Words of the Editor in Chief:

**Motherless births through the artificial womb?**

An artificial womb is an apparatus that would allow a fetus to grow to term, outside of the maternal uterus. This artificial “uterus” should be able to bring to term the product of conception in permitting exchanges in oxygen and nutrients as well as removal of the waste between the fetus and the machine to which it is connected to. In 1924, J.B.S. Haldane called a pregnancy occurring in an artificial environment, from Fertilization to Birth: “Ectogenesis” and predicted that by the year 2074, this technique would be able to account for 70% of all human births.

Can you imagine walking into a hospital nursery full of pre-term babies with no incubators but bag of fluids with infants tucked securely inside? It may appear futuristic, but this looks like Medicine is venturing in a world that can easily remind us of Science Fiction.

In the Greek Mythology, Daedalus, a skillful craftsman and artist, father of Icarus, the uncle of Perdix, strived through his inventions to bring humans to the level of gods. Haldane thought about issues of his time, namely Eugenics with the first widespread debates over contraception and population control. He would be able to justify Ectogenesis with the aging mothers especially on a societal point of view.

The artificial uterus would be a replacement of the usual uterus but would have multiple implications. We would expect it to assist male or female couples in the development of the fetus. It can be compared to a neonatal incubator with specific functions assuming the fetal viability and even allowing possible surgical interventions if needed while responsible for the
nourishment and the evacuation of the fetal waste during the early stages of development. One in 10 US babies are born premature, less than 37 weeks of gestation age and improvements in neonatal medicine have made premature births less than a problem. Many fetuses born from a 22-weeks of gestation have a 50% rate of survival coupled with a high mortality rate due to their lack of formation of internal organs. Unfortunately, they will also suffer from severe disabilities.

Are we ready for such conception of birth? The last 30 years have stimulated an interest in the process. Yoshinori Kuwabara, a Japanese investigator at the Juntendo University in Tokyo has developed an extra-uterine fetal incubation (EUFI) to help in the development of immature newborns, in 1996. He worked on 14 goat fetuses which were placed into artificial amniotic fluid under similar condition encountered in a mother goat. He succeeded to keep them alive for 3 weeks. They believe that they will be able to improve the system and later used it on human fetuses.

Twenty years later, researchers at the Philadelphia Children’s Hospital, in 2017, Alan Flake and his team, developed also an extra-uterine fetal incubation system in which they used fetal lambs placed in a plastic bag filled with amniotic fluid. The umbilical cord of the lambs was attached to a machine to simulate a placenta providing oxygen and nutrients. By the same mechanism, the waste was extracted. The embryos were kept in a dark room while the sounds of the mother’s heart were played loudly. This experience lasted one month, rendering the team to believe that in the years to come, they would be able to repeat such challenge on human fetuses.

Parallely, advancements in neonatal intensive care has pushed back the minimum gestational age from which human fetuses can be kept alive. We have already seen babies from mother with a gestational age less than 22 weeks survive, which represent almost half way to the entire pregnancy (40 weeks). Nowadays, such babies will require extensive NICU care through expensive pieces of equipment. At the University of Edinburg, Colin Duncan, a professor in reproductive medicine, discovered that the use of steroid injection for women at risk of delivering a premature baby, helped accelerate the development of the lungs as it did in the sheep models, improving the survival rate worldwide.

Various institutions have developed and modified their biotechnology to visualize an ex-vivo uterus environments supporting the growth of a mammalian fetus, early in pregnancy while the fetus develops substantially his internal organs during the second half of pregnancy. In the NICU, a premature infant can continue his/her development as a normal fetus of the same gestational age would do inside the mother’s uterus but while in the womb, oxygenated, nourished blood comes in and the waste is carried out through the placenta and the umbilical cord. Once delivered, the premature must breath through his lungs, clean his blood with its liver and kidneys and get nutrition through its gastrointestinal tract.

So, the fetal organ system must be functional prior to a transfer from the womb to the NICU. Therefore, the 22-week gestational age appears to be an absolute limit for a fetus who will have to breathe through his/her lungs as well as other organs functioning adequately. Do we have any other options? An artificial amniotic fluid environment is being implemented with animal models on goats. Another option is an embryo transfer from the uterus of his own mother to the one of a surrogate mother able to assume the nourishment or in an in-vitro model. Such technology will have to be perfected to assure the normal development. We will be able to push the limit further to be able to practice a total Ectogenesis.

An artificial womb may sound futuristic or may appear to be a way to control birth rate, the kind of human being to come to life, the choice in genetic features and even the traits to get passed down to future generations of kids. One will have to measure the impact of an artificial womb in our actual society. Luckily, we are not there yet because, the early days of gestation remain too complex and mysterious for researchers to rear a fetus from zygote to viability through maturation of organs. This miraculous invention, “the artificial womb”, may prove to be a hard sell.

Contraceptives devices have so far regulated
pregnancy and birth rate. We know well how to sterilize, castrate or render fertile a man. We have made progresses in inducing pregnancies or implanting embryos through in vitro fertilization. We have used surrogate mother uterus to bring to term pregnancies. Do we really need an artificial uterus? Can we visualize a society which routinely uses an artificial uterus to achieve a successful pregnancy? One will say, unless the woman has problems to become fertile? An artificial uterus certainly moves the pregnancy outside of a woman’s body.

The notion that a woman has the right to choose and the right to control her body is still being debated with Abortion and religious convictions, but this may offer an alternative when part or the totality of a pregnancy is considered into an artificial womb. If the survival limit of a fetus and the timing in viability is being challenged while NICU are getting more sophisticated, Ectogenesis will certainly provide the same options. How do abortion laws that hinge on viability, can change when a fetus could technically survive outside of the womb at any given point? How do parental rights change?

Conservatives can appreciate how it can become easier for a male gay couple or a transgender to have babies of their own. There may not be a need to be supplemented with a surrogate mother. It will be more practical and cheaper. On the other side, artificial wombs will present major implications for the heterosexual women able to become pregnant preferring to carry their pregnant without hiring a human surrogate.

On an ethical point of view, if abortion remains an option, the fetus can be transferred to an artificial womb and then, may challenge the right to terminate the pregnancy. There may be some arguing that children who grew up in such condition may lack essential bonding with their mother, or others contrarily making the argument that the artificial womb would free women from the tyranny of their reproductive biology as stated by Firestone in his book The Dialectic of Sex, written in 1970.

More, in his column, on the Guardian, Prasad opiniated that the ideas of Gender, Family, Equality may change, inviting men to have a child entirely without a woman. We will then question the concept of Parenthood in women, same sex couples, trans-genders etc. without any prejudice would be able to conceive. Let us be ready to challenge the abortion rights while the parental rights will change and the babies will grow in a deficient psychological world.

Maxime Coles MD

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Sickle cell disease

Sickle cell disease or “Drepanocytosis” is a disease of the Hemoglobin in which the mechanism of delivery of the oxygen is affected in the red blood cell throughout the body. In this disorder, an atypical hemoglobin called “Hemoglobin S”, can distort red blood cells into a sickle or in a crescent shape.

The disease is manifested in the early childhood with characteristic signs and symptoms due to a low number of red blood cell (anemia), repeated infections and periodic episodes of pain. Symptoms vary from person to person being mild for some, but others may require hospitalization for pain control or more serious complications.

The red blood cells sickle and break down prematurely causing the anemia which can be responsible of shortness of breath, while the red blood cells sickle, they break down prematurely, leading to anemia, fatigue, shortness of breath, and finally delayed in growth and development.

Often jaundice can be present due to the rapid breakdown of the red blood cells causing vaso-occlusive crisis, responsible of the painful episodes, following the entrapment of the red blood cells in the small vessels. Such mechanism will impede on the blood flow and deprive the nearby tissues and organs from an adequate nutrition. The occlusions of the vessels, promote organ damage or failure especially in the lungs, kidneys, spleen, brain and bone. A serious complication of this disease involves the vessels supplying the lungs creating a central or a pulmonary hypertension leading to heart failure. We have debated the problem with college athlete with the Sickle cell Trait and the NCAA requirements for sport participation, in the already published AMHE Newsletter (# 237, sept 3, 2018).

Sickle Cell Disease is hereditary and manifests itself in acute crises. If in the past, it was considered like a disease strictly found in black, it can be found now all over the world and is even seen in places where you would not expect it to be present.

Sickle cell Disease (SCD) is an autosomal recessive disorder that results in hemolytic anemia related to an abnormal hemoglobin and a low erythrocyte level. SCD is characterized by vascular occlusive episodes, visceral sequestration and aplastic/hemolytic crises, occurring commonly in bones. We will soon, in a near future, expose the orthopedic manifestations of the disease in one of the AMHE Newsletter to come. But it may be relevant today to only mention some of the orthopedic manifestations like the “hand and foot syndrome”, Osteonecrosis or “Avascular Necrosis”, Acute and Chronic Osteomyelitis, Septic arthritis, Rhabdomyolysis etc.

Today, it is my privilege to have Rita Bellevue MD one of our elder, specialist in the treatment of this disease, bring you some pearls in the history and treatment of such phenomenal disease. The AMHE hopes soon to be able to open an active clinical center in Darbone, Haiti, near Leogane to support the need for a materno-infantile population as well as the one suffering from Sickle cell Disease.

Maxime Coles MD
Sickle cell Disease, a Global Health Priority
Rita Bellevue MD

“Sickle cell disease / Thalassemia” represents the most prevalent genetic disorder worldwide and the first known molecular disease affecting millions of individuals. It is an inherited disorder of the hemoglobin, a protein molecule in the red blood cells which brings oxygen to the tissue.

There are 3 normal hemoglobin’s in an adult: Hemoglobin A constitutes 96% of the normal hemoglobin, hemoglobin A2 less than 4%, hemoglobin fetal(F), less than 1%. Normal hemoglobin’s contain 2 pairs of globin polypeptides chains and to each is linked to a heme group (2 alpha and 2 Beta for hemoglobin A, 2 alpha and 2 gammas for hemoglobin F, 2 alpha 2 delta for hemoglobin A2).

Sickle cell hemoglobin results from a point mutation (GAG to GTG) in the sixth codon of the gene for Beta Globin where the sixth amino acid of the polypeptide chain is valine instead of glutamic acid. This leads to the polymerization of the hemoglobin S molecules when deoxygenated with formation of the characteristic sickle cell shape.

The disease is characterized by painful vaso-occlusive crisis, life-long hemolytic anemia, and progressive organ damage. The pathophysiology of vaso-occlusion is a complex process which involved acute and chronic inflammatory conditions and a cascade of interactions among several cell types including endothelial cells, white blood cells, platelets, cellular adhesions molecules and sickle red blood cells. With vaso-occlusion, the area of the body involved is deprived of blood, oxygen and nutrients with development of ischemia and infarction.

The term sickle cell anemia is reserved for a person who is homozygous for the sickle or S gene (SS). Those who have inherited one S gene and a gene for a different hemoglobin variant or for a Beta- thalassemia mutation are double heterozygotes. An individual who has one sickle gene and a normal gene has sickle cell trait (AS, carrier state) and does not have sickle cell anemia. The most common sickle cell disease encountered are SS, SC, S Beta Thalassemia, SD Punjab, SE, SO Arab. Sickle cell anemia is the most severe form of the disease. Individuals with SO Arab and SD Punjab have the same symptoms as SS. SB0Thalassemia are variable.SB+ thalassemia and SC appear more moderate.

However, all sickle cell disease variants share the same clinical symptomatology, the severity is unpredictable and progressive. Organ damage may be detected for the first time during the fourth even the fifth decade because of different complications such as (Hip avascular necrosis or sickle cell retinopathy in SC and S Beta+ Thalassemia), following a routine eye examination or a hemoglobin electrophoresis. It is important to keep in mind that individuals with SC and SBeta-Thalassemia may have a normal hematocrit and hemoglobin level and often are diagnosed as having sickle cell trait and treated as opiates seeking individuals in the Emergency Department.

Here are some of the common complications of Sickle Cell Disease:
- Vaso-occlusive crisis or pain crisis / dactylitis
- chronic pain and various co-morbidities
- Hematologic complications( Aplastic crisis, splenic sequestration, increased hemolysis)
- Major organ complications( CVA, Acute Chest Syndrome, Pulmonary Hypertension, Cardiomyopathy, Cholelithiasis, Renal Disease, Ophthalmologic complications, Priapism, Leg Ulcerations, Avascular Necrosis, Sickle Cell Liver Disease, Arthropathy, Neuropathy).
- Infections and Sepsis.

Geographic Distribution of the Sickle Cell Gene:

The Sickle Cell gene is widely distributed throughout the world and is associated with haplotypes representing independent mutations. These mutations happened in areas where malaria was common. Some studies shown the relative infrequency of malaria in person with the sickle cell trait (AS). In endemic areas of malaria there was a natural resistance against the development of malaria in patient with trait. There are 5 known globin Haplotypes, named after the places where they
were first described:

These are the Benin haplotype, the Bantu haplotype (Central West Africa) the Senegal haplotype (Central African Republic), the Cameron haplotype, the Asian-Arab haplotype (India and Middle Eastern Arab Countries).

The Asian haplotype is found in the Eastern province of Saudi Arabia but patients from the Western province have the Benin Type. The Benin haplotype spreads to North Africa, Sicily, Greece, Albania, Southern Turkey. The Benin haplotype is seen also in Algeria, Morocco, Tunisia. The Bantu haplotype is seen mostly in Angola, DR Congo, and Mozambique. The sickle cell gene is in lower frequency in Iran, Syria, Jordan, the Bedouins of Israel and Palestine. Slave trade accounts for the Distribution of the S gene from Equatorial Africa to North America, Central and South America and the Caribbean’s (which include Spanish speaking countries such as Puerto Rico, Cuba and Dominican Republic). The S gene is mostly the Benin haplotype and In South America mostly the Bantu haplotype.

Sickle Cell Gene in UK came mostly from Caribbean’s, Ghana, Nigeria, and Central Africa. In France mostly from North and West Africa and in Germany from Turkish Immigrants.

The diagnostic of sickle cell disease cannot be made by the sickling and the solubility testing methods because of their inability to differentiate sickle cell disease from sickle cell trait. Solubility testing also has false positive and false negative results. The false negative is seen in severe anemia, patients on chronic transfusion, always during the neonatal period because of the high percentage of fetal hemoglobin (Hb F) and with deteriorated agent. The false positive is seen in hyperlipidemia, extreme leukocytosis, hyperglobulinemia, with too much reagent and deteriorated agent. Solubility testing does not detect individuals who have hemoglobin C, D, E, O Arab and Beta thalassemia trait.

It is appropriate only in an emergency to determine the presence of hemoglobin S in a patient seen in The Emergency Department as the results of the blood send for electrophoresis is not immediately available. Hemoglobin electrophoresis, isoelectric focusing and high-performance liquid chromatography are laboratory methods used for the diagnostic of sickle cell disease. Some accurate, rapid and inexpensive tests for SCD are being developed and tested.

**Intervention in sickle cell disease:**

The introduction of universal newborn screening in United States with prophylaxis penicillin, pneumococcal vaccine and basic vaccinations, comprehensive health care, transcranial doppler and prophylaxis transfusion have decrease morbidity and mortality (90% of children live to adulthood). SCD affect approximately 100,000 individuals in United States. The transition from pediatric to adult care, treatment disparity remains a problem from lack of access to adult specialty providers. Although individuals with SCD are living longer long term complications and lifelong disability still remain a crucial problem for many. Beside chronic transfusion only 2 medications are approved to treat the Disease: Hydroxyurea for adults (underused by clinicians or very poor adherence by patients) and young children (2 years and older) and more recently in 2017 Endari (adult and children from 5 years old). New drugs are on clinical trials. The only cure is hematopoietic stem cell transplantation but not every individual affected has a HLA- matched sibling donor. Gene therapy is currently being tested in clinical trials and is promising. Gene editing techniques are in their infancy.

Newborn Screening with comprehensive care is now universal in United Kingdom. UK has the highest number of patients in Europe. Newborn screening has been increasing in European Countries.

**Sickle Cell Disease: A Global Public Health Problem and Challenge**

More than 300,000 infants are born with sickle cell disease every year globally where up to 1 to 2% occur in high resources setting and more of 90% of birth occur in developing countries mostly in Africa and India. Most of these children died undiagnosed from overwhelming pneumococcal sepsis, splenic sequestration, or malaria. The following table is an estimated Number of newborns with SCD in Africa and India for the year 2010 (Piel et al. 2013)

<table>
<thead>
<tr>
<th>Country</th>
<th>Sickle Cell Birth/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nigeria</td>
<td>91,011</td>
</tr>
<tr>
<td>Democratic Republic of Congo</td>
<td>39,743</td>
</tr>
</tbody>
</table>
What about newborn Screening in these Countries?

The vast majority of infants and children are not routinely screened for SCD. Screening newborns, prophylactic penicillin, pneumococcal vaccine and vaccinations, daily hydroxyurea is lifesaving. However, neonatal screening is available only in few countries of the Sub-Sahara Africa. Implementation of newborn screening worldwide could save the life of almost ten millions of children.

In Tanzania, the need for intervention to reduce the mortality was recognized. As such Tanzania is developing a national policy under the leadership of the Minister of Health and Social Welfare.

Many countries such as Benin, Ghana, Cameroon, DR Congo, Tanzania and Nigeria have established Sickle Disease Centers. Successful pilot newborn screening studies have been done in many African countries. An important feature is the interest of the Minister of Health or the Central and State Government support in the development of newborn Screening with establishment of Centers (20 in Uganda in 2017) often in area with high number of infants with Sickle Cell Disease (Ghana, Tanzania, Uganda as examples). In June 19, 2018, World Sickle Cell Day, the Minister of Health in Uganda announced that hydroxyurea should be added to the essential list of medications available to the public. The announcement followed the study done to evaluate the safety of hydroxyurea in a malaria-endemic area. Newborn Screening is so crucial because approximately 1000 infants are born daily in Africa with sickle cell disease. In Uganda babies exposed to HIV were tested for HIV and SCD. The implementation of a universal vaccination program is an opportunity to diagnosed SCD in babies not tested.

In India, newborn screening is now conducted. The Central and State Governments are establishing Centers for diagnostic and comprehensive care for individuals identified with the disease. The Asian haplotype has a more benign course because of a high fetal hemoglobin. But there are individuals who have severe sickle disease, developed sepsis, required transfusion and benefited from hydroxyurea.

What about middle-income countries. In Jamaica newborn screening and Health Care Maintenance are essential components of SCD in Jamaica and have been in existence for years. The Minister of Health is very involved in Jamaica in Education and the provision of comprehensive care to Jamaican patients. The Childhood Survival for SCD in Jamaica is 84%, compare to 94% in USA, 99% in UK and only 10% in Africa. In Brazil, after 10 years there is a steady decrease in mortality rate. An important fact is involvement of the government of Brazil in newborn screening, testing, education and the production of educational brochures.

The United Nations have designated Sickle Cell Disease as a Global Public Health Problem on a resolution in December 22, 2008, with June 19, becoming a National and International Day each year. The first World Day was celebrated on June 19, 2009.

Quoting DR Ohene –Frimpong MD of the Sickle Cell Foundation of Ghana and active member of the Global Sickle Cell Disease Network

« Unfortunately, despite the work done in Ghana and across Africa, much remains to be done to reduce infant mortality. 90% of children with SCD in resource-poor countries will not survive to adulthood. In Ghana, we have seen that simple public health measures, especially newborn screening, help children lead more normal life. In the first 10 years of newborn
screening, we made dramatic improvement in reducing sickle cell related childhood mortality»

In 2016, ASH the American Society of Hematology formed the ASH Coalition. The Coalition is taking measures to raise awareness of SCD in Africa and low resource areas globally in an effort to improve health outcomes for people with the Disease from infant to adulthood.

This quote from DR Alexis Thompson President of the American Society of Hematology and active Leader of the ASH Coalition could be apply to low income countries where newborn screening is not established and where sickle cell anemia is not recognized as a global health issue.

«One of the greatest hurdles we face in the heartbreaking rate of mortality caused by SCD in SUB-Saharan Africa is lack of awareness of the condition and the simple relatively inexpensive intervention that can save lives. It starts with early recognition, ideally through newborn screenings».

In conclusion, Sickle Cell Disease is a global health issue. We need to work together to find solutions to resolve the problem. The establishment of newborn screening is important for the prevention of death in newborns and children < than 5 years of age. It is time to invest in sickle cell as a priority.

Rita Bellevue MD
Member AMHE, New York Chapter
Mali e Beti

2 sè marasa ki te viv youn pou lòt e pa t ka viv youn san lòt, te fè menm bagay la nan leve chak piti fi yo, Mali e Beti, kokou, pòy e tokay. Si w te li deskripsyon chak, ou ta fè konklyizyon ke pa gen fason pou yo te ka tolere youn lòt e poutan yo pa t ka viv separe youn de lòt. Mali e Beti te rive mare lombrit yo ansann. Yo te abite tou pre nan Bapeudchoz. Se te bèl mèvèy pou obsève kijan 2 kokou sa yo te kouvè tomtom ak kalalou. Se sèten ke pataje menm san se yon fenomèn pou respekte.


An plis de sa, Beti te gen repitasyon yon moun ki aktif. Depi l te piti, li te toujou pre pou ede, ke se òganize batèm poupe, e lè l ap grandi li te sèl chèf kanbiz. Par examp, si w bezwen reyisi yon ti suye pye pou fèt yon moun e ben ou rele l. Li te bon nan koòdinasyon. Se konsa yo te ba l ti non jwèt la fougueuse. Mali toujou cheche rezon pou youn bagay pa ka realize. Beti toujou jwen fason pou akonpli l.

Fason yo panse te kou lèt ak sitwon. Si gen yon bagay ki pou fèt, ke se mete lòd nan dezòd nan yon kay, pran inisyat yon sote kôd, jwe marèl, ou te mèt konte sou Beti. Avèk Beti, aksyon se plop plop. Avèk Mali, li te toujou pè pou li pa t deranje manicure li, sal ou byen chifonèn rad li epi li te paresèz. Yo te rele l précieuse, tout tan l nan tulututu e ap fè enteresant. Men si w te gen afè ak Beti e ben ou te charye 2 chay sou do w paske Mali pa t manje anyen k frèt pou defan kouzin li. Si w te touche cheve Mali ou t ap gen pou korespòn ak Beti, bon jan famm vanyan.

Vanyan nan tout sans! Sa k te distenge Beti, li te renmen patiše nan diskisyon politik ou byen debat nenpòt sijè daktuile. Li te toujou kampe dòkout devan ti mesye yo lè konvèssyon sa yo ta p fèt. Li te gen bon jijman e analiz li te byen kampe. Li te chaje ak konvisyon e li pa t kwè nan chanje pozisyon dprè kouran ki te an vòg la. Natièmman, li te fè lekòl e elèv sou katye a souvan te vin kote l pou ede yo fè devwa. Mali te plis kou mazèt e Beti te plis kou bolid.


Sepandan, Beti pa t ka chanje ët Mali nèt. Kote Beti te liberal, pwogresis, Mali te konsèvatris. Beti te kwè nan yon sosyete ki bay pòv ak rich menm pwoteksyon. Mali te pou moun rich; li te...
konsidere moun ki pa genyen comme des minables et leur langage, le créole, une pourriture. Malgré tout jefò Beti te fè, oryantasyion politik Mali pa t janm chanje.

LA MEDECINE ET LA PRETRISE, CES PROFESSIONS DANS LA VOIE DU SACERDOCE.

Un prêtre est venu se décharger l’autre jour du lourd bagage qui l’étouffait depuis quelques années. Dans le recueillement et le silence de mon cabinet de consultation, il m’a fait part du récit triste et accablant des décès à répétition de membres de sa famille qui ont expiré ces derniers mois.
Il s’est réveillé de grand matin pour se sentir découragé, désespéré sans plus de désir de continuer à vivre. Il voulait se donner la mort. Il luttait contre la dépression depuis plusieurs années, à la suite de la mort de sa sœur cadette, et a vu son deuil se prolonger quand son neveu de 50 ans devait mourir de leucémie quelques mois plus tard. Il était très proche de ce dernier. Il a bien quatre-vingt six ans, l’âge où le corps chancelant, plus tremblant sous le poids des ans, de plus en plus de mal à gérer et à digérer les pertes émotionnelles, les séparations et les départs imprévus. J’ai toujours été friand des bonnes conversations qui en appellent à l’intelligence des gens. Et j’apprends tous les jours à mieux vivre en me mettant à l’écoute des autres. Alors, une fois la prise de l’histoire psychiatrique et l’examen mental terminés, je me tournais vers lui pour lui demander si il referait le choix de la prêtrise, si jamais il avait à le refaire ? Il me donna
un oui catégorique et avança très fièrement qu’il n’a rien regretté du temps passé à servir Dieu et ses prochains. Quand il devint prêtre, il avait 28 ans; il prit sa retraite voilà plus de cinq 5 ans après une cinquantaine d’années de service religieux. Il m’apprit ensuite qu’il passa deux années à étudier la médecine avant de réaliser qu’il avait un penchant pour la prêtrise et abandonna son premier choix. Comme Pierre jetant le filet sur le sable pour suivre Jésus, et passant de pêcheur de Poisson à pêcheur d’homme, il abdiqua la blouse et le stéthoscope pour embrasser la bible et la soutane.

Etrange de volte de face et de métamorphose me disais -je bien, car j’ai vu des prêtres se convertir en médecins, des pasteurs, des sœurs religieuses devenir infirmiers, infirmières, mais pas souvent le contraire. Je reconnais bien qu’il y a toujours eu des points de jonction entre les deux professions ; La pratique de l’une comme de l’autre exigeant bien un engouement pour le sacerdoce. D’ailleurs les hôpitaux, à cote des églises, servaient toujours d’enclaves ou les deux fonctions se coudoyaient et se juxtaposaien pour mieux servir les souffrants et les mourants.

Dans nos hôpitaux d’autrefois, en appui à la science médicale, desservie avec désintéressement par les médecins, sous l’égide suprême de la déontologie, les religieux priaient encore pour les patients et coordonnaient le service à la cuisine et à la pharmacie.

Je suggérais à ‘mon père ‘ qu’il aurait pu servir avec autant de ferveur et d’amour en étant médecin au chevet de ses patients qu’en allant se faire prêtre ; Je lui parlais de Saint Luc, médecin de son état, et qui fut aussi disciple de Jésus Christ. Mais Lui, pourtant, il en voyait les choses autrement. Nous tombions tout de go dans ce qui était, et ce qui devrait être la fonction du médecin par rapport à celle du religieux.

Je lui ai aussi parlé de ces prêtres et autres religieux, y compris des pasteurs, qui se sont enrichis des dons destinés aux plus plus faibles et aux démunis. Il admettait bien qu’il existe partout des éléments marginaux qui nuisent par leur comportement à la bonne réputation de la profession ; que le scandale arrivera toujours mais que malheur sera à celui par qui il arrive.

Nous admettions ensemble, au bout de la conversation, que la prêtrise comme la médecine d’ailleurs, restent des voies royales de service à la communauté ; que les règles imposées a chacune d’elles sont des garde fours incontournables pour se prêserver des tentations auxquelles nous exposé le besoin d’une vie riche et aisée.

Il était franc et honnête, capable d’accepter que l’imperfection est en tout et partout, que le besoin de se dépasser est un travail constant de tous les jours.

Il ajouta alors qu’il est du devoir de chaque individu de purifier des tentations de la vie facile que le métier semble parfois offrir ; de se rappeler, prêtre, pasteur ou médecin, la raison première qui avait motivé le choix de profession qu’on avait fait ; d’éviter de se laisser souiller par les scandales qui enlissent la progression de nos actions.

Nous nous séparions pour la journée non sans avoir compris que si le corps physique et mental du patient recourent souvent à la médecine pour se guérir, c’est à la sagesse et a la compassion du religieux qu’ il va toujours se référer dans les moments noirs et ténébreux qui ponctuent son existence.

Rony Jean-Mary, M.D.
Coral Springs, FL .
Le 11 Novembre 2018
Santé : L’Hôpital adventiste d’Haïti procède à la première chirurgie du remplacement total du genou en Haïti

L'hôpital adventiste d’Haïti (HAH), dans le cadre de sa restructuration s'est doté d'une salle d'urgence flambant neuf avec des médecins disponibles aux heures du jour et de la nuit. L'hôpital s'est également amélioré dans le service post-Urgence et les soins spécialisés. Avec ses trois nouvelles salles d'opération inaugurées en Avril 2016 respectant les standards internationaux, l'hôpital adventiste d’Haïti est le centre hospitalier le mieux équipé pour réaliser des interventions chirurgicales très sophistiquées en matière de chirurgie orthopédique.

Happy Birthday
Peu importe de vieillir une année, nous resterons jeunes. MC

Hommage à nos amis disparus

L'amitié ne veut que ton bien.
Recueil : Des vers à cœur ouvert (1997)

L'amitié est une main qui vous soutient, 
Dans la douleur comme dans le désarroi ;
L'amitié est une oreille qui vous écoute,
Aussi bien dans la peine, que dans la joie.

Sabine Dubreuil

A day in the park at Boca Raton

Voir l'album
Cette consultation préliminaire a permis aux membres du Comité et du Secrétariat Technique de partager avec ces représentants des informations concernant la démarche et la réalisation de ces États Généraux et de mieux comprendre le rôle des sages-femmes dans la société haïtienne.

Les représentants de ce secteur ont fait la présentation de ce secteur en exposant les différents problèmes auxquels sont confrontés les professionnels évoluant dans ce secteur. Parmi les problèmes évoqués, il convient de mentionner la méconnaissance de
cette profession en Haïti, la crise d’identité professionnelle, le défaut d’intégration des sages-femmes à tous les niveaux de la pyramide sanitaire, les mauvaises conditions de travail, l’absence d’un salaire raisonnable, la difficulté de collaboration avec les autres professionnels de la santé ainsi que des problèmes d’intégration des jeunes sages-femmes sur le marché du travail après avoir effectué leur service social.

S’agissant des EGSN, ces professionnelles saluent cette initiative du président de la République, tout en espérant que celle-ci puisse permettre au secteur des sages-femmes de mieux se positionner, de pouvoir jouer son rôle au sein de la société et surtout de sensibiliser la population sur l’importance des sages-femmes tant au niveau de la capitale que dans le milieu
rural. Elles ont toutefois émis des réserves par rapport à la finalité des documents qui sortiront de ces États Généraux.

La rencontre avec les représentants du secteur des sages-femmes et de reproduction s’inscrit dans le cadre de la deuxième phase des États Généraux Sectoriels de la Nation qui consiste à sensibiliser et mobiliser les différents secteurs concernés, élaborer les cahiers par secteurs, collecter les informations concernant l’état des lieux des secteurs, faire une synthèse des documents de politiques publiques sectorielles. Des membres du Comité de Pilotage, Paul Gustave Magloire, Eugenia Romain et du Secrétariat Technique Louis Naud Pierre ont participé à cette rencontre.

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Sabine Dubreuil
Dear AMHE members, family, and friends;

Contribute to the AMHE Sickle cell Clinic in Leogane NOW at Gofundme.

AMHE is seeking to raise $200,000.00 to Build the Clinic. We are waiting for your contribution.

1) We have created a Gofundme; your generous tax-deductible donations, earmarked for the clinic, will be sent to the AMHE Foundation and a receipt mailed to you.
2) Forward this message to your friends and family, promote it on your Facebook, Twitter, Instagram and any social media you use.
3) You can also send your contribution by check made payable to the AMHE Foundation and mailed to:

   AMHE, Incorporated
   1166 Eastern Parkway, 2nd Floor
   Brooklyn, NY 11213

4) Ask friends and family to donate by sending them the link above
5) Add a link to this project on your Facebook page

Sincerely,

Maxime Coles
Maxime Coles M.D., F.I.C.S., F.R.C.S., F.A.A.N.O.S.
Orthopedic Surgeon and Traumatologist
AMHE Central Executive Committee Past President
AMHE Board Of Trustees

More informations
Corner of Traveller: 
La Rubrique de Odler Jeanlouie MD

NEW ZEALAND: AREOTA
(LAND OF WHITE CLOUDS)

“I got to say, God really outdid itself down here” Bob Harper.

In a nutshell, New Zealand is glamorous, prosperous and progressive. How much better could it be?

The country covers 268,838 sq. km, that is twice the size of Florida. Its population has reached 5.01 million. Contrarily to the Australians who eliminated all but a few of the Aborigines (now 0.5% of the population), the New Zealanders are 1/3 Maori in census number. Healthcare and education are considered basic human rights. Women, LGBTs are treated as equal.

Jacinda Ardern, the Prime Minister of New Zealand, is only 38. She is the only female head of government who, in a Western democracy, has given birth a to child, while in the active exercise of her function.

The first European to reach New Zealand was Abel Tasman in 1642. That was 400 years after the Maori settled on the land that they called Areta. However, there is historical evidence that the area was already inhabited several thousands of years earlier. In 1769, James Cook took possession of the land on the name of the British crown. It became independent in 1907.

The government is unicameral, headed by a prime minister. New Zealand is a member of the British Commonwealth, as such, it is a constitutional monarchy. Queen Elizabeth is the head of state; she is locally represented by a governor general.

Geographically, New Zealand is made of the North Island and the South Island, located between the Tasman Sea and the South Pacific Ocean. The capital is Wellington, not Auckland; both cities are located on the North Island. Only 20% of the population live on the South Island.

Both English and Maori are official languages. Most of the population is Christian, though 38% claim to be agnostic. The average New Zealander is 38-year old. Age expectancy at birth is 81 years. Infant mortality rate is 4.4 per 1,000 live births.

New Zealand’s GDP is $189 billion, growing at 3% per annum. GDP per capita of $38,900 (vs India: $1,940). GINI coefficient is 36.2%. The unemployment rate is 4.9%. The literacy rate is 99%.

The country mostly exports dairy products and meat. It imports petroleum, machinery, and electronics. Its main trading partners are Australia and China (not the US).

The country is at the forefront of the anti-nuclear pacifist movement and is deeply involved in the fight against global warming. Because of its anti-nuclear stand, New Zealand is no longer a partner in the mutual defense pact with the US and Australia.

From all vantage points, the future of New Zealand is bright.

The Traveller (Odler Robert Jeanlouie, Tuesday, October 9, 2018, Auckland, the former capital of New Zealand.)
Published on the AMHE Facebook page last two weeks
Articles parus sur la page Facebook de l'AMHE durant la dernière semaine
Haiti…Haiti…Haiti…Your video is popular in Quebec - Power of Positivity - The first published results of the phase 1 clinical trial testing anti-CD47 therapy against cancer. - Compliments to Monsignor Bishop Sansaricq - What it represent for our Orthopedic residents to be part of the AMHE Residency Program from 2005 to Present - Another potent medication released on the market today, cleared by the FDA. MC - Rodrigue mortal mdat radiosolidarite. MC
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July 20 – 28, 2019
Discover Cuba and Explore its sandy beaches!