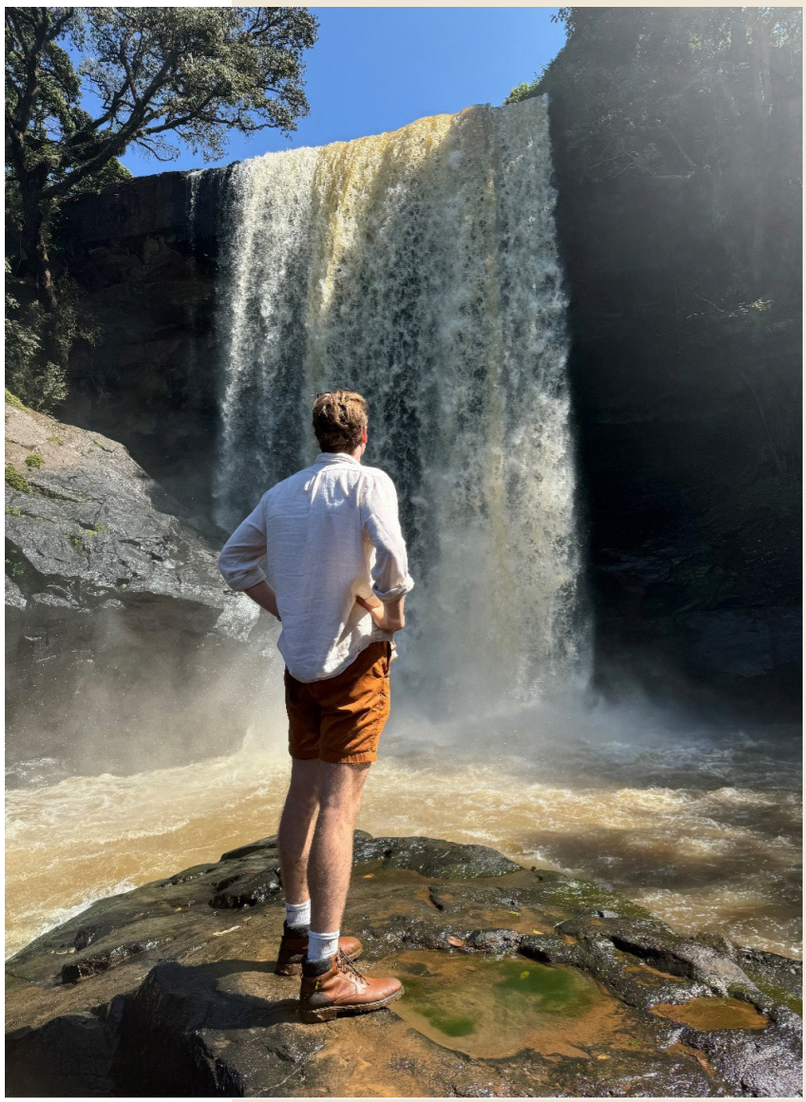
Go to Kenya

by Alexander Shinnerl, MS4

As I sit in the Nairobi International Airport, drinking what will be my last Tusker for a while, I reflect on my time in Kenya. For the last two months I have been working in the city of Eldoret through IUSM's connection with AMPATH.

I arrived during a resident strike. By the time my plane landed in September, the registrars (what much of the world calls residents) had been working without pay for over two months. Even now, registrars are working pro-bono as their lawsuit bounces through Kenya's legal system. At the same time, medical students begin the ninth year of their six-year medical training program. While COVID-19 has played a role, administrative issues also contribute to these delays. Medical training here is undeniably challenging.

Despite this, the resilience of these doctors and students shines through. They face these training challenges head on, supplementing their knowledge wherever and whenever possible. I had the pleasure of teaching an ultrasound session with portable probes I had brought from the States. What began as an afternoon scanning session extended well into the evening, we made sure that every student had ample time to get the images we were looking for.
Teaching was only a small part of my experience abroad. I spent time in TB and HIV



clinics, ICUs, and the wards absorbing the quintessential components of medical education, while also observing the variation of themes between the American medical juggernaut and a hospital in sub-Saharan Africa. I contributed to the successful treatment of patients with tuberculosis, rheumatic heart disease, and advanced HIV-associated opportunistic infections that I had only seen in textbooks.

And by the same token, I watched helplessly as patients died from tuberculosis, rheumatic heart disease, and advanced HIV-associated opportunistic infections that I had only seen in textbooks. One patient was a 25-year-old woman who had experienced an ischemic stroke after a lifelong battle with HIV due to off-and-on treatment. While antiretrovirals are often available in Kenya, there are many reasons why someone would "default" on their medication regiment. In her case, we presume her challenges with adherence stemmed from the need to hide the diagnosis from her husband. One way or another he found out while she was pregnant. Beyond this, much of her history is unknown, as the stroke left her mute, and with a confirmed diagnosis of HIV she was excommunicated from her family. Her husband took their now 3-month-old child and blocked any attempts at communication. Early results during her hospital course were promising, she was able to sit up and look at us during rounds – every once and a while I thought I saw her smile. But after nearly a month in the hospital on appropriate ART and Anti-TBs, her condition suddenly worsened. Every day became somehow worse than the last. She died in the wards, without ever being upgraded to the ICU.

Global health is a complicated beast. I am not going to pretend to understand it all after a two-month rotation. Sure, there are obvious structural factors, financial constraints, resource limitations, and different disease burdens. But can the centuries of damage endured by this part of the world and her people ever be undone? I don't have an answer for why some patients died from their disease and others were treated without issue. I don't know what killed our patient. It could have been another stroke, an infection

that wasn't covered, or possibly a reaction to the cocktail of medications she was taking. Or could it have been something completely different that didn't even make it onto my differential? With medical school graduation in sight, I look in the rear-view and recognize an ever-expanding blind spot. The more I learn, the more I realize how much I still don't know.

Go to Kenya, your clinical years should be pushing yourself from your comfort zone. Practicing medicine in this setting is different. We couldn't get results from a repeat head CT when our patient started crashing, I will never know if it was a second stroke that killed her. You may find out that not having immediate diagnostic capabilities and access to all possible treatments is not how you want to practice medicine.

However, for some it will be a "good" different. You often won't know the answers, and it can be a challenge to search them out. While treating our aforementioned patient, I encountered our infectious disease doctor buried in a likely outdated neonatology textbook, searching for clues regarding the treatment of her newborn child. You may find that these are your people. I would watch the same doctor resurrect patients from the crypts of cerebral toxoplasmosis over a weekend, and then invite us over to sample his newest margarita recipe.

Regardless of what side of "different" you fall on, you will never have this opportunity again. Take out the loans, get a grant, ask your mom for money, go to Kenya.