OPERATION SMILE

In 1982 Bill Magee. a plastic surgeon from Norfolk, Virginia, travelled to the Philippines with a small surgical team to carry out some work on children with cleft lip and palate anomalies. Within a few days he realised that one trip alone would not be sufficient to deal with the many hundreds of patients and their parents who, having heard about the opportunity to have corrective surgery, had made their way to the hospital at which they were working. Operation Smile was founded to provide reconstructive surgery to children and adults with cleft lip and palate and now the organisation arranges Missions to almost twenty countries each year including Kenya, Russia, China and Brazil.

Whilst the main purpose of the charity is to provide surgery to correct cleft lip and palate anomalies in those countries where there is an unmet need, Operation Smile also provides free medical and dental services to those people in the United States who are unable to afford treatment.

Education is a particularly important aspect of the work carried out by Operation Smile. During the Missions each visitor is paired with a member of the same speciality from the host team with the aim of providing educational support in all aspects of the management of the patients including nursing, play therapy, dentistry, speech therapy, anaesthetics and surgery. The eventual aim is for Operation Smile to withdraw from a site having provided sufficient educational support for local staff to deliver the necessary service – in many instances the charity just provides funds to allow the local teams to function effectively. It should be emphasised that the educational process is not all one-way, and the members of the visiting team have plenty to learn about working in an environment less fortunate than that from which they came.

In addition, each year Operation Smile invites nurses, surgeons and anaesthetists from the host countries to an intensive three-week training programme in Norfolk, Virginia, during which lectures and surgical sessions are held to cover the management of patients with craniofacial anomalies. This programme, which includes training in microvascular techniques, is provided without cost to the participants.

In order to finance each Mission (often more than one a month) considerable fundraising is undertaken in the United States, ranging from high school activities to major events organised through local groups in the cities. Each Mission can comprise over 30 members flown together with disposable equipment to the host country and the logistics behind organising the safe arrival of all of this lies with a coordinator who is often a pre-medical student.

Each Mission lasts about two weeks and has a preliminary screening stage during which patients are selected for surgery according to strict protocols (cleft lip and palate children take precedence over adults, and all clefts over burns and orthopaedic problems). During this first week the theatres and wards are prepared for the patients. The second week is devoted to operating and the teams work, often two per theatre, to treat as many patients as possible. Usually a small team remains behind for a third week to manage any post-operative problems which might arise.

Further information: http://www.operationsmile.org

OPERATION SMILE 2001

J Howie, Theatre Sister
Furness General Hospital

I had always wanted to do some voluntary work in a third world country, and when I mentioned this to Peter Dyer last year he suggested that I join the Operation Smile team.

I was accepted for the Mission in Kenya at Eldoret in November 2001. I contributed $400 towards expenses and paid for the visa to enter Kenya. The Operation Smile team gave me the chance to arrange my travel so that I could stay on for some extra time in Kenya.

Week 1 After some delays *en route*, I arrived one day late at Eldoret, where I was met by team members. At the hospital we found 300 patients waiting at the gates. These were mainly children with cleft lips and palates but there were also a lot of burns patients. Many patients and their families travel long distances to be seen. Local people will go to the villages with transport to bring patients to the centre but some patients will walk, and for some of them this means walking for several days. Operation Smile is promoted on radio and television and through the churches, to ensure that as many people as possible will hear that teams are there, offering a free service which could make a huge difference to their and their families' lives.

As soon as I arrived the nurse co-ordinator showed me the stages which the patients must go through. These were:

- medical records
- photographic identification

- pre-op nursing assessment
- vital signs
- anaesthetic assessment
- surgical assessment
- speech therapy.

I worked on vital signs all morning and then went to the operating theatre where I emptied boxes and stocked the shelves with stores we had brought with us. After this I worked in assessment until 6.30pm when we closed the clinic, having seen 204 patients. The remaining patients were told to come back the next day, as we would see and assess everyone who came.

The following day we got to the clinic early and found some patients already waiting for us. One patient's contractures were so bad that she was unable to walk, and another's arms were adhesed to her chest wall.

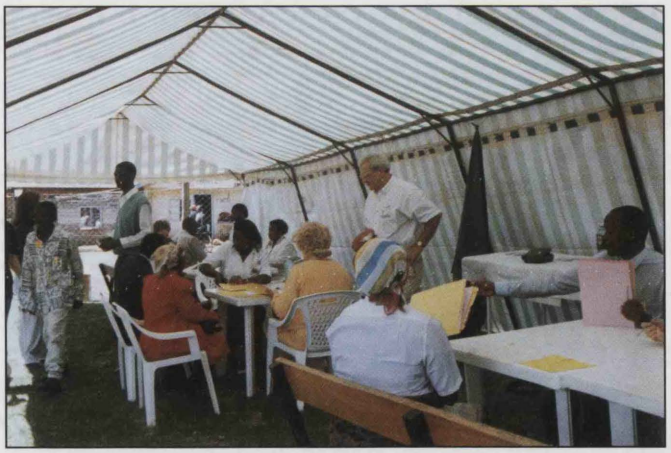
I spent the morning setting up the theatre. We had the use of two theatres in a four-theatre complex. They were new but had no ventilation system, big old autoclaves and only two Little Sister autoclaves for instruments. There was someone to wash the instruments for us and disposable drapes and gowns were sent from the United States.

Two tables were set up in each theatre and an area in the corridor was allocated for local anaesthetics to be done. I was to manage one of the theatres, staffed with local nurses.

We spent the afternoon assessing patients and the clinic finished at 6pm.

The next day there were slightly fewer people waiting at the gates when we arrived. I helped some mothers and children out of a jeep, and a two-day-old baby with a cleft face arrived. She will have to be put on the world programme.

At the end of the day operating lists were drawn up and posted outside the hospital. Some people were disappointed not to be included, but we are hoping to return this year, which may give them their opportunity. One problem is that,



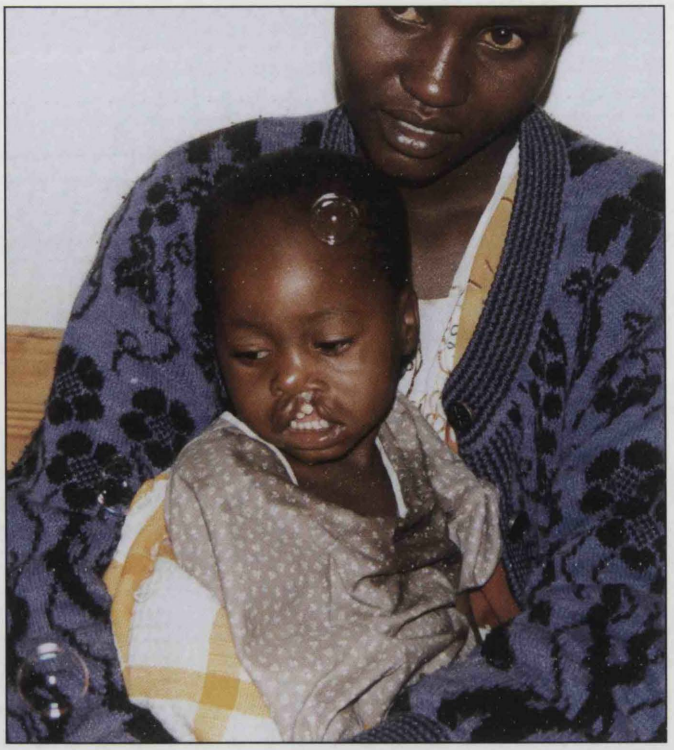
due to poor nutrition, there are a lot of anaemic children. We provide iron tablets but, I was told, not all the parents give them to their children.

Week 2 After a free day we started operating at 8.30am and worked until 8.00pm. Lunch was at 3.00pm when we took it in turns to go out. There were three nurses between the two theatres, and as the new girl I was greatly helped by the other two.

The rest of the week was equally busy. We nurses had one night each on call but only once were we called out: a cleft palate patient had haemorrhaged.

I had trouble with the diathermy machines brought over from the United States, which kept giving me electric shocks. The electrician discovered a fault in the mains and mended it, and I was reminded of those long-ago lectures about grounding electricity.

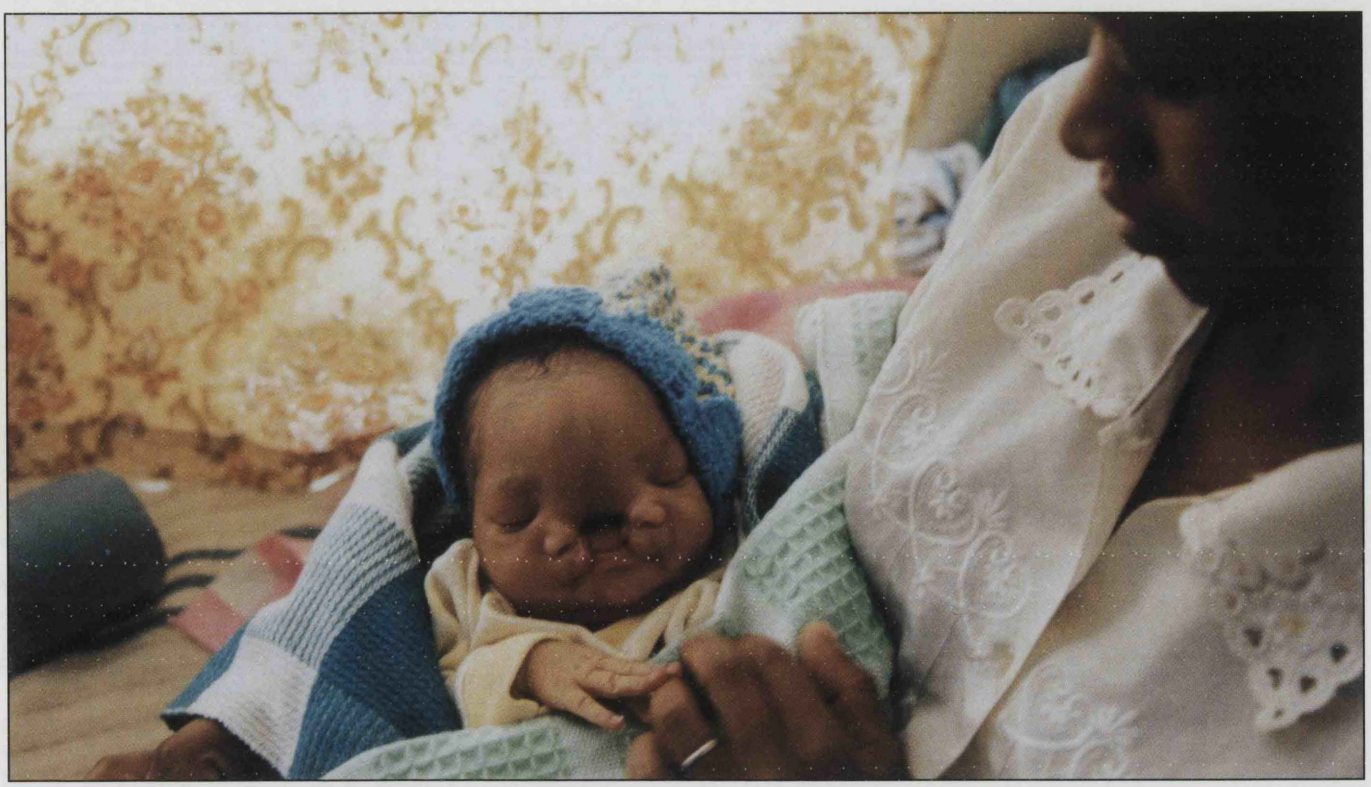
By Friday we had run out of gowns for the scrub staff. We discovered that the local staff had gone through the rubbish and recycled the paper gowns. As they appeared to be packed and sterile, we used them, whilst being very aware of the high incidence of HIV in Kenya.



We finished operating at 2.00pm that day. It took all afternoon to check our supplies and pack everything away, after which I took the night flight to Nairobi. Difficulties at the airport were dealt with by the mission coordinator who was excellent at negotiating problems such as these.

On Saturday a group of us went to the Nairobi National Park to see the animals and after a party at the hotel we all went to the airport where we took flights to our home destinations.

I arrived home very tired and with mixed feelings. I was glad to have helped a few people to have a better life but simultaneously felt very inadequate as there were so many more who needed our help.



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