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Timor Leste

Dr Mark Moore

20 - 27 June 2104

INTRODUCTION

This return Plastic and Reconstructive surgical team visit to the Hospital National Guido Valadares in DIli was generated at the specific request of the Timor Leste health authorities. After the review of the visiting surgical team component of the ATLASS project at the end of 2013, the focus for further aid delivery by RACS, and sponsored by DFAT, was to be in support of the newly developed Family Medicine Programme for the new Timorese doctors recently returned from Cuba.

With our teams having been managing ,in particular cleft lip and palate and burn deformities since 2000, and over the last 5 years or more, the identification and training of a local counterpart Timorese surgeon there is an ongoing need to continue to maintain this service and teaching role. In the field of cleft lip and palate alone, with the present Timor birth rate you would expect more than 50 new cases per year to be born. In addition to the primary surgery requirement, our team has over the last two years introduced other elements of a conventional cleft multidisciplinary team, notably speech pathology and orthodontics. In recognition of this need for ongoing support of this embryonic cleft surgical service in Timor Leste , their Health Ministry made a formal approach to RACS and DFAT to facilitate this mission.

In addition to the surgical team funded by DFAT, we were accompanied by Ms Celina Lai, speech pathologist from Royal Darwin Hospital who was able to maintain and develop her teaching relationship with her counterpart Timorese colleague, whom she met during our June 2013 visit.

TEAM PERSONNEL

The visiting team was comprised as follows :

Dr Mark Moore	Plastic and Craniofacial Surgeon Women's and Children's Hospital and Royal Adelaide Hospital.
Dr Andrew Fenton	Anaesthetist Royal Darwin Hospital
Sr Joy Booth	Theatre Nurse / Educator Royal Adelaide Hospital
Ms Celina Lai	Speech Pathologist Royal Darwin Hospital

PARTICIPATING LOCAL STAFF AND COUNTERPARTS

Those local staff involved in the teams clinical and teaching activities included ;

Dr Joao Ximenes	Plastic surgical trainee /counterpart , HNGV
Ms Alotu da Costa Sarmento	Speech Pathologist , HNGV

The Outpatient staff who organise and facilitate the assessment clinic on Saturday morning.
The operating theatre staff – nurse anaesthetists, and scrub / circulating nurses, sterilising department staff, all contributed to a safe and consistent level of care for the patients treated.
The ward staff in both the male and female surgical wards who prepared and managed post-operatively the team's patients under the supervision of Dr Joao Ximenes.

Mr Sarmento Correia , RACS resident coordinator, Ms Karen Myers, RACS administrator and Ms Kate Moss, RACS Project Officer arranged and organised the patient clinics, and various logistic issues for the team travelling to and from Timor Leste as well as whilst in country.

OVERVIEW

This Plastic and Reconstructive surgical team visit to HNGV, Dili occurred in response to a direct request from the Timorese health ministry to continue to provide a clinical and teaching service to our local counterpart surgeon Dr Joao Ximenes and those patients in the region with specialist reconstructive surgical needs. Following our team's last visit to Baucau in November 2013, the latest review of the ATLASS programme as delivered by RACS in Timor Leste recommended a change in focus. A specific need identified by the Timorese health ministry to assist in the ongoing training of the recently returned Timorese medical students in a more broad-based Family Medicine Programme resulted in DFAT funding being diverted in this direction.

Within the RACS Global Health office and especially from the Timorese side the need for ongoing delivery of surgical care and teaching in the area of cleft lip and palate , and burn injury / deformity was well recognised. Prior to this visit our teams have been involved in training Dr Joao Ximenes in aspects of cleft surgery, whilst also introducing the concept that cleft care is a multidisciplinary team approach delivered over an interval from birth to maturity. We have thus been able to move from the scenario of when we started in 2000, where many cases presented late in childhood, often not having attended school, to the present with most cases presenting early in life – with the resultant ability to perform early cleft surgery and idealise outcomes from the viewpoint of feeding, speech, appearance and educational opportunities. Ongoing support of Dr Joao X and his fledgling team is essential if we are not to revert to the old inferior model !! Indeed during this visit an example of how wrongly surgical aid delivery can occur was recounted to us. In February 2014 a team of overseas surgeons of unknown skill level performed 23 cleft operations in a fashion that seemed to fall outside internationally accepted guidelines for cleft missions, which is unacceptable.

The arrangements for our teams visit began with forwarding the waitlist of patients seen on previous visits to Mr Sarmento. He was able to utilise this as the basis for the list of patients presenting to the outpatient assessment clinic on the Saturday after our arrival. 35 patients were examined and an initial surgical list for the first 3 days constructed. Whilst patients from most of Dili and other outlying regions were able to present for review at the correct time, those from the Bairo Pite clinic decided to attend some 4 hours late !! The staff from this clinic were informed that

their continued failure to arrive at the clinic at the allotted time risked compromising the care of the patients they were referring. These patients were reviewed on the Monday between surgical cases.

Dr Joao X commenced the clinic and upon our arrival had already commenced allocating patients to surgical lists – he is well able to assess and establish the appropriate pathway of management for both cleft and burn deformity cases.

Surgical cases commenced on Monday morning and continued for the following 4 days. Activity within the theatre complex seemed better coordinated and slightly more efficient than on previous visits. We were accompanied by 2-3 nurses who regularly worked with the team for the whole week, as well as 3 junior nurse new to the operating theatre. Details of the teaching and interaction with the nursing staff is incorporated in the attached report from Joy Booth.

Dr Joao X has in our absence performed a further two cleft cases, which he was able to show the clinical photos of before and after repair – these results showed be is well able to undertake incomplete unilateral cleft repair with great skill. This appears to be the most common presentation of cleft lip and palate here in Timor Leste. On this visit we commenced him on trying the dissection and surgical exposures which go with the more severe complete cleft lip – increasing dissection of the nasal septum and lateral nasal wall. At weeks end he has a grasp of what is entailed with this approach and how he can add it to his surgical armamentarium. By weeks end he has now performed about 70 cleft repairs, and our team since 2000 has now completed over 800 cleft surgical procedures.

The expansion of the cleft lip and palate team concept continued with Celina Lai, Speech Pathologist from Royal Darwin Hospital cleft team accompanying us. She was able to attend the assessment clinic on Saturday, where we identified suitable cases in need of speech assessment and therapy, which she was able to see later in the week with her local counterpart Alotu da Costa Sarmento. The details of their activities is also attached in a separate report.

Regular pre- and post-operative ward rounds were held led by Dr Joao X – no specific post-operative issues arose whilst the team were still in Dili. A wound infection with lip scar breakdown presented the following week and Dr Joao X communicated with us to discuss the appropriate approach to management.

Burn management, both acute and long term remains a complex and expensive problem for HNGV. Short discussion were had during the week exploring options for a dedicated burn area / ward with staffing just to deal with these cases. Several options exist, either within the surgical wards, or preferably in an entirely separate location – this is possible within the present hospital structure, and would improve the delivery of burn care in the acute setting. As with previous visits there are always complicated, late presenting and challenging burn cases , which languish in hospital for far longer than necessary, and at much greater cost, which would

be dramatically improved with such a facility. Education of staff has occurred with a EMSB burns course last year, as well as previous visits by medical and nursing staff to Surabaya. The latter remains a lower cost and more comparable teaching opportunity, which is still available.

SUMMARY OF CLINICAL ACTIVITIES

1. Screening

Details of waitlisted patients from previous visits were forwarded to Mr Sarmento, and a number of these presented to clinic. There remain many who failed to attend and will be followed up for future visits.

The outpatient screening clinic was again very efficient, with Dr Joao X again directing much of the process.

2. Surgery

Surgery proceeded in a very efficient fashion. The theatre complex has an extra theatre now, as well as a small theatre for local anaesthetic procedures – overall this has led to an increase in activity.

As noted above Dr Joao X has continued to slowly but consistently develop his cleft surgical skills – albeit whilst still functioning as a general surgical trainee, and principle burn surgeon in his regular work hours. His dedication and commitment remain impressive, and it is to be hoped that this will be recognised by his own hospital administration and MOH.

3. Post-operative care

No specific upper respiratory infectious disease issues were noted on this visit, and thus no cases had to be deferred or cancelled as a consequence.

All patients were allocated to and nursed in separate 4-6 bed bays in both the male and female surgical wards, with no early complications noted.

SUMMARY OF TRAINING ACTIVITIES

1. Informal training

a. Outpatient clinic

This was largely an arena to teach and discus clinical cases with Dr Joao, and also identify those cases suitable for referral for speech and dental assessment and management. Again an opportunity to amplify the concept of the multidisciplinary team approach necessary for cleft treatment as Timor Leste moves into the modern world – in contrast to what was done by the visiting Korean group !!!

b. Operating theatre

Discussion of the ongoing training of Dr Joao in cleft and burn surgery was detailed above. His apparent comfit in performing this surgery improves with each visit, as he builds his numbers of cases.

Anaesthetic teaching was limited to interaction with 3-4 nurse anaesthetists all who have worked with our teams in the past. They were all actively involved with almost all of the cases we treated. The only medical anaesthetic trainees were away in Fiji furthering their training.

Nursing education , especially of the scrub nurses and young trainee nurses is detailed in Joy Booth's report. Reinforcement of the recently introduced surgical checklists and surgical instrument and disposable counts were especially targeted, this being a major advance on previous operative theatre nursing care.

Post-operative recovery as an area of relevance remains a major ongoing deficiency – no consistent framework, or protocol for recovering patients after surgery is evident.

2. Formal training

With the RACS commitment to direct surgical training in Timor Leste in a state of transition – the Family Medicine Programme was due to start the week after this team visit. There were on this visit no formal didactic teaching opportunities. The team would be happy to contribute to the FMP teaching during any future visits.

3. **Training priorities / recommendations**

As discussed in previous reports the outpatient and operating theatre remain a much underutilised teaching forum for junior doctors and medical students. I can only assume that with better communication of our visits to the local medical community / medical school that these teaching / training options could be better attended.

Ongoing up-skilling of operating theatre and ward nursing staff remains a priority for the delivery of high quality surgery, both in the field of cleft and burn surgery but also more widely. While some progress has been identified on this visit compared to the last this needs to be supported and maintained.

Burn treatment, the development of a stand-alone treatment facility and improved nursing care , as discussed above remain a high priority if there is to be progress in diminishing the morbidity and mortality from burns – whilst from a hospital cost viewpoint, also a reduction in financial burden to the MOH.

EQUIPMENT AND SUPPLIES

There were on this visit no issues or concerns over equipment or supplies. The customs exemption forms provided for entry into Timor Leste proved useful in allaying the concerns of officials at the airport.

Excess surgical consumables, sutures, dressing etc suitable for use by Dr Joao and his team were left with him.

VISIT ORGANISATION

The pre-visit preparation and planning of this visit was professionally overseen by the RACS staff in both Melbourne and Dili. There were no issues with travel, visas or excess baggage, all of which had been anticipated and appropriately dealt with.

The distribution of patients from around the country suggested the visit had been widely communicated, resulting in a productive educational and service delivery visit.

RECOMMENDATIONS

With the volume of existing cases, as well as the ongoing newly presenting cases, both cleft and burn, there is a clear need to continue the support and training of the fledgling reconstructive surgical service in Timor Leste. This was clearly evident from discussions with Dr Joao X, as well as Dr Joao Pedro , the newly appointed Clinical Director of HNGV. Not only the ongoing up-skilling of Dr Joao X, but the appointment and involvement of the speech therapist in the ongoing care of the cleft patient represents a major step forward in recognising cleft treatment goes beyond isolated operations, and in the modern world should be a team based model from birth to maturity.

Follow-up visits later this year and in following years should continue to provide the framework to up skill, teach and develop this cost – effective reconstructive surgical service.

ACKNOWLEDGEMENTS

Thanks are due to the ATLASS and RACS Global Health staff in Dili and Melbourne for their excellent organisation.

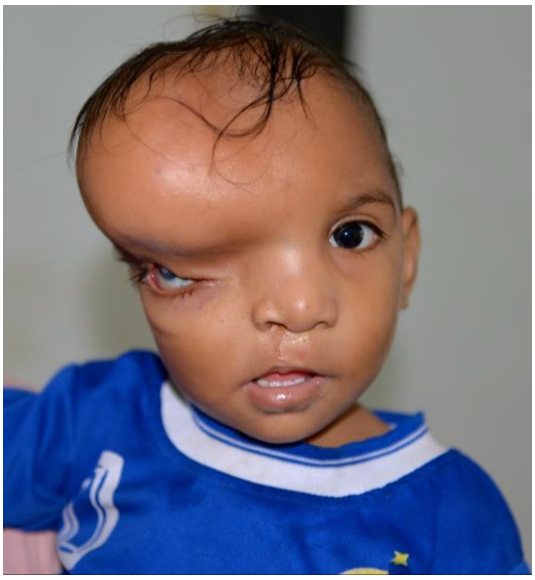
The medical and nursing staff at HNGV, Dili who worked enthusiastically with the visiting team.

Qantas and Air North airlines , in providing extra baggage allowances for the teams travel to and from Timor Leste.

The various surgical and anaesthetic supply companies, and assorted public and private hospitals that continue to support our teams work in Timor Leste.

SUMMARY OF CLINICAL ACTIVITIES – PLASTIC SURGERY

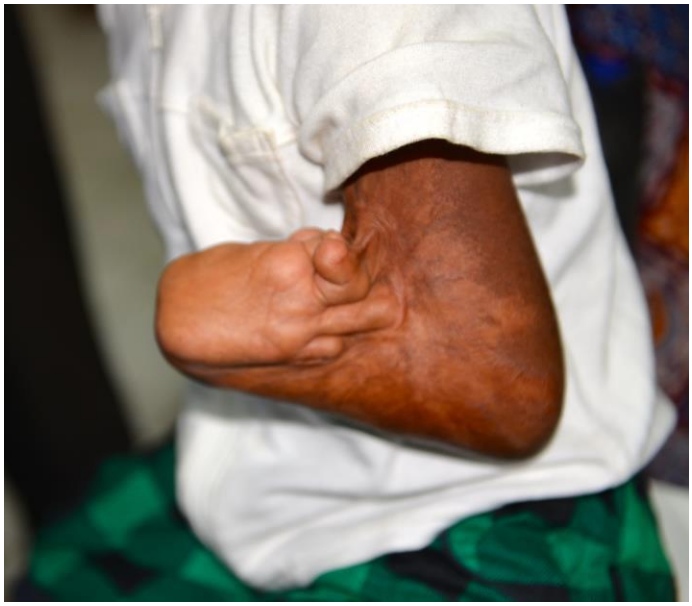
TOTAL PATIENT CONSULTATIONS		**52**
	INITIAL	**33**
	REVIEW	**19**
TOTAL SURGICAL PROCEDURES		**28**
	CLEFT LIP	**13**
	CLEFT PALATE	**7**
	BURNS / CONTRACTURES	**5**
	OTHERS	**3**



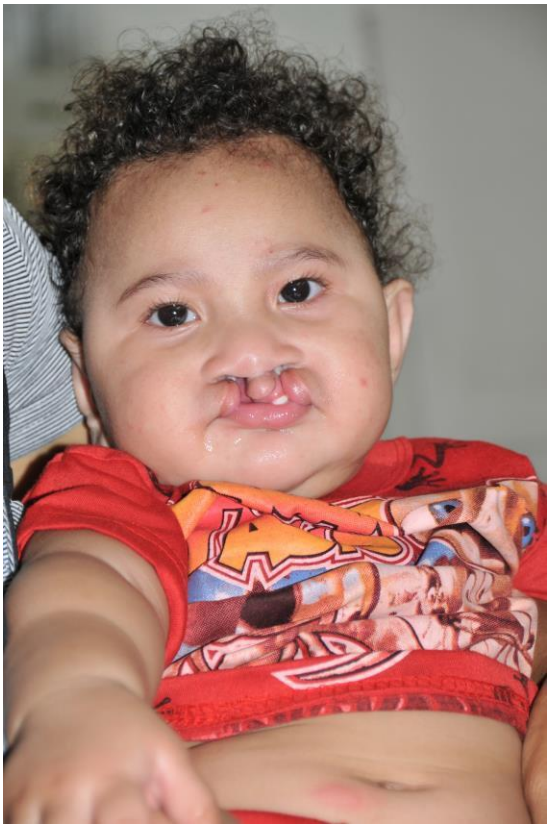
Right cleft lip and palate , and right frontal encephalocele (Tessier 10-11 cleft)

Lip repair in Dili in June 2013, returned for cleft palate repair in June 2014.

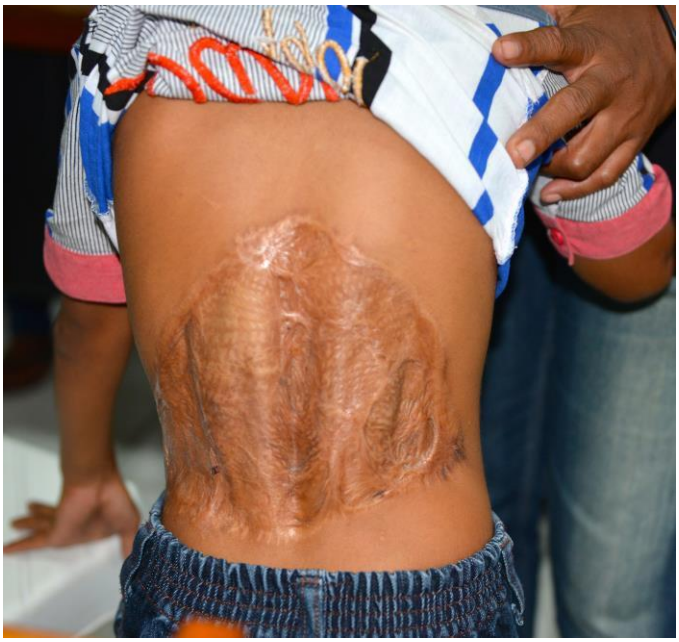
Developmentally making progress and needs referral to Australia for craniofacial surgery to correct his frontal encephalocele.



Burn contracture L arm / hand in 8 year old – sustained age 2 months



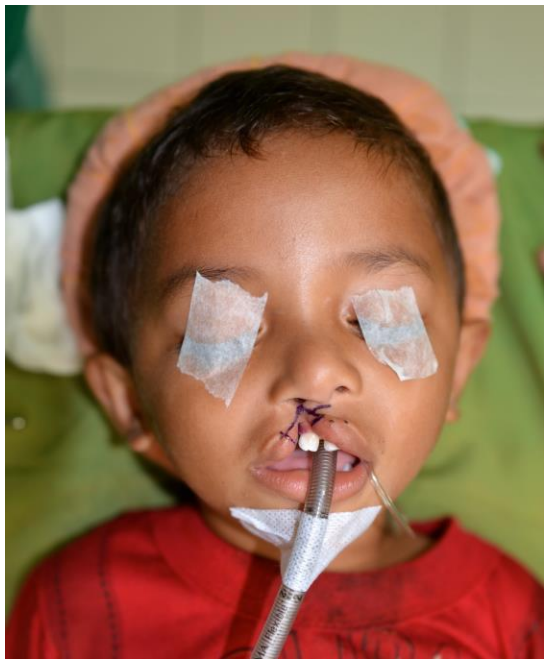
Bilateral cleft lip and palate repaired in Dili in June 2013, returning for cleft palate repair



2 year old with large pigmented lesion on back in 2008. Returned at age age 8 years for review after early excision and skin grafting

Dr Andrew Fenton and local nurse anaesthetist intubating child for surgery

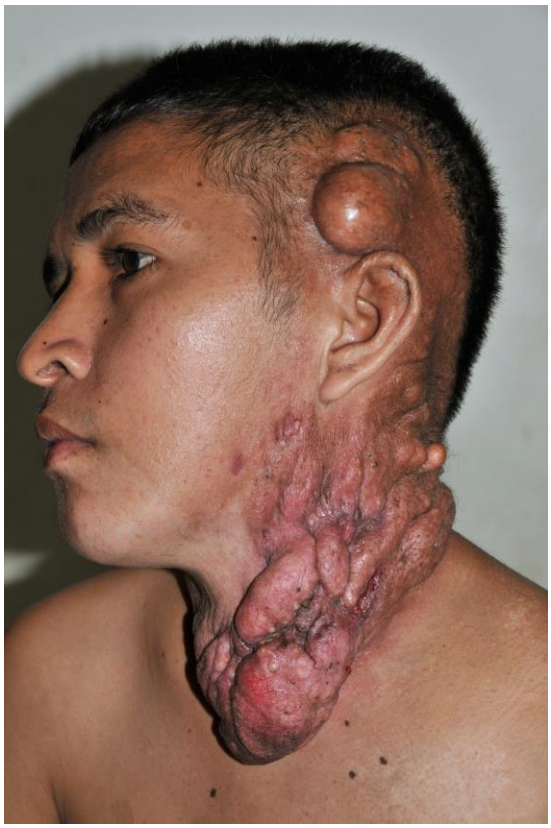
Dr Joao Ximenes performing pre-surgical markings for cleft lip repair



Pre- and post-operative views of R unilateral incomplete cleft lip repair

Dr Joao Ximenes on post-operative ward round in HNGV

Dr Joao Ximenes, Sr Joy Booth and the operating theatre nursing staff



Patient with soft tissue hamartomata , seen in 2012. Biopsied and arranged for surgery in Adelaide in 2014-07-15

Post-operative review in follow-up clinic in HNGV

Child with previous cleft lip repair waiting for cleft palate repair

Young cleft patient giving the ‘thumbs up’ on the visit