

Humanitarian Missions in the Third World: A Polite Dissent

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“It is better to light a candle than to curse the darkness.”

This Chinese proverb was the motto of the Barsky Unit, which had been established in Saigon during the Vietnam War to train Vietnamese surgeons in plastic surgery. I joined the unit in 1969, and in 1970, I continued in Huê with the International Rescue Committee until 1972. Since then, I have spent 1 to 2 months a year in Southeast Asia, training local surgeons on an individual basis.

Today, after all these years, I feel authorized to express my concern over the objectives and results of overseas volunteer surgical teams. We think that Western colonialism is a thing of the past. I am afraid we may have switched to a new humanitarian colonialism of a different kind.

In March of 2002, in a Southeast Asian city, a foreign team of 20 operated on 98 children with cleft lip and palate. There were four operating tables, with one table left for the local surgeons to perform their emergency procedures. The local surgeons operated on only three of the 98 cleft lips, although they had already performed hundreds of these operations and had superb results. What about the visiting surgeons? Two of them were okay. The others were not, but they were training their residents using the poor kids of Southeast Asia.

Over the years, I have talked repeatedly with local colleagues. Do they like it? No. They face it. It is a sort of a diplomatic trade-off, an exchange of equipment against handfuls of poor kids. This goes on all over the world. We believe that we are the good guys because we help the poor. Are we? Our big teams are geared toward the “body count.” My 2 years in Vietnam with the Barsky Unit and the International Rescue Committee between 1969 and

1972 kept my ears filled with the body count, whenever I listened to the radio.

For the body count, two kids died in an Asian provincial hospital 4 years ago after a cleft palate operation. In our countries, it is malpractice. There, the excuse was that there was no proper intensive care unit. These malnourished kids should not have been operated on in the first place, just as we would not have operated on them at home. But there was the body count. Less than 100 cases per mission seems unacceptable to the team leaders.

And it goes on. In March of 2003, making headlines in a Southeast Asian journal,¹ a foreign team performed 135 operations in 5 days and left. Obviously, “the results are perfect and the complication rate is nil.” But who does the follow-up? The local doctors do, and they are not so enthusiastic.

The cost for the Western donor, per operation, is enormous. In 2002, a team leader giving an interview to a Cambodian newspaper² put the cost of a cleft lip operation at \$1000 (U.S.). For 95 operations, that is \$95,000 U.S. If, however, a local surgeon in the same hospital performs the operation, it costs only about \$80 U.S., as it would in Laos or in Vietnam.

In December of 2002, under the aegis of Handicap International, supported by Smile Train and other foundations, an all-Lao team went to Pakse, South Laos, to operate on children with cleft lip and palate. The total, all-inclusive cost for the 95 operations performed in 2 weeks was \$7414 U.S. (i.e., \$78 U.S. per patient).³ But \$78 U.S. represents 3 to 4 months of a nurse’s salary. Poor people do not have that kind of money.

The advantage of using the foreign teams is that they pay the cost. The operation is free.

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But is the Western donor's money well spent with all big teams? Do the poor kids get better value for the extra dollars? I am not so sure. Not all teams follow the example of Interplast Australia, which sends only surgeons active in cleft lip and palate programs at home.

Being a volunteer does not necessarily mean you're qualified. Being a good plastic surgeon is not a qualification per se either. I remember meeting a renowned hand surgeon a few years ago heading a cleft lip and palate team and demonstrating a Furlow operation. Being a junior plastic surgery resident is also not a qualification.

One should never perform operations abroad that one would not do on one's own private patients at home, and our residents should not be left alone to perform a cleft lip and palate operation if they are not allowed to do them unsupervised at home. The local surgeons who do the follow-up examinations estimate that the complication rate for cleft palate operations performed by amateur foreign plastic surgeons is 30+ percent, and that is a conservative estimate. The poor of the Third World are not experimental fodder. Too often over the years, I have been shocked by papers at meetings establishing technical improvements developed while on humanitarian missions abroad.

What seems to me to be a common flaw of many missions is the absence of groundwork. An exploratory mission composed of home experts, sometimes volunteers, visits a hospital, defines needs, goes to the Ministry of Health, and promises the equipment, and that is it. A chosen hospital gets the responsibility of gathering the 100+ patients for the visiting team. Do these home experts know anything about the local surgeons and the local anesthetists? Without having worked with them alone for 2 or 3 weeks, how could they get to know them and discover how qualified they are?

They really should. The local colleagues know infinitely more than one assumes. In Laos, in 1991, I partnered for 6 weeks. I had been proudly demonstrating the rotation advancement method of cleft lip repair when, at the end of my stay, the local surgeon asked me to see some of his cases. He had used the Le Mesurier technique and had perfect results. And here was a surgeon from a country that had just been isolated for 15 years. It filled me with respect for my counterpart.

It comes as no surprise that out of ignorance of the abilities of the counterparts, the respect they deserve is too often underestimated.

A young anesthetist said to an elderly local colleague who had spent 10 years in Germany and who was asking, obviously in poor English, to examine the anesthesia machine, "do not touch, this machine is fragile." The local colleague was the head of the department.

A foreign surgeon replied to a local surgeon who requested to scrub with him, "no, thank you. I prefer to work with my nurse."

Is this any way to make friends?

I am always amazed by the reports of foreign teams. One recommended that "a nurse should be trained to assist in microsurgery" in a hospital where there was no microscope and no one performing microsurgery. In a chart, I found, "would recommend a Chinese free flap." I performed a fasciocutaneous flap. It worked. And if I had needed a tube pedicle flap, I would have done it. But I was there for 4 weeks, not 1. Dr. Javed Iqbal of Peshawar, in a letter of 1993, wrote superbly on the matter.⁴

This ignorance of the local working conditions leads to other aberrations. Recently, I met a team of decent, well-intentioned surgeons wanting to help in the development of hip prosthesis surgery. In that country, the operation is already performed, but only for the rich, who can pay for the prosthesis. It will not be for the poor. Is this a priority? Besides, for people who are used to squatting, a hip prosthesis could be problematic.

I have often heard "you must help us to practice modern techniques." But we should not forget that in our countries, the new techniques have been developed to cut down on the prohibitive cost of hospitalization. We should consider the priorities in countries where hospital costs are \$2 U.S. a day or less.

Rich countries have donated much heavy equipment that, after being photographed with the ambassador for the local newspaper, goes to rust because no one pays the maintenance costs. I saw an air-conditioned operating room in a district hospital where there was no electricity for 50 kilometers around and just enough gasoline for a few motorbikes.

Some big groups have put forward their teaching programs while still mostly focusing on their body count. But how can you teach a local surgeon whose language you do not speak and who knows hardly a few hundred words of English when you plan to do six operations a

day? Is this the way it is done in our teaching programs?

Thirty years of 1- to 2-month solo stays in Southeast Asia have convinced me that teaching local surgeons takes time when you respect their established pattern of work. In 1 month of full-time work, at best, I can claim 30 to 40 operations. But these are operations my colleagues have asked me to perform with them on patients they have selected, and not the other way around. Not many cases, but it is teaching.

To balance what might seem a one-sided view, there are extenuating circumstances. Ministries of Health over the world are not necessarily interested in checking the credentials of the visiting surgeons. Local counterparts might not be interested in operating on poor patients who cannot pay them something even if the hospital costs are covered. And the needs can be too important for the too few local surgeons to cope with.

In conclusion, for ethical reasons, we should abandon the body count mentality. Twenty operations performed perfectly for the purpose of teaching are better than 100 amateurish ones performed by volunteer plastic surgeons. The future lies in the substitution of smaller teams of two or three competent visiting surgeons staying longer on par with their local colleagues, as is already done by many of us.

If big teams still want to go on, they should limit themselves to operating on cleft palates and secondary cleft lip nose and palate problems, where experienced surgeons and anes-

thetists, as well as equipment, are a prerequisite. They should leave their counterparts to do the cleft lip operations until their set-ups allow them to do everything themselves.

All the money saved by not sending as many people with donors' money could be used to establish funds to cover the cost of the operations performed by the local surgeons who have been trained by us. This way, with the same amount of money, if we remember the \$80 U.S. versus the \$1000 U.S. cost, it will not be 20,000 children with cleft lip and palate who would be operated on by visiting foreign surgeons but 240,000 children operated on by local surgeons who would have kept their dignity and would love us for it.

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