Family as a cure

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The phrase "ubuntu," which means "I am because we are," was championed by Archbishop Desmond Tutu, as he led South Africa's Truth and Reconciliation Commission in the late 1990s. It contrasts starkly with Western philosopher René Descartes' famous phrase, "I think, therefore I am."

"I am because we are" reflects that identity, happiness and well-being lie in collectiveness rather than individuality. It was this phrase I thought of as I listened to a patient, during my third-year clerkship family medicine rotation.

We sat in a small windowless clinic room, sheltered from the frigid December air. The patient across from me was a refugee from Darfur, Sudan. At the age of 11, civil war separated Abdullah from his family. He then fled to Indonesia and lived there for several years in a large community of Afghan and Somali refugees. At the age of 18, he moved to Canada and was finally able to locate his family through the Red Cross with assistance from the social worker at the intercommunity health centre. He learned that his mother was ill after having had a stroke, one of his brothers had fled to Libya and the remainder of his family was still living in a refugee camp in the Darfur region where instability continues to this day.

"So, what brings you in today, Abdullah?"

Abdullah shared that his mood was extremely low. When I asked why, he looked at the small space of flooring between his shoes, "Because I am separated from my family, I am always sad."

In medical school, we are taught the mnemonic SIGECAPS, when screening for depression. "G" in the acronym stands for feelings of guilt.

"Do you experience any feelings of guilt?" I asked.

"I feel guilty that I am here safe, while they are there. I feel hopeless." He stared fixedly at the poster behind me.

Abdullah shared that for months he had imagined the faces of his loved ones; his distress grew when he heard news of more violence in the region. I ran through the supports usually offered to patients with mental health concerns and asked if he would be interested in talking to the social worker at the clinic.

"I am okay to talk to someone, but I don't want to talk about myself," he said. "I want to find out how I can bring my family here. I need action." For a moment, his eyes met mine.

> **"The thought of reuniting with my family is the only thing that gives me purpose and hope."**

Medication and therapy are important, but often it's structural forces that deeply affect our well-being. What Abdullah needed most was his family brought together again in safety. The Canadian Council for Refugees estimates the average wait time for family reunification in Canada is 39 months. For refugees like Abdullah who come from the African subcontinent, wait times are even longer. There are rigid timelines for applications, costly application fees and narrow definitions of which family members are eligible.

We tried to help Abdullah reunite with his remaining family members. My preceptor and other staff at the clinic wrote letters to the minister of Immigration, Citizenship and Refugees of Canada; clinic staff worked with the Red Cross to locate family members and organized a meeting with his local member of parliament. Five months later, we still don't know if his mother will be accepted into Canada. Given her recent stroke, Abdullah worries that she won't live long enough for the opportunity.

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On a warm June morning, Abdullah cycles to see me again. My preceptor had told him that I was interested in writing about his story, and he had agreed to come in to speak with me. As he walks into the clinic, I am struck by how young he is. I ask about his mother, who he says is "still in Darfur and without the medication she needs." To talk to her, he needs to text someone in her region, who then climbs a tree to get enough of a signal to text someone else; a third person will then relay a message to his mother through word of mouth. The last time he heard from her was a few months ago.

Abdullah says his brother is threatened "from all corners and all areas," and feels so alone he considers returning to Darfur from Libya, despite the threat of violence.

"I just want to affirm how brave you are," I tell him, "for surviving what you have gone through."

"You might think I am brave," he says, "but I just want people who are reading

this to see my desire for fairness." He pauses and continues, "I have gone through wars, I have been homeless, I have had no education, I have faced pressure all the time. All I am asking for is a just life."

The sun streams through the glass windows, its rays illuminating the far corners of the room.

"The thought of reuniting with my family is the only thing that gives me purpose and hope." He looks at the table, where the phone sits connecting us to the Arabic interpreter.

"I want people who read this to ask themselves, 'Does he deserve this pain'?" The room becomes silent.

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In medical school, we are taught to take a history, do a physical, and then formulate an assessment and plan. But what do we do when the best plan involves not solely a prescription or a referral but our advocacy? I think back to the first time I met Abdullah in December. I thought he might benefit from talk therapy and perhaps medication, but what Abdullah really sought was reassurance that I would use my privilege as health care trainee to advocate for his family's safe arrival to Canada. What he may have really needed was for me to witness his full humanity and to be moved to action — not out of charity but from a belief in justice.

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This is a true story. The patient gave written permission for his story to be told.

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