Physicians Provide Medical Care Around the World

International Mission Services: Helping Around the World

There are lots of ways physicians give in every day life. Long hours first dedicated to study, and later, dedication to helping and healing. Here we introduce you to a few physicians who went the distance to help patients on international medical mission trips.

Dr. Jessica Kisicki (kneeling) of Cheyenne is pcitured with Guatemalan patients and a fellow volunteer on a 2018 volunteer mission trip to La Pila with Great Commission Outreach.

Dr. Chuck Franklin, a family medicine doctor in Newcastle

Dr. Chuck Franklin of Newcastle has been part of international medical mission trips since 1982, while he was in residency. Today, his wife, a nurse, and their daughter, also a nurse, make regular trips to help people of Third World nations. On occasion he goes on mission trips without his family, which was the case in 2017 when he and a good friend went to some of India's remote villages to care for patients.

Our first mission trip was to the island of Roatan, which is part of Honduras. This was during residency in 1982. This was a two-week elective. At that time there was no medical care except for a nurse who traveled among three islands.

We next went to the mainland of Honduras shortly after Hurricane Mitch. There was rather severe malnutrition and starvation there including a little girl of 11 years old who we treated. She was getting better and started being able to sit up and then walk but then she passed away suddenly.

We've to Honduras or somewhere else nearly every year over the years. I've gone to a number of countries with different groups, including a couple of months in Venezuela, Peru, Nicaragua and Haiti.

Two years ago, I went to India with my good friend Dr. Michael Duerhssen. A government helicopter flew our group into a very remote village on Christmas Eve where we spent the holiday with the people there and then held clinics for a couple of days. We hiked from one village to the next, holding clinics for a day or two at each village. We had to hike out a total of 100 miles to the nearest road.

The local people helped us carry our medical equipment, which consisted of approximately 700 pounds of baggage. All the villages are along the river and we were told that they basically had no medical care except for village health workers who had two weeks of medical education.

For about six months out of each year the villagers cannot leave the valley because of monsoon rains. During the other six months if they want to leave they must hike 100 miles over very rugged terrain, crossing the river many times on bamboo bridges. When the monsoons come, the bridges washout and they're trapped in the valley until after the monsoon season. Then they rebuild all the bridges and hike out the next year.

Anything they want or need to bring, they must carry on their backs. They pretty much live as it was several hundred years ago. They were very clean polite and helpful. There were a lot of Christians as well as Hindus in the valley. We really enjoyed the experience.

I think the most interesting case was when repaired a cleft lip of a little girl that was about 18 months old. We told her

Volunteers in India for a medical mission organized by Chuck Franklin gather around a patient in preparation for surgery. Photo Credit: Chuck Franklin

In India, Dr. Chuck Franklin of Newcastle, worked in rugged conditions. Photo Credit: Chuck Franklin

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> Newcastle, WY

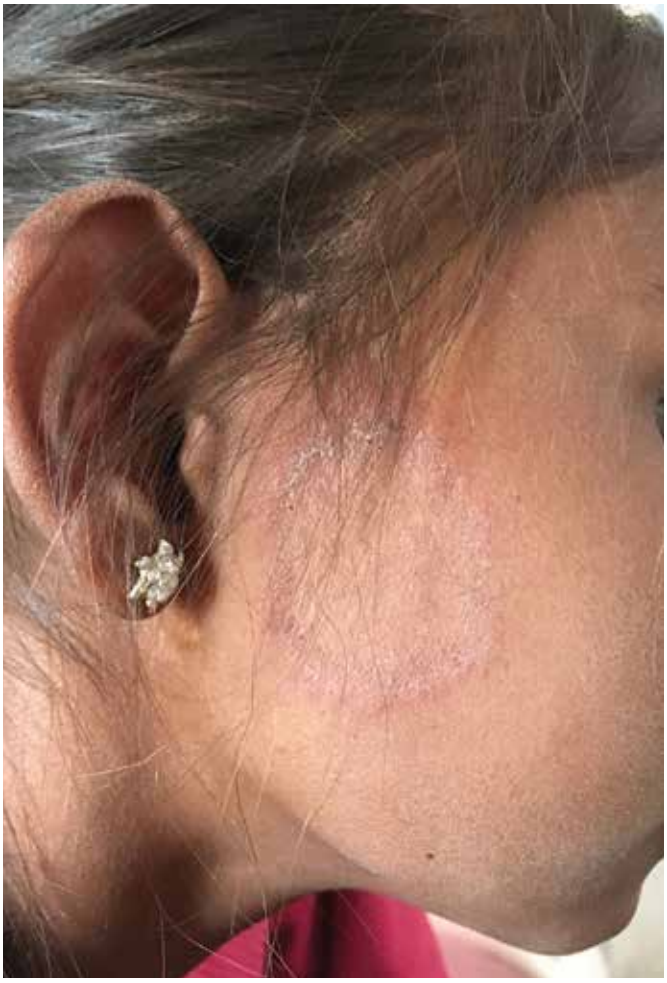
mother that we were not plastic surgeons, and we couldn't do it but she said if we didn't, then no one ever will. So, we sedated her with ketamine and repaired her lip. The next morning, she was eating better. Months later, we received email from an Indian who lives in the town at the end of the road, telling us the girl was doing very well.

Three or four trips have been organized through our church but most of the time we just get local nurses and interested people and make the trip ourselves.

In Venezuela a mission pilot would fly some of us into short dirt strips in small villages, and we would camp out for a night or two and hold clinics. Then he would return to pick us up. Occasionally we backpacked into villages if the plane was down for maintenance. In 2007 I was there for a month. A week after I returned home, the Venezuelan government placed the rest of the group under house arrest and soon after ejected them from the country.

Dr. Julie Neville, a dermatologist at Cheyenne Skin Clinic

Dr. Julie Neville of Cheyenne Skin Clinic joined a medical mission trip organized by Passion to Heal through its Me to We program. From her post – a school in rural Rajasthan, India, she and a team of eight other providers saw 2,000 patients, often unaccompanied school children. Providers weren't "roughing" it, Neville says, as they had a chef providing a variety of Indian meals at camp. On walks around the camp, sari-wearing locals frequently greeted guests with a traditional Indian greeting – Namaste. The trip from Denver to Delhi to Udaipur was long, but along the way she says she developed an awareness of her own limitations and what it means to get back to (medical) basics.



Dr. Julie Neville says cases of ringworm, were common in Rajasthan, India where she volunteered. Photo Courtesy Dr. Julie Neville

I began this trip with a sense of open-mindedness and cautious optimism that my presence in India would help the patients we would be working with and allow for personal growth as to the culture and diversity of another area of the world, in this case, rural Rajasthan, India. It was about expanding my horizon and view of the world. Despite reading about other parts of the world, our own view tends to be limited to the experiences we accrue in our lives and by coming in contact with an area so different from my own, I could grow to appreciate both the differences and similarities universal across the world. In addition, I relished the idea of giving back in appreciation for all the opportunities and training that I was privileged to receive in my life.

On reflection after the trip, I experienced a sense of humility. In beginning to work with the community, the excitement became intermixed with a level of despondency given

There was no shortage of patients in need of help, says Dr. Julie Neville, a dermatologist in Cheyenne. Photo Credit: Dr. Julie Neville

the overwhelming needs of the patients – needs that included malnutrition and poverty. But, after working for a few days, one realized that they too have much to offer including joy in the children and happiness with our presence there and a strong sense of community and one's place in the family structure, often attributes diluted in western cultures.

The presence of hard work and compassion for others was present. This included teachers assisting their students at the clinic or siblings helping each other to navigate what would likely be a confusing and unfamiliar system in receiving health care. In a sense, I believe our place was, to some degree, providing dermatology care but also serving as ambassadors for the Passion to Heal organization's "Me to We" program in which one would hope this small facet of the program will help to build trust in the tribal communities and advance the program's other goals including agriculture and education.

It is hard not to come out of this experience with a sense of gratitude. It is gratitude for one's station in life as a female raised in a country with opportunity and equality to my peers. A gratitude to experience another culture and the vibrancy and beauty held within.

Gratitude for having many of the conveniences that are available to us while many that we worked with deal with the daily struggle of providing for their basic needs of adequate food, water and shelter. It is also gratitude to the patients who welcomed us into their community with joy and to the organization that provided us this opportunity and continues to work daily in India.

With regards to dermatology and healthcare in the area, it

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requires a radical shift from the way we treat patients in North America. Our medical protocols typically rely heavily on testing, whether it is laboratory testing, fungal KOH preparations, bacterial cultures, or biopsies for pathological diagnoses. When these options are unavailable, you learn to treat with what is available in the pharmacy and what is the likely cause. We are trained to diagnose a condition by determining the single etiology for the problem if possible and then targeting treatment to that etiology.

Without testing and without the ability for patient follow-up, we prescribed many more combination creams having efficacy against bacteria, fungus, parasitic diseases and anti-inflammatory steroids in order to broadly cover many potential causes of the skin condition.

Many of the dermatologic problems we saw, including lice, scabies and bacterial infections, can be treated but one becomes aware of the limitations present and the necessity of accommodation and adjustment for the resources available. Often children were present with their school group only and when instructions are given to an 8 -year-old child without their parents present, and given the high illiteracy rates in the area, it's hard to know if written information will be understood and the message adequately conveyed. In addition, a child with lice may return to their home and sleep head-to-head with other members of their family who likely also are infected, so we tried to encourage these children to also have their family members treated.

As we took care of many patients who may not have been familiar with how to use the creams, open the tubes and how much to use, we enlisted demonstrations of products and often took to massaging in the cream to show them how it was done. This served the two-fold purpose of demonstration but also enlisted the power of touch which transcends the language barrier.

Many of the conditions we saw are attributable to the conditions in which the patients live. Eczema, dry skin and lips were common and likely exacerbated by the arid climate and prevalent smoke produced by cooking using wood fires indoors and a lack of ventilation systems. Adequate hydration was more difficult given the necessity of hauling drinking water. Most patients had little access to lotions and so we encouraged them to use mustard and coconut oils, which are available to them. Dry, cracked hands and feet are common and attributable to fact that the majority of patients arrived without shoes and given the agrarian nature of the society. Many of the children I saw did not have socks, which would enhance the moisturization capabilities of the creams we gave them. We saw many cases of tinea with often cases of inflammatory tinea capitis in the scalp including kerions and lymphadenopathy. Given the proximity to animals - goats sleep in the same home as their owners - this was likely part of the cause.

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Malnutrition, anemia and parasitic diseases were prevalent given the inadequacy of consistently reliable food sources, vegetarian diets with insufficient protein sources and the presence of open wells as a water source in which parasites were common and the practice of boiling water before drinking was not common. We witnessed several cases of active mumps as children are not vaccinated against this as well as varicella. It is much less likely in western medicine to see these conditions given our high vaccination rates for both.

Overall, this was such a humbling and powerful experience in stepping outside of my comfort zone and witnessing a culture and medical practice so different from my own. It is a lesson in assessing my limitations in what I could treat and developing adjustments to work around this.

It went back to the basics of diagnosing and treating conditions to the best of my ability without testing. It is also a centering experience in which we all become focused on the minute details of our own day-to-day lives and by getting a chance to experience the lives of others much different from your own, you become appreciative for what you have been given.

Dr. Jessica Kisicki (in spectacles) gathers colleagues turned friends for a photo op during her June 2018 misison trip to La Pila, Guatemala. Photo Credit: Dr. Jessica Kisicki

A volunteer with the Great Commission Outreach works with a Guatemalan patient. Photo Credit: Dr. Jessica Kissicki

Jessica Hughes Kisicki, the director of the Emergency Department at Cheyenne Regional Medical Center

Dr. Jessica Kisicki works in emergency medicine for Cheyenne Regional Medical Center. She traveled to La Pila, Guatemala with Great Commission Outreach in June 2018, where the organization has partnered with the village and provide healthcare with volunteers visiting every three months. This was her third trip to Guatemala, and certainly not her last – she hopes to adopt another village and apply GCO's principals there.

Friends of mine started the faith-based Great Commission Outreach (GCO) in 2016 to provide medical care and help a small community thrive independently in southern Guatemala. So, I was happy to join their work and serve the 120 families and other villages in the area.

La Pila is a village about two hours by bus from Antigua, a trip we took daily from our hotel. Once at the clinic, we see patients and give them primary care and medications. If there is a greater need, we work to set up care in the cities. An example of that being eye surgery to treat a boy's strabismus.

Generally, we give every patient we see vitamins and anti-parasite medications because they can be deficient and there is not clean drinking water. Our work in La Pila isn't just about medical care, but in supporting the general health of the community. Last summer, donations allowed us to buy water filtration systems which we installed, allowing families to access clean drinking water. We have teamed up with the village people to install flush toilets, cementing dirty areas in the school, painting the school and making benches for the school.

We focus some attention on the school, with the goal of keeping children in school as long as possible. We also created the opportunity for people to sponsor children in the village if they are in school. We provide a food basket and breakfast for the child each day as long as they stay in school.

We do this work in a place where resources are scarce, but while maintaining the culture and supporting their basic needs.

When we visit on Sundays, the local Guatemalan women make us a chicken soup with fresh vegetables.

We are trying to help the people of La Pila become self-sufficient. The unmarried women, who also are unable to work, now have a shop in which they make and sell items. This new enterprise allows them to earn money to support their children.

Being able to spend your time (and talents) serving others is life changing, and with that in mind, I'm planning another medical mission trip to Thailand in October.

Sarah Maze, WWAMI Student

Sarah Maze, a second-year student at the University of Washington School of Medicine, was raised in Ranchester. She traveled to Dhulikhel, Nepal, through the school's Global Health Immersion Program on a Global Opportunities Fellowship in summer 2018. A Spanish-speaker, Maze's first medical mission trips were in Honduras. In Dhulikhel, her focus was on a public health campaign on gestational diabetes.

My primary goal was, first and foremost, to learn about

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Community partners from the departments of Nutrition, Pharmacy, Physiotherapy, Community Programs, and Education pictured with Sarah Maze (pink shirt, front row) after the first Gestational Diabetes Mellitus Education Session at Dhulikhel Hospital, August 2018.

the community--their unique needs, approach to healthcare, understanding of healthcare and chronic disease. With that knowledge I could effectively work with local partners to create a project that would have a positive impact and made sense in their current structure. So, in communication with local care providers and community members, I identified a specific need in gestational diabetes education. The hospital in Dhulikhel is a community hospital, serves a vast population and supports numerous departments, and medical, nursing, dental, and physiotherapy schools. They currently hosted diabetes education sessions for patients and community members, facilitated by nurse educators and pharmacists. That session is great, but it doesn't focus on gestational diabetes.

The maternal mortality rate in Nepal is dangerously high due to a number of factors including lack of infrastructure for travel in rural areas, low health literacy, cultural practices, lack of primary care and follow-up, to name a few, and the incidence of gestational diabetes is steadily increasing.

I decided to work with departments around the hospital and combine all their current methods of gestational diabetes diagnosis, education and follow-up into three elements. First, weekly gestational diabetes education session held in the obstetrics and gynecology ward for patients who were there for appointments or who had recently been diagnosed along with family and community members.

Second, creating an educational brochure to distribute at the hospital and rural outreach clinics. Third, create a one-page infographic detailing culturally specific diet recommendations to manage the condition.

The diet plate I created by taking pictures of local foods at markets and transforming the current recommendations that were distributed by the hospital nutritionists into completely picture format, which made it more accessible for patients of all literacy levels.

There is a rising trend toward early intervention and education about chronic disease in Nepal. Like many countries, the Nepalese are in the midst of an epidemiological transition from a largely infectious disease burden to one of chronic disease. The general understanding of healthcare and disease in this manner is important for people to understand and takes time. Dhulikhel Hospital does phenomenal community outreach and education efforts, so their community is making great strides in understanding the idea of chronic disease and the importance of risk factor reduction and lifestyle modification.

It is hugely important to see this work through the lens of the community and culture, and it was a privilege to work with local care providers and educators to learn about their current methods and how to best reach our target population.

Dhulikhel Hospital has a rather significant international presence, including students there for clinical rotations, visiting physicians there for guest lectures at the medical/nursing/dental schools, so it was a different experience than I'd had in the past with smaller organizations. That in itself presented an interesting opportunity to learn about healthcare structures around the world. I also entered into my Nepal experience speaking very little Nepali, which was not something I have faced in my previous travels.

Weekly, we had dinner at a local cafe and had a Nepali lesson by the owner and his sons, which helped to slowly build my vocabulary, but certainly not to the point where I would feel comfortable having an important conversation in Nepali.

The language barrier was an interesting challenge. Many people spoke English and others could if necessary, but I wanted to be able to communicate with people in familiarity. So that was an expected, and welcomed, yet challenging obstacle.

Interestingly, the hospital conducted the majority of its business in English including keeping patient charts in English, though some patients were not well versed in the language.

This experience continues to bring me joy and leaves me excited to continue exploring and incorporate international work into my future career as a physician.