

Obstetric Care in Georgia and Armenia

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The author (L) with some of the paediatric staff in Georgia

Last year I was able to go to Georgia and Armenia with Kybele (www.kybeleworldwide.org), a US based humanitarian organisation dedicated to improving childbirth conditions worldwide through medical education partnerships. The charity organises in-country programs to improve essential treatment, technology and training of health care workers to make childbirth safer and less painful. There is also a continued commitment to member partners as an information resource. Although the charity provides support with in-country transport and accommodation, the trip is otherwise self-funded by the participants. It was a huge benefit to be supported by an AAGBI travel grant which allowed me to join a team promoting modern safe anaesthetic practice, disseminating evidence based practice goals, and encouraging audit and continued education.

I travelled with a team on their recent visit to the countries of Georgia and Armenia in the Caucasus. We visited 19 hospitals (13 in Georgia, 6 in Armenia) in 2 weeks. We were able to gather information and provide clinical teaching in regional



anaesthesia. Clinical instruction was done in the labour wards and operating theatres with informed and consenting patients. The techniques that were taught included spinal anaesthesia for caesarean section, epidural and combined-spinal epidural labour analgesia. We were granted a full spectrum of liberties, including bringing the support person (husband or mother) into the delivery or operating room, a practice that is not routine. Team members were able to demonstrate analgesia for a primiparous patient, who delivered without pain or motor block, with her husband at

her side. Patients and family members were grateful for this opportunity and thanked us profusely. We were featured on a Georgian television program. The film team were personally moved by this experience because they had all had poor birthing experiences.

We gave three short medical education conferences (in Tbilisi and Kutaisi, Georgia; and in Yerevan, Armenia). Conferences were interactive and attended by more than 120 physicians. Translators were utilized and in some cases slides were translated into the local language prior to our arrival. Healthy debate did not require encouragement - the process appeared very constructive, and allowed different interested parties to air their position. At the Kutaisi conference the Deputy Health Minister was present and participated fully himself, having been a physician before; but he also had to explain the Government's position on licensing and funding.

We obtained Ministry of Health approval in Georgia to import bupivacaine (plain and hyperbaric), ephedrine and phenylephrine for teaching demonstrations. Currently these drugs are either not available or available only on the black market. The only local anaesthetic widely available is 2% lidocaine. Healthcare providers in Georgia have requested our help to gain approval for long-acting local anaesthetics and ephedrine in their country. This would be a great step forward in the development of regional and obstetric anaesthesia. Regional anaesthesia supplies, textbooks and other teaching materials that the team had brought with them were donated to various units.

We observed that anaesthesia conditions were much worse than expected in both countries. In Georgia, anaesthesia monitors were limited or non-existent. We observed entire lists performed with only an occasional finger on the pulse (no BP, SpO₂ or ECC). In Armenia, monitors were more available but they weren't always used - there was little sense of the importance of the use of anaesthesia monitors during surgery. A few hospitals were well equipped but it appeared that maternity provision was



The visiting Kybele team with our hosts in Armenia

universally poor. In some cases available anaesthesia monitoring consisted of only of manual blood pressure measurement; even then it was used rarely, if at all.

For caesarean section, general anaesthesia was most commonly used. We noted the use of diazepam as a pre-med. There was neither pre-oxygenation, nor antacid prophylaxis, nor the use of rapid sequence induction as we recognise it. Left lateral tilt to reduce aorto-caval compression was not utilised. Maintenance was with intermittent ketamine and relaxant.

Regional anaesthesia was utilized for obstetrics in only a few hospitals. This was partly due to limited availability of local anaesthetics and equipment, and the very limited regional anaesthesia training. Implementation suffered due to a lack of subsequent education of mothers, obstetricians and paediatricians. Public perception was another aspect. The physicians stated there was little public desire for regional techniques, however no prenatal education or information was offered. Mothers would encounter strong negative peer pressure and a very small number of severe complications had received



large media coverage. This was further confounded by the financial implications of an extra service in a culture placing little value on the abolition of labour pain.

There were many leftovers from the Soviet Union days, such as very old Russian ventilators, and myopia as an indication for caesarean section through fear of retinal detachment. There appeared to be inadequate sterile technique both for surgeons and anaesthetists. Surgical drapes were applied with bare hands; in some cases spinal anaesthesia was done without gloves, drapes, hat or mask. We found two operating tables in the same operating room, with questionable separation of equipment and personnel. The availability of any recent medical texts and journals was very limited, although we did meet the creator of the fledgling online medical informatics service in Georgia.

We felt that we had learned much. We also felt that we had made strong connections, imparted some of our views on intra-partum care, as well as promoting a desire for review and audit, both personal and institutional. The interaction does not end here. The group will continue to work with local contacts having obtained a better perspective on local needs and desires. Already we are investigating avenues of improving medication supply and licensing, and are approaching various bodies with regard to providing more modern equipment. Future plans are for longer visits within this improved environment to allow the full implementation of modern obstetric anaesthesia care. We are also aiding local audit and research, encouraging submission to international meetings and supporting exchange educational visits. I have personally gained much from this trip. It is humbling to see what educated, dedicated people can achieve with extremely limited resources. It was a delight to be able to provide information and knowledge to enthusiastic physicians, and also to participate in debate.

Simon Millar

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The view from the cathedral in Yerevan, Armenia