Generalist

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A Mission to Africa,
Journal of a Lambaréné Schweitzer Fellow

by: Benjamin Gilmer, Class of 2006

Ben Gilmer, a Brody School of Medicine 2002 North Carolina Schweitzer Fellow, was selected as one of this year’s five recipients of the Albert Schweitzer Lambaréné Fellowship to spend three months working at the Albert Schweitzer Hospital in Gabon, West Africa. Ben’s selection to the Fellowship is an honor for him and for us since the program, begun in 1978, usually selects students from medical schools in New England. Ben is only the second Fellow from a North Carolina school and the first from Brody to be selected. The following is an excerpt from the journal he kept while serving in Lambaréné.

Gabon is a small country on the western coast of equatorial Africa. It is roughly the size of Colorado and is blessed with infinite natural beauty and resources. Gabon still contains forests that remain untouched by man. Of its 1.3 million inhabitants, 75% are sequestered in the capital city, Libreville. Those Gabonais who are not rich from either the petrol or lumber industries are very poor. Those who live en brusse,(in the forest) survive day-to-day by living off the forests, harvesting bananas and leaves of manioc, and hunting antelope, snake, and porcupine. Gabon is also rich in culture, supporting nearly 40 different ethnic groups, most of whom have their own language. French is, however, the unifying language.

Lambaréné is a small town about five hours drive to the south of Libreville. It sits perched on an island in the middle of the Ogooué River and is the second or third largest city in Gabon. It is home to only about 20,000 people.

About a mile from Lambaréné is the Hôpital Albert Schweitzer (HAS) situated on the northern banks of the Ogooué. It’s about

A few months have passed since I left Gabon and each day new experiences and realizations continue to be born out of this marvelous opportunity.

Ben Gilmer examines a child on the Pediatric Ward at HAS.

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The Power of No

In October, I was pleased to be a speaker at the Annual Business and CME Meeting of the American Academy of Pediatrics in San Francisco. Through the six days of the meeting, we dealt with some thorny national and international child health and welfare issues. I learned a few new things in primary care and picked up some specialty pointers as well. To detail all of that for you would take all of this newsletter, so I will concentrate this editorial on some information from one of the sessions dedicated not to children, but to the physicians who provide them care.

The session was on lifestyle and one of the speakers questioned whether many of us have a life to which we can attach a style. I've written before about the importance of our dedication to our patients, to the need for us as health professionals to put the good of our patients before our own. Self sacrifice in medicine is not only noble, it is often necessary. Unfortunately, an increasing number of physicians tell me that they are feeling beaten up and burned out to the extent that money, prestige, and even job satisfaction provide little compensation.

We joke in pediatrics that one of the first words that children learn, often despite our attempts to prevent it, is no. How is it then that this word, so much used in our childhood, is so easily forgotten as we become adult professionals? We've even created a new word, multi-tasking, to explain the result. Unfortunately, like many other things, the ability to multi-task seems inborn or perhaps developed early. Not many can do it consistently or continue to multi-task for extended periods of time. Despite time management courses, mentoring sessions, use of PDAs and other technology, there are still only 24 hours in a day. (And did I mention that sleep deprivation is another disease of our time?)

Unfortunately too, I’ve watched students and colleagues, professors and friends try to do so much, that little is done well. Over the years I have counseled students, looking toward careers in medicine, who get so involved in undergraduate extra-curricular activities that look good on a transcript that they forget that good grades look even better. Some of them who make the cut carry that attitude and philosophy into medical school and realize too late that while residencies want well rounded physicians they, first and foremost, want physicians who know the material well and can focus on the singular task of providing good care to their patients.

Some of the best multi-taskers I know are primary care physicians. They care for their patients well, they are good spouses and parents, they are pillars of their community, and live fulfilling lives. That’s as it should be. Society needs people like them to make society work. That said, one of our tasks throughout our education and professional lives is to learn again to say no. One of our tasks is to pick and choose those things which will most benefit society and our humanity and beg off on those things that others might do equally well or perhaps better. We need to be selfless in our physician careers, with just a hint of selfishness to maintain a healthy balance. Some of us really need to get a life.
Students at the Brody School of Medicine joined others from around the nation in celebrating the sixth annual National Primary Care Week during October 17-23. The event is sponsored each year by the American Medical Student Association (AMSA) to direct attention to the importance of primary care. This year’s event called on individuals, communities and health professionals to build on Healthy People 2010, by taking specific steps to improve the health of our citizens.

AMSA members at Brody, took this mandate to heart, planning and implementing a weeklong series of conferences focused on Caring for the Underserved: Careers in Community Health. The week got underway with a Community Health Fair which was held at the Food Lion in the Stanton Square Shopping Center. The students checked blood pressures and provided health education and brochures to members of the local community on Sunday afternoon.

A series of noon seminars were then presented throughout the week to commemorate the weeklong event. On Monday, faculty from the Departments of Family Medicine, Internal Medicine and Pediatrics gathered for a Panel Discussion centering on careers in primary care. This was followed on October 19th with, Dr. Julius Mallette and Dr. Thomas Irons presenting a discussion on Minority Issues in Primary Care. On October 20th, Dr. Patricia Lowery of the Department of Pediatrics teamed with Carol Irons, a Pediatric Asthma Case Manager, to present a discussion of Asthma. On Thursday, Dr. Jeffrey Severa, a Brody School of Medicine faculty internist who recently moved to Edenton, NC from Pennsylvania, spoke to students about choosing a career in rural health.

Each year, during Primary Care Week, the Eastern Area Health Education Center (EAHEC) sponsors a Medical Recruiting Fair. This year’s fair closed out the week, sharing information on eastern North Carolina’s health career options with our medical students and residents. Participants included 12 hospitals from throughout the region, and 102 students and residents attended the fair.

National Primary Care Week is hosted each year, at ECU by the Generalist Physician Program and the Brody chapter of AMSA. We are especially thankful to our co-sponsors, the ECU chapters of the Student National Medical Association (SNMA), the Pediatric Interest Group and the American Medical Association (AMA). With their assistance, the week was an outstanding success!

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Two Brody students were recently honored at the 2004 Annual Meeting of the North Carolina Medical Society (NCMC). Stefanie Putnam and Lindsey Hughes were elected officers of the Medical Student Section of the medical society. Stefanie will serve as Co-Chair and Lindsey, will serve as Treasurer, both taking office this Spring.

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The week got underway with a Community Health Fair which was held at the Food Lion in Stanton Square located behind the medical center.
a 40 minute walk, 20-minute jog, 5-minute boat ride, or 7 minute cab ride to the center of town. Daily, I would either walk or run to town, either to buy food at the open market or to have grilled fish and a Rejab, a local brew, at one of the hundreds of fish stands. Schweitzer chose well when he decided to establish his hospital there. It is a natural wonderland, dominated by a powerful river that fosters wildlife including electric eels, pelicans, crocodiles, manatees and hippos. The Ogooué is bordered by dense tropical forests housing enormous trees, monkeys, apes, elephants, and some of the most poisonous snakes in the world including the black mamba and Gabonese viper. The forest, “la brusse,” is saturated with plant diversity and various medicinal herbs. The average 12 year-old in Gabon can easily identify at least 20 different plant species that are used as medical remedies. I have heard of plants that restore hair loss and others including the famous eboga, supposedly only found in Gabon, that will enable you to visit God. Yet, amidst all of this beauty, the same social problems and diseases that Schweitzer confronted still plague the people today.

The Schweitzer Hospital: The current hospital rests beside the original structures that Schweitzer built in 1913 from a chicken coop. Today’s hospital consists of the Polyclinique where all of the internal medicine consultations and x-ray services are performed. This is the nucleus of the Schweitzer campus. Radiating from it are independent, free-standing wards including pediatrics, surgery, and internal medicine. On the campus, there is also a kindergarten, elementary school, leprosy village, many small houses where employees of the hospital reside, and a world-class malaria research center. It is mind boggling how Schweitzer, a

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single individual, has shaped the health care of this country.

The *grande docteur*, as he was called, cared for patients well into his eighties. I spoke to Albert, the eldest man residing in the *Village Lumière*, a sequestered pocket of the HAS created to allow leprosy patients a place to live. He remembers Dr. Schweitzer well. I asked him what Schweitzer was like and he simply said, “Il ferait tout pour ses patients et il a travaillé pour nous jusqu’à sa mort.” (He would do everything for us and he worked for us until the day of his death.)

Pediatrics: The pediatric ward, was a powerful experience. It was a stimulating balance between being mentored and autonomous. I fell in love with the Gabonese children and would often come after hours to visit them on the wards. I was immediately accepted as a team member there and truly felt valued. This, I suppose, was the first, most impressive realization—that I had a purpose here and was not just the student. I continued to grow clinically and became increasingly more confident about my ability to communicate with the patients, which was more of a cultural challenge than linguistic. I also discovered that there was a level of paternalism exhibited by the doctors which I perceived as excessive. Later, however, I realized that this type of communication was often the only way that some patients would internalize medical directions. Learning how to relate in this way came as a total shock to my Southern style of communication. Soon I learned to be frank while also being compassionate and thoughtful.

La Protection de la santé Maternelle et Infantile (PMI) PMI is a community health program established by the hospital almost 20 years ago in an effort to extend prenatal and pediatric care to the 15 villages within a two hour driving or boating radius of the hospital. As the pediatric medical student, it was my responsibility to assist in the missions to these villages which were always on Wednesdays and Thursdays.

The objective of these is to provide vaccinations to the children, chart their growth, do nutrition consults, perform consultations and physical exams for the *enfants maladies*, provide routine antepartum exams for the *femmes en grosse* and perform neonatal exams for the *nouveau nés*. The vaccinations are free but other consultations cost 2,000 CFA (about $4). The cost of the consultation includes all medicines, which are distributed on the spot. PMI is an excellent service for the local people and we would routinely see between 50 and 100 patients each day. It is much more cost effective to be seen by the PMI team versus going to HAS due to transportation issues and the increased cost of a consultation (6,000 CFA/$12). The villagers appreciate this service and they take full advantage of it.

PMI afforded me a unique opportunity to experience the people and their communities *en brusse*. In these villages, I saw the inside of their thatch-roofed shacks, learned how to build “three rock” fires for cooking, participated in classes in their secondary schools, played soccer with their children, carried babies to their homes, helped cook meals for the villagers, counseled women about the importance of protecting themselves from AIDS, gave classes on nutrition and TB, tasted their native culinary delights, learned how to prepare manioche, shopped in their local markets, visited their churches, discussed local issues with village chiefs, and

**Mission to Africa**

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One of my greatest learned clinical skills in Gabon was estimating anemia from their conjunctivae and I can now say that I have seen some really white eyes. Much more. Most importantly, I had the privilege to take care of their children.

The first month, I learned and practiced every aspect of the PMI service. I learned to give vaccinations to the children, do prenatal exams, examine newborns, do gyn consultations, weigh the babies, chart their growth and update their carnets de santé, (a portable health record that each patient brings with them to each health visit), organize the truck and supplies, prepare the mobile pharmacy, learn the medications and finally to learn the most common diseases and their treatments.

After the first month, Dr. Diallo, my mentor, informed me that she would be leaving for two months for her vacation in France. Although alarming at first, her absence inspired me to exert more leadership both as a doctor-health educator and as a team leader. It was my first realization that I would actually be a doctor one day and that I would play a critical role in many of these peoples’ lives. But to them, I was a doctor and was playing a very important role in their lives already. Because I was making decisions autonomously, I was energized to do the best I could, and firstly to do no harm. I respected this new responsibility and discovered a great pleasure in reviewing my books at night making sure that I hadn’t made any mistakes during the day and learning about new cases. I can remember my first solo day heading to Bifoun and studying like a madman in the truck on the way.

My most important job during these PMI days was deciding which children needed immediate hospitalization, and then convincing the mamans that going to HAS was truly a life or death decision for their child. Most of these moments involved young children with severe malaria and anemia, “palu avec anémie sévère.” One of my greatest learned clinical skills in Gabon was estimating anemia from conjunctivae and I can now say that I have seen some really white eyes. For most of the palu patients, however, I felt reasonably comfortable treating on an outpatient basis. On several occasions though, I had sleepless nights because several families with really sick children never made it to the HAS, despite the hospitalization en urgence pleas that I issued. I can remember trying to convince a grandmother of a very sick, malnourished child who most certainly had malaria that it was an “obligation” to come to the HAS that night. My insistence angered her because she had no means of paying, nor traveling and was already exhausted by her trip to the PMI. Others patients presented with Buruli ulcers, severe malnutrition, acute asthma, broken bones, severe dehydration, incarcerated hernias, tet spells, hydrocephalus, severe infections associated with scabies and much more. Each time, I had to pray that they understood the importance of coming to the hospital and that they would arrive in time.

My time with the PMI team was rich with experiences, both culturally and medically. Traversing each of the villages, children would run along the road screaming “La PMI arrivé!” It was a classroom that I will never forget.

Below is an excerpt from a PMI day at Bifoun.

May 14, 2004–PMI–Bifoun We loaded up the truck and set out on our two-hour drive to the village of Bifoun. Along the way, after realizing that I had to be responsible for the consultations des maladies, I quickly opened my books and had the biggest cram session of my life. As we pulled into the village, we recognized that about 100 young mothers and their babies were impatiently waiting to be seen. A pediatric consultation on the PMI service.

A pediatric consultation on the PMI service.
Excerpts from a Schweitzer Journal

waiting for us. It was a small building with a dirt floor and no electricity. By our standards, it would be considered a shack suitable for storage but today it would be a hospital.

Sophie, our nurse majeur, started today’s TB education session while I began weighing the babies on a scale that dangled from a mango tree limb. Quickly, an hour passed and all 105 screaming babies were weighed and plotted along their growth curves. Then it was time to divide and conquer, Sophie called for all the pregnant women to come forward while I called for all the malades to come forward and render their carnet de santé.

My heart raced as I realized that now my actions truly had repercussions, both good and bad. This was the Africa experience that I had dreamed about–heading to the bush to finally put into practice all that I had painfully tried to put into memory. I imagined how overwhelmed Schweitzer must have been after arriving to the shores of Lambaréné. On his first day in Gabon, which was his first work as a physician, he saw 40 patients within the confines of a chicken coop. Well, this is what I had asked for, never actually imagining that this reality would actually present itself. It’s amazing how fear changes your outlook on learning and assuming certain responsibilities.

My first patient presented with a very anxious adult who turned out to be the child’s grandmother. She had just traveled two hours from a remote, interior village. Her first language was some other dialect so her French was somewhat broken. The child she had brought, lay limp in her arms. “Palu,” she said, which literally means paludisme (malaria) but commonly refers to a bad fever. Indeed, the child was hot, dehydrated and had the largest spleen I had ever seen—all signs that he needed to be evacuated today to HAS. I examined the boy who suddenly became very fussy when I woke him up and found that his hands were as white as mine, a sign of severe anemia. Because, I had already seen two anemic children die during the previous week, there was no question that this child needed a real doctor not someone who was trying to be one. Something brewed inside me as I knew that there were no interns, residents or attendings around. I told the grandmom that they needed to get their affaires ASAP and that we could drive them to the hospital tonight when we return. She said, “But Doctor, we have no money, no ride, and my daughter doesn’t even realize that we are here. It will be impossible to get to the house and back before you leave tonight.”

It’s important for the patients to bring their own supplies to the hospital because there is no cafeteria, no sheets, no services to support the non-medical needs of the patients. The patients actually participate in their care, something that Schweitzer introduced to his patients early on. Every patient had to have a family support network to cook, clean the room and provide the linens. At night, if you walk past the ward you see little fires burning as people prepare their meals. The patients are even required to bring their own thermometers and record their am and pm temperatures. It’s startling to see even young children responsible for pricking their own fingers while self-monitoring glucose levels.

Again, the grandmother said, “I’m sorry but it will be impossible for us to come, can’t you just do something now, at least get the treatment started.” After observing some of the differences in African communication, most notably a stronger paternalistic role, I
It was sobering to leave them, knowing that I had my nice room to go back to while they slept together on an old cracked, dirty mattress, not knowing how they would eat for the week, much less pay for their hospital expenses. I was relieved that the next patient only had a cold and needed some saline nose drops which work great for colds and are cheap as dirt. She was followed by another child with a huge scrotal hernia. He too, needed immediate surgical treatment and we no longer had any room left in the truck for them. Soon it was pushing 6:00 PM and none of us had even had the time to eat any lunch. I grabbed a Snickers bar and shamefully ate it recognizing that none of the patients had had anything to eat or drink either. Soon, it was dark and I remembered that there were no lights in our little barn. I cranked up my ophthalmoscope and let its light burn bright during the last patient interview. Finally, we had finished, only to pack the truck, load the sick boy, whom I had already almost forgotten, and drive the two hours back to HAS.

After arriving at HAS, I helped get the the little boy, Stephan, checked in, but discovered that there were no beds in pediatrics. “You see, we came here for nothing,” the grandmother said. In a panic, I ran around and finally found a bed on the surgery ward where she and the boy could sleep for the night. Later, I brought them some milk and yogurt from my fridge, because they had literally had nothing all day. Stephan voraciously drank the milk and then grandma drank what he didn’t want. It was sobering to leave them, knowing that I had my nice room to go back to while they slept together on an old cracked, dirty mattress, not knowing how they would eat for the week, much less pay for their hospital expenses. I was relieved, though, knowing that they had, at least, made it to the hospital and that Stephan was still alive. What a crazy day!

Ben is currently working on a project to replace the timeworn, ultrasound machine at HAS. If you are interested in learning more about this or about Ben’s experiences at HAS, please contact him via email at BPG0509@mail.ecu.edu