



Landscape near St. Francis of Assisi Mission in Nharira, Zimbabwe, Africa.

TEACHING IN AFRICA

MEDICAL ETHICS ZIMBABWE-STYLE

BY FR. THOMAS NAIRN, OFM, Ph.D.

Early this year, I spent six weeks teaching a medical ethics course at Holy Trinity College in Harare, Zimbabwe. I have conducted this class in Zimbabwe's capital city every other year since 2004, and my experience of Africa and the Franciscan life in that continent extends back at least another decade.

I first visited Africa in 1993 when, at the request of the head of the Franciscan Order, I conducted the canonical visitation of the Franciscans in South Africa. In 1997, I conducted a similar visitation to the Franciscans in East Africa: Kenya, Uganda, Tanzania, Rwanda, Malawi, Zambia and Burundi. The experiences at the time touched me so personally that, back in the U.S., I suggested to the head of the Franciscans that I would be willing to help with education in a developing Franciscan entity in Africa. Since the college was just beginning (this was around 2002), we agreed that I would teach there for



Weaver birds build nests that hang like ornaments in the trees.

approximately six weeks every other year.

Today, the school trains seminarians from the Franciscan, Redemptorist and Carmelite orders as well as the Congregation of the Holy Spirit. Students come from Zimbabwe, Zambia and Malawi. The college comprises one-half of Nazareth House, a rather large complex in eastern Harare. The other half of the building is housing for the elderly poor, the primary ministry in Zimbabwe of the Sisters of Nazareth who run the house (hence the name). Although located on one of the major thoroughfares of the city, the grounds of Nazareth House are filled with gardens. These gardens have become a favorite place of mine. As my students formed small groups and discuss medical ethics cases, I often watched the weaver birds constructing their complex nests right outside my classroom window.

SPOTTY ELECTRICITY

Most of my visits to Zimbabwe have been during times of economic and political crisis. During this trip, however, the country was probably in the best shape I have ever seen. For over a decade, Zimbabwe has experienced hyperinflation (reaching 230 million percent annually). In fact, during the two years since my last visit, the government removed 22 zeros from its currency! This change began in mid-2009, when the country's Multiple Currency Act made the U.S. dollar and the South African rand the official Zimbabwe currencies, along with the Zimbabwe dollar. Of the three, the U.S. dollar is now the most official currency for all practical purposes. The currency act seems to have stabilized the economy, making inflation a virtual non-issue, filling the stores with goods and finally giving people an incentive to save. It was odd going into stores and even into Zimbabwean banks and seeing people use U.S. dollar bills.

However, some things about life in Zimbabwe have not changed. Electricity is spotty. We were

often without power, but at least the outages did not go on for days, as was the case the last time I was there. I usually was up before dawn, which meant I sometimes shaved with a razor in one hand and a flashlight in the other. Telephone lines are often out. The house I lived in had been with-

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out a working phone line for several months. This meant no modem connection to the Internet, not to mention broadband, which is just beginning to appear in Harare (and is too expensive for most people, including the Franciscans). When faced with such daily occurrences, most people just shrug and say, "It's Zimbabwe!"

SPARSE TECHNOLOGY

Living in such a country underscores how deeply we in the West have integrated technology into everyday life, often without realizing the implica-

Photos courtesy of Fr. Thomas Nairn, OFM



Fr. Tom Nairn leading his medical ethics class for seminarians in Harare, Zimbabwe.

tions. When I teach medical ethics in Zimbabwe, I have to recalibrate my thinking, taking into account that many of the major health issues — malaria, for example — are so low-tech that something as simple as mosquito netting can make a critical difference.

Even though the seminarians and I share a common faith tradition, I also have to take into account their vastly different life experiences. This realization hit me as I was preparing to teach medical ethics at the college for the first time. One night about six weeks before I left for Africa, I suddenly awoke in a sweat, realizing that my entire course presupposed the presence of advanced medical technology — the one thing I could not count on in Harare. What one might expect to find in any medical center in the U.S. is often non-existent in Zimbabwe, turning what we in the U.S. would understand as routine medical care into situations of triage. If an elderly person is on a hospital's only ventilator, and a younger person who has a much better chance for survival comes in and requires the machine's assistance to breathe, what do you do? Do you keep the older person on the ventila-

tor and allow the younger one to die, or do you remove the older person? These questions, rare in the U.S., are common even in a large city like Harare.

Being forced to face questions such as these, however, has not blunted the Zimbabwean empathy and respect for the sick and the dying. The process of decision-making is somewhat simpler, for people do what they can and realize the limits of what they can do. Sickness and dying are part of life, and there isn't the denial of death that has often characterized American culture. Similarly, illness and disability are not hidden away.

PERVASIVE SPIRITUALITY

Furthermore, the spiritual dimensions of illness are taken more seriously than they might be in the U.S. To an extent, this also has something to do with the animism that is part of the mentality of those living in Zimbabwe. Zimbabweans are comfortable talking about spirits — both good and bad. They will speak of witches and curses. Most of my seminarians would have consulted both Western doctors and traditional healers. Knowing this, I speak more of the spiritual dimensions of illness than I would to classes in the U.S.

The concept of healing is a very important aspect of the lives of the people of Zimbabwe, as it is for Africans in general. Their understanding of healing, however, is much more comprehensive than it is in the West, taking into consideration not only the physical, mental and social elements of existence but the spiritual and even cosmological elements as well.

Compared to their U.S. counterparts, my students thus have a very different understanding of healing; a different appreciation of what it means to be a patient and a much different approach to such notions as autonomy and informed consent. As I often do in the United States, I began my course this year by asking my Holy Trinity students to form groups and define the terms "health" and "sickness." Their definitions were in many ways comparable to those of my American classes, but with different emphases. Most of my African students speak of balance when they speak of health. They understand balance, however, in a cosmological sense, incorporating the notions of evil, of spirits and of God.

Similarly, when my African students speak of the spiritual, they mean the world of spirits. These understandings coexist rather easily with more typically Western understandings of dis-



After Sunday Mass at St. Francis of Assisi parish in Harare



An Apostolic church meeting outside Harare.



that set the sickness into motion is not addressed, the person will continue to suffer.

For this reason, people in Zimbabwe will often go to a Western physician and to a traditional healer, and they will follow the directions of both. During difficult economic times, traditional healers often get the edge. As one of my students told me, “If I don’t have money, all I have to do is to give a stick (*chibatiso*) to the healer. When I am able to pay, I give him the money and he returns the stick. This is called *kudzikinura* (redemption).”

Furthermore, many Catholics in Zimbabwe are moving to the indigenous Apostolic churches because the latter promise cosmic healing. These churches claim that because the Holy Spirit is present in the churches, they have greater power than witches and sorcerers (and the Catholic Church). They claim they are able to discern the will of God and the wishes of the ancestors, thus are able to preserve the balance of the cosmos through their teachings and practices.

ease and cure. My students readily acknowledge that diseases have natural causes, and they accept Western ideas of bacteria and viruses. For them, however, these only partly explain health and sickness. They know that not all who are exposed to a virus will develop a disease. Therefore, they also want to know why a *particular* person succumbed to a virus, why a *particular* person contracted a disease.

The answer, many of my students believe, involves a personal and even a cosmic power — the influence of enemies, witches or the spirits of angry ancestors. Thus, although Western medicine can answer part of the question of sickness for them, they also believe that if the personal cause

WEB OF RELATIONSHIPS

Teaching in Zimbabwe forced me to take a very different look at medical ethics myself and, I hope, deepened my understanding of spirituality and humanity and led me to greater humility about my own ideas and attitudes as well.

For example, in my medical ethics course, I ask students to envision the web of relationships that surrounds a sick person. Part of my reason for doing this is to help them broaden their understanding of who are “care givers.”

In the United States, students generally begin by naming the persons typically in proximity to

the patient, such as physicians or nurses, then they branch out to people such as social workers, sacramental ministers and even people in the finance department and at the health insurance company. Before long, I have filled the entire blackboard with these relationships.

I have learned how my African students' concept of healing affects their view of a sick person's relationships. When I ask the web of relationships question in Zimbabwe, I also fill the blackboard — but with very different entries. When one understands their ideas regarding sickness and healing, it is not surprising to see one of my students put "enemy" among the relationships surrounding a sick person, and another place "witch." Such answers, however, provide us an occasion to compare and contrast Catholic and African understandings and raise questions for class discussion about how our Christian faith supports and challenges our cultural views.



FREEDOM OR ABANDONMENT?

Some of my best discussions about the sacraments of healing and the role of the priest and other ministers have occurred in Zimbabwe. It is not at all a stretch for my African students to understand the use of oil and prayer in effecting healing and salvation — it is much closer to their lived experiences than for many of my American students.

However, such common medical ethics issues as respect for autonomy and informed consent lead down rather interesting paths in Zimbabwe and elsewhere in southern Africa.

In the United States, I often speak of our fundamental understanding of autonomy by quoting a 1891 U. S. Supreme Court decision that states: "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."¹ I might add Michigan Supreme Court Justice Thomas M. Cooley's 1888 description of autonomy: "The right to be left alone."²

When I describe this benchmark American concept in Zimbabwe, my students' eyes grow wide and their jaws drop. What we prize as "freedom from restraint and interference," they see as abandonment. Rather than the "right to be left alone," my students speak of "*munhu munhu nekuda kwevanhu*." Literally, this means "a person is a person through [other] persons" and usually

is articulated as "I am because we are." This attitude emphasizes interdependence rather than independence. Especially in the villages, medical decision-making can become a family affair, where family is understood well beyond our nuclear understanding of family and may even encompass at a minimum aunts, uncles and cousins.

Similarly, my students who come from Malawi let me know that forms of consent accepted in the West, and even in Zimbabwe, are foreign to them. The reason for this is that most regions of central and southern Malawi are matrilinear and matrilocal marriage systems. This means the husband leaves his village and clan and lives with his wife's family (the opposite of what occurs in Zimbabwe). Since the husband enters the wife's family, it is not the husband, but the wife's brother who is considered the head of the family. As family head, it is he — and not a child's father — who would give consent to medical procedures.

CROSS-CULTURAL APPLICATIONS

As a Westerner, I realized early in my teaching in Zimbabwe that I was there to teach medical ethics from a Catholic and Christian point of view and not a Western one. Our Christian ethical tradition can be at home in many cultures. Thus, although I am convinced that the Western notion of autonomy has served medical ethics well, I also know that it is not necessarily appropriate for all nations and all cultures. One of the joys of teaching in such a different culture has been the challenge to my own assumptions. Allowing these challenges has, I hope, made me a better ethicist.

Having been in Zimbabwe several times now, I feel that I am beginning to be trusted by my students. I try to teach the Catholic tradition and do not try to make them mini-U.S. citizens. I try to respect their traditions, but I also try to show them how the Catholic tradition of health care and medical ethics can challenge their understandings and customs — just as it challenges U.S. understandings and customs. I think my students are coming to realize that the Catholic medical ethics tradition has something positive to say to Zimbabwe — just as it has something important to say to the U.S.

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NOTES

1. Justice Horace Gray, *Union Pacific R. Co. v. Botsford* 141 U.S. 250 (1891).
2. Thomas M. Cooley, *The Elements of Torts* (1888), 29.

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