Pre-Medicine Internship Program

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Pole! Pangusa: What Kenya Taught Me About Medicine, Equity , and Human Connection

"Pole! Pangusa," I said gently to a woman as I poked her finger to obtain a blood sugar. Her daughter, scared for her mother, clung firmly to her leg. For a second, the woman paused, and her face lit up to which she instantly said, "you know Swahili!" Although my Swahili proficiency was far from fluent, I never would have expected a simple phrase to bring someone so much joy. As the steady stream of patients rotated through the vitals station at our remote community clinic, I realized just how easily a small gesture could build connection. This was a way for me to give back, even slightly, for the immense hospitality I'd received in just the few days that I had been in Kenya. From the moment I stepped out of Mombasa International Airport, I was greeted with a warmth and kindness that far exceeded my expectations. The mentors and interns at International Medical Aid made me feel instantly at home, setting the tone for an internship that would profoundly change me in every way possible. Before I had even set foot in a hospital, I met Kate, a previous intern packing up to leave after two life-changing months. As she tearfully recounted her experience, I felt an unexpected reassurance. I knew then that I was exactly where I was meant to be.

My love for medicine began in the third grade, when my dad experienced pituitary apoplexy, a rare hemorrhaging brain tumor. I remember the paramedics rushing into my parents' room and swiftly taking my dad away in an ambulance–bombarding him with rapid fire questions, sticking him with needles and electrodes. My mom's relentless advocacy eventually got him transferred to a different facility with more specialized resources and experience with this rare condition. My dad underwent two brain surgeries and has since made a near-full recovery. I remember being so confused and scared for my dad. I so badly wanted to understand what was going on, and my unceasing questions were continually met with answers that I couldn't quite comprehend. I spent years following his journey, going to appointments, and gaining exposure to different specialists.

Just a few years later I would find myself in that same ambulance, not as a patient or daughter, but as an emergency medical technician. Serving predominantly low-income communities has opened my eyes to the complexities that exist within medicine and how social determinants of health shape people's outcomes and experiences. Whether it's an elderly patient nearing the end of their life, a scared immigrant mother relying on her child to translate, or a war veteran dealing with PTSD, I have learned to meet each person with the same empathy and compassion I would give my own family. I see them not just as patients, but as whole individuals with layered histories, and with loved ones waiting anxiously in the lobby. These experiences have validated my desire to pursue medicine, give back to the community, and shown me that equitable medicine extends healing beyond the physical body to

restore hope to those society often overlooks. Most importantly, it allows me to connect with people in a unique way and to be a source of strength in their most vulnerable moments when they feel scared and confused. My exposure to healthcare in Kenya has uncovered to me new inequities that people commonly face, along with varying cultural understandings of health and healing.

Over the following weeks at Coast General Teaching and Referral Hospital (CGTRH), my understanding of medicine and humanity deepened in ways no textbook could teach. In the Adult and Children's A&E departments, the chaos was unrelenting. Sometimes, it felt as if I was aboard a sinking ship. On my first day, I felt helpless watching patients suffer, begging me to take their pain away. But day by day, I found ways to support both the staff and the patients. Some days that meant small acts of care with comforting families, collecting supplies for a blood specimen, or helping medical staff stay afloat with vitals and charting. Other days, that meant jumping in to do CPR or ventilations. What drew me to emergency medicine is the demand it places on critical thinking and adaptability. Often, you have no idea what situation you're walking into, and you must rely on your experience, intuition, and training to make rapid, high-stakes decisions. I love the mental challenge of assessing patients quickly, thinking on my feet, and finding creative solutions with limited resources. No two days are the same, and I'm constantly learning–whether it's about a rare condition, a new protocol, or a better way to connect with a patient in crisis. My time in Kenya reshaped how I view healthcare. I saw that great care doesn't come from high-tech equipment or pristine facilities, but from empathy, adaptability, and deep cultural understanding.

I also deeply respected and admired the dedication of the healthcare staff that spend more time in the hospital than with their loved ones at home. After speaking with a resident physician during one of my night shifts, I learned that it is a common occurrence to have paychecks delayed months and not be able to support yourself financially. Many physicians have to work at both private and public hospitals to stay afloat. Physicians and healthcare professionals in both Kenya and around the world are commonly driven to exhaustion and forced to uphold unrealistic standards. Their time with patients is so limited and they often spend more time charting than anything else. Aside from this, while the EMTALA, or Emergency Medical Treatment and Labor Act in America, ensures that patients receive necessary emergency medical care regardless if they can afford it, the financial burden of medical bills remains the leading cause of bankruptcy in America (Reichert 2014). This flawed system has a ripple effect on patient care, especially on marginalized groups and it is so often that patients fall through cracks (France 2013, Reichert 2014). Along with this, insurance plays a major role in care. While many people don't have insurance to begin with, other insurance plans frequently fail to cover crucial aspects of medical care. As a result of this, patients don't seek help until their problems are beyond the level of a primary care physician. This typically ends up in medical bills that are significantly more expensive

(Reichert 2014). This further hinders people from calling for help and often forces people to make sacrifices regarding their homes, food, or family in order to pay for necessary treatments or medications. If people are unwilling to make these sacrifices, they have no choice but to live in pain which has harmful long term effects on not only the physical body, but also mental health and self perception. Profit-centered healthcare is not healthcare, it's a business. Until that changes, people will continue to fall through the cracks.

In the New Born Unit (NBU), I discovered immense purpose caring for fragile new lives. My rotations in both the NBU and L&D unit exposed me to joy, loss, and the raw intensity of human experience. In both units, the team's resilience and reliance on each other, on faith, and on community revealed the strength behind their continued service, despite severe resource gaps. Along with this, their views on death and dying were much different from what I have been accustomed to at home. Instead of seeing death as a "medical failure," it is viewed in a more natural light. Oftentimes, the medical staff would turn to their religion for guidance. While the advanced technology that I am accustomed to at home definitely makes healthcare more efficient and effective in some cases, it is not a requirement for survival. Everyday, I witnessed creative, life-saving adaptations in resource-limited settings. I was stunned by the lack of continuous monitoring in Accident and Emergency and New Born Units, however, this uneasy feeling that I experienced made me question all the "extra" things that we do in the US. I found that tourniquets for starting an IV aren't absolutely necessary, rather, a tied glove will do the job just the same. I learned that alcohol wipes can just as easily be replaced with a little cotton and rubbing alcohol. I discovered that fancy intravenous drip machines can be replicated with simple, crafty techniques and the cure for malaria can be found on a tree in your back yard. Being immersed in a new healthcare system and way of life opened my eyes to the daily realities many patients face living here. But beyond the challenges, I witnessed resilience, strength, and an extraordinary sense of community. I'm truly grateful for everything I learned and for the people who shared their time, stories, and trust with me. I left Mombasa inspired by the kindness of strangers and the immense dedication of healthcare workers.

My experiences with medicine and emergency care in rural, low-income areas at home and abroad has revealed how deeply institutionalized harm and community dynamics shape patient experiences. While physicians are trained on how to manage medical problems, the root causes of a large majority of suffering often lie far outside the hospital, entrenched in systems that fail to provide consistent, accessible, and equitable care. Living in a rural community can be extremely stressful and isolating, leaving individuals and families worried about where their next meal or paycheck might come from. Feeling helpless in these circumstances forces people to forfeit their own health and wellbeing just to stay above water financially. Geography plays a critical part in healthcare, its accessibility, and quality

as a whole (Reichert 2014). With my experiences in healthcare, my eyes have been opened to the realities of low income populations living in rural areas. Firstly, I would like to point out the challenges of geography when it comes to emergency medical services. Serving rural areas means wide coverage areas and long commute times. Aside from the financial burdens of healthcare in low-income communities, rural areas pose an entirely different obstacle. If a patient is in critical condition in the United States, sometimes their only option is flying in a life flight helicopter to get them to a hospital faster than we could on land. While this is way more efficient, the cost of a medical helicopter flight is enough to put people underwater financially. Those who can't afford to pay these hefty medical bills will often have them sent to collections. When this happens, the collection agency will contact the patient regarding their missed payment and potentially file a lawsuit if they are unable to pay these bills. This will also negatively affect a person's credit score which will limit them even more in the future. This also impacts EMS agencies. When these bills are sent to collections, the EMS agency does not get compensated for their services. This shortfall directly impacts their budgets and finances, limiting their ability to retain and pay staff adequate wages, upgrade equipment, or expand coverage–further widening the care gap for rural populations. After speaking with an EMT during my first shift in the Accident and Emergency Department, I quickly realized that the infrastructure to support emergency medical services simply doesn't exist. Instead, people typically rely on family, friends, community, and natural healers to care for their health.

When patients fall between the gaps left by broken healthcare systems, they often look to their community for support. Although these struggles represent larger systemic failures, the work of communities is essential for not only survival, but for preventing future injustices before they start to begin with. In social activist Leah Lakshmi Piepzna-Samarasinha's book "Care Work: Dreaming Disability Justice," she describes a community-based care network that rewrites independence as interdependence. She states, "In the face of systems that want us dead, sick, and disabled people have been finding ways to care for ourselves and each other for a long time… Sometimes we call them care webs or collectives , sometimes we call them 'my friend that helps me out sometimes,' sometimes we don't call them anything at all–care webs are just life, just what you do" (Piepzna-Samarasinha 2018: 18-20). Our society has failed people, framed them as burdens, and forced them to take up as little space as possible. Leah also highlights how race, gender, class, and disability all play a role in shaping who gets care and its accessibility. These struggles expose the larger systemic failures of healthcare in the United States. The ability of these communities to come together and support one another just goes to show the power and importance of mutual aid. Mutual aid can take on many forms (Piepzna-Samarasinha 2018). In my dad's case, it was a simple act of my neighbors stepping up in a time of need that made the difference. Because of them, my mom was able to seek out better care for my father without the stress of finding childcare. After my dad's arrival back home, we didn't have to worry about

meals as my neighbors continued to show up and support my family. I see these small but meaningful gestures echo in my role as an EMT. No matter what situation I find myself in with a patient, I have learned to never come from a place of judgement, but a place of respect for their resilience. While a community can act to buffer institutional gaps and a source of dignity or care, it shouldn't be the only safety net. Humanizing medicine means recognizing that patient care includes their backgrounds and identities, not just symptoms or medical treatment. I believe that implementing the health humanities and concepts regarding the social determinants of health into medical education will not only help physicians' ability to better care for patients, but it will also help to address the root causes of their suffering.

In an article by emergency medical physician Helen Ouyang titled "Where Health Care Won't Go," Dr. Ouyang discusses rural health and the concept of "medical deserts." Specifically, she discusses a Tuberculosis outbreak in Marion, Alabama which is a mostly African American town in the southern "Black Belt" region of the United States (Ouyang 2019). Here, it is common for patient-physician relationships to be rooted in mistrust and abuse of medical authority. These healthcare shortages and inaccessibility in rural America are a result of the intersection between poverty and historical racial injustice. In these areas, there is also a lack of transportation services for residents to receive appropriate medical care which may be extremely far away. In an effort to improve access and quality of care in these areas, there are increasingly more incentives for physicians to practice in rural areas, bringing medicine closer to these residents. These complex social and economic issues that are present within marginalized communities have a direct impact on public health (Ouyang 2019). In Kenya, I noticed similar mistrust in healthcare, infectious disease, financial burdens, and an extreme lack of health literacy. We must approach these challenges from different angles to not only support the people in these communities, but also support the physicians while breaking down trust barriers for patients and making knowledge more accessible.

One of the greatest takeaways after reflecting on my time in Kenya is that kindness and optimism are not byproducts of circumstance, but conscious choices that we make everyday. Despite limited resources and systemic challenges, I witnessed people approach life with such gratitude and joy. The kindness I received from hospital staff to program mentors to strangers on the streets of Mombasa left a lasting impression and taught me that compassion doesn't require abundance, but intention. This simple truth will continue to guide me as I work towards a career in medicine. My patient encounters have validated my desire to pursue medicine, give back to the community, and shown me that equitable medicine brings healing beyond the physical body. Equitable medicine brings hope to those society overlooks. As I clock into the hospital, step onto the ambulance, or continue my journey in healthcare, I bring with me the advocacy that my mom demonstrated for my dad. I bring with me the ability to slow

down and truly listen to what patients have to say. And most importantly, I bring with me the commitment to seeing patients as whole people and challenge the systems that continually fail them.

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