BOMS: United Kingdom doctors in the Third World

C J BURNS-COX

In 1979 five doctors met to consider how to increase the number of United Kingdom registered doctors working in the Third World. Each believed that many doctors would like to help but lacked the knowledge of where help was needed and of working conditions in Third World countries. There were three problems to solve.

Information required and provided

Firstly, there needed to be a change in attitude to working in the Third World. Senior doctors, the royal colleges, and the Department of Health and Social Security should, through their training programmes, encourage doctors to go, while not of course discriminating against those staying behind. The returning doctor may well bring with him or her something extra that is a bonus to British medicine. The appointment system should be reviewed to take into account the problems of resettlement on return.

Secondly, doctors had difficulty finding when and where they were needed. This could be helped by a double register: one list of doctors keen to go and another of vacant posts.

Thirdly, doctors and their families needed information and sometimes training before going abroad. This could be provided by an advice pamphlet on work and life in the Third World, by putting doctors in touch with someone recently returned and by developing contacts with doctors and agencies who would be able to give the necessary training.

These problems seemed capable of solution and thus was born BOMS or the Bureau for Overseas Medical Service, which was soon given infant baptism by the Charity Commissioners. We found all sorts of people who either could not understand why such a bureau had not been formed before or had wished to set one up but had not had the opportunity. Everyone was most encouraging. The Commonwealth Foundation generously primed the pecuniary

pump, enabling us to start with a full time secretary/administrator and a temporary rented office in the London School of Hygiene and Tropical Medicine.

We soon became aware of the growing need for trained staff other than doctors. As there was no comparable organisation to arrange work overseas for these groups we began to expand to cover all types of health worker from physiotherapists to pharmacists and midwives to administrators. Our committee now includes three non-doctors. Eighteen months ago the Nuffield Foundation gave us support to continue this expansion of the register and to acquire a computer to run more efficiently. The register now has a growing number of a wide variety of health workers and the computer is now in full use. This has also been accompanied by a move into a new, more permanent office at the Africa Centre, Covent Garden, a lively spot and a relevant name, although our activities are world wide.

This adventure is great fun and exciting, not to say rewarding. For instance, we recently received a request from the International Rescue Committee in New York for two doctors to work in southern Sudan; within two days two British doctors had agreed to go. Just as quickly we were able to supply a medical officer for Tristan da Cunha. We were also able to find pharmacists for Thailand and Zimbabwe at short notice.

Among those to whom I am grateful are the staff at the London School of Hygiene and Tropical Medicine, the Commonwealth and Nuffield Foundations, not to mention our lowly paid administrators, who have enabled BOMS to reach its fifth birthday with 1000 health workers on the register. One of our patrons is Maurice King, who wrote recently, "We have four and a half billion patients in the practice." Why should we ignore them by default?

Response now

If you have any suggestions for making the bureau more effective or would like to help in any way please telephone, write, or even better register and—as John Ebdon would say—if you have been, thank you for reading this.

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Insulin infusion pump

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A young man, a stranger, was sitting next to me on the Greyhound bus travelling across America. As I gave myself a jab he asked if he could have one as well—thinking that it was heroin and not knowing that I was diabetic. Injections have plagued me since I was a child but now I am free of the inconvenience of daily or twice daily shots; hence this burst into print.

I have experienced many great advances towards improvement of the daily management of the condition: 27G disposable rather than reusable (for three weeks or more) 25G needles; disposable syringes

graduated in units rather than the metal ones that were graduated in marks and had to be boiled and kept in surgical spirit—the marks often being a source of confusion for patients and sometimes nurses; an accurate painless pin prick blood sugar reading by Glucometer rather than testing the urine. Printing the calorie and carbohydrate values on packets of food has been helpful, but more important has been the awareness by the general public and employers that diabetics are not invalids but can lead a similar life, with minor modifications, to that of unaffected people.

Awkward methods

Insulin injections have always been a tiresome part of my life and I fought for many years against twice daily ones despite the promise

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of better control. I started on lente insulin, which was painful to inject and the control of my sugar was hopeless. I often had to be woken in the morning with sugar because of hypoglycaemia. Semi-lente and ultra lente gave better daytime urine sugar results and fewer early morning hypos but control was far from ideal. The next change was to Actrapid and Monotard, which being monocomponent insulins meant less antibody formation and lower dosage (and hence less volume to inject). It gave good control and acceptable HbA_{1C} results (the glycosylated haemoglobin being an index of glucose levels over the previous eight weeks or so).

Improved administration and lifestyle

The change to an insulin infusion pump has been marvellous. The machine weighs 272 g and its vital statistics are 16 cm long, 8.5 cm wide, and 2.5 cm deep—about the size of a paperback book. It is an Auto-Syringe AS6C pump but this has already been superseded by a smaller version. The insulin is administered through a 27G needle placed at a 45 degree angle subcutaneously into my abdomen and taped down with Op Site or Micropore. I am entirely unaware of its presence and play sport with the needle in place and without pain. Just over two feet of thin plastic tubing connects the needle to the 3 ml syringe which is held in the infusion pump. The plunger is pushed in at a preset rate under battery power and just before a meal I can increase the rate transiently to get a bolus dose to cover the extra requirement for insulin. Most of my dresses now have small holes in the side seam for the tubing to pass through and the pump itself is carried in a black or white pouch that hooks over a belt. It is attached to me almost continuously day and night but the tubing can be disconnected from the pump and capped

when taking a bath or swimming. The needle site is changed every three or four days when irritation starts at the point of insertion. Leaving it too long could lead to infection but this has not happened to me so far.

Most advances, both in medicine and elsewhere, have disadvantages as well as advantages. The disadvantages of the pump are, firstly, the cost, both the initial outlay and the cost of syringes and catheters, which in South Africa are not covered by Medical Aid schemes. Also, the size and weight of the machine make it fairly obvious and it may be too obtrusive for self conscious people. Its owner must be motivated to make it a successful form of treatment and technical and medical advice from someone experienced in its management are essential.

In the two years that I have had the pump I have certainly experienced the advantages. Being an anaesthetist means delayed meals or unpredictable meal times—not ideal conditions for a diabetic. Because the bolus dose is given just before the meal, however, times can be slightly more flexible. This is an advantage in my social life as well. I can now go to the theatre and have dinner afterwards instead of a rushed snack beforehand. Although not a medically recognised advantage, there is some more flexibility in what I eat though this is not something to be abused. I think all my friends agree that they would much rather I was on the pump—they say I am a much easier person to be with, with fewer bad moods because of low blood sugars. More even sugars obviously agree with me.

It is a great boon to feel so much better and have a freer social life. No longer do I need to inject myself on trains, buses, and aeroplanes. Few people comment on my "life support machine" (as my friends call it) and strangers assume that it is a Walkman cassette player, a money purse, or a gun.

Dug out alive

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It happened on a Saturday afternoon in July a good many years ago at the site of the Roman city of Viroconium (Wroxeter), five miles from Shrewsbury. It happened because we did not observe the rules for safety when digging trenches. A friend and I, together with some sixth form boys and girls, were engaged in the task of putting a trial trench across the site of a suspected military ditch in a field about 100 yards from a lane. The work had been progressing steadily over several weekends and the trench, one and a half metres wide and 40 metres long, was beginning to yield results. A "V" shaped ditch lined with clay had appeared and was a bigger thing than we had anticipated. On that Saturday afternoon we had removed the bottom layers, the findings were collected and labelled, and the ditch profile was clear. The ditch was about three and a half metres wide and about four and a half metres deep. The sixth formers had gone home, it was around half past five, and James and I stayed behind to do some photography, put further touches to the measured drawings, and have the inevitable chat.

The ditch fill was loose in places and sizable stones and earth were not well consolidated in the upper layers. Moreover, the weather had been dry for the past few weeks. We had placed several pieces of

corrugated sheeting against each side, and these were held in position by stout cross battens to give some support to the side of the trench. They held back tons of ditch fill. I was on top and James was crouching near the bottom when I heard a slight rumble. He called out: "Some stones have fallen on my leg and I can't move them." James was a big strong chap. I got down the ladder into the trench, went to the edge of the ditch, and slid down the inner slope. As I started to free his legs there was a kind of roar, a piece of tin sheet fell over him, and a wave of stones, clay, and soil slid down on us from one side. I scrambled upright as it covered the tin sheet and in a few seconds my legs and left arm were pinned.

The rising tide slowed a little and finally stopped about four inches below my shoulder girdle. A strange quietness was broken by a faint voice from below: "Goodbye, John." A few seconds later came a faint and last mumble and I was quite alone, able only to move my head, and look up at a strip of cloudless sky. I remembered that when a dog howls it lifts its head back, and so did I. But after three or four efforts I stopped for the reason that it seemed futile so to waste my precious breath, and each breath became more difficult and had to be forced. A wasp flew around my head and I idly wondered whether it would sting me. I could wriggle my feet and drew slight comfort from that—my spine was intact. I hoped that if the other side should fall in I would get a clout on the head from a really big rock and so be unconscious when I was buried alive. Yet the urge to live remained and I forced each breath in and out against the increasing pressure on my chest. With increasing lack of oxygen, however, I felt hazy and rather ceased to care. I dwelt on events of early childhood.

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