

## ESSAY

# Global Is Local: July at a Teaching Hospital in Texas

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It was 1:00 AM. I was the supervising resident on the Pediatric Hospital Medicine service at my home institution in Houston, Texas just a few months after returning from Uganda, where I had spent a clinical year as part of my combined residency program in pediatrics and global child health. I returned a page from the emergency department: "We have a 10-year-old girl\* to admit. She has a 3-month history of cough, weight loss, night sweats, fevers, and a positive quantiferon test. She and all her family members also have a skin rash that looks like scabies. She is stable from a respiratory perspective, and we'd like to admit her to your service for further workup and treatment." I paused as my mind turned to the dozens of patients I treated with pulmonary tuberculosis during my year in Uganda, many of them with the triple burden of tuberculosis, HIV, and malnutrition. "Oh," the emergency physician added, "and the family is from Rwanda only speaks Kinyarwanda."

I relayed the information to my intern. She was in her first week of residency, adapting to night shift, learning the geography of our large hospital and a new electronic medical record, and steadily managing 1 admission after another while figuring out how to balance cross-coverage duties. She was primed in her new role as doctor to absorb information as quickly as it was offered to her. I took a moment to describe the infection control precautions she would have to take when she entered the room and how to find and use the video telephonic interpreter service at our hospital. I explained that however difficult, a thorough interview was essential to proper diagnosis and treatment of this patient. Drawing on my experience with tuberculosis in Uganda, we reviewed the key questions she should ask and discussed the diagnosis of pulmonary tuberculosis.

I supported my intern while she worked for nearly an hour to collect all the relevant information as she saw this disease process for the first time with poor-quality interpretation services in the middle of the night. We learned that the family was not from Rwanda, as initially relayed; they were Congolese refugees who first sought asylum in Uganda and only weeks ago had been resettled in Houston. I helped my intern navigate language and cultural barriers and contextualize the interview. For instance, when the family seemed more interested in whether their friends would be able to bring them home-cooked food than the possibility of a diagnosis of pulmonary tuberculosis, I surmised that the family had been in survival mode and focused on daily necessities for quite some time, a reality for many of the displaced families I cared for in Uganda.

A few hours and many admissions later, another call came from the emergency department: a toddler with fevers and refusal to bear weight. To my astonishment, the emergency physician reported that the family spoke only Kinyarwanda. Bearing no relation to the other family, they were also Congolese refugees who had resettled in

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Houston via Rwanda. I turned to my other intern and, for the second time that night, explained the process of working through the video telephonic interpreter service. I was relieved that this time it was a more familiar chief complaint, and I guided my intern in a broadened differential that took into consideration the child's travel and exposure histories.

During my next call, I admitted a 13-month-old American child with severe malnutrition, complicated by neutropenia, vitamin D insufficiency, and global developmental delay, ultimately found to be caused by neglect. Weighing the size of an average 4-month old, this 13-month-old had the marasmic appearance of many of the malnourished children I had cared for in Uganda. This perspective allowed me to appreciate the gravity of his illness and the need to balance his workup for failure to thrive, about which the Pediatric Hospital Medicine service was extremely knowledgeable, with his simultaneous treatment. I was hopeful that with proper caloric support and clinical monitoring, this child could flourish as I had seen many severely malnourished children in Uganda do under the care of a multidisciplinary team of doctors, nutritionists, and nurses despite the lack of resources.

Later that month, I admitted a 4-year-old girl from Afghanistan with partially treated malaria who presented with fevers and reported "seizures," as well as a positive malaria blood smear. I was immediately concerned for cerebral malaria, a

devastating effect of complicated malaria that I had seen play out in critically ill children in Uganda. Upon my assessment, I was reassured by the well-appearing child with a normal neurologic examination, which was inconsistent with my experience with cerebral malaria. After I relayed these concerns to my intern, she returned to the family with a Pashto telephonic interpreter to learn that the child had not had *seizures* but rather *shivers* associated with chills. This misunderstanding had been passed down from the initial emergency department interview conducted with the child's father, who had limited English skills and a thick accent. These crucial distinctions drastically changed the subsequent workup and care for this patient.

Finally, during my last week on the rotation, I cared for a child who had presented in hypovolemic shock due to cholera. I recalled the many children I had cared for in Uganda with acute watery diarrhea, many of them presenting for care so late that they were unable to be successfully resuscitated. I used this case as an opportunity to teach my interns about how to make a clinical assessment of the degree of a child's dehydration.

Back in Texas after my year in Uganda, as I reacclimated to the American health care system and all its luxuries and challenges, I was uncertain how the skills and knowledge I had acquired abroad would apply back home. Then, as a senior resident on the Pediatric Hospital Medicine service, it became clear: Global is local.

Over the course of a few weeks, I encountered pulmonary tuberculosis, malaria, severe malnutrition, and cholera. I had patients who were immigrants and refugees, who needed interpreters, thorough exposure histories, and a heightened sensitivity to their newness in the US medical system. In many ways, these patients were more similar to those I encountered during my work abroad than to the cases presented in the textbooks, care guidelines, or teaching conferences at my home institution. I know that increasingly, patients like these will walk into hospitals large and small in communities across our nation, making competencies in global health an important component of the education of all pediatricians.

It was because of my mentors and patients in Uganda that I was uniquely prepared to diagnose and treat these conditions and deliver care in a culturally competent manner back in Texas. As importantly, I carried my experiences with me as a supervising resident; I seized opportunities to teach other pediatricians in training, to expand their knowledge of tropical medicine, and to sharpen their skills in cross-cultural care. As increasing globalization and socioeconomic diversity make global health education relevant for all pediatricians, my training abroad has made me a better clinician and educator, not only to the benefit of my patients across the globe but also for my patients and patients of my learners locally, now and in the future.

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