Community-oriented Care

Aimee Ostick, MD

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I started residency with a set of interests, all of which have changed, except my love for people. That interest evolved over the last 3 years during my residency. At the end of my intern year, I felt what I loved about family medicine had been significantly drowned out by sleepless call nights and the demands of off-service rotations. I wanted to reconnect with people and start to develop and understand what my role was to be in family medicine.

I had already taken an interest in our resident-run refugee clinic that we had in our department. I sat down with one of my faculty mentors, and we discussed how difficult it was to have conversations about women's health with our Iraqi refugee female patients, especially in the presence of their families and husbands. We talked about starting an education group class targeted to this population. Iraqi refugee women come to the country significantly under-screened and uninformed. Many have never had a Pap smear or mammogram, and a similar number don't understand what they are. In our refugee clinic we found significant difficulty in discussing these sensitive issues with the women. I remember talking to one of the patients with her husband, and when we broached the subject of women's health, she became quiet and withdrawn. I asked her husband if he would mind leaving the exam room, and he was immediately offended and refused. In any other situation with another patient of a different background, maybe this would have set off an alarm. But, that was a normal dynamic in their culture and in their immediate life. I knew right away, we had to take a unique approach.

I decided to start a group education class with these women in their homes. At first, we started with benign issues like nutrition and cardiovascular health. At the end of the first session we passed around ripped pieces of paper for them to anonymously write down topic requests for the next meeting. Reading those little pieces of paper was like lifting off tiny layers and peering into their private lives, which were no doubt filled with questions and concerns. They wanted to know about vaginal discharge, how to detect breast cancer, sexually transmitted infections, what menopause feels like, and how to avoid becoming pregnant. I think an immediate and immense sense of trust was gained after that first session. I was nervous about offending any of the women by discussing private issues in a public setting. I wanted to let them tell me what they needed and how I could give it to them. We had struck a cord, and we only were able to do so because we met them where they were—in their own homes. As a result, the sense of comfort they felt and ease of discussion that flowed was extraordinary. After our discussion, we would all indulge in the food to which we all contributed and talk about their children, families, and their experiences coming here to America.

The momentum for the group was quite strong. Word spread fast, and women were bringing other family members and friends that were not even patients in our practice. This group soon started to define my last 2 years of residency. Many of the women and their families became patients in my continuity clinic. Some of them were referred to me from the refugee clinic, because of my particular interest in women's health. Most were from Iraq, as they represented a large part of our refugee clinic. I also saw patients from eastern areas of Africa that suffered from generations of conflict. One, in particular, I will never forget. She came to me in crisis, not able to return home to her husband or three little boys. They came from war-torn Sudan as refugees via Egypt. She was a victim of rape as a refugee in Egypt and was now suffering at the hands of her own husband in a country that had promised to protect her. A common thread with my

From the Department of Family and Community Medicine, Thomas Jefferson University.

Iraqi patients was a conservative Muslim background, and this made the topic of domestic abuse a particularly delicate conversation. I realized I had to explain some basic human rights that we often take for granted in our country. We saw each other every week for counseling and eventually prenatal care for her fourth child but first daughter. She named her "Manar," meaning "light," with a middle name of "Packer" after my maiden name. This experience made me realize how much education is needed in this community about domestic violence. Our next group meeting revolved around this issue.

These women have touched me and made me reflect more on my life and career than I think they realize. My love for people and my place in family medicine started to take shape into the form of community medicine. I realized that we had taken "difficult" patients with complex psychosocial and cultural issues and found out what made them tick. This is a private, closed off community, and expecting them to indulge in sensitive topics during a 15-minute office visit is impractical. As a result, we can miss things. Meeting them in their homes and becoming a familiar face as their primary physician broke down walls. I think an important trend in health care is making large changes in a small community through cultural relevance. Understanding our immediate community is becoming a necessary component to controlling cost and chronic disease. Through this connectedness we can deliver effective, relevant health care. Because of my experience with the refugee clinic and women's group, I've decided to do a fellowship in community medicine. I hope this will increase my understanding of the communities I serve for years to come.

CORRESPONDENCE: Address correspondence to Dr Ostick, Kaiser Permanente, Department of Family Medicine, 5601 Desoto Avenue, Woodland Hills, CA 91367. aimeeostick@gmail.com.