Reports from Our 2018-19 GHO Global Scholars

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The ASA Committee on Global Humanitarian Outreach sponsors a Resident International Anesthesia Scholarship Program that sends CA-3 U.S. anesthesiology residents to a low-income country for a month. The goal of the program is to embed the resident into the clinical and anesthesia educational program in order for them to more fully understand the challenges and realities of anesthesia care around the world. The residents have an opportunity to interact with local anesthesia, surgical, nursing and other colleagues and participate fully in educational activities. Our goal is to introduce residents to the global anesthesia crisis and motivate them to be a part of worldwide solutions to these complex problems. The following report from four of the 2018-19 scholars gives a glimpse into the value of this experience and the larger work of the GHO committee.

UGANDA

As I am waiting for my departure flight, I cannot believe that it has been a month since I stepped foot into this new territory. I am not an inexperienced traveler nor am I a novice to the medical systems and medical needs in developing countries, but still I struggled emotionally as the month progressed. Uganda is the fourth country in the fourth continent in which I have been fortunate enough to spend some time providing medical care for patients in need. Needless to say, the need far exceeds the resources. The hospital has three neurosurgeons and three anesthesiologists on staff, but they perform more than 1,400 neurosurgery cases a year, mostly for hydrocephalus for Ugandan children as well as children from neighboring countries. There is an estimate of about 6,000 new cases a year in Uganda alone, thus the number of cases has continued to grow since CURE Children’s Hospital of Uganda (CCHU) opened. The number of cases performed with that small staff was not what amazed me. Rather, what amazed me was the attitude and passion the local doctors and health care providers have for their patients. Most of the patients are unable to pay for their care, but that does not stop the doctors from taking care of them. The resources were limited, yet I did not see any sign of frustration (maybe they hid it well or they became accustomed to it). I, on the other hand, caught myself being frustrated more than a handful of times when I felt unease that I had to decide what best to do for patients in situations where I could not provide adequate “standard” of care with the resources at hand. Similar to other developing countries, Uganda struggles to have an adequate number of anesthesiologists. Most of the cases are done by anesthesia officers who have about three years of post-secondary school training. The staff anesthesiologist is usually readily available in case of emergency, but they also play a role in providing care for the ICU patients as well as teaching the local medical students.

In addition to the limited resources at work, there are also limitations on living conditions. Since I left Vietnam in 2000, I have not experienced hunger even when I skipped meals because of being busy at work. Yet I was constantly hungry daily. I could definitely afford to buy extra food to supplement what was provided to me, but I chose not to as I wanted to immerse myself in the full experience of the local people. Even as I was constantly hungry, I was pretty sure that I had more food every day than an average person in Mbale. Moreover, it was definitely not fun to sleep inside the mosquito net, to apply DEET nightly and to take malaria prophylaxis daily; all of which, of course, were a “luxury.” I struggle being a physician in the U.S. from time to time as I feel the resources are wasted, some of the surgeries are unnecessary and sometimes we do things just because we can. I can become jaded and unhappy with myself and my work. Every six months or so, I seek an opportunity to further my education and experience by going on a trip/mission that allows me to learn and to provide care for the ones who need it most.
I was very fortunate to be chosen as one of the recipients of the 2018-19 ASA Global Humanitarian Outreach Program scholarships, which allowed me to spend one month working beside Ugandan neurosurgeons, anesthesiologists and anesthesia officers in providing care for children undergoing neurosurgery at CCHU. Although I am not new to the experience of practicing medicine in the developing world, Uganda provided a unique experience and challenge. In my previous missions, I was a part of a U.S. organization that was equipped with adequate supplies, modern technology and adequate numbers of trained anesthesiologists. In Uganda the resources were limited, including a lack of necessary equipment, frequent need to improvise, low income and the lack of an adequate number of anesthesiologists. I have nothing but the utmost respect for the dedication of the medical staff at CURE to provide the best possible care for patients, day in and day out.

In my humble opinion, these experiences are a must for any physician to have in order to better understand the challenge of practicing medicine around the world and to appreciate the “luxury” that we have practicing medicine in the U.S. As a Navy physician, my time in Uganda was more than a “cool” experience. My line of practice requires me to learn to adapt to a new environment and culture in addition to the practice of medicine, sometimes in an austere environment. My experience in Uganda provided me just that. Time in the operative theater allowed me to learn to be flexible, to adapt, improvise and overcome the lack of resources. My time with the staff after working hours allowed me to learn about their culture, which I will apply in my future line of work should I be deployed to less than familiar places. I appreciated all the opportunities I was afforded overseas. I received many thanks from patients, their families and the host nation for my time and service, but the fact of the matter is, I am the one who should give thanks. I thank them for giving me the opportunity to provide care for them, to help remind me why I chose to be a doctor in the first place, and to allow me to learn how to practice safe medical care even with limited resources and with challenging cases.

I thank the ASA Global Humanitarian Outreach program for choosing me to be one of the winners of this year’s scholarships and CURE Children’s Hospital of Uganda for allowing me to join their hospital staff in providing care for their patients in this past month. The experience is invaluable and irreplaceable by any other means.

– Milan D. Dang-Vu, M.D.

The views and opinions expressed by Milan D. Dang-Vu are those of the author and do not necessarily reflect the official policy or position of the U.S. Navy or the U.S. government.
mentorship of the anesthesiologists there. At MRRH, I was invited to teach basic airway management to non-anesthesia providers and trainees as part of a larger trauma management course. I also provided intraoperative teaching to trainees there. At CURE, I designed and implemented a quality improvement project for the ICU nurses aimed at increasing knowledge of the management of ventilated patients. In addition to hands-on teaching sessions, I designed laminated reference sheets that are now attached to each ventilator to promote knowledge retention.

I also had the opportunity to travel to the capital, Kampala, to help facilitate a short course called Inspire Through Clinical Teaching, which aims to equip health professionals with the skills necessary to become better clinical teachers. While there, I helped hone participants’ skills in leading didactics and medical simulation. Inspire had already been taught in several countries with support from grants and donations through the Canadian Anesthesiologists’ Society International Education Fund (CASIEF) and was being taught for the first time in Uganda.

Finally, I would like to extend my deepest gratitude to ASA for their generous support of my experience in Uganda, as well as to the Beth Israel Deaconess Medical Center Department of Anesthesia, Critical Care and Pain Medicine for graciously allowing me the time away for the experience.

– William “Frankie” Powell, M.D., M.P.H.

If you would like to support access to safe anesthesia through education and the provision of necessary tools to low-resource settings, please consider donating to Lifebox, a non-profit organization that collaborates with ASA. Visit www.lifebox.org for more information.

References:
2. Durieux ME. But what if there are no teachers ...? Anesthesiology. 2014;120(1):15-17.

ETHIOPIA

I remember my medical school interview where I had to explain to a group of physicians my reasons for wanting to attend medical school. My reasons were many, and each applicant had their own specific goals to embark on this medical journey. Despite what our individual motivations were, at the core of wanting to become a physician lies the concept of service to others and compassion. As anesthesiologists, taking care of a person in their most vulnerable state where they are asleep, unaware, unconscious and not present is a humbling experience. Moreover, having reliable access to necessary equipment, drugs, machines, adequate light, vaporizers or oxygen makes our job not just easier to perform but safe for our patients.

Now imagine working in an O.R. that is missing a ventilator, or pulse oximeter, or an endotracheal tube of the right size, and being asked to provide the same anesthetic as you would in a fully equipped O.R. Imagine taking care of a septic ICU patient and not having vasopressors available. Or imagine consulting for a neonatal anesthetic but postponing a lifesaving surgery because the right-sized endotracheal tube was out of stock.
Many anesthesia providers in Ethiopia are asked to take care of complicated surgical cases in circumstances most of us would be unable to work in. While rotating as a resident at the CURE International Hospital in Addis Ababa, I was able to observe, learn, teach and work with the local anesthesiologists. I went with the mindset that I would be working with physicians who lacked fundamental medical knowledge or who were mediocre at technical skills. This is because, let's face it, I and many of us have been painted an image of third world country medicine as being backwards and unsafe. Unfortunately, despite some of these images we have painted for ourselves being true, I was pleasantly surprised to have also found the opposite.

During my rotation, I worked alongside anesthesiologists who embodied the reason why I wanted to go to medical school in the first place. They were compassionate and knowledgeable; they championed for their patients and were dedicated to improving the medical care they were providing. They knew they lacked resources and hospital-wide protocols, but they were eager to learn “Western” medicine and were open to ideas to improving hospital systems issues. Many worked closely with organizations such as the World Health Organization or the World Federation of Societies of Anaesthesiologists in implementing protocols to improve the quality and safety of their anesthetics. Their motivations to be leaders and champions in a hospital setting that most of us would give up on was exceptionally inspiring to me.

When I came back to my home institution, I was no longer the sheltered resident I used to be. I returned with new skills I would otherwise not have acquired. I learned new nerve blocks and neuraxial techniques on pediatric patients. I learned how to rely on physical exam to assess fluid status or proper ventilation of a patient. Most importantly, I learned how to manage the lack of resources while providing safe anesthesia to patients who often have complicated or unknown past medical history.

Today, I feel a sense of obligation to equip and enable the anesthesiologists in Ethiopia with the tools they need to improve their perioperative care. As the new global health and equity fellow at UCSF, I will be going back to Ethiopia to work on projects focused on partnering with local physicians to improve anesthesia care.

In conclusion, medicine in low- to middle-income countries is far from perfect. However, my time at CURE has shown me that a few motivated physicians championing for their patients can turn an imperfect and frustrating system into a solution for so many patients. I am grateful to ASA for enabling such an eye-opening and uplifting experience in my medical career. I am thankful to realize that good medicine is not just based on the availability of resources, but on the advocacy of a trained medical provider about his/her patient and the ability to provide genuine and compassionate care for an individual in need of medical attention.

To all the physician champions in Ethiopia who work in an austere environment and yet provide the best medical care to their abilities, thank you for being inspiring role models.

– Betelehem Asnake, M.D.

Continued on page 66
This past spring, I was able to travel to Ethiopia as a CA-3 under the ASA’s Resident International Anesthesia Scholarship program. This program funds CA-3s to do a month rotation in partner hospitals in resource-limited settings. I chose to go to CURE Children’s Hospital in Addis Ababa. CURE International is an NGO that runs permanent surgical hospitals in eight countries. CURE Ethiopia was founded in 2008 and provides mainly orthopedic and plastic surgery care to pediatric patients who otherwise would have few options.

As a medical student, I was fortunate to spend a summer at CURE Uganda’s pediatric neurosurgery hospital. However, that role was research-focused with little clinical time. As a senior anesthesia resident, this rotation was completely different. I was able to work alongside Ethiopian CRNAs, SRNAs and anesthesiology residents to provide care to these pediatric patients with often advanced pathology due to limited access to medical care. This involved teaching the residents on things such as ultrasound-guided blocks and intraoperative opioids due to limited prior exposure. As this was one of their pediatric focused rotations, it also included teaching the aspects of pediatric anesthesia that differ from adult care. Taking this role allowed me to begin the transition from resident to attending and to focus on how I will supervise/teach in this new role. I also learned a great deal from people who were used to working in a setting with limited resources. I never thought that I would be doing halothane induction, but this rotation changed that!

The medical and non-medical staff were amazing and very welcoming. They did everything they could to make me feel at home while at work and during off time. It was great to learn about each other’s backgrounds over Ethiopian coffee or injera and traditional food. Interacting with patients and families from multiple different backgrounds, as they had travelled long distances to get care that was otherwise not available, proved to be very rewarding and eye opening. The hospital had excellent facilities, and it was obvious that the staff took great pride in providing a very high level of care to their patients.

As a military doctor, my options to participate in global health during residency were limited. ASA’s scholarship allowed me to have an experience that will change the way I practice and will prepare me for settings where I may not have all of the resources I desire. I encourage residents to apply for the program and for members of ASA to consider sponsoring a resident. I would also encourage people to look into CURE International if they are interested in supporting or participating in high-quality surgical care in the developing setting.

– Jordan Lane, M.D.

The views and opinions expressed by Jordan Lane are those of the author and do not necessarily reflect the official policy or position of the U.S. Army or the U.S. government.

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Dr. Asnake teaching ultrasound at CURE Children’s Hospital.

Dr. Lane teaching ultrasound at CURE Children’s Hospital.