

Letter to Editor: Rare Craniofacial Anomalies in Charity Missions

T Abulezz

Citation

T Abulezz. *Letter to Editor: Rare Craniofacial Anomalies in Charity Missions*. The Internet Journal of Plastic Surgery. 2013 Volume 10 Number 1.

Abstract

LETTER TO THE EDITOR

<http://ispub.com/IJPS/10/1/14520>

Sir,

I was honored to participate in this work with Dr Fadaak and Dr Jadulkarim. Although I am not agreeing completely with some procedures that were done, but I found his work and his honest description of the circumstances of the operation is very worthy and gives a good realistic idea about what is going on in missionary work. My participation in discussing the work and publishing it is to throw lights on what is happening in medical missions. In my place in Egypt, we received two missions in 2009 and in 2010 and although the Rotaplast. Missions we received were different than what Dr. Fadaak and Dr Jadulkarim were doing, still, in our missions; we experienced some drawbacks of missionary work.

Short-term medical missions (STMMs) provide a good chance for poor and difficult-to-reach patients. Thousands of physicians travel every year, to third-world countries, volunteering their time, knowledge and skills. They may be individually-organized groups; or within Non-Governmental Organizations such as Operation Smile, Orbis, and Médecins sans Frontières that have an ongoing presence in many countries. Volunteers may focus on direct patient care, medical education, public health promotion, or improvement of the health care infrastructure. Some missions are concerned with particular medical problems such as cleft children; others may have different specialists of various medical branches. Some groups are secular, whereas others are coordinated by religious organizations, and their work may include an element of proselytizing (4).

Missionary work in the third world countries has become

common practice; however, there is a lack of standardized objective evaluation tool to assess patient safety, quality control, and mission impact. STMMs are an important component of modern global healthcare and a rapidly growing sector that accounts for millions of dollars of public and private funds. This missionary work also deals with millions of needy people who cannot find the proper healthcare provided, however, they are often locally organized and privately funded without restrictions.

Most surgeons do not have previous international experience and lack an understanding of what is expected and what care they can provide. The unknown factors include case types, patient volume, postoperative care, and equipment. This can lead to disastrous results, such as 2 patient deaths after cleft-lip and palate repair, a result that would lead a malpractice suit in most Western countries (5). Several websites are describing the success and the achievements of these missions; however, little can be found about the complications that sometimes occur and are often left untreated. No one talks about his failures or his mistakes.

Many organizations have programs that rely solely on visiting volunteers to provide healthcare or other services. Due to high costs, schedule constraints and complicated logistics, these global health endeavors take the form of short-term medical missions, which may cause significant harm (4). In surgery, complications may be inevitable, but when they affect a poor patient in a developing country who is being treated by a volunteer physician, the situation can be politically as well as emotionally charged. Operation Smile volunteers have been accused by local surgeons of “dumping” their complications when their mission is over, though the organization refutes this charge (1). Some countries have regulations designed to encourage continuity of care when visiting providers go home. El Salvador, for

example, requires that visiting physicians be hosted by a local institution that can provide follow-up care. But many countries do not have the necessary infrastructure for monitoring volunteers or even for enforcing their own regulations (1).

Although many volunteering groups collaborate with one another and with host governments, there is no formal system for coordinating or evaluating the work of so many volunteers (6). However, most of these organizations conduct internal evaluations, and they tend to agree with experienced volunteers on some guidelines for effective overseas missions. It is best, they say, to send an advance team so that requirements such as lodging, an adequate electrical supply, clinic space, and surgical facilities can be anticipated. Many stress the importance of developing strong relationships with local physicians on the basis of respect for their skills, knowledge, and traditions and, whenever possible, using locally available medications.

Most of the participants in missionary work are well-qualified and well-trained persons. However, some other recently-graduated doctors and sometimes even medical students (3) are tempted to participate in these missions for several reasons; one of these reasons is tourism. Missions can provide low-cost trips and opportunities for vocational adventure for those people. Those junior doctors also gain some experience by working in conjunction with seniors and also they can have the opportunity to do surgeries that they are not allowed to do in their home countries. In spite of good intentions, international volunteer work that does not follow best practice principles can be wasteful, unethical, and harmful. In order to make a significant, high-impact difference, missionary programs must apply best practices and must be committed to spreading best practices and eliminating the worst practices that are prevalent in other organizations with volunteer abroad programs (2).

I congratulate Dr Fadaak for his honesty and his braveness in describing and sharing his experience. I also thank express my great appreciation to him for sending this article to me to participate in its editing and possible publication. Dr Fadaak and his colleagues have performed a vast number of cases over a 15-years period. However, I was surprised for the large number of cases (more than 140 in average for every mission) in the midst of poor equipment and availabilities. I could imagine the difficulties he has met when I read his statement that he “had to do his plastic surgeries on a regular wood table placed in a corridor in that small hospital”. This reminded me with what Dr Wolfberg said describing his

own experience in missionary work: “Each surgeon operates on as many as 15 children each day with the use of local hospital equipment augmented with supplies brought from home”.

In many underprivileged countries, like Yemen, the options for individuals who require specialist interventions in plastic and other surgeries are limited and an unacceptable large percentage of population in the rural areas has no access to any form of surgical aid (7). Some countries have mechanisms to send patients abroad, but for the majority there is no service, and the individual is left to suffer the consequences of life-long disability, social exclusion

Dr Fadaak’s cases are very interesting and most of them are quite rare anomaly that requires the participation of many surgical specialties. However, I may not agree with Dr. Fadaak’s decision to operate the 25-years patient with wide Tessier cleft no. 1-13 and frontal encephalocele by dissecting and mobilizing only the skin of the displaced nasal ala taking care not to touch the encephalocele sac. The patient has been with this same abnormal facial shape for 25 years and he could have waited for another 6-months period when another mission can be arranged in which a neurosurgeon would assist in excising the encephalocele. Dissection and mobilization of the skin carries the risk of injuring the encephalocele, especially with the evident lack of instruments and equipments. Furthermore subsequent scarring would make exposure and dissection of encephalocele more difficult and more hazardous to the patient. In case 2, Dr Fadaak operated a 7-years old boy with no 4 Tessier cleft in two stages with only two weeks interval which I think a very short interval to operate in the same anatomical region. He should have had some reasons that precluded the performance of the whole surgery in one session, however once the first stage was done, the child could wait for another mission after 6 months to complete the surgery. This would also avoid operating the child at the last day of Dr. Fadaak’s stay in that mission. One of the most beneficial guidelines is to follow a conservative approach in choosing patients and operations to apply what was stated by Dr. Migliori, “don’t operate the day before you leave” (1). In case 3, the surgery resulted in moderate benefits; maybe because of the lack of correction of the elongated midface skeleton. The patient is 15, he could better been imaged by CT or even plain X-ray for better evaluation and better surgical plan. Concerning soft tissue correction, I think the result would be much better if the incision was a zigzag rather than a straight line. The best

result was achieved in case 4, however, the nose will need secondary rhinoplasty and the nostril is already obstructed with evident telecanthus and displacement of the left eye which may induce diplopia. The clothes and the background of the child's photo including her mother indicate a high socioeconomic level that could enable the family to travel abroad for better chance or even to wait another mission by Dr. Fadaak where he can arrange for a team including a neurosurgeon, an ophthalmologist and a craniofacial surgeon.

I don't know the reason for the conchal cartilage graft vs. cranial bone for nasal dorsum augmentation as this was not the case of any of the authors' cases presented in this article.

The severe lack of diagnostic equipments and operative instruments and in some cases, the lack of surgical specialist

may undermine the great effort Dr Fadaak has done because these unsafe situations could have resulted in major complications to the patients and even make the procedures difficult and hazardous. However, I appreciate his point of view as he couldn't see any of his patients after operating them because of poverty and difficult transportation; a situation that made him decide not to postpone cases requiring neurosurgeons. In this situation the cooperation of local authorities and local medical teams are of utmost importance. I wish publishing of this article describing Dr. Fadaak's experiences in treating Yemeni patients should draw the attention of more humanitarian organizations and also the official WHO health organizations to those poor and needy patients who cannot afford the transportation charges rather than diagnostic and therapeutic surgeries' charges.

References

Author Information

Tarek Abulezz, MD

Plastic Surgery Department, Sohag University

Sohag, Egypt

t_abulezz@yahoo.com