Helping Out Becomes an "Elixir for the Soul"

Vargas Hand Therapy International Teaching Award 2001: Kampala, Uganda

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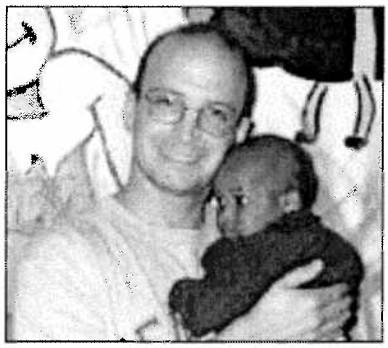
The 'Pearl of Africa' or 'The Heart of Darkness', where am I today? Uganda is both of these, compressed in a small space. As I open my eyes and look up at my mosquito net, I am grateful. Though the mosquitoes aren't nearly as prevalent as in Wisconsin, each has the potential for carrying malaria. This is my first morning in a third world country. Dr. Scott Kozin, my partner in this volunteer effort, has done this once before. I remind myself of his words, "Once you do something like this, you're hooked." Frankly, I wonder how many times I will disagree before our two weeks are over.



Hand surgeon Dr. Scott Kozin was both partner and mentor.

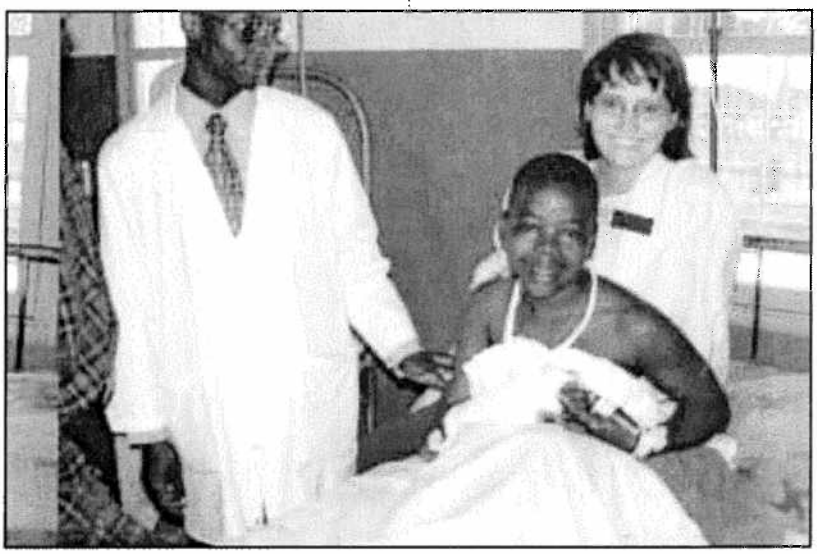
The Hospital

On the grounds of the Makerere University, the Mulago Hospital sits atop one of seven large hills in Kampala. Makerere University was founded in the 1930's (the oldest medical school in East Africa) and provides the only orthopedic residency program for 1,000 miles.

Patient care is provided at two separate sites, new and old. The New Mulago Hospital was built in the early 1960's and is a 5 story open building in disrepair. Sepsis and infectious cases, internal medicine and maternity wards are contained within. Old Mulago Hospital was built in the 1930's. We spent most of our time here. It is not one building, but a series of eight or ten small one-story buildings interconnected by sidewalks.

It was with some excitement that we made our way from the Occupational Therapy school to the Orthopedic ward. We passed by laundry drying in the sun-drenched grass, smoky fire pits, smiling dark faces of children playing in the dirt. Happy native chatter slowed as we passed, but the smiles broadened and we felt welcomed.

Ward 7 consists of a long single room with about 50 or 60 patients lying in cots along the wall. The ceilings are high, the walls unfinished, and the windows without screens or glass. The dim lighting within is mostly natural, making for a large contrast from the bright equatorial sun outside. Patients lie on their cots. Family members sit and sleep on beautifully woven mats next to the cots and provide for most of the patient's needs.



A sweet 13-year old orphaned girl, whose dominant hand was twisted radially at the wrist, is treated by Gail Groth, MHS, OTR/L, CHT (right) and a Ugandan physical therapist.

I'm told Ugandan wards are similar to those in other third world countries. We shouldn't be too quick to dismiss the benefits of this arrangement. In *The Gift of Pain,* Dr. Brand has observed that when a patient is surrounded by a loving community who will stand by him when pain or tragedy strikes, there is less fear and suffering.

There were four or five nurses for the ward who still dress in the old attire: dresses, governmental badges to signify rank, and little white hats, a throwback to colonial days under British rule.

The Patients

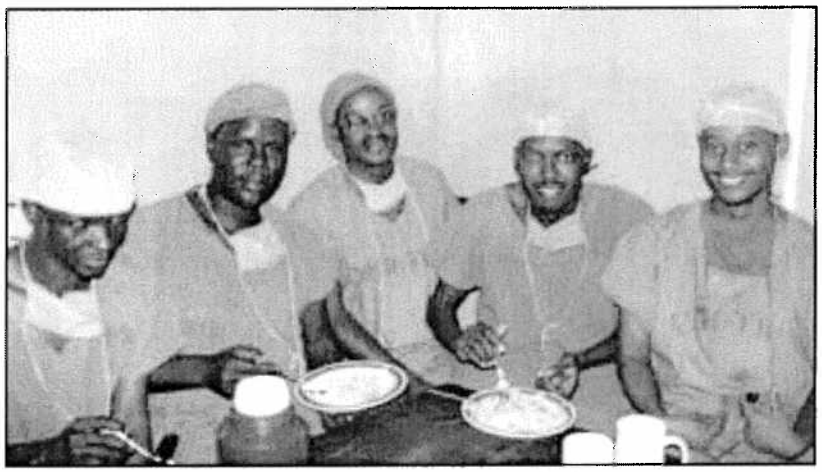
Three-fourths of our patients had some form of trauma to their upper extremity. Large bony defects from old gunshot wounds, finger and hand amputations, burn scar contractures, and surgical scar contractures came to us. We saw previously undetected Bouttonierre deformities and upper extremity fractures from moving vehicle and farm machinery accidents. We also saw syndactylies, radial deficiencies, post-polio patients, and some leprosy. I admired Dr. Kozin's remarkable clinical skills and the deep compassion he was able to convey to his patients.

A sweet 13-year old orphaned girl came with her aunt to see if the American doctor could help her. Her dominant hand was twisted radially at the wrist, virtually perpendicular to her forearm. Her aunt reports that when she was only one or two she broke her wrist. She was in no pain, but had significant difficulties in writing, preparing meals, and dressing herself. It was thought that the growth plate had been previously damaged. Dr. Kozin performed a Darrach procedure. Several days later we reduced the bulky dressing and replaced it with a splint. In the mean time I had been working with the OT and PT faculty on pattern-making and post-operative care. The local therapists were able to fabricate the splint with minimal assistance from me.

Serial casting was unfamiliar to the therapists, though Plaster of Paris was prevalent. It was, as someone said, an "elixir for the soul" to bring the OTs and PTs together, train them, and watch them rectify a PIP joint flexion contracture in only 4 cast changes.

Teaching

Dr. Naddumba, chief surgeon of the Orthopedic Department, organized a continuing education program structured around our visit. In attendance were fourteen orthopedic residents and faculty, 60 OT and PT students and faculty, and several health professionals from the community. Dr. Kozin was well prepared to lecture with a large 3-ring binder of slides, and his laptop with several digital presentations.



Orthopaedic faculty and residents at the Mulago Hospital at the Markere University

We struggled through several formal lectures in small rooms with poor lighting and ventilation. But the greatest hindrance to education was our American accent. The orthopedic residents made their preferences for informal clinical teaching known.

Dr. Kozin commandeered our schedule and increased surgical teaching opportunities for the residents and clinical teaching for the OT and PT faculty. This made for a more workable arrangement on a daily basis. Dr. Kozin, by the way, is a gifted teacher who adapts easily to changing circumstances and needs.

Preparations

Health Volunteers Overseas was vital to the success of our trip. We were advised on which vaccinations were necessary (I needed 14), how to buy prophylaxis against malaria, which airline to fly, and even the acceptable length of skirts and dresses. No question was too small. My home church, medical organizations and vendors all willingly donated supplies and needed items—totaling 69.5 pounds of an allowable 70 lbs. My children readied themselves for African pen pals. Sleeping pills helped to offset the 24-hour trip with 8 time-zone changes.

The Country

Sandwiched in-between Kenya to the east and the Democratic Republic of the Congo to the west, Uganda is located in East Africa. Her southern border is Lake Victoria. The equator passes through the southern part of the country. Uganda is about the size of Oregon. The terrain is beautiful—70% forest, woodland or grassland. Just over 10% of the land is dedicated to national parks, forests or game reserves.

The weather is fabulous. The temperature hovers at a comfortable 65 degrees at night and 77 degrees during the day... year round! The trees and flowers are thick and lush. Only precipitation levels differentiate the seasons.

With 1 million people, the capital city of Kampala is the largest city in

continued on page 18

VARGAS AWARD

continued from page 17

Uganda. Twenty million people live in Uganda and speak 52 different tribal languages. These are 'home' languages with English being the official or public language. Their spoken English was heavily British in accent and word usage, creating some difficulties in communication.

Ugandan People

Two-thirds of the Ugandans profess Christianity (strong Baptist presence, also some Catholic, Methodist, and Lutheran). Theirs is an overt, fundamentalist faith with gospel services on television, open prayer on the wards, frequent 'God bless you' and impressive church attendance on Sunday. Also impressive was the length of time spent in worship: four or five hours are not unusual.

The health status of the country is abysmal by western standards. Fifty percent of the women are illiterate (and therefore not able to speak English) and have an average of 6.9 births. Infant mortality is nearly ten percent. Average life expectancy is 37 years. Ugandans are quick to point out that theirs is the only country in Africa with a decreasing HIV rate. Government statistics report that 20% of the population is HIV positive.

The dreadful Ebola Zaire virus surfaces every now and again. The same day AAHS notified me of the Vargas award, I read in the newspaper that there was a large and unconfined outbreak of the virus just north of Kampala. I resolved not to worry about it, which became more difficult when health professionals began to die. The outbreak ended 3 months before we arrived.

Leisure

Uganda's Lake Victoria is the source of the Nile River that flows north and offers extreme whitewater rafting. Class V and VI rapids were too much for this novice, though Dr. Kozin fared much better. Thrown from the raft, I was plucked out of the Nile by Moses, a Ugandan kayaker strategically placed to save drowning customers. (I would have thought it more appropriate if Moses was in a basket and I plucked *him* from the Nile.)

A chimp from the Jane Goodhall Chimp Orphanage also benefits from the visit.

We also had the good fortune of treating a chimpanzee with a serious hand injury at the Jane Goodhall Chimp Orphanage in the nearby city of Entebbe.

Sobering visits to an orphanage kept us cognizant of our many blessings, and made each of us sharply miss our own children.

Finals Thoughts

Dr. Scott Kozin had it right. Having done it once, I can't wait to volunteer in a third world country again. The various physical discomforts pale in comparison to the unqualified enrichment of the experience. I do believe we helped quite a few people along the way and hopefully more individuals will benefit indirectly from our efforts in the future. The people I encountered haven't changed my life, but have made it more interesting and less routine. Dr. Miguel Vargas and his family have shown great foresight in establishing the means and structure for these experiences. We are deeply grateful to them and to the AAHS for making this possible. ■

DIGITAL HAND SURGEON

continued from page 1

Medical Records: The Physician's Responsibility

By tradition (and law), physicians record the medical record. The document is the joint property of the physician and the patient with duties and privileges for both parties. Beginning in the 70's, medicolegal issues escalated the demands on the medical record. In the 80's, it became popular to link the completeness of the record to billing, with Medicare leading the way for spiraling upward requirements. In the 90's, patients themselves began a heightened interest in their own medical information with the blossoming of the "information age."

Combined with the increasing complexity of medical documentation is the staggering cost of duplication. In the current state process, re-dictating, faxing, copying, collating, filing, and refilling of the same bits of medical information are routine throughout the entire medical delivery system. Each and every time a patient endures a new medical encounter, old medical information is re-recorded, typically from the patient's memory.

Therefore, at the outset of the new millennium, doctors can no longer scribble a note, meaningful only to them, and call it a medical record. Rather, the complete demands of patient medical information management have been relegated to the doctor, in addition to the expectation of providing detailed written instructions, rationales for treatments, medication lists and warnings, etc... all without any corresponding increase in reimbursement.

David B. Nash, MD, Associate Dean for Health Policy at Jefferson Medical College in Philadelphia, was quoted in the 8/21/00 *American Medical News*:

"The barriers to physician adoption of this technology are more