

As seen in...



On a Mission

DUKE RALEIGH HOSPITAL STAFF IS CHANGING LIVES IN RALEIGH AND AROUND THE WORLD

BY PAGE LEGGETT

Doctors and nurses are in the business of saving lives. What seems extraordinary to the rest of us is all in a day's work for them.

But, the life-saving mission work some of the medical staff at Duke Raleigh is involved in can take even them by surprise.

Take Pam Borden, for instance. She's a nurse in the neurosurgery department at Duke Raleigh. She's accompanied Dr. Michael Haglund and other medical professionals to Uganda three times. (At press time, she was preparing for her fourth mission trip – this time to Rwanda.)

GOING ABOVE AND BEYOND

As part of the Duke Neurosurgery Training Team, Borden was in Uganda to train other neurosurgical nurses. But, having been an OB nurse, she noticed what she termed a "dire need" at the Ugandan hospital for neonatal resuscitation training.

She mentioned her concern to an obstetrician at Mulago Hospital, and together they prepared and submitted a proposal to mandate neonatal resuscitation. Because of their efforts, a new training course was born. So, a nurse whose original mission was training other nurses involved in cranial and spinal cord surgeries

ends up helping save newborn lives.

Borden is quick to share credit. "This is a total team effort," she said. "I just helped set the wheels in motion."

Those wheels led to 102 Ugandan nurse-midwives being certified in neonatal resuscitation. And, that's just the first graduating class. The curriculum is firmly in place, and the course is ongoing.

"These nurses didn't know how to recognize when a newborn was in distress. They hadn't had the training," Borden said. "Now, they understand the basics. They know what to look for. And, they're able to begin the initial steps – to stimulate first breaths and keep the baby warm. Their early intervention is helping keep compromised newborns from requiring more intense resuscitative measures."

Borden also saw that the staff at Mulago Hospital was using the cuffs of their Latex gloves to tie newborns' umbilical cords. American hospitals use cord clamps – a product the Ugandan medical staff had never seen, said Borden. "Latex gets wet and slippery. Occasionally after a birth, the little rubber knot would slip off, and the baby would bleed out." After becoming aware of the issue, the Duke Raleigh staff collected and donated proper equipment to Mulago Hospital. The staff was elated to receive these life-saving supplies, Borden said.



The Duke Neurosurgery Training Team is building a lasting partnership with the staff at Mulago Hospital in Kampala, Uganda.

The doctors and nurses on these missions aren't just dropping in, operating and flying home. They are developing long-term relationships with the hospital staff. They are not just donating equipment (although that is part of their mission); they are teaching people how to safely use and properly maintain it.

"We come back repeatedly. We teach, and then we reinforce what we teach," said Borden. "It's a year-long effort just to get ready to go on one of these trips."

And, it's an effort supported by everyone at Duke Raleigh.

In some cases, the work is even led by someone at Duke Raleigh. Dr. Michael Haglund, professor of neurosurgery and neurobiology, is also the director of the Duke Neurosurgery Training Program. He has led teams ranging from 22 to 55 medical professionals to train the Ugandan neurosurgeons, anesthesiologists, nurses and biomedical engineers.

Over the last four years, Dr. Haglund's project has delivered more than \$5 million worth of new and used medical equipment and performed more than 130 neurosurgical procedures. This delivery of technology and training has *more than doubled* the surgical capacity at Mulago Hospital.

Before Dr. Haglund's involvement, there were five neurosurgeons available to treat 30 million Ugandans. His goal is to train Ugandan neurosurgeons in Uganda so that by 2020 there will be 14 neurosurgeons spread out across the country.

A BROAD DEFINITION OF "COMMUNITY"

"Community is one of our core values," said Paige Humble, director of marketing and communications at Duke Raleigh. "When we think of our community, we think about those we serve locally as well as the impact we can have around the world."

"Duke Raleigh encourages all team members to give back to their community," Humble continued. "We have employees and medical staff involved in community outreach in a variety of ways from donating their time to Urban Ministries locally to these examples of international mission work. [All these stories] illustrate how our medical team members use their talents and resources to have an impact on the health of communities around the world."

Dr. George Edwards, a hand surgeon, has been impacting the lives of people in Leon, Nicaragua for more than a decade. He's been on a mission trip to Nicaragua's second largest city each year since 2000. The missions began after Hurricane Mitch devastated an already impoverished country.

"Starting in 2003, Duke began sponsoring orthopaedic nurses and therapists to travel with our group," Edwards said. "They have become an indispensable part of our work as our volume of patients continues to increase each year."

Dr. Edwards began going to Nicaragua as part of Raleigh-based Co-operative Orthopedics between Nicaragua and America (COAN),



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a group that organizes three to four trips each year to the second poorest country – behind Haiti – in the western hemisphere. “Leon is a good base because of the opportunity to teach, a safe environment, good food and water and existence of a relatively large hospital.”

Just as with the mission work in Uganda, Dr. Edwards and the COAN team make training one of their primary jobs. “We have residents with us for every surgical case and on hospital rounds,” he said. “Although they save some of the more complicated cases for us, we make sure the residents participate and perform the more routine procedures.”

The doctors and nurses in these third-world countries have the same compassion as their American counterparts. But, they’re often hobbled by what they *don’t* have. Nurse Borden said of her experience in Uganda, “These people are working with almost no resources. A lot of their equipment is very antiquated and sometimes no longer functioning. But, they work with what they have.”

DISASTER RELIEF

Perhaps nowhere in the world are doctors and nurses making do with less than in Haiti. Even under normal conditions, Haitian medical care is shockingly inadequate. After the earthquake in January 2010, the situation was dire. Doctors and nurses didn’t have the luxury of planning for a year for this trip.

Dr. Don Edmondson, an anesthesiologist, said he and other Raleigh doctors were hearing reports of how desperate the situation was. “We heard estimates of 300,000 to 400,000 crush injuries,” he said. “There were stories of amputations being performed with hack saws and without anesthesia.”



Dr. Haglund and his colleagues performing surgery in Uganda.

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He and 12 area doctors, nurses and physical therapists put together a medical mission trip in a couple of weeks' time.

The stories they heard didn't prepare them for what they saw. "We worked out of a small hospital north of Port-au-Prince in a little village called Milot. It was outside the damage area," Dr. Edmondson said. "There were between 400 and 450 trauma victims in a 70-bed hospital. We performed more than 100 operations in a single week. That hospital normally does about 1,000 a year."

That Milot hospital has just two operating rooms. Dr. Edmondson's group converted three exam rooms into makeshift ORs to meet the demand.

"This was the worst orthopaedic disaster in the history of medicine," he said. "Port-au-Prince is built mostly from cinderblocks. It's very hilly, and there are no building codes. Homes weren't built to withstand an earthquake. When it hit, it was as if a blender of cinderblocks landed on people. More than 250,000 people didn't survive."

But the scale of the relief effort matched the scale of the disaster. It was a multinational effort with the military of a number of different countries involved. Bonding with the other medical staff was nearly inevitable.

"Everyone slept outside under mosquito nets," said Dr. Edmondson. "There was a small kitchen in the mission compound. We'd come back from a day of performing surgeries, and the villagers would have set up pots, built fires and have a huge vat of Cajun rice waiting for us."

"One of the most moving things about this for me was seeing how well the local people took care of us and the trauma patients," he said.

Taking care of one another is a necessity in a country as poor as Haiti. "Nursing is a very understaffed profession in Haiti," Dr. Edmondson explains. "When you're in the hospital there, it's expected that your family will provide basic care. They'll bathe you, feed you and empty bed pans."

But after the earthquake, many trauma victims were left without any family. And, the people being treated in Milot were from Port-au-Prince – a six- or seven-hour trip by car. The Milot villagers became their family. "They bathed and clothed these strangers," Dr. Edmondson said. "Some local mothers breast-fed orphaned babies."

The patients were being cared for in tents like those seen in the TV show *M*A*S*H*. Dr. Edmondson said the tents, housing 50 to 70 patients each, became their own small communities. They elected leaders who helped keep order in the midst of the chaos.

Dr. Edmondson feels such a bond with Haiti and its people that he returned this June. He said only about 50 patients – mostly paraplegics – remained at the hospital. "Haiti gets under your skin," he said. "I'll definitely go back again."

A CULTURAL EXCHANGE

Obviously, these missions are about more than medicine. They turn into cultural missions, too.

The medical staff spends time outside the hospital. Borden says she and the team will visit orphanages and bring gifts they've collected for the children or made during the year. "We reach way into the community, far from the hospital campus," she said.

But, some of the work that goes on inside the hospital has a cultural component, too. Borden reports, "Nurses in Uganda don't do assessments on the same level as we do in the U.S. They don't have stethoscopes or reflex hammers. They're not taught to interpret data. We show them what our responsibilities are in the U.S. and help broaden their skills."

"We are changing the culture of the doctor/nurse relationship in Uganda," she continues. "Of course, it's up to their culture to ultimately define how that will work. But, we have seen the Ugandan doctors slowly learn to accept this cultural shift."

As Borden prepared for her latest mission trip – to a place she's never seen – she anticipated the friendships yet to be formed and the lessons she'd teach ... and learn. She was focused specifically on the training she'd be leading, but – perhaps recalling the neonatal resuscitation training that became a surprising P.S. to her neurosurgery mission – she said, "We're there to train their neurosurgery department. But, if we see they need something [beyond that], we may just find a way to make it happen." ♦

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