**Episode 6: Creating sustainable global partnerships.**

**Guests: Dr. James Netterville & Dr. Wayne Koch**

**Question:**  Dr. Netterville and Koch have been role models in sustainability over decades. What was your thought process when first deciding to go abroad and how did you create a sustainable environment?

**Dr. Netterville**

* None of us had a plan from the beginning, we take advantage of opportunities as they come up. We were both raised in environments of service.
* Serendipity in reconnecting with a Dr. Farrah, a lecturer from college 20 years prior who recommended participating in a surgical trip to Africa.
	+ In 2 weeks: operated on 100 head and neck tumors in two weeks, helped these 100 families and now we’re leaving…yes we’ve helped them, but what have we left behind? How can I make this, a point-of-care situation, into a sustainable program?

**Dr. Weidermann**

* In global surgery, the paths aren’t always illuminated for you. Often a door will open suddenly and it’s best to just walk through it and see what’s on the other side.

**Dr. Koch**

* I was raised in a faith based community in which medical mission work has been going on for over 100 years. As a child I’d read biographies of these mission workers who’d go into the far East and live there forever.
* The **Christian Medical and Dental Association (CDMA)** had a short-term medical mission program–my first trip was to Ecuador as chief resident at Tufts, and didn’t participate in global surgery work for another 15 years.
	+ As far as sustainability, having people on the ground sponsoring that program provides continuity, but there’s still that same lingering feeling of going to do cases, leaving, and wondering what happens after we have left.
* The book *When Helping Hurts* examines how well-intentioned individuals from developed countries can inadvertently disrupt more vulnerable populations—this reflects some experiences within short term trips.
* Joined **Pan African Academy of Christian Surgeons (PAACS)** which starts residency programs in Africa, mostly led by missionary physicians who start African residency programs and combats problems created by short term mission work.

**Question:** When we look at global surgery it’s a pyramid. At the bottom of this pyramid are short term trips. Higher in the pyramid, there are fewer people involved. The top of the pyramid is policy makers in WHO, etc. I see what you and Jim do as being towards the tip of this pyramid–so few do it–creating long term sustainable academic programs. What are some examples of shortcomings in shorter term programs?

**Dr. Netterville**

* Most physicians have big hearts, and want to make a difference. When opportunity arises to go to the developing world, most don’t have deep roots but are well intentioned. We’re attracted to go into that setting when the opportunity arises. Some of these trips don’t have preplanning or postplanning. This is where immature efforts made by well-intentioned people get criticized.

# *Seven Sins of Humanitarian Medicine*

**Dr. Koch**

* There’s a book called *When Healthcare Hurts.* One issue is the potential for socioeconomic disruption–if you charge nothing for care, this may hurt local doctors, and can also interrupt confidence in local physicians as well as the expectation that care needs to be paid for.
	+ For example, **MBingo Cameroon Baptist Convention** runs all administrative aspects, sets prices, and pays nurses/staff even though they don’t pay US physicians. You need to understand economics, otherwise you can undermine the care of local trusted physicians.
* Sustainability of equipment/supplies-We do it in a way that local vendors can have business models that work for them. We don’t bring everything in ourselves.
* With regards to sustainable research- We need to be careful to give others–especially those whose home we’re visiting–precedence regarding who the author is, what research is done, how it’s done, etc. Give precedence to locals, and try to understand the culture that informs the endeavors we undertake together.

**Question:** can you give a broad definition of what sustainability entails in global surgery?

**Dr. Koch:**

* Sustainable means a **self-reproducing** group effort, self sufficient, and affordable.
	+ For example, in PAACS, almost ½ the faculty are now Africans who graduated from the program, staying on as faculty at the places where they trained.
* There is also the issue of **local authorization**- Africa is changing, quality of healthcare is improving, and countries like Kenya are appropriately increasing their scrutiny as to what we’re doing surgically as outsiders.
	+ In Cameroon, we work through the **Baptist Health Institute** which is recognized by the Cameroonian government.

**Dr. Netterville**

* In Otolaryngology, we pour 5-6 years of teaching into trainees so that they can go out independently and do a great job. But education is forever.
	+ With work in LMIC’s the goals is to achieve self-sufficiency-carrying on the education and transfer of skills. Helping them have appropriate facilities, and working within their setting so that the care delivered is affordable.

**Question:** Education is one of the major foundations for sustainability. Dr. Koch and Dr. Netterville have co-authored *a paper about subspecialty training in Africa* (1). What is the landscape of head and neck care in Africa?

**Dr. Koch**

* That paper was with the help of a wonderful colleague Dr. Johannes Fagan, who has trained 12-13 African head and neck surgeons in a 1 year fellowship set Cape Town, all of whom have returned to their respective home countries and serve as academic leaders.
* The fellowship program in Camerron has also trained fellows who are now in Kenya, Ethiopia, and Madagascar among other countries.
* These fellowships have helped to spread expertise around the continent and the graduated fellows reproduce these efforts in their home countries.

**Question**: Dr. Netterville, do you feel like there’s a particular benefit to training African surgeons locally rather than bringing them back to the States?

**Dr. Netterville**

* Dr. Koch and I participate in the African caucus at the **American Academy of Otolaryngology-Head and Neck Surgery** meeting.
	+ At one of the meetings an African surgeon stated, “when you want to train us as Africans, don’t come to our country and operate without me. Don’t bring me to the US and show me fancy equipment that we cannot access. Come to my hospital, operate with me on my patients, and show me how to do a better job.”
	+ This led to performing a “needs assessment” in Nigeria and Kenya.
		- Doing needs assessments is crucial. (how can we help you? What do you need re skills/education/equipment?)
		- Unsuccessful in working with surgeons at the large national hospital in Kenya due to the limited number of ORs for high volume. An alternative was to bring the surgeons and their patients to a smaller hospital with greater OR availability
		- Training in their setting is very important but it’s also important to host surgeons from LMIC’s at our institutions. However, the vast majority should be done in their home country with their own patients.
			* It provides exposure to how a tertiary care level in the US functions which may spur ideas on how their systems may be improved or they may identify practices/workflows that are transferable .

**Dr. Koch**

* I echo Dr. Netterville’s statements. You need to ask yourself what resources are available in the place you are traveling?
	+ For example, robotic surgery likely won’t come to Africa soon. Free flaps can be technically trained in Africa but it’s probably not a sustainable business model there yet.
* Brain drain is also a big problem in Africa. There are good medical schools, and smart people– the financial allure of working abroad can be strong.
* The pay that African doctors get in Africa is worlds different than what the same person could make if they went to Europe, US, etc.
* PAACS and Johan look for people who are philosophically committed to giving back to their home nation. That’s an important aspect of how we plan our training. We partner with people who already have that vision.

**Question:** With respect to summing up everything, both of you mentioned that we’re not really sure if the old model of short term surgical trips were doing anything positive…what have you done with your work globally to know that you’re actually helping? Have you been able to objectively measure?

**Dr. Netterville**

* The best place to start is to find an area or group that has a need, work with that group, do a needs assessment to find out what educational needs they have, and what level of education already exists.
* Good hallmarks to strive for– are we delivering the same level of care as in the US? The burden is on us to get as close as possible. It would be tragic to go over and deliver substandard care. We look at patient outcomes using the same standard as in the US, following that data through both regional doctors and phone calls.
* We are looking at education too– what were the skill sets before and after a trip? Our group has changed thyroidectomy and how it’s performed in all of Kenya. We have 30 ENTs in Uganda that are now doing ear surgery at a high level that we have brought over ear surgeons to help in their training. This impacts a country of 30 million people.
* Over the long term, intermittent and ongoing educational programs can have a tremendous impact on subspecialty care and practice patterns in a country.

**Dr. Koch**

* Looking at outcomes is something we’ve only begun to do at Mbingo. (*Windon et al. 2021*)
	+ In Mbingo, we looked at all ENT procedures done there both when we are and aren’t there and categorized them.
	+ In Cameroon,we work with regional clinics/hospitals, have a network of follow up and continuity of care which provides a general sense of outcomes.

**Dr. Netterville**

* It is sad that medical students don’t have opportunities. Have worked at AAOHNS to try to create a database of resources because I can’t take every medical student in the country with us.
* People try to make it black and white, but all of our efforts have merit. Going independently is wonderful. Taking a large group to train and inspire is also phenomenal. All of this is good, we just have to work very hard to make sure that we are creating a better world for people in these countries.

**Dr. Koch**

* I came to global surgery later, a big barrier to entry is financial. I don’t know of a university in which business folks are fully happy that people are going and spending time/efforts without getting paid.
* I personally decrease my percent effort at my primary institution to sustain going to Africa 10-12 weeks per year. You can choose global surgery as an academic career and there is some philanthropy/grants available but it’s not an easy path, especially if financial constraints are part of your equation.

**Organizations**

**Academic Model Providing Access to Healthcare (AMPATH)**

<https://globalhealth.iu.edu/impact-map/ampath.html>

Pan-African Academy of Christian Surgeons (PAACS) at Mbingo Baptist Hospital.

<https://paacs.net/>

<https://paacs.net/what-we-do/training-sites.html>

**Humanitarian efforts and organizations database** [**https://www.entnet.org/get-involved/humanitarian-efforts/map/**](https://www.entnet.org/get-involved/humanitarian-efforts/map/)

**References**

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