A 2013 Gambian Experience

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Introduction – The team (fig 1)

Dr Keith Thomson, Consultant Anaesthetist, Basingstoke
Dr Gary Dickinson, Consultant Anaesthetist Winchester
Dr Helen Simmons, ST6 Anaesthetist, Manchester
Dr Rupert Pemsel, CT1 Anaesthetist, Basingstoke
Dr Kirsty Macfarlane, FY1, Carmarthen, Wales
Emma Williams, ODP, Portsmouth
Gemma Stephenson, ODP, Portsmouth

Fig 1. The team in a tree

We were also accompanied by two GPs, Dr Alan Budd from Reading and Dr Trevor Keeling from Bracknell with their wives, Margaret and Jackie.

The Anaesthetic team ran a three day conference for anaesthesia providers from 12-14 February at the Royal Victoria Teaching Hospital (RVTH) in Banjul and the GPs were involved in holding clinics in poor areas of town for people who were excluded from any medical care due to the cost. The four clinics held during the week each lasted up to four hours; the whole team participated in the first one and Dr Rupert and Dr Helen joined them for two of the other three.

Fig 2. ACTs = Anaesthetic Conference Team

Fig 3. ACTs = African Care Team

All team members wore black polo shirts with *ACTs 2013* on the back and the Mercy Ships logo on the front. *ACTs* stands for *Anaesthetic/African Conference Teams* (fig 2) or for the GPs – *African Care Teams*.(fig 3).

Day 1

The team departed on a 7am Thomas Cook Airlines flight from Gatwick, landing in Banjul 6 hours later. The baggage allowance on the flight was 15-20 kg, with a maximum of 5kg for hand baggage, but I managed to take a six extra kg in a *Stuffa* jacket a Christmas present from my son which has 12 concealed pockets including one large enough for a laptop. At Banjul Airport security Gemma's luggage was checked for drugs and they were upset about my having a projector, apparently I needed a letter from the hospital to bring it into the country. From the airport we travelled by coach to our hotel, passing a local brewery en route. Our guide said he was a Muslim and didn't drink but he thought the driver, who he referred to as 'a plastic Muslim,' probably did! Unfortunately just as we were disembarking from the bus at the hotel Dr Rupert vomited all over a slightly awkward character who later on in the week demanded 400 Dalassies (about £8) for the laundry bill for his rather tatty t-shirt! We checked in at the Laico Atlantic Hotel which was ideally positioned, with the beach on one side and the RVTH just across the road from the front entrance.

Day 2

We were met by Mr Momodou Baro (fig 4) the senior anaesthetic nurse who was in charge of anaesthesia training in the Gambia. He took us on a guided tour of RVTH (fig 5).

Fig 4. Momodou Baro

Since the visit a year ago it seemed that there were even less anaesthetic drugs available.

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Fig 5. Entrance to the RVTH

They were not doing any spinals for caesareans because of a lack of ephedrine and three months before had also run out of ketamine. The only drug available for post-op analgesia was intramuscular diclofenac. The only anaesthetic drugs were thiopentone, suxamethonium, atropine, pancuronium, neostigmine, an intermittent supply of pethidine, diazepam and halothane. The only fluids they had were dextrose 5% and occasionally blood when available. What was good to see was a caesarean section being performed under general anaesthetic using one of the four new *Glostavent* anaesthesia machines (fig 6) the hospital had recently received after a generous donation from the Port Authority.


Fig 6. Glostavent in use

The technique for GA for caesarean section was thiopentone, suxamethonium, intubation and then 0.5% halothane, sometimes supplemented by pethidine if available. Up to 40 units of syntocinon was apparently the dose recommended by a visiting Cuban anaesthesia team consisting of two doctors and two nurses all of whom only spoke Spanish.

Day 3

I went for a longer run (77 min) along the beach as part of my training regime for the London Marathon on the 21st of April. That afternoon all the team participated in a medical camp organised by Sam and Vicky the local YWAM (Youth with a Mission) missionaries in a slum area of town. It was well organised with a large canopy (fig 7) under which were several tables and chairs for consultations.


Fig 7. Canopy

Nearby was a waiting area for patients with about 30 seats (fig 7a).


Fig 7a. Patients waiting area

Dr Alan's first patient was a woman with dyspareunia with the history given by her husband! His second patient was a man who claimed that a cobra had spat in his eyes about two weeks before and his sight was now impaired. We each saw between 20 and 30 patients during the 3.5 hr clinic (figs 8, 9, 10).


Fig 8. Dr Trevor's consulting area

My most interesting patient was a child of 10 who looked unwell and was complaining of shortness of breath, particularly when lying flat. On examination she had a dyastolic murmur suggestive of mitral stenosis. A Nigerian doctor working with us said she would arrange for her to be seen at a clinic at the MRC (Medical Research Council) the following week and she would possibly be sent to Senegal for further investigation.

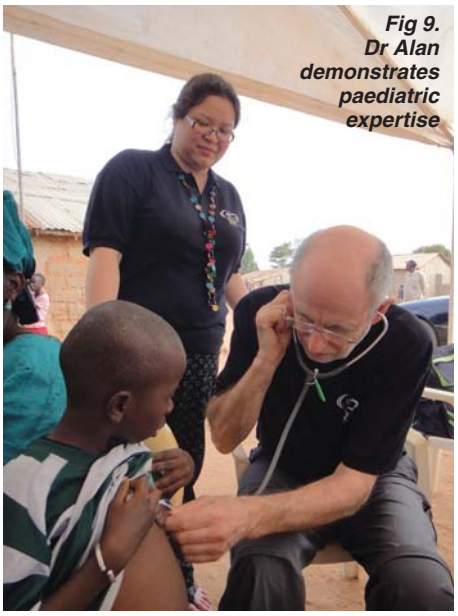
Fig 9. Dr Alan demonstrates paediatric expertise


Fig 10. Dr Kirsty examines a child

I also saw cases of ringworm, whole body pain and one woman accompanied by her 5 children who when I enquired who was the patient, she replied all of us! Rupert saw one lady with huge ascites and large neck nodes. He was genuinely moved by what he saw at the clinic and commented *I probably have more money in my bank account than some of these people will earn in a lifetime* (fig 11).


Fig 11. Dr Rupert with new friend

Many children turned up to see what was happening and team members had fun playing with them. (figs 12, 13)

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Fig 12. Gemma with kids


Fig 13. Jackie blowing bubbles

Day 4 (Monday 11th February)

The whole team (minus Alan and Margaret) went for a *Gambian experience* arranged by our guide Karamo (we called him 'Caramel'), in a very elderly Land Rover without a roof (fig 14). We called it the mean green machine.


Fig 14. Gambian experience with Karamo

The driver was a young man whose name sounded like 'Allodynia.' The trip began with a visit to a crocodile park with some optional close contact with some of the residents (fig 15),


Fig 15. Gemma with scaly friend

even some potential 'airway adventures!' (fig 16) We also visited a museum with displays of old weapons


Fig 16. Airway adventures

and masks and pictures of Gambians who had fought on behalf of Britain in the 2nd World War. We then drove to a small wood where we sampled some palm wine and watched a demonstration of how to harvest palm nuts from the top of a tree (fig 17).


Fig 17. Climbing a palm tree

Rupert made an impressive attempt to copy the local expert. The third stop of the day was a park where we met some friendly vervet monkeys. They would sit on your shoulder and take nuts from your hand in a surprisingly gentle manner (figs 18, 19).


Fig 18. Emma + new friend

The next stop was a school which seemed to be mainly an income generating exercise (fig 20). Our Gambian experience continued with a two hour bush drive to Paradise


Fig 19. Gary + new friend


Fig 20. Local school

Beach for lunch and a swim. During the journey we had a puncture but this did not prove to be a problem as 20 minutes before, as if in anticipation, we had collected a spare tyre


Fig 21. Changing a tyre

(fig 21), I even had time to photograph my shadow (fig 22).

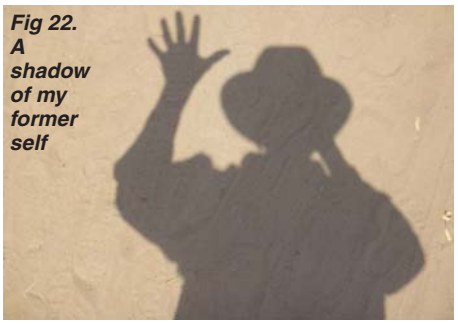
Fig 22. A shadow of my former self

We handed out pens to enthusiastic school children who pursued our vehicle (fig 23).


Fig 23. Give us some pens

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After a good lunch it was at least an hour's drive back to the hotel. The old Land Rover had to be crank started, double declutching was required to change gear and braking was definitely a challenge for our driver who did a great job in the circumstances always staying a sensible distance behind the vehicle in front.

Conference Day 1

57 delegates attended the first day, approximately equal numbers of anaesthesia providers and medical students. The programme consisted of presentations (fig 24) on the use

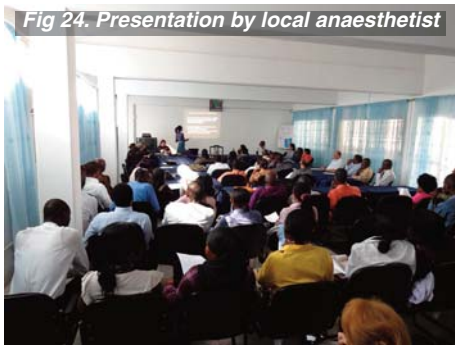

Fig 24. Presentation by local anaesthetist

and theory of the *Life Box* pulse oximeter followed by discussion groups (fig 25) during which nine

Fig 25. Discussion group

scenarios were considered where the oxygen saturation had fallen below the minimal acceptable value of 94%. During this time Momodou Baro suggested that I accompanied him and Dr Solanki to the American University to attend a 'white coat' ceremony at which medical students who had reached the end of their pre-clinical studies were awarded a white coat as a symbol of the start of their clinical training. (fig 26)

Fig 26. White coat ceremony

Some impressive speeches were made by senior faculty members at the college and the audience were also informed about plans to start building a new University next year. I was asked to say a few words and decided to talk to the students about the need for some Gambian doctors to train as anaesthetists. I also reminded the students that they should treat their patients in a way they themselves, their family or friends would like to be treated if they were a patient.

The quiz at the end of the day's training on the use of the *Life Box* went well, although my colleagues thought that my last question was rather mean: 'life boxes take AAA batteries – true or false?'

The mix of delegates in some discussion groups did not work so well because the final year medical students seemed to rather take over and inhibit active participation by the trainee anaesthetic nurses.

That evening most of the team had dinner at the Coco Curry Restaurant as guests of the owner who was delighted to have been treated for free at the clinic we had all participated in two days before.

Conference Day 2

Morning presentations were on topics which included *Anaphylaxis* followed by 34 years of experience as an accident doctor by Dr Alan and then *Airway Adventures in Africa* by Dr Keith. In the afternoon we had a useful session where case presentations were given by trainee anaesthetic nurses. The day ended with another prize quiz.

Conference Day 3

We ran a modified ALERT Course (Acute Life Threatening Events, Recognition and Treatment). This consisted of several presentations and then workshops. The quiz at the end of the day was specifically on the contents of the text-book 'Obstetric Anaesthesia in the Developing World' by Clyburn *et al*. All the anaesthetic nurses had been given a copy donated by the AAGBI at the previous conference in 2012.

Dinner that night was at a beach restaurant two minutes away from the hotel called *Nefertitis.* We had a main course there with Momodou, Vicky and Sam (fig 27) as our guests and then returned to the hotel for puddings.

Fig 27. Vicky, Momodou and Sam

The last Day

I went for my usual five mile morning jog but for the last two miles I was joined by a local man called Simon who had just broken up with his girl-friend the day before (Valentine's Day). He was a painter and decorator when he could find work. He told me that although most people in his country were poor he thought they were often much happier than people in the West who seemed to have much more material wealth. When we eventually arrived at the beach adjacent to the hotel I asked him what size his feet were. He said 42/43, so I took off my size 42 Nike trainers and gave them to him. At 11am we boarded the bus for the airport where I used my *Priority plus* card for all eleven of us to access the so called *1st class lounge* which provided comfortable seats and free drink, although the Wi-Fi didn't function .

In conclusion

This was a very worthwhile week. Our group, ranging in age from 26-72 had bonded really well considering that most did not know each other. Even as the organiser I hadn't actually met four of the team before. The Conference seemed to have been a success, Momodou and Dr Solanki seemed pleased (fig 28). At the end of the 3rd day we handed out a *Life Box* provided by the Life Box Foundation in the UK to every anaesthetist who had attended Day 1 of the Conference (fig 29). The aim of the Life Box Foundation is to provide a Life Box for every operating theatre in the world.

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Fig 28. Anaesthesia team with Momodou and Dr Solanki

Fig 29. Presentation of a Life Box

At present there are many thousands which do not have any pulse oximeters. But in practice where should a Life Box be kept? Who would have the key to the cupboard? Who should be able to use it? In my opinion the long term aim should be to give every anaesthesia provider (fig 30) in Developing World countries their own personal Life Box.

Fig 30. Life Boxes for all

The GP clinics (or so called 'medical camps') organised by YWAM missionaries Sam and Vicky, who also organised the food provided to delegates at the end of each day of the conference, I believe were a success.

My future idea is to persuade more GPs to travel to Banjul for a week's package holiday at a relaxing beachside hotel with good food (fig 31), swimming pool (fig 32) and leisure facilities (fig 33).

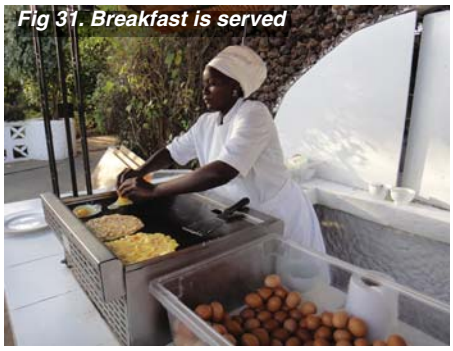

Fig 31. Breakfast is served

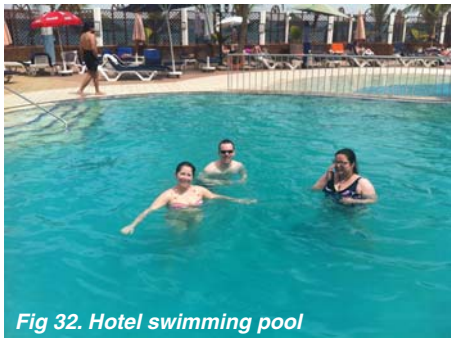

Fig 32. Hotel swimming pool

Fig 33. Alternative pool!

During their stay they can be involved in providing some medical care for the poor in deprived areas.

PS. Next Anaesthesia Conference 7-14 February 2014.