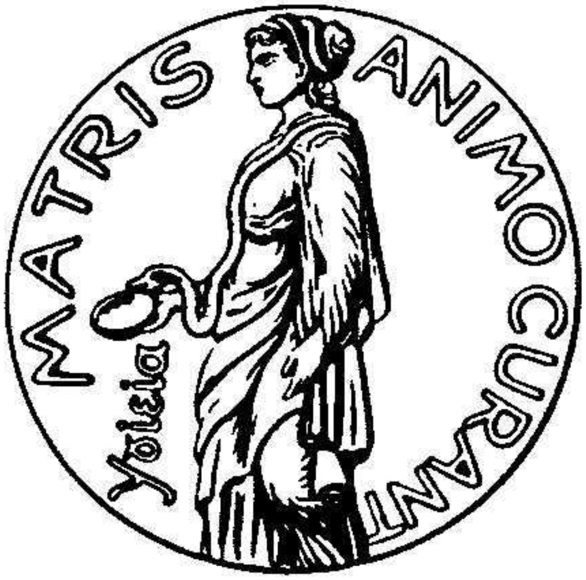
Young Forum Medical Women's International Association Bulletin

Issue 5.1 May 2016



Letter from the Editors

Dear Young Forum Members of the Medical Women's International Association

We are thrilled to welcome you to the latest issue of the bulletin. Firstly, thank you for those members who have written in to share their experiences, reflections, and thoughts with all of us. Our authors are from across the globe including Africa, Europe, Asia, and Canada.

In keeping with the theme of our triennium, our feature article is inspired by a new partnership between the Canadian and American Medical Women's Association to target interviewing skills to encourage violence victims to disclose their stories to health professionals with the goal of seeking support.

We hope that you can continue your support of the newsletter by writing articles, sharing the bulletin with friends, and inviting your colleagues to join the yMWIA.

This summer marks the upcoming triennium in Vienna. We hope that you will be able to participate and enjoy the special reception for Young Doctors. As a special highlight, we have an article that outlines the major project of the triennium, the e-learning tool to educate healthcare providers about Violence Against Women (p 5). As you will see, many efforts across the globe have been focused on this issue. Our feature article, by Brar, Abdou and Rohr-Kirchgraber, highlights a new partnership between our Canadian and American associations to tackle the issue of confidential interviewing as a way to identify patients in need of intervention from violence (p. 9).

It is our pleasure to serve as the Editors to the Bulletin. If you have any ideas for upcoming topics, please feel free to contact us. Archives of the newsletter can be found at www.mwia.net

Your Editors,

Pamela Liao CANADA
Charlotte Roehrborn GERMANY

The Portrayal Of The Ill And Illness

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"What is not fatal is not cancer"[1] Dr. George Groddeck, considered as a founder of psychosomatic medicine, proclaimed in "The book of It". The myriad of ways in which diseases and those affected are depicted in literature are countless. But how have they shaped us, and more importantly what do they mean once we ourselves get ill.

Does our language, the terms we use to describe illnesses have powers beyond our understanding. Do they come to play when we get ill, when we are presented with a chronic disease. Do we suddenly conform to the language used, and perhaps fall victim to word play.

In Susan Sontag's widely acclaimed book "Illness as a metaphor" she depicts her own journey while struggling with a cancer diagnosis. She sourly concludes that metaphors hold no place in the journey towards recovery. "I want to describe, not what it is really like to emigrate to the kingdom of the ill and live there, but the punitive or sentimental fantasies concocted about that situation: not real geography, but stereotypes of national character." [2] Susan writes.

On the other hand one can argue that the power of science is greater, that it has the function and capacity to discard any metaphors or myths of disease created throughout history. Another standpoint is that we simply cannot shake diseases off of their symbolic values and literary depictions. But the most important question has fervently survived the test of time since the publication of Sontag's trailblazing piece back in 1978. That is; does our culture and written word shape the individual experience of illness? Moreover how well do our scientific findings translate in comparison to the more easily accessible world of literature. And how aware are we as physicians of the contemporary views on illness and the ill in our modern day culture.

Surely this awareness has a pivotal role in the mode of which we communicate with our patients. All these questions are worthy of our attention on the journey towards becoming great physicians. Studying how cancer has been depicted throughout history in literature is a journey filled with fearful and dark adjectives, metaphors and symbols. It is almost unanimously described as a death sentence. And the stigma surrounding neoplasms is a burden that unfortunately is carried by those who have it. Nazis at one point in time described Jews as a cancerous lesion that was tarnishing the “pure” body of the German people. Sontag states “ conventions of treating cancer as no mere disease but a demonic enemy make it not just a lethal disease but a shameful one.” [2,3]

This account is especially problematic while patients that might react to certain symptoms out of fear and shame[3] neglect to contact the health care system. Thus the stigma around cancer created by cultural depictions finally becomes an obstacle, and may very well worsen a diagnosis while staggering patients from reaching out.

However Sontag also concluded that once the causes of diseases are unveiled the metaphors would succumb to fill any role or function and thus be abandoned over scientific facts. But this might take a very long time, as plausible disease causes often if not always require great periods of research. But one can not escape that viewing a disease as a biological phenomenon rather than a social or moral one is a vital if not critical realization on the road towards recovery while suffering from a disease.

Imagining society taking on the same standpoint is mind-boggling. Until then it lies upon us as caregivers and physicians to strip metaphors of their powers by exposing, criticizing and increasing awareness around their invisible yet significant role.

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Is Medical Care Rendered During Free Medical Outreaches Quality Service?

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Medical outreaches are common in developing countries like Nigeria where most of the populace live in rural communities and villages. Outreach strategies are linked to the organizations mission; define targets, goals and milestones.

An outreach is an effort by individuals in an organization or group to connect its ideas or practices to the efforts of other organizations, groups, specific audiences or the public 1. Typically, non-profit civic groups and religious organizations engage in outreaches. Health care delivery in Nigeria is plagued by inaccessibility, inconsistency, and poor organization thus the rural people who constitute about 70 % of Nigerians have the least access to health care 2.

Medical outreaches are organised by religious bodies, faith based organizations and non-governmental associations. These outreaches are due to the poverty of the people as most of them cannot afford quality health care and also because of cultural and traditional beliefs. These medical outreaches deliver free dental, medical and surgical services at little or no cost to the public hence the large crowd that turn out for such programmes. Sometimes camps are set up. A room is cleaned, disinfected and used as the operating room. Nevertheless, the question is if such services rendered are safe especially when the services are rendered by personnel not based in that country. During such programmes, a field hospital is set up with or without surgical theatres and laboratories.

Such programmes are sustained through financial donations from individuals, religious groups, civic organisations and donations from pharmaceutical companies.

In as much as such outreaches may alleviate the sufferings of the masses, it may also have its problems especially those organised by organisations and personnel not based in the country. The question about their certification and licence to practice in the country arises if they are qualified medical doctors, dentists, pharmacists, nurses, laboratory scientists or whatever they claim to be. When surgeries are performed, one may be worried about the competency of these foreign surgeons. Though there is poor health care seeking culture in some countries, any dental or medical service rendered should be quality and standard service offered by qualified personnel.

This kind of program is vital because most of the patients cannot afford the cost of buying their own prescriptions or paying for their surgeries. Most of the male patients show up with hernias overdue for surgery.

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New Collaborative Living Document on Violence Against Women

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CANADA

Welcome to the Medical Women's International As … al! Learn about
addressing violence as it faces clinical situations f … xperts across the

Here is announcing a new international peer-reviewed resource addressing violence against women, a collaborative effort between the MWIA and yMWIA.

The Medical Women's International Association has put together a comprehensive manual addressing violence against women and girls for use in a professional healthcare setting. The manual emphasizes key aspects of care, focuses on learning through cases written by physicians around the world, and offers additional clinical templates and supports. Through the collaborative effort between the organizations members, ranging across 6 continents, this manual uses clinical cases as the cornerstone its pedagogy. The global context allows healthcare professionals to apply the learning points from each case in a variety of situations, and is looking for further input to help strengthen it discourse and impact. The project is accepting further cases and further information around local and community violence and support resources.

The MWIA Living Violence Manual will serve as valuable resource in many communities across the globe working towards equity and safety for women, children and their families. The site will go live after the triennium in Vienna this summer. Stay tuned!

Musings of A Junior Doctor

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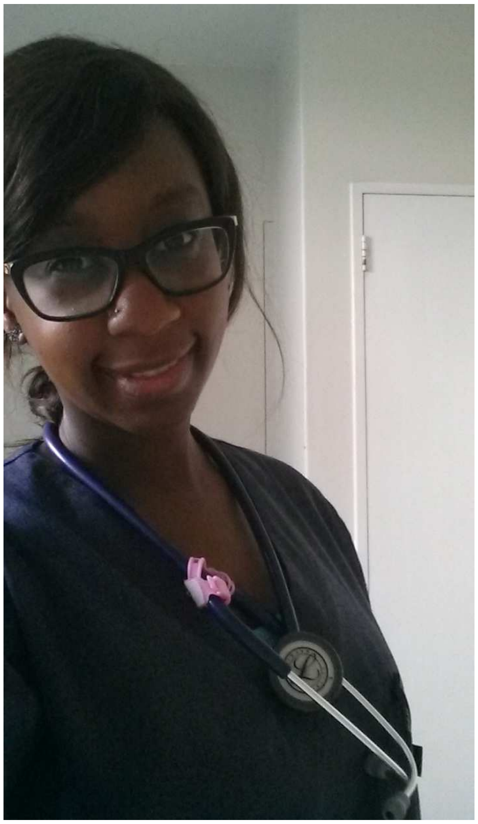

Its 5am and I am sitting in casualty huddled by a wall heater with two nurses. The foyer is empty and an uncomfortable stillness fills the corridors. I am find myself reflecting on the night's events; a upper GI bleed, a neonatal resuscitation, a toddler that lodged peanuts into both her nostrils…I giggle at the last one. I am barely out of medical school, starting a compulsory two-year internship in a state hospital in a low/poor income community, a rural setting. Six years of medical school did not prepare me fully for the challenges I was beginning to encounter as a junior doctor; the shortage of resources, the language barriers, the inadequate man-power, the limited health education of my patients and the lack of supervision occasionally encountered. A few weeks prior I had called home and told my mom that I was unhappy, unsettled in my new job but perhaps this was part of growing up, moving into the sphere of adulthood and facing real life problems. I wish I could have been more excited about my career. I mean, this was only the beginning and to commence it with such apathy and disconnect would not benefit me in the long term. I am young female African doctor trying to find comfort in her job, the career that was seven years in the making; a doctor that is learning to understand the system and work efficiently within it, even when all indicates otherwise; a woman trying to carve a niche in the world for a herself, a young adult desperate for change and growth, and familiarity simultaneously. I am trying to hold onto all hope that I will grow to love what I do, believing it was the right career decision and reminding myself, I do this for my people.

A Focus On Intimate Partner Violence

(L to R) Dr Kathee Andrews (Toronto Branch President, Federation of Medical Women of Canada, Dr Robin Kaloty National Resident Representative FMWC, Sarah Survivor and Guest Speaker, and Dr Vivien Brown, National President – Federation of Medical Women of Canada)

Dr Robin Kaloty
National Co-Resident Representative
Federation of Medical Women of Canada

The Federation of Medical Women of Canada (FMWC) lends focus to the health consequences and provider considerations when working with survivors of intimate partner violence (IPV). The event "Caring for Women Who are Victims of Violence … What Can We Learn?" organized by Dr. Kathee Andrews, Toronto Branch FMWC President, took place in Toronto, Canada on May 3, 2016, and was attended by several medical students, residents, and practicing physicians from the local area.

Dr. Robin Kaloty, a Family Medicine resident based out of Women's College Hospital, Toronto Canada, with a special clinical and research interest in IPV, spoke about the prevalence and health consequences of IPV, and highlighted various avenues that clinicians can take to support IPV victims.

But the most valuable learning happened from the first hand account of a survivor. Audience members listened carefully as Sarah Morgan recounted her experiences with sexual assault and psychological abuse. She discussed her various encounters with the healthcare system over the years, highlighting both the positive and negative experiences she had during her journey to finally disclosing abuse and seeking help. The audience engaged in a discussion on strategies to maintain an open and non-judgmental atmosphere in the healthcare setting. Sarah has a bachelor's degree in social sciences and is now working as a crisis worker at a women's shelter in Toronto.

Attendees described the event as educational and eye-opening. "Her story was so touching and will have a lasting impact on me" said Amanpreet Brar, a second year medical student from the University of Toronto.

Several members of the FMWC have been working hard to address barriers to IPV, having recently joined forces with the American Medical Women's Association (AMWA) to create The Confidential Interviews Task Force. This task force advocates for medical schools in North America to train medical students to maintain a confidential environment during patient visits ie. asking the patient's partner to leave the room for the physician encounter. The goal is for confidential patient interviewing to become standard practice, which will in turn address a common barrier to abuse disclosure. Members of this initiative include Dr. Theresa Rohr-Kirchgraber, Dr. Vivien Brown, Dr. Robin Kaloty, Dr. Pamela Liao, Ms. Amanpreet Brar, and Ms. Aya Abdou.

Visit the following links for more information about The Confidential Interviews Task Force: https://fmwc.ca/confidential-interview-task-force-launched/

Feature Article:

Time to Re-Think the Confidential Interview: Perspective of medical students

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The importance of confidentiality in the physician-patient relationship has been captured within the Hippocratic Oath (Davis et al., 1999). In a health care context, confidentiality relates to the obligation, described by Hippocrates, of a health care professional never intentionally to disclose anything revealed in personal communication with a patient (Davis et al., 1999). Therefore, it is reasonable to conclude that the patients expect physicians to respect their right to confidentiality and protect all personal details unless they give permission to disclose information. Since confidentiality lays down the foundation for a physician-patient relationship, it is crucial that the medical curriculum incorporates adequate training and assessment of medical student's understanding and application of these concepts.

I still vividly remember my visits as a teenager to the family doctor along with my father. I was not in medical school then but I still had a grasp of the words confidentiality and privacy. I can't count the number of times I had hoped my family physician would ask my father to step out while we discussed my health concerns. A couple of times my father himself asked me if I would prefer him waiting outside but it was disappointing for me to see that my family physician did not take an initiative to create such an environment for me and his other patients. What surprised me was that I was not the only one awkwardly entering my family physician’s room with a visitor, I saw many couples and family members doing the same. It brought flashbacks of the news of intimate partner violence, sexual assault, and domestic violence to my mind. I cringed at those thoughts and wondered whether any of his patients are yearning to talk to him about confidential matters such as violence in the home, sexual activity, or even depression.

Upon entering medical school, I had hoped to learn a lot more about confidentiality and the ways of establishing a confidential interview with my patients. The terms confidentiality, privacy, and ethics were thrown at me numerous times and these terms eventually assumed the shape of a tangled yarn of wool. The Bates Guide to Physical Examination and history taking gave me the following description of a confidential interview, “Whenever visitors are present, you are obligated to maintain the patient's’ confidentiality. Let the patient decide: “I am comfortable with having your sister stay for the interview, Ms. Jones but I want to make sure that this is also what you want. Would you prefer if I speak to you alone or with your sister present?” I read these sentences and thought back to all my visits to the family physician. Would this be sufficient to create a comfortable environment for my patients? Would a victim feel comfortable asking their family/friend/abuser to leave?

While attending a Federation of Medical Women of Canada (FMWC) conference, I had the opportunity to hear a talk about Intimate Partner Violence and discuss the issue of confidentiality with a physician from the American Medical Women’s Association (AMWA) and fellow medical students and residents. We conducted a literature review and found out that the lack of training regarding confidentiality and ethics has been established by a number of studies. One survey conducted on medical education in US and Canada in which 123 deans and 91 course directors provided information about 91 medical schools’ curriculum (6 Canadian) (Lehman et al., 2004). One-fifth of schools provided no funding for ethics teaching, and 47 (52%) did not fund curricular development in ethics (Lehman et al., 2004). Institutions with a dedicated ethics faculty member were twice as likely to have a mandatory introductory ethics course (64% versus 32%, p <.05) (Lehman et al., 2004). The primary obstacles to ethics education were thought to be a lack of time in the curriculum, a lack of qualified teachers, and a lack of time in faculty schedules (Lehman et al., 2004).

Another study looking at the avoidable breaches of confidentiality among 211 law, medical, and dental students found that in 6 cases they tested, a violation of confidentiality by studies was found in all cases (Elger, Haring, 2005). Upon further research, a study was found that looked at the perceptions of medical students and residents regarding intimate partner violence (IPV) and found that there were many misconceptions, such as a fear of offending patients by screening for IPV (Sprague et al., 2013). Most students and residents surveyed recognized that timely identification of IPV was highly clinically relevant although they underestimated its prevalence in clinical practice (Sprague et al., 2013). Some of the barriers to a proper IPV assessment - which would include a confidential interview - were a lack of time and knowledge, with lack of training being the main barrier identified (Sprague et al., 2013). More than 75% of surveyed students and residents were interested in acquiring further IPV training and education (Sprague et al., 2013).

A more recent study looked at the effectiveness of various IPV education methods on increasing knowledge and behavior (Zaher et al., 2014). The training methods included IPV workshops, problem-based learning, and added training regarding supportive resources (Zaher et al., 2014). It was found that these methods only increase physician knowledge and management skills of IPV (Zaher et al., 2014). Only by the addition of support resources to the IPV training was there a change in physician behaviour as well as knowledge, indicated by an increase in referrals to IPV support services (Zaher et al., 2014).

Moreover, in most of the literature review, it was found that none of the medical curriculums emphasized the importance of a confidential interview. The scenarios focused on keeping patient information, EMR data and records private but the importance of creating a confidential space and environment for the patient in an office or hospital had not been emphasized. The emphasis on confidential interview in medical school curricula will greatly improve IPV, sexual assault, domestic abuse identification and management. It will make sure that the vulnerable patients feel comfortable and at ease while discussing their health concerns with their family doctor. I often hear medical students say that they feel privileged that the patient's lives are like an open book in front of them but they need to learn to create an environment where patients feel comfortable to open their book.

The only way to ensure the patient has an opportunity to discuss sensitive topics such as abuse, sex, and mental health, is to have confidential time at every visit with every patient aged 12 and over. The American Medical Women's Association (AMWA) and the Federation of Medical Women of Canada (FMWC) have joined forces to push this teaching into the medical school curriculum and exam rooms across North America. In coordinating efforts, we hope to develop procedures that ensure every patient has the ability to discuss sensitive concerns with their physician.

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Changes to Cervical Cancer Screening Interval Impacts STI Rates in Canada

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Previously, cervical cancer screening for young women in Canada began at 21 years of age and continued every 2-3 years, with cessation at age 65 (1). Recent changes to screening guidelines have been published in North America by both the Canadian and US Preventative Task Force, calling for screening to occur at 5-year intervals 2,3 as opposed to 3-year intervals. This has prompted questioning around the implications of increased latency between screening and possible impacts on rates of diagnosis and treatment of sexually transmitted infections (STIs). A recent Canadian study confirmed that STI screening decreased in relation to cervical screening guideline changes (6).

There has been a mixed reaction to the changes, notably between the United States and Canada. The Society of Obstetricians and Gynaecologists of Canada do not support the current Task Force recommendations citing their lack of widespread applicability: evidence is only presented for women with normal screening and does not speak to abnormal result patterns (1). However, the American Association of Obstetricians and Gynaecologists accept the US Preventive Task Force guidelines, with the most striking change for women aged 25-60: screening with cytology and HPV testing is conducted every 5 years (3). This is in comparison to European standards of care, where in England for example, the NHS uses a 3-year system for screening for women aged 25-49 (4). In a Canadian context, Bogler et al. showed that a change to Canadian guidelines resulted in decreased STI screening among women aged 19-45 (6). This can have serious health implications for women.

Taking note of these findings, it is critical to counsel women to promote successful follow-up. Literature has supports anticipatory guidance and increased confidentiality promotes compliance, result retrieval, and return to care (5). With new guidelines, it is imperative that healthcare providers screen high-risk populations for STIs in the context of cervical screening (6).

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MAKE A DIFFERENCE - EXCHANGE IDEAS

- *Original submissions for the next issue of the Young Forum's Newsletter are currently being accepted.*

- *Please send news items, articles, commentaries, school exchange reports, local MWIA activities to our editors.*
- *Reports must be carefully proof-read prior to submission.*
- *Please include author name, country, email, photo, and articles not exceeding 500 words.*
- *Submission link available on our Facebook page and www.mwia.net*