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Winter 2011

International Update Newsletter

Being the Change: Ending “Duffle-Bag” Medicine

Natasha Demehri, FSU College of Medicine – Class of 2012

As the American medical community continues its involvement in global healthcare, critics continue to criticize the practice of so-called “duffle bag medicine,” a reference from a 2006 JAMA article which addressed the lack of sustainability of international medicine. Through the founding of the non-profit organization ‘Heal the World,’ however, the methods of international healthcare have been advanced, and we can now ensure both effective and sustainable healthcare.

In 1988 Paul Farmer established a

method of healthcare in Haiti that revolutionized the way physicians think of global health. His well-known method involved educating local healthcare workers, using local resources, expanding the local infrastructure, and working with the community to help it “heal itself.” Using this idea we can better address important global health challenges such as the “brain drain” that continues to plague much of Africa and Southeast Asia.

(On the picture: Natasha Demerhi performing HIV tests in post-war Gulu, Northern Uganda)

(...continued p 4.)



Save the Date!

2011 AAFP Family Medicine Global Health Workshop

- ✓ Learn the latest in global family medicine development;
- ✓ Develop lasting approaches to sustainability issues;
- ✓ Network with leading international developers;
- ✓ Earn CME Prescribed credits.

October 13-15, 2011
Hotel Salomar
San Diego, California

Visit www.aafp.org/intl/workshop for details



American Academy of Family Physicians
Center for International Health Initiatives
Winter 2011

2010 AAFP Scientific Assembly through the eyes of International Members

Portuguese Residents Learn about Family Medicine in the United States

Tiago Vilanueva, FM resident, Algueirão – Rio de Mouro Health Centre Group, Sintra, Portugal

Luís Filipe Cavadas, FM resident, Lagoa Health Centre Group - Matosinhos Local Health Unit, Matosinhos, Portugal

From Portugal to Denver

American Family Physician had until 2010 a Portuguese language version (six issues per year), which hosted an annual contest based on Multiple Choice Question tests. The three candidates having the highest scores as well as a fourth candidate drawn from the remaining pool of participants would earn a fully-paid trip to the AAFP Scientific Assembly the following year. After taking part in the contest throughout 2009, both of us ended up with a ticket to Denver in 2010. As such, we came in loaded with high expectations regarding the scientific value of the event.

American pulling power

The American style of providing postgraduate education and training is definitely unique, at least compared to what we are used to in Portugal and the rest of Europe. During the preparation to the conference we were very impressed, for instance, with the fact that they had received all the slides of almost all the presentations practically two weeks in advance.

One thing is for sure, we left with the idea that American-style education and training makes you definitely feel alert and not feeling like you are going to fall asleep. Better still, it makes you leave craving for more! Even though some lectures were better than others, and some were more engaging than others.



Portuguese FM research was represented by two projects carried out by Dr. Cavadas (right): Aspirin in Primary Prevention of Cardiovascular Disease and Postpartum Contraception.

Eager to learn

The hands-on lectures, with paid volunteers and live video footage, were a new concept to us. We particularly enjoyed Dr. Scott Flinn's workshops on several sections of the muscular-skeletal examination, which allowed us plenty of time for peer-to-peer training after seeing Dr. Flinn explain and demonstrate several physical examination gestures on

a volunteer, and provide invaluable take-home messages. The fact that the session was videotaped and projected on a giant screen allowed us to understand some finer details of the examination that would not have been possible otherwise.

Reaching out to the world

In this meeting we had the unique opportunity to meet very important people in North American and World Family Medicine like Professor Richard Roberts and Professor Daniel Ostergaard.

We thus engaged in a lively debate encompassing fundamental aspects of world Family Medicine, as well as ongoing projects that enable the provision of equitable primary health care, particularly in the developing world. There was also room to discuss and present innovative projects, and among them, a Portuguese project carried out by the authors of this article. Using an email listserv for Portuguese family medicine residents and young family physicians, we have created Virtual Conferences. Special guests, who have already included Drs. Richard Roberts and Barbara Starfield (both from the USA), answer questions and engage in stimulating discussions with the participants of the listserv, which currently has about 860 subscribers from Portugal and some other countries like Spain, Brazil, and the United Kingdom.

We were fortunate enough to have passed by the AAFP International Section booth and chatted with the staff, as that's how we found out about the International Networking Meeting just hours before. We thus had a chance to meet doctors from both the US and overseas who had worked all over the world and had amazing stories to tell. It was particularly interesting to hear about the projects carried out by the AAFP in countries like Georgia or Tajikistan, which we seldom hear about in the news.

Conclusion

We really enjoyed our time in Denver, and managed to take some valuable knowledge and skills back home. If it had not been for the AFP Portuguese edition, we would have not been able to come over and experience Family Medicine in the United States. And while we were there, we always had the feeling that we can practice Family Medicine all over the world, in countries with different cultures, beliefs and in the way of performing some skills. We all are Family Physicians having the same goal – to take care of our patients in a holistic and family-oriented way. Wherever we are, Family Medicine feels like the best specialty of the World!

Family Medicine at the Top of the World

Doug Lindberg, MD

Awaking to a crisp Himalayan morning never gets old. We sit around our kitchen table, sipping “Top of the World” coffee, and wonder what adventures this new day will bring to our little hospital in Far Western Nepal. We moved to Dadeldhura five months ago after having done a rotation here in 2006 during our residency, which we both did in Waukesha outside Milwaukee. I’m serving as medical director, and Ruth is juggling her roles as mom, doctor, teacher, etc. We’re loving the experience of fulfilling our dreams of working here!

HDCS TEAM Hospital Dadeldhura is set in the hills with breathtaking views of the Himalayas to the We have a great location right off the main road. So in spite of our rural location, we’re still accessible to people even in remote areas, some of whom still have to travel up to two days or more to get to us. At this point, we’re the only long term doctors working in the hospital, although we usually have the help of Nepali residents and expatriate volunteers as well. We’re the main medical center for one million people in the seven Far West districts. Thus, we never know who or what is going to walk through the door.

A typical day starts with rounds at 8. We usually have at least forty “birami” (patients) in the hospital, so our beds tend to be pretty well occupied. We break for a morning all-staff devotion meeting at 9 and then finish up rounds. The typical day then becomes atypical. A patient who was attacked by a bear may be in the ER, we see a woman with a ruptured uterus every two to three weeks which obviously pulls several staff into the OR for a couple of hours, road traffic accidents are not an infrequent occurrence, and meetings always seem to be creeping in and demanding our time and attention. The more everyday and typical rhythms of the hospital and outpatient department also unfold around us, with close to two hundred outpatients being seen per day and 1700 deliveries taking place annually. All told, no two days are the same. In fact, in our time here thus far, there has yet to be a day when I haven’t seen something I’ve never seen before, or pathology that’s advanced to uncharted waters (i.e. a woman with postpartum hemorrhage with a hemoglobin of 1.1). Never a dull moment! The day usually wraps up by around 6, and I jump on my mountain bike and pedal about a mile back home, often with a list of things I need to look up or take care of that evening running through my mind.

Poverty grips the hills of Far Western Nepal. It’s amongst the poorest places in a country that consistently ranks near the bottom in health and development statistics. We struggle with this reality each day. What do we tell a mom who delivers a baby boy who has spina bifida when the nearest neurosurgeon is eight hundred kilometers away and the cost of the surgery and aftercare would be several years



Dr. Lindberg with his patient who is on his way home with his wife after a long hospitalization

worth of wages? But at the same time, this reality presents us with the fulfillment of serving our neighbors and knowing that if it weren’t for our hospital, they wouldn’t receive the care they need. The woman with the hemoglobin of 1.1 lived. Patients are receiving DOTS for their TB and regaining their health. Prenatal care is being provided. All of our ladies who’ve come in with uterine rupture since our arrival have walked out of the hospital. The knowledge that we’re making a difference buoys us each day even as we face the difficult realities of practicing medicine in an under resourced situation.

The mid level provider practicum is in full swing this week. We have at least two of these three month classes each year, where we take ten local health assistants working in rural district health posts and put them through a program to improve their skills. They’re incredibly resourceful and eager to learn, and we’re impressed with their clinical acumen and willingness and ability to serve in such remote places. We also will be starting a skilled birth attendant class later this year along with expanding our family planning services. We have students and residents with us all the time, both Nepali and expatriate. The training aspect of the hospital makes it an exciting and dynamic place to work!

Who knows what the years that lie ahead will bring. We have dreams, to be sure. Expanding our community health outreach, starting a hospice program, finishing our new hospital building which we’re currently fundraising for, and even starting a family medicine residency are all things we talk about while sipping chiya with our cohorts here. But for now, we continue to learn about our community and our hospital- the needs, the strengths, the challenges. With seven of the ten tallest mountains being in Nepal, we really do live at the top of the world. And after the long years of training and dreaming to serve in this place, working here makes us feel that way each day!

Being the Change

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On a trip to post-war Northern Uganda in 2009, our team addressed this challenge by using the country's own resources – Clinical Officers. These healthcare workers are the equivalent of U.S. Physician's Assistants, and in Africa their degree is much less marketable than a Medical Degree. This essentially leaves Clinical Officers as the only medical hope left for war-stricken towns of Africa. On our trip we treated 1,749 patients and distributed 93,000 vitamins, 600 reading and sunglasses, 400 pounds of medicine, and 5,510 packages of agricultural seeds. We completed 281 lab tests, did 74 ultrasounds, fed over 1,000 people, de-wormed 975 villagers, and counseled over 100 trauma victims. At the end of the day, however, our most sustainable impact was teaching the clinical officers through classes in infectious disease and medical care, permitting them to care for the local community after we left.

Whether improving water filtration systems in Costa Rica, working with local volunteers to desensitize children to the sounds of war in Africa, or completing dental hygiene education in India, the impact of sustainable care must be recognized as the most priceless asset that we carry with us.



Natasha Demehri (5th from right) and fellow Medical Students from FSU College of Medicine stand alongside their partnered Clinical Officers in Gulu, Northern Uganda. Along with a group of physicians they helped train the Clinical Officers and learn from them to help provide sustainable care



WONCA Conferences in 2011 at a Glance:

See Wonca website www.globalfamilydoctor.com for more information

❖ 2011

21 – 24 February	Asia-Pacific Regional Conference	Cebu Philippines	Paradigms of Family Medicine: Bridging Old Traditions with New Concepts	http://wonpacebu2011.org/
8 – 11 September	Europe Regional Conference	Warsaw Poland	Family Medicine - Practice, Science and Art	http://www.woncaeurope2011.org

AAFP Family Medicine Global Health Conferences and Meetings in 2011:

- International Networking Meeting, a special event during the 2011 AAFP Scientific Assembly, Orlando, FL, September 14-17, 2011. Contact Alex Ivanov for more information – aivanov@aafp.org
- Annual AAFP Family Medicine Global Health Workshop, San Diego, CA, October 13-15, 2011. See the workshop website www.aafp.org/intl/workshop for more information

Global Health rotations at residency programs – opportunities for students

Israel and Palestine - A Global Health Elective in a Complex Setting

David McRay, MD, John Peter Smith Hospital Family Medicine Residency Program

As a part of the expanding international health curriculum at the John Peter Smith Hospital Family Medicine Residency Program in Fort Worth, TX, Dr. David McRay will be leading a third annual Global Health Elective in Israel and Palestine in March 2011. The rotation is designed for second and third year residents at JPS but is open to fourth-year medical students as well, when space is available. While the goals of the elective focus on some aspect of each of the six ACGME core competencies for residents, the primary objective is to enhance the residents' understanding of systems-based care through exposure to the wide spectrum of health care systems present in Israel and the Occupied Palestinian Territories. The group will spend one week interacting with the students, residents, and faculty of the Department of Family Medicine at Ben Gurion University in Beer Sheva, Israel. They will learn about the well-developed, primary-care based, single-payer, tax-funded Israeli health care system that guarantees every citizen access to high quality medical care.

While in the West Bank for the final three weeks, the residents and students will visit hospitals and clinics in Qalqilya, Ramallah, Bethlehem, and Hebron. They will gain insight into the complex, fragmented health care system available to the Palestinians by examining the UN refugee



Dr. McRay teaching the ALSO course in Jericho, Palestine

programs, the Ministry of Health of the Palestinian Authority, the NGOs that provide a wide variety of health care services, and the limited private options available to those who have the means to afford them. They will also have an opportunity to examine the history of the Israeli-Palestinian conflict and the implications of the continuing military occupation on the provision of health care in the Palestinian territories, as a result of restrictions on movement, barriers to care, and competition for limited water resources.

To find out what other family medicine residency programs accept medical students, see the AAFP Directory of Residency Programs with International Rotations – www.aafp.org/international/residencies

A Path toward Sustainable Health Programming in Haiti

Becky Eleck, MD

In Haiti, a foreigner's first visit is jokingly referred to as a doctor's visit. They hope that it is painless and over quickly. To build any sustainable, culturally appropriate program, relationship building must come first. Unfortunately, without this vision, programs dreamt up in the US and other "developed" countries often fail.

As a resident at Middlesex Hospital Family Medicine Residency Program, I am in a 4-year program with a Global and Community Health track. Through rotations in Honduras and Guatemala, journal clubs, constant mentorship, international conferences and working with global and local community organizations, I discerned my own career in global health. Flexible rotations gave me the time to study Creole and attend cultural seminars in Haiti. I focused on building relationships in Haiti and began the slow process of building a health promoter training program. For the past year, I partnered with productive cooperatives Haiti (pCH), a Haitian NGO, that specializes in economic development,



Sharing a sip of water with Veland, a young friend in Port-au-Prince

cooperative formation, agricultural training and adult literacy. They embrace the idea of incorporating a health delivery model that empowers local villagers. Utilizing Helping Health Workers Learn, and other materials from the Hesperian Foundation, I wrote a proposal to add health promoter training to pCH's mission and presently am

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writing course plans with role plays and active learning to accompany the text of [Where There is No Doctor](#).

Ultimately, I built a partnership that will enable me to work stateside, maintain a family life, and commute to Haiti for four 2-week blocks each year where I will teach

and precept health promoters. This may not have been possible without a longitudinal program and such a dedicated discernment process. Other family medicine residencies should consider this four-year model as an alternative to the one-year global health fellowship.

(Please direct your questions or comments to Dr. Becky Eleck – beckyeleck@yahoo.com)

Creating a Global Health Curriculum on a Budget

Ron Chambers, MD

During residency training I undertook a global health experience called “Project Kenya” which was one of the most rewarding experiences in my medical career. I was truly amazed by the number of people our trip was able to help, and the desperate poverty the people we served live in day-to-day. It was “eye opening” for everyone involved; for me the experiences both emotionally and medically ranked paramount above anything I saw or faced in the U.S. during my medical school and residency training. Although exhausting both physically and emotionally, a trip such as this can provide a depth and understanding of serving those truly in need that many physicians may never gain.

Family medicine is uniquely suited to serve the global health community. Unfortunately residency programs may view training residents in global health a daunting task and the added value may seem ambiguous. Student interest, however, has dramatically increased with 6.2% of U.S. medical students undertaking an international health experience in 1986 compared with 27% in 2006. It is therefore reasonable to argue that at a time of decreased interest in family medicine the recruiting value of a solid global health curriculum may benefit competitive residency programs as well as help residents gain the skills, knowledge and awareness to become physician-leaders prepared to actively face global health challenges.

Curricular development remains a difficult undertaking for community hospital based programs with scarce resources. With collaboration and the use of online resources, however, interested faculty may offer solid training with little to no monetary investment of the residency program. Our curricular structure, didactic lectures, informational checklists, skills workshops, focused/longitudinal coursework, and evaluations have been successfully put in place without funding, allowing



Ron Chambers, MD, reviews wound care with medical student Vanessa Ray

a global health experience that promotes education, cultural exchange, and hands on experience for interested resident physicians using a needs assessment driven program design. Online resources including aafp.com, globalhealtheducation.org, isp.swanhi.org were used for development. For further information and an overview of our curriculum please contact: ronald.chambers@chw.edu.

Disclaimer

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Physicians With Heart in Tajikistan

"Looking down, I could see something from the peak that was great – a family doctor who had dedicated himself to the people of his community. In that moment, I felt humbled and honored to have spent a day with greatness" - Richard Roberts, MD, President of Wonca, View from a mountain, WONCA News, Vol. 36, No. 6 December 2010 (www.GlobalFamilyDoctor.com). Dr. Roberts was a member of the PWH delegation in October 2010 as well as Drs. Gilbert, Casey-Ford and Bruehlman who share their 2010 PWH Tajikistan Airlift experience in this section.

The Future Fetoscope

Lisa Gilbert, MD, resident-recipient of the AAFP Foundation PWH scholarship

The sky is a dusty blue as we drive past rows of mountains and fields to reach the village. Several clinics are cradled against these mountains, right up against the border of Uzbekistan. The small village called Tractor is cared for by a lovely doctor, shy at first, uncertain of what to do with us American doctors. Her first patient is a young pregnant woman. Dr Mahfuza realizes that I am unfamiliar with the fetoscope and her hands guide me to find the position of a baby within the amorphous tummy of a patient. Then this little devise is placed on the abdomen and somewhere over where the baby's heart might be; I smile to hear the almost silent low thub thub thub thub thub.

Leaving the clinic, Dr Mahfuza invites us to accompany her on some home visits. We take off our shoes to enter the first home, our right hand placed over our hearts and enter with a smiling "Salaam aleikum." On the center of the floor lies a "Persian" rug and along the edge of the rug are soft floor cushions for kneeling, drinking chai and in our case, for examining newborn

babies! The first patient is a young woman who had just delivered some thirty-six hours before. This woman was at term and feeling pressure, thought she merely needed to use the bathroom. She found herself catching a baby boy instead. His shoulders landed in the dirt next to her clay house and she scooped him up in her dress, hobbling back to the house. They then frantically called Dr Mahfuza, who came in time to deliver the placenta, wash the baby who still a bit sandy and wet, and slightly bruised. But now he is doing well, healthy and happy. We are given fresh sweet persimmons to eat, which grow all over their town.

We did another home visit and returned to the clinic where we are



Total population	6,640,000
Gross national income per capita (PPP international \$)	1,560
Life expectancy at birth m/f (years)	63/66
Healthy life expectancy at birth m/f (years, 2003)	53/56
Probability of dying under five (per 1 000 live births)	68
Probability of dying between 15 and 60 years m/f (per 1 000 population)	225/177
Total expenditure on health per capita (Intl \$, 2006)	71
Total expenditure on health as % of GDP (2006)	5.0

Source: <http://www.who.int/countries/tjk/en/>

given pilaff to eat, a greasy rice dish that is a specialty, to be eaten with one's right hand. Dr Mahfuza quietly gives me a long silk cloth to be made into a dress, to remember Tajikistan. Like Josephs coat of many colors, it is a whirlwind of hues, design and texture. It is rich. The persimmons, the pilaff, the fabric, the fetoscope. It puts me in a state of surreal awe at the generosity of those who have so much "less" than I do.

The following day was the Family Medicine Symposium at the medical school for family doctors across the nation. This is the climax of our trip, filled with inspiring lectures that that make me crave to be a better doctor, to be more generous with my

time and energy, to promote and fight for the health of my patients. In the afternoon, there are four breakout sessions. I teach on Respiratory Illness, to a group of physicians many of whom have been practicing medicine longer than I have been alive. I find this incredibly daunting, especially as my topic seemed so simplistic. I had expected young students or residents and instead found myself faced with wise grey-haired men two to three times my age, wearing stern expressions. In the end, they too are generous enough to accept even with what little I could give.

For a debriefing, we are asked to bring an item that symbolizes the trip to Tajikistan. There are many different kinds of items and stories with each person, from kleen-ex to gifts that people gave them, to shoes, to dresses to photographs. I realized that my item was something I do not yet own- a fetoscope.

Through this cone-shaped instrument, I heard heart tones, soft, distant, fast. Yes, I have much yet to learn about so many things...about physical exam skills, about medicine, about cultures, about how to make the most of limited resources. Even the fact that I do not own a fetoscope is telling of how much I have been blessed and yet how poor I am in other ways. As I reflect, I think of how we all must look and listen hard for 'new life' that is being conceived in a person, in a tribe, in a nation. While not always apparent at first glance, there is always a fragile life that must be guarded and cherished. What a privilege to be able to place my hands, even for a moment, on a pregnant nation, a "third-world country", and feel the tiny kick of what good things are emerging. What a privilege to make a difference in our world.

Tajikistan Reflections

Gwen Casey-Ford, MD, resident-recipient of the AAFP Foundation PWH scholarship

The patient, a young woman with a headscarf, a velure dress and tired eyes, explains her symptoms: headaches, insomnia, fatigue. She thinks perhaps she has an infection. The doctor, an equally young woman with a starched white lab coat and a lovely smile, knows more. She knows this patient quite well, knows that she is recently married, has been unable to conceive, and has a difficult relationship with her mother-in-law. She knows that this is a terrible situation for a young woman in Tajikistan. She diagnoses the patient with depression. This seems like a perfect Family Medicine moment, the sort of thing that transcends international boundaries. Then the doctor turns to me and, earnestly seeking new information from her foreign colleague, inquires if I have any opinions about the choice between Prozac and amitriptyline for the treatment of depression. She sometimes uses Prozac, she explains, but for many patients it is prohibitively expensive.

I realize that I have no opinions about this at all. This question had never occurred to me. As a young American doctor, I have, in fact, never used amitriptyline for the primary treatment of depression, because here Prozac is \$4 /month.



Left to right: Drs. Rosanne Gager, Casey-Ford and Gilbert, FM residents, at the Family Medicine Symposium in Tajik State Medical University

I have countless memories from Tajikistan - visiting numbers of hospitals and clinics; meeting many wonderful people; sitting on a bus, caught between a very large wedding party and an equally large herd of cows; drinking holy water from Mecca, and (last but not least) watching the gentleman in the park across from our hotel who, for a fee, will take your picture with your choice of props: a large dilapidated teddy bear, a stuffed tiger with a cowboy hat, or a rocking horse. My most important memory, however, is of the devotion and true Family Medicine approach of the family doctors, like my colleague described above, whom I met in Tajikistan. This is quite a feat when you consider that, under the Soviet system, a well-child check required five specialists and took all day. The energy and intelligence that must have been necessary to create even a nascent family medicine system from such a fractured base and with so few resources is truly extraordinary. Yet, these physicians and their patients are daily faced with challenges that I cannot imagine because - like my Tajik colleague's dilemma - they have never occurred to me. They deserve all the support we can give them.



Care at gunpoint

Rich Bruehlman, MD, Co-Chair of the PWH Family Medicine Symposium Planning Committee
(This story was sent as an email while Dr. Bruehlman was still in Tajikistan)

Hello to all. Our Physicians with Heart trip to Tajikistan is going very well. Those of you who have done medical work in developing countries know that you are likely to return with an inspirational story or a new hero. Here is a story that I hope will make you feel proud to be a family doctor, proud to help our residents graduate from our program, or proud to work with family doctors.

Wednesday we traveled by car about 90 minutes west of the capital Dushanbe to the rayon (province) of Tursunzade, very close to the border with Uzbekistan. The 8 family doctors on the trip split into 4 groups of 2 each and went to different rural health centers. To say these centers had limited resources would be understatement. We met a woman family doctor there by the name of Dr. Mahfuza. She has served the community for over 20 years. Originally a pediatrician, she had completed a retraining program to become a family doctor.

Dr Mahfuza told us of a patient encounter in 1995, shortly after her graduation from medical school and during the civil war that raged on and off in Tajikistan for many years after the breakup of the Soviet Union. Three armed gunmen broke into her home and threatened to kill her husband and then 3 children if she did not come with them to treat one of their comrades-in-arms for a gunshot wound. She protested that she was a pediatrician (family medicine not yet recognized as a specialty) and had never held a scalpel blade in her life. Understand that medical school in Tajikistan starts right after high school, lasts 6 years, and is laden with lectures but offers minimal patient care experience. Nyet, come with us, you are a doctor, they said. She grabbed a



Dr. Mahfuza (middle) with PWH delegates, Drs. Gilbert (left), Bruehlman (right), and Alex Ivanov, AAFP International Activities manager acting as interpreter, in her office discussing the patient's (sitting) case

needle holder, a scalpel, some scissors (all unsterile) and some suture material. They drove her blindfolded to where their comrade lay bleeding with a GSW to the arm. The bullet was lodged in the fat but had not hit bone. It had created a flap laceration that required major suturing. She sterilized the instruments by pouring some of their vodka into a pan and lighting a match. She then successfully removed the bullet, opened an amoxicillin capsule and sprinkled the contents into the wound, and sutured the wound closed. No drain available. Then she prayed, for she felt certain that if he developed a wound infection, she and her family would be shot anyway.

A week later the 3 gunmen came again with her patient. His wound was not infected. She removed the sutures. Years later she saw the man again, who thanked her profusely for saving his arm.

- ❖ **Physicians With Heart is a collaborative effort between the American Academy of Family Physicians Foundation and Heart to Heart International, with significant assistance from the US Department of State. The partnership started in 1993 with the Airlift to St. Petersburg, Russia. Since that time, the project has delivered medical aid worth approximately \$150 million. This annual project has a three-pronged mission:**

Medical Aid procurement and delivery



Medical Education



Children's Project

