Christian Surgery &

Listening to the inner voice

Have you ever wondered whether there is something that He really wanted you to do...? Such was this challenge into Africa...

In 2005, I was challenged to take a surgical/medical team into Rwanda. This came about after talking to Russell Lee in Sydney. Russell is the organiser of a charity Operation Open Heart which is dedicated to taking paediatric cardiac surgical teams into areas of need – in this case Kigali in Rwanda. This trip was to be part of a world wide response to mark the ten year anniversary of the genocide. A giant mea culpa for ignoring pleas from both UN commanders on the ground in 1994 and the people themselves, pleas which if responded to in a courageous and timely manner may have averted much of the subsequent genocide. The fact that nearly a million Rwandans died in one of the biggest acts of ethnic cleansing the world has witnessed remains a living testimony to our apathy. And to the Rwandans durability and their power of forgiveness.

My initial reaction to Russell’s challenge was that this was not something that I was going to be comfortable dealing with. My previous experience of being badly wounded in a terrorist attack in Africa coloured my feelings negatively about this project. I indicated that if there were more than 10 people interested then I would offer serious consideration to being involved. Surely they wouldn’t get more than 10 people... In my soul was the sense that He was calling me but I still wasn’t sure. Uncertain, I looked for people to read. John Stott, one of my favourites and an avid bird watcher, focused my attention on self centeredness – its emergence as a worldwide phenomenon – its evidence in the rich variety of words in our language which are predicated with self, and Malcolm Muggeridge’s phrase “dark little dungeon of the ego” appeared from ‘somewhere!’ They all seemed inappropriate in my attempt to rationalise my way out of this. I think though when God wants you He is very persistent...

“Where can I go from your spirit
Where can I flee from your presence
If I go up to the heavens you are there
If I make my bed in the depths you are there
If I rise on the wings of the dawn
If I settle on the far side of the sea”

I had the feeling by now though that maybe this was something that God wanted done so ‘reluctantly’ my name was then put on the Hope Rwanda website and the response was ‘disappointingly’ overwhelming!! More than 30 people with some kind of medical skill were so moved by the project that they offered to volunteer their time to go into Rwanda to give some kind of medical assistance. I could (I thought) no longer ignore the prompting.

The medical-surgical team included people from all over the world: England, South Africa, New Zealand, America and Australia. All Christians united in the belief that they could contribute and all in their own way responding to that quiet persistent inner voice or in my case voice plus written word.

Those who volunteered covered the medical spectrum, –nurses, physiotherapists, occupational therapists, hospital administrators, and pharmacists. The response was such that it was decided therefore that two medical teams would go into Rwanda under the Hope Rwanda banner. Since I was the only surgeon I led one team, and the other team coordinated by Dr Simon Wu from Sydney was allocated to a separate more northern peripheral hospital. With the cooperation of the Rwandan government, we all duly arrived and were allocated Gisenyi Hospital, which is in Rwanda but only just – it is only 800 metres from the Congolese border.

Gisenyi Hospital is a 300 bed facility which has a catchment area of approximately one million people. It is staffed by five doctors, who are all grossly overworked, and draws not only from

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Christian Surgery & Medicine in Rwanda
By Dr Paul Anderson
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the Rwandan but also the Congolese side of the border. It was in a state of general disrepair, having been overwhelmed and overrun at the time of the genocide in 1994, with little being done to repair it since. Its location is on Lake Kivu, which provides a contrasting scenic background and also provided great respite for the team as on its shores amongst all the poverty is a 4 star hotel with good security and excellent food. One of the things about taking a team into Africa is that you don’t want to spend a great part of your time treating your own team!

The hospital is situated on a dirt road leading into the town of Gisenyi; further down the road is the congested Congolese border. Opposite the hospital is the prison, which is full to overflowing. The hospital grounds are serviced by prisoners dressed in pink (easy to spot) – the HIV+ve prisoners being given retrovirals in return for their labour. The policy is also to offer prisoners reduction in their sentences if they demonstrate that Christ has been invited into their life and if the fruits of his Spirit are evident for all to see. Third world they may be classed financially and on GDP but not when it comes to living faith – as we were to constantly witness. We on many occasions felt our faith was third world but were being daily taught by a people we had come to help in a way we hadn’t expected.

Medically the real challenge for this team was where to start. There was a great lack of everything, with only one x-ray machine servicing the surrounding population of one million – the sole radiographer in a lead apron with all the lead at the bottom! We subsequently brought him a new one on the next trip but weren’t sure whether the large radiating smile was entirely due to gratitude.

There were/are two theatres – only one of which was working. The theatre had electricity but that was intermittent with no overhead theatre lights, – merely a stand alone reading lamp with a 100 watt bulb (see the video at www.hospitalsofhopeafrica.org) —there was no diathermy and all anaesthesia was ketamine with a mask and oxygen. Intermittently the electricity would cut out and someone would have to leave the theatre, run down the hill and start the generator before there was enough light to be seen for the procedure to continue. Having said that, the first ‘operation’ that I was part of was a caesarean section – I had tried to prepare for that scenario by assisting at three caesarean sections before leaving Adelaide. The caesarean section was unlike anything that I had seen in Adelaide and the fact that the neonate had an Apgar of 2 would probably indicate the degree of difficulty of the procedure. However that the neonate survived is probably the metaphor which is Africa, – that survival requires extra ordinary strength and serendipity.

The challenges from a surgical point of view are multiple and such are the conditions that frequently one questions whether such a mission can achieve any short term or long term good – a feeling the rest of the team experienced from day one. I had spent in total ten years in Africa previously and memories were instantly rekindled so the adjustment wasn’t as great as for some-- but for many of the medical team this was their first experience of these conditions. Briefings and debriefings became a twice daily event. Prayer was an essential part of our preparation and conclusion. Our two interpreters, wonderful Christians who were vibrant demonstrations of God’s love in action, became deeply imbedded in our team.

The conditions were totally foreign to all – hygiene was non existent – sterilisers were broken, wash-up for theatre didn’t work and a hand bowl and soap was used. Ventilator tubing was perished and held together with tape. All were potentially overwhelming to new recruits. It was a matter of constantly reassuring and re-evaluating what one hoped to achieve in a situation such as this and wondering why at times we were there. Our interpreters frequently reminded us – His love in us is to be taken and distributed to those who need it. Our team approach became that we had to proceed with very ‘small steps’. This became the title of the documentary that the channel seven reporters Rachel and Sharon, who were travelling with us, made and is available from the author or through Hospitals of HOPE Africa website. From a general medical/surgical team point of view the ‘small steps’...
Christian Surgery & Medicine in Rwanda

were as basic as going to the market and buying sheets, towels, bowls in which the patients could be washed, and basic hygiene taught to the nurses on the wards. Surgically listening for bowel sounds was a fascination.

The nursing encountered was more patient watching and IV insertion. Very little hygiene existed with no barrier nursing and no isolation of infective patients—although the HIV patients are in a separate ward. A significant amount of UN aid is going into the HIV programme. Nurses in Rwanda are graded A1 or A2. A1 nurses are the ones who have had some tertiary education, whereas the A2 nurses have just had generally 2 years of secondary schooling. The amount of nursing training then is enormously variable and the nursing team found that basic principles of hygiene had either not been taught or there was lack of implementation. We therefore introduced a hand washing protocol, to try and cut down the cross contamination, and instructed staff on how to look after patients, wash them and prepare them for surgical procedures. There was no such thing in the hospital as a central kitchen; – all food for patients was supplied by patients’ families. Cooking facilities existed around the hospital with open fires where families brought food, which was then cooked for the patients. Most patients were malnourished and those patients who, through the genocide or other conditions such as HIV or malaria, had no family did not do well in hospital. Nutrition not unnaturally became a team focus – what could be done about improving it and therefore increasing the effectiveness of any medication given. Surgically, I was able to do small procedures such as inguinal hernias and lumps, but I found advice was also sought on mastitis, goitres and on orthopaedic problems such as chronic fistulae secondary to osteitis. One can also be amazed at the degree of skill that exists with people who have graduated with a basic degree and then have been forced to become obstetricians, gynaecologists, urologists, orthopaedic surgeons and general surgeons. Indeed it was impressive, given the circumstances and lack of hygiene, that there were not more significant complications.

Obviously this was difficult to assess as often the patients would leave hospital and there was no follow-up. Therefore one assumed that if there were serious complications they would re-visit the hospital. Certainly none of the surgical procedures that were witnessed ended up with significant post operative complications.

With this medical surgical allied health team it was decided at the end of a two week period that a meeting should be held to decide on the effectiveness of our intervention and what strategy one would adopt in terms of assistance or aid. This evaluation decided that there were several things which were needed. The first was a building a facility where healthcare could be distributed to the local community. The hospital in Gisenyi was barely functioning and was in great need of refurbishment/rebuilding. The second was in establishing some kind of coordinated community healthcare programme. It was therefore decided that in any subsequent visit a community questionnaire would be prerequisite in terms of establishing a community healthcare programme to go with a new hospital. (This was subsequently done and is now on the website). The third area identified was that there was a great need for education at both the most basic level and also at the level of the graduate staff. What impresses one from a surgical point of view is that you have doctors coming through a system, without specialist training, ending up with some specialist skills and knowledge and a general specialist expertise which itself can be quite daunting in comparison to those from a Western surgical model. Certainly the doctors who were designated surgeons in Gisenyi Hospital were able to provide a wide range of expertise, from orthopaedics/gynaecology/general surgery/urology. Hospitals of HOPE: Africa sprang from this.

After our return and much soul searching and listening for that inner voice (we were much better at that now) it was established to work in conjunction with the Rwandan government and philanthropic groups to achieve the best African hospital model and community health care plan through Hospitals of HOPE: Africa. This organisation has now established a website which details the undertaking and actively seeks both individual and corporate sponsorship. The result so far has been surprising in terms of interest and pledges of support. This has come from many areas and indicates a global interest in being able to contribute to something which has the potential to positively impact the lives of many below the global poverty line. The logistics of undertaking something as audacious as a 300-bed hospital have to be coordinated. The organisation so established has already been granted land, the design has been donated by a New York architect and the project has a Rwandan supervisor doing logistical work such as sourcing building supplies, labour etc. Interest has so far been from larger corporate groups, including the Clinton Foundation.
The other concern that had been voiced was a strong desire for postgraduate teaching. Out of this desire/need has developed Specialist without Borders. Like Hospitals of HOPE: Africa this is a non profit organisation but with the specific aim of taking medical/surgical/nursing and allied health specialists into areas of need for 1-2 week period of teaching primarily using the SCIM module.

SWB seeks through a website to coordinate specialists in medicine nursing and allied health who might want to donate 1–2 weeks of their time in third world countries, teaching in the area of their specialty. It seeks to deliver the best possible medical education into areas of greatest need.

The first workshop/conference which has evolved out of this organisation is scheduled for Kigali in Rwanda in July of 2008. To date, there has been a commitment from five surgeons and a physician to be part of a structured clinical instruction module which will be trialled for the first time in an African setting. This is basically utilising the specialists to create their own supervised teaching modules. These can be as simple as inguinal hernias or appendicectomies, or more advanced, in terms of rectovaginal fistula and/or treatment of burns and skin grafts depending on the need. Hopefully the establishment of a website for Specialist without Borders will allow third world countries to register their educational needs and then globally match that with specialist availability and specialisations.

It was felt that this was the best way that people with medical expertise across the whole spectrum could contribute in the most positive manner. While it still remains to be evaluated, the feedback so far has been extremely positive, and certainly the interest from surrounding African countries is enthusiastic.

It is also hoped that with the establishment of a facility which has the potential for quick medical and surgical care, that both undergraduates and graduates may well be interested in spending some time at this facility, increasing their knowledge of tropical medicine and surgery and contributing to the ongoing education of all the health personnel. What will hopefully be established with the new facility is a secure compound, which will be a serviced house close to the hospital. This will allow for visiting medical personnel to have a place which they can stay cheaply and securely. The other arm of this is to identify those African personnel who might well benefit from an RACS scholarship/fellowship to upgrade their skills by working in a Western environment and returning to impart those skills to their colleagues.

What comes out of an experience like this is difficult to evaluate solely from a surgical viewpoint. I think one can end up being extremely disappointed that one can’t contribute more from ones surgical/medical experience. But the experience can also change your view on life. There is also the obedience to a spiritual prompting and the visualisation of God’s work amongst the financially deprived but spiritually rich – there is a tremendous teaching on forgiveness. Here are people who have all witnessed atrocities and for whom the Christian majority have forgiven their attackers. There is much to learn spiritually. We didn’t achieve as much as we thought we would on this visit but we learnt a huge amount about the Rwandans and through them about ourselves spiritually – here are a people so very grateful for anything that you can do for them. You end up thinking what else you could possibly do to make some improvement in their lives. And slowly it dawns that you are there not just for that moment but for the time it takes to help brothers and sisters in Christ; that this is not a journey that begins and ends with an African experience, it is a journey that draws you closer to Christ through helping those who belong to His family; that learning to hear His voice gets easier the closer we are to Him and that the quiet inner voice can be unmistakable when we learn to remove self... We started to realise that even with a little a lot could be done. With much listening He would suggest how much more could be done.