Lessons Learned in Patient Care During a Semester Circumnavigating the Globe

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When I was a little girl growing up in East London – a small coastal city in South Africa’s Eastern Province – long before I ever dreamed of becoming a doctor, I dreamed of traveling “over the seas”. I like to think that I suspected back then that traveling would teach me far more than learning my A-B-Cs (and later the Krebs cycle) ever could.

Since medical school typically does not lend itself to a great deal of traveling, I jumped at the opportunity to complete a Semester at Sea (SAS) as a fifth year medical student at the University of Stellenbosch. SAS is essentially a floating university onboard the MV Explorer, a passenger ship of the Institute for Shipboard Education, which sails around the world and teaches classes at the same time.

In my case, SAS was to take the shape of a Public Health elective. Direct clinical experience would be in short supply due to licensing regulations in various countries. As expected, my knowledge and skills in applying principles of public health did indeed skyrocket – but to my surprise, I learned just as much about patient care during four months of circumnavigating the globe.

From the Japanese, I learned humility. As a former karate-ka, the ojigi, or bow of greeting, was not new to me; however, using it as part of everyday interaction certainly was. I saw old grandfathers bowing in answered greeting to their grandchildren; this two-way show of respect and humility was perhaps one of the most beautiful interactions I have seen.

Ojigi seemed a natural greeting that the body easily adapted to, and to our mirth, many students onboard the MV Explorer still absent-mindedly bowed to one another in greeting several days after departing from Japan.

It is so easy for those in healthcare to get carried away by the importance of saving lives; I felt that this greeting reminded me to give a person’s hu-
manity due consideration. Although I cannot transfer this greeting to the South African context – I would probably frighten my patients – I was reminded that in the same way, the physician’s service to the patient’s dignity begins long before the examination commences.

**Much of Asia is of Buddhist persuasion, and an important lesson I learned in these countries was never to touch a person’s head.** In Buddhism, this is taboo, as the head is the literal and figurative highest part of the body.

Thus, I had to change my approach to interacting with children. No more ruffling of hair or patting on the head. (Who really likes having their hair ruffled, anyway?) This was the beginning of learning to interact with children on their own level – one class that is certainly not taught in medical school.

**Singapore echoed the reminder not to disregard nature’s remedies.** In South Africa, physicians have a contentious relationship with traditional healers. This is not entirely without reason, as many herbal decoctions prescribed by these healers can cause anything from enzyme induction to severe poisoning, none of which is desirable in a population with high rates of immune suppression and malnourishment.

Unfortunately, this situation has led to a tendency to label all natural remedies as “unscientific and therefore useless.”

While visiting Singapore’s Botanic Gardens, I located the Healing Garden – a massive section dedicated to the medicinal plants of the world. The array of plants was incredible, from plants that could reportedly soothe menstrual cramps to others that claimed to relieve angina.

While I believe that medical control regulations and evidence-based medicine prohibit physicians from prescribing anything that has not been researched and declared efficacious for its exact purpose, the Healing Garden left me with a single thought: Centuries ago, man noticed the antipyretic, analgesic, and anti-inflammatory properties of the willow tree’s bark.¹ Today we call it salicylic acid. The scientific method exists to help us assess that which is at our dispensation – not as an excuse to eliminate it.

**In Vietnam I learned that patient advocacy extends beyond national boundaries.** Here, I floated on the Mekong Delta in a rusty old boat, watching the ramshackle houses on the banks. At these houses, I met the families whose lives revolved around this filthy river that I could not touch for fear of the mi
crobes it harbored. They bathed in it, washed their clothing in it, and drank from it. The water was as often their livelihood as their demise. A child’s first bout of gastroenteritis was seen as little more than a rite of passage, and doctors were unaffordable.

At a Vietnamese orphanage for abandoned disabled children, I met children with some of the worst flexion contractures I have seen, while other rooms were filled with babies suffering from untreated hydrocephalus. If a medical student ever wanted to see the sunset sign, this was the place. I thought of the relatively simple surgery to insert a ventriculoperitoneal shunt, but I was told by the staff at the orphanage that a doctor only periodically attended to scrapes and bruises. All this was happening while a large private hospital was situated no further than a ten minute drive from there.

This was the first time that I realized that my own country, where we lament bad healthcare and florid corruption, could be seen as privileged. No child here has to die from hydrocephalus. That day I realized that the people for whom I advocate are more than the people of South Africa, more even than the people of Africa. As I walked out of the orphanage, all I could think of was how to fix this – this country I had never before seen nor felt particularly drawn towards.

In the global village, the disenfranchised of Vietnam – and of any other country – are our compatriots, too.

**Having grown up in the Eastern Province of South Africa,** I was taught to use two hands when items were exchanged between myself and an isiXhosa individual. I had always viewed this as a “nice” custom, but not one that belonged to me.

As we started traveling towards Africa, however, I noticed that the custom was shared by various cultures around us. The more I practiced it in Mauritius and Ghana, the more I grew to like it.

Consider the scenario: a patient walks into a consultation room, their file in hand. The doctor reaches out with one hand while still writing a note on his desk with the other. At the end of the consultation he walks the patient to the door, hands the patient her file and simultaneously greets the next in line, for his is a busy clinic.

Now consider a scenario where the doctor consciously takes the file and later also hands it back with both hands. The gesture forces the doctor to stop whatever he is doing, take cognizance of the person in front of him, and dedicate those seconds to the person alone – very similar to the *ojigi.*

**Traveling taught me the value of talking about food.** To travel means that you are dependent on interaction with others, lest you leave the country having gained no social enrichment. It is unlikely, however, to learn what you really want to learn by cutting to the chase.

In *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* by Anne Fadiman, the Hmong lament the intrusiveness of the Western physician’s questions compared to their traditional healers, the *txiv neeb,* who are more con-
cerned with the daily life of their clients. Fadiman writes that, according to the Hmong, “You can miss a lot by sticking to the point.”

Medicine teaches us to get to the point. Consultation time is limited, so we expect that a patient must understand that our second question after “How are you?” may well be “Are you sexually active?”

![Dried fish sold at an open market in Port Louis, Mauritius](image)

But I learned that talking about seemingly inconsequential matters could assist an individual in opening up to more intimate questioning. Not only is sustenance one of the things we have in common – whether it be the delicate sushi in Japan, phở in Vietnam, or dried fish sold in the open markets of Mauritius – it is a comfortable topic despite the oft-accompanying connotations of hunger. Ask a patient in South Africa what they eat on their porridge in the mornings, and you will get an idea of their income. The very poor will eat it plainly, while the more comfortable individual can add mounds of butter and brown sugar to their morning meal.

I discovered that people were wary of discussing matters pertaining to their health if we had not first had a “normal” conversation. In any case, what use was it to me to know that yes, a certain family frequented an alternative healer, when I did not understand their livelihoods? I learned so much about countries by talking about the “mundane”.

**Traveling showed me the value of speaking someone’s language.** Before stopping in a country, the entire ship could be heard practicing and mispronouncing the new languages we would soon encounter. "Hello" and "thank you" were practiced as well as "Happy New Year" in Vietnam during the Tết holiday.

The faces of locals brightened when we stumbled over these phrases to communicate with them. Why? Our clumsy tongues did little to make an exchange of words easier, but the effort we made to speak their language showed that we recognized them as a valuable entity.

I have grown up in a country with eleven official languages, where only two are widely used for academic and business purposes. It is easy to fall into the trap of the “international business language” and expect that simply because a patient understands a language they will enjoy its usage.

I want to see my patients’ faces light up in the same way that people around the world did when I danced my clumsy dance though their languages. I want my patients to think, “She may be really terrible at this language, but surely she cares to try.”

From a clinical point of view, I want to be able to get more information from my patients than the basic translations for “pain”, “itch”, and “cough”.

**The Swiss physician Paracelsus described man as a microcosm of our world.** Perhaps he was right in an unintended manner, because in four months and thirteen countries, I gained a confidence in patient interaction that may well have taken many years of experience to hone.
And of course, it is difficult for a class to be as much fun as a day spent discovering a brand new city.

ACKNOWLEDGMENTS

The author would like to acknowledge Professors David Morris and Louise Harmon for invaluable writing advice, and Stellenbosch University Faculty of Medicine and Health Sciences for supporting a semester abroad unprecedented in its nature.

REFERENCES

