

A Global HRST

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A recent piece on National Public Radio (“Volunteer docs in Peru take a shopping trip to look for patients”)¹

highlighted challenges of carrying out a successful surgical short-term mission, which utilizes volunteers effectively and addresses expectations in the host community. While it is not likely your experience, nor the NGO you volunteer with, perhaps you have seen or heard others talk similarly about less-than-favorable ventures abroad. Insufficient patients available, hosts failing to notify hospital staff of your impending visit, discovering another group had just been at the site and teaching the same materials you had prepared ... these are only a few of the stories we have all listened to while assuring ourselves that our missions are different, or that these events are just part of the business of international voluntary medical service. But these occurrences not only undermine productivity, they also demoralize the local community and discourage participants who expected worthwhile use of their most valued resources: time and effort. Can we challenge ourselves, our universities and our NGOs to transform water cooler sighs into forces of yet greater significance? Could the success of common best O.R. practices transfer to our efforts in the global humanitarian scene?

In many ways, challenges in humanitarian outreach programs echo those we have been addressing in our own hospitals, focusing on the “Highly Reliable Surgical Team,” or HRST. Preoperative checklists are now a well-accepted and essential component of the high-reliability team. How could we apply concepts from a preoperative checklist to the planning and execution of voluntary medical services abroad, the “Global HRST”?

What Are the Characteristics of a “Global HRST?”

Right Procedure

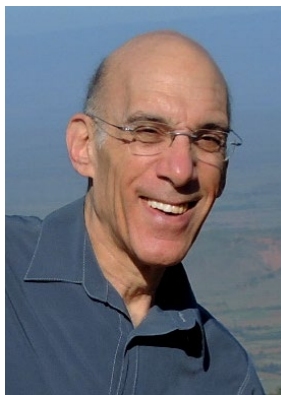
We must ensure that the mission addresses a need identified by the recipients. Teams are often invited to develop programs based on the needs perceived by a single host colleague. Do the goals of the host and the invitee fully align? The host might agree that a proposed training is valuable, while also being attracted to the boost both in their professional and material benefits by allying with a team from abroad. Sometimes educational activities might be directed more by the visitor’s expertise than by needs on the ground.

Right Patient

One might ask, “Is this the right locale and time to undertake the project?” Many of us have participated in productive missions where local, non-participating staff were left troubled by the sequestration of O.R.s by the NGO project. One surgeon recently commented that his staff tolerates the visiting team’s impositions because the donated supplies and equipment are so needed. However, he ruefully added, it also undermines their sense of mutual respect.

Introduce Team Members

Are all the vested interests identified? Who has been left out? What other agencies are doing the same, or complementary, work in this region? What other external partnerships exist in this department/hospital? For short-term surgical programs, are other groups “competing” for the same patients? Volunteer groups, NGOs and academic institutions need to be aware of other agencies working in the same, or complementary, arena



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for best use of both host and invitee resources. In-country hosts need to be encouraged to disclose the agencies and academic programs with which they have developed working relationships.

Necessary Equipment and Supplies Are Available

Visiting surgical programs have the responsibility to ensure they can provide effective therapies and safe anesthesia to patients.² Improvisation should be minimized; standards should conform to published international standards, which specifically address elective surgery in austere surroundings.³ Some NGOs, such as Operation Smile,⁴ already adhere to worldwide standards of care.

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Review Anticipated Critical or Unexpected Steps

Teams need to be prepared with alternate plans for unexpected events. Examples include equipment held up in customs, hospital facility unprepared to assume the extra burdens expected, illnesses or absences among the team members or host colleagues, and unexpected need for ICU care. Early “fire drills” can review management of common emergencies as well as team response to a bad outcome.

Debrief

Just as there needs to be a critical review of procedures used during surgery, there should be critical review of the outreach program. Like researchers utilizing IRBs, volunteer organizations should avail themselves of objective evaluation of their surgical and educational activities.⁵ Were the activities aligned with the stated goals? Is the program best organized to meet the organization’s goals? Do donors play a substantive role in directing program goals? Are human and material resources used wisely? Are there changes that would promote better outcomes? Professional societies such as ASA, the World Federation of Societies of Anaesthesiologists (WFSA) or subspecialty societies are encouraged to continue to develop benchmarks and guidelines for safe, well-coordinated and effective international medical service programs.

Opportunities need to be explored to engage outside, dispassionate review of missions. Networks, which include host countries and the large array of medical ventures, need to be developed to determine guidelines for the best use of resources and locales where they take place. How can both activities and locale need be adjusted to meet evolving requirements?

Specimens Correctly Labeled and Sent

Sustaining an “institutional memory” of what works and doesn’t work is a real challenge. Volunteers and host country staff change over time, risking the need to rediscover past difficulties. A structured QA mechanism and opportunity to review short- and long-term outcomes of both educational and service components support improving results and growing an institutional memory. Members of host country and visiting teams play vital roles in the process.

Although there are many strong and cogent reasons for collaborative work among NGOs, academic programs, government agencies and in-country hosts, it is clear there are also substantial barriers defending a status quo for hosts and volunteers alike.⁶ While many volunteer groups unquestionably do excellent work, steps might be taken toward the Global HRST that could contribute to well-coordinated, collaborative and efficient outreach, minimizing duplication and disruption. Measures should include developing sustained, open communication among agencies and hosts, initiating external review procedures, and donors taking greater initiative to promote collaborative work. Particularly important in this evolving field are highly focused groups, such as the ASA Committee on Global Humanitarian Outreach (GHO), international panels at ASA, and subspecialty societies that offer the scaffolding to further explore and implement these imperatives.

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