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Editorial

The governance of overseas surgical collaborations – BFIRST/BSSH

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Summary Clinical governance is the structured approach to maintaining and improving the quality of patient care and is a vital part of global surgery. BFIRST and BSSH closely collaborate with local doctors on a number of overseas projects, seeking to strengthen and develop local knowledge and skills, aiming for an independent local practice in reconstructive and upper limb surgery.
Thoughts on essential requirements, improvements and pitfalls in the ethical approach to global collaboratives are presented.

This consensus paper was written by the faculty for the 2nd British Society for Surgery of the Hand/the British Foundation for International Reconstructive Surgery and Training Overseas Day, April 2018. This meeting focused on the clinical governance of overseas surgical collaborations. Our panel consisted of Consultant surgeons and therapists, as well as Plastic and Orthopaedic surgical trainees from the UK and abroad involved in Global Surgery. All authors are involved in long-standing key- and hands-on roles in active international collaborations centred on promoting the training of surgeons and allied personnel in LMICs; both as educators and learners.

Our faculty was based in the UK, Ethiopia, Vietnam, Sudan, Malawi and Bangladesh.

Clinical governance is the structured approach to maintain and improve the quality of patient care and should be applied in every healthcare. The aim of this paper is to present our view of the governance principles which we believe must be applied in global surgery.

The basis upon which High Income Countries (HIC) countries traditionally have offered healthcare related help to Low and Middle Income Countries (LMIC) to date has been

Content taken from presentations, but not presented as a whole at the 2nd BFIRST/BSSH Overseas Day, April 2018.

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based on the availability of resources and expertise. HICs have expertise but relatively few patients, whilst LMICs have many complex patients, but poor resources and may lack expertise in certain areas. It is important to recognise that this paucity of expertise is both due to a lack of access to training as well as the essential availability of manpower in medicine, surgery, therapy and nursing. The lack of resources can include anything from simple suture materials to complex imaging.

After the Lancet Commission on global surgery published in 2015,[1] surgery has been recognised as being a crucial part of the deficiency in healthcare in resource poor countries. The inadequate access to safe surgery for 5 billion people needs to be addressed on many levels. This paper considers the governance in the direct interaction between surgeons from resource-rich backgrounds and surgeons from resource-poor backgrounds, they allied health personnel and their patients.

We have sought to contribute to the setting of governance standards in the provision of educational collaborations in global surgery, especially trying to highlight issues which we feel are important in ensuring optimal benefit and avoidance of harm.

Our thoughts have been set out in a number of sub headings below, which takes their cue directly from the presentations on the day of the meeting.

Collaborations, not missions

In order to foster long-term and useful collaborations, we feel that the essential initial step must be an invitation extended to the organisation or individual from the local unit in the LMIC. Such an invitation encourages and fosters buy-in as well as a mutual responsibility from both the local and the visiting surgeon, because the local surgeons have themselves chosen who they wish to collaborate with. Given the multitude of Non Governmental Organisations (NGO) available, this can be a difficult choice and it is therefore paramount that the NGOs are able to demonstrate a good governance structure and tangible, lasting results.

We would encourage the use of the word "collaborations", instead of "missions", as we believe this is more descriptive and respectful.

First do no harm – Practice safe surgery, lay good habits.

Globally 134 million patient safety events occur every year. This equates to approximately 1 in 10 patients being harmed whilst receiving healthcare. Two-thirds of these safety events occur in LMICs.[2,3]

Patients in resource poor settings clearly have the same right to receive safe treatment as anywhere else. It is therefore important that the visiting surgeon practices only within their field of expertise and only what is appropriate within this setting; has an in-depth knowledge of local resources; arranges for adequate follow-up and the provision for potential post-operative complications to be dealt with by adequately trained personnel in a timely manner and adheres to all the safety measures put in place for safe surgery (e.g. such as the WHO checklist and team brief).

This concept is embodied in Mike Waldram's (Consultant Hand Surgeon, Royal Orthopaedic Hospital, Birmingham (personal communication)) suggested memorable acronym on the subject, which states that you only operate on a patient when you are quite clear that:

D-you know the Diagnosis
O-you know and can do the Operation
C-there is no or low Comorbidity
1-you can complete it in one procedure.

You are then less likely to get into difficulty or even worse leave behind a bigger problem.

In their paper, Maine et al.[4] highlight the real possibilities of postoperative complications being much more prevalent in LMIC settings compared to HIC settings. The fistula rate following primary cleft palate repair in two Ecuador centres was 20 times greater than the rate recorded in a USA craniofacial centre. The reasons for this were thought to be multifactorial, but it is an important message for visiting surgeons to realise that complication rates may be higher than expected. It is imperative that any visiting team is not only aware of this phenomenon, but additionally takes every pre-emptive step possible to reduce the risk of complications, as well as ensuring reliable follow-up to identify and manage these patients is in place.

We feel it is better to operate on fewer patients, but pass on good clinical practice and lay the foundation for the local doctors to perform the surgery themselves.

Follow up your patients

When establishing a partnership with local surgeons, the follow-up of patients is secured and any complications can be dealt with efficiently. Regular visits by the same team to the same area can also facilitate personal follow-up by the visiting clinician of course.

When NGOs were asked about whether they provided any followed-up for their patients McQueen et al. [5] found that nearly 90% made provisions for this, but only 1/3 of patients were followed up longer than 3 months. Paediatric patients pose further specific challenges in follow-up, which should include the whole growth-period of the child in order to assess whether the primary intervention was adequate or need ongoing adjustment.

Ensuring open lines of communication are important for feedback and advice regarding post-operative patient care. A multitude of freely available online communication platforms provide the opportunity for audio and visual communications, all of which can provide access to timely and appropriate advice between clinicians.

Consent

Consent for surgery should be available in the local language and done with local translators or doctors and nurses who can explain the procedure and potential complications to the patient in a language they are able to understand. It is the responsibility of the visiting team to ensure that every effort has been made to establish adequate informed consent.

Consent for photography and the sharing of clinical pictures must equally be available in the local language, especially if utilised for publications.[6]

Table 1 Criteria for BSSH support to perform voluntary work overseas (Internal BSSH document).

	Teaching	Mentoring local surgeon(s) and allied healthcare workers	Delivering medical care
Substantive NHS contract	+++	+++	+++[a,b]
Independent sector only	+++	+++	++[a,b]
Surgical or anaesthetic trainee with NTN or post CCT[d]	+++	+++	+++
Retired with valid licence to practise (On GMC Register)	+++	++[b]	++[c]
Retired (no licence to practise)	++[c]	+[c]	-
Hand therapist[e]	+++	+++	+++
Nurse[f]	+++	+++	+++

+++ Full Support.
++ Support with minor conditions.
+ Qualified support with evidence required.
[a] Surgeon and Anaesthetists own responsibility regarding scope of practice.
[b] Need evidence of appraisal and revalidation.
[c] Need evidence of CME and experience.
[d] Trainees under direct Consultant Supervision.
[e] Hand Therapist with British Association of Hand Therapy qualifications.
[f] Nurses with Royal College of Nursing registration.

Expert trainers

Both the Royal College of Surgeons of England [7] and the Royal College of Surgeons of Edinburgh[8] underline that surgeons who teach must have expert knowledge of their subject matter and be able to apply that knowledge in specific clinical situations, as well as demonstrate excellent communication, leadership and team working skills. We therefore believe that the surgeon-trainer, who teaches in LMICs must be expertly qualified to both undertake and teach on the subject in question. Table 1 shows the internal BSSH document outlining the minimum requirements of individual clinicians from the UK who are considered as potential collaborators in overseas projects.

It is important that we set standards for visiting surgeons in order to ensure a measurable quality and discourage unethical surgery.

When operating abroad the General Medical Council's pillars of Good Medicine still stand.

Flexibility without compromise

A thorough knowledge of locally available resources is essential,[9] and working within them ensures reliable results can be reproduced after the departure of the visiting team. Any special instruments brought by the visiting team to facilitate surgery, must be left behind if the same surgery is to be undertaken and provisions for servicing such equipment must be put in place.

Trainees

Trainee involvement in projects overseas can have a potentially overwhelmingly positive impact on the success of the project and its sustainability.[10]

Trainees can bring energy, enthusiasm and drive to tackle challenges in a resource-poor setting. They have the ability to form global networks which facilitate the spread of ideas and sharing of information. As the next generation of global surgeons, it is vital that trainees engage with global surgery at an early stage in their career so that they are prepared and equipped to be effective global surgeons later in their career.[11]

Alongside the potentially positive impacts of trainee involvement in global surgery, there is also potential for negative effects. It is therefore essential that Plastic and Orthopaedic surgical trainees also recognise their important responsibilities with regards to the governance in overseas collaborations and the promotion of responsible and appropriate trainee involvement in global surgery.

Given that the overall aim of overseas collaboration is to strengthen and develop local knowledge and skills aiming for an independent local practice, it is crucial that trainees from HICs are careful not to dilute the training of the local surgeons. To that end, trainees must be mindful of opportunities to offend local customs, patronise local surgeons, or to damage the reputation of the HIC Plastic and Orthopaedic departments they represent; same as their Consultant counterparts. Prior to going overseas, trainees should appreciate that overseas collaborations are not the appropriate context in which to seek to increase their own surgical experience.[12,13] Wherever possible they should ensure that it is the local surgeons who are the ones operating under supervision, rather than themselves.

Registration

Registration with the LMICs' medical body is paramount if performing surgery in order to allow an overview of the foreign medical assets operating within that country and to ensure compliance with local requirements. The minimum criteria for volunteers must also include a valid registra-

tion with their own country's statutory body; up to date appraisal, revalidation and Continuous Medical Education as well as a Criminal Record Bureau check within the last 3 years and a certificate of Good Standing from the General Medical Council.

Indemnity organisations provide cover for overseas work if informed in time, and regular visits can be built into the yearly contract.

Feedback

Feedback serves as an improvement and empowerment tool for both the HIC and LMIC surgeon. This can take the form of a structured on-line form or free text, or face-to face meetings. Many people are very polite in their feedback – too polite perhaps, but familiarity and openness engenders useful feedback on training methods and future needed developments. This is crucial for progress.

Feedback may also tell you what the local surgeons need, which may be very different from what was originally offered.[9]

Therapy

No training of local surgeons is complete without including the principles of therapy within the multi-disciplinary team. Therapists must of course also be registered with their professional body, sufficiently skilled in undertaking the specialist work (e.g. hand/speech/burn therapy etc.),[12,13] and are expected to work within their scope of practice, just like the surgeons.

One of the main difficulties for the development of a sustainable local therapy service is the paucity of available therapists in LMICs and when present, the local workload which encompasses so many subspecialties in surgery and therapy, is frequently overwhelming and leaves little time for learning. It is therefore imperative for the visiting surgeon to support not only the visiting therapists, but also the local therapists.

Do not try to break any records

Faced with an overwhelming volume of clinical problems it is tempting to work as hard as you can and to finish as many operations as possible in the time allotted, but this can bring more problems than it solves.[14] Often the hidden cost of visiting foreign teams is forgotten.[15] Even a short visit may have a negative impact on theatre availability later on, especially if theatres are shared between many specialties and time to accommodate visiting teams has been "bought" by swapping theatre slots. It is important to recognise that the daily influx of cases does not stop and that there is likely to be a backlog of cases waiting for the local surgeons when the visiting team leaves. Understanding the wider effect of collaborations is important for good relations and efforts to minimise any negative impact should always be undertaken and reviewed at regular intervals.

Offer more than just surgery: Educate, educate, educate.

Broadly speaking there are two forms of overseas collaborations: service-orientated and educational.

A service-orientated visit provides individual patients with surgical treatment otherwise not locally available. This can help the local population by providing acute and lasting surgical treatments.

An educational visit provides the local surgeons with the knowledge and skills to perform the surgery themselves, long after the visiting surgeon has left.

The latter forms the basis of the BFIRST and BSSH visits.

It is clear that it is not just surgical techniques which may be useful: the training of therapists, who can provide targeted pre- and post-operative enhanced care; nurses who are able to take appropriate care of the patients post-operatively; communications courses; academic support for presentations and publications; alongside many other services are often invaluable to the LMIC surgeon. We must therefore try and think in an innovative and comprehensive way when seeking to provide a multifaceted and useful support.

Developments introduced should effect a lasting change in practice. To do so, a close and ongoing dialogue with the local doctors is essential long after the visit,[16] taking into account both the impact on the LMIC as well as the HIC. In HICs this will necessarily include formal recognition of volunteering, appropriate monitoring, mentoring, evaluation and above all support from the Royal Colleges, the General Medical Council and government.[17,18]

Sustainability

The ultimate aim of the visiting surgeons and teams should be to encourage and develop sustainability. Success is being no longer necessary!

It is not about you, it is about them.

Be a friend.

Declaration of Competing Interest

None.

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