# The Path to OPD

**To the editor:** It was a short distance, no more than 50 yards or so, between the front door of our house and the entrance to the Outpatients and Casualty Department. But it was a huge distance psychologically between home and work, between family and the distress of sick patients. In early years it was unpaved, a dirt road that turned to sticky mud in the summer storms, through which we had to pick our way, step by step, through each one of those 50 yards. It was also part of the main entrance to the hospital, so it was a place of greetings and roadside conversations in Zulu, a familiar, shared space.

We traversed this path up and down, there and back, countless times over the 10 years we worked at that rural hospital. It lead us again and again, back to a place of encounter, of learning, of coping with our inadequacies in the face of illness and distress brought about by factors way beyond our control. We mostly walked it, usually blithely, often expectantly, sometimes reluctantly, and occasionally grumpily, especially when there was yet another drunk patient who had interrupted our sleep with trauma wounds from an overindulgence. On that dusty road I felt I sometimes walked like John Wayne, the only defence between me and the unpredictable drama of the casualty being a ballpoint pen slung in my left pocket, to write prescriptions and orders that I hoped the nurses would carry out. We sometimes walked it in apprehension and fear, having been told over the phone what the problem was, and not knowing what to do. Quite often we ran, called by the desperate pleas of a midwife trying to resuscitate a newborn, or cope with an obstetric calamity beyond her abilities.

In the middle of the night from the deepest part of sleep, we might be roused by telephone to come as quickly as possible. There was that moment of anxiety when the phone first rang, worse in the first few years, a fear of the unknown, the possibility of being faced with a situation beyond our capability, mixed with some measure of intrigue. And where a few minutes before I might not have been particularly enthusiastic to do anything further that evening, once the call came, there was no hesitation, no dilemma or question. My sleepy reluctance was swept aside by the prerogative of the patient's distress. On the path between my bed and the outpatients department, I transformed, I changed, from a sleepy companion into the role of the problem-solver, enticed by the possibilities and gripped by the energy of not knowing exactly what was waiting for me at the other end.

The path taught us many things. Back and forth we trudged, again and again, each time learning something new, sometimes just a nuance, or a variation on a well-rehearsed theme. Other times gave us some extraordinary first and only experiences that stick in my memory. For example the chap with the mamba bite who took nine ampoules of antivenom before he sat up suddenly and pulled the tube out of his throat. Or the time I was called in the middle of a stormy night to resuscitate six members of the same family who had been struck by lightning while sleeping in the same hut, and had died on the spot. Or the policeman who had been shot at point-blank range in the throat, and was in the process of exsanguinating until I blindly stuck an endotracheal tube down his throat and inflated the cuff. Most often though, after hours it was for an emergency Caesar, or to give the anaesthetic for a colleague who was operating. In the dead of the night, with just four or five of us sorting out the problem, only we knew the true story: how close the patient had come to dying, the level of our desperation deep in the patient's abdomen at the critical moment of the operation, and how the situation had eventually played itself out. It felt almost conspiratorial, as if we were stuck on a lifeboat with the patient in the middle of a sea of complacency, as everyone else in the world slept the good sleep.

The walk back was usually slower than the walk there. Ambling home after a long afternoon in outpatients, or stumbling home in the middle of the night after a session in the operating theatre, pondering over the operation that we had just performed, knowing that I wouldn't easily get back to sleep, even at 3am. Stepping through the front door, trying to make the transition back to being a father or a partner, while the drama of the patient's situation replayed itself in my mind. Drawing up the defences, shaking off the emotions of the desperate and the dying, I let out a breath and re-entered my family role again, trying to be normal.

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