The Dr. Yuk Chan Ma and Dr. Yuen Kok Chan Prize in Multicultural and International Medicine

2010 Applications

WINNER: Elizabeth Chertkow
Guatemala

Atitlan is a lake in the highlands of Guatemala known for the breathtaking volcanoes that frame its shores. The Mayan towns surrounding the lake are only accessible by boat or steep paths. During the rainy season, the land becomes so engorged with water that mudslides are rampant and villages can be cut off from medical services, clean water and food for months at a time.

In July 2010, I had the opportunity to work for a month with Mayan Medical Aid, an organization that provides primary health care and works to reduce child and maternal mortality in the Atitlan area. Our team consisted of local nurses, translators, two physicians and several medical students. Together, we would travel by boat or foot to neighbouring villages and run clinics with the limited medical supplies we had. Many people had made difficult journeys through the mountains to reach us and the spectrum of need was tremendous.

While the clinics were rich clinical educational experiences, the most powerful lessons I learned were related to the social and cultural aspects of health in Guatemala. I made a special effort to learn the language and educate myself on traditional medical practices and beliefs regarding the origins of various illnesses (for example, in Mayan culture fever is thought to be caused by excess sun). I found that being familiar with such beliefs was instrumental in building a therapeutic alliance and gaining credibility with my patients.

The highlight of my experience was living with the local nurse practitioner, Guadelupe, who led an emergency obstetric service in the region. In addition to teaching me about local customs, Guadelupe told us stories about childbirth in the highlands and the limited training available to midwives. Accompanying her on an emergency obstetric call was one of the most exhilarating and terrifying experiences of my summer.

The lessons I learned about social and cultural aspects of health care in Guatemala have inspired to initiate change at home and abroad. My dream is to one day return to rural Guatemala and teach local health professionals how to manage obstetrical complications in low-resource settings. I also have a renewed interest in seeking to understand the socio-cultural influences behind each patient I see in Montreal. Finally, I hope to share the stories and experiences that I collected during my time in Guatemala with my peers and to continue to learn from their collective narrative.

Alexander Caudarella
South Africa

My greatest fear has been to lose what makes me human. Each person defines their humanity differently but for me it is my ability to feel -- to feel the beauty of life or the tragedy of illness. In March 2010 I had the privilege to do rotations in Cape Town, South Africa and subsequently in Puvirnituq, Northern Quebec. I have decided to recount one particular story to best reflect the new cultural understanding I have gained.

Riding to Khayelitsha from Cape Town I took a train from heaven to hell. Cape Town is arguably one of the most beautiful places on the planet and I had landed in a township, truly a slum, of 2 million people outside of town. Many were sick; some worked but most had little or no money. At the clinic my supervisor had a beaming smile. He excitedly explained that we would soon enter chaos. Outside rows and rows of unsteady tin houses as far as the eye could see. However, for the first time in South Africa, I saw no barbed wire and there were no fences. This was a busy clinic, he explained, and as close as one could come to the third world in South Africa. We walked through the hospital -- past an emergency with blood-stained curtains but no bleeding patients, past peeling paint and old equipment. He passionately explained the need to understand the emotions of patients and the importance of exploring their psychosocial profile. He reminded me that to empathize with patients and to listen was to help. He sat me down and walked me through an exercise in mindfulness. We stepped out and saw an unbelievable number of patients who had waited since 4 a.m. One we saw had struggled with pain, poverty and family illness and, although my supervisor had worked with similar stories for twenty years, he treated her as if she was the only person in that clinic – providing more empathy and more humanity than I had seen anywhere at McGill. Despite all the pressures, he somehow found the time and still emptied the clinic that day. He reminded me that rather than looking at it as chaos we had to remind ourselves that this was simply another opportunity to help. He taught me that to understand where people come from and what they want is to help. It is obvious that South Africa still has two worlds, two cultures, and two medical systems (even within the public system). They may cross paths but they are not coexisting. In his landmark work, “The Two Cultures”, C.P. Snow explained that although communication existed between Science and the Humanities, they had simply talked past each other instead of listening and opening a conversation, without which, a resolution of conflict would never be possible. The same must be true of South Africa. Surprisingly I saw a similar disconnect in Northern Quenec – problems with crime, nutrition etc. in otherwise stable nations. When I reflected this to a lawyer familiar to both worlds he said “yes but the difference is that South Africans have hope.” All the lessons I learnt on listening to a culture’s needs in South Africa are apparently in even greater need in Quebec.

Nicholas Chadi
Peru

McGill South America Health Initiative (MSAHI) and clinical elective in infectious diseases

When I created the McGill South America Health Initiative (MSAHI) in September 2008, my objectives were clear: I wanted to build a long term partnership with a Peruvian healthcare organization. After many months of research, I finally found in the Hogar San Pedro the ideal partner for my project. From July 1st to August 7th 2009, accompanied by nine of my classmates, I lived five of the most fulfilling weeks of my existence, working as a medical volunteer and participating in patient care and medical outreach campaigns. After ten months of preparation, I was thrilled to be able to spend priceless moments with extremely dedicated local professionals who gave me an extensive exposure to healthcare provision in an under-resourced community.

In the following year, I was extremely motivated to improve my initiative. In September 2009, I associated my project to the International Federation of Medical Students' Associations to insure its sustainability in future years. I also recruited a group of 14 medical, nursing and physiotherapy students who would be travelling to the Hogar the following summer. In December 2009, seeking further guidance in improving my project; I travelled to Guatemala for 2 weeks where I worked as a medical volunteer with a small NGO called Mayan Medical Aid. On my return, humbled and enlightened, I knew that I wanted to return to Peru to follow-up with my project, support the new groups of volunteers and ensure that the help and resources we were gathering (financial and material) were adapted to the center's needs. Aware of the presence of a public health center located across the street from Hogar San Pedro, I seized the occasion to organize a clinical medical elective in Infectious Diseases with the team of doctors from the clinic, whom I had worked with in July 2009. Hence, from June 19th to July 20th 2010, I was back in Peru where I completed an eye-opening course while spending abundant time with the employees, patients and volunteers at the Hogar.

Deeply committed to my first months of clerkship, I am now completing the handover of my duties as the coordinator of MSAHI. Although it saddens me immensely to have to let go of my project, I find infinite satisfaction in considering that MSAHI is becoming a self-sufficient and sustainable community centered initiative which is now getting ready to send a third generation of healthcare students to Peru in 2011.

Julie Désalliers
Ecuador

I have been interested in sustainable development for a while: I studied in anthropology and did a master's degree on gender relationship and contraceptive use in a rural Burkinabe community. I'm now studying medicine and had the opportunity to be part of a great research project last summer 2010. Since the last three years, a team of medical students and professors/doctors from the PRAM (participative research at McGill) has been implicated in a long-term partnership with the rural indigenous community of Chilcapamba in Ecuador. The concept of a "participative research", where the needs and research goals come directly from the community, enchanted me since I have always been against the idea of imposing our own values and norms. The community had decided last year that they wanted to work on reproductive health issues. That same year, the government of Ecuador had targeted women who have a poor access to health services for a public health campaign and Pap tests were performed directly in the community. The results were to arrive during the summer. Since most of the women had never undergone this test before, we decided to explore the women's experience of this campaign in collaboration with the actively engaged president of the community, Juana Morales. We designed a qualitative protocol using focus groups and individual interviews. I also wanted to investigate more about the follow-up in this particular campaign (which turned out to be not that well established). I spent half of my time in the nearby hospital with the obstetricians, observing and learning about the relationship between the doctors and the indigenous population and was then able to use the resources of the hospital to organize the delivery of the results in the community. Additionally, I was organizing focus groups with the women of the community in which I was living. These focus groups were an incredible opportunity to learn about their experiences and expectations and elaborate on a subject they usually do not broach. As women had many questions, I used illustrations to explain health issues pertaining to the female anatomy; in particular, cervical cancer. Juana was able to understand the approach to health and diseases of Western medicine. As such, she became an important educator by translating her knowledge into a form that would adhere to the Quichua culture. Forming a community leader was maybe the best part of this project as it is representative of "sustainable development".

Baijayanta Mukhopadhyay
India

I spent four weeks at the Calcutta School of Tropical Medicine, situated in a bustling Indian metropolis of 15 million with a fascinating diversity in its demographics. Whilst there, I learned of the innumerable challenges in running a public hospital that remained severely under-resourced despite a ceaseless influx of patients. I saw patients unable to pay the three thousand rupees necessary to get imaging done – or worse, unable to pay for their own intravenous fluids; I attended clinics in which one physician would see sixty patients in three hours, many of them having taken long trainrides from distant villages to get their three-minute consultation. In contrast, India also has a flourishing, high-tech health care sector that services both the domestic well-heeled and medical tourists. This disjuncture can be nauseating.

Despite little diagnostic support, I was impressed by the resourcefulness of doctors at the School. Relying on an extensive database of knowledge, without PalmPilots, without the Internet at their fingertips, their attention to nuances of history and subtle signs derived on clinical examination became critical to care. With that wealth alone, they worked tirelessly to care for patients. When a full-time private practice would be significantly more lucrative, the physicians with whom I worked still arrived at the hospital daily to deal with the hordes awaiting them. One patient once asked a physician to refer him to his private clinic, and the doctor refused outright, saying that he would not entertain such suggestions at the hospital. This principled attempt to keep the two systems separate impressed me, especially given the discussions in Quebec about mixed private-public practices: the doctor would not use public resources to promote his own profitable practice.

The experience taught me how imperative well-functioning public systems of medical care are the backbone to health in any country. It is not enough to train professionals, to ensure they remain in the country, to build hospitals and to have cheap generic medicines available – all of which India does in abundance. If these assets are not distributed to the population fairly, health inequalities will persist.

International efforts thus need to focus on supporting systems of accessible care. The elective resolved my commitment to ensure that equitable access to health care for all citizens remains the core principle that guides my work, certainly abroad, but not forgetting that we in Canada cannot become complacent either.

Signe Richer
Tibet

Ladakhi Landslides – an unexpected lesson in emergency disaster relief

Our international team of medical students, dental students, residents, and physicians were to spend the month of August trekking to remote Tibetan settlements to set-up mobile clinics. Due to flooding and landslides in Ladakh on August 5th and 6th, 2010 a meticulously planned humanitarian mission transformed into an emergency situation.

Trapped on the road between two landslides near a tiny village, Neemu, we set up disaster relief clinics and treated affected locals, stranded foreign trekkers and Indian army personnel. Working with very limited resources, we saw several hundred patients.

When the road re-opened we returned to Leh. In the unrecognizable city, there were crushed cars, crumpled buildings and a bulldozer clearing mud from within the hospital. There was no electricity and very limited running water. The statistics became very abruptly real; "185 dead, several hundred still missing". We worked with local health professionals and determined that our services would be most useful in the heavily devastated Tibetan refugee settlements around Choglamsar. We set up clinics there and helped dig out houses and temples whose interiors were packed with mud. To contextualize the gravity of the destruction, 94.8% of the dwellings were considered semi-permanent or temporary by the 2001 census of the region.

I was initially attracted to the project because Himalayan Health Exchange's expeditions return yearly to the same valleys and I felt like I was contributing to something sustainable. Our target population in the Zanskar valley could not be seen in August 2010 due to the scale of devastation that prevented us from getting to the trail-head. I can only hope that the people we did see near Neemu and in Choglamsar will get some follow-up in the difficult years to come. The public health ramifications of the disaster were evident and will have long-lasting consequences – there needs to be plans to prevent the spread of disease, to ensure adequate nutrition and clean drinking water and for the provision of relief housing, especially before the winter.

We offered the people of Ladakh medical relief and they demonstrated to us an acceptance of life's realities as they moved towards rebuilding their world. The Ladakhi people embodied a lot of the values that we needed to emulate to be effective caregivers in trying circumstances: perseverance, mental and physical fortitude, ingenuity. I hope these assets stay with me and I can incorporate them into both my professional and private life.

Ilan Shahin
Israel

In June 2010, I did a rotation in rural family medicine at Ben Gurion University in the Negev desert of south Israel, with two weeks spent at a clinic in an unrecognized Bedouin village of 4,000 with unreliable water and electricity as a consequence of that unofficial status. This was a definite threat to health, compounded by the fact that roughly half of the Bedouin are under the age of 14. Additionally, the cultural practice of cousins marrying cousins led to high rates of a Bedouin-specific deafness syndrome and a high prevalence of congenital diseases such as Tetralogy of Fallot and tracheoesophageal fistulas. Furthering the challenge is the fact that addressing these practices or discussing issues surrounding palliative care can be very difficult within a Bedouin cultural context. Despite this, I participated in and witnessed innovative cross-cultural solutions to these issues in Bedouin health. We carried out home visits, at times to follow-up on very ill patients, other times to collect a patient and deliver them to the ambulance ourselves as the village's unmarked streets are labyrinthine to outsiders. I joined a palliative care team made up of a Jewish doctor and nurse and Bedouin social worker. We met patients in their homes, often in lonesome cinderblock huts lit up with the patient's and family's warm appreciation of the team's visit. Sometimes further visits had to be arranged so that the Bedouin patient could seek comfort in the listening ear of a Jewish nurse so that they could step outside a Bedouin cultural context. While not part of my elective, I read a book accounting the challenges faced by the multi-disciplinary and cross-cultural group at Ben Gurion University that sought to introduce a pre-marital genetic screening program for deafness in the Bedouin modelled after a program in the Hasidic Jewish community for Tay-Sachs. Working with this population, I could see the obstacles first-hand. However, I also saw a struggling community receive first-rate care by any standards. During this rotation I was able to see how the health care community identifies threats to health and seeks to address them guided only by humanitarian principles. I saw how vital creativity is within a cultural context. I learned about the level of curiosity and inquisitiveness necessary to understand Israel's Bedouin from cultural and social determinants of health perspectives in order to care for them appropriately. I therefore learned how to examine any population, including that which is superficially most familiar – the people of Montreal.