

Briefly

Raising the bar: Hand-hygiene compliance, and policies on dangerous abbreviations, heparin safety, narcotic safety, suicide prevention and pressure ulcer prevention have been added to Accreditation Canada's list of required organizational practices (www.accreditation-canada.ca) if hospitals, nursing homes and other health facilities are to obtain a stamp of approval from the national, nonprofit, independent organization.

FDA inspections: The United States Food and Drug Administration's monitoring of foreign drug manufacturing plants is lax and inadequate, the highly

respected US Government Accountability Office says in a report on the FDA's Foreign Drug Inspection Program (www.gao.gov/new.items/d081047.pdf). Even the basic database of registered foreign plants subject to inspection is suspect. It lists 3249 facilities, but nearly 6800 foreign plants export drugs to the US. On average, about 8% are inspected annually, so a plant can expect to be examined every 13 years, as compared to an average 2.7 years for domestic facilities, states the report.

China health reforms: Over 2 decades after dismantling its universal health care system, the government of China has unveiled a draft health-reform plan

(<http://en.ndrc.gov.cn/>) that proposes to reintroduce equitable, universal access to basic health services by 2010. Crafted in conjunction with 9 international agencies, including the World Health Organization, the plan also indicates that fixed prices will be set for all medical services. It's estimated that about 50% of all health spending in China is currently absorbed out-of-pocket, while 50% of household income is spent on health care. "The percentage of government's input in total health expenditure should be increased gradually so that the financial burden of individuals can be reduced," the draft plan stated. — Wayne Kondro, *CMAJ*

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DISPATCH FROM THE MEDICAL FRONT

Somali symbiosis, part 2:

what I did

As a surgeon, I realized I needed to get past my judgments of how things could be, and my horror at situations I saw, and get down to the business of offering medical and surgical care to those in need.

I was part of a *Médecins Sans Frontières* team that consisted of an anaesthetist, nurse/midwife, medical doctor, logistician and local field coordinator. We hired and trained 150 local staff as nurses, assistants, surgical and anaesthetic clinicians, guards, laboratory workers, pharmacy attendants, cleaners and sterile supplies technicians.

So really, "I" did nothing on my own.

I taught constantly while we performed emergency operations daily. We did caesarean sections on seizing moms, sometimes saving the mom, sometimes the baby, and less often both. We repaired tears in the birth canal, stopped bleeding when we could, and removed the uterus when we could not. We lost a mother and baby who had been in labour for 4 days before her uterus ruptured.

We operated almost every day on the effects of armed conflict. I removed body parts that were not viable — blast



Sara Barnhill

Surgeon John Barnhill and the operating theatre team.

injuries would often take part of an arm, foot, leg, fingers, etc. — with the goal of having a stump that was not infected in a live patient. We removed parts of eyes that were blown out. These were often in children running about town and refugee camps, or nomadic kids tending animals. I grafted skin on areas that had been burned, blown off or sloughed due to infection.

I taught what I knew to the nurses, operating staff and a surgical clinician (formerly an operating room nurse). This is truly what would last beyond our departure.

Much effort was spent trying to instill the belief we could do better and that some of the deaths and disabilities they were accustomed to seeing could be prevented.

We introduced standards, protocols and treatment algorithms that demonstrated in patient outcomes that we could indeed do better. With the instruments, supplies and medications at the *Médecins Sans Frontières* hospital we reliably improved outcomes. We taught and encouraged everyone to bring their illnesses to our attention sooner, as that would lead to improved results.

Encouraging cleaner hygiene standards in an attempt to decrease infectious diarrhea, dehydration and death was a priority. That public health teaching was often integrated with identifying and treating malnutrition.

We even treated non-emergencies when possible. We had normal deliveries, hernias and fractured arms from soccer matches. But, sadly, such treatments were in the minority. — Dr. John Barnhill, Beletweyne, Somalia

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CMAJ invites contributions to "Dispatches from the medical front," in which physicians and other health care providers offer eyewitness glimpses of medical frontiers, whether defined by location or intervention. Submissions, which must run a maximum 400 words, should be forwarded to: wayne.kondro@cma.ca