I was raised in a small mountainous village in southern Iran, a land of poor but kind and generous inhabitants. I was one of very few children who had the privilege of a warm and supportive family. It was in this setting that I became familiar with the lives of underprivileged, gentle souls. Rumi became my idol as I searched for meaning beyond simple “happiness” throughout my youth. Voicing the unvoiced gave meaning to my life. I dreamed of becoming a storyteller who narrates the tales of those who cannot tell their own. I attended medical school with this dream, came to the USA with this dream, and joined Yale, and later on the UVM Larner College of Medicine, with this dream. I focused all my energy on using the podium of global health to relay the stories of the underprivileged to those who may not have heard it.

It was at Western Connecticut Health Network that I finally discovered people, both in the community and among the leadership, who shared this dream. John Murphy, the CEO of Western Connecticut Health Network (WCHN), immediately embraced the global health philosophy. In 2016 when he and the Foundation brought my path to overlap with the Christian and Eva Trefz, my dream finally came true. Global Health at UVMLCOM/WCHN has found an identity in being named after a generous family that cares about making a positive impact. Now, whenever I take the podium to advocate for the underserved, the Trefz name moves the idea forward, giving it sustainability and power. I am humbled and grateful that my lifelong dream has materialized into something tangible.
# Global Health Diaries
## 2017 - 2018

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In past decades, Zimbabwe used to be a leader and pioneer in healthcare and education in Africa. The political and economic turmoil that has plagued our country of late has not left our healthcare system unscathed. The “brain drain” has resulted in qualified doctors and nurses seeking jobs overseas where they get better pay, and financial troubles have resulted in shortages of personnel, equipment, and medicines. Despite these unfortunate setbacks, Zimbabwean healthcare workers have continued to strive to help, heal, and comfort the myriad of sick and desperate people that swarm their doors daily.

Healthcare in Zimbabwe, as in all other countries in the world, is a juxtaposition of light and shadow. Given these circumstances, credit is due to the Zimbabwean commitment to educating and training medical students, and providing them with early and comprehensive access to patients for hands-on learning. Furthermore, due to financial constraints and shortages of specialized equipment, an impressive emphasis is placed on history-taking and physical examination in diagnosis making – a lost art in modern medicine. Moreover, there are few places in the world where one is faced with the reality of both the art and the science of medicine, than in a country like Zimbabwe. Global healthcare goes far beyond lab tests and prescriptions. It encompasses the socio-economic, postcolonial, racial, and religious realities that influence if and how a patient will receive the appropriate treatment.

Over the past two summers, I have been impressed by students, residents, and physicians of Caucasian, Indian, and Lebanese descent who were not content with just their perspective of the world. Rather, despite their varied upbringings, they each sought to expand their horizons and develop the framework of their medical practice with real-life, multifaceted, international experience that will undoubtedly make them better physicians.

There is a saying in Shona: “Kungotya nyanga dzezizi, nyamba manhenga.” (“You fear the horns of the owl, meanwhile they are just feathers.”) There is much to fear in the world today with racism and terrorism casting dark shadows across the globe. I applaud and thank UVM and its Global Health Program for not fearing the horns of the owl, for rising above xenophobia and not being deterred from coming to Zimbabwe to learn and work beside us. I hope to see this and other such programs around the world flourish as we seek to improve healthcare for our brothers and sisters around the world.
ABOVE AND LEFT: TENDAI MACHINGAIDZE WITH UVML.COM/WCHN GLOBAL HEALTH ELECTIVE PARTICIPANTS
The six weeks I spent with physicians and clinical officers in Uganda were a lesson in the fundamentals of medicine. In Uganda, doctors do not enjoy the luxury of being able to order any lab test they may need. Imaging is often performed off-site and rarely returned with an interpretation. Medications are purchased only if the patient can afford them, and the two EKG machines I saw were donated by Danbury Hospital in Connecticut.

Doctors in Uganda must be exceptional at history taking and physical exams. They carry an encyclopedic knowledge of diseases and pharmacology in their heads, and they must have endless reserves of patience, creativity, and perseverance. Being in Uganda took me to the very heart of the practice of medicine.

Through observing their practice, I have realized that Ugandan medical professionals rarely have the resources to arrive at a concrete diagnosis. It is uncommon to know with certainty which pathogen or precise disease process is ailing a patient. What Western practitioners may take for granted, such as bacterial cultures or chest X-rays, pose a logistical challenge here and are thus not always considered a good use of resources. Doctors learn to trust their instincts, manage symptoms, and accept that they may not receive hard and fast answers about their patients. Out of necessity, they have learned to accept and be comfortable with uncertainty.

My most valuable lessons learned while in Uganda were about patient interaction. I watched physicians be a calming and reassuring figure to frightened patients and their families. I saw them sit amicably at the bedside and listen to a patient while holding their hand. I respect their advocacy for financially appropriate treatment plans when families cannot afford more. I have watched in amazement as they unflinchingly tend to horrific wounds and ulcers. I have observed their tireless patience and teamwork as they navigate the barriers of working in a country with more than forty recognized languages and a virtually non-existent medical records system.

I may not have learned as much textbook medicine as I had anticipated, but I certainly learned how to become a more skilled and complete physician. I will carry these lessons forward in my career and I will try not to allow the desire for a definitive diagnosis to cloud my recognition of the patient’s humanity.
KATIE GRENOBLE (SECOND FROM RIGHT) WITH FELLOW GLOBAL HEALTH PARTICIPANTS, DR. SAMUEL LUBOGA, AND HIS SONS SAM AND DAVID.
Ethical Dilemmas in Global Health: Promoting Global Consciousness

COMPILED BY DR. MAJID SADIGH, TREFZ FAMILY ENDOwed CHAIR IN GLOBAL HEALTH AT WCHN AND DIRECTOR OF GLOBAL HEALTH AT UVMLCOM, AND EDITED BY MITRA SADIGH, EDITOR OF GLOBAL HEALTH DIARIES.
NOVEMBER 17, 2017

This post is part of a series of discussions about ethical dilemmas in global health, with responses from one global health leader in the Global South and one in the Global North. Please leave us your feedback in the comments section below, and send us ethical dilemmas you would like to see discussed.

Responses by Dr. Stephen Winter, Director of Global Health at Norwalk Hospital, and Dr. Robert Kalyesubula, cofounder of the African Community Center for Social Sustainability, in Nakaseke, Uganda.

Many students and faculty visiting other countries often deal with culture shock. How can the stress and frustration of culture shock be mitigated? What steps have you taken as a leader in global health to address the challenges of dealing with diverse participant backgrounds and expectations?

Dr. Winter: I think it is important to identify explicit points of contact through which to interact with visiting students and faculty. Among these should include scheduled formal meetings to discuss and review experiences that have led to stress or frustration, and would ideally involve a peer from the host side for regular daily interactions and a more senior mentor relationship on a less regular basis, perhaps weekly, to help participants recognize and talk through situations that have lead to emotional or social distress. I think we have done this at the senior level, for example with Dr. Luboga in Uganda, Dr. Ndhlovu in Zimbabwe, Dr. Kimphuong in Vietnam, as well as Dr. Sadigh, Dr. Jarrett, and myself in the United States. However, I think it would also be useful to promote peer mentoring at the local level to promote cultural competency and establishment of personal relationships that bridge the two cultures. Culture shock and its effects should also be addressed in pre-departure orientation activities.
Dr. Kalyesubula: The key here is pre-departure orientation as well as proper selection of candidates for global health. Unfortunately, not everyone who wants to participate in global health is well-suited for the field. For this reason, a careful selection tool to help determine appropriate candidates is crucial. Additionally, the teams on the ground should be prepared to support global health participants, particularly through the first days of their stay, and should be in frequent dialogue with them. Regular feedback sessions should be held to discuss and explain any concerns, and communication lines should be open from both parties.

Please comment on trends you have noticed in terms of participant differences based on their country of origin. What are their respective experiences? What contributions and challenges do they bring to the program?

Dr. Winter: Although it is unfair to generalize, I think certain themes have emerged, as participants from each country bring different attributes. Our Russian participants share many cultural features with their American counterparts, as many Americans of my generation have ethnic roots in Eastern Europe and Russia. Even so, there are important nuances of interaction that can lead to misunderstanding and loss of trust. A simple phrase such as “We must get together for dinner one of these days” is a representative example. To an American, it is an idea that might lead to a firm invitation at some point. To a Russian visitor, it is a hard commitment to meet for dinner and, when not fulfilled, engenders distrust and confusion about motivation. For our colleagues from Uganda, Zimbabwe, Vietnam and the Caribbean, there are important aspects of religious belief, conservatism in dress and behavior, and family dynamics that must be understood to achieve true cultural competence.

Dr. Kalyesubula: Differences among participants largely depend on differences in character. It is not the country of origin as much as the universities and the cultures of respective institutions that differentiate participant attitudes. Most participants from the Global South tend to be more adaptive and humble while those from well-to-do universities feel more entitled and tend to think they are doing the Global South a favor by “visiting” them. They also tend to think that locals do things the “wrong” way and it is their obligation to correct all wrongs and Westernize the practices. Although they may have good intentions, these tendencies have often made the hosts from the Global South withdrawn, rendering the experience less productive on both sides. Proper induction and orientation, as well as humility, can mitigate this issue.
Let me tell you a story about Happyness. Happyness is a young woman living in rural Nakaseke district about sixty miles outside Kampala, Uganda’s capital. She just had her second baby who was born premature, and will likely not survive to his fifth birthday. This pregnancy was conceived eight months after her last delivery, though we know that rapid repeat pregnancy, those conceived less than twenty-four months following a delivery, have dire consequences for both mother and baby.

Happyness did not want to become pregnant. Ninety-five percent of Ugandan women are with her on this matter, but her husband believed that family planning would cause infertility or cancer. Unfortunately, these myths are very prevalent and make a real difference. Knowledge is power— and in this case, knowledge is life.

According to the World Health Organization, postpartum women are a priority target for family planning interventions because of the consequences of rapid repeat pregnancy, a fact that is particularly obscured in rural areas. Postpartum women often do not know when their fertility returns or how to use breastfeeding as an effective tool for family planning. Also according to the World Health Organization, we must use fact-based education and frequent points of contact, and must meet women where they are. If they do not return for postpartum follow-up, then we need to go where they go.

In Vermont, we are doing just that with another vulnerable group: opiate-dependent women. This population is in many ways similar to rural Ugandan women in that they are poor, lack access to healthcare, struggle with food security, and often do not control their fertility. Our Vermont-based program provides myth-busting education through multiple points of contact at a family planning clinic co-located with the local methadone clinic. In a large and ongoing National Institute of Health-sponsored trial, we have significantly increased the uptake and continuation of family planning while decreasing unintended pregnancy. This is a novel, innovative and proven approach. And now we are bringing it to Uganda.

When I started my career in global health, I perceived a need. I knew the statistics. I knew that as a white American woman I had the privilege of safe childbirth, access to contraception, and a supportive partner. I did not, however, fully realize the impact of that privilege. Nothing prepared me for what I saw. In one Ugandan hospital, I witnessed ten maternal deaths in ten
Unintended pregnancy is the modifiable risk factor. And family planning is the way to do it.

One of the things I have learned about global health is that you need solid, reliable partners on the ground. You cannot just swoop in. Capacity building on the ground is crucial. If you want a program to work effectively, you need continuity and long-standing partnerships built on mutual trust and support.

Over the last year, we have worked to adapt our intervention for use in Nakaseke. Through regular Skype calls and in-person visits, UVM and ACCESS teams have puzzled through how to move this project forward so that it makes culturally appropriate sense for rural Ugandan women.

We are now putting these thoughts and plans into action. We are working to be on the ground to pilot this proven effective intervention in a new context. Between the work being done at UVM and at ACCESS in rural Uganda, we have enormous potential to improve the lives of women and families. We look forward to continuing to grow this relationship, and deepening our mutual exchange through this project.
On Hosting Visiting Global Health Scholars

WRITTEN BY ROBYN SCATENA, MD, ASSOCIATE DIRECTOR OF GLOBAL HEALTH AT NORWALK HOSPITAL
DECEMBER 1, 2017

In the Norwalk Hospital Intensive Care Unit, we have the opportunity to host visiting global health scholars with some regularity. Many of our fellows and residents in the Intensive Care Unit have themselves participated in global health rotations. I asked our trainees to share some reflections on being global health “hosts.” They shared with me the many ways in which they have grown and benefitted.

“Teaching your peers is much harder than teaching students.”

Our residents are quite experienced with teaching interns and medical students within the traditional inpatient team structure, and often have rehearsed discussing core medicine and critical care topics. Through hosting experienced attending physicians from other countries, these residents have been challenged to share their medical knowledge at a higher level and to refine their teaching methods. I can attest that residents who have completed global health rotations abroad and worked closely with visiting scholars here at Norwalk Hospital are very comfortable in the role of “teacher,” no doubt in part because of these challenges.

“We had people from all over the world talking about what is good and bad about their healthcare systems. Together, we learned from each other.”

The exchange of ideas made possible by hosting visiting global health scholars is truly incredible and not commonly encountered in medical residency programs. In their roles as global health hosts, our residents think and reflect on systems of care with doctors who have experienced very different realities.

“Working with visiting global health scholars taught me how important it is not just to build up our health system here in the U.S. but also to share it with people in different parts of the world.”

In hosting visiting international doctors, our residents felt an appreciation for the many capabilities of our medical system—often as a result of contrasts between medical care in the U.S. and in the home country of visiting physicians—as well as the many lessons our system can assimilate from those of other countries. This appreciation creates a desire in our residents to invite others to share and learn alongside them. This spirit of invitation and inclusiveness is
a true strength of our medical system. We welcome new ideas and perspectives and gladly collaborate with medical professionals from near and far who share the desire to improve care.

“I really enjoyed being able to return the favor my hosts had given me when I was abroad— to show them that same hospitality.”

Each resident I spoke with mentioned the incredible reception they experienced on their global health elective. They were overwhelmed by the hospitality and generosity of their host country physicians and excited to reciprocate. I truly believe it is this bond of hospitality, sharing, and connection that makes our program so strong. We reach out and connect with physicians from across the world with a true sense of familiarity. This is the global health family.

“No matter where you go, if you bring a love and passion for something, you will find people like you. For me, medicine and travel allow me to give back what I have gained in this world.”
Ethical Dilemmas in Global Health: Feelings of Guilt and Helplessness

COMPILED BY DR. MAJID SADIGH, TREFZ FAMILY ENDOWED CHAIR IN GLOBAL HEALTH AT WCHN AND DIRECTOR OF GLOBAL HEALTH AT UVMLCOM, AND EDITED BY MITRA SADIGH, EDITOR OF GLOBAL HEALTH DIARIES.
DECEMBER 8, 2017

This post is part of a series of discussions about ethical dilemmas in global health, with responses from one global health leader in the Global South and one in the Global North. Please leave us your feedback in the comments section below, and send us ethical dilemmas you would like to see discussed.

Responses by Dr. Stephen Winter, Director of Global Health at Norwalk Hospital, and Dr. Robert Kalyesubula, cofounder of the African Community Center for Social Sustainability, in Nakaseke, Uganda.

Imagine a junior medical student from the Global North at a National Referral and Teaching Hospital in the Global South, her first time out of her home country. Most of the patients she encounters are very young and desperately sick with limited chances of survival. Staff in the wards are sparse and visibly overworked and overwhelmed. One patient begins to convulse, and the relatives start calling “Musawo, musawo! Our patient is dying.” The only nurse on duty is attending to another very sick patient who needs a blood transfusion.

The visiting student wishes she could help but has neither knowledge nor experience in dealing with a convulsing patient. The patient dies just as the nurse reaches him. The student is depressed and overcome with feelings of guilt that all she could do was stand there and watch.

What ethical dilemmas does this case bring to your mind?

Dr. Winter: This case conjures the ethical dilemma of feeling pressure as a student to act outside of one’s scope of knowledge or experience, and avoiding actions that may cause harm (nonmaleficence).
Dr. Kalyesubula: This is a case of global health resource scarcity and vulnerability. The collaborators from the Global South have limited staff and may also lack established protocols with which to manage emergencies. Avoidable deaths in young patients do not sit well with anyone, but do occur and should be an inherent part of the global health learning process. Limitations such as being present but unable to help and consequent feelings of helplessness should be expected in all global health programs. The extent to which these feelings arise will vary, but this scenario will occur on all sides. For instance, an experienced faculty physician from the Global South in a clinical observership in the United States standing with a junior resident at the bedside of a critically sick patient has to withhold his opinion for a life saving intervention because of the legal consequences of not holding an American medical license.

Was guilt an appropriate response on the part of the student?

Dr. Winter: Certainly not! Unfortunately, guilt is likely the most common response for students and even very experienced faculty like myself. This feeling is usually coupled with a sense of helplessness complicated by our uncertainties of the most appropriate boundaries to respect when operating in another culture.

Dr. Kalyesubula: Yes, it is part of the process of recovery. The main issue of concern is how the situation is handled afterwards. The student needs to be supported through this ordeal in order to draw lasting lessons that can enable growth. The student may also contribute by striving to ensure that resources reach those in need in the future.

What would you suggest should be done to prepare visiting students for such incidents, which they may encounter from time to time?

Dr. Winter: The experience described is relatively common. Preparation should include discussion groups and scenario simulations to inform students of how they may handle this type of situation, their potential emotional response, and held expectations for behavioral and emotional responses. Pre-travel orientation and preparation are essential for beginning the process of dealing with these very difficult situations. It would be meaningful to have sessions discussing ethical dilemmas together with local faculty and trainees during the in-country experience. While in Zimbabwe, I lead a session with senior faculty and Zimbabwean trainees comparing end-of-life decision-making and family interactions in the care of very ill patients in the Intensive Care Unit—including how we were personally affected and influenced by the cultures in which we worked. Hearing the heartfelt responses of the Zimbabwean house officers was one of the most powerful and meaningful teaching experiences of my career.

These ethical dilemmas are not unique to members of the Global North going to the Global South. These dilemmas are universal. As doctors, we share the uncertainties and emotional pain caused by seeing our patients suffer and die. There are many complex ethical problems that we all experience in our work. These questions do not only concern our students. We all benefit from this kind of intercultural exploration.
Dr. Kalyesubula: The collection of vignettes should be prepared and shared with students, and constantly grow with contributions from visiting students. Because partners from the Global South are often left out on this issue, efforts should be made to include the dilemmas they face, some of which are often bordered on technology and access. Additionally, global health program alumni should be encouraged to mentor and help prepare the new teams. If you were her supervisor/attending/advisor what would you say to her at the end of the day?

Dr. Winter: I would say little and listen a lot to allow the student to ventilate feelings and find her intellectual and emotional response to the event- with my guidance if necessary. The way in which the student frames her thinking will give insight as to whether she is at risk for an adverse psychological response during the rotation and may require more intensive counseling or even removal from the environment.

Dr. Kalyesubula: I think I would let the student know that what she is feeling is a normal reaction, and that the experience can lead to the resolve that such scenarios and injustices be minimized- through the effort of the student and others- in the future.
First Experience With Global Medicine

WRITTEN BY DR. SWATI PATEL, RESIDENT AT THE CONNECTICUT INSTITUTE FOR COMMUNITIES/GREATER DANBURY INTERNAL MEDICINE RESIDENCY PROGRAM
DECEMBER 15, 2017

One of the most rewarding aspects of my global health elective was working with the people of Uganda. The doctors, nurses and other staff were so welcoming to us. It was such a pleasure to work alongside them and a joy to get to the know locals, be they patients, caretakers, or others we met along the way. It was nice to learn more about how they lived– their values, difficulties they face, and what life is like on a daily basis.

The most challenging aspect of the elective was not being able to do more. Many patients we encountered lived in poverty and sometimes could not afford medical treatment or testing. Though we offered them the best we could, it was frustrating to sometimes have to change our management because of financial reasons. Sometimes we would not even know what the definitive diagnosis was because patients could not afford the work-up, and we instead gave treatment based on clinical judgment.

Because this was my first real experience with global medicine, the most important lesson I learned was how differently medicine is practiced in different parts of the world. I have great appreciation and respect for the work that Ugandan doctors do. They are somewhat a “jack of all trades.” In the span of twelve hours, they work as general practitioners, pediatricians, surgeons, and obstetricians. Observing their versatility elucidated differences in medical practice between Uganda and the United States. At times, this experience made me feel somewhat inadequate professionally, as these differences became more highlighted. Ugandan doctors have to do everything because if they don’t, there will be no one else to do it. On the other hand, because I practice internal medicine in the U.S., I don’t need to know how to perform surgical procedures.

The elective also made me more grateful for the system in the U.S. as I am able to see its advantages and disadvantages more clearly. I now realize that we are lucky to be part of a system in which money is not necessarily a limiting factor in diagnosis or treatment. I can order tests knowing they will be done, with patient finances rarely crossing my mind. On the other hand, we do things excessively and need to strive toward greater balance. However, I’m glad that for the most part we can offer patients the best care regardless of their economic background.
On a personal level, this experience has also made me very grateful. Being around so much poverty has made me very thankful for how fortunate I am. I experienced a similar feeling more than twenty years ago when I first visited India. The Ugandans I met will have lasting impact on me— their friendly and welcoming culture and hospitality is truly heartwarming. As of now, I am not sure what my future plans in global health will be— but I hope that I can visit other countries and someday return to Uganda.
We were wrapping up our first rotation and the second week in the Emergency Department (ED) at Cho Ray Hospital. A few days prior, we had worked out an agreement with the hospital staff to come in for one evening shift. Although the ED physicians kept warning us that the shift would be incredibly hectic, I found that hard to believe given the enormous volume of patients we were seeing in the three to four hours that we were there each day. We accustomed to the scene: hospital beds constantly rotated in and out, often stacked in rows and side by side, nurses and lab technicians frantically running around, trying to get blood draws and administer medications. But none of that had prepared me for what was waiting for us that night.

We had just arrived at the ED when a heavy thunderstorm started coming in. Luckily, we were already inside. The usual staff that cheerfully greeted us every morning were nowhere to be found. With no way to access patient medical records or look at charts, we began to meander around the floors instead. I was immediately taken aback by how many patients there were – twice, at least, the normal volume we had seen on our morning shifts. There were two, sometimes even three patients to a single bed. The noisy clatter of beds clanging into each other mixed with the groaning of visibly disgruntled patients made me feel uneasy. We had located our friend Dr. Ngoc (the ED physician with impeccable English) buried two rows deep in hospital beds, attending to a frail, elderly woman. My heart raced as she motioned for us to come meet her, my mind figuring out a million different routes to get to where she was.

The six of us (two attendings, a resident, and three medical students) gathered around, bodies awkwardly touching, as Dr. Ngoc presented this case to us. The elderly woman came in that night with shortness of breath. She had a history of hepatocellular carcinoma with ascites, caput medusa, and very visible jaundice. She was so emaciated that the edge of her enlarged liver was easily seen under her costal margin. The chest x-ray showed the right lung diminished to half its size secondary to the hepatomegaly (and likely the source of her shortness of breath). Prior to seeing us, she was in emotional distress, fraught in tears that the staff wouldn’t allow her dinner until her labs were drawn. And although she was in pain, she graciously allowed us to examine her and hold her hands, seemingly relieved by our presence.

This night in the ED is one that I think about quite often. Its events still burn clearly in my mind – the chaotic environment in the midst of a thunderstorm raging outside, and the stress of knowing we were taking up a physician’s time for teaching when she had endless duties to take care of. In that moment, I felt completely useless. However, I’ll never forget our patient. Her kind and open-hearted nature, even in the face of hardship, brought respite to the whole situation. I can never thank her enough for that. I’ll never get to know how she’s doing or even if she’s still alive, but I wish her nothing but peace.
Ethical Dilemmas in Global Health: Promoting Global Consciousness

This post is part of a series of discussions about ethical dilemmas in global health, with responses from one global health leader in the Global South and one in the Global North. Please leave us your feedback in the comments section below, and send us ethical dilemmas you would like to see discussed.

Responses by Dr. Stephen Winter, Director of Global Health at Norwalk Hospital, and Dr. Robert Kalyesubula, cofounder of the African Community Center for Social Sustainability, in Nakaseke, Uganda.

A wide range of ethical dilemmas is integral to global health experiences. Please comment on the following two case scenarios:

A young patient with tetanus suffers from painful generalized muscle contractions every five minutes. The medication that would ease these symptoms is neither accessible nor affordable. A global health participant may be inclined to prescribe this medication for this patient even with a fatal prognosis, thereby hindering access to this medication for another patient who may need it for a nonfatal condition.

How should this ethical matter be best discussed with a medical student or resident?

Dr. Winter: This is a good example of a dilemma that we do not yet frequently confront in the Global North: the means of allocating scarce resources in a way that meets the ethical principle of justice. Resource triage lies outside of the traditional doctor/patient relationship and is a societal construct that must be adjudicated by local law, cultural practice or organizational policy. It is not an appropriate decision for a visiting medical student, resident or faculty member. What would you think if a Ugandan Global Health Scholar visiting Norwalk Hospital argued against, or even tried to prevent, the transfer of a ninety-year-old patient with metastatic cancer to the Intensive Care Unit in accordance with the patient’s clearly expressed wishes, as an inexcusable waste of resources that could be better used in East Africa?
Dr. Kalyesubula: The drug is not available in the first place and needs to be purchased by the patient’s family. Therefore, I think the global health participant needs to assess the family’s needs and capacity depending on the context. After losing a loved one, most African families would find solace knowing they did all they could to save them.

If this drug were purchased by the hospital, the discussion should be centered on resource allocation. Shortly after returning from the United States, I proposed purchasing a dialysis machine to save critically ill patients in urgent need of dialysis. The permanent secretary to the Ministry of Health asked me how many malaria cases could be treated with that money. I stared at him straight in the face and left… But of course I understood him well. Thanks to the Kidney Foundation I founded shortly afterwards, we now have eighty dialysis units in the country, fifteen of which were purchased by the Ugandan government.

Palliative care should always be an option in medical care, but there are exceptions that should be approached with care and contextual and cultural understanding. Global participants should understand that whenever a pen is put to paper someone has to pay and it is, more often than not, an out-of-pocket expense. This simple fact can help guide the practices of global health participants.

A young patient with a treatable disease can be cured by being admitted to the Intensive Care Unit, but doing so would render the family bankrupt, thereby causing significant harm. How should this ethical matter be best discussed with a medical student or resident?

Dr. Winter: My approach to this problem is similar to that of the last question, with an emphasis on family dynamics and cultural norms. Who should get to decide these things in any society? Certainly the answer is never the visiting medical student.

Dr. Kalyesubula: The key here is to involve the family in the discussion and help them make an informed decision. These issues are deeply rooted in culture, and not necessarily the individual. Though the tendency here would be to persuade the family not to pursue treatment, the decision needs to be discussed with care because the family may consider this option as abandonment by the medical fraternity and failure of the medical system to provide care when it was most needed.
Ethical Dilemmas in Global Health: Reader Response

WRITTEN BY REVEREND PROFESSOR SAMUEL LUBOGA
THANK YOU FOR SHARING THESE ETHICAL DILEMMAS.
JANUARY 5, 2018

If I may comment: In regard to the first ethical dilemma in which the visiting student watches a patient endure spasms while approaching a death that could be prevented by a drug that is unavailable and/or unaffordable: It is always difficult for anyone to watch a patient, especially a young one, die. However, it can be particularly emotionally traumatic for a visiting student. I believe the student should desist from doing any such thing as prescribing medication.

The student should, however, be given an opportunity for emotional support, counsel, and adequate debriefing. These structures of support help put this experience in perspective within the challenging context of a resource-limited environment.

In regard to the second ethical dilemma in which the visiting student encounters a young patient with a disease that can be cured by being admitted to the Intensive Care Unit (ICU), but doing so would render the family bankrupt: I would, as the attending medical specialist, explain to the patient’s relatives what would be done for the patient in the ICU and what benefits and limitations would be expected for the patient in that setting, as well as the costs that would be incurred. I would then inform them of the palliative care option and leave them to make a decision as to whether or not to incur the cost of the ICU. I would avoid appearing as if I am discouraging them from putting their loved one in the ICU, as such discouragement may leave patient relatives with the impression that we physicians are insensitive and do not have the patient’s well-being at heart.

Both cases offer an excellent opportunity to ponder these very difficult ethical issues. Thank you.
I have been following the excellent entries in the Global Health Diaries on Ethical Dilemmas in Global Health. I am currently here in Uganda seeing palliative care patients and wanted to respond to a recent case that others have written about, but from the perspective of a palliative care physician.

In regard to the first ethical dilemma in which the visiting student watches a patient endure spasms while approaching a death that could be prevented by a drug that is unavailable and/or unaffordable: Involving the family in a discussion and helping them make an informed decision is an ideal approach to this issue. However, doing so may present the additional challenge of communicating essential information in an understandable way. ICU and palliative care treatment options should be presented. It should be emphasized that palliative care, while having a different, perhaps less desirable outcome than the curative intervention in this particular case, is not in any way an abandonment or a failure of care but rather an alternative form of care and caring in which the patient’s comfort and quality of life continue to be highly valued.

Honesty and reassurance of continued care in the ICU or elsewhere may help the family cope with what must be an unimaginably difficult decision for them to have to make, and will likely help build trust between the family and the healthcare worker. Discussing and modeling good communication, the techniques and skills of shared decision making, the value of support for the family’s decision and struggle, and the potential therapeutic benefits of being there for the family and of symptom management in the face of an inability to select the life-saving option will undoubtedly leave a strong impression on the visiting medical student or resident and will serve him or her well throughout his/her medical career.

While lack of knowledge about palliative care in the public domain may influence current cultural norms, there is an active campaign by the African Palliative Care Association, based in Kampala, to broaden the understanding of palliative care among the public and medical professionals. As such, it is important to clarify that palliative care should not be thought of as
a second-rate alternative appropriate only for dying patients. Rather, palliative care is focused on symptom management as well as honest and compassionate communication, and may be delivered in different situations in concurrence with curative treatment in an effort to alleviate patient suffering from disease and treatments. It is care directed at the whole person that extends to include families, thereby providing a framework for considering the impact of the recommended treatment on the well-being of both patient and family.

In contrast to the idea that palliative care may lead to a perception of insensitivity among physicians, most families, once familiar with palliative care, are appreciative of the efforts made to help the patient and the family, even when their loved one dies.
It’s been a few months since I returned from Naggalama. For better or for worse, I made the decision to leave early, and in doing so prioritized my health and well-being. It was not an easy choice. I spent many sleepless nights trying to figure out if I was about to squander away one of the best opportunities I’ve ever been given. It can be challenging to admit that you are not strong enough, not resilient enough, or just not cut out to complete the task set before you. That being said, I left a part of me with the people I met in Uganda, and a big chunk of that lives in St. Francis Hospital.

I reflect on Naggalama often. For the first few months back at school, the one way to start a conversation with someone was to ask, “What did you do this summer?” Of course, each and every time, I recounted several stories I had told time and time again about my weeks there—soccer matches, late nights with patients, days of rice and beans, and the red dust that caked my shoes.

I retold and reiterated all that I could in a casual conversation, from the first delivery I performed to the first surgery I scrubbed in on. I grew fonder of these memories with each recounting. Some days I would catch myself enmeshed in my own thoughts after telling someone about my time in Uganda. I would scroll through photos stored on my phone and try to remember it all: the sounds, the sights, the smells. Even though my trip ended early, and perhaps with myself in a bit of a rough state, I have nothing but good memories of that time and the experiences I had.
I find myself often measuring aspects of my life and the world around me, against those of Naggalama. Sometimes while reading about a patient or interacting with staff and doctors in clinic, I compare the situation to that of St. Francis. For instance, I cannot help but involuntarily laugh (quietly, or internally of course) in response to patient complaints about a long wait time, or doctors running late. All it takes is a fifteen-minute delay in the United States and patients are up in arms.

Meanwhile in Uganda, some patients are seated in the office waiting for over an hour as the doctor eats lunch, and they never once complain. I remember a patient who was wheeled into the Operating Room for an “emergent C-section” and waited on the bed for two hours because it was not that emergent. Time just has a different sort of fluidity in Uganda, as do attitudes. Perhaps it was the time of the year, the unrelenting sunshine, or something in the water, but the Ugandans I encountered had positive attitudes about everything. I wish I could say the same about my home.

A part of me still hurts for St. Francis Hospital, a facility that, despite the dedication and skill of its staff, struggles day in and day out with a lack of basic supplies – stethoscopes with no diaphragm, one ear piece, and rust on the bell. I wish I could have helped more. I would have loved to show up with the resources they so desperately needed and wanted, instead of those we thought would be a good gift. I know we meant well – all of us – but we just seemed to miss the mark.

Although they were thankful for the time, energy, and compassion we gave them while we were there, a part of me still wishes I could go back and fix more, help more, give more. Perhaps this is part of the experience, the little voice in the back of your head that says, “When you’re done with school you know where you can make a huge impact,” but it’s hard to put off that urge and silence it in the meantime. Luckily, I’ve got a memory like a steel trap, and Naggalama took the bait. I can’t finish the work that needs to be done there now, but I look forward to doing so in the future.
Knowing neither what I would see in the context of the healthcare setting nor in the city itself, I had no idea what to expect from my first trip to Southeast Asia. Our drive from the airport to the Rainbow Hotel was a bit of a shock to me. I had never seen such intimidating traffic or encountered such large gatherings on the sidewalks, people perched on little plastic stools outside their shops. We got out of the van and wove through the circles of chairs, pulling our bags over the broken tiles and looking down the long street at the layers of awnings, water bottles and plastic tubs piled high beneath them. That kind of open community no longer exists in many places in the United States.

Though we all hear about a time when our parents could walk down the block and play in the street with friends, everyone together outside their homes or businesses, the U.S. now feels less communal and more private. While we do interact with friends or co-workers, few of us simply step outside our homes and join others on their front lawns to talk and eat and play. While the sheer density of people here in Vietnam is overwhelming at times, it’s nice to see such strength of community. We often watch the little girl who lives at our hotel bounce between store fronts, chatting with everyone who walks or drives past on their motorbikes and playing with anyone who will join her. These kinds of interactions foster a sense of community that would be difficult to find in most U.S. towns or cities today.

Before this summer, the only resource-thin health settings I had observed were in densely populated cities in the U.S., like the South Side of Chicago where there is extreme poverty by U.S. standards and the few existing healthcare providers are relatively inaccessible to much of the population. Our time at Cho Ray Hospital has provided an incredible window into a health system with providers and technical capabilities just like those we would find in the U.S., but with more patients than we could ever conceive of at home. With the Emergency Department as our introduction to the hospital, we quickly saw just how many patients walk through Cho Ray’s doors.

We watched nurses and family members line the department with beds – rows and rows of gurneys growing larger and larger until patients finally began to move aside and surrender half of their cot to the patients for whom there was simply not enough space. We saw the ways in which family members became directly involved in their loved ones’ emergent care as spouses and children walked alongside the beds, bagging the patients on their way to the
Critical Care Unit of the Emergency Department. Many of the patients we saw had incredibly pronounced symptoms and advanced progressions of their disease that we likely would never have seen in the U.S.

We listened to murmurs and lung sounds, palpated enlarged livers, spleens, and aneurysms, and saw more head trauma than we ever would have at home. The ability to stand in on neurosurgeries at this point in our training, and for surgeons to take the time to explain the conditions and procedures to us in real time, was an incredible opportunity for us.
In every department at Cho Ray Hospital, the doctors were kind, generous, and excited to take us out and show us their city. Meeting people’s families and friends and seeing their lives beyond work added so much to our experience here and our understanding of what it is to be a doctor in Vietnam. As far as our actual experience in the hospital was concerned, I think the Emergency Department was an incredible introduction to the healthcare system.

We got to see what first-line care looks like at Cho Ray, the kinds of disease and injury that push people of all socioeconomic classes to seek out emergent care. While it was a busy, intimidating space, the Emergency Department was made manageable Dr. McNamara who put things into perspective and explained how the conditions we saw would fit into the context of American healthcare. Once we moved to the Neurology Intensive Care Unit (NICU), the pace of work shifted. We had the opportunity to follow patients from their first contact in the Emergency Department, after head or neck trauma, up to the ward where they were treated for their critical conditions. Although we didn’t have an American attending with us, the physicians in the Neurology ICU were incredibly accommodating, inviting us to their surgeries and helping us learn and practice basic procedures like Arterial Blood Gas Analysis. We learned a lot from observing the incredible volume of head trauma management, following certain patients throughout our two-week rotation, and watching surgeries as they came.

With our six weeks here coming to a close, I feel incredibly lucky to have been able to spend my summer here in Ho Chi Minh City. It has been amazing to experience culture so unlike that of the U.S. The food here is fresh, with ingredients and flavors I’ve never encountered before. Just sitting on a street corner, sipping a coffee that’s sweeter, darker, and denser than any I’ve tasted in the past, we get to watch motorbikes and carts go by, and women carrying baskets of fruit on their backs or bahn mi in their megaphoned carriages. Seeing other parts of the country has also been incredible. The regional differences we observed when we visited the North in Hanoi and Ha Long Bay highlighted the diversity of culture here, even between large cities. Even the landscapes we saw on our drives to Mekong and the bay were a beautiful glance into this country’s agricultural roots.

In the hospital itself, we were lucky enough to experience an entire health system unlike our own. Discussing with doctors the ways in which insurance operates here, and how that coverage plays into the ability to provide patient care, elucidated both the differences and many similarities between our two health systems. Many of the payment and access issues that exist here are prevalent in the U.S. as well. And yet, there were moments when an inability
to pay impacted life and death decisions in ways we simply could not wrap our minds around. I know my experiences here will shape the ways in which I see the healthcare system in the U.S. when we finally make our way to the wards this winter. I hope I will be able to apply the things I learned here to my clinical education and career down the line.

Thank you so much for your never-ending warmth and hospitality in welcoming us to your hospital, home, and city. This has been an enriching educational experience for which I am incredibly grateful. I hope to have the opportunity to return someday in the future.
I have been following the excellent entries in Global Health Diaries on Ethical Dilemmas in Global Health. I am currently here in Uganda seeing palliative care patients and wanted to respond to a recent case that others have written about, but from the perspective of a palliative care physician.

In regard to the ethical dilemma in which the visiting student encounters a young patient with a disease that can be cured by being admitted to the Intensive Care Unit, but doing so would render the family bankrupt: For visiting students and health workers, it is often frustrating to accept the resource limitations of the health system in a resource limited environment, and humbling to come face-to-face with individual/family resource limitations that at times result in the inability to treat what might be a curable illness in a different circumstance or environment. Beyond the issue of allocation of scarce resources, and the importance of assessing the emotional and socioeconomic impact on the family of asking them to buy an expensive medication which may be futile in the face of a fatal condition, it is also of primary importance to address the issue of patient suffering- in every environment.

It is always difficult to watch a patient die, especially a young patient, and even more so if they are suffering as they are dying. However, palliative care may provide benefit to the patient, the family, and the visiting student. Although the expensive medications specifically targeting tetanus may not be available or accessible for this family, there are approaches to help mitigate some of the patient’s severe symptoms and suffering while supporting the family during this devastating experience. Morphine, available and free of charge in Uganda, would likely help manage this young patient’s pain and air hunger as respiration becomes increasingly difficult.
Attempting to alleviate the patient’s suffering in the process of dying is, according to the World Health Organization, a human right. It is our obligation as physicians to do so, and is entirely feasible even in Uganda. Presented to the family in a sensitive, respectful, and educational manner, palliative care is also a way to help the family find solace—perhaps not in doing all they could to save their loved one, but in having done all they could to ease his or her suffering. Demonstrating for the visiting global health student or resident that palliative care is available, effective, appropriate, and championed in the global setting is a valuable lesson and might also, by its nature of including the reflective process, allow the student to process the experience as an essential element of becoming a physician.
When I made the decision to pursue medicine I had thought of medical school as a narrow track. I had no idea about the universe of possibilities that would open up to me as a physician. My role model at the time was my father who worked in a traditional busy internal medicine practice. I saw him put his heart and soul into medicine, and it was very inspiring.

On attending my first medical school courses, I became aware of the many opportunities, composed of different doors and pathways, from which to choose. Though I had no idea what global health was, I wanted to be at the forefront of all things exciting, helping patients who were desperate and in most need of care. Thus, I was attracted to the field of Infectious Disease (ID) because of the widespread regions in the tropics and medically underserved areas of the world where diseases ravage the population. Malaria, Tuberculosis, and AIDS were the “big three” at the time. Then there were diseases like dengue, rabies, and something called Ebola— that was before 2013! Infectious diseases seemed so interesting, and the concept of a new, potentially deadly disease spreading across the world had a certain Hollywood luster behind it. I liked the idea of treating and curing a patient. That to me was the “Nectar of Medicine.”
So when it became time as a second-year medical student to decide on a residency, Internal Medicine was the field to which I gravitated, along with many of my close peers. It seemed to keep most of the doors open as I made personal discoveries on the road to a complete medical education. After becoming an infectious disease doctor, I became privy to the many more doorways and passages to explore within the field. There were the traditional models—working in the hospital, for example—but one could also choose to run an AIDS clinic, an STD clinic, a Travel Medicine clinic, an Outpatient ID clinic or office, an infusion center, a wound clinic or any combination thereof.

My interests in tropical medicine and ID seemed well-suited for the frontier at which the lack of decent preventative health contributes to monumental problems in many resource-limited areas of the world. It also seemed to me that these regions with the greatest need have the greatest reward as the impacts are that much larger. You can see it in the eyes of a patient or the patient’s caretaker when you practice that healing art! That is a great part of what makes us so privileged to take care of others.

Now I’m fortunate to have a small, official role in global health as a part-time faculty mentor for the students and residents of the University of Vermont Larner College of Medicine and Western Connecticut Health Network. I mix that in with my “day job” which includes traditional hospital-based infectious diseases (seeing consults) and night hospitalist work for extra income. I have colleagues who collaborate in the global health field, from surgeons flying in for two weeks and operating to the point of exhaustion before returning home to emergency medicine doctors rotating through war torn or environmental disaster areas such Haiti after the devastating earthquake. They give, but they also receive in many ways.

Global health as a career is what you want to make of it, but you need to have a vision for yourself. Now is a good time to reflect on your future in healthcare in general: where you will go and where you want to be. Talk to an advisor, discuss with your peers, and review with your family.

To paraphrase an old Chinese proverb: “Once you find a job you love, you’ll never have to work again.” I’m lucky to deeply love global health and the practice of medicine. It is a special privilege indeed. So here’s to new beginnings, new opportunities, and doors to pass through.
As a physician, I strive to diminish the expanse between myself and those who suffer. It is through enduring pain and suffering helps me better understand and advocate for those in need. Particularly the last seven hours of the climb to Kilimanjaro’s peak induce all manner of suffering: difficulty breathing, extreme exhaustion, bitter subfreezing temperatures, gusting dusty winds, crushing bone, joint, and chest pain, cramps, severe headache, sore throat, and nausea. These forces battle with you to send you back down to the bottom of the mountain. You fight just to keep your balance.

The reminder of the diversity and complexity of pain and suffering is one of my main motivations to periodically trek Kilimanjaro. Climbing the “Big K” takes you through climaxes of pain and self awareness, ultimately shaping you into a more responsive and hopefully more humble person.

But the climb is not all suffering. Many moments are overtaken with admiration and appreciation of the beauty of this magical mountain. You are stunned by the sunrise on Mawenzi, the tip of Mount Meru puncturing the clouds that float thousands of meters below your eyes. You are graced by the astronomical number of stars revolving around you and the dance of sun rays on 22,000-year-old glaciers. You are humbled by lobelias and impatiens kilimanjari, exhilarated by colobus monkeys and ravens flying over Uhuru, and moved by doting Serinus striolatus birds in love.
SUNRISE ON MAWENZI
I read a recent piece by Nikolas Moring on Global Health Diaries and was moved. I could sense that this young man was disappointed, not in his trip but in his decision to return to the United States. I believe there is a difference between the words “trip” and “journey.” The former implies a start and end point, a series of expectations from others and oneself which one must fulfill, and ultimately a return.

Meanwhile, a journey is made of the stories one gathers, the love and openness one offers, and the spirit of compassion and unity. It also implies a look into one’s own being—who one is and who one wants to become, and the distance between these two beings. An investigation into what one has learned, how one has been changed by the experience, and how ultimately one dives into the deepest resources in one’s heart in order to truly know understanding, acceptance, and tolerance.

The irony is in the fact that so many of those who seek a deeper sense of unity and who genuinely believe that this world is good and worth the fight, and to whom tolerance and empathy come naturally, do not allow themselves this grace.

In the case of this young man, there is no place for condemnation. He went to care for others because he cares about others—neither by virtue of blood ties or time spent in school nor by means of a cultural history, but simply because he knows that in the act of caring comes a relationship and in the relationship, stories are exchanged. These stories are what define us, inspire us, and make us more human.

Self-incrimination is antithetical to growth and prevents us from leading authentic lives. We must learn to commit ourselves to learning without fear, anxiety, self-recrimination, or envy, and use these perspectives to help us walk gracefully through our more difficult moments. We make decisions, and sometimes in doing so disappoint ourselves or others. But we think and we learn and we continue to move toward the life in which we believe.
Ethical Dilemmas in Global Health: Assessing Student Success and Safety in Global Health Programs

COMPILED BY DR. MAJID SADIGH, TREFZ FAMILY ENDOWED CHAIR IN GLOBAL HEALTH AT WCHN AND DIRECTOR OF GLOBAL HEALTH AT UVMLCOM, AND EDITED BY MITRA SADIGH, EDITOR OF GLOBAL HEALTH DIARIES.
MARCH 9, 2018

Responses by Dr. Stephen Winter, Director of Global Health at Norwalk Hospital, and Dr. Robert Kalyesubula, cofounder of the African Community Center for Social Sustainability, in Nakaseke, Uganda.

A wide range of ethical dilemmas is integral to global health experiences. Please comment on the following two scenarios:

Upon entering a global health elective program, students are sometimes uneasy about their role in an underserved setting. They may feel that rather than contributing to the global health setting, their presence expends valuable time and resources that medical staff could otherwise use to care for patients. How would you respond to students who feel uneasy about their role in a global health program?

Dr. Kalyesubula: I would explain to students that they should view the global health elective as an investment for the future and, as such, should not expect to provide any immediate contribution to the communities to which they are assigned. Rather, students should use the experience as a stepping-stone from which they can return once they are more qualified to provide patient care. Furthermore, the experience can help them exhibit strong leadership that considers global health principles when it is demanded of them in the future.

Dr. Winter: I would frame this in terms of students’ ongoing training and preparation for future involvement in global health, and the ways in which this experience prepares them for the time when they can give back in terms of capacity building in similar settings in the future. In other words, students are accumulating debt that they should expect to pay back at some future time. By analogy, this situation is similar to what happens on the wards in U.S. hospitals in
Personal safety issues often arise in the context of large cities in both the Global North and Global South, some of which may be relevant to particular international rotations. For example, using boda boda transportation in Kampala comes with a risk of head trauma, as does walking in the wrong neighborhood at night in New York or Harare. Is it enough to warn students of the situations they should avoid, or should we be more proscriptive and possibly punitive rotation (for example) if they do not comply?

Dr. Kalyesubula: It is better to be strict in this respect because students always want to experiment. It is better to be safe than sorry. One bad event can easily terminate an otherwise very promising collaboration.

Dr. Winter: I would recommend that issues involving high-risk behavior be discussed in the pre-departure orientations, and that their importance be emphasized in the program materials. I would also recommend that participants be required to sign a document acknowledging the risk of specific behaviors and promising that they will not participate. Beyond that, I would not be punitive at the level of rotation termination.
I have always seen medicine as a unique way in which to interact with one’s community. Medicine is not only about the care of patients, but also the care of patient families, friends, and the community as a whole. Medicine is the ultimate calling for me in that it provides a means of immersing myself in lifelong learning that can be turned around and given back to the community. Perhaps selfishly, medicine also allows for a sense of fulfillment and accomplishment in my work. The sacrifice and selflessness, while daunting at times, harbors a particular allure as I learn to prioritize others before myself.

While involvement and impact with local community is undeniably important, limiting ourselves to engagement with only the local community may also render our ideas, perceptions, and attitudes limited. Many of us have never had the opportunity to live outside our culture— to have our thoughts challenged and our perceptions changed, or to be in the minority. The ability to empathize, understand, and relate to patients is one of the most important components of medical education. Although this ability can be learned, practiced, and taught within a local community, the impact of living, integrating, and serving in another culture can provide incredible benefit.

Experiencing the ways in which other cultures relate to one another, seeing different expressions of empathy and communication, and being exposed to various perceptions of right and wrong all shapes us as people. It is easy to get lost in the idea that the local community is the only one that exists; the only one that matters. It is here, so present in front of us, and yet we so readily limit our world views, perceptions, and attitudes to our own “cultural bubble.” With this idea in mind, I quickly awakened to the myopic nature of my worldview. Global health provides us with an opportunity to enrich ourselves and those around us.

I realized early on in my global health elective that I perhaps was not cut out for the task set before me. Experiencing the sheer gravity of the despair and suffering that is happening can be suffocating. We begin to question everything you’ve known. We begin to resent ourselves for our privileges and amenities. I struggled early on with knowing that I was making minimal to no impact— that I was merely on the sidelines observing and learning for myself. In this way, my presence there felt selfish. It is challenging to have our thoughts deconstructed and our perceptions of normal dissolved before our very eyes. All these aspects were challenged in
Despite the challenges, I returned home with a refreshed perspective. With time, we begin to use the places we traveled, the people we met, and the stories we were told as metrics against our own experiences. This integration of experience, both constructive and enlightening, helps us put things into perspective. That in and of itself is highly rewarding.

Most importantly, I learned gratitude. Through all the disparity and suffering, the destitution and indigence, I saw gratitude. It is too easy to get wrapped up in ourselves and the things around us, and in so doing forget what it means to be gracious. By noticing the grace and gratitude of others in such simple displays and disparate times, we are reminded to be gracious. Most of the lessons and perspectives I took home from Uganda stem from this sense of gratitude.

I feel as though coming from the U.S. and arriving in Uganda, we come with the experience of one of the best healthcare systems in the world and observe something entirely different. As we come back to the U.S., the excess and superfluous nature of our healthcare system- and our culture in general- slowly dawns on us. I try to remind myself of the simplicity and ingenuity of what I saw in Uganda. I try to integrate the Ugandan gift of making the best of what is into my own daily practice.

I am reminded constantly that even in the face of poverty and limited resources, there are people in Uganda delivering top-notch care to their patients. Rather than using lab readouts or imaging studies, they pay close attention to the patient’s story and concerns. This observation has encouraged me to become a better listener, both professionally and personally, and reminds of the importance of the patient voice- the only thing many healthcare workers around the world have to go by.

Uganda. I cannot explain them all here. I challenge you to go and experience it for yourself. There is more going on than can be put into words.
My interest in science and sustainability began long before my introduction to global health. In junior high school, a working solar updraft tower I created won awards at Connecticut Science and Engineering Fair, and was subsequently featured on the local news for having captured the attention of a wide audience—most likely for its size and appearance, as it took up a sizable portion of my front yard! I continued working on sustainable energy projects through my high school career, during which I also periodically attended the Global Health Evening events.

Through these inspiring lectures, I learned the reality that medically treating a patient is not enough if the patient is returning to an environment that is not conducive to good health. A person needs access to electricity, clean water, and sanitation to maintain their health status. It was through these evenings that I met the Director of the Global Health Program who agreed to help facilitate my first global health experience.

The most challenging aspect of that first exposure was the initial shock of so suddenly finding myself in such a difference place, having left New York City one morning and landed in bustling Entebbe, Uganda the next. But I was immediately mesmerized by the Ugandan people who were so warm, friendly, soft-spoken, and helpful. I had the fortune of several insightful experiences during my trip, the most rewarding of which was meeting the founder of the African Community Center for Social Sustainability (ACCESS), and exploring the organization’s premises in beautiful Nakaseke where I was deeply moved by the children living there. Over 15% of them are orphans, and half of those orphaned are living with HIV/AIDS.

The biggest lesson I learned was, first and foremost, humility. The warmth and humility of the people...
taught me that happiness does not require much. What they are able to accomplish with such limited resources, particularly in medicine, is truly remarkable. The circumstances render the medical profession reliant on the art of listening. My time in Uganda also taught me not to take things for granted, and that real wealth is not about money or possessions, but people and relationships. This realization encouraged me to cherish my family and friends more fully while also reinforcing my desire to work in healthcare.

Meanwhile, the lack of educational programs in Uganda awakened me to the critical importance of preschool education to educational, technological, and economic success. With the Girl Scouts of Connecticut as my platform for promoting educational awareness, I founded a preschool program at ACCESS in the form of a 501(c)(3) charity to ensure its sustainability. Located in Sandy Hook, CT, the mission of Grace’s Promise Incorporated is to develop and support preschool education at ACCESS and hopefully throughout greater Uganda and Africa.

Currently, I am a biology major and STEM scholar in the Honors Program at the University of Connecticut, working with an adviser to develop my own major in Global Health/Population Health. Given the dire need for sustainable healthcare, I am committed to gaining the skills needed to work toward achieving meeting that need.
Our first week in Uganda has been marked by innumerable small adjustments, from learning to be damp most of the time to forcing our guts to wait until 10:30 PM, when dinner is typically served, to eat. However, amidst this period of transition, one of the most endearing and consistent little departures from our lives in Vermont comes on our walks home from Mulago Hospital. Every day we walk home along the same path, identifying the route that would leave us least drenched in our own sweat, and every day we are be greeted by children in our neighborhood of Makerere Kikoni. They grab at us, hold our hands, or often give us swift pokes to the buttocks before running off giggling. We always indulged the children, oblivious to the reason behind their fascination with our skin until one of our taxi drivers told us us that young children are enthralled by bazungos (foreigners) because they grow up on stories of ghost-white spirits lurking in the forests. As white foreigners, we are likely just novelties for most of these children but for some we are their childhood stories come to life.

In most cultures, ghosts occupy a liminal space between the living world and the dead. Perhaps more so than at any other point in my life, this feels like an apt description of my current role as a rotating medical student in the trauma casualty at Mulago Hospital in Kampala, Uganda. While the majority of my time outside the hospital is spent immersed in a world bursting with life, death is an ever-present guest in this department. The majority of trauma we see results from boda-boda (motorcycle) accidents, the consequences of which are often devastating. Indeed, in an effort to see the full spectrum of care delivered here our team visited the morgue where well over twenty autopsies are performed each day, and the dangers of living in a city like Kampala are more palpable. Our first autopsy was a twenty-three--year-old woman who had died of a basilar skull fracture from a boda-boda accident at 8:27 AM that day, literally as our group of rotating students was walking to the hospital. Something as simple as crossing the street has since taken on a more perilous role in my day-to-day life here in Kampala.
Exposure to trauma and death on a scale such as that seen at Mulago Hospital is dramatic for a whole host of reasons, not least of which is that as visiting students, our role is restricted by both our own shortcomings and by the resource-limited setting in which we are guests. Here again we occupy the transitional space of ghosts, present amongst both the carnage and the soon-to-be departed. This may be the inescapable struggle of a student participating in an international health elective. As our program director likes to remind us, “your job here is not to play the part of the savior, but only to witness and hold onto to what you see here so that it may inform your future practice.” I find this refrain next to impossible to apply here in Uganda. I cannot play the part of ghost—existing but not participating in the goings-on of the chaos that rules this place.

So I hold the hands of the children on the way home from the hospital. I want them to know that I’m real and not a ghost. I find some small joy in their laughter and the high fives we exchange when we part ways. Dissatisfied with the role of witness, I conveniently ignore the program director’s advice and opt to internalize another one of his morals. He likes to tell the story of the boy and the wise man who are walking down a beach where thousands of starfish have washed ashore. The wise man sees the boy throwing starfish back into the sea one at a time and tells the boy that his efforts won’t possibly make a difference given the number of stranded starfish. The boy proceeds to pick up another starfish and throw it into the water, smile, and say, “It made a difference to that one.”
Ethical Dilemmas in Global Health: Bidirectional Safety

Responses by Dr. Stephen Winter, Director of Global Health at Norwalk Hospital, and Dr. Robert Kalyesubula, cofounder of the African Community Center for Social Sustainability, in Nakaseke, Uganda.

A wide range of ethical dilemmas is integral to global health experiences. Please comment on the following two scenarios:

How should we screen potential program participants for what we perceive to be potential limitations to cultural integration? For example, should a history of depression or other psychiatric disease be exclusion to participation? Is it fair to exclude a highly motivated candidate based on our biases?

Dr. Winter: I recommend screening candidates for at-risk limitations and having frank discussions with them regarding their motivation and capacity to function in a culturally complex environment. If concerns remain, I would be in favor of risk assessment by a mental health expert, the candidate’s own psychiatrist or mental health specialist if possible. If the candidate is then cleared, I recommend putting together an explicit plan for how they can seek support and assistance while in the field. Although this seems somewhat intrusive, it comes down to a matter of their personal safety and potentially that of our other participants or their hosts.

Dr. Kalyesubula: I think the screening tool for participants should be standardized, and a candidate excluded from participation once considered not fit unless the host institution is briefed, ready, and able to give special attention to such a candidate.

Due to the shortage of medical personnel, global health elective participants often find themselves left unsupervised with patients. This situation is compounded by the fact that participants coming from the Global North may be viewed as more experienced or knowledgeable, and may lead to involuntary engagement in an activity that participants are not trained for. What are the possible solutions?

Dr. Winter: As part of pre-departure orientation, participants must be prepared for these situations and counseled not to act beyond their knowledge, training, or comfort level.
Dr. Kalyesubula: Global health partnerships should ideally have a knowledgeable coordinator/resource medical person who is willing to step in when such scenarios arise. If finances allow, a key person should fill this role in every collaboration. Alternatively, candidates can be paired with doctors-in-training along with the attending to help reduce the likelihood of such scenarios.

The program coordinators should also be selective when sending candidates to different wards and specialties. Students should always be advised not to exceed their limits and to maintain the same ethical standards in place at home. Global health teams should teach students some key basic skills based on their level of training to help minimize such scenarios.

Many women’s health issues are driven by cultural and social forces that global health participants may or may not be aware of, and some of which they may be encountering for the first time. Take for example, (1) a chaotic OB/GYN ward where multiple patients are delivering on the floor unattended, (2) a patient is dying from massive bleeding due to lack of blood transfusion, or (3) a patient has an infection from a self-induced abortion, or finally (4) a patient seeks treatment for a fistula she has been suffering from for several years. How do we help participants deal with these issues, reconcile associated cultural differences, and manage their emotional reactions?

Dr. Winter: While pre-departure discussion groups and scenario training may help attenuate the emotional response, there also needs to be an opportunity for venting, reflection, and self-examination of emotional response in real time in the field as outlined in the response to the previous question.

Dr. Kalyesubula: Proper preparation and orientation are key components of managing these issues, along with careful selection of candidates, as participants need to be able to handle such shocks of life that they are likely to encounter. These unfortunate scenarios are not due to cultural reasons, but rather a mere lack of resources. No one culturally or socially accepts this kind of treatment; it is just the circumstances. Advocacy should be played on the part of all concerned parties.

Many global health participants sometimes feel overwhelmed by the variety of challenges they face. How do we differentiate between those who need further encouragement and support, and those who are simply not fit for global health?

Dr. Winter: I don’t think that we presently have the tools to make this determination. The best we can do is use our existing tools including reflections, interviews, and evaluations by observers as discussed elsewhere. When there is sufficient concern that action such as removal from a clinical site is contemplated, the Director of Global Health should convene a committee of faculty involved in program administration to review the available evidence and come to a consensus conclusion. In order to avoid any appearance of bias or lack of due process, such a decision should not be made by a single individual.

Dr. Kalyesubula: Strict selection criteria as well as regular feedback sessions can help make this differentiation.
Value in Providing for Others

DR. BILAL KHAN, PULMONARY/Critical Care Specialist and Fellow in Sleep Medicine Norwalk Hospital, Connecticut
April 13, 2018

After completing my undergraduate degree in economics, I worked for J.P. Morgan Chase on the fast-track plan to Wall Street. During that time, I joined the volunteer fire department and became an Emergency Medical Technician, just as a hobby. But after a year, I noticed a striking difference between business and medicine: if you are good at something in business, you do not share that knowledge because it increases your value over your competition. But in healthcare, your value is based on what you are able to teach and provide for others, thereby improving their lives and positively impacting your community.

Having grown up in a diverse neighborhood in Queens, New York and traveled extensively throughout my upbringing, I had long been interested in global health when I finally had the opportunity in 2015 to participate in a global health rotation in Vietnam through the UVM/COM/WCHN Global Health Program. As a result of my time there and through attending several meetings with the global health group before and after, my passion for global health grew. During these meetings, the Program Director made a comment that has stuck with me: when we travel to someone else’s home country, we must consider ourselves citizens of the world, and as such have a global responsibility to provide them care. This idea transformed my view of global health from a hobby into a responsibility that we must continue to fulfill.

Volunteers run a clinic providing medical services in Vieques.
My next global health venture was a recent spontaneous trip to Puerto Rico following Hurricane Maria. Unable to find relief groups to join through social media, I instead received a tremendous number of messages from people offering their resources. Many colleagues wanted to join me, and other non-medical people offered their time or donations. My friends in the pharmaceutical field offered their support through supply donations. Although I wasn't planning on leading my own mission, I felt a responsibility to utilize the resources that were so generously offered. When my college friend Dr. Pedro Torres, an Emergency Medicine resident in Puerto Rico, saw my message and informed me of the mission he was planning, we agreed after days of discussion to take on the challenge of doing this ourselves for the first time. To minimize risk, we decided to keep the trip duration short and group size small.

I was deeply touched by the support we received and the many people who decided to join the mission without any questions asked. They trusted me, and I put a lot of pressure on myself to make sure their trust was rewarded. Knowing that mistrust in the system presents a major obstacle to encouraging relief effort donations, I wanted to remain as transparent as possible. Many potential donors are not sure which organizations to trust, and whether their funds will reach the intended people in need.

To ensure that donors saw their support reach the intended recipients, we hired a photographer to take pictures and videos every step of the way. Knowing that success on this mission would lead to enriched support and trust for future efforts, I also regularly updated my social media with live video. We chose to focus on Vieques, an island just off the coast of Puerto Rico, whose inhabitants received very little attention due to the barriers of its location. One might ask why this population doesn’t take the ferry to the mainland for better conditions, but the solution is not so simple. People are attached to the land they grew up on and their roots that are entrenched there. It is not necessarily the physical entities such as a house that keep people attached there as much as the spiritual connection and innate desire to look after the land their families have cared for through generations.

We cannot go to other countries and cultures and tell them how to live. Rather, we must support them so they can continue to live the lives of their choosing. This concept reminded me of the stories the Program Director shared about the challenges to confining Ebola because of the postmortem rituals and burials. The people did not care as much about infection as about their cultural and spiritual beliefs.

I plan to organize more missions to Puerto Rico in the near future, and to establish a team of global health physicians that, in collaboration with academic institutions, could be called upon after a natural disaster or epidemic. This trip came at a good time for me, as I am about to finish my final fellowship and am seeking positions through which I can continue developing my work in global health. Although I try to live my life with conscious appreciation, important events such as these global health experiences remind us of the extent of gratitude we should carry.
The Quandry of Relaying Experience

WRITTEN BY JULIA SHATTEN UVMLCOM ’18
APRIL 20, 2018

It has been almost two and a half months since returning from Uganda. In the midst of
interviews, I work on summing up my experience into a succinct and palatable interview
answer: Yes, Uganda was life-changing. Yes, I will go back. It made me view inequity differently.
It helped me understand the depth of ethical nuance, and that just because something is hard
does not mean we should turn our backs on it. Yes, it was a good experience.

I hear myself speaking these phrases, but how can I truly express my experience? Is it necessary
to do so? And having now been there, I realize that without traveling to a country like Uganda,
it is almost impossible to understand the power that proximity gives a person.

I exchange daily messages with Irene, a friend I made at the College of Ophthalmology
of Eastern Central and Southern Africa (COECSA) Conference. Sometime she sends me
pictures of her patients with their faces fully in view and pathologies grossly abnormal. Every
day, someone walks into her eye clinic with something I have never seen in the U.S. Is she
protecting their identities? Is she getting their permission? I wonder. Sometimes she just sends
me memes that say “Have a blessed day” or “Jesus loves you,” a reminder of my isolation as a
Jew in Uganda, the varied ethics of patient care, and the extent of disease.

The experience feels all around distant. As I travel from residency to residency, I ask the faculty,
“How is your global health program? Where do residents go? Is there an exchange? Would you
support me in returning to Uganda?” But the entire seven weeks feels displaced and dreamlike.
When asked about the details of cataract surgery there, I am unsure how to express that I was
still just adjusting to the fact that patients were not at all sedated, and that fifteen medical
students were crammed in to focus on the steps. I try to describe the pathology, and I am
enthusiastic, but how does that actually come across? It is complicated.

I finished Jeffrey Sack’s book How To End World Poverty and am now reading fiction again. It is
strange how easy it is to just revert to regular life, unwrapping granola bars on the plane and
drinking water from any tap with ease. However, the one thing that has remained a constant is
my desire to go back. As I sort through my rank list, global health plays a noticeable role.

My last thought is that I do not think I have lost my passion for addressing inequity in the U.S.
I recently listened to an interview on the Ezra Klein Show with Bryan Stevenson, a lawyer who
defends prisoners on death row and author of Just Mercy, an incredible look at institutionalized
racism in the U.S. and the dangers of ignoring our collective history here. The interview addresses how the opposite of poverty is not wealth, but justice—and proximity is essential to making change. Stevenson certainly gained that proximity with his work on death row. The interview touched on the wealth gap in other countries and the depth of injustice in not acknowledging the systematic oppression that led to it here.

There is a lot more to read, learn, and experience in this realm. I truly appreciate the experience that this global health fellowship has given me to dip my toes in.
As I continue my rotation at Nuestra Señora de la Altagracia, the way in which “Entrega de Guardia” is conducted sticks out to me. Entrega happens every weekday morning with all the residents and fellows in the entire hospital (over one-hundred trainees in total) and from my perspective, a combination of sign out (from night team to day team), morning report, and grand rounds. I have attended Entrega every day during my two-week rotation here, and have learned something from it each time.

Perhaps the most interesting thing to me is that the entire group prays together every morning and during the evening shift change, with hands held and eyes closed, and the prayer is always explicitly Christian. I was initially taken aback by this practice because it is so different from the thoroughly secular medical culture I am accustomed to. However, over the course of the two weeks, I began to appreciate and even look forward to these prayer sessions. Despite the fact that I am not Christian (I am Muslim), I feel that these sessions bring a greater sense of togetherness, spirituality, and compassion to the group. For me, and I would guess for many of the providers who work in this hospital every day, group prayers are the most peaceful moments of an otherwise hectic day.

Upon reflecting on the reason for this tradition, it occurred to me that it may be partially due to the fact that the Dominican Republic’s population is overwhelmingly Christian (Catholic and Protestant) and that religious observance is relatively common. In other words, there is a sort of religious homogeneity that may make this possible. I then began to see the effects of that religious and cultural relative homogeneity all over the place. I think it is that relative homogeneity that allows doctors, nurses, and patients to speak with each other so informally and comfortably. Though there are likely many contributing factors, I think the religious/cultural homogeneity is an important one. The diversity of many populations in the U.S. often makes that sort of immediate connection difficult to achieve. That is not at all a knock on diversity, but just a thought I had on one of the possible trade-offs.

Another cultural difference I noticed is that doctors often vigorously argue with each other during Entrega—a scenario I am not accustomed to seeing in the U.S.—and then hug and kiss each other on the cheek almost immediately afterwards, as they hug and kiss all of their colleagues. While this practice was also somewhat surprising at first, I learned to truly appreciate the openness and warmth.
Having been an international student for the past seventeen years, I think about home a lot. In Shona, the concept of “kumusha” encompasses the ties that bind us to a specific portion of the earth, and the families and communities that formed us. Regardless of our physical location in the world, these roots determine who we are at our core, and who we will become.

At the 2018 Global Health Day at the University Of Vermont Larner College Of Medicine, while listening to the Dean’s Distinguished Lecture by Dr. Majid Sadigh titled “My Heart Burns,” I was challenged afresh by what it means to be a “global citizen,” and in turn, a global leader in healthcare.

To be a global citizen is to extend my concept of “kumusha” in a way that counters the current political climate. It means moving beyond simple cultural tolerance, and instead embodying the kind of cultural humility that allows me to make the whole world my home. It is about transcending the barriers of race and language, of religion, of socioeconomics, and choosing instead to tap into the fundamental connections that all human beings share.

If I can do this, if I can discard my crippling notion of “otherness” and learn to stretch out my sense of belonging, their sickness becomes my struggle. Alongside my brothers and sisters from every tribe, tongue, and nation around the world, I can apprentice with the problems of global health within their varying contexts and work towards sustainable solutions, not with the superiority that often accompanies education, but rather with true empathy and love.

Home will always be where my heart is. But, my “kumusha” is no longer a single piece of land in Harare, Zimbabwe. It stretches into the horizons, as do my possibilities to help “ensure healthy lives and promote well-being for all at all ages.”
A wide range of ethical dilemmas is integral to global health experiences. Please comment on the following two scenarios:

In a hospital in the Global South, a twenty-three-year-old woman was admitted to the cardiac intensive care unit (ICU) with severe mitral stenosis leading to pulmonary edema during her second pregnancy. This was the second time she was admitted to the cardiac ICU due to acute pulmonary congestion in the setting of severe mitral stenosis from untreated rheumatic fever in her childhood. Because her symptoms were exacerbated with each pregnancy, she had been asked to avoid future pregnancies given the risk to her life. However, her husband wanted more boys so they could help with the work on the farm. The family could not afford a mitral valve replacement for her. The medical students asked why she was unable to avoid endangering her life by receiving a tubal ligation.

**Dr. Winter:** This vignette raises several ethical issues. It is particularly interesting in that it is a situation that could arise in the United States where access to care and inequities in healthcare delivery could lead to a similar ethical dilemma, with many of the same issues applied.

The first applicable principal is autonomy. The patient and her husband have the right to make decisions related to her future health that may be against the recommendations of the treating physicians. We may discuss alternative approaches to treatment and make recommendations for care, but the final decision rests with the patient. A tubal ligation provided without the consent of the patient would be a profound violation of her autonomy.

An understanding of cultural context is also important. A woman who cannot conceive may be considered “damaged” in many societies, and lose her role as a wife, mother, and
community member. In addition, a family without sons in a rural agricultural setting may lack the resources to generate a sustainable income to support an extended family, which may include elderly parents and relatives, who cannot contribute to the economic support of the household. Forcing an intervention such as tubal ligation in this setting may violate the principle of nonmaleficence by disrupting the social and economic integrity of the family.

The ethical obligation to provide the best possible care continues even when a patient does not follow our primary treatment recommendation. Once the team has determined that the husband and wife are committed to future pregnancies without a mitral valve replacement, and that a lower cost approach such as mitral valve repair is not feasible, the family and local health providers in their village should be counseled on how to recognize early signs of cardiac insufficiency in the event of another pregnancy so that monitoring, observation, and treatment can be instituted early in hopes of attenuating her heart failure and optimizing her potential for a safe outcome.

**Dr. Kalyesubula:** This scenario involves several ethical dilemmas that underlie the practice of medicine in resource-limited settings. First is the issue of poverty and resource limitations, and the ways in which this influences the choices of patient and doctor alike. The second is the gender balance and power dynamics within many impoverished families. The third is the doctor-patient power balance and its influence on healthcare delivery. The fourth is the girl child and society norms and beliefs. All these factors influence autonomy.

It is actually a good start that this particular setting had a cardiac intensive care unit and that the patient could actually access it. Most centers in resource-limited settings do not have access to such care and would struggle to make such a diagnosis of heart failure in pregnancy. The previous episode could have aided in early diagnosis in this particular case. As opposed to patients and doctors in high-resource countries, those in low-income countries have to make decisions about the choice of care provided based largely on the social status of the patient—especially for conditions that are out of the realm of “free” healthcare. Whereas Global North clinicians look for the best evidenced care, most of us have to settle for the most cost-effective.

Financial status has a lot to do with the care given or received. Because this family could not afford a vulvular replacement surgery, the patient ended up needing intensive care for the second pregnancy, which would not have been the case had a vulvular replacement been done after the first. With these facts in mind, the medical student feels she or he can help implement a permanent solution by ensuring that this woman gets a tubal ligation and never has to deal with the risk of getting pregnant again, and therefore never endanger her life in the process. It is fair to say that this would be a good approach in the medical student’s view, but it would impinge on the principle of autonomy which is essential to medical care. The underlying social circumstances beyond this simple solution is the husband’s influence on the patient’s choice as well as the family’s future plans in terms of looking at children as major sources of financial support.
What was not mentioned in this scenario is the fact that families still look at the boy child as the heir who will carry the family lineage forward. This notion is shared by both men and women from this part of the world. I have met women struggling to have a tenth child because all the first nine children are girls, and take the risk of pregnancy knowing that the tenth child could also be a girl. It is important to appreciate this concept and be culturally sensitive in global health. It is also important to appreciate that men wield more power in most relationships despite the fact that it is the woman who carries the child for nine months. In Uganda for example, all children belong to the man and his clan. This means that the decision maker, who is often the man, needs to be on board with most family choices. Unfortunately, most men are never present for the birth of their children, and often do not accompany their wives for antenatal visits. They do not hold the hand of the wife to witness the most beautiful gift of children taking their first breath.

This dichotomy is due to cultural issues, also to lack of space for such “luxuries.” Because one room is often shared by four women in labor, men are not welcome and have to wait outside to receive the baby, if they show up at all. For the medical student, this would be a good time to reinforce the ethics around patient autonomy. She or he should be able to give all the information to the family while respecting the decisions made by the patient and her family members. The student should focus not only on the woman in labor but also include the man in the conversation, and not shy away from sharing alternative sources of income for the family while emphasizing the fact that girl children have the same value as the boys. If the student is supported to pass on this information to the family, it may encourage the family to undertake a more informed tubal ligation, thereby shifting the balance onto the mother’s well-being. In any case, if the mother dies in labor, the highly sought-after boy child has low odds of survival in most resource-constrained countries.

That being said, the decision made by the family should be final and respected without judgment. The student should also use this case to learn that the patient has the ultimate say in regards to their health and it is not only up to the doctor(s) to determine what is good for them.
This week I began my rotation at the Hospital Universitario Maternidad Nuestro Senora de la Altagracia, (HUMNSA) a public tertiary care hospital in Santo Domingo specializing in Obstetrics and Gynecology. Treating mainly high-risk patients, HUMNA serves as the referral center for all other public OB/GYN hospitals in the country. This hospital’s large size and comparative lack of resources makes it a very different setting from that of the Cardiology Hospital where I was prior. Although there were several open beds on the Labor and Delivery inpatient unit, the resident informed me that this was a very low census for them, and that there are up to three women sharing a bed during the busiest times.

This is vastly different from what I experienced on L&D at UVMMC where each woman has a large private room and students only enter when the patient gives explicit consent. While I performed less than ten cervical exams during my three weeks on L&D at UVMMC, I was ordered to perform a cervical exam almost as soon as I walked into the L&D unit at HUMNSA. Though I was caught off guard at first, I performed the cervical exam and tried to measure the dilation and effacement of the cervix as best as I could because I wanted to show that I was willing to learn and work hard. Mid-exam, I realized that I hadn’t used sterile gloves, properly introduced myself to the patient, or obtained informed consent. I started to feel guilty about all those things, but there were several barriers to correcting my mistakes the next time I was requested to perform a cervical exam.

My Spanish is still pretty weak— but even so, most of the women on this unit are Haitian and speak Creole or French. The resident interacted with many patients without introducing himself or me, or asking for formal consent, likely because of the language barrier. Though the language barrier certainly makes it more difficult to communicate with the patients as I would like to, the cultural barrier provides perhaps an even greater challenge. There was also a resource barrier since sterile gloves were in limited supply and the resident did not like the idea of me using one every time I did a cervical exam.

I should also describe the general environment of the L&D unit. It is a large rectangle-shaped room with two rows of fifteen beds on either side, separated by a thin curtain that is rarely ever drawn. When the women arrive on the unit, they are given a mostly transparent gown to wear, and lie in the beds with their vulvas exposed while residents or medical students pass by occasionally to examine them.
It took me a whole day to ask what should have been an immediate question: Why are none of the patients accompanied by a spouse, partner, or family member to support them. I was told two reasons: first that there had been incidents of babies being stolen from the nursery, and second that there was not enough space for each patient to bring a family member. It was saddening to see women, already in vulnerable situations, surrounded by people who could barely communicate with them go through it all alone without a single familiar face.

Reader Response: We Either Give Life Or We Take It

WRITTEN BY DR. MAHSHEED KHAJAVI, ASSOCIATE PROFESSOR OF CLINICAL MEDICINE AT FLORIDA STATE UNIVERSITY
MAY 25, 2018

I think the most important word is “vulnerable.” While reading Asaad Traina’s entry “Going Through It Alone,” I reflected on the fundamental lack of acknowledgement of each woman’s humanity. Perhaps the more appropriate word is simply “humanity.” While spoken language is often a barrier, there is an alternative, a universal language: smiling, holding a hand, sitting down and touching an arm, sharing a cup of tea or glass of water… something to say, “You are not alone here. I am with you.”

It is impossible to foster change in an entire system if you are there for short periods of time. However, we can let each person with whom we come in contact know that she is not alone—that she has someone with her who will acknowledge her being by his own.

Fereydoon Jariri wrote that in every interaction we either give life or we take it. There is no middle ground. While language is important, there are other ways of giving life. As we do so, we too are made more whole and more alive.

Thank you again for your words.
P.S. We do not use sterile gloves for pelvic exams in this country either.
Ethical Dilemmas in Global Health: Financial Barriers and Interventions

Responses by Dr. Stephen Winter, Director of Global Health at Norwalk Hospital, and Dr. Robert Kalyesubula, cofounder of the African Community Center for Social Sustainability, in Nakaseke, Uganda.

A wide range of ethical dilemmas is integral to global health experiences. Please comment on the following two scenarios:

A 30-year-old woman was admitted for small bowel obstruction of unclear etiology. Her hospital course was complicated by sepsis, requiring admission to the Intensive Care Unit. During the course of her hospitalization, it became apparent that a laparotomy was required to relieve her small bowel obstruction. However, her family was unable to pay for the surgery, thereby deciding to forfeit her life. My medical students and I considered paying $100 USD each to pay for her laparotomy, but the doctors deterred us from doing so, explaining that this was a daily occurrence and fact of life.

Dr. Winter: This represents a situation that is not uncommon when visitors from the Global North come face-to-face with the reality of true resource limitation. I think we often struggle with a response that speaks to our own emotional reaction when witnessing a death that could be prevented. What does it mean for physicians from the Global North doctors to pitch in enough money to save this patient? Perhaps it signals to the patient and others who know her that their doctors and system of care must be inferior to that of the Western doctors who have intervened with curative (albeit financial) treatment.

What does that mean for the next patient who needs an intervention, and the hundreds after that? How does one justify not also helping the next one? How do local physicians caring for this patient deal with their own feelings of distress from being unable to provide care to their patient, and having to watch them die for lack of resources? How do they feel when you directly point out the inadequacies of their system with a handful of cash?
I think it is an expression of cultural insensitivity that attacks the dignity and emotional resources of the treating local physicians that may even lead them to feel that the systemic inadequacies are somehow their own inadequacies. Just because the physicians are able to stoically deal with their own realities of patient suffering and death due to resource limitations does not mean that they are unaffected or unbattered by the emotional distress and grief inevitable with these situations. Helping provide compassionate emotional support and symptom palliation to the patient, along with support for her family and even her physicians, is the more relevant intervention. If the visitors have financial resources that they wish to share, they should explore ways to extend it through the institution. Or perhaps they can contribute to a fund that supports care for patients without resources (most hospitals have funds for this) or find another way to improve overall patient care. We should not be palliating our own emotional discomfort by amplifying the distress of others.

**Dr. Kalyesubula:** This is really a tough scenario which brings tears to my eyes. I would start by saying that every life counts in its own right. I would like to be nonjudgmental and maintain clear headedness, but I feel like this is really a very sad situation and therefore a tough decision. I would like to avoid echoing what I have already said, but allow me to repeat the fact that money really matters in decisions made by both doctors and patients.

Let’s first deal with the family in this scenario. The family gave up and decided to forfeit her life because they could not pay. There, you have it, the barrier of finances! Could this decision have been different if the patient was a man, breadwinner, and head of the family? I think the likely answer is yes, the family would have sold all they have to save the man. The family decision was purely influenced by lack of resources. They had very little choice.

Let us next move to the visiting doctor and medical student. Likely influenced by their previous experiences seeing people survive after even very serious illness, they were willing to do what was in their power to try to save this woman’s life. They could also have been influenced by the fact that this was a very young woman with a whole life ahead of her. Could it be that it was purely out of the goodness of their heart? These are all possibilities. Because they would probably never face this scenario in their home countries, they may feel compelled to do whatever is in their power.

I don’t think they were wrong, however their decision would have far-reaching consequences, particularly on the relationship between the patients and primary doctors. The family could easily perceive that the local doctors are not doing enough and visiting doctors have the “magic.” This perception could promote distrust and lack of appreciation for the local doctors even though the barrier to care is largely systematic. The visiting doctor and students need to be culturally sensitive.

Now we get to the last issue of the doctors. I can only use my experience from a shared background of limited resources to imagine what might be going on in the doctors’ minds. They had probably seen so many such patients die in the ICU that they had developed the notion that nothing could be done. Death is so common that they feel powerless to do anything about it, and see it as inevitable. “Why waste the little money on such, when more patients
could be saved? The patient is going to die anyway and that is a fact of life.” By seeing patients
die on a daily basis, their value for life has probably been affected negatively, having accepted the
systems inefficiencies and the costs that come with it.

The major dilemma here is how to reconcile these two extreme positions largely informed by
previous experiences. “How do you let someone die when you have the power to save them?
Life has no price tag!” On the other hand, “Why waste very scarce resources on an inevitable
death? So many other lives could be saved instead. Death is normal and should be accepted.”
I feel that this conversation should involve the family. What do they think is in the best interest of
the patient? Surely they would want to give it a shot and see if their loved one could be saved.
I feel the opportunity to save this woman should elicit a debate on how life is valued. If the
doctors decides that death is inevitable, it has a lot of bearing on how they will react and the
care they will subsequently offer.

Even in resource-limited settings, all efforts should be undertaken to ensure that life is saved.
Discussions need to be held about what life really means, and time taken to explore the
possibilities of rejuvenating interest and value for life. On the other hand, the visiting doctors
need to reevaluate and look beyond the impact of the single patient. What happens when
the next patient comes with similar complaints? Perhaps the best way is to solve this issue by
engaging the leadership so that such funds are channeled through a central pool from
which they can be disbursed to address problems from the higher end of the system. The
visiting doctors and students should have a mechanism of dealing with extreme grief, and this
situation should be addressed through the feedback sessions.
Creating a Patient Education Program in Tanzania

WRITTEN BY DR. ALEXANDRA MILLER UVMLCOM ‘18
JUNE 8, 2018

In large, bold type on page nine of my Swahili Medical Dictionary and Phrasebook (MJF Cooper 2006) is written Bora kinga kuliko tiba, which translates to “prevention is better than cure.” Although this phrase is common in English, we forget that for some diseases there is no cure. Cervical cancer is often diagnosed beyond a curable stage in resource-limited settings, despite being a preventable disease. Cervical cancer disproportionality affects women living in rural Tanzania. In fact cervical cancer diagnosis is nearly ten times greater in rural Tanzania than in the United States.

UVM gynecologist Dr. Anne Dougherty has been travelling to rural Tanzania over the last several years developing a cervical cancer screening program. This program is aimed at training local healthcare providers in the “visualization with acetic acid” or “VIA” technique, a simple method that utilizes supplies commonly found in low-resource areas. VIA is successful because women with an abnormal area noted on the cervix are offered immediate treatment with cryotherapy, which is a safe and effective treatment for precancerous lesions. I joined Dr. Dougherty in 2017 for cervical cancer screening, and after many discussions and brainstorming sessions went back in April/May of this year to develop a patient education program.

Our patient education program was conceived after several observations made during our 2017 cervical cancer screening clinics. First, we quickly realized many women were receiving their first ever pelvic exam, which is one of the most sensitive and intimate physical exams performed in medicine. We were acutely aware of our patient’s vulnerabilities and wanted to ensure they were fully informed and felt in control during their exams. Second, we realized that the concept of preventative

DR. ALEX MILLER AND KIARO TENDAU (TRI-LINGUAL TRANSLATOR- ENGLISH, MAASAI AND KISWAHILI) EDUCATING WOMEN PRIOR TO CLINIC
care was as foreign to the women as we were. The idea of going to a clinic when you are feeling well requires a profound shift in thinking.

We also appreciated the fact that we as healthcare providers in the U.S. prioritize and value preventative care, an attitude that may differ from the priorities of women attending clinics in rural Tanzania. Likewise, information that is well-known to us, such as the prevalence and incidence of cervical cancer in Tanzania, is not always disseminated or understood on an individual or community level. Third, due to the high volume of patients attending the clinic in 2017, we started an informal group educational session held before women underwent various preventative health screenings, including a breast exam and HIV testing.

We recognized how engaged our patients were when we showed basic illustrations of women’s anatomy and provided an opportunity for them to ask questions. During these times, we were able to ascertain many popular beliefs regarding cervical cancer screening, such as cervical cancer screening can cause infertility. Women were extremely receptive to education pertaining to their reproductive tract, especially in an environment where women’s healthcare decisions are often dictated by their husbands. Lastly, we saw that Maasai women were especially under-represented at the clinics, and wanted to provide a comprehensive, inclusive, and inviting preventative healthcare clinic. Because Maasai women are deeply ingrained in their traditional pastoral culture, they do not have the same access to schools and seldom learn KiSwahili, the national language As the common language spoken between other tribes, KiSwahili enables social and business interactions as well as interactions with local health care providers.

During our 2017 clinic, we collected data on a little more than 350 women and found that 35% reported no schooling, 37% reported having had “some primary school,” and only 28% reported having had “some secondary school” education. We used this data to tailor our patient education material to a fourth grade level. We also found that only 42% of the women attending clinic identified as Maasai despite being in an area where the local population is about 85% Maasai. These data points helped us develop an innovative cross-cultural patient education program. In order to communicate across a vast cultural divide, we had to sift through many critical elements and not only recognize cultural differences but also puzzle out how to overcome them. Examples included inherent beliefs about health and illness, individual and community prior experiences with healthcare, issues of informed consent and decision making ability, the role of men in women’s health decision making, intricacies of language and working with a translator, and how to evaluate the effectiveness of our program.
We had many logistical considerations for developing patient education material such as using easily transportable materials, durability, and cultural appropriateness of models. In an area where many women are circumcised, we had to consider how to illustrate a vulva that would be meaningful and representative of the patient population. I made a poster using felt that can fold up for easy transportation. Sewn onto the poster is a life-size representation of a Maasai woman with a traditional shuuka (cloth), with her reproductive tract demonstrating a uterus, ovaries, fallopian tubes and cervix superimposed. I made models of the progression of cervical cancer on painted doorknobs as well as felt replicas of crevices. To demonstrate a pelvic exam with a speculum, I made a three-dimensional felt pelvic model that can be placed around a cardboard box. Once the speculum is placed, a cervix can be visualized.

We traveled to village markets holding up the poster and giving demonstrations which were well received by both men and women. Men especially were vocal if they had a personal experience with a wife or mother who had a positive screen or cervical cancer, and were helpful in encouraging women to be screened. We thereby transitioned from a line-by-line translation into local health care providers delivering the educational material themselves. They were excited to have new props and tools to use in their clinics.

Language proved to be a considerable challenge as our message was translated into Kiswahili and Maasai, two languages that are very different from English and one another, and do not have as many specific words or medical jargon that we use in English. One of our pivotal learning points was translating back into English from the translated Kiswahili and Maasai, a process that taught us to adapt the delivery of our message without losing context or meaning. We held focus groups and, with a few groups of women, conducted pre- and post-surveys to determine if we were effectively providing patient education.

My time in Tanzania was ultimately my last coursework before graduation from medical school. This project was not only a culmination of my medical education, as I was able to master the contents of the patient education material, but I also felt a fundamental shift from being a student to becoming a doctor and teacher. I had to extend beyond merely pointing out cultural differences to working within a culture and interacting with patients, ultimately reaching over the cultural divide to connect with them. I had to remember how I felt prior to medical school, before I understood all of the medical

JENNA JORGENSEN ’19 AND AMELIA TAJIK ’19 HOLDING UP THE LIFE-SIZE FELT REPRESENTATION OF A MAASAI WOMAN
jargon. I had to retrain myself to look through the lens of the patient. Our work in Tanzania can be replicated in many situations in the U.S. such as working in rural areas or underserved areas, or with new Americans. Patient education is part of comprehensive medical care, and I owe it to my patients to take a moment to think from their perspective about what some of their barriers may be to understanding their diagnosis or treatment.

This project would not be possible without the generous support and kind donations of the Jerome S. Abrams Memorial Fund and the Eleanor B. Daniels Fund. I am also greatly indebted to Dr. Dougherty for her mentorship throughout my four years at the Larner College of Medicine. Never tiring of emails and questions, she has given me my foundations in humanism and cultural competency. Jenna Jorgensen and Amelia Tajik from the class of 2019 were also vital to this project and are dedicated to improving healthcare for the women of rural Tanzania.
VICTORIA FALLS (LOZI: MOSI-OA-TUNYA, “THE SMOKE THAT THUNDERS”) IS A WATERFALL IN SOUTHERN AFRICA ON THE ZAMBEZI RIVER AT THE BORDER BETWEEN ZAMBIA AND ZIMBABWE. PHOTO BY MARIAH MCNAMARA
Science and medicine have had a significant presence in my life since childhood, as my parents are both physician-scientists. Through the discussion of medical topics at the dinner table and frequent visits to their workplaces, I came to greatly respect these professions. When I was nine, my parents were invited to work as Research Fellows at University College London. During the two years that we lived in the United Kingdom, my parents worked with a number of outstanding scientists and physicians with whom I interacted at an early age. This rich exposure to medicine and science played a major role in shaping my interests which matured through high school and ultimately resulted in medical pursuit.

My involvement in global health began at some capacity during my medical school career when I joined the Office of International Affairs at Kazan State Medical University (KSMU), where I was responsible for running a student exchange program through the International Federation of Medical Students’ Association. However, global health was not part of the medical education curriculum because the term was not commonly used in Russia at the time. The concept was first introduced by the Director of the UVMLCOM/WCHN Global Health Program who, during annual visits to Kazan, taught principles of global health and the art of being a caring physician. These lecture series had a meaningful impact on me by changing my perception of international medicine. Since then, a tripartite exchange program - the first of its kind in Russia - among KSMU, Makerere University in Uganda, and WCHN/UVMLCOM has enabled young Russian physicians to be trained in Uganda.

My current role in the WCHN/UVMLCOM Global Health program is to organize and coordinate global health electives for senior medical students from the American University of the Caribbean and Ross University, two of our partner institutions. I am excited to start my new role as Director of International Affairs whereby I will work with our partner sites to establish a structured educational program for international visitors hosted in the U.S. It is a great honor and privilege to be part of this Global Health Program.

My advice for young students pursuing global health is to be open-minded and respect differences in culture and traditions. Embrace challenges that come your way with a positive attitude. Be an active learner, and strive to fulfill your passion.
Reading “Ethical Dilemmas in Global Health: Financial Barriers and Interventions” moved me to tears. However, I feel that allowing a human being to die a preventable death is not morally consistent with medical mission work.

The very fact that we choose certain countries and see a limited number of patients— as many as humanly possible in the allotted time, which still leaves hundreds unattended— implies that we are already making a decision regarding the allocation of resources. To carry the argument of nonfinancial intervention is antithetical to what is already being implemented: choosing a country and select group of patients who will receive care.

This begs the question: how do we choose to help one person but not the next? Yet we do this every single time we work in resource-limited settings.

We make a decision to go to Vietnam, for example, and help this particular group of individuals. In doing so, we decide that these same resources are not going to, for instance, Guatemala. The physician who chooses to intervene for one group of people has, by her own decision, left others without the same opportunity.

Many years ago in Shiraz, I saw a woman bring in her child who had a fever of 41°C and was actively seizing in her arms. Lacking the funds to pay for the visit, she was told that she had to go to another facility. My mother ran over and immediately paid the fee, and continued to do this over the next month. She used all the money we had and emptied her bank accounts from previous years. Did she save everybody? No. Her response did not even amount to a drop of water in a vast ocean of need. But she did what she could with the resources and time she had. This, of course, implies that there were hundreds of others who would continue to be turned away from the hospital.

We travel with the understanding that our resources— time, finances, and personal affects—are limited. Yet we make a conscious decision to go abroad, and in doing so choose to help as many as we can with the resources and time we have. This is a choice. It leaves many unattended. We choose to help some live with the awareness that others will die. Implicit in the travel and time spent is that we are morally responsible for those who come onto our path. One can argue that it may cause feelings of resentment of inferiority among the people and
staff who reside in those particular areas. Yet why would they allow us to come if they did not believe that we could be of some small benefit?

My decision to pursue medicine was made well after university, where I studied philosophy. The subject allowed me to ponder the existential questions of the human condition, at the center of which is life and all the messy, chaotic scenarios in which one must listen, learn, and decide. To allow one to die from sickness when one can intervene is not only outside of any morality to which we subscribe as physicians and human beings, but it is inconsistent with the larger premise: the fact that every decision we make is with the understanding that to help those with whom we have chosen to congregate means that there are those who will be left without.

We cannot save the world. We make choices to help those we can with the implicit understanding that there are others—millions of others—that we will never reach. In the film “The Blade Runner,” the replicant reaches out as he approaches death to pull the protagonist up off the ledge...the two men who were, just some moments earlier, trying to kill one another. The replicant gives one of the most emotionally moving monologues in cinematic history, Tears in the Rain. Harrison Ford is left in a moment of empathy and clarity and finally speaks:

“I don’t know why he saved my life. Maybe in those last moments he loved life more than he ever had before. Not just his life, anybody’s life, my life.”

To save one life while being unable to save all is a given. To let one life go because on some level we may not acknowledge this fact violates all that makes us human. I must respectfully disagree with the responses to this ethical dilemma. We make choices that help others and in doing so leave others in need. We do this every single day with every single choice. But when we can help one human being, we have a moral responsibility to do so. To allow one to die simply because we know there is not enough for everyone means that we have been complicit. To help one person live knowing others will die means that we have still saved one person.

As written in the 32nd verse of the 5th Sura of the Quran:

“Whoever saves one life, it is written as if he has saved all humanity.”

I leave you with this: what does it mean to have the ability to do so and refrain?
Ethical Dilemmas in Global Health: The Monitoring of Reflections and Social Media Posts

Responses by Dr. Stephen Winter, Director of Global Health at Norwalk Hospital, and Dr. Robert Kalyesubula, cofounder of the African Community Center for Social Sustainability, in Nakaseke, Uganda.

A wide range of ethical dilemmas is integral to global health experiences. Please comment on the following two scenarios:

Participants of our Global Health Program are required to write weekly reflections about their experiences. While the sharing of these reflections with the administration of the Global South could be beneficial for quality improvement, it may also prevent participants from honestly expressing their views. Given these considerations, how should participant reflections be shared with the Global South? What do you think about synthesizing a short summary about site-specific reflections to share with the leadership every six months?

Dr. Robert Kalyesubula: I believe that the sharing of a synthesized summary is more conducive than that of personal stories. However, I feel that this may remove the spirit and feel of the writer, and should therefore be left to the judgment of the Global North to decide what is appropriate.

Another possibility is to anonymize the reflections, which may inspire resolution of the issues expressed. I think it is somewhat unfair for participants to be asked to write reflections if they are not going to be shared. Doing so defeats the spirit of shared values and transparency, which in turn denies local teams the opportunity to improve.

Dr. Stephen Winter: I think that a regular summary of reflections should be produced either to give constructive criticism toward improving the elective, or provide positive feedback to the host participants. Withholding of negative characterizations of the experience would be
inconsistent with our program goals of honesty and transparency. The reflections should be viewed as a quality improvement, rather than a marketing tool.

Global health participants sometimes have difficulty dealing with cultural differences, and respond in ways that may be harmful to themselves or to their relationships with international peers. At WCHN, we try to monitor such conflicts by requiring weekly reflections, and reviewing them in real-time for signs of an evolving problem. In regard to the most junior students, we have on-site residents and senior attendings who, as part of a team structure, identify and respond to problems. What other approaches might help monitor for potential problems?

Dr. Robert Kalyesubula: I believe that pairing global health participants with local peer mentors can provide an open space for participants to freely share what they feel. This exchange can go a long way in terms of monitoring potential problems.

Dr. Stephen Winter: I think these approaches have been effective for our program. The only addition might be to ask the host country site directors to provide regular evaluations of rotating students and residents. However, I think this approach is likely to incur an unacceptable level of additional work for clinicians and administrators who already have a host of other responsibilities. Perhaps they could instead advise the directors here at home to identify trainees that may have a difficult time, so they can be given extra support. This could also be an additional role for the homestay families.

Some participants post their daily observations, accompanied by photos, on their personal blogs. To help address this issue, our Global Health Program has included in the Code of Conduct that any participant must obtain approval from the director at both host and home institutions before posting any such material. Would you consider this censorship, and is it necessary?

Dr. Robert Kalyesubula: Given that posts can be damaging and/or reactionary, some level of control in the form of censorship or guidance is needed. Another issue is the breaching of confidentiality, which I believe is the idea behind laws such as HIPPA in the United States.

Dr. Stephen Winter: Yes, it is a type of censorship, however uncensored social media can be very destructive to individuals and relationships. I think Facebook should not allow neo-Nazi rants, and we should not fail to exercise some control over the content of expressions about the program. Part of the substrate of global health is the development of cultural competence for our trainees. We should not hand them scalpels without prior supervision and surgical training. In the same vein, let’s not hand them a potentially harmful tool without supervision and training.
Unlike many of my colleagues, I have no family members in healthcare. However, I grew up surrounded by cancer, specifically Familial Adenomatous Polyposis. My mother, along with many other family members, were faced with the realities of our medical system and quality of medical care, shortcomings and successes alike. With a strong academic interest and curiosity in science, I sought knowledge but also felt an undeniable yearning to help people. The choice for me was distinct: medicine would give me the opportunity to spend my life learning while helping others through the application of my knowledge.

Growing up, different cultures were hardly a foreign concept to me. With my mother a first-generation American, I grew up surrounded by an immigrant family. However, it wasn’t until my undergraduate studies at the University of Michigan that I was exposed to a wide variety of cultures. My fervor to learn more about medicine and cultures other than my own led me to apply to programs that allowed me to travel. I had the fortune of spending two weeks in Australia studying their medical system, followed by a semester abroad in Germany where I completed my honors thesis on medical experiments during national socialism.

The most challenging aspect of the global health elective is not knowing the culture or language and trying to so quickly integrate into an unfamiliar system. However, this challenge became rewarding after easing into the culture and better understanding it. Language barriers are always difficult, but they are a challenge we also face in our careers at home. With the belief that being able to communicate should never be a barrier, I have strived to learn multiple languages and adapt to the language of my surroundings, which is an incredibly rewarding endeavor.

The foundations of medicine can be learned anywhere, but perspective is gained through experience. The global health experience provides a stark example of the inequalities of medicine around the world. It makes me reflect on how we take basic certainties of our healthcare for granted, such as being treated regardless of ability to pay. The elective also reaffirmed confidence in my ability to be resilient and adjust to new situations. But above all else, I’ve learned the importance of cultural competence. We cannot treat a disease alone. We must treat the entire person. But how can we begin to treat the whole person without understanding their culture?

Additionally, the elective provided me with clinical exposure that I wouldn’t be able to experience here at home. I was able to observe diseases I thought only existed on board exams. While this experience made me a better clinician, the disbursement of my knowledge will make my colleagues better as well. Diseases and treatments I have seen firsthand I am
now able to share with my colleagues, an exchange that has deepened my understanding of medicine as well as that of my colleagues. The sharing of knowledge in the medical field is incredibly underutilized, but so important for the health quality of people all over the world. This experience has also better equipped me to provide care in resource-depleted settings, since these settings are not exclusively abroad but also here at home. Health shouldn’t be only for those who can afford it, but without training in these settings, we as physicians aren’t able to provide the highest quality healthcare.

I am currently completing my graduation requirements, and will soon relocate to Belgium for a year to pursue research at a leading university in digestive oncology. There are no borders when it comes to learning. In order to provide the best care and make a mark in my field, I believe in going where the research is. By training from the best in digestive oncology, I can later apply my knowledge to improve the health of those who need expertise anywhere in the world.
My arrival at a career in surgery was circuitous, to say the least. I studied Spanish and foreign relations in college and had planned a career as a jurist or with the foreign service. As I progressed further down the path of law and government, I discovered that I didn’t like the version of myself that was emerging. I feared the person I might become in twenty years if I continued. I made the difficult decision to change course, and have always been glad I did.

I had been an EMT after high school and returned to working in prehospital medicine and search and rescue. I became a paramedic and loved studying the common denominators between all people, from all walks of life – biology, physiology, and the inevitable conflicts that arise between them and the lives we live. I found renewed purpose and passion in these endeavors and began to question whether or not a career in medicine might be a good fit for me. On somewhat of a whim, I took a job as a medic and unit assistant in the operating room of a large hospital in Salt Lake City where I was trained as a surgical first assistant. It was there that I found the answers I needed. Surgery was and continues to be the only thing I could see as a true vocation, something I could dedicate a life’s work to and remain stimulated, passionate, and fulfilled. Aside from the decision to marry my wife, choosing a career in surgery was the single best decision of my life.

My interest and involvement in global health certainly began with local health. Prior to medical school I volunteered once a week at a clinic in Utah for uninsured or underinsured patients that mostly catered to the homeless. Working in a resource-poor environment meant we had to be creative at times in delivering high-quality care. The parallels between this work and global health were apparent to me and seeded my interest. In medical school, I spent several months of my clinical years working in a clinic in Portland, OR that serves the homeless, uninsured, and underinsured. These rotations were among the most important and formative of my medical school clerkships and provided the right reminder, at the right time, of my beginnings at the clinic in Utah. We did really amazing work for patients, all while under significant financial and material resource constraints.

Among my primary responsibilities in the clinic was spending one day a week in a minor surgery clinic. Even as a student, I was the only person in the clinic with any significant surgical experience. It was then that I saw and fully appreciated the value a surgeon can bring to a resource-poor area, and became interested in global surgical care. It was not until my third
year of surgical residency that I had the opportunity to participate in a global surgery program. Though it was a dream deferred, I was eager to participate when the opportunity arose, knowing just how much satisfaction and personal growth was possible and bolstered by the possibility that I might have something to offer patients or other physicians – wherever it was I might go.
IDR. ZIMMERMAN WITH THE MEDICAL TEAM AT HOSPITAL GENERAL DE LA PLAZA DE LA SALUD, DOMINICAN REPUBLIC
One of the challenges during my time in the Dominican Republic was realizing that their surgeons are great – really great – and that I likely wouldn’t be contributing much in the way of innovation, knowledge, procedural expertise, or even perspective. The fact is that their surgical residents outclassed me in essentially every way. They were phenomenally smart and talented surgeons with technical skills surpassing the training level of their American counterparts. They had immense operative experience, great judgement, and the knowledge with which to operate with true beauty without many or most of the technologies we enjoy in the U.S.

While this was certainly humbling, it also served to remind me that technology doesn’t make me a better surgeon per se. In time, it may make me a more technologically advanced surgeon. And still, it will always be the fundamental surgical principles of knowing when to operate and when not to, knowledge of anatomy and physiology, and the core technical skills of cut, expose, dissect, divide, and sew that make a surgeon great. I witnessed real masters of these principles in the Dominican Republic and I returned to the U.S. with a new drive to focus on mastering the basics that translate to all of surgery instead of focusing on what tool or technology might make things simpler, faster, or easier.

I hope to find opportunities for future involvement in global surgery. My time in the Dominican Republic made clear that I need to focus on specialization in order to offer something unique and needed to other residents, surgeons, and the patients they serve. I don’t yet know what, exactly, that will be for me. Until I have a specialty or skill set better suited to global surgery pursuits, I plan to focus on what I can bring to the residents and surgeons of the Dominican Republic right now. I hope to be an ambassador of sorts to the ongoing relationship between UVMLCOM, Danbury Hospital, and the residents of Hospital General De La Plaza De La Salud in the Dominican Republic.

Realistically, this means hosting Dominican residents in the U.S. and providing educational opportunities like ATLS, POCUS curricula, or surgical simulation curricula that they don’t have access to. I’d like to identify residents or attendings that would benefit from seeing laparoscopic approaches to things like hernias – which are uniformly done open in the Dominican Republic – and connect them with the experts we have in these techniques such that they might gain the exposure and comfort to utilize them in their practice.
There Is a Force Within That Gives You Life

- Rumi

WRITTEN BY DR. MAJID SADIGH, TREFZ FAMILY ENDOWED CHAIR IN GLOBAL HEALTH AT WCHN AND DIRECTOR OF GLOBAL HEALTH AT UVMCOM
JULY 27, 2018

I was raised in a small mountainous village in southern Iran, a land of poor but kind and generous inhabitants. I was one of very few children who had the privilege of a warm and supportive family. It was in this setting that I became familiar with the lives of underprivileged, gentle souls. Through my youth spent searching for meaning beyond simple “happiness, Rumi became my idol. Voicing the unvoiced gave meaning to my life. I dreamed of becoming a storyteller who narrates the tales of those who cannot tell their own.

I attended medical school with this dream, came to the USA with this dream, and joined Yale, and later on the UVM Larner College of Medicine, with this dream. I focused all my energy on using the podium of global health to relay the stories of the underprivileged to those who may not have heard it.

It was at Western Connecticut Health Network that I finally discovered people, both in the community and among the leadership, who shared this dream. John Murphy, the CEO of Western Connecticut Health Network (WCHN), immediately embraced the global health philosophy. In 2016 when he and the Foundation brought my path to overlap with the Christian and Eva Trefz, my dream finally came true. Global Health at UVMCOM/WCHN has found an identity in being named after a generous family that cares about making a positive impact. Now, whenever I take the podium to advocate for the underserved, the Trefz name moves the idea forward, giving it sustainability and power. I am humbled and grateful that my lifelong dream has materialized into something tangible.
What does it mean to have the ability to save a life and not do so?

In Shona, we say Upenyu hunokosha! Life is precious! We cannot save the world, but we can certainly save a world – we can save a mother or a father or a child, and in so doing save a family, a world.

But who is doing the saving? And how is it perceived?

Growing up in Zimbabwe, I experienced the lingering effects of colonialism on a daily basis, as do many doctors and patients in the low-resource settings that are sites for global health work. To put it bluntly, colonialism ingrained in us that “white is better.” With the British bringing books, medicines, and technologies from abroad, we believed their ideologies. In so doing, we subconsciously scorned ourselves and our “backward ways.” Even today, despite efforts in education to overcome this colonial mindset, a vendor on the street in Harare, for example, will call a white woman “madam” and will interact with her in a manner noticeably deferential compared to a black customer in the same situation.

In such a context, a white doctor from overseas, with all the good intentions of serving the underprivileged in global healthcare, going to a village and overriding local black doctors by saving a life where they could not, inadvertently reinforces the notion that “white is better.” That the black doctor is not as smart as the white doctor. That the white doctor is more capable than the black doctor. That what is Western is superior to what is African. This doctor is not just a savior. He/she is a “white savior,” along with all that that encompasses.

Global health is about moving forward, improving, and advancing, and thus should not be constrained by the mistakes of the past. However, in order to not repeat or exacerbate the haunting effects of colonial prejudice and paternalism, we need to keep the past in our minds as a guide for our actions today.

I would not be true to myself or my calling to be a doctor if I did not act in a manner that upholds the fundamental truth that upenyu hunokosha. Whether we are from the Global North or the Global South, in all situations, I believe that life trumps cultural sensitivity and socio-political concerns. To have the ability to save a life and not do so is to do harm.

We cannot, however, forget that our actions occur in a context that we simply do not fully comprehend as visitors, and that the ramifications of our actions will not fall upon us, but on those who call that place home. I have used race as an example here because it is relevant
today on both sides of the world (for different reasons), but this is by no means only a racial issue. The scope of the consequences of acting in such situations is varied and complicated.

The challenge, then, is for us to create new avenues through which to save lives within the cultures and institutions that we partner with across the globe—ways that are informed not just by financial differences, but by history and contemporary circumstances. Ways that foster sustainable local development of medical practice despite limited resources, and that will endure long after we have left.

Without hesitation, always save a life if it is in your power to do so, whatever the context. Upenyu hunokosa! But afterwards, in that warm glow that comes with helping another human being, don’t forget to ask yourself: What is my broader and long-lasting legacy in this community? Then, use the answer to that question to pave a better way forward.
This is the first week during which I have noticed a significant change in myself: I am comfortable. That is, during Monday morning rounds, I found myself as less of a bystander and more of an active participant. Over the past two weeks, I have become accustomed to the language, lab tests, patient population, and attending style so much so that I automatically begin to create a differential diagnosis and have an idea of where to start on physical exams. This is the first time I have found myself effectively doing this.

I am comfortable in the hospital. I am able to greet and minimally communicate with patients in Luganda, allowing me to build trust and, in some cases, even a relationship with patients. While I am often wrong, or have the incorrect thought process, my confidence in my knowledge and ability is slowly increasing. No longer do I wait for Dr. McNamara or Dr. Bachman to take the chest X-ray or brain CT scan. Instead, I am the first to it, holding it up to the windows looking for any abnormalities. My knowledge of the operating room here has increased tenfold. I understand the protocols: attire, footwear, scrubbing, and draping. I even have begun to learn the names of different instruments as they are referred to here – for example, a hemostat is an “artery.” The small antiquated ultrasound machine is still a mystery to me, but I am determined to be able to at least identify the cranial and caudal parts of a fetus by the end of this rotation.

Outside of the hospital, I have grown comfortable with Uganda – the city of Kampala, the people, the customs, the food, etc. I am no longer starved by 3:00 p.m. when lunch is served, and have almost come to look forward to the mound of matoke that inevitably ends up heaped onto my plate. I have the timing of ordering Ubers down to a science, allowing at least an hour to get picked up. Finding my way back to the guest house is simple now; I can even provide direction from a distance away. I have not only come to find comfort in Uganda, but I am falling in love with the country, landscape, and people.

While I could not be happier to be here, and am only halfway through my rotation, I am frustrated at times with my massive – and honestly, endless – lack of knowledge about medicine. This frustration is most apparent when interviewing, diagnosing, and discussing patients with medical problems related to cardiac, respiratory, and renal (the majority of the patients that we see at St. Stephen’s). I try my best to learn what I can from these patients, but I cannot help but feel completely incompetent and idiotic as I repeatedly answer with “I don’t know” to every question posed to me. I am aware that I will never know everything about medicine, but there is a certain incompetence that comes with a lack of understanding of even the most basic
concepts about a topic. While I realize that in only a few months’ time I will easily answer many of these questions that confuse me now, I cannot help but feel frustrated in the moment.

Every day we see a parade of people without adequate resources, suffering from diseases and injuries that would otherwise be managed differently, or at a higher level. In my six weeks here, there is no way I will contribute to the structure of the Ugandan healthcare system, or have any significant impact on the patients receiving healthcare. However, in these six weeks I have begun my career as physician and member of the global community. My impact will not come in the next three weeks, or even next years, but eventually I hope to be a driver of change on the global level.
The Sun is Particularly Harsh Today

The sun is particularly harsh today. The intermittent gush of wind usually provides temporary relief despite the swell of red clay that stains my white coat, but today I feel it making a paste on the back of my neck. The day begins with our routine: waiting for Dr. Cathy to greet us as she promptly does every morning around 9. She is late today. I decide to make a quick dash for the restroom, and head towards the only clean one I know in the maternity ward.

I exit the restroom in synchrony with the opening of the labor and delivery room door across the hallway. It’s Dr. Cathy gesturing me to come in. On the table is a young woman lying down naked with her feet propped on a plastic tarp that she surely brought from home. There is a partially blood-soaked wad of cotton between her legs. On the edge of the table by her feet is a folded bundle of beautiful blue printed cloth with a characteristic pattern that one often sees in shop windows around Kampala. Dr. Cathy begins to open the cloth; I assume to get more supplies the mother has brought for delivery. She opens up each corner slowly. “An abortion,” she says. Lying there in the middle of the cloth is a baby. He isn’t alive. He is small and fully formed with just enough likeliness in his face to the young mother on the table to scare me.

I don’t say anything. I don’t react. Dr. Cathy explains what happened: she had come in with bleeding, the baby half out; a partial abortion around five months. We wait for the placenta. She adds oxytocin to the IV, gives the mother a tablet of misoprostol, says a few words to the woman, and then looks at me and says, “Okay, we will wait, and we can start rounds now.” She isn’t uncaring or apathetic, but says all this with the calm tone of someone who experiences this as a daily reality. We leave the mother in the small, cold room, naked, on her plastic tarp, with her dead child on the corner of that unsteady delivery table by her feet. Her face is expressionless. I wish I had something to cover her with. I wish she had someone to stay with her in the room so she isn’t alone.

I had never seen a dead baby before. I’m not sure if it’s necessarily the baby that made me feel so upset or the way in which I felt the young woman was left exposed in that room by herself. The day followed with me quickly putting my hands to work. I put in my first catheter, gave over a hundred immunizations at the vaccine clinic, and scrubbed in twice: one time to watch a debridement, and a second to quickly help with an emergency c-section that came into the operating theatre at the same time.
My second week in Uganda marked the beginning of another huge shift. In a flash, my week in Kiruddu Hospital’s Emergency Department was over and I was off to start work in Mulago Hospital’s Intensive Care Unit (ICU). The only tertiary hospital in the country, and affiliated with Makerere University, Mulago is the most advanced intensive care facility available. The New Mulago Hospital ICU, currently under construction across the street to advance from a seven-bed to twenty-eight-bed unit, will be functional as of September 2018. Despite its small size, the ICU does not disappoint.

Working alongside the attendings, residents, and nurses, we managed many critically ill patients. Although not all outcomes were good, many patients were appropriately resuscitated, supported, and transferred out of the ICU in stable condition, which was an excellent feeling. In contrast to our ICU back home where almost all patients are admitted for respiratory failure, gastrointestinal bleeding, or hemodynamic instability, here in Mulago over ninety percent of cases are traumatic head injuries and intracranial bleeding from boda-boda accidents.

I saw epidural hematomas, subdural hematomas, subarachnoid hemorrhages, diffuse axonal injuries, and intraventricular hemorrhages. My minimal experience with neurocritical care made this exposure incredibly interesting. Additionally, although I had witnessed the abundance of road traffic hazards on a daily basis, it was surprising to see the devastating end-result. I was able to play a major role in the ICU my second week, presenting on rounds, providing input on management, and presenting to the staff on differentiating and managing types of shock. I was even able to assist with a bedside tracheostomy. It was rewarding to teach my Ugandan peers some of the knowledge I had picked up during my PGY-1 year.

I ended the day with popcorn, chocolate, and avocados from the stand down the street and watched a funny movie. I think it helped me decompress for the day. It wasn’t until later that night when I was relaying the events of the day to my mom over the phone that I finally let myself cry. I’m looking forward to safari this weekend.
Perhaps the most notable and heart-wrenching case of the week is that of a three-year-old boy who was brought in after being struck by a boda-boda. Apparently he had escaped from his mother’s grasp and crossed a busy street unsupervised when a motorbike stuck his tiny fragile body. After sustaining a major head injury, with a CT brain revealing severe cerebral edema and diffuse axonal injury, he was intubated in our ICU for decreased levels of consciousness and ultimately underwent a tracheostomy. He continued to require mechanical ventilation and neurocritical support, and his clinical picture was further complicated by generalized tonic-clonic seizures and aspiration pneumonia. Because his tracheal aspirate culture was obtained after initiation of antibiotics and had returned negative, we were treating him blindly.

At the end of my first week in the ICU, it was this little boy that I worried about the most, and hoped to goodness he would still be there on Monday when I returned.

Although my work experience changed drastically from the first week to the second, some things remained constant. The first thing that comes to mind is the Ugandan cuisine which is a largely carbohydrate-based diet, with meats and vegetables quite a novelty. A staple meal is some combination of potatoes, rice, bread, millet, plantains, corn, and my least
favorite: matoke. For those who don’t know, matoke is essentially steamed and mashed green bananas. Neither sweet nor savory, it just simply is. When it is served, I pray for some type of sauce to cover it with—my favorite being ground peanut sauce or beans— but often times we are not that lucky. With that picture in mind, I have consumed some form of matoke for lunch and dinner every day since my arrival. By day twelve, I began to feel like I had eaten my body weight in matoke. I was one with the matoke. Given that it is the staple food of central Uganda, I continued to embrace my daily dose in order to get the full cultural experience.

My second weekend in Uganda was another exciting milestone in my journey. Rather than going on another excursion, our group decided to stay in the large city of Kampala and experience some true Ugandan culture. We started off early Saturday morning at Reverend Luboga’s farm, where we each planted a new fruit tree as a symbol of establishing our roots in Uganda and providing support to its people. It was a humbling experience. We were then invited to attend a Ugandan engagement ceremony, a very special event where the families of the bride and groom meet for the first time. We all wore traditional African dress with beautiful bride colors and sashes. We were told that we all look very “smart,” which we soon learned means “well dressed.” We did not know the bride or the groom, but Dr. Luboga was the reverend for the ceremony. What he failed to mention was that the bride was a princess of Uganda, and that the Ugandan Queen would be in attendance! We had an excellent time, and of course had our daily dose of matoke for dinner. On Sunday, we toured the Gaddafi National Mosque and the Baha’i Temple before ending the day at the local craft market. Another excellent week in Uganda!
I was deeply moved by the post “Reading “Ethical Dilemmas in Global Health: Financial Barriers and Interventions” and disagreed with the points of view expressed until I read Dr. Mahsheed Khajavi’s perspective, which is exactly my own. As physicians, we definitely do need to be engaged in discussions that eventually lead to decisions made at a societal level. If we do not, then others will. However, faced with an individual situation involving the sacrosanct trust inherent to the doctor-patient relationship, every physician MUST make a decision that is best for the patient.

Had I been in that situation, I would without a doubt had done what that noble lady, Dr. Khajavi’s mother did in another instance. I would have paid (if allowed to do so) for the treatment of the young patient with intestinal obstruction without for a moment caring about hurting the feelings of doctors working in that institution. Too bad! A young woman’s life was on one side of the balance, being weighed against the sentiments of doctors on the other. I know which way I would have come down.

While this decision would not have benefited the society in which she lived, it may have benefited that particular patient and her family. If it had, hurting the feelings of a few doctors would not have mattered to me one little bit! I am very clear about that.
Imagine this scenario: a tertiary city hospital with 1500 beds, over 3000 patients, and an annual admission of 180,000. One-third of these patients die during their hospitalization, and thirty percent within two months of returning home. That equates to 100,000 deaths each year – the equivalent of a New England town that is annually erased from the surface of the earth.

In spite of such horrific odds, we send our doctors, residents, and students to such resource-limited sites. We recognize that they will struggle to understand what they witness, that they will define and redefine the definition of right and fair. They may even remain motionless and mute in the face of their own helplessness as they tackle scarcity of resources amidst the ease and omnipresence of death.

We send them because we know that once the earth has shifted beneath their feet, helplessness will be replaced with empowerment. They return to their own lives with a new perspective, one that honors each individual they had met. They will bring an invigorated sense of service to their hours, emboldened to create meaning of their relationships and commitments. They are
kinder to their own patients and pay closer attention to their patients’ stories. They act less as consumers of material wealth, and more as consumers of knowledge.

We do this work to bear witness to social inequities, to the unshared burden of suffering, to the disproportionate scale of disease. We do this work while recognizing that medicine can encompass presence and human touch at a time when all else has failed.

And they return with humility. They stand beside an intern giving care to over 100 patients with calm and competence. They work alongside a young faculty member who dedicates even Sundays to patients, because “who can turn them away?” Even those of us who are seasoned clinicians find ourselves without function in this environment. Not only is pathology vast and varied, but how do we withhold the principles of “Primum non nocere” in a hospital with a dearth of diagnostic tools, nurses, and physicians in a sea of need? We return humbled by the ingenuity with which our colleagues make a little go a long way, the way in which they quietly shoulder the responsibility of deciding to whom to allocate scarce antibiotics or ICU beds. These are doctors who have the option to work in the United States or Europe but choose instead to serve this community. These are colleagues and friends who look upon us with patience as we fumble with cultural competence, when we make errors in judgment trying to save a life while in fact bankrupting an entire family.

Lastly, our residents and students return to the United States with the image of patients, despite their crippling disease, surrounded by the color and vibrance of their friends and families as they prepare meals and hang clothes to dry in the sun bathing the courtyard. They learn that resilience can survive poverty, and that gratitude can exist even in the last days before death if in the company of loved ones. Suddenly, a place that was once “resource-limited” has revealed itself to be resource-rich in ways that we are only beginning to learn. Many of them will return to these countries, time and again, because it is easy to be happy when life feels so full.

DR. MARY KATE LOPICCOLO AND DR. ALEX MILLER (FRONT CENTER), UVM COM CLASS OF 2018, WITH A GLOBAL HEALTH TEAM
Plant a Tree, Plant Your Roots

WRITTEN BY REVEREND PROFESSOR SAMUEL AND CHRISTINE LUBOGA
SEPTEMBER 14, 2018

Collaboration in home activities promotes bonding among family members. This idea is reflected in the Swahili saying, Suku mbili mugeni. Suku ya tatu mupa jembe. “For two days a guest is regarded as a visitor and is waited upon, however on the third day he is given a hoe to participate in the work (digging) the family does for a living.” Essentially, this means that s/he has become a member of the family.

The global health participants that reside with us partake in home activities to the greatest possible extent. They eat with us, clean, wash, and iron. Before we obtained a more effective washing machine, some attempted to hand wash their clothes. Some have even tried to peel matoke and pound ground nuts for sauce. Participants also join in on our household fun. We sing to them the family welcome song, tusanyakwe okubala mwebale okujja ewaffe e Mpererwe, “we are glad to see you, thank you for coming to visit our home here in Mpererwe,” and the thank you song mebale nnyo kale nolulala okolanga bwotyo, bwotyo, “thank very much, next time please do the same, the same.” They enjoy hearing and singing these short, playful melodies. They also join us in jogging, cross country running, and dancing.

Perhaps the most significant event with long-lasting impact is the free planting at the Luboga’s five-acre garden a short drive away from their home. They bring participants there whenever possible to provide them with reprieve from their computers and cell phones, and to show them an array of food-giving plants many have never seen before, such as banana, maize, pumpkin, cassava, and sugar cane plants. Each participant gets a chance to plant a tree to symbolize their roots in Uganda. These trees are either fruit trees such as mangada (tangerine), ffene (jackfruit), nnimu (lemon), muchungwa (orange), nkomamawanga (pomegranate), kistaferi, muyembe (mango), mapera (guava) or timber trees such as musizi (umbrella) or kalitunsi (eucalyptus).

These trees offer many lasting benefits. Their lively leaves remove atmospheric carbon dioxide, a major contributor to global warming; their fallen leaves increase biomass and help maintain humus and land fertility; their roots hold down soil and limit soil erosion; and in time, their fruit will provide nourishment for generations to come. Their canopies provide shade from the midday sun while creating valuable habitat for birds, of which Uganda is renowned for a rich variety. Participants can take solace in knowing that they can contribute so vastly in the simple act of planting a tree.
(TOP) REVEREND PROFESSOR SAMUEL LUBOGA WITH GLOBAL HEALTH HOMESTAY GUESTS

(BOTTOM) REVEREND PROFESSOR SAMUEL AND CHRISTINE LUBOGA WITH FAMILY MEMBERS AND GLOBAL HEALTH HOMESTAY GUESTS
As my daughter and I sat in the Entebbe International Airport, once again sweating through our clean clothes and beginning to take stock of our time in Uganda, we were glad to be returning home. Simultaneously, however, we were very glad to have come. We felt privileged to visit the beautiful country of Uganda and to meet its kind, welcoming citizens. Although I had heard a lot about the rotation from prior residents, I realize now that there is nothing that truly prepares you for the experience. I think that is what one of our residents, Megan Gething, meant when she said that our global mental health rotation offers a “visceral” kind of knowing. In psychiatry, we know that there is a cognitive knowing and an emotional knowing, and their conjoining is what we call “insight.” Here is my best attempt at conveying my experience to you, and I encourage you to sit back and listen with your emotional brains, as my jet-lagged brain could not figure out what to cut.

Somehow, despite my mental preparation over the past two years for making this trip, I had not imagined that my daughter and I would spend two weeks in the Ugandan equivalent of New York City. There are upwards of one and a half million people (and doubtless many more, as that is census data) who live upon and between the seven hills of Kampala, and—like in my prior home of Manhattan—everywhere you look there are people: people squatting on street corners, people walking, people squeezed into vans/buses they call “matatus,” and people generally criss-crossing over every available surface, avoiding collisions by the slightest of margins with the last minute twist of a shoulder or turn of the handlebars. On the sixteen-hour plane ride there, I cracked open my latest book in social neuroscience written by Kevin Simler and Robin Hanson, aptly entitled “The Elephant in the Brain,” and eagerly immersed myself in examples of the myriad ways our social brains hide our selfish motives, even from ourselves.

The treatise of the book is that our brains are designed to manage other people’s impressions of us, and that in order to hide our less flattering, selfish motivations and behaviors from others, we must also hide them from ourselves. This concept, and the elaboration of it with myriad examples in multiple domains, was an absolute breath of fresh air to my understanding of denial and the incongruence of human behavior. As I first soaked in the sights on the ride from Entebbe to Kampala, my positivity bias seriously eroded by the book I was reading, I had the full-on emotional realization that the human race was doomed: human beings are too good at pursuing individual, selfish motives such as reproducing themselves, and not good enough at persisting at more social motives such as caring for humans already born.
That first day, and on every subsequent car ride, I was astounded by the fact that on every available patch of earth lining the roadside, people were attempting to do what Ugandans call “find money” by selling things. In makeshift and rickety storefronts, vendors were selling just about anything they could to forge a living: crafts, second- and first-hand clothes, large piles of mangos, watermelons, bananas, and jack fruit, pharmaceuticals, food and groceries… you name it, someone was selling it. At regular intervals, manikins lined the streets displaying women’s clothes for sale, and all forms of furniture (beds, sofas, chairs, tables) are all out on open-air display since their sellers could not afford a storefront.

Once in Kampala itself, it was the traffic and in particular the numerous motorbikes that most drew my attention and amazement. In Uganda, motorbikes are called boda boda because at first they were only available to transport people across borders, or from “border to border,” aka boda to boda. Now boda boda are a primary low cost and speedy means of transport, which entrepreneurial Ugandans can purchase with loans, and so thousands of reckless drivers weave in and out of traffic carrying sometimes up to three passengers in a real-life video game with all-too-real consequences.

Aside from the visual, there is no escaping the city with any other modality of perception: all numbers of sounds and smells fill your senses, whether inside or out due to the necessity of keeping the windows open. Your nostrils are filled with unbidden burning smells and your ears filled with chatting voices and music at all times of day or night. From a tactile perspective, the red dust that covers the roads clings to your feet; and sunscreen, DEET, and sweat commingle to line all of your exposed skin. One must stay alert in Kampala, not only due to the road and pedestrian traffic, but also because the walkways are virtual obstacle courses of rubble, can end without warning, and the dust turns to red quicksand after a rain. It occurred to me that one must have strong ankles in Uganda!
I recently spent two weeks at a mission hospital in rural Kenya, where detailed cost considerations are part of the daily experience of every patient. It is humbling to learn that a peasant farming family would have to sell two cows, worth about $150 each, to pay for an EGD plus stent to palliate dysphagia and prolong life in the setting of an inoperable esophageal cancer. But it is also highly encouraging to be at a hospital that demonstrates compassion and respect for life, one patient at a time, even in the midst of needs that regularly outpace resources—and where physicians, surgeons, and administrators provide any available emergency care whenever it is needed, even if payment cannot yet be provided (and, perhaps, will not be provided).

I don’t doubt the many facets to the questions that are raised in these trying financial circumstances. But like Dr. Kapadia stated in his post, I believe that one should always try to help one patient at a time, and begin with the patient who is before us, here and now. This, I think, is what responsibility entails (a word that is made up of “response” + “ability”, i.e., the ability to respond). So if we do have the ability (or money) to care and perhaps cure, we should do what we can—and, of course, do so with sensitivity to the needs of all concerned but always with primary focus on the needs of the person who is our patient, especially when life or limb is at risk.

In case it is of interest, and even though it flips the world the other way ‘round, I attach an article that pertains to such issues, from the vantage point of hospitals in this country that wrestle with the burden of “uncompensated care.”
Visually, to punctuate the red earth, tropical green, and drab concrete of the city, there are the bright colors of traditional Ugandan garb: bright and beautiful heavy cotton fabrics forming head wraps and traditional long dresses called gomezi, which are adorned with high shoulder puffs. Dressed in these bright colors, women walk along the roadside with goods expertly balanced on their heads. When it comes to more modern clothing, the main style is best described as tropical island meets Gucci.

What we call “dress clothes” predominates in Kampala: for men, long sleeve dress shirts, trousers with belts, and leather shoes, many of them with stylishly long pointed toes. Women wear slim-fitting dresses and skirts, tote patent leather handbags, and dressy shoes, which surprisingly take them across the rubble and dust without getting shabby. Inexplicably to us sunscreen-slathered and heavily perspiring Westerners, Ugandans don’t appear to be bothered by the heat! Some even wear knit sweaters, flannel pants, knit and caps. Believe it or not, I spotted more than a few down coats.

What most powerfully strikes me, though, lies in the emotional realm. Riding in a car gives a front-row seat to the lives of poor Ugandans, whose simple and often decrepit dwellings line the roadside and fill the valleys as far as the eye can see. There, by the roadside, families carry out their daily lives for all to see. Mothers work in the yards cooking, cleaning, or crafting while their children play and their male partners are away “finding money.” Some stare back at us in the cars with equal curiosity, while others appear oblivious to the ceaselessly passing traffic. As a witness, one longs to be invisible enough to peer inside their homes, imagining the more private side of their lives and wondering how we, ourselves, would manage.

I did have the chance to visit one such dwelling. As part of the rotation, residents have the unique opportunity to work with a community worker named Beatrice Nianzi with whom Molly Rovin first connected in 2017. The first patient we visited, she had spotted walking on the road. We followed this middle-aged man with bipolar disorder to his dwelling in the slums of Kampala (Beatrice’s word, not mine). After winding our way on a narrow dirt walkway between dwellings, he welcomed us into his tiny shelter. He motioned for four of us to sit on his cot which stood opposite a disjointed pile of his belongings. He carefully brushed off a stool which he placed in the curtained doorway for the fifth one of us.
After telling us his story, he stood up to play his string instrument—called an endigidi—to demonstrate the way he was able to make money before his illness, and the medication to treat it, interrupted his memory and creativity. After a remarkable serenade, he showed us letters he had written to attempt to find international sponsors for the school tuition for his six children from three different women. Staring into the stoic faces of boys of various ages, I fought back tears as I saw photos of faces reminding me of younger versions of my son, who was just about to graduate from a public high school in the U.S. with what I considered an adequate (and even sometimes great) education.

Apparently, public schools in Uganda are grossly underfunded to the point that virtually no learning can occur. Teachers are absent as they need to “find money” elsewhere to supplement their inadequate incomes. Absenteeism is a problem in healthcare as well: the country’s quote-unquote “free health care” is so underfunded that it constitutes more an illusion of social support than a reality. A low-income Ugandan can get a provisional diagnosis for free, but there is no funding for subsequent diagnostic tests or treatment beyond the standard small set of mass-purchased medications. In an upscale mall, I heard a news segment on the radio explaining how the government was planning to fight absenteeism in education and healthcare by implementing a punch-in clock system, as if that would solve the problem. My mind flashed to the recent teacher strikes in West Virginia and Oklahoma and viscerally understood that providing healthcare and education are among the world’s greatest challenges.
The world is becoming smaller and smaller every day. A clichéd saying perhaps, but acutely true when it comes to healthcare. Countries, cultures, and communities are increasingly intertwined via travel and migration. The burden of disease in one country can, in a matter of hours, become the burden of disease in a country on the opposite side of the world. As such, developing sustainable local medical practices around the world is ever more critical as we seek to promote healthy lives for all people.

The impact of the University of Vermont Larner College of Medicine/Western Connecticut Health Network Global Health Program in Zimbabwe goes far beyond what can be quantified in charts and graphs. Rooted in mutual respect and bi-directionality, it is a program that builds frameworks for the future. Among the numerous and multifaceted ways it does so, it empowers Zimbabwean students, doctors, and patients with the opportunity to tell their own stories, in their own voices, from their own perspectives of healthcare in their country. In so doing, it forces them to self-reflect, to analyze their harsh reality and their lofty dreams, and hence to better chart a viable and sustainable course from where they are, into the uncertainties of the future.

The obvious excitements of choosing to do a global health elective in Zimbabwe are numerous – travel, cross-cultural engagement, helping underprivileged patients, seeing tropical diseases first hand, going on safari etc. But, there is more. As you engage with Zimbabwean students, doctors, and patients with cultural humility and a willingness to learn and not just to fix, Zimbabweans are reassured that they too have a role to play on the Global Health stage. They learn that they are not only the object, but more importantly also the subject, of a reciprocal relationship whose heart is our shared humanity and a love of medicine. Imagine then that there is an outbreak of Ebola or Swine Flu within such a framework. Instead of the decaying model of underdeveloped countries waiting for Western countries to come and solve the problem, there would be local protocols and practices in place to tackle the outbreak immediately, treat patients, and prevent its spread around the world. This of course is not an innovative concept, but an indispensable one that we need to constantly keep at the forefront of global healthcare.

Choose today to do a global health elective in Zimbabwe not only for the obvious excitements, but more importantly to build such frameworks for the future. Regardless of what specialty you are interested in, or where you intend to live and work, our goal as medical practitioners is the same. Be the student that views the opportunity to apprentice with these universal problems in healthcare as a fundamental part medical education, and so shape a more hopeful future for healthcare around the world.
Global Health Spotlight

Growth and Recognition

This month, the Global Health Program sends a big congratulations to a few of our partners for remarkable accolades. St. Francis Naggalama Hospital has excelled in the 2016-2017 financial year, and as such has been ranked as second of thirty-three hospitals under the umbrella of the Uganda Catholic Medical Bureau (UCMB). The hospital has also received the highest honor of five stars, an accolade given to only three hospitals. This accreditation is a sign of compliance with the national requirements of the Ministry of Health and professional bodies, and those of UCMB.

Additionally, Universidad Iboamericana has been recognized by the QS Ranking Latinoamericano at the highest level among Dominican universities, and number 123 for Latin America— a twenty-eight point increase since the last measurement earlier this year. Meanwhile, the University of Zimbabwe College of Health Sciences has been formally recognized and approved by the Medical Board of California, USA. This recognition means that education completed at, or qualifications issued by the College of Health Sciences will be accepted toward meeting the requirements for training and/or licensure in California. Graduates of the College of Health Sciences will be able to pursue professional licensing and practice in the state of California.
Sciences are therefore now eligible to apply for a California Postgraduate Training Authorization Letter or a Physician’s and Surgeon’s Certificate.

Furthermore, Sacred Heart University, one of our partner institutions, will send its first group to Uganda this winter for a global health rotation. The team will consist of four physician assistant students and five graduate nursing students. The University also recently opened their new Center for Healthcare Education, a state-of-the-art facility that now houses the College of Health Professions and College of Nursing. The Center offers multi-professional clinics with collaborative services including athletic training, exercise science, nursing, occupational therapy, physician assistant, and speech-language pathology. These exciting developments signify the commitment of our highly esteemed partners to growth and excellence. Congratulations to St. Francis Naggalama Hospital, Universidad Iboamericana, University of Zimbabwe College of Health Sciences, and Sacred Heart University for these grand achievements. We are proud and humbled to call you our partners, and look forward to celebrating future achievements together.

**Announcements**

Congratulations to Dr. Robert Kalyesubula, cofounder of the African Community Center for Social Sustainability (ACCESS), and Estherloy Katale, site coordinator at ACCESS, for the birth of their son Lamson.

A medical camp was held on September 23 in Katanga, Uganda, the biggest slum in Kampala neighboring Makerere University. Over 280 patients came for medical examination and HIV/AIDS counselling and testing. Two doctors, including Dr. Swati Patel, examined the patients with the support of medical students.

Dr. Swati Patel with medical students and members of the medical team at the medical camp in Katanga, Uganda.
Global Health Article of the Month

Innovating Through “Interesting Times” in Global Health

“The reputed Chinese curse—“May you live in interesting times”—warns of periods of turbulence amid changing power structures and the failure of familiar solutions to meet new challenges. Today, the global health community is certainly living in interesting times. Rising populism and nationalism in the USA and Europe is working against the use of national budgets for international aid and development, despite their inextricable link to domestic health. However, such challenges can foster innovative approaches to transform and enhance global health efforts.” Read more in an editorial titled “Innovating Through “Interesting Times” in Global Health” featured in The Lancet about the advancement in technology affecting global health.

Member Highlights

DR. PHAM GIA AN
GLOBAL HEALTH SCHOLAR
DANBURY HOSPITAL

Although this was my first time in the United States, I felt very comfortable thanks to the kindness of program members. The United States is a beautiful and modern country. I had the opportunity to travel to New York and visit my aunts in Ohio and Minnesota. I made many friends from around the world who expanded my knowledge and understanding of their respective cultures—precious experience.

I had the chance to work with many great doctors in the Intensive Care Unit, Neurology Department, and Sleep Lab. I also had the experience of working with residents and fellows, and attending informative lunch conferences with medical students and residents. My time in the elective has elucidated the profession limits of my hospital at home, as well as my own. For instance, my time in the Sleep Lab brought to my attention the significance of sleep disorders. Given that I had not thought much about these disorders in the past, and had minimal experience treating them, I would simply prescribe benzodiazepine for short periods of time without carefully searching for the cause of the problem. However, I will propose that we purchase new equipment for the polysomnographic test upon returning home because I think it is necessary for proper diagnosis and treatment.

I am grateful for the experience I had in the Global Health Program, and am looking forward to applying the lessons I learned into my work at home in Vietnam.
Although I had known about global health prior to college, it was during my undergraduate career that I first learned more about what it entailed. One of the most rewarding aspects of the global health elective was working with the people of Uganda. Doctors, nurses, and all other staff were so welcoming. It was a pleasure working alongside them. It was wonderful to get to know people, be they patients, caretakers, or others we met along the way. I enjoyed learning about their values, struggles, and daily lives. The most challenging aspect of the elective was not being able to do more. Many patients we encountered lived in poverty and sometimes could not afford medical treatment or testing. We offered them the best we could, but it was frustrating to sometimes have to change our management because of financial reasons. The greatest lesson I learned was how differently medicine is practiced in different parts of the world. Doctors in Uganda are somewhat a “jack of all trades.” They are general practitioners, pediatricians, surgeons and obstetricians within the span of twelve hours. I really appreciate the training and work that they do.

The people I met will have a lasting impact on me. It was heartwarming to experience Ugandan culture and hospitality. As of now, I am not sure what my future plans in global health will be. However, I hope I can continue my involvement, and I would love to someday return to Uganda.

Calendar

Upcoming Events

November Calendar

November 1: Dr. Sadigh and Lauri Lennon will meet with members of the Western Connecticut Health Network (WCHN) Foundation Major Gift Team to thank them for their support and update them on Global Health Program initiatives.

November 5: Fourth-year Ross University School of Medicine (RUSM) medical student Joseph Hinojosa will travel to Zimbabwe for the global health elective.

November 6: Dr. Linus Chuang will present a Grand Rounds on Honduras at Danbury Hospital’s Praxair Conference Room at 5 p.m.
November 7: Dr. Sadigh will hold a pre-departure orientation session with Sacred Heart University’s global health team in preparation for their elective in Uganda in January.

November 10: Dr. Eric Neilson from RUSM will site-visit WCHN.

November 10: Dr. Bulat Ziganshin will give a presentation about global health elective rotations for fourth-year medical students from American University of the Caribbean (AUC) and RUSM at Danbury Hospital’s 2 South Conference Room at 8 a.m.

November 11: Dr. McNamara will speak at Saint Michael’s College.

November 11: The Global Emergency Care Collaborative, led by University of Vermont (UVM) faculty Mark Bisanzo, will hold a fundraiser.

November 13: A UVM Global Health Leadership Team meeting will be held.

November 13–14: Dr. Sadigh will site-visit UVM Larner College of Medicine.

November 27: A UVM Global Health Leadership Team meeting will be held.

News from October

October 5–8: (photo left: Alexa Gomez, RUSM Assistant Director for Hospital Support Services, Laura Smith, Medical Student Coordinator at WCHN, and Marie Palomino, RUSM Manager of Hospital Partnerships & Compliance) At the annual RUSM Leadership Conference held in Cancun, Laura Smith of Danbury Hospital and Moira Barber of Norwalk Hospital each received the 2017 Operational Excellence Award from Ross University.

October 5–8: Dr. Cornelius Ferreira, WCHN Family Medicine Clerkship Director, received the “Best Performing Clerkship – Family Medicine – Presented to Danbury Hospital 2016–2017” award by Peter Goetz, RUSM Vice Dean, at the annual RUSM Leadership Conference held in Cancun.

October 5: A follow-up meeting was held with the leadership of the Greater Western Community Residency Program.

October 9: (photo left) A panel was held on Ethical Dilemmas in Global Health, moderated by Dr. Stephen Winter, Director of Global Health at Norwalk Hospital.

October 9: A UVM Global Health Leadership Team meeting was held.

October 11: Dr. Sadigh had a meeting with Dr. Chuang, Chairman of OB/GYN at Danbury Hospital, to discuss the establishment of a global health track in the OB/GYN Department.
October 11: (photo right) Dr. Stephen Winter, Eva W. Trefz, Christian J. Trefz, Tara Locke, and Dr. Majid Sadigh, Trefz Family Endowed Chair in Global Health at WCHN.

October 11: In honor of the one-year anniversary of the Christian J. Trefz Family Endowed Chair in Global Health, a luncheon was held with the Trefz family, Dr. John Murphy, Dr. Stephen Winter, Director of Global Health at Norwalk Hospital, Grace Linhard, and Dr. Majid Sadigh, Director of Global Health at WCHN and the UVM Larner College of Medicine. The group discussed progress in global health and the direction the program may take in the future.

October 11: A Global Health Committee meeting was held at Danbury Hospital.

October 12: Dr. Sadigh and Dr. John Murphy had a meeting to discuss a strategic plan in the future direction of the Global Health Program.

October 13: (photo left) Dr. Sadigh and Dr. Stephen Scholand, Infectious Disease Specialist and Site Director for Global Health in Vietnam at Yale New Haven Hospital, met to discuss grant writing and fundraising.

October 16–17: Dr. Sadigh made an administrative site visit to the UVM Larner College of Medicine.

October 19–26: Interviews for the summer 2018 global health elective were completed with the UVM Larner College of Medicine Class of 2021 students. The selection process is currently underway.

October 20: Fourth-year RUSM medical students Charles French and Israel Oloye returned from their global health elective in the Dominican Republic.

October 21: Fourth-year RUSM student Anita Kisiedu returned from the global health elective in Uganda.

October 23: The Emergency Department Journal Club held a meeting in the Davis Center at UVM centered on two articles, one of which raises important discussion points for treating sepsis in the Global South.

October 26: Fourth-year AUC medical students Gloria Cheung, Janice Hanawi, and Kira MacDougall returned from their global health elective in Uganda.

October 28: Western Connecticut State University and WCHN held the first annual Mission Health Day from 9:00am – 3:00pm. Through the Connecticut Chapter of Happy Period, founded by AUC third-year medical student Elena Gueorguiev during her time at Danbury Hospital, 120 care bags containing pads, tampons, panty-liners, and a bar of soap were distributed to the local community. Read more about Mission Health Day.
October 29: Fourth-year RUSM medical student Julia Hall returned from the global health elective in Zimbabwe.

October 29: A fundraiser was held at the home of Jay and Patricia Weiner of Danbury, Connecticut (photo right) in support of Global Women’s Health at UVM Larner College of Medicine. The organization, directed by Dr. Anne Dougherty, is partnering with the African Community Center for Social Sustainability in Nakaseke, Uganda to help provide contraceptives to women in rural Uganda during the critical period following delivery. The event, with sixty attendees raising over $4000, featured a concert (photo left) with works by Beethoven, Brahms, and Debussy. A heartfelt thank you goes to Jay and Patricia Weiner for opening their home and hosting this wonderful event, and to all who attended.

October 30: (photo right: Joanna Conklin, Laura Smith, Dr. Nguyen Huyen Chau, Dr. Pham Gia An, and Moira Barber) A goodbye party for global health scholars Dr. Nguyen Huyen Chau, Dr. Pham Gia An, and Dr. Benito Sainz was held at Norwalk Hospital. It was wonderful to have them with us. We wish them the best on their return home and look forward to continuing our global health connection.

October 30: Dr. Benefsha Mohammad, surgical resident from WCHN, traveled to the Dominican Republic with WCHN supervising surgical faculty Dr. Laura Withers.

October 31: (photo left: Michelle Truong and Dr. Huynh Kim Phuong, Head of the International Program at Cho Ray Hospital, Vietnam) AUC medical student Michelle Truong returned from the global health elective at ChoRay Hospital in Vietnam.
Global Health Spotlight

Dr. Robert Jarrett and Hearts Around the World in Vietnam

In early November, Dr. Robert Jarrett the founder of Hearts Around the World traveled to Vietnam where he led a team of cardiologists, cardiac surgeons and anesthesiologists on a medical mission at Cho Ray Hospital. The team was greeted by more than a dozen Vietnamese UVM Larner College of Medicine/Western Connecticut Health Network (WCHN) Global Health Program alumni. During the trip, Dr. Jarrett interviewed a number of bright, talented candidates to be selected as the next wave of Global Health Scholars. We, along with the Cardiology Department at Danbury Hospital, are excited to host our Vietnamese colleagues this upcoming year.
Global Health Bridge

Global Health Bridge, a three-day event dedicated to global health, was held from November 20-22 at the University of Vermont (UVM) Larner College of Medicine. It involved a variety of panel discussions and activities lead by faculty and community members, and was attended by over fifty students. Topics covered included the global burden of disease, child and maternal health, emerging infectious diseases, ethics, disability and rehabilitation needs globally, and human trafficking. One session focused on an exercise about responding to Puerto Rico after the Hurricane. The curriculum for Global Health Bridge was compiled in accordance with objectives put forth by the Consortium of Universities for Global Health (CUGH).

Announcements

Congratulations to the following:

Dr. Alexandra Miller, UVM Larner College of Medicine ’18, and Dr. Anne Dougherty et al. for the acceptance of their poster “Cervical Cancer Screening in Rural Tanzania; A Capacity Building Project” at CUGH 2018, and its selection as a finalist for the Lancet Poster Competition.

Dr. Molly Moore and UVM Larner College of Medicine students Saraga Reddy, Amber Meservey, Cole Shapiro, et al. for the acceptance of their poster “Use of Simulation for Preparation of Pre-Clinical Medical Students for Global Health Electives” at CUGH 2018.

Dr. Anne Dougherty and Dr. Robert Kalyesubula et al. for acceptance of their poster “Knowledge, Attitudes, and Use of Family Planning in Rural Uganda: Comparing the Female and Male Perspectives” to CUGH 2018.

Dr. Ziganshin has been invited to give a presentation about WCHN Global Health Program at Ross University’s (RUSM) Internal Medicine Foundations (IMF) clerkships, a six-week transitional held between RUSM students’ return from Dominica and start of their clinical track program to help prepare for clinical clerkships.

Dr. Sadigh has been invited to serve as the keynote speaker for an American University of the Caribbean (AUC) sponsored educational symposium centered around global health, where Dr. Ziganshin has also been invited to be a member of a panel on ethical dilemmas and give a presentation about the Global Health Program. The event will be held on May 12, 2018.

Global Health Article of the Month

Global response to malaria at crossroads

“After unprecedented global success in malaria control, progress has stalled, according to the World Malaria Report 2017. There were an estimated 5 million more malaria cases in 2016 than in 2015. Malaria deaths stood at around 445 000, a similar number to the previous year.”

Read the full article featured in the World Health Organization’s Media Centre about how malaria gains are leveling.
Teaching has always been one of the most rewarding aspects of global health because it can make a difference in the lives of patients and practitioners. Most of my teaching has involved working with nurses and surgical assistants on various projects, but I have also worked specifically teaching surgical residents at the first surgery residency program in Bhutan. The best teaching moments are when students understand something and run with it and make it their own.

I would love to see global health become a bigger part of the way all of us practice. There is so much to be gained from true exchange and collaboration with doctors all over the world. I would also like to see the “global health principles” used to solve some of our healthcare issues. We call it “global health” but the globe is in our own neighborhoods; sometimes we just have to get away for a while in order to better appreciate that.

My experience in global health has been wonderful in all respects. Professionally, it has allowed me to deepen my knowledge as a cardiologist dedicated to the cardiovascular emergency in my country. By spending time in the intensive care unit and other departments, as well as the outpatient clinic, I have familiarized myself with medicines and techniques that are not available in Cuba. I also learned about the computerization necessary for high performance in this profession. Personally, this experience has allowed me to form meaningful interpersonal relationships with fellow cardiology colleagues and create new friendships at Danbury Hospital.

My stay in the United States has been greatly constructive for me in that it gave me the opportunity to excel professionally while gaining meaningful personal experiences. I will pass on all the experiences acquired here onto my colleagues in Cuba. In the meantime, I look forward to continued exchange in the future.
Calendar

Upcoming Events

December Calendar

December 10-11: Dr. Sadigh will make an administrative trip to UVM Larner College of Medicine. The main focus of this visit will be to finalize the student education Global Health track.

News from November

November 1: Dr. Sadigh met with WCHN Foundation Staff to discuss updates about the Global Health Program.

November 6: (photo left) Professor Linus Chuang, Chairman of Obstetrics and Gynecology at Western Connecticut Health Network, gave a talk entitled “De Regresso a Tegucigalpa” at Danbury Hospital’s OB/GYN Grand Rounds about his experience in Honduras.

November 7: (photo right) Dr. Sadigh gave a pre-departure orientation session at Sacred Heart University to nurse practitioner and physician assistant students selected to go to Uganda in January for the global health elective.

November 10: Dr. Eric Neilson, Assistant Professor and Clinical Skills Course Director in the RUSM Department of Clinical Medicine, visited WCHN where he met with members of the Global Health Program on both the Danbury Hospital and Norwalk Hospital campuses.

November 10: Dr. Bulat Ziganshin, Director of global health for RUSM and AUC, gave a presentation about the WCHN global health elective application process and experience of fourth-year AUC/RUSM medical students to Dr. Eric Neilson and WCHN global health leadership.

November 13: A Global Health Leadership Team meeting was held at UVM Larner College of Medicine.

November 13: Dr. Sadigh made an administrative trip to UVM Larner College of Medicine.
November 13: (photo left) Dr. Benefsha Mohammad, surgical resident from WCHN, and supervising surgical faculty with Dr. Laura Withers returned from the Dominican Republic.

November 14: Dr. Sadigh had a conference call with the founder and key leadership of Project HOPE to explore the potential of overlapping interests and future collaboration.

November 17: Joseph Hinojosa, fourth-year medical student from RUSM, returned home early after only two weeks in Zimbabwe due to rising political tensions.

November 27: The second Global Health Informational Session was held at UVM Larner College of Medicine.

November 27: A Global Health Leadership Team meeting was held at UVM Larner College of Medicine.
Dr. Marcos A. Núñez (Dean of Universidad Iberoamericana (UNIBE) School of Medicine), Dr. Sadigh, Dr. Odile Camilo Vincent (Vice Provost of UNIBE), Dr. Amado Castaños Guzman (President of UNIBE), Dr. William B. Jeffries (Senior Associate Dean for Medical Education), and Dr. Jomar Florenzán (Site Director of the Global Health Program in the Dominican Republic).

Dr. William B. Jeffries and Dr. Majid Sadigh travel to the Dominican Republic to work with UNIBE

Dr. Sadigh, Trefz Family Endowed Chair in Global Health at the Western Connecticut Health Network (WCHN) and Director of Global Health at the University of Vermont Larner College of Medicine, and Dr. William B. Jeffries, Senior Associate Dean for Medical Education at the Larner College of Medicine, traveled to the Dominican Republic (photo next page) for a site visit from January 22-26. Dean Jeffries reviewed UNIBE’s curriculum, became familiar with the global health activities transpiring at the institution, and gave recommendations for improving its medical education program.
Meanwhile, Dr. Sadigh collaborated with institutional leadership to help implement a global health track in medical education at UNIBE and create the first Global Health Interest Group (photo below) which will be an active part of UNIBE’s medical campus. Members will be frequently engaged through monthly journal clubs meetings moderated by Dr. Jomar Florenzan, monthly web sessions moderated by Dr. Sadigh, and activities with visiting global health students, residents, and physicians. Members were encouraged to identify an underserved community in Santo Domingo where a free clinic will be opened. He also implemented supplementary social and cultural curriculum for global health participants.

Several agendas have been set in place to address UNIBE’s needs as expressed by Dean Núñez. Dr. Anne Dougherty, Director of Global Women’s Health at the Larner College of Medicine, and Dr. Mariah McNamara, Associate Director of Global Health at the Larner College of Medicine, have agreed to travel to the Dominican Republic to start implementing interventions to alleviate the high maternal and infant mortality rate. Mary Shah welcomed the idea of travelling to the Dominican Republic to help establish access to Hinari and Ovid, portals for accessing hundreds of journals, to accommodate student and faculty needs at UNIBE. WCHN has accepted to support UNIBE’s Simulation Lab through training and provision of supplies.
Global Health Article of the Month

Outcomes of a Coaching-Based WHO Safe Childbirth Checklist Program in India

“The prevalence of facility-based childbirth in low-resource settings has increased dramatically during the past two decades, yet gaps in the quality of care persist and mortality remains high. The World Health Organization (WHO) Safe Childbirth Checklist, a quality-improvement tool, promotes systematic adherence to practices that have been associated with improved childbirth outcomes.”

Read the full article featured in the World Health Organization’s Media Centre about the outcomes.

Member Highlights

DR. CHIRATIDZO ELLEN NDLOVU
PROFESSOR OF MEDICINE
COLLEGE OF HEALTH SCIENCES UNIVERSITY OF ZIMBABWE

Though I cannot say exactly when I first became interested in global health, I was aware of the struggles of underserved populations since childhood and interested in international collaboration since my high school career at the first United World College at Atlantic College, in Wales, UK whose motto was “international understanding.” The schools were set up after the Second World War by a German Kurt Hahn who hoped that international students who studied together were less likely to fight each other in the future. Education of young people from differing cultures was meant to promote mutual understanding. Going back to one’s country was encouraged such that I knew throughout my medical training in the UK that I would return to Zimbabwe despite its low resources.

My role as supervisor of global health participants has been quite rewarding. Participants express interest in various areas of our way of life, as opposed to the “facts” of medical conditions. It is the “hidden curriculum” that needs to be discussed with students—information that cannot easily be found in a textbook. Thus, supervisors need to be resourceful and knowledgeable about their country and its political landscape.

My work with global health has expanded my networks and friendships as well as research and publication opportunities. Global health visitors have brought useful equipment for our university while exposing our students to other cultures, an experience that will make them better people and clinicians. In the future, I hope our college will set up a Global Health Office to help accommodate the growing program.
Global health provides us with an opportunity to enrich ourselves and those around us. While involvement in local community is undeniably important, limiting ourselves to engagement with only the local community may also render our ideas, perceptions, and attitudes limited. By living outside our culture, especially as part of the minority, our thoughts are challenged and our perceptions changed. It is easy to get lost in the idea that the local community is the only one that exists; the only one that matters.

The most important lesson I learned from my global health elective is gratitude. Through all the disparity and suffering, the destitution and indigence, I saw gratitude. It is too easy to get wrapped up in ourselves and the things around us, and in so doing forget what it means to be gracious. By noticing the grace and gratitude of others in such simple displays and disparate times, we are reminded to be gracious.

I’d like to return to Uganda someday. As someone interested in urology, I’d like to help improve the quality of life for those experiencing incontinence and the associated psychosocial stigma that comes along with it. While urinary retention and incontinence are easily managed in the U.S., they can be sources of isolation and social devastation in other parts of the world where people with such health issues are exiled from their communities. I’d like to develop my skills to one day help alleviate these issues and improve quality of life for those who need it.

Announcements

Dr Sadigh will climb Mount Kilimanjaro to benefit a Ugandan hospital. Dr. Majid Sadigh has thrice climbed Mount Kilimanjaro. The first time was to earn forgiveness from his late father, the second to learn humility and the third to accompany his son and build relationships for his ongoing attempt to create a health center at the base of the mountain. But a greater purpose will power him on his upcoming fourth climb. Sadigh aims to raise money for a microbiology lab at the St. Francis Naggalama Hospital in Uganda, one of the many places he partners with around the world through his Global Health Program. “This time I have a bigger motivation,” he said. “My heart has been touched by the poor people of Naggalama.” Dr. Sadigh hopes to raise $19,341 — one dollar for each foot of the climb — to cover the cost of the lab. Read more about the cause in the NewsTimes.
Congratulations to the following:

Professor Chiratidzo Ellen Ndhlovu, MD, Faculty of Medicine, University of Zimbabwe College of Health Sciences for receiving the 2018 Drs. Anvar and Pari Velji Global Health Education Award. The award will be presented in New York City at the 9th Annual Consortium of Universities for Global Health (CUGH) Conference on Saturday, March 17, 2018, between 12:45 pm and 1:45 pm.

Alexandra Miller, Larner College of Medicine ’18, and Dr. Anne Dougherty et al. for the acceptance of their poster “Cervical Cancer Screening in Rural Tanzania; A Capacity Building Project” at CUGH 2018, and its selection as a finalist for the Lancet Poster Competition.

Dr. Peter Saikali et al for acceptance of his manuscript on a tetanus case from Zimbabwe in the Journal of Medicine and Health Research.

Mark your calendars for Global Health Day which will be celebrated April 17-18, and held in recognition of Dean Morin at the Larner College of Medicine in Burlington, Vermont.

Three Vietnamese cardiologists have been selected to come to WCHN for training from March to June.

The second annual Northeast Regional Symposium, hosted by the American University of the Caribbean School of Medicine (AUC), will be held on May 12th at Doral Arrowwood Resort in Rye Brook, New York. Works by student and clinical faculty on international medicine-related topics will be showcased in line with this year’s theme of global health. Dr. Majid Sadigh, Trefz Family Endowed Chair in Global Health at the Western Connecticut Health Network and Director of Global Health at the University of Vermont Larner College of Medicine, will deliver this year’s keynote address and moderate a panel on ethical dilemmas in short-term global health electives. Register for the symposium.

Calendar

Upcoming Events

February Calendar

February 2: Dr. Sadigh traveled to Uganda for a one-month visit during which he will supervise medical students and residents during their global health electives, selecting Ugandan colleagues for training at WCHN, and teaching two courses to Makerere University College of Health Sciences (MakCHS) students and residents: one in tropical medicine and another in the architecture of clinical research. During this trip, he will attempt to climb Mount Kilimanjaro as part of a fundraising campaign to help construct a well-equipped microbiology lab for Naggalama Hospital, a small community hospital in rural Uganda that is also a training site for WCHN and Larner College of Medicine students and residents.
February 8: American University of the Caribbean (AUC) students Gitanjali Lobo and Michael Villasin will travel to Uganda for the global health elective.

February 9: Climb for a Cause: Dr. Sadigh, will begin climbing Mount Kilimanjaro. **Support the cause with a donation.**

February 10: AUC student Susana Preto Ruano along with Ross University School of Medicine (RUSM) students Nwamaka Gloria Akabogu, Aniebietabasi Okon-Umoren, and Olivia Asamoah will travel to Naggalama, Uganda for the global health elective.

February 16: Dr. Bulat Ziganshin will give a presentation about the Global Health Program to RUSM medical students during their Internal Medicine Foundations clerkship in Florida.

**News from January**

January: Students from Sacred Heart University’s Nurse Practitioner and Physician Assistant Programs are currently in Uganda for a global health elective.

**January 1:** RUSM student Stacey Sassaman travelled to Uganda for the global health elective.

**January 3:** RUSM student Angela Okon Edet travelled to Vietnam for the global health elective.

**January 10:** (photo left and clockwise from top right: Dr. Molly Moore, Nina Dawson, Audree Frey, Hanaa Shihadeh, Katherine Callahan, Jordan Munger, Dr. Mariah McNamara) Dr. Sadigh made an administrative site visit to the Larner College of Medicine where he met with the Global Health Leadership Group and the first year medical students selected for the global health elective program.

**January 13:** UVM pediatric residents Natalie Wilson and Ellen Diego, along with UVM internal medicine resident Elena Kozakewich, traveled to Uganda for the global health elective.
January 15: (photo right: Dr. Jomar Florenzán, Martiza Ogando (host family member), and Asaad Traina ’18) Asaad Traina traveled to the Dominican Republic for the global health elective.

January 16: (photo left) Global Health Grand Rounds: Dr. Stephen Scholand gave a talk about Rabies at Norwalk Hospital’s noon conference on January 16th. He will also present “Rabies: The Face of Fear” at the Medical Grand Rounds on May 2nd at Danbury Hospital. In addition to these special events, Norwalk Hospital has been allocated, for the first time, two Department of Medicine Grand Rounds sessions for Global Health topics this year. Jeremy Schwartz, Assistant Professor of Medicine at Yale School of Medicine, and Tracy Rabin, Assistant Professor of Medicine and Assistant Director of the Office of Global Health at Yale Department of Medicine, will be joint speakers on the first and second Grand Round which will take place on March 1st and May 10th.

January 17: A Global Health Committee Meeting was held at the Larner College of Medicine.

January 18: Elizabeth A. McLellan, RN, MSN, MPH, Founder and President of Partners for World Health, gave a talk entitled “Global Impact Local Effort: Making a Difference in our World” at the Surgical Grand Rounds at the Davis Auditorium in the Larner College of Medicine.

January 20: Fourth-year Larner College of Medicine students Eric Schmidt and Stefan Wheat traveled to Uganda for the global health elective.

January 29: Dr. Stephen Winter travelled to Vietnam for two weeks to work on capacity building, conduct bedside rounds in the Intensive Care and Pulmonary Units, and teach didactics on these topics for those interested in intensive care and pulmonary medicine. His responsibilities also include supervision of WCHN and Larner College of Medicine students and residents on global health electives, and holding of feedback sessions with our Vietnamese Global Health Program alumni. In addition, he will be collaborating with ChoRay leadership to implement a supplementary cultural and social curriculum for global health elective participants.
Dr. Majid Sadigh, Trefz Family Endowed Chair in Global Health at the Western Connecticut Health Network (WCHN) and Director of Global Health at the UVM Larner College of Medicine, traveled to Uganda for a one-month visit during which a series of important sessions were conducted with students, residents, physicians, and institutional leadership. Meetings were held with Professor Rhoda Wanyenze, Dean, Makerere University College of Health Sciences (MakCHS) School of Public Health, to establish a new partnership between the two institutions, whereby the Memorandum of Understanding will be finalized. Dr. Sadigh also met with Professor Sewankambo, Former Principal at MakCHS, Professor Charles Ibingira, Principal at MakCHS, Professor Isaac
Ethical Dilemmas in Global Health:
Assessing students’ success and safety in global health programs

Integral to global health experiences, a wide range of ethical dilemmas impact students, residents, physicians, institutional leadership, and patient populations. Each month, we engage in discussions around an ethical dilemma and ponder the responses from one global health leader in the Global South and one in the Global
North. This month’s ethical dilemmas are centered on assessing students’ success and safety in global health programs.

Upon entering a global health elective program, students are sometimes uneasy about their role in an underserved setting. They may feel that rather than contributing to the global health setting, their presence expends valuable time and resources that medical staff could otherwise use to care for patients. How would you respond to students who feel uneasy about their role in a global health program?

See responses and add your own on on the blog >>

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Global Health Article of the Month

Geospatial inequalities and determinants of nutritional status among women and children in Afghanistan: an observational study

“Undernutrition is a pervasive condition in Afghanistan, and prevalence is among the highest in the world. We aimed to comprehensively assess district-level geographical disparities and determinants of nutritional status (stunting, wasting, or underweight) among women and children in Afghanistan.”

Learn more about the use of spatial mapping in understanding public health problems and design interventions.

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Member Highlights

**DR. SIMON OTIM**
MEDICAL DIRECTOR
ST. FRANCIS NAGGALAMA HOSPITAL

I was inspired to become a physician by my older siblings who had already taken up common traditional professions. My engagement with global health came later when, while working as Medical Obstetrician/Gynecologist and Medical Director at Naggalama Hospital, the Director of Administration encouraged me to become involved.

The concept of global health is both humbling and noble. On a personal level, it has taught me respect and appreciation for each patient and the
challenges they face. On a professional level, it has deepened my role as a service provider by challenging me to meet a variety of health needs while maintaining professional standards.

Currently, my role in global health is to teach aspiring doctors and nurses, through clinical study, case discussions, and shared experiences, how to offer quality holistic care in an equitable manner despite the different healthcare systems in which patients and healthcare workers may find themselves. In the future, I would like to continue participating in training programs so as to influence the practices of aspiring healthcare providers and promote global health by providing healthcare services in my community on the basis of the principles of equity. In addition, I would like to keep working toward making Naggalama Hospital a preferred site for global health participants, and to incite discussions that promote the healthcare interests of less privileged people.

GRACE HERRICK
FOUNDER OF GRACE’ S PROMISE INCORPORATED
SANDY HOOK, CONNECTICUT

The most challenging aspect of my global health experience was the initial shock of so suddenly finding myself in such a difference place. I left New York one morning and landed in bustling Entebbe, Uganda the next. However, I was immediately mesmerized by the warmth, friendliness, and soft-spokenness of the Ugandan people. The most rewarding experience was visiting the African Community Center for Social Sustainability (ACCESS) in Nakaseke and meeting its founder. I was so moved by the children living there. Over 15% of them are orphans, half of whom are living with HIV/AIDS.

The biggest lesson I gained was in humility. I learned that happiness does not require much. What Ugandans are able to accomplish with such limited resources, particularly in medicine, is truly remarkable. Meanwhile, the lack of educational programs there highlighted the importance of preschool education in educational, technological, and economic success. With the Girl Scouts of Connecticut as a platform to promote educational awareness, I opened a preschool program at ACCESS and started my own non-profit, known as Grace’s Promise Incorporated, which aims to develop and support preschool education at ACCESS, and hopefully throughout Uganda and Africa.

I am currently a biology major at the University of Connecticut, working with an adviser to develop my own major in Global Health/Population Health. There is a great need for sustainable healthcare, and I want to learn more about how to best address that need.
Announcements

Mark your calendars for **Global Health Day on April 17-18**, which will be held in recognition of Dean Morin at the Larner College of Medicine in Burlington, VT.

The deadline for global health nominations and submissions of posters, photos, and reflections for the Global Health Day celebration is March 19th. **Submissions can be sent to Audree Frey.**

The second annual **Northeast Regional Symposium**, hosted by the American University of the Caribbean (AUC) School of Medicine, will be held on May 12th at Doral Arrowwood Resort in Rye Brook, New York. Works by student and clinical faculty on international medicine–related topics will be showcased in line with this year’s theme of global health. Dr. Majid Sadigh will deliver this year’s keynote address and moderate a panel on ethical dilemmas in short-term global health electives. **Register for the symposium.**

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Calendar

Upcoming Events

**March Calendar**

**March 1:** Dr. Jeremy Schwartz, Assistant Professor of Medicine at the Yale School of Medicine, will speak at the first Global Health Grand Rounds.

**March 1:** Dr. Robert Hecht, Associate Clinical Dean, AUC, and Jeffrey Anderson, Senior Regional Program Coordinator, AUC, will come to Danbury Hospital for an annual site-visit.

**March 1:** Dr. Sadigh will travel to Naggalama to hold feedback sessions with four senior medical students, and then to Nakaseke to visit the new living quarters and developments at Nakaseke Hospital and ACCESS.

**March 2:** UVM Larner College of Medicine psychiatry residents Dr. Kristina Foreman and Dr. Erica Marden will travel to Uganda for their global health elective.

**March 4:** Dr. Sadigh will return from his one-month administrative visit in Uganda.

**March 6:** Dr. Sadigh will give talk on Ebola and Zika viruses at Norwalk Hospital’s medical noon conference.

**March 8:** A Global Health Leadership Team meeting will be held at the UVM Larner College of Medicine.

**March 12:** A session of the Global Health Elective Pre-Departure and Enrichment course will be held.

**March 12–14:** Dr. Sadigh will make a monthly administrative visit to the UVM Larner College of Medicine.
March 12: A Global Health Leadership Team meeting will be held at the UVM Larner College of Medicine.

March 15–18: The 9th Annual Consortium of Universities for Global Health Conference will be held in New York City.

March 19: Two fourth-year UVM Larner College of Medicine students will travel to Uganda for their global health elective.

March 25: Fourth-year Ross University School of Medicine (RUSM)/AUC students will travel to their respective global health elective sites: Lindsey McKe and Britn'y Edwards to Russia; Buddhi Hatharaliyadda and Ernest Okwuonu to Uganda; and Tonia Gooden, Katherine Ar, Stephen Finney, and Daniel Namkoong to Vietnam.

March 26: A session of the Global Health Elective Pre–Departure and Enrichment course will be held.

News from February

February 1–4: (Photo at right: Dr. Stephen Scholand, Global Health Program Site Director, Cho Ray Hospital, Ho Chi Minh City, Vietnam with Dr. "Menn" Prachyapan Petchuay, Dean, Faculty of Medicine, Walailak University) Dr. Stephen Scholand traveled to Southern Thailand to explore the possibility of establishing a new global health elective site in East Asia.

February 2: UVM Ambassadors, representatives of first-year medical students, visited WCHN to learn more about the UVM Larner College of Medicine clinical campus. Dr. Sadigh briefly introduced the Global Health Program during one of the orientation sessions.

February 5: A session of the Global Health Elective Pre–Departure and Enrichment Course was held at the UVM Larner College of Medicine, featuring Dr. Michelle Dorwart who presented “Social Determinants of Health.”

February 6: Audree Frey met with the UVM Larner College of Medicine Communications Team to begin planning the Global Health Day celebration.

February 7–9: Interviews were conducted for fourth-year global health elective applicants.

February 9: WCHN Norwalk Internal Medicine residents Dr. Syed Ahmed and Dr. Robert Wilson returned from the global health elective in Vietnam.

February 9: Fourth-year AUC students Gitanjali Lobo and Michael Villasin travelled to Kampala, Uganda, for their global health electives.
February 10: Fourth-year RUSM student Angela Edet returned from the global health elective in Vietnam.

February 10: Dr. Bilal Khan, Internal Medicine physician at Norwalk Hospital, lead a small team to Puerto Rico to provide medical supplies and care, alongside a local relief group, to those still affected by hurricane Maria. The team included two residents from Norwalk Hospital.

February 11: UVM Larner College of Medicine pediatric residents Dr. Natalie Wilson and Dr. Ellen Diego, and internal medicine resident Dr. Elena Kozakwich, as well as fourth-year RUSM student Stacey Sassaman, returned from the global health elective in Uganda.

February 11: Fourth-year RUSM students Nwamaka Gloria Akabogu, Aniebietabasi Okon-Umoren, Olivia Asamoah, and AUC student Susana Preto Ruano travelled to Naggalama, Uganda, for their global health electives.

February 12: The bi-monthly Global Health Leadership Team meeting was held at the UVM Larner College of Medicine.

February 14: (Photo at left) Dr. Stephen Winter concluded his two-week visit at Cho Ray Hospital, Vietnam. In addition to clinical and teaching responsibilities, he spent his time working on capacity building initiatives and expanding the ongoing collaboration with Cho Ray leadership to implement a supplementary cultural and social curriculum for global health elective participants. He also participated in selection of Vietnamese colleagues to come to WCHN for training, and met with all of our Vietnamese Global Health Scholars in a feedback session.

February 16: Dr. Bulat Ziganshin visited RUSM in Miramar, Florida and gave a presentation to the current Internal Medicine Foundations (IMF) group of medical students about the Global Health Program and global health elective experience. He also met with several members of the RUSM team, including Ainsley Kerr (Program Coordinator), Dr. Sean Gnecco (Director of IMF Clerkship and Medical Director of fourth-year electives), Roxane Grant (Associate Director of the Office of Student and Professional Development), Meredith Salkey (Senior Clinical Advisor), Gary Belotzerkovsky (Associate Dean for Academic and Student Operations), and Marie Palomino (Senior Associate Director for Hospital Partnerships and Compliance).

February 18: (Photo at right: Mr. Bugembe Francis Xavier, Financial Officer, St. Francis Naggalama Hospital, Sister Regina Nantongo, Director of Human Resources, St. Francis Naggalama Hospital, Dr. Majid Sadigh, Sister Frances, Director, St. Francis Naggalama Hospital, and Dr. Simon Otim, Medical Director, St. Francis Naggalama Hospital) Sister Jane Frances, Director of St. Francis Naggalama Hospital, and members of the administrative team traveled from Uganda to Moshi, Tanzania to welcome Dr. Sadigh after his safe return from Mount Kilimanjaro and presented him with a Plaque of Appreciation.
February 20: Dr. Mariah McNamara and Audree Frey met with the UVM Larner College of Medicine Communications Team to continue planning for the Global Health Day celebration.

February 21: (Photo at left: Organizers and energy behind the Climb For a Cause fundraising event, Lauri Lennon, Lauren Post, Grace Linhard, Andrea J. Rynn, and Mary Shah) The Climb for a Cause Fundraiser was a success! Over $20,000 was raised in honor of Dr. Sadigh’s 19,341-foot trek. The proceeds will be used to build a microbiology lab at St. Francis Naggalama Hospital, a small community hospital in rural Uganda that is also a training site for UVM Larner College of Medicine and WCHN medical students and residents. Once constructed, the lab will allow for accurate and quick diagnosis of infections.

February 23: Fourth-year UVM Larner College of Medicine student Asaad Traina returned from the global health elective in the Dominican Republic.

February 26: A session of the Global Health Elective Pre-Departure and Enrichment Course was held, featuring Dr. Molly Moore, who presented “Global Health Payers and Players.”

February 26: The bi-monthly Global Health Leadership Team was held at the UVM Larner College of Medicine.
Majid Sadigh, M.D., (bottom right) director of the Global Health Program at the University of Vermont Larner College of Medicine and Western Connecticut Health Network (WCHN), climbed the 19,341-foot Mount Kilimanjaro to raise funds to build a microbiology laboratory at St. Francis Naggalama Hospital. Read more about the climb.

Global Health Spotlight

The ninth Annual Consortium of Universities for Global Health (CUGH) conference was held in New York City from March 15-18, centered on the theme “Health Disparities: A Time for Action.” The conference covered an extensive span of topics including cybersexual violence, global health law, human rights, and planetary health, as well as reflections and films in global health. Several of our members participated in the event, from the global health leadership team (Photo left) to our international partners including Dr. Isaac Okullo,
Dr. Rose Nabirye, and Susan Byekwaso from Makerere University College of Health Sciences in Uganda.

Many of our members were also involved in presentations. Alexandra Miller, UVM Larner College of Medicine ’18, presented the poster by Miller, Kelly Collier, and Anne Dougherty et al. entitled “Cervical Cancer Screening in Rural Tanzania: A Capacity Building Project,” (Photo right) which was selected as a finalist for the Lancet Poster Competition. Dr. Molly Moore, director of Global Health in the UVM Larner College of Medicine Department of Pediatrics, presented “Use of Simulation for Preparation of Pre-Clinical Medical Students for Global Health Electives” by Moore, Michelle Mertz, and Mariah McNamara et al (Photo below left). Dr. Samantha Dean, OB/GYN resident at UVM Larner College of Medicine, presented “Knowledge and Attitudes of Family Planning by Men and Women in Rural Uganda” by Dean and Anne Dougherty et al (Photo below right). Meanwhile, Professor Chiratidzo Ellen Ndhlovu, faculty of Medicine and the director of Global Health Program at the University of Zimbabwe College of Health Sciences, received the 2018 Drs. Anvar and Pari Velji Global Health Education Award.
Ethical Dilemmas in Global Health:

Assessing students’ success and safety in global health programs

Integral to global health experiences, a wide range of ethical dilemmas impact students, residents, physicians, institutional leadership, and patient populations. Each month, we engage in discussions around an ethical dilemma and ponder the responses from one global health leader in the Global South and one in the Global North. This month’s ethical dilemmas are centered on assessing students’ success and safety in global health programs.

See responses on the blog >>

Global Health Article of the Month

In support of the UN Relief and Works Agency (UNRWA) appeal for health and dignity of Palestinian refugees

“Our research into the UN Relief and Works Agency (UNRWA)’s delivery of health services to Palestinian refugees during the Syria crisis puts us in a unique position to anticipate the challenges of the organisation’s current funding crisis. We have conducted over 90 interviews with health workers and managers, a series of systems modeling sessions, and rigorous analysis of UNRWA health data from 2007–16, and conclude the following.”

Read the article supporting the UNRWA.

Member Highlights

AMANDA WALLACE
MULTIMEDIA COORDINATOR
DANBURY HOSPITAL, CONNECTICUT

I have been interested in art ever since I could hold a crayon, and my mother always encouraged me to pursue that interest. In my twenties, I worked at a real estate magazine where I first became interested in learning to draw on the computer. I then moved on to a team at a residential treatment facility for children where we created learning games and materials for staff to reduce the use of restraint and seclusion. I continued on to Danbury Hospital for filming and editing, and now graphic design.
While working on a project, I begin with a general idea of what I want to do, though it usually is not what I end up with. That initial idea leads me to another and another until something strikes me. Sometimes it is just a shape, which in the case of the Annual Report was a sphere. I wanted to contrast last year’s more angular design. I first became interested in global health while working on the Tropical Medicine modules. I hope my role in producing graphics for global health will continue to grow, and that I will have the privilege of creating in whatever position I hold.

**DR. BILAL KHAN**  
**PULMONARY/Critical Care Specialist**  
**AND FELLOW IN SLEEP MEDICINE**  
**NORWALK HOSPITAL, CONNECTICUT**

After completing my undergraduate degree in economics, I worked for J.P. Morgan Chase on the fast-track plan to Wall Street. During that time, I joined the volunteer fire department and became an Emergency Medical Technician, just as a hobby. But after a year, I noticed a striking difference between business and medicine: if you are good at something in business, you do not share that knowledge because it increases your value over your competition. But in healthcare, your value is based on what you are able to teach and provide for others, thereby improving their lives and positively impacting your community.

Having grown up in a diverse neighborhood and traveled throughout my upbringing, I had long been interested in global health when I finally had the opportunity in 2015 to participate in a global health rotation in Vietnam through the Global Health Program. After Hurricane Maria, I lead a medical mission to Puerto Rico whereby I was deeply touched by all the support we received, and the many people who joined without any questions asked. In the future, I plan to organize further missions to Puerto Rico and help establish a team of global health physicians that, in collaboration with academic institutions, could be called upon after a natural disaster or epidemic.

*(Photo above: Marat Mukhamedyarov, MD, PhD, DSc, director of the Global Health Program at KSMU with Global Health Scholars, alumni, and candidates.)*
Announcements

Congratulations to Dr. Marat Mukhamedyarov, director of the Global Health Program at Kazan State Medical University (KSMU), for his election by the university’s Academic Board to full professorship in physiology.

The 2017 Annual Report has been completed, and has received overwhelmingly positive feedback from Global Health Program members in capturing the spirit of the program.

Mark your calendars for Global Health Day on April 17-18, which will be held in recognition of Dean Morin at the UVM Larner College of Medicine in Burlington, VT.

The second annual Northeast Regional Symposium, hosted by the American University of the Caribbean (AUC) School of Medicine, will be held on May 12th at Doral Arrowwood Resort in Rye Brook, New York. Works by student and clinical faculty on international medicine-related topics will be showcased in line with this year’s theme of global health. Dr. Majid Sadigh will deliver this year’s keynote address and moderate a panel on ethical dilemmas in short-term global health electives. Meanwhile, Dr. Bulat Ziganshin will present about the Global Health Program and serve as a panelist. Register for the symposium.

Calendar

Upcoming Events

April Calendar

April 12: Dr. Majid Sadigh will give a talk about climbing Mount Kilimanjaro at the Annual American Academy of Professional Coders (AAPC) chapter meeting at Danbury Hospital.

April 13: Dr. Majid Sadigh will speak about his experience in global health at the Yale School of Public Health.

April 16: Dr. Majid Sadigh will speak about the UVM Larner College of Medicine/Western Connecticut Health Network (WCHN) Global Health Program at UVM Larner College of Medicine’s “Closer Look Day.”

April 16: A global health elective Pre-Departure Course for first-year medical students will be held at UVM Larner College of Medicine, during which Dr. Molly Rovin, UVM Larner College of Medicine Psychiatry Department, will present “Global Mental Health.”

April 17-18: The Global Health Day celebration will be held at UVM Larner College of Medicine.

April 18: Dr. Majid Sadigh will present “My Heart Burns: Three Words Form a Memoir” at the Global Health Day Dean’s Lecture.
April 20: Dr. Majid Sadigh will present global health opportunities for students at the College of Health Professions’ Spring Meeting, in Bridgeport, CT.

April 23: A Global Health Leadership Team Meeting will be held at UVM Larner College of Medicine.

April 30: A global health elective Pre-Departure Course for first-year medical students will be held at UVM Larner College of Medicine, during which Dr. Molly Rideout, assistant professor of Pediatrics at UVM Larner College of Medicine, will present “Global Child Health: A Case Discussion.”

News from March

March 1: Dr. Jeremy Schwartz, assistant professor of medicine at Yale School of Medicine, spoke at the first Norwalk Hospital Global Health Grand Rounds.

March 1: Dr. Robert Hecht, associate clinical dean at AUC, and Jeffrey Anderson, AUC Senior Regional Program Coordinator, came to Danbury Hospital for an annual site-visit, during which they met with Dr. Bulat Ziganshin, director of the AUC/RUSM WCHN Global Health Program, and other members of the global health team including Dr. Anton Gryaznov, Mary Shah, Lauri Lennon, Laura E. Smith, and Joanna Conklin to discuss ways of encouraging student participation in global health electives and providing support and safety to students during their rotations.

March 1: UVM Larner College of Medicine psychiatry residents Erica Marden and Kristina Foreman travelled to Uganda for the global health elective.

March 4: Dr. Sadigh returned from a one-month administrative and teaching visit in Uganda.

March 6: Dr. Sadigh spoke about Ebola Viral Disease at Norwalk Hospital's medical noon conference.

March 8: A Global Health Leadership Team meeting was held at UVM Larner College of Medicine.
March 9: Global health elective interviews were held at UVM Larner College of Medicine.

March 12: A Global Health Leadership Team meeting was held at UVM Larner College of Medicine.

March 12: Global health elective Pre-Departure Course was held for first-year medical students at UVM Larner College of Medicine, during which Dr. Ben Clements from Family Medicine presented “The Reductive Seduction of Other People’s Problems.”

March 12-13: Dr. Majid Sadigh made a monthly administrative trip to UVM Larner College of Medicine to attend the global health leadership meeting and meet with Edward Neuert, editorial and creative director at UVM Larner College of Medicine, to review publications for Global Health Day.

March 13: Professor Chiratidzo Ellen Ndhlovu, faculty of Medicine at the University of Zimbabwe College of Health Sciences, visited Norwalk Hospital where she met with the global health and medical education leadership.

March 14: Professor Chiratidzo Ellen Ndhlovu, faculty of Medicine at the University of Zimbabwe College of Health Sciences, and Dr. Majid Sadigh visited Professor Linus Chuang, chairman of the OB/GYN department at WCHN, to discuss collaborative research and education in endocervical cancer screening.

March 20: A global health elective debriefing was held for fourth-year UVM Larner College of Medicine participants.

March 20: Dr. Sadigh had a follow up interview by the News Times about his climb up Mount Kilimanjaro. Read the article.

March 24: Eight AUC and RUSM students left for the global health elective: RUSM student Tonia Anna Gooden and AUC students Katherine Elizabeth Arn, Stephen Michael Finney, and Daniel Namkoong to Vietnam; RUSM students Britny LeAnne Edwards and Lindsey Elizabeth McKee to Russia; and AUC student Ernest Ihechi Okwuonu along with RUSM student Buddhi Praharshanee Kumari Hatharaliyadda to Uganda.

March 25: AUC student Susana Ruano and RUSM students Aniebietabasi Okon-Umoren and Olivia Akua Asamoah returned to the United States from Uganda.

March 25: Dr. Anne Dougherty, assistant professor of the OB/GYN department and director of the Global Women's Health Program at UVM Larner College of Medicine, travelled to Uganda to supervise UVM Larner College of Medicine medical students, work with the African Community Center for Social Sustainability (ACCESS) on a family planning project targeting postpartum women, and collaborate with the Makerere University College of Health Sciences OB/GYN Department to develop educational programming.

March 26: A Global Health leadership team meeting was held at UVM Larner College of Medicine.

March 26: A global health elective Pre-Departure Course was held for first-year medical students at UVM Larner College of Medicine, during which Dr. Molly Moore, director of Global Health in the UVM Larner College of Medicine Department of Pediatrics, presented “Global Health Payers and Players.”

March 26: Dr. Majid Sadigh met with Dr. Robert Jarrett, president of Hearts Around the World, to discuss Dr.
Jarrett’s upcoming trip to the Dominican Republic to meet with the global health interest group and lecture about noncommunicable diseases, and to China to explore the possibility of establishing a new global health partnership.

**March 28**: A global health website meeting was held at UVM Larner College of Medicine.

**March 28**: AUC students Gitanjali Lobo and Michael Villasin returned to the US from Uganda.

**March 29**: Dr. Majid Sadigh met with Dr. Linus Chuang, chairman of the OB/GYN department at WCHN, to explore the potential collaboration between the UVM Larner College of Medicine Global Women’s Health Program and the OB/GYN Departments of Makerere University College of Health Sciences and WCHN.

**March 30**: Fourth-year UVM Larner College of Medicine students Susannah Kricker and Astia Roper-Allenzara travelled to Uganda for the global health elective.
Global Health Spotlight

Global Health Spotlight:
Global Health Day Celebration

The Global Health Program at the University of Vermont Larner College of Medicine and the Western Connecticut Health Network (WCHN) hosted “A Celebration of Global Health” at the College April 17 to 18, 2018. International guests included Marat Mukhamedyarov, M.D., Ph.D., D.Sc., Head of International Department at Kazan State Medical University in Russia, and Tendai Machingaidze, M.Div., M.A., a medical student and author studying in Russia who hails from Zimbabwe. They joined WCHN and UVM Larner College of Medicine leaders, faculty, staff and students for several events.

At a special awards dinner held April 17 at UVM’s Alumni House Silver Pavilion, three major global health awards were presented to members of the Larner College of Medicine community. Mariah McNamara, M.D., a UVM faculty leader in the Global Health Program, announced the awards, which were presented by Larner College
of Medicine Dean Frederick Morin, M.D., and Global Health Program Director Majid Sadigh, M.D. Dr. Sadigh also presented Dean Morin with a special thank you gift for his leadership and support of the Global Health Program.

Bruce Leavitt, M.D.’81, professor of surgery, received the 2018 Patricia O’Brien, M.D. Global Health Leadership & Humanitarian Award. This award was inspired by Dr. O’Brien, an assistant professor of medicine in the Division of Hematology/Oncology who is an exemplary humanitarian and leader of global health. The award recognizes an individual who is passionate about health equity and works towards addressing disparities, combating marginalization and helping the under served.

Kristen DeStigter, M.D., Tampas Green and Gold professor and chair of radiology, received the 2018 Beth Kirkpatrick, M.D. Citizen of the World Award. This award was inspired by Beth Kirkpatrick, M.D., chair of microbiology and molecular genetics and director of the Vaccine Testing Center, who is infectious disease specialist, accomplished physician scientist and leader in vaccine research, as well as a dedicated global health champion. This award recognizes an outstanding leader and scholar who dedicates their work towards the advancement of humanitarian pursuits.

Anne Dougherty, M.D.’09, assistant professor of obstetrics, gynecology and reproductive sciences, received the 2018 Majid Sadigh Global Health Education Award, named for Dr. Sadigh, Global Health Program Director and Christopher J. Treftz Family Endowed Chair in Global Health at Danbury Hospital. This award recognizes and outstanding global health educator who inspires students to become leaders in global health.

On April 18, the celebration featured the Dean’s Distinguished Lecture in Global Health on “My Heart Burns: Three Words Form a Memoir” by Dr. Sadigh. Following the lecture, winning submissions to the Photo, Poster & Reflection Exhibit were honored.

The Best Poster Award went to Danielle Ehret, M.D. (Assistant Professor of Pediatrics and Neonatologist). Meanwhile, the Reflection Essay Contest was won by Julia Shatten ’18 for her reflection titled “Ethics of the Theater” (Uganda), and honorable mentions included Amanda Kardys ’20, “Impressions” (Zimbabwe), Stefan Wheat ’18 “The Ghosts of Makerere Kikoni” (Uganda), and Stephanie Brooks ’18 (Uganda).

Photo Winners

Best Composition (Uganda) - Anya Koutras, M.D. (Associate Professor of Family Medicine)

Photo 7: Originality (Uganda and the Dominican Republic) - Tie between Julia Shatten ’18 and Pirapon Chaidaron ’21

Photo 8: Impact (Uganda) - Anya Koutras, M.D. (Associate Professor of Family Medicine)

Winning photos next page >>
Ethical Dilemma:

Assessing students’ success and safety in global health programs

Integral to global health experiences, a wide range of ethical dilemmas impact students, residents, physicians, institutional leadership, and patient populations. Each month, we engage in discussions around an ethical dilemma and ponder the responses from one global health leader in the Global South and one in the Global North. This month’s ethical dilemma is centered on navigating gender norms in a culturally sensitive manner, and advocating for patient autonomy in difficult contexts.

See responses on the blog >>

Global Health Article of the Month

The Blind Men and the Elephant—Aligning Efforts in Global Health

“After decades of increased funding and progress toward major goals in global health, we are entering a crucial time marked by, among other challenges, the recurring threat of pandemics, the global rise of noncommunicable diseases, and potentially catastrophic aid cuts by the Trump administration. How these challenges are met will be dictated by which motivations for global health efforts guide policy and action.”

Announcements

We send a warm congratulations to Professor Rangarirai Masanganise (Dean of University of Zimbabwe College of Health Sciences, UZCHS), and thank him for his support of global health. We also thank Professor Midion Mapfumo Chidzonga, (the previous Dean of UZCHS), and send him the best of luck on his future endeavors. We are delighted that Professor Rati Ndlovu will remain as the Director of the Global Health Partnership.
Thank you to Liz Skarynski of Dress a Girl Around the World for the donation of dresses and menstrual packs to orphans and vulnerable girls at the African Community Center for Social Sustainability (ACCESS) in Nakaseke, Uganda, and to Sacred Heart University’s nursing students for delivering them. Each tee-shirt dress came adorned with undergarments and hand-sewn and painted dolls in the pockets. 

(Photo right: A girl wearing one of a dress and holding a doll donated from Dress a Girl Around the World)

We are in the process of recruiting a 0.5 FTE faculty as Associate Director of WCHN/UVMLCOM Global Health Program. Interested parties please apply. Learn more about the job opening.

Training Tailors for Rural Uganda

Christine and Sam Luboga should be congratulated for their successful enterprise of training women from rural Uganda whom they host for twelve–week training sessions at Chrisams, their co-founded tailoring company. By teaching its participants to tailor, Chrisams helps trainees gain financial independence and contribute to their communities upon returning home.
Calendar

Upcoming Events

May Calendar

May 21: Dr. Mariah McNamara will speak to first-year UVM Larner College of medicine students about humanitarian emergencies.

May 29: Interviews for global health elective participants will be held at the UVM Larner College of Medicine.

News from the Spring

April 2: A global health elective pre-departure session for first-year medical students was held at UVM Larner College of Medicine, during which Dr. Andrew Green, Director of the Pediatric New American Program, presented “Cultural Exercise.”

April 9: A Global Health Leadership Team meeting was held at UVM Larner College of Medicine.

April 10: Photo left: Dr. Robert Wilson, medical resident at Norwalk Hospital, spoke at the medical noon conference at Norwalk Hospital about filariasis and his global health experience at Cho Ray Hospital in Vietnam.

April 12: Dr. Majid Sadigh spoke about climbing Mount Kilimanjaro at the Annual American Academy of Professional Coders (AAPC) Chapter Meeting at Danbury Hospital.

April 13: Dr. Majid Sadigh served as a member of a global health panel at the Yale School of Public Health.

April 16: Dr. Majid Sadigh spoke about the UVM Larner College of Medicine/WCHN Global Health Program to medical students and their families at UVM Larner College of Medicine’s “Closer Look Day.”

April 16: A global health elective pre-departure session for first-year medical students was held at UVM Larner College of Medicine, during which Dr. Molly Rovin, MD, UVM Larner College of Medicine Psychiatry Department, presented “Global Mental Health.”

April 18: Dr. Majid Sadigh presented “My Heart Burns: Three Words Form a Memoir” at the Dean’s Distinguished Lecture during the Global Health Day.
**April 20:** Dr. Majid Sadigh presented global health opportunities for students at Sacred Heart University’s College of Health Professions’ Spring Meeting in Bridgeport, CT.

![Photo of Dr. Majid Sadigh with global health elective participants from Sacred Heart University's College of Health Professions](image1)

**April 22-24:** Dr. Majid Sadigh made a short administrative trip to Cho Ray Hospital, Vietnam to thank Professor Phuong Kim, previous Director of the International Affairs Office, for her leadership and contribution to the Global Health Program, and to welcome the new leadership, Dr. Hoang Lan Phuong, Director of the International Affairs Office, and Dr. Uyen Tran, Coordinator at the Cho Ray Hospital Training Center. During this trip, Dr. Majid Sadigh also met with Professor Son Nguyen Truong, Director of Cho Ray Hospital, global health alumni scholars along with newly selected candidates who will be coming to the United States for training, and four students from RUSM and AUC with whom he held debriefing sessions. Moving forward, our global health partnership with Cho Ray Hospital will operate under the leadership of the Training Center, which will provide participants with support as well as supplementary sociocultural curriculum.

![Photo of Dr. Lan Phuong, Director of the International Affairs Office, and Dr. Uyen Tran, Global Health Program Coordinator at the Training Center, both of the Cho Ray Hospital](image2)

**Photo right:** AUC and RUSM medical students at Cho Ray Hospital

![Photo of (left to right) Mrs. N. Takawira, Deputy Registrar at UZCHS, Professor Rati Ndhlovu, Deputy Dean at UZCHS, Dr. Majid Sadigh and Professor Rangarirai Masanganise, Dean at UZCHS](image3)
April 25–26: Dr. Majid Sadigh travelled to Zimbabwe for a short administrative trip, during which he met with Professor Rangarirai Masanganise, Dean of University of Zimbabwe College of Health Sciences (UZCHS), and Dr. Rati Ndhlovu, Deputy Dean at UZCHS, who will remain as the Director of the Global Health Partnership. He also met with two candidates who have been selected for training at WCHN: Mrs. N. Takawira, Deputy Registrar at UZCHS, who is coming for a short visit to learn about the administration of the medical education and medical school, and Dr. Shalote Chipamaunga, Director of Medical Education at UZCHS, who is coming for a few weeks to learn about the Simulation Lab, Teaching Academy, and medical education system at UVM Larner College of Medicine/WCHN. We look forward to continuing our fruitful collaboration.

Photo left: Dr. Shalote Chipamaunga, Director of Medical Education at UZCHS

April 22–27: Dr. Yun-Pei Lee Chou, Director of the Simulation Lab at UNIBE, spent a week with John Leopold, Director of the Simulation Lab at Danbury Hospital, where they discussed the role of the Simulation Lab in the training of medical students for global health electives.

April 23: A Global Health Leadership Team Meeting was held at UVM Larner College of Medicine.

April 24: Photo right: Dr. Randi Diamond, Dr. Howard Eison, and Lorien Menhennett, a Weill Cornell medical student, have developed educational modules to enhance communication skills of health workers in rural Uganda who work with patients in need of palliative care for their serious illnesses. The program uses documentary video clips of actual palliative care encounters between health workers and community-dwelling Ugandan patients to present the material in a culturally relevant manner. As part of a broader pilot study this April, Dr. Eison and Ms. Menhennett facilitated the presentation of two workshops on “Digital Modules for Palliative Care Education in Rural Uganda: Communication and Delivering Bad News” for health workers at Nakaseke Hospital and the African Community Center for Social Sustainability (ACCESS). The modules were enthusiastically received and, based on preliminary data, appear to be an effective and valuable educational tool.
April 27: Fourth-year UVM Larner College of Medicine student Susannah Kricker completed her global health elective in Uganda.

April 30: Dr. Majid Sadigh held Skype interviews with eight candidates from Kazan State Medical University for the global health elective in the Dominican Republic and Uganda.

April 30: A global health elective pre-departure session for first-year medical students was held at UVM Larner College of Medicine, during which Dr. Molly Rideout, Assistant Professor of Pediatrics at UVM Larner College of Medicine, presented “Global Child Health: A Case Discussion.”

May 1: UVM Larner College of Medicine Family Medicine resident Elizabeth Landell traveled to Uganda for the global health elective at ACCESS, Uganda.

May 2: Dr. Stephen Scholand spoke about rabies at the global health grand rounds held at Danbury Hospital.

May 3: Dr. Majid Sadigh made an administrative trip to Burlington where he gave a presentation to 22 members of the UVM Foundation about the function and structure of the Global Health Program.

May 7: RUSM students Xinuo Gao and Keely Nicole Johnson traveled to Uganda for the global health elective, while RUSM student Ala S Mustafa and AUC student Marisa Anne Carter traveled to Uganda.

May 10: Dr. Tracy Rabin, Assistant Director, Office of Global Health, Department of Internal Medicine at Yale University, spoke at the global health grand rounds, which was held at Norwalk Hospital.

May 12: The second annual Northeast Regional Clinical Symposium, hosted by the American University of the Caribbean (AUC) School of Medicine, was held on May 12 at Doral Arrowwood Resort in Rye Brook, New York. Works by student and clinical faculty on international medicine-related topics were showcased in line with this year’s theme of global health. Dr. Majid Sadigh delivered this year’s keynote address and moderated a panel on ethical dilemmas in short-term global health electives. Meanwhile, Dr. Bulat Ziganshin presented about the Global Health Program and served as a panelist.

May 13: Dr. Winter traveled to Russia to attend the anniversary day at Kazan State Medical University, where he participated in the medical education conference, met with global health program alumni, and gave a series of talks on topics related to the pulmonary and intensive care medicine. He also presented scholarships to four Russian colleagues who were selected for the global health elective in Uganda and the Dominican Republic.

May 14: A Global Health Leadership Team meeting was held at the UVM Larner College of Medicine.
Global Health Spotlight

Passion and Humanity: Journey to a Hospital in Zimbabwe

During a recent trip to Parirenyatwa Hospital in Harare, Zimbabwe, Dr. Scholand was deeply moved by the cancer patients in the oncology ward and wanted to do something to help improve their inpatient experience. Upon returning home, Dr. Scholand shared his stories with his Uncle Marty who was touched and offered to organize a fundraiser to help raise money. They figured even a few enhancements to the hospital room could lift someone’s spirits and inspire them to carry on.

With the goal of raising $3,000 in support of the oncology clinic, a fundraiser was held at Uncle Marty’s golf club in Hanover, Pennsylvania on May 27th. Family, friends, and community members listened as Dr. Scholand gave a fervently passionate talk advocating for patient needs. Together, more than $32,000 was collected.

Thank you to Dr. Scholand and his Uncle Marty for organizing the event, and to everyone who donated to this meaningful cause.
Announcements

Congratulations to Anton Gryaznov for his acceptance to the residency program in the Department of Surgery at St. Mary’s Hospital. Thank you Anton for your great technical contributions to the Global Health Program as our Information & Technology Consultant. We will miss you very much, but are grateful that you will be close by.

Photo left: Anton Gryaznov, Information & Technology Consultant for the Global Health Program

Global Health Article of the Month

“Quantifying the effect of natural disasters on society is critical for recovery of public health services and infrastructure. The death toll can be difficult to assess in the aftermath of a major disaster. In September 2017, Hurricane Maria caused massive infrastructural damage to Puerto Rico, but its effect on mortality remains contentious. The official death count is 64. This household-based survey suggests that the number of excess deaths related to Hurricane Maria in Puerto Rico is more than 70 times the official estimate.”

Member Promotions

Dr. Bulat Ziganshin (Director of the International Affairs Office at the WCHN/UVMLCOM Global Health Program and Director of the Global Health Elective for AUC and RUSM students)

We are delighted to announce that as of June 1st, Dr. Bulat Ziganshin has been appointed as the Director of the International Affairs Office at the WCHN/UVMLCOM Global Health Program, in addition to his ongoing position as the Director of the WCHN Global Health Elective for AUC and RUSM students.

Dr. Ziganshin is an Associate Research Scientist at the Department of Surgery at the Yale University School of Medicine, as well as Research Director of the Aortic Institute at Yale-New Haven Hospital. He received his M.D. and PhD in Pharmacology from Kazan State Medical University in Russia where he also completed residency training in Cardiovascular Surgery. He serves as an Associate Editor of AORTA Journal and
has authored over 100 peer-reviewed manuscripts. He is currently a graduate student in genetics and development at Columbia University.

In this new position, Dr. Ziganshin will work together with Joanna Conklin and Dr. Dilyara Nurkhametova to organize meaningful educational experiences for our global health scholars and visitors hosted at WCHN for clinical or administrative training. We request that all communication related to WCHN-affiliated international visitors be directed to them.

Dr. Stephen Scholand

Dr. Stephen Scholand (Site Director of the Global Health Program at University of Zimbabwe College of Health Sciences and at Cho Ray Hospital in Vietnam)

We are delighted to announce that as of June 1st, Dr. Stephen Scholand has been appointed as Site Director of the Global Health Program at University of Zimbabwe College of Health Sciences, in addition to his ongoing position as Site Director of the Global Health Program at Cho Ray Hospital in Vietnam.

Dr. Scholand is a graduate of the George Washington School of Medicine. He subsequently attended Thomas Jefferson University hospital for his internship, residency, chief residency, and fellowship in Infectious Diseases. Currently, he is Associate Professor at the Frank Netter School of Medicine in addition to his role at the WCHN Global Health Program. He has over 20 years of clinical experience, including work overseas in medically underserved areas of the world, and is the President and Founder of Rabies Free World.

In this new position, Dr. Scholand will orchestrate our partnership in these two countries and implement the new educational and research activities in collaboration with the administration of all institutions. He will also be responsible for the clinical, educational, and research experiences of participants on their global health electives, and will meet periodically with key figures at the training sites to review important issues and concerns. We request that all communication related to the elective sites in Vietnam and Zimbabwe be directed to Dr. Scholand.
Dr. Josue Pichardo (Academic Director of AIDC), Dr. Robert Jarrett (President of Hearts Around the World), Dr. Anjali Dutta (Cardiology Fellow at Danbury Hospital), Dr. Edgar Cadena (Residency Coordinator at AIDC), Dr. Jomar Florenzán (Global Health Site Director in the Dominican Republic), and Dr. Ana Sanchez (Cardiologist at AIDC)

**CALENDAR**

*April 21-27:* Dr. Robert Jarrett (President of Hearts Around the World) visited the Dominican Institute of Cardiology (AIDC), accompanied by internal medicine resident Dr. Laura Mones and cardiology fellow Anjali Dutta. During this visit, they participated in educational activities and medical rounds with local attendings and residents. Dr. Dutta presented on lipids management to local residents, and Dr. Jarrett spoke about cardio-oncology in the Grand Rounds. Meetings were held to discuss the hosting of a new scholar from AIDC at Danbury for computed angiotomography training. Dr. Jarrett also coordinated with the AIDC surgery team for a group of cardiovascular surgeons from the U.S. to work alongside local cardiovascular surgeons in providing mitral valve replacements.

*May 1:* UVMLCOM Family Medicine resident Elizabeth Landell travelled to Uganda for a four-week global health elective at ACCESS.

*May 2:* Dr. Stephen Scholand spoke about rabies at the global health grand rounds at Danbury Hospital.

*May 3:* Dr. Majid Sadigh made an administrative trip to Burlington where he gave a presentation to 22 members of the UVMLCOM Foundation about the function and structure of the Global Health Program.

*May 7:* RUSM students Xinuo Gao and Keely Nicole Johnson travelled to Russia for the global health elective, while RUSM student Ala S Mustafa and AUC student Marisa Anne Carter travelled to Nakaseke, Uganda.

*May 10:* Dr. Tracy Rabin (Assistant Director in the Office of Global Health at Yale University’s Department of Internal Medicine) spoke at the global health grand rounds at Norwalk Hospital.
May 12: The AUC Northeast Regional Clinical Symposium on Global Health was held at the Doral Arrowwood Resort in Rye Brook, NY. The event showcased student and clinical faculty work on topics related to international medicine. AUC students from Danbury Hospital and New York hospitals Bronx-Lebanon and NUMC were provided transportation to the event. Dr. Bulat Ziganshin participated in the Faculty Panel discussion, moderated by Dr. Sadigh, on ethical dilemmas in short-term electives in global health. Dr. Sadigh gave the fervent keynote address, My Heart Burns: Three Words Form a Memoir. Dr. Ziganshin gave an excellent and comprehensive presentation on the WCHN Global Health Elective Program. WCHN global health elective alumni Gloria Cheung and Janice Hanawi presented Global Health: Implementing Sustainable Frameworks of Care, based on their experiences at St. Francis Naggalama Hospital in Uganda. Several AUC deans presented student awards during the closing remarks and there was a lovely evening reception to encourage networking and meaningful discussion.

May 13-18: Dr. Stephen Winter (Director of Global Health for the Norwalk campus of WCHN) travelled to Russia to visit Kazan State Medical University during the 204th anniversary celebration of the founding of the university. During the visit, he presented lectures to the International Education Conference and a keynote lecture for the anniversary celebration. At the meeting of the Academic Medical Council, Dr. Winter presented certificates to the KSMU Global Scholars chosen to travel to international sites in the coming year. He also spent several mornings conducting educational rounds at the Republican Clinical Hospital with students and residents in the KSMU training programs.

May 14: Dr. Anne Dougherty won a Gold Humanism Honors Society award at Honors Night, which was held at UVMCOM.

May 14: A Global Health Leadership Team meeting was held at UVMCOM.
May 20: Danbury Hospital surgery resident Dr. Patrick Zimmerman and attending Dr. Laura Withers visited Santo Domingo, Dominican Republic for a two-week rotation at Hospital General Plaza de la Salud and Hospital General Marcelino Velez Santana, where they had the opportunity to work with local surgeons and surgery residents. They also visited UNIBE’s simulation Lab, and discussed some ideas and projects pertaining to developing simulation labs for UNIBE’s surgery residency program.

May 21: Dr. Judith Lewis (Director of the Psychiatry Program at UVMLCOM) site-visited Makerere University College of Health Sciences’ Psychiatry Department to expand the partnership between the two institutions in global mental health and tour the facility. She also visited Butabika Hospital as well as host sites such as the Luboga’s and Okullo’s.

May 22: The Global Health Elective Bi-Weekly Course was held, during which Dr. Mariah McNamara discussed “Humanitarian Emergencies.”

May 29: Fourth-year global health elective interviews were held at UVMLCOM.

May 30: UVMLCOM Family Medicine resident Elizabeth Landell returned from her four-week rotation at ACCESS.

May 30: Dr. Majid Sadigh met with Dr. Stephen Winter for a debriefing session, Dr. Bulat Ziganshin for an orientation session, and John Leopold to discuss the possibility of collaboration between the simulation labs of Danbury Hospital and UNIBE. He also met with Mary Shah in preparation for her trip to the Dominican Republic where she will be teaching librarians new skills, and developing educational web resource Hinari for UNIBE.

June Calendar

June 1: Dr. Judith Lewis (Director of the Psychiatry Program at UVMLCOM) will return from her site-visit in Uganda.

June 2: Dr. Laura Withers and Dr. Patrick Zimmerman will return from the Dominican Republic.

June 4: A Global Health Elective Bi-Weekly Course will be held, during which Dr. Kristen DeStigter will discuss “Imaging the World.”

June 4: Dr. Majid Sadigh will hold orientation sessions with medical residents from Norwalk Hospital who will travel to Uganda and Vietnam for the global health elective in July.

June 5: Dr. Majid Sadigh will be present “Reflections on Mount Kilimanjaro” at Danbury Hospital’s Gerard D. Robilotti Center at 5 PM. RSVP to Joanna Conklin, joanna.conklin@wchn.org.

June 6–8: Dr. Pariyar, a Nepalese gynecologic oncologist and recipient of the 2018 ASCO IDEA award, will be hosted at Danbury Hospital. During his visit, he will give a presentation about the current status of gynecologic oncology and minimally invasive surgery in Nepal. He will also meet with Dr. Sadigh.
June 11: A Global Health Elective Bi-Weekly Course will be held, during which Dr. Anne Dougherty will discuss “Global Women’s Health.”

June 11: A Global Health Leadership Team meeting will be held at UVMLCOM.

June 11-13: Dr. Sadigh will make an administrative trip to UVMLCOM.

June 16: A global health pre-departure Boot Camp will be held for first-year students at UVMLCOM.

June 18: RUSM student Adam Cerissi will be traveling to the Dominican Republic for the global health elective. Meanwhile, RUSM students Elizabeth Anne Abels and Krist Jeremy Quinones-Lara will be traveling to Mulago Hospital in Kampala, Uganda, and Mahvish Nazir Qazi, Srijita Sarkar, and Shikha Talwar to ACCESS, Uganda.

June 25: First-year UVMLCOM students Katherine Callahan and Nina Dawson will depart for a global health elective at St. Stephen’s Hospital in Uganda, accompanied by Dr. Mariah McNamara and Dr. Paul Bachman.

June 25: A Global Health Leadership Team meeting will be held at UVMLCOM.

June 30: Fourth-year UVMLCOM student Khaled Al Tawil will depart for a global health elective at Kazan State Medical University in Russia.

June 30: Dr. Agaba Peter, an anesthesiologist from Makerere University College of Health Sciences, will arrive at Norwalk Hospital for four months of training in intensive care medicine.
Global Health Spotlight

Endowed Chair Dinner

The first Endowed Chair dinner was held at Le Chateau, South Salem, New York on June 28th. It was attended by eight of nine Endowed Chairs, their spouses, and the donors. Each Endowed Chair spoke about the impact of their endowment on their respective program. Dr. Majid Sadigh said:

“I was raised in a small mountainous village in southern Iran, a land of poor but kind and generous inhabitants. I was one of very few children who had the privilege of a warm and supportive family. It was in this setting that I became familiar with the lives of underprivileged, gentle souls. Rumi became my idol as I searched
for meaning beyond simple “happiness” throughout my youth. Voicing the unvoiced gave meaning to my life. I dreamt of becoming a storyteller who narrates the stories of those who cannot tell their own. I attended medical school with this dream, came to the USA with this dream, and joined Yale, and later on UVMLCOM, with this dream. I focused all my energy on relating the story of the underprivileged to those who may not have heard it from the podium of the global health.

Endowed Chairs

It was at Western Connecticut Health Network that I finally discovered people, both in the community and among the leadership, who shared this dream. John Murphy, the CEO of the WCHN, immediately embraced the global health philosophy. And in 2016 when he and the Foundation brought my path to overlap with the Christian and Eva Trefz, my dream finally came true. Global Health at UVMLCOM/WCHN has found an identity, named after a generous family that cares about making a positive impact. Now, whenever I take the podium to advocate for the underserved, the Trefz name moves the idea forward, giving it sustainability and power. Thanks to the Trefz family, my lifelong dream has materialized into something tangible.”

**Ethical Dilemmas in Global Health**

Integral to global health experiences, a wide range of ethical dilemmas impact students, residents, physicians, institutional leadership, and patient populations. Each month, we engage in discussions around an ethical dilemma and ponder the responses from one global health leader in the Global South and one in the Global North. This month’s ethical dilemma is centered on the monitoring of participant reflections and social media posts while on global health electives.

**Announcements**

**Christian J. Trefz’s birthday** was on June 8th. Happy birthday!

Photo left: **Dr. Anna Nulbat**, a neurologist from KSMU, Russia, and **Dr. Peter Agaba**, an anesthesiologist from MakCHS, Uganda. Let us welcome our new global health scholars who arrived this month for one to four months of training: Dr. Anna Nulbat, a neurologist from KSMU, Russia; Dr. Peter Agaba, an anesthesiologist from MakCHS, Uganda; and Dr. Trần Song Toàn, a Cardiologist at Cho Ray Hospital, Vietnam.
The funds raised from “Climb for a Cause” have materialized into funding a Microbiology Unit at St. Francis Naggalama Hospital that will facilitate accurate and timely diagnosis. Construction will begin July 2018.

Member Highlights

DR. PATRICK ZIMMERMAN
SURGICAL RESIDENT
AT DANBURY HOSPITAL

My arrival at a career in surgery was circuitous. I studied Spanish and foreign relations in college and had planned a career as a jurist or with the foreign service, but discovered that I didn’t like the version of myself I saw emerging. I made the difficult decision to change course, and have always been glad I did. My interest in global health began with local health, prior to medical school in a clinic for uninsured or underinsured patients in Utah that catered mostly to the homeless. Working in a resource-poor environment meant we had to be creative at times. In medical school, I worked in a clinic in Oregon that serves the homeless, uninsured, and underinsured. It was not until my third year of surgical residency that I had the opportunity to participate in a global surgery program.

One of the challenges during my time in the Dominican Republic was realizing that their surgeons have technical skills above the training level of matched counterparts from the U.S., and I likely wouldn’t be contributing much in the way of innovation, knowledge, procedural expertise, or even perspective. The fact is that their surgical residents outclassed me in essentially every way. Furthermore, they knew how to operate with true beauty without many of the technologies we enjoy in the U.S. I witnessed real masters of the fundamental surgical principles and returned with a drive master the basics. Moving forward, I hope to be an ambassador for the global health partnership, and find opportunities for future involvement in global surgery.

TONIA GOODEN
ROSS SCHOOL OF MEDICINE ‘18

Having grown up surrounded by Familial Adenomatous Polyposis, I had early exposure to the realities of our medical system. With a strong curiosity in science, I sought knowledge but also felt an undeniable yearning to help people. The choice for me was distinct: medicine would give me the opportunity to spend my life learning while helping others through the application of my knowledge.

The foundations of medicine can be learned anywhere, but perspective is gained through experience. The global health experience demonstrates the inequalities of medicine around the world, encouraging reflection on the basic certainties that we take for granted, such as being treated regardless of ability to pay. It also reaffirmed my ability to be resilient and adjust to new situations. But above all, it taught me the importance of cultural competence. We cannot treat a disease alone. We must treat the entire person. But how can we begin to treat the whole person without understanding their culture? This experience has also better equipped me to provide care in resource-depleted settings, since they also exist here at home. Health shouldn’t be only for those who can afford it, but without training in these settings, we as physicians are unable to provide the highest-quality healthcare.
I am currently completing my graduation requirements, and will soon relocate to Belgium to pursue research in digestive oncology. There are no borders when it comes to learning. To provide the best care and make a mark in my field, I believe in going where the research is. I can later apply my knowledge to improve the health of those who need expertise anywhere in the world.

Global Health Article of the Month

Housing Immigrant Children— the Inhumanity of Constant Illumination

“On the Wednesday before the summer solstice in the United States, President Donald Trump ended his administration’s policy of forced separation of immigrant children from their parents at the U.S.–Mexico border — a practice characterized by the president of the American Academy of Pediatrics (AAP) as a form of child abuse with long-lasting adverse effects on the developing brains of the 2300 children already subjected to this trauma (see Perspective article by Danaher). Nonetheless, there are still 1100 immigrants being held by the Department of Homeland Security (DHS) at a warehouse on Ursula Ave. in McAllen, Texas. The Ursula facility, as it’s called, is reportedly the area’s first central processing center for immigrant children and families. Alarmingly, according to press accounts, its ‘overhead lighting stays on around the clock.’”

Calendar

Photo left: Dr. Laura Withers, Patrick Zimmerman, Surgical Resident at Danbury Hospital; and Dr. Victor Cabrera at Hospital Marcelino Velez, Dominican Republic

June 1: Dr. Judith Lewis (Director of the Psychiatry Program at UVLMCOM) returned from her site-visit in Uganda.

June 2: Dr. Laura Withers and Dr. Patrick Zimmerman returned from the Dominican Republic.

June 4: A Global Health Elective Bi-Weekly Course was held, during which Dr. Kristen DeStigter discussed “Imaging the World.”

June 4: Dr. Majid Sadigh held an orientation session with Norwalk Hospital medical residents Jonathan Kandish, Amanda Linda, and Sharon Sukhdeo, in preparation for their upcoming global health electives in Vietnam and Uganda.
June 5: Dr. Majid Sadigh presented “Reflections on Mount Kilimanjaro: Climb for a Cause” at Danbury Hospital’s Global Health Evening, during which he shared photos and reflections from his most recent trek up Africa’s highest peak which raised funds for a microbiology unit at St. Francis Naggalama Hospital in Uganda. The talk was attended by Christian and Eva Trefz as well as many members of the WCHN Foundation.

June 6: Laura E. Smith, Global Health Program Coordinator at WCHN, participated as a panelist in AUC’s “Going Global” webinar to talk about the program alongside AUC global health elective alumni Drs. Marcus Powers, Kira MacDougall, Gloria Cheung, and Deyanna Boston.

June 6-8: Dr. Jitendra Pariyar, a Nepalese gynecologic oncologist, recipient of the 2018 ASCO IDEA award, and member of the Nepal Society of Obstetricians and Gynecologists, was hosted at Danbury Hospital per the invitation of Dr. Linus Chuang. During his visit, he gave a presentation about endocervical cancer in Nepal at the Danbury Hospital Tumor Board. The possibility of establishing a global health host site in Kathmandu was also discussed.

June 11: Dr. Majid Sadigh made an administrative trip to UVMCOM. During his trip, he met with Dr. Judith Lewis for a debriefing session about her recent trip to Uganda for Global Mental Health.

June 11: A Global Health Team Leadership Meeting was held at UVMCOM.

June 11: The final Global Health Elective Bi-Weekly Course was held, during which Dr. Anne Dougherty discussed “Global Women’s Health.”

June 13: Dr. Majid Sadigh met with John Leopold, Director of the Simulation at WCHN; Dr. Aparna Oltikar, Chair of Medicine at Danbury Hospital; and Mary Shaw, medical librarian and archivist at Danbury Hospital to discuss the visit of Dr. Shalote R. Chipamaunga, a senior lecturer at UZCHS at Department of Health Professions Education who is coming in September.

June 14: Dr. Majid Sadigh had a meeting with Dr. Royd Fukumoto, Director of the Surgical Residency Program at Danbury Hospital, to review the partnership between the surgical departments of Danbury Hospital and UNIBE and discuss the hosting of a faculty from the Dominican Republic at Danbury Hospital.
June 15: Fourth-year RUSM students Xinuo Gao and Keely Johnson returned to the U.S. from Russia, while fourth-year AUC student Marisa Carter and RUSM student Ala Mustafa returned from Uganda.

June 16: A global health pre-departure Boot Camp was held for first-year students at UVMLCOM.

June 18: Fourth-year RUSM students Elizabeth Abels and Krist Quinones-Lara travelled to Mulago Hospital in Kampala, Uganda; Mahvish Qazi, Srijita Sarkar, and Shikha Talwar to ACCESS, Uganda; and Adam Cerissi to the Dominican Republic.

June 22: Dr. Majid Sadigh gave a talk about global health to the new interns at Danbury Hospital.

June 21–23: Dr. Bulat Ziganshin visited the RUSM campus in Miramar. This was his second trip to speak to a new group of third-year RUSM medical students who are participating in the six-week International Medicine Foundation clerkship prior to starting their clinical core rotations. The presentation includes a discussion of participation requirements, elective and curriculum goals, application and selection procedure, and pre-departure orientation and training.
June 25: First-year UVMLCOM students Katherine Callahan and Nina Dawson travelled to Uganda for the global health elective accompanied by Dr. Mariah McNamara, Associate Director of Global Health at UVMLCOM, and Dr. Paul Bachman, Senior Faculty at UVMLCOM. They are working at St. Stephens Hospital and living with Reverend Samuel and Christine Luboga in Mpererwe.

June 25: A Global Health Leadership Team meeting was held at UVMLCOM.

June 26: Administrative members Lauri Lennon, Laura E. Smith, Joanna Conklin, and Drs. Stephen Winter, Stephen Scholand, and Bulat Ziganshin met with Dr. Freeman, Chief Clinical Officer of WCHN, at Danbury Hospital to provide an introduction and overview of the WCHN/UVMLCOM Global Health Program.

June 27: Dr. Majid Sadigh had an interview with Shannon Toher, a reporter from AUC, during which he focused on his interpretation of and involvement in global health.

June 30: Fourth-year UVMLCOM student Khaled Al Tawil departed for a global health elective at Kazan State Medical University in Russia.

June 30: Norwalk Hospital internal medicine residents Dr. Amanda Lindo and Dr. Sharon Sukhdeo travelled to Uganda for the global health elective.

July Calendar

July 1: Dr. Jonathan Kandiah, internal medicine resident at Norwalk Hospital, travels to Vietnam for the global health elective.

July 1: Fourth-year UVMLCOM student Khaled Al Tawil travels to Kazan, Russia for the global health elective.

July 5: Dr. Stephen Scholand travels to Cho Ray Hospital for a brief site-visit to introduce himself to the new leadership of their global health programs.

July 9: Dr. Robyn Scatena, Associate Director of Global Health at Norwalk Hospital, travels to Cho Ray Hospital for a two-week capacity building visit.

July 12: Dr. Mariah McNamara, Associate Director of Global Health at UVMLCOM, returns to the United States from Uganda.

July 23: Lauri Lennon, Director of Business Operations at the UVMLCOM/WCHN Global Health Program, travels to Uganda for administrative site-visits.
July 25: Dr. Paul Bachman, Senior Faculty at UVMLCOM, returns to the United States from Uganda.

July 27: Fourth-year RUSM students Adam Cerissi, Elizabeth Abels, Krist Quinones-Lara, Mahvish Qazi, Srijita Sarkar, and Shikha Talwar return to the United States from their global health electives.
Global Health Spotlight

Dinner Table Discussion with Ugandan Colleagues

Five RUSM students, two UVMLCOM students, and two medical residents from Norwalk Hospital, accompanied by Dr. Mariah McNamara, Associate Director of Global Health at the UVMLCOM/WCHN Global Health Program, and Dr. Paul Bachman, senior faculty at UVMLCOM, spent the global health elective in Uganda with Reverend Samuel and Christine Luboga this summer. As part of the homestay model, global health elective participants are given classes in the socio-politics, culture, history, and language of Uganda. In July, Dr. Rose Nabirya, Dr. Alex Kayongo, and Ms. Jamidah Nakato met with participants over dinner to discuss the nation’s socio-political status and speak about their lives. The meeting elucidated the role of local people in shaping the progress of healthcare delivery, research, and education in their own country. Dr. Nabirya, Dr. Kayongo, and Ms. Nakato— a leader in healthcare education, a researcher, and a PhD student, respectively — are three admirable examples of the ways in which resource limitations and barriers to accomplishing big objectives can be overcome. With a all-too-common focus on the influence of the Global North on the Global South, the pivotal role of those staying in their own country to help shape the movement of progress is often overlooked. We thank Reverend Samuel and Christine Luboga for providing a space for cultural enrichment and support of global health participants.
American University of the Caribbean (AUC) Newsletter
Centered on Global Health and Cultural Competency

AUC released a Clinical Connections issue, published in July, which was devoted to the significance of the Global Health Program on the medical education of their students. The newsletter opens with Dean Kirkland’s reflections on the importance of global health and cultural competency, followed by the AAMC’s discussion of the value of international elective programs for medical institutions. The Director of the Global Health Program was highlighted in the “Faculty Connection” section in which he shares what he sees as the meaning of global health. Read his thoughts here.

Ethical Dilemmas in Global Health

Integral to global health experiences, a wide range of ethical dilemmas impact students, residents, physicians, institutional leadership, and patient populations. Each month, we engage in discussions around an ethical dilemma and ponder the responses from one global health leader in the Global South and one in the Global North. This month’s ethical dilemma is centered on reader responses to the post entitled “Financial Barriers and Interventions.”

Announcements:

Dr. Tendai Machingaidze, a Zimbabwean medical student in Russia who has been actively involved in our program, is the new Assistant Site Director for our global health site in Zimbabwe. Her responsibilities include assisting the site director, developing and coordinating educational curriculum and activities, developing the global health program, facilitating homestays for visiting U.S. scholars, and supporting participants.

AUC’s “Going Global” Webinar, aired in June, is now online. Laura Dwyer, AUC Associate Director of Admissions, opens the discussion. The panelists, which include Laura E. Smith, Global Health Program Coordinator at WCHN, and AUC global health elective alumni Drs. Marcus Powers, Kira MacDougall, Gloria Cheung, and Deyanna Boston, air at the 8:16 mark. We highly encourage you to listen to this informative and valuable webinar about the UVMLCOM/WCHN Global Health Program.

Grace Herrick returned to ACCESS, Uganda to observe the impact of preschool education on the children and families of Nakaseke. She met with children and their mothers, and supported the school with new educational resources.
Mark your calendars for Dr. Judith Lewis’ presentation about her recent trip to Uganda and global mental health at Norwalk Hospital’s medical grand rounds on September 27th at 8:00am.

Dr. Pierce Gardner, Senior Advisor at the Global Health Institute of Stony Brook University, will site-visit UVMLCOM from October 29–30 to become familiar with the Global Health Program, meet with the global health leadership—notably Dr. Richard Page, the new Dean of UVMLCOM—as well as the global health student interest group. He will also deliver a talk entitled “Academia and Global Health: Benefits and Ethics.”

Dr. Einterz, author of Life and Death in Kolofata, will site-visit UVMLCOM from September 5–7 to meet with the global health leadership, speak to the student interest group, and give a presentation.

**Member Highlight**

**DR. JUDITH LEWIS**  
**PROGRAM DIRECTOR OF THE PSYCHIATRY DEPARTMENT AT UNIVERSITY OF VERMONT MEDICAL CENTER (UVMMC)**

About five years ago, we at UVMMC were given the opportunity to establish a global mental health rotation for our residents in affiliation with Danbury Hospital/WCHN. My experience establishing a global mental health program with my colleagues at the Makerere University College of Health Sciences (MakCHS) has been surprisingly smooth, thanks to tremendous collaboration among the members of MakCHS and its clinical training sites, the UVM Department of Psychiatry, and WCHN.

Through this program, we aim to expose our residents to the practice of psychiatry in Uganda and the presentation of psychiatric illness in an unfamiliar setting and culture while reciprocating the experience by hosting our Ugandan colleagues here in the U.S., sharing educational resources, and engaging in global mental health research.

My global health experience in Uganda opened my eyes in many ways. A month since returning to Vermont, I continue to have a more centered and realistic approach to my daily practice of psychiatry. In the future, I hope to identify a junior faculty member who can oversee this rotation and build collaborative bridges with the clinicians, faculty, and residents at Mulago and Butabika hospitals. For budding global health advocates: keep your goals modest and your heart wide open!
Global Health Article of the Month

National Geographic Explorer Reza Helps Refugees Tell Their Stories

“For magazines like National Geographic, Time and Life, photographer and explorer Reza has traveled to more than a hundred countries, photographing conflicts, revolutions, and both manmade and natural disasters. The resulting photos of his half-century in the field are intended to capture the beauty of humanity that prevails despite the situation.”

Calendar

July 1: Dr. Jonathan Kandiah, internal medicine resident at Norwalk Hospital, travelled to Vietnam for the global health elective.

July 1: Fourth-year UVMLCOM student Khaled Al Tawil travelled to Kazan, Russia for the global health elective.

July 1: Dr. Stephen Scholand, Site Director for the Vietnam and Zimbabwe global health elective, met with Tendai Machingaidze, Associate Site Director for Zimbabwe University, and Amanda Kardys, UVMLCOM ’20 to discuss Tendai Machingaidze’s new role in the global health program.

July 5-7: Dr. Stephen Scholand, Site Director for the Vietnam and Zimbabwe global health elective sites, travelled to Cho Ray Hospital for a brief site-visit to meet the new leadership of their global health programs.

July 9: Dr. Robyn Scatena, Associate Director of Global Health Program at Norwalk Hospital, travelled to Cho Ray Hospital for a two-week capacity building visit.

July 11: Dr. Majid Sadigh met with the global health leadership of Sacred Heart University’s Global Health and Physician Assistant programs to discuss collaboration with ChoRay Hospital.

(left to right): Tendai Machingaidze, Site Director for Zimbabwe University, Amanda Kardys, UVMLCOM ’20, and Dr. Stephen Scholand, Site Director for the Vietnam and Zimbabwe global health elective

Photo left: Dr. Stephen Scholand, Site Director for the Vietnam and Zimbabwe global health elective sites, with the leadership of the Training Center at Cho Ray Hospital, Vietnam
July 12: Dr. Mariah McNamara, Associate Director of Global Health at UVMLCOM/WCHN, returned to the United States from a three-week trip in Uganda where, in addition to supervising medical students, she met with Dr. Isaac Okullo’s family, Estherloy Katali, Coordinator of Global Health at ACCESS, as well as the leadership of St. Francis Naggalama Hospital.

“My visits the past few days have been wonderful. I am grateful for the opportunity to be apart of this global health family.”
-Dr. Mariah McNamara

July 17: Dr. Majid Sadigh met with Dr. Robert Jarrett to discuss his recent trip to Vietnam, as well as future steps toward establishing a new partnership in China.
July 18: Four KSMU residents began the global health elective: two in the Dominican Republic, and two in Uganda.

July 19: Drs. Huỳnh Quang Đại, Mai Anh Tuấn, Võ Ngọc Anh Thơ, Peter Agaba, and Anna Nalbat, global health scholars hosted at WCHN, spent the afternoon visiting Danbury Hospital where they were introduced to members of the global health program and received a tour of the Danbury Hospital campus, including the Simulation Center and Emergency Department.

July 21: Dr. Robyn Scatena returned to the United States from Vietnam.

July 23–24: Dr. Majid Sadigh made an administrative site-visit to UVMLCOM, during which he met with medical education and global health leadership.

July 25: Dr. Paul Bachman, senior faculty at UVMLCOM, returned to the United States from Uganda.

July 25: Dr. Majid Sadigh met with Dr. David Kramer, WCHN Endowed Chair in Orthopedics, to discuss the possibility of collaboration with the UVMLCOM/WCHN Global Health Program.

July 26: Dr. Majid Sadigh met with Mr. Rudy Ruggles to inform him about the structure and content of the UVMLCOM/WCHN Global Health Program.

July 27: Fourth-year RUSM students Adam Cerissi, Elizabeth Abels, Krist
Quinones-Lara, Mahvish Qazi, Srijita Sarkar, and Shikha Talwar returned to the United States from their global health electives.

July 31: Dr. Anna Nalbat, Neurologist at KSMU, returned to Russia from the United States.

**August Calendar**

**August 1**: Global Health Panel at Pediatrics Resident Conference at UVM

**August 2**: First-year UVMLCOM students Christina Dawson and Katherine Callahan return to the U.S. from Uganda.

**August 3**: UVMLCOM Global Health Associate Director and Program Coordinator tour a bed and breakfast place to rent two rooms in Burlington for potential use in September and October for Global Health Program Scholars and guests

**August 5**: Fourth-year UVMLCOM student Khaled Al Tawil returns to the U.S. from Russia.

**August 7**: Global health dinner with Global health Scholars and members in Norwalk

**August 9**: Second planning meeting for Dr. Einterz and Dr. Gardner’s visits to UVM

**August 11**: Norwalk Hospital internal medicine residents Dr. Jonathan Kandiah, Dr. Amanda Lindo, and Dr. Sharon Sukhdeo return to the U.S. from their global health electives.

**August 13**: Global Health Leadership Team meeting

**August 17**: Student Interest Group fair to inform first-year medical students about global health program during orientation week

**August 27**: Global Health Leadership Team meeting
Global Health Spotlight

Early Childhood Development Program

The African Community Center for Social Sustainability (ACCESS) is a grassroots organization that reaches out to the community through medical, educational, and economic empowerment initiatives. The ACCESS Early Childhood Development Program (AECDP) is a recently developed strategic initiative used to promote interest in education in children and their parents.

KLM airlines has given AECDP a donation to help provide enrolled children with extra play and school materials. On August 28th, a few KLM members visited the ACCESS headquarters where they participated in AECDP activities including playing, eating, singing, and dancing. The event was attended by sixty-six mothers and children.
August 20–25: Dr. Jeffrey G. Wong, Associate Dean for Medical Education at the Penn State College of Medicine, worked with 14 faculty from the UNIBE School of Medicine in Santo Domingo, Dominican Republic. Largely based on basic science modifications of the well-studied Stanford Faculty Development Center (SFDC) teaching model of faculty development, these workshops were designed to help enhance effective teaching abilities in a multitude of teaching venues and for a variety of learners. Participants found the four-day course challenging, helpful, and rewarding.

Cross-cultural faculty development for basic science teachers in the Dominican Republic. (Photo credit: Dr. Jeffrey Wong).

Updates to the Newsletter

Starting this month, we are beginning a new section for the newsletter which includes a clinical vignette, photo quiz, as well as a photo and reflection contest. We highly encourage you to participate. Annually selected winners will be granted free registration to either the annual Consortium of Universities for Global Health conference or Unite For Sight conferences.

Photo Quiz

WHAT IS YOUR DIAGNOSIS?

Submit your answers here>>
Clinical Case Quiz

WHAT IS YOUR DIAGNOSIS?

A family of green monkeys at the Mulago Guest House, Kampala, Uganda. (Photo credit: Dr. Majid Sadigh)

Photo Contest

WHAT IS YOUR DIAGNOSIS?

Mulago Guest House (Photo credit: Dr. Majid Sadigh)
Reflection Contest

Submit a 300-word reflection from your global health elective experience to win free registration to annual CUGH conference or Unite for Site Conferences.

My Experience at a Glance

JOHN ISA NGBEDE
PGY1, INTERNAL MEDICINE DEPARTMENT
KAZAN STATE MEDICAL UNIVERSITY, RUSSIA.

I knew little about the complications of AIDS (tuberculosis, cryptococcus meningitis, CMV, toxoplasmosis, candidiasis), or diseases like tetanus until I realized they were immersed in the daily routine here at Chirudu Hospital in Kampala, Uganda. Slim disease, as it was known when it was first discovered here, affects about 7.3% of the population, and brings many with advanced complications to Chirudu Hospital.

Lack of diagnostic resources demands deep medical knowledge and clinical judgment from medical caregivers, as these are the only diagnostic tool in their hands. Interactive seminars and lectures given by a team of doctors, nurses, and pharmacists had the most educational value for me, and was a showcase for demonstration of amazing intellectual capacity, teamwork, and up-to-date medical knowledge of caregivers at MakCHS.

The insight and medical knowledge I have acquired in Uganda will help me educate young medical students and peer residents at KSMU toward understanding the cultural and economical attributes of healthcare delivery as well as the significance of taking a good history, performing a meticulous physical examination, and using scarce resources judiciously and thoughtfully.

Focusing on the education of the next generation of medical students and instilling the principles of global health has the potential to positively impact the future of the medical landscape.
Announcements

On August 17th, Dr. Bulat Ziganshin traveled to Miramar, Florida to present about global health elective opportunities available to senior RUSM students. He also met with Alexa Gomez, MBA, Assistant Director for Hospital Support Services, and Ainsley Kerr, MBA, Global Health Elective RUSM Coordinator, to discuss plans for a site-visit to Uganda to market initiatives for global health at RUSM, as well as changes to student selection and orientation procedures.

After reading the article “The Economic and Social Impact of Informal Caregivers at Mulago National Referral Hospital, Kampala, Uganda,” written by Mitra Sadigh et al., two women will work with JENGA Community Development Outreach, a non-profit charity base in Uganda, to support informal caregivers at Mulago.

Read the article here >>

Dr. Stephen Winter will move out of the state of Connecticut, but will continue to support the WCHN Global Health Program as off-site Senior Advisor.

The Russian translation of Tropical Medicine 101 and 202 modules are under print.

A panel discussion of ethical challenges titled “Bi-Directional Engagement: A Practical Tool for Navigating Ethical Dilemmas in Global Health Education Partnerships” has been submitted to CUGH. If accepted, the panel would be moderated by Dr. Anne Dougherty (UVM), and panelists would include Dr. Nelson Sewankambo (MakCHS), Dr. Pierce Gardner (Stony Brook University), Dr. Harriet Mayanja (MakCHS), Dr. Suzanne Sarfaty (Boston University), and Dr. Tracy Rabin (Yale University).

The Global Health Program is supporting the MakCHS International Office in establishing the Global Health Information Center (GHIC) which will be a cornerstone in the training and orientation of Global Health Program participants in Uganda. The space has been acquired and Dr. Joseph Kajubi, Emergency Department Residency Program Director at Makerere University, has accepted to spearhead this new initiative. He is currently drafting a proposal for the function and structure of the GHIC.

Dr. Joseph Kalanzi, (left) a resident in the pioneer class of the MakCHS Emergency Medicine Program, is currently leading development of the emergency medicine education and training programs for medical students and pre-hospital care providers.

The Memorandum of Understanding (MoU) for Collaboration between Dalian Municipal Central Hospital in China and WCHN is in the final review process.
The MoU for collaboration between the Makerere University School of Public Health (MakSPH) and WCHN is in the early review process.

The MoU for collaboration between Walailak University in South Thailand and WCHN is ready to be signed.

Program Policy Updates

All global health program participants in Uganda will have access to a kitchen, refrigerator, and microwave if they are interested in preparing their own meals.

Participants staying with Drs. Isaac Okullo or Sam Luboga’s families will be served free breakfast and dinner during the weekdays.

Article of the Month

A Remembrance of Life Before Roe V. Wade

This article recounts the experience of a young nurse who suffers severe health complications from an illegal abortion that ultimately cost her life. Her story reminds us of the significance of the landmark Roe vs. Wade case of 1973.
Ethical Dilemmas in Global Health

Integral to global health experiences, a wide range of ethical dilemmas impact students, residents, physicians, institutional leadership, and patient populations. Each month, we engage in discussions around an ethical dilemma and ponder the responses from one global health leader in the Global South and one in the Global North. This month, Dr. Cyrus Kapadia, Professor Emeritus of Internal Medicine at Yale University, shares his response to the post entitled “Financial Barriers and Interventions.”

Calendar

**August 1:** A Pediatrics Residents Global Health Lecture was held at UVMCOM.

**August 3:** A dinner was held with Vietnamese Global Health Scholars and Dr. Winter’s family (photo right).

**August 3:** Dr. Mariah McNamara, Associate Director of Global Health, and Audree Frey, Program Coordinator of Global Health at UVMCOM Larner, toured two rooms for rent in Burlington for potential use for the Program Director and/or international guests.

**August 4:** First-year UVMCOM students Christina Dawson and Katherine Callahan returned to the U.S. from Uganda.

**August 4:** A social gathering (photo left) was held with Global Health Scholars, Dr. Stephen Scholand, and Dr. Bulat Ziganshin’s family.

**August 5:** Fourth-year UVMCOM student Khaled Al Tawil returned to the U.S. from Russia.

**August 7:** Global Health Leadership at WCHN held a dinner (photo below) in Norwalk for Dr. Stephen Winter and Global Health Scholars from Vietnam.
August 9: Dr. Mariah McNamara, Associate Director of Global Health, Audree Frey, Global Health Program Coordinator, and Carole Whitaker, Assistant Dean for Medical Communications and Planning at UVMCOM, held a second planning meeting for Dr. Einterz and Dr. Gardner’s visits to UVM in September and October, respectively.

August 9: Dr. Eunice Kang, Internal Medicine Residency Program Director at Norwalk Hospital, met with Dr. Bulat Ziganshin, Dr. Robyn Scatena, Dr. Stephen Winter, and Laura Smith to discuss global health elective applications for Norwalk residents/faculty.

August 9–22: Dr. Sadigh travelled to Uganda for a site-visit where he met with MakCHS leadership, including Principal Professor Charles Ibíngira and Deputy Principal Professor Isaac Okullo, as well as many global health members.

August 11: Dr. Jonathan Kandiah, Internal Medicine resident at Norwalk Hospital, returned to the U.S. from Vietnam. Meanwhile, Dr. Amanda Lindo and Dr. Sharon Sukhdeo, Internal Medicine residents at Norwalk Hospital, returned to the U.S. from Uganda.

August 13: A Global Health Leadership Team meeting was held at UVMCOM.

August 17: A Student Interest Group fair was held during medical student orientation week at UVMCOM. The Global Health Leadership Team staffed a table at the event to encourage student interest.

August 22: Members of the Global Health Program met with the Danbury Hospital Foundation to discuss preparations for the 2019 WCHN/UVMCOM Global Health Day, which will be held in Connecticut on June 4, 2019.

August 27: A Global Health Leadership Team meeting was held at UVMCOM.

September Calendar

September 1: Dr. Sahand Arfaie, Co-Director of MICU at Fargo North Dakota, travels to Uganda for a capacity building visit. He will work directly with Dr. Jane Nakibuuka, Director of the ICU in Mulago Hospital, to improve the management and administration of critical care services and to participate in education of medical students and residents.

September 3: Dr. Shalote Chipamaunga, senior lecturer at the University of Zimbabwe, arrives in Burlington, VT for a three-week trip during which she will learn about the UVM Teaching Academy as well as the undergraduate, postgraduate, and continued medical education programs at UVMCOM and WCHN.

Photo Left: Dr. Jane Nakibuuka, Director of the Mulago Hospital ICU, welcoming Dr. Sahand Arfaie to the Mulago ICU. “We are excited to work side-by-side with Dr. Sahand Arfaie on many educational projects in the Mulago ICU.”
**September 6:** Dr. Ellen Einterz, Dr. Majid Sadigh, and Dr. Margaret Tandoh present “Humanitarian Emergency Response” at the Emergency Medicine Grand Rounds at UVMMC from 1–2 PM.

**September 6:** Dr. Ellen Einterz presents “Life and Death in Kolofata” at the Davis Auditorium UVM Medical Center at 7 PM.

**September 10:** A Global Health Leadership Team meeting will be held at UVMMC.

**September 10:** Fourth-year AUC students Sameena Haque and Gina Cha travel to the Dominican Republic; fourth-year AUC student Zohaib Zia and fourth-year RUSM student Claudia M. Fontes to Vietnam; and fourth-year RUSM student Laurenie Louissaint to Uganda for the global health elective.

**September 11:** A debriefing session will be held with students who returned from Uganda in August.

**September 12:** Dr. Tracy Rabin from the Yale University School of Medicine presents “Perspectives in Physician Obligation to Treat” at the Global Health Grand Rounds at Danbury Hospital.

**September 12:** Dr. Majid Sadigh presents “How Did it Begin?”, the story of the Global Health Program, at the Philanthropy Dinner.

**September 15:** Dr. Shalote Chipamaunga visits Danbury Hospital.

**September 24:** A Global Health Leadership Team meeting will be held at UVMMC.

**September 26:** Dr. Emmanuel Denis Morgan, a pathologist from MakCHS, arrives at Danbury Hospital for six months of training.

**September 27:** Dr. Judith Lewis presents on Global Mental Health at the Norwalk Hospital Medical Grand Rounds.
Photo News

Dr. Majid Sadigh with Professor Isaac Kajja, Head of the MakCHS Department of Orthopedic Surgery.

Leadership of St. Stephen’s Hospital.

The WCHN flag will be posted in the newly constructed Microbiology Lab at Naggalama Hospital.

Dr. Majid Sadigh with ACCESS Leadership

The Hypertension Clinic at Nakaseke Hospital.
Global Health Spotlight

Life and Death in Kolofata

Dr. Ellen Einterz, Peace Corps Volunteer and medical doctor in Africa for thirty years, spoke at the UVM Emergency Medicine Grand Rounds at noon, and later in the afternoon to the community, about international development, humanitarian assistance, medical treatment in impoverished communities, armed conflict, and refugees in Africa. Here is the video of her presentation and the link to her book, Life and Death in Kolofata: An American Doctor in Africa, which is a narrative along with a compilation of her letters home.
**Dr. Anne Dougherty**, Director of the Global Women’s Health Program at UVMCOM, Dr. Mundaka, an OB/GYN physician from Uganda, and Dr. Sarah Heil, a PhD researcher at the Psychiatry Department at UVMCOM, were in Nakaseke to adapt a family planning intervention targeting postpartum women used with opiate-dependent women in Burlington.

Over the last six months, they have investigated methods of adapting the U.S. intervention to be effective and culturally appropriate in rural Uganda. The intervention utilizes incentives such as garden seeds, pampers, and sugar for women to come for one-on-one family planning education sessions where they receive a selected family planning method free of charge.

During their most recent trip to Nakaseke, the group held a community sensitization event targeting men whose knowledge of family planning is often inaccurate. They also held soccer matches with boda boda drivers and taxi drivers as competing teams. During half-time and between matches, the team discussed family planning myths and answered questions. The boda boda team won the match, and received a goat as the winning prize.

**September 4- 20:** **Shalote Chipamaunga**, PhD, Senior Lecturer at the Department for Health Professions Education at University of Zimbabwe College of Health Sciences, visited UVMCOM and WCHN. During her trip, she met with the leaders of medical education and the Global Health Program including the Active Learning, Clinical Simulation, and Teaching Academy teams as well as the Office of Medicine Student Education and Continuing Medical Education Program. She also attended administrative meetings and clinical conferences.

*Photo Left: Shalote Chipamaunga, PhD receiving a gift from the UVMCOM global health leadership.*
The Distinguished Philanthropy Dinner was held at Rolling Hills Country Club in Wilton, Connecticut on Wednesday, September 12th. John Murphy, Chief and Executive Officer of Western Connecticut Health Network, spoke about the impact of philanthropy and the humanistic mission of medicine, while Dr. Majid Sadigh, Director of the Global Health Program, presented “Encounters at the End of the World” in which he reflected on his early observations in Uganda.

Photo Left: (left to right) Dr. Võ Ngoc Anh Thọ, Dr. Mai Anh Tuấn, and Dr. Huỳnh Quang Đại at the Distinguished Philanthropy Dinner.
Member Highlights

Agnes Muhum The Unsung Hero in the Room

BY JAMIDAH NAKATO

Have you ever felt that there were moments when you forgot to appreciate someone? That someone who inspired you, brought out the best in you, contributed to your every breath, perhaps without you even noticing it? It happens even to the best of us.

During my time working as administrator of the Yale Global Health Office, I spent the majority of my time with participants of global health, which included faculty, residents and students. I also worked with a woman who cleaned and organized the office and the house where our visitors stayed. She washed their clothes and organized their rooms. She was always there on-hand to help everyone the best she could. For the duration of her work with the Global Health Program, she was greatly admired for her honesty, reliability, and caring character.

She always had a beautiful smile. If you want to know how important a person is to you and what impact they have on your life, try doing without them. Better yet, try finding a replacement. This might take eons, if it happens at all. If you have someone akin to this, please treasure her. You never know until she is gone that she was the unsung hero in the room. You yourself might be the unsung hero in the room to someone. You never know.

Dr. Sahand Arfaie, Critical Care Specialist and Co-Director of the Critical Care Unit at Essential Health-Fargo in North Dakota, returned from his three-week volunteer trip at Mulago Hospital, Uganda where he discussed a variety topics and protocols with the anesthesiology, internal medicine, and emergency medicine residents and faculty, in addition to providing care to patients in the critical care unit.

Participation in the program here in Mulago Hospital has certainly opened new perspectives in terms of the gravity of need for human capacity, especially in light of the imminent opening of the new Mulago Specialty Care Hospital, along with the strive for the best care possible given the circumstances, hope, relentless pursuit of improving quality of care and knowledge, and humility. I have been humbled to be around clinicians with little to no expensive/often wasteful objectivity that we are so accustomed to in North America via various diagnostic testing/modalities. Despite the odds and the uncomfortable sensation of “not knowing what is happening,” they manage to use their best judgment with their eyes and ears, skills we have leisurely stepped away from in lieu of luxurious diagnostic tools.

I have come to realize that life here, due to various restraints, forces one to be patient. Patience that often times cannot be an option in a critical care setting, and yet looms over this seven-bed medical intensive care unit. Despite its pace, things happen. Patients get to live another day. Patience, coupled with medical decision-
making under restraints that often lead to choices that would be utterly unacceptable in North America, are a normal day of life here in Mulago. I have come to accept that given the circumstances, one needs to adapt drastically, an adaptation that is necessary for international capacity building.

Photo Left: Sahand Arfaie (right) and Joseph Kalanzi (center) in the Emergency Department at Mulago Hospital, Uganda

Reflections

Calmness and Stillness of Uganda

AMANDA LINDO, MD
INTERNAL MEDICINE RESIDENT, PGY-2
NORWALK HOSPITAL

In Entebbe airport, things were calm. No one was hurried or in a rush. Everyone worked together almost as one cohesive being. Once home, the little things like carpeting, a queen-sized bed, and a proper shower felt like the world’s most extravagant luxuries. I had to do laundry (which for once I actually enjoyed, as I had missed the smell of my laundry detergent, oddly enough) and get groceries, which was something similar to taking a child to a toy store for the first time: overwhelming and magical. Having not seen much fresh produce or meat in a while, I went a little overboard. I bought so much produce, some that I don’t like that much but was just so happy to see (such as lettuce), that some of it went bad. I immediately felt terrible for wasting food, remembering the staff at St. Stephen’s Hospital with their one daily meal of matoke. I made a mental note to be more conscientious in the future.
There was no doubt that I missed the simplicity of Uganda most after returning stateside, but I was happy to be home with family and friends. I had returned a completely different person—more independent, more mature, more cultured, and more confident. The personal and professional challenges I encountered made me a stronger person and clinician. I am grateful for having travelled abroad for the first time, and to Uganda specifically. I don’t think I could have felt more welcomed anywhere else, which is what ultimately made the experience so positive. I had never considered visiting East Africa before this trip, but now it will not be long before I find myself heading back to Uganda.

Reflections

GINA CHA (AUC)
SANTO DOMINGO, DOMINICAN REPUBLIC

On Thursday, the doctors and I walked the streets of the neighborhood that we worked in and checked people’s blood pressure. Doctors educated patients with elevated blood pressure on the importance of being compliant with their medications and/or seeking medical care. On Friday, the doctors and I attended a local elementary school where we gave a presentation on the importance of hand washing.

(right to left): Dr. Jomar Florenzán, Dominican Republic Site Director, Sameena Haque, fourth-year medical student at AUC, Gina Cha, fourth-year medical student at AUC, and Danny Capellan, Coordinator of the International Affairs Office at UNIBE.

SAMEENA HAQUE (AUC)
SANTO DOMINGO, DOMINICAN REPUBLIC

The tiny clinic was composed of only three or four exam rooms. On this particular day, the electricity was off. We started seeing patients in the dark, using the flashlights on our smartphones to conduct physical exams. I remember thinking of the disparity and the juxtaposition of two worlds. How do we live in a world where one person has a light in their pocket and another has none at all?

ZOHAIB ZIA (AUC)
HO CHI MINH, VIETNAM

I feel honored to be learning from the doctors, nurses, and my fellow students at Cho Ray Hospital. I hope to bring an enhanced range of skills and a lifetime of experiences back with me to apply to my career in medicine.
CLAUDIA FONTES (RUSM)
HO CHI MINH, VIETNAM

I was unaware that scooters are the most common form of transportation within the city. It seems as though there are no real rules of the road, as the bikes yield at red lights and then proceed despite our right-of-way. The best way I can explain what I saw is “organized chaos.” This type of driving would not work in the U.S. In fact, many people would get hurt. However, in Ho Chi Minh City it makes sense, it works, and it’s the way of life.

LAURENIE LOUISSAINT (RUSM)
NAGGALAMA, UGANDA

After drainage of her abdominal wound, the decision was made to place a drainage in her abdominal cavity to allow continuous drainage over the next few days. The surgeon turned to me and asked, “what instrument would you like to use to drain the fluid, doctor?” I immediately responded with the option of a JP drain. He replied, “when you have a limited amount of resources, you have to think outside of the box.” He then turned to one of the nurses who brought over an NG tube to which he made multiple holes at the end. He left it in the wound, sutured the external end of the remaining makeshift drain to the superficial skin, and placed an iodide-bathed gauze and dressing was placed over the open wound instead of a wound vac. Those words, “think outside of the box,” stuck with me.

Announcements

Congratulations to Dr. Robert Kalyesubula, Founder of the African Community Center for Social Sustainability (ACCESS), for being the winner of the 2018 Segal Family Foundation Grassroots Champion Award.

Read more about Dr. Kalyesubula and this award here.

We welcome Dr. Benjamin Clements as Director of the Global Health Program at the UVM Department of Family Medicine. Dr. Clements is a family physician and Assistant Professor at the University of Vermont Medical Center and Larner College of Medicine, where he completed both family medicine residency and medical school. He is a 2004 graduate from Bates College with a B.A. in English, and has a post-baccalaureate degree in Health Sciences from Harvard University. He is a Fellow of the Academy of Wilderness Medicine, board member of the Vermont Academy of Family Physicians, and member of the Gold Humanism Honor Society.
Congratulations to Dr. Tran Song Toan from Vietnam for successfully completing four months of cardiology training at Danbury Hospital.

Left: Dr. Tran Song Toan receiving a cardiology-training certificate.

Dr. Sadigh will be spending Mondays and Thursdays at Norwalk Hospital.

We welcome the arrival of our Vietnamese colleagues to WCHN for training in pulmonary, sleep medicine, and cardiology for a four month training.

Photo left: Dr. Nguyen Thanh Nam, pulmonologist (left) and Dr. Duy Khoa Duong (right) pulmonologist. and photo right: Dr. Vo Phuong Loan, cardiologist.

Follow-Ups

Memorandum of Understandings (MoU)

• MoU with Dalian Municipal Central Hospital has been completed.

• MoU with Walailak University, South Thailand is in its final stages and under review by the Legal Office of Walailak University.

• MoU with MakSPH is under review by the Legal Office of WCHN.

The Russian translation of Tropical Medicine 101 and 102 will be out of print this month.

New Policies

Free breakfast and dinner will be provided during weekdays at the homestays (Reverend Professor Sam Luboga and Dr. Isaac Okullo) and St. Francis/Naggalama Hospital.
Ethical Dilemmas in Global Health

Integral to global health experiences, a wide range of ethical dilemmas impact students, residents, physicians, institutional leadership, and patient populations. Each month, we engage in discussions around an ethical dilemma and ponder the responses from one global health leader in the Global South and one in the Global North. This month, **Dr. Lauris Kaldjian, Director of the Program in Bioethics and Humanities at the University of Iowa Carver College of Medicine**, shares his response to the post entitled “Financial Barriers and Interventions.”

Article of the Month

The Death and Rebirth of Globalism

“The US Government is leading a movement to reverse globalisation. The principal victims, Bremmer argues will be those living in some of the most rapidly changing nation-states today—South Africa, Nigeria, Egypt, Saudi Arabia, Brazil, Mexico, Venezuela, Turkey, Russia, Indonesia, India, and, of course, China. “Their fate”, Bremmer writes, “will determine the future of the entire 21st century global economy”... Anti-globalist trends are causing pain and suffering—to migrants, to the poor, to the socially excluded. But some countries are trying to use global health as an instrument to turn back this tide of isolationism.”

Photo and Clinical Quizzes

Answer to the last issue photo Quiz:

The patient was a sixteen-year-old Muslim laborer from Kampala with constrictive pericarditis from tuberculosis (engorged jugular veins, swollen cervical lymph nodes, and massive cardiomegaly from mainly pericardial effusion). To save his life, an emergency drainage of pericardial fluid was crucial. He died less than twelve hours after this photo was taken, because the surgeons were engaged in congested operating rooms.
Answer to the last Clinical Case Quiz:

The photo shows Dr. Kenneth Opio, a gastroenterologist at MakCHS, performing an endoscopy on a patient with engorged esophageal varicose veins from a disease call “schistosomiasis” in Pakwach Hospital. Close to Gulu and Murchison Falls by the West Nile in Uganda, Pakwach is a town where almost everyone has Schistosoma, a worm that lives in the human portal system, causing liver damage and portal hypertension. During this time, our group with Dr. Opio was conducting a study on the etiologies of gastrointestinal bleeding in this community.

Photo Quiz

An Old Man in Cho Ray Hospital, Ho Chi Minh, Vietnam

WHAT IS YOUR DIAGNOSIS?
Photo Contest

A view of Cho Ray Hospital from the Rainbow Hotel, Ho Chi Minh, Vietnam (Majid Sadigh)

Early Morning Shopping (Majid Sadigh)
Ever heard of the term “twitcher”? This word may conjure up eye or muscle twitching. Or maybe something related to seizure activity, which is exactly how this birder describes this phenomenon: “The very mention of some exotic avian delight, a purple Peruvian rock thrush for example, sends them into paroxisms. They literally twitch; hence “twitchers.” (Terrence Hollingworth, Blagnac, France).

I never knew this group existed until this week. During the migration season, which is occurring now, a small fraction of birds become disoriented and lose their way. Instead of flying north, they fly south, ending up in unusual places. Their mistake becomes an opportunity for this specific group of people. Once sighted, the network of twitchers lights up with posts and communications. These individuals will literally drop everything they are doing and drive long hours or canoe or fly out (often across many countries) in order to add the bird of their list of rare bird sightings. Some birdwatchers may take offense to this term, and push to differentiate themselves from what they consider more of an adrenaline seeker/checklist ticker without real appreciation or care for birds or the community of birdwatchers. They argue that once twitchers capture the bird on their lens, they do not consider the bird for another moment, even though these birds struggle with exhaustion and fear, and often ultimately die in the foreign setting.

Others argue that even serious birdwatchers, those who can spend hours watching even the most commonplace of birds, can still jump up at the chance of such a rare sighting. After all, poets of all ages have written about all kinds of birds, from pigeons to skylarks, representing the most singular of human emotions, as in Emily Dickinson’s “Hope” is the thing with feathers, even as an exploration of humanity’s transience and the inevitability of death, as Keats’ nightingale.
Calendar

September Calendar

September 6: Dr. Sadigh made a monthly administrative visit to UVMLCOM.

September 6: Dr. Sadigh participated in the panel “Perspectives on Emergency Care Needs” at the UVMLCOM Emergency Medicine Grand Rounds.

September 6: Dr. Ellen Einterz presented at the UVMLCOM Emergency Medicine Grand Rounds at noon, as well as at a community presentation at the Davis Auditorium in the evening.

September 9: Two fourth-year AUC students, Sameena Haque and Gina Cha, arrived to Santo Domingo where they are being hosted by Mr. Ogando’s family for a six-week global health elective.

September 9: Zohaib Zia (AUC) and Claudia Fontes (RUSM) traveled to Vietnam for a six-week global health elective.

September 10: A Global Health Leadership Team meeting was held at UVMLCOM.

September 11: A debriefing session was held with UVMLCOM students Katherine Callahan and Nina Dawson.

September 11: A planning meeting for Global Health Bridge was held with the Active Learning Team.

September 11: Laurenie Louissaint (RUSM) traveled to Naggalama, Uganda for a six-week global health elective.

September 12: A planning meeting was held for a visit from Dr. Pierce Gardner, Senior Consultant to the Global Health Institute at Stony Brook University, in October.

September 12: Dr. Tracy Rabin, Assistant Director of the Office of Global Health at the Yale University School of Medicine, presented “Perspectives on the Obligation to Treat: Global Health, Resident Training, and Health Emergencies” at Danbury Hospital’s Global Health Medical Grand Rounds.
**September 12:** The Distinguished Philanthropy Dinner was held at Rolling Hills Country Club in Wilton, Connecticut.

**September 12:** Dr. Vo Thi Phuong Loan arrived from Vietnam to Danbury Hospital for a four-month cardiology training.

**September 17:** A pre-planning meeting was held for the 2019 Global Health Day celebration with the global health leadership and a member of the WCHN Foundation.

**September 20:** Dr. Tran Song Toan, a global health scholar, left Danbury Hospital after completing a four-month cardiology training.

**September 24:** A Global Health Leadership Team meeting was held at UVMCOM.

**September 24:** Dr. Nguyễn Thanh Nam and Dr. Dương Duy Khoa arrived from Vietnam for a four-month pulmonary training at Norwalk Hospital.

**September 26:** A dinner was held with Dr. Judith Lewis and the WCHN medical education and global health leadership.

**September 27:** Dr. Judith Lewis, Director of the Psychiatry Residency Program, and Megan Gething, fourth-year psychiatry resident at UVMCOM, presented “Global Mental Health in Uganda” at Norwalk Hospital’s Global Health Grand Rounds. Read about Dr. Lewis’ experience during her recent trip to Uganda here.

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**October Calendar**

**October 1:** Global health elective applications are due for first- and fourth-year medical students.

**October 4:** UVMCOM students Katherine Callahan and Nina Dawson speak at Essex High School to Global Leadership Program students about their global health experience in Uganda this past summer.

**October 9:** Drs. Vo Ngoc Ahn Tho, Mai Ahn Tuan, and Huynh Quang Dai return to Vietnam after a four-month training in infectious diseases and intensive care medicine.
October 19: Zohaib Zia (AUC) and Claudia Fontes (RUSM) return from a six-week global health elective in Vietnam.

October 19: Gina Cha (AUC) and Sameena Haque (AUC) return from a six-week global health elective in the Dominican Republic.

October 19: Laurenie Louissaint (RUSM) returns from a six-week global health elective in Naggalama, Uganda.

October 22: Elena Gueorguiev (AUC) travels to Kazan, Russia for a six-week global health elective.

October 22: Dr. Daria Artemeva arrives from Kazan, Russia to Danbury Hospital for a six-week neurology training.

October 29–30: Dr. Pierce Gardner, Senior Consultant to the Global Health Institute at Stony Brook University, Visiting Professor meets with the UVMLCOM medical education and global health leadership, and presents “Academia and Global Health: Benefits and Ethics” at the Family Medicine Grand Rounds.

**Photo News**

Amanda Lindo, with St. Stephen’s Hospital medical staff

Maritza Ogando, Sameena Haque, Gina Cha and Jesus Ogando at Ogando’s Homestay

from Left to Right: Mariah McNamara, Margaret Tandoh, Majid Sadigh, and Ellen Einterz during Panel discussion on “Perspectives on Emergency Care Needs”

Shalote Chipamaunga with Audree Frey in UVMLCOM