Some Essential Considerations for a Successful Volunteer Project

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There is an urgent need for cataract surgeons from developed countries to volunteer their time and expertise for the teaching of new cataract surgeons in developing countries. New cases of global cataract blindness each year are exceeding the number of cataract surgeries performed. At present, there are approximately 20 million patients who are blind from cataract. This number will rise to 30 million in the next 20 years unless forceful corrective measures are taken now. This article discusses selected aspects of conducting a successful volunteer cataract project with special emphasis on preoperative screening and patient selection. The surgical management of hypermature cataracts, which are frequently encountered, is also discussed. Suggestions are offered for how to address the associated issues of local ophthalmopolitics, local health care economics, and VIP consultations. The great majority of ophthalmologists who overcome inertia and complete their first volunteer visit to a developing country continue to serve on a regular basis. Specific information is given for the finding of volunteer organizations and of areas in need.

At present, there are 50 million blind people worldwide. The problem is certain to worsen as the average human life span continues to increase with an accompanying increase in age-related diseases, including cataract and glaucoma. In fact, it is predicted that by the year 2020 the number of people worldwide who are blind will be at least 75 million unless eye care delivery improves.[1] The great majority of today's cataract blind will die without ever having the opportunity to have their sight restored (the term "blindness" is defined by the World Health Organization as 20/400 or worse vision in the better eye) .[2]

Because about 50% of the blindness is caused by cataract formation-making cataract the leading cause of worldwide blindness-there is an urgent need for an enormous increase in cataract surgery. The ultimate solution to this problem is complex and involves many facets that include: (1) The training of many more cataract surgeons in the developing countries; (2) The creation of more institutions where cataract surgery can be performed; and (3) Increasing the efficiency and productivity of already existing institutions.

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Seven years ago, after 25 years of private practice, I began what I call a new phase in my medical career, that of international volunteerism. During those 7 years I have made 43 visits to 23 different countries. Approximately half of those visits have been for the purpose of performing cataract surgery in areas with large cataract backlogs and too few ophthalmologists; the other half have been to teaching centers in developing countries for the purpose of presenting a 2-week glaucoma workshop that I have developed. Although I was an active global tourist before my volunteer work, I have since been to places that I would have never seen otherwise: Kyrgyzstan, East Asian Russia, Albania, Haiti, Cuba, Nigeria, the Solomon Islands, Mongolia, Vietnam, and remote areas in the mountains of Guatemala, to name only a few.

Teaching — A Lasting Contribution

I will limit my discussion to selected issues related to cataract surgery volunteer projects, which usually involve surgeons from the economically developed countries visiting locations in economically developing countries where there is a large cataract backlog and too few ophthalmologists. The primary purpose of these projects is usually the performance of free cataract surgery on the poor. The actual number of cataract extractions performed by these volunteers, however, will be relatively small and do little to reduce the cataract backlog. The really significant and lasting contribution by the visiting surgeons will be that of teaching, not only of surgical technique, but also of ways to increase productivity and quality of outcome.

There are many ophthalmologists in developing countries that are excellent surgeons, and volunteer surgeons will discover that the teaching goes both ways. However, these local surgeons are often located in remote areas and/or are so busy that they have no opportunity to train new surgeons. It is paradoxical that countries with huge backlogs of cataract blind often offer very limited high quality training opportunities for their own resident ophthalmologists. A desirable arrangement would be for ophthalmologists in training to be present for volunteer cataract projects in which they can first observe and eventually begin to do supervised cataract surgery.

The Ophthalmologists' Special Gift

Ophthalmologists who are cataract surgeons are blessed with a precious gift. We have the ability to restore sight to the blind with a relatively short, safe, and successful operation. Not only are our skills desperately needed in countless places, but also, we are able to perform our surgery in almost any location.

We can give our own local anesthesia, we have portable equipment that can be operated (with an electric generator, if necessary), our instruments are small and can be sterilized with chemical solutions if autoclaves are not available, and our patients can spend the night after surgery sleeping in a town hall or house without the need for special nursing care or medications. I have performed manual extracapsular cataract surgery with implantation of posterior chamber intraocular lens (IOLs) in small mountain towns by using the bedroom of a house for an operating room and a kitchen table for the surgery (Fig 1). Many who are not physicians have a strong desire to do volunteer work but don't know what to do or where to go; we cataract surgeons have it easy in this regard.

I will discuss certain aspects of volunteerism in economically developing countries that I consider to be of especial importance for cataract surgeons. Experience has been my teacher as well as leagues with many years of volunteer experience of their own. At the end of the article, I will list several publications that I consider to be excellent sources of additional information for those who might wish to learn more about this most satisfying of services.

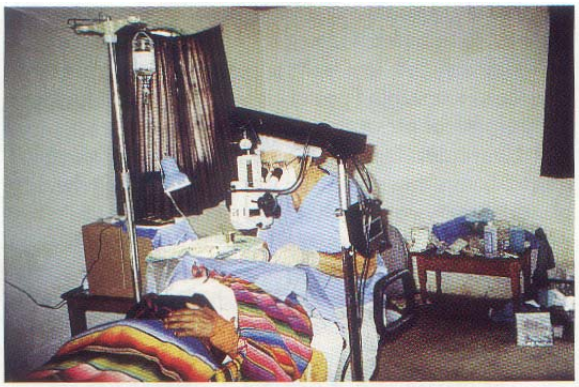

Figure 1. ECCE/Posterior chamber-IOL in bedroom of a house in a mountain town of Guatemala.

Figure 2. A "winner" pictured with the author.

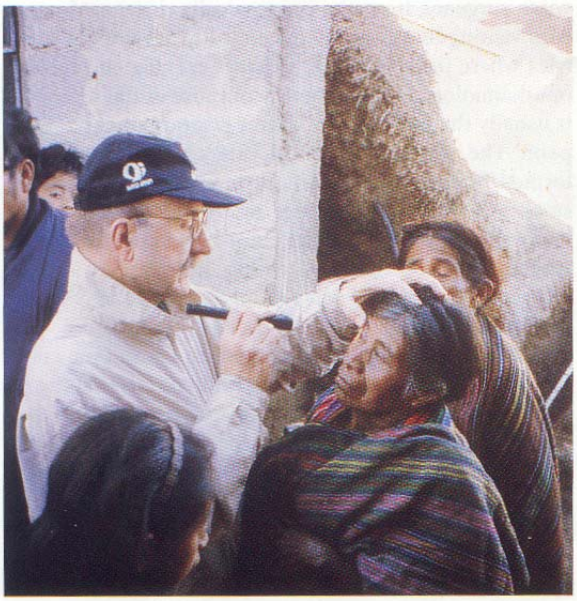

Figure 3. The author screens for cataracts in Guatemala.

Essential conditions

Although there is no one formula that applies to every project in every location, there are a number of basic principles that apply to most. Regardless of the location, however, there are 2 essential conditions that must be satisfied for any project: (1) There must be an invitation from the local ophthalmologist, and (2) The local ophthalmologist must commit to providing postoperative follow-up care for the complications that may arise.

Challenges on Arrival

It is important to recognize and mentally prepare for the probability that when you arrive at your destination you will be confronted with an environment far different from the one that you left at home. If you have crossed time zones you will be affected by jet lag, you will be experiencing an unfamiliar working environment, you will have acquired a new "partner" in the host doctor, and you may be faced with a language barrier. These changes will create challenges; however, all can be overcome and usually add to the sense of accomplishment in the project.

It is not unusual for you to perform the surgery at a location that is not the home base of the host ophthalmologist. It may be a hospital in a rural area, away from where the host ophthalmologist practices. Thus, the staff, equipment, and policies of the project hospital may be unfamiliar to the host ophthalmologist as well.

Preoperative Screening and Patient Selection for Surgery: The Key to Success

This aspect of a project cannot be overemphasized. The quality of visual outcome is just as important for patients in developing countries as it is for your own patients at home. The attitude that "anything is better than what they have" for patients with advanced cataracts can lead not only to poor results for the patients in question but also can have a strong and long-term negative effect on the acceptance of cataract surgery by the community. Contrary to what we might think, cataract blind people in developing countries are frequently reluctant to have sight-restoring cataract surgery for a variety of reasons.[3]

Knowledge that others have had poor visual outcomes after cataract surgery reinforces this reluctance. Although good surgical technique is necessary for good outcomes, unless patient selection has been done carefully, even the best surgical technique can result in an unhappy patient. To have happy patients (and happy surgeons), we must choose patients that are "winners" (Fig 2).

If you are fortunate, the host doctor will have performed preoperative screening before your arrival. In fact, prescreening of patients is a requirement of some volunteer organizations and for good reason. Your time in the host country is limited. Once the word is out that an "American doctor" will be coming, the host institution will be flooded with hoards of patients with a large variety of eye problems, from presbyopia and dry eyes-to untreatable blindness caused by glaucoma, retinal detachment, and other conditions. If a screening has not been performed before your arrival, you will have to spend an enormous amount of time and energy finding those patients with cataract blindness. Not only is general screening in many developing countries time consuming, but also, it is usually frustrating, heartbreaking, and fatiguing. You will need all of your energy for the primary purpose of your visit, cataract surgery.

Prescreening by the host doctor also serves to give you advance knowledge of the number of surgeries you can expect to perform. This information is important for determining the amount of supplies that will be needed for the project. Even if the host surgeon has conducted a screening before your arrival, you should make every effort to do a secondary screening. I have never had a host doctor take offense with this practice. In fact, it is always a teaching opportunity for both the host and the visiting ophthalmologist and also serves to minimize surprises at the time of surgery. Although not always possible, this is best performed with slit lamp. There will be times when your best judgment tells you that surgery is not indicated. Resist the pleas from the patient for you, the American doctor (who, by definition, can work miracles), to do something. The host doctor may disagree and choose to do the operation himself. That's OK. Do your best not to let this bother you or interfere with your relationship.

It is not possible to state a specific visual acuity that qualifies a patient for cataract surgery. The degree of visual disability varies for different tasks. Another consideration is that of priorities. Patients with bilateral mature cataracts have vision loss that prevents independent living and should receive surgery before others who have not yet reached that stage of impairment. Restoration of vision to a person with hand motion or worse vision because of cataracts returns not one but two individuals to productivity-the previously dependent blind patient and the other person (often a child) who has been the caretaker.

Attempt to complete the final screening of as many patients as possible before starting surgery to construct the surgery schedule with priorities in mind, i.e., the most needy patients first. Others can be added as supplies last and time allows. If there are supplies

remaining after you have completed the clearly indicated operations, resist the temptation to stretch your luck and skills by operat-ing on those with marginal indications. It is far better to leave the extra IOLs and other supplies for the host surgeon to use on appropriate patients after your departure.

Visualization of the posterior pole is usually not possible in patients with advanced cataracts; accordingly, pupillary examination is extremely important. Even in the presence of a mature cataract, pupil reactions are essentially normal unless significant other pathology is present (Fig 3). An afferent pupillary defect or a sluggish pupillary reaction are strongly suggestive of advanced posterior pole disease and signify poor potential for useful vision after cataract removal. It is far better to have short-term disappointment from not performing the surgery than the long-term resentment that surely will follow unsuccessful cataract surgery because of unmet expectations. In addition, the demand for IOLs and suture far exceeds the supply: To perform cataract surgery on a patient with a poor prognosis is wasteful and deprives others of the opportunity for restoration of vision and independent living.

Screening should provide answers to the following questions: Is the cataract indeed the cause of the visual loss? What is the status of the other eye? Which eye should receive the operation? It is not always the eye with the worst vision. If the cataract is unilateral, what is the etiology? Trauma and/or inflammation can lead to other conditions (lens subluxation, posterior synechiae) that make the cataract extraction much more difficult. If it is a unilateral cataract, should cataract extraction be performed at all (especially if there is no A scan available)? Is pseudoexfoliation present? The prevalence of pseudoexfoliation is surprisingly high in many developing countries and is associated with a 6 to 10 times increase in the rate of complications at the time of surgery.[4] Even if a slit lamp is not available, pseudoexfoliation should be suspected if there is poor pupillary dilation with drops and should be looked for in the operating room with the microscope when the patient is on the table before surgery begins. If there are signs of pseudoexfoliation, be prepared for the possibility of vitreous loss and the need to use an anterior chamber IOL.

I can give examples of what I consider the 2 extremes, the "winners" and the "losers"; however, many patients fall in between and your clinical judgment and priorities will make the determination.

Examples of obvious "winners" are patients (assuming normal pupillary reactions) with either bilateral dense cataracts or patients blind in 1 eye with an untreatable disease and a dense cataract in the other.

My examples of "losers" include patients with a unilateral cataract if the vision in the other eye is normal and there is no equipment available for A scan, keratometry, or refraction. The same applies to second eyes of patients who are pseudophakic in 1 eye with good vision but are without a record of what power of IOL was used and/or no A scan capability. In both of these examples, the risk of anisometropia is high and, if created, would result in an unhappy patient. Others examples of "losers" are patients with complicated cataracts secondary to uveitis, trauma, or other conditions that significantly reduce the chances for a successful outcome. As noted previously, unhappy patients can do much damage to the reputation of the cataract program and create a future barrier for other patients in need of cataract surgery.

The Surgery — Some General Considerations and Suggestions

Checking Equipment and Local Routines

I perform a number of rituals when preparing to operate in a location that is new to me. I always insist on inspecting the equipment in the operating room before starting the surgery. I prefer to go in the late afternoon or night before the start of surgery when it is quiet and I can take my time without getting in someone's way or feeling rushed. If you have brought portable equipment you can do the adjusting during the assembly.

It is best to have the local operating room supervisor with you during this check. Not only can the supervisor help you find what you need but also you can take this opportunity to get to know the supervisor and discuss the issues of patient flow, drop regimen, a place to give the blocks, and scrub routine. Be sure you are talking to the "boss" or a delegated representative. Many hospitals have rigid hierarchical systems that should be respected. You can create a serious and uncomfortable situation by asking an underling to do something that falls in the job description of a superior. There is much prestige associated with assisting the visiting doctor and you may inadvertently bestow that prestige on the wrong person.

For me, the most important items to check beforehand are the microscope and the chair. It seems that there are no 2 scopes alike. If the scope has foot controls, practice the various maneuvers. Equally important is a comfortable chair or stool of the correct height. You will be sitting for long hours several days in a row so be sure to get what you need, even if that means bringing in something from another part of the hospital. If the stool or chair is not adjustable, choose one that is appropriate for the lower heights-you can always add folded sheets to elevate yourself should the

need arise. I have been in situations in which I have not had the opportunity for a precheck of the equipment and have always suffered accordingly. Be sure to ask about, learn, and follow the local scrub routine. To do otherwise can convey arrogance and disrespect for the local system.

Patient Flow

Efficient patient flow is important. There are 3 separate, but connected segments of patient flow. The first is from the preoperative patient waiting area to the place where you will be giving the anesthesia. The second is from this area to the operating table. The third is from the table back to the postoperative patient area. Obviously, good coordination between these segments is essential to good patient flow. Many of the facilities that you will visit for cataract surgery have either not been exposed to cataract surgery previously or, if they have, it has been on a much smaller scale. Thus, there is a need to organize a team of helpers and teach them how to keep patients coming to and from surgery in a timely manner.

In general, cataract surgeons desire big pupils and soft eyes. Therefore, I give detailed instructions to the helpers about administering drops and the use of pressure-lowering devices such as a Super Pinkie, Honan balloon, or digital pressure. Sometimes the local dilating drops are less effective, so I always bring my own as well as at least 2 Super Pinkies. One should clearly write down explicit instructions stating when to start dilating, which drops to use, and when to bring patients to the surgery area. Take nothing for granted and be sure to personally show how to administer drops and apply the pressure-lowering device if you are using one.

Instruments

Should you bring your own instruments? For me, it depends on the circumstances. If I am going to a new location and the purpose of the visit is for cataract surgery, I bring my own instruments. Working with familiar instruments avoids a potential major cause of frustration. However, if the purpose of the visit is to teach glaucoma surgery, I do not bring instruments unless I plan to give them to the institution. Obviously, it is important to teach with what will be available after your departure.

The type of cataract extraction I perform on visits to developing countries is manual extracapsular with the implantation of a posterior chamber IOL. Thus, the instruments I bring are based on that procedure.

Even if the volunteer organization or the host institution say that they will supply instruments, I bring selected instruments: needle holder, fine forceps with teeth, 2 tying forceps, universal scissors, a Simcoe cannula, a 30-gauge air cannula, and a device for IOL manipulation. That list must be expanded if no instruments are supplied. If you have the luxury of having access to 2 sets of instruments, bring both. This will speed up turnover time, especially if an autoclave is used for sterilization.

The First Few Cases

Don't be in a rush to start surgery. Remind yourself that you are in an unfamiliar environment. I suggest the following approach. Watch the host surgeon do the first case or two. You can observe the scrub routine, the gowning and gloving, and the skills of the scrub nurse (if there is one). Who does the preparation of the patient and how? How is the patient draped? What type of cautery is used (sometimes it is a heated muscle hook). During this time you will also have the opportunity to observe how that particular operating room functions-the flow of the circulators and other helpers. In short, who does what?

Force yourself to be deliberate and slow, especially for your first few cases. Expect the unexpected to happen-hopefully, it will be less disturbing when it actually does. Do not try to compete with the local surgeon for speed or number of cases performed. Be flexible and patient. In spite of the above preparations you can be sure that it will take several cases to establish a rhythm and good teamwork. You will be amazed how smoothly things will go once everyone knows his or her job. All involved with the project will find great joy and satisfaction by participating in a process that restores sight to a previously blind person. When things are going well and you are comfortable, invite the local helpers to watch an operation (especially when you are removing the nucleus) and allow them to look through the microscope before and after an operation. They will be amazed and honored-it is an experience that they will never forget.

A Few Surgical Tips

It is usual to encounter advanced cataracts when performing volunteer work in developing countries. Many will be mature or hypermature. Although one might expect a relatively high incidence of phakolytic glaucoma in this setting, my experience has been that it is rarely seen.

A bothersome aspect, when performing surgery on hypermature cataracts is the milky liquid cortex that appears in the anterior chamber as soon as you start the capsulotomy. Also, the anterior capsule in hypermature cataracts tends to be especially tough and difficult to cut. In this situation, you will encounter 2 problems: (1) You will have difficulty seeing the anterior capsule to complete the capsulotomy, and (2) As the capsular bag deflates with the egress of liquid cortex, the posterior capsule comes forward and can be accidentally cut with the capsulotomy needle. There is a simple way to overcome this problem and avoid potential complications. I have found the following technique to be highly effective (Fig 4).

After making the corneal-scleral groove, enter the anterior chamber with an unbent disposable 25- or 27-gauge needle attached to a syringe filled with air. Inject air until you feel resistance, then withdraw the needle so that just the tip is in the needle opening and gently press posteriorly to allow the aqueous to exit the chamber through the needle hole. Next, advance the needle and inject more air. The anterior capsule is now tamponaded by the airbubble and should be slightly concave. Withdraw the unbent needle (keeping it on the air-filled syringe), bend it to your liking, and reinsert it through the existing needle hole. You should now be able to perform a capsulotomy, adding extra air if needed, with little or no escape of milky fluid.

I make the corneal-scleral groove more anteriorly (almost corneal) when performing volunteer surgery, especially in countries where the eyes are smaller than usual. This, along with a soft eye, minimizes the possibility of repeated iris prolapse during surgery.

You can expect to have vitreous loss during some cases for several reasons. It may have been awhile since you have performed manual extracapsular surgery. In some locations, there are many patients with pseudoexfoliation with associated broken zonules and a thin posterior capsule (in several places, almost half of my patients have had pseudoexfoliation). When pseudoexfoliation is present, it is safer to lift out the nucleus with an irrigating vectis rather than pushing it out with inferior pressure. The latter is more likely to rupture the zonules already weakened from the pseudoexfoliation process.

The important thing is that you are prepared for the possibility of vitreous loss and have an appropriate plan of action. It is doubtful that you will have a vitrector at your disposal so you will be performing a scissors vitrectomy. It is better to cut the vitreous at the anterior pupil margin before removing it from the anterior chamber. Engaging the vitreous at the wound edge with a cellulose sponge and putting it on traction before cutting is no longer recommended because of the danger of associated traction at the vitreous base, which may contribute to a later retinal detachment.

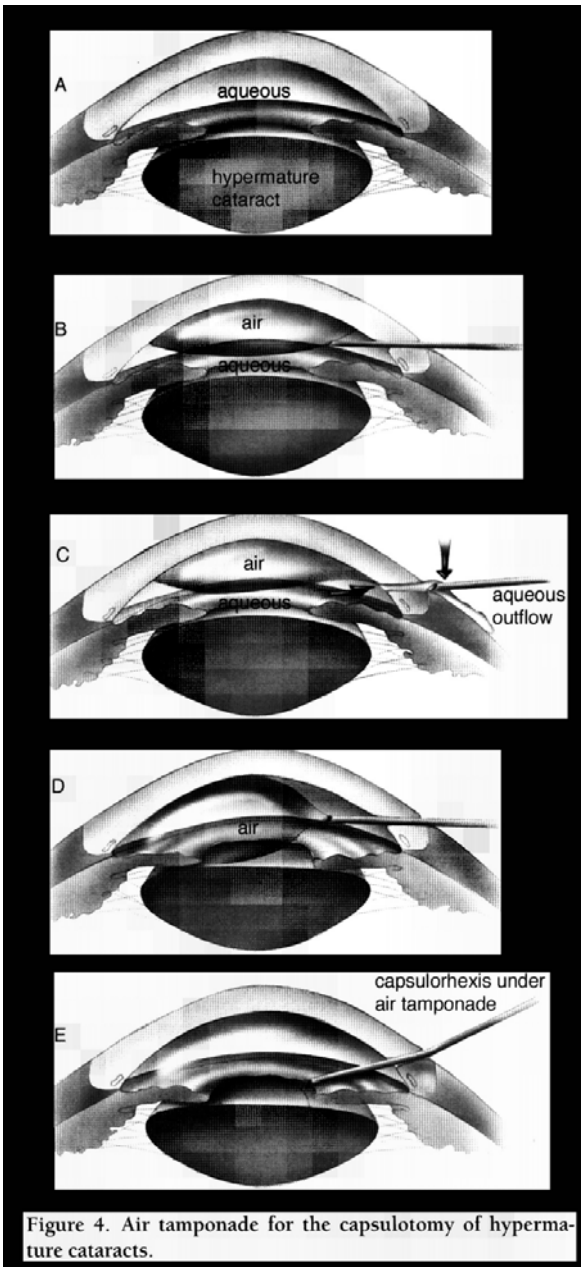

Figure 4. Air tamponade for the capsulotomy of hypermature cataracts.

Also, be prepared to use air for IOL insertion if you do not have viscoelastic or run out of the supply that you brought. You may have forgotten how well air works. I prefer to use running 9-0 nylon for wound closure with the knot buried in the groove.

Patients are usually discharged on the first postoperative day after a penlight check. Those with any complications (e.g., iris prolapse) can be returned to the operating room as needed. Once the patients leave the hospital, it is rare for them to ever return, even if asked to do so. For this reason, I always do a peripheral iridectomy at the conclusion of surgery.

Co-Existing Cataract and Glaucoma

Glaucoma is the second leading cause of blindness worldwide. The volunteer ophthalmologist will encounter glaucoma when serving in developing countries even when the purpose of the visit is for cataract surgery. [5] In the absence of an afferent pupillary defect, a patient with moderate glaucoma and a visually disabling cataract is a candidate for combined cataract extraction and a filtering procedure if the vision potential justifies the procedure. However, as noted above, it is extremely unlikely that there will be meaningful postoperative follow-up. Postop-erative steroids should be continued in combination surgery for a prolonged period of time, 3 months if possible.

If the primary purpose of your visit is for cataract surgery, I strongly advise against performing filtering glaucoma surgery except as part of a combined procedure. Even if the operation is successful in lowering the pressure, it is likely that there will be an associated negative impact on the community because you have failed to improve the patient's vision. Patients and their friends and relatives rarely understand the "insurance" value of filtering surgery for glaucoma, especially in the setting of a short-term cataract project in a developing country.

Types of Cataract Surgery Performed In Developing Countries

By far, the most common type of cataract extraction performed in the world today is intracapsular without insertion of an IOL. This is regarded by many as an incomplete operation because most of the patients lose their aphakic glasses within 3 years, cannot or do not get replacements, and are back to count fingers vision.

There are ongoing efforts to train these surgeons to put in anterior chamber IOLs in uncomplicated cases. [6]

The second most common type of cataract extraction is manual extracapsular with placement of posterior chamber IOLs. Most newly trained cataract surgeons in developing countries are being taught this method. With the production of inexpensive but high quality IOLs, suture, and viscoelastic, it is now economically possible to offer this type of surgery to most in need. However, as noted in the beginning of this article, there is an urgent need to train many more surgeons. You can help.

Phakoemulsification is performed in some large univer-sity and training centers, and by relatively few private practice ophthalmologists in developing countries. How-ever, the expense of the equipment and consumables, the long learning curve, and the lack of technical support for malfunctions make its use prohibitive in most locations. There are many phako machines (often older and donated ones, but new ones as well) resting unused in closets off the operating rooms in eye hospitals in many developing countries.

There are several small incision manual extracapsular techniques being performed and taught. If these tech-niques require special instruments they will not be practical for widespread use. In addition, although they look easy when performed by the masters they are often difficult for others to learn. An advantage is that usually (if performed well) they do not require sutures. I question the touted advantage of less induced astigmatism if the technique is performed in locations where there is no available A scan capability. What good is preventing 1 to 2 diopters (D) of astigmatism if the IOL is 3 to 4 D off?

Consultations on VIP Patients and Difficult Cases

The host doctor may ask you to examine and/or do surgery on friends, relatives, or government officials. Also, these privileged individuals always seem to be at the front of the line. Giving preference to these patients used to annoy me; I came to serve the poor, not the privileged. However, a colleague once told me to look at this situation in a different way-you are helping to build up a "credit balance" for the host doctor (especially with government officials) that can be used in the future when he or she is requesting new equipment and educational materials.

However, do not be afraid to set some limits and see these special patients in addition to, not instead of, the common clinic patients. If asked to see VIP patients, I will often ask to see them at a special time outside of the usual clinic hours to avoid displacing other patients.

Include the host doctor as a colleague in the consultations. This is an opportunity to create good will and strengthen his or her reputation. Be aware of the fact that many ophthalmologists from developing countries have not had the benefit of a good basic education. Tact is required to avoid putting the host on the spot in this regard.

Often, difficult cases are saved up for you, the visiting "expert." Again, do not let your ego overcome your better judgment. Patients with problems that would present a challenge to you in the familiar surroundings of your own office or hospital shouldn't be considered in unfamiliar surroundings. Recognize your limitations and avoid potential surgical misadventures that could well cast a shadow over the entire visit.

Local Ophthalmo-Politics

I have yet to visit a place (including our own country) where there was more than one ophthalmologist or institution without encountering competition, often quite open and intense. The official host doctor and/or institution has the advantage and often will arrange for local TV and newspaper coverage at the host institution. Certainly, he or she deserves something extra for the time and effort involved in the organization of the project. At times, the other ophthalmologists or institutions are ignored altogether. I am uncomfortable in this type of a situation, especially if lectures are involved. I make an effort to request that other local ophthalmologists be invited to the lectures if this has not already been done. I also make an attempt to balance the attention given and consider it a matter of professional courtesy to visit other ophthalmology institutions in the area.

Much more is involved than just ego. Without exception, in every country that I have visited-including Communist countries-private practice has taken root and is rapidly growing. Private offices, frequently in the homes of the ophthalmologists, provide supplementary income to the usually meager salaries paid by the governments.

An obvious public favoring of one ophthalmologist over another will often have significant future financial consequences.

Local Health Care Economics

Volunteers travel to developing countries expecting to serve the poor and assume that the poor will not be asked to pay for their services or for the donated supplies. In fact, there is often a mixture of the truly poor, who have no money, and those who are able to pay something. Hospital policies vary and it is beyond the scope of this discussion to describe the numerous variations. Unfortunately, there are costs that we are not aware of that prevent the poor from having surgery; some are unavoidable, others are not.

The poor in developing countries have no disposable income. They work today to pay for tomorrow's food and other essential living expenses. There is nothing left over at the end of the day. Thus, costs of transportation for the blind patient and the caretaker/guide, the loss of income of the caretaker while escorting the patient to the hospital, and the food costs and other expenses involved in being away from home frequently create insurmountable financial barriers for the poor to even show up at a clinic or hospital.

The great majority of cataract projects in which I have participated have been open to all regardless of financial status and have been conducted with genuine compas-sion and dedication shown by the local hospital staff. The goal in these places has been to help as many patients as possible. In addition, the majority of hospitals where I have served have not charged the patients for care received.

However, in some locations, even if the poor patient can make it to the hospital there may be other financial barriers that preclude surgery. These include revenue producing hospital charges for such items as unnecessary laboratory tests, charges for registration, charges for records, laundry charges for hospital bedding, and "nursing care." Thus, even though the project has been advertised as "free cataract surgery," other associated hospital charges may exclude a large number of the poor for cataract surgery.?

Unfortunately, there is also a dark side to cataract projects in some locations. There can be entrenched and hidden local customs that attempt to control who is seen and when. Local hospital personnel are often "gatekeepers" and take under-the-table payments for the chance to see the visiting doctor and/or secure a place at the front of the line. Prescreening by the host doctor helps to avert this situation. I have never suspected a host doctor of being involved in this type of activity. Waiting until all patients have been screened to make out the surgery schedule based on the degree of visual disability is one way of thwarting these schemes.

Another tactic, if you suspect that the poor are not getting attention, is to take a penlight and go through the crowd waiting outside of the clinic door to look for white pupils. On several occasions, I have worked with a host doctor who, suspecting payoffs to local hospital personnel, started out by placing all waiting. patients in a long line and quickly checked for cataracts with a penlight. Those with obvious cataracts were then placed at the front of the line. This totally disrupted the system and resulted in much unhappiness and noisy arguments at the back of the crowd by those who had prior "arrangements" with the hospital staff.

Becoming involved in local health care “economics” can quickly become a quagmire for short-term visiting volunteers who have no idea what goes on behind the scenes. Unless there are blatant inequities, do not get involved. This is true especially for the first few days of a project. It robs you of the energy needed for your surgery. However, feel free to discuss your feelings with the host doctor and the hospital administrator at the completion of the project. You can make a return visit contingent on the changing of policies to which you strongly object (although, in my experience, this has rarely happened.)

Reports

I make it a policy to write a comprehensive report about the project for the sponsoring organization once I return home. I keep a daily journal during the project to use as a source for future reference. You acquire valuable information that is useful to the organization and for those making future visits to the same location.

Follow-up With the Host Doctor After Returning Home

The common result of working closely with someone on a common task-especially one that is as emotionally charged as restoring sight to the blind-is the development of strong feelings of camaraderie. In such a situation it is easy to make promises about what you, as the visitor, will do for the host doctor when you return home. This is normal and desirable. However, there is a strong tendency in the heat of the moment to promise more than can be delivered. Thus, it is best to make promises conditional if there is any doubt that they can be completed. You will probably be busy when you return home trying to catch up with family, mail, office backlog, and other time-consuming tasks. Many promises, especially if they involve third parties, can take a large amount of time and depend on the third party's willing-ness and ability to deliver. What takes only a few minutes of request time by the host may take many hours of your time to satisfy the request.

E-mail availability is spreading rapidly in most areas of the world. If the host doctor has access to e-mail, you can maintain close contact for patient follow-up and personal messages.

Inertia and Getting Started

Inertia prevents many from going on their first volunteer project. The reasons for the inertia are too numerous to discuss. However, once the volunteer has overcome the inertia and been involved in a project, most find the experience so deeply rewarding that they continue to serve on a regular basis.

There are literally hundreds of opportunities available to as many locations. Most projects last from 1 to 3 weeks but longer or shorter periods are available as well. How do you find out about what's out there? It's easy. Call the American Academy of Ophthalmology (415.561.8500); ask for the international office and request information about the Academy's International Volunteer Registry. You will be sent a brief form that asks your preferences such as: length of service, where you would like (or not like) to go, what you can provide (cataract surgery, teaching). Your reply will be fed into a computer that will identify organizations that match your needs and interests. You will receive in short order a thick stack of informational reports from those organizations. This service is free except for your phone call and the stamp to return the preferences form.

For your first project, I suggest that you do 3 things. First, go with an organization that has many choices of destinations and that provides you with all of the supplies and equipment you will need for the project. This will make getting ready for the project easier. Second, go with another ophthalmologist who has been on at least 1 previous project with that organization. And third, try not to do too much on your first trip-strive for quality, not quantity.

Suggested Reading

1. *Before You Go, Information for Ophthalmologists Volunteering in Developing Countries,* Foundation of the American Academy of Ophthalmology, 1999. Free for the asking.
2. *Eye Care in Developing Nations*, Third Edition, 1999, Larry Schwab, MD. Published by the Foundation of the American Academy of Ophthalmology, USA ISBN:1-56055-043-0.

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5. Standefer J: Management of glaucoma in developing countries. Before You Go, Information for Ophthalmologists Volunteering in Developing Countries, in Lewallen S (ed): Foundation of the American Academy of Ophthalmology, 1999, pp 12-14
6. Snellingen T, Shrestha JK, Huq F, et al: The South Asian cataract management study. Ophthalmology 107:231-240, 2000
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