Fighting Here, There and in All Directions

Annual Review: July 2014- June 2015

► What You Really Need to Know in the Field: Annual Global Health Track Workshop, September 2014

The focus of the 2014 GHT Workshop was “practicability” and “applicability” of the contents as I’ve felt that global health workshops are not practical enough. The only and best way to implement this idea is to set up all sessions as a “learning by doing” format. That is, for example, instead of talking about how to make health education materials for those who neither read nor write, but also have the participants actually develop them during the session.

The total of 21 family medicine residents from Arizona, Michigan, New York and northeast Ohio participated in the 3-day activities to share experiences and to learn about global primary care from each other. Most of the instructors of the workshop were graduates of our track of the Dept. of Family Medicine, UHCMC.

Dr. Margaret Larkins-Pettigrew presented at the first Asher Lecture in Global Health, entitled, “Establishing North to South Collaborations as a Foundation for Sustainable Education Programs”, focusing on the lessons she learned from her effort to establish the OB/GYN residency program in Guyana.

We will focus on practicability and applicability in the 2015 workshop with the same approach so that participants are ready for the next global health assignments.

► Going Back to “Physical Exam” for Mayan Women - Here’s Why.

Our “More Skills Less Pills” program has three components: 1) Pain Away (exercises), 2) Power to Change (group problem-solving skills), and 3) Do-It-Together Health Education (interactive hands-on health education).

The Mayan women, who had no habit of exercising and felt uncomfortable doing it when we first introduced Pain Away in 2013, are now doing it quite regularly. They
report they feel better afterwards. The group problem-solving skills in the Power to Change have been utilized, as we designed, to tackle various issues such as working as a group, responding to urgent job orders and etc. The groups have developed and implemented their action plans for the problems they identified as a group.

Meanwhile, the ‘Do-It-Together Health Education’ sessions have revealed deeper issues than health and health knowledge. For example, their interest in PAP smear opened up a whole new discussion about male dominance in household, potential spousal abuse, and suspicious feelings towards husband’s fidelity. We realized that ‘health’ is only an entry point to understand those women’s issues about their well being, and it is indispensable to capture the core of the problems, which we should address in our training modules. That is why we believe it’s best to conduct one on one ‘health exam’ again to understand how their construct of pain experiences is related to their deeper issues and concerns. This step is critical to identify the most pressing issues among them and to further design workshop modules that address health issues from their perspectives.

► Clinical Practice Comes First in Global Health: The 29th Annual Meeting of the Japan Association for International Health

In November 2014, I was invited as a speaker for the 2014 Joint Conference: The 55th Annual Meeting of the Japanese Society of Tropical Medicine and the 29th Annual Meeting of the Japan Association for International Health. The focus of the discussions was how to develop human resources for global health. Other speakers and audience seemed to believe that global health had been practiced by those who were trained in a special way particularly in academic settings. By presenting the uniqueness of our 10-year global health track, the combination of inpatient skills and community care, I emphasized that those who actually dealing with patients’ sufferings and practicing clinically day in and day out in a local community would be able to utilize their skills and knowledge globally.

► One Resident’s Presentation Ended up 6-hour Discussion with No Break in Chiang Rai, Thailand

The reason I keep going back to Chiang Rai, a northern town of Thailand, is because I see it as a frontline of primary care. How can you teach residents while seeing 150 patients a day, totally exhausted and no time to precept your junior colleagues? How do you discuss disease prevention in an area flooded with cheap greasy food and sedentary
life style? Wait a minute, does it sound like our practice in Cleveland except we see only 30-40 patients a day?

When the Thai Ministry of Health told them to start a “family medicine training program”, the faculty members at the Chiang Rai Provincial Hospital never thought about teaching actual practice of medicine to the residents. Teaching epidemiology, concepts of family medicine and psychosocial care in a conference room is the training, they thought, and that’s what they did. As a result, one of the residents presented spiritual care of patients as the family medicine in his presentation.

I asked, “What is the goal of care?” “What is your plan of treatment? You need to provide both medical and psycho-social care” and etc. All of sudden, both residents and faculty members got drawn into a discussion on dynamic and exciting nature of patient management, particularly complex and challenging cases. Through the discussions, it became clear to them that they should spend more energy on actual treatment plans and patient management utilizing whatever resources they have. At the end of the 6-hour discussion, they all agreed to start a weekly morning journal club and case discussions before their busy clinic starts. They also came to understand the importance of solid bedside training.

It was a slow process, but they finally accepted our proposal to start practical faculty development workshops with us. This is a typical case about developing family medicine from scratch. In order to practice global health, it is important that you are able to work effectively here for our patients first and foremost.

Dr. Kerry Lecky (GHT ’08) and Dr. Alex Howard (GHT ’14) joined me in this trip.

► **Family Medicine Is Being Developed in a Massive Scale in China**

It was the 2nd year that I was invited to lead teaching rounds at the family medicine department in the 2nd Affiliated Hospital of Zhejiang University in Hangzhou, China. Standardized family medicine training yet to be developed in China. In this hospital, family medicine is adult inpatient medicine, similar to the hospitalist work in the US.

The striking feature of their practice is much less concern for cost and dire needs for teaching. The patients tend to stay in the hospital way longer than needed. For instance, a 3-week admission for syncope workup! (We usually keep our patients for a day or two in the US.) And residents and junior attending physicians are craving for interactive, practical bedside rounds with discussions on actual patient issues. Every time I visited the hospital, I was surrounded by many house staffs, pushed into the front of the group, forced to turn around, answering their questions coming from all directions.

They try not to miss a single word coming out of my mouth, diligently take notes and follow me all the way for a few hours. I arrived on Sunday evening, jump-started my
round on Monday morning until Friday. I was told my Friday would be a light day, just visit a community health center and give a small talk there. A ‘community health center’ turned out to be a 200-bed post-acute care rehab hospital, when I arrived more than 50 people are anxiously waiting for me at the lecture hall. My ‘small talk’ ended up becoming a 50-minute lecture followed by rigorous Q&A sessions. My hat’s off to those eager Chinese learners, no wonder they are the driving force for change in many fields.

Moreover, the residents have started translating my “Inpatient Handbook” into Chinese. I’m going back to conduct faculty development workshops to broader audience next year on.

Dr. Alex Howard (GHT ’14) joined me in this trip.

► Bedside Observership in Cleveland

Not only going abroad, I’ve been accepting international students for bedside observership in our inpatient service. They contacted me because they want to know how we train residents and medical students in the US. In many parts of the world, opportunities for dynamic, interactive bedside teaching are rare and I have an increasing number of requests every year. I accommodate them for 2-3 weeks in length. They would follow the inpatient team all day starting at 7am. This past year, I accommodated 4 Japanese and 4 Chinese students. For the first time, two Japanese medical students were from my alma mater, Tokyo Medical University. They were so motivated to learn everything in this opportunity, they even went down to Guatemala with us to get a first hand exposure to global health. In April, the Dean of Tokyo Medical University also visited me to observe our bedside education.

► Peacebuilding in Darfur, Sudan

I was asked to join the implementing team of “The Project for Strengthening Peace through the Improvement of Public Services in Three Darfur States”, a project to assist peacebuilding in war-torn Darfur by helping rebuild primary care. It is an official international assistance by Japan International Cooperation Agency (JICA). As an advisor for public health/community health, I organized a 3-day workshop with Sudanese counterparts: the provincial health administrators and healthcare providers in Darfur. What really struck me was the high turnover of the staff members. Only 30% of them are retraining their job more than 6 months. It has to do with the general social anxiety due to huge uncertainty for the future of Sudan. Every time we visit, it is highly likely that we start with team building with new people. Our assignment is to effectively improve the care of people by government employed healthcare staff in the field, which is nothing but challenging. The project runs for four years, and I will return to Sudan twice a year.

► Other remarks

I was awarded with the Outstanding Faculty Teaching Award from the graduating class of 2015 of family medicine. Thank you!
Forward

I would like our global health program to be the epicenter of global primary care network. Please join us in future trips and our efforts in global development programs. If you know any places in need of help in primary care training, please let me know. I would like to go wherever it is, since there are no borders but only frontiers for global primary care training.

Please send me your comments and inquiries about this newsletter, the Global Health Track, future trips, & etc. Thank you for your interest and support.

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