Guyana Global Health Elective

Post-experience report

I was scheduled to complete an elective in global health in Guyana. I left for Guyana as planned, but on Day 6 contacted Queen's with several concerns about the experience, made the decision to leave with Queen's support on Day 9 and returned to Canada on Day 11.

In this report I will provide further details about the elective as planned and the issues that arose, reflect on the experience, and consider what may be done in future to help ensure a more positive experience in global health for myself and other residents.

Background

I found out about this elective opportunity through an email sent to Queen's family medicine residents by a faculty member of the Department of Family Medicine. I contacted the preceptor, Dr. A, later that day to express my interest in learning more about the experience. Over the next several months leading up to the departure date, I had meetings/email contact/phone discussions with Dr. A, Queen's, and Ms. B – a nurse and representative from the organization responsible for coordinating the trip. I completed the predeparture requirements for Queen's.

The final group departing for Guyana included myself, Dr. A, Mr. C (role of Executive Director - from the organization and is Guyanese but lives in Canada), four nurses, one medical administrative assistant (also originally from Guyana), and one teacher who previously had worked in a hospital. A nurse in a leadership position in Guyana also joined the group upon arrival in Georgetown.

Prior to departure, my understanding of the elective was that we were going to Guyana to conduct rural clinics under the Guyanese Ministry of Health. These clinics were to be held in remote villages in which the sole health care provider was a

Community Health Worker with approximately three months of training. We were to fly into and out of the capital, Georgetown, but would travel to and be based out of three locations: Lethem, Berbice River, and Linden. From each of those "home bases" we would travel to a different remote village each day to conduct clinics. There were a few clinics scheduled in the towns in which we were staying as well.

The experience would be coordinated and run by a Canadian Christian organization. This organization has been conducting similar trips to Guyana and Zambia every year for approximately the past fifteen years.

Personally, I have some prior global health experience and significant prior travel experience. As a medical student, I volunteered in global health in South East Asia. During medical school/residency I completed rotations in remote Northern Canada and internationally. I have travelled to approximately thirty countries, both developed and developing, and for the majority of these trips I have travelled solo, completely independently.

Timeline

Day 1 – group meets at airport in Toronto, overnight flight to Georgetown

Day 2 – arrival in Georgetown

Day 3 – land travel from Georgetown to Lethem

Day 4 – Lethem – church, meeting with local doctor

Day 5 – remote clinic

Day 6 – Lethem – prenatal clinic, group excursion to Brazil. Email to Queen's

Day 7 – group - remote clinic. I stay in Lethem (ill)

Day 8 – group - remote clinic. I stay in Lethem (ill). Second email to Queen's

Day 9 – remote clinics. Decision to leave

Day 10 – group - leaves Lethem by road. I fly from Lethem to Georgetown

Day 11 – flight from Georgetown to Toronto

Issues

1. Border crossings and luggage

The group met at the airport in Toronto. We were given a suitcase of medications to take as our second piece of luggage. If asked, we were to state that we had not packed the bag but that the group leader, Dr. A, had. Dr. A was to keep a list of the medications. The above had all been discussed prior to departure.

At the airport, we were given a label for the suitcase and asked to put not only our name but also our home address on it (rather than that of the organization or our destination in Georgetown). This was unexpected – the teacher in the group questioned the utility of this and was told by Ms. B that "this is the way that it has always been done" and furthermore something to the effect of that the teacher should stop arguing or it was going to be a difficult few weeks.

In the check-in line I was asked by Dr. A to carry his blood pressure cuff for him in my personal luggage. I felt uncomfortable by this request, but felt that I was unable

to decline as I had already agreed to carry an entire suitcase that was not mine. I opened the blood pressure cuff to see what it was and then added it to the extra medication suitcase that I was carrying.

Immediately prior to landing in Georgetown we filled in the customs/immigration forms for Guyana. I had had prior discussions with Dr. A about the process of entering the country and was aware that we would be indicating we were in the country on vacation. I was not entirely happy about this, but from discussions with others (e.g. residents) it appears that it is fairly ubiquitous in global health/other training experiences. I was not, however, prepared to be asked to indicate "no" to the question regarding whether I was bringing "pharmaceuticals" into the country. I challenged this, and was told by Dr. A that we were not trying to be dishonest, that the Ministry of Health knew that we were in the country and knew that were bringing medications into the country. I was told that the group had the necessary documentation from the Ministry of Health, that this was the way that this was always done, and that what customs meant by the question was illicit drugs. I felt very uncomfortable with this situation and considered refusing and getting on the next plane back to Canada. However, I thought that I might be overreacting – I was tired following the overnight flight, and did not know whether this, too, may be common practice.

On Day 6, the group was in Lethem. There was no clinic that afternoon, and so an excursion was planned for the group to go across the border to Brazil. I asked Mr. C whether there were any visa requirements to go to Brazil. He said no. I inquired further, and he stated that we should not bring our passports, because if we brought our passports we would need a visa that we would have had to have obtained in Georgetown. I declined to go on this excursion.

On Day 10, preparations were being made for me to leave the group the next morning. The first step in the plan was for me to take a plane from Lethem to

Georgetown. Everything was organized for this when late in the evening I was informed by Dr. A that I would not be able to bring my large piece of personal luggage on the small plane. I said that the plane was not going to be an option then, and we would have to figure out alternate travel arrangements. He replied that not being able to bring the luggage on the plane was not a problem, and that one of the others would just bring my bag and belongings back to Canada when the rest of the group returned. I declined this option, stating that I was not going to ask one of the others to take responsibility for my luggage when crossing a border. He replied with a raised voice, "You are OBSESSED with the baggage!" I was aware that neither Dr. A nor Mr. C would be travelling back to Canada with the rest of the group, so it would have been one of the other group members being volunteered by Dr. A to take responsibility for my luggage. Following this conversation, it was determined that the large bag would in fact be able to travel with me on the small plane and that is what occurred.

2. Relationship with local practitioners

The group was in Guyana under the Ministry of Health; however, upon arrival in Lethem it seemed that there was not an ideal relationship between the group members and the local practitioners in Lethem. The group requested a meeting with the local doctor at the hospital in Lethem. The entire group attended the meeting, but the conversation was dominated by Mr. C, Dr. A, and the local physician. During the conversation, group members told the local doctor that he had a very nice [hospital] building, but that the medical training of the physicians in Guyana was inadequate and that the quality of care the local physicians were providing was inadequate. The local doctor told the group that he felt that the group was not needed in the Lethem region. He requested that the only referrals to the physicians in Lethem from the group be for those patients who may need surgery. He then took the group on a tour of the hospital. The tour included the operating rooms – the local doctor stated that Guyanese surgeons

from Georgetown visited Lethem to perform surgery, and that the majority of the postoperative care was done by the local physicians. Dr. A stated to the doctor that this care would not be appropriate in Canada and that this was not up to the Canadian standard. Following this meeting, another group member approached me and asked if I, as a doctor, was comfortable with what had been said to the local doctor. I indicated that I was not.

On Day 6, we had been scheduled to hold a clinic at a remote village. Plans changed at the last minute due to vehicle difficulties (see below). I was asked to observe a talk by Dr. A on prenatal care. It is my understanding that this talk was given to the women who happened to be in the antenatal clinic waiting room at that time. Certainly the Medex (nurse practitioner equivalent) who was running the clinic was not aware that this talk would be given during scheduled clinic time, and the talk delayed her clinic. During this talk, Dr. A indicated to the patients that they may not be receiving adequate care, and that he would "check" their charts to ensure that they were. Following the talk I was brought into the clinic room by Dr. A and, in front of the Medex and patient, was asked to observe the clinic encounters, check the charts, and correct anything not up to standard. I felt extremely uncomfortable about this, indicated to the Medex shortly thereafter that I just wanted to learn how prenatal care was provided in Guyana, and left the room as soon as I could.

3. Supervision

Prior to departure, my understanding of the elective was that we would be conducting family medicine clinics. I had several conversations with Dr. A regarding common chief complaints and common illnesses seen by the group in Guyana. I received written documents of common medical conditions and some examples of medications that we would have available. These discussions/documents all included both adult and paediatric conditions, and I prepared for the clinical aspect of the

elective accordingly. At the airport in Toronto, Dr. A stated that during the clinics I would be seeing all the paediatric patients, and he would see the adult patients. Once in Guyana, he indicated to me that he was not comfortable seeing paediatric patients. I was aware prior to departure that Dr. A's medical background is in a specialty that is not family medicine; however, it did not occur to me to question his comfort in managing the patient population that we would be seeing, or in supervising a resident in a family medicine setting. During clinics he did answer any questions I had, and did bring me in to see his patients if there was an interesting physical finding or diagnosis.

On Day 6, in front of the whole group, Mr. C stated that plans had changed for the clinic on Day 8. The new plan was for Dr. A to stay in Lethem to give a talk, and for the rest of us to go to a remote village to conduct a clinic. This would have left me as the sole MD at the clinic, completely unsupervised and with no access to backup. I stated that I was a resident, and I would not go to the clinic without supervision. Dr. A stated that it would be fine, that we would ask a local physician to go with me to supervise. I stated that Queen's had approved this rotation based on Dr. A being my supervisor, and stated that I would not go to clinic if he was not going. Following this exchange, several members of the group approached me and commended me in refusing to conduct a clinic unsupervised. Later, Dr. A apologized for this, and stated that he would not wish for me to pick up bad habits from the local physicians.

4. Ground travel

Prior to departure I had a discussion with Dr. A about the vehicles we would be using for ground transportation. I was assured that we would be taking safe four-wheel drive vehicles that were privately chartered for the group. I knew that we had two 13 hour trips driving to and from Lethem, and I knew that the remote villages where we would be conducting clinics would be approximately one hour each way from where we were staying. I was prepared for the road conditions to be challenging.

We found out upon arrival in Guyana that we would be leaving from Georgetown to go to Lethem at 3am. We were told this was to ensure that we arrived in Lethem before dark. There were three vehicles: two four-wheel drives and a minibus. The road conditions were admittedly quite an adventure at first – unpaved roads, potholes that were several feet deep, fishtailing across the road to avoid the potholes, and backing down a muddy embankment with limited visibility onto a ferry. We passed a bus by the side of the road on the edge of the rainforest that had broken down – the passengers had been there all night without water. One of the drivers remarked that that was what the public transportation did: drive through the night through the rainforest, and that this was an example of why we were not doing so. We also passed a truck that had overturned by the side of the road. One of the group's four-wheel drive vehicles began to have difficulty within a few hours of leaving Georgetown. The brakes continually seized up, and blue foul-smelling smoke repeatedly came out of the exhaust. We started to make frequent stops of increasingly long duration, and it became evident that we were not going to reach Lethem by nightfall. It was not an option to leave the one vehicle and return for it in the morning, as we were told that it would be stripped for parts over the course of the night. In the end, the vehicle that I was in (minibus) left the convoy to travel solo after dark for the final 1-2 hours ahead of the two four-wheel drives. This trip took 17 hours in total.

I am not aware that there was any method of communication between the vehicles or between the vehicles and either Georgetown or Lethem. At least three Guyanese group members had cell phones, but cell phone service appeared to be available only once we were within minutes of Lethem.

The broken vehicle received some repairs the next day (a new filter). On the morning of the first clinic day, the vehicle had difficulty starting. Despite this, once it did start, the group set off in the two four-wheel drives. There were not enough seats in just the two vehicles, and so I, as one of the smallest group members, shared the front

passenger seat. There was only one seatbelt in the two vehicles that I am aware of, and this was in Dr. A's seat. The small roads to the remote villages were little more than wheel ruts, including steep hills that ended in deep potholes that were not visible from the hills. We nearly ran off the road on several occasions. We left the clinic early that day so that we would not be travelling back to Lethem on those particularly difficult roads after dark. Again, there were frequent stops due to the one vehicle having difficulties. At one point, again after nightfall, on the main road, a large part of the bottom of the vehicle fell off. It was reattached – using a luggage strap or something similar. Total travel time that day was at least four hours, double what was expected.

The next day, the vehicle was again taken in for servicing. I did not attend clinics on the following two days because of illness, but I was told that there were only a few stops due to vehicle difficulties.

The second long trip (13 hours) from Lethem to Berbice River was planned for Day 10. The same two four-wheel drive vehicles and one minibus would provide the transportation. The group was informed 1-2 days in advance that this trip would commence at 1am. The plan was to drive through the savannah and the rainforest at night, with the plan of reaching Berbice River before dark. Apparently it was unsafe to travel in the Berbice River region after dark due to narrow roads. I was confused given that the rationale for previously leaving Georgetown so early was to travel in the rainforest and savannah during the day and arrive in Lethem before dark, but that now it was acceptable to drive through the same road in the dark. I inquired about this, and it was reiterated that it was fine, and important to reach Berbice River before dark. I was concerned by this, and also concerned about how rested the drivers would be – two of the three drivers had a long day planned on Day 9 driving the group to and from remote villages for clinic, and would only have a few hours of rest before embarking on the 13 hour trip early on Day 10.

5. Religion

The organization for this experience is a Christian organization, and I had numerous conversations with Dr. A and Ms. B prior to departure about the role that religion would play in this experience. I made it clear from the beginning that although I am Christian, I am not actively religious. It was my understanding that religion would be a minor aspect of the trip: we had the opportunity to attend church if we wished, and grace would be said at mealtimes. As well, Mr. C would give a devotional to the patients who were waiting for the clinics to begin as the rest of the group members set up. Prior to departure, I was not sure how I felt about the religious affiliation of the organization. I spoke with other, similarly non-religious, residents who had had global health experiences with other Christian organizations. Their experience was positive. I decided that I would use this aspect of the trip to "test the waters" to help me determine whether I would consider future global health experiences with a religious organization. I thought that at the least it would be interesting to see how traditions in church were different in Guyana compared to Canada.

Religion was more prevalent in the experience than I had anticipated. At church in Lethem, we were asked to introduce ourselves and our medical role. I did so, but was not comfortable with it. I felt it implied that religion somehow was a motivating factor for my coming to Guyana to help provide medical care, which certainly was not the case. The group was asked to sing in front of the congregation and I declined to participate. Mr. C gave the sermon to the congregation that day, and also on at least two other evenings that week in Lethem. At each mealtime, grace was said. In addition, at breakfast Mr. C also gave a small sermon. There were a variety of topics, but one day the sermon discussed how God would find even non-believers. Given that I had been forthcoming about my lack of active religiousness, I felt quite offended by this talk.

I do not know whether a devotional was given to the patients as they waited for the clinics – I was busy setting up. The patients were asked about religion at clinic registration. I was told by another group member that patients seemed fearful when asked this question, as if an "incorrect" answer would render them ineligible for medical care.

6. The clinics

I had been interested to see how the family medicine clinics would run, and to learn how they were effective given the scarce resources and lack of ability for continuity of care. Once in Guyana, I began to have the opinion that the clinics were often undermining the Guyanese health care system, and in some cases there was the potential for harm for the patients.

It is my understanding that the medications that the group brought were mainly donations or purchased by the organization at a vastly discounted price from drug companies. I was told by another group member that Dr. A also purchases some medications out of pocket – in particular antibiotics that were requested by the Guyanese Ministry of Health at the last minute. Some of the medications had potential utility, such as antibiotics, anti-worm medication, vitamins, and acetaminophen/ibuprofen. Many medications were difficult to use without continuity of care/follow up, such as seven day packages of medications for hypertension (Coversyl), diabetes, depression, or asthma. The medications in the suitcases did not match the list that accompanied the baggage (see above regarding border crossings).

I was told by a group member that there have been instances where patients have received a medication from the Canadian physicians (e.g. Tylenol), and when they are given the same medication from the local physicians (e.g. acetaminophen) they will not take it because it does not look the same and it is perceived as not being as good.

The clinics were run in the community health posts of remote villages. I saw all the paediatric patients, and at times adult patients (parents of the children, or if there were no children to see). The patient acuity was quite low: the children mainly appeared to have mild upper respiratory tract infections, and were given acetaminophen/ibuprofen and seven days worth of vitamins. Anti-worm medication was also frequently given. A few children received antibiotics if a bacterial infection was suspected. The adults generally presented with mild upper respiratory tract infections, musculoskeletal pain, or chronic symptoms such as abdominal pain x 6 years, or fatigue x 3 years. Occasionally patients came in for medication refills, or occasionally for a second opinion – those who had seen a Guyanese/Brazilian specialist but the condition had not resolved. A few patients were referred to Lethem. Reasons for this included consideration for surgery/procedure as requested by the local physician (e.g. cleft lip and palate, lesion removal), work-up (e.g. for fatigue, abdominal pain), or continuity of care (e.g. refills of diabetes medications). A referral letter was written on lined paper/on a patient registration card and given to the patient to bring to Lethem. It was unclear how patients would obtain the money/means for travel to Lethem. I was also told that there had been issues in the past with patients bringing these unofficial referral letters to the hospital and not being seen by the physician. I am not certain whether the general registration cards with the patient encounter documentation stayed with the local health care worker or whether they stayed with the organization.

During the clinics, the nurses in the group did public health presentations to children in the local schools on topics such as dental care, worms, and sexuality. These talks seemed very well received. On at least two occasions, the nurses brought a child (the youngest was age 5) out of school to be seen by a doctor, unaccompanied by a teacher or parent. The children seemed terrified, and I was uncomfortable assessing them. One nurse remarked on how different it was in Guyana, that it would never be

acceptable to take a child out of school in Canada. I did not reply, but I felt that it was not acceptable in that situation either.

On one occasion during dinner Mr. C commended the group on a good day's work at clinic that day, and stated that today, the patients we saw received "proper care."

Leaving Guyana

On Day 6, I attempted to discuss some of my concerns regarding the above issues with Dr. A, specifically with regards to the safety of the ground transportation and that the local practitioners did not appear to want the group running clinics in the region. Several other group members had approached me with various concerns, and so I also requested to Dr. A that we all have a group meeting to discuss some of these. Dr. A stated that the best recommendation he could give me was to "not get so worked up." I said that I thought there were some things that were worth getting worked up about. From other conversations, Dr. A was also aware of my concerns regarding not declaring pharmaceuticals at customs, and regarding conducting clinics without supervision.

Given this unproductive discussion, and given the other events of that day (asked to critique local practitioners, asked to run a clinic unsupervised, and asked to cross into Brazil without a passport/visa), as well as the other ongoing issues, I decided to contact Queen's that evening. Following email contact and discussion with Queen's, I made the decision on Day 9 to leave Guyana and return to Canada as soon as possible. I told Dr. A that I had spoken with him about some of my concerns on Day 6. I said that since then I had been in correspondence with Queen's, and that they felt it was in fact something to get worked up about. I said they thought I should come home to Canada and that I agreed.

Dr. A and Mr. C were very efficient and quite helpful in organizing my departure. Mr. C gave me cash to purchase my plane ticket from Lethem to

Georgetown, plus cash for any overweight luggage charges and for the airport tax in Georgetown. Since returning to Canada I have received a substantial partial refund from the organization for the portion of the trip for which I was not present. The Guyanese cash I had been given to assist in my departure was subtracted from this refund.

Mr. C indicated to the rest of the group, to the owners of the guesthouse, and to organization members in Georgetown and Toronto that I was leaving because I was sick. I had indeed been ill with GI symptoms on Day 7 and 8, but these had resolved by Day 9. At the morning grace on Day 9, a special prayer was said for me to not feel "dissatisfaction." In the evening grace, a special prayer was said for me to not feel "afraid." At the evening meal it was also disclosed to the group that I would be leaving. I was quite emotional that evening – between the huge decision to leave, the special prayers (regardless of what was said, it was quite touching to be named in special prayers), and the group singing happy birthday to me – I would be leaving the group the next morning, on my birthday.

Whenever it was brought up that I was leaving because of illness, I said I was feeling better, and that Queen's had other reasons for asking me to come home, but I did not insist that the true reasons for leaving were acknowledged. At that point, I just wanted to get home – many people involved with the organization were being very helpful in facilitating this, and I did not want to say anything to jeopardize it.

Reflection

I truly believe that all group members had good intentions, and that they were all involved with this trip in order to help improve the health of the people in Guyana. However, I did not agree with many aspects of the experience from a legal, safety, or ethical perspective, and I do not think it was an appropriate experience for a resident trainee.

Group members were told at a meeting a few months prior to departure that "teamwork and flexibility" were key attributes for each group member to have in order for the experience to be a success. I kept coming back to these words, both during and after the trip – I feel that my definition of these words is much different than the organization. To me, teamwork and flexibility means everybody working together to come up with the best way for something to be done, even if that is not what was originally planned. I think that to the organization, these words mean something to the effect of don't argue and do what is asked of you as a group, even if that is not what was originally planned.

Despite all the issues, the trip was certainly a learning experience for me – just not the learning that I had initially planned! There are many areas where I will be able to apply what I have learned to any future experiences in global health to minimize the risk of a further unsuccessful experience.

1. Independence

In this experience, nearly everything was arranged by the organization. This included everything from the clinics to accommodation and transportation to food and water. Initially I was excited about this – I was looking forward to not worrying about the logistics and focusing more on the global health aspects of the experience. During the trip this lack of control made me feel quite trapped. I felt powerless to modify aspects of the trip that I did not agree with (e.g. vehicle safety), and was worried about

how I would manage once I left the group if I received no support from the organization (e.g. for arranging transportation and accommodation en route back to Canada).

Queen's ensures that global health participants are registered in the ESP (Emergency Support Program), and that they have contact information for the Canadian High Commission in the country of their trip. It was somewhat comforting to have these resources, but I think in future I will take additional steps to maximize my ability to be self-sufficient in the event of an unexpected separation from the rest of a group. For example, I would consider bringing maps of the area, contact information for transportation options, and, if one exists, a guidebook that includes logistics planning (e.g. Lonely Planet). I would consider bringing an inexpensive cell phone and purchasing a local sim card for emergencies. Even something as basic as bringing water purification tablets will ensure that I am less reliant on others. I would suggest that Queen's make an addition to the predeparture training to ask residents to consider what they would do/what they would bring with them in the event of unexpectedly needing to manage on their own during a global health experience.

2. Global Health

This experience allowed me to learn more about "caravan medicine" in global health. I suppose that an advantage of this type of global health is that it is possible to see a large number of patients over a large geographic area over a relatively short period of time. However, following this experience I feel that the challenges and limitations of caravan medicine outweigh the benefits. In particular, I feel that the lack of continuity of care is a serious issue that impacts the effectiveness of assessments and treatment plans.

Given my concerns regarding caravan medicine, I do not believe that this is something that I will become involved with in the future. I think that I will instead

search out different types of global health experiences. One example could be becoming involved in international public health, such as disaster/epidemic response, or health teaching. I do think that the health teaching that was done by the nurse group members in Guyana was beneficial. Alternatively, I would consider becoming involved with a "niche" caravan – caravan medicine where only a specific service is provided that is not otherwise available in the local health care system, such as Pap smears or vision testing. Other potential options could include working in a locally established and run clinic, or transporting remote patients to a central location to receive health care.

During this experience I also began to appreciate the importance of the relationship between the global health care providers and the local practitioners. I had assumed that because the group was in Guyana under the Ministry of Health, that there would be a strong working relationship with the local physicians. I was dismayed to find that this was not the case during this experience. In the future, I will be certain to clarify the attitudes of any organization towards the local health care system, and how the global health goals fit into the local health care system, prior to departure.

I was, however, lucky to have the opportunity to observe the interactions between different local health care practitioners. One group member was a nurse with a leadership position in Guyana, and I accompanied her to the hospital in Lethem one afternoon. The local physician completely ignored me, but it was encouraging to observe all the different health care workers who wished to speak with this nurse. They told her about recent successes as well as their plans and ideas for how to improve health care in Guyana. This afternoon provided me with a different, and positive, perspective on health care in Guyana.

3. Religion

Prior to leaving for Guyana, I was uncertain how I would feel about the group's religious affiliation. I had hoped that the religious aspect of the experience would be minimal, and that religion would just be a common feature that enabled group members to come together to be involved in global health and patient care. During the experience, I found religion to be incredibly pervasive and at times offensive. Group members considered the experience to be a "mission," and considered themselves "missionaries." It appeared that, for many group members, religion was deeply entwined with their motivations for providing health care. Any religious beliefs that I have are not at all related to why I am learning to practice medicine. Again, I think that it is for this reason that I was uncomfortable with activities that suggested otherwise, such as introducing myself in church. As well, there seemed to be an assumption, with which I disagreed, that individual sacrifice and acceptance of difficulties (such as poor transportation) were necessary for the good of the mission and the team. Furthermore, the religious affiliation of the group impacted patients, who apparently became confused and apprehensive when asked their religion.

It was certainly a valuable learning experience to be involved with a religious organization in global health, but for all these reasons, I do not plan to pursue this again in the future. I would suggest that Queen's also consider in which instances it is acceptable for a global health experience to have a religious component.

4. Risk tolerance

The ethical scenarios in the Queen's predeparture planning for global health address a number of potential issues that could arise, such as whether you would choose to drive a motorcycle knowing the high risk of crashing, whether you would choose to cross a border without documentation, or whether you would choose to wear personal protective equipment if that was not the norm in that country. After

completing these scenarios prior to departure, I was aware that I have a low risk tolerance. The experience in Guyana not only reinforced this, but I also learned that several aspects of risk in global health and international travel are non-negotiable for me. For example, complete honesty during border crossings is very important to me – including customs declarations, appropriate visas, and carrying only personal luggage. Feeling personally safe is also important to me. I am aware that there is some element of personal risk during international travel, such as different road and transportation conditions than are present at home. However, it is important to me to be able to modify travel plans in the middle of a trip if a concern arises. Looking back, this is what I have done when I have organized my own travel logistics in the past. I believe that my lack of ability to have control over safety and logistics was a major factor in my discomfort with the ground travel during the experience in Guyana.

I am not certain how best to approach the issue of risk tolerance for future global health experiences. I tried to ask many of the appropriate questions regarding risk prior to departure, and in many cases there was a discrepancy between what I was told and what actually occurred. Sometimes this was an issue with lack of communication from the organization, but other issues, such as the faulty vehicles, perhaps could not be predicted in advance. Next time, I will absolutely ask further questions prior to departure regarding border crossings. I will not assume that others will share my viewpoints on this issue. I will also look into how major global health organizations manage border crossings and visas – even though it is ubiquitous to send health care workers into countries "on vacation," I find it difficult to believe that this would be the approach of organizations such as Doctors Without Borders or the Red Cross. I would suggest that Queen's determine whether it is acceptable for residents to enter a country "on vacation" for the purposes of global health.

5. Familiarity

This experience looked overall great on paper: an organization with fifteen years of experience with global health in Guyana, a well-respected supervisor with ties to Queen's, an elective suggested and endorsed by a faculty member at Queen's family medicine, and an experience with the approval of the Ministry of Health in Guyana. I knew that there would be some challenges, such as the religious affiliation, and the questionable ability for continuity of care in the rural clinics; however, looking back, I think that I was lulled by the ties with Queen's and the longevity of the organization's involvement with Guyana into thinking that potential drawbacks couldn't be so bad.

I would recommend that Queen's does not approve a future residency global health experience with this organization unless it can be demonstrated that significant modifications have been made. In the future, I will certainly be more objectively critical when evaluating an organization/potential experience in global health to help determine whether the potential experience is right for me and meets my goals for global health.

Conclusion

During my experience in Guyana I learned a great deal about myself and my approach to global health. I think the most important thing that I learned about myself is that I have the capability to stick up for myself and issues that I believe are important, and that I have the strength to go against popular opinion and remove myself from a situation that I do not feel is appropriate. With regards to global health, I feel better prepared to evaluate and plan global health experiences in the future. Following my presentation to other PGY-2 residents about my experience, I hope that they too will be able to incorporate these learning points into any future plans in global health. I will be providing a letter of constructive feedback to the organization at their request, and I

hope that they take my comments seriously to minimize the premature departure of a group member in the future.

Finally, I would like to thank the Department of Family Medicine at Queen's. There were several stressful days in Guyana as I attempted to work through the issues and make the decision to return home early. I am extremely grateful to the Department for their support and advice both during and after my experience in Guyana.