

**AMHE – NY Chapter
General Assembly Meeting
December 5, 2009**

Scientific Committee Report

After four months of preparation, the Scientific Committee, under the umbrella of the NY Chapter of the AMHE conducted its first Medical Mission to Justinien University Hospital. The mission was made possible thanks to the on-site support of three outstanding and self-less individuals: Dr. Guerline Roney, Dr. Jean-Lenic Joseph and Dr. Marlyse Dominique. It was further supported by the General Director of Public Health, Dr. Gabriel Timothee and the Northern Delegate of the Government, Mr. Georgemain Prophete. Thanks to their enthusiastic approval of the program from the beginning, the local authorities, who initially had a lukewarm attitude toward the mission, eventually warmed up to it and for the most part gave us a warm welcome.

This initial trip certainly intended to support the teaching program at this University Hospital, but mostly was a fact-finding mission set up to determine how to proceed with similar programs in the future.

The first participants of the mission were: Drs. Alix Dufresne, cardiologist at Interfaith Hospital, Brooklyn, NY and former President of the NY Chapter of the AMHE, Yves Manigat, Laparoscopic and bariatric surgeon and former President of the CEC of the AMHE, L. Herve Thelusmond, Cardiologist at Maimonides and Coney Island Hospitals, Brooklyn, NY, Dany Westerband, Director of Trauma at Suburban Hospital, Bethesda, MD and myself. Carol Dubuche, Pediatrician at Woodhull Hospital, Brooklyn, NY should be listed with the group, since only a last minute injury to her partner prevented her from joining the group. These outstanding physicians shared one common bond. We were all born in Cap-Haitien and when the idea of the mission was raised, they all volunteered without any hesitation whatsoever.

We were confronted with several hurdles.

- 1- Where to stay
- 2- Where to eat
- 3- Mode of transportation
- 4- Access to the different services - Credentialing
- 5- Access to the residents
- 6- Clearing customs with loads of medications, medical and surgical supplies.

The first three were graciously resolved by the dynamic trio on-site, for the most part using their personal funds to provide us with tasty, hearty Haitian meals, like we can only dream of here. They were also personally available for our transportation back and forth between the hotel and the hospital. The last three were not resolved until the last week, or even until the last day, when all of a sudden while the participants were already literally in the air traveling, I was told that credentials needed to be verified. However, this issue was resolved essentially by a “fiat” of the General Director of Public Health Dr. Gabriel Timothee who designated Dr. Donald Francois to facilitate our arrival. Dr. Francois welcomed us at the Port-au-Prince airport and had our list of medications and medical equipment cleared through Customs, even before our arrival.

Once in Cap-Haitien, we had to first meet with the Representative of the Health Minister for the North of Haiti, Dr. Ernst Robert Jasmin, the Medical Director, Dr. Jean-Gracia Coq and the CEO of Justinien Hospital, Pr Pierre Chavannes.

Our program included morning rounds with the residents in Internal Medicine, Family Medicine and Surgery, participation in outpatient consultation, emergency room visits, surgical procedures and a formal didactic program that ran from 1 to 5:00 PM. Overall the program was a big success. , but a few corrections and better planning will be needed for the future programs. Indeed, we gave 30 lectures and workshops in EKG and echo-cardiography to the residents in Internal and family medicine, Surgery, Urology, Anesthesiology and Pediatrics. These lectures well attended by the attending physicians as well. The news of our presence spread around very fast and our cardiologists received consultation requests for patients who came from as far as Milot and Port-Margot. Morning rounds in Medicine were conducted every morning at 7:00AM by Dr. Dufresne. In surgery, the rounds were often disrupted by the frequent arrivals of major trauma cases. One case gave Dr. Westerband the opportunity to demonstrate the use of Sonography in the management of the abdominal trauma. Often times, these cases were a source of frustration, with not even oxygen available for the intubated patient, not even a 10 cc syringe available to draw blood. Our morning rounds were also interrupted by multiple impromptu meetings that the director of the Hospital was arranging for me with different members of his staff, but they were necessary in order to familiarize myself with the structure of the hospital. As far as surgical procedures, we fell short of our expectations, because

- 1- There are only one anesthesiologist, one anesthesiology resident and four nurse anesthetist
- 2- There are only two operating rooms.
- 3- Surgery has only two operating days: Tuesday and Thursday. One Tuesday a month is monopolized by the local orthopedist who performs all procedures one day a month. The Tuesday of our mission unfortunately happened to be his day.
- 4- We had seven cases scheduled for the Thursday session, but only completed three, because of unexpected emergencies.

At the end of the program, we donated two EKG machines, five glucometers, three brand new stethoscopes and two sphygmomanometers, packs of suture materials, a Pleurevac, lots of prosthetic meshes, stapling devices and lots of medications. We had a debriefing session with the residents and the attending staff and we heard praises and criticism. The residents were extremely grateful and sincerely hope that we will return. They contributed from their meager income to prepare a “chiquetaille” dish for us, they played the guitar and sang for us and finally, everyone of us received a beautiful piece of typical Haitian wood carving.

However, this experience allowed us to understand the structure of the health care system and the teaching program for the residents and identify many shortcomings of the hospital, some that we may be able to change and some that will require a concerted effort by the government and the local authorities. For example, we discovered that there was a director of formation for the residents, who expressed his displeasure that the program did not get his approval prior to our arrival. We apologized and asked him to provide us with his teaching agenda, so that we can integrate our effort within his plan. However, although he has been named to this position seven

years ago, he has not been able to organize any teaching activity, because he did not have any financial support.

We also felt acutely the lack of radiological facilities on the premises of the Hospital. There is a director of radiology with a staff of seven radiology technicians, but any patient in need of an X-Ray, must travel nearly 30 minutes by ambulance to have his or her test at a private radiology office. We also discovered that three radiology machines were given to the hospital by a private consortium, but they broke down shortly after being brought on-line. Presently, there are new machines installed, but they have not been used, because the director is looking for a maintenance contractor. The obvious question is why the contractor who does such a great job for the private radiology office would not want to also work for the hospital. Other radiology machines – C-arms – are seen in different locations, none of them working. The director of radiology was not aware of the one in the operating room.

There is a critical shortage of supplies at the Hospital, particularly, IV fluids, suture materials, basic surgical tools (e.g. clamps, retractors etc.), and stoma appliances. However, in the midst of these deficiencies, we identified some wastes that can be easily corrected.

- 1- Choice of antibiotics: Every patient in surgery is on Rocephin (In the US, it costs \$56.99/ 1 g,) or Rocephin + Metronidazole for prolonged periods of time, even for clean operations, instead of cheaper Kefzol or one time pre-operative dose.
- 2- Every patient on antibiotics has a running IV, even if he or she is eating, instead of using saline or heparin-locks.
- 3- Patients are kept NPO and on IV fluids for at least 5 days after any intestinal anastomoses, even though they have evidence of GI function.
- 4- All wounds are kept dressed, while the clean ones could be left open.

Additional observations of some basic problems that can be easily corrected:

- 1- Need for portable screens in these open wards to provide some privacy to the patients
- 2- Need to segregate infected patients from elective or non-infectious cases to prevent cross-contamination or nosocomial infections
- 3- Strict rules for utilization of antibiotics to prevent emergence of resistant strains of bacteria.
- 4- Strengthening of protocols – adoption of more modern standards in the operating room: Need for scrub nurses in the OR, need for instrument and needle counts, etc...
- 5- Need for control of the number of visitors to the hospital and the duration of the visits to reduce the crowding of the open wards.
- 6- Establishments of standards of care and protocol for dealing with emergencies
- 7- Providing water to the residents and interns who at times spend two weeks without a shower.
- 8- Better support of the residents by the attending staff – most of whom spend less than two hours/day working with the residents.

More costly improvements needed include:

- 1- Refurbishing the locals – the roof of the operating room is leaking and there are puddles of water in the hall ways. Mold is seen on the walls of the surgical ward.

- 2- Expanding the hospital bed capacity (Justinien is the reference hospital for the North, Northwest, Northeast and the repatriated citizens from Dominican Republic and Provinciales (Bahamas). Young pregnant women were lying on the ground next to the entrance of the Maternity ward.
- 3- Installation of functioning toilets for both patients and visitors.
- 4 - Survey and upgrade of the electric grid for the hospital, which now depends on a combination of individual generators and the city power plant, causing a lot of power surges, brown outs and still black outs. A large generator given by the US Southern Command was seen disemboweled in the yard of the hospital, with parts being extracted to be sent for repair. Hopefully...
- 5- Creation of a trauma/acute care unit with bare essentials such as Oxygen supply, adequate IV fluids and catheters, Pulse oxymeter, etc...
- 6- P.A (public announcement) system
- 7- Government/police/religious programs to reduce the level of violence in the regions: Gunshot wound, stab wounds, bludgeoning are daily occurrences that consumed a large portion of the already meager resources of the institution

The following comments come from our internal medicine colleagues:

- 1- There is a need for similar events in the future in view of the "learning hunger" from the residents.
- 2- For each trip, we should try to have people from medicine at least 2, pediatricians, surgeons, intensivists or anesthesiologists. A total of 5 to 6 physicians seem to be the right number
- 3- It is important that the physicians have prior teaching experience and be able to deliver at least part of the lectures in French or Creole
- 4- We should continue to provide basic lectures about physiology and patho-physiology
- 5- Classes about ACLS and preventive medicine should be given and universally accepted guidelines should be part of the curriculum
- 6- There should be a plan for a returning trip in the following 6 months of the same group of physicians, so that reinforcements of prior teachings can be done
- 7- Some technical procedures should also be taught, in function of each specialty- for example how to perform EKG, rectal examination, breast examination...
- 8- Need and importance of workup - although the specific tests might not be available in Haiti, but some of the residents will apply to USA or Canada and be familiar with some of these tools
- 9- The lectures about preoperative evaluation should probably also be given to the medical residents, since they should be the ones assessing the patients prior to surgery
- 10- We should establish a system via email or scanning where we could be available for advice about a specific patient, for reading a difficult EKG or integrating the values of some blood tests

On the positive side, this mission has allowed us to identify some partners that can prove to be helpful in the future. Dr. Manigat has initiated a rapport with AMERICARE, a philanthropic organization based in Connecticut that provided large amount of medications (antibiotics, anti-hypertensive, analgesics, anti-inflammatory, hypoglycemics etc...). This rapport needs to be maintained, as this resource may be tapped again in case of major natural disasters.

We also established contact with a Portsmouth, Maine based philanthropic group named "Konbit Sante." The executive director of the group is Nathan Nickerson who travels to Haiti every two

months. The group has been involved with Justinien Hopital for the past seven years. They have established a storage facility to collect all materials, medications and equipment coming from various donors. The inventory will soon be on-line and available to all interested parties. "Konbit Sante" has also the possibility of transporting heavy equipment from the US to Cap-Haitien and is in the midst of negotiating tax exemption with the government for these goods. They are open to cooperating with us in this regard.

Contact was established also with Genevieve Poitevien, MD, Dean of Uni-Q (Quisqueya University) who is very interested in working with us on future programs.

Above all, we have been touched by this bunch of young Haitians, full of enthusiasm, very intelligent and trying to make health care happen under the most difficult of circumstances. From their pocket money, they buy supplies and medications for the indigent patients. Pulling patients out the jaws of death with their bare hands, they create something out of nothing. For their patients, they are the images of God. For us, they are the symbol of this Haiti that lives the impossible, Haiti that should not exist anymore, but a Haiti that will one day, like the Phoenix rise up from its ashes, because of its youth, the youth like the one whose life we have shared for a week in Cap-Haitien. We may not be able to rebuild the Hospital, but by God, we have to go back there to continue to support these courageous young women and young men and help them achieve all their potentials.

Once again, we would like to express our gratitude to Drs. Guerline Roney, Dr. Jean-Lenic Joseph, Dr. Marlyse Dominique, Dr. Gabriel Timothee, Mr. Gerogemain Prophete, without whose assistance this mission would not have been possible. Thanks are also in order for Dr. Ronald Sanon who donated an EKG machine, stethoscopes and blood pressure cuffs as well as Dr. Bellamy who supplied us with boxes full of medications, eye drops etc... We thank Jennifer Zellinger of Astra-Zeneca for donating an LCD projector and samples of Arimidex. We thank Debra Jones of Covidien for all the prosthetic meshes and the stapling devices. We thank also Novartis for a large supply of medications. Thanks also should go to AMERICARE for all the medications. Finally our gratitude is immense toward the members of the chapter who contributed to the purchase of a brand new state of the art 3-channel EKG machine that was given to the Medical service and to the members of this first mission. Drs. Dufresne, Manigat, Thelusmond and Westerband who during the week of Thanksgiving and the week of Dr Dufresne's birthday, left their practices and families to take care of their Haitian brothers and sisters.