# Teachable Moments From the Maasai

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I HAVE BEEN a pediatrician for more than 20 years and love my chosen profession. However, there are times when I feel underappreciated. I spend too much time and energy with parents who refuse vaccines. I think about how families will grade me on their clinic experience and how these data will be publicly available. I feel the pressure of short, rushed visits, with a constant push from my organization to see more and do more. Some days I feel I am working more with the computer than with patients. Last summer, I took a vacation and had an experience that impacted me greatly.

As part of my trip to Tanzania, I volunteered in the Olmoti Clinic, a small rural clinic that serves 6000 Maasai. The Maasai are people from a seminomadic, tribal, polygamy-based community in Eastern Africa. They live in primitive huts made of cow dung and thatched roofs (called bomas) and herd cattle and goats for a living. They are some of the poorest people in Tanzania, earning about $1/day.

The trip was organized by Diane Raleigh, a clinical psychologist I met through friends. Diane served in the Peace Corps in Somalia and Nigeria 50 years ago. At that time, she had founded an orphanage for babies whose mothers had died in childbirth. In 2009, Diane traveled to Tanzania and was inspired by the Maasai people she met there. With the owner of a local tour company and a respected elder midwife, she raised funds to support a Maasai village called Olmoti. By engaging with village leaders, they have changed the health and well-being of the community. They put in a pipeline to bring running water, built a health center, a schoolhouse, and developed a program sponsoring teen girls to attend a boarding high school. As a result, women and girls no longer spend hours walking to gather water. Pregnant women can have safe, healthy deliveries at the clinic. Mothers are now sending their youngest children to school because it no longer involves a long dangerous walk. The boarding high school is forestalling early marriage and childbirth, thus allowing for a different path.

I met with Diane to discuss visiting Tanzania and volunteering in the clinic. Since the clinic is run by medical officers who are locally trained nonphysicians, she was especially interested in having a Western-trained physician evaluate the care and clinic processes. Initially, I was excited to practice medicine in a different country but shortly after, the nerves settled in. What could I really do to help? How would I manage without my computer, access to online resources, and similar colleagues? What would I do if I discovered a rare disorder about which I knew nothing? How would I relate to people who were so different? Despite these hesitations, I knew I had to seize the opportunity, if for no reason other than the intellectual challenge and stimulation it would provide.

When we arrived in Olmoti, we were greeted by the village women, singing, chanting, and taking our hands in a warm embrace as if we were longtime friends. They wore brightly colored garments and ornate beaded jewelry, including earrings that stretched their earlobes and necklaces that they took from their own necks to adorn us. We felt instantly welcome.

Over the 4 days I was there, I saw approximately 100 children in the clinic. I worked side by side with the medical officer, Peter, who spoke basic English, Swahili, and Maa (the language of the Maasai). Typically, the mother would enter the room first with the child, and the father would be a few steps behind. Several times I almost closed the door before realizing the father wanted to come in as well. As in the United States, the mothers seemed to be the primary caretakers for the children and did most of the talking. Unlike my practice in the United States, where my medical assistant asks for the chief complaint, takes the vital signs, and has the patient undress, Peter and I did everything ourselves. Instead of an electronic health record, the clinic staff uses composition booklets for patient documentation. However, the booklets for patients that I treated were mostly blank. When there was a booklet indicating a previous visit, it contained a very brief note that was easy to read. These notes were limited to the key components of the history, physical, diagnosis, and plan. Freed from extensive charting, almost all our time was focused on engaging with patients. Because of the language barrier, I had to rely heavily on my

observation skills—skills that, with the greater emphasis on technology and the electronic health record, I realized I had been using less and less in the United States. In Olmoti, before I heard the history or did the physical exam, I noted how each child walked into the room, his appearance of strength, his breathing, and overall condition. I made the assessment of sick or not sick the moment I laid eyes on the child.

The vast majority of children I saw came in with common pediatric symptoms: coughs, congestion, and diarrhea. Although infections were still common, the cause of their symptoms was sometimes unexpected. The most frequent concern was cough. Most children with cough had no difficulty breathing, no wheezing or rales, no rhinorrhea, and no fever. Unlike children with coughs and normal lung exams in the United States that are usually caused by mild respiratory viruses, the most common source of cough for the Maasai children was different. Many of the children and their parents smelled like smoke. When I asked Peter about this, he told me that no one smoked cigarettes, but everyone cooked over open fires. This chronic indoor smoke was the catalyst for their coughs.

Some children had typical asthma symptoms. The only asthma medications available were oral albuterol liquid, prednisone tablets, and intravenous aminophylline. I was surprised by the lack of any inhaled medications. When I asked the staff about these treatments, they told me they thought oral and intravenous medications were still the standard of care. I realized how difficult it was for clinic staff to stay up to date with current treatment recommendations when relying on decades-old textbooks and no Internet access. This was a chance for me to be helpful. At the very least, the clinic could avoid the unnecessary purchase of aminophylline. This medication is no longer recommended for acute asthma because of its poor efficacy and adverse safety profile. Without inhaled medications for asthma, we used more prednisone than I would in the United States.

After I saw 10 different patients having a cough for 3 days, I asked Peter, "Why always 3 days?" He informed me the Maasai use the expression "the day before yesterday" because they don't use clocks or think about time like we do. In fact, patients never told me how long symptoms were going on until I asked them. At home, I am always thinking about time. My daily clinic schedule has patients every 15 to 20 minutes, and after my medical assistant puts them in an exam room, I have just about 10 minutes to cover a long list of topics, which feels impossible on some days. In addition, I'm also taking care of all the other things that go on in a pediatric practice. In the Olmoti clinic, I had no set schedule and no agenda other than addressing the current issues that each family brought to me. Charting in the composition booklets felt like a breeze. The line stretched far out the door, but people waited calmly, without impatience. Working under these conditions was a pleasure. It reminded me of the reasons I became a pediatrician and taught me to stop worrying so much about time.

Another common concern was eye problems in babies. Mothers described eye pain in their babies yet I didn't see the babies rubbing or touching their eyes, and there was a normal eye exam. I then learned the concerns were that flies would flock to the children's eyes. Previously the community had had a tradition of cutting a circle on both cheeks of babies to draw the flies away from babies' eyes to their bloody cheeks. Fortunately, this practice had been abandoned, although the flies persisted. The only suggestions we had for these children were antibiotic ointment and increasing face washing.

I was surprised by the sheer number of patients who wanted to be seen. Some patients even came from neighboring Kenya because they heard that a Western-trained doctor was in the clinic. The line outside the clinic remained long, and I was unable to see everyone during my short stay. However, I did not feel time pressure like I do in the United States, probably because the families were incredibly patient and calm. There was no way to sort out who had serious or acute illness, who wanted a second opinion about a longer standing issue, and who just wanted their child to be checked. There were plenty of children with old injuries or previous diagnoses where there was nothing new to offer and no change in treatment plan. For most families, I offered reassurance that everything appropriate was being done for their child. Even though I often didn't do or add much, the families seemed to feel better after a visit with me. The experience reinforced the value and power of being a Western doctor, therapeutic listening, and a tactile physical examination.

At the end of each child's exam, parents would thank me, and say a Maasai expression that meant sorry for bothering you. At one point, I apologized to Peter because I realized there would be so many extra patients coming to the clinic on his usual day off. His reply was clear, looking me straight in the eyes and saying "you are a gift from God." This seemed a little excessive, as I really didn't think I had special skills. When I reflect though, it is all about perspective. I work in a large health care system in which I'm one of more than 1000 quality physicians. My clinic has 8 pediatric providers, and each one is top-notch. In that setting, I'm just one of many. For the Maasai, I was a connection to Western medicine, a healer, and a teacher. As the end of my short time in the clinic approached, I realized the feeling of being deeply appreciated by the Maasai was something missing in my practice back home.

During my stay, I was lucky to be able to experience several Maasai celebrations. The first party was held for the chief medical officer's birthday as well as for having been named the "best clinic in the region." The preparations included the slaughter of a goat and huge pots of food cooked over open fires. The clinic elders and staff attended as well as the chief medical officer's family including his 2 grown daughters, Gladness and Happiness. As the visiting doctor, I was treated as a guest of honor. There was great joy in the community, with eating and singing. On the last night, as a grand farewell, I was treated to a special performance with singing and dancing.

As they danced, the women's necklaces jingled adding to the music and festivities.

Now, back in the United States, when I wear the necklace given to me, it will jingle as I move, and I'm reminded of my time with the Maasai. It is amazing how people who have so little can have so much joy in life. I had great fun and learned unexpected things. It was the difference in culture that had the most impact on me. For my office checkups, I'm trying to start each visit by taking some extra time to actually sit with each child. I will read part of a book with the younger ones or talk with the older ones about what they like to do for fun. This human connection to my patients and families has always been important for me, but this added attention has led to greater work satisfaction. The volunteer experience also reminded me of the special power that comes with being a physician. As pediatricians, parents trust us with their children. Even though parents of my patients might not express gratitude at every visit, I've started to notice and appreciate the times that they do. My time with the Olmoti families rekindled my joy in being a pediatrician. In the end, I know I received more than I gave.