

Reborn in Honduras

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A car horn blared outside the cement-block clinic in Santa Lucia, Honduras, just as we were finishing our dinner of tortillas, beans, and rice. The on-call team, visiting for a 2-week international health experience, met a young mother clutching a bundled infant to her breast. She wore the garb of recent childbirth—white cloth turban on her head and cotton stuffed in her ears to keep out the “cold.” I recognized her husband; only yesterday I’d removed the sutures from his repaired scalp machete wound. The mother handed the baby to me. Opening the bundle I discovered a gray and floppy 11-day-old infant with shallow respirations. I swallowed hard. This baby needed a pediatric intensive care unit. For me, that rotation was at least a decade ago. The local physicians stayed in the background, allowing our visiting group to run the show.

The Ohio team included three family physicians, two dentists, two midwives, four family medicine residents, four fourth-year medical students, and three nursing graduate students. The team was big on enthusiasm and used to “big city” medicine. Half of the group was running a clinic in a village 2 hours away. The remaining crew was a little bored, deciding what card game to play. This rural Honduran

clinic was founded several years ago by a US physician who took “the bus to the end of the road” and then worked with the local community to build the clinic. Now, two full-time local physicians staffed the clinic, supported in part with semiannual visits from Ohio teams to replenish supplies and give the regular doctors a break. Prior to this, a public health nurse and an occasional visiting physician provided medical care to the community.

The team worked swiftly. This baby was delivered by a local birth attendant and had not eaten for 4 days. His airway was managed with a small mask and an old oxygen concentrator that made up for its lack of efficiency with its noise. Was it being effective? Hard to tell. The pediatric nurse practitioner student, a former pediatric intensive care nurse, stepped forward. She attempted to start an IV line and failed. The dentist/oral surgeon succeeded in placing the IV in the baby’s foot. Supplies were found or creatively adjusted to be appropriate for a baby. Glucose was added to a saline IV bag. Antibiotics were given through the IV. Someone located the dusty suitcase that contained medications for resuscitations. Some necessary meds were missing; the fourth-year student interested in anesthesiology substituted comparable ones. Every team member, naturally and without much discussion, created a role.

The baby’s breathing became erratic, so the team began to bag the baby. Then the infant stopped

breathing. In the United States, the baby would have been intubated and eventually hooked up to a ventilator. With no ventilator, we could only continue bagging for so long. Transport to a Honduran hospital that could care for a baby this sick was a 6-hour car ride through the mountains, and most of the road was unpaved. This baby was probably too ill to survive the trip. I led the discussion: “What is our end-point here? I am not sure it makes sense to intubate this baby.”

“We could take turns bagging him.”

“But we are talking a 6-hour car ride.”

“You know what that road is like. We just did it by bus last week.”

“But he looks a little better.”

“Does the family have gas money? Money for the hospital?”

“What does the family want?”

“Let’s talk to Miguel.”

Dr Miguel, the local doctor, spoke excellent English. Normally our translators were ninth graders from a well-to-do English school in northern Honduras. This conversation would be too complex for them to translate.

Dr Miguel spoke to the family. They wanted us to continue breathing for the baby until they could bring the local lay minister to baptize the baby. A small town, the priest came only once a month to say Sunday mass, so a local woman ministered to the needs of the parish in his absence.

After 30 long minutes, she arrived. A petite woman, in her 50s,

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she had shoulder-length dark hair and not a strand of gray. A pink blouse was neatly tucked into the waist of her knee-length straight skirt; she wore flip-flops. Her presence was calm but authoritative. We quit bagging the baby, moving back from the exam table for the baptism. She rattled off Spanish prayers and blessed the baby with holy water that she carried in a small jar. The mother sobbed as she held her infant. The father grieved vocally as well, his hand resting on the mother's shoulder. Quietly, the lay minister consoled them.

"Let's remove the IV line and take them to a private area where they can sit with the baby."

"Should we stay with them or not?"

"What is culturally appropriate?"

"Let's ask them."

Through a ninth grade translator, we asked the parents what they wanted. They asked that staff sit with them, so Dr Ed and I, two nurses, a medical student, and two translators stayed. The rest of the team sat out on the clinic steps and talked. At midnight, we took up a collection for funeral expenses, discussed taking shifts so the on-call staff could have a break, and the rest of the team went to bed.

The on-call team, family, and lay minister huddled in a room with a bed and several chairs. All focused on the infant who was swaddled in a blanket in his mother's arms. His breathing was labored and his color gray. The minutes ticked by—this could last all night. About 2 am the child stopped breathing for about 20 minutes, and the lay minister performed last rites. Dr Ed examined the infant and pronounced him dead. When the mother readjusted the baby's head, he began breathing again.

All eyes in the room were riveted on the infant. He took several slow breaths but intermittently quit breathing for 5- to 10-minute intervals. Then, in the silence, he began to cry. As he cried, his color changed from ashen to pink. The team talked among themselves.

"What's going on?"

"Should we restart the IV?"

"This kid is supposed to be dead. He was septic when he came in. Did the antibiotics just kick in?"

"What do we tell the parents?"

The lay minister seemed to sense our confusion. She stood up and through a translator talked about what had just happened. "This child has been reborn. This is not the child who was brought into the

clinic sick and dying this evening. This child was baptized in the Lord and is now a different child. Bless the Lord."

The father talked through a translator, saying that they wanted to take their son to a small hospital in El Salvador, just across the border, about a 1-hour drive. Then the father stood, bowing slightly to the team: "You have used your medicine. It was good medicine, and you have saved our son. You have done all that you can do. Now it is time for someone else to help our son. Thank you for all of your hard work and care." I gave the father the funeral money for gas. The on-call team escorted the family out to their friend's car. The father held the infant as the mother climbed into the front seat and then handed her the bundle. As they drove off, we watched the red taillights of the car move down the hill and pondered what it was that we had just witnessed.

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