Spring 2009

AMWA Connections

American Medical Women's Association

Message from the President

Beatrice S. Desper, MD

Dear AMWA Members,

For those of you not present at our dinner in Williamsburg, I thought you might like to know a bit about me and how I ended up in Louisiana and became current President of the American Medical Women's Association. My name is Dr. Beatrice S. Desper, commonly known by my patients as Dr. Bea. This is how Donald Trump's words, "never, never quit" apply to me and to the American Medical Women's Association.

First order of business was to be born to wonderful parents in the USA. My mother and father worked hard to ensure that their four children all had the opportunity to go to college, which had been denied to both of them. We were raised in a nursing home where we learned to care about people and to develop a good work ethic through the many daily tasks. My mother was the nurse 24/7 and my dad did everything else.

I married much too young during college, but luckily had promised my parents that I would finish school. That I did with a degree in Chemistry from the University of Massachusetts in Amherst, with a young daughter born during my senior year and twins on the way at my graduation. These three were followed by two brothers a few years later. By age 28, I was a single parent and wondering what was to come next.

A friend asked what had I always wanted to do and my reply was "I used to want to be a doctor, but by the time I finish training I'll be forty years old!" He responded with the challenge: "You will be forty anyway so why not be a doctor?" That was my impetus to enter Tufts University School of Medicine, graduate, and move to Hartford to do my residency in OB/GYN, finishing at forty. Over the next 20 years I practiced OB/GYN in a group and then for the local hospital. At the end of my contract, the new terms offered to me were a cut of about 40% in benefits or if that was not acceptable, I could always buy back my practice. My reply: "Thanks, but no thanks." My supportive husband, Ken Jovin, encouraged me to explore other alternatives.

After a series of unsuccessful job searches, I landed in Louisiana with a friend from my residency. As is so often the case with doctors, that relationship ended in 2005 and for the first time I was truly on my own. I started a practice in GYN only, and it has been a struggle. About a year ago I purchased my first office as I went on Medicare! We are now on the verge of having a profitable practice. I continue to see new patients every day.

I joined the American Medical Women's Association as a medical student to get their student loans and have been a member for over 30 years. Needless to say, I've seen many changes. Once I started attending the national meetings, I never stopped coming. The members of AMWA have been mentors and friends throughout the years. I have high hopes for this organization's future. Over the last few years, Presidents Susan Ivey, Diana Galindo, and Claudia Morrissey, with the help of their boards, have persevered and done a remarkable job in turning a potential defeat, and an end to our organization, into a victory. We are now financially in the black and attracting new members.

Domestically, AMWA will fight to ensure that 47 million Americans, many of whom are women and their children, are able to access the preventive and curative health care services that they need to lead healthy and productive lives. Services must be evidence-based, in-

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In This Issue

Annual meeting Recap from AMWA Headquarter

Lindsay Groff, Executive Director

The 2009 AMWA Annual Meeting was a huge success overall. AMWA's hospitality suite drew members and non-members alike resulting in 29 new AMWA Members! The hospitality suite proved to be fertile ground for interactive dialogue, camaraderie and various AMWA-related sales in membership, AWHS jewelry, AMWA scarves, t-shirts and books. The women at the Women's Health Congress were a pleasure with whom to work. At the Board of Directors meeting on Sunday, the Board unanimously announced that AMWA will partner with the Women's Health Congress once again for 2010.

AMWA Meeting Photo

AMWA Meeting Photo

AMWA Meeting Photo

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corporating the growing body of research findings on sex-based differences in disease prevention, presentation, course, and response to treatment. AMWA will continue to push for the incorporation of these findings into medical school curricula. We must carry forward this momentum and continue to partner with like-minded organizations to achieve our goals; our primary one being to ensure medical care for all in this country. Our shorter term goals are to maintain the continuation of AWHS, the American Women's Hospital Service, and raise the funds to confirm our legacy in storage and exhibition at Drexel University. Our journey will have peaks and valleys along the way. But when we arrive at our 100th anniversary in 2015, we will have a mega celebration and then continue for our next 100 years. I encourage all of you to be part of this dream.

Please join us.

Beatrice S. Desper MD

Connections is a publication of the American Medical Women's Association

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JEAN L. FOURCROY, M.D., PH. D., M.P.H.

Originally as a child I had planned to become a doctor - as a child playing with dolls! I am not sure where the idea came from, but it was constant. I went to college at the University of California, Berkeley as a pre-med (which is a combination major of psychology and biological sciences.) However, I dropped out at the end of the third year to put my first husband through graduate school. This was 1951. In 1962 I realized for a variety of reasons that I had to finish college with four children and returned to San Jose State University to complete my college degree in 1964. At that time, I was asked to teach all of the labs (embryology and comparative anatomy) by the person who turned out to be my strongest mentor, Dr. James Heath. This meant that I worked on my master's degree in biology at San Jose at the same time. In 1967 I was asked to take over the lectures. However I realized by 1968 that I had to get a Ph.D. to be tenured and entered the University of California, San Francisco (UCSF). There I was fortunate to meet my next mentor, Dr. Laurel E. Glass. At no time did I contemplate going to medical school because I was now thirty-eight years old - too old by the standards of the day; (I should also point out that in 1950 UCSF took one woman per 60 students and in 1968 they took two women per 120 students). During the course of my studies and completion of my Ph.D., I realized that I still wanted to go to medical school. With the help of my faculty, I took the Part 1 Exams and in 1972 was admitted to the Medical College of Pennsylvania (also called Woman's Medical College) as a third year student.

Biography

Dr. Jean L. Fourcroy postponed studying medicine to support her husband's career and raise a family. She was 42 years old and the mother of four teenagers when she began training as a physician in 1972, and has gone on to become a leading advocate for women in medicine and a nationally-recognized scientist and surgeon.

Although she had enrolled in pre-med classes at the University of California, Berkeley in 1951, Jean Fourcroy sacrificed her interest in medicine to support her husband's career. She dropped out of school, but she never lost her desire or determination to pursue medicine. In 1962, with four young children—the baby still in diapers—Fourcroy enrolled at San Jose State University to complete her bachelor's degree. It was just the beginning. By the time Jean Fourcroy received her M.D. from the Medical College of Pennsylvania in 1974, she had already earned her master's degree in biological sciences and completed the course work for her Ph.D. in anatomy.

While serving a surgical internship and residency in urology at George Washington University in Washington, D.C., Dr. Fourcroy completed her Ph.D. dissertation in 1977. In 1981 when Dr. Fourcroy received her board certification in urology, she was only the fifth woman in the United States to do so. Dr. Fourcroy continued her academic training and received her master of public health degree from the Medical College of Wisconsin in 1999. While working as a staff urologist in a Washington, D.C., private practice in 1979, she also volunteered as a urology consultant for Project Hope in Guatemala. As a captain in the U.S. Navy, Fourcroy served as an academic urologist at Bethesda Naval Hospital from 1980 until her recent retirement. During her tenure there, Dr. Fourcroy also worked as a medical officer with the Food and Drug Administration in the Division of Clinical Laboratory Devices. With the FDA, she was involved in many aspects of the regulatory process. Her research experience in insect physiology, developmental and reproductive biology and in occupational safety enabled Dr. Fourcroy to become a leading expert in areas of drug abuse, particularly anabolic steroids. She was recently appointed to the board of the U.S. Anti-Doping Agency and has been an invited presenter at Drug Enforcement Agency workshops, both in the United States and abroad.

In 1999, Dr. Fourcroy received the Camille Mermod Award from the American Medical Women's Association for which she served as president in 1995. She is also past president of the Federation of Professional Women and the National Council on Women in Medicine. In 1996 she was named the Woman of the Year by the Women's Medical Association New York City. Dr. Fourcroy received the American Urological Association Presidential Citation Award in 1998. An active member of the American Society of Andrology, Dr. Fourcroy received an Outstanding Service Award from the organization in 2000.

Question and Answer

What was my biggest obstacle?
Children, husband and money… (I know this is more than one!) When I started medical school, the children were 18, 16, 15 and 12 years of age. To date, none are happy with my returning to school. My husband was an alcoholic, which in fact made it a necessity to pick myself up by my bootstraps. Money was short. However, I was fortunate to be able to teach through most of my career. When I went to medical school, my stepfather and mother loaned me $3,000 to pay the two-year tuition.

How do I make a difference?
I am hoping that I have made a difference by mentoring others. By chance I went into a surgical specialty, urology. The mentors at the Medical College insisted that I should do a surgery residency and the urologists at George Washington University encouraged me to go into urology. I did not realize at the time that I would become the fifth woman urologist. I have been fortunate at every point of my career to use my inner resources to grow even when bad things happened to me. I have been able to meld the world of science and medicine hopefully to the benefit of patients and society. I have used my skills organizationally to lead the American Medical Women's Association and to encourage other women urologists through the Society of Women in Urology (which I founded) and a variety of other areas.

Who was my mentor?
One has more than one mentor in life. My strongest mentors were my mother and grandmother. My grandmother danced on the stage the world around before settling as a single mother in a small town in New Jersey with four children. She was the doctor, the vet and the philosopher of this village. There was nothing she could not do. With a maternal lineage of strength there was no thought as to whether it could be done. Other mentors have included a variety of peers, friends and professors who helped with the path.

How has my career evolved over time?
For me, change was a necessity. How has it evolved? There is no part of my life I would eliminate nor perhaps repeat. Every part of my education and training has added depth. I went from being a housewife in Palo Alto (where I was involved in too many community activities), to graduate school, medical school, residency, academic practice with the Navy and the Food and Drug Administration, and finally to a free-lance consultant in urology/endocrinology. And through it all, life is (and must be) a continuing building process. In between, I still try to keep up with arts, for example painting and music.

From the exhibit of Changing the Face of medicine http://www.nlm.nih.gov/changingthefaceofmedicine/physicians/biography_119.html

AMWA greatly appreciates Jean for her continued service!

At the Very End of Life: The Emergence of Policy Supporting Aid in Dying Among Mainstream Medical & Health Policy Associations

Kathryn L. Tucker, JD, Director of Legal Affairs, Compassion & Choices

In 2008 four major national medical professional and health policy organizations adopted policy in support of aid in dying, the practice of a physician providing a prescription that brings about a peaceful death to a mentally competent, terminally ill patient. This represents a significant turning point in American society's evolution to empower terminally ill patients with information and choices about how they will die. This article reviews this development, sets it in context with other developments, and makes several predictions about the impact it will have on continued progress toward freedom of choice at the end of life.

The organizations adopting policy in support of aid in dying include the American Medical Women's Association (AMWA), the American Medical Student Association (AMSA), the American College of Legal Medicine (ACLM), and the American Public Health Association (APHA). Previously, organizations of this sort, like the American Medical Association (AMA), held positions opposing aid in dying. Others, recognizing the split in views on the issue among members, had adopted a neutral position, such as that taken by the American Academy of Hospice and Palliative Medicine (AAHPM). What prompted so many medical and health policy associations to break with tradition on this issue in 2008? The answer, in short, is evidence.

The chief argument raised by medical professionals against aid in dying had been the idea that making this option available would be harmful to patients and to the practice of medicine. By 2008, however, a decade of data on how aid in dying was working in the state of Oregon was available.

The Oregon Death with Dignity Act (Dignity Act) was implemented in 1998. The law permits mentally competent individuals who have less than six months to live to obtain a prescription for medication that can be self-administered to bring about a peaceful death. The Dignity Act survived a series of attacks brought by opponents in court, by federal legislators, and by a former United States Attorney General; it has been implemented without interruption since 1998.

Under the Dignity Act, patients must follow a strict set of procedures to establish eligibility. A physician must determine that the patient has a life expectancy of less than six months; this diagnosis must be confirmed by a second opinion. The patient must make multiple requests, waiting at least fifteen days between the first and last request, must establish capacity to make medical decisions, and must be informed of palliative care options such as hospice, if not already receiving such services. If all of these procedures are followed, and the patient is deemed eligible by the physician to obtain the life-ending medication, an Oregon physician can provide the requested prescription.

During the decade that aid in dying has been legal in Oregon, close to 30 terminally ill individuals each year have gone through the process, obtained and taken the medication, and died peacefully. Those present at these deaths, usually close family members, report that the patient was enormously relieved to be able to make this choice. On a date chosen by the patient, loved ones may gather around for a final goodbye. The patient consumes the medication, becomes drowsy, falls deeply asleep, and after a short period of time ceases to breathe. The long road from diagnosis to curative treatment to palliative care to death has ended on terms acceptable to the patient. More patients obtain the medication than go on to use it: some fraction each year receive the medication, put it in the medicine cabinet, feel comforted to know it is there, and never take it.

Demographic data about the patients who choose to use the Dignity Act show that most are dying of cancer. The next most common terminal illness is amyotrophic lateral sclerosis (ALS). Those using the law are insured, well educated, and receiving comprehensive pain and symptom management, typically through hospice services. Opponents of the Dignity Act legislation had argued that such a law would be forced upon the uninsured, the poor, minorities, persons without access to hospice, or disabled persons. The data have disproved this conjecture. In addition, a number of unexpected but significant developments occurred in Oregon following implementation of the Dignity Act. Referral of patients to hospice care increased dramatically, as did physician enrollment in continuing education courses on how to treat pain and symptoms associated with terminal illness. It is likely that physicians want to ensure that no patient makes use of the Dignity Act due to inadequate pain and symptom management. This galvanized both the increase in hospice referrals and physician efforts to learn more about treating pain and symptoms.

Clearly this evidence persuaded medical professional and health policy experts at APHA, AMWA, AMSA and ACLM to adopt policy supporting aid in dying. When the policies were under review by these groups, arguments against adoption of such policy were presented. For example, during the policy development and consideration process at APHA the Disability Section of that organization argued vociferously against adoption of the policy, claiming that it would put persons with disabilities at risk. This argument was thoroughly considered; indeed, it prompted APHA to consider the policy over a two-year policy cycle rather than a single-year cycle. After careful, evidence-based consideration of those arguments, the health policy professionals at APHA ultimately rejected them as unconvincing and adopted its policy in support of aid in dying.

In another significant development in 2008, voters in the state of Washington considered the issue and, after an intense campaign with opponents making the same claims about harm to patients and the medical profession, voted to adopt the Washington Death with Dignity Act by the significant margin of 59% to 41%. The Washington measure is virtually identical to Oregon's and will be implemented in March 2009.

The experience in Washington with aid in dying will, no doubt, be closely watched and will contribute to the body of data on how the availability of this intervention impacts end-of-life care. Such data will then inform consideration of policy and legislation in other states.

As a result of a court case, Montana recently recognized that the freedom of its terminally ill citizens to choose aid in dying is a fundamental right protected by its state constitution's guarantees of privacy and dignity.

Public support for empowering dying patients with the freedom to choose aid in dying is strong. The Pew Research group reported in 2006 that 60% of Americans "believe a person has a moral right to end their life if they are suffering great pain and have no hope of improvement," an increase of nearly 20 percentage points since 1975. Certain religious groups and disability rights groups oppose adoption of policy and passage of laws permitting this choice. Yet, the opposition to aid in dying by religious organizations does not necessarily reflect the views of those who profess to hold religious views. For many years the vocal, well funded opposition succeeded in limiting the legal practice to the state of Oregon; though, it is no secret that the practice goes on covertly in every state. When a patient does not feel able to discuss the desire for aid in dying with his or her physician, or cannot find a physician willing to provide it, the patient may seek assistance in hastening death from a family member or loved one. Unfortunately, these incidents often involve a violent means to death, such as gunshot. Cases of this nature appear with disturbing frequency in the newspapers. That is now changing with the passage of Washington's law, recognition of a constitutional right in Montana, and the significant trend of support for the practice among medical and health policy associations. These changes should, and likely will, prompt other medical and health policy associations with policies opposing aid in dying, adopted before the evidence revealed that having this option presents no risk to patients or the medical profession, to revisit their outdated policies. Unfortunately, the AMA has a long, well known history of being slow to adopt policies reflecting changing societal norms. For example, for many years the AMA opposed most forms of medical insurance and group health plans, including Medicare, labeling them as "socialism."

A fraction of terminally ill patients–including those who have excellent pain and symptom management–confront a dying process so prolonged and marked by such extreme suffering and deterioration that they decide aid in dying is preferable to the alternatives. Having this option harms no one, and greatly benefits both the relatively few patients in extremis who make use of it and many more who draw comfort from knowing it is available should their dying process become intolerable. The trend in policy among mainstream medical and health policy associations is clearly in favor of supporting this compassionate opinion.

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Member Updates

AMWA Branch 30 participates in the Annual Legislative Leadership Conference

AMWA Branch 30 members joined the California Medical Association for the Annual Legislative Leadership Conference on April 14, 2009 in Sacramento, California. After a morning of advocacy training, they met with legislative staff to discuss their views on current senate and house bills, including two initiatives by representative Mark Leno, one which proposes a single payer healthcare plan and another which would eliminate toxic chemicals in baby products. There they met and recruited a new AMWA member, Evelyn Li, MD, President of Patient Advocate Organization and medical consultant for the movie, Life for Sale. They also met with Jessica Nunez de Ybarra, MD, MPH, a Public Health Medical Officer, to discuss her work in the Division of Communicable Disease Control. We would love to hear from other AMWA branches.

Please send updates to info@amwa-doc.org and let us know what you are doing.

Pictured above in front of Governor Arnold Schwarzenegger's office are (left to right) Evelyn Li MD, Kay Williams MD, Eliza Chin MD, Laurel Waters MD, and Rose Lewis MD.

Note to Readers from the AMWA Communications Committee Co-Chair

Do one thing every day that scares you." Eleanor Roosevelt

Those words can support your self-care via courage to risk it. "What's the risk?" are words I learned in 1974 as a visiting resident at London, England's world famous Maudsley Psychiatric Hospital.

First, care for yourself with healthy meals, enough good sleep, exercise, laughing 200 times, and participation in a creative art. Then turn to time to consider speaking up for yourself, at work, school and/or in your personal life.

Speaking up can include requesting a promotion, other or fewer responsibilities, or reporting abuse by a more senior person at work or at home. It's not easy, but it's your life and you must be your number one senior advisor.

Contact me with comments or questions,

Leah J. Dickstein, M.D., M.A.
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Update from AWHS Overseas Grant Recipient, Misty Richards
Living in Good Health Together: The Engeye Health Clinic

Bryan Meltz Photography

Misty felt she was at home as she landed in Entebbe, Uganda as she had been there twice before on medical missions to the Engeye Clinic in rural Uganda. This time they were opening the new Engeye Laboratory, a building over a year in making. Also on this trip the four board members, including Misty, were planning to meet with several Uganda organizations to implement partnerships to help the Engeye clinic become self-sustaining.

Since the clinic opened two years ago, 1500 patients have been seen. With the Ugandan nurse, doctor and lab manager, the Engeye Health Clinic treats patients six days a week. It is run by a US based non-profit with the long range view of handing it over to the Ddegeya village, where it now is based. The main objective of the team was to treat as many patients as possible while simultaneously learning from and educating our Ugandan nurse, Joseph. The 16 member team was comprised of medical students, family practice doctors, pediatricians, architects, as well as public health officials; so that we were in a good position to educate and to learn the way they practice medicine in Uganda. The Engeye Health Clinic, more than anything, is a partnership between Ugandans and Americans who are both passionate about improving health care through the practice of compassionate medicine in this little village.

Bryan Meltz Photography

Misty was there to act with two others as laboratory manager, a monitoring arrangement. With donations and community help the laboratory was opened with close to $15,000 of equipment. They were ready to go, and patients were waiting through the night outside to be treated among the first. On this first day of the new laboratory and the fresh team from abroad, 115 patients were treated. At least that many were treated daily for the whole trip. It was a pleasure and a privilege to watch Joseph, our Uganda nurse with his special relationship with the patients. In Uganda, medical treatment begins as the patient walks through the door. Family news is shared and followed with a warm embrace.

The laboratory opened on the second day of the trip to allow all the participants to experience the work in the medical clinic first. The most common ailments seen were malaria, malnutrition and osteoarthritis. People came with chronic reoccurring malaria because they had sold the mosquito nets provided by the clinic. People coming to the clinic did not have the means to feed their families and selling the nets seemed reasonable. Most villagers in Ddegeye live below any poverty line, however established. Malaria control cannot work without assurance that the nets are used. Osteoarthritis was also a major problem as most villagers work in the fields with damage from the repetitive motion of hoeing and harvesting so great that it was painful for some to even walk. Prevention is vital for these complaints. Although we cannot tell people in third world countries how to live, we can help them access resources to bolster general health care.

The new laboratory is a beautiful structure with four large rooms. Two were for patients, one for a pharmacy and one for the diagnostic equipment. Three students spent an entire day sorting the donated equipment and preparing protocols. It is now possible to test for strains of malaria, perform pregnancy tests, run urine samples through a battery of tests, perform hemoglobin and blood sugar tests and prepare smears with the limited stains brought by the trip participants. Power for the laboratory was provided by solar panels. As part of the plan for this trip, meetings were held with various Ugandan authorities to develop working partnerships to maintain the Engeye clinic and nurture public health in the region. Partnerships were established with the Ugandan Ministry of Health and Uganda Cares (an HIV/AIDS organization). Through these it is hoped to subsidize antiretroviral treatment using local government funding and also to be able to refer to specialists when needed. To fight the poverty it is hoped to introduce micro-financing to allow villagers to obtain small loans to start businesses and improve the overall quality of their lives.

Bryan Meltz Photography

The Engeye Health Clinic is set right in the middle of an incredibly rural village in Uganda. The clinic is submerged in the village life and its doors are open to everyone. While patients are being seen, local children often visit to watch what is going on. They desperately want to help in any way they can, running errands and helping carry water, for instance. Misty states that the children have been an integral part of her three visits. She has watched them grow. Some have overcome sickness and malnutrition and some have perished. Many of these children die from preventable complaints and they have been sacrificed due to lack of resources and access to health care.

One lasting memory, thanks to solar panels they could project a movie for the children. Wall-E was chosen; just perfect for these children as its message is portrayed by action, rather than language, and their delight in seeing electricity in movement was a joy to see.

Visit ***www.engeye.org*** to learn more about the clinic.

Note: Misty Richards was the recipient of a grant from AWHS (American Women's Hospitals Service) to help defray the travel costs and allow her to make this trip.

Advocacy Updates

AMWA Policy & Advocacy Update 2009-present

January 6, 2009---AMWA singed on to a letter to President-Elect Obama to tackle the national problem of overweight and obesity in children and adults as they are an epidemic that needs to be addressed as part of the healthcare problem. The letter was initiated by the Center for Science in the Public Interest.

January 17, 2009---AMWA signed onto a letter to the Senate initiated by the National Center for Immigrant Women's Rights urging the Senate to pass the reauthorization of the SCHIP program which now includes immigrant children.

January 28, 2009---AMWA signed onto a letter to Senator Baucus requesting special consideration be given to women's health, that specific items be included, and that uninsured women be included in any bill emanating from his committee, The Senate Committee on Finance. This effort is being lead by the National Women's Law Center.

January 31, 2009---Dr. Omega Silva attended the Herndon Alliance annual meeting at the Mayflower Hotel at which its 2009 board was ratified and listened to presentations on healthcare moderated by Bob Crittenden with survey research by Celinda Lake on the Cost of Doing Nothing, Public Plan by Richard Kirsch with Healthcare for America Now, Anthony Wright of Health Access California and Ron Pollack of Families USA on state and national work to maximize chances for national reform. The group agreed it must be done this year or never and the president's budget must get the ball rolling. The discussion was centered on effective ways to push the process.

February 16, 2009---AMWA signed on to a letter generated by the Alliance for Justice regarding the Medical Device Safety Act which advocates especially for women who may be harmed by devices marked specifically to control women's reproductive health.

March 3, 2009---AMWA signed onto a letter initiated by the Society for Women's Health Research to urge congressmen to sign on to sponsor HR1032, the HEART for Women Act, which would bolster efforts for research, education and heart disease screenings for uninsured and underinsured women.

March 4, 2009---AMWA sent a letter to the Deputy Managing Editor of the Associated Press concerning the media reports on the Final Exit Network which has been charged with assisting suicides in Arizona. The media seems to have confused legal aid in dying with assisting suicides.

March 27, 2009---AMWA decided to partner with Physicians for Reproductive Choice and Health to sponsor a day of lobbying on the Hill on June 12, 2009 to advocate for the Reproductive and Sexual Health bill ( ). We will have training on the bill and how to lobby on the 11th sponsored by PRCH for only 15 AMWA members who will sign up for the day to participate in the program at the Hyatt Regency on the Hill. The Policy and Advocacy committee prepared an announcement for the event at our meeting at the Annual Meeting on March 22, 2009 in Williamsburg which should be in circulation soon.

April 27, 2009---AMWA has teamed up with the National Academies of Practice to bring patients' and practitioners' voices to health care reform sometime in mid May when it is anticipated the bill will be completed and a hearing will be held.

AMWA Student Region 9 &10 Update
California, Nevada, Oregon, Washington, Hawaii, Idaho, and Montana

Regional Student Coordinator-Lisa Sprowl
I am a fourth year medical student at Chicago Medical School. Next year I will be a Family Medicine resident at Sutter Sacramento.

I have been involved with AMWA all four years of medical school. During my first year I was one of the chairs of the planning committee for my school's Woman to Woman Soiree, a networking dinner for medical students and alumni. Then, I was the President of my school's AMWA for my second year. AMWA was the most active organization at my school during that year with many successful events, including an HPV Vaccine Panel, Breast Cancer Awareness, and the Woman to Woman Soiree. Last year, I was the Region 6 Regional Student Coordinator. I worked very hard to collect the contact information of the 30+ chapters in my region, as well as keeping all of the chapters informed of all the National AMWA activities. My involvement in AMWA and other organizations was recognized with the Outstanding Female Student Leadership Award in 2007 and 2008. Since I grew up and went to college in California, I decided to spend the majority of my fourth year in California. Therefore, I took on the Regional Student Coordinator position for Region 9/10 this year. I have enjoyed being actively involved with AMWA and I look forward to continuing to be part of AMWA.

Touro University College of Osteopathic Medicine-Mare Island
Touro's Women's Health Club (WHC) has had (and will have) a phenomenal year hosting an HPV vaccine speaker, fundraising for Women Organized to Respond to Life-threatening Disease (WORLD) while inviting their panel to discuss the reality of living with HIV, coordinating an AIDS awareness display on campus, organizing film showings on-campus for women's health related issues, planning a Vagina Monologues production open to the community, and coordinating the largest community event held on our campus called The Teen Life Conference (TLC) for the fourth year in a row. The TLC is an annual community-wide high school outreach project aimed at educating teens of Vallejo about osteopathic medicine, salient health topics, and providing these teens access to various health screenings. This year 150+ students from the local community will take part in learning about diet and exercise, stress management, educational endeavors including how to become an osteopathic medical physician as well as other healthcare professionals, health and nutrition, teen pregnancy, breast cancer, psychological health, drugs/alcohol/smoking/ teen violence, and social-well-being. The WHC is a tremendously active club on the Touro University campus and will remain a strong presence in the coming years.

Students participating in an obstacle course at Touro's Teen Life Conference. Photographer: Andrew Ho

University of Nevada School of Medicine (UNSOM)
UNSOM's AMWA has had several activities over the course of the year. Last semester they participated in the Susan B. Komen Walk for Breast Cancer. Recently, a local female surgeon invited about a dozen local female physicians and all the female medical students to her home for wine, appetizers, and socializing. It was well attended by the students and was a great opportunity to talk to female physicians. Finally, they just finished a poster display for a local library that has a program called "Changing the Face of Medicine" running during the month of March. The display highlights some of the prominent female physicians and students in Reno, and offers advice to aspiring junior high and high school kids.

Member Benefits & Corporate Partners

Interested in getting more involved with your AMWA membership? Join one of the 14 Committees and Working Groups, and donate your time and enthusiasm to grow AMWA as an association. Email your interest in a committee or questions to associatedirector@amwa-doc.org. Here is a listing of all Committees and Work Groups: American Women's Hospital Service, Awards and Nominations, Annual Meeting/Program, Communications, Fundraising, Global Outreach, Membership, Physician Branch Affairs, Policy and Advocacy, Resolutions/Position Papers, Senior Physicians, Student Affairs, Women's Health, and Career Development.

Be sure to attend the face-to-face committee meetings held on Thursday, March 26, in Williamsburg, VA at the Annual Meeting.

AMWA WELCOMES YOUR INPUT

Members of AMWA only, please send an email to info@amwa-doc.org and provide AMWA with news about yourself or give input on issues you would like to see covered in Connections.

Member News
List any recent employment promotions, special awards, or completed projects

Topic Suggestions
Are there any issues you'd like to see addressed? Suggest an article and author, or submit an article yourself.

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