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Lesbian Doctor : A Model For Empowering Professional Minorities*

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Abstract :

Lesbian doctors face discrimination within the medical system and are often isolated and powerless to change their situation. Research carried out in 1993 in the United States involving female doctors showed that 41% of lesbian doctors experienced harassment related to their sexual orientation compared to 10% of heterosexual doctors. A membership survey of the Gay and Lesbian Medical Association (GLMA) in the USA revealed that 59% had suffered discrimination within the profession because of their sexual orientation.

Nothing has yet been reported of the experience or needs of Australian lesbian medical students and doctors. The Australian Lesbian Medical Association (ALMA) was established in July 1999 to support the needs of this group. A questionnaire based on that used by GLMA was used to gather data from ALMA members relating to their experiences of education and the medical workplace. Results were then compared with international research. The research is ongoing.

Lesbian doctors and medical students in Australia experience discrimination within their workplace and express a need for support and mentoring.

Support systems for lesbian doctors and students are necessary in order to reduce the impact of discrimination. The ALMA model will be presented as one that other countries of similar size could adopt.

Keywords

Lesbian doctors, discrimination, support

Introduction

This paper will document the formation of the Australian Lesbian Medical Association (ALMA), and some of the stories of discrimination told by women within the safety of this group. It will then touch on some of the international literature regarding discrimination experienced by sexualy minorities within medicine. We will present the early data collected from the first ALMA membership survey, which is still underway. Finally, we will present a model for empowerment of these doctors that is emerging through ALMA.

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* *Paper presented at International Confess of Medical Womens International Association, Sydney 2001.*

Our Reality

One ALMA member weeps as she speaks of wondering whether she can keep facing the hospital training. She is a surgical registrar in a large teaching hospital. Within a few weeks of beginning this post she was involuntarily outed by another female registrar. During her time there she experienced discrimination in many ways. On one occasion she was even physically assaulted by an anaesthetic consultant who rushing across to her, grabbed both her arms and held them down while "screaming at me...about 8cm from my face", refusing to anaesthetise the next patient suggesting that she was incompetent. Her record of handling certain procedures was far above average she rang her surgical consultant who agreed that the anaesthetist's behaviour was "utterly unprofessional and inappropriate", but refused to support her when she went to make a formal complaint. When she reapplied for her position the following year, she was overlooked for the job despite having held it for the two previous years. It was instead given to a young male resident who had never performed any surgery. When he did not accept the job she was offered it for a 6-month term only. This was unheard of in this city where all terms were 12-month terms. All this because she was perceived as "different". She adds "which is the word you use when you don't want to say lesbian". She attends an ALMA conference, and the support in the room for her pain and courage is palpable.

She is urged by some to continue, as women in this area are desperately needed. Others offer emotional support through email or phone.

Another member talks of the loneliness of realizing she was gay as a medical student and looking up Homosexuality in Harrison's one study session, and finding it was in the same category as Alcoholism and Paedophilia.

An Australian initiative creating support for lesbians in medicine - formation

The Australian Lesbian Medical Association grew out of the personal need of individual lesbian doctors to connect with each other for professional support.

Two lesbian doctors who had not previously met decided, during a telephone conversation, to have a coffee together. They both had a long-held dream about the possibility of a lesbian doctor's professional association and together decided to have a national conference. Two other doctors were co-opted onto the "Committee for the First Annual Australian National Lesbian Doctors Conference". A venue (with the capacity to seat from 6 to 60) was booked. A flyer containing a conference program was created. At the time the flyer was printed, the program existed almost entirely in the imagination of its creators. The flyer was disseminated from woman to woman. A few brave doctors also left it on coffee tables and posted it on walls. The conference

took place in a nurturing, waters-edge environment on the east coast of NSW in July 1999. A total of 30 women attended. The association was born.

From the first meeting of this group of doctors that was to become ALMA, there was a strong feeling of freedom between the members to say things where they had remained silent. Previouly, many women had not revealed their experiences of homophobia for fear of not being understood, or worse, in the case of those who were employed, of losing their hard-won hospital training positions. Speaking up meant the possibility of having to handle ridicule, or even retaliation, in much the same way as occurs with racism. However, in the case of homosexuality, the individual often can choose to stay invisible, which creates protection of sorts, but has its own cost in the sense of isolation that results.

It was clear from the outset that the connectiong with each other made a difference In the feedback after the first conference one women who had practiced medicine successfully for many years wrote "Thank you...many of us have been longing for this for years. I'am so sick of not really enjoying, not feeling part of, not really into most of the topics of the usual doctors conferences...this weekend has provided inspiration and energy to go on..."

Others wrote or spoke of their feelings of alienation and isolation in relation to the mainstream medical world. Some doctors wrote of the importance of having role models. Many spoke of previously feeling like "...I was the only lesbian doctor in the universe." They spoke of how different it was to realise that there were others with similar backgrounds facing similar challenges.

Lesbian Doctor's Stories

At both the first and second conferences, those who had been on the receiving end of serious and career changing discrimination told painful and touching stories. Several spoke of eventually choosing not to proceed with the speciality of their choice after persisting and un-relenting harassment and discrimination. It was important for women to have the matters put into perspective. At the first conference, a partner who worked in a non-medical profession, after listening to women tell their stories got to her feet and said "Don't you realise that you are talking about being abused. This is abuse." The doctors present had not labelled it in that way. It had simply been seen as part of their professional environment.

One of the ALMA members, as an intern, experienced being at morning report when the medical registrar was presenting a case from the previous night. A woman had presented, having been hit by a heavy object, and it became apparent that the registrar discussing the case had not done a proper neurological examination. He was being

taken to task for this, and in his defense began making a joke of it, saying the woman had been hit by her partner who was a another woman. The room of doctors began making ribald comments and jokes, and as one doctor tried to take the focus back to the case, an eminent cardiologist defended the medical registrar commenting along the lines of "Well, you could hardly expect him to touch her." The ALMA member who tells this story, says she felt incapable of speaking up at the time.

Another doctor in general practice tells of being contacted by various young lesbian medical students, who were feeling the lack of role models for themselves. They reported homophobic comments from other students and in hospital situations. They did not feel safe in declaring their true selves and always kept part of their lives separate. They expressed the need for affirmation of themselves as lesbians who were about to enter the professional world of medicine, where they were only too well aware of the general homophobic attitudes of the institutions they would be working in. Another student tells of being in a Behavioural Sciences tutorial in 1991 where one of the subjects for discussion was deviant behaviour and how to deal with it in a medical sense. Bestiality was discussed, then homosexuality. The discussion continued, and the young student began defending homosexuality as a behaviour that should not be considered deviant. She described it as "a traumatic afternoon for me...retreating to...the back of the discussion group."

Another doctor reports of having to stand in an operating theatre and listen to a urologist put forward his theories of why gay men are deviants. And another time listening to senior colleagues scorn the anaesthetist next door because he was gay. None of these situations have been life threatening to any of the doctors involved, but stories such as these are a part of many lesbian doctors' lives. They are situations which intimidate, shame and push lesbian doctors out of certain work places. They illustrate that if a lesbian doctor is open in the same way as her heterosexual colleagues, she puts herself at risk for making her workplace difficult or even unbearable, and in some cases risks losing her job. In some countries the consequences of being identified as lesbian would most definitely be life threatening. We hope that the existence of ALMA, the Australian Lesbian Medical Association, will be of some support to lesbian doctors in these countries, as well as in Australia.

Experiences and effects of discrimination by sexuality minorities in medicine

Lesbian doctors and medical students face discrimination and homophobia within the medical system, which adversely affects their well-being. Fifty four percent of lesbian doctors and medical students in the USA have experienced discrimination within the medical profession as a result of their sexual orientation.[1] This is predominantly due

to negative attitudes and behaviour of colleagues. A 1986 survey of doctor's attitudes showed that 30% doctors interviewed were opposed to admitting gays and lesbians to medical schools and 40% would not refer clients to gay or lesbian colleagues.[2] A more recent study in New Maxico does show a positive shift in attitudes, with only 4.3% saying they would refuse gay and lesbian applicants admission to medical school.[3] However, research carried out in 1993 in the United States involving 4501 female doctors showed that 41% of lesbian/bisexual doctors (n=156) experienced harassment related to their sexual orientation compared to 10% of heterosexual doctors (n=4177).[4] A consequence of experiences or fear of discrimination is non-disclosure and thus invisibility of their lesbian identity.[5] Medical students are especially vulnerable to the effects of negative attitudes, as they are often just coming to terms with their sexuality and fear the consequences of disclosure within their course.[6] Most lesbian and gay doctors report that they do not disclose their sexual orientation within their profession and that this is due to fear ostracism and of negative affects on their carrer progression.[7,8] This creates a sense of discomfort in failing to be completely honest yet is weighed up against the need to maintain safety.[9] Lesbian and gay medical students and residents attempt to match their selection of residency placement to one in which they will feel welcomed and respected, yet still fear discrimination if they come out.[10] Their sexual orientation affects their choice of career path and a great deal of energy is expended "trying to find a balance between self-protection and self-disclosure" in that choice.[11]

A further factor that perpetuates the invisibility of lesbians within medicine is a lack of curricula content regarding lesbian and gay issues, which has been widely reported in the UK[12], the USA[13,14] and Canada.[15] A survey of 72 gay and lesbian medical students showed that these students wanted a more affirming study experience and wanted gay and lesbian issues to be addressed in all coursework.[16]

Australian lesbians in medicine - a survey

A survey is underway of lesbian doctors and medical students in Australia. This has been sent to 116 women who are on the mailing list of the Australian Lesbian Medical Association (ALMA). So far 40 (34.5%) lesbian doctors and medical students have responded. The survey is a 26-item questionnaire, asking sexuality identification, degree of disclosure within the profession, degree of social connectedness within and outside medicine, level of medical education received regarding lesbian and gay issues. Respondents are asked about the usefulness of various ALMA activities and finally about their experiences of harassment and discrimination as a result of their sexual orientation. It is returned anonymously.

Some items are compared with the same items used in the USA Gay and Lesbian Medical Association membership survey of 1994. In particular 19 women (45%) had experienced some form of discrimination within the medical profession (compared with 54% in USA), see table 1. The most common form this took was being socially ostracized by other doctors.

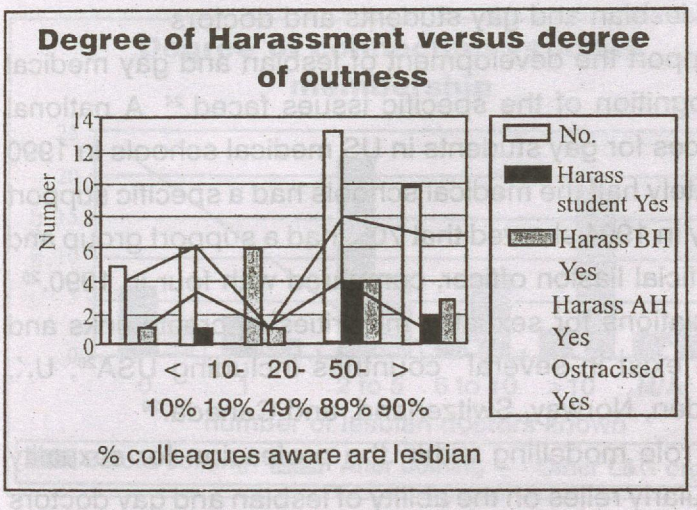
The level of harassment as a result of sexual orientation is seen in Table 2, with two thirds of respondents having experienced harassment in their personal life, and 10% having been physically assaulted. The degree of harassment does partly correlate with the extent to which respondents have disclosed to colleagues, however degree to which they are ostracized does not. see Figure 1.

Table 1 : Discrimination within the medical profession

Type of discrimination	Australia N = 40 %	USA N = 255 %
Job-related : denied promotion	15.0	14.0
Medical School rejection	2.5	2.0
Postgraduate training : denied place	10.0	9.0
Denied referrals	0	7.0
Socially ostracized by other doctors	25.0	34.0
Other professional	20.0	17.0
Total - any discrimination	**45.0**	**54.0**

Table 2 : Experiences of harassment related to sexual orientation

Place	Australia N = 40 %	USA N = 255 women %
Medical School	15.0	-
Workplace	22.5	-
Personal life	67.5	35.0
Physical assault	10.0	5.0



Improving well-being of sexuality minorities within medicine

Recommendations in the literature to improve the situation for this particular minority group in medicine are :

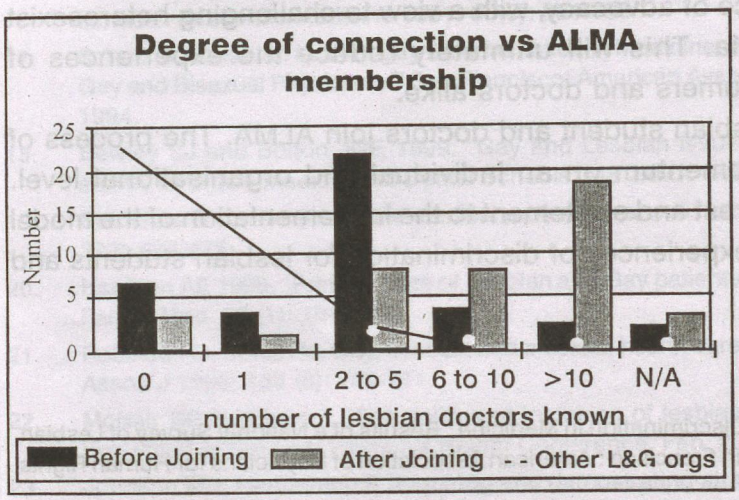
- Develop guidelines on anti-discrimination that include for this particular minority group in
  - Advocate for legislative reform in this regard[17]
  - Inclusion in medical school and health institution policy-for example in the UK only 10% of the medical schools have specific policies protecting medical students against discrimination.[18] The UK based Gay and Lesbian Association of Doctors and Dentists (GLADD) held a workshop on challenging workplace bullying and homophobia in the NHS and addressed the need for a national guideline addressing homophobia.[19]
- Increase curricula content of lesbian and gay issues, in an integrated fashion, including specific areas of knowledge, skills for sensitive communication and positive attitudes towards lesbian and gay patients and colleagues.[20 21 22 23] ALMA survey respondents were asked about their recollection of receiving education regarding lesbian and gay issues. Twenty-three (57.5%) had not, and of the 17 that had, only one recalled education within her workplace. Four recalled education within postgraduate training at an average of 2 hours each, and 15 received during undergraduate training at an average of 4 hours each. Regarding policy development by ALMA, 27 (67.5%) agreed. There were 15 comments provided, with 9 specifically suggesting policy on inclusion of lesbian issues in medical education.

- Create support systems for lesbian and gay students and doctors
  - Medical faculties to support the development of lesbian and gay medical student groups in recognition of the specific issues faced.[24] A national survey of support services for gay students in US medical schools in 1990 showed that approximately half the medical schools had a specific support group.[25] A repeat survey in 1994 showed that 70% had a support group and nine schools had an official liasion officer, compared with four in 1990.[26]
  - Develop doctors associations for sexuality minorities to create links and support.[27] Association exist in several countries including USA[28], UK, France, Germnay, Sweden, Norway, Switzerland, and Canada.[29]
  - Enable mentoring and role modelling within the profession for sexuality minorities, which particularly relies on the ability of lesbian and gay doctors to disclose their sexual orientation within their workplace.[30] Of the 40 women responding to the ALMA survey, 33 indicated they were willing to be mentors to other lesbian medical students or doctors.

A model for empowering professional minorities

The presence of the organisation has changed lives. Mario, started her association with ALMA began saying that she did not want to acknowledge her connection with the organisation openly. Over time she has become comfortable with a visible role on the organisation's steering committee. Stephanie wanted to help create the ALMA entry into Mardi Gras. At first she said she would help with behind the scene production of the entry. Then she said that she wanted to go in the parade, but would wear a wig and a mask. In the event, she marched proudly as herself!

The membership of ALMA is extremely diverse. Individual members have a wide range of political views economic background. Despite the diversity, these doctors have been empowered by their links with each other. The ALMA survey revealed that many respondents had developed new connections with other lesbian doctors and students as a result of joining the group. It it also clear that very few respondents belong to other lesbian and gay organisations. Seeing other doctors living openly as lesbians and doing well professionally empowers others. It inspires courage. It is a demonstration that lesbian sexual identity and medical professionalism are not incompatible. In fact, the strong vibrant professional role models that now exist within ALMA are role models for professional excellence.



Member of ALMA have realised through our experience of establishing ALMA and on the needs expressed by members of our group that the organization is developeing a model for empowerment. We see a several stage process in the formation of such a group, with each stage building on the previous, as group members gain in strength and affirmation of purose. This has parallels with the six-stage process of 'coming out', developed by an Australian, Vivienne Cass that has been widely accepted as a model for gay identity formation. [Cass V 1984] Cass describes a process from identity confusion, to comparison, then tolerance, acceptance, pride and finally identity synthesis. From tolerance to synthesis, the process involves increasingly seeking social contact with other lesbians and an increasing commitment to the wider homosexual community. Identity synthesis recreates connections with the heterosexual community.

Our model is in the process of development and currently has the following stages :

Stage 1 - Individual connections
begins with enabling connection between individual lesbian doctors
Stage 2 - Networking
more advanced networking at a local, State and National level.
Stage 3 - Mentoring and role modeling
This reduces the sense of isolation and difference.
Stage 4 - Advocacy within medicine
As we gain strength from these connections, we also gain an ability to advocate improving the well being of lesbians within our profession.
Stage 5 - Advocacy within society

Finally, we develop a wider voice of advocacy, with a view to challenging heterosexist assumptions and homophobia. This will ultimately reduce the experiences of discrimination for lesbian consumers and doctors alike.

As each month passes new lesbian student and doctors join ALMA. The process of empowerment is gathering momentum on an individual and organisational level. Members look forward with interest and excitement to the implementation of the model and subesequent reduction in experiences of discrimination for lesbian students and doctors.

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MEDULLARY AND ANAPLASTIC CARCINOMA THYROID

By

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Medullary carcinoma is a cancer of the parafollicular cells also called as C cells. They are derived from altimo branchial bodies located in the upper and middle portion of thyroid gland. This carcinoma (MTC) recognised since 1959 by Hazard et al. It is found in 5-10 percent of all thyroid malignancy and it can present in different ways.

1. Sporadic - 90%. It occurs as a localised lesion in one or both of the lobes.
2. (a) Famlial association with multiple endocrine neoplasia (MEN 2A) syndrome described by Sipple in 1961. It is associated with phaeochromocytoma and hyper parathyroidsm and it is autosomal dominent inherited. The thyroid nodule may not be evident until the age of 40 usually it is slowly growing but some times may be rapid.

   (b) Multiple endocrine metaplasia (MEN2B) syndrome is more aggressive and 5 years survival rate usually less than 35%. It develops before the age of one year and it is characterised by MTC, Phaeochromocytoms with marfanoid habitus and multiple mucosal neuromas affecting lips, tongue, oropharynx with ganglio neuromas of gastro intestinal tract that may produce bowel mobility disorder.

   (c) Non men medulary (MTC) Carcinoma - This has been described recently as autosomal dominent condition with no associated endocrinopathies. The mean age of presentation is 45 years and disease is more indolent with 5 years of survival age, upto 20% of the patient with apparently sporadic disease are found to have relatives with MTC. All first degree relatives over one year old should be screened by clinical examination and measurement of basal calcitoninelevel. As C cells produce calcitonine a polypeptid which lowers blood calcium.

CLINICAL FEATURE :

Most sporadic cases present as thyroid mass or nodule and 25% of patient have palpable lymph nodes metastesis at the time of presentation. those with the disease of MEN 2A may also have clinical features of phaeochromocytoma and or hyper parathyroidsm. Moreover MEN 2B will additionally display multiple mucosal

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neuromas in tongue, lip etc. MEN is autosomal dominant and medulary thyroid MTC will be identified as known families by hormonal screening prior to its declaration as thyroid tumour. MTC not only produces calcitonin but other substances like serotonin prostaglandin, 5-Hydroxi indoleacetic acid. Carcinoembryonic antigen histaminase and prolactant. This can be used to assess the presence, extent and recurrence of the disease both pre and post operatively. However, only calcitonin and CEA are assessed. High circulating level of other substances are responsible for diarrhoea with extensive MTC. There is no place of measuring calcitonin in all patients with thyroid nodules but if MTC is suspected on fine needle aspiration biopsy or from clinical history or if there is bilateral upper polar calcification or signs of phaeochromocytoma or hypercalcaemia, then calcitonin should be measured. If calcitonin is raised, urinary vanillylmandelic acid should be measured preoperatively. All relatives of patients discovered to have medullary thyroid cancer must have calcitonin levels assayed. If calcitonin is normal then the test repeated using a provocative test with calcium and pentagastrin.

All patient with MTC require total thyroidectomy with meticulous removal of all thyroid tissue and preservation of all para thyroid glands and recurrent laryngeal nerves, chances of cure are improved by care, primary surgery including prophylactic central lymph node dissection from the thyroid bone to the innominate vessles, because 50% of the patient present with nodule metastasis. Routine radical neck dissection is performed only when cervical metastistis are apparent.

Phaeochromocytoma should be excluded by preoperative investigation in patient with MEN 2A and or 2B and adrenalectomy undertaken two weeks before thyroidectomy to prevent adrenergic crisis. Patient of MEN 2A should be screened for hyper parathyroidism and should be treated accordingly. Treatment is the key to cure, Radioiodine, external radiotherapy have no role in the management of primary disease. After successful surgery patient should be followed by sequential calcitonin assays. Although raised post operative calcitonin does not guarantee recurrent disease but is strongly suggestive, particularly if the level continue to rise. It should be noted that other causes of raised calcitonin include other malignancies, renal failure and pregnancy.

Metastatic MTC may be troublesome for local recurrent disease or diarrhoea. Debulking of metastases or therapy by external radiotherapy or chemotherapy is occassionally feasible.

ANAPLASTIC THYROID :

Anaplastic thyroid is the worst of all thyroid malignancies and of the most aggresive of all human neoplasm. Death occurs within a year of diagnosis in 90% of patient and

account for 3 - 30% of all thyroid cancers. They are commonest in the area of endemi goitre and women are more affected. Elderly patients are more affected and are bein diagnosed late being ignored, thinking as a case of a differentiated tumour of papiear or follicular type. Such tumours histologically coexist with anaplastic cancer in man cases. It presents as a fixed mass in the centre of the neck surrounding the trachea infiltrating local structure even the carotid arteries and the lumen of trachea causin stride dysphagia for oesophageal involvement and recurrent nerve palsy and pai etc.

MANAGEMENT :

Biopsy is the first essential with the object to differentating between lymphoma an true anaplastic cancer. The distinction is not always possible in fine-needle aspiratio biopsy and open or core biopsy may be necessary.

Curative surgery is almost never possible even Jereb who operated on 37 of 79 case could obtain macroscopic clearence only in 5 patients and with adjuvant radio therap only 1 patient survived for 10 years. Traditionally debulking surgery is attempted bu in less than $^1/_2$, limited objective of freeing the trachea and oesophagus is achieve Indeed the sole result may allow tumour to fungate through the wound. Super radica surgery even as extensive as pharyngolaryngectomy has been advocated but no generally accepted as useful. Pre-operative radio therapy do not help the tumour t shrink to perform radical surgery. But some have advocated radio therapy an chemotherapy following surgery. But most elderly patient can not tolerate suc aggressive triple insult. So this should be restricted to rare younger patient presentin with this disease. For the majority of the patient biopsy followed by attempted palliatio with radio therapy is all that is needed.

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FIRST WOMAN DOCTOR IN THE WORLD

By

DR. (MRS.) B. CHANDRA

Elizabeth Blackwell (1821-1910) is considered as the first woman doctor of the world. She was also a pioneer in promoting education of woman to become physician.

Elizabeth was born at Bristol in England on the 3rd February, 1821. She was the daughter of Samuel and Hannah Blackwell.

Elizabeth's family was very well to do, engaged in sugar refining business. Her mother Hannah Blackwell had nine children, five girls and four boys. Four maiden aunts also lived with the family in Bristol.

Elizabeth's family and her father believed in equality of the sexes and did not care much for the girls. They wore simple clothes, but her aunts always disapproved of the simple dress worn by their nieces and also lack of interest in feminine affairs.

In 1832 the Blackwell family emigrated to the United States.

Elizabeth's father and her family became involved in the anti-slavery movement. Elizabeth joined several abolitionist society. Like young generations she was very undecided about her future. She was not sure what to do in life. But she was certain not to devote her time to the usual occupations of her contemporaries, that is, to be Lady like and husband hunting. Worst of all she did not like to have a family and bring up children. In 1838 her father died in Cincinnati. At this she was forced to support the family. It was a nightmare for her. However, she and her sister dcided to start a school to support the family. The school lasted for six years.

In 1845 she visited her best friend who was dying from Uterine disorder. Her friend was a very self respecting woman following the Victorian style. She did not disclose her disease to any doctor as there was no woman doctor. Elizabeth's friend sought medical help when she was unable to bear her pain. But it was too late. She died due to the Uterine disorder. Before she died she made an earnest request to Elizabeth to become a woman doctor. Elizabeth had never entertained the idea of becoming a woman doctor. However, after the death of her friend the idea of becoming a doctor began to grow in her mind. Elizabeth wrote to several eminent doctors stating her idea of becoming a woman doctor. But the doctors did not encourage her.

However, she without being discouraged applied for admission to the medical school in Philadelphia and New York City. Unfortunately she did not get admission in any of the schools. So Elizabeth began to study medicine independently until 1847.

However, she did not give up her hope of getting into medical institutions. She applied to various medical schools. Finally she gained entrance to Geneva Medical School in Geneva, N.Y.

When she was admitted in to Geneva Medical School she had great difficulty in finding somewhere to live.

The idea of taking a single woman from Medical School as a lodger was more than most of the land-ladies could face.

In 1849 she graduated and was top of her class. But to her great dismay she found no hospital in the United States would admit her to gain the ward experience which was essential for a doctor.

She went to Paris and joined La-Maternite (a hospital and school for Midwives). She worked for fourteen hours a day and gained a lot of experience. She planned her future to become a gynaecological surgeon.

Elizabeth's dream of becoming a gynaecological surgeon was shattered on the 4th November, 1849. Early in the morning Elizabeth went to the ward for syringing the eyes of a baby suffering from purulent ophthalmia. While she was syringing the infant's eyes some of the water accidently squirted into her own eyes. She rubbed them and totally forgot about it. That very evening both her eyes were swollen and fnflamed and she could not see. She had contracted Purulent Ophthalmia form the baby's eye.

She was treated in the same manner as it was done in those days. Her eyes were syringed regularly. Cautery and leeches were applied, and the membrance which formed over her eyes were carefully removed. After three weeks her eyes opened again. Elizabeth was completely blind in one eye and partially blind in the other and so her dream of becoming a surgeon shattered.

Fortunately Elizabeth obtained permission from Sir James Pagot to Study at Bartholomews Hospital in London.

She returned to the United States in 1851 attempted unsuccessfully to obtain a medical position in any hospital or even in a clinic, in spite of her excellent training and impeccable credentials. She was even refused a post in a dispensary in New York.

In 1853 Dr. Blackwell opened a dispensary in New York City. The dispensary was staffed entirely by women and later became known as New York Infirmary. Here during the civil war she trained nurses for the Union Army.

She returned to England in 1857. After struggling in England for 18 years in 1857 she assisted in founding the London School of Medicine for Women.

Struggling throughout her life Elizabeth Blackwell not only became the first woman doctor of the world, but also she paved the way for medical education for women.

She died in Hastings in England on the 31st May, 1910.

INFLUENCE OF MIND ON PHYSICAL PERFORMANCE

By

DR. MEENAKSHI GHOSH., M.B., D.G.O., F.R.C.O.G.*

INTRODUCTION :

Influence of mind over body in health and disease had been recognised over thousands of years.

Socrates in 400 B.C. had said "As it is not proper to cure head without body, so neither it is proper to cure body without soul".

Hippocrates said "In order to cure the human body, it is necessary to have knowledge of the whole thing:. Psychologists from Freud onwards to date have recognised dysfunction of mind as a cause of physical illness and had stressed the necessity of treating mind as well, to cure sick body. It is recognised that psychological factors are mainly responsible for diseases like ulcerative colitis, peptic ulcer, migraine, asthma, anorexia nervosa and some skin diseases and many other conditions.

Traditionally medical profession has been concerned with physical illness & has concentrated its research on understanding & controlling the organic factors. Psychiatry on the other hand emerged as a profession devoted to the study and treatment of mental illness. Both the viewpoint are limited, an illness may be primarily mental or physical, it is always a disorder of the whole person, one affecting the other. Psychologist Seguin has stated that the new approach "has as its aim the study of man as a whole, a totality, considered as such in health and disease". reiterating what Hippocrates said ages ago.

This holistic approach is called psycho-Somatic approach, it should be applied not only on diseases brought on by emotional tension, but also where no cause other than physical ones are apparent. It has been observed by Dunbar (psychologist) that it is more important to know what kind of patient has the disease than what kind of disease that patient has.

The concept of Culture in relation to disease is discussed by sociologist Margaret Mead. We shall find its relevance in the patients, I am going to present.

Mind is a powerful factor in controlling our body and behaviour. In ancient India and even now it is said that yogis can develop their mental power to such an extent that they can completely control the body including respiration and beating of heat. With highly developed technology in these days, it is possible to define, measure and monitor all bodily parameters, but we have not been able to locate mind or measure or monitor it, we believe it to be a product of brain which exerts its influence on body through nervous and endocrine system. With highly efficient diagnostic gadgets and potent therapies available in present day, we tend to overlook the importance of mind.

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In the days when physicians did not have such array of diagnostic and therapeutic aids, they knew its importance and paid attention to it.
My mother used to say that in their younger days, when somebody was seriously ill, Sir Nilratan Sirkar was called in. He would come and stand at the bedside with a broad and reassuring smile on his face and say to the patient "you are much better to day", and the patient would feel half his/her illness has vanished. He had such reassuring pressence, that inspired confidence & sense of well being in the patient.
In our undergraduate days the first lessons in obstetircs were that there were three basic factors in labours.

1. Power - Uterine contractions
2. Passage - Comprising cervix vagina and pelvic floor and bony pelvis
3. Passenger - The Foetus - Its presentation and position etc

Of these power is most important, on it mostly depend the passage of the baby through the birth canal.
Strong uterine contraction can also overcome mild defects in other two factors. It can overcome-

In passage

i) cevical dystocia and rigidity of other soft tissue

ii) mild pelvic contraction

Passenger - Rotation of occipito posterior can be helped by strong contraction and it also helps delivery of malpresentations like Breech or face, It is on power ie uterine contraction mind exerts its effect, I will present series of obstetric cases to illustrate.
Cases presented are :-

1) Obstetric cases at Lohia Matri Seva Sadan, a Hospital equipped with usual facilities during 1980-81

2) A series of labour cases at Kharberia village maternity centre, a small village maternity unit with 8 beds run by Y.W.C.A. The facilities available were primitive. The figures comprises patients from 1976 to 1982 also presented are.

3) Labour cases undergoing Caesarian Section for inertia at Lohia Hospital during 1999-2000.

4) Cases at A.M.W.I. Mission hospital Undergoing operative delivery for uterine inertia during 1999-2000.
Lohia Matri Seva Sadan has all the facilities of a city hospital. The village unit was looked after by a Redcross trained midwife and a dai. Delivery was conducted in clean and more or less aseptic conditions. There was no doctor.
All the patients were seen by me antenataly and provided with iron and vitamin

tablest and given tetanus toxoid. If any abnormality developed during labour, the patients were transferred to a city hospital.

TABLE-I

Total number of deliveries

Lohia Matri Seva Sadan from 1980-1981	.....	2026
Kharberia Village Maternity Centre from 1976-1982	.....	2064

TABLE-II

	Normal Delivary		Abnormal Delivery	
	Total	Percent	Total	Percent
L. M. S. S	1681	83%	347	17%
K. V. M. C.	2026	98%	38	2%

In K.V.M.C. cases were taken as abnormal when they needed transfer to hospital. In L.M.S.S abnormal cases include those who needed operative interference.

TABLE-III

Types of operative interference at L.M.S.S.

	No.
Caesarian Section	134
Low Forceps	185
Others	27

TABLE-IV

Indications for interference at L.M.S.S.

Caesarian Section :	
Cephalo-pelvic disproportion	6
Post Maturity	12
Toxoemia with foetal distress	6
Antepartum Haemorhage	10
Elderly Primigravida	5
inertia leading to prolonged labour & Foeal distress	35

Abnormal presentation :	
Transverse	- 8
Brow	- 1
Breech	- 9
Face	- 1
Cord prolapse	- 1
Previous history of C.S.	- 25
Foetal distress due to other causes	- 15
Total	- 134

Forceps :	
Uterine inertia	100
Foetal distress	85

TABLE - V

Types of abnormality requring transfer to Hospital from K.V.M.C.

Eclampsia	2	Prolonged Labour due to inuertia	6
Antepartum Hage	8	Abnormal presentation	
Toxoemia with anaemia	8	Hand prolapse	1
		Brow	1
		Big boy with Breech	2
Cephalopelvic disproportion	4	P.P.H.	6
		Total :	38

TABLE - VI

Parity of patients :

	Primigravid		Multigravida	
	Total	percent	Total	Percent
L.M.S.S.	676	33%	1352	67%
K.V.M.C.	840	40%	1224	60%

TABLE - VII

Age of Primigravid Patients

	L.M.S.S.	K.V.M.C.
Upto 24 yrs.	480	840
25 yrs. - 30 yrs.	185	nil
Above 30 yrs.	10	1

Lohia Matri Seva Sadan 1999-2000

Total no. of deliveries : 3164

Normal -- 1902 C. S. -- 1262

Age & Parity of patients undergoing C.S. :

Parity : Primi -- 922 Age : upto 24 yrs. -- 327

Multi -- 340 25 yrs. - 30 yrs. -- 804

above 30 yrs. -- 131

Indication for C. S. : Inertia -- 281 Others -- 981

A. M. W. I Mission Hospital 1999 -- 2000

Total no. of deliveries : 532

Normal -- 394 C.S. -- 119 Forceps -- 19

Age & Parity of Patients undergoing C. S. :

Parity : Primi -- 62 Age of Primigravida :

Multi -- 57 upto 24 yrs. -- 42

25 yrs. - 30 yrs. -- 15

above 30 yrs. -- 5

Indication for C. S. ---- Inertia --- 30 Others -- 89

Indication for Forceps : Inertia --- 12 Others -- 7

Discussion :

In these series we find development of inertia and operative delivery was much higher in the patients at the city hospital. We found mental make up of two groups of patients were quite different. The atmosphere at the place of delivery was also different City dwellers these days seem to regard pregnancy and labour as a major ailment. Both the patients and their relatives are all tense, worried and apprehensive.

This may be another effect of nuclear family with excessive attention on children, which we find these days. This attitude is getting worse with years. You are confronted with the question from the very begining-- doctor is she going to have a Caesarean Section? The women I used to see at the village, took their pregnancy as a matter of course. Their grandmothers and mothers had all delivered babies and so will they. There was no fuss about it.

Also the place of delivery had different effect on their mental reaction
In the city hospital the patients get all the necessary medical care, but they have to face the ordeal of labour in unfamiliar foreign surroundigs in detached clinical atmosphere. Nurses are also often unsympathetic and forebearing. In the village the centre was like a home away from home for the women. The patients came from nearby villages. The midwife and the attendant were personally known to them. They were familiar both with the surroundings and personnel. There was no rush so the midwife could spare time to talk and reassure the patients. This inspired confidence and there was much less tension.
This mental attitude had reflected on the performance in labour which compared quite favourably with the city hospital.
From these series we see that incidence of inertia was much less in the village. The number of inertia cases at the hospital presented here is not the true picture of all the inertia cases. Many women with inertia are delivered normally with syntocinon drip. As most of the women receive syntocinon drip these days, it is difficult to assess the number of women suffering from true inertia. In the village there was no facility for giving syntocinon drip. If they did not deliver normally within reasonable time, they were transferred to hospital. You see very few needed that. Most of the transferes were due to haemorrhage or other problems.
Usually the undernourished thin women there did not develop inertia, whereas women with good general health and muscular development at the city often suffered from inertia.
We also see that both inertia and operative interference are going up at Lohia Hospital as patients are becoming more sophisticated and also tense. At Mission Hospital also incidence of inertia is fairly high.

It may be argued that difference may be due to-

1. Village unit was catering to limited area of population
2. High risk patients were screened antenatally and advised to attend city hospital. In reality they all landed up at the centre even when advised to go to hospital, and were transferred if necessary if any problem arose.
3. Younger age group of primigravida compared to Lohia Hospital. But age group of A.M.W.I. Mission Hospital were comparable.

Taking into consideration all these factors, the number of inertia patients requiring operative interference at village centre is definitely smaller.
I believe mental reaction of patients had a large part to play in this. It seems cultural difference which had been mentined earlier, also affected the mental attitude of these patients

CONCLUSION

In conclusion I would repeat what Socrates said more than two thousand years back. "It is not proper to cure body without soul" or what I would call the mind. Physicians can not ignore a patients mental state, it needs to be attended to as well as the body. In a pregnant woman we should try to build up her psyche so that she takes her pregnancy in a calm confident manner. Proper counselling and relaxation lessons may help. May be if we could build up small units where patients knew doctors and nurses closely and built up rapport, better performance in labour could be expected. I would again emphasise that when treating a patient for any disease or disability we must not overlook the mind.

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BOWEL AND BLADDER TRAINING IN INFANTS

By

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Bowel and Bladder Training When and How

Mothers are worried about toilet training their child during nursery years. However a child cannot successfully undertake this task until he or she is physiologically ready for this. Bowel and Bladder functions remain a completely involuntary process, (beyond the baby's conscious control) till the age of one year. Thus it becomes important for our mothers to know the normal pattern of bladder and bowel control.

Bowel Control

The baby's brain and bowel are too immature to co-operate during the early months of life. But the gastrocolic reflex is active and the infant tends to defecate after each feed. This reflex weaknes by the age of 4 months. As such after the age of ***5-6 months*** the mother may hold the baby in a confortable position after feeds because this is the natural time for him to evacuate. ***The mother must not force the child in to her own pattern.***

The infant can be placed on the toilet seat or pot by the age of ***8 to 10 months*** since he can sit without support. Mother should offer the pot regularly praising him if he evacuates but not fussing if he does not do so. Many mothers hold the baby by about 6-8 months on the feet each morning and initiate bowel movement. Psychologically this has a good effect on the child due to close contact with the mother. A child always needs few moments of mothering before a fresh napkin is put on. A child must be cleaned with soft cotton soaked in clean boild water and dried each time after he evacuates. At times he may continue sitting on the potty without passing stool. He should be discouraged from doing so by his removal from the potty after sometime.

At ***15-18 months*** age the baby can walk and is ready for initiating toilet training. The child can be taken to the toilet at regular intervals. At 2 years the child is trainable. Between ***$2^1/_2$ - 3 years*** age, the child can withold and postpone the bowel movement. Infact after 3 years they make a fuss for privacy.

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Bladder control can be delayed due to

1) Individual Variation
2) Enforced toilet training causing faecal smearing here and there.
3) Psychological factors - Disturbed parent child relationship, sibling rivalry.
4) Mental Retardation - It should be excluded by a proper check up.
5) Spinal cord Lesion - Meningocoele and Spina Bifida.

Bladder Control

Infant has small bladder, poor sphincter control and more of fluid diet as compared to adults. In the early months he passes urine frequently without any conscious control. The child is ready for urine training at about 2 years of age. Control is achieved first during the day and later in the night. By $2^1/_2$ years his retention lasts for about 5 hours. but may occasionally lose control. At the age of 3 years he may remain dry throughout the night or may wake up on his own and ask mother for being taken to the toilet. There is a wide variation in the age at which youngsters have full bladder control. The preschoolers and 5-6 years olds need occasional reminding and involuntary voiding may occur during play or excitment. Lapses in bladder control are common and they should be taken as a feature of normal growth.

The child's performace is affected by -

(1) Temperature - There is more frequency of urination during winters due to less loss of water by sweating.

(2) Intake of fluids - Excessive intake of fluids causes more of urination and vice versa.

(3) Illness - Less intake of fluid and diet during illness causes less of urine output.

(4) Mental Retardation. Forced toilet training and spinal cord lesions affect bladder control as much as they affect bowel control.

ENURESIS

Bedwetting is a common problem faced during early years usually after the child has attained voluntary bladder control. Regular as opposed to occasional bed wetting is known medically as ***Enuresis.*** These children are not alarmed by the stimulus for urinating even after the age of five years. They are unable to hold the bladder leading to bedwetting. Underlying responsible factors are :-

(1) Heredity : Same problem may be found with one or both parents of the child suggestive of hereditary factor.

(2) Emotional strain such as studies or examinations at school.

(3) Change in Environment - Changing to new shcool or another house or arrival of new baby.

(4) After illness or accident.

(5) Rigorous or Early Toilet Training - Many parents expect their children to behave like grownups, when they are not ready for it. The child feels insecure and tries to call the attention of parents by wetting the bed.

Managemen: Parent's attitudes have an important influence on the atitudes of the child. The child can be encouraged to void immediately before going to bed and to cut down intake of drinks just before going to bed. The child should never be made to feel shameful nor punished for bed wetting. Instead he should be led to the toilet as soon as he wakes up during night to prevent wetting of the bed. In fact the mother can help the child develop, control of bowel and bladder at the correct age by achieving child's co-operation, and by proper guidance.

NUTRITIONAL ANAEMIA

By

USHA B. SARAIYA MD. DGO FIAC, FICS, FICOG*

Of all the health factors affecting women in India anaemia is perhaps the commonest. It is estimated that 60% of women in India have at some time in their lives suffered from anaemia. It is also the most important single factor responsible for high Maternal Mortality. It is estimated that 20% of all maternal deaths are due to Anaemia.

What is Anaemia ?

It is a low Haemoglobin content of Red blood cells, as also a decrease in the total number of RBC's

Haemoglobin carries Oxygen to each and every cell in the body. In Anaemia each and every cell is deprived of adequate Oxygen and hence it's performance is below par. Brain cells are the most sensitive as they require a large amount of oxygen to function well.

What casues Anaemia ?

Most cases are due to Nutritional deficiencies. Iron and folic acid are required for normal haemoglobin formation. Iron cannot be synthesised in the body but can be stored in the body. Folic acid cannot be synthesised nor can it be stored. Both these essential nutrients have to come from a diet and have to be absorbed from the intestinal tract.

Dietary sources are green leafy vegetables, cereal, pulses, some vegetables and fruit. Haem - Iron is derived from meat, poultry and fish. This is better than iron of vegetable source. In vegetarians, iron absorption can be improved by high Vitamin C levels. This is possible by adding lemon, orange or amla in the diet.

Excessive intake of tea or coffee reduces Iron absorption.

Other factors which reduce Iron absorption are chronic intestinal infections and diarrhoeas. Chronic blood loss is caused by hook worm infection and malaria, leading to anaemia.

Who is vulnerable to develop Anaemia ?

It is mainly a disease of low socio economic strata of society. Poverty is the root cause of this illness. Women eat last in many societies and they traditionally get only the left overs. Hence they develop chronic nutritional deficiencies.

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However social patterns like excessive days of fast, food taboos and constant control of weight has resulted in appearance of anaemia in women of all strata of life.

The most vulnerbal group are pregnant women. Foetus requires 350-450 micrograms of Iron. The growth and development of placenta and increased blood volume require additional Iron. The iron stores in a perfectly healthy woman may be able to take care of 1st pregnancy. However multi paras will invariably end in a deficit Iron status.

Young girls starting their menstrual lives will also become anaemic if their diet is deficient and iron stores are poor.

In children, anaemia does maximum harm. It retards the physical and mental development of the child. It may lead to permanent impairment of mental and motor development leading to deficit of 5-10 points in IQ. These children show a poor performace at school and eventually are school drop outs. They become a permanent liability to the nation.

Hence prevention and correction of anaemia in Women and children is the most important Public Health Measure to improve the quality of life in India. The future generations will be ruined if we do not declare a 'War on Anaemia'.

Hence FOGSI has decided declare a "War on Anaemia" and concentrate its efforts on overcoming this disease during the year 2002.

How can one Diagnose Anaemia ?

Clinical features of anemia are as follows :

1. Pallor - A wan look
2. General Fatigue - lassitude
3. Breathlessness and Palpitations
4. Giddiness on exertion
5. Loss of weight
6. Swelling of feet

However these are seen only in advanced cases. Due to chronic Anaemia there is an "Adaptation syndrome". It is surprising to see many anemic individuals carrying on their activities without any complaints.

Laboratory Investigations are a must to diagnose Anaemia.

A simple blood test will give a full picture. The following chart will give an indication of the severity of anaemia.

	Normal Values	Anemic
HB%	10 -11 gm	< 10 gms
RBC	4 -5 million	< 4 million
PCV	39 - 42%	< 30%
MCHC	32 - 36%	< 30%
MCV	75 - 100 microns	< 75 microns
Serum Iron	more than 40 mgms	< 30 mgms
TIBC	200 -350/ugms per 100 cc	> 40 ugm/100 cc

In addition to this, other tests required are :-

- Stool examination
- Serum protein - total and differential
- Tests to exclude haemolytic and congenital anaemias.
- Blood group - Rh factor.

A general health check up is advisable. It is essential to make every individual aware of the fact that he or she must know the Hb% and Blood group and Rh factor. Unless every child is impressed upon at school about the importance of preventing anaemia, there will be no impact on the control of this condition.

Effect of Anaemia on Pregnancy

1) Pregnant woman after 4 months of pregnancy starts looking pale and is not able to cope with her activities. This is because by 4th month iron requirement of the foetus start and foetal blood is formed.
2) High susceptibility to urinary tract infection, genital tract infection and frequent colds and cough.
3) Swollen feet and/or generalised swelling.
4) Breathlessness Development of a "haemic murmur" in the heart.
5) Intra Uterine growth retardation
6) Eventually cardiac failure.
7) Preterm labour.

During labour, the woman is at greater risk

1) Highly susceptible to APH and PPH. Even normal amount of blood loss may lead to collapse and death.
2) Foetal anoxia and distress. May even end in still birth.
3) 20% of all Maternal Mortality is due to anaemia

Post partum complications

1) Failure of lactation
2) Puerperal sepsis
3) Subinvolution
4) In case operative procedures are carried out, delayed wound helaing.

The effects of anaemia on the foetus are also significant

1) Low Birth weight Babies
2) Birth asphyxia
3) Chronic neonatal illness "Inability to Thrive"
4) Poor Iron stores lead to development of anaemia at age 10 months
5) Increased Perinatal - Infant Mortality Rates

Hence every pregnant woman needs to have Hb% check up done at 4 months and again at 8 months. In rural India, this becomes difficult. However every effort must be made to provide this facility to all pregnant women. At least they must be made aware of its need.

Treatment of anaemia

This is a challenge, mainly because of its magnitude. Otherwise it is a very simple disease to treat and the treatment is low cost, effective and complication free.

Prevention is not only better than cure but also cheaper than cure. Every young girl must be treated and evaluated for anaemia before she becomes pregnant. It may be worth while to prescribe 100 days of Iron and Folic acid supplement to each and every girl at certain phases in her life.

a) When she starts menstrual life
b) When she gets married
c) When she completes 3 months of pregnancy
d) And for three months after delivery

Iron - Folic acid tablest (IFA) large - Small are distributed free of cost at Government Health Centre. To prevent deterioration of quality it is now supplied in a strip of 10 tablets in bubble packs. It is important to avoid drinking tea or coffe, one hour before or after taking IFA.

Parenteral Iron therapy is advisable in

1. Severe Iron deficiency
2. Close to term
3. Malabsorption syndrome
4. Poor tolerance to oral Iron
5. Poor compliance

Preparations available are

Iron Dextran

Iron sorbitol citric acid complex

Estimation of Iron requirement

1. Hb deficit x 200 = Iron requirement in Mg
2. 3 x wt in 1bs x Hb deficit in % = Iron requirement in Mg

These injections have to be given by a Medical person after a test dose. Allergic, Anaphylactic reactions occasionally occur so proper consent needs to be taken.

It may be worth while to keep the patient in the Health centre or dispensary for 2 hours after injection.

A deep intra muscular injection using z (zed) technique is the routine.

Patient may be warned about development of arthralgia / myalgia and fever at home. Suitbale symptomatic treatment should be prescribed otherwise the patient may not return for next injection.

Blood transfusion

It is reserved for severe anaemia (Hb <7gms) on the verge of cardiac failure. It may also be considered for a woman in early labour with severe anaemia.

For cases of Haemolytic anaemias it becomes a good mode of treatment and ensures better foetal and maternal outcome. Packed cell transfusion of fresh blood with simultanenous injection of diuretic minimises complications. Hospitalisation is required.

Conclusion

Creating awareness about anaemia will be a major "Thrust Issue" for every member and every society.

This can be done by

1. Giving public lectures
2. Writing articles in lay press
3. Addressing school girls and women's clubs.
4. Encouraging every patient under their care to have and Hb test and Blood Group / Rh test.
5. Creating awareness about proper diet, eating habits and sources of dietary iron.
6. Arranging Anaemia Camps, Rallies and Walks.

It is hoped that some impact will be made on this "Scourge" by a positive attitude of all AMWI Member. Women Doctors are in a special position to undertake this project.

THE NEWER GONADOTROPHINS

By

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AND

USHA B. SARAIYA , MD DGO FIAC FICS FICOG*

Introduction :

Almost a century ago, the importance of gonadotrophins was recognised. It was found that these gonadotrophins which were controlled by the pituitary (Crow et al) affected the genital organs. (Aschner et all) and that ovulation were dependent on the cyclic release of gonadotrophins.

In the early part of the twentieth century, there was hardly any treatment available for treating and inducing ovulation in anovulatory infertility. Kaplan from Israel introduced low dose radiation of the pituitary gland which did give some good results, confirming the fact that pituitary was responsible for ovulation.

The Newer Gonadotrophins :

Four gonadotrophic hormones of gynecologic importance were discovered. They were :

1. Follicle stimulating hormones (FSH)
2. Luteinizing hormone (LH) or Interstitial cell stimulating hormone (ICSH)
3. Human chronic gonadotrophin (HCG)
4. Pregnant mares serum gonadotrophin (PMSG) with FSH and LH activity

Milestones in the production of Gonadotrophins :

Initially, Gonadotrophins from animals were produced, but due to the development of antibodies to them, the focus shifted to the extraction of human gonadotrophins. Gamzell et al and bettendif et al successfully produced human pituitary gonadotrophins for the first time, from cadaver pituitaries. Lunenfeld in 1963 produced human menopausal gonadotrophins from urine.

A. Human Menopausal Gonadotrophins :

These are extracted from the urine of the menopausal women. It contains both 75 IU of FSH and 75 IU of LH. It was of only 2-5% purity, as it contains several urinary impurities.

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* *Paper Read at International Seminar in Durban South Africa*

B. Purified urinary FSH :

Also called Urofollitropin (UFSH) - was produced by removing most of the LH using an immuno affinity column of antibodies against HCG. It has 5 IU of FSH and less than 0.7 IU of LH.

C. Highly Purified FSH :

Has less than 0.001 IU of LH and much less low levels of contaminating urinary proteins. This enabled subcutaneous injections.

Human Chrionic Gonadotrophins :

Extracted from placenta, it is administered intra-muscularly. It is available in ampoules of 500-5000 IU. Its effect is similar to LH. It maintains the corpos luteum.

Need for alternatives :

Problems faced with urinary gonodotrophins were :

1. Large aliquots of only menopausal women's urine needed. This excluded a large population of women undergoing HRT.
2. Because of impurities, there were batch to batch variabilities. Concurrently developments in treatment of infertility were taking place. Clinical experience proved that for follicular stimulation in a woman with functioning H-P axis, only FSH is required. Homburg (1988) and Regan (1989) proved that excessive LH was undesirable.

New Era - Recombinant Technique :

Through advanced genetic engineering, we are now in the era where recombinant gonadotrophins were being produced and used. The advantages of these are :

1. Very high purity - 99.9% FSH
2. No batch to batch variabilities
3. Production on demand
4. Better results

Recombinant FSH Production - General Principles :

The production principles of recombinant FSH, LH and HCG are more or less similar, as all are heterodimers that have a common alpha subunit and hormonally different beta subunit.

Chinese hamster ovary (CHO) cells are used as host cells, as FSH molecules require complex glycosylation. By gene encoding alpha and beta subunits of FSH are identified

and separated. FSH genes are spliced with a suitable vector (bacterial/viral DNA) which can be incorporated into nuclear DNA of the host cells. These genetically engineered cells produce recombinant FSH, which are purified, measured and sealed.

Results with Recombinant FSH :

Studies with WHO Group II showed that with recombinant FSH :

1. Less total dose required.
2. Shorter treatment time.
3. More oocytes - hence more embryos
4. Statistically higher pregnancy rates.

Studies clearly proved the greater efficacy of recombinant FSH.

Bergh et al Gonal F v/s Metrodin HP		
	Gonal F	**Metrodin HP**
No. of patients	119	114
No. of amp.	21.9	31.9 P<0.0001
No. of days	11	13.5 P<0.0001
No. of oocytes	12.2	7.6
No. of embryos	8.1	4.7
Ongoing pregnancy rate	47%	35%

Klcaeaf et al ESHRE - 98		
	Gonac F	**Metrodin HP**
No, of cycles	102	250
Total amp.	28.6	37.7 P<0.001
Days of FSH	10.4	11.9
No. of oocyte	11.2	9.9 P<0.04
Preganancy rate	31.4	21.6
Implantation rate	18.7	13.3

A double-blind study - Frydmal et al (ESHRE - 98)		
	Gonac F	**Metrodin HP**
No. of patients	130	116
Oocyte recovered	11	8.8 P=0.0001
Total amps.	27.6	40.7
Days of FSH	11.7	14.5
Patients with dose increase	56.2%	85.3%
Ongoing pregnancy	20%	20%

Recombient LH :

Pharmacokinetics of rLH and uLH are similar. Half-life of rLH is 12 hours and slightly prolonged after extravascular administration. Half the administered dose is available systemically.

rFSH alone is sufficient to stimulate follicular growth but inadequate to induce steroidogenesis. It should be combined with recombinant LH in such cases. rFSH and rLH can be given together. Currently, there are two preparations of rLH available, viz. rHLH serona and crystal chem, which are being used for clinical trials and commercially.

Recomibinant HCG :

The European recombinant HCG study group has performed a multicentre, double blind randomized study comparing the efficacy and safety of recombinant HCG (Ovidrel) and urinary HCG, for inducing final follicular maturation and early lutenization in women undergoing ART. A study was done on 190 women. rHCG was given subcutaneously. Results show that for triggering ovulation rHCG seems to have significant advantages compared to uHCG in terms of number of mature oocyte retrieved, luteal progesterone and local tolerance

European rHCG study group		
	rHCG	**uHCg**
Oocyte retrieved	11.6	10.6 (not significant)
Mature oocyte	9.4	7.1 (P=0.02) significant
Serum progesterone	Higher	Less
Clinical Preg. Rate	33%	25%
Adverse effect	22.7	45.1 (P=0.0004) significant

Case studies have shown that patients with recurrent empty follicle syndrome could be successfully treated with rHCG. [Human reproduction - 1999 July 14(7)]

Conclusion :

More trials and studies are being done using recombinant gonadotrophins. There is no doubt that these newer gonadotrophins are the pillars for artificial reproductive techniques of the future.

Even though they are still in the realm of research, these are the promising drugs for the twenty-first century. The cost, which is still prohibitive, is likely to be reduced in due course, when production commences on a commercial scale. It will then be available to average patients seeking infertility treatment.

After all, what is in the realm of research today, becomes the clinical practice of tomorrow.

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ASSOCIATION OF MEDICAL WOMEN IN INDIA (Central Office)

Address for correspondence : Cytology Clinic (AMWI), OPD Building 1st Floor, Cama & Albless Hospital, Mahapalika Marg, Mumbai 400 001.

Minutes of the AMWI Council Meeting held on 1st December 2001.

The Council Meeting of AMWI Central Office was held on Saturday 1st December 2001 at the Seminar Hall, Cama & Albless Hospital, Mahapalika Marg, Mumbai 400 001 at 4.30 p.m.

I. Roll Call and Apologies of absence

Members present :

Dr. Manju Mataliya, President
Dr. Dinoo Dalal, Vice President
Dr. Usha B. Saraiya, Secretary
Dr. Sudha Sheth, Treasurer
Dr. Tulsi Basu, N.C.S.-West Bengal
Dr. Mehroo Pardiwalla, N.C.S.-Mumbai
Dr. Kamla Sengupta, Council Member, W.B.
Dr. Jyotiben Trivedi, Central Asia Vice President
Dr. Dina Patel, Past President
Dr. Mandakini Megh, Council Member
Dr. Deepti D. Donganokar, Mumbai
Dr. Sunaina Bhasin, Mumbai
Dr. Jayshree Jhaveri, Mumbai
Dr. Rajni Bapat, Mumbai
Dr. Manorama Purwar, Nagpur
Dr. Naina Kunnawar, Nagpur
Dr. Arati Basu Sengupata, Kolkata
Dr. Vandana Walvekar, Council Member & Chairman, Bombay Branch

Apologies were received from :

Dr. Minaxi Ghosh Dr. Arti Roy Dr. Urmila Khanna Dr. Billimoria.

II. Minutes of the last Coucil Meeting

The minutes of the last Council Meeting held on 25th January 2000 at Cytology Clinic, Cama & Albless Hospital were read and confirmed after due corrections.

Proposed by Dr. Tulsi Basu

Seconded Dr. Kamala Sengupta.

III. Business arising out of the minutes

Dr. Dalal informed that the new amendments to the Constitution were with the Charity Commissioner, Mumbai and had not yet been sanctioned. Dr. D. Dalal and A. Billimoria are working on the same.

No improvement has been carried out at the AMWI room housed at IMA Building.

The AMWI National Cogress was being held on 2nd December 2001 at the West End Hotel. Precongress session had already been held on 1st December at Seminar Hall, Cama & Albless Hospital. The Congress is hosted by Mumbai branch.

West Bengal Branch is planning to hold the next Regional Congress at Calcutta. The Members decided that it was not possible for India to hold the International Congress.

IV. Report of the 24th International Congress

The 24th International Congress was held at Sydney in April 2001. Dr. Tulsi Basu, National Correspondening Secretary from West Bengal attended the Congress and read out the report. 3 members from Mumbai and 3 from West Bengal attended the Congress.

One more doctor from Maharashtra Chandrapur Dr. Kiran Adnankar also attended and read a paper.

Dr. Dipti Dongaonkar received the Lovejoy Scholarship of MWIA.

The International Conference was not as well organised as the previous ones. Dr. Jhirad Oration was given at the time of the Conference in Sydney. There were a total of 465 delegates. Next International Conference will be held in Tokyo in 2004.

Dr. Basu said International Council had voted to reduce a lot of expenses. The past presidents will not be funded, only the immediate Past President will be given travelling expenses.

Dr. Jyotiben Trivedi was installed as the Central Asia Vice President for the period 2001-2004. Detailed report will be in the next Journal.

V. Constitution amendments and registration for Income-Tax exemption

Dr. Dalal informed that the new amendments to the Constitution were with the Charity Commissioner, Mumbai and had not yet been sanctioned. Dr. D. Dalal and A. Billimoria are working on the same.

Application had been made by the Auditors for the Income Tax exemption a year ago, but there is no reply to the same. Pending this the auditors feel that a certain sum of money should be kept aside in case IT is to be paid by the Central Office.

VI Reports

a) Central Office :

The report was given by Prsident Dr. Manju Mataliya.

Dr. Mataliya informed that the new branch was started at Nagpur with 100 membners as a result of hard work and special efforts of Dr. Manorama Purwar and Dr. Manju Mataliya. Dr. Manju Mataliya - President of AMWI was invited to preside over the installation cremony wherein Dr. Manorama Purwar was installed as Founder President by Dr. Mataliya and remaining office bearers were also installed along with her. This was followed by CME programme.

Dr. Manorama Purwar was the Chairman of the branch and the branch was very active.

Dr. Mataliya informed that she is also trying to revive the Aurangabad branch, which had been started with 16 members but is not active at present.

b) West Bengal Branch :-

Report of West Bengal branch was read out by Dr. Saraiya as sent to her by Dr. Arti Roy. They are doing very good work and are active with the Mission Hospital. The report of the branch has been separately filed. They are to be congratulated for the exemplary work being carried out.

c) Mumbai Branch :-

Report of Mumbai branch was read by Dr. Vandana Walvekar. The Cytology Clinic is very active and the annual courses are held as usual Dr. Shirin Mehtaji Competition and the Slum Clinic are actively working. Report is filed. Mumbai also brings out 2 Newsletter every year.

d) Nagpur Branch :-

An impressive report of the activities was presented by the Secretary Dr. Naina Kannawar. Members congratulated the office bearers and especially Dr. Manorama Purwar for the excellent work done in the first year itself.

e) Any other Branch :-

Dr. Mataliya is trying to revive the Aurangabad Branch and Dr. Basu start a new branch at Delhi.

f) Editor's Report :-

The editors report was E mailed to Dr. Mataliya. Apologies were received from editor Dr. Ghosh. The Journals for August 2001 were distributed. Only 1 issue is printed every year. After some discussion it was decided that the Journals will be posted to all members individually from the Mission Hospital, Calcutta. It will also include the audited statement of A/c every year. All branches are requested to send any special news of the branch for publishing in the Journal and try for at least one advertisement from each branch.

g) Dr. Jhirad Libray :

The report was read by Dr. Saraiya. It is now housed in Cytology Clinic so that it can be better looked after.

h) National Corresponding Secretary :

As per the last meeting we have 2 National Corresponding Secretaries. Dr. Tulsi Basu had taken up the work of National Corresponding Secretary West Bengal. She said they had a no. of International guests this year and the main among them was Dr. Michelle Harison who stayed for almost 1 month. They have also received some donations and gifts from abroad. 1000 Swiss Frances were donated. Dr. M. Pardiwala Mumbai branch said no MWIA update has been received this year.

VII Treasurer's Report and audited statement of Account

The Treasurer's report was read by Dr. Sudha Sheth. Audited report 1999-2000 was presented. 2000-2001 was ready but not signed. It was decided that Bomaby branch would pay International dues for 60 members, West Bengal 30 and Nagpur 10 members. Nagpur branch said they would send a total of Rs. 2,500/- per year for the next 3 years, as International dues.

The Treasurer felt that all branches should contribute Rs.2,000/- per year as incidental expenses to the centre as otherwise centre has no income. After some discussion it was decided that Bombay and West Bengal wile send Rs.2,000/- and Nagpur Rs.1,500/- for the next 3 years.

The audited statement was proposed by Dr. Dina Patel seconded by Dr. Arati Basu Sengupta and passed unanimously.

VIII Appointment of Auditors

The same auditors M/s Kulkarni & Kulkarni to continue - proposed by Dr. Mandakini Megh seconded by Dr. Dipti Dongaonkar.

IX Report of Golden Jubilee Scholarship

The report of the Golden Jubilee Scholarship was read by Dr. Saraiya. Dr. Sarita Bahlerao was given the scholarship of Rs. 2,400/- per year for a second year. The report of the work done will be published in the Journal. Dr. Sarita be requested to give the report of work done 2001-2002.

Dr.Mataliya informed that she had received an application from Dr. Geeta Balsekar for the Scholarship. Her project is "Perinatal outcome for Twins". The members felt that the scholarship should be advertised in the Journal each year so that members from other states can also apply. Dr.Balsekar's application was accepted. She was asked to submit the details of the project with her biodata.

X Appointment of new Council Members and election of new office bearers

As per the constitution 1 council member is to be appointed for every 25 members to a maximum of 6 council members form every branch plus office bearers.

West Bengal has proposed the following names :

Dr. Kamla Sengupata - Office Bearer
Dr. Arati Roy
Dr. R. Iyer
Dr. Tulsi Basu - N.C. Secretary Past
Dr. Urmial Khanna
Dr. Meenakshi Ghosh - Editor
Dr. Arati Basu Sengupta - Office bearer
Dr. Ratna Sanyal

Bombay Branch :-

Dr. Dinoo Dalal - Office bearers
Dr. Usha Saraiya - Offic bearers
Dr. Vandana Walvekar - Council Member
Dr. Dina Patel - past President
Dr. Mehroo Pardiwala, N.C.S.
Dr. Sudha Sheth - Treasurer
Dr. Neeta Bhogilal
Dr. Dipti Dongaonkar
Dr. Jayshree Jhaverl
Dr. Maju Mataliya - Immediate past President

Dr. Jyotiben Trivedi - Central Asia Vice President

Nagpur Branch :-

Dr. Manorama Purwar - Office Bearer Dr. Naina Kunawal Hanspal Dr. Ujjwala Deshmuk

Dr. Mataliya informed that she had received nominations for the office bearers from Mumba West Bengal and Nagpur branch. She read out the nominations for various posts. Nomination were discussed. It was decided that the President and Secretary should be from same branc for better functioning of the office and Nagpur branch should also be given a chance to represe at Central Office as office bearers, as they were also paying all the dues. Members suggeste that in future if there are more than required nominations elections should be held for election o office bearer as is done in various other organisations.

The Office bearers for 2002 - 2004 as decided after some discussion were as follows :-

President	:	Dr. Kamla Sengupat, West Bengal
Immediate Past President	:	Dr. Manju V.Mataliya
Vice President	:	Dr. Dinoo Dalal, Mumbai
		Dr. Usha Saraiya, Mumbai
Secretary	:	Dr. Arati Basu Sengupta, West Bengal
Jt. Secretary	:	Dr. Manorama Purwar, Nagpur
Treasurer	:	Dr. Sudha Sheth to continue
Editor of the AMWI Journal	:	Dr. Minaxi Ghosh, West Bengal to continue
National Corresponding Secretary	:	Dr. Mehroo Pardiwalla, Mumbai
		Dr. Tulsi Basu, West Bengal, will continue as Nationa Coresponding Secretary
Central Asia Vice President	:	Dr. Jyotiben Trivedi

It was also confirmed that as per the past convention the Presidents will alternate between Wes Bengal and Mumbai at present and that later on Nagpur or any other branch should also b given a chance at Presidentship by rotation when due..

XI Speech by outgoing President

Outgoing President Dr. Manju Mataliya thanked all the office bearers for their co-operatio during her term of office and promised all her help in the future. She informed that durin her tenure 2 council meetings were held and she was able to organise a "National Congress after a long gap of several years.

XII Installation of new office bearers

The new office bearers were installed and the President's Medal was handed over to th new president.

XIII Speech by incoming President

Incoming Presidnet Dr. Kamla Sengupta promised to do her best in the next 3 years.

IIX Any other business with the permission of the Chair

As there was no other business the meeting ended with a vote of thanks to the chair.

Dr. Manju Mataliya
President

Dr. Usha B. Saraiya
Secretary

N.B. : As audited accounts have not been received these could not be printed in the Journa Journals can be sent to the newer brnaches only if there is some financial contributio towards it from them.

ASSOCIATION NEWS

West Bengal Branch

Our Association and our Mission Hospital are getting busier day by day.

Hospital - there are practically all departments. Dental and opthalmology departments are functioning to full capacity.

Paediatrics Dept. is very popular. All immunization is being carried out.

Gynaecological and obstetrical dept. - is run by very eminent doctors. It is a very busy unit.

Surgical : is being looked after by Dr. Urmila Khanna ex. head of dept. C.N. Medical College Surgical Department is also busy, same is true of plastic and reconstructive surgery. Ultrasonography is done twice a week. There is Yoga Meditation, Homeopathy, retarded children counselling as well as pain clinic.

The ambulance donated by Dr. H Mcdonald has become very useful especially for Health Camps which are held every month and transport of patients and doctors in emergency.

Family Planning and child Welfare Centre at Lenin Sarani after a small lapse has started in full swing.

Library - is functioning where future programmes, M.W.A updates and foregin journals are available.

Executive Meetings are held every month.

Scientific Meeting - There are three Orations and two awards given every year, one workshop and at least 6 scientific meetings. Last one was on post. Menopausal problems.

Social - Besides the routine festival days celebration where staff of the hospital are involved, the doctors have picnic every year.

Visitors : Dr. Cajsa Rangnitt treasurer of MWIA visited us early this year. She and her group were in Kolkata for less than a day. Our nurses organised a cultural programme. It was a lively afternoon. They gave generous donation and were pleased with the Hospital. After all, this is The Only Secular Hospital in the World for underpreviledged women and children run by women without any Governmental Support. For the last Five years Association of Medical Women of America AMWA are sending us regular donation and I hope they will continue to do so 5% patients are from minority group and over 98% doctors giving honorary services are Hindu so there is no difference in cast creed or religion.

EXTRACTS FROM PUBLICATIONS

Booklet For Work on Gender and HIV / AIDS

UNIFEM's new publication "Turning the Tide. CEDAW and the Gender Dimensions of the HIV/AIDS Pandemic," contributes to understnading how the world's foremost blueprint for women's human rights can be put to work to address the HIV/AIDS epidemic from a gender perspective. The book is intended to be a resource for National AIDS councils, HIV/AIDS activits, women's human rights activists, UN partners, and others who are doing work in this area and was enthusiastically received by the CEDAW Committee.

For More information, Contact Ilana Landsber-Lewis,
CEDAW Advisor,
Email : ilana.landsberg-lewis@undp.org

WHO Launches Tobacco-Free Sports Campaign

WHO points out that tobacco companies spend millions of dollars every year sponsoring sports events. "Many athletes, sports fans and spectators are young people," the WHO reports, adding that recent data suggest that one-third of young smokers start before the age of ten. At the same time, youth consumption of tobacco is up in many parts of the world. Although tobacco companies claim that they do not target youth, the WHO says they advertise on "team jerseys and caps, tote bags and T-shirts, fields and stadia, cars and sports equipment" in order to "create a positive association between tobacco and the strength, speed, grace, success, fun and excitment of sports. "tobacco kills more than four million people every year, according to WHO figures, and it is estimated that tobacco will kill 8.4 million people every year by 2020.

Go Between No. 8
December 2001 - January 200

Eiimination of Violence Against Women Day

"The commitments made by Member States must be our lodestar in our mission to free women from violence, wherever they may live," the Secretary-General said. "Violence against women is not a 'women's' issue, but one that concerns us all - especially men. Men must work to confront what should be described as men's violence against women, and recognize and respect the equal role and rights of women. When it comes to violence against women, there are no grounds for tolerance, no tolerable excuses," Mr. Annan continued.

Go Between No. 8
December 2001 - January 200

WPAW (The Population Institute)

Statement on Population Stabilization by World Leaders From the Population Institute, Washington

Humankind has many challenges : to obtain a lasting peace between nation; to preserve the quality of the environment; to conserve natural resources at a sustainable level; to advance the economic and social progress of the less developed nations; to assure basic human rights and at the same time accept responsibility for the planet Earth and future generations of children; and to stabilize population growth.

We believe in the principles of solidarity, tolerance, respect for nature and shared responsibility.

We believe in an indispensable foundation of a more peaceful, prosperous and just world.

We wish to reaffirm the goals of the International Conference on Population and Development, Cairo, 1994 : to reduce infant mortality; to reverse the spread of HIV/ AIDS, malaria and other major diseases; to halve the proportion of people living in poverty and to ensure equal access to all levels of education for girls and boys.

We want to preserve the world so that future generations of children will have adequate food, housing, health services, education, earth resources, and employment opportunities.

We believe that the time has come now to recognize the worldwide necessity to achieve population stabilization. to enhance the integrity of the individual and the quality of life for all, we believe that all nations should participate in setting goals and programs for population stabilization. Measures for this purpose should be voluntary and maintain individual human rights and beliefs.

We urge national leaders to take an active personal role in promoting effective policies and programs. Emphasis should be given to improving the status of women, repspecting human rights and beliefs, and achieving the active particiaption of women in formulating policies and programs. Attention should be given to improving women's reproductive health

Mahin Karim (WPAW Coordinator)
E-mail wpaw@populationistitute.org

European Federation of Women Working in the Home

NGO holding Special Consultative Status with the UN

The Federation Europeenne des Femmes Actives au Foyer requests from Governments

- the recognition and quantification of the economic and social value of unremunerated family work and its inclusion in satellite accounts which are consisten with core national GDP accounts.
- the right of every women to a basic pension supporting a reasonable standard of living this pension should be calculated by taking into consideration the amount of time spent carrying work out within the family not be linked to one's own income nor with any employment statute and guarantee access to quality services and care.

King Faisal International Prize

Invitation to Nominate

The General Secretariat of the King Faisal International Prize is pleased to invite universities, scientific societies, research centres, and other learned circles throughout the world to nominate candidates for the year 2003 (1423H) Prize in Medicine. Nominees should be widely recognized for outstanding contributions to the following topic : Breast Cancer

The Prize Consists of :

- A certificate written in Diwani calligraphy and presented in a leather folder, describing the work for which the winner is awarded the Prize;
- A Commemorative 24-carat, 200-gram gold medallion;
- SR 750,000 (US$ 200,000).

Joint winners share the cash prize

General Remarks :

- In order for nominees to qualify, all conditions must be fulfilled.
- Required documentation must be receive by the General Secretariat of the King Faisal International Prize no later than **31 May 2002** (19.3.1423H).
- Winners will be announced in **January 2003** (Dhu Al-Qada 1423H) and will be honored at an official ceremony later in the year in Riyadh.

- The decision of the Prize's Selection Committee is final.
- Nominations are to be sent directly to the General Secretariat in Saudi Arabia, for details contact the MWIA Secretariat.

(Conditions and Requirements can be obtained from the secretariat e-mail : mwia@aol.com)

German Foundation for International Development

The German Foundation for International Development (DSE) offers a "Physicians Programme" for Medical and Dental students and young doctors and dentists from Africa, Asia and Latin America. If you are interested, please contact :

German Foundation for International Development (DSE)
Centre for Education, Health and Public Administration
- Public Health Division -
- Physicians Programme -
Tulpenfeld 4, 53113 Bonn/Germany
Phone : (+49)-228-2434-802/804/806/807
Fax : (+49)-228-2434-844
E-mail: aerzteprogramm@dse.de

or

Department of Tropical Hygiene and Public Helath at the University of Heidelberg (ATHOG)
- Physicians Programme -
Ringstrass 19D
69115 Heidelber/Germany
Phone : (+49)-6221-13823-30/31
Fax : (+49)-6221-13923-20
E-mail : dieter.hampel@urz.uni-heidelberg.de

Gender Unit Coordinator Positon

IDRC is seeking qualified candidates for the position of Gender Unit Coordinator. Working as the leader of a team and under the supervision of the VP Program and Partnership, the incumbent, through collaboration with Program Areas, Regional Offices, and Secretariats, is responsible for the development and implementation of gender programming at the Centre.

To find out more about the detailed job description, click on :
http://www.idrc.ca/careers/pr205.htm

AMWI (W.B.) Mission Hospital are grateful to

American Medical Women Association for their yearly donation

ARMENIAN CHURCH,

Lutherans World Services

Mennonites,

Salvation Army for their Donations in Kind

Dr. Cajsa Rangnitt treasurer of M.W.I.A for her personal Donation

At the meeting of Journal Committee held on 17.2.2001 following resolution was take

"It was resolved that 30% of membership charges from members should be contributed towards the Journal". Unless there are contribution from branches it is not possible to bring out 2 issue of Journal a year which we are trying.

Dr. Cajsa the Treasurer of MWIA Meeting the Doctors

WAR AGAINST RUBELLA

Will 'YOU' be our ally?

R-VAC

Rubella Vaccine Live BP

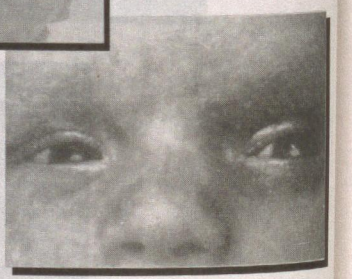
The affordable treatment
for avoidable circumstances

Mental Retardation

Ear defects

The pioneering
VACCINE against Rubella

- Effectively controls Rubella and CRS
- High safety and efficacy record



Eye defects

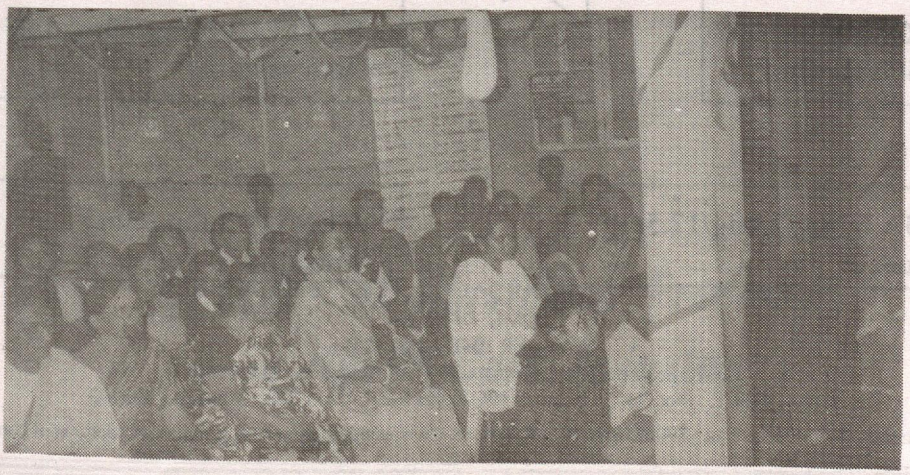
Serum Institute of India Ltd.

S.No. 212/2, Hadapsar, Pune 411 028. INDIA
Enquiries : 501, Dalamal Tower, 211, Nariman Point, Mumbai - 21; Tel: 284 0370 / 337, 283 0147, Fax : (022) 204 4389

For the use only of a Registered Medical Practitioner or a Hospital or a Laboratory

Dr. Cajsa Rangnitt & Group in O.T.

Nursing Trainees dancing for the treasurer of M.W.I.A. Dr. Cajsa Rangnitt & Group



Christmas Celebration in Mission Hospital M.W.I.A.

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