

## Rahima Dawood Memorial Lecture 2002: Surgical Training in Africa

### Christine Evans.

Smithy Cottage, Llanarmon – Yn – Tar, Nr Mold, North Wales,

Email: [christinemaryevans@hotmail.com](mailto:christinemaryevans@hotmail.com)



Yusuf D Kodwawala and Christine Evans

### The Present

The Master of Medicine (MMed) Postgraduate Training Programme is organized by different surgical departments in the East and Central African region. The question is however whether the programmes are of equivalent standards. Training in general surgery and Orthopaedics are widespread while the other specialties have scattered facilities and often non-existent.

### The College of Surgeons of East, Central and Southern Africa (COSECSA).

The College was established in 1999 to set up new standards and hopefully of equivalent standard throughout the region. Most hospitals in the region were assessed as possible training centres for the College. Plans for Fellowship examinations in general surgery and Orthopaedics are at advanced stage and hopefully in a not too long a future other specialties such as urology, neurosurgery, plastics and thoracic surgery will follow.

### Countries visited as Rahima Dawood Traveling Fellow.

As a Rahima Traveling Fellow, I had the opportunity to visit the entire eight constituent Countries of the Association of Surgeons of East

Africa (ASEA) were visited. The following were my observations.

### Ethiopia

Ethiopia is a non-commonwealth country with a 50% to 50% population of Moslems and Christians. The Specialists were staying and active training programmes at fabric of Black Lion Teaching Hospital was good, wards are well run, there was good ITU and theatres were adequate though there was some shortage of equipment. AIDS was less of a problem. With the big population there was inadequate numbers of trainees for expansion of specialties.

### Malawi

Malawi had good teaching, daily combined meetings including weekly radiology sessions. The staff worked longer hours in government service and were very committed to teaching. The theatres were reasonable; the wards were not under control of the nurses who appeared demoralized. The prevalence of AIDS was high including among hospital staff.

### Zimbabwe

The economy was collapsing. There were no equipments and lacked anaesthetic agents. The

doctors and nurses were not being paid and were fleeing the country. The frequency of AIDS was high in part due to better testing. Despite all this the best standards were maintained. Very good teaching, excellent library and internet facilities were noted. The wards were immaculate and nurses were in charge. Ward rounds and teaching were well attended, those remaining being very committed to teaching and learning

### Zambia

Ndola was the best hospital visited for its leadership and innovation. There was large scale renovations and ward upgrade using outside monies. An excellent Tropical Research Centre with lab and library facilities was available for hospital. Upgraded hospital laboratories were in place. Woefully the hospital suffered shortage of staff. For instance, the hospital had no Obstetric and Gynaecology consultant for 2 years till September. Teaching was more difficult due to few staff

### Mozambique

The country had no problems with loss of staff possibly because of language restriction. Teachers and trainees were well motivated and not so concerned with private practice. Shortage of trainees to fill future posts and the rest of this large country with specialists raised concern. Can we accommodate their needs as far as the Membership of COSECSA is concerned?

### Kenya

Kenya was well organized, had reasonable numbers of trainees and teachers were present but needed better specialist training. I was depressed about the lack of facilities, totally inadequate endoscopic facilities which made it difficult to advance with any modern investigations. There was still need to be brought into the idea of COSECSA examinations

### Tanzania

Muhimbili the main teaching hospital was being upgraded at the time of my visit. Orthopaedic facilities were excellent and there was a new cardiac theatre. The trainees were happy with their training, had good library /internet and committed teachers. There was great shortage of

surgical trainees; none in first year MMed programme. All young doctors preferred to go into community medicine. The wards were under control of the nursing staff. Apart from urology at KCMC in Moshi, there was poor training in specialties. Doctors had to go abroad for specialist training.

Tanzania was more committed to COSECSA and examinations especially the Minister of Health, but the higher education councils considered this is a duplication of effort

### Uganda

Mulago Hospital was well organized and reasonably well staffed and motivated to teaching and the new College. The country was stable economically. The country seemed to have reversed the plague of AIDS, this having come from the advice from the very top, TO BE FAITHFUL. The hospital lacked Equipments.

### Reasons for Optimism

Despite all the problems mention above, there were reasons to be optimistic about the future:

- Good doctors and nurses still remained.
- Doctors/medical students still learnt good clinical skills, take good histories and examinations, and **don't rely on investigations** to make a diagnosis.
- Many doctors were motivated to teach and enjoyed it.
- High standards of specialty training in certain places exist, both mission and private.
- Commitment to Outreach clinics by plane or car.
- Easy contact between colleagues by email

### Reasons for Pessimism

These include:

- Poor pay and low morale especially among nurses.
- Staff and doctor shortages
- Very poor equipment especially fiberoptic endoscopies and few teaching aids if any.
- Poor maintenance of other equipments, such as diathermy/light sources
- Some awful ward conditions out of control of the nurses.

- Carer mentality increases sepsis especially with prosthetics/implants
- Septic patient [burns/Aids] stuck out of the way and sometimes forgotten leading to stench and squalor
- Many library and internet facilities are poor.
- Some ITUs no ventilators
- AIDS, perhaps a small light at the end of the tunnel

### What to Do

There is need to:

- Pay increases especially those in full time teaching posts.
- Improve pay and standing of nurses.
- Keep ward discipline; omit visitors except for short designated visiting hours.
- Make sure on call and teaching do not take second place to private work.
- When on call do evening teaching ward rounds
- Persuade more doctors to do surgery, better funding for trainees by Government / surgical departments to work / train away abroad or in districts

### Aim of COSECSA

COSECSA was created:

- To standardize the training
- There is starting membership examination
- In 2004 there will be an exit fellowship examination in general surgery and orthopaedics
- College examinations have succeeded in West Africa

### When all is said and done

It really comes down to all countries to spend more on Health Care. I am sure we could get more help from rich outside agencies, certainly more help from the rich drug and instrument companies. DO NOT LOSE HEART.

### Urology Training in ASEA Countries

Urology training in the region is patchy and fragmented. Except for KCMC in Moshi and Harare urology under control of general surgeons.

There are two centres with either MSc or MMed in urology although one other department on the way. There are too few trainees coming into urology. Is it because it is an unattractive specialty? This shouldn't be so, for those wishing to take up private practice this is a lucrative area of surgery and 40% of all general surgery is urological.

We must try and stop the general surgeons from being occasional urologists in private practice. Remember urology is interesting.

### Urology by country

#### Ethiopia

There were only six urologists in Ethiopia, three in Black Lion and 3 outside. Surgical trainees spend 6 months in urology. Norwegians were giving a 5.1 million krone package of equipment including video teaching stack, diathermy, light source and irrigating fluid. Training scheme needed to let trainees go to Addis and teachers are needed for teaching endoscopy including ureteroscopy and PNL (percutaneous nephrolithotomy).

There is a high incidence of stone disease. Established ESWL [Dornier] machine in a good setting with C arm and US. This hospital could become main teaching centre for stone disease. Radiologists are willing to learn renal access and TRUS and biopsy.

#### Stone disease

- Stone Disease is much less common in rest of ASEA, but proper treatment relating to this century must be taught to all urologists
- AT PRESENT the standards are 20 years out of date.

#### Uganda

Uganda had only 8 urologists at the time of the visit, five were in located Mulago National referral Hospital, one worked in Nsambya missionary hospital in Kampala and two were in Mbarara Teaching Hospital. Specialty urology was therefore only available in three hospitals. Lacor mission hospital performed cystoscopy, had endoscope but no urology expertise.

## Tanzania

There were only seven urologists in Tanzania, four of them in Muhimbili in Dar es Salaam and three in KCMC in Moshi. In Dar es Salaam urologists still covered general surgery when on call. Separation of duties was therefore needed. The urologists were trained in TUR and optical urethrotomy. Extensive and well kept set of scopes were available, thanks to the senior nurse in theatre. Good ultrasound service on the ward was also available.

## KCMC in Moshi

KCMC had Impressive commitment to Urology and teaching. There were two trainees at the time of the visit. They performed about 80 TURPs; video stack for learning was available. Academic MSc not taken for 3 years [equivalent FUrol], a 12 month diploma certificate. Urodynamics primitive, at least a start. Overseas help from Holland, UK, US and Germany was available. Biennial workshop was a must for all aspiring urologists.

## Zimbabwe urology

Harare had seven urologists. Despite the poor economy, the standards of urology were high. However, operations were sometimes postponed for various reasons including lack of anaesthetic services. Teaching in Harare was excellent. CMG machine was there but disappeared into the mists of Chinhoyi, and what happened to the proposed urology training centre there?

There were 2 urologists in Bulawayo. Despite certain constraints, good surgery went on. There were Poor equipments; the endoscope in Mpilo was just missing a diathermy lead! I replaced it in December 2003. Hopefully things will improve shortly for these brave people

## Zambia

There were only four urologists in Zambia. I spent quite a bit of time in Lusaka and also in Monze. Since paediatric urologist visited, hypospadias results were great; endoscopy was all in place but needed to take scopes out of theatre to protect them. There was a move to develop a self contained urology unit and MMed [Urol] programme. The former had

backing of Ministry of Health. There was uncertainty about source of money.

## Mozambique

The country had only three urologists; first went there 3 years ago, I was impressed by surgeons and teaching commitment. Two of the urologists had trained in TURPs in SA, thanks to Professor Naude. Mozambique did not only have a severe shortage of urologists but of the trainees as well. Beira had none since early 2003. Most staff in Mozambique wished to stay in their country which was good.

## Malawi

There was one urologist in Blantyre. A single general surgeon was competent in endoscopy with working scope. He had taken time to learn at KCMC twice. The commitment to teaching in Malawi was good though there were few trainees if any. There must be millions who have no access to any form of urological surgery

## What We Need To Do In Urology

There is need to carry out the following to develop urology in ASEA constituent countries:

- Develop separate departments in all main teaching hospitals
- Have a shared curriculum for MMed Urology in all these countries
- When college organizes Fellowship, Urology Fellowship should be in the forefront, urology should not lag behind.
- Urology section of ASEA should be started and should meet annually.
- All attend workshops at least 2 yearly for CME
- Attract more trainees.
- When trained ensure all specialists are provided with working endoscopes especially if going to district hospitals
- Improve maintenance. Embarrass firms.
- Train theatre technicians to maintain equipment
- Develop urological database on ASEA website for trainees here and overseas

Finally, I propose that College of East Central and southern Africa through Edinburgh and other UK colleges, BAUS and other interested

countries to fund 1 year posts overseas, no longer than that, for training for those who wish, registration in UK essential.

Remember urologists are surgeons and need to be well trained in all general surgery before specializing; the time for superspecialization is not yet here

### **Why I Love Africa**

I love Africa because of its smiling faces, the consideration and courtesy shown at all times, the wonderful singing, the amazing and often magnificent landscape and the bravery in adversity of all people.

**Thank You.**