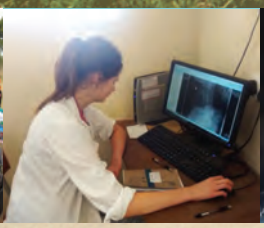
my trip to... Zimbabwe

Rebecca Horton presents some cases from an elective in Zimbabwe



CASE 1: demons or streptococcus?

'Is she possessed?' A twelve year old girl has come in because she 'can't stop moving' and her family is not sure what to do with her.

It's been going on for a month. She's been prayed for at church, friends have suggested the witch doctor, she's being bullied at school. Now the family has pooled its funds to bring her to the largest hospital in the country, Parienyatwa General in Harare. 'They say go to special class!' she sobs. I sit down next to her on the bare metal bed, take her hand... there's a crowd of medical students and yet nobody seems to acknowledge her tears. She takes off her jumper and reveals a sign rarely seen in the UK today, but bearing the name of a great Christian physician of seventeenth century England: 'Before he can raise a cup to his lips he does make as many gesticulations of a mounteback; since he does not move it in a straight line, but has his hand drawn aside by the spasms, until by some good fortune he brings it at last to his mouth'.[1] It's Sydenham's Chorea, secondary to rheumatic fever. The infection is easily cured by penicillin, and her movements subsided the day the haloperidol arrived. We celebrated together as she left; she'd been practising her maths in her hospital bed and was looking forward to returning to school.

When she first came in there had been anxiety over whether she could be demon-possessed. The burden of neurological disease in Sub-Saharan Africa is high; and equally underreported.[2] Cultural and religious factors clearly influence the value and meaning placed by society on neurological symptoms, and possession was considered in a way which it would not have been in the UK. Belief in a supernatural, spiritual realm was the social norm and this change was refreshing. Freedom to mention faith in God without fear of being dismissed made me feel more at home, but there were times when it became uncomfortable. Challenged that my worldview is more materialistic than I'd cared to admit, I realised that I'd put boundaries on what I think God can and cannot do. This case was, as all illness is, a result of living in a fallen world. But I don't think this girl's chorea was any more supernatural than a cold or a broken leg; we should be careful not to assume supernatural aetiology more readily with neurological or psychiatric conditions. The concept of demon-possession remains uncomfortably alien.

Rebecca Horton is a medical student in Norwich

CASE 2:
typhoid, guilt and kissing through veils

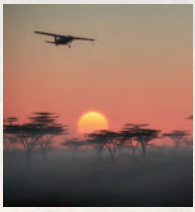
He's carried in stiff, still, abdomen rigid, not crying. Parents accompany this nine-year-old boy to clinic at Karanda Mission Hospital, where I spent the final two weeks of my elective. It was obvious he was very sick, I suspected bowel perforation. One of the doctors informed me this could be caused by typhoid. Antibiotics were prescribed, a surgeon performed a laparotomy and wash out of his abdomen: at least I could explain what was happening to his parents. Thankful (for the umpteenth time on elective) for those long winter afternoons spent practising consultation skills, I talked his parents through the diagnosis. Going away really did make me understand why the medical school is so keen for us to number our points and draw pictures to explain!

'Is the house too dirty? I'm worried it's my fault. Should I send him to live with relatives? I am worried I just can't give him enough, and what if living with us means he gets sick?' She'd been turned away from her local hospital in Harare and made the five hour journey to Karanda. Epworth, Harare has an outbreak of typhoid and his parents are worried it is something they could have prevented. We talk about how most parents of sick children feel guilty, no matter if there was anything they could have done. We talk about how even if we can reduce the risk next time, this does not mean it was their fault. We talk about her love for her son, of God's love for her son and we pray. She let me into her life, trusted my explanation about her child, and taught me of her world in Harare. 'I thank you from the bottom of my heart' she says, and mine still thanks her more deeply than I suspect she realised.

Although communication worked well in this case, all too often it was not so easy. English is the official language but most families speak the local language Shona day to day. There is a limit to what you want to say in someone's second language and discernment of that limit was not always obvious. This decision changed with each new encounter, but added complexity which I hadn't seen in practice at medical school in Norfolk. Anne Michaels said, 'reading a poem in translation is like kissing a woman through a veil'.[3] Whilst my elective involved neither poetry nor veils, this truth began to resonate with me more. Michaels meant that you either sacrifice detail to meaning; or meaning to exactitude. I found that you lost the intimacy of examining someone's thoughts. Facing a language barrier strengthened my consultation skills, taught me about translators and made me more aware of how I use my words.

CASE 3: a breathless silence

A mother lays her sleeping daughter on the bed. She's warm, but her eyes are open and why is she so still? This is not what I expected when I answered the ward call and I'm thankful that the doctor was on my heels. We say 'O death, where is your sting?' (1 Corinthians 15:55, NKJV), but I'll tell you now, that sting of death shook the ward to the core. So close together we can feel everyone's breath and somehow this makes it all the more poignant that this little girl no longer breathes. Her mother howls. I don't know how to go about writing about her grief; actually, it isn't mine to talk about at all. The parents of the boy with typhoid sit there in silence: we knew it could have easily been us. She died of a diarrhoeal disease, only having been sent home from a clinic the day before; this was preventable. And now it is too late. And nobody else cries. And everything stops. And the ward falls silent. A meagre privacy for her death, a vigil for her loss.



Although there are many encouraging stories of recovery, supportive families and tight knit communities, it would be misleading to leave out the many things which caused frustration. Malnutrition, death by diarrhoea, burns. HIV, although greatly improved by World Health Organization anti-retroviral initiatives, is still common. Amputations for osteomyelitis and diabetes. All rooted in deep international inequality and although this drove me to properly consider medicine abroad, I felt seriously underequipped. Used to being able to order pretty much whatever test I want and being assured of follow-up appointments, the lack of health infrastructure added yet another challenge. The missionaries turned to prayer for their patients; I could see how easily you could turn to despair instead.

personal reflections

Visiting a mission hospital encouraged me to live more wholeheartedly for Christ. Seeing the doctors and nurses joyfully give of themselves reminded me that any sacrifice is worthwhile, and equally how quickly we become disillusioned the moment we set our hopes on anything apart from Christ. Privacy on the ward and personal autonomy over decisions seemed less valued. This set up is not without its disadvantages, but I wonder if in the UK our fierce independence robs us of community. It certainly seems to make us strive for a control which is unobtainable. In a land where death is closer people realise more that we cannot control whether we live or die, and maybe being less safety conscious is an outworking of this. Without condoning driving without a seatbelt, perhaps our aversion to risk and illusion of control is worth contemplating. I must admit I did enjoy riding in the back of a truck a bit too much!

Flying home I wrote a list of things to remember. First, the mother of the boy with typhoid reminded me of the importance of loving your patients. A genuine interest in patients' lives is distinctive – much more so than a prompt differential. In her story, and others, I realised how much it is valued when you sit down and take an interest in someone beyond their health. I've learnt this in the UK too – but seeing it even when I knew very little about their culture, even with the language barrier, even when I felt powerless, was what drove the point home. Second, to pray continually without ceasing. I am guilty of being prayerless throughout my working day, and seeing the surgeon open in prayer before opening the abdomen reminded me of our constant dependence on God. Thirdly, many men and women of faith I spoke to reminded me to count everything as a loss compared to the all surpassing greatness of knowing the Lord. ▪

REFERENCES

1. Vale TC, Cardoso F. Chorea: A Journey Through History. *Tremor Other Hyperkinet Mov*. 2015:28(5):tre-5-296. *bit.ly/2CceSTO*
2. Jamison JT et al (eds). *Disease and Mortality in Sub-Saharan Africa (2nd Edn)*. Washington DC. The International Bank for Reconstruction and Development / The World Bank. 2006, Chapter 23. *bit.ly/2j0atLS*
3. Michaels A. *Fugitive Pieces*. London, 2009. Bloomsbury Publishing