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Summer 2011

International Update Newsletter

Dare to Care: Lending a hand in Haiti

Kumapley Lartevi, MD, Georgetown Family Medicine, R2

On January 12, 2010 Haiti was struck by a 7.0 magnitude earthquake, the country's most severe earthquake in over 200 years. By February the Haitian government confirmed a death toll of 230,000. Since, an already impoverished country has been left to literally and figuratively pick up the pieces.

In an effort to assist the Haitian people, several organizations have given opportunities to volunteers to help in Haiti. As a second year Family Medicine resident seeking a way to contribute, I discovered the outstanding work being done by the CRUDEM Foundation in Milot, Haiti. As part of a team lead by faculty from Georgetown University School of Medicine and comprised of individuals with various specialty training, we headed to the town not too far from the large northern Haitian city of Cap Haitien. In Milot, we were based at Hopital Sacre Coeur: the largest private hospital in the North of Haiti. It is a 73-bed hospital that has provided uninterrupted service for 25 years.

During our mission, we taught a four-day course in

emergency obstetrics and neonatal resuscitation and provided a wide array of clinic care. Our clinical experiences ranged greatly. Images of the long lines of people awaiting evaluation outside several tents that were our clinics and urgent care facilities, remain vivid. Despite this bleak imagery, our days were generally optimistic and positive. From the compound where we resided, the sounds of children's laughter as they walked slightly after dawn in their uniformed school attire were the introduction to our mornings.



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Our days were busy and the hours at work were long. But the individuals in need of care compared to the small number of health care providers, often left one with a feeling that we were coming up short. Our days would end in fellowship. As with other meals, we would gather together for dinner and review the events of the day, brainstorm how we could improve our efforts and offer one another constructive feedback. With heavy eyelids emblematic of our hard day of work, those conversations would continue into the night until the group collectively decided it was bedtime. We were housed in a multi-room compound that had several beds in each room. At that point of the evening we would prepare for bed and the compound would quickly become quiet as everyone fell asleep. That silence would be interrupted early the next day with the sunrise as individuals awakened in attempts to intensify our efforts of volunteerism. This daily routine, with some variation, was reoccurring until our departure from Haiti.

Overall, we accomplish a lot on our mission. The course was well-attended and great strides were made

towards establishing a curriculum and furthering efforts to develop a sustainable model. Our clinical encounters further enriched the experience and provided much needed health care to those we treated. Working so closely with the other members of the team has forged a bond amongst the group that I am confident will remain strong into the future. It was the hope for experiences like this that attracted me to a career in primary care.

In closing, I would add that as medical providers, even if we consistently fall short on international missions, we must continue to persistently pursue perfection. As long as those who can contribute monetarily and professionally continue to do so, there will be hope for the underserved, disadvantaged and sometimes forgotten individuals in Haiti and elsewhere in the world. Tande!!! A Haitian Creole word often said emphatically to draw one's attention that simply means 'listen'. Collectively, we must continue to 'tande.' Consciously, we must strive to never let those voices grow quiet.

Disaster Relief in Japan Highlights Importance of Family Physicians

Ian Demsky

Associate Public Relations Representative, University of Michigan Health System

In recent years, University of Michigan (U-M) collaboration has helped bring family medicine training to Japan

When the earthquake and tsunami struck Japan on March 11, disaster teams rushed to treat those who were gravely injured. But in the days and weeks following the initial crisis, the largest medical challenge was not treating patients with traumatic injuries.

Providing routine care for people with a host of issues from chronic diabetes to imminent childbirth proved more challenging, says Michael Fetters, M.D., M.P.H., M.A., the director of the University of Michigan's Japanese Family Health Program.

In 2009, the program was awarded a \$1.4 million grant from the Shizuoka Prefectural Government to help establish a family medicine residency training program and help Japanese doctors revamp the way family medicine is practiced in Japan. Despite having a universal health insurance program, the health care system in Japan funnels specialists into offices where the majority of their work is general care. This setup does not leave them adequately prepared to contend with the broad spectrum of conditions seen in family practice, Fetters explains.

Recently, two of Fetters' colleagues from the U-M-affiliated Shizuoka Family Medicine program, visited the disaster zone: Shinji Tsunawaki, M.D., who is just finishing his first year of family medicine training, and Yosuke Fujioka, M.D., a former physician at U-M's Japanese clinic in Ann Arbor.



Shinji Tsunawaki, M.D., (masked) of the U-M affiliated Shizuoka Family Medicine program, assesses a pregnant woman who was stranded in a remote area following the March 11 earthquake and tsunami. Photo: courtesy of Dr. Yosuke Fujioka.

When they arrived in the town of Minami Sanriku on March 25, they discovered that those who had been seriously injured had already been treated by physicians from the Japan Disaster Medical Assistance Team and the Japan Red Cross.

Although primary care doctors have a national organization with a certification process, the government does not recognize the specialty and many doctors do not hold family physicians in high regard, Fetters says.

“When I arrived, there was a mismatch between many of the doctors’ training and the needs of the disaster victims,” Tsunawaki says. “There were a lot of people who needed ordinary care – the kind of stuff that family doctors do.”

Fujioka met a pediatric heart surgeon who encountered many primary care problems he was unsure how to treat, such as a diabetic patient having trouble with his insulin dosing.

“While the disaster relief teams were providing urgent care, most of the patients needed medications and support for chronic conditions, or they had the kinds of common problems that family physicians specialize in, like respiratory infections or diarrhea,” Fujioka says.

When the two doctors asked who was caring for the local pregnant women, the disaster teams were at a loss.

Fujioka and Tsunawaki examined one woman whose obstetrician was missing and believed to have been carried away by the tsunami. They provided prenatal care for her and the unborn child, and helped her get in touch with a hospital where she could get ongoing care.

They also provided prenatal care to another woman who was only two weeks away from her due date, but was stuck in a remote area with no car and no gas. Using an ultrasound machine borrowed from an Israeli disaster team, they were

able to scan the baby and confirm it was in a normal position for birth. They contacted Japan Self-Defense Forces, who transported the woman to a hospital two days later. Before they left the home, the doctors assisted a 92-year-old family member with terminal cancer who was having trouble breathing.

They also provided care to a woman who had recently given birth, which the pediatrician who stopped by the day before to check on her baby was not trained to do. “I am used to seeing pregnant patients, kids, old patients,” says Tsunawaki. “They’re just the usual things I do.”

While the scope of the tragedy still has not been fully assessed, Fetters says he hopes that the value of the efforts of the two primary care physicians and their colleagues with the Japanese Primary Care Association will earn them the respect and recognition they deserve. Yukishige Ishibashi, M.D., vice-president of the association, is proud of the work they were able to accomplish. “We had a chance to show that teams that included family doctors, dentists, nutritionists and pharmacists working together could play an important role,” he says.

More information can be found at www.pcfforall.primary-care.or.jp/eng/

The Red and Green Lunch

Perry Pugno, MD, AAFP Vice President for Education

One of the aspects of international travel that I appreciate the most is the opportunity to experience other cultures. For me, one of the best ways to do that is through their foods. I thoroughly enjoy sampling foods from around the world, and eating with the “locals” in the places and settings where the general population has their meals.

On a recent trip to Ethiopia, I found myself experiencing the cuisine of a culture that was very different from any other I had tasted before. It’s important to know that there are very few foods that I don’t enjoy eating. In fact, I LOVE food in general. However, during a noontime while at the Addis Ababa Medical School’s teaching hospital, a colleague and I found ourselves in hospital’s cafeteria food line. Being a bit late in the lunch line, we found ourselves with only a single option available to us. It was an “avocado juice and strawberry” drink. I really enjoy avocados, especially in Mexican food, and strawberries are one of my favorite fruits. But together...I wasn’t too certain that sounded like a good idea. Well, I was wrong. The combination, though unusual to a U.S. palate, was surprisingly good...and as a physician, I can attest to its obviously excellent nutritional value. So, I learned to be a bit more “open” in my thoughts about what might be a good combination.



One more experience from my Ethiopian food exploits happened when I was on my way back to the U.S. While in Addis Ababa I came to appreciate the spicy, hot combinations they sometimes cook into their meal items. I like “spicy hot” things, so while still in

Ethiopia, I bought a big bag of red pepper chili spices to bring home so that I could try out some of the recipes I collected while there. When I was going



through the customs, however, the officer pulled out my bag of chili powder and questioned whether I should be allowed to bring a food product like that into the U.S. I was “saved” by his supervisor, however, who looked at the bag of bright red powder and said, “Let him keep it. Nothing bad could possibly live in that stuff!” So, now I’m ready to make my own authentic Ethiopian food.

Lessons from Kapsowar

Elizabeth Elliott, MD, UPMC St. Margaret – Family Medicine Residency Program, PGY2

There are some things you just can't learn in the States. Well, maybe you can, but it would be a lot harder, take a lot longer, and Medicare certainly wouldn't pay for it. Thankfully, as one of the Global Health Track Residents in my program, I've had the opportunity to work and learn in a much larger classroom than our small hospital in Pittsburgh affords.

Daktari, Daktari, come quickly there is an emergency in male ward. CLICK! The nurse calling me hung up without giving me any opportunity for questioning, so I abandoned my post in female medical and went to see what the matter was. As I raced up the hill other emergencies I'd seen raced through my mind: machete wounds, perforated typhoid, tension pneumothoracies, and countless others. Of course when I arrived, it was none of the above. I found a 20-year-old man lying completely still on one of the many beds in the ward surrounded by worried family members. Over the next three whirlwind minutes I quickly assessed the patient who wasn't breathing and had a heart rate in the 50s, took a broken history from the family through the usual double translation system of tribal language to Kiswahili to English, discovered that the patient had poisoned himself with something that usually gets sprayed on cows, collected an ambu bag and started positive pressure ventilation, ordered 2mg of Atropine, and phoned Dr. Jones, my attending. Dr. Jones came and together we pumped the man's stomach, administered charcoal, and gave the patient so much atropine that I was in SVT. Still, he just wouldn't breathe. Since we obviously couldn't stand there and bag him all night, we ended up deciding to intubate him and allow his family to breathe for him through the night. Of course, that decision then led to an hour long thrash of trying to co-locate a blade, a tube, and a stylet. After calling in the OR manager from home and raiding the anesthesia stash, we did eventually succeed. Thanks to the dedication of his family who stood up bagging all night, and several gallons of atropine, the patient survived, walked, and talked.

The first lesson this patient taught me was to do what you know while calling for help. I had never seen organophosphate poisoning before, but it was the only farming poison I could come up with and it fit the pattern. I also knew that people die without air. So I bagged and gave atropine. Since that was all I knew, I then called my attending who was able to confirm the diagnosis and lead the rest of the resuscitation. So even, if like me, all you can remember is the ABC's, simply doing what you know will save lives and calling for help will deal with the rest.



The view from the main "hallway" of the hospital between women's wards

The next lesson was to know your environment and the resources which are available in it. As soon as I said "cows" Dr. Jones knew the diagnosis as it is unfortunately rather common in that part of Kenya. He also knew, after thirty minutes of futile hunting for tools, that calling the OR manager would work miracles. He had keys to every building on the property and could immediately locate any supply we needed. As a foreigner in that setting, I would have been left entirely floundering if he hadn't been able to locate those crucial resources.

Finally, and most importantly, I was struck by the indispensability of family. With the nearest ventilator 2.5 hours away over dangerous mud roads, that man would have died without his family stepping up to bag him. I think the same thing is true in America, it's just not quite so blatantly obvious, so we choose to ignore it. The simple fact of the matter is that we need families, patients need their support, and we as physicians need families to be intimately involved in their patient's care. With ventilators but without families we may survive but none of us will thrive.



Two of the "peds" patients outside the children's ward.

Hands On in Uganda

Katherine McClellan, MD, University of Utah Family Medicine Residency Program

I had performed hundreds of physical exams. I had been taught, observed, tested and graded on my ability to examine a patient. I was about to graduate medical school. But I had not recognized the young child's massive spleen. And as I listened to my classmate's quick lesson on how to correctly and adequately examine a spleen, I began to realize that he relied on his hands in a way I had never observed in my 4 years of medical education.

In January of 2011 I traveled to Gulu, Uganda to spend a month studying tropical disease and social medicine with a mixture of both American and Ugandan medical students. A large portion of our time was spent in the classroom learning about the deep and violent history of Northern Uganda or on site at various organizations observing different approaches to providing and funding medical care in these communities, but we spent the afternoons on the wards visiting, getting to know and examining patients.

I traveled through the wards with my Ugandan counterpart, Richard, who served as both a partner and a translator. Our job was to get a thorough history and physical and to present our assessment and plan back in the classroom, not so different from life at Georgetown.

To me, a young Ugandan child with subjective fevers needed a thermometer, a blood smear and an IV, STAT. Yet as I flitted about racking up medical costs and wondering how Richard could spend so long examining such a small body, he confirmed the diagnosis without me.

His hand had felt enough babies' brows to confirm a high temperature on his own. He began the spleen exam in the left lower quadrant, far enough from its anatomical location to palpate the border just past the umbilicus, nearly 4 times its normal size, and confirmed it with Castell's Sign, an exam I had only read about in books. The blood smear meant little to him, as the mother's story,



Dr. McClellan (center), Richard Tuwayenga (left), a Gulu University medical student, and an interpreter (right) taking tea between lectures.

patient's age and time of year all pointed to Malaria. He agreed with me on the IV.

On the one hand, we came to the exact same conclusion. On the other, if my blood smear returned normal or inadequate or lost in the system, the child may have waited through days of further tests and questions without the needed antibiotics.

Physical exam skills are not lost in American medical education, but they are not emphasized either. One of my greatest lessons during my 4 weeks in Gulu was to slow down and use my ears, my eyes, my hands and then use technology when needed. I may never see a case of malaria in my own clinic, but I will never again miss a child's enlarged spleen or rely on the chart instead of my senses. I am a better physician since my lesson that day and the answer was all in my hands.

*** For more information on the course, please visit <https://sites.google.com/site/socialmeduganda/home> ***

Family Medicine in Lebanon

Jinan Usta, MD, American University of Beirut Medical Center, Department of Family Medicine

In 1979, the American University of Beirut (AUB) initiated the first Family Medicine (FM) training program in Lebanon and the Arab world. It did later on contribute to the development of Family Medicine residency programs in Arab countries like Bahrain, Jordan, UAE, and Oman. The curriculum of the program was structured to follow the guidelines of the American Board of Family Medicine and to comply with the requirements of the Arab Board of Family Medicine. The training took place in ambulatory and hospital settings, and graduates were

granted accordingly admission privileges to non-critical units in almost all hospitals of Lebanon.

In 1995, the University of Saint Joseph (USJ) established another program with the collaboration of the University of Montreal that is following the Canadian standards. The training occurs primarily in ambulatory settings.

Residents of both Lebanese programs perform well in the American and Arab Boards of Family Medicine. They occasionally collaborate with each other in undertaking academic activities and in the promotion of the specialty through the Lebanese Society of Family Medicine.

Each program graduates around 4-6 residents a year following 4 years of training. So far there have been

Continued p. 7

Health Care in South Africa

Sondra Goodman, MS, AAFP Foundation, Manager, Programs and Grants

I recently attended a course on global health, offered through the University of Missouri-Kansas City (UMKC) and organized in collaboration with the University of Western Cape (UWC) in South Africa. Nine students from UMKC attended the course. We listened and learned from government officials, local leaders, and researchers, and had an opportunity to observe care delivery at several health care and community facilities in Western Cape Province.



Sondra Goodman, MS, MPA candidate, UMKC, with Gail Hughes, MPH, DrPH, Professor/Deputy Director, South African Herbal Science & Medicine Institute, UWC (left) and Ehimario Igumbor, MPH, PhD, Senior Lecturer, School of Public Health, UWC (right)

Experiencing a country's health care system is as much about what a nation values as it is about the health of the country. South Africa's health care mission is to improve the health of all people by providing a balanced health care system, in partnership with all stakeholders, within the context of optimal socio-economic development. I see the following underlying values in South Africa's health care mission: 1) health as a human right; 2) institutionalizing Traditional African Medicine, and 3) Ubuntu.

UBUNTU literally translates into "a human being is a human being through other human beings." As explained by Desmond Tutu and Nelson Mandela in 1999, Ubuntu means that one can't exist as a human being in isolation. It speaks about our interconnectedness and when one has this quality – Ubuntu – he or she is known for generosity. Ubuntu has various aspects and does not forbid self-enrichment, but when one does, the question is: are you going to do so in a manner that enables the community around you to also improve?

South Africa has a 2-tiered health system: public

and private health care. The public system serves 80% of the population: the private sector, 20%. Health care support is 98% government-funded, with the remaining 2% comprised of donor funds from community-based organizations, NGOs, and non-profit organizations. Both public and private health care sectors receive almost equal government support.

Primary Health Care (PHC) is the backbone of South Africa's public health care system. In addition, South Africa has layered health care that recognizes and provides both Conventional (allopathic) Medicine and African Traditional Medicine (ATM). ATM works as essential part of providing high quality, cost-effective and accessible patient-centered health care. The Traditional Health Practitioners Council regulates practitioners and integrates ATM into national health care policy. The Directorate of Traditional Medicine coordinates and manages ATM initiatives within the Department of Health. The medical doctorate degree in African Traditional Medicine takes 5 years of training - the same amount required for a doctorate degree in allopathic medicine. In addition, the government provides funding for ATM research and development.

Free health services offered in South Africa include family planning, infectious disease management, oral health services, immunizations, primary healthcare services, and antiretroviral treatment for AIDS patients. The values of the PHC system are: integrity, openness and transparency, honesty, respect for people, and commitment to high quality service. When visiting Delft clinic I saw the services described above being offered, and signs were posted throughout the clinic encouraging patients to file complaints if health care values were being breached. Focus in the clinic appeared to be on HIV/AIDS, TB, chronic and non-communicable diseases, maternal health and childhood health, and trauma.

Community empowerment is another important part of the patient-centered PHC system. Strategies we learned about at another clinic we visited, UWC Community Rehabilitation Project located in Mitchells Plain Township, included home visits, group meetings, outreach workers who provide health services to the community and community level health workers.

These are amazing times for healthcare in South Africa. Dr. Nomonde Xundu, Health Attaché, Embassy of the Republic of South Africa, spoke of alliances that enabled sweeping health reforms to pass, including the new National Health Insurance (NHI) scheme that received its first national funding in February 2011. Its goal is to enable the creation of an efficient, equitable, and sustainable health system in South Africa, based on the principles of the right to health, social solidarity and universal coverage. It has been projected that NHI will take 14 years to phase in.

Continued from p. 5: **Family Medicine in Lebanon**

120 graduates. Of the 60 family physicians practicing in Lebanon, 55 are graduates of these programs while the rest have migrated to practice abroad. The unstable political situation has pushed almost 20% of the graduates to migrate in pursuit of another nationality mostly in North America. Another 19% of the graduates sought higher and secure income in the gulf countries, including Saudi Arabia. It can be argued that the deteriorating economic situation in Lebanon has undermined the specialty instead of strengthening it despite the fact that Family Medicine is considered good in “cost containment”.

The health care services in Lebanon can be appropriately described as “open market”: the client has access to medical care he/she desires as long as he/she can pay for it (most clinic visits are paid out of pocket), or has adequate insurance. Most insurance companies have adopted the strategy of issuing a limited number of reimbursed clinic visits per year of enrollment. Patients tend to search the internet or ask someone around to know which specialty they need to consult for their ailment, owing to the limited number of reimbursable clinic visits. For the same reasons, and because of the abundant number of obstetricians and pediatricians in Lebanon, most family physicians have restricted their practice to general medicine with few (around 10) having pediatric patients and only one practicing obstetrics.

Moreover, to ensure a stable income, almost all family physicians enrolled either in administrative jobs (health management consultancies within Ministry of Public Health, insurance companies, United Nations, drug company) or as physicians in primary care centers run by private nongovernmental organizations or institutions. In these centers, physicians are usually underpaid and pressured to see more patients in a short period of time, therefore relying more on referrals and investigational workup to make proper diagnoses. Moreover, in the

absence of proper referral channels, most referred patients are ‘lost to follow up’ by being referred back and forth among specialists, making it difficult for the family physician to provide comprehensive care, assure continuity and coordination of care, and become the patient’s advocate. In such set up, the family physician is perceived as less knowledgeable doctor, and maintaining a good doctor- patient relationship becomes a challenge.

This perception of “incompetency of family physicians” is furthered by the national social security fund and the insurance companies, who, in their attempt to do cost containment, made their approvals for costly diagnostic radiology requests or prescription medications issued by family physicians conditioned by the counter approval of specialists in related field. In addition, their reimbursement for the professional fees of family physicians is comparable to a general practitioner (physician who did not go through residency program) although Family Medicine is recognized as specialty.

All of these factors contribute to the “brain drain” of Family physicians who are “migrating” to countries where they feel family medicine is better appreciated, or are “internally migrating” by shifting to other specialties like neurology, infectious diseases...

It is therefore crucial for the Lebanese Society of Family Medicine as well as for the academic training programs to do necessary measures to stop this ‘brain drain’. Definitely, an awareness campaign education the public, insurance companies and other medical colleagues about the role of Family physician is in order. A pressure should also be employed to design and implement a national primary care strategy where the role of the primary care physician is strengthened and protected. Training the large number of general practitioners (around 4000) to become family physicians would provide a powerful body that can impose its practices on other doctrines and regain the principles that are being lost.



Wonca Guidebook on Rural Medical Education

Barb Doty, MD, Wonca Working Party on Rural Medicine Member

A meeting on a Guidebook on Rurally Based Medical Education organized by the Wonca Working Party on Rural Medicine was held in the Rockefeller Center in Bellagio, Italy May 30-June 3, 2011. The Working Party on Rural Medicine of Wonca had a terrific opportunity to utilize the Center to organize the publication of a new 20 chapter Guidebook on Rural Medical Education, slated to be published through the Rural and Remote Medicine online journal (Australia) in 2012. The lead editors are Dr. Alan Bruce Chater of Theodore, Queensland, Australia and Dr. James Rourke, Dean of Medicine at Memorial University in St. Johns, Newfoundland.

Dr. Barbara Doty, AAFP Board of Directors member from Wasila, Alaska attended the meeting representing the U.S. and is coordinating the

AAFP Members involved in Wonca



Dr. Barb Doty (second on the right) at the meeting with the colleagues from Memorial University, St. Johns, Newfoundland.

chapter on Support at the Rural Training Site, which includes subchapters on mentoring, the learner in difficulty, support of the student and student's family in the rural setting, and establishing professional relationships in a rural setting. The guidebook will include major sections on Undergraduate Medical Training for Rural Education in the Post-Graduate and Practice setting, an overview of Rural Medical Education Systems in different settings, and a section discussing the bigger picture of Rural Medical Education development, which includes some of the advocacy, political, and government interface issues that may be factors in successful rural medical education development. Participants include rural family physicians from Australia, Canada, U.S., Malaysia, Greece, Great Britain, South Africa, Nigeria, to name a few.

U.S. authors participating include AAFP members,

Drs. Thomas Norris, Professor and Interim Chair of University of Washington Department of Family Medicine, and Suzanne Allen, Vice Dean for Regional Affairs, Co-director of Targeted Rural/Underserved Track (Trust) of University of Washington, and David Schmitz, President of the Idaho Rural Health Association.

The purpose of the guidebook is to organize and co-locate resources on rural medical education in an enduring interactive format, useful for rural medical education planning and implementation around the world.

The gathering in Italy was the result of a generous grant from the Rockefeller Center which sponsors conferences that promote opportunities for improvement in global health and well-being.

For interest or more information, contact Barbara Doty at barbara.doty@aafp.org

**AAFP SCIENTIFIC
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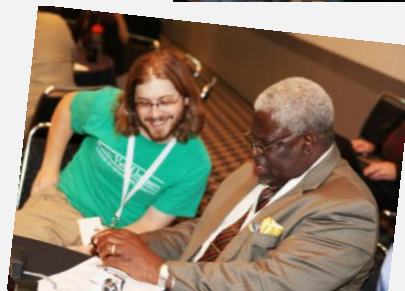
Thursday, September 15
Room # W340B, Orange County
Convention Center

2:00 – 3:00 p.m.

- *Networking meeting:* Global Development of Family Medicine

3:00 – 4:30 p.m.

- *Reception:* Physicians With Heart 20th Mission Celebration



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