Virtual Mentor
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PERSONAL NARRATIVE

"Hey Daktari, Will You Sign This?"

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My relationship with the Peace Corps volunteers in 5 countries in Eastern Africa is different from any of my previous experiences with patients. For the most part, it is satisfying; its challenges principally clinical. As in any situation, however, occasional difficulties of a more personal type arise. Several aspects unique to working for the US government in Eastern Africa lend themselves to potential problems: the closeness of the community, the level of stress and fear in the volunteers, and the potentially conflicting expectations of the various roles I have as physician to this special community.

The volunteer experience is an intense one. Each country has approximately 150 volunteers who spend 2 to 3 years “in country.” Their dependence on Peace Corps staff leads to very close relationships. Volunteers often stay at my house when they are in Nairobi. Some have difficulty making the transition from this friendship to a patient-physician relationship. For example, although I am very comfortable being called by my first name, as is the norm with other staff, most volunteers prefer to call me "Doc," "Dr. D.," "Daktari," or some variation. When the volunteers get together in the evening, the staff is usually invited. When I attend, I sense that I become a damper on the festivities, especially on the amount of alcohol consumed. This may not be a bad thing. It is likely that my presence reminds them of my in-training exhortations regarding all kinds of health risks, including the use of excess alcohol. It is clear that the volunteers want a certain distance from "their" physician, partially because I will soon be doing their testicular exams or Pap smears, but there is more to it than that. Maintaining a certain professional relationship helps sustain my role as their health advisor and, in many respects, as their "parent in absentia." Most of the volunteers are about the age of my 3 sons, and I am comfortable with this role. I have just never experienced it before in my professional career.

I have often used the analogy of a "stress test" for the Peace Corps volunteer experience. I tell the volunteers that just as we exercise a patient to look for any evidence of cardiac ischemia, they are undergoing a two-year life stress test. It is quite understandable that health or behavioral issues, easily kept at an acceptable level in their previous life, manifest as problems in Africa. I also tell them that the coping skills they develop during this experience will be of tremendous value to them the rest of their lives.

Relatively minor symptoms can become exceedingly frightening when you are living 50 kilometers from the nearest village with a phone and 2 days travel time from competent medical care. When they do come to the medical unit, a thorough exam and use of appropriate diagnostic tools usually allow me to reassure them of the benign nature of their symptoms. However, some are convinced that their symptoms indicate an undiagnosed tropical illnesses. For example, one young man experienced total temporary paralysis while lying in bed at his site. Though the neurologic exam was normal, he was certain that he had some tropical illness and was frightened to return to his remote village. When I cannot find a cause for the volunteer's symptoms and begin talking about how to cope with the problem, I often sense a feeling of skepticism. "Look Doc. This isn't stress. My hair is falling out." "You mean to tell me that I have not had a menstrual period for 6 months because of stress?" "So what if the 10 stool examinations you've done show no parasites, Doc, I know this cramping is not related to stress. This is not the irritable bowel syndrome I had in college."

Occasionally, the roles of physician-as-clinician and physician-as-administrator come into conflict of what I call the “company doctor” type. Reimbursement for travel presents one such potential conflict. A volunteer comes to Nairobi for a presumed medical visit. After a normal exam and very little evidence of any problem, I am presented with a form to authorize reimbursement to the volunteer for travel to Nairobi, hotel charges, and per diem. "Hey Daktari. Will you sign this?" Usually we can negotiate this. Occasionally, the request for signature comes after one of the nurse Peace Corps Medical Officers has already seen the volunteer. I suspect that the old shuffle is occurring. If you do not like the response from one person, you go to another hoping for a different, more favorable reply. How well I remember this ploy as our sons were growing up.

The most difficult challenges surround the fundamental ethic of physician confidentiality. The role conflict arises when I learn, as part of a medical interview, that the volunteer is engaging in behavior that puts him or her at too high a health risk in Africa. An example might be repeated episodes of refusing to use safe sex practices with multiple partners. The HIV risk in the Eastern African countries is far too high for me to allow this type of risky behavior to continue. When I become aware of this behavior, it is incumbent upon me to initiate procedures for the volunteer's separation from the Peace Corps. Another example entails the Peace Corps' zero-tolerance policy on the use of illicit drugs. The risk to the volunteer from the drugs is made all the greater by stringent in-country laws against illegal drugs: the standard jail term for possession of illegal drugs in Kenya is 10 years. On the one hand, I try to foster a relationship of trust with the volunteer that includes confidentiality regarding information given in the course of a visit. On the other hand, I have a clear moral obligation to do the "right" thing for the volunteer even if he or she is unhappy about it. I also must honor the agreement I made with the US government when I was hired to adhere to the regulations of the agency. Informing volunteers of the limits to confidentiality is part of the Peace Corps orientation

process. They are informed that non-disclosure of a significant health problem is grounds for dismissal.

I am glad that we did not title this month's theme the "difficult patient." The patients are not difficult. There are just some difficult issues that arise in the course of providing care to this unique group. Perhaps the issues I am facing are no different from those in any patient-physician population. However, they sure seem different, more common, and more troubling here in Eastern Africa.

Robert Davidson, MD, MPH is professor in the Department of Family and Community Medicine at University of California, Davis, where his interests include both rural health and the organization and financing of health care systems. In the past few years, he has served as both the Director of Rural Health and earlier as the Medical Director of Managed Care for the UC Davis Health System. *Out of Africa* is an on-line journal of his odyssey in the U.S. Peace Corps as the area Medical Officer in Eastern Africa.