

11-FEB-C-3

OUR FULL DAY IN PIBOR WITH THE MURLE IN OUR CLINICAL REVIEW OF THEIR PROBLEMS AND ATTEMPTS TO ADDRESS THEM IN HALF A THOUSAND OUTPATIENTS “UNDER A TREE” IN OUR “MOBILE CLINIC” TRYING TO STAY IN THE NEME TREE’S SHADE, AND THEN SET UP A SURGICAL SUITE IN OUR SLEEPING QUARTERS

February 19, 2011

We are doing it! And doing it well in wholesale quantities. As predicted, the hundreds of patients that had heard about us and were waiting at clinic on the Lily River bank were nearing a thousand colorful Murle patients in all their colorful cultural varieties and with a myriad of disease problems we treated as outpatients. These were the usual—Diarrhea, Acute Respiratory, Malaria (among the first killers) and DJD (Osteoarthritis) and GERD (GI distress from reflux or peptic ulcer) and scores of parasitic problems, including worms by the boatload, and an amazingly high incidence of STD’s which included Syphilis which is almost always undertreated. We worked hard and fast, often dragging the local team forward, with little incentive for efficiency since there will always be more patients and they will always leave a bunch behind at the end of each clinic day unseen.

Jowang Kaka Killitchaka is the County Medical Director of PiBor County (0904738270) He is the Clinical Officer I have been dealing with here who would cheerfully write out the correct prescription after we concur on the diagnosis, only to find the patient hanging around us, which is my signal that nothing we had just written is available here since they expect us to have all the meds that a WHO mobile clinic would have. We had packed mainly the surgical supplies to do a few demonstration cases and to try to teach a few of the locals how to handle surgical emergencies—MSF injunction against our letting anyone in on surgical secrets. It is a bit like the charade we had played at German Doctor’s Emergency Hospital in Kauda, where they pretended to call Germany and get an injunction against our operating since they said we had to remain indefinitely afterwards to follow up all such patients in the event some late complication developed. It was there that the retired doctor, who was very up to date in his devotionals, but pre-WWII in his medicine, had left the compound and left to even more retiring nurses who said repeatedly the mantra I most enjoy as a “self-fulfilling prophecy.” There is really nothing we can do for these people.” We saw patients dying of tuberculosis in the huts assembled there for

inpatient care and asked what drug therapy they were on. “Oh, nothing, since we do not want to get involved in long term treatment of anything and we do not give out these drugs (which they had in their pharmacy stock.) In several simple cases that could have been treated as ambulatory outpatients, I asked if we might schedule them since we had an anesthetist and a surgical scrub team and me and a medical student—“Let’s go!” They returned to say “We called Germany--- without a phone—and they said we cannot allow any operating here since they do not want to be liable for any results that may follow.” So, there really is nothing THEY can do for these patients –just like MSF which is “Not the MSF way.” So, there definitely IS something that WE can do for these people and I hope they just stand aside so we can get to it.

In the over five hundred patients screened today for treatment, almost all had some kind of illness that required deworming, anemia support, immunization, hygiene advice, and personal malaria protection like bednets—and most needed all of the above. A few had surgical problems and could be fixed if we had time enough for their care. SO, we selected a few. One woman had a large abdominal wall hernia sticking out like a protruding proboscis, and it was easily reducible and a “Wowy Zowy “ case which would be spectacular as a demonstration and one we could fix.

A young woman with a massively distended abdomen has a single large mobile cyst which is probably ovarian—I would love to have carried the InterSon probe with us—but she could be relieved of this as I had once done in Old Fangak of a large solid ovarian tumor that weighed about as much as the residual patients after I resected it with the suture removal kits I had left over from Anne Arundel Medical Center when they went to disposable suture removal kits. I did her under spinal anesthesia in the year that John Sutter had gone with me as senior GWU medical student and she was confronted as she lay awake in the Old Fangak jail which we used as our “OT” and we presented her her tumor as she stared wide-eyed on being relieved of this mass. Here is another young girl who is NOT pregnant and has what appears to be a triplet pregnancy that is very inconvenient for her. I have told her at first to get to MCH at Werkok where they might be able to do both Ultrasound and resection. But, if she is still there tomorrow at the clinic on the river bank, I will offer to do her here.

A young boy was brought to me hardly able to stand up and sweating profusely quivering with the rigors of malaria. In a minute, he was under the IV tree and getting an IV infusion of quinine for his malaria control.

A woman came to us with a tender abdominal mass and she probably has a walled off abscess. I am reluctant to operate on her since we have no “ICU Follow-Up” but we decided to keep her at the riverbank in the thatched tukul with rocephin (ceftriaxone) being infused IV. She would be a good immediate relief except that she might need prolonged treatment beyond our being here and she is probably not one we can leave in the “gap” between us and the arrival of the team on February 26 who will look after our follow-up.

But among about twenty patients with hernias, I suggested a further “bridge to peace.” The people here need the kinds of drugs and equipment we have at Werkok, where the MCH {*Mission for Children’s Health*} is in the rural areas off any public transport and in their non-urban area of sparse population, the patient flow is very spotty. Here we are flooded. So I suggested and Ajak agreed, we would get a truck load of these elective operations to be done and send them to MCH at the time we are there to conduct a surgical workshop and demonstration session with docs from Bor and Akobo and overcome the terror of the mystique of operation which has apparently held MSF and others in thrall.

We have seen the upmarket facilities of the MSF camp and we have also seen the large volume of patients we treated under a tree today on the Lily River with very primitive facilities and no fleet of MSF vehicles and planes and a staff from Nigeria Kenya and all over the world with less than we volunteers have to do. The exception of the Murle of PiBor and no other South Sudanese could be convinced to come to the heart of Murle country to keep this as a sustainable enterprise. Our only assistants were Murle and they have no other choice as to where they can be or where they can go to practice the healing arts except here with their people. So we are training the right group. It gives me pause to see that a number of our patients who have been coughing blood for a year or more and have night sweats and weight loss (one twelve year old girl insisted she was “shrinking”) we have no anti-Tb drugs. We are told to refer them to MSF for DOTs MDT (Directly Observed Therapy of Multi Drug Treatment.) Why should the one most sustainable and long term program be the one exception to the general rule we have encountered to date? These patients are at the peak of their infectivity, and have been walking around with such florid and obvious Tb that there certainly cannot be much of a surveillance community outreach program.

Further, a lot of the men had STD’s represented by a drip or painful urination and even more women had PID (pelvis inflammatory disease) from STD’s a few of whom had ulcerative genital lesions—[probable syphilis which is prominent here as well as the gonococcal disease is endemic. So, this social disease which is the pattern of epidemiologic care is the kind that should be picked up by some kind of public health care community social medicine program which is the alleged strong suit for which acute care is foregone, such as injury or illness or obstetric disasters which they essentially write off. It means that health care, to my view on the river bank in a couple of days seeing nearly a thousand patients by now—does not exist in PiBor. It needs more than redevelopment; it needs a startup from a zero base.

**SUSTAINABILITY: FROM SIMPLE BEGININGS, A MASS CLINIC
“UNDER A TREE IN THE RIVER LILLY BANK” AND AN ELECTIVE
OPERATION UNDER SPINAL ANESTHESIA IN OUR SLEEPING
QUARTERS UNDER AIR COVER FROM BATS—THE VERY FIRST**

OPERATION EVER DONE IN PIBOR, BLESSED BY REV ORUZU WHO COMES TO THaNK GOD FOR THIS EVENT

I had an idea as I saw more and more young males with inguinal hernias that need repair. Everyone has been frightened to go to Bor, especially, the HQ of the Dinka Bor. But Werkok is outside Bor even if inside the Dinka Bor country. It is a six hour road trip to Werkok, and the representatives here are the leaders of our group—Dr. Ajak, a Dinka Bor from the MCH as its Medical Director, and Jacob Gai who is the administrator of the MCH. The both of them are the ones designated to assume responsibility for distribution of the resources and the training from our program and the container just delivered. We have already encountered several drugs they do not have here which are available in abundance in MCH and we contacted Jon Hildebrandt and MCH so that when he comes up on Monday he will carry in a list of six drugs we had called down to them. Some are available here, but like the “Source” bottled water we have just purchased, the cost is tenfold since the transport from Bor is added—four cases of half litre water bottles cost us \$58.00 US in the market today, possibly since a crew of white men came along with Moses and Juono to pick it up. But the Benzyl Penicillin and the single best agent to be used for syphilis—an IM dose monthly for three months, sells here for over ten dollars per dose whereas it is two dollars for the whole course at Werkok. So we can make available those agents they need and do not have, as well as furnish those drugs they have ordered and have never been delivered or got siphoned off into the market, or those which even if they have are prohibitively marked up to usurious levels.

Juono told us that at least twice a year someone dies here at PiBor because they are taking some medicines that are unknown, in the wrong dose and are not marked as they are “fallen from a truck: and placed on sale at the riverside market. The consequences for those who do not die is not known except that a lot of money, drug sensitivity, and lifesaving function is lost annually because of completely unrestricted drug sales—a commodity on the black market that commands a high markup.

Further, we identified a half dozen patients who have fixable problems, and rural MCH has good resources and few patients, whereas here we have lots of patients and NO resources for virtually half of the diseases we encountered. So, we named six patients from today alone who can go to MCH for an elective operation, along with the two people who are going to be trained with us here in the first operations done her in PiBor—essentially in the “Clinic Under a Tree-equivalent”—our Operating Room in our sleeping quarters with bats flying air cover—a historic operation that is first in PiBor history—down the path from an equipped and staffed hospital run by an international organization that prides itself on having got the Noble Prize. We are making history here, but not a terminal history since “Elijah “is assisting us and will be carrying on after we are gone. And he will be trained as he will be on the truck that will go down to Werkok with the half dozen patients both for their security and for training purposes since he will participate

in their care and join in the tutorials at MCH and then come back with them in the truck which will also be loaded with the equipment we have promised and the apportionment that our Leaders Ajak and Jacob will guarantee.

I saw one patient today “under the tree”—she was Rev. Oruzu’s sister. She was treated well and swiftly with all the rest. We also had what is probably the best “front row seat” in the drama of every patient’s personal drama of quiet desperation. In all their tribal fiery they came and sat in front of me. I had tried to take photos from a distance, but it turned out that it was only facial close-ups and the pointillism of their facial markings as beauty marks and their elaborate headdresses and ear rings and necklaces all of which were on display when they were walking through town. But when they opened up in telling their story about how many pains and sufferings they had, it was a complete absorption and were unaware that they were on film right in my face. It is the G B Shaw quote I have on a slide: “The people of this world put on a Great Show; but only the doctors have a front row seat!”

And, now, we have come back to the sleeping quarters where the patients cannot pursue us at SALT “Serving and Learning Together”. We carried one of them with us. A strapping young man who was told he needed to sell four cows to purchase a passage to Juba to get his hernia repaired. We brought him in and “a la Ephraim MacDowell” had our kitchen table converted to an operating table and spread out our instruments on the bed we would not be using again tonight except that we are moving him in with us since he has a spiral anesthetic and will not be walking home nor getting up to pee. We had him pee in order to get the bladder empty for the liter of fluid we infused to give him a route for analgesia if the spinal anesthetic was inadequate. In a single pass on his first ever spinal anesthesia attempt got spinal fluid return so he is a confirmed “one shot one kill Special Forces jump man.” Then with Dir. Ajak helping Zach, a Sacramento firemen and teaching Elijah with Josh serving as anesthesiologist, we had a smooth and easy operation done as a complete success. This was the first ever operation ever carried out in PiBor. Rev Oruzu came in and praised God saying he had never expected to live to see it, and this was the response to many prayers and the fulfillment of the promise of the Peace initiative Contract with all the chiefs and the commissioner and all the peoples of the Murle who have been near desperate for the health care and equipment (a second order gift, to be coming back with the post-op patients to be fixed in Werkok along with the two trainees who will accompany them to be able to carry back the skills—the first priority of the Mission to Heal here on this site.

The local pastor came by to offer a prayer that this first success may be the first of many to come and that the effort so well begun might not be derailed by any of the naysayers. These can be petty as in the tribal rivalries so far held at bay, or they can be official as in the MSF embargo on any definitive health care initiatives to redevelop here at PiBor. Rev Oruzu was the first Murle ever to visit the US. He is the one from the meeting in Louisville to Grand Rapids to our last year’s meeting in PiBor to make all the promises this trip fulfills. He is overjoyed and is

assembling the chiefs and commissioner to let them know of the progress based in their pledges of nonviolence. He is going to conduct a service tomorrow in his churches and tell them all of our services here which will result in a still larger number of “patients under a tree” and a greater number for our surgical services here and the filling up of the truck load to Werkok to come back with further promises of the peace bonus. On Monday when Jon Hildebrandt arrives, the Murle representative that Ajak had met in Bor will be handing over the money that was the government’s “peace bonus” for following up on the peace initiative we had brokered last year.

Peace in Our Time is an epigrammatic phrase that is often derided in hindsight, but, for now, PiBor is riding high on our “burgeoning “Clinic under the Trees” and our Operating Room in ours sleeping quarters.” To echo Rev Oruzu—Praise God!