

Program Improves Medical Training in Uganda

After receiving medical training at the University of Wisconsin, Madison, and the University of Pennsylvania, Philadelphia, Dr. Asghar Rastegar returned to his native Iran, taught medical school, and collaborated with several American institutions, including Yale University in New Haven, Conn. During that time, he says that he developed a sense of what strategies are the most effective at improving physician training.

Since his return to the United States 25 years ago, Dr. Rastegar, who is currently professor of medicine in nephrology and director of global health in the department of medicine at Yale, has devoted himself to improving medical training globally.

In 1995, he and his colleagues developed a collaborative program with Kazan (Russian Federation) State Medical University, aimed at boosting that institution's capacity to train their own physicians. Fifteen years later, Dr. Rastegar and his colleagues are still working with the Russian medical school to help them define their needs and improve medical training.

In an interview, Dr. Rastegar discussed a similar program in Uganda.

How did you get started with the physician-training program in Uganda?

After the success of the collaborative model in Russia, Dr. Majid Sadigh, also of the department of medicine at Yale

and a close colleague who had worked extensively on this model, became interested in creating a similar program in Africa.

For decades, Yale's department of in-

tervention medicine has sent residents to work overseas for 4- to 6-week periods at as many as 16 different sites.

Four years ago, the International Health Program in the department of medicine, which has been funded by Johnson & Johnson as well as our own institution, decided to develop more in-depth collaborative programs with five sites. We applied the Russian model to Makerere University in Kampala, Uganda, with a capacity-building focus. As in Russia, the plan was to help enhance physician training with the goal of improving patient care. Makerere is one of the oldest medical schools in Africa, and probably the best known medical school

outside of South Africa. Mulago Hospital, which is affiliated with Makerere, is the main referral hospital for patients from all parts of Uganda. It has about 2,000 beds, and it handles up to 5,000 patients. It is a very underresourced hospital, and unfortunately about half the patients have HIV disease. Our goal has been to train their physicians so they can train their own specialists and subspecialists within 10 years.

What are the main elements of the physician-training program at Makerere?

Under Dr. Sadigh's leadership, we have an exchange program with Makerere that involves students and faculty. At any one time, we have two to four faculty members from Makerere who spend anywhere from 4 to 12 months at Yale. These faculty members come to receive specialized training in areas such as cardiology, kidney disease, and emergency medicine.

In addition, faculty from Yale and from other medical schools go to Makerere; we have medical residents there at all times, funded through the Yale/Stanford Johnson & Johnson Global Health Scholars Program. The idea is to help the Makerere faculty define what they need, and then find the resources to respond to that need.

What are the challenges of developing a training program in another country?

The key is to find the right partner and develop a relationship based on mutual respect. We didn't go to Mulago to do re-

search; we went to improve patient care through education. There are other medical schools from the United States and Europe doing work with Makerere, but we were surprised that very few had become directly involved in providing the hands-on training to improve patient care. Research is critical to improving patient care, but often the fruit of such discoveries is not translated to improvement in patient care locally.

The people we have worked with at Makerere are as committed and intelligent as anyone I have worked with anywhere in the world. They know what to do to improve care, but they don't have the capacity to train specialists, so they are missing individuals with badly needed knowledge and skills in specific areas. That's the part we are playing.

How can other physicians in the United States get involved to volunteer on a short-term basis?

They can get involved through the Yale/Stanford Johnson & Johnson Global Health Scholars Program, which we at Yale codirect with Dr. Michele Barry, professor and senior associate dean for Global Health at Stanford (Calif.) University. The program is funded by Johnson & Johnson, and it selects residents and career physicians through a competitive application process. The funded scholars receive a travel award on completion of their 6-week assignments. More information is available on our Web site (<http://medicine.yale.edu/intmed/globalhealthscholars>).

—Interview by Heidi Splete



Ugandan students and faculty visit Yale University as part of the exchange program.

COURTESY DR. ASGHAR RASTEGAR

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A Different Kind of IQ Test

Everyone has an ick quotient – or IQ – and it varies from person to person.

Mine was tested recently while watching a cooking show in which an elegant Italian woman prepared a delicious-looking meal featuring ... rabbit. My ick quotient has so far stopped me short of eating rabbit, but Lorenza certainly made it look appealing. And, if I suffered from chronic *Clostridium difficile* infections, and she told me that eating Thumper would clear it up in a day, I might well give it a try.

More patients with chronic *C. difficile* might have the option to put their ick quotients to the test and consider fecal implantation – that is, if more physicians and health care providers are willing to push the limits of their own ick quotients and perform the procedure.

During a press briefing at the annual meeting of the American College of

Gastroenterology, Dr. Lawrence J. Brandt of Albert Einstein College of Medicine in New York said the procedure has become so commonplace that his nurses have become injured to it, and no longer have to draw straws when a patient arrives for fecal implantation.

He is getting about three calls a week with inquiries about it, he added.

Fecal transplant is exactly what it sounds like: taking the fecal contents from a healthy person and transplanting it into a *C. difficile* patient – via delivery methods that include nasogastric tube, enema, and oral capsules — to get rid of the *C. diff* and restore the sick person's healthy gut bacteria. That sounds revolting to many people, including doctors and health care workers. But ac-

cording to Dr. Brandt, the implantation is safe, easy, and inexpensive. And the limited patient data show a cure rate of nearly 100%, with patients reporting that they feel better as soon as the next day.

Dr. Brandt said that his first choice for a fecal transplant donor is an "intimate contact." (I doubt this crosses the mind of many couples during the "in sickness and in health" part of the wedding vows.)

He also has had donors who are siblings, nonrelated household contacts, and friends.

Stay tuned: Although the largest reported case series numbers fewer than 20 patients, Dr. Brandt said that perhaps

clinicians should consider fecal transplant as therapy for chronic *C. difficile*. If they can get over the ick factor, that is. ■

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