**Chapter 15**

**Specialists without Borders – fully grown**

There was certainly a ‘feelgood’ factor about the first seminar with Specialists without Borders, on the flight back to Australia. Already there had been a number of positive emails from those who had attended, and especially pleasing, from a personal point of view, the very positive feedback from the medical students. They were unanimous that it had been a wonderful experience, which would impact their medical careers, in addition to ultimately possibly medically assisting where they could in Africa. One of the medical students from Melbourne offered to be a medical student liaison for future trips. The surgeon in me while enjoying the feedback, realised this was just the first seminar, and the success of this concept of medical teaching was very dependent on specialists not only offering their time but also paying their own way. Surgical scepticism is a well-developed trait, so despite the success, part of me was still wondering whether this seminar was just a one-off!

Returning to Adelaide and immersed in surgery I was again surprised after a few weeks. Several of my colleagues, having been on the trip, volunteered to be on the *Specialists Without Borders* committee, although living in Perth/Melbourne /Sydney and Brisbane. They would give our local committee, a true Australasian flavour. It was also in that way the endorsement of the SWB concept which generated even more enthusiasm, not only to continue but also to become the best. Congratulations from colleagues was satisfying, but clearly formal feedback and suggestions from Nikita were needed before planning the next seminar. The committee quickly organised a questionnaire, sent by email to Nikita, for distribution to his colleagues allowing independent and anonymous feedback. This feedback was coordinated by Megan who was surprised that within 2 weeks she had approximately 50 replies. A meeting with all the new committee consultants was then coordinated to consider both the feedback, as well as any new ideas for the next seminar.

All the specialists on the committee flew into Adelaide, on a weekend. The enthusiasm at that meeting was again really encouraging. The general feeling in our discussions was that what had been an interesting concept, was now proven to have potentially significant value. Naturally, there had been some doubt that *Specialists Without Borders* was just another good idea, but now we had all seen it was a good idea which worked and had the potential to help. The committee consensus was as the next step before expansion to develop SWB into an international best-quality medical education organisation/charity. At the meeting was our accountant Craig, who to everyone’s delight announced that SWB was now a registered charity. This meant those working with the charity could now be allowed tax deductions for meetings attended and especially for the African seminars. I do remember the collective smile when that was announced by Craig. Donations were also now tax deductible introducing the prospect of ongoing financial support.

The other aspect of having such a range of specialists input, was that most of the specialists’ consultants were involved in medical education, lecturing to medical students. From the beginning there had been a desire amongst all of us, to present a programme of the highest medical education standards we could, given the circumstances.The first seminar had been centred on areas within the specialities, individual lectures on, for example, certain approaches to hernias in surgery, followed by discussion. Katherine, one of our consultants, remarked that she felt there could have been more interactive discussion following the lectures, and that we were a bit formalised. Feedback from our Australasian medical student representative, who was also invited to our meeting, gave us even further insight into how we could improve what we presented. Kym, showing great enterprise, had contacted Rwandan medical students after collecting their emails at the seminar. That feedback information indicated to us that we hadn’t really considered certain cultural implications.The Rwandan medical students had suggested we might lecture in smaller groups, for example, ten doctors or nurses. I think we all realised that this was also part of what made Rwanda so welcoming, a natural shyness and humility, that smaller teaching groups maybe more effective.

Several weeks later Katherine emailed the committee; her idea was that we construct for teaching what she called SCIMs. (Structured Clinical Instruction Modules). Essentially teaching in small groups using teaching modules within each speciality. The idea was forwarded to Nikita, who checked with some of his colleagues, with the almost immediate feedback that they thought it was potentially a great idea. Small group (SCIMs) teaching he added could easily be incorporated into the venue that we had at the Senegal hotel, as it was such a large space. Katherine then offered to create a format for the SCIM teaching approach, allocating 45 minutes per session. Each speciality SCIM could have a topic in the morning and afternoon sessions. Katherine suggested possibly two consultant specialists per SCIM, who alternated the 45-minute sessions, as she explained this type of teaching was quite intense, provided we had enough specialists volunteering. Then she suggested specialists could create learning objectives for SCIMs that could then be part of ongoing teaching objectives per speciality available on our SWB website. Kym then suggested medical students could also be part of the SCIMs ,acting as examining role models for the specialist.

This then became the hallmark of our teaching, and in the following years *Specialists Without Borders* became known for it. Amongst the committee, the idea of developing an original concept for medical teaching in Africa was also a source of some pride.

The other consideration for the committee came from several Rwandan specialists via Nikita.A request for SWB specialists to demonstrate their practical expertise operating in the local hospitals. However, the committee decided that that was outside our educational remit, and no matter how much we liked the practical side of our speciality, there were issues, such as potentially leaving behind complications. A few colleagues suggested that it also would require medical registration and indemnity.And if there were complications from complex procedures, they could potentially negatively impact the growing reputation of SWB. Therefore, we informed Nikita we would do ward rounds and offer advice where needed, but no actual direct patient involvement.

Further feedback from Nikita helped develop a programme for the following year. We agreed that the programme would be changeable depending on specialists who would volunteer to come and teach. Due to the number of specialists who had said they would return I was quietly confident. Not only that, but as I was asked to speak at the College of Surgeons meeting, and to write another article for the Surgical News on *Specialists Without Borders* I knew more consultants were interested in joining us. Our Facebook page and website started to get enquiries not only from specialists wanting to contribute but also from other countries, such as Uganda, enquiring about possible seminars. My feeling at that stage was to wait and see, a successful second seminar would really establish us as an organisation, and then SWB would have a format we could replicate. With these developments and the busyness of surgery, the year went quickly. But with the chosen SCIMs format and so many people contributing, we were well prepared and ready 2 months before the seminar date Megan had programmes printed and sent. Twelve consultants had volunteered mostly from the Australasian region but also from the UK and America.

The second seminar naturally felt far more well-prepared, due to the feedback that we had received and that now we knew the requirements to specifically target the needs of the Rwandan medical community. Katherine had organised the SCIM programme on a rotational basis. Each teaching session would be for 45 minutes, with the specialist lecturer presenting for 20 or 30 minutes followed by a question time and interactive discussion.The night we assembled before the second seminar, was not only like a family reunion but an extended family reunion, welcoming the 5 new consultants into the family.Their presence now meant that we could also present with greater specialist diversity in medicine, kidney disease and paediatrics. Talking about our new teaching format I could sense the positive anticipation amongst the specialists in teaching with SCIMs. Everyone seemed to understand this would allow greater interaction with the Rwandan doctors and nurses, thereby also getting to know them on a more personal level. We had again selected 6 very motivated and interested medical students. An article about SWB in the Australian student medical news elicited sixty enquiries from medical students to accompany us. The question then became how did we choose only six students? At one of our board meetings, Kate suggested that each of the students write two paragraphs, detailing how they thought their medical career would benefit from participating with SWB in Africa. I selected the top ten from fifty-five replies and submitted those to the committee. They responded that it was a difficult choice as all ten students demonstrated an impressive and genuine desire to give back. Making it more difficult, they all supplied excellent compelling reasons to come with us. The six we finally selected, fitted in perfectly with the specialists, something the students in their evaluation remarked on, that there were none of the normal barriers between students and specialists.

The seminar was over four days. There were again over 100 doctors with some nurses and medical students also attending. Opening the conference with most people standing, due to the desks arranged in groups in the large hall, I welcomed everyone and explained the new teaching format. Then explaining the new SCIMs format I pointed at the groups of desks, each of which had a sign, for example, Paediatrics, Urology etc. Surprisingly, the 45-minute rotation went without a hitch, helped undoubtedly by our medical students who helped guide each of the groups to the next set of tables until everyone became familiar with the rotation system of teaching.Then acting as role models on which examination techniques could be demonstrated.Nikita found me after two hours of teaching commending the new teaching structure, saying he was getting lots of positive feedback.We all sensed the positivity Nikita was getting, certainly over morning and afternoon tea, there was relaxation and wonderful banter. The medical students also collected names and email addresses, so that we could follow up with those who attended.

The end of the seminar seemed to come too quickly. At our final dinner, Nikita paid tribute to all the specialists and students, telling us all that we were making a significant difference and hoping to see us all again the following year. Many of us had not planned to return home until the end of the week, which enabled us to respond to requests for ward rounds in the local hospitals.

Having been contacted by the Uganda Medical Association, I met their representative on the Friday to discuss a possible future seminar in Uganda. By this time, we had also had inquiries from Botswana, Malawi, Tanzania, and Zimbabwe.When we discussed this informally as a group on Friday night, we thought the greatest need was Malawi and Zimbabwe.This would be an agenda item when we had our first formal meeting after our return to Australia.

Returning to Australia and reflecting on the *Specialists Without Borders* second seminar was immensely satisfying on several levels. Firstly, we now had quite a clear direction along with an innovative way of teaching (SCIMs), which also took into consideration cultural aspects.Secondly, the people who were volunteering all had an abnormal amount of kindness and compassion, which seemed to unite us as a big happy family, quite the contrast to the normally competitive world of surgery. Thirdly, being responsible for an organisation such as SWB, was not as arduous as I had imagined, not only because of the commitment and willingness of those involved in the committee to take responsibility, plus their desire to promote the concept, but also thanks to Megan’s growing commitment to our development. Her commitment above and beyond, was later recognised by an anonymous donation, which allowed her to travel with us to Africa.

The next meeting of the committee, after we returned from Rwanda, considered the request from Uganda for a seminar the next year. The consensus was that while we were still in the process of getting established, and developing an efficient teaching programme, we would just stay with Rwanda.After the fourth year of seminars in Rwanda, the committee decided that we were well enough established, that we could try and branch out in Africa. In 2013 the committee decided that we would run a seminar both in Malawi and Zimbabwe. Fortunately, now with both a national and international identity, we had communication directly with teaching professors in both countries. Direct communication of our teaching needs was made easier.SWB was also fortunate at that stage, to have an educational expert from Flinders University in Adelaide volunteer to come with us, to evaluate our educational teaching in both Malawi and Zimbabwe.The publication of his findings internationally further boosted the SWB educational reputation.

Reaching out from our website and Facebook page for consultants to help lecture, we ended up in 2006 with nineteen volunteer specialists, in addition to Don our educational evaluator, as well as the six medical students selected to accompany us. By this stage, with the range of specialists volunteering, we were offering to teach in orthopaedics, vascular surgery, urology, neurosurgery, gastrointestinal, colorectal surgery, ear nose and throat surgery, neonatology, radiology, paediatrics, psychiatry, oncology, and trauma surgery. We were also developing professionally as a medical education organisation. Megan sending out teaching and learning objectives to all the volunteers, as well as a programme to help them prepare. The committee decided that we would go to Malawi first and run a three-day conference followed by flying to Harare for a two-day conference.

The welcome and the experience were again extremely positive, as we had come to expect in Africa by this time, each country having slightly different medical needs. Both countries commended the informal SCIM teaching approaches. Don, our dedicated educationist, had decided immediate feedback/evaluation of the seminar would be useful, and then a follow-up in six months’ time, to see whether what we had taught had had an immediate and long-term impact. His informal report to us after the first day’s teaching, from more than 70% of those attending, indicated that the teaching was appropriate for what they needed and that that the attendees thought it was relevant to their everyday practice. That was a great encouragement to us, Katherine was especially delighted that her SCIMs were seen as a successful teaching method. Meeting the new specialists who were volunteering was again very encouraging.To quote from one specialist Amanda. “There is obviously a great need in Malawi for an improvement in healthcare, and our teaching model seems to really suit their needs’The enthusiasm from the professors there who also had a shared passion for postgraduate education was apparent, and it was heartening to be made so welcome.

Leaving Malawi, with requests to return the next year, we headed to Harare in Zimbabwe. The reception again was extremely welcoming, with the conference held in the wing of the old hospital. The significance, we were to learn, was due to the venue having been an “all-white” hospital, prior to the change from the previous colonial government. The combination of lectures, with the SWB Structured Clinical Instruction Module style of teaching, was again commended. The seminar received similar positive feedback to Malawi and a request to come back again.

By this time our medical students had become an integral part of our team. I remember Heidi, one of our six medical students at the time, remarking. “I had the opportunity to travel with the amazing team of *Specialists Without Borders* specialists. The local doctors and students who attended the sessions were enthusiastic learners and the feedback was consistently positive. Being a part of this remarkable programme was truly an inspirational experience. We learnt about the importance of sustainable change, medical care in developing countries, and the many essential diagnostic and management skills required for clinical practice.”

SWB, it seemed was achieving even more than we had imagined when first established. I think from a personal point of view what was further quoted by Heidi was also very encouraging for the future. “The specialists all made us feel extremely welcome, and we will take with us many fond memories, not only of the seminars, but she also sharing our meals together with local doctors and students, an inspirational and truly fantastic group of people.” SWB it was fair to say, had come of age as an international medical education provider.A novel way of providing medical aid and contributing to the growth of medical education.The long-term feedback from Don who emailed participants 6 months after attending our seminars, endorsed the immediate benefits he had initially found about our teaching.Attendees indicating that after six months of us giving our lectures, 70% felt that the seminar was still having an impact on their knowledge and clinical practice.

It was very satisfying as the committee remarked that in terms of the range of specialists that we could now such a variety of teaching topics to the host countries. In addition, we now had an official pamphlet that was distributed to those specialists who had participated with us, and now we could also reach out to other specialists. I was obviously happy to continue as the chairman, and the leader of each of the missions, which at our meeting the SWB board agreed with; one of our specialists paying me a compliment, I think, that I demonstrated that a leader didn’t always have to be at the front! For the next four years we continued to offer a diverse range of topics with a full programme each year. Adapting to local requests, as in 2017, presenting in Malawi on how to undertake medical research, to ensure consideration for publication in some of the more prestigious medical/surgical journals, was an enjoyable addition. That also meant ,as an organisation *Specialists Without Borders* was growing in its teaching capacity while becoming synonymous with excellence in teaching and innovative teaching methods. Having such an established format and reputation after 10 years, also meant that as an organisation it was now much easier and enjoyable to head and organise. So much so that the committee began wondering whether there were other parts of the world that we could reach out to, such as the Asia-Pacific region.However,our informal enquiries suggested having a not-for-profit organisation such as SWB, despite our medical teaching reputation, was not really fit for their purpose.SWB not having an official, university or government affiliation.

Unfortunately, my role as chairman was compromised in 2018 by an ankle fracture. This was further complicated through several failed surgeries leaving me with no option but to resign as chairman. Fortunately, Kate, who was our extremely capable vice-chair, then took over for which I was most grateful. However, I didn’t realise that one of her first decisions would be to change the name of *Specialists Without Borders* to PANGEA. From a purely marketing point of view, I thought this could be a risky change, however well-intentioned, as SWB had spent ten years building up an international educational reputation. *Specialists Without Borders* had also the name association with *Doctors Without Borders (MSF)* ,which while a completely separate entity has an outstanding international reputation*.*The medical students who accompanied us often remarking the similarity of SWB with MSF made their CVs a little more impressive.While the name change therefore felt, after the prolonged personal establishment process , a little like a death in the family, I realised after some reflection, that this was just a personal feeling. Far more important was that what had been started would be continued, with all the potential ongoing benefits, not only for those in Africa but also potentially for other Asia-Pacific regions in the future.