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Out of Africa

I knew that he was going to die. I do not remember when it became evident to me, and I was not sure how to tell the family. I thought that I could arrange a family meeting and inform them of the sad reality in a calm, sympathetic manner. The patient had chronic lymphocytic leukemia, and his case was advanced. The only medication available to him was chlorambucil. As the days passed, I could not bring myself to call the family meeting because they had so much hope. Every day as we got results and I shared them, I would sandwich the bad news with some optimism to ease their pain. "Well, his white blood cell count has come down, but his platelet count and red blood cell counts are very low, and this puts him in danger of bleeding. The medicine is bringing the white cell count down but has not yet brought the other cell counts up. What we can do is give him some blood." I tried not to allow despair to creep into my thoughts or my voice. I knew that the blood bank had no platelets or packed red blood cells. He was not eating or drinking, and we had placed a nasogastric tube through which his family fed him wheat or millet porridge (manufactured tube feeds are not widely available in Uganda). I tried not to think about the time that he had almost died a few weeks before.

I had been called to the bedside because the patient was in respiratory distress. The doctor on call was in his office when I arrived, and I wondered why he was not at the bedside. I took one look at the patient and had to step away for a moment to compose myself. I felt the tears threatening to come, but I had to stop them. This was not the time for emotions. I had to assess the patient and make some quick decisions. The doctor on call seemed to have given up. He was a young trainee in a system in which you treat when you can and, if the situation is hopeless, you move on to the next patient. There are no resources for perpetuating hope. This is so different from my practice in the United States, where if a patient wants everything done, we will do it. We are not taught when to give up hope, and futility does not figure into the allocation of resources. I looked at the patient struggling to breathe and felt that I had to do all that I could for him. I asked the doctor on call to place the patient on oxygen and hoped that the tanks were not empty. I was worried about a lot of things, such as pulmonary embolus, myocardial infarction, and pneumonia. Diagnosing any of these would not be easy (the hospital did not have a computed tomography scanner, and obtaining cardiac enzymes was not as simple as clicking a button on a computer). First things first: the chest X-ray. I thanked God that we were in a private hospital, one of the best in the city of Kampala, so we were able to get a chest X-ray right away.

DOI 10.1002/jhm.447
Published online in Wiley InterScience (www.interscience.wiley.com).

As we transported the patient (portable X-rays are nonexistent), the resident told me that he had called the consultant (the equivalent of an attending physician in the United States), who happened to be out of town. The consultant instructed us to transfer the patient to Mulago Hospital (the largest tertiary center in Uganda with well over 1000 beds and some of the equipment that you might find in an American hospital). I wondered how an attending physician could be out of town and leave a resident in charge. The thought was disturbing, but I had no time to ponder it. I later learned that physicians are so poorly paid that many have their own private clinics. My patient got the X-ray, and I reviewed it with the resident. ''Tuberculosis,'' he said. Tuberculosis was this resident's reality. Many patients who need chest X-rays in Uganda have tuberculosis. As I reviewed the X-ray, though, I was certain that this was congestive heart failure. However, in Uganda, congestive heart failure is rarely diagnosed in the hospital. Patients with an ejection fraction low enough to cause congestion generally die before they get to a hospital. I knew that some furosemide would work for this patient, but I could not get the resident to listen to me. He had orders from the consultant to transfer the patient immediately, and the ambulance was ready. I tried to convince the resident to administer furosemide before transferring the patient, but he feared administering a drug not approved by his superior. As the patient was loaded onto the ambulance, I reflected for a second on how different things would be if we were in the United States. We arrived at Mulago in record time, and I tried to get the intake doctors to understand what the problem was; however, they did not want to hear from the US doctor. I stared in frustration as they wasted valuable time. I wondered how long the patient would survive in respiratory distress with nothing being done. I called the patient's son and asked him to come to Mulago immediately. Miraculously, he had already been on his way. As I held the patient's hand, sure that he would die right then and there in a waiting area as nobody did anything, I saw the patient's son. I knew that he was a pharmacist, and I asked him to go to the pharmacy and buy furosemide and some syringes. In Uganda, one can buy any medication without a prescription. Luckily, the hospital pharmacy had the drug. We treated the patient, and in no time, his breathing had returned to normal.

I was jolted back to reality. He was dying, and I knew it. He had had many close calls. There was the time that he got the wrong blood during a blood transfusion. I informed the doctor on call as the blood was being administered that I thought the patient was getting a transfusion reaction because he had rigors. The physician on call suggested covering him in blankets, and I suggested stopping the infusion and administering steroids. The pack of blood showed that he was getting his blood type. The patient was typed and crossed again, and to our surprise, we got a different result. I went to the laboratory to perform a third, tie-breaking cross match and was surprised to note that the reagents had passed their expiration date. However, I knew that these were small battles we were winning and that there was no winning the war.

I recognized that the challenges of practicing medicine in the developing world were many. I wondered how the patients of families with fewer resources survived. The answer was obvious: they didn't. I personally picked up blood when it was available from the blood bank and vividly remember walking from the blood bank at night to the private hospital with units of blood in each hand. Once we arrived at the hospital, I had to warm the blood to room temperature by holding it close to my own skin. Many tests that we perform routinely on a hospitalized patient in the United States are not available.

There was still the problem of breaking the news to the family. Despite everything that had been done and the many near misses that the patient had survived, he was still going to die. It turns out that the family was more intuitive than I thought. One day, the son came to me and asked how long his dad had. ''Not long,'' I said quietly. I thought about all that I could potentially do if I had the patient in the hospital at which I worked in the United States. Would it have made a difference? I do not know. It was impossible doctoring this patient, and I suspect doing it in a resource-rich environment would not have made it any easier. You see this patient, perhaps the most important patient of my life, certainly a patient that I will never forget, was my father.

It had been 15 years since I had traveled to the United States for an education. I knew that my father was so incredibly proud of me. I think that he was the happiest I had ever seen him when he attended my graduation from medical

school in Minnesota. I had been looking forward to this visit back home because it had been 3 years since I had last seen my family. I was somewhat concerned because my father had told me a week before I traveled that he was not feeling well. When I arrived, there seemed to be relief on my brother's face when he met me at the airport. We drove straight to the hospital, and along with the joy of seeing me, I could sense that my father was glad that I was home at this particular point in time. They had just received the diagnosis. He had leukemia, and they were glad that their doctor was home. They had particular faith in the daughter (sister) sent abroad for an education. Things would now be okay. Initially, I never got to choose the role of doctor that I played in the final chapter of my father's life. The decision was made for me out of my family's desperation to make sure that they had left no stone unturned to help my father, and I accepted it out of necessity. As my father became my father when I entered this world, I became his doctor when he was leaving it; there was never any question in my mind, as there never was in his. As it became clear that my father would not survive, I chose to continue the role of doctor. I have watched many patients die as a physician and have done my best to make sure that their passing is comfortable, peaceful, and dignified. The doctor could help this patient die, but the daughter could not watch her father go. When it was evident that he had only days to live and did not need this doctor or know his daughter, I flew back to the United States. Three days later my father died. I was not physically at his bedside, but my spirit was. I have no regrets. Although the head knows that he passed on, in my mind's eye, he is laughing and has a twinkle in his eye. I could not bear to see him without life. A piece of my heart is buried with him, and for this reason, I will never be out of Africa.

ACKNOWLEDGMENTS

The author is indebted to J.B. Kisuule and seeks to honor his life of service. Thank you to Dr. Roy Ziegelstein for his help with this article.

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Received 5 June 2008; revision received 19 August 2008; accepted 28 September 2008.