

Report to MA Medical Society and Alliance Charitable Foundation
February 17, 2010
Submitted by The Albert Schweitzer Fellowship

The Albert Schweitzer Fellowship received \$5,000 from the Massachusetts Medical Society and Alliance Charitable Foundation to support 2009 Lambaréné Schweitzer Fellows from Massachusetts medical schools.

Lambaréné Fellows spend three months serving as junior physicians in pediatrics or medicine rotations at Hôpital du Albert Schweitzer (HAS) in Lambaréné, Gabon. Four Fellows are selected from a highly competitive national pool of applicants each year. Elizabeth Portnoy and Anne-Lise Paisible, University of Massachusetts Medical School served as 2009 Lambaréné Fellows. While in Lambaréné, Elizabeth and Anne-lise provided necessary medical care for hundreds of patients from the local region. They also grew significantly in their professional development as physicians. We are grateful to the Massachusetts Medical Society and Alliance Charitable Foundation for helping to make this inspiring work possible.

Elizabeth Portnoy worked in adult medicine from May 1 – July 31, 2009. In her final report (attached), she reflects on how this experience has increased her confidence as a doctor.



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me to learn that definitive diagnoses are not possible to make in many patients. One of the attendings I worked with hammered into me on a daily basis that I will never know everything, but I know how to think and do a physical exam, and that can go a long way. A couple of times in the last month, I found myself seeing a patient where I didn't know what was wrong, and there was no attending around to ask (theoretically there should have always been one, but practically that wasn't always the case), and having learned that it's ok that to not have a definitive answer right away, that I can still treat symptoms and address major issues while I try to figure out what's going on, was definitely an invaluable lesson to learn.

Anne-lise worked in adult medicine from August 1 – October 31, 2009. While there she patients who were primarily seeking care for HIV/AIDS, malaria, and TB. She shares the stories of two of these patients with you here:



- **23 y/o female** with chief complaint of wet cough and weight loss x 2 months. Subsequent sputum analysis and blood tests revealed that she had a pulmonary TB infection and was HIV positive. Seeing her during consultation, I would've thought she was 13 years old at most. But she was a mother of two small children, the youngest an 6 month old infant. She came in with her mother and infant to receive the results. When we proposed immediate hospitalization for her, she mentioned not having any funds to pay for additional testing specifically the

CD4 count, for which patients pay the equivalent of \$10. The mother of the young woman then called the father of the child to come into the clinic so he could help defray the cost of testing. When he arrived, he was visibly upset asking his girlfriend how she got infected insinuating that he could not have possibly infected her. For me, although I had observed and even given patients the results of their HIV test, seeing the dynamic between grandmother, mother, infant and father of the infant highlighted the effects on the entire family. The patient was hospitalized for about 10 days which is standard protocol for acute TB infection though her CD4 count was over 700 and thus did not need anti-retroviral treatment.

- Another interesting case was a **50 year old woman** from Oogue-Ivindo province, which is pretty far from Lambaréné. She presented for treatment of lower respiratory tract infection that seemed like it wasn't well treated at the clinic in her hometown. I couldn't understand why she had made the trek to Lambaréné given the distance. When I suggested a HIV test, she vehemently declined stating that a family member told her that such a diagnosis was synonymous with death. I didn't persist as it is the hospital's policy to require patient authorization in order to do an HIV test. Although her CXR showed some small areas of hilar opacity, because she lived so far, she stayed overnight in the hospital to complete some other analyses. The next day during morning rounds, she was strongly encouraged by hospital nurses to take the test and begrudgingly did so. Because the hospital uses ELISA test, when blood samples are drawn in the morning, the results are available by mid-afternoon. Unfortunately, before we could give her the results, she left the hospital citing a family emergency back home. I was struck of course by the result, this patient had none of the common clinical signs of

immunodepression that I was used to seeing. In addition, her early discharge from the hospital, reluctance to get the test, and long travel distance made it all the more unlikely that she would ever return to Lambaréné to get the results.

Expense Report

The funds (\$5,000) from Massachusetts Medical Society and Alliance Charitable Foundation were allocated to support the airfare and room and board for Lambaréné Schweitzer Fellows Anne-lise Paisible and Liz Portnoy, fourth year medical students at the University of Massachusetts.

| Direct Expenses (2 Fellows) | |
|------------------------------------|-----------------|
| Roundtrip Airfare Boston to Gabon | \$5,463 |
| Room and Board | \$6,000 |
| Total Expenses | \$11,463 |

Attachments:

1. Final Report, Elizabeth Portnoy
2. Final Report, Anne-Lise Paisible

Final Report

There are so many things to write about in a final report of my three months at HAS. And I have been having trouble organizing my thoughts on the experience, to try to articulate what it's like, what I experienced and learned, in a neat document. The truth is, I think it will take a lot longer than a few months to process the experience, because it's hard to step back and reflect on what's going on while it's still happening. I hope that during this year I will find enough time to adequately reflect on the amazing experience I had at HAS.

To give a general overview of what I did at HAS on a day-to-day basis: In the morning, usually at 7:30, we'd round in the medicine ward, known as the Kopp. Rounds consisted of both attendings, two or three nurses, and me (and, for a while, two to three other medical students, which made things kind of a zoo).

Our patients in the Kopp ran the gamut of illnesses, but many fell into broad categories. Many of the inpatients were admitted for malaria (whether or not their thick smear was positive). Part of the reason for this was that overnight, if patients came into the emergency room with a fever, they got admitted with presumptive malaria, even if the thick smear was negative. The people admitting from the ER are nurses, not physicians, but are very skilled at what they do, and have a lot of experience. It is logical that after seeing thousands of patients with malaria over the years, one could assume malaria in a patient with a high fever, in the absence of another clear sign of infection (like a productive cough). I think we often attributed fevers to malaria on rounds, because that was what the admitting diagnosis was, and didn't always truly search for another source of fever. Although it's likely that at least some patients with fevers didn't have malaria, but rather had some other sort of infection, either bacterial or viral, and some likely had undiscovered HIV (and HIV tests were not ordered on healthy-appearing patients with suspected malaria, for better or worse).

Some of the patients in the Kopp we were just watching every day, hoping that the disease or illness they had would manifest in a clearer manner, and we could treat it. More than a few patients, especially those who were immunocompromised, would have fevers with no clear source of infection. For these patients, much energy was put into figuring out what it was we needed to treat.

Several interesting cases stood out during my three months in medicine at HAS. One was a middle-aged woman I saw in the Polyclinique, who came in with mild shortness of breath and chest pain for several weeks. The only thing that really stood out in the history and physical was some crackles in her lower right lung, and tenderness at her liver. She turned out to not have a right-sided pneumonia, or a liver abscess (as I had thought), but rather a pericardial effusion, which Dr. Justin saw while doing an abdominal ultrasound. I thought

she was interesting for a couple of reasons (only one being that pericardial effusions aren't that common); the first being that she went home for two days between when I first saw her and when we did the ultrasound, which scared me because I gave her the ok to go home, and she turned out to have a potentially life-threatening illness. But she asked me if she could go home for the night because she had to tell her family she was going to stay in the hospital, and neither they nor she had a telephone. That was definitely a problem unique to HAS that I can't imagine encountering in the US. The second part that was interesting was that she turned out to not have a tuberculous effusion (which would have been the most likely), but she did turn out to be HIV-positive. The truth is, we tested far fewer patients for HIV than we should have, and if she hadn't had such an uncommon illness, we probably would not have gotten one for her. We had several days where we did 6 or 8 HIV tests, and more than half were positive, which clearly means we weren't testing enough people (in a country with an official national rate somewhere around 8%). This patient was quite lovely, and took her diagnosis as well as anyone I saw. She seemed to understand, and was upset, and then wanted to know about treatment. Her reaction was in stark contrast to another woman who was hospitalized about the same time, who denied outright that she was positive, despite her having had multiple positive results in the past. She and her husband (who, she told me, cheated on her frequently then refused to use condoms) screamed and yelled at Dr. Natacha, told us they were both negative, and white doctors didn't know what they were doing. Dr. Natacha told us later that she was sure the patient's husband was aware of his own positive status, because he was wearing a work uniform from one of the large oil companies in the region, and the large employers routinely test their employees; and that he was also probably on antiretrovirals, because he looked completely healthy while his wife was visibly wasting away. She said that she has seen cases many times before, where a husband is on treatment for HIV and does not even tell his partner he is positive.

That kind of case makes me want to tear my hair out in frustration at the unfairness of it all. In the US, HIV/AIDS is made out to be a disease of choice: unscrupulous philanderers, immoral gay men, prostitutes, people who aren't morally strong enough to abstain from sex. (The Bush administration's refusal to give aid money to African HIV/AIDS organizations that promote anything other than abstinence says it all.) The reality is that it's an infection of the powerless, as if the poor women in a male-dominated society don't put up with enough injustice as it is.

It's true that the poorest and most vulnerable of the world continue to die of diseases (and *non*-diseases, like starvation and malnutrition), but AIDS is different. It may not kill as many people as malaria or other tropical illnesses largely confined to the developing world, but seeing *who* it kills hit me the most. Young women, most with young children. Middle-aged men, likely breadwinners for their families. I can't think of another illness that selects what would otherwise be the most healthy and productive members of society.

And amid it all was Dr. Justin. It was no secret that I loved working with

Dr. Justin. Part angry, protective father-figure, part jovial teddy bear, part cynic, part bleeding-heart, he's one of the few doctors I've ever worked with that I truly want to emulate in some way when I am a physician. One day he told me, "Every young person who dies in my arms, I think, 'What could I have done differently? What more could I have done for them?'" I was really struck by his sense of responsibility to patients, his feeling that if someone doesn't come back for antiretrovirals until they're near death, that somehow *he's* responsible, that he feels he could have done something more to convince them to come for regular treatment. Watching him gives me hope that spending too much time amid death and suffering and chaos does not necessarily mean you will become inured to it, which is one of my fears.

I also learned a lot about the practice of medicine from watching Dr. Justin address every aspect of care. For many physicians, medical care ends with making the correct diagnosis and writing the correct prescription. Not for him. He took a long time to educate every patient with a new diagnosis of HIV. (He never seemed rushed, he explained the disease in simple yet descriptive terms, and always drilled home the point that people can live long lives ["you can live to be as old as me"] if they take medication regularly.) He spent hours making organized files for every HIV patient. He spent his Saturday morning teaching a group of patients about diabetes care, diet, and foot care. (I half expected a halo to spring out from his head at any time.) But his approach to being a physician is similar to the approach of a physician I worked with during 3rd year (who also makes my short list of role models in medicine), who told a story about being a resident and driving home late at night when he came across a car wrapped around a tree. He tried to get at the patient, but was unable to because the door of the car was stuck shut, and he couldn't get in the car any other way. He said, "It didn't matter that I knew all the medicine in the world, if you can't *get to* the patient, you can't help them." Justin made me think of this story, because he made sure that part of his job was *getting to* the patients, explaining the value of taking high blood pressure meds, or antiretrovirals, or watching one's diet. I often think that physicians in the US (or anywhere, I guess), spend a lot of time making diagnoses and finding the best medicine to prescribe, when in reality nothing was very well explained to the patient, who goes home to not take the new fancy medicine that was meticulously prescribed.

One of the first experiences I had with him that stuck with me was seeing him handle the case of a young woman who was dying of AIDS. She was cachectic, unable to even walk on her own, and her older sister had abandoned her pretty much right after she found out she had AIDS. Because patients are cared for almost completely by their guardian, her abandonment meant she had nothing to eat, no one to give her medication, no one to bathe her, etc. After she was "discharged" (because she wasn't even taking medication, and there was no way to care for her without a guardian), she had nowhere to go, she just stayed in her bed and we rounded around her. Over the course of a week, Dr. Justin and Dr. Gregoire (the medical director) called multiple relatives, but no one would come get her, despite their promises. Meanwhile the girl had completely stopped eating and was just lying in bed unable to move. Finally, today, Dr. Justin was so

upset on rounds that her family had still not come for her (saying, “How can you abandon your *own daughter* like this??”), that he left rounds in the middle to try to figure out a solution, and made sure she was washed by one of the nurses, and given new clean clothes, and put in an isolation room by herself with clean sheets (which she was). Then they located an aunt in a nearby village and had the hospital car and driver bring her there, where she was welcomed by neighbors while her family was out. This girl was one of the saddest things I have ever seen; I sometimes couldn’t even bear to look at her. And it’s not like she was the only young woman there close to death from AIDS, but something about the way she was abandoned, and Dr. Justin’s and the nurses’ continued concern about her, really touched me. I still don’t understand how he can work there every day for 14 years and still muster that kind of emotion over a case like this. Not that I’d expect someone to be callous and unemotional if faced with such a sad situation, but their level of concern was amazing. We had another really sad case of a girl who was deathly ill from undertreated type I diabetes. (As an aside, I wish I could poll US doctors to see if they think it’s even possible for an adolescent to die from an illness that’s been treatable since the early 20th century.) She was 14 years old and looked like a cachectic 8-year-old, with multiple infections and a hemoglobin of 5. She was a patient in the Kopp for several weeks, and Dr. Justin was visibly upset by this girl every morning on rounds. At the time it seemed to me that if you worked here for years you’d either become somewhat emotionally immune to such needless suffering, or you’d burn out and quit, and he’s clearly done neither of those things.

I did learn a lot at HAS, some of it actually diagnosis-and-treatment related, though most of it was not. The most important thing I learned about the practice of medicine, which is crucial to learn at some point in training, is that I will never know everything, but I do know the basics, and I can trust my instincts. When I started out in clinic, I wanted to find an identifiable disease in every patient that I saw. It was difficult for me to learn that definitive diagnoses are not possible to make in many patients. One of the attendings I worked with hammered into me on a daily basis that I will never know everything, but I know how to think and do a physical exam, and that can go a long way. A couple of times in the last month, I found myself seeing a patient where I didn’t know what was wrong, and there was no attending around to ask (theoretically there should have always been one, but practically that wasn’t always the case), and having learned that it’s ok that to not have a definitive answer right away, that I can still treat symptoms and address major issues while I try to figure out what’s going on, was definitely an invaluable lesson to learn.

And while I’d like to paint a picture of a smoothly-functioning hospital, there’s no denying there were frustrations, the details of which are not appropriate for a public document such as this. But in the end, the good always comes with the bad, and no place is without its problems. I like how Mr. Teh phrased it, which is that the Schweitzer spirit is not dead, it’s just sleeping. I hope that one day enough people who care about Schweitzer and his philosophy

and mission will re-take control of the hospital. There are so many hard-working and dedicated employees who speak of Schweitzer like he's an uncle they've talked to over dinner, it's hard to imagine that one day the hospital won't become the institution it has the potential to be.

When all was said and done, when we had seen our last patients, hugged everyone goodbye, and packed all of our stuff up, I still didn't want to leave. True, it would have been nice to be at home for a week or two to see my family and friends and not sleep with giant spiders in my room, but I didn't want to permanently go home. I didn't even come close to learning everything I could have there. Towards the end, the consultations were getting a little repetitive (complaints of back pain, fever, etc), but every few days there would be a *really* interesting case, like leprosy or Sheehan's syndrome or things that we aren't even able to diagnose there. Cases that if we saw them in the US they'd get a team of specialists and a case presentation dedicated to them. Consultations could never get boring when there was always the chance for a very interesting medical case to walk through the door. And even when there was a relatively run-of-the-mill medical case, sometimes it was attached to a very interesting person. And I liked living there, disconnected from television, relatively disconnected from the internet, where we could sit on the porch and talk or read books. It's just a different, and more relaxed, lifestyle than I'm used to at home. I think I would love to live part of the year like that, and part of the year in the US (not to be too superficial, but we all have little aspects of modern, industrial life that we can't give up for good). But I can definitely see myself working and living in a place like Lambaréné (though actually I think a similar place doesn't exist anywhere on earth) in the future. While it's hard to contemplate life after residency while struggling to apply for it at the moment, I think I will likely end up somewhere outside the US for part of the year.

Overall, I had a truly excellent experience in Lambaréné. The aspects that I found frustrating were absolutely outside the control of anyone in the US, so I don't really have any big suggestions. It was invaluable to have orientation with all of the fellows from last year before we left. I think it would be helpful to have a FFL mentor already set up before going to Lambaréné. (I know that this is a relatively new thing, and possibly that's why we got mentors a little late, but it would have been nice to have correspondance already established with someone before going.) Also, and I know you in Boston have little control over this, it would be nice to have some overlap at the hospital with the other students for an orientation. We tried to have a brief one in Libreville with the two new students, but at the hospital would have been ideal. When we arrived we never even met the Swiss students, so it was a little tough getting our bearings at first. Maybe if there was a mandatory built-in time on either end for orientation for everybody, but I don't know if that's feasible. These are all small things, I think overall everything was organized really well, and I felt prepared (as prepared as one could be) to go there. It was also nice knowing that if we sent an email to someone in Boston, we would get a response within hours. It made us feel like

people were watching out for us and we had someone to turn to if anything happened. In general, I have nothing to add that would help things run better – I think everyone who was helping us and coordinating everything did a great job, and we really appreciated having that support throughout our stay.

Anne-Lise Paisible
U. of Massachusetts Medical School
Lambaréné Schweitzer Fellow 2009
Final Report

Documentation

During the first month, I did morning rounds with two attendings, Dr. Natasha and Dr. Arnaud. Dr. Natasha is originally from the Ukraine and she and her husband who is a surgeon have worked in a various developing countries in the Caribbean and Africa for more than ten years. I also worked with Dr. Arnaud, a French physician, who was temporarily replacing Dr. Justin, the chief of internal medicine, on vacation for a few months. Morning rounds began at 7:30 with a report from nurses on call the previous night. Rounds at HAS are informal there are no formal presentations. We looked at the patients vitals, reviewed their medications, and ordered labs.

Then for the rest of the morning, I would see patients in the Polyclinique with either Dr. Arnaud or Dr. Natasha. The first few days involved shadowing and just trying to get a grasp of the language and hospital routine. In the afternoon I would see patients with either attending in clinic and end the day with afternoon/evening rounds at the Kopp, the other name for the medicine service. During the first month I worked closely with the attendings seeing patients with them in clinic. Then in the second month, Dr. Carmen, a Colombian physician, who works for in both the lab and clinic went on vacation for a month. Since that only left two attendings at the clinic, I started seeing patients on my own just to relieve some of the burden for the other docs. Because the other attendings' offices were just next door, I never felt like I was alone left to figure things out by myself. There was always someone I could ask if a question came up. At the beginning, I was nervous about seeing patients on my own, feeling self-conscious about doing the whole medical interview in French. I remember thinking what if I don't remember which nouns are feminine or masculine? The patients I encountered really didn't care about little grammatical errors here and there. They were very appreciative of the care they received and just wanted to be treated with respect. In a short time with practice, the routine became almost second nature.

Schedule Outline

Once you become acclimated to the routine, the schedule doesn't change very much. We begin morning rounds at 7:30 and then start seeing patients in clinic. Midday break is from about 12—2:30 and at first glance this may seem like more than enough, but I came to appreciate this break especially during rainy season. Midday heat during this time of the year can really be tiring. Then from 2:30—5, I continued seeing patients in clinic and completed the afternoon rounds at the hospital. Because the lab results are on a separate form than the patient's chart, we have to copy the results into their chart which is really quick. The great thing about the lab is that patients who have labs done

before 11 or 12 will get their results that same day. Many of the afternoon appointments are patients awaiting results.

Weekend call or night call during my time in Gabon was optional. Physicians take call from home and staff from either emergency or internal medicine will call their cell or the Motorola. As a fellow, I wasn't expected to take call, and in fact the physicians told me to take advantage of site seeing instead.

There are a few meetings/conferences that staff members attend weekly. On Monday mornings at 7:30 there is the *collège médicale* where physicians and hospital administration meet. Students are generally not invited to attend these meetings, although you will be asked on your first day to attend in order to introduce yourself to hospital staff. On Wednesday mornings at 7:30 there were various educational presentations for instance on chronic back pain and preeclampsia/eclampsia. Fellows present a topic of their choice in French once during the rotation. I did my presentation on myocarditis and the pediatrics student, Beno, did his on necrotizing enterocolitis.

Friday morning conferences were more informal and focused on interesting X-ray findings and case presentations from different services. Generally, the Wednesday and Friday conferences are attended by both nurses and physicians from different departments. There were a few *cours*, or educational presentations during my fellowship. One presentation included a nice, overview of TB by a French pulmonologist visiting HAS. This was really helpful as it explained to staff the importance of wearing masks and the impact of multi-drug resistant TB. Prior to this, nurses expressed that wearing masks made patients feel ostracized and ashamed.

Patient Population

The patients I encountered were from a variety of socioeconomic and cultural backgrounds. Compared to the rest of central Africa, Gabon is considered relatively stable with an economy that relies heavily on petrol and lumber industry. In addition, the country's relatively stable political environment makes it an attractive place to eke out a living for many West Africans. While the majority of the patients are Gabonese of Fang ethnicity, the largest ethnic group in Gabon, there is a large community of West Africans. I didn't expect for the population in Lambaréné to be so diverse. Interestingly, there is an Asian community, mostly Chinese, in Lambaréné who were hired to work on the lumber and petrol industries.

In terms of socioeconomic factors, I met patients from various backgrounds. The majority of younger patients age forty and younger could read and write, but for the older generation that wasn't always the case. Depending on the nature of the patient's illness, their cultural and religious beliefs could impact the clinic visit. For instance, quite a few patients I have met in Lambaréné said they consulted the *nganga*, or traditional healer, before coming to clinic. I've heard interesting accounts from patients as far as remedies. One patient believed that drinking her own urine could help treat HI. Also some HIV

positive patients felt their illness was due to jealousy or a spell that someone in the community put upon them. There are many other accounts, but some of the traditional forms of medicine has a firm position in their lives and how they view health. That's not say that all Gabonese follow this tradition but as some readily deny any confidence in traditional healers.

Some of the diseases I encountered were no different than what you would see in the States though the management might differ. As far as chronic illness, diabetes and hypertension are also common in Gabon. Being in a tropical climate, I saw diseases that are of course inherent in this area such as bilharzia or malaria. Providing care in Lambaréné, forced me to change the order of differentials in my mind. For example, if a patient walks into the states with acute onset loose stools and no other symptoms, one might attribute this presentation to acute gastroenteritis and send them home if afebrile. But in Gabon with an estimated prevalence of HIV/AIDS at 8%, HIV has to be high on the differential. Sometimes even if patients did not present with signs or symptoms suggestive of the virus, we still tested anyway. I will never forget one patient I met in clinic who traveled from a distant province with intermittent cough, no fevers, and unremarkable chest x-ray. When I suggested HIV testing in clinic, the patient responded with "*le VIH c'est la mort*" or HIV is equivalent to death. She was hospitalized overnight just to get some extra lab tests. The following day, the nurses managed to talk her into getting the test. But before the results were available she had already left the hospital citing a sick relative back home. I always wonder what happened to her. After seeing patients like this in the hospital, I tried to recommend HIV testing to all patients. Some of the illnesses I encountered included:

HIV/AIDS

TB

Malaria

Loiasis

Hypertension

Diabetes

Renal failure

Syphilis

Toxoplasmosis

Gastroenteritis

Pharyngitis

Anemia

Sickle cell crisis

Pneumonia

Malignancy

CHF

Cardiomyopathy

CVA

Snake bite

Pleural effusion

Hepatitis

bilharzia

Reflections

Where do I start? I learned an incredible amount while in Gabon. Reflecting on my experience, I've realized just how different the practice of medicine can be depending on where you are in the world. For instance, when I first arrived I was ready to do tests and lab orders *before* administering antibiotics. But I quickly realized that waiting one week for a Chlamydiae lab test was risky in that some patients never returned for their results. In that respect, the impetus to treat before lab confirmation is certainly a lot stronger given the challenges patients face in access to care. The other adjustment for me was that when I had just arrived in Gabon, I couldn't help but reflect on the limitations of health care in a rural setting like HAS. For instance, I can remember several patients in renal failure who required dialysis, but without any dialysis machines in Lambaréné, we were powerless to treat them. We wrote them a letter and recommended they see a specialist in Libreville. In another instance, a young woman in her 20s was hospitalized for hepatitis of unknown origin, perhaps autoimmune, who a few days into her stay had a CVA. Without a CT scan, we had nothing to go on but just the physical exam findings. At HAS, all we could do for this young woman was to check her vitals, and give her some Aspirin. In the U.S., this patient would have had a battery of tests and labs, but as the old adages goes, we are forced to work with the tools at hand.

After this experience I learned to trust my eyes and ears more. Learning medicine in a country where diagnostic tools abound, it's easy and convenient to have tests that will support the presumed illness. But at HAS, the best tools focused on physical exam and basic tests such as CBC, chest x-ray, and HIV testing. I remember one patient who presented with dysphagia and I initially thought this was likely due to spicy foods as everyone adds *piment* to their food. After asking some questions and doing a physical, I realized that her weight loss and oral thrush made this case more complex than I originally anticipated. In the end, tests showed that she was HIV positive. While the hospital is capable of caring for patients living with HIV/AIDS, there are some who slip through the cracks. I wish that the hospital had social workers or case managers to help patients cope with their illness and to reinforce the importance of medication and periodic doctor's visits. When I started the fellowship, working alongside Dr. Natacha, I was stunned at the amount of work that physicians face. Oftentimes, it's the physicians who call patients asking why they can't make it to their appointments or what barriers prevent them from receiving the free retroviral treatment. A case manager would give patients the opportunity sit down with someone and ask questions but also relieve some of the burden placed on the doctors.

Even though I had traveled to neighboring Cameroon on a previous trip during medical school, HAS was like nothing I have ever seen before. In Cameroon, I was at one of the largest hospitals in the country and if patients could not pay the hospital fees upon admission, then they didn't get care, it was unfortunately that simple. But at HAS, even if patients were unable to pay and that is the case with an estimated fifty percent, the hospital and staff provided care anyways. To me this represented Schweitzer's concept of

reverence for life, the idea that human life is important even if there is no monetary gain attached. In a provincial setting like HAS where the hospital faces continual financial hurdles, I found this reverence for life a unique aspect of my fellowship unlike any previous international experience.

Culturally, I found so many similarities between previous experiences and my time in Gabon. For instance, it is accepted and actually preferred to refer to older patients as *maman* and *papa*. Sometimes I had no idea who was related to whom, as it seemed that everyone was considered *les parents*. As I learned, even if someone isn't your relative, they still are considered part of the family. For instance, introducing your cousin as a cousin is almost considered a demotion. So instead, you refer to your cousin as your brother or sister. In addition, many of the same nonverbal expressions that I had encountered in other cultures also existed in Gabon. The *huh*, *mmhmm* were very present in everyday speech in Gabon. There were many other similarities such as Haitian *kompa* music which reminded me of the zouk and coupé décalé heard in Gabon.

There were social dynamics that were very similar to what I observed in Cameroon. For instance, I met several male patients married *monogames* but who also had relationships with other women. But the times when I got the nerve to ask how they would feel if their spouse dated other people, the reaction was often somewhere close to "well I'd leave her." A woman who has another relationship is considered unfaithful and untrustworthy. As an outsider looking in, it's easy to dismiss cultural perceptions as ridiculous or wonder why women would subject themselves to this double standard. But in one conversation I had with a staff member at the hospital, she told me that women are obligated to accept the fact that their husbands or significant others will cheat. From her perspective, if the woman tries to find someone else better, she will likely find herself in the same situation. It's almost universally accepted that men will cheat or will sometimes physically abuse their partners.

Like other experiences, the stigmatization of HIV/AIDS was also present in Gabon. Getting patients to be honest with their spouses about their HIV/AIDS status seemed almost impossible. The disease still is very much stigmatized to the point that often patients are abandoned by their families in the last stages of the disease. Being ostracized from your family in a culture that's very community-oriented may perhaps be more difficult than the disease itself. I remember patients with AIDS, who a few weeks prior to their deaths, were virtually abandoned by their families. In addition, patients are required to have a family member or *guardian* to assist in their care. Without the support of family, patients have no one to depend on as many Gabonese define themselves as part of community, which incorporates family, friends, ethnicity and an entire village.

My experience in Gabon was absolutely, for lack of a better word, amazing. I learned an incredible amount about myself, tropical medicine and medicine in general. Collaborating with hospital staff who worked in other countries around the world added to the richness of the fellowship. I was able to exchange ideas and perspectives with people whose experiences differed from my own. Although admittedly I was a little nervous to embark on a rural international medical trip, I am grateful to have had such an

opportunity. This fellowship has shaped me and further encouraged my interests in infectious disease and international health. I hope to be able to incorporate more international experiences in my career in the future.

Recommendations for the Fellowship

I really enjoyed my experience at HAS thanks in part to the hard work of Lachlan, Devon, and ASF staff. As far as recommendations to improve the fellowship, I wish that students could take the chance to work in other departments for a few days. I think it would add to a richer experience and make us more knowledgeable of how other services are run. When I started my rotation in Gabon, I also brought this up during the *college medicale* and was told that generally students will stay in one service during the time at HAS, however in some cases if there is enough help, I think fellows can work in another department for a few days. Looking back it's the one thing about my experience I wish I had pursued. There's nothing like seeing care of patients from the perspective of another discipline. In addition, medicine attendings were often consulted for co-management of patients in surgery and ob/gyn with diagnoses of HTN, diabetes, HIV/AIDS. If the hospital and the foundation could coordinate to inform the foundation when other medical students would be doing rotations at HAS, this may facilitate students being able to experience more than just one service.

In the end, this was a great experience of helping to provide care and educate patients regarding their illnesses. It would not have been the same without the HAS staff who enlightened me about Gabonese culture and customs, my fellow ASF fellows, and friends that I made while in Lambaréné.