The Rahima Dawood Oration

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SURGERY IN THE POST COLONIAL WORLD

When, almost forty years ago, I was preparing to come to Africa, I imagined that my work here would largely consist of treating people afflicted with infections peculiar to the tropics. In my early days, secluded on the rampart of the Albertine rift, I have indeed seen the struggle between man and the multifarious species, large and small, with whom he shared the environment. I have seen lesions associated with tropical virus, bacteria, protozoa, helminths, reptiles and mammals; I have seen conditions secondary to natural selection in response to the ecology of that environment; I have seen pathology due to cultural practices, mostly of the kind that have lost touch with their original environment induced purpose; and I have seen the impact of the capricious tropical whether. But even then, in the beginning of my African career, the proportion of my work that would have deserved to be categorized as "tropical" was small. By far the greatest demand on my time was posed by surgery of the female reproductive organs.

During the subsequent decades geographic pathology changed drastically. The first modern pandemic to occupy the African surgeon was trauma, caused by accidents to begin with, a sign of increasing lack of the social discipline required to harness energy, and later, violence, another form of social failure.
The second pandemic was cancer, or rather, a dramatic change in the epidemiology of cancer: the old African cancers, mostly associated with virus, have been joined by the cancers hitherto common in Caucasians only, mostly cancers associated with western lifestyle or cancers of unknown causation.
The African pandemic of degenerative disease represented the third wave of the cosmopolitan pandemics: diabetes, hypertension, arteriosclerosis, osteoarthrosis and every other "life style" related pathology one can think of.

The HIV pandemic coincided with my fourth decade on this continent: the triumph of a remarkably adaptable virus that left its vanishing hosts inhabiting the vanishing forests and invaded the only abundantly available host, a host, whose simian promiscuity is amplified by mobility, hitherto possessed only by birds, a political animal of limited intellect that continues to cherish belief rather than rationality.

Whilst lately I perceived among Africans the emergence of autoimmune diseases, I shall not nominate these as the fifth epidemic. That position is occupied by mental disorders, foremost depression. Hence, in four decades, I saw the principal cosmopolitan classes of pathology arriving on the continent of Africa. As I had the good fortune to travel extensively, I have become familiar with a large area of Eastern Africa, consisting, perhaps not by chance alone, with the region in which the Association of Surgeons of East Africa operates.

During my peregrinations I made another observation pertinent to this discourse: Tropical diseases, trauma, cancer, degenerative conditions, mental disorders are overshadowed by the morbidity associated with childbirth and the female reproductive organs. Female pelvic pathology is pandemic, and is poorly attended to because gynaecological surgery is not reintegrated into general surgery.

I have never been to Asia, Oceania or South America or the Caribbean but there is written evidence that similar epidemiological changes have taken place throughout the tropics and that the successive waves of cosmopolitan pandemics together with the explosive population increase and, I dare say, with the reemergence of tropical disease, notably malaria, overwhelmed the medical services of many counties. It is convenient at this point to widen the focus and look beyond the tropics and their climatic and environmental peculiarities. To begin with, South Africa is not in the tropics; neither is the Mideast, nor the numerous countries stretching across Southern Siberia. Apart from the absence of tropical disease proper, all these countries, all these societies share the epidemiological changes I have observed in Africa: trauma, cancer, degenerative disease, depression, gynaecological pathology, explosive population growth

and collapsing medical services. Soon, with the spread of HIV to Asia and South America, in terms of epidemiology, there will be very little difference between the majority of poor member countries of the United Nations, countries where three quarters of the world's population live.

Wirchow has recognized that epidemics represent social pathology. What are then the common denominators of the social pathology so prevalent across the major area of the globe? But first let us dwell on terminology.

Forty years ago we used to speak of under-development. The term was discarded, not because it was historically incorrect but because, with the upsurge of political correctness, it was deemed to be derogatory. "Less developed" replaced "Under-developed", avoiding the insult but still lacking clarity. The designation "Third World" gained currency and was useful as long as there was a Second World, the Socialist World, clearly cleaved from the First World, referred to, in the ancient tradition of Rome, as "the West", although geographically the West is mostly in the north. I shall eschew pigeonholing China for China was extant long before this race for the first, second and third places began and China was and is neither first, second or third.

To talk about the South may sound neutral enough but merely to point to a huge swath around the globe, a swath laying South of North lacks explanatory intent.

"Poor": then, or, rather, to be, again, politically correct and avoid the connotation of poverty as something to be ashamed of - perhaps because it is often regarded as self-inflicted, "resource poor country", this newest euphemism, out rightly nonsensical, for neither the Congo nor Bolivia or Papua-new-Guinea are resource poor.

This terminological plethora has its explanation: the family of nations is disinclined to use the most appropriate adjective, which is "post colonial", for Guatemala, Haiti, Algeria, Zambia, Angola, Madagascar, India, Kirgistan, Vietnam, Fiji and East Timor share one common element in their otherwise diverse histories: they were colonies until recently and the post colonial status harbours its own set of social pathologies as did the colonial times

The social pathology of colonial times was racial discrimination, disregard for freedom and the incomprehension on the part of the ruler of the cultures of the ruled, cultures dictated by the environment. The arrogance of the ruler, believing himself to be superior, in the end, doomed his designs. On the other hand, the colonial times were an epoch of advancement, of the spreading of superior technology and of relative peace. The defenders of colonial history will enumerate the achievements of the colonial administrations, in particular, in the context of this presentation, the spectacular increase in life expectancy of the population, pronouncedly so in the British colonies in Eastern Africa.

If one wishes to understand history one should not indulge in value judgments, for politically correct notions to the contrary, values, including so called human rights, are subject to the shifting and shaping and erupting and leveling forces of history just as earth's crust is to tectonics and erosion.

All of us are products of multifarious cultural influences, some of them colonial: the Roman Empire still casts its shadow over the entire west and its former colonies. However, specific cultures are of survival value in specific environments and the most conspicuous element of material culture is technology.

During the most recent colonial era western technology and therefore western organization of politics and economy overwhelmed the rest of the world. People may resent history, people may condemn the process of assimilation but the fact is that most of the world's population desires to partake in the promises of western technology with the same fervor with which they embrace a western lifestyle and worship, here, in Africa, foreign, if not exclusively western gods, introduced by missionaries, for the new religions were the Trojan horses of cultural change.

Among the driving forces of the independence movement was the perception that colonialism, by discriminating and segregating the ruled from the ruler, perpetuates the technology gradient. Independence was thought to lift the world to the technological standard of the west and to equalize economic and social disparities, whereby the emerging nations sought to retain some characteristics of their original cultures, characteristics which, however picturesque, have little survival value.

Indeed, in the beginning, the post colonial era was a time of high achievements in terms of indices which now would be referred to as human development factors, even higher in hopes. The achievements of the first post-independence years in terms of the health of the post-colonial nations diminished over the time not only because of bad politics and bad economy but also because the people were genetically, biologically, psychologically, socially and culturally ill prepared to absorb the onslaught of western technology and lifestyle, constant rapid changes at an

ever accelerating rate. Also, forty years on, the prospects of achieving, in the foreseeable future, western indices in terms of energy consumption, life expectancy, life span without disability, educational standards etc. are receding. The population growth (in East Africa in hundred years the population has increased by a factor of 15), the concomitant environmental degradation, the fall in productivity, the

deterioration of infrastructure, the decline in educational standards, the increasing insecurity - and one could add to this list liberally - have negated the chances of development in terms of assimilation and utilization of technology. Although the history of the last fifty years may well be perceived as an era of increasing disequilibria between rich and poor, some of the negative factors referred to are standard post colonial fare except the population growth, which is itself the result of western technology combined with the relative peacefulness of desalinization in most countries, amplified by the fecundity ethos of traditional chiefs, bishops and Imams, all male.

As Rome declined, Europe became a place of disorder, lawlessness, famine, and sequestration. This was so although in all the successor states or starlets and polities the ruling class continued to behave as Romans, they spoke Latin, dressed in tunics and togas, continued to worship the assorted deities introduced or adopted by the Romans and many continued to claim to be Romans. The masses, first relieved to be able to dodge taxation and forced labour, craved for the order and security that prevailed in the Roman past. Even after warlords had overrun the continent and destroyed it, when Europe began to reorganize itself it did so under the auspices of Rome, for the Christian Church presented itself as new Rome, the legitimate successor of the ancient state.

The characteristics of the post colonial condition are far more pronounced after the recent desalinization and can be studied in more than hundred examples, some waxing, some waning.

The hallmark of the post colonial state is that it sees itself as the successor of the former colonial ruler and it adheres to the inherited concentration of power in an individual who is monarch and governor and American style president and tribal chief all amalgamated into one person. This strong presidency maintains all the power structures through which the colonizer ruled, structures that the populace resented and continues to resent.
The post-colonial state remains stagnant. In the former colonies the means of production are continued to the controlled by the state or by the oligarchy whereby the members of the owner's club are recruited from amongst the old and the new establishment, the latter relentlessly imitating the former in apparel, and in lifestyle, including hobbies and in arrogance.

For, if one characteristic of the post-colonial world is the retention of the colonial power structure, the other is imitation, imitation in rituals, organisatory structures, professional functions, particularly in externalia, imitation of the former colonial power by the successor societies.

Furthermore, the professional elite, closely related and interdependent with the political and economic oligarchy, is preoccupied with guarding its privileges. Its willingness to compromise principles, principles which it espouses in conferences and seminars - is one of the single major factors which allows the post colonial ruler to assume dictatorial powers and allows the bureaucracy to perpetuate authoritarian policies.

The stagnation and the failure of the postcolonial world is the failure of the universities and the professionals, of lawyers, teachers, architects, engineers and of doctors. For, to refocus these deliberations on medicine and surgery, the fact that countless people do not get treatment at all, is to a large extent the fault of the medical profession. And the unmet needs in surgery, even more so the poor results of surgery are signs of our own shortcomings, individually and collectively. For, remember: "The poor results of surgery are the results of poor surgery".

The social pathology of the postcolonial era consists of arrogance, arbitrariness, stagnation, imitation, the hypocrisy of political correctness, a loss of sense of reality and the resulting pretentiousness. One finds the same social pathology among the professionals, in the universities, medical schools and departments of surgery: the result is poor performance.
Why do we perform surgery so poorly, poorly in the sense of organization, judgment, and techniques? We have talented people. I find, even in the most dilapidated and dirty teaching hospitals, both senior surgeons and postgraduates, who are conscientious and knowledgeable and postgraduates who if only someone would teach them how to operate neatly and gently, would become outstanding surgeons. When I make rounds in public hospitals and teaching institutions, many of them malodorous places of suffering that resemble Dante's Inferno, I am often amazed how many doctors there are, how much is written in the notes and how much knowledge and how many ideas come to the fore. Yet, talent and knowledge are not deployed rationally.
The reasons for this dysfunctional state are multifarious

but prominent among them are three: the desire to adhere to routines and rituals in socio-economic environments which have changed and mock the revered customs; the uncritical adoption of western specialism; the desire to copy the "gold standards" of the west. This unhappy combination of stagnation, sequestration and clumsy attempts at a technology leap characterizes postcolonial surgery.

Surgery in the postcolonial world is maladapted to the conditions prevailing in the postcolonial countries. In consequence, surgery in the post colonial world is split into surgery of the rich and surgery of the poor, a split which, at the same time, separates teacher from apprentice, because surgery of the rich is surgery by a privileged cast of seniors and surgery of the poor is surgery by largely un-supervised juniors.

The steady deterioration of public hospitals, the dilapidation, dirt, the lack of equipment, the lack of maintenance, the lack of instruments and drugs, the poor state of libraries is universal, yet the lack of funding, of money is not the core of the problems. For the core problems of surgery in the postcolonial world - of the post colonial world altogether - are, in the first place, a matter of attitudes. The failure to adapt to reality is paralleled by pretension. The pretentiousness of the professions is staggering, judges, lawyers, teachers, doctors and priests act in an imagined world far remote from the concerns and needs of the populace, far from real life.

Although one of the outstanding characteristics of the post colonial world is the steady improvishment of larger and larger sections of the society and the concomitant enrichment of the oligarchs - to which the professionals belong or at least desire to belong - a situation that is amplified by the new class of western missionaries, the bankers and neoclassical economists, money actually is not the central problem.

If manna fell from heaven in a postcolonial country, the oligarchs would collect it and resell it to the poor or barter it for political support.

If manna fell onto the health sector, onto the teaching hospitals, manna in form of CT scanners, Doppler's, MRI machines, drugs of every class, electric driven operating tables, instruments, the efficacy of post colonial surgery would not improve - indeed it might even deteriorate.

This is then the bleak reality in which we work, we the surgeons, the professionals, individuals, mostly well meaning, well educated, well trained. We have, some of us have, accomplished remarkable feats in our respective professional spheres but, as a group, as a profession, we failed, not at last because we pretended that the dysfunctionality of society is not our fault but it is the fault of the colonial past, of the present governments and of the west.

No doubt the social pathology of colonial times has left scars. No doubt the politicians have much to answer for, as do the missionaries - whether of religion or of capitalism. No doubt the uncomprehending west, preoccupied with burgeoning technology and the burgeoning social problems of a declining culture focusing on the fetish of longevity, has much to answer for. Notably, in the context of surgery, the Colleges of Surgeons and the Surgical Societies. Our colleagues in the west
have exerted enormous influence upon our organisatory structure and upon our technology, undue influence, to which our own establishment has succumbed. Two examples are the submission to specialism and the bedazzlement with gold standards. The ideology of specialism and the copying of methods inappropriate in the biological, socio-economic and cultural environments prevailing, created havoc. The poor performance of surgery is the result of multiple sets of inappropriatenesses.

There are signs that the post-colonial era is coming to an end. The children and the grandchildren of the establishment are not willing to follow in the footsteps of the leadership. This is noticeable in politics, in economy, in the schools, in the universities and is very noticeable in the departments of surgery, specifically so among the postgraduates. The changes heralding the end of the post-colonial area are not driven by moral issues, by a moral rearmament, rather, they are driven by the insight that the post-colonial era represents a failure of a whole generation of presidents, politicians, senior civil servants, professors, and, in our context, also senior surgeons. The new generation refuses to continue believing or pretending to believe in a make believe world. They have a grievance: they know that their fathers cheated them of the opportunities of independence by refusing to see reality.

The young generation of surgeons is ready to readjust training, organization, methods and procedures to the prevailing circumstances. In the same manner as is the case in politics and economy, the conservatives, having resisted change for decades, have become insecure and confused and very often simply inert.

It behooves me to add to my scathing criticisms at least a few suggestions. I shall propose a list of innovations and readjustments. I champion the youth, champion the postgraduates. I wish to accelerate the demise of the post-colonial era for their and their patients' benefit.

The goal of undergraduate education and training should be refocused: graduates must again be competent doctors, competent to cope with a great variety of pathology common among our people.

Such education cannot be provided in classrooms to large groups of students. Huge medical schools nested in huge hospitals are miscreants, not capable to deliver what they are expected to: multitudes of well versed young doctors. This is borne out by the fact that now we teach at postgraduate level what we used to teach to undergraduates. Instead of reforming education and training, instead of decentralizing, demystifying and debunking and simplifying, the period of education and training is endlessly prolonged and again concentrated in the same, often nefarious, teaching hospital environment.

Decentralize medical schools. Give back to undergraduate education a vocational content. Do not allow specialization immediately upon completion of internship; do not allow super-specialization, train competent generalists. Evolve regional curricula and a regional degree structure. Simplify surgery.

One of the great inspirations of the Association has been to give support to Maurice King and help him in writing "Primary Surgery", the most useful volumes one can imagine. At the same token it is a lasting shame for the post-colonial surgical establishment that it has not embraced the book and has not made it the backbone of education, training and practice - presumably because it challenges pretension.

There are many more steps we must take to initiate the process of recovery from post-colonial stagnation. We should minimize rotational schemes and experiment with apprenticeship. We should reassess our technology and de-ritualize our practice.

We should recognize that whilst the burgeoning commercialization of medical practice is one of the consequences of structural adjustment, it need not be as deleterious as it has become. Private practice, private hospitals can be usefully integrated into teaching and research and in this manner the medical care for the rich can be made to serve the poor. Many of our senior surgeons excel in their private practices and only there. Let us oblige them to utilize this opportunity for teaching as well as for the economic improvement of their juniors' life.

Above all, our teaching and our practice must refocus on principles. The principles of surgery are universal, are few and are magnificently simple. Unfortunately the practice and the teaching of surgery in the postcolonial world are far removed from principles.

Lastly, we must again be humble; surgery is a craft that makes use of the scientific method of Popperian falsification. The art of surgery consists of judgment and of the beauty of an operation well done, done gently, with respect for living tissue, for every cell, with reverence for form and function, carried out with compassion, always remembering that the only justification for invading the body of another individual is the intent to restore homeostasis.

Whilst western technology is our destiny we must embrace it with consideration for appropriateness, equity, affordability - otherwise our practice will lack its ethical purpose: beneficence.

It is a truism that many, if not most of the postcolonial regimes lack the ethical foundation of beneficence. I submit that from the point of view of the poor post-colonial surgery increasingly lacks beneficence.

Mr. President, this is then my message. I wish to narrow down now my focus to our region. Having completed my rounds through eight medical schools as the Rahima Dawood Traveling Fellow, I am certain that surgery in the region, its teaching, the research and the practice need to be reinvented. I am also certain, Mr. President, that at least half of the schools I have visited, particularly the largest ones, do not have the emotional resources to reinvent themselves. Past glory hangs around their necks like a millstone.

It is for this reason that the smaller schools stand out well: the enthusiasm in Eldoret is catching, the inventiveness of Mbarara inspiring and, above all, the discipline of Addis exemplary. Indeed in Addis is the only department I have seen that performs first class surgery amidst squalor. These three departments gave me hope, as did, in a lesser way, Dar es Salaam. I am sorry that I did not have the time to visit Maputo, Blantyre and Moshi; possibly these three could also serve as germination centers for regeneration. However, in the meantime, we have to think of different solutions.

Once upon a time society requires new structures to rejuvenate, focus, and yes, to reinvent itself. Perhaps our new college, the College of Surgeons of East and Central Africa, is such a new structure with promise. I have been an opponent of the College since it has been first muted 35 years ago, for I did not think that we needed to introduce institutions rooted in the European Middle Ages. I still remain skeptical of pomp and circumstance but I think that the new college, if we keep it out of the reach of the stale establishment, may be the solution to some of our problems. The new college, by wrestling control from governments and universities and by watching, impartially, over the

progress of our postgraduates, which on occasion may translate itself of taking them away from what I call the nefarious environment of the lumbering teaching hospitals, has an opportunity.

The College will need help from sister institutions abroad. One is gratified to learn that our friends in Edinburgh, the College as well as Ethicon, are willing to help. We should accept that help humbly but not without conditions. This college of ours must not become an imitation, neither in its structure nor with regard to curriculum and syllabus. The new college must eschew specialism and as far as gold standards are concerned it must evolve its own. If the new college succeeds in becoming the guardian of the principles of surgery in East and Central Africa and at the same time the promoter of the youth, then the College will restore the beneficence of surgery in the region.

This is then my Rahima Dawood Traveling Fellow message for the year 2001. Whether the college will absorb the Association of Surgeons of East Africa - to which I have belonged for 34 years now, or not. Long live the College of Surgeons of East and Central Africa!

Thank you.