News Update: The Anaesthetic Friendship Society - supporting anaesthetic clinical officers in the southern districts of Malawi

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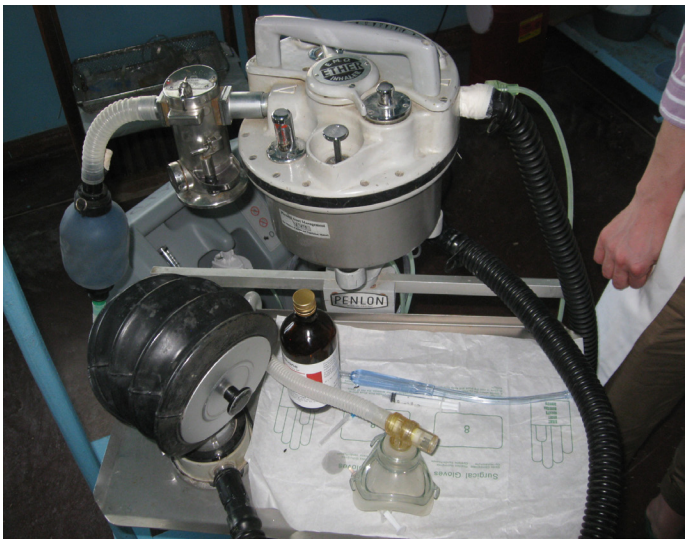
The Anaesthetic Friends Society (AFS) was formed in 2009 with the aim of forming friendships between districts hospital anaesthetists in Malawi and their colleagues in the UK.

AFS´s foundation was a response to the observation that an anaesthetic clinical officer practicing away from the central hospitals can easily become professionally isolated.



Old Equipment in the district

Discussing the anaesthesia machine

Providing quality anaesthesia and high dependency care around the clock for a relentless series of challenging obstetric and surgical patients is difficult in any circumstances. In remote district, rural and mission hospitals it can feel almost impossible. There may be limited opportunities to discuss and plan the management of complex emergency cases, and even fewer chances for the essential debrief required when things have gone badly or indeed particularly well. The ever-present challenge of limited resources is a particular problem for the isolated anaesthetist. It may be very difficult to persuade hard-pressed managerial colleagues with no specialist anaesthetic knowledge just how impossible one's job has become without certain items of equipment or drugs. Having to continually think 'outside the box' to find innovative solutions to an ever varying array of day to day problems might be considered intellectually stimulating, rewarding and even fun for a motivated team of colleagues. For a lone practitioner it can be an exhausting and demoralising struggle in which one's failures and triumphs go equally unrecognised. While professional isolation does not inevitably lead to 'burn-out', most of us will know a friend or colleague whose initial passion and hope for what they might achieve in their anaesthetic career has gradually declined over time. Vocation may be replaced by acquiescence; an unhealthy circumstance for the anaesthetist and his or her patients.

AFS tries in a very modest way to address some of the problems of isolated practice. It has at its heart the simple aim of encouraging support, friendship and solidarity between individual anaesthetists in Malawi and their colleagues in the UK. Through individual partnerships, district hospital visiting programmes and continuing professional development the society attempts to place each southern region district anaesthetist in a community of international colleagues and friends.

AFS is an individually structured organisation. It is not a charity and has no formal funding. It is the sum of the social relationships among a group of anaesthetic friends bound together by their desire to support each other and provide the best care possible for their patients.

Thus far eleven AFS partnerships have been formed between individual anaesthetists in Malawi and a colleague in the UK. More than 30 Malawian anaesthetists have joined and are waiting for partnerships. Each partnership has its own character. Some simply involve occasional exchange of letters or emails. Some UK anaesthetists regularly send journals and educational materials of interest to their Malawian partners. Some partners have managed, through letters, email and text messaging, to develop real friendships and share news of family, friends, and daily events. Difficult or interesting clinical cases have been discussed using email or Skype phone calls. This has proved to be educational for both parties. UK anaesthetists are often fascinated to hear about the unique clinical challenges presented to their Malawian colleagues. The Malawians in turn are offered a window into the very different experience of their UK partner. Rich discussions ensue when minds from such different clinical environments meet. There is more in common than one might think. I recall receiving a text message from a Malawian partner late one evening; a request for a discussion about a recent case of an infant that had died from paraffin ingestion. She felt her management had been questioned by a local colleague from another specialty and she was left feeling partly responsible for the child's death. Although I had had no experience of such a case I did have access to books, the internet and journal articles that my Malawian partner could not easily access. Together we were able to establish that her management of

the child had been exemplary. Within her resources, she had done all that could be done. The unfortunate child was still dead, but at least my friend was left with the confidence to treat similar patients in the future and educate others at her

AFS-consultant teaching difficult intubation procedures in the district theatre

An example of the goals of AFS unified in one activity was the most recent district hospital visiting programme completed in March 2012. As with previous district visiting programmes AFS was supported by Dr Gregor Pollah, Head of the College of Medicine Department of Anaesthesia and Mr Cyril Goddia Principle of the Ministry of Health School of Anaesthesia at Queen Elizabeth Central Hospital in Blantyre. Eight hospitals in the Southern Region were visited by the authors. The programme included visits to district hospitals at Mwanza, Thyolo, Machinga, Balaka, Ntcheu, and Chiradzulu, and mission hospitals at Nchalo and Mulanje. At each hospital the anaesthetists had arranged an educational seminar for all hospital staff. At most hospitals these formed part of the morning handover or an established rolling CPD programme. The clinical topics were chosen for their interest and relevance to all specialities and cadre of health worker, but also to particularly emphasise the essential but often overlooked role of the anaesthetist in the team management of challenging cases. A good anaesthetic clinical officer leaves training school equipped with knowledge and a skill set that goes far beyond the ability to anaesthetise patients safely for surgery and site difficult cannula. The specialty of anaesthesia can however remain 'mysterious' and is frequently misunderstood by many other specialities. If an anaesthetist's skills are not fully appreciated they risk being an underutilised resource.

Seminar topics included the management of post-partum haemorrhage, perioperative management of eclampsia and pre-eclampsia, coagulopathy, haemorrhage and appropriate use of blood products, perioperative management of diabetes, and the history of anaesthesia.

The local anaesthetists, inspired by recent cases, had chosen their topics well and each seminar, starting with a presentation, generated a great deal of discussion. Participants shared experiences and informally presented the details of cases related to the topic and controversies were debated. After a seminar on maternal diabetes the case of a very sick mother whose apparently healthy newborn baby died several hours after delivery was described by the obstetric clinical officer.

Anaesthetic teaching in the district 2012

He now wondered if the mother had been diabetic and the baby had died from neonatal hypoglycaemia. The impression of the group was that this might be a more frequent problem than was often appreciated. After these seminars the focus moved to theatres and the anaesthetists. At some hospitals we worked together in the operating theatre, and by coincidence, often on cases that mirrored the earlier seminar topic. We examined the anaesthetic equipment together, discussed the hurdles and barriers to providing an ideal service, and discussed experiences of difficult clinical cases. Common themes emerging at many of the institutions included the development of high dependency units, problems preventing efficient use of the Malawi Blood Transfusion Service, the devastating tide of maternal mortality, the paucity of opportunity for continuing professional development and career progression, and the powerful influence of management and the motivated individual on the day to day workings of a small hospital in a resource-poor environment. At some hospitals we took time to chat about families, colleagues and friends, ambitions and achievements and share a soda or a meal together. In summary, these district visits truly combined the triple ethos of AFS; support, friendship and solidarity.

Moving forward our hope is that this infant organisation will grow steadily to include all those who wish to be involved. There is work to be done identifying UK anaesthetists willing to form partnerships with their Malawian colleagues. We need to use the information technology now easily available to allow greater communication within our community. We are looking forward to the 2012/13 district visiting programme, renewing old friendships and establishing new ones.

The members of AFS share the ambition that their activities will somehow contribute to a reduction in professional isolation of district anaesthetic practice thereby improving the wellbeing of anaesthetists and their patients in Malawi.

Information:

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The AFS-group in Nchalo hospital 2012