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## Collaterals

IN A SUNLIT WARD OF SUNKEN BODIES, THE YOUNG UGANDAN woman's full, round face hinted at health. As the white coats marched toward her bed, she passed her nursing infant to her mother and fastened the large button at her shoulder in one fluid motion. She had recently arrived at Mulago Hospital, the large public hospital in Kampala, Uganda, complaining of difficulty breathing, unable even to hang a load of laundry. I too had just arrived at Mulago, but from the United States, and had joined my first resident report. When the Ugandan physician paused in his English discourse on superior vena cava (SVC) syndrome to address the young woman briefly in Luganda, she smiled with her lips tight and held out her arms for inspection.

As a group looming over the bed, we assessed the pertinent findings: no swelling in the legs, no wheeze or crackles in the lungs, no thrush in the mouth. Her thin lower body contrasted with the pillowy edema of her face, neck, and arms. We traced the map of engorged veins on her chest and neck, milking the vessels to see which way they filled. The Ugandan residents quietly showcased their anatomical fluency, mentioning the azygous, internal mammary, lateral thoracic, paraspinal, and esophageal veins. With the SVC largely blocked, these collateral veins had already created a crucial backup system, opening alternate paths back to the heart.

We talked pathophysiology, running through a list of possible culprits, from bronchogenic to thrombotic. The initial hope, always, was that this could be extrinsic compression from tuberculosis, because TB would mean treatment and possible cure. But her initial studies had come back negative for TB, and other infectious possibilities seemed unlikely (she did not have HIV). We crowded around her chest film at the one working light-box, studying the shadow of her massively enlarged mediastinum, discussing approaches to biopsy, even reviewing which potential neoplasms would be more responsive to radiation or whether steroids might be indicated. I was impressed by the high level of discussion among the residents and curious to see how this woman's treatment course would evolve, and how closely it would compare with what she might have received in the United States.

Many Americans working in hospitals outside the United States speak unthinkingly in these comparisons. Mulago Hospital is always contrasted with a US hospital that seems increasingly utopian with each missing blood test, unavailable antibiotic, and dying patient. Visiting physicians underscore the "otherness" of the non-US system, partly to

process experiences, partly to reassure that ineffectual failings at disease can be blamed, at least in part, on the resources at hand. It is a hollow reassurance, but a common source of comfort. There is an unspoken assumption in the United States that US physicians go "to help Uganda." But young US-trained physicians are less proficient at bedside procedures and physical examination skills than Uganda-trained physicians and are less accustomed to working with minimal supervision. In general, US physicians don't speak the language, have little first-hand knowledge of major tropical diseases, and often spend a lot of emotional energy getting through each day. We want to be of use, we want to learn, we want to treat this woman with SVC syndrome and the wards full of patients even sicker than she is, but we are not adept at making things happen in a system that is opaque to outsiders.

Visiting physicians' comments on daily rounds highlight systemic differences. Comparisons are made in deference: "In the United States, we just don't see malaria, so please teach me what to look for first in cerebral malaria." In frustration: "At my hospital back home, this surgery would have happened two weeks ago." In relief: "Thank God I don't have to admit this many patients at home." In wonder: "I can actually feel his aorta. Patients here are so much thinner than patients in the United States." In anger: "I just watched a 38-year-old man die in front of me who would have walked out of a US hospital." Mulago is portrayed as a collateral system, rising out of a fundamental need and working hard to meet demand but overwhelmed by the surges of patients and fundamentally not always up to the task.

I fear that this constant refrain, this distancing, makes us at times insufferable to our Ugandan colleagues. "I am not you," these phrases remind everyone, over and over. "These problems are yours. I only visit them." The temptation is for everyone to throw up their hands, laugh the continent catchphrase "T.I.A.—This Is Africa," and promise each other to meet back in the States. Even when the Ugandan interns ask eagerly for review tips on US board examinations and jokingly compare our lives with those of the physicians they see on *Grey's Anatomy*, the distance widens. Together, we emphasize differences in experience and opportunity and imagine the health facilities of the United States as gleaming centers of infallibility, wide-open veins bringing streams of patients back to health.

In so doing, the resourcefulness that is as much a part of Mulago as hopelessness is downplayed. In the relative ab-

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A Piece of My Mind Section Editor: Roxanne K. Young, Associate Senior Editor.

sence of nurses, family members come to live in the hospital and care for their relatives, often creating an informal network of assistance for those without family. Patients arrive by ambulance, but also by wheelbarrow. Physicians relabel and reuse blood tubes, perform bedside lymph node biopsies at no charge, and make transfusion decisions based on conjunctival pallor if the family cannot afford to pay for a complete blood cell count. An echocardiogram probe is lovingly duct-taped; ECG suction cups are cleaned and reused. Women in scrubs don knee-high boots and calmly squeegee water toward the drains when it rains through the latticework walls. This is not to romanticize the experience of being a patient or a clinician at Mulago, just to highlight the adaptability and politeness inherent in a system where collateral solutions are needed daily.

Often, it is not enough. In the weeks that followed, I returned to this young woman's bedside and practiced more of the Luganda I had learned. Her husband and mother slept on woven mats flanking her cot, cooking, washing laundry, soothing the 4-month-old infant sharing her bed. I asked my language instructor how to say "You have a beautiful baby" and "What is his name?" to be able to greet the child, which always brought smiles from the adults. We piled blankets at the head of his mother's cot and tried diuretics. Oxygen could have eased her symptoms, but with one large green tank available, the six attached nasal cannulas went to those with more acute needs. She was treated against hope for tuberculosis, without improvement.

Eventually the CT results came back on x-ray film, 16 virtual slices through her chest confirming a tumor. She needed radiation, or chemotherapy, or a stent placed by a vascular surgeon, none of which was accessible. Even if the family had been wealthy, the main cancer center at Mulago was in danger of closing. As the weeks slipped by, the child learned to sit unassisted, clapping his hands and looking around the open ward, but his mother did not start treatment. Slowly, I came to understand how theoretical most of that high-level diagnosis and treatment discussion with the residents on that first day had been. The whole report had been a fairy tale of possibilities, far removed from reality because of economic and geographic circumstances.

Day after day, this woman and her family led their lives in the hospital, with no clear plans for treatment. "Do you ever ask the patients or families if they have questions?" I asked one of the Ugandan residents one night. We had just triaged a woman who presented with a massive stroke to the emergency department, neither of us

quite meeting the pleading eyes of her husband. "No, it takes too long," she replied. "They will ask too many questions we don't have the answers to. They all want to know if they're going to be fine." The answer hung between us, unspoken but obvious with one glance around the crowded room: *No, despite your collective relative youth, we hear your impressive cardiac murmur, feel your distended abdomen, look into your eyes that do not see. We smell your infected leg, give morphine for your crushing chest pain, shake our heads at your CD4 count. These signs mean that you, and you, and the long line of you's stretching down the corridor are, for the most part, never going to be fine again. And you, with the swollen face and the nursing baby, in the end you aren't going to be fine either.*

Even if I had wanted to answer this woman's unasked questions, I could not have begun to explain in Luganda the rushing of blood, the adaptation of collaterals that goes only so far before being overwhelmed, the pathophysiology that made her face round like the child's even while it robbed her of air. Even if I had stolen a few minutes of an overworked nurse's time to translate, I had nothing to say. I could not say, "You have this swelling, probably from some kind of tumor, and your doctors are doing everything they know how to do to help you," because it would have been a lie. Her highly educated physicians knew what she needed but could provide none of it. I could not say, "You will die, likely without receiving any treatment, simply because I am talking to you in Kampala and not New Haven," because it would have been the truth but would have served no purpose.

And so, six weeks later, I said the next best thing, the collateral statement when there are no answers to the real questions. She and her family greeted me warmly, as always, and we exchanged the now-familiar Luganda greetings. I explained with a touch of guilt that I was returning to the United States. We never mentioned the disease that will probably kill her quickly without treatment. "Bera belungi," I said quietly, "be well." As always, she clasped my hand, smiled, and said, "Weebale, Musawo"—"Thank you, Doctor." I smiled back and simply said once more, in Luganda, "You have a beautiful baby."

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