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JayDoc Free Clinic's Role in Healthcare for the Latina Immigrant:

A Clendening Fellowship Proposal

Kourtney Bettinger

February 16, 2009

SOM 2012

Introduction

A summer of service learning in the Yucatan Peninsula sparked my interest in humanitarian aid and public service, particularly in relation to the Latino population. In efforts to find further direction, I participated in an additional summer of service learning, this time in the northern Mexican state of Tamaulipas. Through the two summers of teaching children and adolescents, as well as volunteering in the pediatric oncology ward of a public hospital, I realized my future entailed a fight against poverty via public health. I subsequently switched my math and biology majors to Spanish, Latin American Studies, and International Studies; I knew that medical school would teach me the health aspect, but I needed to first learn the language and culture of the population I most wished to serve. Over the next few years I spent a large chunk of time in Latin America in various capacities: summer study abroad in Costa Rica, which involved researching the country's deteriorating national healthcare program; a Rotary New Generations Exchange with a Peruvian medical student; semester study abroad in central Mexico, where my advanced Spanish abilities allowed enrollment in classes with Mexican students; and teaching English in Monterrey, Mexico, a major northern metropolis.

I came to understand the issue of immigration best during my time in central and northern Mexico. Unlike in southern Mexico, proximity to the border caused many people to seek temporary relief from economic burdens by going to the United States. For example, I had a young professor, Elizabeth, with whom I developed a close friendship. About halfway through the semester, she began talking about how she and her husband would have to go to Las Vegas for a few months to build up capital in order to open a business back in Mexico. I was shocked because they were in the middle class, far from the level of desperation I imagined the typical immigrant to possess. Elizabeth shared her concerns for both herself and her husband, the difficulty of obtaining a temporary work visa, and her fear of the United States. We stayed in contact, and she later told me about her menial job in Las Vegas despite her Masters Degree in education and that her husband ended up working in California's wine valleys. Elizabeth's experience made immigration a reality and offered insight into what Latina immigrants must face both before and after arrival to this country.

During a summer internship in Washington, D.C., my interest in immigration took another turn. I worked with parents, mostly mothers, through a project with Teaching for Change, an organization that promotes social justice starting in the classroom. One morning I had a two hour interview with Brenda, a mother and school secretary who had emigrated from El Salvador. Our discussion began with topics revolving around D.C.'s public schools, but it progressed into an intimate conversation about her personal life – her abusive boyfriend, her fear of being HIV-positive because he cheated on her, the cultural pressure to bow down as an obedient woman, and her desire to grow stronger and stand up for herself. I realized that she faced the crossing of her homeland's traditional culture with the more liberal cultural of her adopted country. As I walked back to the office, I knew that Brenda had sparked my compassion for the struggle of Latina women in the United States.

Background

The United States is a country of immigrants and, because of immigration, the Latino population is rising dramatically – from 35.6 million in 2000 to 44.3 million in 2006[1]. The Kansas City metropolitan area fits with national statistics – the size of the Latino population continues to rise. Wyandotte County is more than 25 percent Hispanic and Kansas as a whole has had more than 15 percent growth in the Latino population. While Kansas is not even in the top ten states with the highest Hispanic populations, California leads the nation with

over 13 million Latinos[2]. The Bay Area alone is home to nearly 1.5 million Hispanics, which is 75 percent of the entire Kansas population[3].

While not all Latinos residing in the United States were born in Latin America, of those who were, more than 20 percent live below the poverty level[4]. In fact, 45 percent of Latin American immigrant households use at least one welfare program, if not more[5]. It is of no surprise, therefore, that these immigrants do not receive adequate healthcare. Thirty percent of adult foreign-born Latinos report lacking a medical home. Additionally, "foreign-born and less-assimilated Latinos – who mainly speak Spanish, who lack U.S. citizenship, or who have been in the United States for a short time – are less likely than other Latinos to report that they have a usual place to go for medical treatment or advice[6]."

Plan

I propose to research the healthcare availability for Latina immigrants in the Kansas City area, primarily through KC's safety net clinics and particularly in terms of what role JayDoc Free Clinic plays within that system. Although regular clinic operations on Monday and Wednesday evenings are not conducive to ongoing care for chronic conditions, JayDoc has Women's Night every other Tuesday, when students and physicians see patients specifically for women's health issues. It is an opportunity for women to receive prenatal care for the course of their pregnancies, annual pelvic exams, and HPV vaccinations, all at no cost. JayDoc also offers information about SOBRA, an emergency program for undocumented immigrants that provides state reimbursement for giving birth at a Kansas hospital[7].

The first step of my project is to gain a better understanding of what JayDoc offers Latina immigrants, how many Latinas it helps, and in what capacity it serves them. I will track how many Latinas receive treatment at JayDoc throughout the summer, not just on regular clinic evenings and Women's Nights, but also on Diabetes, Ophthalmology, and Physical Therapy Nights. In addition to numbers, I plan to compile a list of the most common treatments being sought by Latinas. I can achieve all of this by being at JayDoc nearly all Mondays, Tuesdays, and Wednesdays of the summer, when I will also be able to talk to students and physicians about their encounters with Latina patients. I recently spoke with Dr. Calkins, the faculty adviser for Women's Night, and he agreed to serve as a gateway to information concerning care at both JayDoc and KUMC.

JayDoc's policy is to refer patients seen during regular clinic operations to a medical home. Because it is primarily an acute care clinic, patients who need help with chronic conditions are better served elsewhere. Referrals are made primarily to safety net clinics, which comprise the next step of my research. Not only is JayDoc an operating member of Wyandotte County's Safety Net Clinic Coalition, but it also plays a role in the system by referring its patients to other, affordable healthcare facilities. I have volunteered with Social Services, the entity of JayDoc responsible for referrals, and look forward to gaining a deeper understanding of its relationships with these clinics. I would like to know how many Latina patients receive further care because of the Social Services Program, which I can do through JayDoc's postcard program that has been established with the sole purpose of tracking referrals.

The second step of my project, therefore, is to learn about Kansas City's free and reduced-price clinics that serve the Latina population. After researching the individual clinics, I will set up site visits in order to talk to their staff and see how they operate. I plan to ask about their demographics, the predominant medical

needs of their Latina patients, and the barriers the patients face in meeting those needs. In addition to completing my research, I will serve as a communication link between JayDoc and the other clinics, especially because I begin my tenure as an Executive Co-Director on the first of May. I will also meet with representatives from community centers, such as El Centro, to discuss how they perceive the availability of healthcare and what they recommend to their Latina members in terms of finding affordable medical care.

After thoroughly investigating the situation in Kansas City, the third step of my research is to compare it to the University of California at San Francisco Students' Homeless Clinic in relation to San Francisco's Community Clinic Consortium. I choose the Bay Area as a comparison city because of its large Hispanic population and my personal interest in the region as a potential site for residency. UCSF Students' Homeless Clinic has multiple facilities that focus on different populations through both clinical care and health education. I am especially interested in its Women's Clinic, which operates Thursday evenings, and the 5th Street Clinic, which provides care to the homeless on Tuesdays and Thursdays[8]. Although the Students' Clinic is not affiliated with the Community Clinic Consortium[9], I seek to gain an understanding of how their services complement each other. Two partners of the Consortium are particularly appealing. Mission Neighborhood Health Center guarantees Latinas a medical home that is bilingual and bicultural. In addition to general adult and children services, it offers a specific program for women, so Latinas are able to afford healthcare for themselves at the same place as for their family[10]. The other member, St. Anthony Free Medical Center, has a patient base that is 61% Latino[11] and the clinic is similar to JayDoc in that it has a triage system each morning to determine which individuals will be seen[12].

Most of the research will be from Kansas City, as my obligations to JayDoc as an Executive Co-Director require me to be here nearly all of the summer. I am confident that I can learn about the Bay Area's healthcare availability for Latina immigrants through online research and phone calls before physically visiting clinics in late July. I will go to San Francisco for a long weekend, during which I will visit clinics much in the same way I will in Kansas City. My goal is to go to UCSF Students' Women's Clinic Wednesday evening and its 5th Street Clinic Thursday evening in order to see how they operate during clinic hours. I am communicating with Rebecca Mitchell, a medical student at USCF who is particularly interested in international women's health, to arrange site visits. I will then have Thursday morning and all day Friday to explore partner clinics of the Community Clinic Consortium. Both Mission Neighborhood Health Center and St. Anthony Free Medical Center are open and see patients in those timeframes. Again, I will speak with physicians and staff as I see firsthand how they operate and serve the Latina immigrant population.

I will conclude the summer compiling data from JayDoc, creating a report about JayDoc's current contributions to Latina healthcare as well as how it can improve its role within Wyandotte County's Safety Net Clinic Coalition, and comparing what I have learned about Kansas City and San Francisco in terms of healthcare for Latina immigrants. The culmination of my research will result in a presentation for students and faculty in the fall as well as a report to JayDoc's Executive Board about my findings.

Goals

I have three personal goals for this Clendening Fellowship. First, as an Executive Co-Director, I want to dedicate my summer to gaining an understanding of JayDoc's role within Kansas City's safety net clinics and within Kansas City's uninsured/under-insured population. I hope to define this role and discover how to improve not only JayDoc's relations with other clinics that serve Latinas but also how JayDoc itself serves

Latinas. Second, I combine my interests in maternal and child health with my interests in the Latino population and culture to focus my research on healthcare available to Latina immigrants. My professional goals involve fighting poverty in the Latino population through healthcare, and this summer provides an opportunity to gain more knowledge on the complexities of the issue. Third, I hope to complete my residency in the Bay area, so I would like to familiarize myself with both its immigrant situation and its community clinics, particularly the role that students, residents, and physicians at UCSF play in that network.

Additionally, I believe that my post-research presentation would be of interest to my peers because they volunteer at JayDoc. I will reiterate the importance of JayDoc and all safety net clinics, ideally encouraging them to spend more time at JayDoc. If nothing else, it would promote social awareness and promote offering services to the indigent.

Logistics

Timeline:

May 18 – 29: Familiarize myself with JayDoc's services to Latina immigrants and put into place a method for tracking statistics, which will continue throughout the summer

June 1 – 12: Research Kansas City's free and reduced-price clinics and set up site visits with those that serve the Latina immigrant population

June 15 – July 10: Complete Kansas City site visits

June 15 – 26: Research UCSF Students' Homeless Clinic as well as San Francisco's Community Clinic Consortium

June 29 – July 10: Contact West Coast clinics via telephone and email to discuss their logistics and set up site visits

July 13 – 22: Draft project report

July 22 – 27: Fly to San Francisco and visit clinics as earlier outlined

July 29 – 31: Complete final report with compiled statistics from JayDoc as well as information from San Francisco trip

Budget:

June and July Rent in Kansas City	$695 x 2 =	$1390
Roundtrip Airfare to San Francisco (see attachment)		$376
Transportation in San Francisco*		$100
Total		$1866

*I will not have to pay for room/board in San Francisco because I will stay with my cousin.

Faculty Mentor:

Dr. Allen Greiner, Department of Family Medicine, Adviser for the JayDoc Executive Board

Faculty Contact:

Dr. John Calkins, Department of Obstetrics and Gynecology, Adviser for Women's Health Initiative Program at JayDoc

Contact at University of California at San Francisco:

Rebecca Mitchell, Medical student

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Issues of Adherence to Antiretroviral Therapy in HIV+ Adolescents

Project STAY

New York City

Summer 2009

www.projectstay.net

Clendening Summer Fellowship Proposal

Sarah Devlin

Submitted Feb 16, 2009

Introduction

At the end of 2004, an estimated 7,761 young people ages 13-24 in the United States were living with AIDS, a 42% increase since 2000.[1] Furthermore, in 2006 more HIV infections occurred among young people ages 13-29 than any other age group (34% or 19,200 cases). According to the Centers for Disease Control and Prevention, "these data confirm that HIV is an epidemic primarily of young people and underscores the critical need to reach each new generation of young people with HIV prevention services."[2] In reality, numbers of new HIV diagnoses are suspected to be much higher due to the fact that many HIV positive adolescents remain asymptomatic and have not yet been tested for HIV.

With the development of highly active antiretroviral therapies, the survival rates of children and adolescents with HIV have greatly improved. But, strict adherence to the demanding drug regimen is essential to avoid developing viral resistance to medications and to achieve the full clinical benefits. Unfortunately, adherence of adolescents to HIV medication regimens is not optimal.[3] Adolescents face similar barriers to adherence as adults and children but also face additional challenges associated with their unique developmental level.

General barriers to adherence include negative side effects of medications, inconvenience, changes in routine, complexity of the regimen, distrust of healthcare providers, and a difficulty in coming to terms with their life-threatening illness. Additional barriers for adolescents with HIV can include fear of disclosure of HIV status to family and friends, lack of adult or peer support to reinforce their adherence, and a conflict between challenging authority figures and needing to depend on adults for help. Furthermore, some asymptomatic adolescents have difficulty accepting implications of a serious illness because they are feeling well. Many early adolescents, who still use concrete thinking, have difficulty grasping the concept that there is a connection between strict adherence to antiretroviral therapy and the prevention of disease progression. Finally, many adolescents living in inner cities fear they will die of violence and not of AIDS and thus are not focused on adhering to their antiretroviral regimen.[4]

Studies in older adolescents with HIV infection have focused on factors that are associated with decreased adherence to drug regimens. Results from one such study, the Research Excellence in Adolescent Care and Health (REACH) trial, which used 231 HIV positive adolescents that were on highly active antiretroviral therapies, suggested that later HIV disease stage, dropping out of high school, more alcohol use, and lower CD4 count were all associated with decreased adherence to antiretroviral drug regimens.[5]

Another issue that deals with adherence to medical regimens includes access to healthcare. Adolescents prefer medical care that is specifically geared toward their age group with providers who understand them.[6] Systems in which clinics have multi-disciplinary care in the same facility increase ease of access for these adolescents. It is important to work as a team of clinical and community-based providers and services to provide these adolescents with support as they struggle to overcome the barriers to their treatment. Thus, it is essential that these physicians, nurses, social workers and counselors create and maintain a strategy to help these patients maintain adherence to their drug regimen. Adolescent HIV clinics such as Project STAY in Harlem, a part of New York City, have incorporated an interdisciplinary, patient-centered system to improve the quality and comprehensiveness of care that is given to their patients.

Project STAY

New York City has been particularly affected by the HIV/AIDS epidemic. As of 2006, over 98,000 people were living with HIV/AIDS in New York City which accounts for 1.2% of their population.[7] In 2005 and 2006, increases in the number of new HIV diagnoses were observed in both the 13-19 and 20-29 age groups in New York City.[8]

Project STAY (Services To Assist Youth) is a health clinic in New York City devoted to treating adolescents, ages 13-24, who are at-risk for or are living with HIV. Project STAY provides counseling, testing, and treatment services as well as general primary care and family planning services for young men and women in the New York City area. It is funded by the New York State Department of Health's AIDS Institute and is affiliated with Columbia University's Mailman School of Public Health.

Project STAY uses a patient-centered model of care to assess each individual's situation and develops strategies to address health-compromising behaviors, treatment options, and counseling support. Their interdisciplinary services provide the youth an opportunity receive holistic and individually tailored care. The core values of Project STAY are reflected in this quote by Alwyn Coholl, MD, Director:

> *"To be truly engaged in health care, all young people, particularly minority and other high-risk youth, need medical services that are tailored to their life stages and life styles. Project STAY meets young people on their terms and in their languages, so they feel safe and more open to the best care our team can give."*

In addition, Project STAY has a Mobile Health Team that provides interactive, multimedia sex education workshops for NYC high schools and community based organizations. They also offer individualized counseling and non-invasive screening for STIs and HIV. This aspect of Project STAY offers the clinic an opportunity to promote HIV prevention and awareness in NYC where it is critically needed.[9]

Personal Motivation

Although it is early in my medical career, I believe I am most interested in a future in primary care, specifically pediatrics. Within any pediatric practice, adolescents are a large portion of the patient population. Adolescents are a special and important subgroup of medicine as they have health concerns and needs that are exclusive to their developmental level. They are a challenging yet incredibly rewarding group of patients to work with. I believe that adolescents need advocates to help them through this tough stage in their development. I want to be that physician.

In planning a research project dealing with adolescents, I knew I wanted to focus on issues that are particularly important to the health and future of this group. Some of the most important adolescent health issues today are those of sexual health, including unplanned pregnancies, substance abuse, and sexually transmitted infections, which includes HIV/AIDS. Although sexual education and prevention awareness is an important and essential focus, it is currently a controversial issue facing our youth today. I have been fascinated by the effects education and prevention has had on our youth and knew I would want this to be part of my research proposal.

Through an HIV/AIDS awareness presentation, I became interested in the effect this epidemic is having on the adolescent population. In order to study a group of adolescents facing the HIV/AIDS epidemic, I knew I needed to go to an urban area. I have friends living in NYC who have agreed to let me sublease a room in their apartment for the summer and felt that it would be a great place for me to find a clinic that might specialize in my interest area. I am excited to have the opportunity to work with this special subgroup of adolescents.

Goals/Objectives

I would like to explore the strategy of the clinic in improving adherence to antiretroviral therapies and the barriers of adolescent adherence according to Project STAY staff members. In addition, I would like to explore their perceived success in strategy efforts.

I want to answer the following questions:

- What are the barriers to adherence in Project STAY's patient population?
- What is Project STAY's strategy to increase adherence to antiretroviral therapies in their HIV positive adolescent patients?
- How is using an interdisciplinary approach helpful?
- What is Project STAY's perceived success of this approach?

This project will allow me to achieve the following overall goals:

- Gain an understanding of the scope of the HIV/AIDS epidemic in adolescents in New York City
- Raise awareness of the unique position of adolescents with HIV/AIDS
- Work with inner city adolescents to broaden my experience and prepare me for a career as a family physician or pediatrician working with primarily adolescents

Methods

I have contacted Dr. Natalie Neu, Medical Director of Project STAY, and she has agreed to provide me with the opportunity to come work at the clinic to complete this research project. I will spend 8 weeks (June 1 through July 24) in NYC working with Project STAY. My goal is to explore and document the clinic's strategy of promoting and improving adherence to antiretroviral therapies in their adolescent patients. The interdisciplinary treatment approach used by this clinic is of particular interest to me. The interplay of counseling services, clinical medicine, and outreach organizations in helping patients maintain adherence to medications will be interesting to observe.

To achieve these goals, I plan to interview the physicians, nurses, social workers, psychologists, outreach directors, and staff members of Project STAY. My questions will be focused on the barriers to adherence as seen by the Project STAY team, the current adherence improvement strategies, and the perceived efficacy of these strategies. I have attached a sample list of questions that I plan on asking during the interviews. I will email the list of questions to the interviewee beforehand to allow the opportunity to explore answers before our meeting.

In addition, I plan on observing the Project STAY team members and watching their interactions with their patients. This will allow me to watch their methods in action. By interviewing and observing the Project STAY team, I will be in a better position to explore and document their strategies in working with their patients on adherence. I will also attend support and outreach meetings as the opportunities arise.

When I am not interviewing and observing the Project STAY team members, I will have the opportunity to work with adolescent HIV positive patients in the clinic. Dr. Neu assured me that they would be more than willing to have me working with their team of healthcare professionals and their patients throughout the summer. I will also be able to help with their Mobile Health Team, raising awareness of adolescent HIV/AIDS, counseling, testing and prevention strategies.

I have also contacted and met with Dr. Lore Nelson, MD, and adolescent specialist at KUMC. She has agreed to work with me as an advisor in whatever capacity might be necessary and is excited about my proposal.

Conclusion

I am excited about the opportunity to study adherence improvement strategies in the adolescent HIV positive population of Project STAY in New York City. This project will allow me to work with a subpopulation of inner city adolescents that I would not be able to work with in Kansas City. I feel that my time spent researching and volunteering with the clinic will greatly impact the youth of Project STAY. Furthermore, it provides me with the chance to explore and raise awareness about an important health issue facing our youth today. I am confident that this opportunity will not only impact the

direction of my future medical career but also my future patients by allowing me to broaden my experience with diverse adolescent patients.

Contacts

Dr. Natalie Neu, Medical Director, Project STAY,
Dr. Lore Nelson, Department of Pediatrics, KUMC

Budget

Plane Ticket: $300
Food for 2 months (at $20/day): $1,200
Rent (staying with a friend) for 2 months: $1,000
Unlimited Metro Pass for 2 months: $162
Total: $2,662

I understand that I will be responsible for any additional costs outside of the support provided by a Clendening Summer Fellowship.

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Project STAY Team Member Name: _____

Date: _____

Adherence Strategies for Project STAY

Sample Interview Questions

To your knowledge, does Project STAY have a formal policy or strategy to improve adherence in your HIV positive patients to antiretroviral therapies?

Are there different individual strategies depending on the different disciplines within the clinic? If so, what is your specific strategy and how does it differ from others?

Do you monitor your patient's adherence? If so, how?

If you find out a patient is non-adherent, what steps would you take with your patient to help them become adherent?

What do you perceive to be the most common barriers for your patients in adhering to their medications?

How often do you meet with each patient?

Please explain typical cases (for example, how many meetings with patient before starting antiretroviral therapy, what are the steps taken if a patient refuses to take antiretroviral therapies, etc.)

What are your personal strategies for helping your patients maintain adherence (if different from the overall strategy)?

How successful do YOU view the adherence improvement strategy employed by Project STAY?

What challenges are facing the Project STAY team?

What could be done to improve Project STAY's adherence policy?

Urban and Rural Comparative Health, Ecuador

A Clendening Summer Fellowship Proposal

Khanh Huynh

Class of 2012

February 16, 2009

INTRODUCTION

"Are you Mexican?" I often get asked this question and though the obvious answer lies within my name, I nonchalantly reply with a *"no."* But the truth is, I have always felt passively *"Mexican."* Besides sharing some physical characteristics, the Hispanic culture has mesmerized me ever since my freshman year in a high school Spanish class. A few simple phrases turned into complete sentences with properly conjugated verbs. I knew that learning the language and using my understanding of the culture would be something I want to pursue later in life, wherever my academic career takes me.

My participation in a summer study abroad program in Guadalajara, Mexico opened my heart and mind to a world that I only knew in Spanish textbooks and stories. Having lived part of my childhood in Vietnam, I have a degree of understanding about cultural acceptance and societal norms. However, the trip transformed my perspective on humanity beyond any expectations. I quickly immersed myself in the Hispanic culture, living with a host family and several roommates while attending the Universidad Autónoma de Guadalajara. My learning expanded outside of the classroom while traveling around the city. Although I lived in one of the wealthiest districts in Guadalajara, the disparities among the people are apparent through the mothers and their children begging for money. Furthermore, the hustle and bustle of city life diminished and the landscape appeared more barren and dilapidated as I ventured to the periphery of the city. Just within five weeks, my host family became my confidant, and I am even more fascinated with the society and language. The experience was somewhat bittersweet, leaving me with many unanswered questions about the quality of life and social justice in other parts of Latin America.

BACKGROUND

With a brief glance at the history of the Republic of Ecuador, one might presume this great nation has it all. Ecuador is a mosaic of indigenous communities that encompass descendents of African slaves and people of colonial Spanish origins. Colombia, Peru and the Pacific Ocean encapsulate the country while it straddles the equator (*Ecuador* translates to *equator*). Its topography contains remnants of the great Incan Empire, the Andes peak, miles of rainforests, and the volcanic Galapagos Island. In the 1960s, Ecuador's economy transformed from a traditional agrarian culture to an industrialized civilization through the discovery of oil. However, due to plunging gas prices and infrastructure destruction from the weather phenomenon, El Niño, the country fell into a recession in the 20th century. As its leaders implement measures to stabilize the economy, such as replacing its national currency with the American dollar, the social and health disparities worsen between the Spanish elite and the indigenous peasants.

My journey to Ecuador is made possible through Child Family Health International (CFHI). In 1992, Dr. Evaleen Jones founded CFHI on compassion and hope for equality after witnessing babies being born on newspaper scraps through her travels in Ecuador. It is one of the leading nongovernmental organizations located in San Francisco, California. CFHI provides students with a

comprehensive clinical and cultural immersion in a developing country. Students will be working with local health professionals under immensely different circumstances, utilizing the limited resources to care for a variety of patients. CHFI directly benefits partnered communities in Bolivia, Ecuador, India, Mexico, Nicaragua and South Africa with the program fees and the involvement of professional health participants. Their mission statement is to provide and strengthen healthcare services in needed communities worldwide.

The Urban and Rural Comparative Health Program emphasizes the differences in the healthcare services in two very different settings through clinical rotation and cultural experiences. The urban portion of the program allows me two weeks in Quito, living with an Ecuadorian host family. The time will be divided among language courses, lectures, and clinical rotations. The clinical rotations start from Monday through Friday of each week, up to four different clinical sites. The possible rotations include internal medicine, surgery, obstetrics, and pediatrics; while at the clinic, I will be taking patient histories and perform physical exams in Spanish. Also, there will be informational sessions on the healthcare system of Ecuador and common diseases in the region. This will help me develop a larger sense of cultural competency and public health knowledge.

While rotating in the clinics under the supervision of local preceptors, I will enroll in medical and conversational Spanish during my stay in Quito. Furthermore, the school organizes various activities such as cooking classes, salsa dancing classes, and other cultural activities that are optional. Clinical rotations as well as cultural activities will enable me to practice and utilize my medical and conversational Spanish in their appropriate surroundings. Dr. Susana Alvear is the medical director and has extensive experience mentoring U.S. medical students. Under her tutelage, I can refine my Spanish language skills while serving the people in need.

The second portion of the program will begin in Chone, a rural town in the Manabí province of Ecuador. I will assist local physicians at Hospital Napoleon Davila Cordova for the last two full weeks. Tropical maladies such as chagas, malaria, leishmaniasis, dengue, machete wounds, and/or snakebites are prevalent in the region, and I hope to encounter some of them for learning purposes. I will collaborate with other students in case discussion and lectures while experiencing a wide range of pathologies in Chone.

OBJECTIVES

In many parts of the world, there is an uneven distribution of healthcare that leaves many people helpless. Not only will I expand my knowledge of medicine and patient care, I will deepen my sense of humanism and commitment to service. It is often easy to lose sight of my purpose as I continue my studies in the pre-clinical years. Therefore, connecting personally with the people of Ecuador and exploring social justice and healthcare disparities will remind me of what medicine truly is and push me onward for the years ahead. I am aware that my language skills and clinical knowledge may limit the practice of medicine during my journey, but I am confident that my contribution to the communities that I will serve in is not an illusion. In my travels, I want to

compare and contrast the current system in the U.S. with the system in Ecuador, both in the urban and rural settings and utilize the knowledge to better patient care in my future practice.

My journey commences three weeks early prior to the starting date of June 6th, 2009. This will decrease personal frustration and increase my overall experience in my program. My goals are to acclimate to the new surrounding, improve my conversational Spanish, and learn the local customs of the people. Then, I will participate in a four-week program, Urban and Rural Comparative Health in Ecuador. The two phases of the program will allow me to have better perspectives on the access of healthcare in the country and the resources that are available in two contrasting settings.

METHODS

My method of transportation will depend on the location of my host family and the local clinics and/or hospitals. Most often, students are placed in host families that live close to the Amazing Andes language school. If the distance is relatively close, walking should suffice. However, public bus transits are the most practical means to travel around the country.

BUDGET

Airline Ticket: - $800
Application Fee: - $95
Program Fee 2009: - $2185 for a four-week program*
Total: - $3080
Clendening Summer Fellowship: $ 2000
Out of Pocket: - $1080 + three extra weeks of home stay/language courses**

*Included:

- Pre-departure orientation materials and guidance
- Two meals and accommodation with a home stay family (private room). The local coordinators will charge you for additional nights outside the program dates
- International Emergency Medical and Medical Evacuation Insurance
- Airport pick up on arrival
- Orientation to the program
- Thirty hours of Spanish classes. Additional language training beyond 30 hours: $6/hour
- Limited e-mail and internet access
- All preceptor, hospital and coordinator fees
- Extra activities such as salsa classes, cooking classes organized at the language school etc.

Not included:

- Airfare to Quito, Ecuador
- Airport drop-off
- Passport or visa fees
- City transportation to and from clinic sites
- Other expenses of a personal nature like weekend and after-hour activities. This includes but is not limited to local transportation, tourist trips in and around Quito, and any personal expenses incurred

**The additional money will be from a summer loan and my personal bank account. I have a valid passport and up to date vaccinations. Furthermore, I will receive additional necessary vaccinations and prophylaxes before departing.

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CONTACTS

1. CFHI Student Program Coordinator
   Nick Penco

2. CFHI Local Coordinator
   Rosita Tamayo

What are the Attitudes and Practices of Non-therapeutic Male Circumcision among Chinese?

A Clendening Summer Fellowship Proposal

Li Jia

2009

INTRODUCTION

Non-therapeutic male circumcision (NTMC) became a part of American culture in the last century and continued its role of being a cultural and social norm in the United States in the 21st century (1-3). In contrast, around 70% of world population, including Chinese, does not practice NTMC in their own cultures. As the proportion of immigrants increasing each year, one in eight residents in the United Stated was an immigrant in 2007. Jia et al. suggested that the prevalence of NTMC in the United States might continue to decrease as the proportion of immigrants increase (10). However, this study assumed that NTMC would never become popular in these foreign cultures. Therefore, further studies are needed to establish the assumption.

BACKGROUND

NTMC, an elective procedure, yet remains as one of the most common surgical practices in the United States. Although it peaked at 85% in 1965, the incidence of NTMC has declined over the years (1, 3-5). The national average incidence in 2005 was 56% among newborns in hospitals (5). Several factors may contribute to this decrease in popularity. For instance, the American Academy of Pediatrics (AAP) has stated since 1971 that available medical evidence is insufficient to recommend routine male circumcision (6). In addition, a cost-utility analysis by Von Howe showed that routine male circumcision could not be justified both financially and medically (7). Medicaid coverage for neonatal male circumcision has been discontinued in 16 states (8). More interestingly, the NTMC incidence in the west coast of the United States was the lowest at 31.1% due to the highest percentage of immigrants who do not practice NTMC (5).

More than two third of immigrants in the United States come from countries not practicing routine male circumcision (9). Because of the absence of studies on the attitudes toward and practices of NTMC among immigrants, Jia et al. explored and compared the opinions and behaviors of immigrants and non-immigrants toward NTMC. The study found that a strong preference expressed by immigrants including Chinese not to practice NTMC (10). However, the recent reports from China suggest that NTMC may become popular among the future Chinese immigrants (11).

Due to the AIDS epidemic in China, Chinese government is considering pro-circumcision policy since studies have shown that circumcision could reduce the risk of HIV infection by up to 60% (11). The World Health Organization also recommends male circumcision as one of the ways that developing countries, especially in Africa, could use to fight the spread of AIDS (12). China had an estimated 50,000 new HIV infections in 2007, compared with 70,000 in 2005. There were about 700,000 people living with HIV/AIDS 2007 in China, 58% came from sexual transmission (13). If the Chinese government decides to promote male circumcision nationwide, it would be interesting to identify any oppositions or cultural issues against such an intervention of HIV infections in China.

Thus, the purpose of this study is to identify the perceived benefits and barriers of NTMC among Chinese in China. The results will not only provide insights on how people recognize NTMC to policy makers in China but also help us better predict the future immigration impact on the practice of NTMC in the United States.

METHODS

IRB Compliance

The proposed study method (extended interviews) was submitted to KUMC IRB for the exempt application (HSC #11690) on January 13th, 2009. Li Jia also completed Human Subjects Protection Training on January 14th, 2009. The IRB review came back on February 12th, 2009. Li Jia was asked to contact the Ministry of Health in China in order to determine what procedures he may need to follow in order to obtain permission to conduct this research in China. Li Jia has made more than ten phone calls to five different agencies in China including (Ministry of Health) since February 12th. However, no agencies knew how to handle this situation. Li Jia is wondering how he is supposed to do next at this stage. Nevertheless, this project will not be started without an approval from the KUMC Human Subject Committee.

Participants

About 24 participants both males and females aged 18 and above will be recruited randomly. All interviews will take place between May 25th and June 25th, 2009 in three different cities in China (Beijing, Xi'an, and Guiyang). These three cities are geographically separated and represent different culture backgrounds in China.

Instrument

A script will be used for extended interviews with open-ended question (Appendix A). The questions were initially developed based on findings from a literature review (14-17) and were pilot-tested in Jia et al. previous study (10). A questionnaire in both English and Chinese (Appendix B and C) will be used to collect demographic data from each participant.

Procedure

At the first phase of the recruiting process, the first author will solicite people in person and talk to them about the nature of the project. Once individuals agree to participate in the study, their contact information and availability will be obtained. Participants will be notified of the date, time, and location of their sessions. Reminder calls will be placed to all participants the day before their sessions. Each extended interview will last about 30 minutes. The extended interviews will be held at various locations based on each participant's preference. Prior to the start of each session, the moderator will greet participants, explain the study, obtain their verbal consents, set up a digital recording device, and ask the participants to complete the demographic questionnaire. All the tools for conducting the study will be based on theories presented in *Methodological Review: A Handbook for Excellence in Focus Group Research* by Debus (18) and current literature on the topic of qualitative research (19-20). No identifiers linked to the human subjects will be recorded.

Data Analysis

The quantitative demographic data will be analyzed using SPSS 15.0 for Windows. Descriptive analysis of the participants will be performed based on gender, age, religion, education level, and ethnicity/race. The recorded sessions will be transcribed verbatim. Only qualitative data relevant to the attitudes, beliefs, and practices of NTMC will be considered for further analysis. Patterns will be identified from the data by systematically comparing what each individuals says under each topic (18). Representative comments for each theme will be quoted.

BUDGET

A round trip airline ticket $1,400 (Kansas City, United States and Beijing, China)
A round trip airline ticket $300 (Beijing, China and Xi'an, China)
A round trip airline ticket $300 (Xi'an, China and Guiyang, China)
Incentives for 24 extended interview participants ($10 each person) $240
Taxi costs $160

The total cost of the study will be $2,400. However, the Clendening Summer Fellowship will only cover up to $2,000. The rest $400 will come from the savings of the investigator's student loan and supports from his relatives in China. In addition, Li Jia is bilingual in both Chinese and English. Therefore, he is capable of conducting the proposed study independently to minimize the cost.

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University of Kansas Medical Center

APPENDIX A: Script for Extended Interviews

1. Informed Consent and Guidelines.
   - Address the consent.
   - Collect demographic data.
   - All comments are confidential and used for research purpose only.
   - The entire session will last no more than 30 minutes.

2. Introductions.
   - An extended interview will be conducted.
   - We will discuss the status of male circumcision in China.
   - I am interested in all your ideas, comments, and suggestions. There are no right or wrong answers.

3. Top-of-mind Associations.
   - What is the first thing you think of when you hear male circumcision?

4. Feeling about the Topic.
   - What has been your male circumcision experience? (attitudes, beliefs, and practice)
   - Are you aware of any differences in attitudes, beliefs, and practice? (your family, relatives, friends, and other people worldwide)
   - About 70% males worldwide do not practice male circumcision. However, male circumcision is still prevalent in the United States. How do you know feel about it?

5. Benefits and Drawbacks.
   - Are there any potential benefits from and drawbacks to male circumcision?
   - What factors would influence a family's decision regarding male circumcision?
   - Should we promote NTMC to control the incidence of HIV/AIDS infections in China?
   - What percentage would you estimate the current male circumcision rate in China? What do you think this is attributed to?
   - Do you plan to adopt male circumcision if you immigrate to the United States?

6. Summary and Closure.
   - Anything else that we have not mentioned that would be important to you regarding the topic?
   - Thank you so much for coming.

APPENDIX B: Demographic Data Collection Sheet

Instruction: please circle **only one answer** for the following questions.

1. What is your race?
   - Han
   - Other, please specify_____

2. What is your religion?
   - Christian
   - Muslim
   - Buddhist
   - Other, please specify_____

3. What is your gender?
   - Male
   - Female

4. What is your age?
   - 18-29
   - 30-39
   - 40-49
   - 50-59
   - 60 or greater

5. What is the highest grade you have completed?
   - Less than primary school
   - Primary school
   - More than primary school but less than high school
   - High school
   - Some college
   - College graduate
   - Master's Degree
   - Doctoral Degree

6. What is your occupation(s)?
   - Please specify_____
   - Retired, please specify the occupation(s) before you retired_____
   - No occupation

7. Is male circumcision popular in your community?

4----------3----------2----------1

Very popular Somewhat popular Not popular Very unpopular

8. What is your marital status?
   - Single (Never married)
   - Married
   - Separated
   - Divorced
   - Widowed

IF YOU HAD/HAVE **A SPOUSE**, PLEASE ANSWER THE FOLLOWING QUESTIONS.

1. What is your ex-spouse/spouse's race?
   - Han
   - Other, please specify_____

2. What is your ex-spouse/spouse's religion?
   - Christian
   - Muslim
   - Buddhist
   - Other, please specify_____

IF YOU HAVE **A SON** WITH THE ABOVE PERSON, PLEASE ANSWER THE FOLLOWING QUESTIONS.

1. Is your son circumcised?
   - Yes
   - No

2. Who made the final decision if he was circumcised?
   - Father of my son
   - Mother of my son
   - Father and mother of my son together
   - Other, please specify_____

IF YOU ARE **A PHYSICIAN**, PLEASE ANSWER THE FOLLOWING QUESTIONS.

1. Which type of medicine are you practicing?
   - Traditional Chinese Medicine.
   - Modern Western (Allopathic) Medicine
   - Neither, please specify _____

APPENDIX C: Demographic Data Collection Sheet Chinese Version

下列问题请只选择一个答案.

1. 你的民族是什么?

- 汉族
- 其它, 请注明_____

2. 你的宗教信仰是什么?

- 基督教
- 穆斯林教
- 佛教
- 其它, 请注明_____

3. 你的性别是什么?

- 男
- 女

4. 你的年龄是什么?

- 18-29
- 30-39
- 40-49
- 50-59
- 60 或 大于 60

5. 你获得的最高学位是什么?

- 小学未毕业
- 小学毕业
- 小学毕业但高中未毕业
- 高中毕业
- 学士学位
- 硕士学位
- 博士学位

6. 你的职业是什么?

- 请注明_____
- 已退休, 请注明退休前职业_____
- 无职业

7. 男性去包皮在你居住的区域流行吗?

4----------3----------2----------1
非常流行 比较流行 不流行 很不流行

8. 你的婚姻状况是什么?
- 单身 (从未结婚)
- 已婚
- 分居
- 离异
- 鳏夫/寡妇

如果你已婚或者结过婚, 请回答下列问题.

1.他/她的民族是什么?

- 汉族
- 其它, 请注明_____

2. 他/她的宗教信仰是什么?

- 基督教
- 穆斯林教
- 佛教
- 其它, 请注明_____

如果你们有男孩, 请回答下列问题.

1. 他有做过去包皮手术吗?
- 有
- 没有

2. 谁作得去包皮手术决定?
- 孩子的父亲
- 孩子的母亲
- 孩子的父亲和母亲一起
- 其它, 请注明_____

如果你是一个医生, 请回答下列问题.

1. 你的行医领域是什么?
   - 中医
   - 西医
   - 其它, 请注明_____

Clendening Fellowship Proposal:

Understanding the Barriers in Adherence to the Recommended Dosing Schedule for the HPV Vaccine

Manesha Lankachandra
February 16, 2009

Study Purpose:

To analyze the barriers responsible for the low rate of adherence to the recommended three dose administration schedule of the quadrivalent HPV vaccine (GARDASIL) among women in an urban Kansas City clinic.

Design:

In 2007 the Healthcare Foundation of Greater Kansas City began an initiative to provide free HPV vaccine to uninsured or under-insured 9-26 year olds in the Kansas City area. The program collaborated with local safety net clinics and local health departments to promote the delivery of the vaccine. Patient level data was collected at each distribution site.

I hope to provide a questionnaire and conduct telephone and in person interviews with women who have and have not received all three doses of the HPV vaccine through the free vaccination program run by the Healthcare Foundation of Greater Kansas City. The questionnaire and interview will address what factors have influenced their ability to return to the clinic for the second and third doses of the vaccine. These factors are varied and could include individual perceptions about vaccine efficacy, the mobile nature of the young adult population, and the perceived beliefs of parents or partners.

Introduction and Background:

Genital Human Papillomavirus (HPV) is one of the most common sexually transmitted infections in the world with incidence rates of approximately 5.5 million per year and overall prevalence rates nearing 27% with the 20-24 age group in particular showing an alarming 45% prevalence.[1] Although HPV infection is often subclinical, infection with high risk HPV types such as 16, 18, 31, and 45 may progress to cervical dysplasia, carcinoma in-situ, and cervical carcinoma. HPV 16 and 18 account for approximately 68% of squamous cell carcinomas of the cervix and 83% of endocervical adenocarcinomas.[2]

The public health burden of this and its related diseases has lead to widespread interest in the development and institution of effective prophylactic vaccines against HPV. Thus far, the most successful of these vaccines has been the quadrivalent HPV vaccine for types 6, 11, 16, and 18, which is being heavily marketed by Merck and Co. under the trade name GARDASIL. In a 2007 trial, vaccine efficacy for the prevention of high grade cervical lesions was 98% in the susceptible population, and other trials have shown similar results. [3][4][5] The vaccine must be administered in three separate .5 mL doses. The second dose should be administered two months after the first dose and the third dose six months after the first dose.

As the vaccine gains wider use, it is becoming apparent that although women and girls go in for the first dose of the vaccine in significant numbers, far fewer follow up with the second and third dose. Reasons for this low rate of adherence among the girls and women who are receiving the vaccine may depend on many factors including their own perceptions about the vaccine and its efficacy, the perceived environment and attitudes of the support staff at the clinic where they received the vaccination, the

mobility of the young adult population, and their perceptions about the beliefs of others such as parents and partners about the vaccine.

There have been several studies discussing the perceptions and knowledge of women about HPV, the vaccine, and cervical cancer before they choose to receive the initial dose of the vaccine,[678] but very little research about what keeps people from adhering to the recommended dosing schedule once they begin. The most successful of the previously mentioned studies about the perceptions and attitudes involved in choosing to receive the initial dose of the vaccine tie together many different behavioral theories to try and predict and explain such positive preventative behaviors, and I hope that I can use some of these same ideas to try and understand the barriers to adherence that women who start but don't finish the recommended dosage program of the HPV vaccine face.

Budget:

Living Expenses: $600/month x 2

Supplies for Questionnaire: $50

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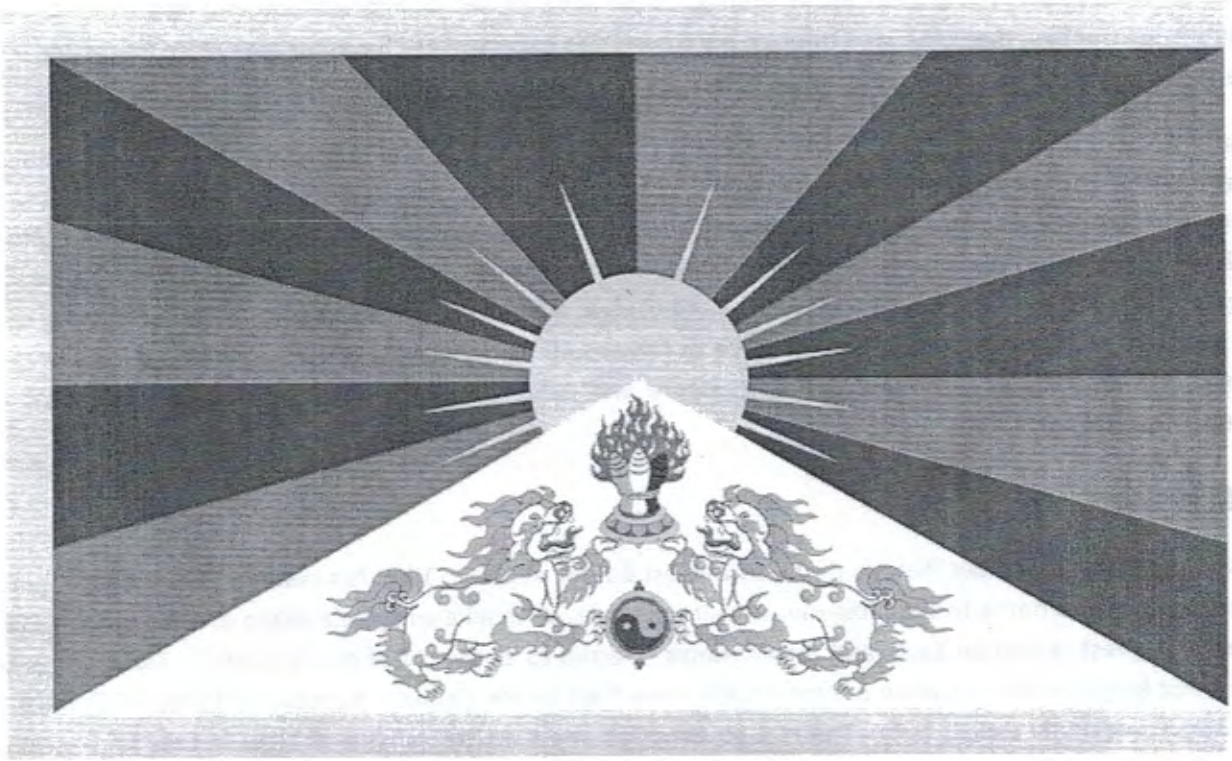
Traditional Tibetan Medicine



A Clendening Fellowship Proposal

April Alexandria Leonardo

University of Kansas, School of Medicine, 2012

February 16th, 2009

Introduction

In the West, traditional Tibetan Medicine is considered a form of Alternative Medicine, but for Tibetans and many other groups, traditional medicine is their primary form of healthcare, with Western medicine as the alternative. Which type is indeed the *alternative* is a matter of perspective, and it is my opinion that the two should be considered equal, but different, and can be used together to achieve optimal therapeutic outcomes.

I remember a day when I was eight, sitting anxiously in the doctor's office waiting to get a wart on my toe burnt off. To my surprise, and subsequent bafflement, the doctor suggested perhaps I go home and bury a potato in the back yard and in a few days the wart may disappear. I was taken aback, skeptical, and thought the doctor either considered me gullible or was making fun of me. I couldn't see how medicine - pills and procedures - had anything to do with buried potatoes. As a child growing up in Los Angeles, I had great faith in the "home remedies" my mother and grandma remembered from Mexico, but I had never thought of them as *medicine*, alternative or otherwise. It wasn't until later that I began to realize that traditional and modern practices were intertwined, both part of the greater art of healing. I have since gained an appreciation and respect for the many mentalities surrounding medicine, and through my travels and experiences I have become more interested in how different peoples and cultures approach medicine.

This summer I intend to go to India, Tibet, and China to learn about Traditional Tibetan Medicine. By witnessing and participating in their style of medicine, I hope to gain a better understanding of the mindset surrounding their healthcare beliefs and practices. This interest stems from my 29 months spent in Morocco and Western Africa in 2006-2008. I lived in a mud house in a remote village in the Sahara Desert of southern Morocco and traveled through Egypt and Western Africa. I have gained knowledge, awareness, and some level of understanding of how Islam, isolation, resources, and culture all play in to how health is perceived, what is considered important, and how medicine is practiced. I would like to compare and contrast my experiences in Africa with what I will experience in India and Tibet.

Background

Tibet lies on the Qinghai-Tibet Plateau of the southwest border of China: Tibet is a plateau region in Asia, north of the Himalayas, and is home to the indigenous Tibetan people. With an average elevation of 4,900 meters (16,000 ft), it is the highest region on Earth and is sometimes referred to as the "Roof of the World". Tibet was once an independent kingdom but has been predominantly controlled by the People's Republic of China (PRC) since 1959 with a small part under India's reign. The PRC government and the Government of Tibet in Exile (in Dharamsala, India) still disagree over when Tibet became a part of China and whether the incorporation of Tibet into China is legitimate. (1)

Tibetan medicine is a traditional system of medicine that has been practiced for over 2,500 years and is still practiced today in Tibet, China, Nepal, India, Bhutan, and Mongolia and is spreading into North America and Europe. Traditional Tibetan Medicine was created through the integration of elements of Indian, Chinese, Mongolian and Greek medical traditions. What makes Traditional Tibetan Medicine (TTM) unique, however, is Tibet's culture, its high altitude and isolation, the way it was created from the fundamentals of so many ancient and respected medical traditions, how it embodies many of the lessons of Buddhism, and the way in which the availability of different herbs endemic to Tibet alter its practice. (6) (1)

Tibetan medicine, or *gSoba Rig-pa*, the science of healing, uses ingredients such as herbs, trees, rocks, resins, soils, precious metals, saps, etc. as treatments or medicines. Traditional Tibetan Medicine has been particularly successful in its treatment of chronic diseases such as rheumatism, arthritis, ulcers, chronic digestive problems, asthma, hepatitis, eczema, liver problems, sinus problems, anxiety and problems connected with the nervous system. (5)

Tibetans categorize disease origin as "long term" and "short term" with ignorance and unawareness being the ultimate long term causes of all diseases. An individual blinded by ignorance or delusion cannot see the root of their illness, which in turn gives rise to the three mental poisons: desire, hatred, and stupidity. The short term causes of disease are the three humors (*Nyipa sum*): wind energy (*rLung*), bile energy (*mKhris-pa*) and phlegm (*Bad-kan*). These three humors are produced by the three mental poisons: desire gives rise to wind, hatred to bile, and stupidity to phlegm. These three humors constitute the basic energy system in the body and are entwined with all the vital functions of the body, organs, seven constituents (food/nutrition, blood, flesh, fat, bone, marrow, and semen), and three excretions (perspiration, urine, and feces). When the three humors, seven body constituents, and three excrements are in balance, one is healthy. (4)

The basic objective of Tibetan medicine is to keep in balance the *Nyipa sum - rLung, mKhris-pa* and *Bad-kan*. These factors may be influenced by climate, demons, diet, and behavior.

rLung arises at dawn and in the evening in summer; *mKhris-pa* arises during the autumn at midday and at midnight; *Bad-kan* arises in the spring in the morning and at dusk. The female spirit influences are connected with desire and attachment and give rise to *rLung* problems. The male spirit influences are connected with anger and hatred and give rise to disorders from *mKhris-pa*. The *klu* (water-dwelling spirits) and *Sa-bdag* (specific spirits that govern or haunt particular places) are connected with ignorance and give rise to *Bad-kan* disorders. If any of these spirits were disturbed, they could cause harm and those affected would have to consult a lama or tantric practitioner for a divination. Only through a religious ceremony could the spirits be expelled. (7)

The general description of *rLung* is that of a subtle flow of energy out of the five elements (air, fire, water, earth and space), though it is most closely connected with air. *rLung* is not, however, simply the air that we breathe, but rather something that carries us along and, should the winds turn bad, could prevent us from functioning properly. It has been described as rough, light, cool, thin, hard, and movable. The general function of *rLung* is to help growth, exhalation and inhalation, the separation in our stomachs of our food into nutrients and waste, and most importantly, to aid in the function of the mind, body, and speech. The nature of *rLung* is both hot and cold. (See Appendix 1a)

mKhris-pa is the hot nature within our body, commonly generalized to mean "bile" from the gall bladder. Of the five elements, *mKhris-pa* is most closely related to fire. *mKhris-pa* is described as oily, sharp, hot, light, pungent and moist. The most important function of *mKhris-pa* is to keep the body's temperature balanced. It helps with the digestion of food and it is what makes us feel hungry and thirsty at the right times. *mKhris-pa* also gives skin its gleam and helps keep pores clear. The nature of *mKhris-pa* is hot like fire or the sun. (See Appendix 1b)

Bad-kan is often referred to as "phlegm," relating most closely to water and earth. *Bad-kan* is described as oily, cool, heavy, blunt, smooth, steady and sticky. Its main functions are to maintain bodily fluids, mix food in the stomach, steady the mind, and keep joints flexible. The nature of *Bad-kan* is cold, like water or the moon. (See Appendix 1c)

To put all of this information together, consider what happens when one eats or drinks something: the *Bad-kan* will mix the food in the stomach, the *mKhris-pa* will digest it, and the *rLung* will separate the essential nutrients from the waste products. The core of the essential nutrients will then form blood; the essence of blood forms muscle tissue; the essence of muscle tissue forms fat; the essence of fat forms bones; the essence of bones forms marrow; and the essence of bone marrow forms the regenerative fluid, or semen. (7)

Similar to Western practice, the three methods of diagnosis for when there is an imbalance of *Nyipa sum* are observation, palpation, and questioning. Observation is done via urine analysis and by looking at the tongue. The urine sample needs to be from the first urination of the day and the patient should have refrained from eating spicy foods, drinking alcohol, and having sexual intercourse the night prior. The analysis of the urine is broken down into eight sections: color, vapor, odor, bubbling, sedimentation, and albumin content. The intake of food and drink as well as the season and nature of the disease will lend to the color of the urine. The color, moisture, texture, and presence or absence of a superficial coating are all examined in the observation of the tongue. (10)

The second diagnostic method is the reading of the pulse, which is completed in 13 steps. For the Tibetan physician, the art of pulse reading provides invaluable information as the pulse is considered a messenger from the patient to the physician. In order for an accurate reading, the patient must be as rested as possible. The physician places the index, middle and third fingers on the patient's radial arteries, leaving a space equivalent to the width of a grain of rice between each of the three fingers and keeping the fingers half an inch from the crease of the wrist. The physician will examine the pulse on both of the patient's hands, starting with the left on a male and the right on a female. (4)

The third and final method of diagnosis is inquiry - asking the patient how and when the problem started, its location, and which foods harm or help them.

There are four levels of treatment: advice regarding diet, advice regarding behavior, the prescribing of medicine, and the performing of surgery/physical therapy.

For the more minor illnesses, only the first level of dietary advice is necessary. If the second level becomes necessary, however, such behavioral advice as staying in dark and warm places, changing environments, increasing social support, taking cold baths, using a cool perfume such as sandalwood, or running for exercise, may be given. Medicine, administered in various forms: decoction, powder, pills, etc. is generally from herbs and is considered the third treatment level. The final level of treatment is surgery, divided into mild and rough. Mild surgery could be considered a massage with year-old butter and oily compresses, while rough surgery could be placing moxa (Mugwort herb) on selected parts of the body, saunas, mild purgatives or emetics, sitting below a waterfall, blood-letting, golden needle therapy, application of heated surgical stylets (primitive piercing mouthparts of some nematodes), and cupping (when a vacuum is created by air heated by fire in a glass cup placed flush against the patient's skin). (3)

It is the belief in Traditional Tibetan Medicine that all types of disease and illness can be categorized within the *Nyipa sum - rLung, mKhris-pa,* and *Bad-kan*. Dr. Tamdin Sither Bradley, a Tibetan physician, explained the rationale behind the belief that all illnesses are defined, and therefore confined, within the reigns of the *Nyipa sum* by comparing sickness to a bird and the *Nyipa sum* to the sky: "A bird has the freedom of the skies and yet it cannot fly above the sky." It is the aim of Tibetan Medicine to treat the cause or the root of the disease, not merely its symptoms. (4, 7)

Plan/Goals

I have organized this endeavor into three segments: the first part will be spent in India, the second in Tibet, and the third in China. Tibet, as a concept and as a people, is scattered. When the government of Tibet was exiled, it moved into Dharamsala, India. It is there that the medical school is situated and where I will begin my research. The Tibetan Autonomous region, which doesn't encompass all of what was originally Tibet, is where I will go next to visit the main hospital and travel to a few villages to witness the essence of Traditional Tibetan Medicine. From there I will move to just outside of the border of the Autonomous region into a poor Tibetan village that is now part of the People's Republic of China (PRC).

India: 7-12 days

The goal of this segment has two parts: 1) to visit the primary medical school responsible for training physicians of Traditional Tibetan Medicine around the world, witness how the classes are run, how the curriculum is arranged, compare the environment and attitudes to those of American medical schools, and gain a general appreciation for different methods of receiving a medical education. 2) To experience a local clinic where physicians of TTM treat patients on a daily basis. I hope to gain an understanding of what kinds of ailments are most common, how they present, what kind of relationships the physicians have with their patients, how they interact, what types of therapies are prescribed, how the physical exam is taken, and the level of patient and physician satisfaction.

I will fly into New Delhi and spend a day or two adjusting to the environment. From there I will travel north (a 2-3 day trip) to Dharamsala. I have been invited to the medical school by the school director, and though I have been informed that I cannot take any classes because they are taught in Tibetan, I was encouraged to see the facility, learn about how TTM is taught, and explore the area. I have also been invited by Dr. Dolma, the Dalai Lama's personal physician, to shadow her and a fellow physician in a local clinic in Dehradun, a 10 hour bus trip southeast of Dharamsala. I will be there about a week. This will be my first clinical exposure to Tibetan medicine and I will be working hands-on in the clinic with Dr. Dolma who will be providing me a foundation of knowledge and experience of how Tibetan medicine is practiced, including how to take and understand the pulse.

English is a primary language spoken in India so I am not concerned about this as an obstacle in planning. I have been in contact with Dr. Dolma and the medical school in Dharamsala, Men-Tse-Khang, and everyone who I have dealt with has communicated in English very well. Dr. Dolma frequents Lawrence, KS and has been hosted by close friend of mine in Linwood, KS while giving talks at the university.

Tibet: 2-3 weeks

From Chengdu, China, I will take a 3-day train ride into Lhasa, Tibet. From there my stay will again be broken into two parts. A Tibetan medical student, Vende Gyal, has agreed to work with me. He is in his 3rd year of medical training and also does research in smaller villages. I will accompany him to one of the villages where he is studying Maternal and Child health and stay there for a few days. He also does work in Lhasa and told me there is a physician in Lhasa that would be willing to work with me. It will be interesting to compare how the practice of Traditional Tibetan Medicine differs between Northern India and Tibet.

Dr. Lhakpen has agreed to allow me into the Men-Tse-Khang hospital in Lhasa which will allow me a glimpse into how a major hospital that blends both Tibetan Medicine and Western Medicine is run. Dr. Lhakpen's husband, Mr. Pasang Tsering, works for One H.E.A.R.T. Tibet, a non-profit organization founded in Utah under the umbrella

of the University of Utah Health Sciences Center. He has expressed his excitement to have me visit one of their nearby projects where I may not only witness village life, but will also have the opportunity to speak with villagers and see firsthand how international aid groups are coming together to improve the health of the indigent. With my experience in Peace Corps, I have offered to help in any way I can during my stay.

Again, though I am aware that English is not a main language in this area, due to the high volume of international traffic, English is common enough that I should be able to use it to get around. I speak Spanish and Arabic as well which will broaden my linguistic base should I require additional options through which to communicate. Also, the people with whom I will be spending my time speak English well. Regardless, I plan on learning the basics of Chinese and Tibetan before I embark on this trip.

China: 2-3 weeks

The majority of my stay in China will be in Qinghai, working with the Mayul Gesar Charity in association with KU. I have been invited by the charity to stay at the monastery and participate in a project building a school. The KU group has arranged for a translator, and though they will need him as a resource for most of their stay, they have offered to allow me to utilize his skill for several days. I am hoping to take that opportunity to interview several of the villagers regarding their access to healthcare - both traditional and western, how they view each type of medicine, what elements of TTM they regularly practice, and what they view as their greatest health need. Through these questions, I hope to learn more about how TTM manifests itself in a community setting as opposed to a clinic. I have also been asked by the KU team on behalf of the charity to evaluate the local water supplies so that should a problem be identified upon the analysis of the tests, the group of KU professors returning to Qinghai next year will be able to implement any plan deemed necessary and continue with further research.

Leaving Qinghai, and on my way to the airport, I will stay a few days in Beijing. Lee Weingrad of the Surmang Charity Foundation has asked to meet with me to discuss the health status of Tibet and the ways in which organizations in China and abroad are working to improve it. He seemed eager for me to visit their site and meet with him so that I may better understand the needs of Tibet and the efforts being made to remedy the poverty and ignorance that are fatal.

Methods

I will be working with physicians in clinics, with non-profit medical organizations, through an alliance between the East Asian Studies Department at KU and the Mayul Gesar Tibetan charity, alongside individual students or non-profit administrators, and on my own. I will operate through observation and note-taking, photography, hands-on application of new concepts, and interview. Data concerning various aspects of the practice of Traditional Tibetan Medicine will be compiled, analyzed, and presented upon return to the U.S.

While the main ambition of this project is to better understand the fundamentals of Traditional Tibetan Medicine and gain a more intimate awareness and knowledge of it than can be found online, I am fully aware that two months of independent research is not a sufficient allotment of time to fully grasp the breadth and depth of all that encompasses Traditional Tibetan Medicine. So, in compromise, I have delineated below what I truly hope to gain from this experience and how it is I plan on accomplishing my goals.

I have always wanted to practice medicine abroad, in a developing country. I have, since I could understand its meaning, wanted to dedicate my life and career to the elimination of health disparities and improve access to healthcare for those too distant from healthcare facilities or too poor to receive proper care. My extensive travels as well as my experiences in the Peace Corps have only heightened these goals and have been the deciding factor in my choice to pursue an MPH as well as to become a medical doctor. I have witnessed medicine on so many levels: as an EMT, a wilderness ranger/guide, in a clinic in Fiji, at a hospital in Mexico, in a national teaching hospital in Burkina Faso, in regional and local clinics all over Morocco, etc., but never from a people with such a different and holistic understanding and conceptualization of life and health as those in Tibet. In Tibet, the traditional way of practicing medicine is an art that takes into consideration the person's life: mental health, physical health, environment, etc. I value their idea of trying to heal the whole person instead of just an ailment. I very much want to experience how their health care system works and I want to learn firsthand what I like and dislike about it. This way, when I become a physician, I will be able to incorporate the things I have learned from around the world and ultimately deliver the best care I can. When should alternative medicine be used? When does it work the best? Why are some people more or less comfortable with it? Are there socioeconomic classes of people that depend on it more than others? Do certain regions use TTM more than others? What does TTM look like in real-time in a household, a clinic, a community? What makes Tibetans believe or not believe in it? Does access to Western care, the lack of it, or the treatment that Tibetans get at Western facilities influence their perspectives? Do different generations have distinctive views of TTM? What are some of their cures for common colds, headaches, or stomach cramps?

The method of diagnosis by pulse is also very interesting to me. It seems that a large portion of TTM is dependent upon reading the pulse. Throughout my stays in India, Tibet, and China, I will have the chance to visit many clinics, hospitals, and villages where I will be able to see how this works and gain some clinical knowledge concerning how to be more aware of what different pulses indicate, or at least how to recognize them. It is fascinating that in Western medicine we feel the pulse primarily to count the number of beats per minute and note if it is strong or irregular, but it is not one of the primary factors from which our diagnoses are made. What are the physicians of Tibetan Medicine feeling for and how can they infer so much and retain accuracy? What else are they looking at? I would also like to visit the various pharmacies just to see how they are run.

Conclusion

I am excited for the opportunity to travel to India, Tibet, and China and experience their rich cultures. The Clendening Fellowship Opportunity will also allow me to further take advantage of my experiences in the Peace Corps. It is my sincere wish to return to KUMC next year with an increased wealth of experience, excitement, and knowledge that I may share with my classmates. I want to broaden the horizons and minds of my future colleagues about the ideas and practices of alternative medicine – medicine that has been around for thousands of years. I believe it is my duty to acknowledge and learn about all different types of medicine so that I may be a better physician for my patients.

I have attended all of the Clendening meetings and presentations and have been planning my research project since August. I know that many things do not go as planned and I am well prepared for this. I have been in contact with many other people and organizations so that should some aspect of the above plan fall through I could arrange for something else. Also, my time frame is rather fluid, as each person who has invited me to work with them has generously offered to allow me to stay for as long as I like. Therefore, if one thing falls through, I could remain longer at another location. Peace Corps taught me, among many things, to be flexible: I have

become quite skilled at navigating through foreign countries with or without proficient language ability (but to pick it up quickly!); I am comfortable creating new itineraries if something goes awry and I am good at finding alternatives when a road seems blocked. I am resourceful when it comes to achieving my goals, which are, in this case, learning about TTM as a lifestyle and as a practice. In all, I am looking forward to the opportunity this fellowship will give me to become the best doctor I can be.

Logistics

I will leave for Morocco on May 20th, spend one week there visiting the grave of my host sister and inquiring into some more detail about the traditional customs of Berber medicine.

At the beginning of June, I will fly to New Delhi and then move on to Dharamsala to visit the school where a tour has been arranged. From there I will travel South to Dehradun where I will work with a Tibetan physician in the clinic there – arranged by Dr. Dolma, the Dalai Lama's personal physician. I will stay approximately 5 days. Next, I will take a bus into Chengdu, China, from where I will take the train into Tibet. I plan on being in Tibet by the 3rd week of June. I will spend 3 weeks in Tibet, split between Lhasa and the surrounding villages. By July 10th I will be back in China, working in Qinghai with the KU group in association with the Mayul Gesar Foundation. On August 1st I will return to Kansas in anticipation of the start of Year 2!

Main Budget

I will find affordable places to stay and inexpensive means of traveling from one place to the next once I am on the ground and can better explore my options. A stay with the monastery in Qinghai has been arranged for my final leg of the trip where I will be working alongside the KU team.

$600.00 from Casablanca, Morocco → New Delhi, India

$89.00 Train from Chengdu, China → Lhasa, Tibet

$65.00 Train from Lhasa, Tibet → Xing, China

$1,300.00 from Beijing, China → Kansas City, U.S.A.

Indian Visa: $112.00

Tibetan Travel Permit: $100.00

Chinese Visa: $169.00

Average range of hostel prices/night throughout India, Tibet, and China: $3.00 - $7.00

Monastery Donation for food/lodging in Qinghai for 2 weeks: $200

I am aware that the Clendening Fellowship is not enough to cover my projected budget and I will take full responsibility for all additional expenses. I saved my readjustment stipend from the Peace Corps for such a summer learning adventure.

Appendix 1 (7)

1a. Five Types of *rLung*

The first is called *Srog-'dzin* (life-grasping *rLung*). It is located in the brain and it is involved in the swallowing of food, inhalation and spitting, eructation and sneezing, the clearing of the senses and intellect, and the steadying of the mind.
The second type of *rLung* is *Gyen-rgyu* (upward-moving *rLung*). It is located in the chest and is responsible for speech, the improvement of health and vigor, lending luster to the skin, and promoting mental curiosity and diligence.
The third type of *rLung* is *Khyab-byed* (all-pervading *rLung*). It is located in the heart and is used for lifting, walking, stretching, grasping, and the opening and closing the mouth, eyelids, anus, etc.
The fourth type of *rLung* is *Me-mnyam* (fire-accompanying *rLung*). It is located in the stomach and it promotes digestion, metabolism, and develops the seven bodily sustainers known as *lus-zung dhun*.
The fifth type of *rLung* is *Thur-sel* (downward-cleansing *rLung*). It is located in the rectum and its purpose is to deliver the fetus and to expel feces, urine, semen, and menstrual blood.

1b. Five Types of *mKhris-pa*

The first type of *mKhris-pa* is called *'Ju-byed* (digesting *mKhris-pa*). It is located between the stomach and intestine and works to promote digestion – the breakdown and separation of food/fluids into essential nutrients and waste. *'Ju-byed* produces body heat and provides energy to the other four types of *mKhris-pa*.
The second type of *mKhris-pa* is called *sGrub-byed* (accomplishing *mKhris-pa*). It can be found in the heart and is used in anger, aggression, and hatred. *sGrub-byed* is the initial driving force behind desire, achievement, and ambition.
The third type of *mKhris-pa* is called *mdangs-sgyur* (color-changing *mKhris-pa*). It is located in the liver and functions to maintain and promote the red-coloring of the blood.
The fourth type of *mKhris-pa* is *mThong-byed* (seeing *mKhris-pa*). It is located in the eyes and it allows for vision.
The fifth *mKhris-pa* is *mDog-sel* (complexion-clearing *mKhris-pa*). It is in the skin and works to clear the skin and provide a healthy and wholesome color.

1c. Five Types of *Bad-kan*

The first *Bad-kan* is called *rTen-byed* (supporting *Bad-kan*). It is located in the chest and its main function is to support the remaining four *Bad-kans*.
The second *Bad-kan* is called *Myag-byed* (mixing *Bad-kan*). It is located in the upper region and it is responsible for the mixing of liquids and solids into a semi-liquid state.
The third *Bad-kan* is called *Myong-byed* (experiencing *Bad-kan*). It is located in the tongue and senses/experiences the six primary tastes.
The fourth *Bad-kan* is called *Tsim-byed* (satisfying *Bad-kan*). It is in the head works to increase the sensitivity and power of the five senses.
The fifth *Bad-kan* is called *'Byor-byed* (joining *Bad-kan*). It is in the joints and is responsible for their flexibility.

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Contacts

I have over a dozen other contacts, so included here are only those with whom I have corresponded with regularly or who have agreed to let me work with them this summer. I am grateful to all the others who, over this 6-month process, have led me to the following individuals who were instrumental in allowing this project to take form.

Eric C. Rath Associate History Professor at theUniversity of Kansas	Mr. Pasang Tsering/Dr. Lhakpen OneHEART Tibet/Women's Dept. at Mentzikhang Hospital
Chris Jones Project Manager	Carrie Tudor Research in Tibet for 6 years on Women's Health
Dr. William Hale Lawrence doctor; studied Tibetan Medicine in India	Lee Weingrad: Surmang Charity Medical Center
Dr. Dawa Dolma (Dalai Lama's personal physician) Director of Mensikhang School of Medicine in Dharamsala	Vende Gyal Medical Student in Tibet

Revised Clendening:

I will spend 3 weeks in Dharamsala working with a physician at a local clinic and staying at a nearby monastery. It will be a 5 minute walk from the monastery to the clinic. As it is set up now, I will be with one physician for 2 weeks and another for the 3rd week. I am going to try to arrange to work with the two physicians concurrently over the 3 week period to get a more continuous and comprehensive view of two different physicians and their approaches to traditional Tibetan medicine. It is my hope to be able to interview patients in the waiting rooms or outside of the clinic as well if language allows.

I will be spending 4 weeks in Tibet with the Tibetan medical student I mentioned in my original proposal. We will be working both in clinics and the main hospital in Lhasa. I will be able to shadow and ask questions of the physicians as well. I believe at this juncture I will have the most exposure to village health as well.

The part of my project planned for China fell through due to a conflict in dates. I have been offered the opportunity to work in a hospital in China, in the Quinghai province, which I will keep as a back-up option should either option in India or Tibet be compromised for any reason.

Ayurvedic Medicine and *Dosha* Profiling as a Key to Genomic Medicine

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Introduction:

Different medical disciplines utilized drastically different theories. Frequently these theories rest upon axioms that are completely outside the reach of other medical systems. For example the Chinese and Indian concept of *qi* or *prana* has no clear correlate in Western, or Allopathic, medical theory. However, despite non-intersecting axioms, different medical systems persist. This is largely because they all achieve results. What this makes clear is that, regardless of axioms, some items in each theory are valid and effective. The field of Integrative Medicine is slowly gaining influence, as disparate theories and ideas merge together in uncertain fashions, provide results, and are disseminated. An excellent example is the recent acceptance of Orthomolecular medicine's treatment of cancer with large doses of vitamin C. Although still not entirely understood, the treatment has seen positive clinic trials, and is now being requested by even oncologists in our own KUMC[i]. The current advances are proof enough of the value of integrative investigation. Indeed, the future of Allopathic medicine, Genomic Medicine, may benefit from drawing upon India's traditional medicine, Ayurveda.

The current Allopathic medical system is, by necessity, preoccupied with treatment of the majority. Research studies, the cornerstone of Allopathic theory and progression, inherently focus upon treatment that works for the majority. Current Allopathic studies have little room to examine outliers, more interested in whether or not the drug or treatment under study is effective for the majority of study participants. These outliers might be the result of flaws in the study or, very frequently, they are the results of important genetic differences that can drastically influence the affects of a treatment. The rapidly expanding realm of Genomic Medicine, or personalized medicine, which attempts to account for these genetic differences, is rightfully seen by many as the future of Allopathic medicine. It is a huge advance beyond medicine for the masses, finally reaching into each individual to predetermine how they will react to a given drug or treatment. Already, clinics and health care providers are utilizing what little we understand of our genetic code to predict individuals' reactions to medicines through preemptive genetic testing.

Unknown to many Allopathic physicians, the traditional medicine of India, Ayurveda, has long dealt with personalized treatment. In Ayurveda, each individual's physical and mental constitution is determined by the mixture of three constitutions or *doshas*. This system is called *Tridosha*. *Tridosha* seeks to understand each individual's mix of *doshas*, to determine their *prakriti*, or nature. Ayurvedic practitioners begin treatments by determining their patient's *dosha* type, because this has far reaching implications on what type of illness the patient may have and, importantly, which treatments will be effective for that patient. For millennia Ayurvedic physicians have utilized *Tridosha* to great effect in treating their patients. Indeed, the concept is so powerful, that it has well rooted correlates in other traditional systems of Asian medicine, even overshadowing the concept of *yin* and *yang* in traditional Chinese medicine[ii].

Both Genomic medicine and the *Tridosha* system seek to use a better understanding of the individual patient to improve treatment. Current Genomic medicine is bound by the limited understanding we have of the human genome, but in areas we understand, there are great treatment utilities. One current use of Genomic medicine is establishing a patient's level of drug metabolism through analyzing their Cytochrome P450 or acetylation enzymes. This is particularly useful for treatments that have a small

therapeutic range that varies among individuals, such as warfarin. By analyzing a patient's genetic data, the physician immediately has an idea of whether the patient will need smaller or higher doses than the "average" patient. Unfortunately, the testing to determine this is costly and potentially imprecise. Just because we see that a patient has hypoactive Cytochrome P450, any number of other metabolizing enzymes may be higher or lower than expected; we simply don't have the mastery of the human genome to be certain. So what is the relation to Ayurveda and *Tridosha*?

My hypothesis is that the Ayurvedic *Tridosha* system may be just as effective as genetic testing, if not more so, at determining a person's rate of drug metabolism. Furthermore, it's much cheaper, allowing access even to the underinsured and uninsured. D*osha* typing is shorthand for determining a patient's metabolism and genetic make-up, improved through the crucible of millennia of practice. They may be effective placers in determining genetic similarities, where superficial things like "race" continue to fail. *Dosha* types are very specific, combining the three *doshas* in percentages. For example, one person may be 80%, 14%, and 6% of the each of the three *doshas,* respectively. Collectively this determines their *dosha* type. Soon, we may be able to say that because a person has a specific ratio of *doshas,* they are likely to metabolize this drug very similarly to other people with that *dosha* type. This would bypass our previously discussed current difficulties with Genomic medicine. But the first and current step is to determine whether there is, indeed, a linkage between metabolic enzymes and *dosha* types. So far, one study has found a reasonable correlation between genetics and *dosha* type by analyzing HLA types[iii].

Due to the high cost of genetic panels, I will be relying on genetic panels already ordered by cooperating physicians. I will be looking at the correlation between numerous enzymes and *dosha* types. The data that I collect is dependent upon the ordered genetic panels, but as most panels screen for multiple enzymes, I should receive a large sample size for many enzymes. The goals of my project are to gain a stronger understanding of Ayurveda, and to explore the correlation between various enzymes gauged by genetic panels and *dosha* types. My hope is that with enough study, the system of *Tridosha* may become short-hand for many genetic tests, at a cost that is affordable for all. Establishing a correlation between genetics and *dosha* types allows for a multitude of research to follow. In the future, we may be able to assess the function of an unknown gene through its association with a *dosha* type. By determining the functional changes between slightly different *dosha* types and observing unknown genes that change with them, we gain another clue in establishing the function of unknown genes. *Dosha* typing may indeed become a key to unlocking the field of Genomic medicine.

My Background:

Since I was young, my mother has treated my headaches with acupuncture points, my colds with Homeopathic tinctures of bacteria, and nausea with foul tasting Ayurvedic salts. Because of my mother's influence, I've held a degree of both curiosity and skepticism about other systems of healing. During my undergraduate years at Cornell University, I began research with Dr. Eloy Rodriguez. Doctor Rodriguez was interested in finding non-patentable, and therefore affordable, treatments for common diseases. I joined him to research alternative methods for treating diabetes type II, a cause of great morbidity throughout the world, and especially among the underinsured and uninsured. Among other discoveries, it turns out that a simple vegetable, commonly prescribed in Ayurveda, is as effective for reducing

glucose levels as most prescription pharmaceuticals. This sparked a ferocious interest in Ayurveda and other alternative fields of medicine.

Now in medical school, I've found myself most captivated by discussions of practical issues. How do we get treatment to the uninsured? How do we continue to make breakthroughs and improve our treatment of patients?

One clear answer is to pursue unconventional pathways, and continue to explore alternative systems of health with an open mind. In accordance with this, I am now actively pursuing the specialty of Integrative Medicine.

Objectives:

- Analyze correlations between Genetic Panels and *Dosha* Typing Surveys
- Publish results with a focus on Application for Physicians

- Intern under an Ayurvedic practitioner
- Document successful treatments of ailments that are not well treated with Allopathic Medicine
- Gain a fuller understanding of Ayurveda and how it may relate to Allopathic practice

Method:

For the data collection and analysis, I am in contact with Dr. Drisko, the director of KUMC's Department of Integrative Medicine and a physician who routinely analyzes patients' genetic panels and has agreed to sponsor my research. Additionally, I will contact physicians around the country who also routinely analyze patients' genetic panels and ask for their cooperation in distributing and returning my surveys. I will use a published survey that has been shown, through rigorous double-blind trials, to correspond with the *dosha* typing of well renowned Ayurvedic practitioners[iv]. I will distribute the *dosha* survey to the available patients and collect both the survey and their genetic panel results. Then, with Dr. Drisko's guidance, I will analyze the data and submit an article for publication containing the results, with a focus on practical application for physicians.

I am also in contact with an Ayurvedic practitioner, Michael Ferranti, who runs his own clinic in Manhattan, New York City. He is a specialist on incurable disease, and has been featured on radio and TV shows by such hosts as Marta Stewart. I will intern under him for a week (or possibly two if he finds the time), learning how he determines patients' *dosha* type and observing his treatments. I will also be paying close attention to his treatment of incurable diseases and other diseases that have a poor prognosis in Allopathic Medicine.

The data collection portion of the project is dependent upon the number of patients that Dr. Drisko and the other physicians prescribe genetic panels. For this reason, this part of the project will likely span the summer to allow for the greatest collection of data. The internship will take place in between, although Michael Ferranti and I have not yet set a definitive time.

Significant time prior to and after my visit to NYC will also be spent on reviewing Ayurvedic literature, under the guidance of Michael Ferranti.

Conclusion:

Finding funding for unconventional research projects is often difficult. When I heard about the Clendening Fellowship, I was just ecstatic. I'm so glad to have an opportunity to apply for a summer experience that will be truly interesting and valuable beyond words.

Through my publication, and the research that it may trigger, physicians will be able to better serve their patients, both insured and uninsured. *Dosha* typing promises to be a valuable, yet simple and inexpensive, tool for physicians that will continue to increase in utility as more research is done and further correlations are discovered.

Contacts:

Dr. Jeanne Drisko
Director of KUMC's Department of Integrative Medicine
edu

Kenneth Michael Ferranti
Founder of Gotham Ayurveda

Budget:

$120	Cost of printing *dosha* typing survey packets (estimating 8 physicians at $15 each)
$98	Cost of survey postage (covering mailing to the physicians and their costs mailing them back) (estimating 8 physicians, but excluding Dr. Drisko to whom I can hand deliver)
$164	Thank you gift certificates for cooperating physicians, and postage (estimating 8)
$270	Plane Ticket from MCI airport to JFK airport (quote from Orbitz.com)
$270	Food in Manhattan, one week
$300	Housing in Manhattan, one week - will be provided for a low cost through a friend
$25	Week long metro pass for NYC subway
$110	Taxi fare to and from JFK Airport
$100	Thank you gift for Michael Ferranti

Total: **$1457**

Note: Cost may vary slightly depending upon physicians cooperating, and stay length in NYC. I will provide any funding if costs exceed the Clendening donation and return any unused monies.

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[i] Dr. Jeanne Drisko, personal correspondence.

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iii Patwardhan Bhushan, Ph.D., Joshi Kalpana, Ph.D., and Chopra Arvind, M.D. "Classification of Human Population Based on HLA Gene Polymorphism and the Concept of Prakriti in Ayurveda." *The Journal of Alternative and Complementary Medicine*. Volume 11, Number 2, 2005, pp. 349–353

iv Rajani R. Joshi, Ph.D. "A Biostatistical Approach to Ayurveda: Quantifying the Tridosha." *The Journal of Alternative and Complementary Medicine*. Volume 10, Number 5, 2004, pp. 879–889

Clendening Fellowship Program

Department of History and Philosophy of Medicine

University of Kansas School of Medicine

February 2009

Physicians' personal beliefs versus clinical practice: a discrepancy?

An exploration of adolescent birth control prescription in an urban Christian setting.

Megan E. Spokes

School of Medicine

Class of 2012

Megan E. Spokes
SOM 2012

Introduction:

With regards to reproductive medicine, physicians have the right to refuse services to patients based upon moral and ethical beliefs[1]. Do physicians, however, always choose to exercise this right? Do physicians' personal beliefs always coincide with their clinical practice? If a discrepancy exists, what are the factors that influence the physician's decision to set his personal moral beliefs aside in the face of his practice?

In order to explore this issue, I plan to investigate birth control prescription to adolescent patients at the Lawndale Christian Health Center on the West Side of Chicago. The Lawndale Christian Health Center (LCHC) provides faith-based care to the surrounding urban community. I believe this environment is an ideal setting to study the conflict between personal beliefs and clinical practice as the patient population in the urban setting presents many unique challenges. While physicians may hold their own personal morals, do they expect their patients to adhere as well? I am interested to see whether physicians' personal views correspond with their clinical practices and explore the factors which may contribute to any discrepancies.

Background:

I have spent the year prior to medical school working full-time at the Lawndale Christian Health Center (www.lawndale.org). With over 125,000 patient visits a year and more than half of the patients uninsured, LCHC provides Christian health care to the underserved population of the Lawndale and Garfield communities. The clinic was founded by a small local church in 1986 (Lawndale Community Church) and has since grown to provide services at three locations throughout the West Side, staffing almost sixty providers. The clinic is open about its non-denominational Christian affiliation. In its interview process, the administrators openly discuss faith with each applicant, exploring the applicant's religious views and moral beliefs. Regarding birth control prescription, however, practices within the clinic vary, as is common across various Christian denominations[2]. I am interested in whether the various practices are attributed to differences in beliefs, or whether other factors such as the urban environment or patient wellbeing influence the physicians' decisions.

As a medical assistant in the Pediatric Department, I quickly learned which providers did and did not prescribe birth control to adolescents; rarely discussed, however, was the basis behind these decisions. If a conflict arose regarding a patient seeking birth control and her scheduled

[1] (Mirkes, Aug 2008)
[2] (Schenker, Jul 2000)

provider, it was often resolved before the encounter even occurred. The appointment was rebooked and no discussion was involved.

My Endeavor:

It is my goal to investigate the relationship between physicians' personal beliefs and their clinical practice. What are the physician's motives? What, if any, are the reasons a discrepancy exists?

My motivation for this project stems from a long discussion with one of the administrative physicians at the clinic regarding his personal journey through the ethics of teen contraceptive use. Dr. Wayne Detmer, a family practice physician and graduate of the University of Chicago's Pritzker School of Medicine, has been on both sides of the argument. He has always believed in abstinence before marriage, but used to prescribe birth control to his unmarried patients. He explained with multiple moral justifications. With teen pregnancy rates very high in urban populations[3], Dr. Detmer saw birth control as the lesser of two evils, a practical approach to the environment that his teen patients were facing. He felt that encouraging safe sex was more beneficial than allowing his personal beliefs to affect his patients. Dr. Detmer also felt that by prescribing birth control, he was able to establish and maintain a doctor-patient relationship that otherwise would have been terminated had he referred the young woman to another prescribing physician. His thoughts have now changed.

Dr. Detmer believes that discussing his views openly with his patients, explaining his reasons for not prescribing birth control, is more important than his previous justifications. He emphasizes the value of beginning a discussion. Although some patients may move on to other physicians without thinking twice, he believes the few individuals he may impact are worth the effort[4], (and perhaps the moral resolution he has found). Dr. Detmer's personal journey amplified my interest for this investigation. He has put much thought and ethical exploration into determining his clinical practices. Although each provider will have a different level of intensity in regards to moral and ethical exploration, I am interested in dissecting the thought process of these physicians in the urban Christian setting, focusing specifically on the decision to prescribe birth control to adolescents.

Logistics:

This summer, I plan to spend 8 weeks in Chicago completing my project. I will be dividing my time between the interview process and direct patient care. While my main research is focused

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[3] (Phipps MG, Feb 2008)
[4] (Morrison-Beedy D, Mar/Apr 2008)

on the physicians' decisions, I also plan to use this experience to increase my personal exposure to urban medicine. I have arranged with a number of the pediatricians at the clinic to spend two days a week working alongside them with patient care, learning firsthand the challenges of working in urban medicine.

With regards to the interviews, I plan to conduct them in a two step process. First, I will distribute a questionnaire regarding general beliefs and birth control practices. Second, I will conduct a face-to-face interview to discuss the questionnaire and collect any additional thoughts. I am distributing the questionnaires prior to the interview in order for the physicians to spend time evaluating their answers. I plan to review the questionnaire with the provider in a private interview, stimulating conversation regarding his/her beliefs and practices. More than one interview with an individual provider may be held if necessary.

I am excited for my findings as I believe multiple factors are involved in physicians' practicing decisions. I am curious as to the priority placed on personal beliefs versus societal and environmental factors as well as the wellbeing of the patient. I am excited for the opportunity to return to the urban setting, this time as a medical student, and feel that my own personal beliefs will be challenged this summer. I believe my research may also benefit other physicians as they are faced with ethical dilemmas. By opening up the discussion, perhaps resolution may be found.

I have included a sample of the questionnaire I will be using for discussion [Appendix A]. The questionnaire may be adapted as I am beginning application process through the Human Subjects Committee of KUMC. Dr. Allen Greiner of KUMC's Family Practice Department is acting as my principle investigator for my project and will be co-signer on my Human Subjects Research approval.

When in Chicago, I plan to live either with a college friend or with a family from the clinic. Having lived in the city for a year and within two miles of the clinic, I am very comfortable with the area and competent in maneuvering the city. I plan to drive to Chicago from Kansas City so I will have my car available for daily transport. I also plan to use public transportation (The El) at times as well.

For the first six weeks, my schedule will be two days per week working on interviewing (distributing, conducting, compiling), two days per week working in the pediatric department and one day per week completing administrative business and continuing research regarding my findings. The last two weeks of the eight I plan to compile my research and create my presentation. (I will most likely continue to work in the pediatrics department as well). I will present my findings to the clinic staff during my final week.

At Lawndale, my mentors will be Dr. Wayne Detmer of Family Practice (OB/GYN focus) and Dr. Kathryn Miller of Family Practice (Pediatric focus). I hope that my research will not only provide personal growth for me, but also stimulate discussion among the providers at Lawndale. As Dr. Kathryn Miller noted, "We [physicians] often are too busy to stop and think about why we do what we do in our daily practice, and especially to stop and discuss these decisions with our physician peers."

Budget:

$1400 rent + utilities in Chicago
$300 food/groceries for 8 weeks
$100 gas for transportation to/from Chicago from KC
$50 administrative fees (paper, printing fees, coffee for providers during interviews?)
$150 gas for daily commute to clinic
$150 car insurance x 2 months

$2150 total
*I plan to acquire any additional costs not covered by the Clendening scholarship.

Conclusion:

I am excited at the potential opportunity to pursue an issue about which I am very passionate. I have always been interested in serving the urban population and am interested in the dynamics between the Christian health care setting and the population which it serves. The moral conflict is a constant ethical topic in the medical community[5] and I am excited to explore its everyday application, as my peers and I too must decide how to approach moral issues when we are in practice.

I thank the Clendening Fellowship Program and the Department of History and Philosophy of Medicine for the wonderful opportunity for students to pursue a more anthropological interest within the medical field. As a student of the social sciences (a Psychology Major from the University of Notre Dame), I am intrigued with the social application and community practice of medicine. I look forward to hearing from the committee. Please do not hesitate to contact me for further information or suggestions regarding my desired project.

Megan E. Spokes

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[5] (Parsons, Feb 2007)

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Appendix A:

Questionnaire:

1. How long have you been practicing at LCHC?

2. What brought you to practice here?

3. What, if anything, is different about practicing at a Christian clinic versus a non-Christian clinic?

4. What are your personal beliefs regarding birth control?

5. What are your personal beliefs regarding adolescent birth control use?

6. Do you prescribe birth control to your patients?

7. Do you prescribe birth control to your adolescent patients?

8. If yes, what factors contribute to your decision to prescribe birth control to your adolescent patients?

9. Have any of your aforementioned views or practices changed throughout your medical career?

10. Do you have any additional thoughts or experiences you would like to share?

Megan E. Spokes
SOM 2012

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