had placed an interosseous line into the girl's left lower leg. I tried to stay out of the way since the situation appeared grave, and the nurse then began doing chest compressions. I looked nervously back and forth from the rapidly decompensating child to the grandmother, and I wondered all the while if she had any clue of what was happening. After the baby's pulse returned, she still was not breathing, and we had to transport her to a different room to receive oxygen therapy since there were no ventilators here. After oxygen and additional CPR, the doctors stopped knowing it was futile, and I looked at the *gogo* who stared on in silence while I continued to ponder whether she had comprehended the chilling finality of what had just taken place. Immediately afterward, I asked Dr. Richardson who replied that the woman most certainly knew what was taking place. It seemed even worse than ignorance to me that the woman had followed the entire situation and showed no tears and no reaction whatsoever. This was infinitely more terrible than seeing a teenager weep after being diagnosed with HIV. No flat line, no alarm from a machine, no rush from a crash team, and worst of all no evidence of human pain or sorrow was there to mark the death of the child in any way remarkable. This was the Africa I had expected—ruthless and unforgiving.

In the average developing country, a malnourished child with HIV has approximately 30% mortality. I knew things were grim in the government hospital, but after watching the faces disappear day after day, I could not believe our odds. By the end of the project, I would find the pediatric ward mortality rate over two months to be almost double the average, and that data is currently being used by USAID, UNICEF, Action Against Hunger, and National Nutrition Council workers to effect some type of change in the local circumstance. However, beyond the lost children, it was the attitudes of the staff that sent me reeling toward the canvas like a boxer who finally discovers an opponent who hits harder than he. Sensational newspapers and radio stations warned people against going to hospitals which were billed as death traps and as places which could not ensure confidentiality about one's HIV status. While there was some legitimate criticism there, it was the *expectation of death* by everyone involved that stifled Ward 8 like a choking smog. Paul Farmer once wrote about establishing a hospital to train doctors in Haiti, and he talked about combating the "tendency for Haitian doctors to shrug their shoulders." Mbabane Government Hospital was a mirrored situation in which death was nearly a foregone conclusion for those in the hospital, and so there was no motivation or impetus on the part of those delivering care to fix a broken system. Additionally, the people on staff saw themselves as having made a social leap above the vast majority of their patients, and it showed as they puffed up with their own pride.

Yet pride is an obstacle to good medicine, and I began to hate to rise out of bed in the morning. For the first time in my life, I believed I was depressed. Is it any wonder that people offered with such poor standard of care turned to traditional healers called *Sangomas* or to the influence of dead ancestors on their fate? Where else were they to find hope in the wake of the weekly funerals which had almost become a cultural norm at this point? And for the most personally distressing consequence, how was I ever going to bridge this cultural divide in a way that I could make a difference in these peoples' lives? Farmer is also quoted in *Mountains Beyond Mountains* as saying, "There is nothing like a cure to a disease to change peoples' cultural beliefs,"<sup>2</sup> in reference to blending the efficacy of scientific evidence-based medicine with near universally held notions of Haitian Voodoo. I discovered that the adherence rate of patients at the Baylor Clinic to HIV regimens were better than those in the US, but I wondered if

this had not more to do with the constant and painstaking awareness of mortality in the third world than our efforts. Even so, I was learning an extraordinary amount, but I felt like I was *doing* absolutely nothing. In context of the Judgment of the Nations, “Then the righteous will answer him and say, ‘Lord, when did we see you hungry and feed you, or thirsty and give you drink? When did we see you a stranger and welcome you, or naked and clothe you? When did we see you ill or in prison, and visit you?’ And the king will say to them in reply, ‘Amen, I say to you, whatever you did for one of the least brothers of mine, you did for me.’”<sup>3</sup> Mt 25:37-40. I would often walk the streets at dawn to clear my mind, and one day, I was approached by a boy named Wandil. He told me how he had no mother, no father, and no place to work. He asked only that I give him some sort of job or food. I did not have any food with me, and I made a feeble reply about how he should come visit our clinic up the road even though I knew he might be above our age cutoff. Perhaps our social worker could plug him into a resource he could use, but I doubted he would come. I will always wonder about him.

Where was Rudolph Virchow’s physician, the “natural attorney for the poor?” I hated how so many people beyond our clinic sought to take advantage of me since I was a white man from the United States. I wanted to guard what funds I had for those who needed it most, and when our drugged security guard asked for help, I resented him. I became shamed by my Swazi friends at the clinic who gave to him freely. I said, “Mlungisi! What are you doing? This man is high all of the time, and you have to save your money for your son and your schooling!” It was so typically American to exalt the demands of the individual. Mlu failed to see the distinction in need. In a culture where everyone called others by our equivalent for brother or sister and called their elders all father or mother, the Swazis only saw another Swazi who could be helped. I was passing through the fire of my crucible....

Then, I became ill. At first, I simply could not leave the toilet, and then the fever began with aches all over my body to an intensity I had never known. It is one thing to be alone in a foreign country and another to be sick in one. I wondered if I was going to die at one point, and the other doctors contemplated taking me to a hospital over in South Africa. Did I really want to be treated there? I remember looking for something to reduce my fever in our pharmacy, and the pharmacist cooed with her sardonic tone, “What did you do?” I had gained the cultural acumen by that point in time to realize that she felt my infirmity was the manifestation of punishment for my sins, and I tasted a tiny but painful fraction of the vile, caustic drink those plagued by the stigma of AIDS swallowed whole on a daily basis. After missing work for two days, one of the doctors brought me some green type of Gatorade improvisation, and I cannot even begin to describe the elation and feelings of goodwill that it elicited in me. What a tiny gesture it was that would not cure me in any way, and yet it changed my whole attitude. Many might see this as “a drop in the bucket” when compared to the staggering need of the poor universally. However, Dunne writes, “Acts of God communicate love to the languishing,”<sup>4</sup> and it seemed to echo Mother Theresa’s sentiment about how we do no great things, but only small things with great love. I began to ascend from my personal inferno as my suffering brought me closer to those whom I meant to serve, and I bore in mind the subtleties of which I was capable to ease the pain of everyone I saw. Simultaneously, I began contemplating the aspects of Christ’s mission that had ended in earthly failure like his persecution and death on the cross, which ultimately became the crux of His call to Salvation. Again I was stuck by the simple faith of Mother Theresa who learned to accept the consequences of what she perceived to be God’s Will no matter if one of her projects to serve the poor was on the brink of termination. She claimed that *there were no accidents* in life, and He would provide where He deemed necessary. In the wake of my own trials, I found that perhaps the deepest grace to be had is the grace we find when it seems there is none to be found at all. My resolve grew as my ambition for my personal vision faded in relation to a general charge to strive for social justice on my own terms. I did not have to move to Haiti, sell all my possessions, and live like Paul Farmer even if I felt his courage should still be emulated by all.

There is a Haitian proverb that reads, “God gives but doesn’t share.” That is to say that the world’s resources will always be limited, but we are left with the mandate to distribute them accordingly as stewards to those who lack. I quit my despair and agonizing over whether I had done enough and instead turned my focus to growing in love and compassion every day for the unwanted, those people who could never reciprocate. Both the terror and the romance of the desert passed away, and I knew it

would be more challenging to make a daily sacrifice to the lives of the poor in my own community than to simply live selflessly in a strange land for a two month stint. I had passed through the fire, and I returned to my homeland steadfast in my aspiration to see America less as “the melting pot” and more as a place of my brothers and sisters who are all similarly striving to achieve “the good life.”

Physicians instill the virtue of hope, and their ability to nourish and embrace that belief is one of the most human characteristics of all. It forges the bond with the patient which is quintessential to the art of medicine. May all of us who aspire to practice this art go forth to seek out the broken, to console the sorrowful, and to bring light to the darkness.

<sup>1</sup> P. 36. Dunne, John S. *The Reasons of the Heart*. Macmillan Publishing Company, Inc, 1978.

<sup>2</sup> P. 100. Kidder, Tracy. *Mountains Beyond Mountains*. Random House Trade Paperbacks, 2004.

<sup>3</sup> P. 56. General editor: Senior, Donald. *The Catholic Study Bible*. Oxford University Press, 1990.

<sup>4</sup> P. 15. Dunne, John S. *The Reasons of the Heart*. Macmillan Publishing Company, Inc, 1978.