Welcome to the 2\textsuperscript{nd} edition of the yMWIA bulletin

Our first issue was an overwhelming success – we thank everyone who contributed to writing articles and sharing the exciting projects they are involved with!

The bulletin is one of the major initiatives started by your current yMWIA Executive group and we hope to continue to meet your needs. Since our last issue, many things have changed within our team, and we are finding many new goals and objectives along the way. Our newsletter is picking up to a steady pace, and we are happy that so many of you have contributed. Nonetheless, we would like to remind you that the newsletter is a work of many hands, and that all of you are sincerely invited to write articles, send in pictures and submit ideas. We are always open to feedback on new ideas and initiatives, so please contact us. If you are starting a project or any kind of initiative, and would like our help in spreading the word, feel free to e-mail us as well.

If you haven't already joined, please sign up for our Facebook page (MWIA Young doctors and medical students) – this is a great way to keep in touch with young MWIA members across the globe. We are happy to report that our Facebook group has doubled during the past year, and thus many more opportunities of connecting are opening up for all of you.

On another note we would like to point out that Oktober 2011 was Breast Cancer Awareness Month. Many of you have reacted to it in our facebook group, and in the spirit of that, we would like to say, and that goes for yMWIA as well: Spread the word!

Charlotte Röhrborn and Pamela Verma
(Executive Secretary / Editor-in-Chief and Director of Communications)
Footprints in the Sand of Time:
Dr. Tumini Bipi Bluejack Wilcox: First Female Doctor In Rivers State and Bayelsa State of Nigeria

Dr. Yvonne Dabota Buowari MBBS, (Port Harcourt, Rivers State, Nigeria) dabotabuowari@yahoo.com

There is long history about female education in Nigeria 1. In the times of old, educating the girl child in Nigeria was considered as a waste of money. Culturally, apart from their traditional motherly role, females were equipped for handicraft, weaving of traditional clothes, pottery, and petty trading 1. Women were thought to be better in teaching, nursing, and catering. When the missionaries introduced western education in Nigeria, Girls were kept at home while their male counterparts went to school. In 1878, the University of Calcutta became one of the first universities to admit female graduates to its academic degree programmes 2. Lady Kofo Ademola was the first Nigerian woman to receive a university degree, which she obtained from Oxford University 3.

BRIEF HISTORY OF BAYELSA & RIVERS STATE

Rivers state is one of the 36 states of Nigeria with the slogan “the treasure base of the nation”. Rivers state was one of the twelve states created by then regime of General Yakubu Gowan in 1967. It was created out of the former Eastern Region of Nigeria on 27th May 1967. Bayelsa state was carved out of it during the state creation exercise of 1996 4. It is located in the delta region of southern Nigeria.

Rivers state was part of the Oil Rivers Protectorate from 1885 till 1893, when it became part of the Niger Coast Protectorate. In 1900, the region was merged with the chartered territories of the Royal Niger Company to form the colony of Southern Nigeria.

The inland part of Rivers State consists of tropical rainforest, towards the coast of the typical river delta environment features many mangrove swamps. Port Harcourt the capital of Rivers State is the nerve centre of the famous Nigerian oil industry and other industrial companies. Port Harcourt is also known as ‘garden city’ because of its beautiful layout and peculiar topography. It harbours a railway terminus and one of Nigeria’s busiest airports. Port Harcourt also has a unique natural advantage of being the nation’s second largest seaport with another seaport at the ocean terminal at Onne.

WOMEN IN MEDICINE

Several women have become doctors before western education came to Nigeria. Dr Elizabeth Blackwell (3 Feb 1821-31 May 1910) was the first female doctor in the United States of America 5. Elizabeth Blackwell was rejected by 16 medical schools but was finally accepted by Geneva Medical College. She was a pioneer in female medical education in the United States. Dr Ginko Ogino was the first female medical doctor to be licensed in Japan 6.

Dr Elizabeth Garrett Anderson (9 June 1836-17 December 1917) was the first woman to gain a medical qualification in Britain. She later started a medical school for women. Dr Lilie Rosa Minoka-Hill, an American-Indian was the second woman in the United States to obtain a doctor of medicine degree. Dr Harriet B Jones was the first woman licensed as a physician in West Virginia. Dr Josephine Namboze holds the record of being the first African female doctor in Eastern and Central Africa 7. In the United States, women were admitted to study medicine at universities as early as 1833, in France in 1863, followed by Switzerland in 1864, England 1869 and Holland in 1878 8.

Dr Tumini Bipi Bluejack Wilcox is the first woman in Rivers and Bayelsa State of southern Nigeria to attend and graduate from a medical school.

The height attained by these great women was not just by a sudden flight. They distinguished themselves in their profession. Significant achievements have never been attained by taking negligible risks.

ACKNOWLEDGEMENT

Mr Idamiebi George Claude-Wilcox is acknowledged for giving information about his wife.

Dr Tamunokuro Ezekiel Diamond is also acknowledged for proof reading the manuscript.

REFERENCES


2. Female Education in www.wikipedia.org


4. www.galleriamedialimited.com
EARLY LIFE AND BACKGROUND OF DR TUMINI Bipi Bluejack Wilcox

Dr Tumini Bipi Bluejack Wilcox was the older daughter of two from the union between Mr. Alfred Sowarifagh Bluejack and Mrs. Belinda Oyiyagh Bluejack of Bonny, Southern Nigeria. She was born on the 4th day of July 1938. Her father was a civil servant with the Post and Telegraph now known as Nigerian Posts Authority and Nigerian Telecommunications. A job that took him to different parts of Nigeria: Onitsha, Enugu, Lagos, Kaduna, Zaria, and Port Harcourt. This made her to attend several schools during her early education as she travelled with her family from one town to the other, ending at Queens College, Lagos, and Queens School, Ede all in Nigeria in 1955. She distinguished herself with top grades in the West African Examination Council examinations.

CAREER

Her father ignored all advice at that time not to send a female abroad to study medicine, which was the thinking of that decade. Her parents believed that their daughter should receive the same education as boys would. They helped her attend medical school in the United Kingdom, the then Global Centre for Education. She graduated as a medical doctor in Plaistow, East London in 1964 at the age of 26. She proceeded from there to work in several hospitals in the United Kingdom. She returned to Nigeria in 1969 as a general practitioner. She took appointment with the Lagos University Teaching Hospital, Nigeria. She later returned to the United Kingdom (Cardif) to complete a course in Diploma in Anaesthesia (DA). Returning to Nigeria in 1974 to Port Harcourt, she transferred her services to the Rivers State government health service, serving as consultant anaesthetist at the Port Harcourt General Hospital and later Braithwaite Memorial Hospital all in Nigeria. In 1977, she decided to take up a training in acupuncture in Beijing, China, a discipline she practiced for the purpose of philanthropy.

As an Anaesthetist at that time, she enriched the lives of all who knew her, tending to the needs of the poor and under-served. At a time where there were few hospitals in her state, patients came from different parts of the state for surgery at the Port Harcourt General Hospital for which she administered anaesthesia. She was called upon at odd hours of the night and when things she needs to work with are not available at the hospital, she uses items from her personal stock without asking the patients to pay.

She served as the Medical Director of the Braithwaite Memorial Hospital from 1985-1986. As a female medical doctor, she was an active member of the Medical Women Association of Nigeria, Rivers State branch and was the president of the branch in her state from 1985-1988. She was appointed as commissioner of health, Rivers State in 1993. An office she held for three years.

She was a chorister at the Christ Interdenominational Church, Port Harcourt, choral group, and women organization of the same church and her home church, St Patricks Church, Ayama, Bonny, Nigeria. She was married to a broadcaster cum oil, and gas administrator, Mr. Idamiebi George Claude-Wilcox. The marriage was blessed with four children, three boys, and a girl. She performed the ‘Iria’ ceremony, a ceremony performed by women of her hometown, Bonny, Nigeria at the attainment of womanhood. She took ill and died on Sunday 16th September 2007. Dr Tumini Bipi Bluejack Wilcox was buried at her hometown, Ayama, Bonny, southern Nigeria on the 13th October 2007.

She set the pace for many to follow. In the present day, many women have studied medicine both at home and abroad. Many Nigerian universities now offer medicine. Educating the girl child is no longer seen as a waste of money. Presently many Nigerian women and women from Rivers State are fellows of different colleges of postgraduate medicine within and outside Nigeria. Nigerian women have become consultants in different medical specialties such as surgery, paediatrics, internal medicine, obstetrics and gynaecology, pathology, preventive and social medicine, psychiatry, medical microbiology etc. Several female doctors are directors at the Rivers State Ministry of Health. More women are in medicine now than in times past. There are several unsung female heroes in the history of medicine especially in Africa. Someday, those songs will be heard.
“WHEN do you wanna go?!” – “Umm, in my third year?” – “No way. You GOTTA have practical skills, or they won’t take you.” Well, I went anyways. In applying for a spot in the ERASMUS program – a European scholarship program giving students the opportunity to temporarily study abroad – the biggest obstacle was to persuade my faculty’s coordinator that I was in fact capable of doing so. Amongst reasons like “If by the time you are about to leave you have a boyfriend, you might not want to go” the, admittedly, unusual point of time in my study career seemed to be strong contra indications of my semester abroad. As I said, in German med-school it is rather uncommon to do a semester abroad as a third year student, having only theory classes so far and no experience with patients or skills of examination. I could see that point; still I felt I could make up for this lack of experience within a few weeks of practicing. What my coordinator did not tell me however, was that in Spain – the country of my choice – a concept of “learning by looking” is being practiced up to starting as a resident. It turned out, that my coordinator’s fears of losing face due to the unskilled students coming from his university were completely unfounded. As I described above, the Spanish didactic system is founded on having the students observe – without touch, and if possible without being noticed – for a very long time, that is, the entire years of study. It is supposed to be a slow and gradual introduction into the work and responsibilities of a doctor. I for myself find that rather unproductive. For one part after a while it gets really boring to only watch people do work, that under supervision and with some practice can easily done by an eager student. On the other hand nothing, I believe, really makes its way into the head unless one has done it with his own hands.

Cádiz is great! Being a rather small city (more or less 120 000 inhabitants), it is virtually full of college students. The beautiful ancient city center is surrounded by water and holds most of the university’s faculties; often times you have a look on the sea while sitting in class. The climate is very hot in summer but also very mild in winter, and having a wonderful long white beach right in front of the hospital it would be sinful not to go out and catch some waves after shift. Yes, I have to admit, I picked Cádiz not for an excellent reputation or other reasons of academical honor, but for the weather, the beach, and the fact that the waves of the Atlantic Ocean are awesome to surf. But back to the medical side of my trip.

It turned out, that my coordinator’s fears of losing face due to the unskilled students coming from his university were completely unfounded. As I described above, the Spanish didactic system is founded on having the students observe – without touch, and if possible without being noticed – for a very long time, that is, the entire years of study. It is supposed to be a slow and gradual introduction into the work and responsibilities of a doctor. I for myself find that rather unproductive. For one part after a while it gets really boring to only watch people do work, that under supervision and with some practice can easily done by an eager student. On the other hand nothing, I believe, really makes its way into the head unless one has done it with his own hands. Meaning, learning by doing is and always has been a successful concept. Well, while looking I was also quite surprised at for example examination circumstances. On the gynecological ward I witnessed an ultrasound examination behind merely half-closed curtains and people, mostly interns or residents rushing in to ask questions or having the doctor look on some chart – while the patient sat there, legs spread having an ultrasound. She was not really comfortable with this, but also did not say anything.

There are a lot of things different than we learn it here in Germany, some better – for example the ratio patient/nurse is incredibly good; sometimes there are as many nurses on the ward as patients that need treatment, a paradise-like situation for German standard – some worse – do not get me started on hygiene in the OR, I really do not want to have surgery in Spain – but I guess everybody believes in their own system, and just the opportunity to get to know another country’s way of schooling is something not everybody has. The experiences and the personal development I have gone through, enabled by the ERASMUS program, are so valuable that I can only strongly recommend taking this opportunity and make it yours.
Vaginal Bleeding in Women – Facts to Know

Dr. Rosemary Ogu, FMCOG, FWACS, Department of Obstetrics and Gynaecology
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INTRODUCTION

Bleeding from the vagina is a normal physiologic process occurring during the menstrual cycle in females of reproductive age group (15 to 45 years). Normal bleeding from the vagina during the menstrual cycle occurs every 28±7 days, lasting for 5±2 days and in quantities of about 50±30 mls. The first menstrual period, known as menarche usually occurs between ages 10-15 years.

Bleeding from the vagina is said to be abnormal if it occurs between normal menstrual periods or if the menstrual periods become abnormal in terms of variable menstrual cycles or variable menstrual flow (scanty or profuse).

CAUSES OF ABNORMAL VAGINAL BLEEDING.

Abnormal or unexpected vaginal bleeding that occurs outside the normal menstrual cycle or causes extreme symptoms during periods can be caused by a wide variety of diseases, disorders or conditions that affect the vagina, cervix, ovaries or uterus. Common causes of abnormal vaginal bleeding include:

- Uterine fibroids or uterine polyps
- Miscarriage or abortion
- Ectopic pregnancy
- Endometriosis
- Hemophilia (blood clotting disorder)
- Hormone imbalances
- Ovarian cysts and polycystic ovary syndrome
- Sexually transmitted diseases (STDs) and pelvic inflammatory disease (PID)
- Side effect of certain medications, such as birth control pills or blood thinners
- Trauma to the vagina or uterus, which can occur as a result of sexual intercourse or the placement of an IUD contraceptive device
- Vaginal dryness
- Cervical dysplasia
- Uterine, vaginal, cervical or ovarian cancer.

Some underlying causes of abnormal vaginal bleeding, such as vaginal dryness and cervical dysplasia, are very treatable if promptly diagnosed.

Sometimes bloody urine, which is due to bleeding from the urinary tract, or bloody stools, which are due to bleeding from the gastrointestinal tract, can be mistaken for vaginal bleeding. Any unexplained bleeding should be evaluated.

Some causes of abnormal vaginal bleeding are serious, even life-threatening conditions, e.g. an ectopic pregnancy or uterine cancer.

Seek prompt medical care if you have vaginal bleeding that is different than your normal menstrual period. Early diagnosis and treatment of vaginal bleeding reduces the risk of serious complications, such as infertility and metastatic uterine cancer.

Seek immediate medical care if you, or someone you are with, are pregnant and have vaginal bleeding or abdominal pain.

Dysfunctional uterine bleeding (DUB) is abnormal vaginal bleeding that occurs during a menstrual cycle when ovulation did not take place. Anovulatory or dysfunctional uterine bleeding is a diagnosis of exclusion.

Anovulatory cycles are common for the first years after menarche (when a girl begins to menstruate), and later in life as a woman approaches menopause (when menstrual periods stop). Approximately 60% of cases occur in adolescents and females under 40 years. Obesity, excessive exercise, and emotional stress may be risk factors for DUB.

What to know more about vaginal bleeding?

Here are some suggested references from Dr. Ogu:

For abnormal uterine bleeding, check out:


For vaginal bleeding, check out:

POTENTIAL COMPLICATIONS OF VAGINAL BLEEDING

The risk of serious complications of vaginal bleeding can be minimized by seeking early medical care and following the treatment plan specifically designed for you. Complications of vaginal bleeding and its underlying cause can include:

- Anaemia, due to excessive blood loss
- Chronic pelvic pain
- Difficulty getting pregnant and infertility from lack of ovulation
- Ectopic pregnancy
- Endometrial hyperplasia from prolonged buildup of the uterine lining without adequate menstrual bleeding (a possible factor in the development of endometrial cancer)
- Pelvic adhesions and scarring of the fallopian tubes
- Severe hemorrhage

EVALUATING FOR ABNORMAL VAGINAL BLEEDING; TESTS

A pelvic examination should be performed.

Tests usually include:

- Complete blood count
- Serum HCG assay
- Thyroid function test
- Prolactin assay
- Androgen levels
- FSH (follicle-stimulating hormone)
- LH (luteinizing hormone)

Diagnostic procedures that may be performed include:

- Endometrial biopsy
- Pelvic ultrasound
- Hysteroscopy
- D and C (dilatation and curettage)

TREATMENT

The appropriate treatment is to evaluate and treat the underlying cause.

For DUB:

Young women within several years of menarche (the first menstrual period) are not treated unless symptoms are exceptionally severe, such as heavy blood loss causing anaemia.

In women of childbearing age, treatment is aimed at achieving regular menstrual cycles with normal patterns. Oral contraceptives or progestogen therapy are frequently used for this purpose. If anemia is present, iron supplementation may be recommended. If pregnancy is desired, ovulation induction may be attempted with medication.

Women whose symptoms are severe and resistant to medical therapy may choose surgical treatments including endometrial ablation (a procedure that burns or removes the lining of the womb) or hysterectomy (a procedure that removes the womb).

CONCLUSION

There exist several causes of vaginal bleeding in young women; some life threatening, some benign. Awareness, early evaluation and treatment reduce the risk of serious complications and permanent damage. Be wise!

Interview with Dr. Pfleiderer

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Q: Dear Prof Pfleiderer, we all know that it must have been a great effort to plan all of the congress, but exactly how much time was involved? How did you fit it in with all your other engagements? Did you have help or was this a one-handed effort?

BP: We started preparing the congress three years ahead - decided on a theme, designed a webpage, formed committees. Most of the work happened about 6 months before the congress started. I had to write texts for the programme book, decided on the scientific programme and last but not least we had to translate all abstracts in English. Most of this happened at night, after my daily work was done. I was fortunate to have help- I had three students Eloise, Anna and Steffi helping me (translating abstracts, sending out notices to authors of abstracts etc.) and Ingrid Fielding, secretary in my lab, who took care of the free housing project and all communications with the consulate in Nigeria. Many of you have communicated with her and the others. Without them I couldn’t have done it and I was very glad to have them around.

(Book Chapter Available!
Yvonne Dabota Buowari of the Medical Women Association of Nigeria, Rivers State branch, also member of the MWIA Research and Scientific Committee and young doctors forum (special interest group) has contributed a chapter to a book titled "Ectopic Pregnancy - Modern Diagnosis and Management", SBN 978-953-307-648-5 edited by Michael Kamrava. Her chapter titled "Management and Outcome of Ectopic Pregnancy in Developing Countries can be viewed through the link: www.intechopen.com/articles/show/title/management-and-outcome-of-ectopic-pregnancy-in-developing-countries)
Medical Women’s Society of New South Wales Mentoring Program

Dr. Emily Gregory-Roberts, Doctor-in-training Representative on the committee of the Medical Women’s Society of NSW, a state branch of the Australian Federation of Medical Women emilygr@med.usyd.edu.au

In Sydney, Australia, the local Medical Women’s Society has launched a mentoring program for junior doctors and medical students. The Medical Women’s Society of New South Wales, a state branch of the Australian Federation of Medical Women, has recently started a program which matches volunteer female doctor mentors (general practitioners, specialists, registrars or residents) with female junior doctors and medical students seeking a mentor. Mentoring within the organization had previously been informal, and the launch of a formalized mentoring program developed in response to a demonstrated need which did not appear to be met within medical schools and teaching hospitals. Our program is coordinated by the junior doctor and medical student representatives on the Medical Women’s Society of New South Wales committee.

The aim is to support junior doctors and medical students, and facilitate their development, by linking them with a more senior doctor mentor. Mentors are doctors at any stage of their career, from junior doctors to retired doctors. The program aims to provide an opportunity for mentors and mentees to develop insight and understanding, to form networks, and for mentees to benefit from the wisdom and experience of other medical women.

The program is designed to be flexible, providing initial training and orientation for both parties, then allowing mentors and mentees to tailor the ongoing relationship depending on their own needs and commitments. As an optional opportunity, mentors can choose to participate in regular mentor meetings to raise issues, work on some "best practice" ideas and for mutual support.

The program provides a mentoring introduction and training night for mentors and mentees, facilitated by medical doctor and professional mentor Dr Alice Killen. The night involves mentoring training, and provision of a framework with guidelines and suggestions for mentors and mentees. Discussion addresses issues such as desirable boundaries, the aims and expectations of the mentoring for both parties, tailoring mentoring to the mentor-mentee pair, and how participants can go about "opting out".

It is hoped that mentors will benefit from the program by learning skills, developing communication, engaging with the thinking of upcoming generations and learning about themselves through the mentoring process. Mentors may also enjoy investing in the future and seeing another person grow. It is anticipated that mentees will benefit by developing a stronger network of influences, feeling supported, developing confidence, learning to make better decisions about work and life, and improving motivation, knowledge, skills and career outcomes. Indirectly, mentoring in medicine is also likely to improve the medical care mentors and mentees provide for their patients.

We are interested to learn about how other Medical Women’s Societies across the world provide support or mentoring for junior doctors and medical students, and what has or hasn’t worked in your experience. Email me with your thoughts!

Interview with Dr. Pfleiderer - continued

Q: How do you feel after the congress? What kind of an experience was this for you, and would you do it again?

BP: On one hand I was totally happy, because the whole congress was just great, I met so many interesting and lovely women from all over the world and made some new friends - but on the other hand, I was so tired. I didn’t get much sleep for weeks....

I had never organized such a huge international congress before and it was basically learning by doing. I also learnt a lot about congress organization. That helps me quite a bit now because I’ve just been asked by the Federal Ministry of Education and Research to organize an international meeting on “Sex and gender in biomedical science and clinical medicine – implications on health care” in Berlin in November 2011. This year is going to be a year of health research in Germany.

Would I do it again? Yes, I don’t have any regrets. You know, without this meeting I would not have learnt as much about global medicine, different health problems all over the world and would not have been part of the executive of MWIA and chair of the scientific and research committee of MWIA now. I am still learning.

(Interview continued on page 8)
Specialist Training Makes the Difference: My Experience as an Anesthesia Resident

Dr. Yvonne Dabota Buowari, MBBS (Port Harcourt, Nigeria)
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I am very happy and glad to be a resident Anaesthetist in training in a Nigerian teaching hospital. Specialist training has changed many of my conceptions about the practice of anaesthesia. I worked in a rural, low-resource setting with only two doctors, neither with any formal training in Anaesthesia, and no nurse anaesthetist. We had to administer ketamine general anaesthesia for all patients requiring surgery. The facilities for regional blocks were not available at the centre. Small masses requiring excisions were done under local infiltration with lidocaine. We had no mortalities, but now I think there are many things we would have done better if we where exposed to some formal of anaesthesia training. For example, no pre-operative visit concerning anaesthesia was done. There was no form of active monitoring of patients during the course of anaesthesia. When a diagnosis is made, the patient was informed and counselled for surgery. Written informed consent is obtained and haemoglobin estimation and urinalysis are requested. If there is glucose in the urine, a random or fasting blood sugar is done. Where it is above the upper limit of normal, the patient is referred to a tertiary health facility for expert management because of the anticipated complications of diabetes mellitus and surgery. Pulse rate, respiratory rate, and blood pressure are measured while examining the patient.

When a patient is wheeled into the operating room, the theatre nurse measures the blood pressure, pulse rate, and respiratory rate at the theatre reception. Intravenous access is established and intravenous fluid is set up for the patient. Premedication of intravenous pentazocin and diazepam is administered depending. Induction and maintenance of anaesthesia was with intermittent administration of intravenous bolus of ketamine. Postoperative management is commenced at the end of the surgery.

Since I commenced by training as a resident in anaesthesia, I attended an anaesthesia refresher course, which has broaden my knowledge of anaesthesia. I have learnt about various anaesthetic drugs and other forms of general anaesthesia after from just ketamine anaesthesia, regional blocks and subarachnoid block. After my training, I am going to administer safe anaesthesia with minimum standards of monitoring. Patients will have adequate analgesia during and after surgery with little or no pain postoperatively.
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.

Statement:

We regret to have to inform our members that our Chair, Ashley Styczynski, has made the difficult decision to resign this summer from her position due to her many other engagements, including leadership positions with AMWA, her widely-funded research on microbicides, and her approaching graduation and start of residency. Ashley wishes all of our members the best for the future, in their careers and endeavours.

Dr. Rosemary Ogu (Interim Chair) and Charlotte Röhrborn (Secretary)