**The HEAR ME NOW Podcast**
**From the Providence Institute for Human Caring**

**Episode 054 — Family Medicine Building Bridges**

(Theme music)

Seán Collins (Host):
Hi everybody. It's the HEAR ME NOW podcast, which comes to you from the Providence Institute for Human Caring. I'm Seán Collins. On today's program, we want to focus on global health equity — the goal that everyone on the planet can achieve the highest attainable level of health, and that individuals and populations are not thwarted in achieving this because of geography or social status or position or economic resources or demographics or their physical condition.

It's a noble goal and it's a huge issue.

The way we've chosen to examine it today is close-up, examining *one* program in *one* place. We're looking at a family medicine rotation underway between Swedish Family Medicine in Seattle and the Kamuzu University of Health Sciences in Malawi.

We're looking for a macro view of what happens when there's a collaboration and a sharing of human resources, building bidirectional medical rotations, where learners are teachers and teachers are learners.

A note on geography. Malawi is a landlocked country in southeastern Africa, tucked between Zambia, Tanzania, and Mozambique. Malawi gained independence from the British Crown in the early and mid-60s and remains a commonwealth nation today. Malawi's population is upwards of 20 million people. The vast majority of whom live in rural areas. The economy is heavily based on an agriculture.

I'm delighted to introduce four guests who are going to join me in conversation today. Two of whom are visiting Seattle from Malawi, Dr. Amos Mailosi, family medicine registrar at the Kamuzu University of Health Sciences. Dr. Charles Hassan, also a family medicine registrar at the Kamuzu University of Health Sciences. Dr. Anna McDonald serves on the faculty at the

Swedish First Hill Family Medicine Residency and she splits her time between Seattle and Malawi. And Carrie Schonwald is the program director for global programs at Providence.

It's wonderful to greet all four of you. Thank you for taking the time to chat with me. Welcome.

Dr. Amos Mailosi (Family Medicine Registrar):
Thank you.

Dr. Charles Hassan (Family Medicine Registrar):
Thank you very much.

Dr. Anna McDonald (Faculty, Swedish First Hill Family Medicine Residency):
Thank you so much for having us.

Seán Collins:
Carrie Schonwald, let me begin with you. You're the program director for this effort. If you jump on an elevator with somebody and someone asks you what it's about, tell me what your answer is.

Carrie Schonwald (Program Director Providence Global Programs):
My answer is that Providence as a system is always focused on equity and health for a better world. Our department, global and domestic engagement focuses on achieving this through community partnerships around the globe. And by leveraging the talents and skills of our own caregivers to partner deeply with those communities. Particularly in Malawi, we were given a great opportunity to join in a partnership a number of years ago, and we knew for many reasons it was the right partnership. But chief among them, was the tremendous focus on reciprocity and equity and the drive of Anna McDonald and other visionary founders of the program to absolutely do all that we can to redress systemic inequities through this work.

Seán Collins:
I said earlier that our goal today is for us to talk about the clinical ways this program bears fruit, how it makes a difference at the bedsides in Malawi, but also in Seattle. But I also want us to talk about the cultural impact on how people practice medicine, how you care for patients, how you think of yourselves as healers, and your relationship with your patients and your

colleagues. Should we start with the impact in Malawi? Dr. Mailosi, what has your experience of the program been while you were practicing in Malawi?

Dr. Amos Mailosi:

In Malawi, family medicine is a new specialty. Currently, we have four people who have graduated. Being new and also being a specialty, which is based at a district hospital, as a specialist, you see many, many patients that in other settings you wouldn't expect a registrar or also a specialist to be seeing. But the impact has been positive because our system at the district, it's mainly the clinic officers who usually have three years of training, without a family medicine resident or a specialist, these have been working alone between most of the clinics. To reach a specialist consultation, you have to call a verified district or refer there. So, our presence at the district has changed a lot, has helped us to strengthen the system, to have opportunities of teaching the clinic officers. And also, to bring the specialty medicine to the patient at the district, that would otherwise not reach it if we are not there. I think the impact is positive in summary like that.

Seán Collins:

Yeah. To clarify a term, when you refer to a registrar, I think in the U.S. system we would say a resident, is that...

Dr. Amos Mailosi:

Yes, exactly.

Seán Collins:

It's a holdover from your British colonial past, right?

Dr. Amos Mailosi:

Mm-hmm.

Seán Collins:

Dr. Hassan, what's your experience with the program?

Dr. Charles Hassan:

Just to add on what Dr. Mailosi has said. As family medicine, a registrar is now a senior resident. In addition to being consultants, also act as tutors. And also, we are involved in the community-oriented primary care, whereby we go to the communities. We go to where the diseases are coming from to see what is really happening for the diseases to happen. We call it a health center visit. We identify a patient and we go to where they're living to see the other determinants of health. In doing this, we tend to do more of health promotion and health prevention, something that the clinical officers at the district hospital don't do. Just also a background information. Mangochi is a big district. It has more than 1.3 million people. So, us taking the medicine to the community, it helps us to do the health promotion and prevention part of medicine that was lacking previously.

Another thing that also have improved the patient care is the family medicine clinic that we are doing at Mangochi District Hospital. We see the complicated cases that the clinic offices, they were managing, but now they have deficiencies in knowledge and skills. So, they refer those patients to us. In so doing, when they refer a patient, we do also teach them... when they bring the patients, we teach them while we are at the same time we're treating the patient, so that maybe they have the knowledge and the skills to do the same with other patient that they will be seeing in future. In a nutshell, family medicine at Mangochi has really brought a positive impact. We don't have actual data, research-wise. But subjectively, even the Mangochi population, really appreciate the presence of family medicine in the district.

Seán Collins:

Dr. Anna McDonald, what's your reaction hearing your colleagues describe the program?

Dr. Anna McDonald:

Gosh, it's just a tremendous sense of pride and gratitude for having been involved in watching the program grow from when it started. I initially went to Mangochi in 2015 when our first class of trainees was there. And they have now all graduated and some of them are holding leadership roles in our department and they're all still involved. To watch them go from a place where nobody really knew what family medicine would look like in Malawi because it is a specialty that is adaptable to multiple different contexts. So, there was a lot of questions from our colleagues in the Ministry of the Health, the clinical officers that Charles and Amos have mentioned, about what is family medicine or why are these doctors here? To watch it go from this place of not really knowing what it would look like, to a more and more developed vision

and a bigger and bigger understanding of the potential impact that family medicine can have in Malawi, I just feel so lucky.

Every time I talk about the work and the program at conferences, people come up to me and say, "How do I get a job like that?" And the reality is there're not that many of them. There're not that many jobs that allow people to work in two different places. It takes a really dedicated group of people to make that happen but I just feel so lucky to be a part of it.

Seán Collins:
It's got to be so gratifying to see a program like this unfold and take root in a relatively short amount of time, less than a decade.

Dr. Anna McDonald:
Yeah.

Seán Collins:
Carrie Schonwald, what's your reaction?

Carrie Schonwald:
Similarly, to Anna, although from a much greater distance because I've never been at the heart of the work in the way that Anna is. But I also feel a tremendous sense of pride and gratitude. I get to be an insider outsider where our organization and our department and our leadership really believes in the vision of this rotation and of the high impact that it can have. I think everybody... it's a very Providence thing to recognize what grace means when you can really have an opportunity to impact lives, but to do it in a way where you are following, not leading. That you are just lucky enough to meet the right people who are dedicated to their own communities and have the skills and the brilliance, but just maybe don't have the resources. In any kind of global health work, if you are in the position of having resources to bring to someone else's vision and brilliance, it is very fortunate indeed.

I have really felt tremendous grace in the last four or five years that I've been involved with this work, both with Anna and her co-manager, Dr. Jacob Nettleton and the faculty at KUHS. And of course, most of all, the registrars and the learners on the ground. I just want to celebrate that because of COVID, it's been two and a half years since we've been able to either bring

registrars here or send U.S. residents there. This fall marks the first time since the spring of 2020 that we could do that.

Seán Collins:

What listeners probably didn't pick up, there was a smattering of applause around the table. The appreciation, I think that things have picked up again is... that that celebration seems to be widely felt. I want to talk about resources, but I don't want to get away from this notion that got brought up in the previous conversation that Anna, you said that family medicine is adaptable to its environment. I'm curious if there's any agreement on what Malawian family medicine looks like.

Dr. Anna McDonald:

Yeah, I definitely would love to hear Charles and Amos's input on this as well. But to me, a family medicine physician in Malawi is really doing it all. When I say that, I mean you heard that Mangochi is a district of over one million people and they are the only doctors working clinically in that district. There are other doctors who are largely in administrative roles because of the way the system is set up. But the family medicine physician at Mangochi District Hospital will do bowel obstructions, they will do C-sections, go out into the community and do this community-oriented primary care that Dr. Hassan mentioned, which is visiting a patient in their home.

Their scope is incredibly broad. My personal hope vision is that as we grow in the number of workers that we have or qualified family medicine physicians that we have, people will then be able to choose their areas of interest and say, hey, you know what? I'll give two examples since I have the luxury of having them here on this podcast with me. But Dr. Hassan has been a leader in ultrasound care and bringing point of care ultrasound to the district. And then Dr. Mailosi has tremendous experience in HIV care and really interested in mental health. In that sense, family medicine can be so many things and they really are some of the best trained physicians that I've had the privilege to work alongside. I'm curious how they would answer that question, what their visions are for the future.

Seán Collins:

Yeah. For the two of you who are living it day-in and day-out, what is Malawian family medicine about?

Dr. Amos Mailosi:

As Dr. Anna has said, I think it's a broad concept because you are like a generalist, but you are supposed to act as a specialist and you are supposed to be a gate a gatekeeper because you are trying as much as possible to make sure that people don't get unnecessary referrals from a district hospital. At the same time, you also have to meet people in their communities. Also, another part, you are supposed to be good with research because you have to practice things using evidence and so it's broad. But also, considering that it's a new program in Malawi, you are also supposed to have enough knowledge of leadership skills because both with the college and also being at the district, if you're going to be the most senior physician, you are supposed to be more of a leader than just being a clinician. Balancing those roles, it's not easy, but it's fulfilling, but it's not easy.

Dr. Charles Hassan:

A little bit of an addition. I look at family medicine in Malawi and I will be like, it's not boring specialty, because you find yourself, for example, this week you'll be doing pediatrics, the next week you can choose, okay, I'll be doing C-section as Dr. Anna has said. Then the other week you'll be doing research. Then you'll find yourself the other week presenting in a conference. This versatility make us also very suitable to be at the district because all these components are there. For example, Mangochi, we can even call it a teaching hospital because nurses students are there, clinic officer students are there, pharmacy students are there. We play all these role. No one can do all this than a family medicine physician. I call it not a boring specialty. I think we make a difference than maybe an internist does at the center level. We're not saying the internist is not important but in Malawi now, with the way 80% of the population living in the rural setting, I think we need family medicine physicians more.

Seán Collins:

Yeah. Yeah. Do you see a way for it to become more popular in Malawi? Is this going to become more the norm do you think or what?

Dr. Amos Mailosi:

I think it's going to become more popular. We are on the right direction. When it started, we were not recognized by the government. But now, although it's not started yet, but the government actually has got posts for the family physicians and they're recognized just like any other specialty. When you finish, you're recognized as a specialist. Their target was that in few years, every district should have two post for family physicians. That's a good direction,

especially when the most powerful structure, which is government in the country, recognize you as a specialty. Lately, we've also been involved in many important programs, like few months ago, last year rather, this year actually. At the beginning, we were involved in disaster management during one of the major cyclones in Malawi that involved flooding, but we are the department that was chosen to be involved in the system because of all the specialties. People recognized that family medicine physician or resident was better placed to be involved in these things. So, little by little, we are going in the right direction.

Dr. Anna McDonald:
Amos, correct me if I'm wrong, but you guys saw something like 2000 patients in the course of a week, is that right?

Dr. Amos Mailosi:
Yes. Yes. (laughs)

Dr. Anna McDonald:
They're being humble. The things they do are incredible. The number of patients they see, the care that they bring to people where they are who would otherwise travel 6, 7, 8 hours potentially, or not even be able to travel at all because of a natural disaster or an illness or whatever it is. Yeah. It's awesome to continue to watch it grow.

Dr. Charles Hassan:
Also, just maybe to add on that. After participating in the cyclone, Anna, we were called by the deputy minister to present the report of what we did. I think this was also another step that okay, now the government recognizes that we are there and after participation, they called us to say, okay, what impact did you do and why do you think we need people like you on the ground? I think that was a plus to us as well as far as being recognized in Malawi is concerned.

Dr. Anna McDonald:
Just to clarify, the deputy minister, if you're not familiar, and guys correct me if I'm wrong, but that's the number two to the minister of health.

Dr. Charles Hassan:
Yes.

Dr. Anna McDonald:
Pretty high up and important that they were recognized for the important work that they do.

Seán Collins:
That's wonderful.

Carrie Schonwald:
Just as a point of comparison, Seán, I just want to share with you that the first year that we did the collaboratory, my department, global and domestic engagement, we also had partners in Guatemala. So, we brought three Malawian physicians as well as three Guatemalan physicians. What was so interesting is that between them, they just identified so many similarities in their systems and challenges and strengths. But what was interesting for me, as the insider outsider with both systems, is that unlike Malawi, at least at that time, there were many clinicians who'd been pressing for years for the ministry to recognize family medicine as a specialty and had not happened, at least at that point. While it is certainly in its early stages as a discipline, it is a discipline and it was just so interesting to see that viewpoint with the crossover between those two groups.

Seán Collins:
Absolutely. We're talking about efforts to achieve global health equity by focusing on a shared residency program in family medicine between Swedish First Hill in Seattle and the Kamuzu University of Health Sciences in Malawi. Doctors Amos Mailosi, Charles Hassan and Anna McDonald are with me, along with program director for global programs at Providence, Carrie Schonwald.

Charles, I'm interested in the use of ultrasound at the point of care. Tell me about what you're doing and how that's working out.

Dr. Charles Hassan:
A little bit of background. For us to graduate, in our fourth year of residency, we need to do a thesis. Looking at Mangochi, yes, we have problems in diagnostic equipments. But the basics, for example, ultrasound scan, we have ultrasound scan and an x-ray. But I felt like that

ultrasound machine wasn't fully utilized. I saw a potential that we can take that ultrasound scan to a bedside as we are doing these days worldwide with POCUS.

Seán Collins:
I'm just going to interrupt to say that POCUS is point-of-care ultrasound.

Dr. Charles Hassan:
Yes, yes. Point-of-care ultrasound. Sorry.

Seán Collins:
So, really at the bedside?

Dr. Charles Hassan:
Yes.

Seán Collins:
Sort of a handheld device.

Dr. Charles Hassan:
Yes, at the bedside. I couldn't just look into POCUS, I wanted now to do a needs assessment study to look at the ultrasound scan in general, to what extent are we using ultrasound at Mangochi?

I'm now finalizing the paper now, and yet to publish. We have seen that we're really using ultrasound scan at Mangochi. Of course, there are issues that we need to address, but for now at least we have the baseline data that we are [inaudible] using ultrasound. The interesting thing that we noted in the study was, most of the indications that we send the patient to the radiology department to have a scan done, were also POCUS. So, there lay a possibility of us now rolling out POCUS. As you know, now POCUS have a lot of impact as far as care delivery is concerned.

Studies worldwide has shown that doing POCUS, point-of-care ultrasound, really impact the patient care positively because you tend to make decisions at the bedside. And also, you view the images live. You are the one who is doing the scan and it's easier for you to make

decisions upon doing the scans there and then. You can also rule out differentials and you can also do ultrasound guided procedures at the bedside. We see potential in POCUS in Mangochi. The other thing that I can also highlight is all of us residents, we know how to use point-of-care ultrasound because it has been an initiative of the department to teach us this point-of-care at ultrasound and ultrasound scanning. Also, we have the privilege of teaching the clinic officers as we are practicing the POCUS at Mangochi District Hospital.

Dr. Anna McDonald:
Can I add one thing to what Charles said?

Seán Collins:
Absolutely.

Dr. Anna McDonald:
There's a lot of studies from western countries about POCUS and how much it improves care, as Dr. Hassan has said about making a decision at the bedside and how much that can reduce delays in care. I would say that's exponentially more true in Malawi. Number one, because you know may be admitted to the hospital and if you... previously, before a ultrasound was there and you needed a chest x-ray, you could wait days for that chest x-ray depending on power supply, depending on availability of chemicals to develop the x-rays, depending on whether the radiographers around are out doing something like TB screening in the community. So, you're talking about moving a potential diagnosis from something as long as a week to minutes at the bedside. I just think the impact is even more exponential in a context where you don't have necessarily reliable access to other diagnostic imaging.

Seán Collins:
Can we talk about that moment where diagnosis could be moved up significantly? It seems like that would have a real impact on the relationship between the physician and the patient. That suddenly, there's uncertainty and then there comes a more focused moment of clarity, that allows for a conversation about someone's health and their prognosis. And there's a week's worth of worry on the patient's part, that has suddenly not taken place. Tell me about that.

Dr. Charles Hassan:

I think from the experience that I have using POCUS, first it brings satisfaction to the patient and also the clinician who is doing the scan there. Because as Dr. Anna has said, you order an ultrasound scan, it takes two days. It is delaying everything that you thought you could have done to the patient. But by doing the scan at the bedside, you make the decision there and also you inform the patient what's really going on, which relieve the stress. Being in the hospital in Malawi, it brings the stress already. The conditions are not as satisfying, as you can imagine. You make the diagnosis, you'd start treatment promptly and you also really reduce time the patient spends in the hospital. So, it is coming back to the satisfaction of both the patient and also the doctor treating the patient because our wards are most of the times full. So, if you reduce the time the patient spends in the hospital, you will also quickly discharge the patient because you have studied the treatment promptly.

Carrie Schonwald:

Seán, can I add one piece?

Seán Collins:

Please go ahead.

Carrie Schonwald:

I was just going to throw in another dimension just from my angle, which is more the administrative angle of a program like this, which is to say that for us as Providence and our department, this piece about POCUS and about the Butterfly ultrasound was speaking of satisfying, was just such an incredibly bright light in the middle of COVID and not being able to send people, because Anna and her colleague Jacob Nettleton did continue to go. We did not send residents, but Anna and Jacob continued to spend as much time on the ground as ever, so that they could continue to teach and learn and support the work that they've been doing all along. There was just this beautiful synergistic moment, which was that Anna of course works very closely with all of her colleagues there and along with them really we're very focused on the idea that if they had more Butterfly ultrasounds, not only would they have the machines, but of course they would have the ability to train more people to use them, or go serve more people, et cetera, et cetera, and on and on.

So, she requested one from us and because we were not able to use budget to send people, it was just this really fortuitous bright light in the middle of COVID. So, we were able to supply

that. Anna and her colleagues continued to build that training. And then along with our partner, SEED Global Health, were able to send another one the next year. It was like this COVID silver lining and I just celebrated the relationship that Anna has with everybody on the ground to really deeply understand what is needed and to have that collaborative relationship with her colleagues in Malawi.

Seán Collins:

That's really beautiful. It speaks to the value of your longevity in the program, Dr. McDonald. You've got some history and you recognize the value that a technological intervention could have. It's really wonderful.

Carrie Schonwald:

And she could provide that voice because she's the one that has the connection.

Dr. Anna McDonald:

I was just going to say, I have to give tremendous thanks to Carrie and the global partnerships team because from day one... When you engage in this work across borders with different cultural context, flexibility is a must and adaptability. I'm just so grateful to have Carrie in my corner. I keep saying everybody needs a Carrie in their corner because priorities change as family medicine grows and changes, and who we have on the ground grows and changes and we are recruiting more registrars into the program. So, our needs are always changing and just really grateful that she's been such an advocate to meet us wherever we are and with what we need to make it happen.

Seán Collins:

Yeah, it's great. Dr. Amos, tell me about your work with people with HIV.

Dr. Amos Mailosi:

Yeah. HIV is still a problem in Malawi. Prevalence has gone down from more than 20 to 14, now it's a bit less than 9%. But most of the districts, these numbers are higher, like Mangochi is one of the district that has got higher HIV prevalence. Also, of note from the past, HIV and other related programs like TB, they've had a vertical approach to managing of the patients. It is not uncommon in Malawi to find a clinic officer or a clinician who is very good with HIV management but who is not good with management of other things like non-communicable

disease and other problems that people living with HIV may also have. Now, with the introduction of antiretroviral therapy, which has been working, people are living longer, life expectancy has moved from 35 to above 63 now. People living with HIV are presenting with more problems other than HIV.

So, the vertical approaches of HIV management may not work. My satisfaction and also my goal are in the program. As a family physician still interested in HIV, I'm going to bring that aspect of not just treating HIV but integrating the whole program, seeing the patient as a whole, not as HIV case. This, I think, can best be done by a family physician. Also, it's removing that vertical approach of managing diseases. It's more of a horizontal approach like treating everyone, any CDs, infectious diseases, integrating everything in one clinic. That's my area of interest.

Dr. Anna McDonald:

I was going to ask Dr. Mailosi to speak as well because he has an incredible gift as I've watched him in the program, for something that we use when we teach family medicine in Malawi. That's called the A3 approach to patient care. The A3 is biopsychosocial and so much of medical care that's delivered in Malawi is taught in the purely biological model. This is the disease, this is how you treat it. Dr. Mailosi just has such a gift for getting at the psychosocial issues which we often know are the biggest drivers of healthcare. I was hoping he could speak a little bit about that as well.

Dr. Amos Mailosi:

Yes. Yeah. That is actually part of the principles of family medicine. You cannot just treat HIV or say, TB or malaria. You're supposed to treat patient as a whole. That has always been my interest and also part of our practice, just as I've said about HIV, that's also why we go into the communities. For example, my thesis is for this program, it's not about particular disease or about something, it's just about how do we break bad news to our patients. Even that aspect of communication's a very important. Also, in different cultures it would mean different things. For example, in medical schools internationally, I think we learn the same way of breaking bad news, but how it's done in America or some corner of the world may be different with how it's done in Malawi. Even in Malawi, different districts may have different cultures, so the same communication may have to be done differently, in a different setting. These intricate differences in cultures and how we understand medicine and how we approach some

problems, how we communicate is also of my particular interest other than just concentrated on disease.

Seán Collins:
One of the driving ideas behind this podcast for the last two and a half years has been conversations about whole person care, seeing in your patient a person, not a collection of symptoms. It seems that the profound truth that people are living longer with HIV which means that they're living longer with other comorbidities and that brings up psychosocial stresses that weren't there earlier. It's a profound focus on that whole person in community. I wonder about what you all in Malawi are able to teach the folks in Seattle about that.

Dr. Charles Hassan:
Of course, as he said, the bio part may be similar. Of course, with the technologies that are here are different because we don't have the privilege of having a CT scan at Mangochi District Hospital. But I've been with them when we are doing the inpatient, the way they approach patients, it's the same thing. Of course, when we are discussing the patient we just add in a little bit of the social part. But the way they practice the psychosocial model I think is the same as we do back home because family medicine here and back home, it is similar but not the same.

On the social aspect, I think here it is also being done well because they don't just discharge a patient but they think of where these guys are going? Who is going to be taking care of these people? For continuity' sake, who is going to be following up to make sure that they're going to finish the course of the treatment that they've been given, which is almost similar to what we do back home. Also, when the patient comes to our clinic, we think of the patient like, okay, we are prescribing this drug, are we having it in the hospital because we have most of the times, we don't have drugs in the hospital. Is this drug available in this hospital or if the patient is going to buy, how much is the drug and is the patient going to be able to buy the drug? Are there other alternatives that we can give the patient?

So, having these discussions here it really reflects on how we practice medicine back home because here, the social status is not as bad as back home. But if these guys here are thinking of the social aspect, it makes us also reflect on how we practice the social aspect of family medicine back home because we all do the same. We need to treat the patient not the disease. We can't leave out the social and thus the psychological aspect if we are to do the holistic

approach aspect of family medicine. I can't really say we are teaching them rather that we are teaching one another.

Dr. Amos Mailosi:

Just to add on that. I think pretty much what has been said by Charles, thinking back in Malawi, I think our lack of resources like investigations, CT scans, laboratory test, and other things, sometimes as a common test as A1C, it's not easily available Malawi. I think that has strengthened Malawian system in terms of other capacities. For example, for you to reach a diagnosis in Malawi, you really have to be very, very good with your physical examination. You have to be very thorough when getting history because if you miss these things, you don't have more options for investigations. So, I think that is what I haven't seen here, understandably so because part of the work up is going to be complemented by the investigations. I think that aspect is the knowledge that we would also bring when examining the patient and also taking the history.

Other things would be the differences in epidemiology. Here, we've learned a lot about things that we don't usually see at home, like substance abuse, things to do with minority communities, things that are present in Malawi but we don't talk about it. And other non-communicable diseases like diabetes and hypertension, heart problems. But also, when they came, I think we shared our knowledge about infectious diseases. TB is common here but it's not as common as in Malawi. We hardly seen malaria here, HIV may prevalent but may not be as prevalent as Malawi. Our knowledge of infectious diseases, I think would also be important here so that's what we brought. It's been a two-way process. We brought something and we've learned something.

Seán Collins:

Anna, you're nodding.

Dr. Anna McDonald:

Yeah. That is absolutely my favorite part of this work is how much each side has to learn from the other. I would always say that I definitely learn infinitely more than I teach when I go to Malawi. It's just such a privilege to examine a problem from a completely different lens. I think it makes both sides a lot richer.

Seán Collins:
Tell me what you did today.

Dr. Anna McDonald:
This morning, one of my colleagues called me and had an interesting sort of rare case that presented, related to a child with TB. And my colleague said to me, "I think maybe you've seen more of this than certainly I have, but probably more than a lot of people have here. So, I wanted to pick your brain about it." And I was like, "Well, yeah I've seen a lot of TB but oh my gosh this is perfect because Charles and Amos have seen exponentially more TB than I have." I talked to my colleague and then quickly sent a message to Charles and Amos. I was like, "Hey guys, what do you think about this case?" And they asked me for the x-ray and stuff and we were just chatting about it.

It's part of what makes family medicine so special is this sort of attitude of collaboration and everybody has something to bring to the table and it just reminds me that every day the practice of medicine is a team sport and that can feel really hard and it's felt really hard through COVID when we were all so isolated. But the joy that I find from talking to colleagues, whether it's here or in Malawi or ideally both, it just makes care so much more enjoyable for me and so much better for the patient.

Seán Collins:
I wonder what the family medicine residency in Malawi can tell us about caring for under-resourced communities in the U.S. I'm thinking about rural communities. I'm thinking about inner city, urban populations, new immigrants. It seems like there would be a lot of folks in the United States who would benefit from this sort of practice being more available.

Dr. Charles Hassan:
Maybe I can just add one from the... we are doing a Global Health Leadership course. So, we have the privilege of meeting other residents. Some of them are global fellows in this training. One of them is in Alaska. From the explanation is said, it is a kind of the rural, we can compare that to the Malawi setting. Of course, it is better than Malawi setting. He's also a family medicine resident who graduated. He was like, "I'm working in this place, I'm doing some procedures that I couldn't have been doing here because there is no surgeon there. There is no somebody who is OBY specialist there." Our specialty is really versatile and it give us the potential of doing some things that people cannot even imagine us doing. If it is working in the

U.S. I think family medicine really designed to places like this, where we don't have specialists to do the actual surgeries to see those complicated cases. I think the versatility of family medicine really suits this local setting.

Seán Collins:
Is there a Pan-African interest in this movement?

Dr. Amos Mailosi:
Yes. There's certainly is one. There's interest. My own program was started like 208. The first year undergraduates were in 2011 and the postgraduate program starting in 2015. But the South African program is very good. Actually, our program is copying most of the things from South Africa. There's a Zambian program, there's a Nigeria program. And in different settings, the [inaudible] are different. So, the curriculums are a bit different. For example, in Nigeria most of family physicians, they are in big cities. While the Malawian program and South African program is very targeting the rural communities. But in Africa it's like there's a growing interest in family medicine.

Dr. Anna McDonald:
There's a group called WONCA, which is the World Association of Family Physicians and there's a group for Africa called, AfriWon.

Dr. Charles Hassan:
Yes. I want to say one thing before we go. It can hurt me if I don't say it. The other thing that I like about this exchange problem is back home, we really read things for example, the things that we read in books that exist in this world, that we don't know when to see them. When we come here, we really see that medicine being practiced. For example, those investigations, those imaging that we see in books, we come here, we really see them being done and it really makes medicine... things make sense that okay, I think we are not dreaming these things really happen. When we go back home with the residents here, they say the same thing. So, medicine it can also happen when the things are limited like this. This thing, I think makes me say, I think this bidirection thing, this bidirection program needs to continue, so that we can enrich both sides with knowledge and skills of how best we can balance up the practice of medicine.

Seán Collins:

It's so impressive what you all are doing. Let me just go around the table and ask you for a final comment on the conversation, but also on where this goes next. Anna?

Dr. Anna McDonald:

I have just such great hope for the future of family medicine in Malawi, for the future of continued cross-cultural collaboration. There's a lot of work and I've been working in global health for a long time that's really rooted in this old model of people who don't know a lot about a context going over and becoming experts in a place, in a field that they've never set foot in. And putting my toe into a world that was so different from everything I had known just really shifted my perspective on medicine, on humanity, on life in such a positive way.

Like what Dr. Hassan was saying, that we each just have so much to learn from each other and rethinking where our balance and priorities are. Back to what Dr. Mailosi was saying earlier, that it's always about that one patient sitting in front of you and the reminder that it's a human being who knows more about their life than we are ever going to know. But the ability to take that big picture view of this is a culture or a place or a space and time that I don't know a lot about. I carry that with me into every patient encounter and I'm like, this is a person who I don't know a lot about. And how do we find common ground and what can I bring to the table and what can I learn from this person and how can we work together?

Seán Collins:

Yeah. Amos?

Dr. Amos Mailosi:

Thanks. The program has had its problems but it's more fulfilling than its downside. I would say that being a family medicine resident and soon to be a family medicine specialist, I can see the future of Malawi and the future of the whole world actually because most of the world population, it's in the developing countries or in the areas that cannot be reached by a specialist. So, I think this is the direction that the whole world should take if you're going to achieve universal health coverage. Because what we need is primary healthcare provision, that our focus is not on a disease but on the whole patient. Their community's psychosocial aspect and everything as a patient. With this bidirection relationship, it's also given us opportunity of having a bigger view, a broader view of global health and appreciating how things are done in different settings. I feel [inaudible] now actually.

Seán Collins:
Charles?

Dr. Charles Hassan:
Mine would be thanking Swedish and Providence organization for letting us know Dr. Anna. She have seen the program like growing from the Baby steps. And now, we can proudly say that we have four graduates and yet to have three other graduates next year. She has been a co-component, driving us, teaching us, driving the whole program, teaching us all the basics that we have now. Thanks to Swedish for letting her go to Malawi. And we need more of doctors like her to make the difference that Malawi needs. And also, thanks to Carrie for making our trip here the success and for sure we have learned a lot something that we're going to deliver back home.

Seán Collins:
Carrie Schonwald, what's your reaction?

Carrie Schonwald:
We live in a time of great opportunity in terms of the growing awareness of the gross inequities that exist across systems. This is particularly relevant where global health partnerships are concerned, as global health as a system was founded on colonialist ideas, which were foundationally racist. That system has both at turns created inequities and attempted to redress them. For this reason, all that the global health community does now really needs to be done through a lens of decolonization, dismantling of the system as it currently exists in which we support leadership that is happening from within communities, their priorities, their goals, their execution. Additionally, the democratization of knowledge is really critical, which is both the funding for and also the access to things like global health research needs that need to be centered on the countries where that research is happening.

Just as an example of this, our very own Dr. Amos Mailosi has published a paper on his work and he was not able to access the paper that he published from Malawi and actually purchased it here. I know that sounds small, but it also I know sounds quite profound and imagine that writ large. So, while we always have more to learn and ways of how to improve the ways that we partner. Providence global and domestic engagement is incredibly proud of having supported 20 U.S. family medicine residents over the last four years to go to Malawi to learn and teach and to have hosted the first seven Malawian trained, Malawian family medicine

doctors to come to the U.S. to learn, including of course, Amos and Charles. And this bidirectionality is one of many starting points for Providence global programs to be a part of redressing inequities and working together toward health for a better world.

On that note, I just want to say how incredibly thrilled I am to have had this opportunity to speak with this group who are true heroes in my mind and are phenomenal leaders of the future in their country. Thank you so much.

Seán Collins:
My congratulations to all of you. It's really impressive the work you're doing. I've really enjoyed this conversation. Thank you.

Dr. Anna McDonald:
Thank you so much for your time.

Dr. Charles Hassan:
Thank you.

Seán Collins:
Carrie Schonwald is the Program Director for Global Programs at Providence

Dr. Amos Mailosi, Family Medicine Registrar, at the Kamuzu University of Health Sciences in Malawi.

He and Dr. Charles Hassan, also a Family Medicine Registrar, are in Seattle at the moment… where they are training with Dr. Anna McDonald – who serves on the Faculty at the Swedish First Hill Family Medicine Residency. Dr. McDonald splits her time between Seattle and Malawi.

Hey Charles and Amos… can you guys suggest a Malawian musician we could listen to as the program ends?

Drs. Amos Mailosi and Charles Hassan:
Driemo! MOJO by Driemo!

Seán Collins:
Alright, MOJO it is!

(music plays)

The HEAR ME NOW Podcast is a production of the Providence Institute for Human Caring. It's produced by Scott Acord and Melody Fawcett. We have research help from medical librarians Carrie Grinstead, Seema Bahkta, Sarah Viscuso, and Heather Martin. Our theme music was written by Roger Neil. The Executive Producer is Michael Drummond.

(MOJO continues, ends)

Seán Collins:
MOJO by Driemo…. new music from Malawi.

We're back in 2 weeks with a conversation about Life and Love and Loss … Tembi Locke will be here to talk about "From Scratch" which debuts on Netflix this month.

Thanks so much for listening today – I'm Seán Collins – be well.

("From Scratch" theme ends.)