

Clendening Summer Fellows, 2007 Directory		
Name	Title	Pages
Kyle Brown	"The AIDS Epidemic in South Africa"	1 - 5
Timothy Fendler	"Health Care Education for American Indians in Montana"	6 - 12
Sushant Govindan	"Privatized vs Socialized Oncology in Kansas City and London"	13 - 20
Anita Gupta	"Naturopathic Lifestyle & Intestinal Cancer"	21 – 26
Kwame Gyasi	"Project STAY in Harlem"	27 - 35
Leonid (Terry) Hansen	"Diplomat of Immunity in Ghana"	36 - 41
Madhu Iyengar	"Cross Cultural Differences in Emergency Medical Care in Los Angeles"	42 - 45
Rachel Moses	"Dance Medicine in New York City"	46 - 53
Elise Schnose	"Health Care in Thailand"	54 – 60
Deborah Scrafford	"Preparing Parents of Chronically Ill Children"	61 – 69
Bradley Thompson	"Venezuelan Health Care Reform"	70 – 74
Erica Ubben	"Adolescent & Young Adult Cancer Survival Rates"	75 - 83

The AIDS Epidemic: The contrast of political will and health care outcomes of South Africa with Uganda

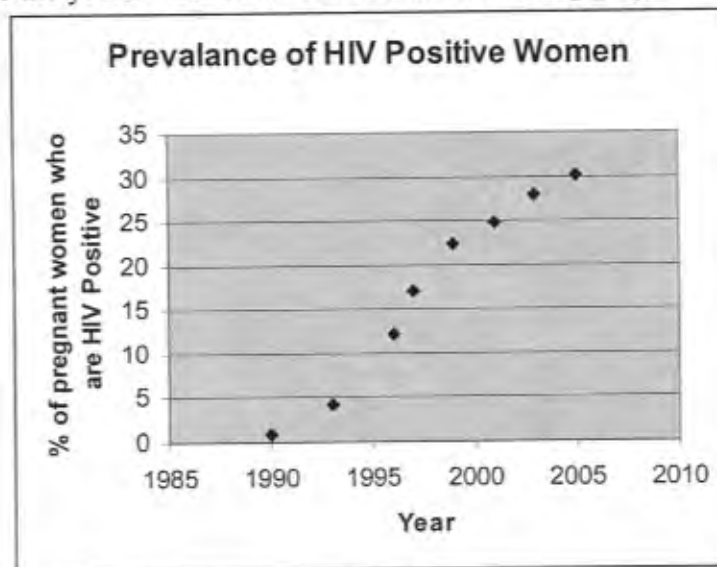
**By: Kyle Brown, SOM 2010
February 19, 2007**



Introduction

In 2001, the 189 state and government representatives of the UN adopted unanimously the Declaration of Commitment on HIV/AIDS, the AIDS epidemic constitutes a "global emergency and one of the most formidable challenges to human life and dignity."² The goal of the UNAIDS project is to reverse the spread of HIV/AIDS by 2015. To begin to understand what will work to reach this goal, it is necessary to understand where the spread of HIV/AIDS is the worst.

The AIDS epidemic is one of the worst in South Africa, where the prevalence of HIV infected people was at 1.5 million in 2005, and over one thousand people die of AIDS every day¹. This is around 11% of the population. But more striking is the rise in prevalence over the years. This is exhibited in the following graph:



When assessing what is needed for proper treatment and prevention, Peter Piot, the executive director of UNAIDS, stated that, "Treatment is technically feasible in every part of the world. Even the lack of infrastructure is not an excuse—I don't know a single place in the world where the real reason AIDS treatment is unavailable is that the health infrastructure has exhausted its capacity to deliver it. It's not knowledge that's the barrier. It's political will."³

The power of political will can be seen by comparing the decline in prevalence in Uganda compared to South Africa. In South Africa, there has been much turmoil since the 1980s, with riots and unrest from the issue of Apartheid until 1985. The first documented case of AIDS was in 1982, and AIDS had not begun to be addressed until the late 1980s when Apartheid was being abolished⁴. The most rapid increase in the prevalence of HIV in South Africa occurred between 1993 and 2000, when major political changes took precedence over AIDS. But there is also a persistent denialism in the country that is exacerbated by South Africa's President Mbeki. He is quoted as saying, "Does HIV Cause AIDS? Can a virus cause a syndrome? How? It can't, because a syndrome is a group of diseases resulting from acquired immune deficiency. Indeed,

HIV contributes, but other things contribute as well.”⁵ In 2000 Mbeki included a number of ‘AIDS dissidents’, such as the controversial American scientist Peter Duesberg, in a committee set up to advise the Government on tackling the AIDS crisis.⁶ President Mbeki also reiterated his views on HIV and AIDS at the International AIDS Conference in Durban which caused hundreds of delegates to walk out in protest.⁷ There are other examples of how denialism has contributed to South Africa’s lack of access to antiretroviral treatments, but these are some key examples.

In contrast, Uganda is one of the few African countries where the prevalence rates of HIV and AIDS has declined from 15% in 1990s to 6.7% in 2005⁸. There the political will has been stronger, and they have a definitive response to AIDS. They have also benefited from being on President Bush’s list to receive funds to fight AIDS⁹.

Plan

The goal and plan for this project is to contrast the “political will” South Africa and Uganda in three areas, orphanages and public health clinic, and AIDS education. This will be accomplished by researching the programs and epidemiology of both Uganda and South Africa.

However, it is important to get firsthand experience of the difficulties experienced by the people in South Africa, therefore I plan to enroll in a volunteer program through STAESA in Cape Town South Africa, and spend 4 weeks studying and working with AIDS health clinics and orphanages. STAESA HIV/AIDS program is divided into two categories: prevention and management. The program gives participants an opportunity to do both. Program participants have a direct contact with the communities for an intensive education on the diseases HIV/AIDS and getting close to HIV/AIDS patients for counseling and dispensation of food and drugs. This program includes an outreach program where our volunteers join the health team for a public HIV/AIDS awareness campaign and distribution of condoms.

On Site Goals:

The aims of this project are:

- (1) HIV/AIDS public awareness program
- (2) To eradicate the spread of HIV/AIDS
- (3) To bring health to the door steps of the communities
- (4) To help educate the public about any health related issues
- (5) To help intensify HIV/AIDS campaign
- (6) To treat and observe patients (medical doctors)
- (7) To give more helping hands in the laboratory.
- (8) To provide food and clothes
- (9) To help in school programs

Research Goals:

Using the above experience combined with interviewing hospital staff and patients to determine what is working, what resources are needed, and what can be done

to decrease the AIDS incidence and prevalence in South Africa. This will be combined with epidemiological research from both countries to evaluate the political will of each country and to determine the impact how that political will contributes to the AIDS solution or problem in each country. Results will be compiled and presented in a research paper and presentation.

Budget

Costs	(in USD)
Airfare	-1600
Program Cost	-995
Application Fee	-75
Visa	-47
Airport Drop off	-30
Limited local transportation	-40
Misc personal expenses	-200
Travel health insurance	-120
Total	-3107
Clendening Fellowship	2000
Total Out of Pocket Expenses	-1107

All other expenses will be paid out of pocket

Itinerary

June 13 – July 11

Allow 1.5 days for travel each way

Flights to Cape Town, South Africa

Sample experiences in the STAESA program:

STAESA's HIV/AIDS project is located in Cape Town, Reiger park, Boksburg and Actonville. Together with local volunteers, volunteers/interns work very closely with HIV/AIDS patients at private homes, hospitals and HIV/AIDS homes. The program gives volunteers an opportunity to have a direct contact with the communities for education and to meet HIV/AIDS patients for counseling, dispensation of food and drugs. Included in this program is an outreach program where volunteers/interns join the health team for a public HIV/AIDS awareness campaign and distribution of condoms. Volunteers/Interns in the HIV/AIDS South Africa project will also be involved in educational and training activities meant to increase awareness to stop the spread of the HIV/AIDS epidemic in South Africa.

These experiences will occur on a Monday through Friday, 8am to 230pm, with 2 days of orientation prior. At the end of the day, the results will be compiled in the evening as well as interacting with host families to gain more insight into the local AIDS epidemic.

Contacts:

Students Travel and Exposure South Africa (STAESA)

South African Branch

Telephone: +27-11-910-4095

Cell Phone: +27-73-651-8203

Fax: +27-11-910-4095

Postal Address:

P.O. Box 15016

Delpark 11

Brakpan 1552

South Africa

Physical Location:

Students Travel and Exposure South Africa (STAESA)

1184 Goede Hoop Ave.

Reiger Park

Boksburg, South Africa

Margret Marquart HIV/AIDS Project

Contact Person – Madam Celestine

Kukaye Orphanage

Contact Person – Rev. Tossy Titus

Bibliography

- 1 - UNAIDS (2006), *'UNAIDS 2006 Report on the global AIDS epidemic', Annex 2: HIV/AIDS estimates and data, 2005*
- 2 - Website: <http://www.unaids.org/en/Goals/default.asp>
- 3 - Website: http://en.wikipedia.org/wiki/AIDS_in_Africa
- 4 - Website: <http://www.avert.org/aidssouthafrica.htm>
- 5 - Iclinic (2000), *'How Can a Virus Cause a Syndrome? Asks Mbeki', September 21*
- 6 - Science (2000), *'SOUTH AFRICA: AIDS Researchers Decry Mbeki's Views on HIV', Vol. 288, no. 5466, pp. 590 - 591, 28th April*
- 7 - BBC.co.uk (2000), *'Controversy Dogs AIDS Forum', 10th July*
- 8 - The "ABCs" of HIV Prevention: Report of a USAID Technical Meeting On Behavior Change Approaches To Primary Prevention of HIV/AIDS, September 17, 2002
- 9 - Website: <http://www.avert.org/aidsuganda.htm>

Helping American Indians Live Healthier
Lives:
The Role of Education in Health
Disparities

A Clendening Summer Fellowship Proposal

by

Timothy Fendler
KUMC School of Medicine
Class of 2010

February 20, 2007

INTRODUCTION

On January 17th, Charles Grim, Director of Indian Health Services, spoke at the grand opening of Lawton Indian Hospital in Lawton, Oklahoma.¹ In his address, he stated, "I firmly believe that each new facility moves us closer to our shared mission of raising the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level." These words, echoing the official IHS Mission Statement, were no doubt spoken to give hope to American Indians in attendance that day. And while a state-of-the-art medical facility is, indeed, a source of hope for a people seeking better healthcare, the plight of American Indians and their struggle to receive such quality services and live healthy lifestyles is not so easily resolved. This serious problem is multi-faceted, and a solution requires much more than new facilities.

American Indian life expectancy is currently 2.4 years less than the average U.S. population, and American Indian infants die at a higher rate than the U.S. infant population, as well.² Tuberculosis, alcoholism, motor vehicle crashes, unintentional injuries, homicide, and suicide all claim higher death rates among the American Indian population than the U.S. population, as a whole.² Perhaps the most well-known and devastating toll on the American Indian population comes from what is fast becoming an epidemic of type II diabetes. Recent data shows that the prevalence of diagnosed diabetes more than doubled from 1994 to 2004 in American Indians under 35, with steady increases in both sexes and all age groups during the aforementioned decade.³ Over 12,000 diagnoses of diabetes were made through ISH health-care services, who treat only an estimated 55% of the country's American Indian population.¹ Though this striking increase can be attributed, in part, to an increased effort in screening and treatment, the numbers are unacceptably high, nevertheless.

While provision of competent providers and suitable technology and supplies are vital in bettering American Indian healthcare, there is also a necessity for education among the patient population. However, the subject of education has always been a contentious one. American Indian populations have often suffered from federal policies that sought to assimilate, instead of educate, over the last 200 years.⁴ Today, groups like the National Indian Education Association work to make sure this is not the case, but there are still inherent difficulties in communicating effectively with American Indian populations, due in great part to vast cultural differences. Among these are language barriers, different communication styles and customs, and the traditionally non-Western belief system of American Indians, who view medicine as a science inextricably linked with religion and spirituality.⁵ An educational program that seeks to better American Indian health by increasing trust and understanding between patient and provider must, then, respect such cultural beliefs and practices.

BACKGROUND & MOTIVATION

I am not a traditional medical student. I made the decision to attend medical school after completing college and teaching high school for a few years. Consequently, I am approaching my physician training from a very different background than most of my colleagues. For example, I did not spend my summers in college working in free clinics and traveling on medical missions, but reading the great books and teaching summer programs. Due in part to this, I will admit that before medical school I was ignorant and naïve about healthcare in the United States. This year has been my first real introduction to many of the health disparities in our country, not the least of which is the predicament with which the American Indian population is faced.

My uncle, Dr. Emmet King, lives in Billings, Montana, and I remember him telling stories, during holiday family gatherings in my youth, about his experiences with American

Indian patients. In speaking with him since I started at KU, I realized that visiting him this summer would provide the perfect opportunity for me to explore some of the health disparities that have arisen in our healthcare system. I feel that inherent in the work of medicine is the obligation to use our skills in helping those who cannot help themselves. Our world is filled with underserved populations, and by choosing this career we have accepted that it is our duty to try and effect positive change. I believe there is no better example of an underserved community in the U.S. than that of the American Indians. As I mentioned previously, this is not a problem with one easy solution, but one with many contributing factors. My history as a teacher evidences my interest in education, and this is the facet of the healthcare dilemma facing American Indians that I hope to study.

OBJECTIVES/GOALS

With the help of my uncle in Montana and Dr. Christine Daley here at KUMC, I have developed a proposal to visit the Northern Cheyenne reservation near Billings, as well as an American Indian outpatient clinic in Billings, in July. Through these experiences, and others, I hope to accomplish the following goals:

- Develop an appreciation for American Indian cultures, practices, and beliefs concerning healthcare, spirituality, and education
- Learn about IHS and its role in providing healthcare for this minority population
- Investigate the health disparities that American Indians suffer, as well as the causes of these disparities
- Study the link between health education and healthy lifestyles, as well as the importance of general education in creating competent individuals who make connections between healthy lifestyles and freedom from disease and injury
- Determine the efficacy of education in combating fatalism and fostering hope among American Indians

METHODS

I plan to fly to Billings, where I will stay with my uncle, using his extra car for transportation. The first of the sites I will visit is the Lane Deer Clinic. This clinic, which serves the Northern Cheyenne Reservation population, is located near Colstrip, Montana, about 120 miles from Billings. I will be shadowing Dr. Tom Schreiner, the Chief Medical Officer at the clinic, as well as accompanying Janet Wolfname, the public health nurse supervisor and diabetes educator, on home visits. During this opportunity, as with all following opportunities that include patient contact, I will speak with patients, as time and consent allow. I will use Arthur Kleinman's Explanatory Model (Appendix 1) to gain an understanding of the patient's beliefs about their illness. In addition, on home visits with Ms. Wolfname, I hope to speak to parents about their education, the education of their children, and their views on how effectively there were/are taught about disease and health risks. Because this can be a sensitive issue, I will broach the subject informally and at my discretion, as opposed to using a formal questionnaire.

In Billings, I will spend time at the Billings Urban Indian Clinic, which is independent of IHS. Here, I have made contact with Dr. Steve Shaub, who volunteers time at the clinic. I hope to shadow him, and possibly some of his colleagues, including Dr. Brian Schnitzer, another clinic volunteer, and Dr. Janice Linn, who runs a diabetes clinic there. This will afford me the opportunity to interact with the 45% of American Indians who live off-reservation and receive treatment from alternative sources to IHS, and possibly to speak with Dr. Linn about the challenges facing physicians in combating the diabetes epidemic among American Indians. The executive director of the clinic is Margery Bear Don't Walk, with whom I also hope to speak concerning access to healthcare for this subset of the population (at the time of this draft, I have not yet spoken with Margery).

Finally, my uncle has an American Indian colleague, also located in Billings, who is in her first year of residency. I would like to dialogue with her about her experiences with education and adversity during her childhood, and discuss how she overcame the obstacles that seem to impede so many American Indians from continuing their education and developing an understanding of healthy living.

Because of my relative inexperience with Indian healthcare, I plan to do preparative work during the spring and early summer in anticipation of my excursion in July. To that end, I will work with Dr. Daley on such activities as the American Indian Health Research and Education Alliance health and wellness powwow on May 5th, as well as participating in activities at Haskell Health Center. At the time of this draft, Dr. Daley has mentioned the possibility of speaking with Randy Barnoskie, MPH and former CEO of Haskell Health Center, from whom I can learn more about IHS (though I have not yet made this contact).

Finally, at the time of this draft, there are two other possibilities I am still pursuing for my time in Montana. Between the Northern Cheyenne reservation and Billings lies the Crow Indian Reservation. I am still attempting to make connections there to see their hospital, but the Crow are less open to outsiders, according to Dr. King. In fact, they also have a tenuous relationship with the Northern Cheyenne, to the extent that the Northern Cheyenne often bypass the Crow hospital when they need serious medical attention, instead risking a longer journey to Billings for such services. I am also attempting to make contacts with DeLaSalle Blackfeet School, in Browning, MT. This school is run by the Christian Brothers and serves American Indian youths. I would like to visit the school, but have been unsuccessful in reaching someone, so far. The school is located in Browning, MT, 350 miles from Billings, so I have included gas and lodging in the following budgetary plan, should I be successful in making contact.

ITINERARY

July 8	Fly to Billings, Montana
July 9/10	Billings Urban Indian Clinic
July 11-14	Northern Cheyenne Reservation (possibly Crow Reservation)
July 15*	Return to Kansas City via plane

* Trip could be extended 2 days if I travel to DeLaSalle Blackfeet School

BUDGET

Round-Trip Airfare	\$500
4 Nights @ Hotel in Colstrip	\$300
Gas (44.5 ¢ mile → KUMC rate)	
Billings to Colstrip, Round Trip, 130 miles	\$57.85
Colstrip to Lame Deer, Round Trip, 25 miles x 4 trips	\$44.50
Meals (\$30/day, 7 days)	\$210
Gift for my uncle for housing & car	\$100
Total	\$1212.35

(Possible additional expenses)

Gas, Billings to Browning, Round Trip, 350 miles	\$155.75
2 nights @ Hotel in Browning	\$160
Total	\$1528.10

CONTACTS

Dr. Emmett King

Dr. Christine Daley

Lame Deer Clinic

Dr. Tom Schreiner, CMO

Janet Wolfname, public health nurse supervisor

Billings Urban Indian Clinic

Dr. Steve Shaub, volunteer physician

Crow Reservation

Dr. Terry Dennis, CMO, Billings Area

DeLaSalle Blackfeet School

Christian Brothers residence ● school

Appendix 1

Explanatory Model* Arthur Kleinman

- 1) What do you call your problem? What name does it have?
- 2) What do you think has caused your problem?
- 3) Why do you think it started when it did?
- 4) What does your illness do to you? How does it work?
- 5) How severe is it? Will it have a short or a long course?
- 6) What do you fear most about your illness?
- 7) What are the chief problems your illness has caused for you?
- 8) What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment

* Adapted from a lecture by Dr. Christine Daley, "Socio-economic Environment: Health Disparities," August 16, 2006.

Bibliography

1. Grim, Charles W. "Building a Healthy Future." Lawton Indian Hospital Grand Opening. Lawton Indian Hospital, Lawton, OK. 17 Jan 2007.
2. "Facts on Indian Health Disparities." Indian Health Services. Jan 2006.
<http://info.ihs.gov/Files/DisparitiesFacts-Jan2006.pdf>
3. CDC MMWR. "Diagnosed Diabetes Among American Indians and Alaska Natives Aged <35 Years – United States, 1994-2004." *Journal of the American Medical Association* 297.5 (7 Feb 2007) 461-462.
4. "History of Indian Education." National Indian Education Association. 2003.
<http://www.niea.org/history/educationhistory.php>
5. Daley, Christine Makoskey & Sean M. Daley. "Care of American Indians & Alaskan Natives." Cross-Cultural Medicine. Ed. JudyAnn Bigby, MD. Philadelphia, PA: American College of Physicians, 2003. 95-128.

*Privatized vs. Socialized Oncology: which
bureaucracy is better?*



*Clendening Fellowship Proposal for 2007
By Sushant Govindan M1
Student ID: 1280863
February 20th, 2007*

Intro

Sorry...you're uninsured.

I remember the experience as though it were yesterday. I had just started the second semester of my sophomore year in college, a time for solidifying my path and career focus. In pursuing a possible medical anthropology major, I had decided to seek an internship with an inner city medical clinic called *La Clinica Medica*. This organization's main goal was to provide gratis or highly affordable healthcare for those who needed it, particularly the uninsured. Looking back on that five month internship, I could not have anticipated how our skewed patient population was going to affect me; this was not because of a scarcity in literature about the topic, but rather it had to do with the fact that I had never been confronted with the issue outside the classroom. *La Clinica* brought a whole new meaning to the term "health disparities", making it more personal than I could have every imagined.

This was an incredibly eye opening time for me, not just about societal problems, but also in the area of self discovery. *La Clinica* unveiled a passion within me to fight for equitable healthcare access. Since that time, I have worked with underprivileged kids on educating them about good hygiene, traveled to Africa to provide healthcare for rural populations, and worked with various urban medical clinics in St. Louis and Kansas City. However, through these endeavors, I have learned that our social justice healthcare services, though successful in many ways, are only band aids on a societal wound that is getting bigger. I believe a comprehensive solution is needed

"You have cancer."

Cancer: this truly is one of the most feared words in the medical world. My passion for oncology began this past October with our Genetics and Neoplasia module. It is difficult to describe the immediate connection I felt with this area of medicine, but I would most liken it to me being drawn to oncology, an area of healthcare where medical practitioners must work tirelessly to give hope to their patients. In a sense, the foundation of this passion is very similar to that of equitable healthcare access: both seek to give hope and comfort to people who, in many ways, are on the brink of hopelessness.

Dr. Gary Doolittle, an oncologist at KU Med, was one of our lecturers; as I wrestled with ideas of how to pursue this newfound interest, I decided to ask Dr. Doolittle if I could begin a preceptorship with him. He was more than willing to help me out, and thus began another process of self discovery. I have been working with him once a week for the past four months, and words cannot describe how rewarding of an experience it has been. I believe what has struck me the most has been the transparency of the relationships between Dr. Doolittle and his patients. Part of this transparency stems from the fact that Dr. Doolittle is an exceptional physician. However, I also believe another aspect of this transparency has its origins in the following: a diagnosis of cancer often times violently thrusts a person into a life or death situation. With such a serious state of affairs where the odds are often working against you, the effort to fight this disease must be a collaborative one between the doctor and the patient; such an effort demands trust and openness. There are certainly exceptions where patients are not as

open, but those situations are rare. Between studying the fascinating mechanisms of cancer progression and observing the doctor/patient relationships that develop, I have fallen in love with the profession.

How does this tie in with my passion for solving our healthcare access issues in America? It is quite interesting, but access issues do not limit themselves to primary care settings; specialties like oncology also feel their ramifications. I began to notice this about a month into my preceptorship; the word "insurance" or "cost" was coming up a lot in conversation during patient consultations. Upon further observation and discussions with Dr. Doolittle about the topic, it became clear that "insurance coverage" and "cost of care" were serious inhibitory factors that came up frequently in oncology. I was immediately intrigued by this as it spoke to another of my deep passions, and after talking it over with Dr. Doolittle, I began recording data on how often "insurance" was discussed during consultations and under what contexts. While all of this was going on, I had been pondering what I wanted to do with my summer; I knew I wanted to pursue my interests in oncology, but I was unaware how to do so. Upon conversing with my aunt Dr. Usha Nair, a gynecologist in England, she suggested that I travel to Britain and work for a summer under an oncologist in a socialized setting. This would serve a three-fold purpose: I could gain experience in a universal healthcare setting, I could further my research on oncology access issues by analyzing firsthand a socialized healthcare system and comparing it to a privatized one, and I would be able to pursue my personal interests in oncology. Upon making all the necessary arrangements with Dr. Nair, and after Dr. Doolittle encouraged me to pursue the opportunity, I decided that this would be the perfect project for the Clendening Summer Fellowship. This venture provides me with the unbelievable opportunity to unite two of my passions and pursue them under the banner of one focused project.

Background

Up until now, I have enumerated the personal reasons as to why this project is so meaningful to me. However, I strongly believe that there are highly practical applications that it could also serve...

2008

"I am absolutely determined that by the end of the first term of the next president, we should have universal health care in this country."¹ With these words, Barak Obama, a prominent presidential hopeful, thrust into the forefront an issue that has been plaguing our country for years: the uninsured. Being such a hot button political issue, many representatives have criticized the lack of adequate care for all American citizens. However, few have put forth a strong proposal to solve the problem until recently.

The growing number of uninsured Americans remains one of our nation's most pressing social issues. From the 2002 Census Bureau, statistics show that more 43.6

¹ Obama, Barack. Speech. Families USA. Conference of Families USA, Washington D.C. 25 Jan. 2007. Accessed on 2 Feb. 2007 <<http://www.foxnews.com/story/0,2933,246800,00.html>>.

million adults and children were without health insurance². Recent data from most major governmental agencies unfortunately demonstrate that the numbers are growing, with estimates reaching 45 million in 2006. Furthermore, research reveals that the uninsured suffer significant lifestyle disadvantages: fewer preventive and screening services, later diagnoses, fewer therapeutic services, poorer health outcomes, and lower annual earnings because of poorer health³.

With more than one presidential hopeful turning to universal healthcare as their solution, American citizens must analyze the experiences of other nations with socialized medical systems. An empirical example of universal healthcare can be found in Britain with their National Health Service, or NHS. Funded by taxation and run by the Department of Health, this governmental organization was set up in 1948 to provide free healthcare for all citizens of the United Kingdom. The system is structured so that every time an individual goes to the doctor or hospital, treatment is provided free of charge. Private healthcare providers coexist with the NHS in order to share the burden; people pay for private healthcare either through insurance or when they use their services. It is estimated that 90 percent of British citizens try to get timely medical care from the NHS before turning to the private sector⁴.

A clear advantage is that every citizen would have access to healthcare, regardless of socioeconomic status. However, a less obvious benefit to universal healthcare appears to be a reduction in cost. For the year 2000, experts estimated that total healthcare spending in Britain was 57.5 billion pounds, which was 6.6% of gross domestic product⁵. Compared to the almost 1.3 trillion dollars spent by the U.S. in 2000, Britain's budget was significantly less⁶. However, experts cite significant shortcomings associated with the NHS: "All too frequently they (patients) don't get care at all; are subjected to queuing for 12 months or more; get better on their own; are sent to other countries for care; are shifted to the private sector for care..."⁷ Some say that this may be acceptable costs in order to ensure that all Americans have affordable healthcare. However, when looking at specific subspecialties, the costs seem to get a bit higher.

Cancer

The financial costs of cancer treatment are a burden to American patients, their families, and society as a whole. Cancer treatment accounted for an estimated \$72.1 billion in 2004, just under 5 percent of total U.S. spending for medical treatment.

² Rowland, Diane. Uninsured in America. The Kaiser Commission on Medicaid and the Uninsured. Washington D.C.: U.S. House of Representatives, 2004. 1-21.

³ Hadley, Jack. "Sicker and Poorer--the Consequences of Being Uninsured: a Review of the Research on the Relationship Between Health Insurance, Medical Care Use, Health, Work, and Income." Medical Care Research and Review 60 (2003).

⁴ Action Network Team. "How the Healthcare System Works in England." Bbc.Co.Uk. 1 Apr. 2005. BBC. 9 Feb. 2007 <<http://www.bbc.co.uk/dna/actionnetwork/A2454978>>.

⁵ Appleby, John, and Sean Boyle. "Blair's Billions: Where Will He Find the Money for the NHS?" BMJ (2000): 865-867.

⁶ National Health Expenditures and Percentage of GDP 2000-2010. Centers for Medicare and Medicaid Services. 2005. 12 Feb. 2007 <http://www.bcbs.com/betterknowledge/mcrg/chap1/ch1_Slide_2.html>.

⁷ Meier, Conrad F. Britain's Deadly Mistake: a First-Hand Report on England's Disastrous Experience with Nationalized Health Care. Chicago: The Heartland Institute, 2002. 1-32.

Between 1995 and 2004, the overall costs of treating cancer increased by 75 percent in the United States⁸. This is in stark contrast to the British system and its low costs. However, there may be a significant downside to the lower cost: higher mortality. Studies have shown that Europeans have significantly lower survival rates than U.S. patients for most cancers; "Differences in 5-year relative survival rates were higher for prostate (56% vs. 81%), skin melanoma (76% vs. 86%), colon (47% vs. 60%), rectum (43% vs. 57%), breast (73% vs. 82%), and corpus uteri (73% vs. 83%)"⁹. Furthermore, English survival rates from cancer are well below the best in Europe. A key factor appears to be the tendency of patients to be diagnosed at a later stage in the disease, which has several possible explanations: shortcomings in patient awareness, delay in patient coming forward with symptoms, delay in onward referral from general practitioners, and delay in carrying out diagnostic tests¹⁰.

The point

It has become apparent to me that there is an enormous amount of complexity surrounding the comparison of privatized and universal healthcare. However, while I have found numerous articles centered upon broad analyses of the two systems, few studies materialized in which the two systems are compared in terms of their effects on specific areas of medicine. From some of the material presented above, it seems possible that experts may not be fully informed by only looking at a general comparison between the two systems. I believe it is necessary to compare both systems in terms of how they affect the different subspecialties so that we will not only know about the general distinctions but also the specific ones. Moreover, I believe experts must now delve deeper into the "why" behind the observed differences; it is only through understanding the reasons causing the differences that an effective solution may be generated.

Due to the relative dearth of literature comparing private and universal oncology systems, along with its pertinence to current political issues, I contend that a firsthand comparison of the two systems would be beneficial. I do not believe I can provide a thorough evaluation of universal and privatized oncology systems in just one summer. However, I would like to begin the process of analyzing the differences, along with the reasons for their existence. I realize that, given the opportunity to do this project, I will only be scratching at the tip of the iceberg. However, it is an iceberg that I would love to attack; I only need some help getting started.

⁸ Cancer Trends Progress Report- 2005 Update. National Cancer Institute. Washington D.C.: U.S. National Institutes of Health, 2005. 14 Feb. 2007

<http://progressreport.cancer.gov/doc_detail.asp?pid=1&did=2005&chid=25&coid=226&mid=>.

⁹ Gatta, Gemma, Riccardo Capocaccia, and Michel P. Coleman. "Toward a Comparison of Survival in American and European Cancer Patients." *Cancer* 89 (2000): 893-900.

¹⁰ Same as 8.

Methods

Sections to the Project

There are three sections to this project: a firsthand analysis of a private oncology system, a firsthand analysis of a universal oncology system, and a deeper literary analysis of the subject. The observational sections have two types of analyses associated with it: a statistical, objective analysis; and my own subjective, editorialized analysis of the interviews. The first section of my project is already underway. With Dr. Doolittle as an informal advisor, I have already begun to record data on access issues related to insurance/cost in his cancer clinic every Thursday from 1-5pm. For me, it was absolutely essential for this project to follow ethical boundaries and respect the confidentiality of the patients; thus, I continuously consult with Dr. Doolittle to make sure that none of the data I record are in violation of HIPPA. The statistics I record are related to a series of questions I ask myself when observing the patient consultation; these questions can be found at the end of this proposal. This aspect of the project is still under review as there have been additional variables discovered and added to the questionnaire during recent weeks. Furthermore, I did not want any investigative influence in the results through leading questions; consequently, I decided to gather data strictly through observations rather than using surveys. I have been recording data since January 25th, and some very interesting stats have already surfaced. In terms of the subjective editorials, those serve two purposes: to help me work through inner struggles and reflections as I delve into this issue, and to bring up possible factors that could be causing the access issues I am seeing.

The second section, given the opportunity, will take place between approximately June 4th, 2007 and July 27th, 2007. I will fly into London on the 4th, at which point Dr. Nair will pick me up and take me to Doncaster to live with her for the summer. I will begin working with NHS oncologists the next day and will continue this every day for the next six to seven weeks. To maximize the experience on a personal level, I will spend time in three different areas of British oncology: four weeks in medical oncology, one week in radiation oncology, one week in pediatric oncology, and one week in hospice care. The only aspect still under question is whether I will be able to spend time in pediatric oncology or not. Both subjective and objective analyses will be performed; however, I have not made the questions for the objective part yet because I would like to familiarize myself with this system a bit more.

The third section, a literature review, has also been taking place since early January, and it will continue throughout the project. Its purpose is to get a more thorough understanding of both systems from other perspectives. What I am especially hoping is to gain access to British libraries that may have articles on the topic not available online or in the U.S.

Goals

My goals are five fold:

1. To develop more sophisticated, ideological tools which are necessary to help the uninsured population of America.

2. Grow in my literary and experiential understanding of both private and socialized oncology.
3. Lay groundwork so I may expand upon this project in the future.
4. Write a professional paper enumerating and analyzing the statistics.
5. Write a subjective editorial about my experiences in order to help me work through my ideas and understanding of the two systems. This could be publishable, but this is mostly for personal reasons.

Conclusion

If nothing else, I hope the depth of my passions for both oncology and equitable healthcare access have been adequately portrayed. What I want most of all is the opportunity to pursue these passions while also producing a product of practical consequence; I wholeheartedly believe this project could achieve both of those goals given the opportunity and resources. My desire is for this project to have a wide target audience, as it preliminarily seeks to shed light upon general differences in oncology between privatized and universal systems. I deeply thank you for considering me for this fellowship.

Budget

1. plane ticket: \$1000.00; orbitz.com
2. food: \$300 (most of this, along with lodging, will be provided by relatives)
3. travel to and from work; \$400 (may need to travel to London for pediatric part)
4. total= \$1700

Itinerary for the Project; all dates are for the year 2007

January 25th-May 31st; completion of the first section of the project/work with Dr.

Doolittle;

June 4th; arrive in London

June 5th-July 2nd; medical oncology research

July 3rd-July 10th; radiation oncology research

July 11th-July 17th; pediatric oncology research (hopefully; otherwise, two weeks with hospice

July 18th-July 25th; hospice research;

Sometime between July 26th and August 3rd; return to Kansas City;

References

1. London Reference information in email
2. Dr. Gary Doolittle, MD: Professor of Medicine at the University of Kansas School of Medicine: Division of Hematology and Oncology. Contact Information:

Questions for private oncology observations (subject to revision)

- I. Was insurance an issue that was considered or mentioned at all during the visit;
- II. Who brought it up?
 - a. oncologist
 - b. Patient;
- III. was insurance mentioned, or was it cost;
- IV. What area was it under
 - a. simply in passing
 - b. meds
 - c. scans/procedures
- V. did it affect access to needed procedures or medications
- VI. General description of the situation

Email confirmation of arrangements in England

Dear Sushant:

This is an official confirmation to your request for a summer placement at the Doncaster Royal Infirmary. I am delighted to hear of your interest in oncology and will be happy to help you secure a 6 week placement at Infirmary.

Doncaster is a reasonable sized town and the Infirmary has a catchment population of 350,000 . As you have cluded to in your letter, medical care is based both in the Primary Care Trusts (community based) and the acute Trusts(hospital based). As such you will perhaps utilize your time more appropriately dividing your placement between the Primary and Secondary Careers.

Once you have decided on the dates we will be in a position to formulate a timetable to suit you. In the meantime I will forward your request to the concerned oncology leads Dr S Pledge and Dr N Tupper who are happy to be of help.

A hard copy of the letter will be posted to you. I shall look forward to reply.

Sincerely,

Usha B. Nair

Usha B Nair
Consultant Obstetrician and Gynaecologist
Urogynaecologist
Women's Hospital Doncaster Royal Infirmary
South Yorkshire
DN25LT

**The Effectiveness of a Naturopathic Lifestyle
(Yoga, Vitamin D and Fiber)
on the Prevention of Intestinal Cancer**

presented to

Dr. Martha Montello

Director of the Clendening Summer Fellowship Program

Department of History and Philosophy of Medicine

by

Anita Gupta

February 20, 2007

Introduction

Cancer affects over 1 million people each year. It is a major cause of death in the United States, second only to heart disease. The number of people living in the US with cancer has grown from 3.0 million (1.5%) in 1971 to 9.8 million (3.5%) in 2001. Specifically, colorectal cancer affects 11% of men and is the third leading cause of death in women of all racial origins.

While cancer survival rates have improved due to earlier detection, more effective treatments, prevention of secondary disease and cancer recurrence, and decreases in mortality from other causes, the patients who survive, continue to deal with the effects. Patients, as well as their family and friends, must deal with the daily struggle in addition to social, psychological, and economic stresses. With the American population aging, the number of people affected by cancer is projected to increase further in the years to come. Instead of simply working to cure the disease once it is detected, prevention is key to helping patients and families retain their lifestyles.

Currently, prevention includes early screening for at risk demographics. Specifically, the colorectal cancer recommendations included a fecal occult blood test (FOBT) every year, or every 5 years if accompanied with a flexible sigmoidoscopy. However, the 2006 American Cancer Society Guidelines for Early Cancer Detection shows that one-time FOBT testing using the take-home method was only 13% sensitive. When done in an office following a rectal exam, only 4.9% of advanced neoplasia is detected. Colorectal cancer mortality has not dropped despite increased FOBT. Hence, it is important to consider another aspect of prevention—reevaluation of nutrition and lifestyle.

One in three people in the general US population use Complementary and Alternative Medicine (CAM), which range from botanicals to vitamins and minerals to prebiotics and probiotics. Just recently, between 1997 to 2002, the use of herbal supplements jumped 50% to 38 million adults. Over the same period, the practice of yoga increased 40%, growing to over 10 million adults. Among cancer patients, 83.3% use at least one form of CAM, with 62.6% using a form of vitamins or herbs. CAM is a therapy that the US population is interested in and needs to be further researched to understand the efficacy concurrent with current allopathic treatment regimens.

While there are many research studies available on the effects of specific nutrients, my proposal is to delve into this existing research regarding yoga, vitamin D and fiber, and compile it into a set of effective preventive measures.

Background

Three weeks before I began medical school, my dad was diagnosed with a rare cancer, duodenal adenocarcinoma. Our family was in shock. My dad was the healthiest man we knew. He exercised seven days a week and was very careful about his diet. Also, no one else in our family had had cancer. We were forced to overcome this initial shock so we could deal with his treatment.

Over the past few months, his treatment has included three surgeries and now chemotherapy. After a partial duodenectomy to remove the cancer, he developed severe jaundice. Just six days later, he underwent a second surgery, a cholecystostomy, where they placed a drainage tube in his gall bladder. Three months later, when he had recovered enough to undergo yet another surgery, they performed a cholecystojejunostomy to remove the drainage tube and connect his gall bladder directly to his small intestine. Throughout this time he was in and out of the hospital. My mom learned how to connect his nutritional IV at night and how to flush the feeding tube every week. We learned how to continue running the household, in addition to caring for him.

Instead of the initial hopes of chemotherapy beginning by October, it was not until late December that he began his cycles. Seven months and three surgeries after the initial diagnosis, my dad is working through three cycles of chemotherapy. During the first cycle, he experienced severe side effects and had to prematurely end the treatments, but he is now currently on cycle two.

The cancer diagnosis has affected my entire family. This was a new experience through which I realized the profound emotional effects of a loved one battling cancer. Through my family experience, I have seen the patients' perspective of coping with a family member's cancer diagnosis and treatment. Prior to this experience, I had not realized the additional stress on the family having to deal with caring for a sick family member. Also, the economic effects of a parent leaving work have been difficult. The patient's personal agony, family and patient coming to terms with the diagnosis, the spiritual aspect of dealing with a life-threatening illness, dealing with the change in lifestyle, and side effects of allopathic medicine are all reasons to research how to prevent this disease.

Understanding the patient and family's emotions, stresses, and lifestyle changes has convinced me that prevention is the key to sustaining quality of life for everyone involved with the patient. When my dad was diagnosed, my uncle, Dr. Naresh Kumar, who holds Ph.D.s in both naturopathy and yoga, suggested some herbal and alternative cures. Since my dad was seeing an allopathic doctor, we decided to stick to that regiment of care, but my curiosity was peaked regarding the efficacy of CAM.

Project Description

My initial interest in CAM was the effects of ayurvedic medicines on treatment of small intestinal cancer. After speaking with Dr. Kumar, I realized that ayurvedic medicine is a four-year medical degree in itself, and it has a completely different methodology than allopathic medicine. I realized that ayurvedic remedies would be too broad of a topic to cover for the length of this project. However, he recommended naturopathy which includes a variety of herbal medicine, homeopathy, acupuncture, and therapeutic exercise. Dr. Kumar suggested choosing a nutritional aspect as well as a yogic, or stress-relieving, aspect. Dr. Jeanne Drisko in the Alternative Medicine Unit was very helpful and suggested looking into vitamin D and fiber.

Although 20% of cancer incidents are digestive system related, only 2.0% of those are of the small intestine. On the other hand, 57% are colorectal. Because of the dearth of research available specifically on the small intestine, large intestine studies are applied to cases of small intestinal cancer. Studying cancer of both the large and small intestines not only grants me a wider research base on which to focus my metastudy, but it will allow my results to be applied to a larger audience. After speaking to Dr. Kumar and Dr. Drisko, I narrowed down my study of CAM to the effectiveness of yoga, vitamin D and fiber on the prevention of intestinal cancer.

Over the course of this project, I plan to stay in touch with Dr. Drisko and utilize the journals and literature that she has available that are not available at Dykes Library. I also plan to continue contact with Dr. Kumar for updates and direction. He will also be able to send me articles from Indian journals with pertinent information as available.

The project timeline is included below. For the first two weeks, I plan to learn about the individual nutritional aspects of vitamin D and fiber as they relate to intestinal cancer prevention. I will spend week three at the Maharishi University where I will learn more about yoga and the yoga research they are conducting. I will synthesize my research with the new information I gain at the Maharishi University during weeks four and five. Finally, I will compile that research into a technical paper and create a presentation to share my findings.

Timeline

Weeks 1-2	Research benefits of Vitamin D and fiber.
Week 3	Visit Maharishi University to learn about yoga and yogic lifestyle.
Weeks 4-5	Synthesize research with findings at Maharishi University. Call Maharishi University with follow-up questions.
Week 6	Compile research into a technical paper. Create a presentation for colleagues.

Budget

Literature Costs	\$ 250
(books, journal subscriptions, shipping from India)	
Phone Charges	\$ 80
(long distance calls to Dr. Kumar)	
Maharishi University of Management	\$ 400
(gas, 5-day hotel stay)	
Total	\$ 730

Conclusion

I am delighted to apply for this program because I see it as a great way to gain an in-depth experience in critically analyzing research. Research is constantly updating and improving the various aspects of clinical care. Through this experience, I will enhance my ability to interpret research results. Subsequently, when I am a practicing oncologist, I will be able to stay updated on the latest findings. By staying current in both allotropic and naturopathy forms of medicine, I will be able to recommend the treatments in the best interests of my patients.

Contacts

Dr. Jeanne Drisko
G022 Robinson Hall
Mail Stop 2028
3901 Rainbow Boulevard
Kansas City, KS 66160-7316

Dr. Naresh Kumar
A-67 Second Floor, South City- II
Gurgaon, Haryana 122001
India

Fred Travis
Associate Professor of Maharishi Vedic Science
Maharishi University of Management
Fairfield, Iowa 52557

Bibliography

The Burton Goldberg Group. (1993). "Naturopathy." *Alternative Medicine: The Definitive Guide*. Puyallup, WA: Future Medicine Publishers.

Complementary & Alternative Medicine Use By One Third Of U.S. Adults Unchanged From 1997. *Steady Five-Year Prevalence Points To Need For More Rigorous Evaluation*. National Center for Complementary and Alternative Medicine (National Institutes of Health). Retrieved January 23, 2007 from <https://nccam.nih.gov/health/backgrounds/biobasedprac.htm>

Khan, S. & Balick, M. J. (2001). "Therapeutic Plants of Ayurveda: A Review of Selected Clinical and Other Studies for 166 Species." *The Journal of Alternative and Complementary Medicine*. 7 (5), 405-515.

Richardson, M. A., Sanders, T., Palmer, J. L., Greisinger, A., & Singletary, S. E. (2000). "Complementary/Alternative Medicine Use in a Comprehensive Cancer Center and the Implications for Oncology." *J Clin Oncol*. Jul; 18 (13): 2505-14.

Smith, R. A., Cokkinides, V., & Eyre, H. J. (2006). "American Cancer Society Guidelines for the Early Detection of Cancer." *CA Cancer J Clin*, 56, 11-25.

U.S. Cancer Statistics Working Group. (2005). *United States Cancer Statistics: 1999-2002 Incidence and Mortality Web-based Report*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute.

US CDC. (June 25, 2004). "Cancer Survivorship --- United States, 1971-2001." *Morbidity and Mortality Weekly Report*. 53 (24), 526-529.

INTRODUCTION

The Center for Disease Control (CDC) is a leader in public health efforts to prevent and control infectious and chronic diseases and provides a system of health surveillance to implement disease prevention strategies. Scrimshaw and colleagues articulated the discipline of disease prevention as an approach that complements the traditional medical emphasis on treatment.¹ This approach seeks to decrease risk factors in people and promote their healthy behaviors and as a result, shifts significant responsibility for good health from the doctor to the patient. To help define disease prevention and to build bridges between academia and vulnerable communities, CDC established thirty-three Prevention Research Centers within the United States. Each Center conducts at least one main project in research, demonstration, intervention, or evaluation on a predetermined theme.² The Harlem Health Promotion Center located in Harlem, New York is one such center.

The Harlem Health Promotion Center (HHPC), directed by Dr. Alwyn Cohall, is a partnership of community, academic, and public health members which uses research, education, and service delivery to improve the health and well-being of the Harlem community.³ Dr. Cohall is an Associate Professor of both Clinical Sociomedical Sciences and Clinical Population and Family Health at the Mailman School of Public Health, Columbia University and an Associate Professor of Clinical Pediatrics at the College of Physicians and Surgeons, Columbia University. Dr. Cohall serves as the director of Project STAY (Services to Assist Youth) which is a program at HHPC that provides confidential health services to young people affected by or infected with HIV/AIDS.

¹ Schrimshaw SC, White L, Koplan JP. The meaning and value of prevention research. *Public Health Reports* 2001; 116 Suppl 1:4-9.

² Gray, B, CDC partners with communities for prevention research. *Atlanta Medicine*, Volume 76, Issue 3.

³ Green L, Daniel M, Novick L. Partnerships and coalitions for community-based research. *Public Health Reports* 2001;116 Suppl 1:20-31.

PROJECT STAY

Project STAY provides high-risk youth, primarily in the Harlem area, with sensitive and supportive HIV counseling, as well as comprehensive medical, psychosocial and case management services. According to the 2000 U. S Census, adolescents living in Harlem have disproportionately higher rates of sexually transmitted infections and pregnancy, compared to their New York City counterparts. A significant number of adolescents living with HIV/AIDS in Manhattan (a borough in New York City) are from Harlem. (See attached tables on pages 5-9 for Harlem-related demographics and data related to its youth risk behaviors.)

To avoid stigmatizing youth, Project STAY integrates counseling, testing and treatment services into the fabric of health care delivery in an ambulatory care setting that provides a wide variety of primary care and family services. A client-centered model is used to identify each patient's assets as well as risks. A thorough assessment is made of each client and strategies are developed to reinforce areas of strength, while addressing health-compromising behaviors and preparing youth to take an HIV test.

For HIV counseling and testing, the counselor who performs the counseling session is the same counselor who delivers the test results. Clients who test positive for HIV receive a comprehensive clinical assessment, including baseline levels of viral load and T-cell counts and are assigned a social worker. Following the initial evaluation, a medical treatment plan is developed and reviewed with the client and Project STAY team members. To encourage empowerment and participation in the treatment decision-making process, the doctors at Project STAY schedule sixty to ninety minute clinical visits to teach young patients how to incorporate HIV management into their lives.

Clients are seen as frequently as necessary. Those patients who are stable may only need to check in every three months for physical exams, lab tests and medication renewals. Other young people needing more intensive assistance may be seen several times a week until a medical and/or psychosocial crisis has been resolved. On-site support groups are

available and support services are offered to family members and significant others either directly or through referrals to a network of community-based programs.

Some of Project STAY's peer educators reach youth by going to neighborhood street corners, parks, nightclubs, sporting events, and anywhere else young people gather. The educators pass out free condoms and health information at these locations. Overall, the young people who participate in Project STAY are vital to prevention research and help define the research project and disseminate their results, as well as advocate for social policies that can promote health.⁴

The fellowship would provide me the opportunity to work directly under the guidance of Dr. Cohall and his medical staff who are trained in adolescent health, HIV and other infectious diseases. My activities would include participation in health education and STI screening, observation in adolescent HIV clinic, involvement in pharmacy detailing and community health education for Emergency Contraception awareness program, weekly meetings with interdisciplinary staff to review client cases, dissemination of condoms and health information during outreach events, assistance with data collection for core research project at Harlem YMCA and research support of clinic projects. I intend to pursue a career in primary care and this experience would afford a venue to initiate my desire to address the myriad socio-economical issues related to medical care and its impact on adolescents.

⁴ Braithwhite RL, Lythcott N. Community empowerment as a strategy for health promotion for black and other minority populations. *JAMA* 1989;261:282-3.

Budget and Justification
May 29, 2007 – July 31, 2007

Item	Amount	Justification
Airfare	\$356	Nonstop Roundtrip on Midwest Airlines – Kansas City, Missouri to New York City, New York to intern with Dr. Alwyn Cohall on Project STAY (Services to Assist Youth)
Local transportation	\$152	Two monthly unlimited metro transportation passes at the cost of \$76 each will be used to cover cost of travel to and from project sites, including street outreach
Housing	\$333	To cover share of rent (\$900 monthly) and utilities (\$100 monthly) while rooming with two interns
Meals	\$1449	Cover cost of meals (\$5 breakfast, \$8 lunch and \$10 for dinner, totaling \$23 a day) for 63 days
Total	\$2290	

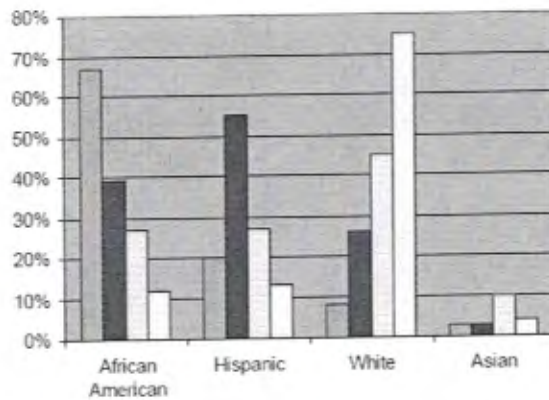
Demographics

Who are the residents of Central Harlem compared to New York City and the United States?

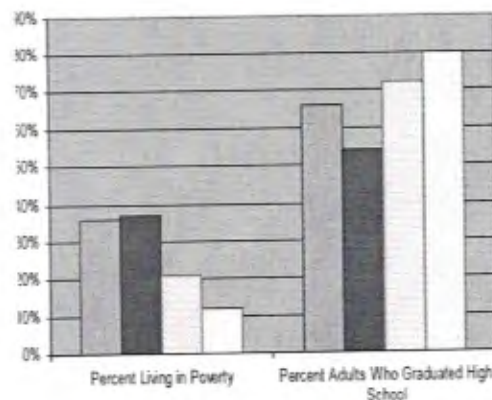
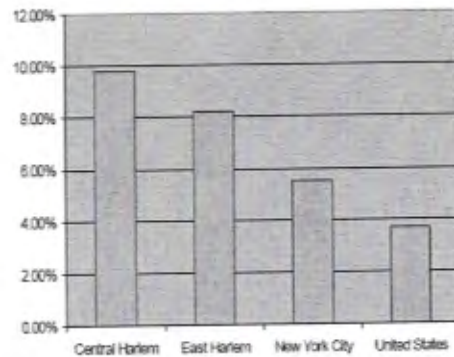
2000 Census Data	Harlem		NYC	US	Central Harlem Disparity (w/NYC)	Central Harlem Disparity (w/U.S.)
	Central	East				
Population	151,113	108,092	8,008,278	281,421,906		
African American	67%	39%	27%	12%	1.5 times	4.5 times
Hispanic	20%	55%	27%	13%	-25%	+35%
White	8%	26%	45%	75%	-80%	-90%
Asian	3%	3%	10%	4%	-70%	-25%
% Born outside the U.S.	19%	21%	36%	11%	-45%	+75%
Median Age	33	32	34	35	-3%	-6%
Median Household Income	\$21,508	\$18,564	\$38,293	\$41,994	-45%	-50%
Percent Unemployed (Population 16 years and over)	9.8%	8.2%	5.5%	3.7%	+80%	+165%
Percent Living in Poverty	36%	37%	21%	12%	+70%	Double
Percent Adults Who Graduated High School	66%	54%	72%	80%	-8%	-18%

Majority of Central Harlem residents are African American with a smaller foreign born population than that of New York City. Central Harlem is ranked one of the poorest neighborhoods in all of New York City, with over a third of residents living in poverty and a median household income that is nearly half of that in the United States. In addition, a third of adults living in Central Harlem have not graduated high school compared to nearly half of all adults in East Harlem.

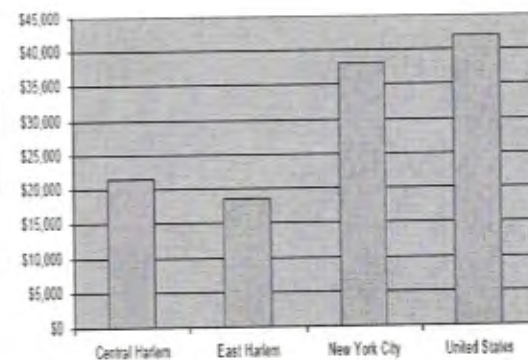
Source: 2000 U.S. Census



Percent of Population Unemployed (16 Years and Over)



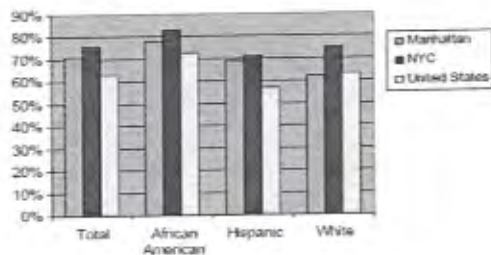
Median Household Income



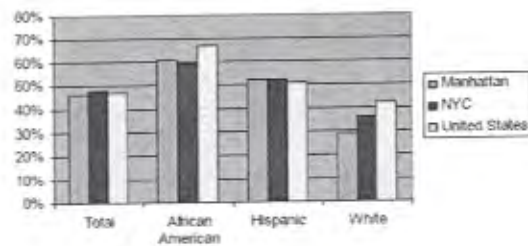
Youth Risk Behaviors, 2003

<i>Sexual Behaviors</i>	Manhattan	NYC	United States	Manhattan Disparity with U.S.
Ever had sex	46%	48%	47%	-2%
Ever had sex-African American	61%	59%	67%	-9%
Ever had sex-Hispanic	52%	52%	51%	+2%
Ever had sex-White	29%	36%	42%	-31%
4 or More Sexual Partners	14%	17%	14%	No Difference
4 or More Sexual Partners-African American	21%	26%	29%	-28%
4 or More Sexual Partners-Hispanic	15%	16%	16%	-6%
4 or More Sexual Partners-White	7%	9%	11%	-36%
Used condom at last sex	71%	76%	63%	+13%
Used condom at last sex-African American	78%	83%	73%	+7%
Used condom at last sex-Hispanic	69%	71%	57%	+21%
Used condom at last sex-White	62%	75%	63%	-2%
Ever Pregnant/Made Pregnant	6%	5%	4%	+50%
Ever Pregnant/Made Pregnant-African American	10%	7%	9%	+11%
Ever Pregnant/Made Pregnant-Hispanic	6%	6%	6%	No Difference
Ever Pregnant/Made Pregnant-White	2%	1%	2%	No Difference

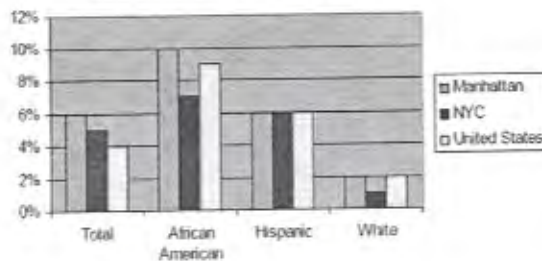
Adolescents Who Used A Condom During Last Sexual Intercourse, 2003



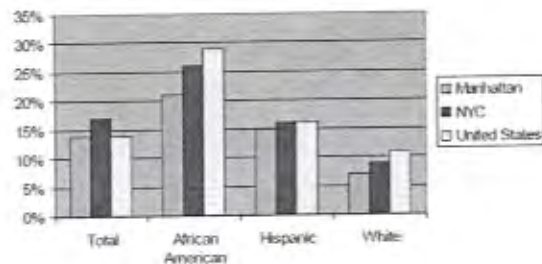
Adolescents Who Have Ever Had Sexual Intercourse, 2003



Adolescents Who Have Ever Been Pregnant or Gotten Someone Pregnant, 2003

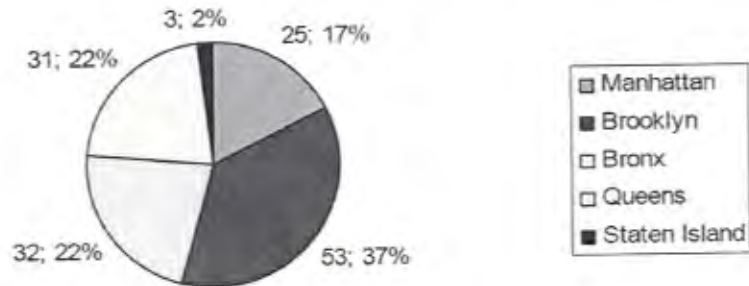


Adolescents With 4 or More Sexual Partners, 2003

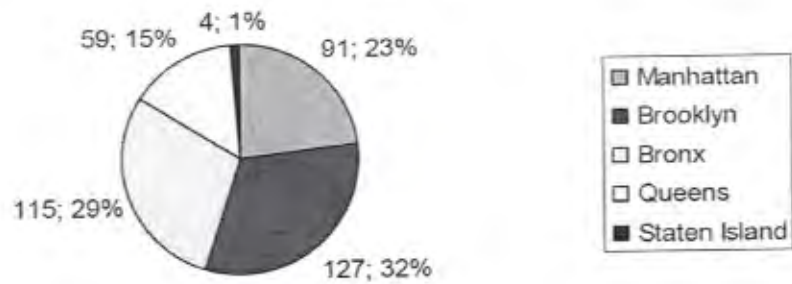


Source: NYC, Youth Risk Behavior Survey, 2003
 CDC, Youth Risk Behavior Surveillance System, 2003

Newly Diagnosed HIV/AIDS Cases in NYC, 2002
(Adolescents Aged 13-19)
Total number of cases = 144

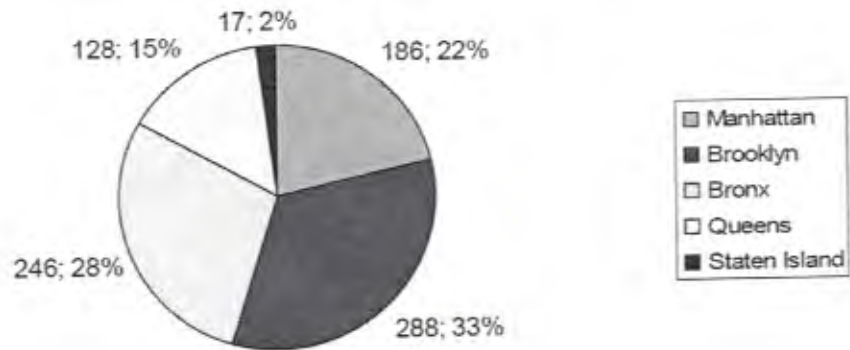


Newly Diagnosed HIV/AIDS Cases in NYC, 2002
(Young Adults Aged 20-24)
Total number of cases = 396

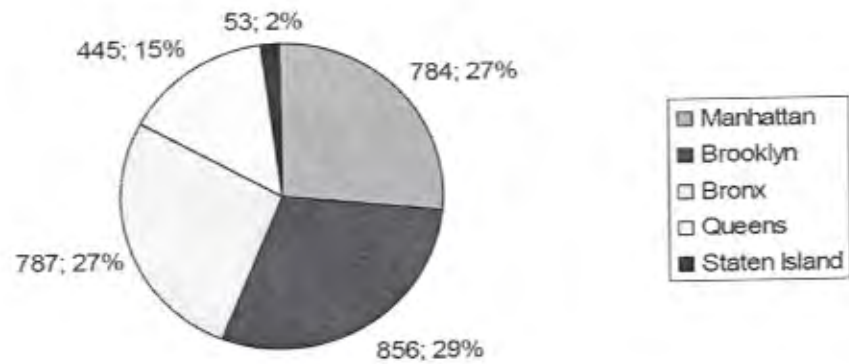


Source: NYC DOHMH, HIV Epidemiology Program

Adolescents Aged 13-19 Living With HIV/AIDS in NYC, 2002
(N=865)



Young Adults Aged 20-24 Living With HIV/AIDS in NYC, 2002
(N=2,925)

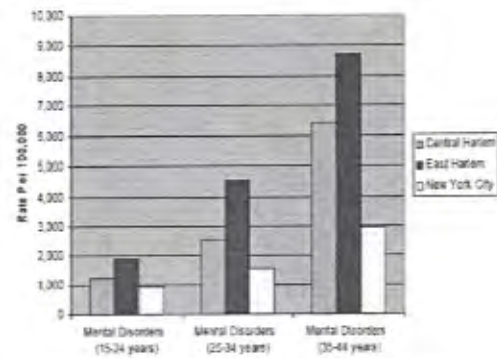
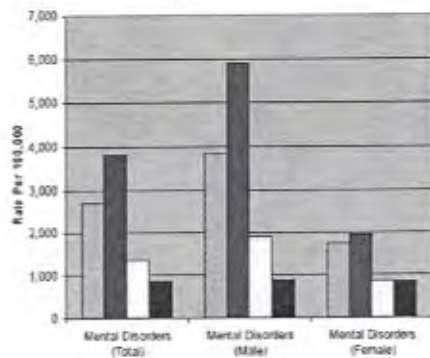


Out of the 186 young people between the ages of 13-19 who are living with HIV or AIDS in the borough of Manhattan, 41% (N=77) of them reside in Central or East Harlem.

Source: NYC DOHMH, HIV Epidemiology Program

Mental Health (ICD-9 codes) – Hospitalization Data by Sex and Age

Rates per 100,000	Harlem		NYC	United States*	Central Harlem Disparity (w/NYC)	Central Harlem Disparity (w/U.S.)
	Central	East				
Mental Disorders	2,711	3,798	1,358	858	+100%	Over Double
Mental Disorders (Men)	3,844	5,913	1,909	879	+100%	Over 3 times
Mental Disorders (Women)	1,749	1,946	857	838	+105%	+110%
Mental Disorders (15-24 years)	1,246	1,880	942	---	+32%	---
Mental Disorders (25-34 years)	2,519	4,519	1,563	---	+61%	---
Mental Disorders (35-44 years)	6,439	8,699	2,947	---	+118%	---
Alcohol Dependence	576	673	184	---	Over Double	Over 10 times
Drug Dependence	529	657	265	---	+100%	---
Schizophrenic Psychoses	450	654	218	---	+106%	---
Depressive Disorder - not classified elsewhere	60	79	24	---	+150%	---



East Harlem residents have the highest hospitalization rates for mental disorders among both males and females, and among all age groups. Males in Harlem and New York City have significantly higher mental disorder hospitalization rates compared to females. This same disparity in hospitalization rates among males and females does not exist when looking at data for the entire United States population. Mental disorder hospitalization rates are highest among 35-44 year old adults, compared to 15-24 and 25-34 year olds.

Diplomat of Immunity

by Leonid Terry Hansen

The Picture

The continent of Africa is a vast and diverse terrain; from lush and endless plains to the majestic heights of Mount Kilimanjaro and the formidable Sahara in between. It is a world where the culture is as diverse as the topography. Africa is by far the most linguistically diverse continent to the tune of 2,000 languages from 12% of the world's population in 54 nations. It is rather typical to meet an individual who speaks multiple languages, practices multiple trades, and yet regrettably negotiates multiple risk factors for infectious diseases daily. Diseases like AIDS and malaria have teamed up to ravage the populations of several African countries. AIDS has an infection rate as high as 20% in some countries such as Botswana and malaria kills 2,000 African children every day. Alongside these two major players is the ever-present affliction by a long list of other infectious vermin that affect the various regions. Many of these diseases however are quite treatable yielding positive outcomes given adequate treatment. Unfortunately, adequate medical treatment is a rare commodity in many of Africa's communities. The risk factors for exposure to these parasites are closely correlated to infrastructural weakness of certain communities resulting in poor sanitation and water source maintenance. In a continent where the majority lives on nearly a dollar a day or less, the people struggle and the governments are unable to generate enough tax revenue to rescue them from the inevitable health dilemmas. The majority of African nations (56%) spend less \$10 dollars per person per year on health. Some do more than others: Tunisia spent \$113 per capita when Nigeria spent \$2 per person in 2002. The status of health in Africa must be improved as an imperative to the survival of its people and ultimately the world. This goal must be accomplished by improving the infrastructure of poor nations so that public health standards can be raised and maintained. In addition to infrastructural improvements, the amount and quality of healthcare that is available must also be improved. As an African by birth and a future healthcare professional I play what I hope will be a significant role in this task.

The Place

Ghana is a country nestled in the heart of what was once known as the British Gold Coast along the southern coast of the West African bulge. In the capital city of Accra I had my first home. The area occupied by Ghana is slightly smaller than the state of Oregon. Ghana remains largely an agrarian society and is among the more economically advanced nations in Africa. However, Ghana is not immune to the common health issues that literally plague the African people.

Ghana is afflicted with all the major infectious disease classes that can be found in a variety of African countries such as AIDS (2.3% prevalence in adults) and malaria. In addition there are certain diseases that are somewhat more localized to the native microbial populations such as Schistosomiasis mansoni. Schistosomiasis infects approximately 200 million persons and kills approximately 280,000 annually world wide. Most of the mortality comes from hepatic granulomas and fibrosis, caused by *Schistosoma mansoni*. Schistosomiasis is transmitted by freshwater snails living in the slow-moving water of tropical rivers, lakes, and irrigation ditches. This trend ironically links agricultural development with the spread of the disease. Both intestinal and urinary schistosomiasis are endemic. Where urinary schistosomiasis can easily be diagnosed using common signs and symptoms such as bloody urine, a simple approach is not yet available to diagnose the intestinal manifestation of schistosomiasis mansoni. Intestinal diagnosis is currently done by fecal cultures and microscopic confirmation of parasitic eggs. Techniques like this require more capital than what is available to many of the small rural clinics where this disease is common and treating misdiagnosed cases simply cannot be endured financially. Fortunately, a more cost effective and probably more reliable dipstick method using monoclonal antibodies is being studied at the Noguchi Memorial Institute for Medical Research (NMIMR) located on the University of Ghana Campus in East Legon Ghana.

Malaria is another common and infectious disease in Ghana (4/100 incidence). It is delivered by a protozoan of the genus *Plasmodium* in red blood cells, which is

transmitted to humans by the bite of an infected female anopheles mosquito. Despite efforts to control its virulence, malaria has probably been the greatest single killer disease throughout human history. Failure of earlier efforts to eradicate malaria and the rapid spread of resistant strains of both parasites and their mosquito vectors has provoked a renewed interest in preventing the disease by avoidance of mosquito bites. The avoidance approach may be nearly futile especially when one does not have the luxury of insulated housing. The approaches for combating the incidence of malaria are moving toward vaccination methods. The development of these vaccines is being undertaken in nine countries across Africa such as Mozambique, Tanzania, Malawi, Gabon, Nigeria, Ghana, The Gambia, Kenya and Senegal, who participate in the Malaria Clinical Trials Alliance (MCTA) supported by a new \$17 million grant from the Bill & Melinda Gates Foundation. There are currently 20 vaccinating agents being studied with several in Phase III of development. These MCTA trials are being coordinated through INDEPTH networks (International Network of field sites with continuous Demographic Evaluation of Populations and Their Health). INDEPTH has three facilities in Ghana alone; at the Dodowa, Kintampo, and Navrongo health research centers. Each of these Demographic Surveillance Systems (DSS) has a diverse list of operations ranging from social and epidemiological studies to laboratory and clinical studies.

The Person

I left Ghana when I was three years old. After a one year stay in London, England my family and I found ourselves in Miami, Florida and we have remained proud members of the US community ever since. Since the age of 12, I have returned to Ghana roughly every other year for an average stay of 4 weeks. It is because of these frequent trips that I consider myself a member of both African and American communities. I have observed first hand that public health policy and regular health care access makes a huge difference in one's life. Whenever I return to Ghana I can't help but reflect on how different my life could be had my family decided to stay so many years ago. From what I observed in my African counterparts, I might be about 30 lbs lighter had I stayed, and by this time in my life I would have had to survive several bouts with infectious disease. Survival is assumed being that my dad, as a physician, would have probably secured my

appropriate treatment. My chances of becoming a medical professional however, would have also diminished significantly due to a heavily burdened school system. Today, as an African-American who is conscious of the on-going health disparity between Africa and America, I feel compelled to take advantage of every opportunity to help the two continents take positive steps toward resolving the common problem.

My father, Dr. Leslie Hansen, began his medical training at the University of Ghana and networks with many of his colleagues who practice medicine all over the world and of course Ghana. As a common goal, my father and some of his colleagues are working to establish new and better health facilities in Ghana. Through this association I am blessed with two opportunities to join the work effort to improve the health status of Ghana. The first is from Professor Fred Binka MD PhD, the Executive Director of the INDEPTH Network. Dr. Binka is a friend of my family and has agreed to take me on as an observer and to provide me some field exposure in the MCTA project. I have also been invited to the Noguchi Research facility to participate in their development of antibodies as tool for diagnosing intestinal Schistosomiasis mansoni. There I will be under the supervision of Professor K. M. Bosompem PhD.

The Plan

Itinerary:

I plan to arrive in Accra, Ghana in the first week of June and leave in the first week of July. Due to the proximity of the research facilities to my house in East Legon, I plan to stay there throughout the trip with the exception of trips taken to rural area facilities where I will stay at a local hostel. The first three weeks will be spent primarily the Noguchi Research facility where I will work from morning till afternoon daily. The last week or so will be spent touring the INDEPTH/MCTA facilities. Some of the specifics regarding my daily duties are still being communicated through correspondence with my research contacts.

Budget:

Airfare: \$1800-2000

Rooming: \$10-15 per night * 3 nights (max) = \$30-45

Boarding: \$3-5 per day * 30 days (approx) = \$90-150

Tourism expenses: \$200

Total: \$2120-2395

Field Objectives:

By the end of my journey I expect to have accomplished the following:

- Understand and practice the techniques used to develop monoclonal antibodies as diagnostic tools.
- Understand and practice the techniques used to develop vaccines against malaria.
- Observe the progress and potential of the health projects at each facility.
- Identify the challenges that are unique to developing and maintaining research and medical facilities in Ghana by interviewing the staff and directors at each facility.
- Identify the future needs and obstacles ahead of the communities in Ghana as they move toward higher levels of public health.
- Develop new ideas for the work of eliminating health disparities around the world.

Despite the many struggles faced by the African community it is a land that is blessed with various natural resources at capacities that are relatively untapped. Africa has played a large part in the world's economy for centuries. Today the health issues that devastate its labor force prevent the communities from reaching their full economic potential. Infectious diseases accounted for 62% of all deaths in Africa in 2001 which is by far the highest rate; the Eastern Mediterranean is a distant 2nd at 34%. The majority of these deaths are caused by a few common diseases (AIDS, Malaria, Tuberculosis etc). We are fighting a global war against infectious disease and we fight on many fronts. Yet somehow it seems like no matter how many battles are won, the enemy has us literally

surrounded and we are in constant need of reinforcements and fresh battle strategies. As an African-American having the benefit of both great American opportunities and African perspective I feel that if I cannot rely on myself to take on the fight then I have no grounds to expect anyone else to join.

Contacts

Prof. K. M. Bosomprah PhD _____

Prof. Fred Binka MD PhD _____

References

Kumar, Vinay Kumar. *Robbins and Cotran Pathologic Basis of Disease, 7th Edition*. Elsevier, 2005. 8.5.2.4).

<http://www.indepth-network.org/mcta/mctaindex.htm>

http://www.indepth-network.org/dss_site_profiles/dss_sites.htm

http://www.indepth-network.org/core_documents/indepth_faq.htm

http://www.globalhealth.org/view_top.php?id=228

<http://medilinkz.org/Features/Articles/dec2002/AfricaHealth2002.asp>



"Cross-Cultural Differences in Emergency Medical Care"



**Clendening Fellowship Proposal
Madhu Iyengar
Feb. 20, 2007**

Personal Background/Ambitions:

My name is Madhu Iyengar and I am a first-year student at KUMC. I received my B.A. from Dartmouth College in 2003 in economics and Spanish, after which I worked for two years in business consulting in Cambridge, MA. I then attended the UCLA School of Public Health where I received my MPH this past spring. I am fluent in Spanish.

This year I have dedicated considerable time to JayDoc free-clinic, working as the Research Coordinator on the Executive Board. We have taken part in a variety of projects this year, with considerable time dedicated to managing the inflow of patients at the clinic. As a free-clinic in the Wyandotte County area, we typically see anywhere from 15-25 patients a night, depending on the number of volunteer physicians we have. Our ability to triage patients is critical to the success of JayDoc.

This experience has sparked a personal interest in emergency medicine. Many of the same dilemmas that arise at JayDoc (triaging patients, making sure that no emergent cases go unseen, etc.) also present themselves in the emergency room.

Project Background:

County Hospital is a 1,395-bed facility located in East Los Angeles, and is one of the nation's largest public hospitals. The county-run facility is a partner institution of the Keck School of Medicine of USC that treats approximately 800,000 patients annually, including at least 200,000 emergency room visits.¹ Almost half of those treated are indigent or uninsured.² To keep up with the demand patients must be transferred without delay from emergency room triage to ancillary services, such as radiology departments, for x-rays, CT scans, MRIs and other diagnostic tests, or on to operating rooms for surgery. Those who need to be admitted to the hospital must further wait for a bed to be freed up, which depends on the speed at which patients are discharged, rooms are prepared and patients are transferred among locations. County/USC Hospital serves an enormous population in the region, with many patients going to the emergency room first, so the waits can be long.

Hospital Posados is a public hospital just outside of the city of Buenos Aires. The majority of patients seen are impoverished and live in the area immediately surrounding the hospital. In some areas around this hospital, there are the villas miserias where living conditions can be very poor. Some homes in poorer barrios and surrounding suburbs have no running water, sewage system or electricity.³ Most all physicians in the emergency department are doing it temporarily, as emergency medicine is not yet recognized as a specialty in Argentina. Because of lack of funding, Hospital Posados, like many public hospitals in Buenos Aires, is short-staffed and under-equipped. The hospital relies on volunteers to assist the residents.

Los Angeles and Buenos Aires are two of the largest metropolitan centers in the Americas, and both consistently struggle to meet their demands for public hospital care.

¹ Website: http://www.usc.edu/schools/medicine/patient_care/hospitals_clinics/lacusc_medical.html

² Website: <http://www.dhs.co.la.ca.us/>

³ Website: <http://www.acponline.org/chapters/dc/spencer.pdf>

Project Objectives:

Compare and contrast the nature of emergency medicine in Los Angeles County Hospital with Hospital Posados in Buenos Aires, Argentina.

Specifically, I am interested in the following questions:

1) What types of medical cases do you typically see?

- A. Types of Cases
- B. Differences in medications
- C. Prevalence of tropical disease
- D. Technological Differences in Medical Equipment

[Information will be gathered through physician interviews and ER Observation]

2) What type of specialist care is available?

- A. Where do patients go after receiving care?
- B. Are surgical/radiological procedures available to indigent/uninsured patients?

[Information will be gathered through observation/interview of hospital administrators/physicians]

3) What is the principle triaging strategy

- A. How many patients are seen in a given day?
- B. How long do they wait to be seen?
- C. Are any patients turned away?

[Information gathered through observation /physician Interviews]

4) What cross-section of the population are the majority that use the services?

- A. Age differences: adults, children, elderly
- B. Uninsured vs. insured

[Information gathered through observation/interviews]

I plan to gather information through observation, physician interviews (written in both English and Spanish), and through verbal conversation with ER employees and patients that are willing to participate. I will prepare written surveys regarding these questions for 1) physicians 2) ER employees and 3) patients.

Ultimately, I would like to not only prepare a presentation delineating cross-cultural differences in these areas, but I would also like to prepare a recommendation to help aid these two public hospitals. I am confident that this exercise will prove helpful not only for me, but also for the participating public hospitals.

Project Logistics:

PART A: June 1-June 30th (Los Angeles County Hospital, Los Angeles California)

Working with:

Dr. Sean O. Henderson
Vice Chair- Department of Emergency Medicine
University of Southern California - Keck School of Medicine
Advisor-Emergency Medicine Student Interest Group (EMSIG)
EMAIL: sohender@usc.edu

I have spoken with Dr. Henderson regarding the project and he has supported my interests. I plan to work with Dr. Henderson in taking patient histories and shadowing in the Emergency Room at LA County, and will interview himself as well as other ER physicians while I am in Los Angeles. I will also interview patients that are willing to speak with me.

PART B: July 1 - July 30th (Hospital Posados, Buenos Aires Argentina)

I would like to go to Argentina along with a program called Experiential Learning International, a non-profit organization based in Colorado. ELI works to place American medical students in service projects in South America. I have spoken with ELI at length regarding the opportunities available to medical students. I will be working from 9am-5pm daily in the department of my choice (Emergency Room in my case). My specific tasks will be:

1. Visit patients with the residents
2. Take patient histories
3. Conduct physical examinations

Contact Information:

Raissa Shafer
Program Manager
Experiential Learning International
8 E. 1st Ave. Suite 102
Denver, CO 80203
303-321-8278

raissa@eliabroad.org

Project Budget:

\$200 Flight to Los Angeles (Room and Board will be covered by family)
\$1200 Flight from Los Angeles to Buenos Aires
\$1055 Room and Board and in Buenos Aires (through ELI)

From Website: The dormitory is located in the neighborhood of Palermo, only a few blocks from the subway line D, dozens of bus lines and Alto Palermo, the top shopping mall in Buenos Aires. This privately owned dorm opens its doors to hundreds of international and Argentine students each year and provides a great opportunity to make new friends. The dormitory includes Shared room (single room available for extra cost), Personal closet with lock and key, Private bathroom in each room, Study room with free Internet access, Cafeteria, Lounge with TV, Pay phones in the lobby, Laundry service, Linens and towels, Cleaning service, and 24/7 staff and security.

Total: \$2455

I understand the total amount exceeds the allowance given by the Clendening Scholarship. I plan to take personal loans for the remainder.

Rachel Moses

2007 Clendening Fellowship Proposal

Dance Medicine: Healing the Artist

Dance Medicine: Healing the Artist

Background

"Dance is an art form that relies on human movement for communication." (1) The professional dancer must maintain a body that can execute the most detailed, often unnatural technical steps, over, and over, and over again. This physically demanding regime is the dancer's livelihood. Practicing and performing dance day in and day out, brings with it a host of unique injury possibilities that have been addressed only recently by the medical community.

Although dance has remained an integral part of society since the beginning of civilization (2) the dance medicine specialty only emerged in the 1980's. Prior to this time, injury prevented most professional dancers from performing past their third decade. Often, the few dancers that could afford medical care were forced to consult uninformed physicians. One dancer with the Pilobolis Dance Company said, "many physicians [did] not understand the language of dance...they nod like they know what you are talking about, but they do not understand. "It can be frustrating and scary as a dancer..."(7) Fortunately, dance medicine physicians like Dr. Rose and Dr. Weiss at the Harkness Clinic for Dance Injury, have enabled this specialty to advance tremendously in the last 15 years. However, dance medicine still faces continued challenges including the need for precise injury terminology, the demand for practical treatment strategies, and the financial barriers to medical services encountered by uninsured dancers (3).

Without a common system of naming, dance related injuries lack universal nomenclature and definitions. From an epidemiological standpoint, lacking a standardization of injury descriptions, as well as similar data collection methods, healthcare workers find comparative studies unreliable. This makes it difficult to share information, develop differential diagnosis, and to create reliable treatment plans (5). With the formation of organizations like the International Association for Dance Medicine and Science (IADMS), specialists continue to work on dance injury terminology (2) to solve continuity of care problems.

Professional dancers suffer from unique musculoskeletal injuries that develop due to unnatural physical placement and unavoidable overuse. A recent study published in the British Medical Journal showed that eighty percent of professional dancers suffer a significant injury each year (4). For example, ballet dancers often suffer from foot injuries due to the use of point shoes. The use of these shoes results in a "nonphysiologic weight bearing that exaggerates the metatarsal arch and...[causes]...distorted posture...[which] may produce fatigue, pain, stiffness of the tarsal joints, hallux valgus, bunions, hammertoes, early arthritic changes, with bony spurs, and narrowing of the joint spaces." (3) Often, traditional orthopedic remedies for such problems do not suit the professional dancer. Arthrodesis, a surgical procedure that fuses joints, would normally be used to reduce similar foot pain. However, this procedure cannot be used for the ballerina, because it reduces the foot's range of motion, ultimately preventing the dancer

2007 Clendening Fellowship Proposal

from executing variations *en pointe*. The dance medicine specialty continues to strives to find realistic injury treatment strategies to prolong dancers' professional careers.

North American dancers "have not been seen in the national health care debate as a unique constituency...(6)" These artists are act as a vertebrae in the "backbone of culture" that perpetuates creative and lucrative ideas. Yet, more that 55 percent of dancers do not have health insurance (8). This fact often prevents them from seeking help for potential career ending injuries before they become irreversible. Programs such as the Harkness Center's Special Assistance Fund (supported by local trusts), subsidize medical costs for dancers in financial need (7). These programs are merely a band-aid for the greater health care problem, which will require massive policy reform.

Existing as relatively new medical specialty, there are many obstacles dance medicine must overcome. Organizations like the Harkness Center for Dance Injury continue to work through these challenges. As more discrete information is obtained and shared about dance related injury prevention and treatment, the more effective this specialty will become. Furthermore, addressing dancers' under representation in health insurance advocacy will further dance medicine's ability to heal. The medical community must continue to realize dancers' importance and act on the need to keep them healthy, contributing members of society. With a Clendening Fellowship, I hope to gain more clinical and research related knowledge about dance medicine at the Harkness Center for Dance Injury.

Motivation

My study of the human body began at three years old in creative dance class. Captivated by the joy of movement, my life's passion was to expand the limits of my physical ability. Dancing felt wonderful. Thriving on the discipline, teamwork, and challenge of classical ballet, the passion grew. Blessed with a malleable anatomy and grit, I continued to excel and loved learning how to manipulate the physical form. Soon, dancing filled my afternoon, evenings, weekends. To feel healthy and alive, I moved.

Through my understanding of movement's importance, I became conscious of illnesses effects on the body. Entering college, I chose to major in Dance and Human Biology, continuing to build my personal knowledge of the body and its capabilities. Taking classes on movement analysis, and spending hours in rehearsal, yielded opportunities to learn about injury. Intrigued by fellow dancers' ailments, I sought information to alleviate the pain caused by the latest case of tendonitis, bursitis, or arthritis. Biology course work further supplemented my understanding of anatomy and strengthened my biological, chemical, and physical knowledge. Research provided an opportunity to study movement related injury and built my analytical skills. Focusing on

2007 Clendening Fellowship Proposal

a biomedical engineering research problem, in a photochemistry lab, our team used a photo activated compound (DPD) to weld type I collagen tissue. Potentially speeding the recovery processes, this bonding agent could eliminate the need for metallic clips and sutures used to repair torn or severed tendons.

Paralleling my passion for movement, my passion for understanding the body and how to alleviate sickness grew with time. Through my life experiences in dance and healthcare, I have become more intrigued with the application of sports and rehabilitation medicine. I look forward to learning more about this area of medicine at the Harkness Clinic for Dance Injury.

Methods/Goals

In an attempt to study further all aspects of dance medicine, I will travel to New York City, NY in the months of June and July. During this time, I will be working one on one with Dr. Donald J. Rose and Dr. David S. Weiss at the Harkness Center for Dance Injury at New York University's Hospital for Joint Diseases and Orthopedic Institute. Both Dr. Rose and Dr. Weiss sit on the board of the International Association for Dance Medicine and Science. Thus, they are actively contributing members to the dance injury codification process. I will attend daily rounds and assist in appropriate clinical procedures. Furthermore, I will observe a minimum of three surgical procedures per week. While in New York, I will also spend a minimum of one weekend day per week in the Physical therapy room at the Alvin Ailey American Dance Center. In these experiences, I hope to gain the most current information on dance injury prevention, surgical procedures, treatment regimes, and dance injury terminology.

In addition, I will spend two afternoons per week interviewing 5 professional dancers in each of the following companies:

The American Ballet Theater
Alvin Ailey American Dance Center
Dance Theater of Harlem
The Merce Cunningham Dance Company
Pilobolus Dance Company

***Interviews will be tape recorded after obtaining dancers permission
Some of the Interview Questions will include:

1. How long have you been dancing?
2. What is your current work situation like?
3. Have you ever suffered an injury that kept you from dancing? What, and how long? Did you seek medical care for this injury?
4. What factors do you think caused this injury?
5. Do you have health insurance? Are you able to pick your healthcare provider? Did your healthcare provider seem knowledgeable about the demands of professional dance?

2007 Clendening Fellowship Proposal

6. What treatment was prescribed? Were you able to comply with the prescribed treatment?

Upon completion of the project, I will compile the information I have gathered on the current state of dance medicine for presentation at the fall 2006 Clendening presentations

Contacts

Donald J. Rose, MD, attending orthopedic surgeon and director of the Harkness Center for Dance Injuries, as well as director of ambulatory surgery at NYU Hospital for Joint Diseases.

David S. Weiss, MD, orthopedic surgeon in private practice in New York City, specializing in dance medicine. He is Associate Director of the Harkness Center for Dance Injuries and is Clinical Associate Professor at New York University School of Medicine.

Megan Richardson, MS, ATC head administrator at the Harkness Clinic for Dance Injury

Shaw Bronner, Physical Therapist, Alvin Ailey American Dance Theater

Kelly Ryan Director of Press and Public Relations American Ballet Theater

Rebecca Wilhelms Company Manager, Merce Cunningham Dance Company

Jun Kuriyashi, dancer Pilobolus Dance Company

Tentative Timeline:

June 16 th	Fly out of KCI and arrive in New York City
June 18 th - June 22	Rounds with Dr. Rose at Harkness and NYU's Hospital for Joint Diseases (approximately 3 surgeries and 2 afternoons in Alvin Ailey PT Room)
June 25 th - June 29 th	Rounds with Dr. Weiss at Harkness and NYU's Hospital for Joint Diseases (Approximately 3 surgeries and 2 afternoons in Alvin Ailey PT Room)
July 2 nd - July 6 th	On call with Dr. Rose Monday, Friday morning Monday and Friday afternoon in Ailey PT Tuesday, interviews with Pilobolis Dance Company Thursday, interviews with American Ballet Theater
July 4 th	Independence Day
July 9 th - July 13	On call with Dr. Weiss Monday, Wednesday, Friday morning Monday and Friday afternoon in Alvin Ailey PT Room Tuesday: interviews with Alvin Ailey Dancers Thursday: interviews with Merce Cunningham Dancers

Rachel Moses

2007 Clendenning Fellowship Proposal

July 17th Fly back to Kansas City

July 18th –
Fall 2006: Make Clendenning Research Presentation

Budget

Airfare	\$350
Rent	\$1200

Unlimited Metro Pass	\$90
Food	\$250
Misc	\$200

Total	\$2050

**any amount above and beyond the Clendenning allotment shall be paid out of my own pocket

Sources

1. Fitt, Sally Sevey. *Dance Kinesiology*. Utah: Schirmer Thompson Learning, 1996.
2. Jonas, Gerald. *Dancing: The Pleasure, Power, and Art of Movement*. New York: Harry N. Abrams, INC, 1992.

2007 Clendening Fellowship Proposal

3. Ostwald PF, Baron BC, Byl NM, Wilson FR. *Performing Arts Medicine*. West J Med. 1994 Jan;160(1):48-52.
4. Dobson R. *Eight in 10 Dancers Have an Injury Each Year, Survey Shows*. BMJ. 2005 Sep 17;331(7517):594
5. Shaw Bronner, Sheyi Ojofeitimi, and Lester Mayers. *Comprehensive Surveillance of Dance Injuries: A Proposal for Uniform Reporting Guidelines for Professional Companies*. Journal of Dance Medicine & Science Vol10, Num 3,4, 2006.
6. Kathleen Bitetti. *Artist's Health Care Task Forces' 1994 Report to Congress* http://www.artistsfoundation.org/art_pages/policy/policy_taskforce_report.htm
7. Harkness Center for Dance Injury News Letter
http://www.med.nyu.edu/hjd/harkness/assets/spring_newsletter_05.pdf
8. Solomon R, Solomon J, Micheli LJ, McGray E. *The "Cost" of Injuries in a Professional Ballet Company: A Five-Year Perspective*. Med Prob Perform Art 11:(4): 164-169, 1999

Dance Medicine: Healing the Artist



**HARKNESS
CENTER**
for Dance Injuries

February 14, 2007

Rachel Anna Moses

Dear Ms. Moses:

I am pleased to inform you that you have been selected to participate in a one-month elective observation under my guidance commencing June 18, 2007. During that time you will have clinical and surgical exposure both through my private practice, our Associate Director's, Dr. David Weiss, private practice and the Harkness Center for Dance Injuries.

Sincerely,

Donald J. Rose, M.D.
Director

DJR/mr

Health Care in Thailand:

An Exploration of the Efficiency and Effectiveness of the 30 Baht Program

A Clendening Research Proposal

20 February 2007

Elise Schnose

SOM 2010

I. Introduction

Thailand is a country known for its traditions centered around a deep respect for ancestors. The country, previously Siam, was declared as the Kingdom of Thailand in 1949. Its name is based on the word *thai* that means freedom. This overwhelmingly Buddhist country retains many other traditions including a strong sense of social hierarchy. While Thailand remains a strongly conservative country, the kindness and hospitality of its people have helped make it a common tourist destination. Thailand is located in Southeast Asia, and significant influences from China and India have developed its unique culture and government.

II. Background

Asian countries generally do not have as developed an infrastructure as Western countries. Both health coverage and health care lag behind more developed countries. However, Thailand has both a progressive health coverage plan and health care which is becoming comparable to more industrialized countries.

The percent of citizens that are uninsured in Thailand in 2000 was approximately 28.7%, decreased from 67% in 1991. In 2001, Thailand's government implemented the 30 Baht program that extended coverage to 18.5 million people out of the country's population of 62 million.ⁱ The 30 Baht program was added to the four existing insurance programs: Civil Servants Medical Benefits, Low Income Card, Voluntary Health Card, and Social Security. The Civil Servants Medical Benefits scheme provides for civil servants. The Low Income Card scheme provides free care for low income individuals as well as the elderly and children less than 12 years of age. The Voluntary Health Card scheme provides for individuals living in rural areas. Finally, the Social Security scheme is mandatory for all private firms to provide for their employees. With the implementation of the 30 Baht program, Thailand has also shifted funds from hospitals to local primary care facilities. The basis of the program is that each patient will pay 30 Baht, approximately \$0.86 in American dollars, for every health care visit.ⁱⁱ

In comparison, the percentage of individuals in the United States that were not covered by health insurance rose from 15.7 in 2004, to 15.9 in 2005ⁱⁱⁱ. Of the 46.3 million Americans that were uninsured in 2005, 8.3 million (17.8%) are children^{iv}. In addition to Medicaid, each state in the US has a Child Health Insurance Program (CHIP). These programs are state run, but federally subsidized and help to insure children not eligible for Medicaid and do not otherwise have health insurance. Individuals could apply for the program in their residing state and if deemed eligible, would be enrolled in the health plan available in their area. The state would then pay the covering health plan for the service. This process begins with a parent or legal guardian applying to the program for their child/children. The computer systems vary from state to state, but generally determine eligibility of the child/children, enroll clients, and determine capitation paid to the health plans. While previously working in this area, I found that this process did not always run smoothly and even though many children obtained the opportunity to receive health care, there were still many that were denied for reasons based on individual state laws.

Thailand's program is very progressive compared to that of the United States. It was also implemented, after many years of planning and debate, with little resistance or shortcomings. Recently there was a military coup in September of 2006 where the Royal

Thai Army overtook the government of Prime Minister Thaksin Shinawatra. There is no information available on how this change in government has affected the 30 Baht program.

III. Motivation

Before starting medical school, I worked as a consultant for a company that implemented computer systems to run CHIP's in each state. My work in this area sparked my interest in how, even with accessory programs to Medicaid, there is such a large percentage of uninsured individuals in the US which has a per capita income of approximately \$38,000. I have always had an interest in Asian countries due to their rich and varied cultures, but when I learned about the progressive health coverage programs that exist in Thailand, I became interested in discovering more. Thailand's per capita is close to \$7,000 and they have been able to implement a universal health care program. During college, I studied abroad with a program, Semester at Sea, based on a ship that traveled to many destinations around the world. My voyage sailed around the Pacific Rim and included many Asian countries, one of which was Thailand. Unfortunately, the summer that I traveled was at the end of the SARS epidemic and, for safety reasons, the organization decided to change our itinerary to avoid any possible epidemic threats. This setback only increased my desire to learn about and travel to this unique part of the world and this program presented the perfect opportunity for me to do both. I believe that studying Thailand's system, the manner in which they have implemented it, and its success on a patient level, will help me understand possible areas of change and improvement in the United States effort to provide more complete health coverage to its citizens.

IV. Method

I will be traveling with a fellow classmate and we will be working through Global Crossroads, an organization that has public health volunteer programs in Thailand. We will be working for four weeks at a polyclinic in Bangkok, assisting the public health officials and nurses. Global Crossroads has informed us there is not a need to speak Thai.

With this program, we will not only be shadowing in a public health clinic, part of the 30 Baht program's focus to increase primary care, but we will be working with the patients and assisting in providing care. I will use this first hand patient contact to gather information in order to complete my objective on how many patients seen in the public health clinics are using the 30 Baht scheme as compared to other insurance programs. I also intend to use this time to learn about patient satisfaction with both the 30 Baht program and the country's move to a primary care focus, and if they have noticed a difference on an individual level. I believe that my one-on-one contact with patients will be sufficient to acquire this information, but I have attached a survey in the appendix that I will use to get statistical data on the patients served in the primary care clinic. During this part of my research, I intend to pay specific attention to the coverage and care that children receive and this may involve speaking with the parents or guardians and children themselves.

I will also learn from the staff at the public health clinic about their perception of the efficiency and effectiveness of the 30 Baht program compared to other health programs in Thailand. From the staff that manages both the health care aspect and the business aspect of the clinic, I will be able to gain a full understanding of the positive and negative attributes of the various health programs. This knowledge from individuals that have worked in health care will also be beneficial my research about how the coup d'etat has affected their practice.

Once I have gathered all of this information, I will be able to contrast Thailand's health coverage system to that of the United States in order to gain a better understanding of how Thailand has been able to implement such a progressive health care program which the US has not.

The project run by Global Crossroads includes housing with a host family or in a hostel and meals. We will arrange our own transportation between Kansas City and Bangkok. We also plan to spend time for personal travel after we finish our time with Global Crossroads.

Unexpected expenses in the budget account for non-volunteer related travel within Bangkok and food if we occasionally chose not to eat provided meals.

V. Specifics

a. Timeline

6/11/2007	Arrive in Bangkok/Volunteer program orientation
6/11/07-7/6/07	Work in Public Health Clinic in Bangkok
6/8/2007	Depart Bangkok
6/8/2007-7/30/07	Personal travel time in Southeast Asia
7/30/2007	Return to Kansas City

b. Budget

Global Crossroads Program	\$1,295.00
Flight MCI-BKK	\$1,500.00
Unexpected expenses	\$100.00
Total	\$2,895.00
Student Responsibility	\$895.00

c. Contacts

- i. Miss Misha R. Risley (Asia coordinator)
- ii. Mohan Adhikari (US volunteer coordinator)
- iii. I will get the name of the site contacts within a week

VI. Objectives

- a. To learn about how many individuals seen on a regular basis in public health clinics are covered by the 30 Baht system.

- b. To learn about the satisfaction of the individuals in Thailand's health care system.
- c. To learn the organization of Thailand's 30 Baht health care system and specifically how it pertains to child health care.
- d. Learn about the affects of the military coup in September of 2006 has affected the 30 Baht program.
- e. Compare and contrast these results to health care systems in the United States.

VII. Survey

1. Please specify your insurance or method of payment

☐ Civil Servants Medical Benefits

☐ Low Income Card

☐ Voluntary Health Card

☐ Social Security

☐ 30 Baht Program

☐ Self-Pay

☐ Other Please specify: _____

2. If you are covered under the 30 Baht program, did you previously have health insurance?

☐ Yes

☐ No

3. Please rate your satisfaction with your health care coverage plan (1—lowest to 5—highest)

1

2

3

4

5

4. Do you feel there has been an improvement in Thailand's health care since 2001?

☐ Yes

☐ No

5.

Additional Comments:

Kop-khun (Thank you)

ⁱ Towse, Adrian; Anne Mills; Viroj Tangcharoensathien. "Learning from Thailand's Healthcare Reforms." BMJ 328:103-105 (10 January 2004). <http://www.bmj.com/cgi/content/full/328/7431/103>

ⁱⁱ Towse, Adrian; Anne Mills; Viroj Tangcharoensathien. "Learning from Thailand's Healthcare Reforms." BMJ 328:103-105 (10 January 2004). <http://www.bmj.com/cgi/content/full/328/7431/103>

ⁱⁱⁱ United States. US Department of Commerce. US Census Bureau News. Washington: 29 August 2006. http://www.census.gov/Press-Release/www/releases/archives/income_wealth/007419.html

^{iv} United States. Center on Budget and Policy Priorities. The Number of Uninsured Americans is at an All-Time High. Washington: 29 August 2006. <http://www.cbpp.org/8-29-06health.htm>

Through a Parent's Eyes: Preparing the parents of the chronically ill child for a lifetime of care.

Clendening Fellowship 2007
Deborah Scrafford

First year Medical Student 2010

Goal:

My project will look from the perspective of parents with chronically ill children to learn more about their experiences with the health care system as well as its resources during the treatment process. I feel this is of vital importance because the caregiver of the child, the parent, will be the constant support, guide and most importantly the teacher of the chronically ill child. In order for this parent to best prepare and care for their child they must understand the diagnosis and the many resources that will be available to them throughout the treatment process. This understanding implies a knowledge of the disease, its medications and the proper lifestyle changes that need to occur in order to best prepare the child for a lifetime of medical care. This project will learn more about what a parent goes through in learning of their child's illness and what resources best helped them to understand their child's diagnosis as well as how prepared they were for what laid ahead of them as the guardian of these little patients. It is my hope that the more prepared a parent is the better the child will be cared for and taught to manage their chronic illness.

"My Inspiration"

Dressed as a pirate to greet the kids to burn camp I eagerly awaited the faces of children I knew from my previous year of working at camp. As the children filed off the bus and gazed upon the camp ground for the first time that summer their eyes glimmered with hope. Unfortunately some of the kids come to camp barely able to make eye contact for fear of the judgmental looks of horror and fear that society sometimes greets these children with daily. Susan (pseudo name for confidentiality purposes) was a special camper from my previous year who had found a way to crawl into my heart and form a special bond with me. She had been burned badly in the face, particularly around the eyes so it was sometimes difficult to find the sparkle in her eyes as we had been taught to help us look past the disfigurements and look more into the heart of the child. When I first met Susan she was barely able to look up from the ground, let alone crack any resemblance of a smile. I desired to give her special attention in an attempt to help her feel loved and show her there are those who would look past her burns. That first summer I saw remarkable improvements over the week she was at camp. By the end of the week she was looking at people again and on occasion would crack a smile to light up the room. Granted it was not much but you could see how camp had shown her something about the importance of looking past a specific illness or disfigurement. This year Susan came bounding off of the bus talking to other kids, smiling, running and laughing. I was shocked at the improvement in her self esteem and happiness. I noticed this change in the children in more than one child. In fact almost every camp we served there were kids who left camp more independent, confident, and happy.

Camp furthermore taught me the value of the home environment can have in the child's perspective of their illness. All the campers we serve come from many different backgrounds from around the Dallas and Ft. Worth area. At camp I could see differences a family could make in the life of a child. Spina Bifida week was one of the weeks that seemed to show what a difference a family member can make in the life of a child. Some children come to camp obviously never having been away from home as evidenced by their inability to transfer themselves and their aptness to immediately look to an adult to do these transfers, help them clean themselves, retrieve food, and wheel them around. I

assume these children often came from parents who wanted desperately to protect their children and help them in every way possible because of their "illness." On the other hand there were children who did everything on their own and to outside world only appeared to have a special diagnosis because of their wheel chair. They were able to do all their transfers, toiletry needs, play competitive basketball or even climb an seemingly impossible ropes challenge course. These children often had either been to camp before and learned from their peers that they could do all of these activities or had parents that insisted they have as much independence as possible in order to have the best shot at a normal life.

My summers working at Camp John Marc have changed my life and will influence the way I practice medicine for a lifetime. I want to incorporate what camps like this one offer children into the pediatricians office to give the children the best chance for a life free of the stigma or the pains a disease can present to such young and innocent children. Susan like many of the other campers has given me inspiration as to what camp can give to one small child. Now I wish to learn more about what occurs before camp and at home within the family. Parents are the guardians of these amazing children and need to be given special attention in order to ensure the children have encouraging environments like camp within the home. I feel the first step to this lifelong journey is understanding how we deliver diagnosis to the parent and what resources we initially offer them through this difficult time. Do we offer them support groups or environments like camp? Are parents able to understand their child's diagnosis enough to know what it means long term and how to help their child earn independence in their treatments and medications? Furthermore, I want to learn from the families what physicians have done well and what could improve in the treatment of a chronically ill child. We know how to physically treat their illness but are we serving fully the emotional side of the illness?

Camp has shown me how just one resource can dramatically change the life a child such as Susan. I do believe resources such as a camp can help children gain the independence and confidence they need. I feel through this summer's learning I can expand my knowledge to a more basic level of the first steps taken in our treatments of chronically ill children.

My Research

Delivering a diagnosis of a child to a parent is a moment that will forever change their life. It is a moment full of questions and fear and often trust in the words and advice of the physician. In the matter of a moment their lives change dramatically. This is also the moment where we can prepare the parent for what their child's diagnosis means as well as make sure they are given all the proper resources to help them best navigate through the health care system and its resources. I want to look into the ways we tell patients families about the little one's diagnosis as well as look at what resources we present to them to help in their understanding and acceptance. Lastly, I would like to look into how we can empower parents to enable their kids to seek independence in their medications and treatments in order to lead as normal a life as possible. This is really important especially for the pediatric population because often diagnosis's can make the child feel they are different enough that they don't want to take the proper medicines because it makes them feel different than their friends. Additionally there is a great

desire to shelter and give this child extra protection by doing everything for them because they are "sick." However this only strips the child of an independence and responsibility for their own illness, especially as they age. There is also the barrier of helping a parent to understand what the diagnosis means, especially considering their varied educational backgrounds. I believe that it is in the way we tell patients and their parents about their diagnosis and the resources we first offer that we can really help them long term with the best management of their disease as well as make sure socially they are not suffering. This summer will be a summer of my learning more about this initial step in the treatment of pediatric patients of chronic diagnoses.

Plan:

I will be spending 8-10 weeks working in different physician's offices talking to parents about their experiences with the diagnosis process and resources. When the patient and family arrive for their visit I will give them a packet of information with an informed consent, a short summary of my research as well as short survey. During their wait for their visit they will be free to fill out the survey. I will see the physicians normally scheduled patients either before or after their normally scheduled appointment to discuss this with them in an interview format depending on their wait period. I hope to rotate pediatric offices on a 1 week to 2 week basis.

The interview will take place in a private room and will be tape recorded. Finally I will process the surveys and interviews with parents to look at the best methods of delivering a diagnosis and what resources were most helpful to them. I will also draw together what helped the parent best understand their child's diagnosis and how they handle enabling the child with independence.

Questions:

Survey Questions:

1. What was your initial reaction to learning of your child's diagnosis?
 - a. Angry
 - b. Sad
 - c. Feeling of Guilt
 - d. Blame
 - e. Other (please explain)
2. Where were you first told about your diagnosis?
 - a. Exam Room
 - b. Hallway of clinic or hospital
 - c. Quiet separate room
 - d. Over the phone
 - e. Other:
3. Who was present when you were told about your child's diagnosis?
 - a. Your child

- b. Your immediate family
 - c. Doctor
 - d. Nurse or office staff
 - e. Other:
4. What resources were you offered following your diagnosis?
- a. Financial Resources
 - b. Written pamphlets or other Educational Resources
 - c. Support Group Contacts
 - d. Camps
 - e. Other (please explain)
5. After your doctor told you about your child's diagnosis, where did you go for more information?
- a. Internet
 - b. Doctor
 - c. Pamphlets or Papers given to you by the physician
 - d. Friend
 - e. Books
 - f. Other (please explain):
6. Did you feel satisfied the way the doctor shared the news with you and your family?
- a. Completely Satisfied
 - b. Somewhat Satisfied
 - c. Neutral
 - d. Dissatisfied
 - e. Very Dissatisfied
 - f. Other (please Explain)
7. On a scale of 1-10 (with 10 being understood completely and 1 being did not understand at all) how well did you understand the diagnosis?
8. Do you feel you have a firm understanding of your child's diagnosis today?
- a. Yes
 - b. No
 - c. Unsure
9. How did your doctor explain the treatment options?
- a. Oral
 - b. Pamphlets
 - c. Books
 - d. Other (please explain)

10. Do you understand what your child's medications are used for?
- Yes
 - No
 - Unsure (please explain)
11. How did you learn about the medications?
- Conversations with the physician
 - Internet
 - Friend or Family
 - Pamphlet
 - Other (please explain)
12. Do you believe it is important for your child take their medications exactly according to your physician's instructions?
- Very important
 - Important
 - Not very important
 - Not at all important
 - Depends on My Child's symptoms
13. Do you feel it is important to attend regular doctor's visit?
- Strongly Agree
 - Agree
 - Disagree
 - Strongly Disagree
14. Does your child take their medications as prescribed?
- All of the time
 - Most of the time
 - Only when symptoms arise
 - Never
 - Other (please explain):
15. What resources did you use to explain the diagnosis to your child?
- Books
 - Pamphlets
 - Internet
 - Oral explanation
 - Pictures or other Drawings
 - Other (please explain)
16. Did you discuss the reasons for taking the medications with your child?
- Yes
 - No
 - If no, why not:

17. What resources were you offered to help with the emotional aspect of coping with a chronic illness diagnosis?
- Support Group of other parents
 - Support Group for families (the kids are involved)
 - Counseling
 - Child Life Caregiver of the hospital
 - Camps for the child
 - School programs
 - Other (please explain)
18. Of the resources you were offered what was the most useful resource and why?
19. What kinds of support or resources are offered on checkup visits?
- Resources to help with the cost of visits and medications
 - School Resources
 - Pamphlets to help with your child's understanding of their ongoing treatments.
 - Emotional Support Resources such as support groups
 - Other (please Explain)
20. Is there anything else you would like to share about the diagnosis experiences or the resources offered to you throughout the treatment of your child?

Interview Prompts for Parents:

- Can you tell me about how you were first told about your child's diagnosis?
- Were you offered resources? And if so what kinds were they?
- Do you understand your child's diagnosis now? How did you learn what you know about the illness?
- Where do you draw support?
- What was most beneficial to helping your child adjust and learn about their diagnosis?

Contacts:

Kathy Davis: She is a pediatric education coordinator at KUMC. She is helping me plan and execute this project. She will be my mentor this summer and help me work out problems that may arise as well as help guide my efforts.

Humans Subjects committee: I am in the process of submitting a proposal to this committee to get this approved in case I decide to further this research later down the road in my professional career. My summers at camp instilled a passion in me and an education that will forever change me. I feel I have a duty at this point to share any knowledge I may gain from what I learn this summer and because of this want to take it through the proper committees. I met with Dan Voss, on the human's subjects committee, to talk about my project and the likelihood of it being approved. I was met with enthusiasm to take this project to their committee. I met with Chet Johnson, chair of

pediatrics about the project and in order to receive approval. He was very enthusiastic and did sign his approval. I will be submitting the proposal for review within the next two weeks. However if for some reason this project does not merit approval I would be willing to do this summer as strictly my self education and learning more about this initial steps in a diagnosis.

Dr. Shaw and Dr. Gilmer: I will present my research ideas to their pediatric members meeting at the end of March to see what physicians would allow me to conduct this research in their offices this summer. They seemed enthusiastic about the project and were encouraging that the project would find support among the pediatricians.

Dr. Chet Johnson: I have met with Dr. Johnson about the project in order to receive approval for research. He has offered to speak on my behalf as well in order to make sure enough physicians sign on to allow me to work on the project with their patient's families.

Dr. Talkad Raghuveer: a neonatologist at KUMC is interested in my project. He will serve as another contact to help recruit physicians to allow me to conduct my research in their offices.

Budget:

There are no costs of the research I anticipate other than a tape recorder and the use of my computer. I will use the money for living expenses seeing that I will be unable to work for the summer because of the time I wish to invest this project.

Housing: \$400 per month (3 months)

Transportation: \$300

Groceries: \$250 per month

Bills: \$500

Total ~\$2,250

I will absorb whatever costs I have that are not covered by the fellowship.

Preparation:

I will spend 1-2 hour a weekend from March to June reading a few books to learn more about qualitative research as well as how to conduct an interview.

Bibliography:

Camp John Marc:

www.campjohnmarc.org

I spent 2 summers working on staff and 1 week of a third summer as a volunteer.

Research background:

3 Years at the University of Notre Dame researching in an immunology lab looking at Malaria. This experience allowed me to help design a more basic science research study.

I presented my research at the Autumn Immunology Conference in Chicago in November of 2005.

Bradley Thompson
2/16/2007

Venezuelan Health Care Reform

Introduction:

The Venezuelan government is currently expanding and further socializing its medical services. This healthcare reform initiative is an aggressive program, thus creating a window of opportunity for the analysis of the transitioning process. As the Venezuelan medical system exists today there are two sectors; one public and one private. Universal healthcare does exist; however, private healthcare is preferred by Venezuelans who can afford it. Because the Venezuelan private sector is unencumbered by the insurance industry, objective analysis of its cost-effectiveness can be made relatively easily. The essential problems facing the Venezuelan healthcare industry, although grossly magnified, are not unlike those facing the United States. I believe that studying the effects, both positive and problematic, of the Venezuelan medical revolution can reveal valuable insights which will help American politicians and healthcare providers make wise choices as they attempt to reform our healthcare system.

Background:

Venezuela had long been a free market society whose market forces were driven primarily from oil. As recently as the 1980's Venezuela had strong political and commercial ties with the United States and modeled many of its industries after those in the United States. With respect to the medical industry, Venezuela chose to provide a two-tiered system, private and public, with the intention to fulfill the needs of all of its citizens. At that time the infrastructure of both the private and public healthcare systems were considered among the most advanced, comprehensive, and well funded in Latin America. Most importantly access to care was widely available. Since that time the system began to be polarized. While the private sector remained relatively efficient the public sector declined to an unacceptable level. Infrastructure deteriorated, waiting rooms were flooded with patients and only 1.3 hospital beds existed for every 1,000 inhabitants: less than one-half of that recommended by the World Health Organizations. Change was desperately needed.

With promises of aiding the poor and eliminating corruption, Hugo Chavez was elected to his first term as president of Venezuela in 1998. Not only had the conditions of public healthcare deteriorated, but the greed, which sometimes accompanies capitalism, had become excessive. By the time Chavez took office, more than eighty percent of the population lived below the poverty level. In 1999 Chavez's government produced a new Constitution which promised free and quality healthcare as a guaranteed human right to all Venezuelan citizens. To that end Chavez named Dr. Gilberto Rodriguez Ochoa to be his first Minister of Health. Although Dr. Ochoa was a lifetime proponent of public healthcare and preferred the elimination of private clinics and hospitals, he began his service as Health Minister by trying to work within the existing system. Unfortunately the system was so dysfunctional and so resistant to reform that progress was discouraging. Faced by the same kind of resistance to change in other areas of government Chavez embarked on his Bolivarian Revolution, a movement to

implement socialist democracy throughout the country. Earmarks of the movement include the denunciation of capitalism, privatization, and globalism. It is a pro-poor movement which aspires for total social justice for all, a staunchly nationalistic ideology, and demands a totally centralized government.

Early in the Bolivarian Revolution the Venezuelan administration declared that decentralization of the medical system was to blame for the prohibitive costs and ineffectual performance. In response the government enacted a referendum in 2000 which was designed to elevate the previous concept of healthcare from "medical assistance to social and participatory medicine," according to Luis Montiel, junior minister to Chavez¹. The referendum introduced several revolutionary ideas: that sports training is a vital part of the medical community's responsibility; that assistance in social development must be given; and that help in developing positive family relationships should be a part of the comprehensive, grass-roots medical concept. Furthermore, healthcare was to be given at virtually no charge. Last, but certainly not least, the administration introduced the concept of "social missions" - programs designed to help the poor in various aspects of their lives, especially in medical care and education. The social missions were to be financed by vast amounts of oil money.

The social mission for healthcare has become very successful and very important in Venezuela. Its expansion continues to be a work in progress. Called **Mission Barrio Adentro**, which means "Inside the Poor Neighborhood," this medical delivery system is actually a third tier of medical care in Venezuela. The concept is to take medical care to where it is needed most. The Mission Barrio Adentro concept has grown in four important stages.

Introduced as a reality in March of 2003, **Barrio Adentro I** was designed to provide medical and dental care as well as sports training to the poorest of the poor. Initially it targeted the poorest urban districts in the largest cities and the most geographically isolated areas of rural Venezuela. Virtually identical clinics were and continue to be built with well-equipped examination rooms and doctors' offices on the ground floor and living accommodations for the medical staff on the second floor. (The medical staff is expected to live within the community it serves.) Each clinic is designed to serve only several hundred families. Many more physicians were necessary than Venezuela could supply to accomplish this goal. In 2003 approximately 20,000 Cuban doctors were brought to Venezuela to help staff the clinics. In return, Cuba received Venezuelan oil at a substantially reduced cost. For their services, Cuban and Venezuelan physicians received \$250 and \$600 per month respectively. To date 2500 such clinics have been built with a goal of constructing 5000 in the near future. **Mission Barrio Adentro II**, introduced in June of 2005, addresses the need for specialized and outpatient care. Under this plan, hundreds of Integrated Diagnostic Centers and Integrated Rehabilitation Services Centers have been built throughout the country. Services offered include emergency services, specialized laboratory assistance, endoscopy, electrocardiography, surgery, intensive care, and x-ray. **Mission Barrio Adentro III**, also begun in 2005, focuses on upgrading existing public hospitals. Infrastructure is being

¹ Glott, Richard. Hugo Chavez: The Bolivarian Revolution in Venezuela. Verso, 2005.

remodeled and new medical equipment purchased. Just announced in November, 2006, **Mission Barrio Adentro IV** provides for the building of sixteen new hospitals around the country, especially in poor areas. The pattern is clear and logical. The primary care physician takes care of as much as possible in a community based setting. If the patient needs more care, he is sent to the specialist clinic and then on to the hospital if his condition is quite serious.

To fully implement the Mission Barrio Adentro plan, a huge number of medical professionals will be needed. To this end, Venezuela is focusing on medical education as well as delivery. Annually, hundreds of students from Venezuela study medicine in Cuba's Latin American School of Medicine. All Cuban physicians practicing in Venezuela are responsible for having two medical students in training under them at all times; this is a system called "medical school without walls" and was developed by Cuban and Venezuelan medical educators. Often these students are being taught in rural areas with the intention that the students will stay in the remote area to practice. Very often students who study in large cities do not want to return to their remote area. Venezuelan and Cuban educators envision training 80,000 new doctors from all over Latin America in the next ten years. In the near future Chavez promises to open a second Latin American Medical School in Venezuela.

There is hopeful anticipation regarding these new policies and only the future will tell whether this inclusive plan of socialized medicine can resolve the issues facing the nation. One important gauge for monitoring the efficacy of Venezuela's new policies will be the management of infectious diseases. Warm tropical climate and close living quarters, especially within the barrios of the nation's capital Caracas, have long made transmittable diseases a major cause of morbidity and mortality. Increased incidence of dengue fever, malaria, measles, and tuberculosis has appeared in recent years as a result of deterioration of the public healthcare. In August 2001 one the Venezuelan government implemented the immunization plan which the health ministry claims will improve vaccination rates.

Objective:

Using my undergraduate background in Comparative Economic Systems, my fluency in Spanish, and my three year experience as a full-time emergency medicine clinical researcher, I intend to do a comparative medical systems analysis using a survey style approach.

My primary objective is to **find a correlation between the cost of care, access to care, the use of care, and the quality of care** within private and public hospitals (including Barrio Adentro facilities). Some questions I hope to answer are: Do patients who use the public hospitals tend to seek routine care more often or less often and why? What do private care seekers value most about their care and under what circumstances would they consider using public care? Finally, I would like to assess how people would feel about a single universal healthcare system if the government were to continue increasing public spending while restricting the private sector.

My second objective is to understand the sentiment of healthcare providers by creating a **work:reward ratio**. Contributing factors will be hours of work per week, financial compensation, vacation, location of practice, quality of education, opportunity for continued education, quality of colleague's work, satisfaction from helping others, driving interest in medical science, job security, prestige. I want to assess how effectively they feel they are able to meet the demands of their patients given the time and resources they have. Furthermore, I will learn how they feel the system could be improved, what the advantages will be that the socialized system will bring to them, what they fear about the changes that are taking place, and what factors they feel will lure people to a medical profession.

Finally, I will analyze published data from the health ministry regarding the vaccination rates and incidence of infectious disease starting in the year 2000 through the present. I will continue to monitor this data as long as the Missions Barrio reform continues.

Methods:

Patient Interviews:

I will visit the waiting rooms of various departments of several private and public hospitals interviewing patients one on one. Information regarding their behaviors and opinions will be collected in a consistent fashion. I will use standard questionnaire form for each person I survey and analyze cumulative information for correlations specific to the responses from within both sectors. I will remain focused on correlations between cost of care, access to care, the use of care, and the quality of care. Below is a list of some of the questions I will use:

- How frequently do you seek medical assistance?
- For what purposes do you seek medical care?
- What issues have prevented you from seeking medical care in the past?
- How satisfied are you with the care you have received in the past?
- Have you ever received private/public care in the past?
- How will a universal health care plan effect how you use medical services?

Physician and Nurse Interviews:

I will interview physicians and nurses from private hospitals and public hospitals (including Barrio Adentro facilities). Questions will relate to a work/reward ratio:

- How many hours per week do you work?
- How many patients per day do you see?
- Do you have the resources you need to examine and treat your patience effectively?
- Do you feel you are adequately compensated for your work?
- Do you feel that your job is secure?
- What changes do you feel need to be made to the old system?
- How do you feel about the changes in medical care and what are your concerns?

Means:

My contact is a Dr. Luis Guillermo Torres physician at Clinica La Vina in the city of Valencia. He is a family friend and will provide housing. Valencia is the second largest city in Venezuela and is in close proximity to the capital Caracas. I will be going to Valencia during spring break to plan the study in more detail, make contact with physicians, and acquire written permission from hospitals to interview their patients.

Costs:

Airline: \$1,000

Food: \$500

Transportation: \$300

Bibliography:

Glott, Richard. "Hugo Chavez: The Bolivarian Revolution in Venezuela".
Verso, 2005.

Glott, Richard. "Prevention and Solidarity: Democratizing Health in Venezuela", Monthly Review 56.8, January 2005

Maybarduck, Peter. "The People's Health System: Venezuela Works to Bring Health Care to the Excluded". Multi-National Monitor. October 2004

<http://www.greenleft.org.au/2007/699/36312>

Lost Between Two Worlds: The Lack of Improvement in
Adolescent and Young Adult Cancer Survival Rates

A Clendening Summer Fellowship

Project Proposal

February 20, 2007

Submitted by

Erica Ubben

Introduction:

In May of this year, I will officially be considered a survivor of adolescent cancer. It will be five years since my last chemotherapy treatment. Approaching such a landmark makes me wonder how I got here, what I will do now that I have gotten here, and what happened to all of the others who are not here to join me.

I was first diagnosed with Ewing's Sarcoma when I was fifteen years old. I was sent to a pediatric oncologist at a children's hospital on referral from the surgical oncologist who had made the diagnosis. I went on to have two separate years of chemotherapy, multiple surgeries, radiation therapy, and an autologous stem cell transplant. Throughout my treatment, I had very little contact with other adolescent cancer patients. While there were many organized activities for the younger children, tea parties and puppets were of little interest to teenagers. The adolescents I did get to talk with all seemed to be doing poorly. Most of us had relapsed and had spent years in treatment. When I no longer saw many of them in the clinic, I was too scared of the truth to ask what had become of them.

When I turned twenty-one I aged out of the children's hospital and continued my follow up care in an adult care setting. I found myself once again a misfit, but this time amongst other patients who were much older than I was. The transition to a new set of doctors presented me with a new set of problems. My doctors were often unaccustomed to dealing with the issues that faced a young adult after cancer treatment. My care that had always been managed by one doctor was now covered by four different doctors who left communication and management up to me.

After some initial difficulty of finding the right doctors and learning to handle the complexities of health insurance, I have managed and now I am quickly approaching the day when my journey will be, by textbook standards, at its end. However, just as everyone else, I will forever be changed by the experiences of my adolescence. I live with the physical and emotional scars of my treatment, the compassion and humility I have gained, and the unending desire to be deserving of this second chance I have been given. It is only fair to my comrades who were not given that second chance; those teenagers who will never know the pride of a diploma, the nervous excitement of starting a new job, or the joy of their own weddings. It is for them that I want to do this project.

Background:

Recent research has come across a disturbing finding, adolescent and young adult cancer patients' survival rates are not improving as well as those of their younger and older counterparts. In a report published by the National Cancer Institute in June of 2006, adolescent and young adult cancer patients, typically defined as patients 15 to 29 years of age, were shown to have the least amount of improvement in their five year survival rates. Between 1975 and 1997 five year survival rates improved more than 1.5% for cancer patients younger than 15 years old and those older than 50 years old. However, for patients 15 to 24 years of age survival rates improved less than .5% and for those 25 to 34 years old no improvement was seen (Bleyer "Clinical Trials" 1647).

In 1975 a diagnosis of cancer between the ages of 15 and 29 years old held a better prognosis than one in any other age group. However, since then survival rates have not been improving as they have in other age groups. As of 2000, this lag in survival rate improvement indicates a worse prognosis for young adults with cancer than twenty five years ago. While cancer occurring between the ages of 15 and 29 years old only accounts for 2% of all invasive cancers, it is still the leading cause of non-accidental deaths among adolescents and young adults (AYA) (Bleyer *Cancer Epidemiology* 1-14).

There are many prevailing theories as to why survival rates are not improving for these patients, including a lack of proper health insurance, a lack of inclusion in clinical trials, biological differences, a lack of referral to tertiary care centers, and their unique psychosocial needs not being met. Many AYA patients are at risk for aging out of their parents' insurance so this could be a contributing factor. A lack of enrollment in clinical trials, which often provide the newest advances in treatment, could also cause a lack of improvement in survival rates. Cancer occurring between the ages of 15 to 30 is 2.7 times more common than a diagnosis during the first 15 year of life (Bleyer *Cancer Epidemiology* 2). However, only 2% of AYA patients are enrolled in clinical trials during their cancer treatment, as opposed to 60% of patients younger than 15 years of age (Bleyer "Clinical Trials" 1646). Part of this problem comes from the fact that more than 90% of cancer patients aged 20-29 years old are cared for by community physicians who have less access to clinical trials (Bleyer "Clinical Trials" 1649).

Whatever the cause may be, I would like to find out why the survival rates for AYA cancers are not improving and what can be done to prevent more deaths of these people whose lives have truly just begun.

Goals:

1. To research current survival rates and some of the possible reasons why survival rates are not improving for adolescent and young adult cancer patients.
2. To gain first hand experience with medical professionals who work with this unique patient population.
3. To use my paper and presentation to raise awareness amongst my colleagues and possibly highlight things they can use in their own practices to help improve survival rates.
4. To assess whether or not I would like to pursue a career working with adolescent cancer patients.

Project:

I would like to begin my project by looking at the current research on adolescent and young adult cancer. I will focus on the incidence of cancer in this age group, overall survival rates as compared to other age groups, and current theories on the lack of improvement in survival rates for AYA patients with a focus on a lack of participation in clinical trials and research. I would like to look at solutions that are being implemented by oncologists as well as things that all physicians could do to help improve survival rates.

Once I have done sufficient research on the topic, I will conduct interviews with people who work with AYA patients. I would like to get different perspectives on the topic. I plan on interviewing people who focus on more of the psychosocial issues of this patient population as well as people who have done more research on the medical side of the issue. In this regard, I will interview Dr. Joan Haase, a professor in pediatric oncology nursing, who has done extensive research on the coping mechanisms and psychosocial issues that face adolescent and young adult cancer patients, and Dr. Archie Bleyer, a leading expert on adolescent and young adult cancers and their lagging survival rates.

As well as interviewing people who have formally researched the topic, I would like to shadow several doctors who work with this patient population to get their views on the topic, to see how these perspectives differ between physicians of different specialties, and to see their interactions with patients and how these differ. I will shadow and/or interview doctors who work with adolescent patients, pediatric oncologists at Children's Mercy Hospital, pediatric oncologists at the University of Kansas Hospital, and medical oncologists at the University of Kansas Hospital.

Potential Complications:

The research on the topic of adolescent and young adult cancer survival rates is fairly new and as a consequence, the availability of books on the topic is limited. I have allowed room in my budget to purchase these books as they are not available at any local libraries. The relative novelty of the subject also means that there are few people who specialize in adolescent and young adult cancer clinical care. I hope to still get sufficient information for my paper by looking at the available research, interviewing people whose research has focused on the topic and leaving ample free time during the summer to shadow different doctors so that I will have more opportunities to see them interact with adolescent and young adult patients.

Conclusion:

After my initial research, I have realized what a widespread problem the lack of improvement in adolescent and young adult cancer survival rates is. I want to know why and I want to know what is being done or what could be done to save more people who have just entered the prime of their lives. It is a topic that I hope to research not just as part of a Clendening Fellowship, but also as a possible career focus. I feel that the Clendening Fellowship is the perfect avenue in which to begin my research and I would very much appreciate the chance to share my findings with my peers so that they too will know that this problem exists and what they could do to help.

Contacts:

1. Joanne Haase, PhD, RN
Holmquist Professor in Pediatric Oncology Nursing
Indiana University School of Nursing
2. Archie Bleyer, MD
Oncologist and Medical Advisor at St. Charles Medical Center
Director of CureSearch Aflac Adolescent and Young Adult Cancer Research
Professor of Pediatrics at the University of Texas Medical School at Houston
Mosbacher Chair Emeritus and professor of pediatrics at the University of Texas
M.D. Anderson Cancer Center
Director Emeritus of the M.D. Anderson Community Clinical Oncology Program
3. Michael E. Rytting, M.D.
Medical Director Adolescent and Young Adult Program at the Children's Cancer
Hospital at M.D. Anderson
4. Masayo Watanabe, MD
Director of the Solid Tumor Program at Phoenix Children's Hospital
5. Loretta Nelson, MD
Division Chief of Adolescent Medicine at the University of Kansas Hospital
6. Robert Trueworthy, MD
Professor of Pediatrics, Division Chief of Pediatric Hematology and Oncology
7. David Bodensteiner, MD
Professor of Medicine, Division of Hematology/Oncology
8. Susan Stamm, RN, MSN, CPNP
Children's Mercy Hospital
9. Julie Hamlin, APRN, BC, CPON
Children's Mercy Hospital Division of Hematology/Oncology
10. Leonard Sender, MD
University of California, Irvine Medical Center, Children's Hospital of Orange
County (CHOC)
Developer of Adolescent and Young Adult Cancer Program at CHOC

Timeline:

Preliminary Research: June 4 – June 15

Interviews, Shadowing and Continued Research: June 18 – July 13

Work on Final Paper and Presentation: July 16 – July 27

Budget:

Mature Beyond Their Years: The Impact of Cancer on Adolescent Development; by Kathleen L. Neville	\$35.00
Cancer in Adolescents and Young Adults by Archie W. Bleyer, Ronald Duncan Barr	\$169.00
Cancer and the Adolescent by Ronald Barr, Archie Bleyer, Myrna Whiteson, J. Gordon Arbuckle, Jillian Birch, Laurence Brugiere, Peter Selby, Ian Lewis, Timothy Eden	\$78.95
Miscellaneous Travel or Communication Costs	\$100.00
Total	\$382.95

Potential Questions for Physicians and Researchers:

How long have you worked with AYA oncology patients?

What other patient populations have you worked with?

What things do you think make AYA patients unique?

What challenges, unique to AYA patients, often arise during treatment (physical, emotional, etc.)?

In your own practice, have you developed a sense that adolescent and young adult patients don't do as well as other age groups or that their survival rates have not been improving?

Why do you think that survival rates aren't improving for this age group?

Would you say that the problem is a biological one, a psychosocial one, a financial one/lack of access to healthcare, a lack of treatment compliance, a lack of research or clinical trial participation or just a combination of factors?

What do you think could help the survival rates improve?

What age group of patients do you feel is most often referred to clinical trials? And the least?

Do you often refer your AYA patients to clinical trials? Why or Why not?

Do you feel that adolescent patients should be treated at adult or pediatric hospitals? Is it important that they are treated at tertiary care cancer centers?

Do you think that more hospitals will begin setting up clinics just for adolescent cancer patients?

Do you think that adolescent survival rates will improve?

What is currently being done to improve survival rates?

Do you think that all oncologists are aware of this problem?

Should this be an issue that is of concern for all doctors?

What do you think is most important for future physicians or current physicians to know about working with adolescents and young adults?

References:

Bleyer, Archie MD; Budd, Troy; Montello, Michael PharmD. "Adolescents and Young Adults with Cancer: The Scope of the Problem and Criticality of Clinical Trials." *Cancer* 107.7 (2006):1645-1655.

Bleyer, A; O'Leary, M; Barr, R; Ries, LAG. *Cancer Epidemiology in Older Adolescent and Young Adults 15 to 29 Years of Age, Including SEER Incidence and Survival: 1975-2000*. National Cancer Institute, NIH Pub. No. 06-5767. Bethesda, MD 2006.

Bleyer, Archie MD; Vinyl, Aaron MD; Barr, Ronald MD. "Cancer in 15- to 29-Year Olds by Primary Site." *Oncologist* 11 (2006):590-601.

Drybrough, Karen MSc; Frid, William MSW; Vitko, Kyra; Viach, Alexander; D'Agostino, Norma PhD. "Walking Two Worlds – Adolescent and Young Adult Oncology." *Cancer* 107.7 (2006):1659-1662.

Gibbon, Darlene G. MD; Schaar, Dale MD, PhD; Kamen, Barton MD, PhD. "A Call to Action: Cancer in Adolescents and Young Adults: An Unrecognized Healthcare Disparity." *Journal of Pediatric Hematology/Oncology* 28.9 (2006):549-551.

Schmidt, Charlie. "5-Year Survival Data Not Always a Good Measure of Progress." *Journal of the National Cancer Institute* 98.24 (2006):1761.

Schmidt, Charlie. "Lack of Progress in Teen and Young Adult Cancers Concerns Researchers, Prompts Study." *Journal of the National Cancer Institute* 98.24 (2006):1760-1763.

Zebrack, Brad PhD, MSW, Bleyer, Archie MD, Albritton, Karen MD, Medearis, Sandra MSW, Tang, Julia MSW. "Assessing the Health Care Needs of Adolescent and Young Adult Cancer Patients and Survivors." *Cancer* 107.12 (2006):2915-2923.