

Succor

My visit to a charity institution in Gondar, Ethiopia, taught me two of life's lessons. The date of my visit coincidentally marked my beginnings as a mother. On that day 33 years earlier, my first child had been born and I joined the ranks of those who not only gave birth but also cared for children, placing their children's needs above their own and nurturing, fretting, and praying for their well-being. Mother Teresa had been one such "mother" to the poorest of the poor. With my visit to this institution, which was founded in her name, I learned the profundity of motherhood.

In Gondar, Dr. Shitaye Alemu Balcha, a venerated local internist who pioneered diabetes care in northern Ethiopia, is another legendary mother of many. She has devoted her life to practicing and teaching first-rate medicine; caring for orphans with HIV; raising scholarship money for destitute children to attend the school she helped found; and providing exceptional medical care to patients with chronic diseases, free of charge, in one of the poorest regions in the world. She procures and distributes insulin, gratis; as a result, Dr. Shitaye's "kids" with type 1 diabetes now enjoy a normal lifespan. Many people with diabetes have grown up at the institution in Gondar founded by Mother Teresa, either orphaned or left there by impoverished or single parents unable to care for them. Dr. Shitaye made a point of visiting them from time to time.

It was through Dr. Shitaye that I met Dawit, a young man with type 1 diabetes and a resident of this institution.

On the day of my visit, the senior nun (known as "Sister") took us through the wards. We encountered abandoned children, mothers and babies who required special assistance, and severely disabled and mentally challenged children. They were all well cared for, nourished, and clean; however, because of their sheer number, they were minimally stimulated. On the other side of the well-tended garden, we entered the men's pavilion. Some of the residents there were elderly, some disabled, some mentally challenged, and some seemingly well but evidently socially isolated.

Dawit, a well-built young man, was lying in bed while the rest of the men were wandering about. The staff told us that he wasn't well. That was an understatement. He was clearly in a deep coma, barely arousable to painful stimulation. Dr. Shitaye explained that he had been brought to the institution some time earlier emaciated and weak from uncontrolled diabetes. His family couldn't manage him. Over time, he had learned to manage his illness. Sister said that sometimes he even left the compound (with his insulin) to explore his surroundings.

On this particular morning, he had taken his regular dose of insulin and then gone out in the sun and engaged in hard physical labor cutting down trees. This was a recipe for disaster, and he had developed severe hypoglycemia. Dawit now lay in bed, deeply comatose. Three experienced physicians (Dr. Shitaye, my husband, and I) stood there, knowing what was required

but totally unequipped for the task at hand. We had no IV lines, glucose, or glucagon.

Much has been said about providing diabetes care in low-resource settings. Guidelines have even been written on the subject, most recently by the World Health Organization. Had the authors of such guidelines ever visited Gondar? The barriers here were enormous: no consistent access to insulin, needles, or syringes and no reliable refrigeration (most farmers in Ethiopia do not know what a refrigerator is). Self-monitoring of blood glucose is reserved for the chosen few, and there is an active global black market in glucometer sticks. The World Health Organization document provides no guidance on the treatment of severe hypoglycemia in low-resource settings. What does one do when stripped down to basics—knowledge, skills, and caring, but little else?

Dr. Shitaye asked Sister to bring sugar (*sukari* in Amharic) while we stayed at Dawit's bedside, fretting and praying. The sugar arrived after what seemed like ages. It was table sugar, mind you, not IV dextrose. Together with a male attendant, we spent the better part of an hour trying to get enough glucose (in the form of moistened, coarsely granulated sugar) into this comatose patient's mouth so that he might wake up and get on with his young life.

It was a battle. Dawit resisted and remained lethargic and uncooperative for the longest time. Dr. Shitaye commanded him to swallow. She struggled with all her might, with help from us, to get her "boy" to ingest the sugar and wake up. In his stupor, he was spitting, drooling, and resisting the small amounts of sucrose we tried to get into him. We miraculously managed, grain by grain, to slowly deliver him from danger. He sluggishly responded. It was basic caring and persistence, more a mother's touch than a doctor's bag of tricks. We all felt a sense of healing and that we had restored a life.

This boy, abandoned because his biological parents could not meet his needs, was revived by people for whom nurturing was not a matter of biology but a calling. One month earlier, the message of that year's World Diabetes Day had emphasized the role of family as caregivers and crucial partners in the care of diabetics by helping to enhance adherence, identify diabetic emergencies, and even assist with early detection and prevention of the disease. Lacking all professional tools, we became Dawit's de facto family. As he opened his eyes, on this day that I had become a mother, I felt privileged to have taken part in this boy's rebirth.

We had given him *sukari* . . . sucrose . . . succor. That was my second, most unforgettable lesson in Gondar.

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