As the afternoon training session on nutrition began, the assembled group of Nigerian villagers was asked, “How do you know when you’ve eaten well?” One grinning man sprang up and eagerly exclaimed, “You know you’ve eaten well when you really, really sweat!” In fact, I was profusely (and rather embarrassingly) perspiring at the time, having gathered under greenhouse-like conditions in that rural training site after just eating my spicy West African lunch. Perhaps this fellow was teaching me a nutritional concept I had missed out on in medical school!

I have learned a lot about perspiration in West Africa over the last 13 years. As an American family physician interested in medical relief and missionary work, my first experiences were brief trips to help out in any way possible. Of course I sweated from the intense heat of the tropics—but it was the width of the cultural gap and the intensity of the poverty that affected me more. Could people really get by with so little? Could poverty and its accompanying ill health be so widespread?

I also sweated—and worried—about my travel arrangements, about avoiding malaria, about attempting to diagnose and treat diseases I’d never encountered before, and about my own security as I witnessed a military coup. But I noticed that my patients and my African physician colleagues were also sweating—and smiling. Life in West Africa is hard, and yet Nigerians are considered to be among the happiest people on earth. African hospitality is legendary, and I found the humor of my hosts contagious—even when they were joking about my excessive perspiration!

My family chose to move to north central Nigeria, where I would serve in a mission hospital for 7 years as the director of a family medicine residency training program. Now I sweated alongside my family as we struggled with our language learning, our absence from our extended family and the familiar, and our continued cultural adjustment. We continued to sweat about our personal response to poverty, as our neighbors approached us for help in paying for clothes, medicine, and school fees. Actually our African colleagues, as members of the community, faced even greater pressures to assist with poverty reduction at the most local level, as their extended families and communities turned to them for assistance. There was much to be learned as we watched how Africans respond to Africans.

As a clinician, I sweated over the nearly daily experience of loss of life in our pediatric ward from cerebral malaria and diarrheal illness or the ravages of tuberculosis and human immune deficiency virus infection on our adult service. I lamented the lack of laboratory services and the limited range of therapeutic options—and the accompanying lack of certainty in so many clinical situations. My Nigerian physician colleagues struggled at the same time to learn about developments in medicine in the West and explored what could be carried over to their setting. And we all struggled in a system where medical care is generally paid for in cash “up front”—no matter how medically dire the circumstances or how poor the patient.

As an educator, I sweated over making my teaching relevant to this setting and making my lectures understandable as they spilled off my now-foreign tongue. I sweated with worry over whether my Nigerian resident physicians would be able to safely travel to and from their exams over treacherous roads and, once there, would be able to successfully pass in a system that fails many. And of course I wondered whether these future leaders would be able to stay in a country that needed them so desperately, while the lure of work in greener pastures had called so many other professionals away. Again, I saw how my fellow Nigerian residents and attending colleagues worked hard and sweated plenty in their pursuit of clinical and academic excellence. African physicians in training are remarkably resourceful, finding the educational materials and clinical supervision needed during times of uncertainty and scarcity. I witnessed perseverance and resilience like I’d never

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seen before, coupled with an intensity of personal spirituality and community commitment.

The education of family physicians is not new in West Africa, although the number of qualified providers is still small. Although I’ve now returned to medicine in the United States, I recently had the privilege of sweating underneath an academic cap and gown in The Gambia, as I was accepted as a Fellow into the West African College of Physicians. “Embedded” with my family medicine faculty colleagues, there I saw again how hard they are working to establish our specialty in Ghana, Liberia, The Gambia, Sierra Leone, and Nigeria. I saw how remarkably open they are to the hard work of international collaboration, as they struggle through issues such as competency-based curriculum, sufficiency of the family medicine workforce, and the establishment of quality of care standards. In so many ways, we are more alike than different in academic family medicine.

Being a family physician educator means hard work and some sweat in any setting. As a family medicine educator in West Africa, I must say that I have really, really sweated—and that means I have “eaten well.” The personal benefits to me of working internationally have more than replenished my salt and water losses. I am especially proud to see graduates of our residency program in Nigeria choosing to serve in that region as leaders in medicine and in the community. As opportunities for international collaboration continue to expand, I am even more eager to see how we can sweat together, mutually benefiting our patients, our trainees, and ourselves. No, I’m not afraid of sweating a little more in West Africa in the future, for my colleagues there have taught me how to sweat while smiling—and there is plenty of hard work yet to be done and plenty of smiling to do.

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