Obstetrics and Gynecology Clerkship

La Maternité
Hôpital Calmette
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Phnom Penh
CAMBODIA

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The Clerkship

My time at Calmette was structured so that I spent one month working and taking call with the midwives, two weeks in neonatology, two weeks in outpatient gynecology, and a final month divided between labor and delivery and inpatient gynecology (in reality, solely on labor and delivery). There is some flexibility in this; it depends on your goals and on the objectives that you present on your first day.

Note that the department head, Prof. Sim, travels often and is difficult to track down, even when she is at Calmette. Be sure to ask her to which faculty member you should report or address concerns.

The Daily Routine

The day starts with morning report, at which the previous day's deliveries, C-sections, and hospitalizations are summarized by a midwife in Khmer, with the occasional heavily-accented French word thrown in ("accouchement," "Césarienne," etc). The meeting then often turns to administrative matters, especially on the days when Prof. Sim is presiding.

On some mornings, a DES (intern) presents, mainly in French, on a topic. Topics range from ectopic pregnancy to different vertex presentations and deliveries.

Then, starting at around 9am, everyone goes to their respective assignments.

Cambodian medical students disappear at around 10:30 or 11 am and have classes in the afternoons from 2 to 5 pm; this is a good opportunity to actively participate without having to vie for attention. I generally stayed until around noon on non-call days and returned after lunch for activities in which I felt particularly interested or productive. Call days begin at 7:30am, before the morning meeting, and last until noon the following day.

A Month with the Midwives

The midwives are a lively bunch. They take call every fourth night in groups of about ten midwives and two "cleaning ladies," who act as assistants for episiotomy repairs, too.

Midwives are responsible for the following activities at the hospital:

- Labor and delivery (L&D) (uncomplicated births)
- L&D triage (salle de pré-travail)
- Antenatal outpatient visits (alongside a physician)
- "Baby bath," which is what it sounds like: bathing the newborns
- Neonatal vaccinations
- Prenatal classes for mothers
- Post-partum inpatient nursing care (vitals, medications, etc.)

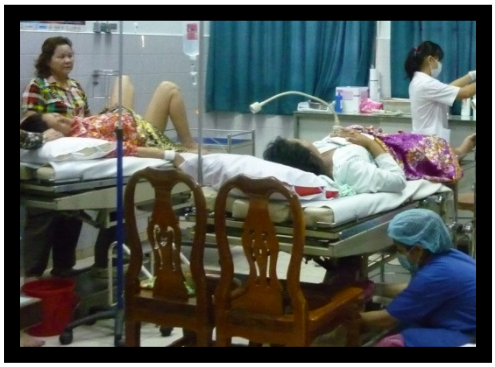
While working with midwives, you'll also be able to observe obstetrical echos by Dr. Huot Seng.

The first two are where you'll gain the most, clinically. In L&D, you'll progress: from observer to preparer of oxytocin and ampicillin injections to repairer of episiotomies to deliverer of babies. In triage, you'll hone your cervical exam, phlebotomy, and IV placement skills in addition to taking vital signs and placing external monitors.

Antenatal outpatient visits are conducted in Khmer but are a good opportunity to practice taking vital signs, fundal height, and Doppler fetal heart tones; smiles and gestures go a long way with patients and midwives.

Baby bath and neonatal vaccinations (Hepatitis B and BCG, specifically) are a unique opportunity to work with neonates.

Prenatal classes are conducted in Khmer.

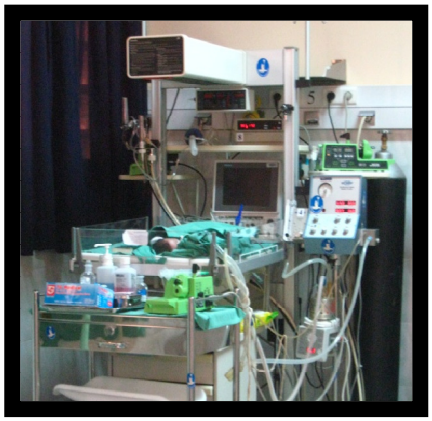


Note that the midwives speak Khmer almost exclusively. Some speak a little broken French, and some a little broken English. Remembering which second language you should use with which midwife is less frustrating than the fact that even if you do remember, communication is limited at best. Be prepared to look up answers to your own questions or to save them for a French- or English-speaking doctor. Internet access was being installed when I was there. This will be an invaluable resource for you and for the continuing education of the staff.

Patient interviews are necessarily conducted by midwives or DES (interns) except in the rare cases when a Khmer patient speaks English or French. Foreign patients are whisked off and seen by faculty members in semi-private rooms. Patient charts are filled out almost entirely in Khmer; you may not even be able to identify a patient's chart, since the name will be in Khmer, too.

Neonatology/NICU

Calmette Hospital is a Level 3 hospital (by French standards, Level 1 by US standards). It is well-equipped, staffed by experts and specialists, and one of the few hospitals with a neonatology unit. So it is telling that the head of the neonatology department chose a hospital in Bangkok as the site of her own delivery.



The neonatology department consisted of three doctors who share a five-day call cycle. The actual NICU was staffed primarily by nurses. The neonatologists were reluctant to go into in-depth explanations of neonatology treatments given my short time with them (two weeks).

I spent most of my time doing newborn exams. Newborns were examined on the first morning after their birth, so there were about twenty newborn exams every morning, divided between one to three students; after becoming confident in our skills, the faculty often left us alone to complete the exams and corresponding documentation. One of the other students or the

nurse can act as interpreter for any questions you may have for parents and any concerns they may bring to you.

You will attend high-risk deliveries and C-sections, so you'll have a chance to learn and practice neonatal resuscitation and newborn care. This complements our Parkland newborn nursery training.

Outpatient Gynecology

Cambodian woman are, generally, very modest. The gynecologic exam is exceptionally awkward. The typical patient enters the room, is interviewed by the doctor in Khmer, then, for the exam, ties a sarong around her waist, removes her clothing from underneath, and then lies on the examining table, where the doctor or nurse cajoles her to raise the sarong to above her waist in order to be examined.

You will see some interesting cases (genital warts, vaginal cysts, cervical cancer, breast masses). Your hands-on experience may be minimal.

Inpatient Gynecology

If you find a faculty mentor to take you on rounds and into surgery, this will be a rewarding part of the clerkship. The language barrier is, yet again, the limiting factor in your direct involvement with patient interviews and exams.

Physician-Led Teams

These teams take call every fifth night and are composed of two doctors and two DES.

Try to cultivate a relationship with your team; depending on that relationship, you may go on rounds in post-partum wards. Although rounds are conducted in Khmer with patients who rarely complain or ask questions, you'll have the benefit of being able to ask questions of doctors and students who train in French and may have some English skills from high school. You'll scrub into surgery with them. As the most junior and fourth person scrubbed in (as in France, there is no scrub nurse), you may not do much more than load needles or pass instruments, but it depends on the head of the team and the DESes. Some will let you close multiple layers once the baby's out.

You'll also have a chance to experience some of the more difficult or high-risk deliveries.

Consider taking call with two different teams in order to get the most of the experience.

Call Nights

These begin at 7:30 am and end at noon the following day. The midwives are Q4; doctors are Q5. Your responsibilities on call will be primarily deliveries with the midwives and C-sections with the doctors. Although you can sleep after the C-sections are over, call nights are a good opportunity to get hands-on action on L&D. (The midwives unofficially divide the night into two shifts, switching at 2 am.)

If you do sleep, there are fold-out cots in the conference room where the morning meeting is held. The three cots are perfect if it's you and the two DESes. If the externes are present, they'll often double-up

in the beds. The tables work well for sleeping, too. BYO sheets/pillows. If the A/C is on, it'll be cold; if it's not, it'll be hot.

The DES—and only the DES, not the midwives—have a copy of the key to the conference room. Try to borrow—and copy—a key from one of them so you won't be locked out.

The hospital is BYO everything, and this is especially salient on call nights. For example, although you can discreetly filch some toilet paper from L&D, you may want to take your own. You may be invited to eat by the midwives, but if you're not, be sure to hit the hospital restaurant before it closes or you'll be stuck eating Ramen noodles from the 24-hour hospital shop, which also sells toilet paper, toothbrushes, and all kinds of other goodies.

There is a microwave and a shower in the midwife call room. I'd use the restrooms in the administrative section of the third floor (directly above L&D) or in the hallway of offices behind L&D.

Benefits of this Rotation

You'll be able to see practices and conditions (especially gynecologic) that you might not otherwise see in the United States. You'll also have lots of hands-on opportunities, from "nursing" skills (IV placement, blood draws) to basic obstetrics (fundal height measurement, fetal monitoring) to deliveries and suturing during C-sections.

The residents, midwives, doctors, and students are friendly and willing to answer your questions.

While I was there, there were presentations by the DES on a variety of topics (uterine fibroids, different cephalic presentations, ectopic pregnancies, etc) every few days. These were mainly in French, or in Khmer with French handouts. These only went on for about a month; I wish that there had been more.

You'll have the unique opportunity to immerse yourself in another culture. Take advantage of the students and midwives who are willing to act as your cultural liaisons as a well as interpreters.

Suggestions for Future Visiting Students

Be prepared to be assertive; it is easy to get lost in the shuffle.

Caught in an unfortunate vicious cycle, Cambodian students are granted very little responsibility, are limited to the role of observer, rapidly lose interest, and, when they show up at all, hover around, pretending to look alert and busy but fooling no one. So they are granted very little responsibility, and the cycle continues. For example, in L&D triage, you're more likely to bump into a bored student than into a patient. By the end of their month in obstetrics—or as their exams approach—the students… vanish. The problem with this student role is that, since you are a medical student, the staff will expect the same of you; it can be hard to convince midwives to treat you like a DES and let you actively participate, especially when you can't communicate effectively with them or the patients...

Ask questions, especially of the French- or English-speaking faculty members. You'll be rewarded not only with the answer to your question but also with further teaching. (The faculty members all seemed to love sharing information. It was easier for them to do so in their native language, but they were equally eager to teach in French or even English if I showed an interest.)

Find a faculty mentor. If you find a good teacher or guide (Drs. Sam Borin and Chou Pinn were exceptionally helpful during my stay), stay close. If they're on a different call team from you, consider switching.

Brace yourself for some glaring breeches in sterile technique. From start to finish, surgery at Calmette bears little resemblance to surgery at Parkland. You'll switch your shoes at the entrance to the OR wing for open-toed shoes worn by many, many other feet. You'll put on your scrubs over your clothing. You'll wash your hands for far, far less than ten minutes without any kind of brush.

The room and operating table will bear visible evidence of the previous patient(s). Those who aren't scrubbed in may not have hair covers or even face masks. I even saw one faculty member eating none-too-quietly in the OR once—but it was okay because the surgery hadn't started yet.

Everything—drapes, towels, gowns—is washed and reused. You'll hope that they're sterilized properly.

Consider learning some Khmer. The language barrier was *the* drawback of this rotation. Private Khmer lessons cost between five and ten US dollars per hour; even a phrase book (about two US dollars at any of the bigger markets) can be a big help. A little Khmer will go a long way with the midwives.

Be prepared to do some outside reading (of the medical variety). Although there were some DES teaching sessions, and the externs may have received some classes at the hospital (in Khmer), it's probably best to supplement the clinical experience with some knowledge. Having internet access at the hospital may, if it's properly done, bring positive changes in the form of continuing education and improvements in patient care.

While we're on the topic of reading, **consider reading up on the history of Cambodia** (see Appendix B). It's important to understand the events leading up to the Khmer Rouge era and to understand that, despite appearances to the contrary, peace and stability have not yet come to the country.

Practical Information

Note that I was in Cambodia in 2010, and inflation was a serious problem. Any prices quoted are for January through March 2010.

Where to Live

Housing is plentiful and inexpensive (by US standards) in Cambodia. Most guesthouses will be willing to negotiate a monthly rate (about 10-15% off the nightly one).

Foreigner-friendly guesthouses (crosses between hostels and bed-and-breakfasts minus the breakfasts) are clustered in four main groups, with plenty of others scattered throughout the city. The "lakeside" area is inexpensive, within walking distance of Calmette Hospital, and a backpacker haven. Security can be an issue in this neighborhood.

The riverside area is somewhat pricier because of its location. If pretty sunrises, lots of nightlife, and hordes of tourists are your thing, this is the place to be.

Many new guesthouses have appeared on and around Street 111 between Sihanouk Boulevard and the Russian market. They are increasingly dodgy as you approach the market, north of Street 214. Guesthouses seemed slightly pricier than lakeside but slightly less than riverside.

The so-called "Golden Mile" (most guesthouse names start with the word golden), is on Street 278 about three blocks east of Monivong Boulevard. Lots of guesthouses, lots of foreigner-friendly bars and restaurants that are posh by Cambodian standards. This is where the expats live; guesthouses are used to long-term guests, and many have kitchens in addition to laundry and internet services.

You may also find housing with expats looking for a roommate. Try < www.expat-advisory.com> for apartment and roommate listings. Although some listings are exclusively for long-term roommates, if you start looking and contacting potential roommates before your trip, you may find a good deal (it all depends on neighborhood and apartment size).

Apartment listings (in English) can also be found at <www.phnompenhpost.com>. Bear in mind that these apartments are targeted at foreigners.

With the exception of the lakeside guesthouses, most of these housing options are beyond walking distance from Calmette Hospital. You'll need a means of transportation to reach Calmette Hospital (see *Transportation*, below.)

What to Wear

Cambodians dress conservatively. Ignore the scantily-clad tourists you'll see. Forget anything you've seen or heard about Thailand, Cambodia's neighbor. Most Cambodians cover their upper legs, knees, and upper arms—at the very least.

Men: long pants and button-down shirts (long- or short-sleeved) seemed to be the preferred combination for the hospital. Tee shirts are acceptable, too. Sandals are appropriate, but flip-flops seem to be reserved for L&D (see below).

Women: at the hospital, you should dress as you would to visit a Buddhist temple. That is, your knees, upper legs, *and upper arms* should be covered. Jeans, capri pants, and skirts are appropriate. I'd avoid tank tops and use any sort of strappy shirt solely as underwear.

Labor and delivery: The uniform for L&D is white. You'll wear your white coat and white pants. Your white coat will get splattered with various fluids, and you'll wash it a lot. Consider taking a second white coat or buying one in Cambodia. Short-sleeved ones cost about $3. You can buy white pants for the same price as a white coat in Phnom Penh, but they'll be some sort of non-breathable synthetic blend (as will the white coat), so consider taking cotton scrub bottoms with you. You'll need dedicated L&D shoes. You can buy plastic Cambodian flip-flips (yes, flip-flops; the closed-toe rule somehow doesn't apply here) for about $2.

OR: Scrubs. Students in Cambodia prefer dark green, but any color is acceptable. You'll be given a single mask and a single hair net. You're expected to reuse them as much as possible—especially the hair net. (Consider taking a cloth surgical cap with you.) Although you can buy a mask on the street (you'll see Cambodians wearing them around the city; it's dusty), just snag them from L&D as needed. The hospital provides OR shoes. There are no face shields, so if you don't wear glasses, consider taking or buying plastic eye protection ($1).

Everywhere else in the hospital: white coat over your (conservative) street clothes.

What you wear outside of the hospital depends on the company you keep; Westerns are held to different standards than Cambodians. (Women: journeywoman.com may be a useful resource.)

What to Take with You

Pack light. (Check out onebag.com if this is an issue for you.) Leave valuables at home.

You can replace just about anything you forget. Cambodia is home to many, many Westerners, so you can find most Western products for prices that, while outlandish by Cambodian standards, are reasonable in US dollars. And Cambodia is home to factories for many US clothing brands whose products seem to "leak" into the major Phnom Penh markets. Even if you're not much of a shopper, you'll come home with more than you set out with.

For about a dollar per kg, you can have your clothing washed. Laundry shops are all around the city, especially in the guesthouse-dense parts of town.

I recommend taking scrubs and a white coat(s). If you need to buy some, your best bet is to have a student take you… (If you want to get there yourself… Allow me to introduce you to the Cambodian way of giving directions: take Sihanouk Boulevard heading west, away from the riverside and Monivong Boulevard, follow it as it curves, and you'll see a temple to the left and Olympic Stadium on the right. Just past the temple, there is a street on the left (and none on the right) with a large pharmacy on the corner. That street, and others around it, are home to a high density of medical supply stores.)

Health Generalities

Water: Buy bottled water—or boil/filter your water. Use tap water for showering and teeth-brushing.

Food: Be prudent.

Malaria: Not an issue in Phnom Penh. Consider bite prevention (nets, repellant) and prophylaxis if you plan to travel extensively beyond Phnom Penh.

What to do if you're unwell: You can obtain most antibiotics without a prescription. Calmette's pharmacy is open 24 hours, staffed by bilingual pharmacists, and well stocked. La Pharmacie de la Gare and UCare are foreigner-friendly alternatives. If you require attention beyond self-medication, the International SOS clinic is reputed to be the place to go. For major emergencies or invasive procedures, Calmette's ER is the best in the city, but if you can make it to Bangkok, that would probably be best.

The US Embassy's list of medical resources is at cambodia.usembassy.gov/medical_information.html

Money, Money, Money

Although the Cambodian currency is the riel (about 4300 riel = 1 USD in January 2010), dollars are a sort of secondary currency; businesses will accept dollars and riels equally, although if you pay in one, you may receive your change in the other. Note that the street exchange rate is 4000 riel to the US dollar.

There are ATMs throughout the city that will, with the usual ATM/international surcharges, allow you to withdraw dollars. Because of the low cost of living, single, large ATM withdrawals can last some time. It's probably not worthwhile to set up a bank account or bother exchanging currency.

Transportation

Phnom Penh is not a pedestrian-friendly city. Crosswalks don't exist: crossing the street is reminiscent of 1980s videogames—with you as the moving target. Most sidewalks have been taken over by informal parking lots, restaurants, shops, or trash. While you can walk in the street adjacent to the sidewalk, you will be harassed every few meters by the driver of a motorcycle taxi (motodop) or a motorcycle-towed cart (tuk-tuk) looking to make a living. Add to this the heat, and even the most relentless walker will probably cave in.

If you take a motodop or tuk-tuk, it is important to negotiate a price first, especially if you're departing from a touristy part of town. (They're used to overcharging—and to being overpaid.) Once you're familiar with the city, you'll know the appropriate price to pay, and the negotiations will be brief (i.e.: you'll state your price or, if you're not coming from a touristy part of town, just pay as you descend). Most drivers have limited English and won't know how to read maps, so when giving directions, remember to (a) speak clearly, (b) know the nearest landmark if you're not going to a common location, and (c) carry a map at all times, especially if you can't direct the driver to your destination. It's common to negotiate a price and depart, only to have the driver stop a few blocks later to ask a second, English-speaking driver to translate for you!

If you plan to buy or rent a bicycle or motorcycle, it may be wise to take motodops for the first week, while you become familiar with the rules of the road. (Initial evidence to the contrary, there *is* a method to the madness!)

Internet Access

Many Westerner-friendly coffeehouses have wi-fi (free with a drink), and internet cafés can be found throughout the city, especially in the tourist centers (about $1/hour in tourist-friendly zones, 1500r/hour elsewhere). If your new home offers wi-fi, be sure to ask about bandwidth: many operate at the speed of cold molasses. The Maternity at Calmette Hospital was installing internet access when I left in March of 2010.

Travel

Cambodia is a spectacular country and welcomes tourists, despite language barriers. The temples at Angkor, alone, merit a trip to Cambodia. Luckily, travel is uncomplicated, even without your own vehicle.

Cambodia has two airports: Phnom Penh and Siem Reap.

Bus travel to other major towns and cities (and to Bangkok and Saigon) is available through various bus companies. Although the country's network of highways is expanding, there are no night buses, and I would avoid travelling in the limited visibility of dusk or dawn.

"Share taxis" are vans on which you can purchase a seat. Seats are often oversold or split, and the taxis are often overflowing with people and products. They may be marginally faster than buses, but that speed comes at a cost.

There are boats connecting Phnom Penh and Siem Reap and Battambang and Siem Reap; they are not faster than buses, just a departure from the ordinary.

Train travel is… virtually nonexistent.

Conclusion

If you're considering obstetrics and gynecology as a field or if you seek an opportunity to women's health in a developing country, this rotation provides an opportunity to do so in a country where French medical studies and Western tourism/NGOs chip away at the language barrier.

Appendix A

Sample Obstetrics and Gynecology Clerkship Objectives

You may be asked for the learning objectives for your clerkship. You can download and translate UT Southwestern's objectives, create your own unique objectives based on your personal goals, or use a generic list of objectives like this one. Ask the Paris program liaison put his official stamp and signature on the print copy that you plan to take with you.

1. Savoir réaliser un examen clinique en consultation de gynécologie. Savoir réaliser un frottis cervico-vaginal. Avoir assisté a une consultation avec un des médecins du service.

2. Savoir réaliser un examen clinique en consultation prénatale. Avoir assisté à une consultation avec un des médecins du service.

3. En salle de naissance, suivre le déroulement du travail d'une patiente et participer a son accouchement.

4. Savoir accueillir une patiente aux urgences. Savoir mener l'interrogatoire. Orienter l'examen clinique et déterminer les examens complémentaires utiles.

5. Savoir lire et interpréter une échographie pelvienne et un échographie obstétricale au 1er, 2ème, et 3ème trimestre.

6. En suites de couches, savoir réaliser l'examen d'une accouchée.

7. Savoir réaliser l'examen du nouveau-né.

8. Connaître les différentes méthodes d'extractions instrumentales (forceps, ventouse) et les différents types de césarienne.

9. Connaître les différents gestes de diagnostic anténatal (biopsie de trophoblaste, amniocentèse, ponction de sang fœtal).

10. Connaître les différentes voies d'abord en chirurgie gynécologique.

Appendix B

Recommended Reading

For traveling, the gold standard

Lonely Planet: Cambodia

On the history of Phnom Penh

Osburne, Milton. Phnom Penh.

On the (recent) history of Cambodia:

Bizot, François. The Gate.

Chandler, David P. Brother Number One: A Political Biography Of Pol Pot.

Chanda, Nayan. Brother Enemy: The War After the War.

Chandler, David P. A History of Cambodia

Chandler, David P. The Tragedy of Cambodian History: Politics, War, and Revolution since 1945.

Chandler, David P. Voices from S-21: Terror and History in Pol Pot's Secret Prison.

Dunlop, Nic. The Lost Executioner: A Story of the Khmer Rouge.

Fifield, Adam. A Blessing over Ashes: The Remarkable Odyssey of My Unlikely Brother.

Him, Chanrithy. When Broken Glass Floats: Growing Up Under the Khmer Rouge.

Kiernan, Ben. The Pol Pot Regime: Race, Power, and Genocide in Cambodia under the Khmer Rouge, 1975-79.

Osburne, Milton. Sihanouk: Prince of Light, Prince of Darkness.

Shawcross, William. Sideshow: Kissinger, Nixon and the Destruction of Cambodia.

Short, Philip. Pol Pot: Anatomy of a Nightmare.

Ung, Loung. First They Killed My Father: A Daughter of Cambodia Remembers.

Ung, Loung. Lucky Child: A Daughter of Cambodia Reunites with the Sister She Left Behind.

Yathay, Pin. Stay Alive, My Son.

Websites

Documentation Center of Cambodia: <www.dccam.org>

Cambodian Genocide Program (at Yale): <www.yale.edu/cgp>

Maurice Glaize's The Angkor Guide: <www.theangkorguide.com>

(Note: although this is a guide to the ruins at Angkor, it's also a worthwhile—and free—introduction to Buddhist imagery in temples and art)

Note that this list is a modern Cambodian canon of sorts. Because these titles are popular with travelers, bound (i.e.: pirated) copies can be found at any Phnom Penh market and some of the more tourist-frequented streets. Photocopying books is illegal and unethical, of course.

Obstetrics and Gynecology Clerkship

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April 5, 2010 – June 25, 2010

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I had no contact with the university while in Ouagadougou; I made all the necessary arrangements directly with Prof. Lankoande.

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Doctors seem to share their cell phone numbers freely with patients, who call them with follow-up questions. Although you might hesitate to call a professional contact's cell phone in the US, I wouldn't hesitate to use that as a means of contacting difficult-to-find professors or residents in Burkina Faso.

The Clerkship

A Note on Medical Studies

Medical school in Burkina Faso follows the French system, with a two-year *premier cycle* followed by a four-year *deuxieme cycle*. During the sixth year, students spend forty-five days in a remote and underserved part of the country. There, in what every student I met called a grueling experience, they are the treating physician at the local health clinic.

Students then complete the *septième année*, which might theoretically be a year-long analog to our sub-internship but is probably more like an internship: student are called *internes* and are responsible for designing a plan of care for each patient. The year is divided into four three-month blocks: internal medicine, surgery, pediatrics, and ob-gyn. Each block ends with a challenging case-based oral exam.

In order to graduate, students must complete a research-based thesis. Most theses seemed more epidemiologic than clinical in nature. Most students collect data for a full year or longer before defending their thesis (*la soutenance*), making medical school effectively over eight years long.

My understanding is that residents must pay for the privilege of training, although they theoretically receive a small salary/stipend in exchange for their services. Most residents moonlighted at private clinics during their afternoons and evenings off.

The Role of the Medical Student

Students complete their three-month ob-gyn rotation during their fourth year; at that point, they have strong nursing skills (blood draws, peripheral IVs, etc.) and are developing ob-gyn clinical skills and knowledge concurrently, through mornings spent at the hospital followed by afternoon lectures. The clinical shift starts at 7:30 with an hour-long, student-geared lecture that is led by a resident and ends at noon. Fourth-years, called *externes*, rotate through L&D/gyn ER, post-partum care, echography, and outpatient clinics and have a long checklist of objectives to have mastered in their three-month stint. *Externes* take call (from 6pm until noon the next day) every sixth day or so in teams of about three students, at CHU-YO and also at regional clinics scattered throughout Ouaga. Those clinics, which are staffed by midwives with one resident, allow for a different experience from that of the university hospital, where patients are referred for complications and where, with multiple residents and upper-level students (*internes*), the fourth-year students are often relegated to menial tasks.

Seventh-year students, who are called *internes,* have responsibilities like those of the US intern. They are the first to see the patient and begin treatment, often with little oversight by residents. They switch services within the maternity every two weeks, rotating through the antepartum unit, high-risk pregnancies, “intensive care,” L&D, family planning clinic, and D&C. They take *la permanence*, the noon to 6pm shift, followed by *la garde* (call) in groups of four or five students; when I was there, this amounted to a Q9 call schedule.

The *internes* and *externes* change rotations every three months, and it is likely that that shift will occur midway through your stay.

Although the experience will be novel and shocking regardless of which of the two groups of students you choose to join, I would align myself with the upper-level students; you'll be challenged to truly care for patients despite the hurdles—rather than merely observing helplessly.

Centre Hospitalier Universitaire Yalgado Ouédraogo (CHU-YO, or "Yalgado")
The teaching hospital is at the pinnacle of a pyramid-shaped healthcare system. Patients receive care at local clinics in their forty-five provinces. Complicated cases are referred to the regional health centers; Burkina Faso has thirteen regions. From there, patients are referred to Yalgado, in the capital.
As the teaching hospital, Yalgado boasts the most experienced staff, the best and the brightest. It is also a hospital in administrative crisis, with glaring lapses in every aspect of management, from payroll to medical record-keeping to facilities/equipment management.

Note that the hospital "day" lasts from the early morning until noon. In the afternoons, the hospital empties except for the team on call. Many physicians work at private clinics in the afternoons, with many of the residents moonlighting at the private clinic of Dr. Lankoande, the head of CHU-YO's ob/gyn service. Either way, hospitalized patients on all but the intensive care unit are left to their own devices—or that of their relatives—until morning.

Morning rounds
The day starts at 8am with morning report, at which the team on call presents the afternoon and night's C-sections followed by the complicated deliveries (the straightforward ones are considered the job of the midwife and are not presented at rounds). The *internes* are responsible for presenting all the cases. Afterward, other *internes* and then the residents ask questions. Sometimes the questions clarify confusing ideas or protocols; more often they become a chance for *internes* to try to catch lapses in other *internes* plans or to nitpick. Faculty are seldom present; the head of the department attended rounds maybe a handful of times in the three months that I was there, usually to chastise the residents for their poor record-keeping. Confusing cases often turned into circular debates, with the residents often lacking the experience or evidence to draw any conclusions.

Maternal deaths are not uncommon. Neither are fetal demises, in and out of the uterus. Uterine rupture is a daily event. Cord prolapse occurs far more frequently than at Parkland. Decompensated anemia is a frequent complication, as is malaria.

Labor and Delivery/Gyn ER
L&D and the gyn ER share one large space at the end of a long dim hallway. The hallway doubles as the postpartum surveillance unit; women lay there for hours postpartum, family members flagging down doctors if it seems like she is bleeding excessively or develops a fever or some other complication.

It's a shocking welcome to this world.

In L&D, which is one large room with low partitions, there are six beds, mostly in plain view. Only medical personnel are allowed there; even family members must wait outside. The air-conditioning has been broken for longer than the fourth-year residents have been there, although the gargantuan units, lights flashing occasionally, still look shiny and new. The ceiling fans work sometimes. The walls and counters are still damaged from a flood some five years ago. The beds are stained and uncovered; each patient brings her own cloth to lay on. You hope that the bleach water that they use to clean surfaces

and equipment (Foleys—yes, Foleys—NG tubes, tape measures, suction bulbs, bedpans) does, in fact, contain an appropriate amount of bleach; sometimes the smell is unconvincing.

The hospital is poorly-equipped. It is the hospital at which some patients arrive after being transferred from local to provincial to regional health center, their degree of distress increasing with each change of scene. Nevertheless, they must, on arrival, purchase even exam gloves. The family of a decompensated patient must purchase IV fluids and an IV kit at the pharmacy before running to the lab to purchase tubes for blood collection. Blood transfusions are only possible with on-site typing.

The doctors' station, if it can be called that, is a mess of papers, with different forms necessary for blood work, government-subsidized testing, and pharmacy prescriptions. (Sometimes the official forms are torn into quarters and the backs are used for prescriptions; the students walk away with the prescription pads donated by pharmaceutical companies.) Anyone can order anything, as long as they place the official hospital stamp on the paper.

Medical records? It seems that the hospital has made great strides in this area. Each patient has a folder: green for gynecology, yellow for obstetrics. Midwives are notoriously poor about documenting; always ask them what they've put in the patient's IV, and don't be surprised if the patient's last cervical exams are documented after the delivery is recorded.

If a patient was seen more than two days ago, her chart is gone to that mysterious sinkhole in which charts just… vanish. Unless a resident or *interne* thinks to save the chart of a patient he knows will return, that patient will receive a new chart on arrival.

Luckily, patients are trained to carry a patient booklet unique to each pregnancy. All exams and results should be documented in that booklet, so you will be able to obtain at least basic information, in French, from patients, regardless of her native language or medical record status.

L&D does not use a board. Through unspoken rules, observation, and intuition, you'll figure out which patients "belong" to midwives and which are *internes'*. Or just ask.

As if all of this were not overwhelming enough, the heat (remember those broken a/c units?) is compounded by the sheer number of bodies in the room. *Externes*, *internes*, nursing students, residents, and the occasional foreign exchange student hover around the six beds and any patients who might be seated on the floor waiting for one of the six beds.

You'll learn to act quickly: to claim a bed, push your way to the patient, and delegate prescriptions and IV placement to the junior medical student. I recommend starting with a week or two as an observer on L&D: you will be disoriented, horrified, and discouraged, but you'll also get a feel for the expectations and the system so that when you return, you'll be ready to assume the role of *interne*.

When to return: I would try to do at least another two or three weeks—if not more—later in the rotation, although when, exactly, is up to you.

Postpartum Care
In the US and in France, routine postpartum care is efficient. There are certain aspects of the exam that are critical, so you perform them and… well, move on. In Ouaga, between *externes*, *internes*, nursing students, and one incredibly slow-moving midwife who runs the show, walking rounds on three four-bed rooms and possible patients on mats in the hallway can easily take three hours.

Obstacles: lack of records (send the *externes* to L&D to try to track down charts); lack of blood pressure cuffs (ask the midwife: she'll produce one); misunderstandings about filling prescriptions (you'll have to look through the patient's meds yourself to make sure she's bought all the required ones); confused nursing students (cultivate patience); too many people in one small space, with ensuing finger-pointing and responsibility-shirking.

The benefits are that, because the hospital sees a high volume of patients, you'll see some interesting medical conditions. Drawbacks include wanting to tear out your own hair and possibly that of others.

Note that you'll be responsible for eyeballing the neonate as well as examining the mother.

High-Risk Pregnancies (Grossesses paths)
This was possibly the most interesting and also the least populated unit.

You'll see hypertension, pre-eclampsia, skin conditions (carbuncles, erysipelas, abscesses), suspected malaria, malaria, malaria, and malaria. There were typically four students covering three rooms, with typically one or two (or fewer!) patients per room. The patient truly became your own patient.

Because the unit was less chaotic than, say, L&D, the resident spent a good bit of time teaching.

When the day shift ended at noon, these patients were tended exclusively by their family members. Only critical care patients were monitored during the afternoon/evening shifts and call. You may have to find an *interne* on call to administer any PM medications or follow up on your patients in the evening.

Because rounding was typically over by 10am, I spent the rest of the morning in L&D or family planning clinic.

Post-Operative and Intensive Care Units
These units are a good place to practice nursing skills and prescription-writing.

Family Planning Clinic
Here, you'll get to practice patient counseling and the basic gynecologic exam. Different contraceptive methods, with condoms and OCPs heavily subsidized by the government, are offered. You may have the opportunity to place or remove IUDs, depending on the relationship you develop with the midwives who run the clinic.

This clinic is, generally speaking, the place for postpartum exams, IUD placement, and, as the name implies, contraception and counseling. The ambiance is genial and the midwives friendly. They will let you participate as much as you are willing and able.

With *externes* and *internes* in a small space, this clinic tends to become crowded. It benefits from one of the few working air conditioning units in the maternity.

***Aspiration manuelle in utero (AMIU* [D&C])**
I didn't rotate through here (poor planning on my part), although I know that the residents are willing to teach you to do D&Cs and let you do them—unsupervised. Be warned that rounding on the AMIU patients takes time.

***Le bloc* (the OR)**
Externes are expected to rotate through the OR, while *internes* focus on the maternity's other units. Students do not scrub in; they merely observe from across the room. The experience is not very rewarding except from the shocking (lack of) aseptic technique and limited instruments. Residents seem to struggle to be allowed to perform surgeries; most assist faculty members.

A senior resident offered me the rare opportunity to scrub in… if I bought my own disposable gown (~$6 and gloves (~$1). (I had a mask, head covering, and protective eyewear.) I thought it was well worth it. Otherwise, you may have trouble convincing the residents and staff that this resource-limited hospital should support your learning by sacrificing a gown and pair of gloves for it.

If you do scrub in, be prepared to merely observe: the team is not used to having students present, and the residents may or may not have the surgical skills to be able to operate and teach simultaneously.

Call Nights
The *externes* took call every sixth night in groups of four, in clinics scattered throughout the city. These outlier clinics see fewer complicated cases—and refer those that they do receive to CHU-YO. Run primarily by midwives, with a resident on call for C-sections, these clinics are a good opportunity to practice uncomplicated deliveries and routine peripartum care.

Transportation to and from these clinics can be complicated; arrange with an *externe* on call or arrange for a taxi to pick you up.

The *internes* take call in groups of four or five, dividing the number of nights of the rotation by the number of groups: this amounted to call every ninth night when I was there. They are responsible for labor and delivery, the postpartum ward, "intensive care," and the "post-op" unit.

Usually, one *interne* assumes responsibility for all of the patients in the intensive care room, which adjoins the L&D/gyn ER hall. This *interne* will check in with the upper-level resident at some point during the night. It's a position that requires a high degree of familiarity with the medical system (pharmacy, lab tests, etc.) and a lot of independence.

The other *internes* spend the night in L&D, checking in on postpartum and post-op patients as needed and writing notes before morning rounds. Although call starts at noon, the afternoon shift is called *la permanence* and *externes* do not arrive until the

evening for the official start of *la garde*. The quieter afternoons are a good time to place IVs and do full patient exams; you'll be expected to delegate such tasks to the *externes* when they are around.

There is an *interne* call room. Lunch and dinner are provided for the call team in that room. I have no information as to the provenance (i.e.: cleanliness) of the food, but I did find it to my liking. There are also two little cafes on the hospital, one open much later than the other, where you can get *pain-bro*, omelette sandwiches, or pasta as well as soda and bags of water. You can refrigerate food and drinks in the DES room by L&D. Label items well and note that at 8am they become common property. There is no microwave.

You may be able to get an hour of sleep if you are lucky, usually by sharing a (twin-sized) bed in L&D (there is one) or in the resident or midwives' call room, which are along the hallway leading to L&D. BYO everything; I usually used my backpack as a pillow. Consider yourself lucky if you sleep at all.

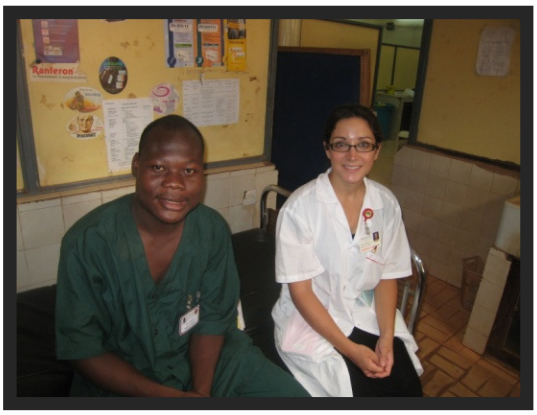
The cleanest bathroom that I found was next to family planning clinic. BYO flashlight (even during the day), toilet paper, and hand sanitizer.

The team on call presents all admissions during morning rounds.

Benefits of this Rotation

This rotation was high-yield, eye-opening, and horrifying all at once. It reinforced any hands-on skills that I'd picked up before arriving and allowed me to see conditions that seldom arise in the US (e.g.: uterine rupture, cord compression, maternal and/or fetal death). At the same time, each birth is special, each treated patient better than she was on arrival. Seeing successful healthcare with limited resources is reassuring and inspiring.

You'll be able to do as much as you are willing or able for each patient. This is truly a sub-I experience. Additionally, because of nursing/equipment shortages, you will learn to place IVs and administer medications. This may not sound like much, but we tend to forget about these details as US medical students.



The residents, many of whom were from neighboring countries, and students seemed excited to show their hospital and university to a visitor. They were equally eager to share local foods and show me their city. I made many friends among the students, without whom I would have been lost in and beyond the hospital.

If you want to start to grapple with the complex interplay of factors that contribute to poor medical care and, well, social disenfranchisement (structural violence, as the literature calls it), this is the place to do so.

Suggestions for Future Visiting Students

It's easy to become jaded. Supplies have a way of disappearing. Students are expected to bring their own blood pressure cuffs and pregnancy wheels; a prescription can be written for a thermometer. That said, **I would avoid bringing anything to the hospital that you would mind becoming separated from.**

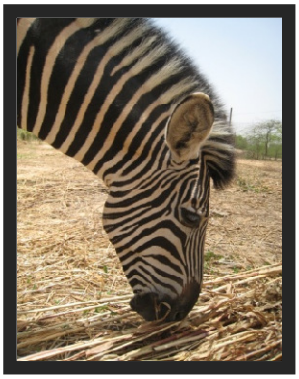
Although every *Burkinabè* I met was friendly and eager to help me in any way possible, **I had to be proactive about what I wanted to see and do.** An upper-level resident was given the responsibility for my rotation, but, although he was very willing to help and to follow the set of broad objectives that I took with me, he seemed relieved to approve my own self-designed schedule. I found my own mentors among the other upper-level residents.

Call is draining (you will not sleep) and can be disorienting; **take some time to familiarize yourself with the system before taking call.** I did not take call during my first two weeks and then took call with an upper-level resident who I knew would make sure I had a positive learning experience. Once I felt more confident, I took call once or twice a week, with different residents and student teams each time.

Do your best to integrate yourself with the students. I received a lot of positive feedback for being willing to help out whenever and however possible and also for being willing to try local foods and drinks; the residents considered past foreign students aloof.

Practical Information

Where to Live



Hotels tend to be for the business traveler and are expensive relative to the country's low cost of living. I found housing, fortuitously, thanks to Dr. David Fort, a UT Southwestern alum who works for the Southern Baptist Convention in Western Africa and is based in Ouagadougou.

Most westerner-friendly hotels are centered around Kwame Nrumah Avenue (from where you can bike or walk to a taxi) or in the Ouaga 2000 neighborhood (you'll need your own transportation; it's across the city from the hospital). The Hotel Independence is located slightly closer to the hospital: it is a short walk from the road to Fada, where you can catch taxis to the hospital.

What to Wear

For your own safety at the hospital, I would expose as little of my skin as possible; protective gear is in short supply. I would wear slacks or jeans. Although some girls wear them under their white coats, I would avoid strappy tank tops. Closed-toed shoes are a good idea, but only use ones that you would not mind having splattered and covered in dust. You can buy plastic clogs that are ugly and functional for about $2 in the markets.

I would also dress conservatively when out and about.

What to Take with You
Pack light, and do not expect to have access to a clothes dryer. Do not take ANY valuables. Bear in mind that the dust and heat are not kind to jewelry, clothing, and shoes.

Medical: anything you may need. As a minimum, take a stethoscope and a good flashlight. I had front-row seats to most speculum exams because my flashlight was the only light source. Also take a pregnancy wheel. Take multiple sets of scrubs and closed shoes that you wouldn't mind leaving behind; they will get dirty.

Health Generalities
Water: Buy bottled water or bagged water—or try to find a place to stay that has a water filter.

Food: Be prudent.

Malaria: Endemic. Prophylax appropriately.

Yellow fever: you will be asked for proof of vaccination on arrival.

What to do if you're unwell: You can obtain most antibiotics without a prescription or simply write yourself a prescription. Pharmacies in the center of town (Pharmacie de l'Independence, for example, across from the hotel of that name) or the Ouaga 2000 neighborhood tend to have foreign customers. If you become seriously ill, consider leaving Burkina Faso.

Money, Money, Money
The CFA (*colonies françaises d'Afrique*) franc is the national currency. The exchange rate was 450 cfa = 1USD when I was there (April-June 2010). Large ATM withdrawals go a long way, since the cost of living is low.

Be aware that most prices are negotiable; in fact, you will be expected to bargain hard. Assume that the stated price is at least double what the vendor expects to receive, and ask locals what typical prices are before shopping.

Transportation
It seems that everyone rides a motorbike. There are motorbike-only lanes, although many choose to ride on the main road. Although there are implicit rules of the road, I was quite happy to let others do the driving. If you are familiar with motorbikes and not risk-averse, this is the ideal way to get around.

Buses are crowded with people, bicycles, and even livestock; I avoided them within Ouaga.

Like US buses, taxis run along lines that cross through many "zones" of the city. You will be charged depending on how many zones you traverse. My daily taxi ride cost 200 francs, for example; it covered two zones. Be sure to ask a local how much you should be paying; otherwise, you will undoubtedly be charged more than locals are.

There are taxis for hire that do not follow lines. Make sure

to take your taxi from a reputable location (e.g.: a large hotel) and to negotiate a reasonable price before departing.

Bike-riding seemed like a death wish, both because of the chaotic traffic pattern and the risk of dehydration in the heat. But it is an option for short distances.

Internet Access

You can find internet access in the bar or lounge areas of the major hotels. Internet shops can be found throughout the city and are inexpensive but tend to have slow connections.

Travel

Burkina Faso is not exactly a tourist destination. That said, the countryside is beautiful, and the regions of the country markedly different.

I did my traveling with friends. The larger hotels organize excursions. Beware of foreigner pricing.

Recommended day (or weekend) trips:

- The sculpture park at Laongo and the Ziniare animal park (zoo); they're both about an hour from Ouaga.
- Bobo Dioulasso, Burkina Faso's second-largest city, and the nearby waterfalls at Banfora. Although it is possible to get to Bobo by bus, you'll require some sort of secondary transportation to get to Banfora.
- The Nazinga game reserve is a long drive from Ouagadougou, but it's closer than the truly large W park in the east and worth a visit during game season.

Conclusion

If you're considering obstetrics and gynecology as a field or if you seek an opportunity to women's health in a developing country, this rotation provides an opportunity to do so in a stable country with astounding poverty levels.

Appendix A

Sample Obstetrics and Gynecology Clerkship Objectives

You may be asked for the learning objectives for your clerkship. You can download and translate UT Southwestern's objectives, create your own unique objectives based on your personal goals, or use a generic list of objectives like this one. Ask the Paris program liaison put his official stamp and signature on the print copy that you plan to take with you.

1. Savoir réaliser un examen clinique en consultation de gynécologie. Savoir réaliser un frottis cervico-vaginal. Avoir assisté a une consultation avec un des médecins du service.

2. Savoir réaliser un examen clinique en consultation prénatale. Avoir assisté à une consultation avec un des médecins du service.

3. En salle de naissance, suivre le déroulement du travail d'une patiente et participer a son accouchement.

4. Savoir accueillir une patiente aux urgences. Savoir mener l'interrogatoire. Orienter l'examen clinique et déterminer les examens complémentaires utiles.

5. Savoir lire et interpréter une échographie pelvienne et un échographie obstétricale au 1er, 2ème, et 3ème trimestre.

6. En suites de couches, savoir réaliser l'examen d'une accouchée.

7. Savoir réaliser l'examen du nouveau-né.

8. Connaître les différentes méthodes d'extractions instrumentales (forceps, ventouse) et les différents types de césarienne.

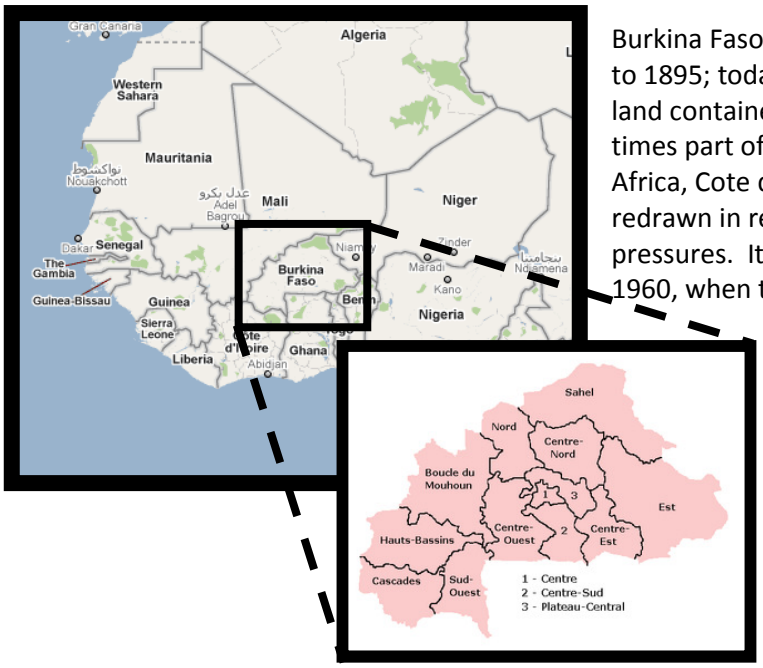
9. Connaître les différents gestes de diagnostic anténatal (biopsie de trophoblaste, amniocentèse, ponction de sang fœtal).

10. Connaître les différentes voies d'abord en chirurgie gynécologique.

Appendix B

Burkina Faso in a (Very Small) Nutshell

Burkina Faso, which has a population of over 15,757,000, is inhabited by 71 ethnic groups. The dominant group (52%) is the Mossi, whose language is Moré and who, since the fifteenth century has inhabited the central parts of what is now Burkina Faso.



Burkina Faso was colonized by the French from 1890 to 1895; today, the official language is French. The land contained within its current boundaries was at times part of countries called Niger, French West Africa, Cote d'Ivoire, Upper Volta, as boundaries were redrawn in response to uprisings and economic pressures. It remained under French control until 1960, when the individual countries in the region gained their independence within a span of months.

Named Upper Volta at independence, the country saw three republics and three military regimes between 1960 and 1983, at which point the current semi-presidential republic took power. Led by Thomas Sankara, who would become the first president, and Blaise Compaoré, the revolution created a national infrastructure and also an autocratic government. In 1984, the country's name was changed to Burkina Faso, "land of honest people." (Burkina means "men of integrity" in Moré, and Faso means "my father's house" in Dioula, the country's second language.)

In 1987, Sankara was assassinated, and Blaise Compaoré rose to power. He was reelected in 1991 election, with eighty six percent of the vote at twenty-five percent voter turnout and has won every election since then. His party continues to dominate the parliament.

The country ranked 177 of 182 countries on the Human Development Index in 2009. The GDP per capita was $522 in 2008, with ninety percent of the country engaging in subsistence agriculture. The infant mortality rate is about eighty five per 1000 live births, and the life expectancy is 53 years. The HIV rate was estimated at 1.6 percent in 2007. Fewer than forty percent of children are immunized against polio, diphtheria, and tetanus. Only thirty-eight percent of children attend school; only thirty percent of girls have that opportunity, with only one percent reaching higher education levels. Women are responsible for sixty to eighty percent of agricultural work.

Burkina Faso is divided into thirteen regions, forty-five provinces, and 301 departments, with regional governments at the provincial level. The health system is similarly divided, with local clinics referring patients to provincial, regional, and finally university hospitals.

Internal Medicine

&

Obstetrics and Gynecology

Clerkships

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July 5, 2010 - January 2 , 2010

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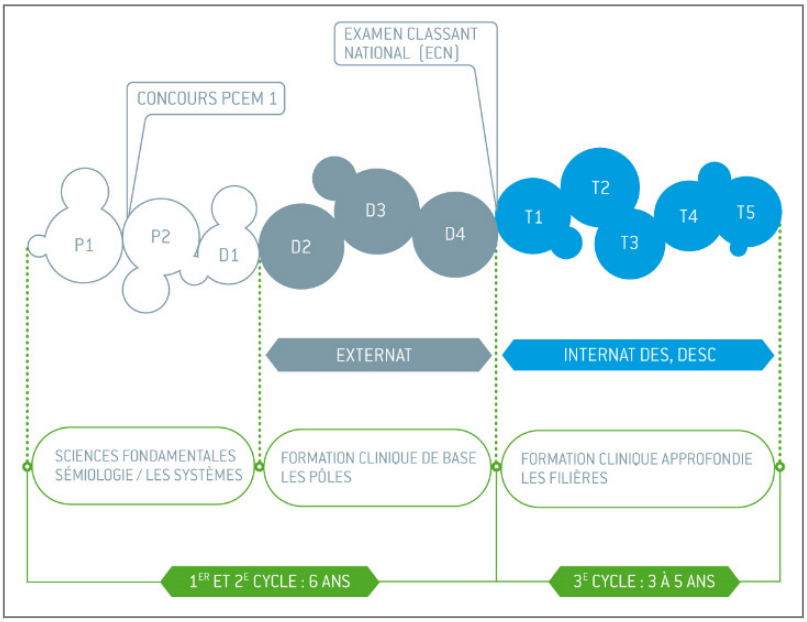
Fréderic should be your first contact for most concerns; I've included others here for completeness but Fréderic and, at times, Steve will be your biggest supporters.

Note that the country code for France is +33. You do not need to dial the initial 0 when dialing from the US.

Medical Studies in France

In France, medical school starts immediately after high school and consists of six years of study, divided into two cycles: *Premier cycle des études médicales* (PCEM) and *deuxième cycle des études médicales* (DCEM). PCEM1 is the first year of studies, in which students are overtly "weeded out"—only those who pass the *concours*, or exam, at the end of the year, proceed to the next year. (In 2008-2009, 2139 students were enrolled in PCEM1 and 418 in PCEM2.) PCEM2 and DCEM1 are analogous to the first two years of medical school in the United States. DCEM 2 through 4 are the clinical years, known as the *externat*; students are *externes*. They are followed by another exam, the results of which are solely responsible for residency placement. Three to five years of residency, called the *internat* (all residents are "*internes*"), complete the training of a doctor.



The Role of the *Externe*

At first glance, the role of *externe* seems comparable to that of the clinical medical student in the United States. Students arrive at the hospital between 7:30 and 8:30, depending on the service. They are responsible for the care of two to four patients on inpatient units. They work closely with a team comprised of other students, residents, and attending physicians and present their patients while making walking rounds (*"la visite"*) with the attending. Additionally, students attend classes, grand rounds, and department meetings. Call nights are divided among *externes* independently of teams, so that they range in frequency from once a week to twice a month depending on the number of *externes* on the service.

The French *externe* is a jack-of-all-trades. While responsibilities can involve hunting down x-ray films and telephoning laboratories for results, externes also perform minor procedures and tests (e.g.: ECGs, PPD placement, salivary gland biopsies). They are responsible for some administrative tasks such as writing prescriptions, discharge summaries, and correspondence to other physicians. Despite the increased responsibilities, the French *externe*, unlike the American one, wears street clothing under his or her white coat.

Externes' clinical duties end at around 1:00 pm, at which point they grab a bite before heading to class from 2:00 to 5:00 pm. Courses cover all the topics for that particular *pôle*, or quarter, regardless of the rotation. For example, a student on a pediatrics rotation would attend classes on pediatrics and hematology, since those are the topics included and tested in that *pôle*.

The Clerkships

French clerkships last three months, during which time students rotate through various services within a discipline. On the first day, all of the *externes* will be expected to create and submit a master schedule, denoting which student will be on which service and when they will rotate. You will also choose your call nights and report your vacation days (students are entitled to one week off per three-month block). Therefore, the first day of any rotation consists of a brief orientation followed by hours of negotiations among the *externes* on the rotation. Be assertive.

Internal Medicine

I started out on this rotation, in July. This is significant for two reasons. First, my French was shaky at best and, second, July coincides with many Parisians' summer vacations. The sacrosanct European summer vacation leads to mass migrations out of the city by Parisians and an impressive influx of tourists. In the hospitals, junior faculty and residents suddenly find themselves responsible for entire units.

For students, summer means less oversight and somewhat more responsibility in the hospital with no afternoon lectures or end-of-rotation written exams. (The oral examination remains.)
On my internal medicine service, there were about fifteen students at any given time (students took their one-week vacations at staggered points), divided into teams of about four. There were at least one or two foreign exchange students per team and one *super-interne*, the equivalent of UT Southwestern's sub-I. The six-week *super-externe* stint is the last rotation of medical school; residencies start in the fall in France.

As *externes*, we were responsible for the full history and physical for all new patients and for their daily care. Routine exams such as EKGs and PPDs were performed by the *externes*, as were skin or salivary gland biopsies. Along with patient care, the externes spent a significant amount of time walking to radiology to collect films and calling various labs for exam results. Although eventually posted electronically, important exam results could only be acquired quickly by calling. Xrays were not digital. There were two attending, one for the infectious disease cases, and one for the others. They made rounds on Tuesday and Friday mornings. Although in theory *externes* were responsible for presenting patients, on my team only the super-externe presented, and the French externe, Italian visiting student, and I merely tagged along, mainly because of language difficulties.

Because patients at Cochin were admitted directly to specialty services (i.e.: cardiology, pulmonology, etc.), patients were admitted to general medicine teams either for infectious diseases or for the immunologic conditions for which Cochin is the regional referral hospital. Wegener's, Churg-Strauss, Waldenstom's macroglobulinemia, and even more unusual conditions were frequent at Cochin.
The thirteen weeks were divided between two services.

Although most of the units were inpatient units, I spent the second half of the rotation in the "day hospital," the *hospital du jour*. As its name implies, the day hospital was a day-long course of therapy or diagnostic exams designed to tackle, in six to eight hours, what might otherwise take the length of a short hospitalization.

Most patients already had either a diagnosis and treatment plan or a short list of differential diagnoses to work up during the day hospital visit. While potentially less intriguing to a student seeking to do the full workup himself, the day hospital offers an opportunity to see the long-term management of the immunologic conditions that Cochin is known to treat.

Obstetrics and Gynecology

I participated in one of two possible obstetrics and gynecology rotations at Cochin-affiliated hospitals. Mine was at La maternité de Port Royal, which was originally housed in the former Abbey of Port Royal, a beautiful cloister that now houses the laundry facility and some offices. The maternity sees 5400 deliveries per year.

The three-month clerkship consisted of four weeks each in the postpartum and antepartum units and one week each in clinics, antenatal/genetics clinic, gynecology ER, and the OR. *Externes* took call five times throughout the rotation.

Deliveries were done either by midwives or midwivery students, with *internes* attending forceps-assisted or complicated deliveries. Medical students were invited to attend on their call nights, when not working in the gynecology ER or following up on hospitalized patients.

The day began with morning report, during which midwives presented the deliveries, *internes* the surgeries, and *externes* the antepartum admissions. Complicated cases were discussed, with the department head offering the final word on any debates.

Students in antepartum wards and clinics were expected to attend a weekly hour-and-a-half conference at which all cases were presented and discussed. All students attended a weekly noon lecture on a research topic.

Protocol and drug options differ somewhat between the United States and France, but, from a student perspective, the largest difference between the two countries might be the expanded role of midwives in France. Midwives were responsible for the postpartum and, along with an upper-level resident and attending, antepartum units. They worked in antenatal clinic, and, as in the US, delivered infants.

Evaluations

Students are evaluated based on performance during the rotation (attendance, interpersonal skills, participation, learning objectives, and knowledge, all weighted equally) and also on an oral exam. The nature of that exam varies depending on the rotation, so that it may be a patient presentation before a

roomful of physicians and other *externes*; a patient interview and workup before a physician; or a free-for-all question and answer session. Finally, along with all of the other students in that *pôle*, students must take written examinations.

The written examinations can be challenging; all written exams in France are in essay format. Questions are in clinical case format and graded based on the use of key words. Unlike some of your Erasmus (European Region Action Scheme for the Mobility of University Students, a European student exchange program) counterparts, you will be required to take these examinations. Consider it a part of the cultural experience.

Benefits of these Rotations

Clerkships in Paris are a great way to see the inner workings of very different health care system from our own. You will have an opportunity to improve your French, reinforce your medical knowledge, and immerse yourself in a different culture.

Suggestions for Future IMEP Participants

Brush up on your French before arriving. You'll gain the most from this rotation if you can minimize the language barrier. Although third-year is busy, a lot can be gained by just spending a few minutes each day listening or watching the news in French; spoken French (speaking and also understanding) will be the key to your success. Consider taking a conversational French course. At the same time, avoid worrying about the French placement exam that is required for acceptance to this exchange program. It is a formality, and you may as well get it out of the way early.

Make every effort to speak French and to observe social niceties. This is not just for your own benefit; those around you will react much more kindly to you if you attempt to speak in their language. This applies to street vendors as much as to patients. Always say bonjour and au revoir. To everyone, always. (And note that "excuse me" is not the same as "hello," and "thanks" is not the same as "goodbye.") You may know this or even think that you do it, but the French probably follow this implicit rule more than you do. Greet—and say goodbye to—people on elevators and sales associates in stores and, of course, anyone you know.

Participate as much as possible. Your learning, obviously, depends on your degree of engagement during the rotation. Moreover, you'll distinguish yourself from some European exchange students, who may take their academic roles more lightly. Call nights are a particularly unique opportunity to see more of French healthcare, since call night duties tend to differ from daily ones. Taking call a handful of times over the course of three months is minimal compared to our call schedules at UT Southwestern.

Practical Information

Where to Live

You will need to start thinking about housing well in advance of your departure.

IMEP participants are offered affordable housing at the highly desirable and highly selective Cité Universitaire (Cité U), a park-like campus with forty international "houses" or dorms. The Cité U is in the fourteenth arrondissement, at the southern edge of the city. It is conveniently located on the RER B line, and is a ten-minute train ride or twenty-minute stroll from Cochin hospital. The College Franco-

Britannique houses students from the Universities Paris Descartes, Panthéon Sorbonne, and Paris Diderot. The rooms are furnished, with the option of a private bathroom. Kitchens are communal. If living at la Cité, avoid the trap of resorting to a more comfortable language when you go home; English, and not French, tends to be the common language. More information and the application form (which should be submitted promptly) are at www.ciup.fr.

Finding alternative housing in Paris is difficult and expensive but can be done.

The program directors can orient you in your search for the perfect home away from home.

What to Wear
French medical students wear (conservative) street clothes underneath their white coats. Leave business casual in Dallas.

Outside of the hospital, anything goes. You're in a big city where, seemingly, everyone has style.

What to Take with You
For the hospital: stethoscope, reflex hammer, penlight. No need to take a white coat or scrubs; they'll loan you the necessary items. Do take your favorite study guide, although I recommend transitioning to French materials as soon as you can.

Anything that you forget can be obtained or replaced with a comparable product. Do remember that the cost of living is much higher in Paris than in Dallas. Also beware of pickpockets and purse-snatchers; they're sad realities in any urban setting.

Health Generalities
Most US healthcare plans will not cover you outside of the US—or will add outrageous fees for that option.

As a student, you will have French health insurance starting from the day you enroll. Therefore, you should make every effort to complete the enrollment process as soon as you arrive; consult with the program coordinator to see what can be done to expedite the enrollment process before arriving in France. Note that student insurance is only available to those less than twenty-eight years of age. Alternatives exist; please contact the program directors for more information.

Bear in mind that your French health insurance will not cover you outside of France. UT Southwestern requires that you obtain emergency medical/evacuation insurance through International SOS (www.internationalsos.com) or a comparable provider and you might want to consider acquiring other, non-emergency health insurance depending on your travel needs.

Money, Money, Money

Costs

Approximate cost of French enrollment and insurance (one-time expenditure): 5€

Estimated monthly costs (recurring)

- Approximate monthly cost of living (housing at Cité U): 600€
- Navigo (monthly public transportation pass): 60€
- Cell phone (variable): 15-35€
- Food: 200€ and up

Through IMEP, reasonably priced housing has been negotiated at la Cité Universitaire. For those renting on their own, 500€ can get you a pocket-sized apartment in Paris.

For meals, you may find yourself eating at or around the hospital and drinking a lot of coffee. You can find sandwiches, crepes, or pastries for around or under 5€. The student cafeteria offers a nearly-palatable three-course meal for 3€. A cup of coffee at a restaurant or cafe's bar will cost you about 1€, but the price will go up at an actual table.

Buying books is optional: the student library has a wealth of study guides and even French-English pocket dictionaries that can be borrowed for two weeks at a time—and then returned and checked out again. Note that the penalty for late returns is suspension of borrowing privileges and not a fine.

Banking

A French bank account will decrease transaction fees and increase ease of purchasing, as domestic credit cards do not exist in France and foreign credit cards are charged fees per use. Some credit card machines, in particular those at train stations, only accept European-style cards with a central magnetic chip, or *plus*. You will also need a French bank account if you purchase a cell phone plan or Navigo public transportation pass or if you plan to use Velib, the bike-share system.

French banks charge a nominal monthly free for the use of a *carte bleu*, or ATM card. Although free, checks must be requested. Additionally, some banks have monthly limits on ATM withdrawals and *carte bleue* purchases. Inform yourself to avoid being caught off guard.

LCL and BNP Paribas are two large banking companies that can accommodate foreigners and have reasonable monthly fees.

You should devise a plan for transferring funds before leaving the United States.

Funding

Some small grants are available through various academic departments at UT Southwestern. Contact Dr. Mihalic for more information.

Loans

Since IMEP students will have dual enrollment at UTSW and at Paris Descartes, loans will be unaffected for the entirety of the program. Bear in mind that loans are adjusted to the cost of living in Dallas. Consult your financial aid officer ahead of time if this seems like it may become a problem.

Transportation

Getting around Paris is straightforward. Although the city is large, the Metro, RER (regional train) and bus networks are equally expansive. Paris's bike-share program (Velib), which is affordable and ubiquitous, is an excellent option.

Consider obtaining a Navigo pass for unlimited access to the Metro, RER, buses, and Velib.

As in most major cities, taxis abound. And, of course, you'll best appreciate the city's many nooks and architectural gems on foot.

Travel

Travel throughout France and Europe is easy by train or plane. Bear in mind that, with the exception of your one week off per block, you will only have weekends with which to travel. Make reservations well in advance, as trains fill up and ticket prices rise as the date of travel approaches.

Also remember that late autumn and winter can be cold, overcast, and gloomy, making for less than ideal sight-seeing.

Conclusion

This exchange will introduce you to an entirely different way to practice medicine. As with any pass/fail clinical experience you will gain as much as you bring.