



American Medical Women's Association
The Vision and Voice of Women in Medicine since 1915



American Women's Hospitals Service Postcards from the Field Summer 2016

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CHIPS Health and Wellness Center Quality Improvement Project - Vanessa al Rashida



Blood glucose testing at a community free clinic

Free health clinics have been in existence in the United States since the 1970s. The purpose of them was to manage and treat patients in the local community who otherwise would not be able to pay for medications and other therapies. These clinics were in response to both to changes in the economy and the health care system. CHIPS (Community Health in Partnership) is one of the free clinics that blossomed out of the need for increased access to medical care to low income people. It was established in the 1990s and located in downtown St. Louis, MO. Due to the patient population being treated in this clinic, the resources are based on donations from local hospitals and laboratory and radiology services in town. There has not been much study on the effects of

Letter from the Editor



Dear AMWA,

Within this issue, we have asked our members to recall their most memorable patient encounters throughout the world. Their experiences are built on a foundation of passion, commitment, and selflessness and rooted in the zest to not only learn more about medicine, but about the cultures of our world and the common entities that intertwine us as humans. We encourage you to reflect on your own stories and the patients that have helped formulate who you are today. Remember to apply for one of the numerous grant opportunities provided by AWHs if you are interested in the opportunity of studying abroad!

Thank you for spending your time reading this issue! We truly hope these tales of compassion and humanity inspire each of you just as much as those who have experienced them.

Best,
Slavica Gjorgjevska

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the free health clinics on the health of lower income and non-insured patients, thus I wanted to gather retrospective data on objective labs (i.e. A1c, lipid panel) and vitals (i.e. blood pressure). Hypertension and diabetes were the diseases observed in this study as there is a high percentage of both in downtown St. Louis then in other areas of St. Louis. Data was collected over a five year period (2011-2015). Based on the findings, the clinic has helped to control diabetes and hypertension in over 80% of the patients with these diseases, with vitals and lab findings either showing a gradual improvement or consistent level of control over the 5 year period. In addition to this study, further intervention was initiated by integrating access to pre-packaged food, free of charge, to help create a holistic approach to the care of patients with diabetes. Patients were also given copies of recipes from the AMWA Centennial Cookbook to help kick-start their goals. With these efforts, it is the hope of the clinic that low income patients receive the best chance at a healthy life.

With the development of the Affordable Care Act in 2010 and further changes to the health care system, the relevance of these free health clinics is put into question. Despite the law being enacted in 2010, there still remained a portion of patients who were uninsured. Some free health clinics have made the switch to accepting Medicare/Medicaid patients however, the need for free health clinics remains essential for those who are uninsured. It is unknown when all U.S. patients will have access to health insurance but for those who are still without insurance, these clinics will continue to be a vital resource to health education and care, in one form or another.

HBS Emergency C-Sections - Needs Headline

At HBS, some 850 babies are born each year. Of the approximately 70 babies born per month, 3 to 4 are born via a Cesarean-Section, 75% which are emergencies.

HBS has a full time gynecologist on staff who lives on campus to be able to assist the pregnant women at any given time. In addition, six visiting surgery teams visit HBS every year, on a rotation basis, performing many different types of surgeries including a number of emergency C-Sections.

Expectant mothers who go into labor usually arrive at the hospital with their families in tow for assistance. After birth, they spend one to three days in post-partum Maternity care before going home. If a woman had a C-Section, she will spend one week in post-partum care. All new mothers receive a follow-up visit one week after their release.



Newborn exam to access the health of this great addition to our world

Hopital Bon Samaritan

Limbe, Haiti

Limbe, Haiti is a market town located 12 miles inland from the Northern coast of Haiti. Hopital Bon Samaritan is a full-service hospital with outpatient services, chronic disease clinics, and operating rooms. The hospital utilizes the volunteer services of health professionals from around the world.



CerviCusco Cytology-Global Health



Peruvian citizens taking in the beauty of the Andes mountains.

My experience here is best described in pictures. I participated in campaigns located in the outer villages of the Andes mountains, where women were educated about their anatomy, the importance of surveillance (Pap smears and breast examinations) and HPV prevalence. I processed endocervical curettings, cervical biopsies and LEEP specimens without conventional machinery, and participated in a tele-pathology conference which enabled the diagnostic expertise of pathologists in the United States to help the women in Peru fight cervical cancer. I was able to help a community health clinic improve its laboratory processes, help with the quality control and validation studies of pathology-related services, and provide a helping hand in expediting the outreach programs. Overall, it was a rewarding experience.

Udai: An Intervention to Improve Newborn Survival - Swetha Iruku

During the summer of 2015, I had the opportunity to go to Rajasthan, India to work on a community based project with Action Research & Training for Health (ARTH), a non-profit organization focused on providing sexual and reproductive health care, and neonatal and child health care to the rural population of this region. My project was titled Udai: An intervention to improve newborn survival in southern Rajasthan. The state of Rajasthan has neonatal and infant mortality rates that exceed the national average (40 neonatal and 55 infant deaths per 1000 live births), despite increases in hospital deliveries and over the past 10 years. Over 75% of these neonatal deaths occur within the first week of life due to weak postpartum care for the mother and newborn.

I assisted with initiation of strengthening newborn care given at ARTH centers by observing current newborn care practices immediately after birth, evaluating available facilities and human resources, and developing a proposal for a newborn care unit within ARTH's clinics. I worked on creating training modules for nurses on newborn care techniques, namely Kangaroo Mother Care (KMC). KMC is the easiest, most effective way to care for newborns, especially those that are at high risk, yet there is a prevalent stigma against skin-to-skin contact because of the prevalent idea that newborns are "dirty" after coming out of the mother's womb. By training the nurses in KMC, they were able to lead counseling sessions with new mothers on how to carry out KMC and its importance.

In addition, I helped develop a take-home kit for newborn care to send home with mothers of high-risk newborns.



Providing a frightened mother with care and encouragement.

The kit consisted of basic items to monitor the baby's health and growth (thermometer and weighing scale), cotton blanket and a set of clothes, a blouse we designed to help mothers carry-out KMC, sunflower oil for skin massage, and finally an educational pamphlet. Such a kit will empower women to implement proper care for their baby by providing them with the tools to monitor their health, identify warning signs in their newborns, and advocate for the health of their newborn by seeking help when necessary. These kits were field-tested and are currently being distributed to mothers. The generous support of AMWA helped this project come to life, as funds were used to help purchase materials for the newborn kits and educational materials. I thank AMWA for its continuous support of women physicians and leaders!

Apply for an AWHs Community Project Grant

AWHS will be soliciting applications to fund a new type of grant geared towards student and resident members of AMWA. These grants are focused on community engagement and include medically-related proposals for:

- (1) Community-Based Research
- (2) Sustainable Community Service Projects
- (3) Community Advocacy/Education.

The primary goals of the Community Project Grants are to:

- Engage AMWA students, resident, and physicians in partnering with under-served communities
- Increase community outreach and resources
- Improve access to or quality of care for at-risk populations
- Maintain community self-reliance by focusing on sustainability
- Promote awareness of issues with medical care access, resources, disparity
- Plan for long-term solutions by empowering residents to explore innovative ideas in addressing these issues

Projects grants will be in the form of grants not to exceed 500\$, and will be awarded based on criteria including sustainability, benefit to community, engagement of community members, and educational value.

For more information or questions please email at AWHS@amwa-doc.org. Applications will be accepted on a rolling basis, with committee selection occurring quarterly.

“Welcome” - Allison Silverstein

In Rwanda, when you greet people, both old and new, they say, “you are welcome.” Now, almost a year after first stepping foot in Rwanda, I remember the first time I was greeted in this manner and the warmth and kindness I felt from the Rwandese immediately upon arriving. This past year, I was fortunate to serve as a Paul Farmer Global Surgery Research Associate through Harvard Medical School’s Program in Global Surgery and Social Change. I took a “year-off” from my medical studies to spend approximately seven months in Rwanda and two months in Zambia under various clinical, research and policy roles. However, I tend to call it my “year-on” because it was filled with hard work—mentally, emotionally, and sometimes even physically.

I met JP my first week abroad. More than anything else, JP’s biggest mistake was being born in Rwanda. He originally presented to a rural hospital and spent a month waiting to be transferred to a tertiary care center. Meanwhile, his painful and swollen knee grew larger than the size of a disfigured basketball. Once at the referral center, a biopsy confirmed suspicions of osteosarcoma and JP waited over a week for a CT scan to assess for metastases. Again, he waited more than a week to get his results indicating he had one lung nodule, a fatal diagnosis given the setting. Our team performed a palliative above the knee amputation and sent JP home to face death whenever it came knocking.

Now, almost a year later, I think about JP almost every day. I also think of my first time in the operating room in Rwanda. The power went out multiple times throughout the day. While the anesthesia machine had a backup battery, the rest of the power relied on a nonfunctional generator, resulting in multiple periods where the lights went out. After we lost power the fourth time, a surgeon shouted “surgery in Africa” and was met with chuckles from his peers, as if this was a typical occurrence—I later learned it was.

The lack of resources, both medical as well as human resources, was often disheartening. It was frustrating to see how many adverse



Feeling humble and totally “zen”

outcomes could have been avoided had the setting been different. However, the care that was provided often superseded what I naively imagined before arriving.

Throughout my year, I engaged in numerous research projects with local partners, learning countless skills myself and also teaching students, residents, and anyone who wanted to listen. Most recently, I spent two months in Zambia working directly with the Ministry of Health to help develop the first National Surgery and Anesthesia Plan to be integrated in their National Health Strategic Plan 2017–2021. It was a humbling experience to sit at the table with Ministry of Health Directors, hospital superintendents, medical school deans, and other key personnel discussing and prioritizing the future direction of surgery, obstetrics, and anesthesia in Zambia.

Ultimately, as I reflect on my past year, I really was welcome, or at least I felt welcome, in both Rwanda and Zambia. I was continually reminded to be grateful for my health, opportunities, and education. I will carry many unexpected lessons with me as I return to my final year of medical school and work in the global health field for many years to come.

Strength of Spirit - Bhavana Singh

I had the incredible opportunity to spend 3 months in Tanzania at the Kilimanjaro Christian Medical Center during my final year of internal medicine residency. While at KCMC, I spent the majority of my time rounding on the inpatient medicine service. My most memorable patient encounter was with patient JM. She was an 18yo female with paraplegia. JM was found to have TB myelitis and it was unclear as to whether or not she would regain function in her lower extremities. Throughout her stay, I was confronted with the limitations of the healthcare system from our inability to image her spine to our choice of therapeutics. Despite this I was impressed with her strength of spirit and that of her family members. Throughout her 30-day hospitalization JM did not develop one bed sore. She was exceptionally cared for by her mother and her other family members.

One day, JM’s mother indicated that she would like to take her home. Although I initially uncomfortable with this decision, I understood that I did not have much of a choice. I was worried that this young woman would be cast aside and would languish. For this reason, I

was even more surprised when JM showed up for a follow up visit with her mother in the outpatient clinic. This experience taught me a lot about the strength of clinical intuition and physical exam skills. It also taught me a lot about the persistence of the human spirit.

My time abroad reinvigorated my commitment to global health as a career goal. I have always been interested in incorporating global health into my practice of medicine. This experience exposed me to the logistics of practicing medicine in a resource-poor environment. In addition to the challenges associated with the delivery of care, I was also provided with a cultural context for how medicine plays a role in a society that is different from my own. I also became very interested in the possibility of developing a research base abroad. There are numerous logistics involved in this process and this experience helped me better understand the planning required to undertake such a project. I am hoping to spend some time abroad in the future in both a clinical as well as research capacity.

The Need to Advocate for Mothers - Katrina McKellips

This past spring, I had the opportunity to spend three months of my final semester of medical school completing an elective rotation in OB/GYN as well as finishing my Masters of Public Health doing research in cesarean section trends at a referral hospital in northwestern Ethiopia. My time in this hospital included some of the most instructive and memorable moments of my medical training thus far. I was asked to write a reflection piece by a group of individuals from my school, Touro University California, who were conducting research on the prevalence of disrespect and abuse among midwives in health centers and hospitals in the area. The following is an excerpt from that piece.

It was three weeks into my OB/GYN rotation that I first witnessed a clear case of physical abuse. After returning from lunch, I stopped by the labor ward to see if there were any laboring women before heading to the outpatient department. Walking down the long corridor, I noticed it was deplete of the usual sea of white coats. I was able to freely move without my usual promenade of pardons, salutations, bidding of peace and do-si-dos with students and nurses.

After arriving to my destination, I realized that my easy travels were due to the fact that there was something of interest occurring in the delivery room. I wiggled my way through a crowd of twenty students to find a thin woman in the lithotomy position with a large pool of blood collecting on the floor. There was one midwifery student who was clearly taking lead on the case. He was shouting at the woman in Amharic as he tried to insert a metal speculum into the woman's vagina. She was crying out in what appeared to be pain as her whole body was shaking and her knees clamping together to avoid his probing.

The scene continued this way for several minutes as I stood watching in silence among the others. The situation escalated as I saw the student's arm raise over his head. He began beating the woman with the metal speculum, first lightly hitting her knees and then forcefully thrashing her thighs and abdomen. At this time, I realized I did not know why the woman was bleeding and had simply been acting as a spectator. I began asking questions to the students around me. Everyone stared wide-eyed at me and nodded as if I were teaching. Finally I spotted a student I had worked with a lot the past several weeks. He said that woman had a second trimester abortion, however, continued bleeding after passing the fetus.

It was now clear to me that there were likely retained products of conception that needed to be manually removed or otherwise the woman would continue to hemorrhage. I became increasingly uncomfortable with the situation, both due to abuse that I was witnessing and my sense of inadequacy in managing the condition myself. I left the room and headed to the outpatient department to speak with my OB/GYN preceptor. After recounting the story, he shrugged as he continued to ultrasound the belly of a pregnant woman and stated that this is the reality of medicine in Ethiopia. I dropped the subject at this point as it was clear the long line of women outside of the office were waiting for him, and he did not have time to have an ethical debate at the moment.

Apply for an Overseas Travel Grant

The AWHs Overseas Assistance Grant provides assistance with transportation costs up to \$1,000 connected with pursuing medical studies in an off-campus setting where the medically neglected will benefit.

The grants are awarded to national AMWA student members completing their second, third or fourth year of an accredited U.S. medical or osteopathic medical school or to AMWA resident members.

Applicants must spend a minimum of four weeks and no longer than one year in a sponsored program which will serve the needs of the medically under-served.

For more information contact AWHS@amwa-doc.org.

Later that evening, I had dinner with three physicians from the hospital. I told them about the woman I had seen earlier in the day. The first to respond was another OB/GYN that I had worked closely with during my time at the hospital. He stated that women make their jobs very difficult at times. Often they are too modest and do not want to cooperate during pelvic exams. A general surgeon responded to this comment by saying that it is not the woman's fault, but inadequate access to pain control. After a long discussion on pain management there was a break in conversation. Eventually, the third physician, another general surgeon, began to speak. He stated that there is single moment in his career that he regrets and that continues to haunt him. When he was a medical student, a laboring mother was crying out in pain and was not following his commands. His response was to kick her in the abdomen. The woman became fearful for her child and was cooperative thereafter.

The mood at the dinner table became somber after this story, but it was apparent that everyone was reflecting on the situation of abuse of delivering mothers in the country. As is the case of many seeming atrocities that occur in the world, the situation is much more complex than appears from the outside. I have reflected many times over on the case I witnessed and have mixed emotions of guilt, sorrow, anger, and even tacit acceptance. There are stark gaps of resources at the hospital that include limited man power, financial restraints, and poor access essential medications including analgesics. Despite these challenges however, abuse of laboring women is an unjustified reality that many bear in some of their most vulnerable moments. This experience has shed light on necessity to continue to strive to bridge the gaps in access to quality healthcare and to advocate for the improvement of perinatal treatment of mothers.

Back to Basics - Cece Cheng

An ancient Chinese proverb states that women hold up half the sky, but the reality begs to differ. Too often women are undermined in societies that value men. There are huge disparities in women's rights and access to safe and quality health care. As I progressed through my years in undergrad, the encouragement and empowerment I felt was a direct contrast to the struggles of the women whom I helped. I came into medical school armed with a passion for women's health -- I knew I wanted to work with marginalized populations on a global level to ensure that health care was a human right for all. The question was, how? And when would I ever feel confident in my ability to take care of others?

A little over a month ago, I packed up my bags and traveled to Tanzania, a beautiful and ethnically diverse country in East Africa. I had been extremely fortunate in my early years of medical school to work in well-equipped clinics and hospitals in Ecuador and China, but this time it was different. The Monduli district hospital was small and lacked many resources taken for granted in the States, or even big teaching hospitals abroad. I knew it would be more challenging than anything I had ever done. However, fresh from my third year clerkships, I felt much more secure in my knowledge base in the diagnosis, workup and management involved for many common and unusual diseases. I hoped these newly developed skills would make up for all I lacked as I worked in Monduli. Along the way, I had some unforgettable experiences and learned some valuable lessons.

Achieving Cultural Competency

The village that we worked in was in an area nicknamed "Massai-land" for the Massai tribe that had roamed there for generations. As a result most of our patients were Massai. They were unique in that they still adhered to a traditional nomadic way of life. They men were polygamous and typically the village leaders, while the women were married at a young age and expected to become mothers and caretakers. There was a lot of deep-rooted tension between the Massai and physicians in the field of women's health – the Massai used polygamy as a method of family planning and spacing out pregnancies between wives, they had practiced home births long before the advent of modern medicine, and even had traditional healers within each village. As a result, sometimes it was difficult to bridge that gap and provide the standard of care for them as for our other patients.

One memory that sticks out in particular was of a woman, who was in the last trimester of her 8th pregnancy that was brought in seizing due to uncontrolled eclampsia. She had never used contraceptives before and also lived in one of the remote villages so had a hard time following up with her prenatal appointments despite the early warning signs. The only definitive treatment for eclampsia is delivery, but it was clear that our efforts were futile. We tried to induce her labor even though her baby had no heartbeat when we listened with a wooden fetoscope; we transfused her but her hemoglobin and hematocrit levels kept decreasing; she never regained consciousness. It is situations like this that remind me each time how health care and access to health care is inextricably linked to the social, cultural, and economic norms of a particular community or region. In order to really effect change, we must first address these underlying issues.

Education is Key

While I was in Monduli, I wanted to learn more about the cultural barriers to contraceptive use and family planning that women faced. My colleague and I spoke with many women in the hospital and nearby villages on their views surrounding contraceptive use. With this knowledge, we then hosted numerous educational sessions – at a local college, a secondary school for Massai girls, and even a spontaneous small group in the post-partum ward at the hospital. We created pictorial brochures about the different types of contraception that are available and used that as a



Massai-land hospital

starting point for our discussions. It was incredible how genuinely interested everyone was. It was as if no one ever talked to these women about this! No one had ever told them they have options or that they can choose! During those teaching sessions, I realized the big impact a little bit of knowledge can make and finally understood the extent of my role as a medical provider in the care of these patients. Whether at home or abroad, as physicians, what better position are we in than to make our patients' needs heard and show them that they are not alone in their journey?

Being A Resourceful Generalist

In developing countries such as Tanzania, the government funds most public hospitals. This means that the salaries for medical providers and the availability of medical supplies are predetermined by how much money is allocated to a single district. It can be very unpredictable what medical supplies are available when and health care providers must be creative when it comes to the care and management of their patients. For instance, when doing phlebotomy, instead of using a tourniquet, nurses would take the rim of a rubber glove and tie that around the patients' arms to obtain adequate blood flow. One night, the labor and delivery ward ran out of Pitocin and could not help expedite labor for women who had been already been in labor for over 12 hours. During a surgery, the electricity went out (a common occurrence in that area) and we finished the operation using only the flashlight app from my phone.

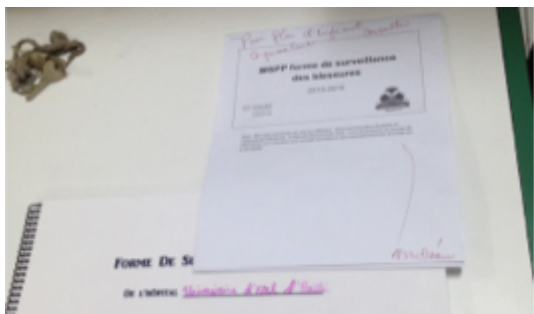
Despite these limitations, I was amazed at how calm and collected the physicians remained. In addition, I was constantly amazed at the breadth of knowledge each physician had, not only in his or her own fields, but also in primary care. Seeing how medicine is practiced abroad has made me appreciate the basic skills of the physical exam and pattern recognition diagnosis. Often, during our clinical rotations in the states, we begin to rely on ordering unnecessary labs and imaging to confirm a diagnosis that could have been reached through a simple history & physical examination. Sometimes, we might rotate through services that are not exactly the most interesting. But in the world of global health, it all matters! Every minute skill is important and you never know how that piece of information will benefit your patients abroad.



Making friends and sharing knowledge to provide the very best medical care

A Multi-site Pilot Injury Surveillance Project in Haiti - Martha Ingram

This summer, I and another colleague spent 8 weeks implementing a pilot trauma surveillance logbook in four hospitals across Haiti. Over the past five years, the Ministère de la Santé Publique et de la Population (MSPP) of Haiti has been working to strengthen the National Health Infrastructure associated with providing Essential Emergent and Surgical care to its citizens. To date, the country still does not have a robust way of monitoring the incidence and character of traumatic events in Haiti. For this practicum, my colleague and I designed a potential trauma surveillance form, of checklist format, compiled it into a logbook that could be distributed to hospitals across the country. The majority of the practicum experience was spent training and implementing this pilot surveillance project in four of the largest cities across Haiti. We spent a week at each site training Emergency Department nurses and physicians on how to use the logbooks, and requested each site to use the book for four weeks. After a site had completed a four-week trial of the book, my partner and I returned to collect the data recorded and to implement a feedback survey among the staff regarding the utility of the logbook. Following the completion of this pilot project, we were able to present our initial impressions to the Director General of the MSPP, who requested the pilot be continued for six more months.



We developed a pilot trauma registry logbook, and a formal training presentation, that were delivered to each pilot hospital site. A copy of the training presentation was left at each site to inform any new healthworkers on the purpose and methods of this project during the weeks that we could not be physically present at the hospital site.



Nurses teaching each other how to fill out the book and when to use it. These secondary trainings would occur in the Emergency Department.



The Emergency Departments were always full of patients coming in to be seen and treated. We found that the highest rates of accuracy and completeness in using the logbook occurred among facilities where residents and nurses managed to fill out the logbook records at the time of, or shortly after, the arrival of trauma patients at the hospital.



Nurse asking our translator a question while using the logbook registry. My research partner and I remained in the Emergency Departments for a week to help the local physicians and nurses integrate use of the pilot logbook into their particular systems of patient care.



Following a 4 week trial period of using the logbook to record patients with injuries, my research partner and myself (pictured) would take de-identified pictures of data recorded in preparation for data entry and analysis.



At the end of our project, the Director General of MSPP requested that we keep the project going- which meant we had to make revisions and print out 12 more books to distribute to the hospitals before leaving the country!



We also used the data collection phase to obtain feedback from the healthcare workers on how the pilot went. Pictured above, a nurse is working on the feedback survey, which were administered using an iPad.



Despite hardships incurred by a tumultuous sociopolitical heritage, season of natural disasters, and challenges to public sanitation, Haiti's beauty always blew me away. To me, this picture captures the beauty of health advocacy and suggests restoration is completely possible for this country. I am so grateful to these hospitals and this research, for inviting us with open arms, and to AMWA for their financial support in assisting with the transportation required to carry this project to hospitals across the country.



American Medical Women's Association
The Vision and Voice of Women in Medicine since 1915

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