

# A PROMISE

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**INTERNATIONAL BALINT AWARD 2004**  
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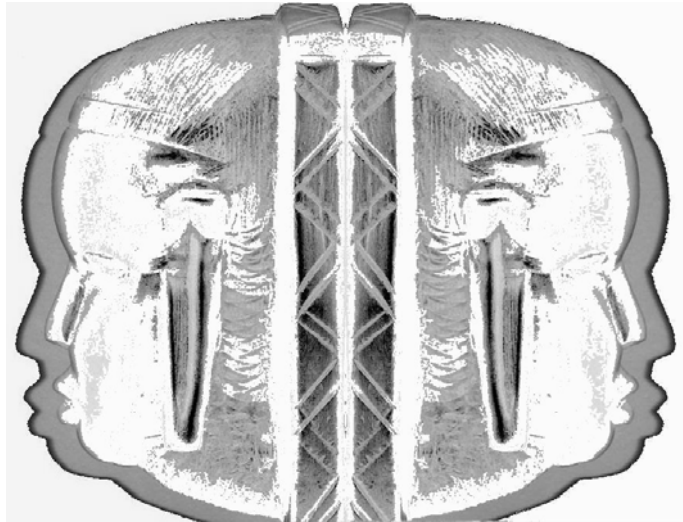
**1st prize**

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**Axel J. Telzerow**

*A Promise*



Axel J. Telzerow



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**Line of Vision** This work is divided into three parts with the *Moment* as a core: [1] First, an *Insight* in the general situation is given: South Africa is - like other countries of the Sub-Saharan-Zone – fundamentally affected by HIV/AIDS. [2] Second, the *Moment* of the patient-student-contact is described contextually and introspectively, quasi like a dialogue. [3] The work ends with *Another View*. – I do hope that I have the privilege to take the reader with me on that travel.

## **Insight**

On the days of admission there is a lot to do at the Chris Hani Baragwanath Hospital. One says that the 'Bara' is not only the largest hospital of the southern hemisphere, but in fact the largest: That means every day thousands of in- and outpatients depend on this public hospital, since it provides health care for Soveto, the township. A hospital in the middle of poverty, brute force and HIV. Many patients suffer from the immune deficiency, many patients also have tuberculosis and many patients are dismissed in a condition which would justify an emergency admission in Europe. Worlds meet at the Bara: (Lack of) education, arrogance and humility, gratefulness and joy, giving and wondering, laughing and suffering, assuming responsibility and having to assume responsibility; and: Different cultures and languages come into contact, but hardly mix.

In the Department of Internal Medicine every 5th day is a day of admission. That means every doctor admits between 20 and 30 patients in addition to his workload in the wards. Sometimes more, sometimes fewer. The doctors are happy if there are fewer patients, then it is a good day. If there are more, it is a bad day. Because many patients must be cared for until the next admission day, since then there are new

patients. Few remain for more than 5 days because resources are scarce.

HIV changes a society, has an impact on life, changes medicine. Generations and villages disappear. One says that formerly Bara had the complete range of diseases, nowadays it is different. Today it is mainly AIDS. A virus determines society, consumes life, and dictates medicine. A never ending story: One patient arrives in a weaker condition than the next. Some come on their own, many are carried or are sitting in a wheelchair. The admission department is divided into four smaller units with two doctors each. Then there are two additional units, one as intensive care unit, one for patients with psychiatric disorders. - Confused, recalcitrant patients are strapped to the bed with bandages. The bandages are tight. The psyche has to wait, since treating the somatic symptoms is more urgent. So urgent that the dispensing of food can be considered as treatment.

At the Bara, patients are addressed as Baba or Mama. Originally, in the South African culture these terms are used to show respect to the addressee. At the hospital, they are above all easy and quick to use. A man is Baba, a woman is Mama or sometimes Sweetie.

## **Moment**

Today it is our day of admission, and we have lots of things to do: anamnesis and diagnosis, setting up intravenous accesses, supplying medication. Everyone is busy with his patients - or with getting hold of a set for one more lumbar puncture or even a pleural drainage. The mobile X-ray machine and the ECG are in continuous operation.

In the beginning I did not notice him because silent patients easily get lost in the masses of people. This Baba is quietly lying on his bed. Only after the doctor asks me to establish an intravenous access, I become aware of him. I go to the patient's bed, say hello and explain what I am going to do. He pulls up his sleeve, so I can set up the access. Compared to other patients this one has a neat appearance: His beard is well cut, his clothes cleaner. He smiles, slightly timid and insecure, just as someone not knowing what to await in this situation. In his eyes there is a glimmer of gratitude that someone is taking care of him.

*This is the kind of timid gratitude I see in many patients from Soweto: They are not used to being cared for by others, and above all by a doctor. They blindly trust the doctor: He is not questioned, not criticized even if a lumbar punc-*

*ture has to be made several times. How often do they go to the doctor in Soweto? And what academic background a doctor must have!*

The physicians examined him already half an hour ago: 35 years, male, at the hospital because he has had continuously growing pains in the abdominal cavity for two weeks. Some findings are striking: the rebound tenderness of the lower abdomen, the fever and sweating, the rapid heart rate and the loss of weight. He looks worn-out, i.e. his temples are slightly sunken inward. Considering the massive soor in the oral cavity we have to think of HIV/AIDS and the related opportunistic diseases. His medical report shows he has tested positive. Baba is well-informed: Like so many others this patient has the immune deficiency.

The medical staff does no longer call it HIV/AIDS, but '*retro-positive*', because there are fewer patients who understand that diagnosis. But the diagnosis still does not explain the acute abdomen, so the doctor asks for the blood values and an X-ray of the abdomen.

*One more again! One more patient with HIV/AIDS. Again and again. They are worn-out. What an expression! Consumer goods can be worn-out, but a human being - how-*



*ever, it is the disease that wears people out, in this aspect the image is true, but it is inhuman. Meanwhile I am happy to see a patient who is growing old in dignity and without the immune deficiency. A whole generation, no a whole country is dying here! - They tell me: Be careful because of HIV! You come first and then the patient. - Only if you protect yourself, you can protect others! They show you statistics that's unlikely anything happens to you if you give someone an injection - provided you wear gloves.*

There are other patients requiring attention first. And the X-ray images still have to be developed. After a while, the images are not yet there. - What comes to my mind is the association that an acute abdomen is an emergency which should be clarified as soon as possible. This case is urgent! - I go to the Radiology Department to fetch the images. The air fluid levels which can be seen on them are classical. This Baba has an intestinal obstruction. - In the doctors' room we meet to discuss the images. We quickly agree that the patient must be operated and call the surgeons.

When the surgeons arrive, we jointly go to Baba's bed that is two doctors each from the Internal Medicine and the Department of Surgery, me as a student and a nurse. We are standing around his bed. The surgeons hold the X-ray im-

ages against the neon light of the lamp and confer with each other. - So far nobody has said a word to the patient! We all look at the image of the lower abdomen. The surgeon goes to the patient and touches his abdomen. He also comes to the conclusion that an operation is absolutely necessary, because this is an emergency and luckily, they have free capacity in the Department of Surgery.

*He is lying. We are standing. We are talking - above him, about him. Baba is looking and watching. He is listening. How much will he understand from our conversation? Does he already know that we want to operate him? - I think he is still smiling. We did not even introduce ourselves.*

The surgeon approaches the bed of the patient, again places his right hand on the abdomen and explains to the patient that he has to be operated, that there is no other possibility. It is the first time that he directly talks to the patient, to Baba with the acute abdomen. - But the latter shakes his head, slightly at first, then with more emphasis until a whispered 'no' breaks out of his mouth followed by a louder: 'No, no, no'. - At first, the surgeon shows no reaction, then turns round to us to explain that the patient does not want to be operated. The atmosphere becomes increasingly charged with helplessness and indifference. Not every pa-

tient with HIV/AIDS is offered an operation. - We do not understand him. - Did he understand us?

*It is the first time at the hospital that I see a patient who refuses treatment. It is the first time that a patient says 'No'.*

One doctor of the Internal Medicine talks to the patient in a loud voice: "Baba, if we do not operate you, you will be dead tomorrow. Not every patient with AIDS is offered an operation. You don't even know how lucky you are." But our Baba only replies: No pressure, no harassment! - It still sounds like his 'no, no, no'. For the two surgeons the situation is clear: The operation has been offered, but the patient refused it. He had his chance of an operation, but he did not take it. They voice their irritation once again and repeat that the patient will not survive the following days. The examination is recorded in his file. Baba had his chance. For the other doctors it is all over: The refusal is also recorded in the medical report. New patients, other patients will come.

*I am standing here, I understand the doctors, and there are so many patients. I understand the patient, nobody has talked to him. But I do not understand this situation. - I have seen a lot of patients suffering and dying, laughing and*

*wheeping. The formula seems to be 'Babas per time', the more rapid the better. Young doctors who start with lots of enthusiasm, but get quickly frustrated by reality and even end up not telling stories about patients, but stories about figures. I do not understand that the patient has not even been properly informed. There were four doctors and only one patient.*

He is lying on his bed with the blanket pulled over his head. He wants to sleep. - As the other doctors disappeared to go on with their work and I have some time to spare, I return to his bed to talk to him about the operation. He is not sleeping, but only dozing since he has so much pain. I call him Baba. He turns around. There it is again, this gratitude. I take the X-ray images to explain them to him. I repeat and affirm the words of the doctors as if time would change them. I explain to him why his pains have increased. It is an inflammation. I explain to him that he might die from this inflammation. But he repeats that he does not want to be pressurized, does not want to be harrassed. - This time I don't turn away from him, but ask why he feels so pressurized and why he is so scared.

I think he has understood me. His only reaction is: No harassment, no pressure, no operation. The X-ray images still

in my hand I explain to him that nobody wants to pressurize him, but that he is going to die if he is not operated. He turns away. On his report I had read his name: Abel. The name of this Baba is Abel!

In South Africa people speak eleven different languages. It's true that English is the official language but also only one of many languages. A male nurse who is near us starts to speak Zulu to the patient. - Now the words no longer come so hesitantly as before in English, the patient speaks more rapidly and more at ease! He tells us that years ago he had an operation at his head from which it took him very long to recover. He wants to see his mother before an operation, she has to be involved in the decision. - Not after the operation, but before. The male nurse speaks to him insistently, but with little empathy. I raise the X-ray images once again to explain the origin of the pains. The male nurse translates. The patient understands what we tell him. But he still only shakes his head, because he does not want to be operated. - His mother has got no telephone, we cannot call her.

*Abel is not able to make a decision. First, his mother is not here and then nobody has informed him properly. In this situation he is overcome above all by one feeling: Fear. And with this fear he is alone. Eleven languages and no access!*

A nurse approaches me and tells me we have no right to urge the patient to take a decision. He has the choice and he refuses. Patients are to do what the doctor says. If patients do not follow the advice of their doctor, they are to leave the hospital, because otherwise they fill up valuable bed capacity. Talking any longer to this patient would be a mere waste of time. - With these words she goes to the bed of the patient and scolds him: How ingrateful he was! He was occupying a bed in the hospital. If he did not follow the advice of the doctor, he should go home! - The patient slowly turns his head to the other side. He does not want to listen. He does not want to go home either.

Meanwhile the doctors have prepared the discharge form for the patient in which he applies for his discharge. He is to be dismissed since he refuses treatment. He signs the papers. The doctor from the Internal Medicine is only shaking his head. It is his experience that too many patients have too much fear of an operation. Another doctor curses the patient and the workload, because today is a strenuous day.

*One can feel their anger and aggression. His fear and anxiety, too. His fear is their anger. Their aggression is his anxiety.*

For Abel treatment is finished now. He is to be sent home. He has no right anymore. Once more, I go to the doctors and talk to them about my impression. He is going to opt for the operation, as with the time his pains will increase more and more. - I have a strategy in mind, the strategy to act as a mediator to bring both sides together.

*The situation seems senseless and messed up. Senseless, because Abel's pains are steadily increasing, but a solution would be possible. Messed up, because Abel has been dismissed and formally is no longer a patient.*

Again I approach the patient's bed to talk to him. His pains have become worse. I repeat what I said before, but this time I promise to accompany him to the Surgery Department. We communicate using our hands and the help of the nurses. He understands. And I understand, too. He gives his consent.

*All of a sudden, for me the feeling of helplessness vanishes, the situation seems no longer hopeless and messed up. I feel that his operation makes sense. It means stopping passivity and trying to save a life. I'm glad that Abel has given his consent for the operation.*

I inform the other physicians about Abel's decision and go to the Surgery Department. However, they have no capacity left. The surgery rooms are already occupied or reserved and the surgeons have no time or even look for assistance. They put him on a waiting list.

At night, I see him again. He is sleeping on a stretcher in the hall of the Admission. His medical report is lying on his belly. Some of the neon lights are switched off. He is lying in the hall because he is no longer a patient of the Internal, but has been assigned to the Surgery Department. Probably, he will be transferred only in the morning. The waiting patient is now in a transfer zone: Between Internal and Surgery, waiting for free capacity in the surgery room. When he wakes up, we shortly talk to each other. - I explain to him that he will be operated as soon as possible. Unfortunately, I am not able to tell him when this will happen. - I had promised him to go with him to the surgery room. I had promised to accompany him. Again there is this glimmer of gratitude in his eyes, but now anxiety seems to prevail.

*I remember my promise. I'm afraid I will not be able to keep it, since nobody knows when Abel will be operated. I look at him as he is lying there and I don't know what else I*



*can do. It's a strange situation, because Abel's chance of an operation is my hope against this helplessness.*

Abel undergoes operation the next morning. They find tuberculosis in the peritoneum and several perforations. Now we know the reason for the acute abdomen, but there is not much we can do for him. He is transferred to the surgery ward. There, his consciousness becomes increasingly clouded. He doesn't regain consciousness; he doesn't see his mother again. Four days after I last saw him he dies.

I was able to listen and show more understanding to the sick patient than others, because as a student I had the possibility and time to do it. This is the only reason. Nothing else. I had no obligation to admit twenty to thirty other patients.

If health and disease are so close in hospitals, at the Bara there are also different languages, cultures, worries, rationing and different skin colours. The word 'fate' feels different here than in Europe! Opposites collide and it's in this area of tension that Bara becomes an even more unreal place. For me, Abel made the difference in the face of indifference; he made the difference in the face of helplessness. But I know I could not hold my promise. I could not help him. I

only think 'Oh, Africa!' thus putting a great distance between me and all the Abels, Mamas and Babas of this world.

## Another View

Van den Heever:

*"Say the word "Baragwanath" today and most South Africans will immediately see pictures of broken bodies, oceans of blood and, above all, overcrowding.*

[...]

*Of course these pictures do conjure up something of the truth. This is the imprint that abides but is by no means the total 'Baragwanath'. Day by day thousands of people pass through the hospital, some to receive trainings here, some a visitors, some to serve here but the majority as patients. Baragwanath has become a reflection of the South African condition, with its diversity of peoples, languages, cultures, expectations and fears. It is people that makes "Bara" great."<sup>1</sup>*

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<sup>1</sup> Van den Heever, C: The History of Baragwanath Hospital. In: Huddle, K / Dubb, A: Baragwanath Hospital. 50 Years. A Medical Miscellany. Bertsham 1994: 5.

Blumsohn:

*"How many of us, who have treated the poor and the sick, have seen – seen and not just looked at the contents of a kitroom in a Black hospital? – at the pathetic tattered clothing and meagre possessions of our patients, - a picture which itself tells a story.*

*Have we noticed, or been aware of, the humiliation the poor patient undergoes when he cannot produce even the pitifully small hospital fee? Can we really conceive or understand this public humiliation, - this loss of dignity?*

[...]

*How many of us can even begin to identify with the human wrecks we have all seen – human wrecks, on the scrapheap – the forgotten people, forgotten, bypassed by all? Can we begin to appreciate the hopelessness of people at their helplessness and dependence on others? Do we care?*

*We are all fine scientists with considerable knowledge and wisdom, we are all sound teachers, even good clinicians. Are we good doctors?"?"<sup>2</sup>*

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<sup>2</sup> Blumsohn, D: The History of Baragwanath Hospital. In: Huddle, K / Dubb, A: Baragwanath Hospital. 50 Years. A Medical Miscellany. Bertsham 1994: 7. quoted from: Blumsohn, D: The pathology of poverty. The Leech 1980: 50(1).

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20<sup>th</sup> of October 2003 to  
8<sup>th</sup> of February 2004  
Nov. 2004

Frankfurt, den 11/11/2005

A handwritten signature in black ink that reads "Axel Telzerow". The signature is written in a cursive style with a long horizontal stroke above the name.

*I would like to express my gratitude to Mrs. Kessner for translation, and to Prof. Blumsohn who had been such an inspiration for both my clinical work as my daily life.*

**Reasons** [1] I wanted to reflect my time in Africa: The placement seems like a dream! Culture, accumulation of diseases, educational background, and a lot of other things are too different, that a successful integration could take place. [2] It is a wish to show differences between Africa and Europe: Not only is the input of resource different, but also the goals themselves. [3] There is no criticism about the medical stuff in Africa. The workload is enormous. The patients' prognosis inauspicious. This report is dedicated to them.

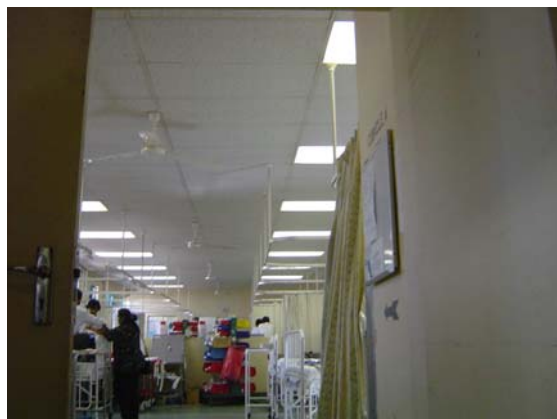
What is, if  
the question itself includes the answer?

What is, if  
divine silence concludes the divine approval?

What is, if  
the act of questioning releases ourselves?

Ricardo Molina

Admission Ward



[www.chrishanibaragwanathhospital.co.za](http://www.chrishanibaragwanathhospital.co.za)