Welcome from your yMWIA Chair

Welcome to yMWA! We are a subcommittee of the MWIA consisting of young physicians and medical students. This subcommittee was formed at the 27th International Congress in Ghana that took place in 2007. It was created to address the unique concerns and needs of young physicians and physicians-in-training worldwide. We renewed the subcommittee at this year’s 28th International Congress in Germany because even in the year 2010, we are still facing common issues of gender discrimination in training, unequal salaries compared to male colleagues, and fewer promotions to leadership and administrative positions among numerous other subjects reminding us that women have not yet achieved parity in medicine.

An article published in Nature revealed that women must be 2.6 times more productive than men to receive equivalent peer-review analysis. As Dr. Gabriele Kaczmarczyk, distinguished physician, author, and leader, shared with us in her workshop on Leadership Training for Female Physicians, “It is time to get out of the hamster wheel [and establish ourselves in the leadership realm through networking and self-presentation].” Now is the time in our careers to set ourselves on an ascending track and counter traditional trends. Your involvement in MWIA is the first step in making important connections and utilizing one of the most valuable resources available – each other!

As your new leadership representatives, our task for yMWA is to enhance dialog between young physicians and medical students internationally regarding common struggles and unique solutions. We are beginning the process through our biannual newsletters. Please distribute these among your medical women’s organizations. We also hope that you will share with us interesting articles, research projects, or stories that we can publish in our future newsletters. Additionally, we have a Facebook page (MWIA Young Doctors and Medical Students) that we hope you will join, and it can serve as a fantastic forum for discussion and networking between meetings of the MWIA International Congress. You can also stay up to date on meetings in your region by checking out the MWIA website (http://mwia.webtop.de/). Finally, you can start planning your trip to the 29th International Congress of MWIA in Seoul, Korea in 2013! We know it is an experience you will never forget!

On behalf of the yMWA Subcommittee,

Ashley Styczynski, yMWIA Chair 2010-2013
Educatng Tomorrow’s Doctors on Health Inequalitys in a Globalised World

Presented as a poster presentation at the MWIA International Congress in Muenster

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Please be aware that the following is based on my own experiences in the UK. I would be very interested to hear others’ perspectives, whether it be ideas on future methods of teaching or the situations in your countries. I am in no doubt that disadvantaged groups are present in every corner of the globe, but are they as marginalised and do the same levels of health inequalities arise?

The theme of the 2010 MWIA Congress was Globalisation in Medicine. In our increasingly globalised world, the doctors of the future will inevitably encounter a diverse range of patients, including those from disadvantaged groups, in whatever field they chose to work. They must be equipped to effectively care for these groups. Health inequalities occur for disadvantaged groups due to a combination of inadequate provision of healthcare services, difficulties accessing these services, and the existence of patterns of disease that differ from the general population. Whilst studying the healthcare of prisoners, prostitutes, asylum seekers, refugees and homeless people, I grew to appreciate the needs and vulnerabilities of marginalised sections of society. I plan to outline these barriers and how they can be taught to students in a practical and sustainable way within the undergraduate medical curriculum.

Disadvantaged groups within society: the UK picture

The number of households recognised as homeless is in excess of 40,000 in Scotland and well over 75,000 in England (1). In Scotland, the number of prisoners has risen by 10% in the last ten years (2) and over 100,000 girls in the UK are involved in prostitution (3). Asylum seekers make up less than 0.5% of the UK population but are concentrated in certain cities, making up 5% of the London population (4). As such, healthcare professionals will be exposed to a variety of disadvantaged groups throughout their career.

Results of a retrospective cohort study conducted in Glasgow, reveal that the mean age of death in homeless people compared to non-homeless is 14 years less in women and 12 years less in men (5). Recent studies show that the levels of mental illness, in particular anxiety and depression, are higher in refugees and asylum seekers than in the general population (4). However, all disadvantaged groups are at risk of mental ill health, with over 90% of prisoners suffering from a mental disorder (6). Asylum seekers and refugees can also present with complex medical problems, including infectious diseases, malnutrition and mental ill health due to trauma, torture and violence (4). Inequalities will persist if healthcare providers are not aware of the needs of disadvantaged populations.

Communication with disadvantaged patients

The majority of medical students, certainly in the UK, are from a middle class background and have very little exposure to deprivation (7). A recent study of UK general practitioners showed that many feel inadequately prepared to cope with these patients (8). Medical schools must prepare students to care for all people, including those who are disadvantaged. This preparation comes through experience, early exposure to a variety of patients, education on health and social inequalities, and appropriate, relevant, and socially accountable communications curricula.

In their “Tomorrow’s Doctors” document, which outlines the standards required for UK medical graduates, the General Medical Council states that graduates must ‘Communicate clearly, sensitively and effectively with individuals and groups regardless of their age, social, cultural or ethnic backgrounds or their disabilities, including when English is not the patient’s first language’ (9). Poor communication between doctor and patient, foreign language barriers, the effects of substance misuse and mental instability can all be barriers to quality healthcare. If they are to reduce health inequalities doctors must be able to effectively communicate with disadvantaged patients. UK medical students receive a high level of communication skills training (9) but how often does this include a consultation through an interpreter or taking a history from somebody from another culture?

Social and cultural differences in those from disadvantaged groups

Perceptions of healthcare, health seeking behaviour, presentation of symptoms and beliefs about what the doctor can provide for the patient, are culture-bound and can vary between social groups within the same culture. Asylum seekers may express their symptoms in very different (and culturally-bound) ways. Medical schools must prepare future doctors to deal with an increasingly diverse patient population, including marginalised groups. It is important to teach students to think outside of their own cultural perceptions, maintain an open mind, and occasionally alter the terminology that they use. It is also important to stress that sufficient consultation time is needed to reduce the patient’s anxieties and build a trusting relationship with certain patients (4). This may not always be possible in what is an already overburdened health service but simple measures, such as booking double appointment times for those with additional needs, can facilitate more effective healthcare delivery. The set of skills for managing diverse populations and the knowledge of cultural differences is known...
...as ‘cultural competency’. Cultural competency is gained through experience of a variety of patients during medical school. However, doctors can only be culturally competent when the resources, such as interpreters and longer consultation times, are in place (4). When culturally competent, medical students and doctors are better able to care for their disadvantaged patients.

The importance of holistic care

Patients who belong to disadvantaged groups often have very different priorities from the general population. A homeless person with a chaotic life and who is struggling with addiction, debt and unemployment is unlikely to be concerned about having hypertension unless this manifests as a myocardial infarction so is unlikely to adhere to anti-hypertensive medication. Similarly, the management of an asylum seeker depends on where they are in the asylum process. If they are destitute, worried about family or friends or awaiting asylum decisions, practical help may be of more value to them than pharmacological interventions for physical or mental illness. Thus, expression of symptoms can vary greatly between patients, as can the doctor-patient relationship. In disadvantaged individuals who rarely have contact with the healthcare profession, they may have unrealistically high expectations of what the doctor can provide for them. As a result, the doctor may have to prioritise care for those coming from disadvantaged groups, as they will often present with a complex picture of social, physical and psychological needs. A good knowledge of the value of holistic care is thus essential for medical students. This knowledge is acquired through experience of working with particular disadvantaged groups, in order to gain an insight into their unique needs and the barriers to their healthcare access.

Student Selected Components

However, there is a limit to how much students can be taught within the confines of the undergraduate curriculum. This is why the Tomorrow’s Doctors guidelines recommend that students explore areas of their own interest as extra Student Selected Components (9). These could give students the chance to gain experience of working with particular disadvantaged groups, in order to gain an insight into their unique needs and the barriers to their healthcare access.

The influential role of Tomorrow’s Doctors

Finally and most importantly, medical students are often unaware of the impact that they can make in tackling health inequalities. This contribution extends beyond their future role as a future doctor to their respected and influential position within their communities. Medical students and doctors are well placed to act as advocates for change in a world of inequalities that extend far beyond healthcare (15). However, health inequalities can only be addressed by the medical profession if they are fully aware of the needs and priorities of disadvantaged groups and the barriers to them accessing healthcare services.

This awareness comes from making small, sustainable changes to curricula to ensure that there is a more universal and inclusive approach to the topics covered, which represent the needs of the entire patient population. At an undergraduate medical student level, more practice in communicating with marginalised groups and exposure to a variety of patients from all backgrounds can help to ensure that our future doctors are receptive to all patients’ needs. Experience of the multidisciplinary team and of the effects that psychological trauma can have on healthcare delivery can also help students to provide the best quality of care to all patients in the future. Finally, Special Study Components provide students with the opportunity to gain extra experience of particular marginalised groups, outside the standard medical curriculum. Tomorrow’s doctors must be able to care for all members of society in order to ensure equitable healthcare access for all.

References

A Rare Form of Child Abuse
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Child abuse is the physical, sexual, or emotional mistreatment of children. Most child abuse occurs in a child’s home with a smaller amount occurring in the organizations, schools, and communities the child interacts with. Child abuse can cause serious harm to its victims. Every child is vulnerable to abuse.

Child sexual abuse is a form of child abuse in which an adult or older adolescent abuses a child for sexual stimulation. Forms of child sexual abuse include to engage in sexual activities (regardless of the outcome), indecent exposure of the genitals to a child, displaying pornography to a child, actual sexual contact against a child, physical contact with the child’s genitals, viewing of the child’s genitalia without physical contact, or using a child to produce child pornography.

The mother of a three years old kindergarten girl noticed her daughter had vagina pain while bathing her. The mother was surprised and inquired on what happened. The girl opened up to her mother that her female teacher at school takes her to a secrete place during the school break period, gives her sweets and biscuit for her not to cry and inserts her finger and pencil into the child’s vagina. This has going on for a period, gives her sweets and biscuit for her not to cry and inserts her finger and pencil into the child’s vagina. This has going on for the past one year since the child started the school. The teacher instructed the child not to tell anyone. The matter was reported to the law enforcement agents and the school headmistress. The female teacher was dismissed from the school and arrested.

The effect of child sexual abuse include depression, post traumatic stress disorder, anxiety, propensity to revictimization in adulthood and physical injury to the child among other problems. Depending on the age and size of the child and the degree of force used, child sexual abuse may cause infections and sexually transmitted disease. Depending on the age of the child, due to the lack of sufficient vaginal fluid, chances of infections are higher. Most sexual child abuse offenders are acquitted with their victims like in this case of the child’s schoolteacher. Child abuse is a complex phenomenon with multiple causes.

My First Poster Presentation
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I saw the MWIA conference theme and subthemes on the internet. I got interested and decided I must submit abstracts at the conference. I thought of what to present and finally settled down at two of the subthemes. Gender violence: vulva injury inflicted by an intimate partner, a case report and cultural basis of medical systems at the young doctors and medical students programme: puerperal and care of the newborn among the Ibani people of Nigeria. I have never had any presentation before both poster and oral presentations in front of professional colleagues.

I wrote two abstracts and submitted it to the conference. One day I received a mail that both abstracts have been accepted as poster presentation. Oh, I was happy. I knew work has just begun.

I went to the internet and gathered as much information I could on poster presentation at conferences. It took me several days to go through all the information I managed to gather. I wanted the best out of it.

I read, proof read and gave it to my colleagues to proof read what I have written down. The poster was presented at 13.40 and 14.00 hours on July 30, 2010. It was not an easy task presenting two posters same day. At the end of everything, I felt fulfilled.
The Medical Women International Association 28th Annual International Congress from a Student’s Perspective

The Medical Women International Association conference took place from July 28-31st in Munster, Germany and was a great opportunity to bring students and young doctors from around the world together to discuss common issues. This was one of few international medical conferences that not only encouraged student delegates, but offered a specific forum for students and young doctors. After the 2007 congress meeting in Ghana, a group of new doctors and medical students decided that in Munster, a student group for the MWIA needed to be established. Many thanks go to Katharine Schutte-Nuttgen, Drs. Inke Donch, Bettina Pfeiferer, Anne Grund and Heiki Beckmann for organizing the student group.

The first part of the student forum included a discussion meeting in which a council for the students and young doctors was voted in. The members of the council are:
Chair: Ashley Styczynski, USA
Co-Chair: Rosemary Ogu, Nigeria
Secretary: Charlotte Roehrborn, Germany
Director of Communications: Pamela Verma, Canada
Directors of Public Relations: Eva Roehrborn and Jasmin Nasri, Germany

At this meeting an email list serve was established as well as email newsletter to be sent to all students twice yearly to keep students involved.

Next there was an entire day session for medical student and young doctors to give a unique platform for research findings. The program included a poster competition in which there were three prizes given out for best student posters with the FMWC Poster on the Smear Campaign winning one of the prizes.

Finally, a social evening to network with colleagues from all over the world and form lasting connections capped off a great 4 days in Munster. The next meeting is to take place in Seoul, Korea in 2013 and again will include a special forum for students and young doctors and hopefully will build on what has been established in Munster.

Respectfully Submitted,

Kristin DeGirolamo and Pamela Verma
UBC Federation of Medical Women of Canada Branch

Sharing our experiences from the 28th MWIA Congress

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I and my colleague have joined the most beautiful conference in a small beautiful city Munster. The generosity of the Bohn’s Young Medical Women’s Association have made available for us to spend such a delightful time in MWIA’s 28th Congress.

MWIA conference was not only valuable, but also a joyful experience for both professional and personal development for us as medical doctors. Meeting with like-minded medical women from almost all over the world in a very professionally and gently organized conference is, I suppose, the most exciting and meaningful time spending for medical women. The gender sensitive issue that is experienced by women doctor but not talked aloud can be discussed openly. You do not feeling judged or finger pointed by not so many but “dominating” gender in the field of medical profession.

The MWIA conference arms us with a wealth of experience, knowledge and ideas, and allows us to exchange firsthand experience of how gender discrimination in medical field is affecting women globally as a professionals, as women and as mothers. These experiences and insights then can be shared with colleagues and most importantly these experiences will then hopefully influence the development of policy on winning social and even economic justice for medical women, who cares on their shoulder much of burden of healthcare system and are unfairly paid for their effort.

Now to briefly introduce Mongolian health system and the role of women in medical sector: Mongolian health sector is in transition from socialist centralized reform to more market oriented decentralized system with a high number of medical doctors per population (33 physicians serve 10000 people). Women doctors comprise more than 80% of physicians. The health system is in the process of switching from a centralized system of specialist clinics to a family clinic system. Family doctor clinics have 3-6 physicians, each physician with her own nurse. Each physician cares for 200-350 families and 350-600 children. The small district and regional hospitals face shortages of drugs, raw materials, and functional equipment. Women doctors are professionally as powerful as the male doctor, but management positions are often times offered to the medical minority group – males. Female doctors are mostly active, generous and open-minded. Therefore, the group of doctors from different backgrounds has founded Mongolian Medical Women’s Association. This Association has ambiguous plans to actively involve Mongolian medical women in association. The current board members and members are highly respected doctors by citizens and by professionals.

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A Snapshot of the 28th MWIA International Congress
Photos submitted by Pamela Verma

Thoughts on the MWIA Congress
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“It’s heartening to see a coming together of medical women from across the globe. People coming to conferences in traditional Nigerian dress is refreshing compared to stuffy suits. From a breadth of attire to a breadth of topics held every 3 years.”

Any feedback on the MWIA congress?
http://www.surveymonkey.com/s/HDK6MCL
Acknowledgements

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Medical Women’s International Association
We represent women doctors from all five continents.
Our aims and goals are:

- To promote the cooperation of Medical Women in different countries and to develop friendship and understanding between Medical Women throughout the world.
- To actively work against gender related inequalities in the medical profession between female and male doctors including career opportunities and economical aspects.
- To offer medical women the opportunity to meet so as to confer upon questions concerning the health and well-being of humanity.

Now Accepting Submissions for our Spring Issue
Suggested topics:
* Promotion of international exchange opportunities, conferences, and other announcements
* Regional events and activities
* News items
* Updates on latest research
* And much more

Send to: secretariat@mwia.net
Deadline: May 1st 2011

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