

Global Health Reflections

The University of Vermont and Western Connecticut Health Network



2017

THE PRACTICE OF GLOBAL HEALTH connects us to people of diverse perspectives and colors, and upon reflection, to ourselves and the lived experience. We learn to respect differences and recognize shared humanness. We cultivate pure human connections rooted in empathy, unhindered by superficial separations created by classism, racism, colonialism, and structural oppression. We are invigorated by the fortune of understanding others through their histories, strengths, weaknesses, fears, and failures. We learn about ourselves by reciprocating that vulnerability, by being exposed openly. In that openness we discover weaknesses, impurities, prejudices, and deficiencies in our own substance. We are then driven to improve our humanness — to become more caring, more compassionate, more aware, and more giving.

Tragedy and suffering born from human rights inequalities, particularly health inequality, social injustice, and poverty are illuminated on a grand stage under a beam of light. All that is usually hidden is revealed. We stand united on the stage to advocate for those who have been enshrouded behind the curtain. Their tragedies teach us something about resilience, and we find hope in their strength. Their stories tremble through the comfortable encasement of our privilege until it cracks. We learn to care about something outside of ourselves.

In discovering the roots of empathy, we rediscover what beckoned us toward the field of medicine. In its essence, this profession is a calling. At the service of the underserved, we follow that calling.



MAJID SADIGH, M.D.
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Photographs from the 2017 photo contest *Global Health Views* appear on pages 1, 2, 23, 21, and the inside back cover.



Deyanna Boston, M.D., won the award for “Most Impact” with this photo during the 2017 Global Health Celebration at the Larner College of Medicine.



Global Health Celebration photograph awardee: Rafael Khalitov, M.D.
A mother hugs her severely ill daughter and prays in Mulago Hospital, Kampala, Uganda
★ Most Original



Global Health Celebration photograph awardee: Bryce Bludevich, M.D.,
Larner College of Medicine Class of 2017
Upward Climb
★ Best Composition

Global Health Celebration Marks International Partnerships in Education and Patient Care

Physicians and educators from the Dominican Republic and Kazan, Russia, along with faculty and staff from the Global Health Program of the UVM Larner College of Medicine and Western Connecticut Health Network (WCHN), visited the Larner campus April 24-25, 2017 to participate in a Celebration of Global Health.

Distinguished guests included Julio Amado Castaños Guzman, M.D., president of Universidad Iberoamericana (UNIBE) and Chairman of the Board of Hospital General de la Plaza de la Salud in Dominican Republic, and Dilyara Nurkhametova, M.D., internal medicine specialist and coordinator of the Kazan State Medical University Global Health Program in Russia. Other Global Health Program guests included Majid Sadigh, M.D., Trefz Family Endowed Chair in Global Health and director, WCHN Global Health Program; Stephen Winter, M.D., director, Norwalk Hospital Global Health Program; Bulat Ziganshin, M.D., an associate research scientist in surgery at Yale School of Medicine and WCHN Global Health faculty member; and staff members Lauri Lennon, Laura Smith and Joanna Conklin.

The two days of activities included tours, meetings with faculty physicians and global health students, and active learning classroom observation. UVM Larner Global Health Program faculty members Mariah McNamara, M.D.'02, assistant professor

of surgery; Michelle Mertz, M.D.'06, assistant professor of family medicine, and Molly Moore, M.D., assistant professor of pediatrics, served as leaders of the event.

On April 24, visitors and members of the College community attended a Dean's Distinguished Lecture in Global Health on "Global Health in the Dominican Republic" by Dr. Castaños, followed by an awards ceremony and reception featuring an exhibit of posters, photographs and reflections submitted by Global Health Program participants.

The UVM/WCHN Global Health Program recognized Dr. Castaños and Dr. Nurkhametova with the Dean's Distinguished Lecture in Global Health and Celebration of Global Health awards, respectively. Bryce Bludevich '17 was named the recipient of the Beth Kirkpatrick, M.D. Citizen of the World Award and Andrea Green, M.D., assistant professor of pediatrics, was named the recipient of the Patricia O'Brien, M.D. Global Health Leadership & Humanitarian Award.

Photo award recipients in three categories recognized at the April 24 event were:

- Originality: Rafael Khalitov, M.D., a physician from Russia who did a clinical rotation in Uganda; ("A mother hugs her severely ill daughter and prays in Mulago Hospital, Kampala, Uganda")
- Composition: Bryce Bludevich, M.D., Larner College of Medicine Class of 2017 ("Upward Climb")
- Impact: Deyanna Boston, M.D. ("Untitled")

Written reflections award recipients were:

- Imelda Muller, M.D., Larner College of Medicine Class of 2017 ("Kaleidoscope")
- Mitra Sadigh, UVM post baccalaureate premedical student ("Jebaleko")
- Janel Martir, M.D., Larner College of Medicine Class of 2018 ("Olumwa: The Dangers of Complacency in Global Health")



REFLECTIONS
AWARD
WINNER



Members of the Western Connecticut Health Network/Larner College of Medicine Global Health Program along with global health visitors Julio Amado Castaños Guzman, M.D. of the Dominican Republic (fourth from right) and Dilyara Nurkhametova, M.D. of Russia (sixth from right).



IMELDA MULLER, M.D.

Class of 2017
Uganda, Winter 2017

The Centimeters Between Our Hands

I called the name written on the torn pink form in my hand, broken syllables falling slowly from my lips. I scanned the crowd, searching for upturned eyes among a sea of blank faces. When my gaze met hers from across the room, I again attempted to pronounce the name in front of me. This time she rose in confirmation.

I watched as she smoothly navigated the rows of crowded benches, mechanically stepping over the legs of patients slouched against the walls. With a smile, I welcomed her into the small room. On the door was taped a white piece of paper with the word “skin” scrawled across it. It covered a sign that once read, “Pediatrics.” I motioned toward a wooden stool next to the doctor’s empty chair—an old school desk.

“He just stepped out for a moment,” I explained cheerfully, taking my seat on a stool across from her. She looked through the table in front of us. “The doctor will be right back,” I continued, unsure of whether I had spoken clearly enough. She remained motionless, a statue of defeat.

As we sat in silence, I scanned her skin for a dermatological impetus for her presence. Dark, gritty papules littered her arms and face, exposed beneath a beautiful yellow and white gown. A breeze swept through the empty room, teasing us with a welcome reprieve from the heat. The sun’s glow illuminated the sharp contours of her silhouette, creating rays that emanated from the lesions cascading across her cheeks. Her features were otherwise indistinguishable against the aggressive light that shined behind her.

As we sat, small pieces of her face appeared to swell and run downward, glistening in the light on their journey into

her lap where they disappeared. Alarmed, I soon realized that these were tears. As she wept, her sobs erupted in quivering waves that rushed down her shoulders, eroding her stillness.

“I am so sorry,” I said in a language she did not understand. I began to reach toward her, but quickly withdrew my hand, unsure of whether this was an acceptable way to console her. The smile I had displayed as I welcomed her suddenly seemed

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inappropriate—a cruel juxtaposition to her anguish. She spoke through her tears with a raspy wailing tone as she gestured to her face and body.

After only about twenty hours in Uganda, I struggled to find the words to bring her solace. Instead, my brow furrowed and the corners of my lips fell downward as the magnitude of her torment reached me. I tried some other small phrases and shook my head, the only expressions I knew to convey my acknowledgment of her suffering. She did not look up. My words fell through the air and my contorted face was lost in the space between us.

Compelled to reach out to her again, my hand stopped next to hers this time. It rested on the table where it remained until the doctor returned. The centimeters between our hands felt like miles that mocked the ocean which had so recently separated us. ●

Kaleidoscope

Winner of Global Health Day 2017 Reflections Contest
Imelda Muller, M.D., Uganda, Winter 2017

*Tiny shadow forms topple over each other,
Crowding around the man and the truck.
Rising in swells,
Moving toward the wall where he is pinned.
Falling smoothly in concert.
As the truck teeters on the ledge.
The weight of their jostling vibrations,
Abrasively declare his fate, and
Travel up my arms as the front lens spins in my fingers.*

*I change my position,
And a new recollection emerges.
As light floods into the tiny space,
Lighting the faces of little ones,
The once vague silhouettes,
Drenched and dirty,
Declare their resounding identities.
Unmistakable laughter manipulates an inquiry of happiness,
And I am surprised by their extraordinary colors.*

*A lone figure is frozen in isolation,
Shrouded head to toe in a forgotten hallway.
The others diverge around the impedance,
Avoiding the colorful sheet that squeezes his swollen body,
While their stereotyped synchrony,
Dehumanizes the only remaining evidence of love, and
Facilitates a silent disappearance.
His cruel and brutal death will go uncontested, for
In the face of a habitualized precedent,
Justice is suffocated by unforgiving subservience.
A single figure cannot stand alone,
And must instead hope for a hardened heart to survive silently.
Against the force of
Alternative facts that sterilize
history.*

*Their dances meld together,
As they work quickly in their white uniforms.
And they assume perfectly practiced positions,
Flowing between the beds,
Banishing doubts of efficiency,
As they move thoughtfully from patient to patient.
With flawless demonstrations of a resourceful permutations,
They answer a chorus of hushed pleas.*

*And every turn reveals the promise of
Circumferential consideration, and
Infinite novelty.*

*They jump and tumble
Falling over each other,
As each climbs to the top,
Shrieking in victory,
Only to find a new summit.
Some slip through the rungs on the rusted slide,
Some plunge toward the sea below,
To a graveyard of broken donations.
And their splashes flicker in the light,
Foreshadowing cries muffled by tetanic bruxism,
Before each succumbs to
The transparent demise of good intentions sent from
A foreign land.*

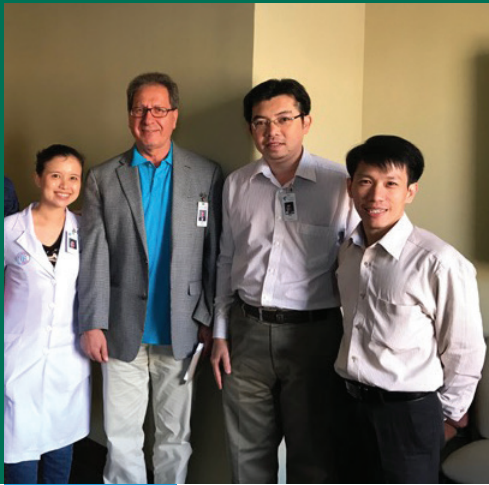
*New shapes come excitedly into view,
Revealing a parade of beaming women,
Glowing in brilliant mosaicism,
Of glittering gomezis,
That explode into spontaneous dance.
Hundreds of family, friends, and neighbors share
Their contagious energy,
Erupting into song and laughter that
Whirls into jubilant tradition.
Succulent smells tickle the noses of the crowd,
And Intermingling parts meld together
Satiating bellies with delectable sustenance,
In celebration of a blissful partnership.*

*I remove the lens from my eye,
And paradoxical juxtapositions dissolve away as I am
Immediately blinded by the sun.
The validity of my memories are put to question, and
My senses are overtaken by
Calm in the chaos and
A welcoming embrace.
While I wash the bleeding earth from my feet
I can hear voices filled with hope,*

And I ponder the weight of my Kaleidoscope.



REFLECTIONS
AWARD
WINNER



LONG H. TRAN, M.D.

Global Health Scholar from Vietnam (shown at right)
Danbury, Conn., USA, 2016

The Success of a Medical Collective

I am grateful to have experienced true American life. The organization arranged a very nice house for us close to the hospital with a nice friend from the Dominican Republic with whom we shared and exchanged our cultures. I had a warm dinner with Ms. Lennon's family for Thanksgiving, attended a New Year party at Dr. Winter's home, and had a meeting night with international friends at Dr. Sadigh's home. Everyone was always beside us to help, share, and teach. We traveled to some famous places and saw many things. I learned not only about the English language, but also about culture and communication skills, thereby gaining a greater understanding of Americans and of the United States.

Three things struck me about the hospital. First, while medical care is very expensive, the quality of care is very high. Second, human values are cherished. Patients are cared for as if by their family members. The pain and anxiety of loss is understood and shared. Third, protection of environmental resources and prevention of pollution are part of the consciousness of every individual. Better use of antibiotics in the community is very useful for the treatment of infections, nosocomial pneumonia patients are almost rare in my time here. This reflects the success of a community, of a medical collective, rather than of an individual.

I have gained improved medical knowledge and thinking skills during my time in the United States. Professionalism does not require a thorough understanding of everything, but rather an attentive

investigation and careful use of all resources to best treat the patient. The endeavor may or may not be successful, but that is all we have. I am thankful for Dr. Winter and Dr. Scatena who taught me important reasoning skills, and for the fellows and resident physicians. Witnessing the devotion of nurses and respiratory technicians helped me understand the full meaning of the Intensive Care Unit. Nursing care plays an important role in determining the success of patient treatment. The careful, meticulous work of nurses and technicians greatly

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minimizes risks for ventilated patients.

I am also grateful for Dr. Shahid, Dr. Sanderson, and Dr. Batson for imparting knowledge of neurosurgery that will be useful in my practice. I learned many lessons about the prevention of the spread of pathogens from observing the work of sanitation workers. Differences that stem from differing living habits between Americans and Vietnamese, aside from economic conditions, render the remedy a difficult problem.

I would like to thank all members of the global health program for the opportunities, exposure, and experience I had in a public hospital where I saw medical conditions close to those of my own society, and learned not to become lost upon return. •

Woody Hard Leg

Color ascends her plump form in layers—from the wide double skirt up to the chemise beneath the long sleeve blouse beneath the heavy rain jacket, up to the hat which she took off before sitting down in the chair. Despite the layers, she cannot hide her legs, the swollen, thickened skin, what we soon learn to be described clinically as “woody hard.” The shape of her sandals is imprinted on the tops of her feet. She tries to tuck her feet under the hem of the billowing skirts, but my eyes have already spotted the growth on her left lower leg. From the boggy epidermis, it rises first as skin-colored specks with sheen, resembling dewdrops. As it proliferates, drops coalesce into plaques, and later into nodules, organizing in rows like a garden. With time, the larger nodules ulcerate and the skin breaks open like a cauliflower, even accumulating pigments of color along the edges. In shades of yellow and orange, her

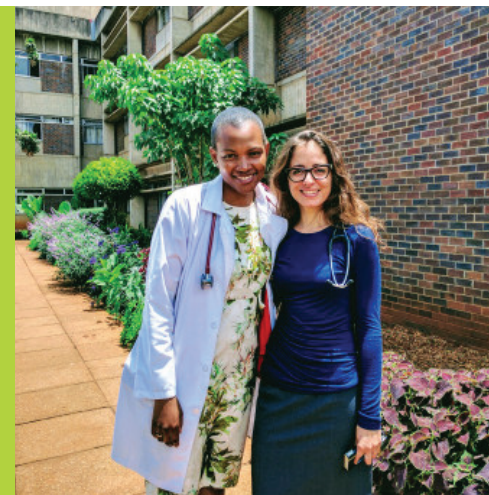
As a new diagnosis, and naive to chemotherapy, she qualified for a study that consists of a bronchoscopy during which fluid from deep within the lung is collected and tested for evidence of more extensive disease.

leg is adorned in the way of a fallen log, deep in a forest, supplying nutrients to a colony of mushroom.

Her name is Glory. She was diagnosed with HIV years ago, but had defaulted on antiretroviral therapy. She does not offer an explanation, but does share that funds

were not a part of it. Later, the resident tells us that the answer is in the bracelets stacked up her wrists. A true believer, she had cast hope anchored in money onto the Church, and had forgone life-saving therapy for years until the swelling of her legs advanced to her hips, and the pain kept her up at night. Now, at the age of forty-seven and a CD4 count of sixty-five, she has acquired human herpesvirus 8 (HHV-8), the virus at the heart of Kaposi Sarcoma (KS), a vascular tumor that like any other cancer can start small and spread big. As a new diagnosis, and naive to chemotherapy, she qualified for a study that consists of a bronchoscopy during which fluid from deep within the lung is collected and tested for evidence of more extensive disease.

Two months later, she has returned to KS clinic for follow up. The resident finds her chart, and leafs through the multiple sheets until he finds the report. He stares at it while inconspicuously shaking his head. “TB.” This changes everything. The patient will need to start anti-TB medications immediately. Treatment of her cancer, as well as of advanced HIV, will have to wait. He explains all of this in a quiet voice to the patient. Each nod of the head is accompanied by “yes, doctor.” While the breakdown of actions to follow, “first we need a viral load, then report to the pharmacy, next...” is clear and well understood, it fails to deliver the real message. She gathers the ends of her skirts in one hand and her large shoulder bag in the other, pushing off the chair with the less diseased right leg with a heaviness that remains long after the door closes behind her. •



KATRIN SADIGH, M.D.

WCHN assigned faculty for program development at Zimbabwe University (shown at right)
Zimbabwe, Summer 2016



ERIN PICHOTINO, M.D, M.P.H.

Class of 2017

Uganda, Winter 2017

Noticeably Absent

Orthopedic Trauma rounds are every Monday morning. We visit each and every patient, take down dressings to look at wounds, review x-rays, and as a team come up with a plan for the week. Other than that, the orthopedic officers and nurses are responsible for following the plan, performing wound care, administering antibiotics and otherwise managing the patient, consulting the surgeons if and when necessary for proper patient care. The day-to-day needs of the patient including procuring implants and medications, bathing, feeding, and physical therapy if needed are taken care of by the caretaker, friends and family members who come to the hospital to help. Most of these caretakers sleep outside the hospital on the concrete, washing and cooking in the open space between wards.

Last Friday, as we waited for the theater to start, we did an impromptu ward rounds. What we found was many of our patients with infected wounds. We were told there were no gloves, so the officers weren't taking down dressings. Carl and I started handing out gloves (sterile and non-sterile) that we had in our pockets and slowly we were able to make our way through the patients. What stopped us in our tracks was a man with an external fixator from an open tibia fracture after a boda-boda (motorcycle) accident.

Something we take for granted in the United States is our sense of smell. We hear about nurses on the wards being able to smell *Clostridium difficile* and *pseudomonas*

infections. Here in Uganda this skill is a necessity. The smell was the first indication that something was wrong. Then, we noticed the flies. The wounds were weeping a greenish fluid and there were patches of flies all over the bandages. As I observed, I noticed a weird spasm or tremor in his leg. We asked him questions and he was unable to answer. I asked the resident if the patient was in septic shock. He asked me why I thought that and I responded, "fever, tachycardia, hypotension, altered mental status." The resident told me to ask the patient again to speak. When I did, I realized he was unable to open his mouth. He had lockjaw. He had tetanus.

After a traumatic injury in the United States, every patient is given a prophylactic tetanus shot. Here in Uganda, there are so many accidents and so few resources that this doesn't happen.

Did we give him tetanus with the insertion of the external fixator? I wondered. When was the last time someone checked on the patient or took down the bandages to check the wound?

Did we give him tetanus with the insertion of the external fixator? I wondered. When was the last time someone checked on the patient or took down the bandages to check the wound?

Perhaps it was inevitable that the patient acquired tetanus, but we didn't

have the resources to treat it either way. The protocol is for antitoxin, antibiotics, vaccination, sedatives and supportive therapies. We weren't equipped on the orthopedic ward to provide this. The team discussed the best approach and consulted the medicine team to see if we could transfer the patient for a higher level of care. Medicine denied the transfer due to the open and contaminated wound and

external fixator—it wasn't safe for the other patients on the ward, they said.

On ward rounds this Monday, the patient was noticeably absent. I was hopeful that he had been successfully transferred to the medicine ward for tetanus treatment. When I inquired, I was told they took the patient to the operating theater early Saturday morning to amputate the infected wound. He died several hours later. •



Dr. Pichiotino (wearing red cap) with fellow global health elective participants



STEFAN WHEAT

Class of 2018 (shown second from left)
Zimbabwe, 2016

Combating Medicine’s Hidden Curriculum

“But we had forgotten that alongside Orwell’s dark vision, there was another - slightly older, slightly less well known, equally chilling: Aldous Huxley’s Brave New World. Orwell warns that we will be overcome by an externally imposed oppression. But in Huxley’s vision, no Big Brother is required to deprive people of their autonomy, maturity and history.” – Neil Postman

My family reached the saddle of Thorung La pass on day fifteen of our twenty-one day trek of the Annapurna Circuit in Nepal, the three-hundred kilometer trail encircling the Annapurna massif. On day sixteen I turned nine years old, and on day seventeen I developed appendicitis. That first night after I began to develop symptoms, I remember clearly when our sirdar, the leader of our expedition, entered the tent where I was screaming bloody murder— writhing in pain, but perfectly lucid. He sang a very tranquil song in Nepali and proceeded to inform my father—within clear earshot of myself—that he did not think I would survive to reach the nearest hospital. This marked my first experience with poor bedside manner.

Now, one year after returning from an elective in Harare, Zimbabwe through the University of Vermont Global Health Program, and with the experience of most of my third-year clerkships behind me, I can see that my experience in Nepal is far from the exception with respect to appropriate modeling of patient care. Indeed, the “hidden curriculum”—the process by which the bright-eyed compassion for the human condition that drives students to the practice of medicine is snuffed out and replaced by callous apathy—is an ever-present feature of medical education. One particularly insidious feature of the hidden curriculum is that it treats compassion as

a fixed trait, rather than one that can be cultivated as an educational goal.

Unfortunately, global health education is not spared the profoundly damaging influence of the hidden curriculum. Just as the pressures of medical education can lead to apathy and indifference, the heavy burden of the global health agenda combined with the critical needs

...the heavy burden of the global health agenda combined with the critical needs of planetary health can overwhelm the compassion that drives students to care about the interconnected and interdependent global medical and environmental initiatives.

of planetary health can overwhelm the compassion that drives students to care about the interconnected and interdependent global medical and environmental initiatives. After all, how can adding the complexity of environmentalism to the equation serve to promote, much less expedite, the execution of the sustainable development goals? True, it is critical that students be mindful of the complexity of the issues posed by the planetary health initiative and that they consider both the feasibility and sustainability of their efforts. However, the opportunity offered by our

increasingly global community coupled with the unique challenges posed by the planetary health movement make now precisely the occasion for lofty ambition and the time to fight the forces of cynicism.

We cannot separate human health from the health of our global environment, and apathy has no role in the efforts to tackle the formidable challenges posed by the one health initiative. How, then, do we as students combat the apathy bred by the hidden curriculum found in medical education? First, we must identify those individuals who we wish to emulate as models of compassionate care, and recognize such individuals precisely for their ability to engender empathy within the confines of rigorous science. My time in Zimbabwe was highlighted by working with Ruth, my teaching resident, who exemplified daily the qualities of a compassionate physician. I remember watching her on one of our first nights

Volunteering in Indonesian Borneo for Health in Harmony was the single most inspiring professional experience of my life.

in the emergency room as she helped another resident perform an emergent pericardiocentesis for a patient with tamponade while still closely monitoring the fourteen-year-old boy behind her with idiopathic toxic epidermal necrolysis. While later reflecting on the chaos of that night, Ruth lamented that she was not able to do more for the boy and resolved to follow up on the patient’s case with the host-country resident. In so doing, Ruth taught me that developing the skills for delivering compassionate care, far from being fixed, is the work of a lifetime and the most valuable ability a physician can cultivate.

Beyond identifying role models for the delivery of compassionate care, it is critical that we cherish and nurture our goals and believe in a path forward that can

encompass the lofty ambitions of global and planetary health. Volunteering in Indonesian Borneo for Health in Harmony was the single most inspiring professional experience of my life. Working for an organization whose mission explicitly combined environmental sustainability with access to healthcare for underserved populations was invaluable to me as a bridge between my passion for environmentalism and my choice to pursue a career as a physician. Attending the 2016 Consortium of Universities for Global Health Conference in San Francisco and witnessing global health’s shift toward emphasizing planetary health reaffirmed my desire to expand upon the model I saw in Indonesia.

In the pursuit of the ambitions of planetary health and the one health initiative, we must remain cognizant of the frailty of the human psyche in the face of overwhelming challenges. The great task confronting this movement is similar to the challenge presented by the hidden curriculum of medical education: paralyzed by what can feel like an insurmountable undertaking, humans are prone to indifference. While George Orwell’s warning against the dangers of censorship in “Nineteen Eighty-Four” was in keeping with the fears of the 20th century, Aldous Huxley’s “Brave New World” more closely approximates the perils of the 21st. Where Orwell cautioned against the concealment of information, Huxley lamented “man’s almost infinite appetite for distractions.” Orwell envisioned the path to ruin paved by guns and violence, Huxley by detachment and apathy. However, as anyone who has worked abroad in global health can attest, the warmth of the people you meet breeds a sense of investment that leaves no room for apathy. Global health has thus provided me with the tools and the drive to pursue my goals and to rage against the complacency and insensitivity engendered by the hidden curriculum. •

Olumwa: The Dangers of Complacency in Global Health

Recipient of honorable mention at CUGH 2017 Essay Contest

“Olumwa?” I asked in my best impersonation of a Lugandan accent. The patient pointed to her belly. She looked as if she had swallowed the moon. She was writhing uncomfortably on her bed in the maternity triage, lying on a single sheet of black plastic. I scanned the room one more time to look for any physicians. The interns, called “junior officers,” were on strike after not having been paid for 5 months. The strike was a drastic measure to confront the unfairness of their plight. The residents, called “senior officers,” were taking exams and studying in the small hallways in Makerere University, quizzing each other on clinical technique and treatments. The attendings were around, but they were few and spread out. It was just us: me, my two medical school classmates, and the midwives called “Sisters” who were charged with directing admissions at the maternity ward at Mulago Hospital. The patient rummaged through her mamma kit and handed me a set of sterile gloves.

“Omanyi luzungu? I’m a medical student from the United States. The Sisters and I are going to take care of you today,” I told her. She nodded.

We admitted up to 70 patients a day at maternity triage. On average, approximately 50 of our laboring patients deliver vaginally and approximately 20 deliver by emergency C-section. Mulago has two operating theatres, and the medical staff must triage the most important cases, for instance uterine ruptures

are given priority over women with cephalopelvic disproportion, but sometimes the mothers in the high-risk obstetrics ward like those with severe pre-eclampsia jump the list quickly if needed. Women in the post-natal maternity ward who have severe postpartum hemorrhage jump the list, too. With the sheer volume of patients and acute cases we see every day, not every patient can have immediate access to a theatre or a skilled attendant. Despite the best efforts of the medical staff, this lack of clinical resources and clinicians resulted in devastating stillbirths, terminations and in some cases, maternal death. This was my reality for 6 weeks.

When I returned home, I used the phrase “I got used to it” while relating my experiences to a friend. I paused to reflect on the reflexive casualness of my response. I was referring to the shock I felt my first day of working on the wards where I witnessed overcrowded hallways, women laboring in bathroom stalls and sitting in long lines for the operating theatre, and one maternal death from an uncontrollable postpartum hemorrhage. During my time in Uganda, I treated rural women with HIV who struggled to get access to triple-drug therapy HIV medications, pregnant women who presented with vaginal bleeding after their spouses physically abused them, and elderly women who lived with chronic pelvic pain after years of untreated infection from rape.

Experiences such as these are not



uncommon in the Global South where one hospital alone can magnify global inequalities and injustices. In 2015, the World Health Organization reported that the risk of a woman in a developing country dying from maternal-related cause is about 33 times higher compared to women in developed countries. In sub-Saharan Africa, 1 in 41 women die in childbirth or related complications. Before my work at Mulago Hospital, these numbers were only abstractions. My experience in Uganda humanized the reality that hides behind statistics. I witnessed the tireless efforts of the medical staff who do the best they possibly can given the painfully challenging circumstances. Frankly, I knew this was injustice. Did this mean I had now habituated to it?

The phrase “I got used to it” suggested a complacency. It was as if the limited resources, congestion, and absence of physicians made the reality of injustice somehow more psychologically palatable. But was it ethically palatable as well? Complacency is dangerous. It creates both an expectation and an excuse for the social, economic and institutional causes of human disease. It redefines injustice as a default condition in some parts of the world and not in others. It regularizes global inequality. Essentially, this is structural violence because it neutralizes an

otherwise grotesque reality: the comforts and conveniences of the Global North are achieved (to some extent) at the expense of the Global South. We tolerate the injustices because they are embedded within the ordinary, and we are too far removed to witness their lived experience.

When I feel inertial pull toward complacency, I remember the question I asked my patients most often during my work in Uganda: *Olumwa?* This translates into “Where does it hurt?” As humans, we know what it feels like to hurt, and the universality of pain reminds me that people and communities all over the world are unjustly suffering. We should all hurt for that. My global health work has forced me to grapple with questions of responsibility, accountability and ethics. There is no compass to guide us toward perfectly informed social actions that overall alleviate the injustice and inequality that denies certain individuals health access and quality care but not others. But we can and must try. •



Mulago Hospital, Kampala, Uganda



JANEL MARTIR

Class of 2018
Uganda, 2017



Medicine as Jackson Pollock

You often hear people say that medicine is more art than science. I am starting to realize that when they say “art,” they do not mean Michelangelo; they mean Jackson Pollock. It is messy and chaotic. The people holding the paintbrushes have as little idea of how it’s going to turn out as you or me. When you learn about a medication, treatment, or procedure, you expect it to work. But in real life, how effective are these measures? What are they really doing for the patient? How much does it cost? Does it just prolong their pain? Memorizing a list of drugs and their mechanism of action, contraindications, and side effects, does not paint a picture of a sick human being with an entirely different reality.

A woman we saw last week out on the ward was sent to the Cardiac/Coronary Care Unit (CCU) yesterday. She has mitral stenosis and tricuspid regurgitation, which basically means that the valves in her heart are not working well and blood is not flowing the right way. As we talked about treatments and valve replacements and medications, I realized that this woman is going to die. She cannot afford a new valve for her heart. She may spend the rest of her life in the hospital getting pricked by needles and gawked at by medical students. She is only forty years old.

So again I ask, what are we really doing to help her? On the flip side, in the United States this woman may be given a new heart valve regardless of her ability to pay for it. Only afterwards when she gets stuck with the medical bill and has to file for bankruptcy do we see the consequences of treating. The balance between under and over treating is difficult to find.

I find it interesting that Cho Ray Hospital has some very advanced equipment but lacks the staff or beds to support the number of patients they

care for. A cardiology patient will get an echocardiogram, but will be missing something more simple such as their intake and output recorded. It seems that there is a discrepancy in resource allocation. Compared to the United States, doctors do much more here and nurses do much less. Family members take the role of caregiver by feeding, bathing, and changing their loved ones. Despite the challenges that family members, doctors, nurses, and hospital staff face every day in such a busy hospital, they still do a remarkable job treating patients with the system they have.

On a different note, I have been watching the videos of the murders of Alton Sterling and Philando Castile. I cannot imagine the feelings of anger, helplessness, and grief the black community must be experiencing, this week especially. I take for granted how safe I feel as a white person every day. Even here in

I find it interesting that Cho Ray Hospital has some very advanced equipment but lacks the staff or beds to support the number of patients they care for.

Vietnam, I get special treatment. I have been ushered to the front of a long line of people waiting for an elevator. I have been helped by multiple people at a fruit market when other people were there first. I have been told that my white skin is very beautiful because the Vietnamese prize fairness and perceive darker skin as lower class. I have been taught by Vietnamese doctors while Vietnamese medical students vying for their attention and the chance to learn are ignored. I am halfway around the world and am still witnessing institutional racism. This is a global health problem as dire as any other. •

JULIA COWENHOVEN

Class of 2019 (shown at right)
Vietnam, Summer 2016



SARAH KING, M.D.

Class of 2017
Uganda, Winter 2017

Outrage as Impact

I’ve been home now for just over a week. I was so excited to return to my friends and family and, perhaps most of all, my two dogs, that the realization that I was home did not sink in for a couple of days. Thoughts are now setting in. I feel sad that I was not able to help more, and guilty that I am able to fly across the world back home to my comfortable bed, to my car, to my healthy family and friends. I feel guilty realizing just how very privileged and lucky I am. We give one of my dogs who is fourteen years old a medication for her painful arthritis that many patients in Zimbabwe cannot even afford. I’ve been struggling with feeling despair about the lives and suffering of so many people, of such profound poverty.

One of the most frustrating parts of coming home is noticing how difficult it can be to recognize our own privilege.

One of the most frustrating parts of coming home is noticing how difficult it can be to recognize our own privilege. It’s so easy to get caught up in our own lives without understanding just how lucky we are, without realizing what it means to have nothing. It has been saddening to return home and be faced with the political discourse in this country—to see our own government shutting the doors to the

populations most in need outside of our borders, but very likely within our borders as well.

I’ve been listening to a five-part podcast series by *On The Media* describing poverty in America. One concept discussed has hit home for me as I try to grapple with my time in Zimbabwe. The narrator describes the rejection of empathy by psychologist Paul Bloom, author of *Against Empathy*, who argues that compassion, caring, and love can be useful, but putting yourself into the shoes of other people can lead to burnout. I’m not sure that I entirely agree with this line of thinking. However, I did identify with the described rejection of empathy by playwright Bertholt Brecht:

“When he depicted injustice he did not want us to say, ‘yes, I felt like that too, it’s only natural. It’ll never change. The sufferings of this man appall me because they are inescapable.’ Brecht worked willfully to undermine our empathetic tears so that we could see more clearly and say, ‘that’s not right! That’s unbelievable! It’s got to stop. The sufferings of this man appall me because they are unnecessary.’”

This, ultimately, is what makes me feel empowered to use my experiences in Zimbabwe to make a difference in the future. I don’t need to tuck away my compassion and love for a suffering person, but rather need to use my own outrage at the injustice to make an impact. •



JAMIDAH NAKATO

Former coordinator of the Makerere University/Yale University Collaboration, founded by Dr. Majid Sadigh. Uganda, 2017

Bringing a Unique Perspective to Healthcare

I worked for the Makerere University/Yale University Collaboration as an administrator for almost six years until retiring last September to pursue my PhD. Working for the collaboration gave me the opportunity to meet new people, exchange ideas with brilliant students, staff, and visitors, and provide them with guidance or a listening ear when they needed it. At first, it was difficult to make new friends in such a short time only to say goodbye six weeks later. But with time, I felt increasingly inspired by the experience. Many of these program participants were in Uganda for the first time. Some, not ever having heard of Uganda, had found it on a map just before arriving. And their challenge was perhaps greater than ours: not only were they meeting us for the first time, but they were placing their lives in our hands, trusting us to guide them through the highs and lows of this strange six-week rotation.

Through attending a number of feedback sessions held with participants, I noticed a recurring pertinent issue: the gaping shortage of staff in government hospitals, especially Mulago, one of the nation's national referral hospitals with a huge patient burden and a higher burden of disease that inhabitants of Uganda and neighboring countries feel can only be treated there. At first I just listened, marveled, and groveled at this fact. I had watched as scores of doctors, students, and visitors came from around the world to conduct research aimed at solving medical problems, and then left or moved on to another project after criticizing the human resources shortage but leaving the issue otherwise unaddressed.

But one day, it hit me.

Why would I expect health and medical workers to solve a non-medical problem? I asked myself. I have extensive training in management and administration. I have

lived, worked with, pondered, and discussed this problem countless times. Uganda is my country. No international knows its ins and outs better than I do. But what have I done toward addressing the severe shortage of healthcare workers?

I realized that I could become part of the solution rather than continue to lament the problem. That I could address the problem myself, and commit myself to understanding it. It was time for me to come out of the shadows and conduct my own research project. This was my chance to contribute to research as I had seen countless others do through the collaboration. One does not need to be a doctor to make a contribution to healthcare. I had the advantage of familiarity with the management field and experience working with the health sector.

I thus committed myself to developing a proposal: "Employee Skill Management in the Health Sector: A Public Institutions Perspective." This research project is aimed at understanding the factors influencing the shortage and optimization of human resources in health and non-health sectors. It will help the government, administrators, and other private players, particularly those in the health sector, create a conducive environment for the retention, productivity, and commitment of health care employees in Uganda and the rest of the world.

I am now in the process of making my own contribution to medical care, just as the doctors I had worked with—but from a different perspective. I hope the results of my research will move other medical administrators to improve the healthcare system in Uganda through management enhancement and optimal use of existing human resources. We can all contribute to healthcare in our unique way, if only we take the initiative. •

Caring For One Patient, Serving an Entire Community

"Anxious to bring both the year and New Year's Day into line with the West, Peter decreed that the next new year would begin on January 1 and that the coming year would be numbered 1700... But to blunt the argument of those who said that God could not have made the earth in the depth of winter, Peter invited them "to view the map of the globe and gave them to understand that Russia was not all the world and that what was winter with them was, at the same time, always summer in those places beyond the equator." – Robert K. Massie, Peter the Great: His Life and World

As a graduate of Kazan State Medical University, I am proud that my Alma Mater was among the first Russian institutions to send graduates and residents to medical facilities in other countries. Global health is one of the most powerful tools with which professional horizons can be widened. It reminds us why we chose medicine in the first place.

As I walked through Norwalk Hospital for the first time, I was astonished by the picturesque architecture and landscaping. With each new patient admission, we passed by the hospital's elegant panoramic windows with views of young flowering trees outside on the way to the Emergency Department. These observations of nature, however short-lived, balanced my routine, in turn helping me connect more deeply with patients, take more thorough histories, perform better physical exams, and greater understand the illnesses. Just a mere glance outside the window gave me the gift of awareness beyond the hospital rooms.

Suddenly I was not at the bedside of a patient with diabetic ketoacidosis, critically low hemoglobin, or severe sports trauma, but of a human with dreams, endeavors, accomplishments, and a full life that cannot not be directly seen. Perhaps the patient in Room 5 had helped build a hospital, and the patient in Room 12 had helped grow beautiful community gardens. These thoughts lead me to the realization that by caring for a patient, I am serving the entire community—a realization that helps me be a better physician.

Some of the strongest clinicians and educators with whom I have had the honor to work led our teams at Norwalk Hospital. This training gave me meaningful opportunities to learn new things. One of the residents gave a thought provoking presentation that sparked discussion among several doctors, one of whom was a patient's visiting relative. This exchange of information among health care providers, patients, and relatives creates a stronger support system for patients and their families. It is a dialogue we need to incorporate into Kazan State Medical University, for the sake of those in need.

Unfortunately, doctors who practice in rural Russia have a lower chance of incorporating modern medical technologies into their respective practices. Two incredibly useful technologies at Norwalk Hospital included an electronic medical record system, which helped improve connectivity throughout the hospital, and a video interpretation service which helped break down language barriers between us and our non-English-speaking patients.

At Norwalk Hospital, I felt like I was part of a progressive and supportive community full of inspiring role models. I was able to take part in the professional, cultural, and social landscape of the hospital and connect with people from around the globe. Such wealth of medical and cultural experiences provoked new ideas that I hope to realize through hard work on the wards and dedicated global health advocacy. •



RAFAEL KHALITOV, M.D.

Global Health Scholar from Russia Norwalk, Conn., USA, Spring 2017

La Doctora Americana

Among the sea of residents dressed in well-fitted white jackets, pressed white pants, and white shoes, I stood out like a sore thumb in my baggy light blue UVM scrubs, navy blue clogs, neon socks, and dirty white coat overstuffed with my stethoscope, Harriet Lane handbook, notebook, pens, hand sanitizer, and tissue paper. Unlike in the United States, the training level of medical residents in the Dominican Republic are identified by the color of their tops with green signifying first-year resident, yellow second-year resident, blue third-year resident, black first-year fellow, etc. There are no specific colors for the interns (equivalent of fourth-year medical students) while the pre-interns (equivalent of third-year medical students) wear light brown scrubs.

My attendance at La Entrega of La Guardia is another abnormality in itself since no other medical students attend these morning reports. I broke even more traditions by not sitting in the designated section for pediatricians, as my attempt to find empty seats often placed me near the senior obstetrician and gynecologists. Yet, no one commented on my attire or asked me to move. I was excused from these customs simply because I am an American.

Being an American medical student gave me unique privileges that did not always sit comfortably with me. For instance, the attendings told me to help myself to the freshly brewed coffee in the office of perinatology, and residents brought or shared their coffee with me on several occasions. I was grateful for their

generosity but couldn't help but wonder if these offerings were "normal" for a medical student, or benefits specific to guests and exchange students. I was also given opportunities to perform newborn exams, place nasogastric tubes, and even draw blood, all of which are valuable learning experiences that I truly appreciate.

However, I mostly saw the clinical duties of the interns from the medical schools in the Dominican Republic limited to recording measurements and bringing blood to the laboratory. Was it fair to the local students that I was offered these additional opportunities? Was I robbing them of essential learning moments? I imagined that I would feel that way if I was in their position and saw that a "foreigner" was privy to extra opportunities. I couldn't

I couldn't help but feel guilty that I was depriving local students of hands-on experiences that are so invaluable in the medical profession.

help but feel guilty that I was depriving local students of hands-on experiences that are so invaluable in the medical profession.

Were these extra opportunities given to me because I was perceived as an American doctor rather than a student? I was often referred to as Doctora despite my constant explanation that I had not yet graduated from medical school. That title implies deeper patient care responsibilities that I am still working towards accepting as I approach the start of my residency. I was



Jessica Huang, M.D., (left of center, in blue) with the HUMNSA medical team.

also concerned that this term would create a false expectation or impression of my medical knowledge and clinical experience. To prevent any misunderstandings, I made sure I was honest with the residents about what I knew and did not know, and that a procedure (i.e. placing a nasogastric tube) was explained clearly to me before performing it.

However, when I debriefed with Dr. Jomar Florenezan, she shared that she had a lot of autonomy and hands-on experiences when she was a medical student in the Dominican Republic. While it is possible that there have been some recent changes to the medical education infrastructure, our conversation also revealed the difficulty and danger of generalizing my narrow experiences as a universal representation of the teaching here. I also later heard other pre-interns and

interns referred to as Doctor and Doctora, observations that helped me realize that these terms are culturally used for medical students among residents and fellows.

When the patients and families saw my white jacket and called me Doctora, they truly believed that I was a doctor despite my introduction as a medical student on their health care team. I am not sure if they were able to tell that I was an American or assumed that I could provide higher quality care. If anything, my initial inability to answer their questions on the location of the laboratory or the length of their child's hospitalization may have implied the opposite. Hopefully this image or assumption changed as I learned more about the hospital, its service, and workflow, and became more integrated with the team.

From the local provider's perspective, though, I learned that the general perception is that training is better in United States given the available resources, ongoing research, and higher compensation. Many of the students and physicians I spoke with expressed aspirations to obtain further training or practice in the United States. Perhaps it is a case of "the grass is always greener on the other side," but I would have appreciated the opportunity to complete their pasantía, a year of apprenticeship in an underserved region, before obtaining my medical license. I feel that these extra clinical experiences would have provided greater preparation for my residency.

This idea led to the question: would incorporation of this extra year of training into the American medical education system improve the mortality rate or clinical outcomes that are often attributed to the new cohort of residents that begin in July? •



JESSICA HUANG, M.D.

Class of 2017 (shown at right)
Dominican Republic, Winter 2017



**ROBERT KALYESUBULA, M.D.
MBCHB, MMED, FSN**

Cofounder, ACCESS Uganda
New Haven, Conn., 2016

Turning Vulnerability Into a Great Inspirational Tool for Global Health

During my fellowship at Yale University, my wife came to visit me with our four-month old son. It was winter and everything was new for the family. One week into her visit she got a fever and was rushed to the emergency room. I was immediately called in, not to attend to her, but to our son as the doctors cared for my wife. A myriad of tests were performed including a CT scan. In the end, a diagnosis of malaria was made and the team wanted to take her to a high dependency unit. I later joined the discussion and convinced them that she would be fine if we treated her with Coartem, an antimalarial consisting of artemether and lumefantrine.

Because the hospital did not have this kind of drug, the doctors wanted to contact the CDC in Atlanta to get it. Otherwise Quinidine, a drug sometimes used to treat heart rhythm problems but with antimalarial properties, would have been used! Luckily, I had travelled with a few doses of Coartem which I offered to treat my wife. A week after her discharge, I received a bill of \$8,000 in my mailbox which kept increasing every week thereafter. This bill totaled more than a quarter of my year's fellowship funds. I was so confused and felt so vulnerable to the point of wanting to quit my fellowship prematurely.

How could this have happened? Why is it so expensive to treat malaria in the USA? From where am I going to get all this money to pay the bills? These and many more terrifying questions ran through my mind. I realized my experience in the

United States was not unlike that of the medical students and foreign physicians I have hosted in Uganda.

Every year we receive hundreds of medical students, residents and faculty from the USA and Europe in Uganda. It is often their first time in Africa. Though they receive countless briefings before they arrive, nothing seems to prepare them for the realities they face on the medical wards and in their daily routine. Very sick, young patients on the wards with HIV-AIDS and sepsis is a common scene. Often the beds are scarce, to the extent that some patients have to be nursed on the floor and most times by a close relative because the

I don't pretend to have all the answers, but allow me to share a few lessons I have learned over the years.

nurses are equally limited. Privacy, which is at the core of medicine in students' home countries, is a luxury saved for those able to afford private room costs. The litany of stark comparisons between host and home institution often exceeds what they ever imagined before leaving their home country.

The visitors are thus very vulnerable, and a single extreme event such as the death of a young patient could tip them over and irreparably scar them. These life events have the potential to limit future possibilities of becoming the compassionate, empathetic and passionate

doctors that we often want them to be. How can this situation be handled? How does a good global health program turn this vulnerability into a life changing experience that could have a lasting impact? This is indeed a difficult question which needs to be answered by every global health program. I don't pretend to have all the answers, but allow me to share a few lessons I have learned over the years.

Each of us has a point of vulnerability that is often heightened by an unfamiliar environment. What differs from one person to another is the level of resilience. Participant resiliencies vary and are often hard to predict before they face real life

I returned home after my course to become one of four nephrologists serving a country of close to 36 million people.

experiences. It is very important to be aware of and appreciate vulnerability when it surfaces. When the clinicians come to a foreign country for the first time they need to be patient with themselves. They need to take time and be willing to learn not only the medicine but also the culture and environment in which they have gone to work or study. They should be willing to be silent but curious observers who may not be able to contribute much at the outset. However, every lesson should be used to learn and prepare to give back when the right moment comes. For the medical student, it may mean completing

residency as to gain skills in order to return and treat the patients who enabled them to learn so much.

Great global health participants look at every patient as an opportunity to learn something new, not only in medicine but also in culture. They use their experiences as a platform for building empathy, which is the essence of medical practice. Vulnerability of patients and students should stimulate us to look deep in ourselves and draw from inner strength to make ourselves and, more importantly our patients, better.

Global health programs should establish a feedback mechanism as well as a learning environment in which the incidences of vulnerability, contention, tension and struggles from within and without can be discussed in a free and non-judgmental environment. Once this process is handled well, it can lead to an infinite spring of energy that can transform participants not only into global health champions but also into doctors who serve the minority and people in need in their home countries.

To end the story of the piling bills, mentors at Yale University found a way of settling the bill and I never heard from the hospital again. I returned home after my course to become one of four nephrologists serving a country of close to 36 million people. We have also been able to set up a community program called the African Community Center for Social Sustainability (ACCESS) which serves people from rural communities. ●



MORGAN HADLEY

Class of 2019

Zimbabwe, Summer 2016

The Difference Between Knowledge and Comprehension

Before coming to Zimbabwe, I had been warned that many of the patients I was going to see would die. These words intimidated me, but after five weeks I have yet to be stared in the face by death. Instead, patients disappear from their beds. The man from Ward C8 that spoke no English and only wanted to lay on his right side was simply not there one morning. The bed of the woman with labored breathing and severely decompensated heart failure was empty the next day, as was that of the woman with Kaposi Sarcoma on her vocal cords, and that of the very skinny man with HIV and a history of strokes. They were just gone one morning, and new patients shortly took their places. For the number of patients that have died in the wards, I feel like we have seen just as many discharged. In the Intensive Care Unit, however, the ratio does not seem to be quite as even. The man with tetanus, the woman with goiter, and the girl with the necrotic uterus...all three disappeared, leaving behind empty beds.

Many of these patients seemed to be stable or improving. Staff are not fazed by losing patients, and it seems to be dealt with very subtly. This speaks to the normalcy of death in the hospital. I think it would be a difficult adjustment to work in a system in which there is often very little that can be done for someone who is really sick besides accepting the fact that they are most likely going to die.

However, this week, what stood out to me most was a patient from the Neurology Clinic. The patient was a thirty-two-year-old mother of two, separated from her

husband and unemployed. She presented with progressive chorea of her shoulders and arms, and some short term memory loss. The patient's aunt who was with her explained the patient's history of worsening symptoms. When the patient was asked to describe the problem, her answer was simply, "my shoulders," and when asked to, she was unable to remember a series of four numbers. Through discussion, it was discovered that her father and uncle had both experienced a similar condition which continued to worsen, and eventually lead to their deaths. With the patient's symptoms and family history, everyone's thoughts jumped to Huntington's Disease.

And right there, my mind stopped. The idea that this woman, at the young age of thirty-two, had already begun an irreversible, steady decline was hard to grasp.

And right there, my mind stopped. The idea that this woman, at the young age of thirty-two, had already begun an irreversible, steady decline was hard to grasp. Huntington's is something I have read and learned about. I know it is inherited in an autosomal dominant manner and that the length of the trinucleotide repeat correlates to how early and severely the disease presents. But knowledge of the disease is very different from comprehending how it affects a person. To actually observe a patient facing this death sentence was emotional. As the

doctors began discussing how to make a formal diagnosis, whether genetic testing would be useful and for whom, and how to best inform the family, I was stuck thinking about this woman's children and what their future holds. I also thought about the patient's mother who already had to watch her husband suffer from this terrible disease and now is most likely going to have to face it again. And finally, my thoughts landed on the patient and what lies ahead for her. Honestly, I cannot imagine what her experience must be like.

In other news, so far the third and final set of attendings have been awesome. Their fresh energy has been much appreciated and needed, as well as their interest in spending time with us outside the hospital. For dinner earlier in the week, we all gathered at Dr. Oltikar's apartment. During much of the evening, I sat back and listened to an interesting conversation about medicine and the

differences in systems throughout the world. Conversations like this one are always enlightening as there is so much I don't know.

What stood out most to me was the statement, "Before you can connect with a patient as their doctor, you need to connect to them as a person first," which was then modified to emphasize that this is especially the case if one wants to be a good doctor. This thought touched me because it demonstrates that the human element of medicine still exists. No matter the most recent technology invented, the number of patients to be seen, or the amount of paperwork to complete, good doctors make the effort to connect with their patients. This human connection is part of what drew me to medicine. It was incredible to hear that even in our system in which testing and imaging play the lead role, this element has not completely disappeared. •

GLOBAL HEALTH VIEWS



Global Health Program participant Nicole Woodel, M.D. , in the Dominican Republic.



APARNA OLTIKAR, M.D.

*Chair of the Department of Medicine, Danbury and New Milford Hospitals, Western Connecticut Health Network
Zimbabwe, 2016*

Everlasting Hope

Zimbabweans have the unusual custom of naming their children after important events or emotions they experienced at the time of the child's birth. In 2004, for example, when swimmer Kirsty Leigh Coventry represented Zimbabwe in the Athens Olympic Games, a great many newborns were named "Back-stroke," denoting the event which won her a gold medal. A young waitress I met at the Victoria Falls Hotel explained that her name was "Happiness" because that is what her parents had felt when, after many years of trying to have children, she was born. Things were decidedly different when her youngest brother, the last of seven children, was born unexpectedly many years later. His name was Hardship.

I met Everlasting Hope while rounding on the general medical wards of Parirenyatwa Hospital during the two weeks I spent in Harare, Zimbabwe in August 2016 as part of Western Connecticut Health Network's Global Health Program. I remember being immediately captivated by the biblical proportions of the name, eager to hear the story behind it. Regrettably, I never got the chance. Everlasting Hope, a thirty-four-year-old woman, had been admitted the day before after suffering a massive stroke that left her unable to speak, swallow, or move her entire right side. Her communication was limited to a series of desperate blinks and hand gestures, which frustrated both of us.

Everlasting Hope's hospital care consisted of one liter of intravenous fluid per day, and oral blood pressure medications and aspirin, neither of which she could swallow. Not surprisingly, her condition progressively deteriorated. She died four days after being admitted. I remember explaining to the American medical students in the program that her care would have been very different had she been admitted to a modern, multidisciplinary stroke unit. She would have received nutrition through a feeding tube, medication to prevent blood clots, Telemetry Monitoring to assess for life-threatening cardiac

arrhythmias, and daily speech and physical therapy. More importantly, I explained, in a less resource-constrained medical environment, Everlasting Hope may never have had the stroke because her high blood pressure and high cholesterol would, hopefully, have been diagnosed and treated early.

I returned to Connecticut a few days later, preoccupied. As Chairman of the Department of Medicine at Danbury and New Milford Hospitals, much of my job involves finding ways to continuously improve the prevailing systems and processes in place for patient care. Since returning from Zimbabwe, I find myself no longer thinking just about the patients in the hospitals and communities that my organization serves in Northwestern Connecticut. I think about Everlasting Hope and the countless other patients like her at Parirenyatwa Hospital.

How, I constantly wonder, do we build better systems and processes that could be implemented there, so that patients like Everlasting Hope have a chance for a better outcome?

And this, perhaps, is the greatest value of global health: it expands the boundaries of what we, as physicians, consider to be "our" medical community. After witnessing, firsthand, the devastating impact that globalization can have on vulnerable populations in cost-constrained medical environments, the mission of global health has become personal for me. It is no longer about bringing healthcare equity to nameless, faceless people on a distant continent across the sea. It is about dear colleagues and patients with whimsical names and warm, toothy smiles whose stories I know and whose suffering I have, however briefly, shared. For me, it will also always be about Everlasting Hope. Wherever my future adventures in global health take me, I know that her story and her name, with its latent promise that better times must lie ahead, will guide me. •

Healthcare as Necessity

Observing healthcare delivery here has shown me more than just a different system; I've witnessed a completely different view of healthcare. What procedures are performed, who performs them, what medications are used and how resources are allocated is very different here compared to home. Medical professions have to maneuver a unique balancing act of treating patients with exotic (at least to me) diseases with limited resources while also giving care to a constantly over capacitated hospital. These are vastly different situations from anything we have

I have been welcomed into the homes and lives of locals. I have witnessed the value people place on family and the lengths they are willing to go to care for them.

seen in the United States. However, the most unexpected thing I discovered here in Vietnam is how differently the patient population views healthcare. Healthcare is often seen as a commodity in the United States and, as such, people have expectations of service.

In Vietnam, healthcare is necessity. It's something that people get because they require it to live their lives. They want to receive their treatment and continue on with their lives. They don't seem bothered by how they are cared for, as long as their ailments are taken care of. It's a different experience for me that makes me examine what creates a culture of consumer healthcare, like in the United States, versus a culture of healthcare as a public resource, like in Vietnam. This contrast makes me question the proper mode of healthcare delivery, and the one in place in the United States.

An equally important part of my time in Vietnam has been my discovery of Saigon

and the Vietnamese culture that I know so little about. I've always considered myself more American than Vietnamese. This fact is something I've come to regret as I further my career in medicine and feel compelled to change that so I can practice in a Vietnamese community in the United States. Coming to Vietnam has allowed me to immerse myself in real Vietnamese culture. I have been welcomed into the homes and lives of locals. I have witnessed the value people place on family and the lengths they are willing to go to care for them. I have experienced the warmth that Vietnamese people have towards total strangers.

I'll remember the interventional cardiology team calling me randomly to check in on me in the evenings and invite me to hang out. I'll remember the street vendor who warned me to not confuse the 20,000 dong bill with the 200,000 dong bill because people might try to rip me off. I'll remember the hospital staff taking time out of their days to show me where I can get good ice cream or milk tea. There is so much goodness in the people here, despite the fact that they live in what I would consider very hard situations.

In addition to all of this, I've discovered that Saigon is so much more than what I saw when I visited two years ago. It's more than the crowded streets of District 5 or the western tourist areas of District 1. There's the Chinese community in Cholon, the expatriate Korean community in District 7, and the rapidly expanding and changing Western expatriate community in District 2. There's craft beer, Indian food and sports bars that show the Superbowl. Saigon is so much more multicultural than I had ever expected.

I came to Vietnam expecting to improve my Vietnamese and see different pathologies. I'm leaving with a newfound appreciation and understanding of a growing and thriving culture and community. •



BILLY TRAN, M.D.

*Class of 2017
Vietnam, Winter 2017*



MITRA SADIGH

Editor, Global Health Diaries Blog
Uganda, 2016

Jebaleko

“Jebaleko, Nyabo.”

“Kale, Jebaleko Ssebo,” I respond to the jolly man standing to my left behind the emblematic blue-against-lemon-yellow MTN stand where we are both waiting to buy airtime, something I seem chronically depleted of these days, an affliction with my lazy 1000-shillings airtime purchases the likely culprit. A surprised smile conquers his face, eyes shining with perfectly aligned teeth.

“Thank you for learning our language,” he responds in impeccable English, his accent a sonorous blend of British and Ugandan. His inquisitive expression makes it clear that he was testing me to ascertain whether I had bothered to learn the response to one of the most common greetings in central Uganda: Jebaleko, meaning “well done.” I beam with this welcome yet undeserved encouragement, relieved that my efforts to adjust to the life and culture here, and to connect with people, have not been completely for naught.

“Olunaku Olulungi,” I tell him. Have a good day.

I do not blame him for testing me. Not everyone makes the effort to learn about the place they are venturing to, let alone the language. The amicably pale dark-haired girl sitting to my left on the journey from Amsterdam to Entebbe with squinting eyes and a vague idea of her purpose as a missionary in Uganda stared at me blankly when I told her I was staying in Kampala.

“What’s that?” She asked, eyes blinking vacuously. My jaw dropped and must have remained ajar while I flummoxed over how someone could travel to a country without even knowing its capital. She explained that she had been praying fervently to God for an opportunity to go to Africa, and when he gave it to her, she immediately jumped on board with the group of twenty-something

that, with a quick scan around the plane, I realized overwhelmed the flight. I could have spent the several-hour flight sharing with her the vastness of the African continent and its myriad of cultures and peoples, but I figured the existence of a city named Kampala was enough of a lesson for the day.

While this young woman seemed somewhat cognizant of her own naivety, the middle-aged woman sitting to her left was set in her mission.

“I want to know what values Ugandans are raising their children with, and to show them the proper teaching,” she chimed in cheerfully. I wanted to tell her that she should start imposing her “good values” on her own country before judging and influencing the values of people she knows nothing about, but I remained silent, hoping her time in Uganda would change her perspective, maybe even cause her to reconsider her own values.

I hope that my two flight friends are learning some Luganda. I continue on my day’s journey, Birkenstock sandals cushioning my feet against the rough unevenness of the auburn road. The sun sits in the sky weightless, too early to emit any serious heat. As I scratch off the airtime code and enter it into my phone, I feel the smooth cloth of my burnt orange skirt, purchased in a village two hours North, tickle my properly covered knees as it dances with the breeze. The contrast of my navy blue tank-top stark against the happy-hued flow that begins at my waist makes me feel like a contradiction, one I have become increasingly aware of.

I recall a recent conversation with a shopkeeper.

“Do you wear these?” she asked, holding up a pair of bright short-shorts, her young eyes flaring impishly.

“Not here,” I told her laughing,



REFLECTIONS
AWARD
WINNER

discarding the blouses I was considering, complete with frills and golden buttons I would never wear at home but would attempt to disguise myself in here.

“Oh, so you respect our customs?”

“Of course!” I replied. “I am in your country.”

“Are you sure!” she exclaimed, a common Ugandan response that translates more accurately to a surprised, “really?” “Here in Uganda, we respect our traditions. We cover our bodies.” She continued, “In the USA, women walk around practically naked,” her face contorted as she looked me up and down, trying to gauge if I was one of those people.

“Oh? Where in the USA have you been?” I asked, trying to be polite.

“I haven’t been there, but my sister lives in Miami and says the women never wear clothing.”

While wondering why she would sell a garment she has such strong feelings against, I tried to explain that not everybody in the USA walks around bare and that Miami is a specific kind of place, about cultural differences and perspective taking, about being comfortable with the human body... and then stopped abruptly, wished her a good day and walked away frazzled, wondering if I should have just smiled and agreed.

It struck me that despite my careful efforts to dress according to tradition, the shopkeeper, or anyone else, might judge me for what she imagines I wear on my own terrain. My attempts to look inconspicuous are futile, as not even the darkest tan would camouflage the whiteness of my skin, an attribute I have never been so aware of.

The Lugandan words flowing from my lips will be plastered with the accent of an American, as my covered knees will not compensate for the many eyes that have glanced upon my thighs and my skin that will always gleam privilege.

Nachimuli, meaning “pretty flower,” is my Ugandan name, a sign of caring and acceptance from local friends. As sweet as it is, I cannot escape the knowledge that I am a pretty Mzungu flower wrapped in a Luganda word. My skin color effortlessly negates what I clothe myself in, what words I utter, what smile I wear, what name I answer to.

I have been told by my host sister that the word originates from zigunguzi, meaning a flying object, because the Whites always arrived from the air. “What do you need to fly? Money,” she had said.



These white people who come in zigunguzi became Mzungu, which has also come to signify “wealthy.”

The first week of my first trip to Uganda, a handsome twenty-something man asked me, “What are you doing here?” A common opening question to spark conversation. I thought I would make a friend.

“I’m here exploring, learning about the country, and doing some medical research.”

“Research, eh?” His expression darkened. “What kind of “good work” are you doing here, Mzungu? You came all the way across the ocean to save us Africans from our poverty, mm? We are lucky you’re here to rescue us... how would we get along without you?” he hissed.

His eyes burned contempt, his face darkened with disdain for everything impure, unjust, and malicious about the world: me and all the other Mzungus. I wanted to run, to cry, to fight with him that not all of us are bad, that I am not personally responsible for a continuing history of oppression, colonization, and injustice, that I do not think I am here saving anyone but myself, as indignation rose in my chest on the threshold of eruption– but as I looked into him and into the hatred he felt toward my race, what could I say? He was right. “Mighty Whitey” has intruded on his people’s lives for centuries. I simply stared back, head tipped down and mouth sealed shut, learning my place in a country I am not from, a culture I will never be accepted into, and a history I can never completely understand.

And yet, despite these struggles, the impulse to connect remains. On a bad day, I can recall this smiling man with perfect teeth standing beside the MTN stand with whom, with a simple greeting foreign to my awkward tongue, dressed in an uncomfortably long skirt and Birkenstock shoes under which popped out my white skin that is so vulnerable to the equatorial sun, I connected, even if only for a passing moment. ●

I Could Not Stop Watching Him

Anonymous
Vietnam, 2016

Being on the Infectious Disease/Tropical Medicine unit has been pretty wild. Since we have already taken a class on infections, I feel like I have more of a learning base for this compared to cardiology. It is also less hectic and crowded compared to cardiology, so we have more time and space to perform assessments and discuss patient cases. Our attending is very soft spoken, but knowledgeable and helpful.

We have seen many things that we would never see in the United States including two necrotizing fasciitis cases, three Stevens-Johnsons patients, and plenty of cellulitis, meningitis and encephalitis. These cases are so fascinating. The different bugs and antibiotics we learned about are so pertinent here. It is eye opening that many of these patients who are very sick are so young. Encephalitis seems more common here than in the United States, and many of them seem to be between twenty and forty years old. We also saw the most severe presentation of gout that I have ever seen. The patient had tophi everywhere, covering his hands and feet, lower legs, and even the backs of his thigh and buttocks. His hands and feet were disfigured, and for some reason he was on a ventilator as well. He looked young, probably under fifty years. I cannot imagine how one would adjust to such a condition. I wonder what his life is like now, who helps take care of him, and most importantly, what parts of his life he lost when this disease started to become so debilitating.

There are some differences that I have seen on this unit compared to those in the United States. First, many patients are not sedated while on ventilators. I would say at least half of them are awake and able to move, and the least they can do is

track you with their eyes. Second, the use of antibiotics given for various illnesses, such as cellulitis, differs. Here, ceftriaxone is commonly given for cellulitis, and many of us were wondering why because many cellulitis cases are for gram positive organisms and ceftriaxone is more for gram negative. However, we found out later that ceftriaxone is much more available in Vietnam compared to cefazolin, which explains why physicians choose to frequently prescribe it.

We have seen many things that we would never see in the United States including two necrotizing fasciitis cases, three Stevens-Johnsons patients, and plenty of cellulitis, meningitis and encephalitis.

At the end of the day today, as we were finishing a discussion about another patient, a male patient caught my attention. I could not stop watching him. He was in four point restraints with ropes, along with a sheet that was wrapped around his chest and up underneath his arms, and tied to the head of the bed, presumably to keep him from sliding down. He was sedated and on a ventilator. His eyelids, jaw, and legs were twitching/fasciculating, but he was still fighting his restraints a little bit. Or maybe he was just involuntarily flexing his arms... I couldn't really tell. Something about him reminded me of someone, maybe a patient I had seen before but I'm not really sure. As the team turned their attention to him, the doctor told us he had suffered from organophosphate poisoning, which he had done intentionally in a suicide attempt. I wonder if he will make it. •



BRYCE BLDEVICH, M.D.

Class of 2017
Uganda, Winter 2017

A Great Surgeon

He was a young man with a seemingly bright future ahead of him, a university student with a loving family. He was only twenty years old when he came to Mulago Hospital. He was skin and bones by the time he had arrived, his eyes were sunken and blank as if he knew the end was in sight. Under his thin bed covers lay the source of his malady: an open midline incision. The suture lay exposed, along with his spleen and small bowel. His tattered skin crisscrossed over his open abdomen, the edges of his incision well worn. He had multiple enterocutaneous fistulas.

A surgery gone wrong, they had said. An infection. He'll be fine. We've seen worse. Soon he'll go to the theater. He will be saved. Sadly, they were wrong.

After having been in the hospital for about three weeks, Moses was slowly regaining his strength. The surgical team had found a sponsor to pay for a central line and total parenteral nutrition (TPN).

Not all surgeons are great. although most aspire to be. In a place like Mulago, many if not all of the surgeons display some of the qualities of a great surgeon. While the surgeon who initially treated Moses may not have possessed great skill, they were likely calm in the face of the uncertainty that is felt when performing an emergent exploratory laparotomy. Surgical skill can be gained through hours of practice and diligence, but the drive to continuously improve that skill is much harder to learn.

While the surgeons here at Mulago work with much less than we do at home, they

know the virtue of patience. After having been in the hospital for about three weeks, Moses was slowly regaining his strength. The surgical team had found a sponsor to pay for a central line and total parenteral nutrition (TPN). Everything was set for him to begin TPN, except the intensive care unit was at capacity. Meanwhile, central lines were not allowed on the normal wards. Hence the team was patiently waiting, checking every day and persevering through the bureaucracy. Knowing that the surgical team would be unable to provide ideal treatment for the patient, they continued to provide the next best possible care: keeping the patient hydrated and the wound clean, the only the things they could control at the time.

Moses' story is not one of a great surgical triumph. In fact, it is more a story of failure than anything, but it showcases multiple qualities that a great surgeon should possess. The final quality that Moses' case brought to life is the ability to innovate. When faced with almost no surgical instruments, scant resources, and unreliable electricity, surgeons in Mulago need to be ready to improvise and innovate at a moment's notice. This ability to change procedures and re-purpose ordinary objects is one of the most important qualities a surgeon can have. One must constantly pioneer new ideas and make improvements. This quality in particular seems to be the cornerstone of surgery: the ability to continuously work towards improvement. While the surgery performed in Mulago may not be cutting-edge, I would wager that the surgeons possess the qualities that make a surgeon great. •

A Bridge Connecting Two Islands

Majid Sadigh, M.D., Trefz Family Endowed Chair in Global Health at Western Connecticut Health Network, and Director of Global Health at The University of Vermont Larner College of Medicine.

The following is an excerpt from a panel entitled “Building ethical and effective partnerships between institutions in LICs and HMICs” at the 2017 Consortium of Universities for Global Health Conference.

Forming and sustaining equitable partnerships with international colleagues is a challenging endeavor. It requires passion, leadership, transparency, cultural sensitivity, friendship, and endurance. All the time and effort spent is an investment toward something valuable. Mistakes and miscommunication are unavoidable. Pain is an inherent part of any growth process.

What we gain from a global health partnership is clear: a reminder to our medical students, residents, and faculty that empathy has called us to medicine. We want to connect with patients and families from diverse backgrounds. We care about human stories. We are patient advocates and have been licensed to serve. We want to teach them that we are all connected genetically, across all boundaries, political or otherwise. We want to teach them to celebrate diversity and eliminate boundaries. But it is not our place to define the needs and desires of our international partners. Instead, we must understand their hopes through transparent communication. We can make known our resources, and leave it to them to choose how to use those resources to the potential they envision. It is our responsibility in the Global North to share our resources toward fair, equal access for all.

At the heart of any true collaboration is preservation of the dignity of host institutions. We only do harm by trying to teach locals how to do things “the right way.” We do not know what “the right way” is for them. We can only understand the issues through the power of observation and by asking questions to learn. This is about them, and only then can it be about us. Partnership in global health is not a business model, but a love story. Both sides are in love with a philosophy. Collaboration grows around a beautiful, unified humanitarian concept. Although a Memorandum of Understanding establishes the “rules of the road,” it is insufficient in securing sustainability. With time, the relationship evolves into a true friendship that binds partners together in ways that transcend business. This friendship allows for a deeper understanding of each side’s needs and

barriers, promoting cultural understanding and integration. When friendship binds the players, creative solutions can be found to sustain the program and support friends through difficult times. These are the principles we follow wherever we are.

The infrastructure of a successful global health program consists of a home site and a host country site. At home, an emphasis must be placed on the selection and preparation of American participants interested in global health, and in the support of guests in education and research. In the host country, support systems must be in place for participants sent to elective sites, as well as the alumni of the program—those who have completed the rotation and have returned to their home countries in new positions. The program in the host country must also focus on selection of new candidates.

I would like to share a few lessons learned through decades of work in global health. Seek to partner and work together for mutual benefit and equity. Graciously embrace immersion into the new culture and landscape. Commit to empowering the host country through capacity building. Fight for social justice and equity of resources. Create a co-nurturing environment by recognizing cultural and social factors and adapting to local needs and priorities.

Service, training, and research should work in concert. While many engage in global health with the goal of research, its impact is compounded by service and training. All research endeavors should be centered on how to better serve patients and communities.

To meaningfully advocate for anyone, one must approach the cause free of assumption, bias, and condescension. One must simply ask, from a place of candor, what their needs might be. They have something to teach you, and you have things to learn from them. This truth lies at the heart of global health.

Act with intention and understanding. An international collaboration is akin to a marriage between a plant and a human, with similarities and dissimilarities. If you are patient, committed, and focused on

the mission, the partnership will thrive like the Lobelia that blooms only every fourteen to sixteen years. Its beautiful flowers are worth the wait, as is the flourishing of a

truly equitable partnership. A global health program is essentially a bridge connecting two beautiful islands to allow an equal exchange of complementary resources. •

GLOBAL HEALTH VIEWS



Photograph by Rafael Khalitov, M.D.



KATHERINE WANG, M.D.

Class of 2017

Uganda, Winter 2017

Have You Ever Lived Like This?

It's hard to believe that it's been less than a week since we arrived home. It simultaneously feels like I've been back for an eternity, Uganda a distant memory, and like I was just there yesterday. Home is such a vastly different place—from the weather and physical setting to the people and customs. On the flip side, it is so familiar that it has been easy to settle back into the routine, hopping back into a car to drive on the right side of the road, and working out on the treadmill. I almost wonder if it's been too easy, given the prevalence of reverse culture shock. Maybe it just hasn't set in yet, but I am certainly happy to be home.

However, within the familiarity of home, I am more aware of the things I take for granted here that make life easier. For instance, bringing my grandparents to the dermatologist the other day opened my eyes to a world of convenience. The car they requested through their insurance never arrived and, luckily, I was home, as they surely would have been late had they turned to public transportation. It was an easy drive—nicely paved roads without boda-bodas zipping around or dangerously aggressive drivers. They already had an appointment in clinic, rather than a daily walk-in clinic. When my grandfather was asked at check-in if he wanted to sign up for a program that allows for sharing of his Electronic Medical Record outside of their network, I realized how much I had missed our record systems!

My awareness has extended beyond just this particular event. I now notice the many choices of food to eat, the free time to catch up on shows, and the indulgence of lazing around the house. I feel almost guilty to be enjoying these luxuries.

Many Ugandans would ask something along the lines of, "how is it living in these

conditions?" or "have you ever lived like this?"

Honestly, the living conditions were not uncomfortable. Sure, I complained when my shower sprayed/leaked all over the floor since there weren't curtains, and about there being too many bugs, but I was thankful to have a shower to use. Even though the accommodations in Nakaseke were basic, there was still a flushing toilet, shower head, bed, desk, and an electric outlet. It also wasn't my first time living more simply. I have traveled to various parts of China since childhood, seeing all different levels of infrastructure. I have used squat toilets for years and know to always travel with extra toilet paper. I took a mixture of shower and bucket baths at my grandfather's, slept on the floor on mats, and since then, have witnessed the huge changes that come with the growth of cities over time.

Maybe I was taking the question too literally, considering it on a purely basic level about the accommodations. Or perhaps the knowledge of an endpoint subconsciously made me feel better. I knew I'd be returning

Maybe I was taking the question too literally, considering it on a purely basic level about the accommodations.

to Kampala, and after that, back home. But not everyone has the ability to just get up and leave. It might not be the living conditions that are necessarily bothersome either (which is what I believe I was being asked about), but rather the general, bigger picture elements that would stand out to me the most if I stayed long term, namely the lack of infrastructure and scarcity of resources. Granted, I would have been able to afford private services if needed had I stayed longer. ●

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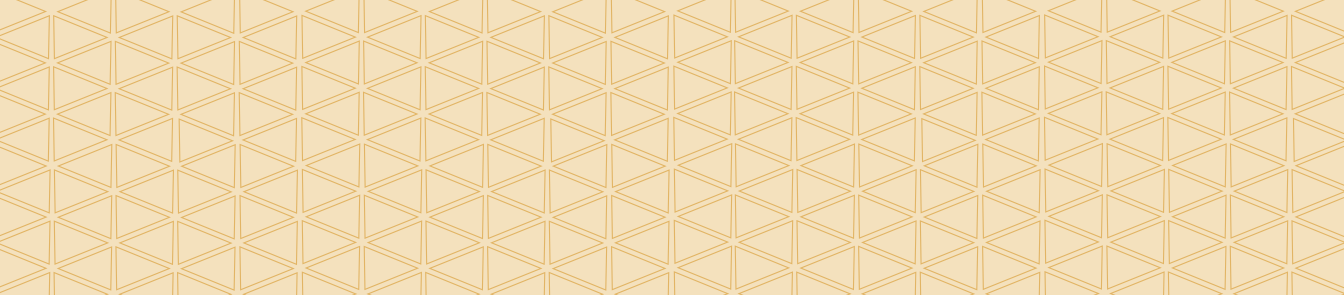
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