

How has your elective led to improved care for your future patients?

G. Kay

Manchester Medical School, University of Manchester
grantalistairkay@gmail.com

In the words of doctor and medical anthropologist Paul Farmer, ‘The experience of suffering ... is not effectively conveyed by statistics or graphs. The “texture” of dire affliction is perhaps best felt in the gritty details of biography.’⁽¹⁾ During my elective in rural western Kenya, I would come to appreciate what this means. The statistics are shocking enough, but we are accustomed to hearing them. Globally, 90% of malaria deaths occur in sub-Saharan Africa.⁽²⁾ In the part of Kenya I visited, 83% of infants harbour the malarial parasite *Plasmodium falciparum*, which is the leading cause of death for infants in the area.^(3,4) In addition to malaria, the rural population in this region also bears a high burden of other diseases, particularly HIV/AIDS and tuberculosis. It was through the ‘gritty details’ of my experience caring for an infant, whom I will call Mary, that I came to appreciate that hidden behind the statistics on infant malaria mortality is a child convulsing and dying in a hospital bed.

As medical students, we are taught that with good knowledge and clinical skills we will be able to effectively treat patients. However, the story is not as simple as the disastrous coalescence of parasite and child. Mary became sick and died owing to a complex web of social and economic circumstances, ranging from the lack of a bed net to poor access to hospitals and vital equipment. As such, despite many years of medical training, my clinical skills were not likely ever to alter the outcome for Mary, nor for the next child with malaria who would be arriving later that day. As this editorial will show, that has had a huge impact on how I view my role as a doctor and how I will care for my future patients.

Mary was a three-month-old baby who was admitted to the ward following sustained convulsions and, like the majority of children on the ward, appeared to be suffering from severe malaria. She had been ill for the last two days but her parents had not brought her to hospital, possibly

deterred by the difficulty of travelling there or the health-care costs involved. From the end of the bed I could tell she was seriously unwell. Her breathing was rapid and shallow, and she was choking on copious secretions. The nurse asked for suction but the machine was broken. After several minutes a very ineffective foot-operated suction pump was found, but this failed to clear the secretions. I auscultated Mary's chest and heard widespread crackles and extreme bradycardia, followed shortly by silence. There was no pulse and no respiratory effort. There were only myself and two intern physicians' assistants present, and the realisation that I was going to have to lead the resuscitation suddenly hit me. There was no crash team available, no defibrillator and no senior doctors who could be contacted. I shouted for a bag and mask and started chest compressions and, after many minutes, an ill-fitting, well-used mask arrived, which did not work. We carried on resuscitating the tiny infant for several more minutes before a senior nurse told us to stop. I looked around at everyone, bag and mask still in hand, and hoped someone else would want us to continue, whilst knowing we had lost her. The language barrier meant it was impossible for me to explain what had happened to the family who were at the bedside.

The experience of caring for Mary impressed upon me how 'large-scale social forces crystallize into the sharp, hard surfaces of individual suffering'.⁽¹⁾ She was born in an area where malaria is rife, with no bed net to protect her, with limited community health care and prohibitively expensive hospital fees. When she arrived at the hospital, life-saving drugs were not available and equipment was absent or broken. It has been said that as doctors we 'are not trained to understand such social forces, nor are we trained to alter them'.⁽⁵⁾ However, this experience made terribly apparent the nullifying effect that the infrastructural, economic and political difficulties of health-care provision can have upon the clinical skills and medical sciences I have been taught.

In order to improve care for my patients in the future, I have realised I have a role to play outside of the clinical environment. When I visited malaria clinical trials ongoing in the area, I met doctors who were undertaking this wider role. Their work focuses on long-term research into malaria vaccines, mass drug administration and other public-health interventions. However, the teams of researchers and medical practitioners also provide curative malaria treatments to patients who would otherwise not receive them. This recognises that 'distal' interventions (such as the treatment of malaria with medication) and 'proximal' interventions (such as providing bed nets) are '*complementary, [and] not competing*'.⁽⁵⁾ Without this wider approach, it is hard to imagine how clinical medicine could ever have met the needs of Mary, or prevent other children like her from becoming just more malaria mortality statistics.

References

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