



From Central Africa to Egypt: A Surgeon's Journey

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From 1977 to 2012, I served as a volunteer, church-supported general surgeon at the Bongolo Hospital in the central African country of Gabon. During that time, I oversaw the development a 150-bed hospital and helped create the Pan-African Academy of Christian Surgeons (PAACS), which between 1997 and the 2013 established 9 surgical residency programs in 8 countries in Africa. In 2013, I accepted an invitation to open a 10th PAACS training program at Harpur Memorial Hospital in Egypt, a 100-year old Anglican institution in the Delta of Egypt that had been entirely directed by Egyptians for the previous 40 years.

Little did I know how drastic the change would be to my surgical practice and how much I would have to change to adapt!

A Failure to Communicate

When I arrived in Egypt I couldn't speak, understand, or read a word of Arabic. In Central Africa, I spoke French and communicated easily with our medical staff and my patients. This was possible, because early in my career, I had learned both French and a local African language as part of my orientation to Central Africa. I was no longer a young man when I arrived in Egypt, and after six months of intensive Arabic study, I could not function without a translator in my clinic, in the operating room, on rounds, and when talking with nurses, pharmacists, or patients' family members. What I was able to do was greet people in Arabic, shop for food, and get around in a taxi without confusing the driver too seriously. Because most Egyptian doctors speak English and because on most of my days I worked with bilingual residents who

translated for me, I managed a bit better in the hospital.

Inability to speak and understand what nurses, other physicians, and patients are saying is fertile ground for misunderstandings and misperceptions. A week or two after I arrived, I was asked to see a young woman who had undergone a laparoscopic cholecystectomy in Cairo a week earlier. Her abdomen was mildly distended, and she was septic. An ultrasound showed a dilated common bile duct with two stones in the head of the pancreas. A gastroenterologist had performed an ERCP and a sphincterotomy, but the stones had not passed. With the family's permission, we took her to the operating room and found 1000 mL of infected bile and generalized peritonitis. A surgical clip had come off of the cystic duct after the surgeon removed the gallbladder. I eventually found the leak and tied it off. After irrigating her abdomen copiously, we left suction drains and closed. After she woke up she was taken to the intensive care unit. The family was very anxious to find out from me what happened, but at that moment I could not find anyone to translate. What I managed to say to them in broken Arabic still makes me blush. Literally translated, I said "She OK now, much, much!" I will leave it to the reader to imagine how much confidence that gave her family! No matter how well trained or experienced we are, if we speak like 2 year-olds, we will be seen as a bit stupid! When we can't talk or understand, the trust so essential to successfully manage sick patients will be weak at best. Effective communication is so important to building trust that time spent in learning the predominant language is time well spent. Where it is not possible, spending the



money to hire full-time translators is worth every dollar.

Building Trust

In Gabon, I was one of only a few trained surgeons for more than 200,000 people in an area the size of Massachusetts. I regularly operated on patients who had traveled more than 350 miles from the capital city, but because surgeons were in such short supply, they were willing to wait a month or longer for an elective procedure. The result was that complaints and challenges to my medical opinion were unusual. A local proverb that worked in my favor stated, “Offend the witch doctor and end up dead!”

Even as late as 2012 when there were other surgeons on our staff, we were able to control most aspects of our surgical practice. But when I arrived in Menouf, Egypt, I was an outsider and an unknown, and like any other surgeon starting a practice I had to present my credentials, prove my competency, and earn the trust of the hospital director and the surgical team. This is true anywhere in the world, but is magnified when a stranger comes to town from another country, especially one who doesn’t understand the language and understands even less the way people think!

Humility, patience, and a willingness to listen to local surgeons and to patients go a long way towards building trust. An outside surgeon’s skill in the operating room and on the wards is helpful, but it can take up to a year to gain the confidence of others to make major changes. It takes both competence, humility, and time to establish a foreign surgeon’s reputation.

Unlike most of the rest of Africa, Egypt has no shortage of hospitals, doctors, or surgeons. The country graduates 20,000 MDs a year and the vast majority of them are not able to enter specialty programs. Residency programs in Egypt are poorly organized, lightly supervised, and usually completed in three years *if* a resident successfully passes a government written “Master’s examination.” Residents have to be self-motivated and self-directed in their learning, since curricula are

vague, formal teaching is limited, and operative experience is all too often limited to assisting the professor or operating on small cases without adequate supervision and teaching.

Although there are some excellent and reputable Egyptian surgeons, all too often surgeons who have passed the written and oral government examinations learn to operate *after* they have been licensed, and with inadequate or non-existent supervision by more experienced surgeons. This is true in many developing countries, not just Egypt. To hone their skills, these young surgeons learn by reading or by trial and error, unless they can work with a more experienced surgeon. However, working with “experienced” surgeons who were not well supervised or systematically trained themselves has serious drawbacks as well. These training programs are more like apprenticeships and are not conducive to evidence-based learning. Surgical traditions that are passed down from one surgeon to another are then considered “best practices,” often with catastrophic results. To limit the damage when there are complications and to protect their reputations, surgeons are tempted to blame their patients for complications that occur and refuse further treatment. These practices do not allow young surgeons to learn how to prevent or treat surgical complications when they occur. Not surprisingly, patients and their families respond by distrusting most, if not all, surgeons.

Perceptions and the Impact of Worldviews

Surgery in Egypt is a different paradigm from surgery in sub-Saharan Africa, and population density is one of the most important contributors to that. During my first six months, I thought Egypt was experiencing an epidemic of appendicitis. Every other day or so, I found myself removing an inflamed appendix. Eventually, it occurred to me that Egypt, with its population at 90 million, might not have 10 times the frequency of appendicitis as Gabon but simply more people. It turns out that the population of Egypt is 64 times greater

than the population of Gabon (90 vs. 1.4 million)! There are no reliable figures about the incidence of appendicitis in Egypt, and the WHO doesn't track that information.

Worldviews are also hugely important in determining which paradigm of surgery is the most broadly accepted. The worldview in most of sub-Saharan Africa is Animistic, which translates into the widespread belief that disease and accidents are primarily caused by sorcerers who for hire, direct evil spirits to harm others. Animistic people accept that modern medical care and surgery are helpful to resolve medical problems that sorcery cannot help; but they fault our methods because we can't explain *why* a particular disease or incident occurred in *their* body, as opposed to someone else's. Animists claim that they are able to ascertain the answer to the question "why did this happen?" with the help of "good" healers who consult "good" spirits. Surgeons who openly mock these beliefs are considered by Animists to be fools.

Despite these beliefs, most animists will respond positively when asked by a Christian healthcare worker if they would like prayer for healing or prayer for God's protection. They honestly believe that there are evil spirits lurking around them who might harm them. They may not believe in Jesus, but they are hopeful that Jesus is more powerful than the demons that constantly threaten them and their families.

Muslims believe in the power and the malevolence of *shayateen* (demons) as well, but the concept that demons might be the cause of surgical disease is less accepted than among Animists. Such belief also contradicts orthodox Islamic teaching that nothing happens apart from the will of *Allah*. Muslim patients are not above consulting a spirit guide or pinning a verse of the *Qu'ran* on their clothing for protection from the "Evil Eye," but if they follow the teachings of the *Qu'ran*, they are more likely to be fatalistic about bad outcomes. I will never forget the response of a Muslim father when I sorrowfully told him that his newborn son had died in surgery from overwhelming sepsis. Placing his hand on my

shoulder, he *smiled* and said in front of his weeping wife, "Don't feel bad, doctor. It was *Allah's* will!" He meant it and thought it would comfort me, but I was too shocked by his insensitivity to reply.

Nevertheless, it would be a mistake to assume that in Islamic countries fatalism will protect surgeons from lawsuits and claims of malpractice! Muslim patients in Egypt are far more likely to accept medical and scientific explanations for disease than elsewhere in Africa, and Islam is strongly supportive of modern medical care and generally accepting of scientific explanations of diseases and their management. I have been surprised at how quickly my Egyptian patients switch from trusting our team to accusing us of malpractice, after their family member experiences a complication. They are far more likely to challenge the medical advice of their doctors than their Western or Central African counterparts. On many occasions, family members without any medical training overruled or challenged my treatment suggestions. On one occasion, an 18-year-old construction worker cancelled his sister-in-law's emergency C-section, despite the fact that she was hemorrhaging, preferring to take her home until her husband finished work that evening! The husband of a 20-year-old woman who had injured her hand and cut a tendon while harvesting a crop decided she could wait a week while he decided what to do! This is one of the most difficult aspects of practicing surgery in Muslim countries and is a reflection of the low esteem and trust for surgeons and the prevailing view that women cannot make decisions about their own bodies.

In addition to Animists and Muslims, there are significant Christian populations throughout Africa whose worldview embraces both spiritual and medical views of disease. Christians in Africa generally accept spiritual cures, such as healing through prayer and casting out evil spirits in Jesus's name. At the same time, they accept advanced medical treatment. Their faith that God can heal them in response to prayer, either miraculously or through a physician's skill and knowledge,

often leads them to seek out capable Christian healthcare providers who integrate their faith and practice. Unlike Muslims and Animists, Christians understand the concept of serving in mission out of love, and why an expatriate doctor might give up wealth, fame, and family to serve the poor in a foreign land.

Other Imprints on the Surgical Environment

The city of Menouf boasts three government hospitals and, at last count, four or five private hospitals, one of which is Harpur Memorial Hospital. If one includes all of the surgical specialties, there are approximately 50 surgeons in Menouf! Five or ten of them have operating privileges at Harpur Memorial Hospital. With just three operating rooms and one or two anesthetists providing coverage each day, the competition to start a case can be brutal. Unfortunately, competition does not mean that high standards are widely applied in the city's operating rooms. In fact, competition encourages them to cut corners.

In our hospital in Gabon, I had full control over our operating rooms and could insist on high standards. The rooms were regularly cleaned, sterilization procedures were rigorous, and the rooms were well-staffed with trained OR nurses. Anesthesia was part of the Department of Surgery and worked closely with our surgeons. Surgical cases were scheduled on a first come, first serve basis and could be booked with confidence weeks in advance.

The surgery scheduling system in a hospital always reflects cultural norms and practices. When I began practicing in Egypt, I was surprised to learn that the surgeon who got into the operating room first was determined by his reputation, his friendships, the preferences of the anesthetists, and the operating room nurses. My efforts to institute a system based on the urgency of the case or a first-come, first-serve basis were welcomed with polite smiles and nods of acceptance, but complete non-compliance. Eastern culture reveres elders, so much so that O.R. nurses are ashamed to make older surgeons wait. However, this does not include older expatriate surgeons!

The scheduling problems finally came to a head one day when five surgeons showed up at 9 am to operate on a combined total of more than 15 cases, each one having been told he could start at 9 am! By the end of the day, everyone was frustrated and angry! After that, we made moderate progress in instituting a more rational system, though there were frequent lapses. The key to success in these situations was to enlist the full support of the O.R. team for change. That, however, took time, patience, steady pressure, and a willingness to listen.

The shortage of anesthesiologists and the lack of nurse-anesthetists created other problems, because anesthesiologists have operational control over scheduling and can choose which surgeon will be served first. The anesthesiologists in Egypt were a law to themselves, and had strong financial incentives to run two or even three general anesthesia cases simultaneously. This was especially true if the anesthesia machines were equipped with working ventilators. The surgeons had no choice but to agree to share their anesthetists with one or two other rooms, unless they wanted to wait until all the other cases on the docket were finished.

In every country in the world, culture influences written and unwritten operating room priorities, operating room policies, and the roles of doctors, nurses, and ancillary personnel. Egypt's best hospitals may be comparable to community hospitals in the United States, but the vast majority of them, including the hospital in Menouf when I first arrived, seem to be primarily focused on providing surgical services with speed, simplicity, and economy. These would be laudable priorities if they were designed for the best interest of the patients. But from what I observed, the OR policies were primarily designed to meet the needs and desires of the surgeons and the anesthesiologists. There was at times little concern for patient safety, as evidenced by frequent breaks in sterile technique, limited cleaning of the OR before and after operations, and a near-total absence



of formal training in these critical areas for the OR nurses and ancillary personnel.

These lapses were not intentional, but occurred because over time, other culturally rooted issues gradually and imperceptibly became more important than patient safety. Culturally-related issues are, for the most part, invisible to insiders and difficult to expose without pushback. Most of the Egyptian surgeons and anesthesiologists that I worked with vociferously disagreed when I challenged their attitudes towards patient safety.

Another cultural issue is the wide gap in authority and responsibility between doctors and nurses. This is probably the result of the even greater difference in their educational levels. OR nurses and OR techs often don't even have high school degrees. As a result, they do not see themselves as important team players whose performance or lack of performance affects patient outcomes. Instead, they see themselves as employees whose job is to serve doctors quickly and without discussion. If they see practices that adversely affect patient care, it is not up to them to point them out, unless they want to lose their jobs.

That leaves doctors as the sole guardians of patient safety in the operating rooms. Most of the surgeons and anesthesiologists I worked with were not even aware of the major safety issues I saw until I brought them up. But because Egyptian culture is highly sensitive to public shaming, I could never bring up issues in the presence of nurses or conscious patients.

Changing the negative cultural influences of the surgical environment takes a great commitment to not publicly shame an errant colleague. As the writer of Proverbs stated, "There is a time and place for everything." I learned that the time and place to institute cultural change in the surgical environment was when I had tight control over my emotions and could make gentle observations and suggestions. Over time and with repetition my suggestions eventually become someone else's idea, making their adoption even easier. Other ways forward were to humbly ask for advice on how to make the operating room safer for patients, and to be scrupulous in modeling best practices.

Conclusion

When medical professionals step out of one culture into another to serve in mission, the transition is far more complex and difficult than even those with wide international experience may realize, especially if it involves a change between widely divergent cultures, the need to learn a new language or work through a translator, and understanding a completely new worldview. Understanding how these issues affect medical practice requires a mixture of humility, curiosity, and perseverance. Done well, it can bring about successful transition and widen doors to successful ministry.

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