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Dust

By Mary Pan

I slept in my scrubs. It was a restless sleep, an on-call sleep. The kind of half sleep where your mind won't turn off, skimming on the surface, bobbing just below consciousness, ready to pounce. Mothers of newborns know this kind of non-sleep too. I was the lone physician in charge of a rural Kenyan intensive care unit. The phone call summoning me to the ICU awakened me at 5 a.m., ringing shrill through my drafty one bedroom apartment.

It was winter in Africa. The air was cool as I shuffled out the door in the just-morning light. As I ran across the dusty copper road, the dirt rising into the air under my feet, the weary world was already awakening. Others seemed to move in slow motion, not understanding the urgency of my summons. I trotted, then ran, self-conscious and conspicuous, fueled by anxiety.

I hurried across the dirt road, tearing through the empty corridors of the now-familiar hospital, flinging wide the doors to the tiny medical intensive care unit, six beds in all, for adults and children alike. I was in charge. My patient in duress, a young woman with post-operative complications, was in the corner bed. The nurses looked up as I entered but they were not moving, not hurried and harried as I expected them to be. I asked what was going on. Silence. They were bagging the patient: forcing oxygen into her lungs by compressing a bag, in her case through a tube in her throat—a tracheostomy.

I had participated in many "full codes" during my medical training in the States. Teams of people would fill the tiny room of the dead or dying patient, each with a role and purpose—a coordinated attempt to bring a person back to life. Here, there was no rhythm of intravenous medications and chest compressions. There were no rules of resuscitation or options for chronic mechanical ventilation. I asked if she had a pulse. No one had checked. She didn't.

The surgeon showed up at that point and replaced her tracheostomy tube. I started chest compressions and gave her epinephrine and she began breathing on her own and regained a pulse. The surgeon and I discussed the fact that she had probably suffered brain damage since she was without oxygen for some time. Her pupils were fixed and dilated: a telltale and ominous sign. If she coded again she was unlikely to recover. Twenty minutes later she stopped breathing. All we could do was watch her die.

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When they asked me to bring a roll of electrocardiogram paper, I said yes. It was just paper, but paper that was hard to come by in rural Kenya. It seemed like something I could do. Just

like working in the small hospital for a month, learning and teaching. It felt like I was helping; contributing my time and that ream of EKG paper.

Only it didn't arrive as expected. My luggage was lost, somewhere en route to Nairobi. Most likely it was snatched from the Nairobi airport, targeted as a westerner's luggage, walked right out the dirty sliding doors of baggage claim without question. Maybe just a sideways glance.

Missionaries at the Kenyan hospital prayed for my bag and the precious EKG paper contained within. Many times during those first few weeks, working in the unfortunately termed "Casualty" (Emergency Room) or managing patients in the intensive care unit, I coveted that specially lined paper, so prevalent at home.

In rural East Africa, I was without so many diagnostic tools; I had to rely on my fund of knowledge or suffer the lack thereof. It was an entirely different way of practicing medicine, simultaneously terrifying and freeing. There was no CT scanner, no radiologist to read the x-rays. Even the one staff pediatrician was out of town when I arrived. Although I was a novice physician, early in training, I was considered the expert in neonatal intensive care issues. We thought long and hard about what labs and studies to order because patients paid out of pocket for each test. Sometimes they ended up just staying at the hospital after they were discharged, loitering in the murky hallways or sienna-stained grounds, until they'd procured sufficient funds to pay for their stay.

Under-resourced, we relied on the vanishing skills of the physical exam, hoping touch would reveal clues to the diagnosis. It was a blind medicine by today's standards, but somehow more exhilarating, more satisfying, more full.

It took seventeen days, but that day I came home from my shift to find the lost bag sitting outside my apartment door. Where it had been and how it managed to finally make its way to the small town of Kijabe 50 kilometers northwest of Nairobi will forever be a mystery. I hurried the precious ream of electrocardiogram paper over to the hospital, proudly presenting it to the physician on call. He was ecstatic. It wasn't until days later that I learned that the EKG machine itself was, in fact, broken.

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I lodged myself in the tiny spearmint bathroom and stuffed half of a peanut butter and jelly sandwich in my mouth. It was my first day on call at Kijabe Hospital and I was overwhelmed and jittery. The smell and taste of the peanut butter, comfort food literally brought in a jar from home, gave me a moment's reprieve. No time to digest, I stepped back out into the Emergency Room, or "Casualty."

A Kenyan Clinical Officer—a physician in training—hurried up to me, donning a short white coat and clipboard. It was early afternoon and a 22-year-old man had been transferred to us from another hospital because he was deteriorating. Our staff had already ordered some basic blood tests and performed a lumbar puncture to examine the patient's spinal fluid. We were looking for signs of infection. The young patient had presented to the outside hospital five

days prior with a headache and fevers. They were concerned about malaria or meningitis, but had not performed a lumbar puncture, which can be diagnostic for meningitis. One of the staff physicians had warned me earlier: "Here, they think everything is malaria." The other hospital did treat the patient for malaria, but it was unclear whether or not any definitive studies were performed to make that diagnosis.

Upon arrival at our hospital, the patient became unresponsive and began to have generalized tonic-clonic seizures—rigid and violent jerking of the limbs. The Clinical Officers had given him the anti-seizure medications diazepam and phenobarbital.

As I approached the patient, his right arm was seizing, his left pupil was blown (a sign of serious and permanent brain damage) and he was unresponsive to painful stimuli. He was thin and lanky and so young. My mind raced. The only intubation equipment—a way of maintaining his airway so his lungs could receive oxygen—was at the other end of the hospital. He had been seizing and unresponsive for the past 24 to 48 hours. The nearest CT scanner, which could give us valuable insight into damage to his brain, was 50 kilometers away in Nairobi. Suddenly the patient's family appeared. They said they couldn't get the money required to pay for the CT scan until the following day at the earliest.

There were several possible scenarios: intubate the patient myself, pool money to pay for the CT, drill a "burr hole" to relieve pressure on the brain. I wanted to hide in the spearmint-colored bathroom, barred off from the chaos of the situation. I wanted to savor my peanut butter and remind myself it's not always, not everywhere, so hard. I eventually decided to seek counsel.

I found the surgeon in his outpatient clinic. As I explained the situation, I felt an instant release: camaraderie is therapeutic. The surgeon suggested the burr hole; he's a surgeon, after all. He took the patient to the operating theatre and drilled a hole in his head which produced frank pus; thick greenish-yellow fluid poured forth from the opening. Pressure relieved. The patient had a brain abscess. This was my first hospital admission of the day.

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Walking through the wards sometimes felt like avoiding land mines—scattered bedpans, people washing themselves with soapy water, buckets of vomit, trays of chai, plates of yesterday's food. Often labs ordered the day before were not actually performed or recorded accurately in the patient's chart. So they need to be reordered, or checked on by traipsing down the hall to the lab where all of the results were kept, written in pencil, in a ledger book. If I needed a consult I could page the desired physician, but if it was a surgeon usually I would just look for them in one of the operating theatres.

I entered the hallway adjoining the operating theatre, flustered from my morning rounds on the inpatient wards. I was looking to consult the one surgeon we had on staff. It was mid morning and the hallway was cluttered with people in surgical scrubs and caps, sitting on stools. A Kenyan surgical tech smiled at me and lifted his cup of hot liquid. It was tea time.

So much to do, always so much to do. But twice a day, mid morning and mid afternoon, carts of stainless steel cups and plastic pitchers full of hot chai were doled out. Everyone stopped. Staff, patients, maintenance crew and physicians. Everyone stopped for a cup of tea.

It took me weeks to get used to this custom. Seemed odd, but also strangely dignifying, to wheel carts of chai twice daily among rows of suffering patients, many with end-stage cancer, advanced AIDS, or severe complications from tuberculosis. I was always rushed, wanted to get things done, but grew to respect and emulate the universal taking of time for a reprieve.

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Everyone kept asking her if she was pregnant. She kept assuring us she was not. She was young and thin and short, even by Kenyan standards. Her cappuccino skin was creamy smooth and she was pretty. She wore flowered fabric dresses and smiled shyly, but never showed her teeth. Her belly swelled under her shirt: gravid, protruding. Three months of worsening abdominal distension. I wasn't sure if I believed her, this denial of being with child, with a progression and physique so classic for pregnancy. I'm skeptical by nature. But there was no ultrasound to prove her assurances wrong.

We took the patient to the operating theatre one humid afternoon. An exploratory laparotomy, the poor man's imaging modality: cutting into the abdominal cavity to determine what this massive bulge might be. It was the most impressive surgery I'd seen. The mass took up her entire peritoneal cavity, the bulk of her abdomen.

The obstetrician, experienced in all gynecologic surgeries, couldn't even get around the massive growth. He had to call in the general surgeon. I heard him mutter under his sterile mask, "I don't usually work above the uterus."

They eventually had to drain it. Six liters of pus. Six. Liters. Milky greenish-gray. Draining, draining. It felt like we were draining the life from her, stealing the bulk of her tiny girth away.

We sent the murky fluid straight to pathology, but the results were all inconclusive. Clear answers were lacking, other than the patient was right, telling the truth all along. She never seemed upset at the fact that no one had believed her. But her story serves as a reminder to listen to the patient, even when all logic may point in a different direction.

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I was searching for the death certificate when her husband arrived. The patient had died ten minutes earlier. I had tried to save her but failed.

It was a fluke that he showed up to the hospital at that moment. We hadn't had a chance to call him to tell him: she's dead. It's no small task to tell someone their loved one has died. The hesitancy, the awkwardness, the feeling that these are momentous words you're stumbling over. Never sufficient eloquence. Never adequate empathy. All the more challenging using an interpreter across cultures.

The husband was gracious and thanked me and the nurse profusely for trying to save his wife. He wanted to convey his appreciation. This was his initial reaction. I was puzzled and touched. I had witnessed several deaths, coded many patients, and informed family members of a patient's death before. Yet, this situation was different; I felt responsible. Maybe he picked up on that. Maybe it was the Kenyan way. Maybe he was particularly kind. Maybe he wasn't so surprised that she could die unexpectedly in this land where untimely death is all around. He shook my hand and walked out the double doors. I'll never see him again. I'll never forget him. I turned around, searching for the death certificate as another patient was wheeled into the ICU.

Mary Pan is a family medicine physician with training in global health and narrative medicine. Her work has appeared in Hektoen International, Coffee + Crumbs and Mamalode. She lives in Seattle with her husband and two children.
