

No Borders, Only Frontiers

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Mori J Morikawa, MD, MPH
Director, Global Health Track
Ann S. & Anthony J. Asher Professor in Family Medicine and Community Health
University Hospitals Cleveland Medical Center, Cleveland, OH

A Thought on Patient Care and Clinical Teaching

Annual Review: July 2017- June 2018

“Fury”, a 2014 movie starring Brad Pitt, follows the pursuits of an Allied tank force soldiers’ on a deadly mission during the World War II. Before their final assault against the overwhelmingly superior Germans, they told themselves, “the best job I’ve ever had”, over and over again. It is a scene that has been imprinted in my brain as an ultimate show of professionalism and dedication.

The shortage of competent primary care providers is a serious issue worldwide. Even more concerning is the shortage of competent primary care providers who impart bedside education. In today’s mainstream business model of hospital management, supporting clinical education has never been a priority even though the word “education” is listed as their mission.

“Save Million at a Time” is the motto of my alma mater, Bloomberg School of Public Health, at Johns Hopkins University. It is a concept that I often find hard to adapt at times. As a clinician who values the one to one connection between patient and doctor, I have spent much time teaching residents and medical students at the bedside the value of this interaction. Contrary to the Johns Hopkins’ motto, my reality has been “One Patient at a Time” for many years.

Through primary care, we are trying to provide and protect basic human rights of each individual person. Being competent in medical knowledge and skills are a necessity but are not the only component of providing healthcare. Many hours are spent delving through patient diagnoses and problems that could not be solved by medical tests and prescriptions. With challenging patients where it is difficult to determine their disease or problem, I have learned about human resilience when I look into their eyes and try to deal with their various concerns.

One can often develop a sense of feeling overwhelmed, lost and frustrated as you transition beyond the walls of medical school and find yourself dealing with issues that exist outside the scope of your initial training. In a perfect setting patient initial presentations will ascribe to the standard formulas and guidelines mentioned in textbooks. More often this is not the case and flexibility, creativity, drive and pinch of obsession is required at most times to adequately treat patients. At such time, I swear primary care is “the best job I’ve ever had” because it is during these times that I know that I am contributing to the society through primary care. My hope is there will be many more primary care providers who have passion to engage in global issues through primary care and are able to think this is the best job they’ve ever had.

Global Health Issues

- **What’s Missing: A Simple Tool**

On a clear blue skied morning in May, Dr. Grant Potter (GH 2018) and I were rounding patients in Sinyanga Regional Teaching Hospital, Tanzania when we noticed something was wrong with a patient. This patient who was admitted and placed at the corner of the adult ward was actively seizing in front of us. The clinical officers assigned to the patient had no knowledge of the patient’s diagnosis or their recent vital signs.

Similar situation occurred in the Ntishi District Hospital, Malawi in December. I got called regarding a patient that was admitted 3 days prior and was now deteriorating. When I rushed to the bedside he was already unconscious, cold and clammy. Only vital signs the clinical officer had was taken at the time of the admission. There was no working pulse oximetry on the floor. A nurse was running to the newborn nursery to get a pulse oximeter, while others are trying to figure out what was going on. The patient passed away within an hour.

These examples are only the tip of a larger iceberg. What was missing here was clear: appropriate handover of patients. My residents and I have been in the process of developing the tool. We call it IHOT – Inpatient Hand-off Tool.



Mori discussing with clinical officers in Ntishi.

- **The Challenge: Giving Up Too Soon**

It happens here in Cleveland too. In Tanzania, we came across a few hours old newborn with apnea. A few days old nursing student just stood at the baby’s head at a loss of what to do with an Ambu bag in her hand. I helped her start bag breathing and chest compression. After 20 minutes or so, the baby started breathing, but the pulse was weak and the oxygen

level was low. At that moment, the student and other clinical officers almost gave up doing anything more. As we intubate the baby, we all learned in a hard way how difficult it is to obtain even a single reading on a pulse oximetry device using conventional clip type probe on unstable, poorly perfused tiny limbs.

In this hospital, they have almost everything they need to resuscitate a baby; Ambu bag, endotracheal tube, ventilator, bubble CPAP, and etc. However, the technology alone does not save lives. Reading instruction manuals when they use them does not help. You should already know how to use it properly. But it is still not enough. Above all, you have to be a believer that you can save lives with the technology.

In training programs to introduce any device or interventions, it is crucial to make them a believer that interventions work on patients. If you don't know or never seen how it helps patients, you cannot save lives with that procedure. My sensei in Karate told me that my punches and kicks never work unless I can mentally visualize my opponent being defeated with my techniques. My approach has been working with them side by side and show they can do more to save lives.

- **Keen observation, auscultation, percussion and neurological exam skills will save you as a physician.**

One of the reasons to develop negative mindset in countries with limited resources is an absolute shortage of laboratory support and imaging studies. We often get called to the bedside of an unconscious patient. Evaluate unconscious patients without CT scan of the head? You are left with your physical diagnostic skills. This is the real test of your clinical skill set. In fact, in every day, rounding patients in a district hospital seemed like a neurology round identifying relevant clinical signs, demonstrating exam skills and explaining the interpretation to clinical officers. In that sense, honing my clinical skills to teach residents and medical student every day at the bedside is quintessentially prepared me for difficult clinical situations.

Other Update

- With the funding support from the Fulbright Scholar Program, Dr. Daranee Intralawan and I developed workshops on clinical problem-solving skills and health education and were able to offer to faculty members, residents, and medical students not only in Chiang Rai, but also Chiang Mai and district hospitals near Bangkok, Thailand. Also, the faculty members of Dr. Intralawan's department developed personal/professional goals as well as departmental goals in the next 5 years. It took 6 years but the family medicine residency in Chiang Rai Provincial Hospital has finally come to the point where they could picture what their program should be and gradually move forward on their own feet. I will help them develop an algorithm for seriously urgent cases.

- My annual bedside training in Hangzhou, China, was expanded to community hospitals. The residents who translated my “Inpatient Handbook” last year asked me to supervise a training program they plan to implement based on my handbook. The Chinese residents are also ready to develop their own version of clinical skills training.
- In the second trip to Tanzania, Dr. Grant conducted a survey for 48 nurses and physicians about handoff practice and current use of Pox. The results provided us with insights on how we should modify our current prototype that the graduate students from the Biomedical Engineering, CWRU, designed.



Dr. Grant teaching clinical officers in Tanzania.

- For the 7th year collaboration with Mercado Global, Panajachel, Guatemala, Dr. Aaron Lear (GHT 2006), Cleveland Clinic Akron General Hospital, took over the roles of health team leader. I will work closely with Aaron and provide any help they need.

- The 2017 Annual Global Health Workshop was participated by 30 people. The small group case-based discussions on health issues helped participants understand the reality of problem-solving in the field. The highlight of the workshop was the Ann & Tony Asher Global Health Lecture, “Entrepreneurship in Global Health” by Brian Ginsberg, PhD, Assistant Professor, Department of Global Health, CWRU.



Case-based small group discussion at the Global Health Workshop.

- I was invited to give a lecture, “Global Primary Care and Family Medicine” at the 2017 AAFP Global Health workshop and awarded with the Ostergaard Memorial Lectureship. All I wanted to say was global health sucks!

Lastly...

August 2018 is the 20th anniversary of the Global Health Track, Dept. of Family Medicine and Community Health under my leadership. To celebrate, we are planning to have a ‘Global Health Night’ in November 16th 2018. Please mark your calendar!

Please join us in future trips and our efforts in global primary care. We will continue our fight for the community, training, and system building. Your comments and ideas for our activities are highly appreciated. If you know any places in need of help in primary care training and delivery, please let me know. I would like to go wherever it is, since there are no borders but only frontiers for global primary care practice.
Thank you for your interest and support.

Mori J Morikawa, MD, MPH
Ann S. & Anthony J. Asher Professor in Family Medicine & Community Health
School of Medicine
Case Western Reserve University
University Hospitals Cleveland Medical Center
Cleveland OH USA
masahiro.morikawa@UHhospitals.org
mjmkobe@gmail.com

Department secretary
Stephanie Pollack 216-286-6727

Global Health Track email address:
uhglobalhealthtrack@gmail.com