THE 2004 ABA PRESIDENTIAL ADDRESS

It Ain’t Over ‘til It’s Over

Lynn D. Solem, MD

“‘It ain’t over ’til it’s over’ Yogi Berra proclaimed in 1973 when the baseball team he was managing, the New York Mets, was nine games out of first place. Fans may remember that the Mets defied the odds and captured the pennant by defeating the Cincinnati Reds in the Championship Series. They eventually lost the World Series in seven games. “It ain’t over ‘til it’s over” can apply to many things. Although more commonly used during sporting events, it also rings true for the burn survivor’s struggle for reintegration into society. More accurately, for the survivor, it’s unlikely it’s over. For the Burn Team, when is it over?

In his Presidential address to the International Society for Burn Injuries (August, 2002, Seattle, Washington), Dr. Heimbach asked, “Where have we been? Where can we go?” He challenged the world’s developing countries to adopt modern burn care. He pointed out the fact that burn injuries and burn fatalities in developing countries are a major cause of death and disability. Burn injuries and mortality rates, such as those experienced in developing countries, would not be tolerated in the United States or Canada. Modern burn care, including early excision and grafting, are almost unheard of in most developing countries. As Dr. Heimbach delineated, and subsequently discounted, there are a lot of arguments against adopting modern burn care in a developing country.

The following statistics are taken from the World Health Organization Web site: 1) 29 countries have a life expectancy of less than 50 years; 2) more than one-fourth of the world’s countries have a life expectancy of less than 60 years; 3) Sierra Leone has the shortest life expectancy, 34 years (34 years is probably younger than the mean age of this audience!); 4) life expectancies in the United States, Canada, and Japan are 77, 80, and 82 years, respectively.

More than half of the countries in the world spend less than $100 US per capita annually on healthcare. Compare this with Canada, where spending is more than $2,000 per capita. The United States leads the world in this arena, expending nearly $5,000 per capita annually on health care. Our healthcare per capita spending is more than 50 times the expenditures of half the countries of the world!

We, the Burn Teams of the United States and Canada, have “done it all.” We can treat the majority of burns with relative ease; our burn surgeons can skillfully excise and graft burns of any body area in any age patient; our nurses can dress even the most difficult anatomic sites, and make the dressings stay in place; our burn therapists and social support staff can harangue even the most obstreperous patient into completing rehabilitation. So, what is the next challenge?

Dr. Heimbach drew up a blueprint for bringing developing countries into an era of modern burn care. ‘They cannot do it by themselves; the burn surgeons, nurses, therapists and support staff in these developing countries need teachers and mentors. You, members of the Burn Teams of the United States and Canada, can be the teachers and mentors. As an individual, consider doing what others have done: sharing your knowledge with others who are less fortunate and teaching them to provide modern burn and wound care.

There are several areas to address before you jet off to another country to provide assistance in burn education.

First, consider whether you wish to collaborate with a religious organization. Much of medical outreach is sponsored by and coordinated by religious organizations. Although these groups can greatly assist you in your efforts, the religious overtones can be fairly intrusive. Their requirements for involvement may conflict with your ethics, and it is best to identify what is required of you before jumping on board.

Second, to have the Internal Revenue Service consider your expenses as tax-deductible contributions, the organization with which you affiliate must be nonprofit (and in the majority of circumstances, incorporated in the United States).

Third, the ability to speak the native language is a genuine benefit. Whenever you use an interpreter, you miss a portion of the verbal interaction. This can be critical in the context of medical care. On the other hand, one should never be dissuaded from medical outreach based on language barriers.

Fourth, you need to decide whether you are going as one or two individuals or as a team. There are pros and cons to either choice. Going as an individual requires less planning and coordination; however, a whole burn team provides for more complete education of the participants at the distant site. You also need to determine the desired skills your team will possess. Regardless of your skill set, there is a need for all disciplines.

Fifth, preplanning with a thorough understanding of the facilities and equipment available at the distant site will make your trip more successful. Be prepared to hand carry necessary equipment. Shipping equipment may be unreli-
able, and you may experience difficulty getting it cleared through customs. Your sponsoring organization can be very helpful in facilitating your passage through both customs and immigration.

Sixth, consider whether your medical outreach will be a one-time event or ongoing, recurring support. It frequently takes time for the medical team at the distant site to become comfortable with visitors. Repetitive visits with frequent reinforcement will be more fruitful than a single visit. The length of the mission will also influence its success. A short-term “guerrilla attack,” in which one rushes in and operates on as many patients as possible in as short a time as possible, will benefit a selected number of patients; however, it will do little for the education of your counterpart in the distant site. A longer term commitment, in which you work side by side with your peers will not only help the immediate patients, but will also educate the caregivers at the distant site so they can help future patients. In my opinion, long-term commitments of at least 2 weeks duration are better. When this is combined with follow-up visits, the accomplishments can be dramatic.

Last, the world is large and the number of countries, districts, and options are endless. The area you choose to serve is truly a personal decision.

My experience in international medical outreach is limited to two sites: Hanoi, Vietnam (10 days) and Belmopan, Belize (2 months). Many of you have much more extensive experience. From these trips, I learned to adapt to many conditions, from housing facilities to operating environments. It may take some time to adjust to the standard of living in the country you are visiting. For example, power outages may occur with regularity, but without predictability. When this happens, there rarely is a back-up generator or emergency lighting.

You may be surprised and impressed at how patients and their families cope with the state of health care in their country. In some areas, not only are hospital rooms shared, but often a hospital bed is occupied by more than one patient! It is not uncommon for patients to be unable to afford medications and they must go without.

You will be asked to see many patients that are outside of your area of expertise. Since you deal with burns and skin, you will be asked to evaluate many skin conditions (e.g., scabies, rashes). As a “skin” specialist, you will often see other wound problems. It is beneficial to have some wound experience, including venous stasis ulcers and diabetic wounds. Be warned: you will be considered the omniscient expert from America and will be asked to evaluate everything from eye problems to developmental disorders.

It may help to have an affiliation with a medical school or a teaching hospital. Many American medical schools have international medical experiences as an optional part of their curriculum. It is fairly easy to find medical students and residents who are seeking experience in international health care.

In addition to providing medical care and education, you will have the opportunity to explore, both physically and culturally, the country you are visiting. Every country has a beauty of its own: breathtaking landscapes, historic regions, and exotic foods. Take time to thoroughly enjoy the experience.

There are a few lessons to be learned.
1) Adjust to the pace; many cultures function at a slower pace than we do. Relax and go with the flow. Operating room starting times are only suggestions. Mañana is the rule.
2) Remember you are there to teach. William Mayo once said, “Since the object of travel is primarily self-improvement, time should not be wasted looking for things done badly and for things to criticize.” Positive reinforcement will foster change; criticism will breed resentment.
3) To influence the practice of burn care, you must actively involve the caregivers at the distant site. They cannot learn by merely observing. Dr. Whipple stated, “Actual operative skill cannot be gained by observation any more than skill in playing the violin can be had by hearing and seeing a virtuoso performing on that instrument.”
4) As a burn surgeon, our starter kit is quite simple: a Goulian knife, a hand mesher, a dermatome (preferably electric powered), and a simple, cheap mechanism to secure your skin grafts. Therapists will need to develop inexpensive splinting materials, usually materials that are available at the distant site. Other disciplines will need to develop locally available resources.

Assuming you all now have an interest in international medicine, how does one get started? I propose that the American Burn Association develop an ongoing relationship with a nondenominational international healthcare organization. There are many members of the American Burn Association who may be available to give you advice, in many cases better advice than I have given.

1. Dr. Mani Mani has had extensive involvement in international medical outreach and education. He has written a primer for providing burn care and rehabilitation in developing countries. He kindly allowed me to extensively plagiarize his book and take it to Hanoi. In the near future, we will be working on a Chinese translation of the book.
2. My friend, Dr. Nunez, is a knowledgeable surgeon and a member of the American Burn Association who works in the Dominican Republic. He faces the challenges of burn care in a developing country on a daily basis.
3. Dr. Piccolo, a member of the Brazil Burn Association and the 2002 Evans Lecturer, is a good friend of our organization and has agreed to advise us. He has found a way to provide inexpensive burn care in a developing country. We need to learn from his experiences and share them with others.
4. I am asking Dr. Latenser to head up a Special Interest Group on Medical Outreach. This group will be a forum for the open exchange of information regarding participation in medical outreach.
5. Dr. Gamelli has appointed an Ad Hoc Committee for International Medical Outreach.

It is my hope that we will have mechanisms in place to support your international medical outreach available for you next year in Chicago. You may ask, “What is the reward?” The reward is in your heart and in the hereafter. Besides, if you languish and become torpid, only the vultures will be waiting for you. Remember, “It Ain’t Over ‘til It’s Over.”