Surabaya story

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The boil

It was the fall of 1975. What started out as a pimple on my right index finger had morphed into a giant boil. The finger throbbed, there were red streaks going up my arm, pus had started to ooze out (I could actually take my pulse just by watching it), and I had a fever. What's more, I was a new arrival in Indonesia and had just taken a long train ride, about 12 hours, from Bandung in West Java to Surabaya in East Java where I was assigned to work with the local medical school. Feeling unwell, I was unable to enjoy the scenery. I arrived in Surabaya late and had to spend a restless and worrisome night in a hotel near the train station.

The next morning I visited my sponsor at the medical school and showed him my finger, which he examined with considerable concern. Just as he was about to comment, one of Indonesia's leading heart surgeons opened the door to say good morning to his colleague. When he saw my finger, he suggested I go to his examination room immediately. Four young men in short white coats stood near the exam table as the surgeon made his preparations. I assumed they were medical students who were going to dutifully watch their esteemed professor lance a boil. I was relieved and confident I was in good hands.

My year in Indonesia as a Henry Luce scholar

On September 21, 1975—a warm cloudy day—13 individuals, ranging in age from their early 20s to 30 and hailing from different parts of the country, met for the first time at the Brookings Institute in Washington, DC. They had various levels of education, experience, and expertise, and their interests were quite different. But, the overarching goal of each was the same—to reap the benefits of spending a year living and working in Asia.

The author in Surabaya, East Java, 1976.

The Luce Scholars Program was organized and supported by the Luce Foundation, which was created in 1936 by Henry R. Luce, the founder of *Fortune* magazine and co-founder of *Time* and *Life*. Born in China, Luce wanted to honor his parents, who were Presbyterian missionaries and educators in China during the early 20th century. The foundation sought to create and support cultural ties between the two countries.

In 1974, it launched the Luce Scholars Program to give promising American scholars-to-be, who might otherwise have no experience of Asia, the opportunity to

Artist's studio and family compound, Ubud, Bali 1976. Balinese artist

live and work there. The program was, in part, an effort to establish a counterpoint to the European-centered Rhodes Scholar Program with the goal of promoting intellectual, scientific, humanitarian, and cultural understanding.

After a series of briefings at the Brookings Institute, the group traveled to San Francisco for a continuation of the introductory meetings at the offices of the Asia Foundation, concluded by a week in Hong Kong at the Chinese University. The participants rapidly bonded; we were bound together by a sense of adventure, and a desire to nurture and learn from each other. We afterwards departed for our various postings in Hong Kong, Indonesia, Japan, Malaysia, Singapore, Taiwan, and the Philippines. To keep in touch and share experiences with each other, one of us, a scholar in Japan, launched a newsletter to circulate among the other scholars throughout our year in Asia. Some fifty-six letters managed to exchange hands, which, as I was reminded when I recently reread them, formed a delightful hodgepodge of typed and written notes full of observations, insights, and personal feelings. They reminded me of a lost world with no internet, cell phones, search engines, social-media sites, GPS navigation, translation apps, or other easy (and affordable) means of communication. The letters reflect personal journeys of self-discovery, of which my journey was no exception.

Surabaya, East Java, Indonesia

I was posted to Surabaya, Java's second largest city and the capital of the province of East Java. Located about 400 miles east of Indonesia's national capital, Jakarta, Surabaya had a population of slightly more than two million in the mid-1970s, and it was far less cosmopolitan, far more isolated, and much less likely to have tourists than cities in West and Central Java.

At that time, Surabaya had severe public health problems. Some of the data I collected during my stay revealed that treated piped water served only 17 percent of the population, while a vendor system served another 27 percent. This left more than one million persons without ready access to treated water. Surabaya had no

municipal sewage system, and much of the 500 tons of refuse that it generated daily was dumped and often burned in open areas. There were, unsurprisingly, high rates of morbidity and mortality in this tropical climate, especially from gastrointestinal disease and mosquito-borne disorders such as malaria and dengue fever.

One advantage to being based in East Java was proximity to the island of Bali, which, at the time, had yet to be fully developed by high-end hotels and resorts. Transportation from Surabaya to Bali was affordable and readily available. There was a *bis malam* (night bus) that left Surabaya in the early evening, stopped around midnight for a rest and snack break, and reached the ferry to Bali around sunrise. After crossing the Bali strait, the bus journeyed several hours to the capital city, Denpasar. Cheap and very suitable accommodations were readily available at Kuta Beach or nearby Legian.

After several visits, my interests turned to the vibrant art scene and, in particular, the growing artist colony in the town of Ubud, located about 20 miles north of Denpasar. I became friendly with a local artist who introduced me not only to Balinese painting techniques, but the important intersection between culture and art. At one of my visits, the artist agreed to paint a picture of his family compound using oil on canvas, which is not the traditional means of Balinese painting. After a couple of months the painting, including a beautiful hand-carved frame, was ready.

Over the subsequent 50 years, I would move the painting thousands of miles to seven different cities. It still hangs as the centerpiece of my home office.

Medical dualism: East meets West

The medical school in Surabaya provided a variety of assignments that exposed me to a wide range of medical and social issues, including practical clinical experiences involving infectious diseases, work with a family planning program, and the opportunity to observe a leper colony on an outer island. One project in a remote village involved developing a means to bring piped water directly into the community, thereby eliminating the need to walk to and carry water from the source several kilometers away. Earlier, when I had suggested that we conduct a survey of the villagers to assess their priorities, they actually placed the piped water supply lower on the list than new shelters for their animals.

I became acutely aware that there were two main sources of medical care as I adjusted to life and work in East Java—Western-style scientific care, and traditional care, or what today is often called alternative medicine. The latter was readily available, quite affordable, and widely used. Services were usually provided by practitioners known as *dukuns,* whose training and experience varied greatly, and whose businesses relied principally on reputation.

I was introduced to Indonesian traditional medicine early on in my stay through a local banker with whom I developed a relationship for the purpose of cashing my monthly stipends. The banker, who was in his mid-to-late 30s, told me that his 10-year-old son suffered from a tropical ulcer. Knowing I was a physician, he asked me if I would recommend a western doctor or *dukun* to treat the boy. Of course, I dutifully recommended a Western physician.

We met again about a month later, and the banker said that because his son's condition had not improved, he planned to visit a traditional practitioner the next day. About two months later, the banker mentioned that his son's tropical ulcer had improved following the regimen which the *dukun* had recommended. It consisted of the purchase of an iguana from a certain local market to be prepared as a soup and satay (skewered meat), then fed to his son twice a day.

This was my first real-world exposure to a traditional medical system of care. Today we are well aware of the prevalence of alternative systems. While the United States is renowned for its scientific medical prowess, the country is experiencing a considerable growth in spending on alternative care modalities that are rapidly expanding their range and influence through the use of social media. Nonetheless, as I observed in Indonesia decades ago, the interactions between the two systems of care, and their collective impact on health and well-being, are poorly understood.

Health-belief models

Over the course of my stay in Surabaya, I gained a better understanding of the role that traditional medicine plays in Indonesian society. I learned how to view health systems as cultural expressions that derive from human reactions to perceived threats to the integrity of individual or group life. On a personal level, I benefited from learning how to understand and appreciate the various modes of socio-cultural interaction.

The medical paradigm that I was exposed to in medical school and residency training largely viewed disease as static and objective, a morbid state to be eliminated.

But the traditional medicine I encountered in Indonesia involved a more dynamic interpretation of disease, one that reflected a dissonance between persons and their lived experiences. This type of paradigm placed a strong emphasis on the ability of individuals to function in their social environments.

These two kinds of health systems—Western-scientific and traditional—do not exist in isolation from each other. They often interact around a single patient or community, and this interaction can cause a dissonance from the vastly different approaches applied to the same illness. At least four areas of conflict emerge when the two systems interact, and, in the absence of reciprocal understanding, respect, and cooperation, the good effects expected from one system can subvert the good effects expected from the other.

One area of conflict involves conceptual differences whereby the meanings of health, disease, and treatment misalign causing confusion and misrepresentation. Structural problems often abound when each system presents alternatives to care for the issue in question, resulting in overlap and redundancy. Since these care systems operate within different cultural and linguistic frameworks, significant communication barriers can arise, leading to misunderstanding and antagonism. In addition, economic considerations impact the competition for patients, and the affordability of the care that is available.

One striking aspect of the health-belief model in Indonesia—and, as I later observed, in other parts of the world—that initially eluded me was the role of suffering as a positive part of medical care. In this model, suffering, in and of itself, is viewed as promoting healing by enhancing the meaning of life and engendering the growth of the individual. Acceptance of suffering can also be construed as having a hygienic function by limiting potential repercussions from the near- and long-term use of pain medications.

Some lessons learned

My experience in Indonesia occurred at a formative time in my career. It greatly enlarged my vision of medicine as both an art and a science. When I returned to the U.S., I pursued a PhD in medical sociology while completing my training in internal medicine. Throughout my various leadership positions and writings, I have remained conscious of the need to broaden the scope of my efforts to encompass various health-belief models, and the social determinants of health. This experience also taught me the importance of managing behavioral change when modifying existing programs or creating new ones. On a personal level, I gained immense appreciation for, and greater understanding of, the importance of cultural sensitivity.

The boil redux

As I was lying on that table in the heart surgeon's exam room, I did not yet understand the health-belief model in Indonesia. When a nurse started to prep the infected area on my finger, I could actually feel pain just from the air movement as she approached the lesion. Visions of the cortical homunculus sped through my mind—that weirdly dysmorphic representation of the relative input of the nerves to the brain from the rest of the body. The area representing fingers is unusually large, indicating how profoundly sensitive fingers are to touch.

Suddenly, I felt four pairs of hands, each pair holding down one of my limbs. The young men dressed in white whom I had assumed were medical students turned out to be orderlies. I saw the flash of a scalpel followed by a scoop-like instrument that removed a surprising amount of pus.

I was in a mild state of shock when the surgeon asked me to turn on my side for some injections—one for the broad-spectrum antibiotic gentamicin, and another for the pain. I managed to ask him in a barely discernable voice, "Why did you wait to give me something for the pain until after the procedure?" The surgeon shrugged and casually replied, "Why didn't you ask?"

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