A Celebration of Global Health Day
APRIL 4-5, 2016

Monday, April 4
8:00 am Family Medicine Grand Rounds “Orphan Advocacy: The Genesis of ACCESS”
DAVIS AUDITORIUM
ROBERT KALYESUBULA, M.D.
President and Founder of ACCESS-Uganda
Rainer Arnhold Teaching Fellow, Makerere University, Uganda

10:00 am–5:00 pm GLOBAL HEALTH:
HOEHL GALLERY
Reflections and Photographs Showcase

12:00 Noon Buffet Lunch, Recitations, and Presentation of Awards
HOEHL GALLERY
for Reflections and Photography

4:00 pm Dean’s Distinguished Lecture on Global Health
SULLIVAN CLASSROOM
Toward Becoming an International Medical University
MED ED 200
ALEXEY SOZINOV, M.D., Ph.D., D.Sc.
Rector, Kazan State Medical University, Russia

Tuesday, April 5
10:00 am–5:00 pm GLOBAL HEALTH:
HOEHL GALLERY
Academic Poster Showcase

4:00 pm Reception and Presentation of Awards
HOEHL GALLERY
for Academic Posters

6:00 pm Community Medical School Presentation “Global Health: A View from Uganda”
CARPENTER AUDITORIUM
ROBERT KALYESUBULA, M.D.
President and Founder of ACCESS-Uganda
Rainer Arnhold Teaching Fellow, Makerere University, Uganda

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Editor: Mitra Sadigh
Designer: Sylvie Vidrine, Graphic Designer, University of Vermont College of Medicine
Photography Credits: Tally Bower, Michelle Dorwart, M.D., Alec Jacobson, Stephen Maurer, Majid Sadigh, M.D., and Tyler Sizemore
The practice of global health connects us to people of diverse perspectives and colors, and upon reflection, to ourselves and the lived experience. We learn to respect differences and recognize shared humanness. We cultivate pure human connections rooted in empathy, unhindered by superficial separations created by classism, racism, colonialism, and structural oppression. We are invigorated by the fortune of understanding others through their histories, strengths, weaknesses, fears, and failures. We learn about ourselves by reciprocating that vulnerability, by being exposed openly. In that openness we discover weaknesses, impurities, prejudices, and deficiencies in our own substance. We are then driven to improve our humanness: to become more caring, more compassionate, more aware, and more giving.

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

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

Majid Sadigh, M.D.
Director of WCHN Global Health Program

When is Our Change for the Better Coming?

Why do patients seek medical attention late in Uganda?

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

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

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

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

On Tuesday, we settled to work in the HIV clinic at Nakaseke District Hospital. Expressionless patients seated in rows turned to look at our foreign faces as we entered the building. HIV prevalence in the district is higher than the Ugandan national average, with over seven percent of individuals infected with the virus. It thus seemed apparent that this afternoon would be overwhelming—not only due to the number of patients in the waiting area, but also based on my understanding of the social, financial, and emotional repercussions of the illness. However, as the clinic began, patient after patient seemed both happy to see new faces and in relatively good health despite their disease and their consequent daily doses of antiretroviral therapy and prophylactic treatment. Young women entered the room emulating fountains of feminine youth, filling me with hope for their long futures ahead. The only real complaint we had received was of back pain from several elderly patients, which was not surprising given their age and lifelong work as farmers.

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

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

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

The Day I Broke the Golden Rule

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

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

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

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

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

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

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

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

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

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

Getting the Pulse Back

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

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

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

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

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

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

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

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

The palliative care team, comprised of nurses and two doctors, sees patients from all over the hospital referred for consultation. From this single service, I referred for consultation. From this single service, I was the first time they had heard that their disease is not reversible. Most of the time, we just listened.

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

You Are An American Doctor

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

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

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

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

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

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

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

On arriving at my dorm within the compound of Pariyenyatwa Hospital (Pari) here in Harare, Zimbabwe, I was offered a Zambezi beer by my new (and unexpected) roommates and advised to read Joseph Conrad’s Heart of Darkness. Much derided (and unexpected) roommates and advised to read

As I begin my rotation here at Pari, the intellectual standpoint that the medical system I am seeing here is miles and miles apart from what I have learned, but I know that I will fall short of capturing the penetrating essence of this place.

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

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

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

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

The dream-sensation that Conrad describes in Heart of Darkness factors heavily in our day-to-day life here in Harare. The past week and a half feels like an eternity and I feel utterly lacking in my ability to relay the essence of this place, much less the overwhelming sense of shock I feel on a daily basis. However, contrary to Conrad’s morose refrain, I do not dream alone. Fortunately, Richard Mendez, Dr. Ruth Musselman, and Dr. Pat Wetherill, my global health team here in Zimbabwe, are all right here beside me. I am thankful for the support, the very personal education afforded me by my program, and the opportunity to share and reflect on this dream like reality.
Nothing Is As Simple As It Seems

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

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

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

One morning on antepartum rounds we encountered a woman who had been admitted for management of a miscarriage at thirty-four weeks. The patient was sitting up in bed, distraught, with tears rolling down her cheeks. My heart ached for her as the doctor presenting her story told us that this was her second third-trimester miscarriage. I could not have imagined the next thing he was about to say: “And early this morning we learned that her husband has died after being attacked by a group of thieves in South Africa.” My fellow resident and I looked at each other, shocked, as the rest of the team continued discussing the patient’s care. While they of course found the woman’s story to be terribly sad, it was as unsurprising to the rest of the group as it was incomprehensible to us. But despite the many sad and shocking stories of delayed medical care and severe complications of pregnancy, it has been a pleasure to join the excellent team of doctors and midwives working in the labour ward where 40-50 babies are born every day. There are no epidurals, no birthing tubs, no electronic fetal monitoring, but amazingly strong women birthing a lot of adorable babies.

Nothing Is As Simple As It Seems

A Symphony of Spring

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

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

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

Despite the struggle of assimilating into an unfamiliar landscape, this gathering of refugees finds joy in the small moments of connection. A mother’s love, an older sister’s hug, a sunny day to share a cup of coffee; it is a mosaic of love that weaves together to create a brilliant illustration of humanity shining boldly against the backdrop of this small corner of thick Dominican forest.
Tatiana Afanaseva, M.D.
J1 Scholar from Russia
USA, 2015

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

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

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

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

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

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

Reconsidering Place and Purpose

Stephen Maurer, ’18 (far left)
University of Vermont College of Medicine
RUSSIA, 2015

My time in Kazan was a blast. The city and the Republic of Tatarstan have an incredibly rich culture, and the cultural atmosphere here is one of peace. Mosques and churches often sit adjacent to one another, a demonstration of the religious tolerance between Islam and Christianity so present in this city, as in the Kazan Kremlin. And for the historically bent, this thousand-year old city bears plenty of monuments and relics of the past.

The people I met have been incredibly kind and accommodating – many also seemed to enjoy gift giving. This experience has made me want to explore the world and expand my knowledge of medical systems around the world and the obstacles faced by different populations. It has truly been a great opportunity to meet so many people from different cultures and hear their points of view. I appreciate that we are partnered with this university – this has been a valuable experience for me, and I think Kazan is a wonderful site for collaboration. I am grateful for the opportunity to gain new perspectives and ideas about the world, medicine, and life in general.

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

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

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