



It's not what we bring. It's what we leave behind.

**SoH NY Presbyterian March 2006 Mission at PPHC
Debriefing Meeting (Verbatim)
Tuesday - May 2, 2006, 7:00-9:00pm
825 Eighth Ave., 35th Floor Conference Room**

Present:

Mission Team NY Presbyterian Hospital:

Kevin Charette (Perfusionist) Ellen Moquete (Cardiac Catheterization Nurse)
Dr. Jonathan Chen (Surgeon) Dr. Alejandro Torres (Catheterization Cardiologist)
Jillian Kirkpatrick (ICU Nurse) Dr. H. Michael Ushay (Pediatric Intensivist)
Dr. Stephanie Levasseur (Echocardiography Cardiologist)

SoH

Philippe Lerch
Victoria Baxa

Dr. Dominique Jan (Pediatric Surgeon)
Michel Longchamp - SoH Board member

PL - One of the major accomplishments of the SoH-NY Presbyterian March 2006 mission at PPHC is the successful operation of five children (complicated cases) of the Angkor Hospital which restored the image of the Center damaged two years ago by the accidental death of two Siem Reap children after their blood transfusions by the local medical staff.

On the folder cover containing the debriefing documents in front of you is a photo of one of the PPHC children operated during the mission which Dr. Chen e-mailed to Edwards Lifesciences through Laura Jackson. We want to have the photo framed and send it to Laura Jackson with our report, to acknowledge Edwards Lifesciences' first grant given to support SoH mission in December, 2005.

JC - Having returned to the same place and found intrinsic change, from my perspective, I consider the two new junior surgeons as the biggest change at PPHC. In addition to Socheat, now they have 3 operating surgeons. In comparison to last year, Socheat participated least this year. It seems he intended to have the two new surgeons gain more experience with our training mission except when he requested to scrub with me in one of the operations. These two young surgeons are extremely good and in some ways may have more potential to do general heart surgery in Cambodia maybe even more than Socheat does. Socheat's interest is definitely privileged more towards adult surgery. The two surgeons seem to have a target in mind and wanted to start operating on smaller children. I



truly believe that they are the future of PPHC on kids and are very dedicated in accomplishing the purpose of our mission to operate on children. They are dedicated and seem to have a better understanding of that having trained in France. Soheat, then could do more with the adult operations.

PL - Did you find any change in Soheat?

JC - He worked with us least this year so I could not give an evaluation of him.

From the overall standpoint, still the only big glaring absence at PPHC is a pediatric cardiologist. The Cambodians we have trained last year seemed to have retained the information and they have received and have been re-applying what was introduced to them last year. But still there is a big gap because there is no real person to screen the children with the echocardiogram and no appropriate person who could diagnose and triage the children. For me it's easy because we have two cardiologists with us. They must have a hard time since they did not have an echocardiogram. Conceptually, they retained a lot of what we did last year. But they truly need a cardiologist to be successful in operating on the children.



JK - I was very much impressed by the nurses & medical staff at the ICU. They are more proficient, have learned a lot since last year and have improved their English. However, everything is still very much protocol-driven. I still don't think they understand the difference between children with congenital heart diseases versus adult heart diseases. Overall, I noticed a great improvement and a lot of enthusiasm in what they do.

PL - You're right. I remembered Kleinman during last year's debriefing meeting saying that the main problem is communication and language barrier.

SL - The knowledge of French made the big difference for me because, Saran, one of the Cambodian medical staff conferred with me more readily and facilitated the process of preparing the children for catheterization, operations and other procedures. Saran was very pleasant as opposed to the communication breakdown between Natasha and me.

JC - I think Stephanie had the least identifiable coordinating person from the Cambodians. I had the surgeons, Mike had the ICU, Jillian had the nurses and Alejandro with that staff who eventually left for France. But there's no one person really like Stephanie or Charlie.

PL - Exactly, Charlie knows the same things, especially on Natasha. I think you handled the situation quite well Stephanie.

JC - Stephanie was being very modest. The whole success of the mission relies on the cardiologists. Some relies on the surgery, or the ICU, but the number one pathway in resolving this is at the OR and that is the decision partially, by and large, made by the cardiologists. And that's the big part that's missing. So Stephanie really did an amazing job of negotiating.

AL - In my perspective, in the future we need more interventional staff like Ellen or a nurse who could readily assist in catheterization lab work and also help the language barrier. We don't much staff assistance but a cath lab.

PL - Did they start fixing the angiograph room?

ALL - It's work in progress.

JC - Could you imagine going back separate from the surgical group as a separate team?

AL - You know there are certain procedures, not very risky, like diagnostic procedures that we could arrange like echo and cath going first.

PL - Were you working in Calmette or with Kry?

EM - We were at Calmette. I have to say they tried very hard to meet all of our basic needs. The nurses at the ICU and the person who scrubbed with Alejandro was fairly knowledgeable. The language barrier was present every now and then. The staff was very supportive, stayed late and adjusted to the situation readily, especially when they have to work on a holiday.

JC - It's certainly amazing they're very humble because they don't have a stake in doing that and Calmette is a totally different place, different administration, salary. It is very impressive that they just came over there and decided to allowed us to use their cath lab. They're terrific.

KC - I've been doing this for a long time in all the missions I've participated, but I've never seen such lack of participation. The staff concerned should have participated more and observed team effort when the perfusionist is there. They didn't quite see us as a team effort. The other staff at the pump, they worked very hard. The other guys didn't feel the same. So going back and forth in different rooms was very difficult. I would like to see them participate more and feel that they should set up the pump and get the next room started. In fact, without that participation, there will be a lot of work to do. And they could have

played that role. In fact, they just sat back and let the other guys work twice as much. It was a little bit frustrating at times watching them just standing there.

JC - Did they get the sense that where they to set things up or did they ever understand some of the nuances we were bringing to them?

KC - Well, remember last year? They still have the most expensive part of that equipment which were not used because the part that costs least was missing?

JC - Kevin was talking about last year when he introduced into the circuit a very important safety measure. It's a very simple measurement which was measuring the pressure in the tube in itself that can reflect very serious things that are going on in the operating field that we can appreciate if there is something wrong with the cannulae that we can't see that would be very dangerous if bypassed. Last year, Kevin had left these gauges that have measured pressure but you can't use them unless you have this ten-cent piece that connects the \$150 gauge to the tube. That's what's missing. It is a very small price to pay for a very important procedure. So Kevin applied a very sophisticated technique to this operation exactly done with the operations. You can use a piece of equipment that they have a lot which was sent from Europe and using this thing for hemofiltration, we ended up transfusing to only about 2 out of 12 children. We were able to do the rest of the operation without using blood. Compared to our stint last year, where the blood products, the actual blood itself, we were a little unsure as to whether they have been well screened and it seemed like it's a little bit old. Even this year the few times we did, in one of them, the actual blood that was used was clearly very old. It could have messed up all the primary procedures done. So, if there is a priority for future groups, is to try to avoid the use of blood products.

PL - There is one question about the equipment brought last year and apparently lost, the HP machine. Did you hear anything about that?

JC - The last thing I've heard of that last year was it went only as far as Paris.

EM - We never saw it.

PL - Because they've been used when Kleinman was there.

JC - No. Not on the pediatric group. We used an old one for the adult group which was already there.

PL - There were actually three of these machines.

EM - They never got to PPHC.

JC - It's too bad because it's not really of no use to anybody except for that group because it's made for this old machine that they have.

PL - Where should it be? With Natasha?

JC - I think it just never made it to Phnom Penh.

PL - No. I carry them myself.

JC - It's too sad. They're old and of no use. They can't even sell them.

SL - Actually, the probe that we don't use at the hospital, which are sitting in my office that I won't let anybody touch them for I want to make sure we are able to donate them. These need adaptors and with adaptors, it will probably work with the new ones.

JC - At NYPH uptown, we just changed from one system to the next and some of the probes we cannot use anymore and may be donated to SoH.

EM - I missed the anesthesiologist last year. We really need at least two anesthesiologists to take care of the children.

JC - I do think we should go back again with a Catheterization team that really needs a dedicated person to put the kids to sleep so they don't move around. Although Cambodian children are as well-behaved as they are, we still need someone to keep them still during cath procedure.

PL - We have to see what the ideal team is. After a couple of years, as you have said, the team should always be the same number? But after they gained experience, the idea is to transform their level of expertise.

JC - I think that day is well in the future when they will be totally comfortable with whoever surgeon they are with, whether they're doing anesthesia, or echocardiogram. I think for now, this is the minimum number of team necessary.

PL - The end of next month we're going to have a mission in Kabul in another hospital, brand new and getting better. The idea is to have local hospital with permanent staff that you're going to improve every time in order that the mission can complete and transfer their expertise. Deloche wants a very light mission you remember he talked to you about that. So very often he sends only one surgeon like when he sent Bernard Vasseur. With PPHC as it is like this, do you think it is something you could do by yourself or to go with a cardio-interventional team?



JC - It all depends on what your metric or goal is. How you measure things. If all they want is someone who could go there and do very easy cases which normally the local surgeons are doing when the missions are not there, then you could probably get away with that. But if



you are thinking more of complicated cases, which is what the mission is doing, then you need the understanding that the children are being taken care of by those expert in their field. Like the catheterization team would decide who are operable or not. There will come a point when you only need a surgeon and a cath person. But the problem is with all the advancement going on, each time expertise level is reached, what you do is just keep on raising the bar a little bit higher each time. So next year when we go back, Mike

doesn't have to sit with the ICU guys and instruct them again the basics. Their conversation will be more sophisticated than last year. All he would say is, "Remember how last year we talked about this"? It's a little bit like going through high school; when you're in junior high, you don't have to talk about the grammar you learned during freshman year. Oftentimes, we are just told to read the book ourselves. It's great then when we get to college, there'll be much more complicated discussion of things we've learned. I think that's a little bit what I imagine the place where PPHC should go. They should keep on trying to push that bar of learning higher. The two new junior surgeons, their goal is that they want to operate on smaller children. They think that there is certain arbitrary cut-off weight going on right now that kids weighing under 10 kilos, they don't operate on them. And that's excluding a good portion of kids in Cambodia to do that. But the only way you can get to that lower rate of weight is through the Cath lab. Those guys (catheterization team) have to be very good to do that. And I have a very superficial understanding of what they do. I have an appreciation that things are going well in their special fields but the actual specifics of what they do and nuances, they alone very well understand. It's a mistake to expect them to barely make the grade. We want them to be very competent in what they do. It's a 15-year endeavor to really see a substantial beneficial result of their training.

DJ - I agree with Jonathan. I think I know Alan Deloche for more than 20 years. He's not doing surgeries now nor in the field now. That means if we want to reach an academic level in Phnom Penh, we have to do complicated cases. The big error they did 15 years ago was to do easy cases. If our goal is to reach an academic level, we have to put together an ideal team: we need two anesthesiologists who are totally educated to share their knowledge. Most of the times you have to be there 24/7. You have to be there at the beginning and end of the procedure. I



think we have to move a little bit forward. I would like to compare what Dr. Yacoub did in Mozambique with a team of 20. In surgery, if your anesthetist is not good, even if you are the best surgeon in the world, your patient could die. I've seen that in many situations.

JC - It definitely falls into the "penny wise, pound foolish category". For example this year getting the Edwards support grant is very important and we think about what the actual funds we need to bring one extra person. For example this year, Johanna Schwarzenberger, most of her plane ticket was covered by the other humanitarian trip she attended. Since she's coming from another trip, SoH just paid for that small fare & hotel cost. Relatively speaking, that's a small amount of money and we are able to get more donations or grant from places like that, we should worry less about the money and more about the concept.

PL - I think like that in Kabul hospital, it has to be very well-organized to have a successful mission.

DJ - I will never do a complicated case without an anesthesiologist.

SL - PPHC is not really close to being able to have a capability to do complicated cases. Just from their diagnostic level, they have a pediatrician taking care of the kids who has a limited knowledge of cardiology. They need someone who is willing to learn to do this and to care for the kids and prepare them for surgery.

ML - Do the Cambodians recognize their limitations?

MU - There are some serious knowledge gaps. Jillian and I know that. For instance, like the nurses at the ICU are very good technically in trying to do the things very well. They take chest x-rays, they extubate, they set things up in an emergency. But they don't process well. They don't do very well at realizing there is a problem. Then very similar with the doctors, they primarily have very limited knowledge of congenital heart diseases. They



understand how the heart works, how to get blood pressure, air waves, but their knowledge of what is actually going on in the OR is at a very low level. But in the same way, they have skill set but not necessarily knowledge set. That has to grow in the knowledge of cardiology. They cannot pinch hit or substitute for cardiology issues of what a patient has. They want to learn more but the reality is that their schedule does not permit a lot of education time. It's like working American residence now. They're in and out of the hospitals according to work load that limits how much education time they are allowed.

One example is when one kid got very, very sick. Once they were told what do, they carry things out exquisitely and quickly. But it took them 10 hours before they let anyone know there's a problem. Even when they know there's a problem, there was a little bit of a paralysis there showing a gap of knowledge. Another area we found when we sense a serious problem particularly when a team like our just comes, it gets busier and busier. I think what happened this year was that cases got a bit more complex and we had to send kids out of the intensive care unit who were still not quite perfect yet. But where they went to after they left the intensive care unit, it's unclear who is guiding them and it's unclear to Stephanie, Alejandro or me who is responsible for their care. Several days we went to the post op and to the regular wards and we basically had to draw the attention of adult cardiologists to the child who was still having a problems. There are some links in the chain that have to be put together yet.



PL - It's a matter of time; there is something in Europe which is quite different like a humanitarian quota day in the working system and they can benefit from that for the administration of the hospital.

DJ - I think what Mike's said is very, very strong. I think Deloche has to be totally aware of what's going on. What I understand is there's a lack of responsible people in the Recovery Room. You don't know who is in charged of the patients when there is a problem. That's very important

because the care of the patients is not only in the ward but also in Recovery Room. This has to be totally reviewed. The team of the mission in charged maybe needs more people to have time to give training or education. And this is part of the organization's goal to provide education. And I could understand that if you worked a lot maybe 12 or 14 hours a day, there's not much time to provide training due to time limitation. Education is truly very essential. Less complicated cases should be done locally and the more complicated ones, perhaps should be done by the mission. And I think that's what we have to in cardiothoracic surgery.

JC - Further, maybe Bernard was the one who's always been very firm in this. The actual number of cases that we did is immaterial. We don't have to do two or three cases day after day. This means we could do one complicated case but more people get educated in the process, then that's what we should be doing.

Kabul will be different from PPHC as managed by Aga Khan with children from Afghanistan and Karachi, Pakistan with American style of organization. In fact, almost the same as NYPH; everybody's in charge of a specific job and every child has a primary care or physician in charge of the care of the patients. It's American system that works very well.

MU - The doctors who go there are primarily for emergency room, anesthesia and intensive care. I have a feeling that outside the US, those 3 specialties are usually merged into one specialty. They are sophisticated about their knowledge of shock in airway management, quite good actually. But then when there's a question about what a ventricular sub-defect was, the question was very, very vague. So their knowledge was much more attuned to running an adult intensive care, which they do. This is one of their greatest love. Things that support how well that unit functions there. That it is a busy hospital when we are not there, predominantly adults. But in a week that we did 12 cases, they did 7-8 adult cases that same day and would have done more except the beds were occupied by our patients. So they were quite busy.

DJ - Do you think that someone should be there who are more interested in pediatric cardiology and come from one year or six months; two or three people in echo, intensive care, and catheterization? Some people need to be trained in pediatrics.

JC - It's funny thing that when the children leave the ICU, like for example those two children who were the beneficiaries, just kind of wandering around. That serendipity in many ways will be solved by a good pediatric cardiologist, somebody who would take ownership of these children and follow-up on them who has a basic knowledge.

EM - They really need at least one pediatric cardiologist based at PPHC.

PL - Deloche tried as a matter of cost, like one year cardiologist. That's one discussion I had with AGA and he said that field maybe I could help you and perhaps I could sponsor an interventional cardiologist for one year.

JD - I don't know if it's necessary that this is something we have to worry. We almost can not imagine taking someone from Europe and putting him there. It has to be a Cambodian.



DJ - In Kabul I don't think we can have that. It's not the same level of medicine. That's why I think in PPHC, the most important thing is to receive education from the mission.

PL - I can tell you after the first heart operation in Kabul, I heard the comments of the team coming back. Deloche was there. They said the team was too short. That's why I thought about you, Jonathan. I said next time Jonathan will be in Kabul.

DJ - Alain Deloche always say the same. When I went to Africa to do some specific cases, when one patient almost die, with one anesthetist, 3 nurses in ICU, pharmacist almost 24/7 for 10 days with only our team. The anesthetist went over to the hospital in the middle of the night. Sharing education is very important.

JC - I think Ellen and Kevin have most experience than all of us in other trips with team of varying size.

EM - Just to give you an example, I once participated in a mission with a group 75 people with 20 cath team?

DJ - What do you think is an ideal # of team?

JC - Ten, probably. Pediatric cardiologists are the base of the program.

EM - Local group should also help identify what they need.

KC - No connection with the patients; engender the hope and passion; to take advantage of the mission team.

PL - Do we still have enough time for the report on the Edward Lifesciences and AGA?

JC - I think we'll just have to discuss that in another time.

The meeting adjourned at 9:00pm.