



N Global Health NEWS

CONTEMPLATION • COMPASSION • ADVOCACY



Lending a Helping Hand at Home and Abroad

By Hanna Ross-Suits (Class of 2015)



Elizabeth Bates, BS, DN, is an instructor with the Nursing Program at PSU, one of the facilitators of the Nursing Residency Program here at the medical center, and a facilitator for the Medical Humanities class. She also works with numerous community groups in Dauphin County including The Giving

Tree—a group of women who take care of people and families who need help with things like meals or clothing items—and the Lower Dauphin Communities that Care that focuses on “making circumstances right for students to grow up healthy and productive.” She works with church groups, medical and nursing students, and individuals and families. She emphasizes, “I do a lot, but I don’t do it alone.”

Whether she works with individuals or grassroots organizations she stresses that it is a partnership, and that she is “just a partner.” She takes the time to build relationships, because, “if you want to see change, you have to be there awhile.” Building relationships is “the most important thing you can do.” She does not promise things she cannot do and she lets people know that she is not there to judge or tell them what to do, but is there as a partner to help them fix a problem.

The Role Model Who Will Never Know

Dr. Bates did not plan to go into nursing. She earned her BS in Mental Health and Individual & Family Studies, and was working in social work in nursing homes when her mother was diagnosed with colon cancer and needed surgery at Mt. Nittany Hospital in State College. She recalls sitting by her mother’s bedside after a successful surgery when a nurse came in to treat a haggard-looking patient in the next bed. That nurse didn’t see a woman wasted by cancer; she saw a human being who needed help. She saw the nurse giving “the ultimate compassion to a most vulnerable person” and without knowing it inspired Dr. Bates to become a nurse.

Dr. Bates earned her Doctorate in Nursing from Case Western and has been going a million miles an hour ever since.

Cape Town, South Africa

Her first trip to South Africa was “the most unplanned thing I’d ever done.” In partnership with the University of the Western Cape, she took Penn State nursing students to Cape Town five years ago to work alongside the nursing students studying there in the hospital and nearby clinics. She fell in love with the place and has been going back almost every year since—in fact, her next trip is in March 2012. She has helped host faculty and students from the University of the Western Cape on our campus.

When asked what she loves about South Africa, she provides a list—the spirit of resilience from the South African people; the fact that they are able to make few resources reach more people; the ideas they have for teaching health education (like using clubs to help patients teach each other about their disease); and watching the impact that the trip has on her students. As she put it, “The experience of living in another place is life-changing.”

Recommendations

To anyone who would like to work with underserved communities, Dr. Bates has some advice:

- Start small and see where it leads you. The most successful programs she’s seen and worked with started small, addressing a few issues or a smaller part of the community, and grew from there. If you’re unsure about how to get started, she recommends asking someone who works with the underserved if you can go along.
- Remember that it is a privilege to serve. As Dr. Bates puts it, “if you’ve been given a lot, you should give something back.” When asked about why she works with the underserved, Dr. Bates mentions that only circumstances separate her from being in their position, and that if she were the one in need of assistance, they would help her in a heartbeat.
- Be good to yourself. As much as we would love to help everyone with everything, it is important to take care of yourself as well. Sometimes you need to give yourself a break and do something just for yourself.

If you’re in need of some inspiration, she recommends Nelson Mandela’s book *Long Walk to Freedom*. I’d say if you need some inspiration, sit down with Dr. Bates.

Field Notes: Kijabe Hospital in Kijabe, Kenya

Carolyn Pennay (MSIV) is currently spending an elective month abroad with Africa Inland Mission (AIM) at Kijabe Hospital in Kijabe, Kenya. This an excerpt from one of her email updates:

Sunday morning, I had arranged to meet the Ob doc on call at 8 am for maternity rounding before church. Just as I walked in he came hurrying down the hallway and ushered me straight back to the OR where an emergency c-section was just beginning. It was a 30-week pregnancy in a mom with known heart failure, severe scoliosis and pre-eclampsia. I got there too late to participate but I was praying frantically for a good outcome for both, knowing that chances were slim that the baby would survive that young in such a setting. Everything seemed to go fine. The mom was stable immediately after surgery and the baby required a breathing tube but seemed okay. After the woman got up the ICU, we faced the quintessential dilemma of resource-poor medical care: there were three patients already on ventilators and now this one required one, too. There were two broken machines there, so we kept her breathing manually while numerous people tinkered with the machines to no avail. Her heart failure was worsening, making it harder and harder to push air into her lungs and maintain good oxygen levels. We were losing ground fast. Stubbornly, we kept going as we all knew the inevitable decision-point was approaching. Finally another doctor joined us in the ICU and sized up the situation, asked who had the poorest prognosis, and order life support to be stopped. I was reeling with the sheer intensity of the situation, with exhaustion from physically working so hard to keep her alive, and with the horrifying reality of literal rationing of healthcare resources. It was a dangerous pregnancy and we all knew from the start that things didn't look good, but somehow that didn't ease the shock of witnessing her death, knowing full well that in the States we would have had ample supplies, medications and techniques available to save her life.

Later on, the day was a bit redeemed by having the ever-sweet privilege of assisting in what I consider to be a quintessential delivery. Okay, so it wasn't quite that, but nearly so. The mom arrived here around 11:30 pm from another hospital where she had been in labor since 4 am. They feared she would not progress further and sent her to us for a possible c-section. Although she was worn out, in pain, and begging for us to cut the baby out of her, there was no medical necessity for it. I enjoyed the sweet job of holding her hand and being her cheerleader for last hour of labor until she delivered naturally a big, beautiful baby girl. Immediately upon seeing her child, she her face lit up



and she declared, "I'm SO happy. That was all worth it." She thanked me repeatedly for encouraging her to stick it out and even thanked the doctor (with whom she was rather irritated during the whole process because he refused her c-section). I think the tragedy earlier in the day made that simple, ordinary victory much sweeter.

Today, I finally got started on my regular rotation here and let me tell you, this is a crazy place! I won't begin to detail each of the patients we saw today, but I will be super busy for the next month. I'm working with an American doctor and two Kenyan residents and absolutely love all of them. The sense of purpose and camaraderie is unparalleled. This whole hospital is a confusing combination of being far better equipped than I would have ever dreamed (they have a world-class pediatric neurosurgeon on staff!) and yet obviously resource-poor compared to any in the States. Every single treatment decision we make is based on what is absolutely necessary and what the family can pay for.

I was also struck anew with a reality that is equally (or nearly so) true anywhere medicine is being practiced: every single one of these patients I've seen in the last 2 days is in the middle of a life-changing experience. From the meningitis patient who may die without expensive antibiotics, to the family with a lost mother and new premature baby, to the happy and healthy new mother last night, I am in the unique position to literally witness countless lives being altered in dramatic ways. I guess that's one of the many things that drew me to medicine – the sheer volume of human life I contact in vulnerable, intimate situations.

Field Notes: CMC-Vellore, India

Laura Spece (MSIV)

I'd like to give you a little introduction to how a patient navigates this 2,500+ bed hospital from the drop off at the casualty bay, to admission on the wards. This machine is behemoth at CMC hospital in Vellore.

1. The ambulance:

The ambulance system is new to Tamil Nadu, and has only been in existence for 2 years or so. You dial *108 and an ambulance is to come in 20 minutes. There are 645 ambulances purchased by the state government, the primary motivation is to decrease the mortality of pregnant women. These vehicles arrive in the bay in every shape, size and stage of disarray. The service is free to any citizen, but paramedics do not exist on government ambulances at this point, it's just transport. Though people still get dropped off in rickshaws and personal cars. If you want a paramedic, you need a private ambulance, which can still be acquired through the *108 switch and costs around \$60. Which you would pay before boarding.

2. The Casualty bay:

You pay an advance. Period. Rather your family member pays an advance, since you might be unconscious or writhing in pain. Typical advances run around \$20. Then you can see a triage casualty specialist (our equivalent of an ER doc) who will stabilize and run any urgent tests. Next you will get sorted into a medical or surgical patient. This is where I picked up on Medicine 4. So picture this: I'm standing in front of a very sick 20 year old (situs inversus with tetralogy of fallot and suspected infective endocarditis causing neurological sequelae from septic emboli), who is pretty comatose, breathing quite fast and about to aspirate on his own vomit.... but I can't send the tubes containing the blood that are already collected and lying on the bed for culture, electrolytes or arterial blood gas analysis because his

dad hasn't come back with his receipts for payment for each individual test! WHOA! And we didn't intubate for a ventilator because the family would go bankrupt. Or even worse, take out a loan at nearly 50% interest to cover it... these loans are a high cause of suicide in India.

Now I don't want to paint a bad picture of CMC, this is just how it works. And the total bill for all of that blood work might only add up to \$8 (it would be WAAAY more in the States). Most of the bill is written off completely, especially since his parents didn't have any shoes. Once the patient is fully admitted to the ward, tests can be ordered without upfront payment. And this kid is really sick and his chances of dying are quite high. It got so bad because he was evaluated at another hospital and was treated for pneumonia...

3. The ward:

Once it's been deemed that you are sick enough to warrant a >2 day stay, or need significant work up, you can get admitted to the ward. When you're poor, this means dormitory style. No private room for you. No flat panel TV. No room service. Your family member will fetch you food and potable water. They will also help to bathe you, use the urinal or the bed pot. For their devoted kindness, they will sleep on a mat, on the floor with you overnight. There are more male than female patients in the wards, and this is generally because more men will seek medical care than women. This is again due to gender inequality. And these people come from ALL over the world. Africa, far north India, Nepal, Bangladesh and Singapore. Because while to you and I this sounds monstrous, the medical care and treatment the patients get here is top notch, and affordable. Nearly every patient can afford a CT or even an MR angiogram. These tests are way out of reach for Americans without



health insurance. So it seems like the lack of comforts is a price these people are willing to pay. Bill collecting is done on Fridays (interns get stuck with this!), and there is a separate section in the medical record for the "financial plan and bill." I've never seen a bill in the States as a medical student, just for reference.

Now if you have money, there is a whole separate section of the hospital. The A ward. Prices here are much higher for private rooms with A/C and more one-to-one nursing care. This is done to subsidize a lot of the costs for the poorer patients. But here, the same docs rotate through the rich A ward, to the poor E ward. So the poor get equally as good of care. Just without the frills.

Only 1 family member can sleep on the floor with the patient on the ward, and she must be female. However, the rest of the family will sleep in the hallways and on the grounds of the hospital! At night, the CMC hospital turns into a neat home of families having dinner and setting up mats everywhere. I was tipped off to this phenomenon by my intern. This photo is of a group of people stocking up on drinkable water for the night. And then of other family members camping out in the hallway outside of E ward.

Obviously, this brings about numerous ethical debates and questions. I am constantly assessing the applicability of the CMC system to that back home. And I hope that you understand that CMC provides excellent care and is exceedingly compassionate. It's just so different.

A Refugee Story (Part 2 of a 3 part series on Refugee Health)

By Pulkit Bose (Class of 2015)

A refugee is someone who has been forced—by war, genocide, or persecution—from one's own country to find refuge in a foreign land. This is not just a displacement from quotidian life, but a sudden loss of what provides the majority of us with a sense of coherence, security and meaning – a house, a family unit, an education, a meaningful job, savings, etcetera.

My journey as a refugee began in the year 2000 with my father's death. I was fifteen. Dad was an engineer and before his death my family had a life of abundance. After he passed, we lost our home and our source of income. His expanding business collapsed and with it brought corrupt debt-collectors – people who valued money above human life. The social stigma of my mother's widowhood meant she was unable to get a job and faced abuse from opportunistic and oppressive individuals. Within months, we were cheated out of almost everything, including a roof over our heads.

My mother's struggle to survive and protect her children from harm made social inequalities and structural violence very real and visible in our lives. For my sister and me, our poverty meant no prospect of higher education. To be forced to run for life is not just a tragedy – it is a grave consequence of complete disregard and contempt for human rights and preciousness of human life. In the face of adversity, my mother taught me what it meant to truly love, hope and persevere. Compassion took on a new meaning for me when I was the one in need of it. We were not alone in these circumstances. Millions of people worldwide faced (and continue to face) life-threatening circumstances that forced them to flee.

My family's challenges continued after we sought refuge in the US, sleeping on the floor of a relative's home for several years and struggling to make ends meet. An immigration judge approved

our case and I finished high school. I could not afford college even though I was accepted to many good universities. We also could not afford to get sick. When mom sprained her wrist, there was no health insurance to cover a visit to the doctor. Luckily, the injury was not severe and it healed. Mom had managed to get us a small room and food by working for the relatives – cleaning, cooking, housekeeping. During this time I began to understand and relate to the voiceless plea of many socioeconomically deprived and marginalized people for quality education and health care in the US.

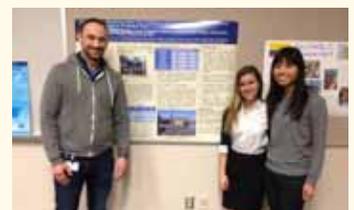
I came to know deeply that people labeled as 'refugees' and 'poor' are not simply needy people with their hands spread out for alms. Refugees are human beings. And just like everyone else, in their human dignity and existence they have a lot of hidden potential and goodness to offer to this world. Ultimately, I was given the gift of a college education by some gracious individuals who believed in my ability to one day serve the society and country that had adopted me. In 2002, my mother went back to school to learn English. After working as an assisted living helper for a while, she became a medical assistant and a certified nursing assistant at a retirement community in California. The humility and compassion she carries in her service for the elderly is exemplary and inspiring to me. In 2009, my sister graduated college and now works as an analyst in the California Governor's office.

Refugees in our community are resilient, but this ability to recover from suffering and loss is not possible without the help of people and organizations from the community. Our collective commitment as a medical community to the relief of human suffering calls us to become aware of the impoverished, powerless and vulnerable persons in our own backyard. An active awareness and acknowledgment of these individuals and their challenges is the first step towards offering them our care and help.

Global Health Night

On Tuesday, January 31st, the Eighth Annual Global Health Night was held at the University Conference Center. Through the combined efforts of the Doctors Kienle Center for Humanistic Medicine, Humanities Department, and the Global Health Interest Group, the event was quite a success. Numerous students as well as physicians attended Global Health Night in order to learn more about research and medical care that benefits the global community. All of the profits from the night went to the Doctors Kienle Center which provides scholarships to Penn State medical students who spend time abroad.

Dr. Jose Stoute from the Department of Infectious Disease started the talks with his presentation discussing the science behind using microwaves to destroy the Plasmodium falciparum, which is one of the five Plasmodium species that causes malaria. This research project is currently being funded by the Bill & Melinda Gates Foundation. Later in the night, Dr. Mackay from the Department of Plastic Surgery discussed his role in surgical medical missions with the organization Operation Smile. He specifically discussed the impact and advances of the Operation Smile mission in the Assam province of India.



Conferences

The following is a compilation of various global health conferences around the country being held in 2012. This list is not exhaustive and you are encouraged to research more opportunities on your own. Global health conferences are wonderful opportunities to gain new perspectives, network with colleagues, and explore your passion for global health.

Consortium of Universities for Global Health

<http://www.cugh.org/resources/events>

Global Health Emergencies Course

Manhattan, NY

March 5-16, 2012.

<http://globalemergencymedicine.org/GHEcourse.html#overview>

Advisory Group for Global Health in Pediatric Resident Education Meeting for faculty involved in leading/directing GH programs for residents

Association of Pediatric Program Directors (APPD) Spring Meeting

San Antonio, TX

March 28-31, 2012

More information from directors:

Dr. Sabrina Wagner

swagner@pediatrics.wisc.edu

Dr. Chuck Schubert

CHUCK.SCHUBERT@cchmc.org

Clinton Global Initiative University

Washington, DC

March 30-April 1, 2012

<http://www.cgiiu.org/default.asp/>

Unite for Sight Annual Global Health Conference: Global Health & Innovation

New Haven, CT

April 21-22, 2012

<http://www.uniteforsight.org/conference/>

Annual Western Regional International Health Conference, At a Crossroads: Choosing Hidden Paths in Global Health

Seattle, WA

April 27-29, 2012

www.wrihc.org

Pediatric Academic Societies (PAS) Annual Meeting

Boston, MA

April 28 - May 1, 2012

<http://www.pas-meeting.org/>

CORE Group Fall/Spring Meetings

Wilmington, DE

Spring Meeting: April 30-May 4, 2012

<http://www.coregroup.org>

Program for Global Pediatric Research Symposium and Workshop: The Global Crisis of Childhood Diarrhea

(Held annually at PAS Meetings)

Boston, MA

April 20, 2012.

<http://www.globalpaediatricresearch.org>

Further info:

Alvin Zipursky MD

alvin.zipursky@sickkids.ca or

Margaret Manley

margaret.manley@sickkids.ca

Institute for International Medicine: Exploring Medical Missions Conference: From Inspiration to Mobilization

Kansas City, MO

June 1-2, 2012

http://inmed.us/exploring_medical_missions_conference.asp

Global Health Council (GHC)

Annual Conference: Setting Priorities & Finding Linkages

Washington, D.C.

July 18-21, 2012

<http://www.globalhealth.org/Conference.html/>

American Academy of Family Practice: Family Medicine Global Health Workshop

Minneapolis, MN

September 6-8, 2012

<http://www.aafp.org/online/en/home/aboutus/specialty/international/oi/cihi/workshop.html>

World Conference for Family Medicine (WONCA): Towards Unity for Health

Northern Ontario, Canada

October 9-14, 2012

www.rendez-vous2012.ca

American Academy of Pediatrics, Section on International Child Health (SOICH) Annual Program

New Orleans, LA

October 20-23, 2012

<http://www.medicalhomeinfo.org/training/conferences.aspx>

American Public Health Association (APHA) Annual Meeting and Exposition: Prevention & Wellness Across the Life Span

San Francisco, CA

October 27-31, 2012.

<http://www.apha.org/meetings/AnnualMeeting/>

American Society of Tropical Medicine and Hygiene

Atlanta, GA

November 11-15, 2012

<http://www.astmh.org/Home.htm>

CMS Mission Trip to the Dominican Republic

By: Josh Burkhart

Over spring break this March 2012, the Christian Medical Society (CMS) at PSUCOM will be taking a team of physicians, medical students, graduate students, a nurse practitioner, and a nursing student on a medical mission trip to Hato Mayor, Dominican Republic. We will be working with Meeting God in Missions (MGM) to care for the physical and spiritual needs of the Haitians migrants who live and work in the sugar cane fields. Amazingly, these people come to the Dominican Republic because it offers a better life than what they had in Haiti. They take the jobs the Dominicans don't want, even though working in the sugar cane fields 8-9 hours a day only

pays the equivalent of a few American dollars. Our short term mission work will be a small, but essential part, of the continuity of care and relationship MGM has with these villages. Even greater than providing much needed medical care and pharmaceuticals, these people are looking for someone to listen to them and provide reassurance -- an invaluable lesson for students about the patient-doctor relationship. Furthermore, the clinic will provide a learning environment for students, who will be running the interviews, performing physical exams, and working side-by-side with physicians to diagnose and create a treatment plan. Although these people are



impoverished and lacking in many modern advances, including medicine, they are generally happy, generous, hardworking, and have a strength of spirit that many Americans lack. We as students and medical providers can learn a lot from them and this trip will be a very life-centering and educational experience for all who are participating.

How to Donate to The Global Health Center Scholarship Fund

If you are interested in donating to the Global Health Center Scholarships you can:

1. Send a check to the Penn State University Global Health Center
2. Go to the Give Penn State fund on the web at giveto.psu.edu
3. Contact Devon Johnson to set up your own scholarship at DominickJohnson@hmc.psu.edu

The Global Health Center provides organization and oversight for the medical center's educational, service, and community research activities in global health. The Center is responsible for promoting global health issues on campus.

If you would like to contribute to the quarterly newsletter, please contact the Global Health Center (nfredrick@psu.edu).

If you are not receiving this publication but would like to be added to the list, please send an email to nfredrick@psu.edu.

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On the Web: <http://www.pennstatehershey.org/web/globalhealth>

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