

Dispatches from Dar

I'D LEFT THE HOSPITAL and was running late for the airport. But I wasn't running. I was sitting in traffic in Dar es Salaam—the wide, deep, unmoving kind of traffic where you go through predictable stages of rage, despair and acceptance, only to have the acceptance disrupted by hope when there's a few metres of progress, wiping the slate clean for the return of rage.

It had been a difficult period in the hospital where I had come to work. The population of Dar has almost doubled in the last decade, to nearly 5 million. Most live in self-built neighbourhoods without access to public water supplies and rely on pit latrines for sanitation. Tanzania has a per capita annual income of around \$600, an average life expectancy of 51, and an overstressed pyramidal health system that feeds patients up to a small number of referral hospitals. There is no pre-hospital system and almost no access to emergency care. Ours was the first Emergency Department in the country, a new addition to a huge national public hospital that was oversubscribed, under-resourced, and simply overrun by needs it couldn't meet. The new ED had radically raised the bar for early resuscitation and stabilization, replacing a barely staffed room where patients waited in metal chairs until they died, or someone from an in-patient service came down and tried to take care of them. We were now seeing a hundred patients a day, triaging within minutes, stabilizing trauma and resuscitating sepsis, and training, training, training. Lives were saved in our little world, probably every day, but the interface with the rest of the system was far from smooth.

We had two ventilators in the ED, so we would insert a breathing tube when we needed to, and when someone seemed like they might survive the experience. But the Intensive Care Unit wouldn't take patients with HIV, so our hands were often tied, and there had been a lot of pushback lately. When we put patients on ventilators, the nurses in the ICU had to call the covering doctors in to help manage the patients. Normally, the nurses pretty much ran the ICU and left the doctors to work their private jobs, but our early resuscitation had increased the need for consultation from the doctors who should have been there anyway. I'd been in the car with our brilliant and flamboyant Tanzanian director when he received a call demanding that we phone the ICU for approval prior to every intubation. We would come to mock this as the pABC algorithm—'p' for phone, and only then the essentials of Airway, Breathing, Circulation . . . I could

hear the voice yelling at the other end of the line. Our director yelled back, gesticulating, as was his style, and let go of the steering wheel completely. The battle had been raging all month, with accusations thrown back and forth, and we'd been told that the ICU doctors were storming in, pulling the tubes and discharging the patients to the wards, where most of them died. I'm the first to condemn the excess of critical-care practice in most wealthy countries, our inability to be sensible, humane and realistic when it comes to death. But most of these were young people with acute infectious or traumatic conditions who needed a couple of days of ventilator support to live thirty more years. So we kept intubating.

The traffic moved a few metres, but only because someone ahead had given up and pulled off the road to take a nap. My taxi was an old Toyota Cressida, and must have been a fully featured luxury model in its day. There was a syncopated click-clack each time we moved forward, as the automatic locks opened and closed, a mechanism probably originally designed to lock the car for safety once in motion. After a particularly loud burst of click-clacks, I looked at the driver. 'Automatic!' he said, which might have meant, 'There's nothing I can do', but the pride in his voice made it sound more like, 'It's a feature, not a bug!' He loved his car. The click-clacks were punctuated by the occasional buzz of a seat belt warning and the dingdong of the open-door signal. Clearly there'd been an electrical short at some point. Or maybe the door was actually open. It hardly mattered at this speed. Click-clack, buzzz, dingdong. Click-clack, buzzz, click-clack, buzzz . . . dingdong. The traffic signals, shiny and well-maintained, cycled uselessly from red to green over the head of a traffic officer, who was the one actually controlling the flow. He worked with a frantic intensity, waving cars through from one side as if the intersection were a closing military border and this their last chance to make it across, even though he had been at it all day. Hard to imagine that he could keep up that intensity in the heat, but every traffic officer in the city seemed to do so. The lights cycled red to green again and again above his head with no relationship to what the traffic was doing. Much had been made of the new signals in the papers—they marked the city as a place moving into the future. They were not without meaning; they just weren't about traffic.

There's a term, *skeuomorph*, for a feature that was once functional and has become decorative. I was taught it twenty years ago with the example of a stitching pattern on a car's moulded vinyl dashboard. Cars originally had leather dashes that *required* stitching to hold the leather on. Once moulded vinyls and plastics were available, the dash could have been a perfectly smooth surface—stitching was no longer a necessary component, but a 'stitch' pattern was often moulded in for decoration. These days *skeuomorph* is more often evoked in the context of computer-user interface—the 'desktop', the way a document crumbles into a trash can when deleted, the folder icons complete with the little tab originally designed to hold a label.

While moulded stitching and desktop imagery evoke an artisanal past, a kind of nostalgia for running fingers across a surface that could not be made smooth, I'd found my world in Dar full of things like the traffic signals—things that weren't quite serving their original purpose, but marked modernity in a rapidly changing city. Click-clack, buzzz . . . dingdong. In that moment, and in that traffic, I wondered if we weren't doing decorative intubations, procedures that would never have a chance to serve their intended function if the patients were prematurely extubated the next day. I wondered if we weren't performing emergency medicine that looked right on the surface, but wasn't the real thing underneath. It wasn't without meaning, but . . .

Then the light turned red, the traffic officer waved us through, and we click-clacked to the airport on time. Our director won the intubation battle and many, many others over the next year before he died unexpectedly at 39. The ICU is under new direction, the ED has seen 100,000 patients, and hospital mortality is down overall. I ended up living in Dar, running the emergency residency programme. The original group of junior doctors became faculty specialists last July, six of eight with permanent government contracts to stay and teach in the department. I saw one of them teach a new recruit to intubate last week. 'I know this guy looks bad', he said, 'but you do this right, and he'll be home to his family in a couple of days.' And he was.