

## ON AFRICA, CHILDREN, AND THE MUTUAL DIMENSION OF HEALING

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### INTRODUCTION

As a young boy, I often refused to finish my plate at the dinner table. My mother would tell me, “Nicholas, think about those children in Africa. How can you waste such delicious food, when they can go for days without a single bite to eat?” Every time I wondered, “Would these children actually be happy eating my leftover Brussel sprouts? Was that even possible?” And then I would think to myself, “One day, I will pack a big suitcase filled with good things to eat. I will go to Africa, visit these children and see if what my mother says is true.”

Many years have passed since those early days of my privileged north-American childhood. It was only recently that I set foot in Sub-Saharan Africa for the first time. As a senior pediatric resident from a Canadian tertiary hospital center, I felt confident about my ability to provide medical care to children in need. During medical school and residency, I had sought every possible opportunity to gain a better understanding of healthcare in its broader sense. From attending global health courses and conferences to volunteering in remote parts of Peru and Guatemala, I had valiantly tried to prepare myself for the land that had fascinated me as a child: Africa.

## AFRICA

When the time came to pack my bags, my mandate was clear: for two months, I was to integrate a team of local healthcare providers and work as a pediatric intern in a busy rural community hospital in Burkina Faso. Along the way, I would acquire a better understanding of maternal and child health while learning how to do a lot more with a lot less. In no way was I expecting to change the world. If all went well, I would manage to share a few concepts with my African colleagues, make accurate diagnoses and cause little to no harm to my young patients. Another more personal objective of mine was to build on the knowledge I had received in medical school about healing and physicianship<sup>1</sup>. Inspired by the emerging literature on whole person care, I wanted to relate to my patients with authenticity, presence, open ears and an open heart<sup>2</sup>.

I could speak volumes about my stay in West Africa. I could describe the blazing heat, the torrential downpours and the countless blood-thirsty mosquitoes. I could write about the lethality of untreated malaria, which still claimed over 400,000 lives worldwide in 2015, the vast majority of these in Sub-Saharan Africa<sup>3</sup>. I could speak about the challenges of being born too soon or about the omnipresence of infectious diarrhea in a place where clear drinking water is a rare commodity. I could also tell true tales of kindness, generosity and resilience of a people who accepted me as one of their own despite my shiny white skin, weak intestines, and lack of understanding of their native tongue. But the one story that I am compelled to share is that of a young boy, Sangaré\*, who I will never forget.

When I set foot in Nouna—a rural community of about 20,000 souls located in the northwestern part of Burkina Faso—my entire body was covered with sweat. My first sight of the hospital where I would be spending the next seven weeks did nothing to cool me down. Sad-looking one-story buildings with no windows were scattered in a gated complex about the size of two American football fields. Between the buildings, a hodgepodge of mud puddles, colourful linens and wooden cooking fires created a peculiar village where dozens of families had set up camp to remain close to their loved ones. The pediatrics wing, the hospital's busiest service, included four patient rooms equipped with a total of nineteen army-style cots. On each bed, two or three young children and their mothers were lying still. The air was thick, heavy and stagnant.

## CHILDREN

It was in one of those rooms that I met Sangaré. Born 10th in a family established in one of the many neighbouring agricultural villages, the boy was eleven years old, but appeared much younger. When he arrived, wrapped in thin linen, lying limp in one of his older brothers' arms, he seemed more dead than

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\* The patient's name and personal details have been modified to ensure anonymity.

alive. Unable to walk or speak, all his energy was focused on the one thing that his body allowed him to do, that is, breathe. Thinner than thin, he was completely covered in wounds, with parts of his body in a state of decay that is indescribable.

It took me over thirty minutes to complete an examination that I usually do in less than five. In all my years of medical training, I had never lost my cool in the presence of a patient. But this time, my five senses were overwhelmed by feelings so gripping that I couldn't focus at all on the task at hand: history, examination, assessment and treatment plan. These four tasks that I typically perform almost instinctively seemed completely absurd in Sangaré's presence. I was totally thrown off by his big black eyes fixated into an empty stare, gazing interminably on what was in front of him.

Eventually, with the support of two of my colleagues who detected my distress, I managed to regain my composure. Sangaré was dreadfully ill for a combination of reasons. But I was convinced about two things: (1) that my patient was hanging on to life with everything he had and (2) that one of the reasons why Sangaré was in such bad shape was a four-letter word: AIDS.

I cared for Sangaré for a total of twelve days. At first, I thought that there might still be hope. Even though he was by far the skinniest human being I had ever encountered, he initially seemed to respond well to intravenous antibiotics and minute sips of milk. By day two or three, he was shaking his head and moving his lips in an attempt to communicate. His stare that had been empty before began to focus on certain objects, his favorite being the black sports watch that I had given him in the hope of raising his spirits.

Even though the pediatrics service was extremely busy, with hundreds of patients being admitted and discharged every week, I managed to hold Sangaré's hand at least a few times every day. Being unable to speak his language, touch and presence were the only ways I could get close to him. He seemed to understand that well, because every time I walked near him, he would stare at me, stare at his new watch—which could easily have been wrapped twice around his wrist—and then at his empty hand, until I reached down to hold it.

Looking at Sangaré was extremely difficult for me. Everything about him, from his deep sunken eyes, to the colony of worms that had nested in his right foot, reminded me of how spoiled I had been as a child. I had taken so many things for granted. I never imagined that nutritious food, electricity and access to essential medicines were goods unavailable to millions of human beings. Learning about it in medical school was one thing, but seeing it up close was a completely different experience.

## THE MUTUAL DIMENSION OF HEALING

During my brief relationship with Sangaré, I gained a new understanding of a notion that had been introduced on my first day of medical school, shortly after swearing to the Hippocratic Oath. “Physician, heal thyself” is a proverb that resonated with me. How can physicians aspire to heal others if they haven’t experienced healing themselves? But beyond the idea of healing oneself or another, Sangaré afforded me a deeper understanding of the transformative dimension of healing: its mutuality.

Sangaré represented in so many ways, what I had always dreaded as a kid: HIV-AIDS, the incurable disease; starvation, the great injustice; hopelessness, the eternal sadness. But more than that, Sangaré embodied the deepest fears and apprehensions I harboured as a young physician: helplessness, the impossibility to cure, and of course, the loss of a living soul. From the beginning, it was clear to me that my role with Sangaré would be to promote healing rather than offer a cure. The first did not exclude the second, but in conditions like his and at such an advanced stage of disease, everything I might do to cure, would be too little too late. What I soon discovered was that as Sangaré became weaker and weaker, healing wasn’t happening in the direction I had anticipated: not only was Sangaré a recipient of my healing efforts, he was exerting his own profound and serene healing power over me. And my soul was taking it all in.

Two days before his death, it was brought to my attention that Sangaré’s family had decided to stop feeding him. Through the skillful interpretation of one of my colleagues, I managed to understand that the milk that had brought a glimpse of hope to both my heart and Sangaré’s eyes had been taken away from him for fear of prolonging his suffering. The sole thought of denying food to a starving child at the brink of death was inconceivable to me at first. But when I reflected on how tightly Sangaré was clenching his jaws when his nurse offered him milk, I was forced to conclude that most of what I had done, allegedly in Sangaré’s best interest, had really been to help me cope with my own sense of apprehension.

When the news arrived that Sangaré had taken his last breath, I was preoccupied with two young toddlers who had, in less than 10 minutes, passed from vigorous to limp due to a severe malarial infection that was threatening to cause irreversible brain damage. Rushing to provide a rapid and effective cure to these two young girls as taught in medical school, it was impossible for me to return to my young friend who had, in the course of his stay, taught me so much about medicine. Only an hour later, when the two young girls had received the first few drops of life-saving blood transfusions, was I able to leave their bedsides and hurry to where Sangaré had been lying feeble for twelve days.

Sangaré had died with no other warning signs than a hint of a fever, probably the only reaction that his body was able to mount to fight yet another infection. I don’t know if it was the sight of the empty half of the bed or the image of my old sports watch, left on the ground in front of it that struck me the hardest. Drop after drop, tears pooled around my feet soaking the old time piece that I just couldn’t pick up. I lost track of time,

staring into the emptiness. Sangaré's parents had taken him with them only a few moments after he had passed away.

## CONCLUSION

Many pages have been written about the virtues, challenges and transformative power of practicing medicine in developing countries. Although I can now appreciate that my mother was right about the hungry children in Africa, I still have much to ascertain until I consider myself a humanitarian. Nevertheless, I would like to share a few concluding thoughts for other trainees who might be contemplating a short term elective practice in resource limited settings: First, pre-departure preparation is key. Yes, this implies brushing up on clinical skills and becoming familiar with the context where the rotation will be completed. This also involves truly understanding our personal motivations and limitations in the setting of a brief elective stay. Second, while "do no harm" should remain one of the central guiding principles throughout the experience, it is important to understand that good intentions will only take us so far. Often times, the meaning of beneficence can vary tremendously in different cultural and spiritual settings and remaining constantly aware of this is crucial. Finally, as confident as we might seem, there is always a part of us that is vulnerable. And it is when we embrace these vulnerabilities that we can truly experience what it means to heal, to be healed and to embrace the richness of whole person care. ■

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