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Early Phi Rho and Zeta Women

About a year ago the first woman to be initiated into Zeta, Susan Boiko (U-M Med '78) visited the chapter house and related her recent African experience in Rwanda teaching dermatology and working with the Pygmy Survival Alliance. Her visit reminded me of the changes in our society of that era that prompted the Grand Chapter just before Susan's initiation to revise its by-laws to extend membership to women and to change its name from Fraternity to Society. Meng Tan, former president of the Grand Chapter, told me that Barbara Blauvett (Alpha Eta, Dalhousie, Halifax) became the first woman member of Phi Rho in 1974. It was not only the right moment and the proper response, but also one necessary for the survival of the Society; membership in medical fraternities was then dwindling rapidly.

Though the sweeping changes that would bring many more women into medicine and all the professions were cultural and philosophical, for me, as an alumni counselor to Zeta, the issues and questions were more practical. How could an all-male chapter house be made not only socially welcoming but a physically suitable residence for women? What about the male-centric boisterousness? What about the bathrooms? An early woman member was the daughter of a sitting Regent of the University - would there be an incident that would direct untoward attention to Zeta by the Medical School or the U-M administration?

The Zeta Alumni Board made a few suggestions to the active membership. The women, even though greatly outnumbered, quickly created a sense of calm and dealt with the problems of physical space. Cheryl Huckins (also U-M Med '78) took the time to write me that "it took three years before all the restrooms were co-ed." Her roommate was Chris Rosenfeld, who started Medical School at age 50, after working as a chemist for Dow. Cheryl recalls that the basement was a dark storage area (now greatly improved), that the Sunday brunch was looked forward to, and that "by the time I left there were more women in the House and it was no longer a novelty to be sharing space with the opposite sex." She wrote that she would be interested "to hear what some of the guys of that era thought". Zeta, always a supportive environment for men, became one for women as well, fulfilling its mission to help medical students succeed. Over the subsequent decades, more than one member has opined that Phi Rho "helped me get through Medical School," both academically and emotionally.

Now Elisabeth Righter has become the first woman president of Phi Rho Sigma, a progression over several extraordinary decades of women assuming much larger roles in American medicine at every level. The present Zeta chapter is robust and enduring, and the House is half-filled with women. Congratulations to them and to their pioneering predecessors. Congratulations to Lisa.

David Schmidt, M.D. (Zeta, U-M Med '59)

In this issue:

Iota Benefit, Phi Rho Sigma medical society alumni honor Fred Paustian

Dr. Carol Drake presents Dr. Paustain with a plaque that will hang in the Sorrell Center.

The Iota Benefit and Phi Rho Sigma Medical Society recently honored Fred Paustian, M.D., for his many years of service to the organization with a luncheon on campus. Dr. Paustian is a legendary UNMC physician and the state's first specialty-trained gastroenterologist. Throughout his career, Dr. Paustian generously supported Phi Rho Sigma and UNMC.

"This is truly an honor and I am thankful for the recognition," Dr. Paustian said. He and his wife, Diane, attended the ceremony with two dozen medical professionals, University of Nebraska Foundation representatives and UNMC Alumni Relations staff.

Murray Awarded Honorary Membership in CMA

Dr. Jock Murray, Alpha Eta, has been awarded Honorary Membership in the Canadian Medical Association, an award made at the CMA meeting last June. Dr. Murray is former Dean of Medicine at Dalhousie Medical School in Halifax, Nova Scotia, He is Chairman Emeritus of the American College of Physicians, Past President of the American Osler Society and Past President of the Consortium of MS Centers.

Eta Chapter members (Creighton University) participate in a Suture Clinic.

GRAND CHAPTER MEDALISTS - 2013

Phi Rho Sigma is now calling for nominations for the Society's gold medals which are to be presented at our June 2013 meeting in Chicago.

The Irving S. Cutter medal is presented to a member of Phi Rho Sigma who has made an outstanding contribution to medicine during his/her medical career.

Our second award, the Jessie Ansley Griffin medal, is given to an individual who has made an outstanding contribution to Phi Rho Sigma Medical Society.

The Paul L. McLain Research award recognizes research done by a society member during his/her medical education. Information on the criteria for this award was sent to all chapters in November.

Nominations for the Cutter and Griffin medals are due in the National Office by February 15th... please send your information to PO Box 90264, Indianapolis, IN 46290 or via email at hrodenbe@sbcglobal.net.

REFLECTIONS ON MY HAITI EXPERIENCE

I have spent nearly one-third of 2012 in Haiti, my involvement ever growing as I attach myself to more and more projects designed with good intentions. I have met amazing people doing amazing things and every chance I get I ask questions. "Why are you doing this?" "How is this helping?" "How can you show that this is helping?"

I never fancied myself as an academic mind. I started medical school holding great disdain for what I understood research to be – a bunch of older, out-of-touch, self-important academics trying to find "answers" to questions nobody but themselves cared about. No offense. But the more I learned about evidence-based medicine and became involved with patient care the more I realized how important research was to guiding medical practice. And beyond that, how research can be used to guide actions on a community, or even global, scale. As a future primary healthcare physician I see this research as the most important moving forward.

In seeing the country of Haiti through this newly developed lens I keep having the same inner debate. Aid distributed to Haiti and other low-resource countries is always measured by volume instead of impact. Countries brag about how much money, food, or medication was given to another country without ever truly tracking the benefits. The organization I have been working with in Haiti falls into the same trap. We report how many bodies pass through our short-term clinic. Without appropriate follow-up we couldn't honestly say if we improved the lives of those patients. We can't even say with confidence that we were not a source of maleficence to the community. How could you tell?

My concerns were not unique. Like-minded people within the organization are advocating for ways to track actual outcomes. Our first test: Electronic Medical Records. You might say that we are overly ambitious, but with the advent of iPads and a local network it becomes relatively easy. Truthfully, if an international medical mission is not performing some sort of record keeping then it can be argued that they are providing a disservice. In addition to keeping patient records, we are beginning to look at population-based metrics of health and wellness. Ones that we find are particularly telling include diarrheal illness, school attendance, and maternal morbidity. Most of these are not formally within the scope of a short-term medical mission, but are a marker of the overall health of a community.

Our first step was to define the health problems facing the communities we wanted to work in in Haiti. While I was down there I conducted a fifty question survey to over 250 randomly selected houses representing over 1000 local villagers. Topics addressed ranged from water to education to breastfeeding and everything in between. Key findings include identifying that 65% of people use surface water such as the river or canal as their source for drinking or cooking and 25% of people do not regularly treat their water. Twenty percent of houses surveyed reported a diarrheal illness in the last two weeks. One third of houses reported having a childhood death. Hundreds of people defecate in the yard or garden. Parents are unable to pay for their children to eat or attend school, but are powerless when it comes to protecting from future pregnancy. A majority of the people think that building a new hospital and school for their community would solve their problems but are unable to describe a way to maintain either with staff and repairs. It was an incredibly useful baseline as it gives us specific numbers and targets.

In the summer of 2012 we gathered objective data on the water quality. Nearly every major water source or storage unit tested strongly positive for coliforms. Borne out of this information and the subjective data from my survey we rolled out a clean water project by partnering with another non-governmental organization that specialized in such programs. We distributed 500 buckets with chlorine and instructions, hired five local Haitians to supervise and experienced a success rate of upwards of 95% for our first few months. Eventually we will conduct a follow-up survey with a control group to see if there is a difference in things like school attendance and diarrheal illness.

As another project to improve the evidence supporting our work I was involved in determining the etiology of one of the most common infectious complaints encountered during our short-term clinics, discharge. By setting up a women's health station we were able to provide the Haitian women with standard of care in a private setting. On top of that we were able to provide an accurate diagnosis where we used to treat empirically. With the success of this project we are looking to increase the evidence supporting the methods we employ.

As I delve more into international medicine I become more focused on primary outcomes instead of the commonly used metrics of gross expenditures and people seen. It is easy to get caught up in the personal reward of "treating" more people, but I wish to practice in a scientific field that is data driven. That is why having international experiences are so important to medical students. It offers an unique learning opportunity to learn about the evidence of practice, but also step beyond secondary outcomes and look at the overall health of a community. In the shifting landscape of the medical field this broad perspective will need to become more dominant as we look to curtail costs and prevent disease instead of control conditions.

Matt Downen

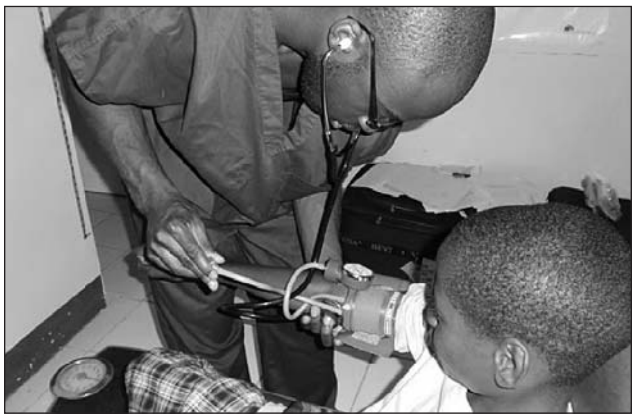
Year 4 - Mu Chapter
University of Iowa

Phi Rho Sigma Foundation Helps Support Service Trip

Dear Dr. Ayres,

On behalf of the Alpha Chapter of Phi Rho Sigma at the Northwestern University Feinberg School of Medicine, I am writing to report a successful service trip in Hagley Gap, Jamaica, serving at the Blue Mountain Project clinic there. We journeyed to the remote village in the mountains famous for Blue Mountain coffee to provide free basic healthcare services and free medications. We also vied to make health education an important component of the trip. We coined the term P.E.A.C.E (Patient Education/Action Compassion and Empowerment) mission to emphasize our earnest desire to make our endeavors more sustainable.

We saw almost 150 patients over the course of 4 days at two different clinics. One clinic was located in Hagley Gap, and the other was in a village called Penlyne Castle located farther up the mountains. We saw patients with both acute and chronic illnesses. Acute illnesses treated included gastrointestinal infections, urinary tract infections, upper respiratory tract infections, and Candida infections. We also caught one case of possible bacterial meningitis that we sent to the Kingston hospital, and it is possible that we helped save that patient's life. Chronic conditions such as asthma, diabetes, and hypertension were also managed. Our clinical team educated patients on important healthy lifestyle habits like diet, exercise, and the prevention of infections. We also discussed what to due in acute situations, like choking, diarrhea, and physical injuries. While we expressed interest in including sexual education as a part of our health education talks, we were discouraged from doing so by the Blue Mountain Project group due to it being a taboo subject for the residents. However, our physicians did take appropriate measures to counsel patients on appropriate sexual practices and care for sensitive organs, and we did make condoms available to patients.



Medical student from Phi Rho had an excellent opportunity to get to know a different culture and way of life. We were also able to get substantial practice performing basic health care skills, and we learned more on how to diagnose illnesses. An important lesson of the trip was about how to manage patient care with limited resources. Lab tests, imaging, and other highly technical resources were not available to us at our clinics.

For patients who were not able enough to make it to our clinics, we made home visits, traveling up the mountains to meet residents in small hut-like dwellings in both Hagley Gap and Penlyne Castle.

Patient Statistics from Our Clinics in Hagley Gap and Penlyne Castle

Of the 145 patients we saw, 41% were male, and 59% were female. The age distribution breakdown is reported in Figure 1 below.

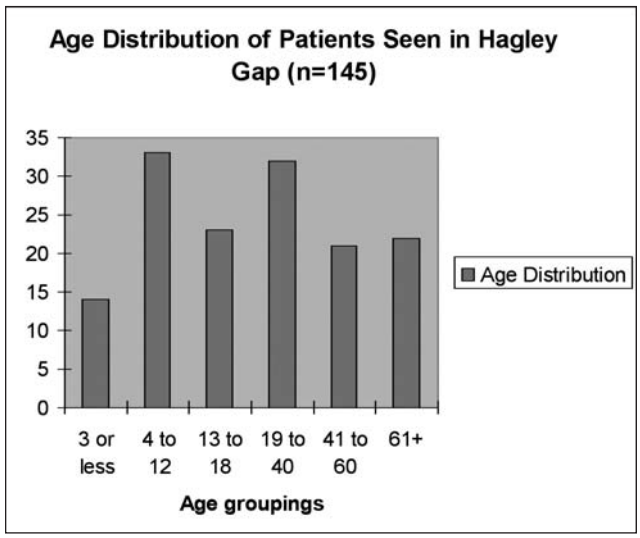


Figure 1:
The broad age range of the patients we saw in both Hagley Gap and Penlyne clinic.

We saw a fairly broad distribution of patients in terms of the illnesses that they had and the diagnoses that we provided, given our limited resources. The breakdown is reported in the table on page 5.

TABLE I
DIAGNOSES FROM PATIENTS SEEN IN JAMAICA (FROM MOST COMMON TO LEAST COMMON) N=145

Diagnosis	Number	Percentage of Patients Seen (%)
Other	33	22.76
Vaginal infection	20	13.79
Arthritis	15	10.34
Infection	15	10.34
Well checkup	14	9.65
Allergies	13	8.96
Hypertension	12	8.27
Intestinal parasites	12	8.27
Upper respiratory infection	12	8.27
Asthma	11	7.59
Eczema	10	6.90
Gastrointestinal reflux disease	9	6.20
Acne	7	4.83
Back pain	6	4.14
Tinea capitis	6	4.14

As evidence from Table I, infections, particularly vaginal infections were prevalent in the community. Outside of the "Other" category and infections, the next greatest number of diagnoses were given for arthritis (~10%). The prevalence of arthritis was probably due to the amount of physical labor performed on a daily basis by the residents there, since the majority of them are subsistence farmers, and they get the majority of their income from farming Blue Mountain Coffee.
Aside from grueling days at the clinic providing care for the residents of the community, our group had the opportunity to learn about Jamaican culture through an orientation, a visit to Kingston, and we were also able to visit one of the farms of the residents. Since our trip was scheduled around the time of the Jamaican elections, we were able to attend a political rally for a candidate of the People's National Party.

In Kingston, we had the opportunity to see the famous Devon House, home of one of Jamaica's wealthiest citizens of the past: George Stiebel. We bought ice cream there, which we were told was the "third best ice cream in the world." It was not completely clear to us who did the ranking or how this was determined, but we enjoyed the ice cream nonetheless. We were also able to spend a small amount of time at the beach.

Volunteers getting the "third best ice cream in the world" at the Devon House in Kingston, Jamaica.

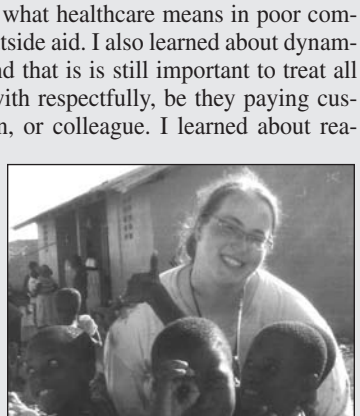
Volunteers relaxing after a hard day at the clinic in the Hagley Gap square. The square consisted of 10 small shops lined up along a bumpy mountain road. It was not as glamorous as Michigan Avenue in Chicago, but we were still able to enjoy ourselves.

In conclusion, we took 10 medical students and 2 physicians (an internist and a pediatrician) to rural villages in the Blue Mountains of Jamaica near Kingston. We saw almost 150 patients and gave them free medical care, free medications, and we educated them on good health practices so that they could take better care of themselves. We learned a lot about a different culture, gained experience practicing medicine in a limited resource setting, and we also had a good time. We are deeply grateful to Phi Rho for making this trip possible for us, and we hope that such trips continue to better the health of the world and to provide an extremely valuable experience to Phi Rho's membership. Thank you for your support.

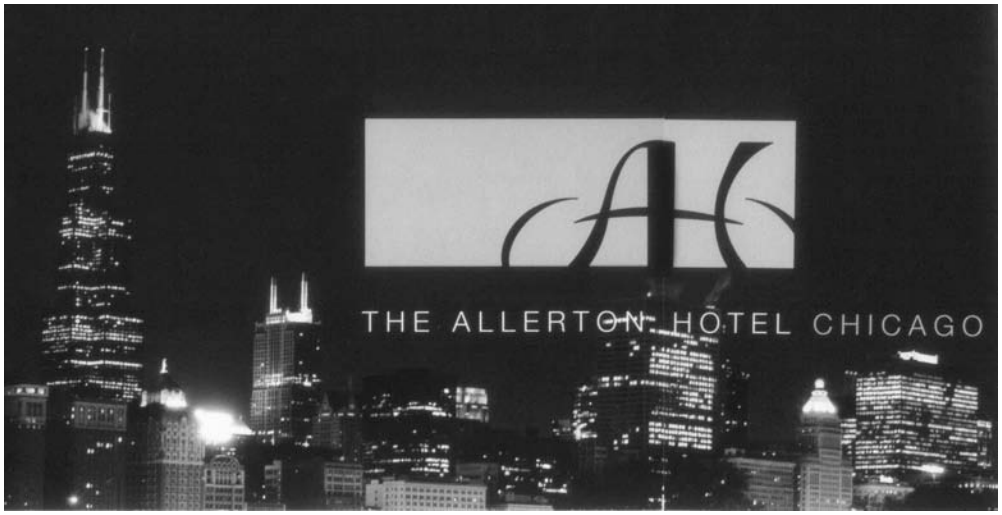
Sincerely,
Oyinlolu Adeyanju
Lead Coordinator for for Jamaica Service Trip

Experience in Haiti

Last summer, I went to an orphanage in Les Cayes, Haiti called Pwoje Espwa (Project Hope). I did odd medical jobs and got to experience what healthcare is like in Haiti by visiting a few clinics as well as a birthing center called Maison de Naissance (Home of Birth). The work done in Haiti was far more significant than the work I did there because I learned so much about what healthcare means in poor communities that rely on outside aid. I also learned about dynamics between cultures and that is is still important to treat all people that I interact with respectfully, be they paying customer, homeless person, or colleague. I learned about reasonable, sustainable goals, and most of all, I learned a lot about myself, perhaps more that I would have wanted to at times. The most important thing that I have carried and will continue to carry away from Haiti is that people are complex but worth the effort even if often irritating.



Lindsay Taute,
Theta Tau



2013 GRAND CHAPTER

We are going back to our roots! Come join us!

Our Grand Chapter meeting will be held in Chicago at the Allerton Hotel which is located just a block away from Northwestern University Medical School where Phi Rho was founded. The dates are June 14th and 15th. For further information please contact the office at hrodenbe@sbcglobal.net.

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