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Wards Apart?: Rethinking the Hospital through a West African Lens

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Two continents, two hospitals

Hospital A has problems. Exterior security is heavy with electronic technology meant to restrict access, but behind the doors the image of order fades. The night shift is so under-staffed that an off-duty EMT is recruited from the emergency department to start intravenous drips on children. Terribly lacking in human resources, this specialist referral hospital depends heavily on the labor of 'techs': minimally trained all-purpose functionaries who fill in the spaces where doctors and nurses should be. The strain is showing. There are minor cracks, such as staff administering medications without confirming patient identity. Simple supplies are lacking - a tube of petroleum jelly for a patient's chapped lips, a board to splint an arm with a positional IV. Abuses of the system proliferate, as patients are kept on narrow gurneys in the admitting department's holding bay overnight. This practice forces patients to pay a hefty deductible out of pocket, a charge that would be waived upon admission, but permits the hospital to avoid a full admission with its attendant recordkeeping and use of human resources.

There are also larger problems indicative of deeper fractures in the system. A traumatic IV start is followed by a nurse insisting on giving the medication in oral form, thus rendering the intravenous line unnecessary. The

oral medication arrives in a capsule, scheduled for administration in the early morning hours, and the half-awake pediatric patient is unable to swallow it. When the child becomes hysterical at the nurse's insistence, the nurse argues that the medication does not come in a liquid form and the child will not be released from the hospital until she swallows the capsule, which has by now melted into a bitter paste in her mouth. A family member pleads with the nurse to petition the prescribing physician to consider a different medication. The nurse returns 30 minutes later and wakes the patient, who has just fallen back to sleep, to administer a liquid dose of the same medication, a form which supposedly had not existed 30 minutes earlier. Upon discharge home, the family learns that a crucial and obviously indicated blood test was never ordered and that the dose of medication the patient has been receiving was prescribed and delivered at half the indicated strength. The physician in charge mentions this casually while advising the family to continue the medication at home using the full recommended dose.

Hospital B also has problems. Security at the exterior gate is heavy, as vehicles are stopped and their passengers interrogated prior to entry. Additional technologies at the admitting department desk meant to restrict access sometimes leave patients waiting in pain while the correct documentation is compiled. Staffing is also a problem here. One particularly fraught day a single nurse is caught between shift changes, left to staff the entire admitting department herself as an ambulance approaches. This specialist referral hospital depends heavily on the labor of ‘volunteers,’ fully qualified but uncompensated nurses who often work for years at a time before being offered a paid position. These quasi-staff members may or may not be present on any given day. Hospital B’s cracks are more obvious: a common referral diagnosis is elevated blood pressure, yet there is only one blood pressure machine in the admitting department. The over-taxed machine works through the night shift, but fails after the first three patients of the day shift. A chronic shortage of examination gloves has led to a situation in which washing and re-using them is a common practice.

Abuses of the system are rampant, and staff members charge patients money to purchase items that are provided free of charge elsewhere.

There are indications of deep systemic fault lines here as well. One day, nursing staff arrive to find that there are no physicians. After failed negotiations, the medical staff have gone on strike to protest wage and labor conditions. Nurses cope with patients arriving for life-saving surgeries as best they can, but many will suffer. A highly effective medication is kept in a locked cabinet. The charge nurse knows the correct dose and route of administration, but she cannot access the medication: the physicians keep the keys in their pockets. The blood bank has the technology to instantly type and cross-match a sample, but the hospital supply is so critically low that patients' family members routinely solicit paid donors from the open-air vegetable market adjacent to the parking lot. A young woman arrives in need of immediate medical attention. After her information is painstakingly documented, two nurses transfer her to the hospital's only available wheelchair and rush up a steep concrete ramp through a guarded wrought-iron gate toward Ward 1. The supervisor turns them away: there are no beds available. Down the hallway, around the corner, down and up two more concrete ramps, they reach receiving Ward 2. Staff refuse to admit the patient, arguing that her paperwork is not in order. One of the nurses runs back to the admitting department, down and up, around the corner, down the hallway, through the gate, past the guard and down again to request the patient's chart. She return, breathless, to Ward 2 just before a baby's head emerges on the cracked vinyl seat of the wheelchair.

The hospital *in situ:* stories from the past

The seed for this paper was planted while my daughter was a patient at Hospital A, in the United States. While one of the 'techs' was taking a medical history, our talk turned to Hospital B in Sierra Leone's capital city of Freetown, where I had just finished months of fieldwork. Given the context of this conversation – a shiny new room in a state-of-the-art American hospital – it is perhaps unsurprising that we began comparing the two. My description of

Hospital B's regular power outages, lack of consistently running water, high mortality rates, staff shortages, dearth of supplies, and malfunctioning equipment prompted the tech to ask: "How can they even call it a hospital?" The question plagued me, begging an answer. How, indeed?

While much has been written about the entangled histories of colonial medicine and competing concepts of health and illness in Africa, the ontological status of the hospital remains largely unquestioned. All hospitals – all institutions, for that matter – have problems. There are clearly stark geopolitical differences between Hospital A in the United States and Hospital B in Sierra Leone. It is also clear that while both institutions deviate from some universalizing norm, both are still hospitals. Are they? If so, why? What is the essence of 'hospitalness'? Does the concept permit varying degrees of lack and dysfunction, and if so where does the line separating 'hospital' from 'not-hospital' fall? Who draws it? What assumptions accompany such definitions? Is there some quality enabling Hospital A to deviate from the norm in a way that Hospital B cannot?

What can be learned by interrogating the concept of 'hospital' from an African perspective? Volumes have been written about health disparities and inequalities between the Global North and South. For historians of technology, perhaps the more important comparison lies in the radically different relationship these two hospitals have with their institutional pasts. Thus, at the risk of oversimplification, we must first consider the histories of these two institutions.

Hospital A's past is firmly linked to European Christian ideals of charity and benevolence. Its precedents were alms-houses, hospices and hostels intended for the elderly and infirm. Among the goals of such institutions was the provision of care for the dying, healing for the sick and wounded, and shelter for the deserving poor. In one wing of the massive complex in which Hospital A sits, a long corridor displays gilt-framed photographs of a succession of previous administrators. In another wing is a hallway lined with photographs of generations of smiling, white-coated medical school graduates. This hospital boasts a history filled with technological and pedagogical firsts, ground-breaking

discoveries in biomedical science, and ever-increasing financial investments which have made infrastructural expansion and cutting-edge technologies the norm. If it is like similar institutions in the United States, this hospital's relationship to its history is indirect, the details trotted out occasionally and selectively, often linked to ceremonial moments and a rosy institutional memory.

Hospital B, at just over a century old, is one of the oldest European-style hospitals on the African continent. It was founded in the late 19th century as a missionary hospital in order "to reach those spiritually, both Mohammedan and Heathen, who in no other way come under our influence." Thus, the fundamental raison d'être of Hospital B was to convert Africans to Christianity and redeem their inherently-flawed African souls. By the 1930s, uptake of the Hospital's services among Freetown's poorest residents was significant enough to attract increasing attention and support from the British colonial administration. The colonial government provided funding to augment the surveillance work already carried out by the medical mission through home visits and weekly mother/baby clinics. Amidst a flurry of 'development' activity, the colonial government assumed full control of Hospital B in the mid-1950s, further facilitating 'colonialism on the cheap' and the collection of data about Sierra Leonean bodies and habits that the hospital reported annually in order to justify its own existence.

The following narrative provides a glimpse of what it was like for one former subject, known then as Tamba, to experience the colonial hospital as a child in the mid 1950s.

> They put me in that place and they would not let me leave. I was a boy, a small boy! I had contracted rheumatic fever and they would not let me go home. I was terrified! I was there, I was just a boy, and there were grown men! I was so scared. I was scared to death. There, when a person died, they just put a sheet, cover it with a sheet, and left the corpse. At night there was no light. Not one light. It was completely dark and I was lying there next to a corpse, with

> the corpse right there! They had me hooked to IVs, medicines, all these things. They kept me there for four weeks! Four weeks! In this place where people were sick, and just dying, dying all around me! As soon as they let me go, I never went back to that place. They sent me home to my grandparent's house and told me to come back in a week because it was a holiday. I never went back. I never set foot in that place again. I did some things, I treated myself. And then one day my heart was bad. I got so scared, I started to run back to that place. I thought I was going to die so I ran, as fast as I could. But when I got to Bathurst Street, it stopped. It stopped completely. My heart was better, and so I never, ever went back to that place again.

Tamba's narrative draws attention to the fact that throughout sub-Saharan Africa the concept of 'the hospital' is directly linked to its origin as part of an oppressive, extractive imperial regime aiming to colonize, 'civilize,' and control. From Africa, histories of biomedicine are constituted of white people in white clothes whose actions ranged from infantalizing benevolence to extreme brutality. For African students, medical history begins with David Livingstone. A 21st-century African clinician often practices amidst the wards of what was once a colonial hospital, the skeleton of a foreign body left behind, the bleached bones of its imported infrastructure jutting out from the landscape. How have Africans repurposed the sedimented debris of colonial medicine? How might foregrounding moments of dissonance or incomprehensibility between 'African biomedicine' and 'biomedicine in Africa' prove useful for destabilizing received notions of technology?

Technologies in use: stories from a 21st century West African hospital

Gloves

Well-meaning donors love to send Hospital B size small gloves. The problem is that very few Sierra Leonean clinicians have size small hands and so it is not uncommon to see the few, prized, size large gloves washed and reused. Washing and reusing latex examination gloves is flatly incomprehensible in terms of mainstream biomedical practice, a system in which the gloves are worn to protect both patient and provider from the transmission of infectious agents. As scholars of science and technology, we might ask: What is a glove for? What is its purpose? What does it do in in the wearer's world? In what ways does it express or embody the clinical norms of this institution? Washing with soap and water will not eliminate all of the potentially infectious agents. If gloves are the first line of defense in an infectious disease protocol meant to protect everyone, then the practice makes little sense. If their purpose is instead to prevent the nurse's hands from coming into contact with the bodily fluids of a patient, or to reconcile an imaginary of clinical practice with a reality of too many size small gloves, it makes a great deal more sense to wash and re-use the available gloves than to touch a patient with bare hands.

An Infant Care Center

Circumstances of extreme exigency can shift questions of expertise, authority, and viability. In the United States, technologies used to detect antepartum and intrapartum death are readily available. Unless it is clear that death has occurred during or prior to birth, the minimum American standard of care is to stimulate and resuscitate a neonate born with no signs of life. The fewer the signs of life, the more aggressive the intervention. Technologies available in Hospital A can quickly produce knowledge deemed authoritative and guide resuscitation protocol.

Sierra Leone has one of the world's highest rates of perinatal death. At Hospital B, when an infant is born not breathing, there were few ways to know if and when its heart has stopped beating. With limited and intermittently available diagnostic technologies, the Infant Care Center takes on a different nature. Fetal scalp monitors, lights bright enough to reveal fine degrees of pallor, external

cardiac monitors (all requiring a reliable, steady supply of electricity), and high-quality pediatric stethoscopes sensitive enough to detect the faintest heartbeat were not part of the available technology I observed. Instead, years of experience combined with fingers palpating for an umbilical pulse proved authoritative. Moreover, while a bag valve mask ventilator hung on the Infant Care Center, there were no oxygen canisters on the ward, and little care to be provided beyond wrapping and labeling the corpse. In Hospital B, the Infant Care Center was used, instead, primarily to display infants. Though not fulfilling its intended function as a portable, fully equipped resuscitation station (as denoted by its proprietary name, the Resuscitaire), the Infant Care Center did perform a critical role in rendering infant bodies visible for the inspection and social acknowledgment necessary to fully transition a neonate into the world of the living.

Acknowledging visually and the production of difference

Understanding witnessing in Sierra Leone is key to understanding the logic informing this public display. A basic social requirement is that there should be as many witnesses as possible when gifts are given or received. One reason is to guard both parties against claims of wrongdoing. A similar logic informed clinical practice in Hospital B, where end of shift 'report' consisted of a departing nurse following an oncoming nurse from room to room checking names off a list. The goal of this practice was simply to show the next shift which name went with which patient. The elegance of this practice contravenes a body of literature centered on the ritualistic elements of shift report, or 'hand-off,' in places like Hospital A. Ritual was the last thing on the mind of one staff member who told me, "In this country our names are all so similar. If you don't *see* the patient you might get confused. There are too many Isatu Kamaras!"

Witnessing was also often a source of authoritative knowledge in the production of sex, as the genitals of newborn infants were displayed to their mothers immediately upon cutting the umbilical cord. When relatives came to the ward, the visit usually included a staff member unwrapping the *lappa* cloth to

display the neonate's genitals. This practice both satisfied curiosity and guarded against accusations of baby-switching. The announcement of 'boy' or 'girl' was insufficient and could later be rendered invalid if not accompanied by visual evidence (as a 2012 court case proved). In my experience of Hospital B, knowledge about the sex of infants was produced by visually *ac*knowledging, or seeing together.

Conclusion

Throughout the continent, Africans have devised strategies to put the colonial in its place. The elements of biomedical practice described here are but a few amongst the countless colonial technologies rendered epistemologically unrecognizable through the practices of those living in the aftermath of formal European colonialism. Hospital B is an example of how one group of Africans have woven their own ways of doing and knowing into colonial infrastructures. It is a place were healing surgery is performed, but also a place where old wounds can be laid bare and exposed to the open air where they might eventually heal beneath a scar. As I demonstrate elsewhere, through reshaping British colonial technologies to suit Sierra Leonean needs, appropriating and deploying them to assert Sierra Leonean social hierarchies, staff here perform a clinical practice which absorbs and disintegrates its predecessor. While history is constantly, often consciously present, it is also subject to constant revision, its terms redefined.

What is a hospital? These stories are meant to encourage more questions than answers, to prompt us to consider how biomedical technologies may be more mobile than immutable, contingent on different concepts of the body, personhood, the firmness of the border between life and death, and user orientation to the past. Ethnographic detail, vivid and nested within a frame that embraces moral and historical imaginations, technologies, and medical spaces,

invites debate about the weight of the past in Africa's technology stories. I seek to foster a reconsideration of the terms of this debate, and to suggest that what a hospital *is* depends on *where*, *when,* and *to whom* the question is posed.

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