CHAPTER FIVE: 1981-1982 & 1985-1986

THE MIDDLE EAST

By now you've gotten the basic picture of my life: Pediatrician. Works with poor kids in New Jersey. Lives in nearby Pennsylvania. Dashes off every now and again, a little too impulsively, to zones of poverty or war.

Now let me add another piece of the picture. More often than not when I've worked outside the U.S, it's been in the Middle East.

Why the Middle East?

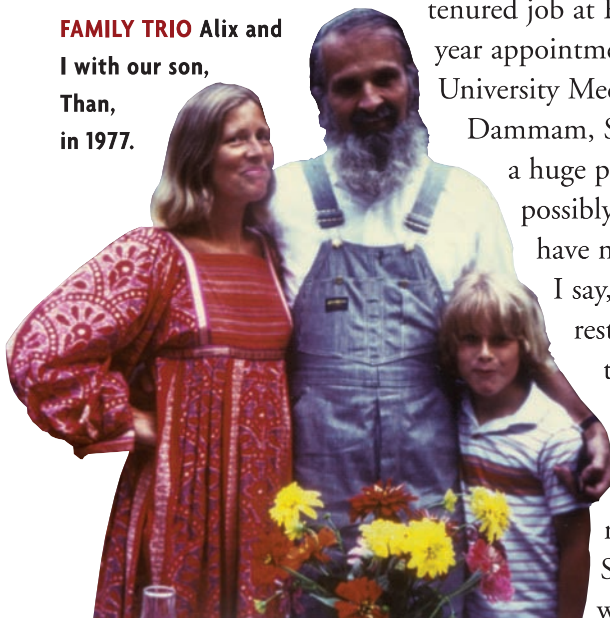
It all started in 1962 with my tour in Turkey as a physician with the Peace Corps. For the most part, I treated young American Peace Corps volunteers rather than local children. It wasn't medically challenging, but I loved being around the idealistic young Americans living on the local economy and helping out at Turkish schools and hospitals. The experience hooked me on the region, and whenever the opportunities arose I went back, or found myself involved with kids from the Middle East. Basically, I liked the peo-

FATHER AND SON **The restrictions on Islamic women meant that more fathers than mothers accompanied their children on hospital visits.**

ple, and liked trying to build bridges to them. Sometimes those cross-cultural bridges were easy to build, and other times they were quite hard.

In 1978 and 1979, while on the faculty at Rutgers Medical School, I took a sabbatical in London to learn how to evaluate handicapped kids. Many of the patients I saw were from the Middle East, as their countries of origin had few treatment facilities then. Returning to Rutgers at the end of the sabbatical, I began to think about specializing in treating handicapped kids. My colleagues on the medical school faculty were tremendously accomplished in fields as specialized as pediatric immunology, pediatric neurology, and pediatric endocrinology. To be a pediatric generalist didn't seem enough. Plus, I felt that restless stirring inside, that old familiar urge to explore the world and try to change it for the better.

In 1981, on short notice, I left my comfortable, congenial, tenured job at Rutgers for a two-year appointment at King Faisal University Medical School in Dammam, Saudi Arabia. It was a huge professional risk, and possibly unwise, though I have never regretted it. As I say, I was personally restless, and life seemed too short to stay at home, even if it meant dragging my family along on my adventures. The Saudi job included working with handi-



FAMILY TRIO **Alix and I with our son, Than, in 1977.**

THE EXPECTED AND THE UNEXPECTED clash on the deserts of Saudi Arabia and its neighbors.

capped kids, which was part of the attraction. Plus, I had always wanted to teach in a foreign medical school, especially in a Third World country.

Granted, Saudi Arabia was hardly a typical Third World country. It had more oil revenues than its government knew how to spend. But it also had the disparities between haves and have-nots that I'd seen before and would see again in Africa, Latin America, and Asia. Life expectancy was shorter in Saudi Arabia than in the West, infant mortality rates were higher, and leprosy and tuberculosis were persistent among the poor. Childhood diseases fatal to undernourished children included whooping cough and measles. So, oil money or not, Saudi Arabia was the right kind of place for me.

The kingdom's health care system was in transition, to put it

mildly. A generation or two before, most Saudis had not known what doctors or nurses were, and they met illness and premature death with fatalistic acceptance. Now, in the early 1980s, with their immense oil fortunes, the Saudis were trying to create a health care system to rival the best in the West. They were building public hospitals in the major cities and special hospitals for the huge royal family and the wealthy elite. They were also building medical schools, such as King Faisal University, in the Eastern Province city of Dammam. No Saudi doctors had graduated from those medical schools yet; and in the meantime, the Saudi government had invited foreigners like me to serve on the faculty. I joined the faculty of the Department of Pediatrics at King Faisal University.

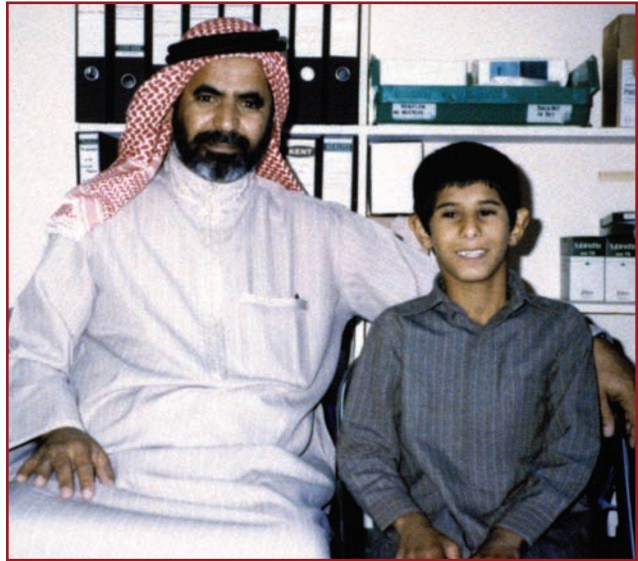
I was relieved to learn that the curriculum was in English.

When Alix and I and our youngest son Nathaniel stepped off the airplane near Dammam the air hit us like a blast furnace. The temperature was well over a hundred and it felt to us as though the humidity was, too.

The oven-like weather added to a bad case of culture shock. In those bewildering first few weeks, I tried to navigate through the bureaucracy of a new university, settle into a new apartment – our three oldest children were all at school or college in the U.S. – and start work in a new teaching hospital where there were staff from all over the world, or so it seemed. English was our common language, but it was a second language for most of my colleagues. In the pediatric department alone, we had nurses from India and the Philippines, and doctors from Egypt, Saudi Arabia, India, the Sudan and Turkey. We could understand each other, most of the time.

Dammam and its neighbors, Al Khobar and Dhahran, form a metropolitan area on the edge of the Arabian Gulf (or what Westerners call the Persian Gulf). From their origins out as coastal

fishing villages, they have grown up to have wide streets, modern buildings, and shopping areas frequented by people of many races and nationalities. Most European goods were available, as well as traditional goods from the Middle and Far East. The local men wore white robes called thobes, topped with a checkered cloth headdress and cinched by a band; and women wore black abayas, which covered them from their ankles to their heads but left their faces visible. The local work week ran from Saturday through Wednesday. Thursdays and Fridays were the Saudi weekend, with Fridays the main day of worship at the mosques.



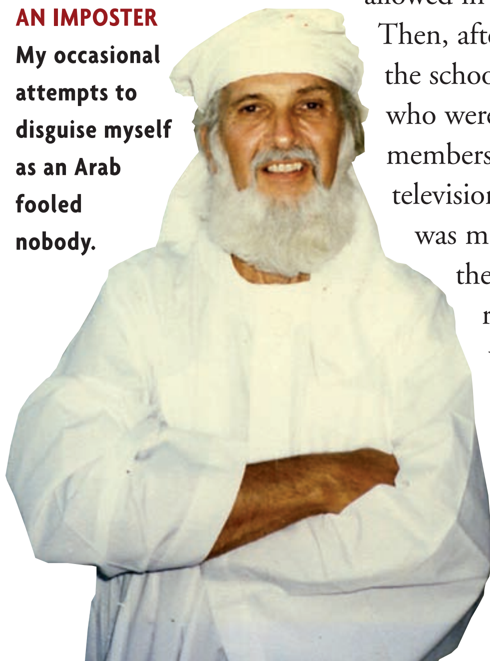
"I HAVE A COUSIN IN AMERICA," this grateful, courtous father told me. "Maybe you know him ..."

The kingdom's brand of Islam restricted women's roles. Women weren't even allowed to drive cars. At first, Alix was upset that she couldn't drive, but after she saw the traffic jams, the careless driving tactics and the accidents she didn't mind as much. Religion affected the male drivers in a different way. We often saw trucks pulled over onto the shoulder of highways, the truck drivers out of their cabs, kneeling in devotion on their small prayer rugs.

Oddly enough, Islam didn't really affect the way I practiced medicine. No Western pediatric medicines or procedures were

banned, and although abortion was outlawed Islam was tolerant of family planning and even of assisted fertility treatments. Every day at the hospital, however, was interrupted five times for prayers. When the muezzin's recorded call to prayer sounded over the public address system, the Islamic doctors would leave their patients, unless they were taking care of an emergency, and return shortly thereafter. The prayers were recited facing Mecca, which was actually west from Dammam. Masses of people knelt in neat rows, bowing down so their foreheads touched the floor.

In the medical school, the classes were segregated by gender. Men and women couldn't be in the same room at the same time. Having to give my lectures twice didn't sit particularly well with a veteran of the Mississippi civil rights movement like me, but I kept my peace. Until a few years before my arrival, women hadn't been allowed in medical school at all. Then, after the King issued a ruling, the schools were opened to women, who were taught by female faculty members, or else by closed circuit television if the faculty member was male. By the time I got there, the King had loosened regulations a bit more and I was able to sit face-to-face with a small group of Saudi women medical students.



AN IMPOSTER
My occasional attempts to disguise myself as an Arab fooled nobody.

They were the first female medical students in the kingdom. Their names were Mariam,

Fatma, Johinah, Hussa, Badriam, Samiha, Hanan and Wafqa. They had been funneled into pediatrics and ob-gyn, to keep them from contact with adult male bodies. I could see their faces, their hands, and their Gucci-clad feet – many of them came from wealthy families. Some of them were in school against the wishes of their parents, and they faced other obstacles, too. While their male colleagues could get training abroad, or sign up for rotations in hospitals in the nearby Persian Gulf country of Bahrain, the women were not allowed to get training outside of Saudi Arabia. At Dammam, they stayed together in a dormitory and they were completely veiled when picked up by bus and transported between the dormitory and the hospital. In the hospital, they were allowed to remove their black abayas and work in their white hospital garb, but they were forbidden to venture outside. They used the long hours of their confinement in the hospital and their dorm to study intensively. That was probably the reason they seemed so bright and well-informed, and superior in knowledge to their male classmates.

I was amazed how well they understood English and how hard they worked. One female student told me that it was taking her too long to read one of the standard pediatric textbooks in English. She had spent from 7 p.m. to midnight plowing through the chapter on asthma! These women students were also especially sensitive to the mothers and children on the ward. They spent extra time with them and helped with the children's dressing and feeding, while the men – as in Western schools – tended to be more hesitant in relating to parents and children.

The Dammam Central Hospital, where I did rounds with the medical students, was where Saudis and foreign workers went if they could not afford private hospitals. The Ministry of Health ran the place, with few first-rate doctors and, from what I could tell, little thought to improving conditions. Inside the hospital's large, rather

primitive building were drab rooms with old iron beds, few nurses, and many patients. On the female wards, most of the mothers were veiled and the children were all sizes and colors. Each room had a hand-made sign showing the kinds of patients who were supposed to be there, but children all kinds of diseases were mixed together, which does not help if the diseases are contagious.

I saw meningitis, pneumonia, osteomyelitis (bone infections), various kinds of blood infections, and some diseases I'd never seen before. At every spare moment, I studied pediatric textbooks, looking up conditions, syndromes and diseases, taking notes and trying to stay ahead of my students and patients. I saw my first case of neonatal tetanus (lockjaw) at this hospital. The infant had been born at home and got an infected umbilical stump, probably from the dirty scissors used to cut the cord. He was as stiff as a board, poor little guy. You could have put his head on one chair, his feet on another, and his legs and trunk would have stayed in the air. I doubt that he survived.

On rounds I saw Omar, a frightened twelve-year old boy with severe rheumatic heart disease, a disease I had rarely seen in the States. He had trouble breathing, his large heart was visibly pounding in his chest, and his lungs were filled with fluid. He started to respond to life-saving measures such as oxygen, i.v. fluids, and heart medicines in doses carefully calculated so as not to make his heart failure worse. It was great to see how quickly Omar recovered, but with the damage to his heart valves, his long-term prognosis was not good.

I saw a two-month old infant whose head was growing much too fast, possibly with hydrocephaly or water on the brain. Right after that I saw another child with a tiny head, or microcephaly, along with severe retardation. She was seven months old, did not smile or roll over, was constantly crying, and had no head control. Her father

UNNECESSARY DAMAGE A vitamin D deficiency gave the boy rickets and bow legs,while the girl was burned with immersion in hot water.

persistently asked if there was an operation that would make her head grow larger. I told her father that she did not have to be in the hospital, that they could care for her better at home. He and his wife were exhausted from the burden of looking after their child.

Then there was Khalid, a young boy admitted in the middle of the night with a very low blood count from an abnormality of his red blood cells that he inherited from his parents. He would have died without the blood transfusion expertly prepared by the lab

CEREBRAL PALSY from a birth injury made this child unable to stand. My recommendation? Teach the parents to administer physiotherapy.

technician, who was from England. The Saudis have no objection to blood transfusions. I, however, was developing strong objections to Saudi inbreeding, which probably was at least a partial cause of Khalid's condition, as well as the conditions of some of the handicapped children I was seeing.

The Saudi practice of marriage between close relatives, especially first cousins, over many generations had a degenerative effect upon the gene pool, and this led to abnormal newborns with problems that nobody could treat. It was also part of the reason behind the large number of Saudi handicapped children that I had first encountered a few years before, in London. The tradition of intermarriage was not something that was ordained in the Koran. It was rather the result of a long-held tradition aimed at keeping wealth within a family or tribe. Also, because of the restrictions on the behavior of men and women, it was hard for strangers to meet in courtship.

What a strange place Saudi Arabia was! And how strange for me, and for others, to spend time in this public hospital! We were the motliest possible bunch, the Moslems on staff emptying outside to pray when the call came, the English-speakers barely able to understand each other's English, the patients burdened with exotic diseases and the genetic misdeeds of their forbears. And almost every conversation ending with the saying, "Inshallah," which

means "God willing." The Saudis truly believe that Allah affects their lives in every way.

Over time, this environment of fatalism began to affect me. A sweet young couple with their infant in their arms came into my clinic one day and told me that they were planning to go on their Haj. The Haj is the pilgrimage to Mecca and Medina that every devout Moslem is supposed to make at least once during his or her lifetime. They asked me to prescribe medicines to keep their baby healthy during this strenuous journey. I talked with them about medications for fever, skin rashes, eye infections, diarrhea and so on. Then it occurred to me that these medications were unnecessary, since the parents firmly believed that Allah would be watching over them. And I told them so.

But they wanted the medicines anyway, just in case, and I gave them to them.

Would you like something to drink?" asked our Australian hosts, at a party in our apartment complex in Al Khobar a few weeks after we arrived. We were pleasantly surprised when we realized the drink we were handed tasted like wine.

In fact, it was homemade wine.

Alcohol is forbidden by law in the kingdom. The penalty for the discovery of possession of alcohol is immediate expulsion, but among western expatriates it was said that the royal family didn't obey the law any more than any one else did.

Initially, I had declared I would never drink as long as I was in the country. But then we learned that many of our expatriate friends made wine and beer secretly in their apartments. My idealism vanished when they offered us recipes, and Alix started making a little wine in a jerry can in the bathtub.

After she made the first batch, I was the first one to reach for

the bottle when I returned home after a frustrating day at the hospital. Because the wine was successful, she branched out and was able to make a couple of liqueurs with a bottle of high octane alcohol, called sediqui, which means "friend" in Arabic. A lot of Westerners drank heavily – partly, I believe, to escape the stresses of living in a radically different culture. We heard of people who were so rowdy in public that they were expelled from the country.

There were several supermarkets in Al Khobar filled with foreign goods, including yeast and fruit juices, the ingredients of homemade wine, and other food like butter and milk – everything but pork, which is forbidden to Moslems. Because we shopped in the afternoon, we often had to leave the store during one of the prayer times. The doors of the supermarket would be locked behind us until prayers were over, then the doors would be unlocked and we'd go back to finish our shopping.

PARTY TIME My Saudi colleagues didnt' object when Alix and I wore Saudi dress. After all, they said, in the West we wear local clothes ...

Alix and I had mixed feelings about living in such a conservative Islamic culture. Being somewhat religious ourselves, we respected the Arabs for being more observant, and more outwardly spiritual, than we were. But there were parts of Islam – or, more precisely, the way they practiced Islam – that we just didn't agree with, especially when it came to tolerance. Centuries ago, Islam

was tolerant of Judaism and Christianity and allowed for the worship of both of these major faiths. That was no longer true. In Saudi Arabia, Christian worship was prohibited for most believers, except on a tiny Aramco Oil Company compound. It was against the law to wear crosses, and the Bible was considered contraband. In the West, Moslems are free to build mosques, but in Saudi Arabia there's no reciprocity.

One of the highlights of our stay in Saudi Arabia was the wedding of one of my male medical students. He was from a small village. His bride was from Bahrain. The wedding was unconventional because it had not been arranged by their families.

Alix and I drove to the wedding together. At the young man's home, we were separated so that I went with the men and Alix went off with the women. After a long meal, I went on a candlelit walk around the village with the groom and his colleagues, complete with the beating of ceremonial drums. Alix was taken to a small room in which the bride, her bridesmaids and a few women from the University were sitting. There they talked and ate from a huge plate of rice and an entire lamb (head and all), the locals eating with their fingers and the Western women using spoons. Alix and the other Western women were taken briefly to look into a room filled with women who were dancing with each other and ululating– lu-lu-lu-lu-lu-lu, a rapid, repetitive trilling with their tongues – in tribal fashion. Then the bride and the women went to the rooftop where scores of other female wedding guests were sitting together.

Leaving his male guests downstairs, the groom came up to the rooftop, the only man present. A woman elder conducted the ceremony. I never saw the bride, nor did any of the other male guests. After the wedding was over, I met Alix by our car and we left, comparing notes on the way home.

My contract allowed me to teach and practice medicine in Saudi Arabia for two years. But I decided to leave after the first year was over.

Some cross-cultural bridges are harder to build than others, as I've said. And my deepest instincts told me it was time to go home, to regroup, and to look for other opportunities at the intersection of pediatrics and poverty.

My impulsive decision to return home had a couple of drawbacks. One was that Alix had adapted to life in Saudi much better than I had. She had a knack for making a cozy nest wherever we went, and when we left Saudi she left some good friendships behind.

The other drawback was that I didn't have a job arranged for my return.

Fortunately, I had good credentials from my Rutgers years, and excellent professional relationships as well. Shortly after returning to the States I went to the New Jersey Department of Youth and Family Services and offered to work for them. Nobody else on the New Jersey medical scene had my kind of background, which included running a multimillion-dollar child abuse prevention project for DYFS while on the Rutgers faculty. I interviewed at DYFS on a Friday, and started work the following Monday.

I've already described my DYFS years in the previous chapter of this book. They were rewarding, and the main focus of my forty-year career. But in working for DYFS, I was never able to totally rid myself of the Middle Eastern bug.

I had unfinished business. I felt I'd set challenges for myself, partially met them but then retreated. And I wasn't going to be totally at peace until I took up those Middle Eastern challenges again.

In 1985, after three years back home, I saw an advertisement for a position running a developmental disabilities program in Qatar, a small country just down the coast from Dammam. I flew

over to investigate. Hamad Hospital, in Qatar's capital city, Doha, was no prize. But there was a highly capable English social worker there, named Fiona. She knew the ropes, understood the culture, spoke the language, and seemed to be on good terms with all the right people. With her help, I felt I could succeed at this challenge. I took a leave of absence from my job at DYFS and took the Qatar position.

But when Alix and I and Nathaniel arrived in Qatar, I found a big problem. Fiona had been fired, as a misguided cost-saving measure.

FREE HEALTH CARE Thanks to oil money, this teaching hospital was modern, well-equipped, and charged no money to its patients.

I didn't know my way through the minefield of Qatar health authorities. I didn't speak more than a few phrases of Arabic. My mission was to help the local handicapped kids – but from the moment I started, my ability to do my job was compromised.

And then there were the kids. Oh my Lord. They were sad cases. Until working with them clinically I hadn't realized how severely brain-damaged and handicapped they were. And the root cause of their handicaps, in many cases, was the same as it had been in Saudi Arabia. They had genetic defects caused by generations of relatives interbreeding. Cruelest of all, their parents, the cause of their defects, never visited them in the hospital.

I used all my professional distancing skills to separate their

hopeless medical conditions from my own internal life, from the optimism and sense of well-being that acts as my source of daily energy. But it wasn't easy.

I wasn't prepared for the feelings that swept over me one morning in November, 1985, when Alix and I were at the swimming pool in our compound.

I began crying.

It surprised me that I started, and then it surprised me even more that I couldn't stop.

It was as though a fire hose had been hooked up to my tear ducts. I couldn't find the spigot to turn it off. Out came a river of tears. I cried convulsively, unable to stop.

Alix walked me back to our villa, guiding me by the elbow. She was shocked and worried. Something inside of me had broken, and we were far from home. Nathaniel, our teenaged son, was confused by what was going on. He had never seen me in such distress.

The next day my boss, the chief in the Department of Pediatrics in Hammad Hospital kindly arranged for me to be seen by an Egyptian psychiatrist.

Dr. Shalkey, the psychiatrist, believed that I had had an acute anxiety reaction. He started me on tricyclic medication, which is part of the accepted regimen for depression. We did not realize that it would take weeks for the medicine to start taking effect. In my case, there was no effect for four months. We struggled through this difficult time while I tried to do my work with the handicapped children. Dr. Shalkey left and another psychiatrist from the Sudan came on the scene, and he too found it difficult to

THE HANDICAPPED CHILDREN OF QATAR The boy with the red headdress had Down syndrome. The rest we couldn't diagnose, because we lacked their familiy histories and the the right diagnostic equipment.

IN HAPPIER TIMES **My pediatric unit colleagues in Qatar. The three in white coats were Egyptian, and those in white robes from Qatar.**

find the right medication to alleviate my daily sense of doom. It was difficult for me to get up every morning and go to work. I spent a lot of time sitting at my desk staring into space.

The three Egyptian pediatric colleagues for whom I was responsible tried to support me, and helped with some of the clinical work on the children's ward. I was deeply worried when one of them mentioned that one of the best treatments for depression is electro-convulsive therapy. I knew that this was indicated for severely depressed patients with a strong suicidal ideation. I was not suicidal. But I was scared of shock treatments. As a young medical student I had worked in a state hospital in Connecticut. One of my jobs there was to assist with the chronically ill patients as they convulsed on their beds after the shock treatment. I still have upsetting mental pictures of the men lining up standing close to the shock table, waiting to be shocked, one by one.

My family and I returned home early in April 1986. My depression worsened and I de-compensated so much that I had to be hospi-

talized in a general hospital. I was so delusional that I thought I had a brain tumor. CAT scans proved me wrong. As my illness worsened my family and my doctors decided that I needed to be admitted to Princeton House, a psychiatric hospital not associated with the university. This was a very difficult experience for them. On my part, I felt tremendous shame for being mentally ill. I did not want to see any of my medical colleagues. Fortunately one of them understood this better than the others, and came to the hospital with chocolate cookies as a present, and left realizing that I wanted to be alone.

During the acute phase of my illness everything seemed utterly hopeless to me. My wife tried to impress upon the psychiatrists my pronounced mood swings, which had been going on for years. She told them about the impulsive decisions I made, dragging the family off to Mississippi, and Saudi Arabia, and Qatar, and some of these other places I'd worked, almost literally at a moment's notice. She loved me deeply but she also recognized that there was something about my highs and lows and my spur-of-the-moment decisions that was outside the boundaries of normal behavior. Finally, in Princeton House, two months after our return from Qatar, one of the psychiatrists, a Dr. Wilson, really listened to Alix and made a new diagnosis.

He said I appeared to have bipolar disorder. In other words, I was manic-depressive, my mood swings controlled by chemicals in my brain. The advertisement I had seen for the job in Qatar had triggered a manic phase of the illness, he said, and a surge of brain chemicals influenced my sudden decision to take the job. The depressive phase, he said, might have been triggered by a combination of internal and external factors.

Internally, Dr. Wilson explained, I'd probably always been predisposed to depressive episodes. Externally, he said, the stress of working in Qatar and the utter hopelessness of the severely handi-

ALIX IN QATAR. My wife kept the family (and me) intact in the Middle East .

capped and abandoned kids there was enough to trigger the acute breakdown by the swimming pool. At least, that was Dr. Wilson's diagnosis – and when I thought back to Mississippi and the milder breakdown I'd had in 1968, I felt he was probably right. In broad outlines, his theory fit the facts.

The doctor started me on lithium. My recovery was dramatic. I have continued taking lithium to the present day. Only once, on a trip to Russia, did I discontinue the medication, and by the time I returned to the U. S. I was quite manic. I promised Alix that I would never do that again. This disease is never very far away from me, but the medication helps to keep it under control.

As soon as I felt better I returned to work at DYFS. My administrative superiors were gracious about having me back, and so were my pediatric colleagues. But I found it hard to shake a sense of shame.

I felt I had failed in Qatar. My mental illness had forced me to return home prematurely. The strange thing about it was that I realized that if I had had a heart attack, cancer, or another major illness it would not have carried the same shame for me as mental illness did.

It was odd, being both a doctor and a patient. In my doctor role, I could have told somebody like me that being manic-depressive was no cause for shame. But as a patient, I was human, and irra-

tional – human enough not to believe what medical doctors said.

At any rate, I recovered, thanks to Alix, my family, good doctors and modern medicine. Before long all was well again, and I was getting recognition for my work as a pediatrician for the poor. Seven years after the Qatar episode, the governor of New Jersey gave me an award for my humanitarian work with children. The following year my alma mater, Haverford College, gave me an honorary doctor of science degree.

I was back on track.

Recently I have wondered what effect being a medical patient and very ill for a period has had on me as a doctor. Has it made me more empathetic? I'd like to say yes – but I don't actually feel a before-and-after difference in empathy levels for my patients.

Instead, more broadly, the disease has helped me understand the tenuousness of my hold, and everybody's hold, on health. It's not something I take for granted any more.

The Qatar episode also made me realize how lucky I am to have Alix in my life. Without her, and without the solid foundation of family life, I might never have recovered. Without her, I probably wouldn't have had the confidence and security to take all those career risks and those global trips in the first place.

Finally, on a practical level, the Qatar episode made one fundamental change in my wanderlust. I still travel. I'll go anywhere in the world to work with kids, if the project is right. But I'll only go for a month at a time.