Virtual Mentor
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PERSONAL NARRATIVE
"You're Doing What?"
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That was the response I heard most frequently when I told my colleagues at the University of California, Davis, School of Medicine that I was leaving to go to work for the US Peace Corps in Eastern Africa. After the initial shock, and a few questions about where and how my wife and I would live, there was unanimous support for the decision. Frequently, a colleague would say, "Wow, I would love to do that." I was tempted to say, "Well, why don't you?" but realized that a decision like this was not and should not be made on the spur of the moment.

The "why" question was and continues to be the hardest for me to answer. I had a great job at U.C. Davis. I enjoyed teaching medical students and residents and my practice through the Family Medicine center was successful and interesting. However, I had a growing feeling that I had lost, or was losing, the desires which pushed me into medicine as a profession in the first place. I was just a bit too comfortable. I missed the feeling of commitment and job satisfaction that I had when I started my career working in an OEO (Office of Economic Opportunity) neighborhood health center in a barrio section of Los Angeles. I needed a challenge.

I need to tell you a bit about what I am doing. On February 1, 2000, I began working for the US Peace Corps as the Area Medical Officer for Eastern Africa. I am a hired employee of the US government and need to emphasize that the real heroes of the Peace Corps are the volunteers who dedicate 2 to 3 years of their lives to working in countries where they are needed.

My primary responsibility is the health of the volunteers who are working in Eastern Africa. I cover an ever-changing area that currently includes 5 countries: Kenya, Tanzania, Malawi, Madagascar, and Uganda. The area expands or contracts as the political climate changes in the nations of Eastern Africa. Ethiopia, for example, had one of the larger Peace Corps activities before the recent political unrest and destabilization resulting from its conflict with Eritrea, another previous Peace Corps country. When the safety of its volunteers can no longer be reasonably assured, the Peace Corps closes down in that country until things settle a bit.

Each Peace Corps country has a medical office as part of the core support for volunteers. For the most part, advance-trained nurses and/or physician assistants staff these. The area physician serves as consultant, mentor, and quality assurance person, and fulfills a host of other duties for the country medical staff. There are 4

area physicians in Africa, their areas roughly determined by dividing the country by the 4 points of the compass. We use regional hubs such as Johannesburg, South Africa and Nairobi, Kenya, for treating volunteers who need levels of care greater than that available in their countries. We can, and do, send volunteers back to the United States on med-evacs when they need levels of care not readily available in Africa.

A misguided and somewhat cynical colleague said before I came that all I would see would be healthy 20-year-olds with sexually transmitted diseases. He could not have been more wrong. I have seen more pathology and interesting health problems in the first 6 months than I would see in years back in the States, even at a major medical center like the U.C. Davis Medical Center. The majority of problems can be roughly divided into 3 categories: stress-related disorders, infectious diseases including tropical diseases, and trauma. I will talk more in the future about some of the tropical diseases we see and some of the inherent problems in trying to avoid them. Much time and effort are spent in preparing the volunteers to avoid health problems "in country" and stay healthy. For the most part this preparation is effective.

However, I have seen a number of unexpected health problems that are initially diagnostic dilemmas, especially without the ready availability of modern imaging techniques now standard in the United States. One such dilemma concerned a 40-year-old woman volunteer whose disorder was ultimately diagnosed at George Washington University Medical Center as a pericardial thymoma. Another case involved a 62-year-old man with cancer at the esophageal-gastric junction. In a recent case, a young volunteer complained that his "belly button" hurt and was pushing out. Examination showed a huge peri-umbilical abscess, which drained 200 cc of foul-smelling, probably anaerobic, pus. He responded well to incision, draining, and antibiotics. My impression is that the base problem is a congenital non-closure of the embryologic vitello intestinal duct that has been asymptomatic up to now. He is winging his way to Washington, and I am sure the surgery residents will enjoy and learn from caring for him.

The Peace Corps volunteers today are far different demographically from their counterparts in the early days of the Corps. The age of the volunteers in my area ranges from 24 to 74, with a large number in their 50s. They bring with them the usual diseases for their age cohort. No longer is a diagnosis of type II diabetes, asthma, or hypertension a cause for rejection from Peace Corps service. What has not changed is the wonderful sense of dedication and challenge that has always motivated volunteers to select Peace Corps service. I have enjoyed all the patients I have cared for, but the sense of dedication and commitment I find in the volunteers makes them special.

I need to put our living situation in perspective. The Eastern Africa hub is Nairobi, Kenya. This is where we live. Nairobi is no longer an easy place to live. Many people who lived here in the past speak fondly of the "good old days" when Nairobi

was considered a great place to live. Certainly the weather is wonderful and the scenery is spectacular. Nairobi is a cosmopolitan city with fine restaurants and modern shopping centers and supermarkets. However, the constant threat of robbery makes it difficult to relax. United States nationals live in virtual fortresses complete with iron bars on the windows, wrought iron security gates on all doors, a wrought iron security grate to isolate our sleeping quarters from the rest of the house, perimeter security lights, and 24-hour security guards at each compound. We carry a radio link to the US Embassy at all times for use in an emergency. Home invasion robberies, street muggings, and the more recent trend of car jackings detract considerably from enjoyment of the city.

More recently, the 2-year drought has produced severe water and, therefore, electricity shortages. On alternating days, we have no electricity from 6:00 a.m. to 6:00 p.m. or from noon to midnight. Water availability is variable. Most homes have plastic tanks to store water, but to be of much value these require electric pumps and electricity. One becomes so dependent on modern appliances in the US that the transition to kerosene lamps and 2-burner gas ranges for cooking seems like a hardship. But it certainly offers the opportunity to return to a simpler way of life. I have found it fun to do puzzles by lamplight, and easy to adjust to a sleep schedule from 8:30 p.m. to 4:00 a.m. so I can have a couple of hours of electricity in the morning.

I am not quite sure how my reflections on working as a physician in Africa will be received by my colleagues and medical students. My experiences are far different from those of the many US physicians who give of their time and talents in the many mission hospitals in Africa. Yet it is certainly helpful to me to reflect on this experience, and perhaps by sharing it with you I can help you contemplate why you chose medicine and what you want from your career. In future segments, I will talk more about my impressions of the health problems in the host countries and of the medical care systems and physicians in Eastern Africa. I will also try to give some personal thoughts and observations as a US physician practicing in Africa. For now, I need to sign off before the electric.i.t.y.. g.o.e.s... o.u...

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