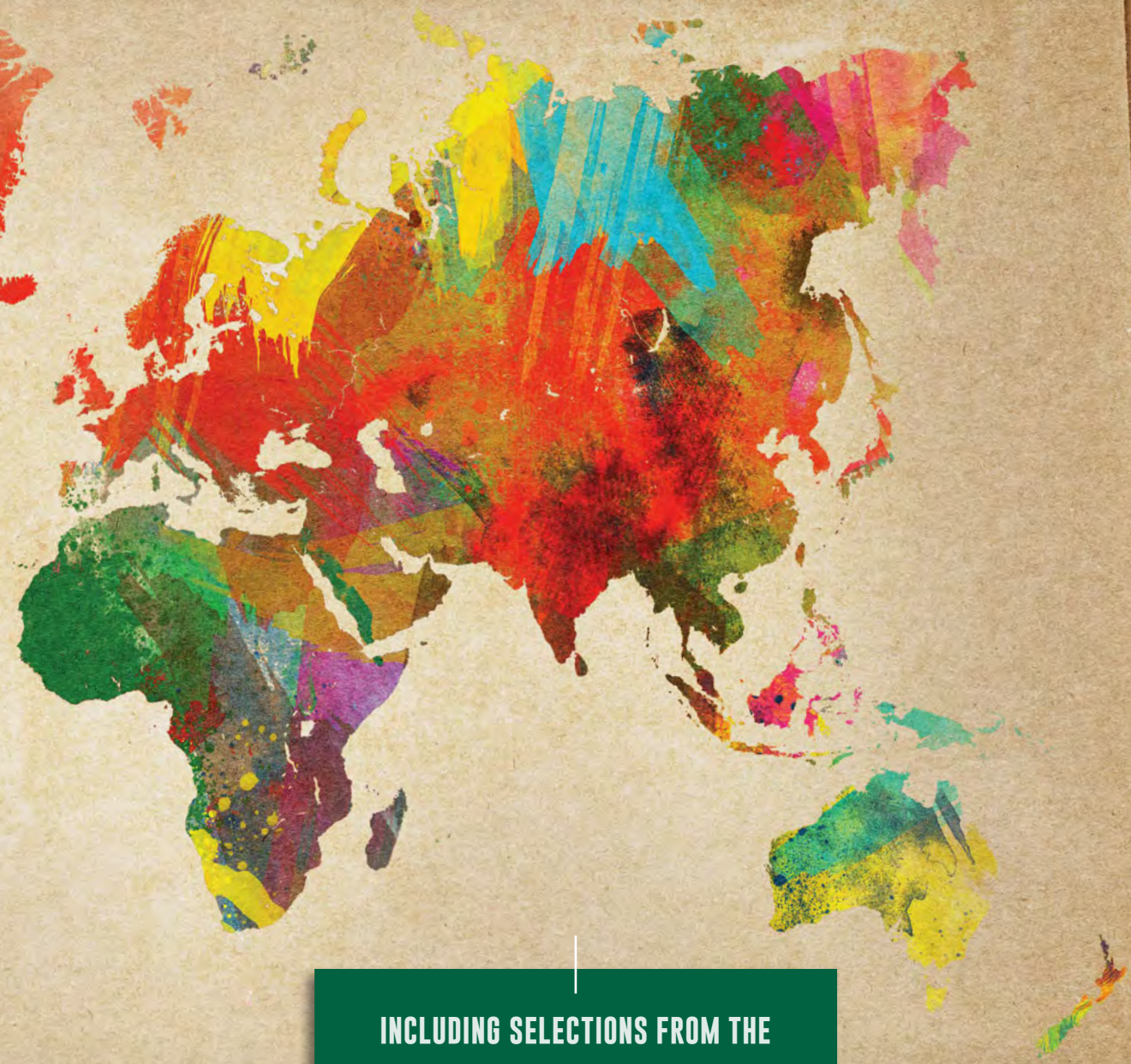
Global Health

Reflections

THE UNIVERSITY OF VERMONT AND WESTERN CONNECTICUT HEALTH NETWORK



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Global Health PHOTO EXHIBIT

2016

THE UNIVERSITY OF VERMONT AND
WESTERN CONNECTICUT HEALTH NETWORK
GLOBAL HEALTH PROGRAM PRESENT

A celebration of global health

On April 4-5, 2016, a "Celebration of Global Health Day" featured a broad range of activities designed to showcase the global health education, scholarship, and service partnerships accomplished through the Global Health Program at Western Connecticut Health Network and The Robert Larner, M.D. College of Medicine at The University of Vermont. A highlight from the program was a photography exhibit and reading of reflections by students, residents, and faculty involved in the program, and awards were presented at the conclusion of the day. Here we present the reflections that were submitted and a sampling of the photographs that were exhibited.

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"Universiade" by Bryce Bludevich.
✸ Awardee for Most Significant Impact

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.
Director of the Global Health Program

TABLE OF CONTENTS

Mary Kate LoPiccolo, '18 (far left)

The Robert Larner, M.D. College of Medicine
at The University of Vermont
UGANDA, 2015

A Young Boy Entered with Big Eyes

After one week in Uganda, I have realized that life here is a constant battle for most residents—a battle against limited funds, resources, support, and often the unfortunate hand dealt them. My own troubles that once felt important now seem trivial in comparison. One patient in particular ingrained this message into my mind.

On Tuesday, we settled to work in the HIV clinic at Nakaseke District Hospital. Expressionless patients seated in rows turned to look at our foreign faces as we entered the building. HIV prevalence in the district is higher than the Ugandan national average, with over seven percent of individuals infected with the virus. It thus seemed apparent that this afternoon would be overwhelming—not only due to the number of patients in the waiting area, but also based on my understanding of the social, financial, and emotional repercussions of the illness.

However, as the clinic began, patient after patient seemed both happy to see new faces and in relatively good health despite their disease and their consequent daily doses of antiretroviral therapy and prophylactic treatment. Young women entered the room emanating fountains of feminine youth, filling me with hope for their long futures ahead. The only real complaint we had received was of back pain from several elderly patients, which was not surprising given their age and lifelong work as farmers.

Yet, as the end of the clinic approached, a young boy entered with big eyes and swollen lips. He placed his blue book containing his treatment record on the table and sat silently, almost nervously, in the chair closest to me. Dr. Herson asked that I interview the patient and record the history of present illness with the help of one of the translators. By glancing over notes of nurses who had previously interviewed him, I learned that his blue book was relatively new. He had been found to have HIV only a few months ago. Someone had recommended that he be referred to both a teen support group and to social workers because he had been struggling with the diagnosis. His most recent CD4 count was below two-hundred, a dangerously low number.

I quickly introduced myself. He responded by looking into my eyes, just briefly. Papules had taken over the skin all over his body, and a crusty, blistering lesion sat above his top lip. Although he did not mention any current pain, I turned to Dr. Herson and asked her to take a look. She talked through a differential diagnosis for his lip lesion—perhaps it was herpes, or maybe streptococcus. She tried to get more information from him, such as how long he had had the lesion and whether his skin itched, but his responses were brief and inaudible, accompanied by a slight nod. After renewing his antiretroviral therapy and prophylaxis prescriptions, we settled on Acyclovir for the current lesion. He quietly stood up and left, head slightly downward and glassy eyes focused on the ground below.

As I walked to the bus, I saw the boy from the clinic standing shyly behind it. I waved to him and he smiled back with big, tired eyes as he stood alone in the bustling village center.

On Saturday, we traveled to a small village in the hills to help out at the African Community Center for Social Sustainability (ACCESS) Family Planning Mobilization and Education Day. After a few hours of meeting members of the community and witnessing the excellent rapport established by two of ACCESS's leaders, we boarded the bus to descend from this hillside village and return to Nakaseke. As I walked to the bus, I saw the boy from the clinic standing shyly behind it. I waved to him and he smiled back with big, tired eyes as he stood alone in the bustling village center. I kept trying to catch a glimpse of him from the window, waving again. We looked at one another as the bus pulled away, and he turned his body, which had aged years over the course of a few months, back toward his village while I watched and hoped for a miracle.

You Are An American Doctor

The first time I met her, she was trying to slip through closing elevator doors. We both apologized profusely and introduced ourselves. She is Vietnamese but lives in the United States with her husband. Later, I saw her in the pulmonary unit. Her mom was sick. She did not understand what was wrong with her. She told me how scared she was. "It's not like the United States," she said.

The patient rooms in pulmonary easily have ten beds. Patients often lay head to foot, two patients to a bed. The room is further crowded by family members who take turns caring for their loved one. Many patients have tuberculosis. The rates of nosocomial infection is unusually high. Nothing about this hospital screams sterile and safe. "I'm scared too," I told her.

Over the next couple days I became more familiar with her mother's case, and would check in daily to see how her mother was doing, and chat with her about life back home or the best phở spots in Saigon. Her mother had pneumonia, complicated by chronic diseases of her liver, kidneys, heart, and entire vascular system. She was an elderly, obese woman with chronic obstructive pulmonary disease and generally declining health before her admission. I looked at her X-rays, listened to her lungs and heart, and watched her ventilator settings. I watched her struggle to breathe. The doctors were giving her antibiotics and a bit of oxygen, but were not treating any comorbidities. Having seen two patients die the previous days, I was worried but hopeful. I spoke with her daughter, prayed with her, and made sure her mother was getting excellent care.

Having seen two patients die the previous days, I was worried but hopeful. I spoke with her daughter, prayed with her, and made sure her mother was getting excellent care.

She came to me many times and said, "You are an American doctor. You are studying medicine in America. You are good, I know you are. You can help my mother. You are better than the doctors here." I reassured her the Vietnamese doctors were in fact a lot more qualified than I was, and that Sandra had reviewed the case and could not see what else to do with the limited resources. But still, her vision of us as Americans, and therefore competent, was unwavering.

Her mother's health declined as the week passed, and so did my hope. Thursday evening, I came in to find her right big toe totally gangrenous. It was charcoal black, and my eyes traced a red, edematous trail up her leg, leading to swollen blisters filled with pus settled by her knee. When her daughter asked me what I thought, it was impossible to paint a rosy picture.

The next morning, like every other morning here, locals parted like the Red Sea for me to ascend the stairs to the eighth floor. The locals looked at me with a mix of bewilderment, awe, and respect that the white coat no longer carries with it at home. As I walked in, I noticed the crowd of nurses and the beeping ventilator equipment. She was coding. I watched the woman watching her mother, crying and praying. I felt helpless, like I had let her down—not because there was anything I could have done, but because I was not the great doctor she saw me as.

Lynn Sipsey, '19 (left)
The Robert Larner, M.D. College of Medicine at The University of Vermont
VIETNAM, 2015

David Reisman, M.D.

Resident in Family Medicine
University of Vermont Medical Center
ZIMBABWE, 2015

We Are Not Here to Save Anyone

Another week has flown by in Zimbabwe with much learned and even a break for a wonderful adventure at Victoria Falls. It seems like we have finally settled in and now know enough people on the labour ward at Harare Hospital to make ourselves useful. The theme of a lack of resources certainly continued over the week. In quick succession, we were involved in two deliveries of babies in need of resuscitation. I quickly ran the first newborn over to the warmer. Oxygen lines were in disarray; I couldn't find any suction catheters, and there were no properly sized masks. As I panicked internally, someone or another would wander over and then disappear, no one seeming concerned. After struggling to find some passable equipment and a few minutes of CPR, the heart rate somehow returned and then increased into the one-hundred-forties. A pediatric intern (where did he come from?) and I continued to check the heart rate and when it did not fall, he walked away.

And just like that, this baby, who ten minutes ago had no heartbeat, was left alone in a back room on a warmer. The quiet did not last long as Michelle appeared with another limp, apneic newborn. This is when resources really became scarce. There was already one premature baby on oxygen and then the one we had just resuscitated was also on oxygen. Suddenly we had another baby in desperate need of oxygen, but none was available. The question quickly became, "which infant does not need oxygen?" After some commotion Michelle began bag masking the new infant while I switched the oxygen back and forth between the other two. For the time being, all the babies have survived. We will never know how those children will do in the long run. I wonder about hypoxic ischemic encephalopathy and cerebral palsy, but for the moment my thoughts are on the immediate situation.

The realities of Zimbabwe in its current state are that resources are in short supply. Certainly things are better than they were eight years ago when inflation was at its peak and the hospital was closed, but they still deal with the harsh reality that some infants and mothers will die due to the lack of resources. For me, having trained in such a privileged locale, this fact is almost inconceivable. In my training in the United States, I have not witnessed the death of one single infant after birth. Yet here I have already seen a handful in three short weeks.

Suddenly we had another baby in desperate need of oxygen but none was available. The question quickly became, "which infant does not need oxygen?"

I feel a wave of emotions: lucky to have been born in and practice medicine in the United States, while also helpless as I know there is very little I can do here. Michelle and I often speak about what we can do and how we can help. But we are visitors here to learn, not to "save" anyone. We try not to interfere, but rather to discuss and understand the obstacles that exist. But deep down we both have trouble not wanting to change things. I imagine this is an inevitable feeling in a global health setting, the kind of feelings that lead people to spend their lives working in the realm of global health. I don't know that it will have that effect on me, but I know what I have seen and learned here will stay with me throughout my practice, and for that I am grateful.

Mama Don't Cry

The loud, distressed calls of an unidentified bird soar in through the screenless windows and resonate in the inpatient solid tumor ward of the Uganda Cancer Institute. They signal in desperation to some power, somewhere, that people are suffering. The lackluster gray floor of the forty-bed facility is crammed with family members of patients living on banana-fiber mats, their few possessions stored in buckets, tea thermoses in hand. The ward spins with cloths, textures, and patterns: pastel flowers sweetening bed sheets, the day's light infusing velvety blankets with sheen, bold colors twisting and melting into gradients on the metallic fabric of traditional gomezes, elegant wraps adorning high cheek-boned faces. Each blink of the eyes is like the turning of a kaleidoscope. And yet the ease of clicks from image to image is obstructed by the white of a nurse's uniform, the sharp metal of a syringe, the banal blue of a portable curtain divide, the muted napkin-like cloths covering oozing, odorous tumors protruding from skin like appendages. The long, pained face of a patient, a few frames later, renders the dancing colors catatonic.

Her daughter is only a few years younger than me. I try to condense this tragic scene between mother and child into a tangible shape that can be transplanted into my own life across the ocean.

Don't cry, Mama, don't cry... calls a voice from this cacophony of images. A woman pleads affectionately. She leaves her own patient unattended for a few minutes and carefully cups misty-eyed Mama's hands in her own. Mama explains to me that after a several-day search for her 21-year-old daughter, she finally found her in the hospital. I glance over at the patient, whose weightless form barely marks the bed cloth.

Her collarbones protrude through her bare torso, the brown glow of her skin dulled. Her eyes are glued open and glazed over with an impenetrable numbness. Her gaze is pulled taut to the ceiling as if by a string. Scattered on her delicate feet jutting out from beneath the sheet, I see invasive blue lesions and instantly recognize her ailment: Kaposi Sarcoma. Pooling in the corners of Mama's eyes, each tear is a jewel of heartache and resignation that streams down her cheeks at various distances from her jaw. She tells me that her daughter is HIV positive and her cancer is in its last stages. Her palliative treatment is lulling her away from this world.

Mama doesn't look at me. With each passing moment, my own gaze seems more invasive. I look down at her hands instead, which are languidly held in the cocoon of knuckles formed by the other caretaker. *Don't cry, Mama,* she coos again.

Guilt quivers through my chest and hot indignation swells in my conscience. Her daughter is only a few years younger than me. I try to condense this tragic scene between mother and child into a tangible shape that can be transplanted into my own life across the ocean. But it's impossible. This kind of tragedy does not traverse the divide between her and me.

I put down my pen, completely aborting the survey that had brought me to the cancer institute. My meager attempt to improve the lives of patients in the cancer ward has proven to be only a self-serving practice in expanding my own understanding, a tap on the glass fishbowl of my own privilege. In doing so, I have triggered Mama's pain and can do nothing to efface the tears that she now sheds silently. I may have even furthered her pain by embodying the injustice that keeps me for my mother but takes Mama's daughter from her. Her tears are in motion, but she stares statuesque into a void I cannot see.

I contemplate the tragedy of a young life suffering such an unfair death and the unnaturalness of a mother watching her child die. I had only wanted to help. But to help I must learn how to give, and to give I must have something to offer, along with the knowledge of what it means to take. I make an oath to myself to someday return with this knowledge, more to offer, and something to give.

Mitra Sadigh
Post Baccalaureate Student in Pre-Medical Studies
University of Vermont
UGANDA, 2015

Tatiana Afanaseva, M.D.

J1 Scholar from Russia
USA, 2015

Reconsidering Place and Purpose

"Traveling teaches people far more than anything else. Sometimes one day spent in other places, gives more than ten years of life at home."

—Anatole France

I never expected the chance to visit the United States. I was so excited when I received the invitation that I began setting goals for the trip that very day: to become familiar with the health care system and medical education in the United States, to improve my clinical skills and English proficiency, and to adjust to a culturally different environment. I can proudly say that I achieved all these goals, and gained even more than I had expected.

I befriended wonderful doctors from all over the world, including very young but mature and talented physicians from Vietnam, India, the Dominican Republic, Uganda, the United Kingdom, China, Canada, and Iran. We supported one another throughout the program, sharing the experience of medical practice in our respective countries, in addition to our cultures, traditions, and histories. They inspired me to read more about my own country and other places thousands of kilometers away from my home. They inspired me leave my comfort zone.

I worked with physicians and teachers who, despite their many years of experience, are still learning and reading the latest articles to expand their knowledge and to best teach younger colleagues. They are extraordinary teachers, specialists, and role models. They patiently and thoroughly answered questions, and enthusiastically explained everything during the rounds. Moreover, I was amazed by their selflessness in working in a free clinic for patients who cannot afford private insurance.

My new friends with their amazing deeds and wonderful plans for the future inspired me to reconsider and adjust my vision of life. These role models included an incredible person with inexhaustible enthusiasm devoting all his life to global health and affecting people's lives in many states all over the world; a couple improving cardiology practice in resource-limited countries; a doctor working with Americares in distant places; a Kurdish woman helping establish a self-sustainable village in Kenya; and a young physician passionately planning to quit his job in five years to work as a doctor for non-profit organizations in remote villages in Africa. All these people completely changed the way I think about the world, and my place and purpose in it.

Moreover, I was amazed by their selflessness in working in a free clinic for patients who cannot afford private insurance.

I am grateful for the opportunity to improve medicine and medical education in Russia. I am confident that applying the knowledge and experience I gained from this experience will give rise to better medical practice in Kazan. This trip left an indelible mark on my soul and mind. It changed me, I am sure, for the better.

The Experiences We Brought Back Home

We recently returned from six weeks in Kampala, Uganda, shadowing, doing research, and studying tropical diseases at Mulago Hospital and the Uganda Cancer Institute. We lived with a host family outside of the city and commuted to the hospital during the week. On weekends we relaxed in Kampala, explored the country, and traveled to Rwanda for a day. This international health elective, which we completed in between our first and second year of medical school, is offered through The Larner College of Medicine in partnership with the Western Connecticut Health Network and Dr. Majid Sadigh.

During our first week in Kampala we worked with Dr. Fred Okuku at the Uganda Cancer Institute. One day in the outpatient clinic we saw a young woman with nasopharyngeal carcinoma. Nasopharyngeal carcinoma is a common cancer here in Uganda and is associated with the Epstein-Barr Virus (EBV). This virus is well known at home because it causes mononucleosis. The patient came in with her older sister and right away we could tell that she was very ill. She looked visibly uncomfortable. Aside from her large neck mass, her left arm was extremely swollen. Her face was puffy; she was struggling to breathe even with a tracheostomy tube, and she couldn't stop coughing. Since we weren't able to provide medical help, we offered what we could: companionship. We talked, and learned about their lives in Kampala. Our patient even smiled as we listened and danced to '90s music in the small patient consult room. When the doctor came back, he was able to prescribe antibiotics so she could get healthy enough to continue her chemotherapy regimen.

When we saw her a few days later she seemed bubbly and bright. Clearly the antibiotics had worked, but so had our conversation. She entered the room, smiled, and began talking to us immediately. Since then, she came back to the clinic several times. Each time we were reminded that even though we cannot yet provide medical attention, taking time to show patients we care is just as valuable.

The next few weeks we were busy between the hospital, the cancer institute and other inpatient wards. We met many Ugandans and other international students. We had clothes made from vibrant African prints and enjoyed meals of matoke (a boiled banana mash), beans, eggplant, and chapati (a fried flat bread). As we settled into a routine between home and the hospital, the once exciting hour-long mutatu (a small bus) trip became ordinary. We were used to passing camels and goats, setting new records of how many people could fit in the mutatus, and bartering for cheaper fares. We learned to tolerate competing strong body odors, getting dust in our eyes, and running out of gas on the side of the road. Boda-bodas, or motorcycle taxis, started to seem more appealing. Most people use them getting to and from work because they can zip in and out of traffic, between cars, and over sidewalks and dirt paths. They are by far the quickest yet most dangerous mode of transportation in Kampala. That said, our program coordinator and host family adamantly discourage taking boda-bodas. They cited statistics of one death per day in Kampala from boda-boda accidents and told tragic stories of muzungus (foreigners) who took boda-bodas and died. Our host father admitted that he once took a boda-boda but paid the driver double to drive half as fast.

After hearing those stories, we were sad to discover that the two autopsies we would be observing one day were boda-boda fatalities. The first victim was a young man and had been a boda-boda driver. Despite his recent trauma, his body showed no obvious signs of death. He wasn't banged up; he didn't have big scrapes or obvious broken bones, and there wasn't much blood. We soon learned that his injuries were internal. The medical examiner found a fractured skull and a brain covered in blood. The medical examiner rinsed the brain causing the blood to wash away. From this he concluded it was a subdural hematoma, which can be caused by blunt trauma and results in veins surrounding the brain rupturing. The medical examiner began to analyze the victim's other organs. He cautioned us from jumping to a conclusion too soon. Sometimes, he said, a boda-boda accident can cause an internal injury, but sometimes an internal injury can cause an accident. In this case, he said, it seemed that the accident caused the injury but that one could never be certain. The medical examiner carefully replaced all the organs, closed up the incisions, and cleaned and dressed the driver.

These patients, along with many others, have taught us many valuable things about medicine, culture, and humanity. We were surprised by how quickly the time flew by, and are excited to share our experiences with our family and peers back home.

Elizabeth Cochrane, '17 (right)
Amy Schumer, '17
The Robert Larner, M.D. College of Medicine at The University of Vermont

UGANDA, 2014

ALEX MILLER, '18 (RIGHT)
Resident in Family Medicine
University of Vermont Medical Center
ZIMBABWE, 2015

The Day I Broke the Golden Rule

I was rounding with a doctor when we were diverted to an emergency. A woman had delivered and was hemorrhaging. Her baby was not breathing and was not responding to resuscitation. The woman was my age but her dark skin concealed any signs of aging. She was experiencing a lot of pain for which no medication was given. It took all my strength to hold her during a torturous examination by the obstetrician to find the source of the bleed. Thankfully her uterus was contracting, however the doctor was forcefully palpating it to further stimulate the contraction which was causing her to lose more blood. She was shivering and her eyes grew white. The doctor left another student and me to massage her uterus. The woman fought us due to the pain. I kept holding her, trying to explain why we were doing what we were doing.

We felt abandoned. The doctor had to round on another eighty patients that morning and was not coming back. The interns in the room were not being very proactive. I kept talking to the woman, cleaning her and trying to keep her warm. It was the least I could do for a woman who was bleeding to death, who had just lost her baby. We checked her blood pressure, started her on fluids, and most importantly politely asked the interns about her treatment plan. One intern went to find blood but returned from the blood bank empty handed. "Blood will not be available for another ten hours," the intern casually said.

This did not seem to faze anyone else but the other student and me. The patient did not have ten hours to wait. Her complete blood count results came back with a platelet count almost ten times less than normal. This woman needed platelets quickly. She was continuing to lose a lot of blood. The urgency and fear in our faces grabbed a doctor's attention, and thankfully we were able to explain her thrombocytopenia. The doctor then told an intern to find platelets and not to return without them. The intern swiftly returned with two bags of frozen platelets. It took another half an hour to get warm water to defrost them until the woman was finally transfused platelets. After two bags she was still bleeding heavily. Another two bags of platelets were found, defrosted and given to her.

I could not decipher this woman's full story—when her labor started or why her baby died. The last I saw of her baby, it was wrapped in a blanket being taken to the mortuary. Her file had been temporarily misplaced. She was in and out of consciousness. At times she would murmur that she did not want us to help and would not care if she would die. Her mouth was dry. I could not find anything in her belongings to drink, so I broke the golden rule and bought her food and drink with my own money. If I was going to break the rule, this woman was surely worth it. I put the straw in the mango juice to her mouth and she drank. She opened her eyes and said thank you.

The trouble is that so many patients are hungry, thirsty and in need of something. Women in labor ask for something to drink all the time, and unless they have something with them they cannot get anything. Four hours from the onset of her bleeding, the woman finally started to clot. It would take another eight hours for her to become stable. By the next day she was talking and eating the food prepared by her husband. I left her curled up on the bed under the small blankets that she intended for her baby. Instead she'll take them home, blood soaked and empty.

I kept talking to the woman, cleaning her and trying to keep her warm. It was the least I could do for a woman who was bleeding to death, who had just lost her baby.

A Symphony of Spring

The car lurches up a hill to reveal a dilapidated concrete foundation that lies within a small clearing of land. The building is like an abandoned skeleton that has been left to rot within the thick tropical forest of the Dominican Republic, soon to be consumed by the impending ecosystem that surrounds it. There are no floors or walls, and the ground is contaminated with remnants of human excrement that leak from the dysfunctional toilets above. A river flows nearby whose pure water has become tainted with trash from the nearby dump site that is carelessly located upstream.

Living within this area is a vibrant and colorful population of Haitian refugees whose buoyant energy and astute resilience fully juxtapose the dull environment which they inhabit. A woman sells eggs, soap, and coffee from the inside of a small shack with a tin roof. Her smile is gentle and her eyes shine bright, like two small windows from which hope and love radiate a reflection of her beautiful soul. Clothes lie drying on the tin roof in the afternoon sunlight. Bright threads of reds and yellows shine vividly amidst a dreary background, which parallel the way that the authentic smiles of the community members who are gathered around cups of tea and lively card games oppose the forlorn environment of which they inhabit—insistently content, resilient and gracious despite the circumstances.

Many of the children are without shoes to protect their feet from impending parasites and infection. They have no toys to play with and yet they continue to carry out a beautiful performance of youth and vitality through their games and imagination. These children do not have access to education or healthcare but their smiles remain innocent, transmitting their untainted contentedness and creativity. Their smiles do not express the reality that they have only a contaminated river to swim in and trash-filled floors on which to live and play. Their smiles do not convey knowledge that they may become sick with infection and not grow up to have the opportunities they deserve. The children carry on joyfully with their games, painting a canvas of resiliency in their wake.

Despite the struggle of assimilating into an unfamiliar landscape, this gathering of refugees finds joy in the small moments of connection. A mother's love, an older sister's hug, a sunny day to share a cup of coffee; it is a mosaic of love that weaves together to create a brilliant illustration of humanity shining boldly against the backdrop of this small corner of thick Dominican forest.

Bright threads of reds and yellows shine vividly amidst a dreary background, which parallel the way that the authentic smiles of the community members who are gathered around cups of tea and lively card games oppose the forlorn environment of which they inhabit—insistently content, resilient and gracious despite the circumstances.

Leah Moody

Global Health Program Coordinator at Western Connecticut Health Network/ The University of Vermont

DOMINICAN REPUBLIC, 2016

Stefan Wheat, '18

The Robert Larner, M.D. College of Medicine at The University of Vermont

ZIMBABWE, 2015

A Paradigm Shift

"It seems to me I am trying to tell you a dream–making a vain attempt, because no relation of a dream can convey the dream-sensation, that commingling of absurdity, surprise, and bewilderment in a tremor of struggling revolt, that notion of being captured by the incredible which is of the very essence of dreams…No, it is impossible; it is impossible to convey the life-sensation of any given epoch of one's existence–that which makes its truth, its meaning–its subtle and penetrating essence. It is impossible. We live, as we dream–alone…"

– Joseph Conrad, *Heart of Darkness*

On arriving at my dorm within the compound of Pariyenyatwa Hospital (Pari) here in Harare, Zimbabwe, I was offered a Zambezi beer by my new (and unexpected) roommates and advised to read Joseph Conrad's *Heart of Darkness*. Much derided as a source of perpetuated racism, Conrad's novella nonetheless contains a number of passages that are striking, some of which I find myself relating to as I begin my rotation here at Pari. The epigraph above relates the depth of the struggle I find myself experiencing in attempting to communicate our experiences here. I may recount the events along with bits and pieces of what I have learned, but I know that I will fall short of capturing the penetrating essence of this place.

Week one necessitates a paradigm shift. Though this is my first formal experience as a medical student learning on the wards, I know from an intellectual standpoint that the medical system I am seeing here is miles and miles apart from what I will see back home. Appreciating these differences has been central to my coming to grips with the raw nature of this experience. First and foremost has been understanding how medicine works in a severely resource limited setting. First line treatments that we take for granted in the United States are not available. However, the consequences of this reality lead to practices that we forego in the states. One of the most common reasons for a patient not receiving treatment here is the family's inability or unwillingness to put forward the money. An MRI costs approximately $1,000 USD, a truly crippling sum for most here in Zimbabwe. The result is that physicians are keenly aware of the cost of each procedure, scan, or treatment involved in their treatment plan for each patient. They advocate for their patient and the cost of their care at every turn. Indeed, Dr. Maturase, one of our attending physicians, explained to us his seminal research on how he has been able to demonstrate marked reductions in overall mortality in stroke patients without the use of imaging, based more on clinical presentation and the World Health Organization stroke criteria. Therefore, while it is challenging to see patients dying here when their outcomes would have likely been much better in the states, it is impressive to see how this resource limitation has led to innovations that dramatically improve patient care.

The cultural component plays an important role in how I have come to process the daily shock we experience rounding in Pari. On returning to check on one of the patients we had seen in the morning, my resident informed me that the patient was exhibiting agonal breathing and would likely not live more than an hour or two longer. When asked if the patient's family should be called, the nursing staff said that they would likely not come. Over the course of the next twenty four hours we lost several other patients, including one of whom was dead when we rounded on him (yes, we rounded on a dead patient—we even made a plan involving calling neurosurgery). Death began to become eerily familiar—you start to eye each newly empty bed in the hospital with a certain degree of suspicion. Part of this familiarity is undoubtedly due to resource limitations, but

another significant contributing element is that the cultural paradigm here is that you bring your loved ones to the hospital to die.

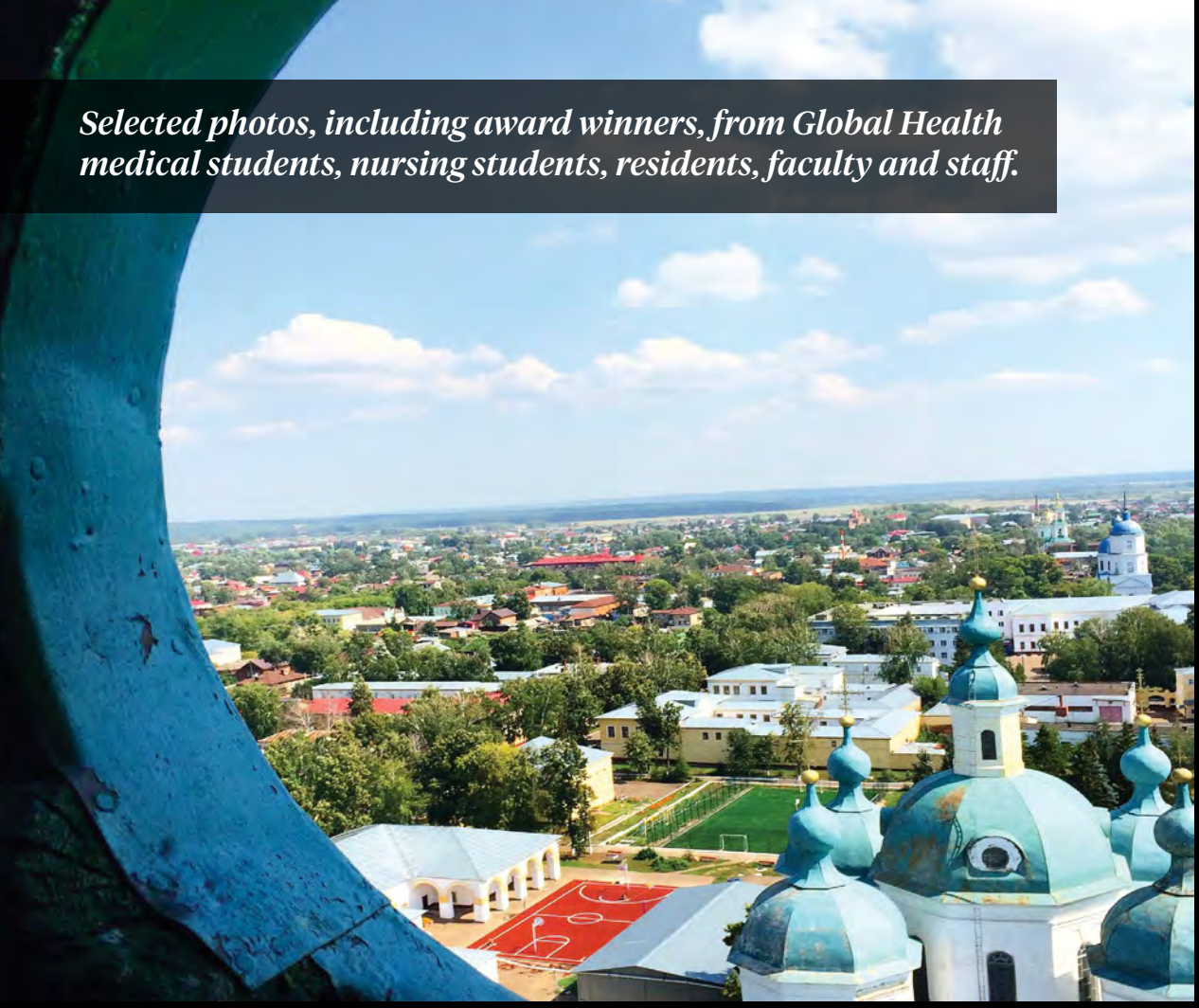
The frequency with which it seems that patients pass on here at Pari can further be attributed to another cultural idiosyncrasy of Zimbabwe: due to the prevalence of traditional and spiritual healers, particularly in rural areas, people often treat western biomedicine as a last resort. The predictable result is that when patients present to Pari, they are often critically ill. Many patients who would undoubtedly be treated in the intensive care unit in the states are routinely covered on the wards due to the overflowing abundance of severe disease. Walking through the wards, it is not uncommon to see patients in status epilepticus, patients with HIV encephalitis, and patients with miliary TB. Though I have seen firsthand the efficacy of traditional healing practices, the result of relying solely on traditional practices, particularly in a country where the prevalence of HIV is estimated at around 16 percent, can be devastating—and in our case, difficult to stomach. Too often we encounter patients with CD4 counts in the single digits. When asked why they defaulted on their Highly Active Antiretroviral Therapy (HAART), many of these patients will tell you that their traditional or spiritual healer told them that they were negative. While, according to the local medical students, this problem is improving and patients are recognizing the need for a combined approach to their ailments, it can be heart wrenching to hear these stories.

Too often we encounter patients with CD4 counts in the single digits. When asked why they defaulted on their Highly Active Antiretroviral Therapy (HAART), many of these patients will tell you that their traditional or spiritual healer told them that they were negative.

Despite these challenges, one overwhelmingly positive part of our experience as medical students here at Pari has been the quality of the teaching. In one of the rounds designed for resident doctors, one of the hospital's senior physicians described—at length—a recent humbling experience where his diagnosis of a myxoma had been proven wrong, all to demonstrate both that dogma has no place in medicine and that we all still have room for growth as physicians. This teaching point seemed particularly in keeping with the strong humanistic focus that is such an overriding principle of medical education in the United States.

The dream-sensation that Conrad describes in *Heart of Darkness* factors heavily in our day-to-day life here in Harare. The past week and a half feels like an eternity and I feel utterly lacking in my ability to relay the essence of this place, much less the overriding sense of shock I feel on a daily basis. However, contrary to Conrad's morose refrain, I do not dream alone. Fortunately, Richard Mendez, Dr. Ruth Musselman, and Dr. Pat Wetherill, my global health team here in Zimbabwe, are all right here beside me. I am thankful for the support, the very personal education afforded me by my program, and the opportunity to share and reflect on this dream-like reality.

Selected photos, including award winners, from Global Health medical students, nursing students, residents, faculty and staff.



"Yelebuga" by Bryce Bludevich '17.
✷ Awardee for Best Composition

"Old Man with Leprosy" by Eunice Fu.
✷ Awardee for Most Original

Mary Katherine LoPiccolo

Stephen Winter

"#4" by Mitra Sadigh.
✷ Awardee for Best Composition

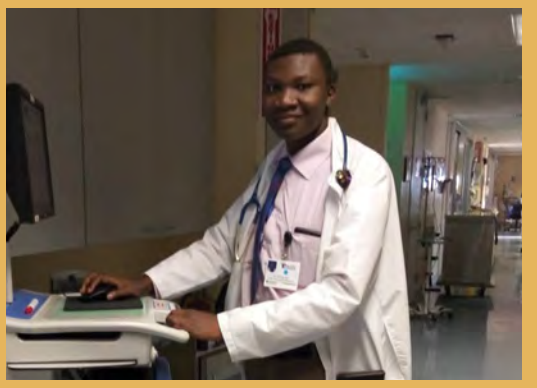
"The Bull" by Ian McDaniels '16.
✷ Awardee for Most Significant Impact

"Buyi Woman" by Eunice Fu.
✷ Awardee for Most Significant Impact

Laura Sibony

Ann Dougherty

Alec Jacobson



Alex Kayongo, M.D.

J1 Scholar from Uganda
USA, 2015

A Beautiful Learning Experience

WEEK 1
It was a Monday morning when the global health program coordinator at Danbury Hospital picked me up from a hotel where I had spent the night. It was freezing cold with currents of very cold dry air blowing at my face when we moved into the car to embark on our journey to Danbury. While at the hospital, I was struck by the enormous Buck Pavilion building with multi-colored fountains in front of it. I could not wait to enter this beautiful building.

Week 2
I was astonished by the diversity of people at the hospital. Most strikingly, doctors on the floor walked so fast and seemed so busy, all occupied on computers. The constant beeping of electrocardiogram monitors every patient was hooked to made me think I was in the intensive care unit. The wards were extremely big but I was surprised that most patients were elderly, above seventy years old, and each team had no more than fourteen patients. Deep in my heart I wished we in Uganda had only half of this equipment. During rounds, doctors mostly concentrated on the electronic medical records. I noticed a big difference: physical examination is very limited in this setting. Physicians hardly palpate the radial pulse, tell the position of the apex beat, feel for the precordium, percuss the chest or asses symmetry. These practices have been replaced by the enormous technological advancements. At least every patient has access to CT scan, MRI, ECG/ECHO and ultrasound scan. I may stand to be corrected, but I learned in my medical training that medicine is an apprenticeship in which the art is passed on from one doctor to another.

Week 3
I was struck by a presentation given by an American doctor in Norwalk Hospital, attended by medical students, residents, fellows and faculty, about a patient he had managed back home in Uganda. He described the ethical dilemma he faced by the financial burden placed on an entire family by sending a nineteen year-old boy with tuberculosis and deteriorating levels of consciousness into the intensive care unit. A moment of silence permeated the conference room. Everyone was so touched by this story. While this experience was very emotional for him, I am used to seeing suffering patients in the ward. Practicing medicine in a resource-limited setting like Uganda seems like a battlefield to many American doctors.

Week 4
I had a chance to rotate in Norwalk Hospital's intensive care unit. I entered a huge twenty-bed intensive care unit with computers scattered everywhere and machines beeping all over with clean ventilators in each room. Peeping through the windows, I saw a very beautiful and healing view across the streets of Norwalk with red and yellow trees, a river, the ocean, and a nice bright sky. Later that evening I walked to the beach, surprised by how it was already dark at 5 p.m. I had never seen this in my entire life, the day getting darker so soon!

While at the hospital, I was struck by the enormous Buck Pavilion building with multi-colored fountains in front of it. I could not wait to enter this beautiful building.

This trip was a beautiful experience. The medical crew, from nurses to attendings, was lovely. I felt like home for the very first time. Bedside didactics were amazing. I witnessed bronchoscopy being performed, and attended a cardiology conference where I saw coronary angiography. At this hospital, I saw a different way of doing things. Residents present patients to the attending, and residents are asked to justify the decisions in management of patients. It is a system-by-system approach where almost everything is tackled.

When is Our Change for the Better Coming?

Why do patients seek medical attention late in Uganda?

As I was going to church last Sunday, rushing, a boda-boda (motorcycle taxi) stopped next to me. On it was the driver, a church member with his ten year-old son holding a nine month-old baby, and another church member running after them! The man jumped off the boda-boda on the side of the road and held the baby up to me. Having been ill for a week, the baby had a pimple on its swollen and tender thigh. His parents had sought care at the local private clinic where they were given oral ampiclox, which they had administered to him for four days. The medication is often over-diluted and underdosed, assuming it is a good quality brand. His parents had tried to squeeze pus out of the small wound opening, resulting in a restless, painful night. The father was relieved to see me, and asked for a prescription for a better drug as the one they had been given had made no difference.

On examination I noted that the baby had a fairly deep abscess on his thigh, and I advised his parents to bring him to a "big hospital." His father was hesitant, expressing his preference for smaller private clinics because of the long queues and poor attention common to big hospitals. I counseled him on a possible need for an incision and drainage procedure, and probably an X-ray to make sure the bone was not involved. I also reminded him that there are often fewer patients at big hospitals on Sundays. On my advice, he went to the "big hospital" rather reluctantly.

I called to check on them that afternoon. The baby had been seen and had had an X-ray confirming the bone was okay. The baby's father was advised to buy gauze, cotton, gloves, a surgical blade, disinfectant and other requirements on a fairly long list for the incision and drainage procedure. Today, three days later, I called to check on the baby and was told he is much better and had gone back to hospital with his mother for review. Hopefully they will be seen despite the chance that they could spend the entire weekday at the hospital. If they fail to get medical attention today, I will advise them to go to the local doctors, the equivalent of clinical officers or physician assistants, at a private clinic down the road.

Across the oceans

Across the oceans and seas, my limited experience of observing health units in the United States, Canada and Europe has been overwhelming. The hospitals do not look like hospitals at all. Many resemble five-star hotels complete with sofa chairs, carpets, flowers, magazines, water dispensers, and no askaris (guards) to chase people out of the hospital. The clinic waiting rooms may have between zero and six patients at any one time, reading magazines or just sitting out the fairly short waiting period.

It all looked so surreal. What I loved most was the artwork. These hospitals are like art museums, often with changing themes. One had depictions of feet, another old faces, others children, or flowers, or houses. The corridors may be dotted with art pieces or huge potted plants, but nearly always with restaurants and book/card /flower shops.

It is only when one gets to the wards that one sees sick patients. One child was riding a tricycle on the ward with its mother in tow just one day after a liver transplant! Another child in isolation who had had a bone marrow transplant for a congenital inborn error was doing class work with a teacher.

During my first visit to Yale New Haven Pediatric Hospital, the pediatric ward had three children: a seventeen-year-old sickler about to go home, a child with leukemia, and a baby with a congenital anomaly. There, babies do not often get sick with febrile illness, or straightforward infections. Most are only seen at the "well child" clinics.

This perspective raised the question: how and when did the United States, Canada and Europe reach where they are now? What did they do right, and what do we do wrong? In one hospital in Canada, a large painting of a Canadian street in the early 1900s looked like Wandegeya, our local peri-urban slum dwelling, with small local shops. When was the turning point?

It seems after the World Wars and the Steel Age, Europe and the Americas changed for the better. But we have had many wars in Africa - when is our Change For The Better coming? When will we be at par with South Africa's healthcare system? What is that magic bullet? Will a national health insurance scheme help? Someone out there, please advise. We need help.

Professor Harriet Mayanja

Previous Dean of Makerere University College of Health Sciences
UGANDA, 2016

SANDRA WAINWRIGHT, M.D., (RIGHT)
Critical Care Medicine Physician, Norwalk Hospital
VIETNAM, 2015

Getting the Pulse Back

Today I learned that the pulmonary department is the highest volume and acuity department at Cho Ray Hospital. It averages one hundred fifty patients in a sixty-bed ward. I will admit that when I walked up to the eighth floor, I was excited to see patients filling the hallway. Room after room was full to double the capacity with patients and their family members doing PT, changing linens, feeding, cleaning, and cooling their loved ones with hand held paper fans, using locally-bought ensure tube feeds, administering medications they bought from the pharmacy, bagging their loved ones because there are not enough mechanical ventilators. I was told by the doctors that there are professional "baggers," people who offer their services to bag the patients for two dollars an hour. Many of them make more than a typical doctor's salary at the hospital.

The X-rays are impressive, and tuberculosis and malignancy are on every differential diagnosis. Patients have little to no exposure to healthcare, so by the time they need medical attention they are severely ill with no past medical history because they have never seen a physician. It is like working up a patient from scratch every time with only lab tests to help figure out what their underlying comorbidities must be. The patients are so kind, happy, and generous in spirit despite most having terminal liver disease, lung disease, kidney disease or malignancy. Regardless of the cause, if a patient has a pleural effusion, he or she is admitted to the pulmonary department and, like in the United States, the pulmonologists treat them holistically, looking beyond their organ system for treatment.

There is little time for doctors to explain what is going on to patients' families, and a respectful barrier of politeness causes families to sometimes be too timid to approach the doctor. The other morning, a jaundiced patient who looked like a teenager but was really much older began to develop respiratory failure and coded. I happened to be nearby and began CPR while the nurses grabbed their medical carts and the resident began to intubate the patient. We were able to get the pulse back.

I was moved to tears when no sooner had I prepared to leave the bedside once the patient was stable when his relatives embraced and thanked me. Other family members just wanted to touch me because they were so grateful. In the ten minutes it took to get the patient's heart back, they had gone to a store and purchased a case of gifts for me. I tried to refuse because they have so few resources, but they were persistent. I had to go to the bathing area the department provides for patients and family members on the ward to weep in private. Fortunately, it is so hot and moist here that maybe they could not tell if I was crying or just overwhelmed by the heat. Later that afternoon, families of other patients reached out to touch me and thank me for my help.

The Vietnamese people call each other brother, sister, uncle, aunt, child. They are like an extended family and treat each other with such regard.

Everyone is in such a desperate situation, yet they put others ahead of their own needs. The Vietnamese people call each other brother, sister, uncle, aunt, child. They are like an extended family and treat each other with such regard. Late that day he coded again. We brought him back but his family knew he was dying, so they requested to bring him home so his spirit would not become a wandering lost ghost stuck at the hospital for an eternity. No sooner had we finished coding this jaundiced patient that the neighboring patient also arrested. We performed CPR on him too, and he was quite hypotensive.

The doctors here are so overworked and underpaid, yet seem to find composure, compassion, and family life balance in the midst of their chaotic lives. It is true that the Vietnamese people are the happiest on the planet. They open up and smile easily once you break the ice and say hello.

I am so grateful for this opportunity of a lifetime. I am unsure if I made any impact on Cho Ray, but Cho Ray has left an indelible mark in my precious bank of memories.

A Treatment that Promised Hope

Last Monday, during our rounds on the female ward, Dr. Violet brought us to the last patient for the day. At first, all I saw were two young girls—one about sixteen years-old and holding a baby, the other thirteen. They had a slight smile on their faces, tinted with trepidation. As we rounded the corner of the cement dividers of the ward, I was struck by the sight of a woman lying on a secluded hospital bed.

She was tiny—her body frail beneath the pink dress that she could barely fill and her temples wasted, forming hollow half-moons on either side of her face. The whites of her eyes were bulging and glassy, and her toothy smile seemed fraught with pain. I honestly have never seen anyone so terrifyingly ill.

Dr. Violet began to tell us the patient's story. She is a 26 year-old woman who delivered a baby boy a month ago in Kampala. She is HIV positive, and according to her sisters, was on treatment until two weeks prior, when she fell gravely ill and was brought unconscious to Nakaseke Hospital. Her sisters were her hospital attendants and the primary caretakers of their newborn nephew. The doctors at Nakaseke immediately started treating her for tuberculosis; however, due to her deteriorating CD4 count and progressive weakness, her health was continuing to deteriorate.

I handed her a few pieces of candy that I shoved in my pockets early that morning, thinking I would see some pediatric cases, and looked down at a perfect child.

In an attempt to lighten the wall of white coats that she faced, I walked over to the youngest sister who was holding the baby boy. I handed her a few pieces of candy that I shoved in my pockets early that morning, thinking I would see some pediatric cases, and looked down at a perfect child. He was quietly sucking on a bottle, as his mother was too ill to breastfeed, and his fingers looped around my thumb as I went to touch his plump cheek. I remembered in that moment that this child was born to an HIV positive mother. "Dr. Violet, has the baby been tested for HIV yet?" She replied with a sigh, "Yes, we are still waiting for the first round of results. However, he presented with oral thrush and has been on treatment for about a week." A seropositive diagnosis was presumably on its way.

This Thursday, we entered the outpatient clinic to work with Sohi, our third year resident from Norwalk, in the HIV clinic. Things were a bit busy that morning, and we decided to wait for instructions from the health care workers and interpreters that we would be teaming up with by sitting on the empty benches behind the HIV clinic check-in table. As I walked toward the bench, I saw the older sister of our very ill patient from the week before. At the end of the bench in the corner of the room, I caught sight of the young woman. We had checked up on her last Friday, and she was sitting up in bed, her eyes not quite as bulged, and her frame gradually gaining strength. Now, it was a completely different picture. Her body was curled up on the granite bench, eyes wide open, teeth bared, and abdomen breathing at a forced, rapid pace. She was obviously suffering and rapidly deteriorating. Had she been discharged? Why was she in the clinic? Where did her sisters and son disappear to?

I found Sohi just as a health care worker was bringing a wheelchair and the sisters appeared behind him. We tried to help as the men carried her into the chair and her face grimaced in pain. Before being wheeled back to the inpatient ward, her youngest sister delicately lifted her worn and wasted feet onto a rolled up blanket sitting on the foot rest. She was carried away as we walked toward the HIV clinic where dozens of patients were lining up for a treatment that promised hope.

Mary Kate LoPiccolo, '18

The Robert Larner, M.D. College of Medicine at The University of Vermont

UGANDA, 2015

Michelle Dorwart, M.D., M.P.H.

Family Medicine Resident
University of Vermont Medical Center
ZIMBABWE, 2016

Nothing Is As Simple As It Seems

It has been a week since I arrived via a bumpy landing at Harare International Airport for a month-long obstetrics rotation at one of Zimbabwe's tertiary medical centers. I vacillate between cautiously navigating a foreign system and readily integrating into seemingly universal medical practices. I am learning that being a doctor in Zimbabwe is in some ways unrecognizably distinct, while in others, comfortably familiar. Some moments are jarring and heart-wrenching, others humbling and heart-warming. The Zimbabweans I have met have been warm, smiling, and eager to extend a warm welcome to "Zim."

Throughout my preparations for this trip, I received undue praise from friends, family, and patients about how great it is that I would travel to Zimbabwe for a "medical trip," with the assumption being that I am somehow going to accomplish something great or to "save" people from death or illness. While I would love to be able to end vertical HIV transmission or to vaccinate everyone against HPV, to claim the title of humanitarian or rescuer of orphan children, the purpose of this trip is comparatively self-serving. I am here to gain perspective—to observe, to experience, and to learn what little I can in this short time about medicine and childbirth in a setting where healthcare resources are scarce, complications are frequent, and the only reasonable birth plan is for both mother and baby to survive. According to a study published by the Zimbabwe Ministry of Health and Child Welfare, in 2007 there was one maternal death for every one hundred thirty-eight live births, and one perinatal death for every thirty-five births.

Prior to departure, we were encouraged to read an article that discusses the arrogance of privileged westerners who imagine they can simply swoop in for a month or two—or even a year or two—and solve what is presumed as the readily solvable problems facing developing nations. Although I wish I had the power and ingenuity to solve systemic health problems here in Zimbabwe, as well as at home in the United States, the more experience I gain in healthcare, the more I understand that each seemingly simple problem is a confluence of social, financial, political, historical, environmental, and religious factors. Meaningful change in any one area requires more than just money or equipment or a new perspective from an outsider. While I hope to never become jaded or to lose hope for a healthier, more just world, I continue to learn that nothing is as simple as it seems.

One morning on antepartum rounds we encountered a woman who had been admitted for management of a miscarriage at thirty-four weeks. The patient was sitting up in bed, distraught, with tears rolling down her cheeks. My heart ached for her as the doctor presenting her story told us that this was her second third-trimester miscarriage. I could not have imagined the next thing he was about to say: "And early this morning we learned that her husband has died after being attacked by a group of thieves in South Africa." My fellow resident and I looked at each other, shocked, as the rest of the team continued discussing the patient's care. While they of course found the woman's story to be terribly sad, it was as unsurprising to the rest of the group as it was incomprehensible to us.

While they of course found the woman's story to be terribly sad, it was as unsurprising to the rest of the group as it was incomprehensible to us.

But despite the many sad and shocking stories of delayed medical care and severe complications of pregnancy, it has been a pleasure to join the excellent team of doctors and midwives working in the labour ward where 40 to 50 babies are born every day. There are no epidurals, no birthing tubs, no electronic fetal monitoring, but amazingly strong women birthing a lot of adorable babies.

Lessons from Guatemala

I recently returned from a two-week trip to Guatemala where I, along with several UVM attendings and residents (in pediatrics, anesthesia, ENT, and plastic surgery), participated in a medical-surgical mission experience. In Nuevo Progreso, a small town approximately five hours from Guatemala City, our team of 50 plus physicians, nurses, and trainees assisted in performing general, ophthalmologic, gynecologic, and plastic surgeries for one week.

Although we all left the country with an overwhelming sense of pride for having accomplished our goal, it was clear that we gained just as much, if not more, than the patients we saw. Reflecting back on my experience now, I can think of three important lessons that I will hold close as I continue my journey in medicine:

A little bit of gratitude goes a long way

A common thread throughout our trip was the gratitude shown by each patient and family member we encountered. Within a few hours of our arrival, we quickly learned that our patients had traveled hours, sometimes days, to arrive at the hospital's doorstep, in hopes of a chance to be seen by a surgeon (there was no guarantee!). Those for whom surgery was an option happily agreed to be operated on, without much of a consent process or overview of risks involved. Mothers willingly handed over their children to undergo cleft lip and palate procedures, silently brushing away tears and smiling to hide their anxiety. Those coming out of surgery thanked their medical teams profusely and their families also expressed immense gratitude. Most heartbreaking for me, however, was delivering bad news and telling an elderly gentleman with a disfiguring, invasive skin cancer, that there was nothing our team, with our limited equipment and time, could do for him. Still, he thanked us for seeing him, shook each of our hands, and held his head high as he graciously walked out of the exam room. I have observed that contrary to popular belief, healthcare professionals in the United States have an often thankless job. The sense of gratitude that we felt from our patients in Nuevo Progreso was invigorating, moving, and contagious.

The practice of safe and effective medicine can be simple

I had heard and read about physicians lamenting the evolution of their practice to what they've coined CYA or "cover your ass" medicine. We live in a nation where patient safety and quality improvement research has created detailed checklists, protocols, consent forms, note templates, and the like, which dominate our time, taking away that spent with actual patients. In Nuevo Progreso, administrative work was limited to standard paper charts for documentation, allowing us to spend more time with our patients and see a higher volume. The turnover rate was unbelievable; our medical-surgical team was able to perform over 300 surgeries in just seven days. Furthermore, the complication rate was extremely low; whatever issues there were, were minor. Witnessing the fluidity of transitions and the exceptional patient care delivered was refreshing, and made me think twice about the way we practice medicine in the United States.

Do not underestimate the power of a small gesture of connection

Having taken some Spanish in college, I felt fortunate to be able to speak with our Guatemalan patients in their native language. I was able to learn, for example, that one non-verbal patient was, in fact, catatonic due to severe depression that had plagued her for over a decade, while one mother carried enormous guilt and self-blame for her child's cleft palate. Many of my colleagues at the hospital, without the assistance of translation services, resorted to gestures and charades to communicate with their patients. Still, I noticed that verbal communication was at times unnecessary, that sometimes all that was needed was an empathetic smile, shared tears, or a strong hug. I vividly remember a scene where a Vermont nurse and a Guatemalan nurse embraced amidst children they had both cared for; the feeling of human connection remained palpable in a room where no words were spoken.

My time in Nuevo Progreso, Guatemala, and each patient I met there, offered a unique, eye-opening experience, while also being a reminder of some of life's simpler lessons, that healing is a gift, meant to be exchanged.

Cordelia Y. Ross, '16
(second from left)
The Robert Larner, M.D. College of Medicine at The University of Vermont
GUATEMALA, 2016

Mitra Sadigh

Post Baccalaureate Student in Pre-Medical Studies
University of Vermont
UGANDA, 2014

Corners

Sister, this patient is very sick.

Musawo, a laudatory Luganda title for Doctor, pauses for an exasperated exhalation.

She needs to be put on oxygen. And she is here in the corner. We should have seen her first. Did you have any sense that this patient is dying?

The question floats out absently from his concerned lips toward no one in particular, dissipating into disjointed particles that elicit no response.

Her saline is empty, sister. She needs saline.

He opens the patient file that lies abandoned on the end of the stark bed, hanging haphazardly off its edge. He flips it open, scans the empty pages and discards it.

This is horrible. She was admitted at midnight last night. She is abandoned in the corner.

A visible panic pools in the valleys behind his eyes. The patient lies behind a closed curtain completely hidden from view. The absence of an attendant nearby makes me wonder how she even arrived at the hospital. Did she self-admit? Did someone bring her and abandon her?

Did you present her at the morning report?

I was present for the morning report, and indeed no mention was made of this patient. The designated intern standing across from Musawo on the other side of the bed shuffles his feet nervously and casts his eyes down at the floor while mumbling something inaudible.

You cannot leave a dying patient unattended in the corner. This time that we spent seeing other patients, we should have been seeing her. She has been here suffering.

Another inaudible mumble.

No, do not tell me that, says Musawo firmly, his hand gripped into a tight fist. He continues deliberately, *Even if you have forty patients, you should help this patient. You should even use your own money for this one patient. The others, they are walking. This one is not. The sisters are busy. You need to come and treat her yourself... otherwise you will find her dead.*

Silence.

The circle of bodies surrounding the bed inflates as if to dilute the concentration of tension. The intern under question dawdles while the other intern stands attentively by Musawo's left side, and next to him an eager visiting medical student lurks over the patient file as if a secret code would be suddenly transcribed onto its dismayed, blank pages. Two more visiting medical students whisper to a third who nods knowingly while the local medical students somberly stand three in a row. Meanwhile, two nurses move about collecting various supplies, their white uniform bonnets perfectly stationary atop their heads like paper crowns, weaving in and out of the circle that morphs disjointedly to let them pass. The patients on the surrounding beds sit up straight and watch curiously, a momentary distraction from their own problems.

Is she pregnant? Can we get a pregnancy test? We should have tested her in the emergency department before admitting her to the obstetrics ward.

Musawo pushes the side of the patient's face with his palm, her head instantly flopping back to where it was. No response.

She has hypoglycemia. Her blood sugar is at 11.
Critically below normal range.

A patient should not die of hypoglycemia.

He pushes her face more aggressively, her weighty head flopping back and forth twice with an emphatic "no" before settling back into its original

position. He places his palm on the center of her chest in between her breasts and shakes from his forearm with his fingers splayed. Her sternum absorbs the motion and shoots back little quivers.

Does anyone have a torch?

He pulls her eyelid open with one hand, holding a small flashlight with the other. The white artificial light shines onto her brown iris that floats complacently in a pool of grimy, sickly yellow. She looks conscious just for a moment until he releases his hold and her eyelid snaps shut.

Severely jaundiced, he notes to the intern adjacent him who records it in the file, one sole scribble on a vacuous page.

This is horrible. These visiting medical students, this is what they will remember from Uganda: that a very sick woman was left in the corner to die.

The patient is completely bare from her waist down. The vulnerable tops of her substantial thighs where her hips meet her legs extend into two thick trunks that swell over bulky knees in a robustly brown hue. The catheter tube trails yellow in between, and empties into a sacrificed medical glove that is tied at the end like a balloon, its fingers plump with crudely concentrated urine and bent comically where the knuckles would be.

Musawo opens the catheter momentarily to extract urine into the syringe he holds in one hand, intently watching the feeble white strip cautiously held in the other. We wait.

He pulls her eyelid open with one hand, holding a small flashlight with the other. The white artificial light shines onto her brown iris that floats complacently in a pool of grimy, sickly yellow. She looks conscious just for a moment until he releases his hold and her eyelid snaps shut.

The patient appears to be in her early twenties with high cheekbones and a surprising softness to her hardy, muscular body. The right side of her lip hangs heavier than the left, giving her mouth a lop-sided strangeness. She looks otherwise normal, as if in a deep, dense sleep. Turquoise flowers are smudged like oil paints on a greasy wax paper pallet against the light aqua fabric of her shirt, the straps of which are broken and dangling helplessly beneath her strong, resting shoulders. Big dark patches of skin, perhaps birthmarks, extend from her right shoulder to under her collarbone like a lonely archipelago on a vast ocean.

She is pregnant, he announces while looking at the strip. He pauses.

She has not even been HIV tested. He turns to the nurse who rushes to fetch a finger prick.

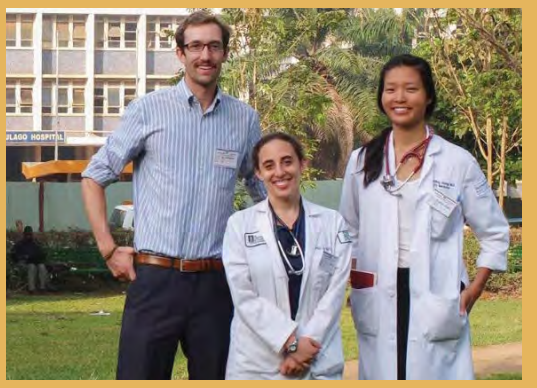
Don't we need consent? Asks a visiting medical student.

In this condition, we need to help her. We need to learn what's happening.

The drop of blood on the end of her middle finger becomes two, then three, then a puddle, then an incessant flow soaked by a cotton ball that needs to be quickly discarded and continually replaced.

Bleeding. Liver damage. Another scribble onto the file.

Her brain is shut off from a lack of glucose. Her other organs might function for some time but not long, maybe only a few minutes, the same minutes that a group of strangers, myself included, are watching her. Her smooth skin is textured with goose bumps, signs of an internal life manifested outward. Her light snoring continues with shallow, undisturbed breaths. The weight of her body is heavy, her muscles, tendons, and bones in deep relaxation on the black trash bag spread beneath her. She is seemingly peaceful despite the chaos transpiring around her. The doctor pulls the pastel yellow-flowered sheet up to her waist as if to tuck her in, and for a moment she looks like she is smiling.



Annie Huang, M.D. (at right)
Resident in Family Medicine
University of Vermont Medical Center
UGANDA, 2014

A Place of Dignity

Uganda is currently one of three African countries including South Africa and Tanzania to have palliative care formally integrated into its healthcare policies. The idea of hospice and palliation is relatively new worldwide, as it only became an officially recognized specialty in the 1980s. The first hospice in Uganda was started in the 1990s, following Tanzania and Kenya, and has since seen impressive growth around the country and increased integration into healthcare delivery. The Palliative Care Unit at Mulago was started six years ago, and has made impressive strides for a relatively unknown and new specialty.

The palliative care team, comprised of nurses and two doctors, sees patients from all over the hospital referred for consultation. From this single service, I felt like I had a unique pulse on the various pathology throughout the hospital, and the chance to peek deeper into the lives of these patients and understand how they relate to their diagnosis. At the core of it all, it is about the patient's quality of life and sense of dignity.

The palliative care team not only worked on symptom management, pain control and psychosocial support, it filled in those layers of communication and advocacy easily lost in a hospital working beyond capacity at all times. The team helped with clinical diagnosis and treatment plans of complex patients, and also helped obtain medications and lab work when needed by going directly to the pharmacy, or coordinating volunteers for those patients without attendants. They helped ensure that the clinical plan was carried out, and that the patient and family were part of the decision process. We explained to patients what it meant to have metastatic disease and what the future may look like—and that even if chemotherapy is no longer helpful, they have choices and we have medicines to help minimize their pain. As treatment options run out, it does not mean that care does as well. For many, it was the first time they had heard that their disease is not reversible. Most of the time, we just listened.

Mulago seems an unlikely place to find dignity. And on those longest days, it seems every patient and staff member could benefit from a touch of palliation. I think that many of the patients we visited did find some peace. Whether they returned home on hospice or remained in the hospital, that additional layer of support was the beginning of dignity- a service that truly should be universally available to all patients. There are so many parts of what we do every day that are resource-dependent, and can become quite frustrating if that is all we focus on. It is amazing, though, what can be achieved with limited resources, and how remarkably uplifting and life prolonging it could be.

Mulago seems an unlikely place to find dignity. And on those longest days, it seems every patient and staff member could benefit from a touch of palliation.

Systemic Social Injustice in Uganda

Uganda is a country of beautiful, resilient people, within a landscape that holds a bloody history. I carry a heavy heart from what I have witnessed at Mulago Hospital over the past fifteen years. The poor sanitation and destitute conditions of many of the patients is overwhelming to observe. The reality that many patients die preventable deaths due to a severe lack of resources is difficult to come to terms with. Their gentleness and innocence are evident by the absence of advocates on their behalf. They are beautiful, generous, and resilient, yet remain helpless, voiceless, and faceless.

These tragedies are the consequence of systemic social injustice. Centuries of oppression under British rule left the nation vulnerable to decades of dictatorship under Milton Obote and then Idi Amin, years of war and civil strife, and government corruption and greed. This sequential tyranny has depleted resources and infrastructure. This depletion has most significantly impacted the poor and impoverished, and nowhere is their suffering revealed more than in the wards where patient families put aside everything to care for their loved ones, and staff do whatever they can in an overcrowded hospital with a shortage of funding, personnel, and resources.

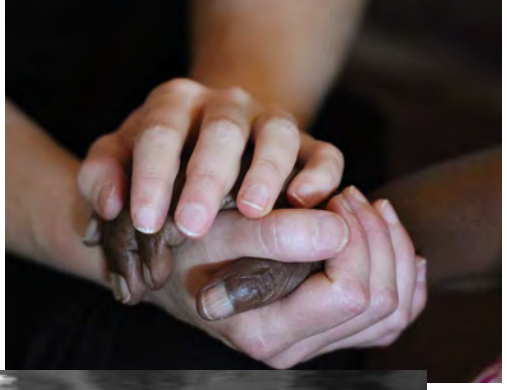
I have inexorable respect and admiration for my Ugandan colleagues, as well as the administrators, nurses and entire staff at Mulago. Many of these people are among my personal heroes. They have enduring lessons to teach to me and to anyone witness to the vigor with which they advocate for their patients. The publicity directed toward Mulago Hospital should be used as a medium to bring awareness of the harsh realities faced in resource-scarce environments to the United States. We do this with the hope that others will join the cause in a simple attempt to advocate for the patients that my colleagues and I have come to know and care for over the years.

I have inexorable respect and admiration for my Ugandan colleagues, as well as the administrators, nurses and entire staff at Mulago. Many of these people are among my personal heroes.

MAJID SADIGH, M.D.
(FRONT, SECOND FROM LEFT)
Director of Global Health at
Western Connecticut Health Network/
The University of Vermont
UGANDA, 2015

In honor of World Health Day, the Global Health Program hosted nine distinguished international guests from Russia, Dominican Republic, Vietnam, and Uganda on April 4-5, 2016 for a "Celebration of Global Health." Designed to showcase the global health education, scholarship, and service partnerships accomplished through the Global Health Program at Western Connecticut Health Network and The Robert Larner, M.D. College of Medicine at The University of Vermont, the celebration highlights included a Dean's Distinguished Lecture on Global Health delivered by Alexey Sozinov, M.D., Ph.D., D.Sc., of Kazan, Russia, a special Family Medicine Grand Rounds and Community Medical School presentation by Uganda's Robert Kalyesubula, M.D., and a photography exhibit and academic poster session showcasing the work of students, residents and faculty.

International guests included Sozinov, who serves as rector of Russia's Kazan State Medical University, and his colleagues Marat Mukhamedyarov, M.D., Ph.D., head of international affairs, and Arina Ziganshina, M.D., coordinator of global health; Marcos Nunez, M.D., medical school dean, and Loraine Amell, Ph.D., dean of international affairs, from Universidad Iberomaericana (UNIBE), and Jomar Florenzan, M.D., global health site director, of the Dominican Republic; Phuong Kim Huynh, M.D., chair of the International Office at Cho Ray Hospital in Vietnam; and Kalyesubula, president and founder, and Estherloy Katali, coordinator, Global Health Partnership, of ACCESS, Uganda.



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