TRIP REPORT
Uganda Charitable Spine Surgery Mission, August 7-20, 2010

Team: Isador Lieberman, MD
Lori Mock, PA
Sherron Wilson, RN
John Balk, medical student
Cori Atlin, medical student
Brian Failla, equipment technician, Globus Medical

Locations: Mulago Hospital
Case Medical Center

Society Sponsors: Health Volunteers Overseas (Orthopaedic Overseas)
Scoliosis Research Society, Global Outreach Program

Corporate Sponsors: Globus Medical

Philanthropic Sponsors: Medwish International
AmeriCares

Local Physicians: Dr. Emanuel Munyarugyero (anaesthesia - Mbarara)
Dr. Stephen Tendo (anaesthesia - Mbarara)
Dr. Titus Beyeza (Chief Dept. of Orthopedics - Mulago)

This year's Uganda Charitable Spine Surgery Mission team consisted of a varied mix of individuals – a surgeon, physician assistant, nurse, two students, and an equipment technician (see Figure 1). Two were veterans (I.L. and B.F.) of previous missions and the remainder rookies. All were from various parts of North America. Most were strangers to one another at the outset, only linked by knowing Dr. Lieberman, and all united by a common vision. The vision was to leave Uganda in two weeks time better than when they arrived, with healthier patients, happier families, and better-equipped and trained local medical teams. The goals were lofty, but as experienced by past teams, attainable only through a patient and concerted effort.

The team consisted of; Sherron Wilson, a surgical nurse from Ft Lauderdale with tremendous spine experience and a calm mature attitude, Lori Mock, a PA from Texas Back Institute, with an infectious, vibrant, and compassionate personality, John Balk, a med student from Akron, who was eager to learn, Cori Atlin, a med student from Toronto, with eyes equally wide as her smile, Brian Failla, the equipment technician, and mission veteran who always has everything under control, and Emanuel Munyarugyero, the anesthesiologist from Uganda, who is an inspiring role model.

Figure 1; from lt - rt, Failla, Atlin, Wilson, Lieberman, Munyarugyero, Mock, Balk

This trip began on a different note than other trips. Firstly, in addition to the omnipresent devastation and poverty in Uganda, there were terrorist attacks which claimed the lives of 74 people just weeks before the team arrived. There was a clear sense of heightened security with metal detectors framing the entrances of hospitals, grocery stores, hotels and restaurants (although one must question the security guards' capacity to secure while sitting at their stations with their chests resting on the mouth of their weapons, or the barrel of the rifle resting on the toes of their shoes). Other medical teams shied away from Uganda, staying an ocean's length from the atrocities of the previous month. Prior to the planned departure, the team unanimously decided to persist with an even stronger resolve. Secondly, this was the first trip for which there was only one surgeon. The caseload was reduced, but the pressure was perhaps higher with only one expert set of hands. Thirdly, this was the first trip without Dr. Mark Kayanja, the heart and soul of the mission project and the local liaison to the Ugandan medical community. The fact that the team forged ahead is a clear testament to their integrity and unbridled dedication to help.

After over 20 hours of traveling from various parts of the globe, the team arrived safely, in Entebbe, to clear skies and 75 degree weather. The ever-so-skilled driver Patrick (another team veteran from 2 and 3 years ago) met the team with a huge smile and hug. He immediately approved of the new team members (Lori, Cori & Sherron, he did not even notice John), then he saw the load of bags and set out to puzzle them into the "Super Custom Eight" Toyota van (the same van for 5 years running). He did manage to fit everything in and leave one seat in the third row to accommodate a passenger. John being the gentleman he is (he did not realize the difficulty of the trip ahead) sat in the back with four others crammed into the second row. An hour and a half later, even with mild Sunday Uganda traffic, Patrick managed to negotiate the streets, pocked with potholes the size and depth of bath tubs, and which are shared by motorists, cyclists, boda-boda (scooter) drivers, and cattle, and deliver the team to the Golf Course apartments.

At the apartments the team was all pleasantly surprised. For Dr. Lieberman and Brian, the homecoming to apartments 353/356 was nostalgic; the brown water, spotty internet and cellular access, brown dust throughout and visions of past team members and their idiosyncrasies. On arrival the van was unloaded of bags and equipment. The team then visited and familiarized themselves with the hospitals where they would be operating – Case Medical Center, a private hospital organization, who generously donated their operating rooms, and Mulago Hospital, the state run hospital.

On arrival at Case, Mr. Metu (Midland Freight Services, Uganda) and his van loaded with supplies (which were generously donated by Medwish Inc, AmeriCares, Globus Medical, and private individuals), was waiting for the team. The equipment was moved to and stored in a private patient room which became command central for the remainder of the mission. Thanks to the efforts and generosity of all the above, it was clear that the mission was well equipped to handle any spine surgery reconstruction that they might encounter.

Case Medical Center is a recently opened private institution which is well-appointed and clean. It was established by Dr. Sebbaale, a classmate of Mark Kayanja. The children's ward is canary yellow and with Disney characters smiling from the walls and ceilings. There was even finger-print access to the operating theatre (OR) and the intensive care unit (ICU), which would later prove to pose a bit of a challenge for hauling supplies back and forth between the OR and command central.

The OR at Case was small, but quite clean. For the rookies, who are all accustomed to state-of-the-art, over-stocked OR's with modern equipment, this OR was not quite the same, but it was more than adequate and far better than what they had anticipated. For the veterans, the Case OR was like sipping from a bottle of ice cold sparkling water during a Texas heat wave. Clean equipment, a working sterilizer, a working fluoroscopy unit, and an OR team with a welcoming attitude.

Mulago Hospital in contrast is the stereotypical image of a poverty-stricken state run (I am reluctant to use the word "funded") hospital in the developing world. Patients suffer side-by-side in rickety beds with flies landing upon their faces. Speckled sunlight pours in through the dust encrusted windows half opened in the decaying patterned concrete walls. Mulago consists of both an upper and lower hospital. The lower hospital is built in a cottage style. The ward sits below a field where laundry is laid to dry in the sun and garbage is burned in piles, feasted upon by cattle and storks. The upper hospital is an open-air concept, multi-storey building. But unlike the glass and concrete high-rise hospitals of the developed world, in this building there are herds of people literally camped out in the hallways with mattresses and pots and blankets, sleeping, chatting and eating while they wait for or tend to their loved ones. The beds are metal frames, sometimes on wheels, with tattered mattresses and often no sheets. The patients

are emaciated; many with full-thickness bed sores (see Figure 2). This image stands in contrast to the nurses who are clad in traditional uniforms of white dresses with a white cap and red belt. For the most part, the nurses seem to be compassionate and engaged, but they are sorely lacking in necessary expertise. The team struggled to appear stoic during this visit feeling such an overwhelming sense of urgency to help those around them. Unfortunately Mulago's condition is deteriorating, despite a newly built spine OR. There is no maintenance infrastructure, the concrete walls are crumbling and moldy, the sterilizers do not work, and half the light bulbs are either broken or burnt out.

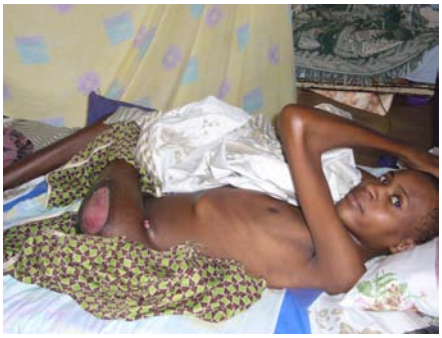

Figure 2; paralyzed from waist down due to bike/car accident, multiple bed sores

At the end of the hospital tours, the team returned to the apartment and assembled care packages for the patients. Sherron Wilson did a phenomenal job of collecting donated supplies from her colleagues. In re-usable "Orthopedic Institute of South Florida" bags, Sherron, Lori & Cori assembled packages of candy, toothbrushes and toothpaste, bandages, antibiotic ointment, soap, face cloths, hair elastics and combs, clothing, crayons, and more. Between the surgical supplies and care package materials that Sherron brought, the airlines could have eliminated their entire debt by charging baggage fees, however with Brian's negotiating expertise the baggage fees for 5 extra suitcases were waived.

The next morning the team met with Dr. Titus Beyeza, the chief of the Department of Orthopedics at Mulago. After a warm welcome and the requisite signing of the guest book Dr. Beyeza discussed and emphasized the importance of the mission and of knowledge transmission. Dr. Beyeza displayed a clear sense of disappointment with Dr. Lieberman's decision to operate predominantly at Case Medical Center. Dr. Lieberman responded with concerns about the sterilizer, the fact that a new sterilizer is months away, and that cleaning and sterilizing equipment at New Mulago then trucking it to Old Mulago Spine Theatre is just not practical. Notwithstanding, Dr. Beyeza re-iterated his commitment to the mission and that the purpose of these missions is not only to perform surgery, but to teach the Ugandan medical team how to provide the best possible care for their patients. This is of course consistent with the primary goals of Health Volunteers Overseas (HVO) and the missions and thus Dr. Beyeza's insights were very much aligned with the team's collective vision. Dr. Lieberman and Sherron both happily agreed to deliver lectures to the Mulago medical team (see Figure 3).

Figure 3; Lieberman giving lecture on scoliosis

Down the hall from Dr. Beyeza's office was the consultation room which was set up to examine and triage patients. After only one day and having never before treated patients together as a unit, the team instinctively assumed their posts and functioned like a well designed mechanical watch. Dr. Lieberman examined the patients, reviewed their x-rays and planned for the types of procedures to be performed. He spoke with a warmth and compassion that instilled a great deal of confidence in each person in the room. John was Dr. Lieberman's right-hand man, ordering labs, looking at x-rays, and taking pictures of the patients and their matching documentation. Lori filled in the patient charts with her notes, while Brian and Sherron were busy organizing the surgical equipment. Cori acted as the scribe, taking detailed notes on each patient, the labs ordered, and Dr. Lieberman's dictations. The team was accompanied by two of the residents from the Mulago Department of Orthopaedics. Dr Michael Mikassa deserves special mention. He was familiar to the team from previous visits and really stepped up to the task of integrating himself into the team on this mission.

On the second day, the team was joined by Dr. Emmanuel Munyarugyero, a man whose poise, skill, and creativity in the operating room bring new meaning to the expression "cool, calm, and collected." "Dr. Emmanuel" as he is affectionately called by colleagues and patients (only because the Mizungos cannot pronounce his name), manually ventilated all of the patients for the duration of their procedures because he had lost confidence in the anaesthetic machine. Like his patients, he never skipped a beat, even when the electrical power was briefly down during two operations (which happened both at Case and Mulago).

By the end of the trip, the team evaluated sixteen patients and operated on eight of them. The first operation was on a fun-loving eight year old boy, J.G., with infantile scoliosis. He had previously undergone a posterior instrumentation and returned for a revision. Due to his growth the hooks became dislodged and prominent. The implants were removed and he underwent a left T7 to T10 thoracoplasty (resection of ribs to flatten the chest hump). J.G. had an uneventful post-operative course. The bravery and stoicism of this small boy was truly overwhelming. He maintained his composure through what must have been

a very painful immediate post-operative period and even mustered the strength to flash us his heart-melting smile (see Figure 4).

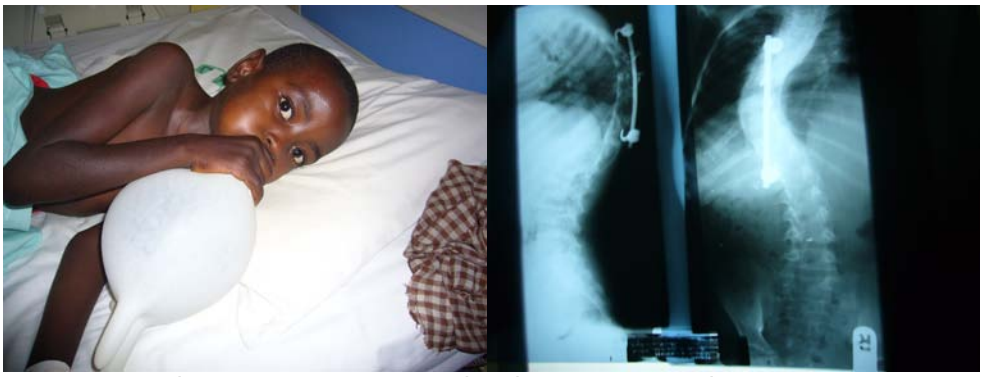

Figure 4; J.G. post-operative day 1, pre-operative x-rays

After the day of operating the team ventured to visit the neighborhood across from the Mulago Hospital. This local slum consisted of a labyrinth of shacks, winding for kilometers alongside the sewage canals (see Figure 5). Children were everywhere. It was filthy. There was a child missing an eye. The stench was often unbearable. The locals watched the team with skeptical looks as if to say “this is our home and we are proud of it”. No one actually addressed the team, however, it was clear they were chatting about the team but seemingly there was no malice in their expressions. Deep in the heart of the slum, alongside the roosters and dogs, the team stumbled across a schoolhouse (see Figure 6). The volunteer Ugandan teacher explained that it was called Basic Education Under Poverty Areas (BEUPA) and that it was community funded. The school was a shack divided into two rooms, one for primary school and the other for middle school. One had some maps of Africa at the front and the other had a small free-standing chalk-board. There were some desks with had benches attached.

As the huddled team cautiously toured through the slum a small girl approached Dr. Lieberman and clutched is leg. Unbeknownst to him she was wearing the most interesting, co-incidental t-shirt (see Figure 7). How she got the shirt, how she knew whose leg to clutch, or what the shirt actually represents was completely irrelevant, as the logo summed up the mission trip in 3 words.

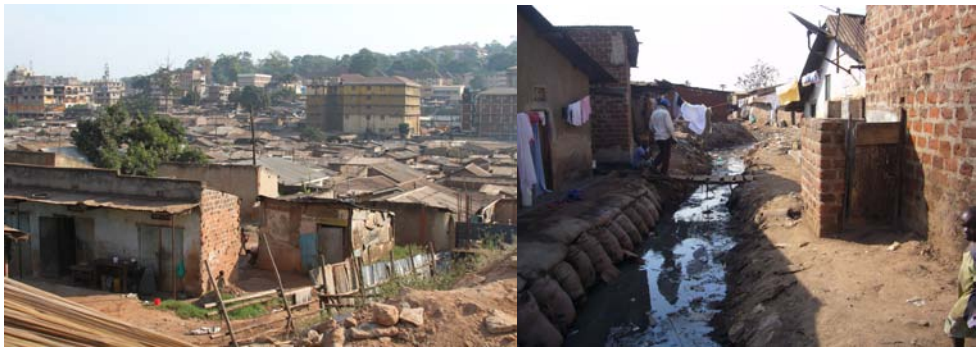

Figure 5; the slums of Kampala

Figure 6; the school house

Figure 7; co-incidental t-shirt

Seeing the slum was an experience that will be permanently etched in the team's memories. There is a need so vast and so dire that even the most motivated and active group could not conquer the task. How do you begin to heal a nation or even continent?

The following day the team operated on an outgoing six year old girl, G.N., who was accompanied by her extraordinarily grateful grandmother and brother. She had a congenital wedged vertebra between T8 and T9 with a rigid right-sided thoracic curve. She underwent a posterior costo-vertebral wedge resection and a right-sided reconstruction and fusion with instrumentation. She had an uneventful post-operative course and was discharged home after three days.

The next day the team tackled two cases of congenital scoliosis. R.K. was a feisty three year old girl. She had an air of wisdom about her which gave the impression that she knew more than her tiny, curvy body might trick you into believing. She underwent a left-sided L3 to L5 growth arrest and right-sided T9 to T11 growth arrest. She made an excellent recovery and even rewarded us with a smile upon her discharge.

The second patient, P.K., was an adorable three year old girl with multiple congenital anomalies resulting in scoliosis. The surgery did not require instrumentation. Both left- and right-sided growth arrests and fusions were performed in hopes that as the child grows, her spine will become better-aligned. She tolerated the procedures well, however in the post operative period she developed some unsustained fevers which eventually settled and she was sent home 5 days after surgery.

Day six started at Mulago where Dr. Lieberman delivered his lecture on the basics of spine deformity and surgical intervention. A number of local physicians and some nurses attended the talk. At the conclusion, Dr. Lieberman invited questions from the audience and no one asked. After much prompting, two of the doctors did ask questions, but it was disappointing that more did not jump at this opportunity to ask and learn.

From Mulago the team returned to Case Medical Center to tackle the most complex operation scheduled thus far. The patient was N.R., a thirteen year old girl with a 60 degree idiopathic scoliosis. N.R. had noticed a progressive curving of her spine over the previous three years and could no longer play sports with her friends (see Figure 8). Her five hour operation consisted of a posterior T5 to L2 segmental instrumentation, correction and fusion (see Figure 9). The rookies, even seeing this procedure up close, wondered exactly how Dr. Lieberman accomplished this seemingly impossible correction. As he stretched, compressed, and rotated the spine, it gradually became straighter and straighter. N.R. was up walking the following day, with a much straighter and balanced spine. After the procedure, a dedicated nurse from Case Medical Center, Christopher, explained to Dr. Lieberman, that this case made him worthy of receiving a cow – the highest gesture of endearment and respect afforded to an individual in Ugandan culture.

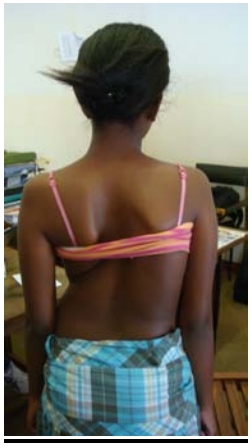

Figure 8; N.R. 60 degree scoliosis

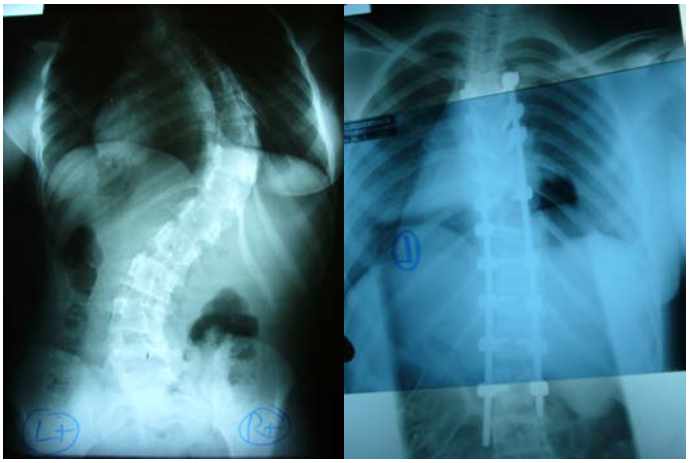

Figure 9; N.R. pre and post operative x-rays

On Saturday morning the team started with a ward round. All the patients were doing well. Naturally they were not enthused to see Dr. Lieberman especially when it came to changing the dressings. There is no way to comfortably take a bandage off a 3 year old child. This tends to be a good cop, bad cop scenario. Dr. Lieberman strips the dressing then the team Lori, Cori and Sherron, with their smiling faces and lollipops, cleanse and dress the wound. Two of the children were ready to go home on Saturday.

From the hospital the team embarked on a "Voyage of Discovery: The goal for the day was to "deliver the goods". A colleague of Dr. Lieberman's from Dallas had sent two boxes of supplies for her teacher cousin who lives in Icanga, and Dr. Lieberman had been in communication with Rabbi Enosh (who leads a small "orthodox" Jewish community just north of Mbale) who had requested a Bris Milah kit (circumcision kit). After a grueling 3 ½ hour drive we arrived in Icanga to meet with the Winkler family, Mat, Sherrie, 6 children and an assortment of animals. Mat is a Baptist "church planter" whose stated mission is to "ensure that all end up in heaven". We were welcomed into their home and treated to a wonderful lunch of Mexican style tacos accompanied by a forthright discussion on the virtues of religion, politics and human nature (see Figure 10).

Figure 10; the Winkler family

Despite the hospitality the team begged their leave to journey on further north to find Rabbi Enosh. On the way Dr. Lieberman made the executive decision to take a small detour (2 hours) to see the peak of Mt Elgon and the Sipi Falls (no surprise). On any other trip this would have been the highlight, however with the preceding and forthcoming visits the beauty of the cloud covered peak of Mt Elgon was virtually all but forgotten to the team (see Figure 11).

Figure 11; Sipi Falls

The team arrived in the presumed area of Rabbi Enosh's village only to find out that they were in the vicinity but still had to follow a "boda-boda" (motorbike taxi) over 3-5 miles of muddy trails to get to his site, after a seeming eternity the van turned in to a compound of huts that were recognizably Jewish. Menorahs and David's Star painted on the walls or fabricated into the iron work windows seemed entirely appropriate below the tin plate roofs (see Figure 12).

Figure 12; village house

On arrival the team was greeted by Shirah, the rabbi's wife, and countless children (see Figure 13). Unfortunately the rabbi was summoned away to a funeral and would not be back. The team did however meet with the members of the community including the Chazzan (cantor) and the emeritus rabbi "Abraham" (presumed to be about 60 years); they invited the team to stay for the Havdallah

ceremony (marking the end of the Sabbath) which was graciously accepted. The ceremony was moving, inspiring and challenging all at once. Here is the team, in the middle of Africa, listening to a community of individuals struggling to survive as “orthodox Jews”, who described how they split off from the conservative Jews of Abudaguya, and who have absolutely nothing of material value, but a paper Torah in a makeshift “aron kodesh” (the Torah ark) and the deep desire to be recognized as Jews.

Figure 13; the Jewish community of Putti

Much to the community’s chagrin, as they had expected the visitors to stay over, and as it was already late, the team decided to face the at least 5 hour drive back to Kampala that evening. The irony of it all was that the treacherous drive seemed far more inviting than a night spent in the mud huts.

The day was as tremendous and diverse as the team was. All still individually in their own way experienced something new in relation to the extremes of human ideology and dedication to cause; from the Baptist church planter on a mission to lead all on a path to heaven, to the Jewish community struggling to be recognized as orthodox.

In the wake of Saturday’s experience the team on Sunday set out on yet another mission. First stop was the hospital to see the patients. N.R. the 14 year old scoli case was doing remarkably well. Her x-rays revealed a tremendous correction of her scoliosis curve. However, as stoic as she was while Dr. Lieberman stripped off her bandages, her uncle on the other hand was not that comfortable with the bad cop routine. As the bandages came off her incision he rolled his eyes and promptly hit the ground. The good news is all he suffered was a bruised ego.

The mission of the day was to visit the equator, purchase the usual “Afrikan Chachkes”, visit the “crocodile center” and have a relaxing day. At the Equator village the team met Tom, an American church volunteer in Uganda, on a 12 month mission to help restore and maintain orphanages. After a few Tusker Ale’s, it was clear that Tom is a newly leaning republican. Even after the Tuskers the day’s drive was anything but relaxing.

On Monday morning, the team operated on a two year old boy, I.A. who came with presumed TB of the spine. He had a very large head, clear developmental delay, and neurological impairment (see Figure 14). He was able to stand only with help from his mother, and seemed to be perpetually sweaty. Dr. Lieberman believed that the there was not appropriate evidence to support a diagnosis of TB, but rather that this child suffered from congenital kyphosis. Both anterior (front) and posterior (back) approaches were undertaken; anteriorly was an L1-2 and L2-3 release, discectomy and interbody graft, followed by a posterior T12, L1, L2, and L3 instrumentation, correction and fusion. As expected this was not TB but a congenital kyphosis at L1/L2 with a wedge vertebra. Once done the team obtained a CT scan of the child's head and through collaborating with colleagues back home (Dr. Daniel Shedid), a diagnosis of Soto's Syndrome was made for I.A.. Soto's is an exceedingly rare disease marked by an enlarged head, developmental delay, and hypotonicity. After surgery, I.A. was still very weak and never regained the ability to wiggle his toes, though it was clear that his sensation was intact. Dr. Lieberman suspects that over time, I.A. will recover to his previous level of motor function, and perhaps with appropriate support and a straight spine, he may make great strides. The team gained a lot from this case; everyone was involved and learned something new! Lori learned that Gellpie retractors were designed to fit around a 3 year old bottom perfectly. John learned how to throw a double tie in an incision less than 2 inches. Cori realized that she must update her iPod music to the surgeon's taste. Sherron affirmed that Dr. Lieberman mumbles while operating, and Brian now knows that sublaminar wires are your friend.

Figure 14; I.A. Soto's syndrome

The following day, Dr. Lieberman and Sherron delivered simultaneous lectures at Mulago Hospital. Dr. Lieberman spoke to the doctors about spinal trauma while Sherron spoke to a room full of nursing staff about primary care. This time, the doctors actually had a number of questions and Sherron's audience seemed engaged and genuinely interested in learning.

Once done with the lectures the team was scheduled to operate on an unfortunate 20 yr male, W.B., involved in a bicycle motor vehicle collision, with multiple injuries including a broken leg, a broken neck, and complete paralysis

with loss of all function below the shoulders (see Figure 15). In an instant he became a shell of a human being. He was suddenly quadriplegic, unable to scratch his nose, nurse his injured leg, or rotate his head. Of all of the patients evaluated W.B. was by far the most in need of care. He had been in bed 2 weeks and already has bedsores on his bottom end and his head. The one on his head was weeping pus. The entire team were shocked by his condition, and even more shocked when the anesthesiologist tried to cancel his surgery. Go figure this kid's only chance was to get his neck stabilized so he could at least sit up and avoid pneumonia and bedsores. After some less than subtle persuasion the anesthesiologist realized that this was the kid's only hope. Considering the theatrics the case went off without any setbacks and Dr. Lieberman was able to decompress (make more room for the spinal cord) and rebuild his neck (see Figure 16). Miraculously, W.B. was also the patient who made the most astonishing recovery. One day after surgery, he was able to move his head from side to side and even began to recover the function of his deltoid and biceps muscles. This would be his saving grace. With a mobile neck and the ability to use his biceps, he could potentially operate a wheelchair. Achieving this level of function would take a tremendous amount of effort and support, but now there is hope.

Figure 15; W.B. broken neck with quadriplegia

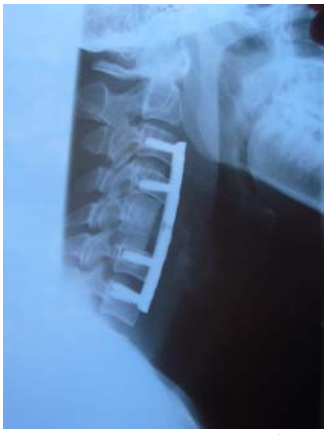

Figure 16; W.B. post operative x-ray

The eighth and final operation of the trip was performed on J.B., a fifty-one year old wheelchair-bound librarian. She contracted TB of the spine and previously underwent a trans-thoracic (through the chest) decompression and reconstruction with rib grafts. Unfortunately, she now endures a great deal of pain as a result of pseudoarthrosis (the rib grafts did not heal) rendering the spine unstable, and was unable to work. J.B. was desperate to alleviate her suffering and was eager to undergo a second surgery if it could benefit her in the long run. She underwent a posterior T4 to T12 segmental instrumentation and fusion, which went as smoothly as could have been expected.

This mission began with tragedy and was fuelled by hope. It ends in much the same way. Since these missions began, it has become abundantly clear that in fact the teams are making a difference. The operating room at Mulago was nonexistent prior to the missions. However, it is perhaps the less tangible differences that are the most fundamental. The medical teams at Mulago and Case were more knowledgeable during this mission than in previous years and demonstrated a thirst to learn.

On behalf of the patients treated in Uganda, the team would like to thank all those who have contributed, supported and encouraged this mission. The team eagerly anticipates next year's mission and your continued support.

Respectfully submitted,

Atlin, Wilson, Mock, Balk, Failla & Lieberman

For previous trip reports please visit the mission blog site

http://ugandaspinemission.blogspot.com/

To continue supporting the mission please visit the fund raising page

http://www.firstgiving.com/ugandaspinesurgerymission2009-2010

To see more pictures please visit Dr. Lieberman's Flickr page

http://www.flickr.com/photos/merlotortho/sets/

Epilogue

Isador Lieberman:
This trip was by far the most paced and organized. We treated 8 patients with 9 surgeries, saw many more in clinic, saw a number of our grateful past patients, and established new contacts and colleagues. On this trip I was privileged to work alongside a truly compassionate and dedicated group. Each team member contributed something unique and in turn experienced the cycle of emotions (excitement, anxiety, intimidation, doubt, homesick, remorse, gratification and guilt). We all still, to differing degrees, take for granted what privileged lives we lead. When one experiences the devastation and suffering it becomes unsettling. Once again my universe has been "realigned". I personally am gratified knowing that Mark's initial and all our continuing efforts are sustainable and will continue to be carried on by others who have been on these missions. In the same light I realize after this trip, that I am now resigned to the fact that I can only do so much; treat one patient at a time and do the absolute best with what you have.

Uganda is still and will be for a long time a developing nation. The corruption is ever present and visible. During this trip I was impressed with the extent of construction in Kampala, yet equally disappointed with the deterioration of the infrastructure especially the roads and Mulago Hospital. There was absolutely no evidence of road maintenance; however, they are building multi story glass and concrete structures on plots of land serviced by a single lane mud road. Apparently the funding for the buildings is from the Global Relief Fund, which has been funneled into the pockets of a few select private developers who stand to profit dramatically. The sentiment is that the intent of the funding is not reaching the end user. How is the village farmer going to gain any benefit from an empty multi story office building in downtown Kampala? As Dr Sebaale (CEO of Case Medical Center) emphasizes, we must make all efforts to "take the foreign aid and get it to the end user". Most NGOs peel off local "expenses" for plush offices, executive expenses and for personnel without regard for the end user. By the time a few dollars actually trickle down to the end user the majority has been lost to its original intent. This observation justifies our mission even more. As a team we have been and will continue to provide services directly to the end user. All funds donated (excepting minimal overhead fees to Health Volunteers Overseas and FirstGiving) are used to provide care to the less fortunate, to provide for education, to provide for medications, to provide for diagnostic testing, to provide for food, lodging and transport of the patients, and to ship equipment and the team to and from Uganda.

I thank all of you who have contributed (institutional and private) and all who have volunteered. I encourage anyone reading this to consider contributing in any way you can, (financial, in kind, volunteer, etc). I look forward to many more successful missions.

Lori Mock:
As the final team member to sign on one week prior to departure, I scarcely had the opportunity to pack let alone anticipate what lay before us. I was relieved to join the rest of the team in London - not only to have company for the remainder of the trip but also to learn I'd be working with some truly incredible and diverse individuals. To say that Uganda is impoverished is an understatement; the overwhelming need and the underwhelming local sentiment was immediately apparent. There seemed to be complete disregard or indifference by the government to improve the living conditions of so many. I couldn't help but wonder how six people, regardless of talent and ability, could significantly contribute to such a devastating situation in two weeks.

Before I had a chance to think about that however, we were seeing patients, unloading supplies and finalizing surgical plans. Our days were always busy and never like the day before. The Ugandan children were beautiful, happy and gracious while their parents expressed sincere gratitude for the slightest of efforts. I am still amazed at the willingness of the parents to surrender their children to us for surgery. We did our best to help them understand the surgical plan but I question how much of that message was received and processed. I guess the love for their children, their faith and a belief that we were good people helped to establish a trusting relationship.

Our team met regularly with the Ugandan physicians and the concept of knowledge transfer was always discussed. They are starved for information, skills training and necessary equipment. Dr Lieberman lectured on two occasions to the residents and staff physicians at Mulago Hospital while Sherron discussed sterile technique and basic nursing skills with the nursing staff. Two of the local residents assisted in surgery the last few days which allowed for further assessment and teaching opportunities.

What an incredible adventure! It is comforting to know that we are the same, regardless of where and how we live - to have our needs and desires for our families' safety and well being effectively addressed. But yet, very troubling to see the horrid living conditions endured by most Ugandans. I now know that this Uganda trip had very little to do with six people hoping to make a significant change in two weeks but rather, six people enabling a few Ugandans to make a significant impact in their country through education, training and support for years to come.

Cori Atlin:
Uganda seemed to me to be a country of many contrasts. The streets are clean, but the wards are dirty. Corruption is rampant, but the people seem genuine and kind. The needs are great, but the resources are scarce. And the people feel no sense of entitlement, when there is indeed at least a basic level of care one ought to be given.

As a newcomer to this mission, I had been prepared by the veterans for what to expect – unsterile surgical equipment, a slower-paced work environment, and the heartbreak of inoperable patients enduring great suffering. What I was not prepared for, however, was the feeling that maybe all of our efforts were for not. During a single day, we visited the Spine Ward at Mulgao Hospital where there were a number of patients whom we could not help. Then we ventured to a local slum, which only served to underline how great the devastation in Uganda, and perhaps the whole of Africa and beyond, truly is. My cycle of emotions began with anger at the injustice and a thirst to effect change, but it quickly degenerated into a deep frustration and feeling of dejection. With so many to help, where do you even begin?

Having completed our journey, I can say with confidence that you begin where ever you possibly can. What may feel like a small contribution can actually make a tremendous difference. Eight people were directly helped on this trip, but the lives of many more were improved, and maybe others will be inspired by what we have done and will do in kind.

It was a privilege to be able to take part in this mission with such phenomenal individuals. I will carry this experience with me forever.

John Balk:
It was a privilege and an honor to have been invited and to have participated in the Charitable Spine Surgery Mission Trip 2010. The people close to me know that I had been looking forward to partaking in a trip of this nature for many years. After the July 12, 2010 terror attacks in Uganda's capital city, Kampala, I had to consider heavily the emotional toll it would take on my family. For without them this trip would not have been a possibility for me. I thank my wife Tracey, daughter Avery, parents, and siblings for their support and understanding!

The ride from Entebbe to Kampala was an eye opener. Smoldering fires, exhaust, and people "just living" where the thoughts that kept creeping into my mind. Why so much smoke, why so many fires, why so much exhaust and what were all these people doing? My questions didn't take long to get answered; people were burning their trash, automobile emissions are not a concern and the people, everywhere, were just trying to get by from one day to the next. It took me most of the trip to get my mind wrapped around the poverty that is omnipresent in Uganda. Just as I was starting to digest what I was seeing, we took a little stroll into the slums, right outside Mulago Hospital. It is indescribable the living conditions those people have to endure on a day-to-day basis. The pictures we took do not do the conditions justice. Human beings should not be subject to those types of living conditions. There were kids everywhere! Why so many kids? What about birth control? So many questions.....

The 2010 spine team; what a great group of caring and hard working individuals. It is with great pleasure that I can now call them colleagues and friends. We all had boundless energy to complete the work at hand. Some of the surgeries were quite long, but no one wavered in their enthusiasm. This was my first exposure to many of the surgeries we performed, so for me there was a lot of uncertainty in the outcomes. Much of my uncertainty came in treating the two and three year old congenital and idiopathic scoliosis patients. I know the capabilities of Dr. Lieberman, so it was easy for me to put my trust in him. But the trust these patients and parents must put in him and his capabilities is unconscionable. It is hard for me to imagine sitting in the shoes of those parents. Not being able to speak our language, the scariness and uncertainty of surgery, the compassion and empathy for your child; yet with all that they were willing to let us treat their children because they knew it was the best for them. The language barrier was at times problematic, however, the one language that we all spoke was the language of human emotion. A smile, a pat on the back, a hug, and tears were a language the Ugandans and the North Americans could all understand and use as a means of communication. In the end, I think we did a lot of good. I am proud of what we accomplished. We brought hope to those in need! It is that hope of changing the human condition or situation that makes me honored and privilege to have been part of the 2010 team!

Brian Failla:
This journey was my second spine surgery mission trip to Uganda. Although the destination was the same and some of the goals of the mission were similar to last year, my experience and what I learned this time was much different. Planning and executing a trip like this requires a huge amount of effort – both mental and physical. But, the immense amount of personal sacrifice that is necessary to pull off a surgical mission like this one to Uganda seems a little smaller to me now. And, things which last year were initially so foreign were this trip familiar. Even some of the challenges that are ever-present when working in an environment, a country and a continent far from home; were expected this trip and tractable.

Conversely, while some of the challenges seemed smaller, the rewards this trip were intensified. The appreciation expressed by the patients and families and staff was again palpable. Associations that were born a year prior grew into friendships. And, any trepidation I experienced prior to the first trip was mostly replaced this time by anticipation and excitement. This second trip has left me with a desire to do more.

I'm borrowing a quote from an unknown source when I say, "I wondered why somebody didn't do something. Then I realized that I am somebody." I hope that if you are reading this and have considered volunteering to help others on any scale, that you'll do it. We have and waste so much. The satisfaction and feelings of accomplishment that you'll realize are exponentially greater than the investment of time and effort that you'll spend. And, I've learned that volunteering can be as much about helping yourself as it is about helping others…

Sherron Wilson:
This past August, I volunteered for a Spine Surgical Mission to Uganda. The only person on the team that I knew was Brian the Globus Company Rep. He reassured me that the Surgeon was great to work with and that he felt I would fit in. With shots and paper-work out of the way, my attention turned to the Mission itself and the patients we would perform procedures on. My colleagues were quite excited about the trip and assisted in collecting medical supplies and also donated personal supplies for care packages for the patients.

This was my first trip to Africa and I was very excited at the thought of just going there. Upon arrival at Entebbe, we were greeted with the excited chirping of Weaver Birds and a pleasant seventy something temperature with no humidity. I could not help but notice the red clay color of the soil.

We visited "The Case Medical Center" where we were scheduled to operate first. The facility was clean and the staff was eager to assist us in any way they could. The operating suites were small and sparsely furnished but had the basic necessities.

On Monday August 9th, we met with the patients at the Orthopedic Clinic and I saw firsthand the severity of the deformities needing intervention. The children were small for their ages and some did not walk. I immediately felt a connection to Joshua an eight year old boy who had previous surgery a year ago. He had a charming smile and bright eyes. His mother was calm and gentle and spoke very few words. Children and adults alike expressed their gratitude for even the smallest gift by gently bowing the knee. I was very touched by this, more so as the behavior was repeated each time anyone was given even the smallest gift.

Upon visiting the "Spine Ward" at Mulago, the State run facility, one could not help but notice the vast difference in the overall ambience of the suite.
The theatre suite at Mulago lacked basic operating room furniture like mayo and ring stands. The Nightingale style ward possessed archaic furniture. The iron beds had foam mattresses some of which did not even have linen. There were make shift barriers of pieces of fabric, that hung from strings around the beds, to afford a measure of privacy. Relatives, the main Care Givers, sat on straw mats on the concrete floor near their loved ones beds.

We had the opportunity to visit the Mulago General Hospital, a huge impressive building from the outside, but as we walked along the wide corridors, there were scores of people laying on straw mats with bundles of clothing and some food and water just waiting, it seems, for what? I do not know. The need for accessible Health Care is great, the need for Compassion and Caring even greater.

When we visited the "slum district", and witnessed the condition that so many people lived in day after day, I could not help but thank God that I am privileged to live in these great United States of America and that I should never take that privilege for granted.

As I reflect on the time I spent in Uganda and the few lives that we were able to touch, it seems just a drop in the bucket, but I received more than I gave; seeing the smiles on the faces of those who could do no more but smile, and the expressions of gratitude from the staff, patients and family members is sufficient reward. I was reminded of the quotation that, "It is in giving that we receive and it is in loving that we are loved."

I was asked if I would be willing to volunteer for subsequent missions. I responded, without hesitation, a resounding "YES". Thank you Dr. Lieberman, and Health Volunteer Overseas, for allowing me the privilege of participating in this mission.