Benedict Cosimi, MD, members, and guests of the New England Surgical Society, I am deeply appreciative for your willingness to honor me with the Nathan Smith Distinguished Service Award. Nathan Smith’s devotion to surgical education and teaching are the hallmarks of his career, which span from 1762 to 1829 (Figure 1). He was involved with the birth of surgery as a specialty in New England. During his long career, he was a major force in the development of Dartmouth Medical School, Hanover, NH. This was followed by an appointment in the new Yale School of Medicine, New Haven, Conn. He further contributed to the establishment of the medical schools at Bowdoin College, Brunswick, Me, and the University of Vermont, Burlington.

In my presentation today, I want to offer you an overview of medicine in Haiti, the poorest nation in our hemisphere. I will also share the influences during my professional life that have led me down this path. The presence of modeling, mentorship, and a personal relationship with individuals with similar interests have provided the direction in my pursuit of medicine in developing countries. Many of the individuals that influenced this lifelong interest have been fortunate encounters at pivotal periods in my professional development.

For more than 35 years, I have assisted in providing medical services at the Albert Schweitzer Hospital, a 120-bed facility in the Artibonite Valley 90 miles from the Haitian capital of Port-au-Prince. It provides some of the most sophisticated medical care by Haitian standards. The facility was created by Larry Mellon, MD, and Gwen Mellon in 1956. Dr Mellon, from the Pittsburgh banking family, was a rancher in Arizona when he learned of the work of Albert Schweitzer, MD, at Lambarene in Africa. The Mellons visited Schweitzer and were so influenced by what they saw that they decided to sell their ranch and pursue a similar hospital in this hemisphere where the need was greatest. Dr Mellon began medical school at Tulane University, New Orleans, La, at age 37 years and Mrs Mellon enrolled in a laboratory technician’s program. The Haitian government allowed the Mellons to use the former Standard Fruit Company site to build their hospital and their home. The facility initially provided acute care but gradually expanded to include public health and community development. The latter programs created the greatest benefit for the population in the district through immunizations, improved water supply, and education to eradicate common diseases such as tetanus, typhoid fever, and diphtheria. They were also successful in decreasing the incidence of malnutrition among the very young. For many years, the Harvard School of Public Health, Boston, Mass, had full-time physicians and fellows providing the organizational structure for these programs.

I would like to briefly share the range of medical problems that we encounter at the hospital. Although I am a pediatric surgeon, I was prepared to work as a general surgeon when I returned to Haiti in 1978 following my fellowship training. As events unfolded, I was the only individual performing pediatric surgery in the country at that time and had referrals both within

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district and throughout the country, which fully occupied my time. I scheduled my first clinic day approximately 10 months in advance so that patients were collected throughout the year. This has continued to be the case unless political turmoil has interfered.

The following images represent the problems that we commonly deal with in Haiti (not shown). They represent the realities of their medical existence and those of all developing countries that cannot provide the basic economic needs of daily life. Unfortunately, I am not able to share all the photographs that were presented at the society’s meeting. I offered an overview of the hospital facilities and common medical-surgical diseases. I emphasized the lack of sophisticated technology, although we had basic laboratory and x-ray capabilities. Trauma, infectious disease, congenital anomalies, and malnutrition were common occurrences. Complex surgical procedures were carefully selected to avoid complications that could not be managed in this medical facility.

Since 1969, I have returned to the hospital for a 2-week period on an annual basis with only occasional interruptions. On many occasions, I have been accompanied by my wife Christine and our 4 children. For each of them, this has been a rewarding experience exposing them to a world beyond our home in Maine. In the early 1990s, I began to include surgical, pediatric, and radiology residents in our group, in addition to a nurse anesthetist and assorted physicians. They were provided with an initial introduction to medicine in developing countries. The experience emphasized a greater reliance on history taking and physical examination in a low technology environment with limited resources. It also raised questions about global health equity and the need for international collaboration. I am gratified that several of these individuals have gone on to pursue international medicine in both Africa and Asia, the most recent member participating in the tsunami recovery in Indochina.

I hope this brief review has heightened your awareness of some of the realities of international medicine, which are very different from our Western world. But it is equally important for me to share how I developed this interest and why it was possible to make it a reality. I do not come from a religious background and do not have missionaries as parents. Medicine in developing countries was not on my radar screen when I first started college. In fact, I began my college career at Princeton University, Princeton, NJ, as an electrical engineer. I dropped out of this program in 2 weeks after realizing that the subject matter and lack of human interaction was less than I wanted. I thought medicine might be a good choice and looked for confirmation. I arranged a meeting to discuss this option with the medical school advisor. He was an older gentleman in his late 70s who immediately asked me to place my hands out straight in front of me. At age 17, I did not have a tremor. This being the case, he suggested surgery as a career. Little did I know that this individual was Allen Whipple, MD, a retired Princeton alumnus who had been the Chairman of the Department of Surgery at Columbia Medical School, New York, NY, and well known for the surgical procedure that bears his name. This may have been a missed opportunity for mentorship.

My mentorship began as a fourth-year medical student at Columbia Medical School. Harold Brown, MD, the head of the Parasitology Department from 1943 until his retirement in 1970, passed on his enthusiasm and excitement to the students. He was affectionately known as “Stooly Brown” and demonstrated a great sense of humor as evidenced in his textbook of parasitology. He provided students with the opportunity to participate in a 2- to 3-month elective experience in medicine in developing countries such as Liberia, or in other countries in South America. Approximately 10% of our class participated in his program. I spent 2 months at the Firestone Plantation Hospital in Liberia in the spring of my senior year.

At the time I finished medical school, I did not think this experience would have long-term significance. I began my residency at the Yale-New Haven Hospital, New Haven, Conn, in 1967. As a planned rotation, all 3rd year residents rotated for a 3-month period at the hospital in Haiti in a program started in the mid-1960s when Frank Lepreau, MD, a board certified general and thoracic surgeon, became the medical director at the hospital where he remained from 1964 through 1973. I returned again to Haiti as a chief resident for 6 weeks and consequently spent almost 3 months of my 5 years in training in Haiti. Imagine the Residency Review Committee’s response if I tried to arrange this today for our surgical residents. This is also a world where reliance on computerized tomography, positron emission tomography, and endoscopic retrograde cholangiopancreatography are not possible, but where history taking, physical examination, and clinical experience are the mainstays of care.
Following the completion of my surgical training, I served a tour of duty in Vietnam. During that period in Saigon, in addition to my military obligations, I performed civilian surgery as part of the US aid program administered by Henry Bahnson, MD. This again provided me with the opportunity to work in a developing country devastated by war and a limited economy. I again saw many of the same illnesses common to Africa and Haiti.

This award today has a very special significance for me because Dr Lepreau received the same award in 1995. His accomplishments were far greater than mine because he provided a continuous commitment to medicine in a developing country for almost a decade, completely giving up his successful surgical practice in Fall River, Mass. He was truly a mentor although not necessarily the easiest person to get along with at times. He had very fixed ideas that you absolutely had to adhere to concerning dress code and professional behavior. However, you also experienced his enthusiasm and appreciated his willingness to have you as an equal member of a team. He made you independent in the operating room. If you needed his help to perform a Cesarean section or a hysterectomy, often extending above the umbilicus, which was challenging for a third-year resident, he was always available since he was frequently completing your history and physicals in the clinic. I remember Dr Lepreau telling me that I had a mastoidectomy to perform on an individual with a chronic infection. He had performed this operation several weeks before with the aid of a surgical atlas in the operating room outlining the procedure. He referred me to the same book and wished me the best of luck. I asked him if he had any pearls of wisdom to offer me. He said when you see the dura, stop.

The patient did well in spite of my lack of surgical training in this area.

I also occasionally contributed to Dr Lepreau’s education. He was an accomplished thoracic surgeon, having performed approximately 500 thoracotomies for pulmonary tuberculosis while in Haiti with limited facilities. His 60-day mortality was only 1.8%. In 1971, a 2-day-old term newborn came to the hospital from a nearby village with a tracheoesophageal fistula and esophageal atresia. I helped Dr Lepreau successfully repair this congenital anomaly without a ventilator or sophisticated postoperative care. We ventilated the patient by hand for the first 6 hours alternating a Haitian nurse every hour until the child was fully awake.

Dr Lepreau was always present. He loved his work and the people he cared for. This was, for him, a consuming passion and it was infectious if you were a young surgical trainee. In an article in the Rhode Island Medical Journal in 1991, he was asked why he chose this career option leaving behind a successful practice and lifestyle. He responded by saying, “For me, it was the opportunity to live an uncluttered life and to practice my craft where it would make a difference, unburdened by lawyers, insurance forms, committee meetings, and telephones.”

In my role as Maine Medical Center’s Surgical Residency Program Director, I am acutely aware of the challenges to provide a viable educational experience for our trainees who are governed by an 80-hour work week and a multitude of requirements created by our Surgical Residency Review Committee. Although the emphasis in surgical education is to go beyond process and develop 6 general competency areas, the means of providing this experience is confusing. How do we produce a surgeon who is knowledgeable, competent, compassionate, and understands the most effective means of providing medical care? It will never be totally provided by an algorithm. We are rapidly losing our mentors, who may differ in style, but provide a successful model for patient care and education. Daniel Tosteson, the Dean of the Harvard Medical School, wrote in 1979 in the New England Journal of Medicine that “It is my impression that the opportunities for developing meaningful fruitful relationships between students have decreased. One factor leading to this situation is the growing specialization of medical education. An expert appears briefly to present his knowledge and disappears rarely to be seen again by the students.” In his book, The Courage to Teach, Parker Palmer builds on the simple premise that “good teaching cannot be reduced to technique; good teaching comes from identity and integrity of the teacher.”

The New England Surgical Society should be proud of its accomplishments, not because I am receiving this award today, but rather because they have fostered and encouraged this teaching relationship from one generation to the next. I am fortunate to have had mentors at crucial stages in the development of my professional life. Frank Lepreau, by example, even at age 92 years, remains a model for my professional behavior. Albert Schweitzer’s reverence for life was fully developed and practiced by Dr Lepreau. In his recently published autobiography, Surgery and Beyond (Figure 2), he outlines the life of an individual who is both an excellent...
clinician and a teacher in the truest sense. I have attempted to emulate his enthusiasm and humanity in medicine and hope to pass this on to the next generation. Even though the world often seems tottering on destruction, I am reminded of a quote by Albert Schweitzer that “you are not able to change the World, but you are able to give hope to one human being.”

I have also been fortunate to practice pediatric surgery with an individual during most of my professional life who shares this concept of mentorship. Besides providing coverage during my trips to Haiti, Albert Dibbins, MD, our past-president, provided me with a model of both clinical and professional behavior similar to Dr Lepreau’s. I am indebted to him, as are our general surgical trainees, for his willingness to share his experience and also his philosophy of patient care. Surgical techniques will change but our ability to comfort and care for our patients will remain personal and not piecemeal. This was the hallmark of his practice and his 10-year tenure as the general surgery residency director at Maine Medical Center.

There are common threads in my experience in Africa, Vietnam, and Haiti. All of them have offered me, as they did Dr Lepreau, the opportunity for an “uncluttered life” in places where reliance on clinical skill and judgement supercede technology. They have offered me a window into places where the culture and management of medical problems are different from our own. The ultimate weaving of these threads is understanding that the most significant thing about international medicine is that it gives us an opportunity to be a better person—an opportunity to serve and to understand the world in a completely different way.

When you have the privilege to provide what may be a small service and receive in return the thanks of someone who has walked miles and sacrificed what little they have to give to receive your care, you are changed, and the world becomes a different place. When you see what some people must do to receive an education or obtain medical care—things that we take for granted—you are given a gift that allows you to step outside of yourself and see the world in a broader context. When you watch and receive the grace with which the mother of a child dying in your care thanks you because she knows that you tried to help and this was enough, it is through them that you become bigger and find your own humanity. It is this that draws you back again and again.

I hope I have fulfilled Dr Smith’s charge to the graduating Dartmouth Medical School class of 1806. In his words, “Improve, perfect, and perpetuate what has been so happily begun by the present generation . . . remember how greatly your preceptors have labored for you, and carry with you wherever you may go the determined resolution to be useful to yourselves, your country, and the world.”

I thank you for the honor of receiving this award.

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Previous Presentation: The unedited version of this acceptance speech for the Nathan Smith Distinguished Service Award was presented at the 86th Annual Meeting of the New England Surgical Society; October 2, 2005; Mount Washington Resort, Bretton Woods, NH.

REFERENCES