



Life and Death in the Third World

SUSAN M. VITALIS

*Park Nicollet Clinic
Minneapolis, Minnesota*

WE IN THE UNITED STATES USUALLY THINK ABOUT DEATH ONLY WHEN WE ARE faced with it and cannot ignore it. In many African countries death is a daily reality of life that cannot be ignored. There is no such thing as the denial of death. This is especially true in countries that are at war. When people rise in the morning, they do not know if they will make it through the day alive—without being shot or afflicted with some disease that is untreatable in their country. Even if it is treatable, they may live a three day's walk away from the nearest health facility. The practice of medicine in much of Africa is immensely different than in the United States, and the ethical dilemmas that are encountered are just as different. My comments in this article will reflect my experiences from working in the United States and with Samaritan's Purse¹ in Kenya, Somalia, Sudan, and Rwanda.

I. MEDICINE HERE AND THERE

What is the driving force behind medicine, and how is it different in various parts of the world? The bottom line, one hopes, is good patient care that prolongs life and reduces suffering. But there are other factors that impinge upon the basic goal of providing good health care. When I walk into an exam room to see a patient in Minneapolis I have much more on my mind than simply thinking about how

¹Samaritan's Purse is an interdenominational Christian organization that does relief work throughout the world. World Medical Mission is the medical branch of Samaritan's Purse.

SUSAN M. VITALIS is a family practice physician working in urgent care. She intermittently does short term medical mission work with Samaritan's Purse.

best to care for the patient. What will their insurance pay for, and can the patient afford services above what is covered? What must I do to avoid being sued by this patient? In Africa, on the other hand, my thoughts beyond good patient care are focused simply on what resources are available to help the patient. And if the resources are limited, is it justified to use them on this particular patient?

The expectations of patients and their families are also very different in the two parts of the world. In the United States people expect to live, and assume all will be done to keep them alive for as long as possible. In Africa people expect to die, and are grateful when help is given that allows them to live a little longer.

II. THE NEED FOR MEDICINE

As I reflect on my experiences as a doctor in Africa, I realize that decisions regarding medical care in the midst of life-and-death situations are often centered on the distribution of resources. This is particularly apparent in the treatment of premature births, where treatment shows how life and death are handled at the very beginning of human life. Through the use of high technology in this country, we are able to keep incredibly small babies alive in neonatal intensive care units. But such technology usually is not available in Africa. At Central Hospital Kigali in Rwanda we had nine premature babies sharing six isolettes and one oxygen tank. The temperature was very difficult to regulate in the isolettes, but we did our best with thermometers taped to the inside of each crib. All of these isolettes were packed into a small room that was separated from the rest of the pediatric ward only by a curtain. There was no isolation and no area for hand-washing; people would move directly from caring for the sick children to caring for the premature babies. The result, of course, was a high infant mortality rate.

Neonatal care was even more difficult in Sudan. When we first went into southern Sudan we were amazed at the incredibly high infant mortality rate. The first baby that was born after I arrived was healthy and doing well, even though he weighed only five pounds. During the night, however, the child died. We realized the next day that the traditional birth attendants had no towels to dry the baby after delivery and no blanket to wrap the baby in to keep him warm. Once we were able to provide them with towels and blankets, the infant mortality rate greatly improved. Here we use complex equipment to keep babies alive. There we needed simple blankets to save the lives of babies.

One morning a woman who was seven-months pregnant came to our clinic in Sudan because she had abdominal pain and was bleeding. Her placenta was starting to pull apart from her uterus—a serious problem. In order to save her life we needed to deliver the baby immediately. This was difficult because we had no medicine available to induce labor and we did not have the capability to do surgery. Fortunately, she delivered on her own within an hour, but I was told the baby was dead. Going back to check on her, I found the baby, completely wrapped in a blanket, unattended on a table. The baby was not breathing, but I felt for a pulse and found one! Through stimulation the baby started to breathe and cry and he opened his eyes a few times. I checked on him throughout the day; each time, he

was still alive but not doing well. He needed oxygen, which we did not have. He died around 8:00 P.M. At the time it seemed as though I was the only one interested in keeping this child alive. All of the local people remained detached. As I reflect on that day, I realize that they knew all along that the child would not live, and they had accepted it much earlier than I did. I could not let the child die until everything possible had been done.

Surgical practice is another area where the differences between the United States and Africa are pronounced. In the United States the main area lacking resources is transplant surgery. Who will be the recipients of organ donations? Those with the means or those most in need? In Africa, on the other hand, organ donation is not even an issue. Transplant surgery is simply not done. Even general surgery, taken for granted in our hospitals, is rationed in Africa due to lack of resources. For example, in Kenya a 14-year-old girl was admitted to our hospital with an enlarged heart caused by rheumatic heart disease. This girl's problems started with strep throat that went untreated, causing rheumatic fever that led to rheumatic heart disease, resulting in her need for heart surgery. The required surgery to replace her heart valve was hindered by many obstacles. The cost for the patient to go to Nairobi, the only place heart surgery was done, was prohibitive. Even if she could have gotten there, she may have had to wait for days or even weeks to be seen initially, and then there were no guarantees that the doctors would agree to do the surgery. When I left the country the patient was still in our hospital, her father desperately trying to work out a way to save his daughter's life. In contrast, my four-year-old niece was recently brought to the doctor due to a fever, diagnosed with strep throat, and started on antibiotics, a process that took approximately one hour.

In another instance, a man came in who had been hit in the head with a machete, leaving him with a cut that went through his scalp and skull and into his brain. He needed a neurosurgeon, but I was all he had. I irrigated the wound, stitched it together, put him on antibiotics, observed him for a couple of days, and then sent him home. He did fine. If I had done the same thing in the United States, I would have faced a malpractice suit, but in rural Kenya I was just doing the best I could with the resources available. Such success is not the norm, however. In Sudan we saw a seven-year-old boy who had been gored by a cow. He died because we did not have the necessary medical instruments to perform surgery. Nor did we have anesthesia or an operating room. In fact we did not even have access to a hospital.

Blood products were also in short supply. At Tenwek Hospital in Kenya if someone receives a blood transfusion they cannot leave the hospital until they have recruited donors to replace the same amount of blood plus one extra unit. One day I walked into the operating room to talk to the surgeon and found that the patient undergoing surgery was not doing well. She had had a Cesarean birth that morning and apparently continued to bleed internally. She was taken back to the operating room to look for the source of bleeding. As I was standing in the operating room, someone from the lab came over and said that they only had one

unit of the patient's blood type, O positive, and she was going to need much more than one unit. I simply commented, "I think I am O positive," and I was quickly brought over to the lab to donate a pint. As soon as I could stand without fainting I carried the still warm blood back over to the operating room, and it was immediately given to the patient. The blood was so desperately needed that no testing of it was done prior to giving it to the patient. Later it was discovered that the patient had leukemia. She died a few days after the Cesarean birth, leaving a newborn baby. This is a real tragedy in a country where baby formula is not available.

Medications were always limited. We were constantly rationing medicines and would still sometimes run out of them. In Sudan the United Nations tried to distribute basic medicines on a monthly basis. They did not accomplish that goal, and we always ran out before the next supply arrived. We would try to give the medicine to the sick, but not the "too" sick. We did not have the luxury of indiscriminately providing medicine to the dying. I learned this quickly during my first morning clinic in Sudan, where I saw a two-year-old boy who was very sick with an infection and close to death. We gave him a shot of an antibiotic, but he died within the hour. The question we later faced was whether that antibiotic should have been saved for someone who had a better chance of survival.

Kala azar is an infectious disease that is prevalent in parts of southern Sudan. It is treatable, but the medicine is expensive and frequently not available. We had an eight-year-old boy at our clinic with kala azar, but we did not have the medicine, so he slowly wasted away. We discovered that the United Nations would provide the medicine if the patient had a positive blood test for kala azar. Weeks passed between our sending some of his blood to Nairobi and the return of the test results. He was positive, but he died during the wait. His mother, who had been by his side constantly throughout his illness, seemed lost; she despaired when he died. They were from a different village, so she was alone. Two more patients—a 19-year-old and a three-year-old—came to the clinic shortly thereafter with the same disease. We were now able to get the medicine, but we had to wait until someone could go to Nairobi to collect it. As we were waiting, the three-year-old died. The 19-year-old was barely hanging on. The medicine finally arrived, and we immediately brought it to the clinic and gave the patient his first injection. The medicine had come too late, for when we arrived at the clinic the following day to give him his next injection, we discovered that he had died during the night.

A lack of vaccines was also a problem. There was a meningitis epidemic while I was in Kenya. The vaccine that protects against meningitis was not available in Kenya. We, at one point, received a small amount of vaccine which raised the question: Whom do we vaccinate first? In some cases entire families were dying from the disease. The symptoms came on very quickly, and frequently people did not have time to get to the hospital before they died. In the course of four months we admitted more than 400 people with meningitis. Of these, more than 100 died. That was just the tip of the iceberg, however, since most did not make it to the hospital. The best way to deal with this disease is by prevention, only possible if you have access to the vaccine. A relatively small amount of money could have

saved many lives. The cost of one complex surgical procedure in the United States could possibly have vaccinated all of Africa against meningitis. That may be an exaggeration, but it raises the question of how resources are distributed. Tetanus and rabies also continue to kill people in these underdeveloped countries due to a lack of vaccine. Occasionally, when a patient in the United States complains about getting a tetanus booster because of a laceration, I am reminded of the people I have seen in Africa who have died a terrible death from tetanus, people who would have been very grateful for the opportunity to have a tetanus vaccination.

III. THE NEED FOR FOOD

Medicines and vaccines are a basic need, but even more basic is the need for food. Malnutrition is widespread and many people live day to day, not knowing when they will eat again. In Mogadishu, Somalia, we frequently worked in refugee camps set up within the city. At one camp we saw an eight-year-old boy whose parents had both been killed in the war. He was very malnourished and did not get better even though we gave him milk powder and high-protein biscuits every time we came to his camp, once every two weeks. We later learned that the leaders in the camp were taking his food and giving it to the healthier children. They kept him malnourished so we would continue to give him food. In their minds they apparently justified their actions by calculating that they were keeping many children alive by sacrificing one.

In Sudan people relied on food distributions from the United Nations, but the food did not always come. We ran a feeding center for people who were malnourished, and we could usually keep the bare minimum needed to feed these people. But when the village began to run out of food, the only place food was available was the feeding center. How does one decide who gets the limited amount of food? One day a mother brought her severely malnourished and dehydrated three-year-old girl to the clinic. The child was skin and bones, and the mother seemed very detached from her. The child was curled up in a bassinet much too small for her, and the mother never took her out to hold her. We gave the child fluids. The mother hardly noticed what we were doing for her daughter, however, because she was too busy caring for her other well-nourished seven-month-old child. The mother had given up on the older child a few months previously, but finally brought her to the clinic when she would not die. In areas where food is limited, sometimes an older child becomes neglected when a new baby arrives. The newborn starts getting the breast milk, and the older child goes hungry. After giving this three-year-old girl intravenous fluids, we decided to give the mother 500 milliliters of water to give the child orally over the course of the morning. Once, we caught the mother drinking the water, and by the end of the morning the child still had not been given much. The mother quit bringing her to the clinic, and we found out that the child died a few days later. Initially I was very angry at the mother. I later realized that she was just doing her best to survive in a country where there is not enough food for everyone. In her mind she was saving one child by sacrificing another. If she divided her resources between them they might both have died of

malnutrition. These kinds of decisions are unimaginable for parents in prosperous countries.

As you can see, these are people who deal with death on a daily basis. I think about Beatrice who is a ten-year-old girl whom I met in Kigali, Rwanda. She had been shot through her face, with the bullet entering just below her left eye and exiting through her right cheek. She was left for dead. She watched as her nine brothers and sisters and her parents were all shot at point-blank range. Beatrice is the only one who survived. She is disfigured from the gunshot wound, has difficulty talking and eating due to the injuries, and has no family. She also has to deal with the trauma of having seen her entire family murdered.

Death is always a real presence in these people's lives, forcing them to make decisions that are beyond our worst fears. I think about Elizabeth, a Sudanese woman who became my friend as we worked side by side in Sudan. One day a rival tribe attacked our village. People were running in all directions trying to escape the gunfire and mortars. We eight expatriates were to be evacuated as soon as possible, and when we heard the United Nations plane fly overhead we ran to the airstrip. Elizabeth ran with us, and as we approached the plane she tried to give me her three-year-old daughter to take with me. Tears were streaming down her face, and when I told her that I could not take her daughter, she cried even harder and continued to hold her child out to me as I climbed onto the plane. It broke my heart to be unable to help. She truly loved her child and was willing to be separated from her if it would mean her child's safety. We were able to leave, but they were stuck in the midst of the battle, facing death once again. Two days later the village was burned to the ground.

Every time I travel between the United States and Africa, it is almost as if I am traveling between two different worlds. In one world, a whole health-care community marshals the wealth of its resources to provide medical treatment for an individual in need. In the other world, the health-care needs of an individual are consistently neglected or even denied because the limited resources must be rationed in light of the needs of the larger community.

IV. THE NEED FOR HOPE

The situation in much of Africa seems hopeless, especially if we look only at the physical realm. But I learned from Christians in Africa how to look beyond the tough realities of life and death, to the hope that is found in the resurrection of Jesus Christ. In Sudan we showed a film called *Jesus*. The people's response to the movie was amazing. They all applauded when Jesus walked into the river to be baptized. They sneered at Judas. Many people turned their faces away from the screen and some cried when the nails were pounded into Jesus' hands and feet. And they gave a standing ovation when the resurrected Jesus appeared to the disciples in the upper room. They realized the significance of the resurrection. It gave them hope. These people who face death daily hold fast to the promise of eternal life.

Yes, we want to direct all God's people to the sure and certain promise of

eternal life, even in the midst of death. But the God who promises a better life to come also challenges us to offer a better life for others right now in this world. The ethical questions of life and death for people in third world countries concerns stewardship in our own country. What we do with ourselves, our time, and our possessions is truly a matter of life and death for those who daily find themselves living between life and death.

In the United States, we assume that life is the norm. We assume that medical care will be available to save us. In parts of Africa, where death is the more present reality, a baby is not even named until the parents are sure it will live. In view of this situation, it remains a challenge for us to provide medical and other material resources to our African brothers and sisters to give them hope for a better life. It also remains a challenge for us to provide a greater hope for them through the gospel, offering them a word of eternal life. Yet as much as some of the African nations can benefit from our help, perhaps the greatest challenge for us is to realize how much about life we take for granted. We can learn from them what it means to live and die on the very edge of life.² ⊕

²This article was written in conversation with Mark and Kathryn Vitalis Hoffman, pastors at Hope Lutheran Church, Fargo, North Dakota.