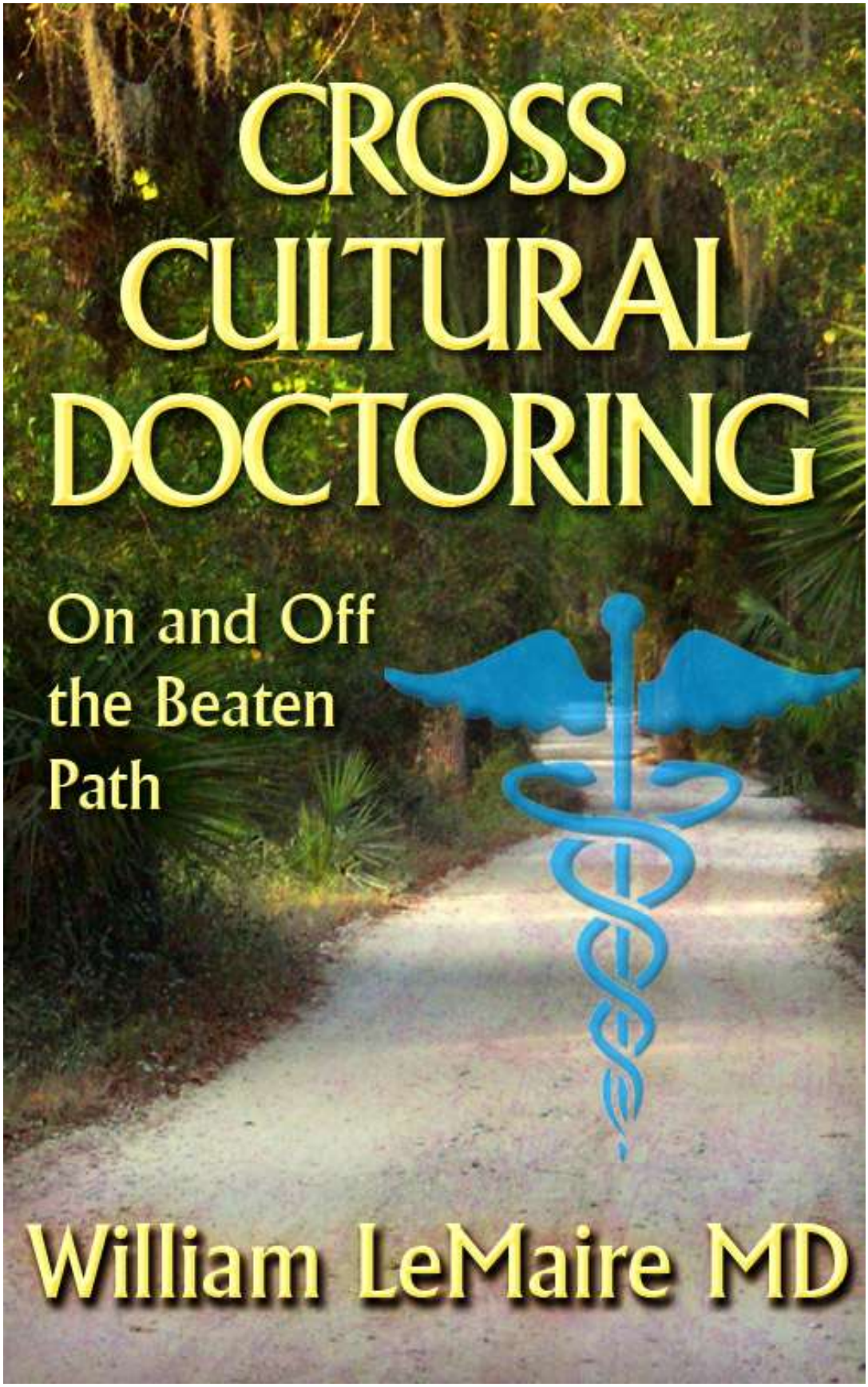
CROSS CULTURAL DOCTORING
On and Off the Beaten Path
William LeMaire MD

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To Anne and our kids, Ingrid, Elke, Tom and Frank. Without Anne I would never have done what we ended up doing. The kids were independent and supportive enough to allow us to to leave the beaten path without worries.

Special dedication: I am dedicating this book to the group of Catholic nuns who run Hospital San Carlos in Altamirano, Chiapas Mexico. Our experience at that hospital is described in Chapter thirteen. We were most impressed with their superior effort to provide medical care to the destitute Mayan population in that area under difficult circumstances and with minimal resources. Thus, rather than selling this book on line I am making it available for free and suggest that anyone downloading the book, make a donation to that hospital in lieu of the usual downloading fee. Their website is:

http://www.hospitalsancarlos.org/

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PROLOGUE

The turning point in my career as an academic Obstetrician and Gynecologist came in 1980 when my best friend died from a complication of cardiac bypass surgery. He and I were in our late forties, at the top of our academic careers and doing well but working hard, maybe too hard. He, his wife, my wife and I had often talked about our retirement that lay still far ahead. We were already making plans, vague of course at that stage, for our post-retirement activities. His sudden death put an end to these dreams. It did however induce my wife and me to think more about values in life other than work and career. Over the ensuing year or so, a more concrete idea began to crystallize in our minds. I was going to continue with my career until age 55 and then retire from my position as professor in obstetrics and gynecology at the University of Miami and pursue different interests. But I am getting ahead of myself. Let me first tell you what led up to to my decision to write a book about our expreiences.

Right from the beginning let me say that we never regretted the decision to leave my academic career and we have never looked back, even though we have kept in contact with our friends and colleagues. In fact, it is at the prodding and encouragement of many of these friends and colleagues that I am finally sitting down to write this book. It was never my intent to do this but invariably these friends would tell me: "Wim, why don't you write a book about your experiences?" They would tell me that every time my wife Anne and I came back from one of our "adventures" and after they had listened to an account of some of our experiences.

I had been reluctant to write a book mainly because I felt that not many people would be interested, but they kept saying how wrong I was. Nevertheless I resisted, maybe out of laziness or maybe because I had no idea on how to write a book, and more likely because of both of these reasons. Then, in the spring of 2008, I was asked to give a presentation at one of the weekly grand rounds, for an audience of medical students, residents and faculty at the University of Miami, where I had spent most of my professional career. My initial reaction was to say no, because I had really nothing scientific to offer, besides I had been out of academic medicine for close to 20 years and had not given a formal presentation in years. When the person asking me kept insisting that nothing scientific was expected but that they wanted to hear about our travels and experiences in different cultural settings, I accepted. That presentation was well received and seemed to be a success. The preparatory work for the presentation put me in the right frame of mind and gave me enough impetus to actually go ahead and start writing. Voila! Here it is.

"The first part of the title of the book reflects a major aspect of my "post retirement" activities as I have kept working off and on as an obstetrician and gynecologist in a variety of cultural settings in different parts of the world. Hence the title: *Cross Cultural Doctoring.* The second part of the title of this book reflects the fact that during my entire career I have followed some traditional and expected paths but at times, also have deviated quite a bit and followed a much more unconventional path, leading up to my retirement and thereafter. Hence the subtitle: *On and Off the Beaten Path.*

The book is written as a series of rather loosely connected anecdotes and I hope that you will enjoy reading them. While many of these anecdotes are medical in nature, I sincerely hope that they will appeal not only to people in the medical field, but also to the non-medical reader and inspire others in different fields of work to get off the beaten path. I am writing this book in a chronologic fashion, starting with medical school and progressing through the various stages of my career. Many of the earlier anecdotes happened more than 50 years ago, and as I never took notes, this book is written from the collective memory of my wife Anne and me. We have often talked about many of these events and related them to family and friends over the years. While I can assure the reader that these anecdotes are real, I cannot vouch for their exact sequence and timing, as time and places may have become blurred over the years. I apologize for any minor inconsistencies or inaccuracies.

CHAPTER ONE: ON THE BEATEN PATH

I grew up in Antwerp in the Flemish part of Belgium and my mother always wanted me to become a Jesuit priest. She didn't say that to me directly, but that was the hidden message I perceived. I certainly was in the right environment to follow that direction as from grade school through high school I was educated by the Jesuits; and a great education I received from them! Thus it came as somewhat of a shock to my parents when I announced towards the end of high school, that I wanted to go to medical school.

At age 17, I entered medical school at the University of Louvain in Belgium. This was a seven year program, where the first six years were entirely theoretical, followed by a one year rotating internship before one actually could graduate with an MD degree. During these first six years, I was the proverbial good student. This gave my mother a glimmer of hope that even after finishing medical school, I might still join the Jesuits. Such a career path is not entirely unusual in that religious order as a number of their priests have advanced degrees in other fields.

However this was not to be, as I met Anne on the swimming team in Antwerp. This first meeting was somewhat of a unusual experience. I had never met her before, but we were swimming laps and we were both in the same lane with at least five or six other swimmers diligently trying to keep on their own side of the lane. When swimming free style, it is not always so easy to swim straight and as it turned out Anne deviated into my path and bumped into me. Without realizing who ran into me I yelled, "Get out of my way!" Probably not a good start for any relationship, but we soon started dating and towards the end of the sixth year of medical school we decided to get married. Announcing this to my parents shattered my mother's hope for a more spiritual career for me. Thus I was made to understand that I was going to be on my own and that my parents were not going to support me during my upcoming year of internship.

As I wrote earlier, in these days (1957) a Belgian internship was an integral part of medical school, to be completed before the MD degree was awarded. In fact that internship was part of the curriculum and required the payment of tuition, however small. It was invariably completed in a Belgian hospital affiliated with the university. Anne and I now faced the prospect of being without income during my year of internship. The question was what to do, especially because Anne's parents had told her that she needed to first finish her degree in medical technology at the university. While Anne's parents finally relented as they realized that we were determined to get married, my parents certainly did not. They did everything they could to dissuade us. One rather amusing (in retrospect) incident occurred when my mother came to the University. Unbeknownst to me she had made an appointment to see the professor in obstetrics and gynecology. She knew that I had befriended him and she thought that he might be helpful in her plan to dissuade me. When she told him the reason for her visit, he immediately thought, as he related later to me, that my mother was worried because I was going to marry some "floozy." So he asked her who the girl was that I was so intent on marrying. She told him that she was the daughter of a medical doctor in Antwerp. He immediately asked her

what this doctor's name was. When my mother told him he smiled and said: "The daughter of Marcel Voet? Well I do know him quite well; he was a classmate of mine in medical school. He is a great guy and has a nice family. Great catch for your son! I would let them go ahead." That was certainly not what my mother expected. While I resisted some other attempts by family members to make me call off our plans, Anne and I started thinking on how to manage for a year without much financial support.

I knew that in the USA, internships are completed after medical school and that interns receive a stipend (rather small). This certainly appealed to us and the idea was born of going to the USA to complete the year of internship. That was easier said than done as such a move was, at that time, unheard of in Louvain. However, it turned out that seven of my colleagues out of a class of about 150 students had similar ideas. Together we petitioned the dean of the medical school to allow us to do that year of internship in the USA. After initial refusal and considerable discussion he finally relented. There was one condition however; we were required upon returning to Belgium to do an additional three months of internship in a University hospital in Louvain. I suppose that was meant to allow the professors there to assure themselves that we had learned "something" in the USA. The result of that condition was that we would miss graduation and officially be awarded the MD degree three months after all the others. That was a small price to pay. The eight of us were thrilled and searched for a suitable internship in the US, which we readily found.

But first we needed to plan for our wedding. My parents were not going to attend and thus Anne's parents decided to move the ceremony and the reception to a small village near Antwerp, where Anne's father had a cousin to whom he was very close and who was the parish priest there. Normally the wedding ceremony would have been held in Anne's parish, an old beautiful and large baroque church in the old part of Antwerp. As Anne's father was a well known and well liked family doctor, many of his patients would have been likely to attend the wedding. Having the ceremony in this church but without my family attending at all, would have been awkward and would certainly have raised eyebrows in the community. Moving the wedding to the small village could easily be justified by the fact that Anne wanted her father's cousin to preside over the ceremony. To everyone's surprise, my parents and sisters decided at the last moment to attend anyway. On June 25th 1957 Anne and I became husband and wife, and after an all too brief honeymoon on the Belgian coast, we started our first adventure together off the beaten path.

CHAPTER TWO: FOR THE FIRST TIME OFF THE BEATEN PATH

My choice for internship was Ellis Hospital, a small hospital in Schenectady in upstate New York. What an initial culture shock that was! The first problem was the language. I knew enough "school" English to get by, or so I thought. Talking on the phone was the hardest. Initially, the nurses in the hospital thought that I was the most conscientious intern they had ever worked with. When I was on duty and the nurses called me on the phone at night, I would always go to the ward, look over the chart, see the patient and then write a note and orders, rather than just handle things over the phone like all the other interns did when called for rather minor matters. Little did the nurses realize that the reason I would get up in the middle of the night and physically go to the ward was due to the fact that I had no idea what they were talking about. I did not understand a word of what the nurses were telling or asking me on the telephone, especially not when they were using even common American abbreviations, like PRN, QID LMP etc. [PRN (Latin) means as needed; QID (Latin) means four times a day and LMP means last menstrual period]. That problem rapidly resolved as I began to understand more and more of the English medical terms. However, there is a major difference between understanding day-to-day common English and grasping all the idioms and sayings. A rather amusing anecdote will illustrate that.

About two months into my internship, I was on call at night when one of the nurses telephoned me in the early evening. A patient was having a bad headache and wanted something for it. I was proud that I had understood the problem over the phone and was even more proud that I managed to order something for her headache without having to walk over to the ward. An hour or so later, the same nurse called me for the same patient because she had been constipated and wanted something for it. Again I understood and again I was able to prescribe a laxative over the phone without having to go to see the patient. A while later the same nurse called to let me know that this same patient was agitated and wanted something for sleep. Once again I understood and prescribed a sleeping pill. Close to the 11pm shift change the same nurse called me once more: "Dr. LeMaire, I am so sorry to bother you again about my patient, but she is really a pain in the neck." Immediately some horrible thought occurred to me. Here is a patient who has a bad headache, is constipated and agitated and now has a pain in her neck. These could all be symptoms of meningitis and here I have been ordering medications over the phone for a potentially serious condition. I broke out in a cold sweat and I told the nurse "I am coming." I ran over to the ward where that patient was hospitalized, went to her room and after introducing myself said "Mrs. X, the nurse tells me that you have a pain in your neck." The patient lodged a complaint about the nurse and me, but we both got off with a minor reprimand and in fact somewhat of a chuckle by the administrator handling the complaint.

The teaching in medical school in Belgium at that time was mostly theoretical, with little, if any, of the hands-on type of experiences that the medical students in the US routinely receive. That undoubtedly has now changed in Belgium. Thus, when I started my

internship I was rather inexperienced in practice compared to the interns in the hospital who came from American medical schools. This may seem ridiculous now, but I had never started an intravenous drip, had never read an ECG (electrocardiogram) at the patient's bedside, nor placed a stomach tube, nor sutured a laceration, nor delivered a baby. Also, while I had been able to observe surgery from distance, I had never actually assisted in an operation. All this I had to learn on the job. As it stands, practical hands-on skills are quickly learned, once the basics have been learned. Thank God, the residents and attendings I worked with were understanding and helpful, without ever making me feel inferior. They went out of their way to give me confidence.

One such confidence-building episode I remember vividly. Sometime in the middle part of the one-year internship, I was on call in the emergency room and was called to see a woman who was obviously in active labor. She was in her thirties and had already delivered several babies before. The problem was that she had had no prenatal care at all and there was no record of her in the hospital. I began by asking her some standard questions, like when her last menstrual period had been and when she thought her due date was. I did not get far with my questioning as she had one contraction after another and she was not interested in answering. Soon the bag of waters broke and she said that she had to push. The only obvious action for me at that point was to get ready for a delivery in the emergency room. There was no time to transport the woman to the labor and delivery room. There was an emergency delivery "pack" in the ER, which the nurses opened for me while I quickly washed my hands and put on gloves. Soon after, a healthy, screaming, but rather small baby was delivered and handed to the pediatric resident who had been called. At that point it became obvious that there was one more baby inside the uterus. Realizing that I was dealing with a twin pregnancy, I panicked as in my limited experience during my obstetrical rotation some months earlier I had never performed or even seen a twin delivery. I asked the nurses to summon the chief resident, who promptly arrived to my great relief. I immediately started peeling off my gloves to make room for the resident to take my place and deliver this twin baby. However, he calmly stood by and, over my objections, bluntly told me "you can do it" even though I kept telling him that this was a first for me. I delivered this healthy, screaming twin baby in front of a large number of nurses and doctors crowding the room, only to realize that this was not the end of it and that indeed there was a third baby. Now I was really ready to step aside and let the chief resident take over. However he remained calm and again, stood by and assured me that I could handle this situation. I am not even sure how many triplets he had delivered himself as they are not too common. Baby number three appeared quickly and also was healthy and vigorous. What a boost to my self-confidence that was! I only delivered one other set of triplets later in my career and that was by C-Section. All three babies came head first. If one of them had been a breech the situation might have been quite different.

What I will never forget is the implied lesson in confidence building the chief resident gave me. I have always remembered that. In fact I have put this approach in practice numerous times when the roles were reversed later in my career as teacher. Often in a somewhat difficult situation at the bedside or in the operating room, a student or more junior doctor would refer to me to take over and finish a procedure he or she did not feel qualified to do. Many times I would reassure and encourage that person to continue while I talked him or her through it. Many of these junior doctors have told me

afterwards how they appreciated this confidence building. Of course one has to be careful to balance this approach with patient safety and I have never delegated responsibility in critical situations and have often taken over when a junior doctor was having trouble.

Schenectady, in 1958, was one of the main headquarters of General Electric and its population had a large number of all sorts of engineers working for GE. I am not sure if that fact plays a role in the story I am about to relate but at the time I did think so.

One of the surgical nurses in the hospital felt that her family was complete and was thinking about some form of sterilization. Sterilization in that era was only permitted under strict regulations. She and her electrical engineer husband thought that the best approach was a vasectomy, but that was not commonly performed in the hospital. A vasectomy is a rather simple outpatient procedure. The nurse had some surgical knowledge and access to minor surgical instruments and to local anesthetic as well. She and her husband decided that they were going to perform the vasectomy at home with the equipment and anesthetic she brought home from the hospital. One evening they started the procedure and everything went well until after making the small incision in the scrotal skin, she ran into a minor blood vessel that she had apparently overlooked when studying the anatomy of that area. When she injured that blood vessel it started bleeding profusely and she was unable to stop it. When they came to the emergency room, her husband's underwear was soaked with blood and so was the gauze pad that they had applied over the area. I happened to be on call in the emergency room and tended to this man right away. As it turned out the problem was rather minor and the bleeding stopped promptly after tying off the small vessel that was the culprit. The only proper action for me at that point was to suture the small cut, place a gauze dressing over it and send the couple home. I can assure you that they were rather disappointed that I did not finish the job they had started.

During that internship I witnessed and participated in a number of rather dramatic cases for which medical school does not prepare the student. The saddest case and probably the saddest of my entire career was the case of a little two or three year old girl who was admitted after inhaling a peanut. That peanut had crumble into multiple smaller pieces upon the attempt to remove it from one of her bronchi by bronchoscopy. As a result the little pieces had lodged further down in the bronchial system. She became progressively sicker and sicker and ultimately died from lipid pneumonitis. I was the intern on the pediatric ward and took care of her for a number of days. She was the nicest and most adorable little girl and it was just heartbreaking to see her slowly deteriorate and die.

Qualifying as the most dramatic case of my internship was the case of an elderly man who had an alleged tumor eroding into one of is bronchi. His private specialist was going to biopsy this tumor via the bronchoscope. Remember that this was many years ago and before the availability of CAT scan, MRI and other modern sophisticated diagnostic methods. I was assigned to assist him, which consisted of supporting the patient's head and move it slightly on directions of the operator, so that he would have better visualization. As it turned out this tumor was an unrecognized aneurism of the aorta eroding into a bronchus and upon biopsy a major gush of blood emerged that continued while the patient exsanguinated within a short period of time practically in my lap, while frantic attempts were being made to staunch the bleeding.

Anne and I lived in a small apartment close to the hospital and got by on a small, very small, salary. So did all the other interns. Therefore our entertainment consisted of pot-luck weekend evenings at each other's apartments on a rotating basis. When it was our turn to host the get together we had told our friends to come around 8:00 pm. In Belgium this means arrival at the earliest around 8:15 or even later. Of course this is quite different in the punctual American culture. That evening the bell rang at 8:01 with the arrival of the first guests. I opened the door, sat them down, started the background music and offered them a drink, as other guests arrived. While they all were sipping their wine, beer, whiskey, or soft drink, someone asked where Anne was. She was still getting ready, not expecting any one until sometime after 8 pm. I told them "Anne is taking a douche." Now, a douche is actually the French word for shower and is also commonly used in the Dutch language, but of course in the English language that word has quite a different meaning. When I told everyone quite innocently, that Anne was taking a douche, people's mouths fell open and I could see on their faces the disbelief and hidden thoughts …"what kind of party is this going to be?"

A similar confusion occurred toward the end of our stay in Schenectady, when the student nurses, many of whom had befriended Anne, who was now in her first pregnancy, told me that they were planning to give her a baby shower. They asked me not to say anything and keep it as a surprise. However, I felt compelled to warn Anne that she was going to receive a gift of a shower for the baby, rather than a bath. I felt that I needed to prepare her for this unusual gift, as I knew that babies in Belgium are washed in a small bath and not in a shower. Of course we had a good laugh when we realized our misunderstanding.

Anne had befriended some of the other interns' wives. Several lived in the same apartment complex and one at least was also pregnant. One evening towards the end of Anne' s pregnancy and while I was on call in the hospital, Anne received a frantic call from one of the other pregnant women, asking Anne if she could come over right away as she had begun labor and needed to go to the hospital immediately. She had a two-year-old toddler at home and her husband was also on call. Of course, Anne walked over immediately, but not before telling her friend that she, too, had felt some stirrings in her pregnant belly earlier in the day. Somewhat later that evening, while babysitting for her friend, Anne's contractions started. She called me and I rushed over to get her, while Anne made arrangements for one of the other women to come and take over her babysitting duties. In the hospital, Anne had a rather fast labor and three or four hours later our first child, Ingrid, was born on April first. When Anne called her family in Belgium they would not believe her at first. They figured that it was an April fool's story.

Our one year in the US was a great experience. We learned a lot about the "American way" and about American medicine as well and liked it enough so that we wanted to come back. But first we needed to return to Belgium to complete the additional three months of internship prior to actually graduating and receiving the MD degree, the condition imposed by the dean of the medical school in Louvain for allowing us to complete the US internship**.**

CHAPTER THREE: OFF THE BEATEN PATH IN AFRICA

At the time I graduated in 1958, Belgium still had a compulsory military service of 18 months. However, I had no desire to join the army. First of all, the Belgian government paid the conscripts barely enough to buy a pack of cigarettes a day; I did not smoke and needed more money than that to support Anne and our daughter. Secondly, from all I knew about a doctor's service in the army, it was boring and I wanted some more excitement. There was a way out though and that was to sign up for three years of duty as a civilian with the Belgian Colonial Health Service. The former Belgian Congo was at that time a Colony of Belgium in Central Africa and was maintaining and staffing a number of health care facilities around that vast country. After making sure that Anne was up to it and ready to travel far to an unknown place in the developing world with a ten month old baby, I signed up for a tour of duty there. But first I needed to complete a required four month course in tropical medicine at the then famous Tropical Institute in Antwerp. There I learned all about malaria, sleeping sickness, leprosy, and many other mean and ugly insects, worms, and parasites and their related diseases. Then we were ready to start our tropical adventure.

Anne and I and our daughter, Ingrid, boarded a Belgian motor ship in Antwerp and sailed to Lobito, a harbor on the Atlantic Ocean in Angola. We had a stopover in Tenerife in the Canary Islands and the entire trip took about two weeks. In Lobito we boarded a train to take us through Angola into the Belgian Congo to Albertville, which is now called Kalemie, a town on the western shore of Lake Tanganyika. We were on that train for several days. The train was pulled by a wood fired steam engine and we stopped every few hundred kilometers to load up on wood. The nasty aspect about that wood-fired engine was that the red hot cinders from the burning wood would blow out of the chimney and drop down on the train behind. There was a flat bed wagon right behind the engine, where the autos that the train transported were located. You can imagine that many of these autos were completely pockmarked with cinder burns on arrival at destination. We also often wondered why there were not more forest fires along the route of the train, as we traveled through dense forests and grass plains.

Anne was bottle feeding our daughter with powdered milk that was dissolved in water. Of course one could not trust the water on the train and she would prepare the milk with bottled soda water (the only bottled water available). We would take turns shaking the opened bottle to get rid of the bubbles before feeding it to the baby, who never turned a hair.

After three night on the train we arrived in Albertville, and boarded an airplane to fly us north to Bukavu the capital of the Kivu province. Bukavu is situated on the south eastern shores of beautiful Lake Kivu, at an elevation of about 1500 meter or close to 5000 feet. Its climate is temperate, with mostly warm days and cool nights. It was then really a rather beautiful and peaceful city. But after the genocide in neighboring Rwanda in 1994, Bukavu and its surroundings became a center for Hutu refugees and witnessed fierce and nasty fighting. In 2004 the city fell to the Rwanda backed rebels and was the scene of

indescribable atrocities and rape. I have no idea what the current status is of this once beautiful city, but from the reports in the press it seems that its infrastructure is in dire straits. A recent book by the British author Tim Butcher, called *Blood River. A Journey to Africa's Broken Hear*t gives an account of his epic travel along the Congo River in 2004. He retraced the exploration by Henry Stanley of the Congo River from its origin to the sea more than a century ago. In his book, Tim Butcher describes the heartbreaking decay and collapse not only of all infra-structure, but also of human communication and interaction in this once beautiful and prosperous region of Africa. The book is well worth reading.

I was scheduled to be in Bukavu for six weeks to get an orientation to the job that was awaiting me in Shabunda, a village in the middle of the jungle, west of Bukavu. At the hospital in Bukavu I shadowed the doctors there and went with them to outlying clinics. I saw cases which I had heard off and learned about in my tropical medicine course, but had never seen firsthand. I learned the practical aspects of treating these cases and about the medications that were available. I was also indoctrinated in the running of a rural hospital and was shown how to order medicine and equipment, how to write monthly reports, and how to interact with the local administration, the hospital staff, and the natives in the village.

When we were ready to go to our hospital in Shabunda, I purchased a second hand Ford Taunus. I was to drive by car with our belongings over the Kimbili Mountains down into the Maniema area where Shabunda is located. This was going to be a full day drive over rugged mountainous terrain and unpaved, often muddy and winding roads. The head of the medical service for that territory felt that it was unsafe for my pregnant wife and our baby daughter to go along in the car and arranged for her to fly there by small plane. On the day of our departure I drove both of them to the local airport where they boarded a small two seater airplane. There was barely room in the jump seat for Anne and the baby. The steering yoke pushed into her protruding pregnant stomach especially on takeoff and while climbing. After seeing them off, I began my trip to Shabunda by car. I had a rather uneventful drive and expected to find Anne with Ingrid already in Shabunda, awaiting my arrival. When I arrived in the late afternoon, I asked where she was. The local authorities were surprised however that I had a family. They had expected their new doctor to be single. Something apparently was missed in the communication. After some back and forth telegrams (no direct phone connection at that time), we found that Anne and Ingrid were sound and safe back in Bukavu. Here is what happened:

The small plane with Anne, Ingrid, and the pilot took off from Bukavu. After about two hours of flying the pilot turned to Anne and said: "I have never been to Shabunda, but I know that I am supposed to follow this brown looking river below us, till it meets up with a blue looking river. At that confluence I am supposed to make a sharp turn towards Shabunda. But I cannot find this confluence and if I keep looking too long I am going to run out of gas. We are turning back." They ended up back in Bukavu. Arrangements were then made for her to fly commercially to Kindu, a larger town north of Shabunda, where I would pick her up by car. This was several hours driving on unpaved roads. The next day we were reunited and were assigned a house close to the hospital. There were five families and a few bachelors, all Belgian, living in similar houses spread throughout the post, which was located a short distance from the actual village.

I started work right away and met all the Belgian administrative people of the village and the medical personnel in the hospital. The hospital was rather primitive, serving a large area. It had close to one hundred beds in various divisions. One doctor was in charge (soon to be me). There was one Belgian nurse and the rest of the staff was the equivalent of health aides. As I soon found out these health aides were competent and able to deal with the usual cases of malaria, pneumonia, malnutrition, parasitic infestations, diarrhea, and minor trauma. Assisting the medical doctor was a Belgian "Agent Sanitaire" which translates in English into Health Agent. Many of these professionals were employed throughout the Congolese health care system. They were specially trained for these positions. Our "Agent Sanitaire," his first name was Freddy, was truly god sent as he was able to handle a million large and small tasks in the hospital, besides taking care of sick people. He would literally keep the hospital running, by making sure that the native employees were working on schedule, wages were paid on time, the pharmacy was stocked at all times, the generator was running, instruments were in working order, the X ray machine was running, clinics scheduled and a lot more. As he had been at the post for some time before I arrived he was also instrumental in getting me oriented and staying on the right track on this new and, for me, somewhat daunting job, fresh out of training. Needless to say, he and I became close friends.

After my first few days in the hospital and village, I learned that a rumor had made the rounds that the new doctor is "muganga mtoto kabissa," meaning: "The new doctor looks like a child." I was then, at age 25, very young looking indeed. During my internship, patients would often respond when they first saw me with "Are you a doctor?" or "I would really like to see the doctor."

In the Belgian Colonial system, like in many other administrations of that era, the efficiency was such that by the time a replacement doctor arrived, the doctor to be replaced was already gone for several weeks. Of course that did not allow for good continuity. I was lucky, as the doctor I was to replace, was scheduled to remain with me for several more months. It is likely that the administration in Bukavu had decided that the new doctor for the hospital (me) was too inexperienced to strike out on his own right away. This was good decision indeed and certainly good for me as the reader will see later.

However, when I arrived, the doctor had been on vacation and was planning to return in a couple of weeks. Thus the hospital had been without a doctor for a while. Soon after arriving in Shabunda I asked the health aides if there were any urgent or difficult cases for me to see. Their response was that everything was under control; except for one case of a rather elderly man who was admitted with what they thought was an amoebic abscess of the liver. An amoeba is an intestinal parasite that can lodge in the liver and cause an abscess. I went to see the patient right away. He looked rather moribund and had a large swelling in the right side of his abdomen. I had never seen an amoebic liver abscess, but knew about it from my course in tropical medicine. The patient had already received the usual medication to kill the parasites in his body, but I knew that the abscess needed to be drained. I had the health aide explain this to his "entourage." I say entourage, because patients in this area, and in other developing areas in the world, often come to the hospital after traveling, sometimes walking, for long distances. If they are very sick they may need to be carried and frequently they would come with their entire

family and even with many villagers. This particular man had about twenty people around him. So he was placed on a gurney and wheeled to the operating room followed by a procession of his family and friends. They all sat down silently and solemnly on the floor outside the operating room.

Inside a male health aide was getting the patient ready on the operating table, while I was scrubbing my hands. I was still doing this when the health aide came over and told me not to bother as the patient seemed to have expired. Indeed he had, and was beyond resuscitation. We needed to go outside and tell his family and friends. As I did not speak any Murega, one of the local languages, I asked the health aide to do the talking by my side. The twenty or so people who had accompanied this man were still sitting solemnly and silently on the floor outside the operating room. I did not understand what was being said, but after about the second sentence this entire group of people that had been so subdued till just before, jumped up shouting and crying, beating their chests and some even their heads against the wall. To me this was a most frightening scene as I was sure that they thought that I had killed their friend, father, or husband. I was also sure that, from the way it looked, they were going to come after me. My cowardly reaction was to run back in the operating room, jump out of the back window and drive home to tell my wife: "Let's get out of here, they are going to kill me." This demonstration outside the operating room had been very frightening to me, but I quickly realized that in fact it was a normal cultural reaction. I did witness similar reactions several times since, not only in the Belgian Congo but also in several other countries where I have worked.

After about two weeks working alone, the doctor whom I was eventually going to replace, returned from his vacation and we worked together for about two months. I was lucky in that regard because he was a board certified and accomplished surgeon and his fame was wide spread in the area. Many surgical patients came from long distances to be operated by him. Some had to walk or be carried from their village in the bush, along dirt roads for days to arrive in the hospital. I assisted him in the operating room almost daily and progressively he gave me more and more responsibility. That helped a great deal to build up my confidence in this new and daunting environment. The hospital was a rather good hospital by Congolese standards but in many ways primitive by contemporary standards. Electricity depended completely on the water levels in the reservoir built up stream by the catholic missionaries and more often than not we were without power. We had a generator but we could only use it sparingly in order to conserve fuel. Many times operations were carried out right next to a window, without the benefit of overhead light and of course no electrical powered instruments, such as suction, electrical coagulation, etc. As we did not have an anesthesiologist most operations were carried out under spinal anesthesia, administered by ourselves, or under local anesthesia and yes, even anesthesia by drop ether or chloroform, neither of which are used anymore these days.

Ectopic pregnancy, or pregnancy in the tube, is a rather common occurrence, especially in areas where infection with a venereal disease is common, such as in this and other areas of Africa, Such infection often lead to damage of the fallopian tube, which then may result in an ectopic pregnancy. If a patient were bleeding inside the abdomen, like for instance from a ruptured ectopic pregnancy, blood transfusion with donor blood was out of the question. In such a case we would have ready on the operating table a sterilized ladle. After quickly stopping the ongoing bleeding, we used the ladle to scoop out the