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PHYSICIANS IN TRAINING

What They Don't Teach You In Medical School

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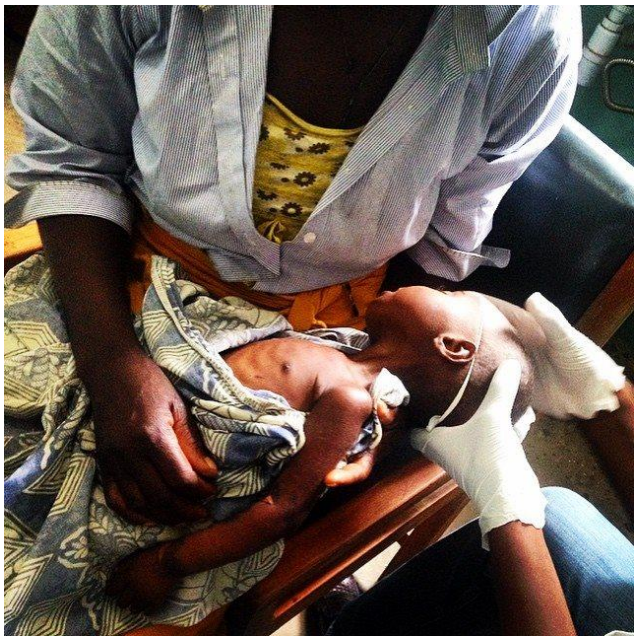
(Names have been changed for the sake of patient confidentiality)

It was 5 AM in Mtunthama, Malawi. As I had done every morning since my arrival in this remote outpost three weeks earlier, I began my day with a run to watch the sunrise and clear my head before heading to the village hospital. Normally, I would welcome the wide-eyed greetings of the locals waving and yelling "Mzungu", which means "White Person". Customarily, I would reply "Mwatzuka Bwangi", which is "Good Morning" in the local Chichewa language. But this morning was different. The fly that had endlessly circled my mosquito net looking for an opening reflected my troubled sleep. Wabwino, the rapidly declining patient, occupied my unsettled thoughts. My strides beat out her name—Wa-bwi-no, meaning "Go with God."

Wabwino was only 2-1/2 years old when she arrived at the clinic a week earlier, brought there by her grandmother. The toddler was later admitted to the hospital for severe marasmus, a form of malnutrition that is all too common in impoverished countries. When I first examined Wabwino in her hospital bed, she was emaciated with each rib visible beneath her fragile skin. But it was her respiratory distress later that day that prodded the medical officers in charge of her care to urgent action.

What had happened to change the situation so drastically? As the chief medical officer assessed this frail child, I quickly rifled through scribbles of hospital inpatient records, her damp outpatient notebook and stapled pages from the nutritional rehabilitation team. None of these documents were integrated well enough to provide a coherent picture. Unlike Western medical systems, incredibly, the responsibility for keeping records lies with the patient rather than the institution. For example, every time a patient arrives at the clinic, he is expected to bring with him the blue book that details his past medical history. In a land in which people have so little and are subject to natural disasters and human error, entrusting this precious document to people in need of care seems, quite frankly, misplaced. As a 4th year medical student from Tufts, I was taught the importance of non-maleficence in medical practice: Do no harm. There is a fundamental cultural difference to actively doing no harm as it relates to accountability. On the bottom right-hand side

of Wabwino's flimsy outpatient documentation, I saw scrawled "Malaria +" with a circle around the plus sign. Demonstrating the inherent problem in such a system, this key piece of information was in her outpatient documentation but had not been communicated to her inpatient team.



In developed countries, given Wabwino's quick respiratory decline, a chest X-ray would have been ordered. In Mtunthama, the thought did not even cross my mind. To recommend obtaining a chest X-ray for every patient in respiratory distress would be infeasible in such a resource-limited setting: The nearest X-ray machine is 15 miles away down winding roads. In its absence, we treat with whatever is available, despite understanding the source of the problem.

Having rinsed off the sweat and dust from my run in the bucket of tepid water placed in the intermittently functioning bathroom, I waited anxiously in morning report, my right foot tapping in anticipation of learning Wabwino's overnight events. Every morning of my time in Mtunthama, save one, a patient was reported to have passed overnight. That morning, Wabwino was not one of them. My heart rate normalized.

It had become my ritual to round briefly in the pediatric ward before the medical officer arrived following his morning tea. That morning, Wabwino's grandmother did not hold her thumbs high, as she had done on previous mornings as we struggled with communication. She barely met my eyes as she shook her head in a sign that needed no translation. Wabwino was lying limp in her grandmother's arms, back arched like a floating ballerina. I listened for the heart's beat, the lungs' breath and shined a light that would be sure to constrict the pupil of any living soul. I found nothing. Neither did the medical officer who performed the exact same exam. All I could mutter was "Pepan" because it was one of the few words I could communicate effectively in Chichewa. "Sorry" did not begin to explain how deeply sad, defeated and frustrated I felt.

My feelings of frustration only grew as the sadness waned. Lack of prevention, education, and resources lay at the core of Wabwino's illness and demise. Lack of accountability and best practices color the periphery. Marasmus is a completely preventable illness, only seen in the Third World and on American Medical Board examinations. If only this family had access to food, an

education about starvation's consequences and signs for which to look, Wabwino could potentially still be living. I say "if only" flippantly because to do this, we would have to rock Malawi's medical foundation. Where do we begin?

Biography from Lauren Rissman, MD

I grew up outside Chicago, Illinois. Then, attended school at The University of Southern California and received a BA in Neuroscience. While there, I founded Female Undergraduates Educating and Leading in Science (FUELS), an organization whose goal is to promote mentorship amongst females interested in science. Then, I spent 1 year in NYC working at a non-profit organization called 52nd Street Project where I helped Hell's Kitchen teens express themselves through performance art. After a "fun year off", I completed medical school at Tufts University School of Medicine. During my time at Tufts, I did research in Voi, Kenya and Mtunthama, Malawi. As I graduated, I was awarded the Leonard Tow Humanism in Medicine Award. Now, I'm a first year resident at Children's Hospital Los Angeles where I hope to create a foundation, so that I may become an outstanding physician and advocate.