TLC Showcase

LACHLAN MCIVER

Introduction to the manuscript 2

Extract from *Life and Death Decisions* 3

About the Writer 8

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Introduction to *Life and Death Decisions*

Life and Death Decisions is my little crate of dynamite. It's part medical memoir, part call to arms for action on some of the greatest but neglected global health crises of our time. With this book, I'm aiming to use the story of my life's journey as the Trojan Horse by which to transport into the minds of readers a series of serious and important messages about the health of our communities and the challenges we all face.

I've lived and worked in some of the wildest parts of the world, from remote Indigenous communities in Australia to the sinking islands of the Pacific and across natural disasters and civil war zones in the Middle East and Africa. I've treated patients with everything from shark bites, stabbings, bullet wounds and burns to HIV, malaria, tuberculosis and leprosy. I've worked for the World Health Organization and Médecins Sans Frontières (Doctors Without Borders) trying to tackle incredibly complex issues like the health impacts of climate change and the rise of antibiotic-resistant infections. I've also had some extremely difficult and humbling experiences with depression, alcohol abuse, bankruptcy and burnout. Those horrors have helped me get to know myself better, recognise my limits and realise some of the dangers involved in us, as a society, having such high – and often impossible – expectations of what doctors do.

Life and Death Decisions takes you on a hectic, high-speed rollercoaster around the world and through the field of humanitarian medicine. It's a fun, fascinating, sometimes tragic and sometimes pretty bloody funny ride.

I'll be forever grateful to Joe and the TLC team for their support in bringing *Life & Death Decisions* into the world. Thanks to the *Chapter & Verse* programme and the exert advice from my mentor, Dr Stephen Carver, I was able to hew this book from the marble of my tropical-disease-addled mind!

Extract from *Life and Death Decisions* by Lachlan McIver

I spent my days in Old Fangak treating the children that kept turning up in our Emergency Room, which, like most of the rest of the hospital, was nothing more than a muddy, mouldy, intensely humid tent. Many of these kiddies arrived comatose with severe malaria, having seizures and showing signs I'd only ever previously seen in medical textbooks. And I spent my nights sweating, swatting at the mosquitoes that bored their way like noisy, vampiric little ninjas through the multiple barriers of insecticide-treated net, then weapons-grade repellent, then my skin, and listening for (that is, hoping not to hear) the radio crackling into life with 'Dr Lachie, Dr Lachie for ER' – the summons to strap on my headtorch and stomp back through the mud in my gumboots to see what new sickness the swamp had brought forth.

By this point in my career, I figured I'd been around, seen some stuff, done some things. But I was still pretty shocked to encounter, on my first morning ward round in Old Fangak, a gorgeous little three-year-old girl called Akong, who'd been carried into the hospital in the arms of a stranger a month earlier, after her alcoholic mother had dumped her and left her to die in an open pit latrine. She was unconscious and severely malnourished, with both TB and kala-azar, otherwise known as visceral leishmaniasis – a parasitic infection spread by sandflies that is usually fatal if untreated. I'd never seen this before in my life but had to learn about it rapidly, as I was now in one of the world's hotspots for the disease. Outbreaks commonly occurred in settings of poverty, conflict, forced displacement, malnutrition and changing climatic conditions: Old Fangak had the royal flush.

Akong slowly recovered and her smile and outstretched, cuddle-seeking arms were the bittersweet highlight of every morning ward round. It was sweet to see her improve, but bitter was the knowledge that she still had no one to care for her.

It wasn't just the rare diseases that served as a reminder of where we were. Every day, young men would hobble in on makeshift crutches, clutching at dirty, bloody, pus-soaked cloths covering gunshot wounds. These were typically from days earlier and thus often infected, given the time it took to trek through the swamp to our hospital. The fighting between the loosely aligned rebel groups and the government forces rarely came close enough to make us feel in real danger, but there was a

strict evening curfew and forays beyond the gates of our compound were few. That meant that I was particularly happy (albeit in a slightly guilty way) to be sent out on the motorboat for the occasional outreach clinic or emergency medical retrieval. The experience of skimming up and down the reed-choked river, grinning at the naked children cavorting in the shallows, watching the birds wheel lazily overhead and waving at the wiry men paddling along gamely in their handmade canoes – hollowed-out logs with the ends plugged with mud – was a rare, visceral, privileged pleasure.

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One particularly sticky midday, as I finished my ward round and was squelching over to the communal dining tent to forage for some lunch, the voice of Jacob, the Nigerian Project Coordinator, came blaring over the radio.

'SOS call, Lachie. Young boy's been bitten by a snake in a village somewhere up the river. Need you to grab the retrieval kit, go with Marie in the boat with Wotjak, find the kid and bring him back if he needs treatment. You cool with that, over?'

'Copy that. On my way. Over and out.'

I swung by the dining tent, kicked off my boots at the door, shuffled through the mosquito net in my filthy socks, stuffed some stale bread and cheese in my satchel, then slipped my boots back on and stomped over to the pharmacy. I rummaged around in the drug fridge trying to find the snakebite antivenom. Eriko, the ever-cheery Japanese pharmacist, heard the ruckus and appeared smiling at my side.

'Do you need some help, Lachie?'

'Hey, Eriko, yes, thanks. Where do we keep the antivenom?'

'It's in the box behind the measles vaccines. Who do you need it for?' 'There's a kid in a village up-river somewhere who's been bitten. We're heading off in the boat to get him now.'

'Ah, I see. Okay. So, ah, are you sure?'

I yanked a couple of vials from the box and pulled my head out of the fridge. Eriko was still smiling politely, but she seemed a bit flustered. I tried to reassure her.

'Don't worry, I've treated plenty of snakebites in Australia. Thanks for this, see you when we get back.'

I stashed the vials of antivenom in the bag of emergency retrieval gear, hoisted the heavy backpack over my shoulders and staggered down to the muddy dock where Marie was waiting. A storm front was closing in as we set off up the river and, as we entered the mouth of a weed-filled lake, the rain came. We found ourselves chugging, achingly slowly, through the thick vegetation that covered the entire surface of the lake, as tropical raindrops the size (and density, it seemed) of sultanas pelted us from every direction. I peered through a hole in my anorak at Wotjak, the captain of our little vessel, as he stopped every few minutes to reach down behind the boat and unclog the outboard motor. Like many men from his Lou Nuer ethnic group, Wotjak had ritualistic horizontal scars on his forehead, but I thought he looked rather worried as well.

Eventually we arrived at the lakeside village that had sent the SOS. We sloshed through the knee-high water to one of the half-dozen little round mud huts and poked our heads inside. Packed into the tiny dark space were a man, two women and four small children, one of whom was wearing a calico cloth and a spooked expression. Fair enough, I supposed, from the little fellow's perspective, given he'd already had to deal with some nasty snake-related business and now a white man had just appeared in his doorway with a bright light beaming out of his head.

With the help of my trusty headtorch I gently lifted back the cloth and found one of his legs was blistered and swollen to twice the size of the other. I removed the makeshift tourniquet that had been applied around his thigh, as the risk of gangrene was already high. We carried our little patient back to the boat, where at least I had decent light and a flat, if wet, surface on which to work. The rain had stopped and the sun was out. I could see the steam rising off myT-shirt as I wiped the sweat from my eyes. Under the curious gaze of the patient's mother, father and about fifteen other folks from the village who'd gathered around the boat by now, I carefully inserted a cannula into a vein in the boy's arm, gave him some pain relief and fluid and drew

up one of our precious vials of snake antivenom. These medicines were expensive, scarce, sometimes dangerous and – in this part of the world – occasionally ineffective due to dodgy manufacturing practices, but this was a 'life or limb' situation.

As I knelt down to give the injection, I felt a hand on my shoulder. It was Marie.

'Hey, Lachie, are you sure?' she asked, nodding in the direction of my syringe.

I felt mildly offended. Didn't my colleagues realise snakebites were common in Australia? We are perversely proud of our reputation as a country supposedly teeming with deadly creatures. Dealing with the consequences of their fangs and stings is the bread and butter of an Aussie rural generalist's job.

'Yeah, it's fine, I'm sure,' I replied, and very slowly injected the antivenom into the IV line, watching the boy's face intently as I did so. The immune response to this type of medication can occasionally be severe, in the form of an allergic reaction, which may, in the most extreme cases, manifest as anaphylaxis: a life-threatening emergency. The wee lad blinked back at me nonchalantly, then looked away and squinted into the sun. So far, so good. I gave a thumbs-up to Wotjak and he fired up the outboard.

The journey home was faster, as we were going down-river and could follow our earlier trail through the weeds in the lake. Our snakebite patient was joined the following day on the paediatric ward by another little girl who'd been bitten on the arm, but not so badly as to need antivenom. That was fortunate, as I had received a sharp slap over the wrist via email from the Medical Coordinator (MedCo) in Juba when she heard I'd given some to the little boy. The snakebite antivenom supply crisis was so severe in South Sudan, there had been a decision made by the MSF project managers to reserve the small number of vials of antivenom we had available in case one of our staff members was bitten and needed treatment. While I understood the reasoning behind this – namely that we had a duty of care to our own employees, and we couldn't expect them to work in a place slithering with venomous snakes and not ensure an antidote was available – this directive still made me deeply uncomfortable. How could we deny life-saving medication to the patient in front of us, knowing it was available but only for those with the right paperwork? I humbly accepted the

reprimand from the MedCo, who assured me they were trying their best to rectify the supply crisis as soon as possible. But I wrestled with the knowledge, as I tossed and turned in my creaky cot, that – if faced with a similar situation – I'd probably do the same again. This dilemma represented so much of what I often struggle with as a doctor: the difficulties balancing the needs of the individual against those of a population; inequities in access to healthcare and medicines; and the impossible question of what value to place on a human life, particularly when it appears to be a zero-sum game.

About the Writer

Dr Lachlan McIver specialises in rural & remote medicine, tropical medicine and public health, and has a PhD in global health. Originally from Millaa Millaa in Far North Queensland, Australia, his travels to date have spanned almost one hundred countries. Lachlan has treated patients in some of the most isolated, volatile, resource-deprived communities on the planet, while grappling with complex health challenges such as climate change and antibiotic resistance.

He has co-authored close to fifty scientific publications in medical journals and textbooks on topics ranging from environmental health and infectious diseases to anaesthetics and emergency medicine. He is an adjunct Associate Professor at James Cook University in Australia and the co-founder of the international non-profit organisation Rocketship Pacific Ltd, which focuses on improving health in Pacific island countries through stronger primary care.

Lachlan and his wife live in Switzerland, where he is the Tropical Diseases & Planetary Health Advisor at the Geneva headquarters of Médecins Sans Frontières (Doctors Without Borders). In his spare time, Lachlan writes and records cheeky, ironic punk-rock music in his basement under the pseudonym The Serpent's Nest.

His first book, *Life and Death Decisions*, an explosive memoir that combines Lachlan's personal journey with an urgent call to arms for action on some of the greatest but neglected health crises of our time, was released in September 2022.

Link to the book: https://www.hachette.co.uk/titles/dr-lachlan-mciver/life-and-death-decisions/9781913068790/