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Clendening Fellowship Proposal

February 14, 2005

Todd Barrett

University of Kansas School of Medicine

Introduction:

Traditional Chinese medicine has been a component of Chinese culture for nearly four thousand years. Defying civil strife, war, and self-induced acculturation, Chinese medicine has flourished and provided a sense of stability for one of the world's oldest societies. Cultural renaissance has occurred numerous times in China. With each renaissance, traditional Chinese medicine has morphed to accommodate key tenets of Confucianism, Taoism, and Buddhism.[i]

The world has now entered an age where science and tradition begin to clash. As Eastern theory and Western science blend, physicians of tomorrow need to educate themselves in order to serve an ever changing planet.

The core ideology of traditional Chinese medicine emerged during the Shang Dynasty, circa 1600 B.C. It was during this period that definitions for disease and illness were constructed. Chinese society viewed illness as an imbalance in vital life energy. Disease was a social explanation for the cause of illness.[i] We still see these definitions in modern China.

Medical theory was codified during the Shang era. Shen Nong, the Red Emperor, wrote the *Ben Cao Jing*, which was the first *materia medica* in Asia.[ii] His successor, Huang Di, wrote the *Su Wen* and *Ling Shu*. *Su Wen*, which roughly translates to essential questions, was the first book of anatomy, physiology, and physical therapy in China. *Ling Shu* elucidated the techniques and theories of acupuncture.[i] These basic principles of Chinese medicine have remained static for nearly four millennia.

The Zhou Dynasty brought philosophers such as Confucius and Lao Zi. Confucianism established a moral code in China that has penetrated virtually all aspects

of Chinese society, including medicine. The Zhou period was also known as the Warring States period. Chinese society was torn by civil unrest and war. The Confucian philosophy established a system to create social balance during times of instability. Benevolence and generosity were taught in order to bring stability and health to the region.[iii]

During the same period, Lao Tzu ostensibly wrote the *Tao Te Ching*. The book, which is fundamental to Taoist faith, played a major role in the ideology of traditional Chinese medicine. Life was described as a pendulum. The world existed in two extremes, and the pendulum of life swung between the two entities. As long as the pendulum was rhythmically swinging, health and happiness persisted. If life fell in the trenches of one extreme, the imbalance caused disharmony and illness.[iv] The concept of harmonic balance is the foundation for Yin Yang theory in Chinese Medicine.

The organs of the body were divided into Yin and Yang counterparts. There was a critical balance between the two systems creating harmony and health. For instance, the heart and large intestine were Yin and Yang counterparts. Factors that damage the lungs were believed to diminish Yin forces in the body. As the equilibrium shifted toward Yang, illness associated with the large intestine would emerge. Herbal therapies and personal social adjustments were made to reduce Yang and elevate Yin levels in the patient's life.[v]

A third system of the body dealt with an intangible life energy called qi. Qi, which was maternally inherited, was created by the kidneys and stored in the gall bladder.[i] Qi traveled the body via a highway of meridians and collaterals congruent to the system of vessels containing blood. Qi was essential for proper functioning of the

human body. When a meridian became blocked, pathology was associated with organs and tissues downstream of the meridian. Acupuncture and moxabustion were created to physically open qi channels. Through suction over the area or inserting needles directly into the blockage, healing qi began to flow to the previously affected areas. [v]

As China entered the twenty-first century, much of the world had adopted Western medicine as a standard of care. The scientific, research based field had proven its effectiveness for the treatment and prevention of disease. During the reign of Chairman Mao Tse Tung, much of China's ancient culture was purged from the nation. Despite the attempts to enforce Western medicine and remove traditional Chinese medicine from Chinese society, the Cultural Revolution was unsuccessful at abolishing traditional medicine from China. What emerged was a unique blend of Western and Eastern theory. The modern hospitals of China emerged. They offer many of the most sophisticated applications of Western medicine while offering a myriad of traditional Chinese regiments. Many in China view Western medicine as a method of cure while traditional medicines are important for recovery and prevention. Eastern medicine is still viewed as way to bring balance and energy to an ailing body. The balance and energy is often used during periods of recovery and prevention.[ii]

European travelers of the 1600's brought the theories of acupuncture and the traditional *meteria medica* to the west. The theories of traditional medicine have drastically different fundamental values with regard to causation and treatment of disease. The Western world of science, which was constructed via the scientific method, often grapples with the abstract concepts of life energy, qi, and the underlying spiritual and social causes of disease accepted by traditional medicine theory.

We are entering an age where tradition and history are meeting the scientific age. The surge of technology over the past century has quickly advanced the field of Western medicine. Human genes have been mapped, metabolic pathways have been unraveled, and scientifically speaking, man knows more about himself today than at any other time in history. As individuals continue to explore and advance knowledge of the physical, there is always a question concerning the abstract nature of man.

One cannot dispute the effectiveness of many traditional Chinese therapies. As curiosity and knowledge of Eastern medicine spreads across America, millions of Americans are delving into the practice of alternative medicine. In 1990, 2.5% of American adults had used alternative medicine in the past twelve months. Research has shown that in 2003, 42% of Americans used alternative medicine at least once during a twelve month period.[vi]

As medical students in the United States, we are charged with the task of treating a new and growingly diverse generation of individuals. The medical community often projects negativity towards alternative therapy. Many often ignore the practice and attempt to dissuade individuals from participating in its treatments. The fact of the matter is that four out of every ten individuals a physician sees in the United States is participating in some type of alternative therapy. Members of the American medical community need to respond to the changing culture in America. The U.S. government recently opened a multimillion-dollar branch of the National Institutes of Health in order to provide scientific evaluation of alternative therapies. As our government and researchers across the nation attempt to bridge the gap between tradition and science, physicians in America have the duty to be informed.

Background:

The goals I have set for my education are geared towards a career in oncology and hematology in the division of internal medicine. My clinical experiences at Kansas City Cancer Centers have been most influential in establishing these goals. Through long-term, personal interaction with oncology patients and clinical staff, I have experienced the triumphs and nadir of oncology care. Oncology is a unique occupation that allows a physician to provide medical, psychological, and emotional support for individuals during the most uncertain battles of their lives. Oncologists have intimate patient interaction throughout the duration of treatment, which may last months, if not years. I hope to lead a clinical staff to provide an amiable and optimistic environment for patients and their support networks. Despite the difficult and unfortunate outcomes of some journeys, I find peace and gratification comes by giving support to patients and their loved ones during their priceless final days together.

While working as supportive clinical staff and volunteering for St. Luke's hospice, I have witnessed the most intimate aspects of a patient's life while dealing with a terminal disease. I have learned that simple words and minute actions from the medical community have a profound impact on an ailing individual. The most striking lesson I learned through my experience was that medicine should treat a person not merely illness. From my experiences, quality of life is an entity of medicine that patients often feel is neglected.

Over the five years I worked in oncology and hospice, I witnessed numerous patients turn to alternative therapies in order to improve their quality of life. Depression management, pain management, and chemotherapy symptom relief are three important

issues in which many oncology patients turn to alternative therapies for assistance. Recent studies conducted by David Eisenberg at Harvard University have now proven through a double blinded clinical trial that acupuncture in conjunction with standard anti-nausea medications provided a statistically significant decrease in nausea associated with chemotherapy treatment as compared to standard therapy alone.[vii]

Intrigued by the therapies that many of our patients were utilizing, I became interested in the field of traditional Chinese medicine. Starting my junior year of college, I began to look at a country, culture, and foreign concept of medicine that has truly altered my view of the world.

As a Kansas Asia Scholar at the University of Kansas, I had the opportunity to explore various aspects of Chinese language and culture. Following a year of courses ranging from Eastern religions to Chinese language, I had the opportunity to travel to China for three weeks. While traveling to seven cities in China, each participant surveyed a different aspect of Chinese culture. Due to my curiosity about alternative medicine, I chose Chinese medicine as my academic research topic. Following the cultural experience in the country, I returned to the U.S. and conducted a series of informational seminars on alternative medicine. The series was given to physicians and medical professionals in rural Kansas communities. While giving these seminars, I began to realize that many physicians in Kansas were very curious about the theories of traditional Chinese medicine, but few were well versed on the topic.

I now realize there is a vast need for medical students in America to open their minds to alternative medicine. Millions of Americans have turned to alternative therapy, yet physicians are unaware of its potential benefit and potential drug interactions.

Over the past year I have researched the uses of alternative medicine in oncology care. There is scarce information about traditional medicine in the scientific literature. Furthermore, studies attempting to quantify the number of individuals using alternative therapies done by Dr. David Eisenberg at Harvard and physicians from the University of California at San Francisco include study populations taken from populations on the East and West coast that have higher percentage of individuals of Chinese ethnicity. There is a severe lack of information pertaining to alternative medicine usage in the Midwest.

In order to assist oncologists in the Midwest, I am developing a quality of life study assessing three factors pertaining to alternative medicine usage in the Midwest. First, the study will attempt to determine the percentage of breast cancer patients currently using alternative therapies. Second, the study will determine the percentage of breast cancer patients using alternative therapies that inform their physicians of such treatment. Finally, the study will evaluate the perceived effect alternative therapy has on quality of life.

The study questionnaire is an adaptation of a quality of life study created by Betty Ferrel at the City of Hope Cancer Institute. Andrea Charbonneau, MD, Sarah Taylor, MD, and researchers in the University of Kansas Breast Cancer Prevention Center are advising the project. IRB submissions will be made to the University of Kansas Medical Center and U.S. Oncology Inc. A sample of 200 women from Kansas City, St. Louis, and Columbia, Missouri will be obtained.

It is my hope that future research into alternative therapies will provide patients with new avenues to alleviate pain, calm symptoms associated with conventional drugs, and control depression.

Although I have traveled to China and am conducting a research project on alternative therapies in the U.S., I am still unfamiliar with how traditional Chinese medicine is truly utilized for oncology care in China. I would also like a broader understanding of traditional Chinese medical theory, so I may better understand the treatments my patients will be pursuing independent of physician assistance.

I will be faced with many patients undergoing life's most difficult challenges. My understanding of other cultures and varied social views will offer patients another method to eliminate their suffering both mentally and physically.

Quality of Life Study: Rough Draft:

This research project is independent of the Clendening Fellowship. I am including a rough draft of my quality of life questionnaire so the committee can gain a better understanding of the information I am seeking from the project. I feel this project illustrates my passion for the field of alternative medicine. I can make the works cited for this project available is so desired. It is currently under construction and between drafts.

Proposal:

I want to learn more about the basic principles of Traditional Chinese Medicine. I would also like to witness how Chinese medicine is used for pain management and depression management in oncology and hospice patients.

I will travel to Beijing, China for six weeks. The goal for the first two weeks of the experience is to familiarize myself with the city and gain an appreciation for the art, food, and culture of the country. It is vital to understand the culture of individuals before assessing them in a clinical setting. I have never traveled to a foreign country on my own, and I am excited to be able to explore a city using my own abilities.

During the two weeks, I hope to visit the Bejing Museum of Science and Technology. The museum is home to some of China's most ancient medical artifacts, including one the world's oldest materia medicas, acupuncture charts and models dating to 200 BC, and one of the largest collections of ancient medical tools and instruments. In addition to the museum, I hope to visit pharmacies across the city. I will look at the herbs being sold and the types of Western medicines that are available.

During weeks two through six, I will participate in a traditional Chinese medicine program that is offered by the University of Ohio College of Osteopathic Medicine. The program is directed by Edward A. Gotfried, DO, FACOS. Dr. Gotfried is a retired oncology surgeon and travels with groups to China annually. The four week program is taught at Guang An Men Hospital in Beijing. The five hundred bed facility averages nearly two thousand outpatients each day. Guang An Men is entrusted by the Public Ministries of Health and is one of China's premier traditional Chinese medicine training facilities.

During the program, I will take courses on traditional Chinese medicine theory each morning from 8:00 AM – 12:00 PM. Each week of the program focuses on a different aspect of TCM to provide a well-rounded exposure. Week one through four will focus on TCM diagnosis, acupuncture, tui na/qigong, and Chinese herbal medicine

respectively. The courses will be taught in English or translated depending on the lesson. A Chinese specialist in traditional Chinese medicine will teach each portion of the course. In conjuction with lectures, a reading selection of translated texts will be assigned. A reading list will be provided to the Clendening Fellowship following return.

This opportunity will provide a structured environment to learn tenants of traditional Chinese medical theory from China's leading clinicians. It is truly a unique experience that few have the opportunity to encounter.

Following lecture each morning, I will follow a traditional Chinese oncologist in the afternoon. Guan An Men Hospital has a division of traditional Chinese oncology. Dr. Gotfried is contacting the director of oncology, Dr. Yao Naili, to set up my clinical experience. I will be paired with a physician that speaks both English and Chinese. This will facilitate my communication with medical personnel and patients at the hospital. As a retired oncology surgeon, Dr. Gotfried has many additional oncology contacts at Guang An Men Hospital.

In my opinion, the clinical exposure will be the biggest learning experience of the fellowship. By interacting with physicians and patients, I will gain a better understanding of how traditional Chinese medicine is used to treat cancer in modern China. In particular, I will witness how another culture approaches depression and pain management.

Throughout my clinical experience a detailed journal will be kept with regard to the variety of treatments I encounter, and the attitudes of physicians and patients involved in these treatments. Throughout the clinical clerkship, I hope to speak with patients and physicians concerning their treatment goals. An understanding of why individuals in

China utilize traditional Chinese medicine in conjunction with Western medicine may give some explanation as to why millions of Americans are turning to alternative medicine. It will be interesting to see if there are cross-cultural reasons for using alternative medicine.

I would also like to better understand how individuals in China approach chronic disease and deal with the mental and physical side effects of treatment. If I can gain a better understanding of how another culture deals with these side effects, I may someday be able to offer a patient a more effective palliative care.

Due to my research project currently underway in the US, I will submit an application to the IRB at the University of Kansas with regard to my Clendening Fellowship. I will also ask for written approval from Guang An Men Hospital in China. The IRB submission has been discussed with Dr. Jerry Menikoff. Although patient and physician interviews will be anonymous and innocuous, I want to cover all legal grounds as to not exclude possible findings from future publications that may develop as a result of this fellowship or my quality of life study.

Following my clinical experience each evening, I will have a one to two hour class in Chinese Language. The Chinese language experience is yet another dimension of the learning opportunity in this fellowship. During my undergraduate education, I was not able to fit many hours of Chinese language electives into my schedule. Many courses were five hours and were extremely difficult to incorporate into a curriculum. The intensive language lessons and cultural immersion will provide an opportunity to improve my Chinese language skills, which has been a goal for many years.

My official application for the program was submitted on February 12, 2005. The official applications were not available until February 1. Recommendation letters were written my Dr. Robert Klein from the University of Kansas SOM and Sue Lorenz from the University of Kansas Honors Program. The application deadline has not yet arrived; so official acceptance letters have not been made available. Dr. Gotfried and Catherine Marshall have stated that all applicants that are in good health and good academic standing are accepted into the program. Catherine Marshall has e-mailed the attached budget for submission to the Clendening Fellowship Committee.

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Program Website:

http://www.oucom.ohiou.edu/international/China/

Budget:

First Two Weeks:	
Lodging at Jian Guo Hotel:	$150
Food:	$100
Transportation (Taxi and Subway)	$40
Misc.	$40

Program fee for med students on non-OU credit option:	$5000
Study Abroad Administrative fee:	$150

Program Fee includes: round-trip airfare, lodging and partial board (breakfast and some meals), excursions, instructional costs

Total Out-of-Pocket Costs:

Passport and photos:	$95 (Already Have)
Visa:	$90
Int'l Student ID Card:	$22
Board (lunch and dinner):	$200
Textbooks and Supplies:	$50
Incidentals/Personal Expenses:	$250

Total Student Cost:	**$6,042**

Timeline:

Depart from United States:	June 1, 2005
Arrive in Beijing:	June 2, 2005
Cultural Tour:	June 3 – 11, 2005
Meet U. of Ohio group:	June 12, 2005
U. of Ohio Program:	June 12, 2005 – July 10, 2005 (Dates may vary slightly)
Depart from Beijing:	July 10, 2005
Arrive in United States	July 11, 2005

I have spoken with Ohio University with regard to my early departure. Catherine Marshall indicated there are many students each year that choose to depart early or delay arrival for personal travel in the country. They will arrange flights to accommodate the dates I wish to arrive and depart.

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[v] Micozzi, Marc S., MD, PhD. Ed. Fundamentals of Complementary and Alternative Medicine. New York: Churchill Livingston. 1996.

[vi] Zoorob, Roger MD, PhD. "Complementary and Alternative Medicine." AAFP Home Study and Self Assessment Program. FP Essentials 293. October 2003: 3-19.

[vii] The Alternative Fix. Narr. Lyman, Will. Writ. Aronson, Raney. Dir. Aronson, Raney. Frontline. PBS Network. Jan 19, 2003.

I would like to extend a special thanks to the Clendening Library staff for their assistance in obtaining many of these texts.

Assessing the usage and efficacy of complementary and alternative therapies in breast cancer patients receiving first line therapy.

Todd A. Barrett

University of Kansas School of Medicine /

US Oncology

November 2004

Purpose: This study will examine the effect of complementary and alternative medicine on health-related quality of life in breast cancer patients. The survey will investigate the patient's attitudes toward complementary and alternative therapies and assess their comfort discussing the alternative treatments with healthcare workers.

The study will consist of a survey analyzing physical, psychological, social, and spiritual well-being. Questionnaires consist of 58 questions. Patients will be asked to rate their response on a scale of 1 to 10.

Women diagnosed with breast cancer receiving Adriamycin and Cytoxan followed by a Taxane will complete the survey on three occasions:

1. Diagnosis - The patient shall complete the survey following diagnosis but prior to the induction of chemotherapy.

2. Post Adriamycin and Cytoxan – The patient shall complete the second survey after the final cycle of Adriamycin and Cytoxan but prior to the induction of Taxane therapy.

3. Post Chemotherapy – The patient shall complete the third survey within one week of Taxane therapy termination

Understanding the impact of complementary and alternative therapies on health-related quality of life and symptom distress may provide information helpful in evaluating new treatment approaches.

Eligibility:

Gender: Female

Age: 18 +

Newly diagnosed, chemotherapy naïve breast cancer patients scheduled to receive Adriamycin and Cytoxan followed by Taxane are eligible for participation in this study.

Quality of Life Scale

Directions: We are interested in knowing how your experience of having cancer affects your Quality of Life. Please answer the following question based on your **life at this time.**

Please *circle* the number from 0 – 10 that best describes your experiences:

Physical Well Being

To what extent are the following a problem for you:

1. **Fatigue**

No Problem 0 1 2 3 4 5 6 7 8 9 10 **Severe Problem**

2. **Appetite Changes**

No Problem 0 1 2 3 4 5 6 7 8 9 10 **Severe Problem**

3. **Aches or Pains**

No Problem 0 1 2 3 4 5 6 7 8 9 10 **Severe Problem**

4. **Sleep Changes**

No Problem 0 1 2 3 4 5 6 7 8 9 10 **Severe Problem**

5. **Constipation**

No Problem 0 1 2 3 4 5 6 7 8 9 10 **Severe Problem**

6. **Nausea**

No Problem 0 1 2 3 4 5 6 7 8 9 10 **Severe Problem**

7. **Menstrual Changes or Fertility**

No Problem 0 1 2 3 4 5 6 7 8 9 10 **Severe Problem**

8. Rare your overall **physical health.**

Extremely Poor 0 1 2 3 4 5 6 7 8 9 10 **Excellent**

Psychological Well Being

9. How difficult is it for you to **cope** today as a result of your disease and treatment?

Not at All Difficult 0 1 2 3 4 5 6 7 8 9 10 **Very Difficult**

10. How good is your **quality of life**?

Extremely Poor 0 1 2 3 4 5 6 7 8 9 10 **Excellent**

11. How much **happiness** do you feel?

None at All 0 1 2 3 4 5 6 7 8 9 10 **A Great Deal**

12. Do you feel like you are in **control** of things in your life?

Not at All 0 1 2 3 4 5 6 7 8 9 10 **Completely**

13. How **satisfying** is your life?

Not at All 0 1 2 3 4 5 6 7 8 9 10 **Completely**

14. How is your present ability to **concentrate or to remember** things?

Extremely Poor 0 1 2 3 4 5 6 7 8 9 10 **Excellent**

15. How **useful** do you feel?

Not at All 0 1 2 3 4 5 6 7 8 9 10 **Extremely**

16. Has your illness or treatment caused changes in your **appearance?**

Not at All 0 1 2 3 4 5 6 7 8 9 10 **Extremely**

17. Haw your illness or treatment caused changes in your **self concept** (the way you see yourself)?

Not at All 0 1 2 3 4 5 6 7 8 9 10 **Extremely**

How distressing were the following aspects of your illness and treatment?

18. Initial Diagnosis

Not at All Distressing	0	1	2	3	4	5	6	7	8	9	10	**Very Distressing**

19. Cancer Treatments (i.e. chemotherapy, radiation, or surgery)

Not at All Distressing	0	1	2	3	4	5	6	7	8	9	10	**Very Distressing**

20. **Time since diagnosis**

Not at All Distressing	0	1	2	3	4	5	6	7	8	9	10	**Very Distressing**

21. How much **anxiety** do you have?

None at All	0	1	2	3	4	5	6	7	8	9	10	**A Great Deal**

20. How much **depression** do you have?

None at All	0	1	2	3	4	5	6	7	8	9	10	**A Great Deal**

To what extent do you fear?

23. **Future Diagnostic Tests**

No Fear	0	1	2	3	4	5	6	7	8	9	10	**Extreme Fear**

24. **A Second Cancer**

No Fear	0	1	2	3	4	5	6	7	8	9	10	**Extreme Fear**

25. **Recurrence** of your cancer

No Fear	0	1	2	3	4	5	6	7	8	9	10	**Extreme Fear**

26. **Spreading (metastasis)** of your cancer

No Fear	0	1	2	3	4	5	6	7	8	9	10	**Extreme Fear**

Social Concerns

27. How distressing has illness been for your **family**?

Not at All 0 1 2 3 4 5 6 7 8 9 10 **A Great Deal**

28. Is the amount of **support** you receive from others sufficient to meet your needs?

Not at All 0 1 2 3 4 5 6 7 8 9 10 **A Great Deal**

29. Is your continuing health care interfering with your **personal relationships**?

Not at All 0 1 2 3 4 5 6 7 8 9 10 **A Great Deal**

30. Is your **sexuality** impacted by your illness?

Not at All 0 1 2 3 4 5 6 7 8 9 10 **A Great Deal**

31. To what degree has your illness and treatment interfered with your **employment**?

No Problem 0 1 2 3 4 5 6 7 8 9 10 **Severe Problem**

32. To what degree has your illness and treatment interfered with your **activities at home**?

No Problem 0 1 2 3 4 5 6 7 8 9 10 **Severe Problem**

33. How much **isolation** do you feel is caused by your illness or treatment?

None 0 1 2 3 4 5 6 7 8 9 10 **A Great Deal**

34. How much **financial burden** have you incurred as a result of your illness and treatment?

None 0 1 2 3 4 5 6 7 8 9 10 **A Great Deal**

Spiritual Well Being

35. How important to you is your participation in **religious activities** such as praying, going to church?

Not at All Important 0 1 2 3 4 5 6 7 8 9 10 **Very Important**

36. How important to you other **spiritual activities** such as meditation?

Not at All Important 0 1 2 3 4 5 6 7 8 9 10 **Very Important**

37. How much has your **spiritual life** changed as a result of cancer diagnosis?

Not at All Important 0 1 2 3 4 5 6 7 8 9 10 **A Great Deal**

38. How much **uncertainty** do you feel about your future?

Not at All Uncertain 0 1 2 3 4 5 6 7 8 9 10 **Very Uncertain**

39. To what extent has your illness made **positive changes** in your life?

None at All 0 1 2 3 4 5 6 7 8 9 10 **A Great Deal**

40. Do you sense a **purpose/mission** for your life or reason for being alive?

Not at All 0 1 2 3 4 5 6 7 8 9 10 **A Great Deal**

41. How **hopeful** do you feel?

Not at All Hopeful 0 1 2 3 4 5 6 7 8 9 10 **Very Hopeful**

42. How important to you is your participation in **religious activities** such as praying, going to church?

Not at All Important 0 1 2 3 4 5 6 7 8 9 10 **More Important**

Complementary and Alternative Therapies

43. Are you currently participating in **massage therapy**?

YES NO

44. If yes, how often?

45. How important is massage therapy in your **breast cancer treatment**?

Not at All Important 0 1 2 3 4 5 6 7 8 9 10 **Very Important**

46. How important is massage therapy to your **quality of life**?

Not at All Important 0 1 2 3 4 5 6 7 8 9 10 **Very Important**

47. Are you currently participating in **acupuncture therapy**?

YES NO

48. If yes, how often?

49. How important is acupuncture therapy in your **breast cancer treatment**?

Not at All Important 0 1 2 3 4 5 6 7 8 9 10 **Very Important**

50. How important is acupuncture therapy to your **quality of life**?

Not at All Important 0 1 2 3 4 5 6 7 8 9 10 **Very Important**

51. Are you currently taking **herbal supplements**?

YES NO

52. If yes, please specify the type of supplement.

53. How important is herbal therapy in **your breast cancer treatment**?

Not at All Important 0 1 2 3 4 5 6 7 8 9 10 **Very Important**

54. How important is herbal therapy to your **quality of life**?

Not at All Important 0 1 2 3 4 5 6 7 8 9 10 **Very Important**

55. Do you feel comfortable discussing complementary and alternative therapies with your **doctor**?

Not at All Comfortable 0 1 2 3 4 5 6 7 8 9 10 **Very Comfortable**

56. Do you feel comfortable discussing complementary and alternative therapies with your **nurses**?

Not at All Comfortable 0 1 2 3 4 5 6 7 8 9 10 **Very Comfortable**

57. Do you feel comfortable discussing complementary and alternative therapies with your **family**?

Not at All Comfortable 0 1 2 3 4 5 6 7 8 9 10 **Very Comfortable**

58. Do you be comfortable discussing complementary and alternative therapies with your **friends**?

Not at All Comfortable 0 1 2 3 4 5 6 7 8 9 10 **Very Comfortable**

AGE: ____

Race:

Asian/Pacific African American Hispanic Caucasian Native American Other

Highest Level of Education:

Primary High School Vocational Training Some College

College Masters Ph. D Professional Degree

Medication List:

End-of-Life Attitudes of Aging Holocaust Survivors

*Pictured above is my maternal grandfather's family prior to the Holocaust. Only three of them survived.

Clendening Fellowship Proposal

Lori Davis

February 14, 2005

Background

There is a six-digit number tattooed on my Bubie's (Grandmother's) forearm. I remember being so surprised and curious the first time I saw it. Hiding it under her sleeve, she makes this physical reminder of the horrors she went through invisible to most people. I remember having no idea that the numbers on Bubie and Zaydie's (my grandfather's) arms carried so many horrible memories and experiences with them. As I grew older, they told me and my siblings what happened to them during World War II. I quickly grew to realize that the visible scars on their arms were not the only ones left on them by the traumatic years they lived through during the Holocaust. The scars left in their minds and their hearts could not so easily be hidden and could never be erased.

Six million Eastern European Jews were murdered during the Holocaust. Only because the war ended before Hitler could accomplish his plan of annihilation did any Jews from Eastern Europe survive. The atrocities that they witnessed and lived through would never again allow them to function as they had prior to the Holocaust. Living for variable periods of time under the pretense that every Jew would indefinitely be killed, the survivors were both physically and emotionally surrounded by death. Their families were murdered, their homes destroyed, their possessions stolen, their beliefs shattered and often times their hopes were completely lost. There was not a single Jewish village remaining after the war (Zajde, 2001). Most of the survivors believed that they would be killed by Hitler and did not understand, after the war, why they were still alive (Zajde, 2001). As one survivor of Auschwitz put it, "you knew you were going to die…" (Solomont, 2005).

When survivors began to rebuild their lives, many showed symptoms of what became known as Survivor's Syndrome. This included signs of "chronic anxiety, fear of renewed persecution, depression, recurring nightmares, psychosomatic disorders, anhedonia… a hostile and mistrustful attitude toward the world, a profound alteration of personal identity…" (Hass, 1990). Life took on a different meaning for survivors of the Holocaust.

Almost sixty years after the end of World War II, the majority of Holocaust survivors today are in their seventies and eighties. They are encountering such difficult life events as the death of loved ones, loss of physical strength and independence, mental

health deterioration, and their own death (Malach, 2001). While the Survivor Syndrome has been used to describe the emotional trauma and disabilities of many Holocaust survivors, there remains a void in assessing the needs of survivors as they experience their own aging and dying processes as well as those of their loved ones (Malach, 2001).

A complex variety of psychological factors may be involved in the way that Holocaust survivors react to the aging process. When survivors experience the death of someone close to them it may trigger a recurrence of survivor guilt, initially felt by many just after their liberation from the camps. There is also indication that grief from losses suffered during the Holocaust may resurface in an aging survivor (Malach, 2001). A dying survivor may have difficulty believing and acknowledging their impending death after they have lived through so much (Berlat and Weiss, 2002). It may be difficult to admit death for some survivors who find strength in the fact that by surviving, they are defying Hitler (Suedfeld, 1998). Other experiences associated with being ill, such as hospitalization or relocation to a nursing home could also revive fears and traumatic memories from the horrors they suffered at the hands of the Nazis (Malach, 2001).

I have always wanted to better understand my Bubie and Zaydie. Nine years ago, my Zaydie died before many of my questions about his life were answered, before I had gained an understanding of the complex issues facing a Survivor when he is nearing the end of his survival. Sixty years ago, my Bubie was surrounded by death and hatred, her identity reduced to the six-digit number imprinted on her arm. She continues to survive after saying goodbye to many loved ones who have passed on in recent years. She continues to radiate with love, despite the horrors that her life has seen. She continues to age and, as she ages, to struggle with the process of nearing the end of life.

Description

My proposed summer learning experience will allow me to explore some of the challenges that face the aging Holocaust survivors and to consider appropriate methods to overcome some of these difficulties with the care provided for the aging and dying Holocaust survivor population. My Clendening project will involve, first and foremost, spending a large amount of time with Survivors of the Holocaust. A United Jewish Communities National Population Survey from 2000-2001 estimated 122,000 Holocaust

survivors living in the United states (Solomont, 2005). There are large survivor populations in New York City, Washington DC, Chicago, Southern Florida, and even a decent size population here in Kansas City. I will spend time meeting with Holocaust survivors in Kansas City, Chicago, and Boca Raton. My interactions with the survivors will include an interview and a standardized questionnaire. Some information will also be gathered from videos taken of survivors telling their personal stories of the Holocaust.

I plan to gather background information not only through research papers and books, but with a visit to some of the cities in Poland where many of the survivors were born and lived until they were deported. While none of the Jewish communities of Poland survived the mass extermination by the Nazis, many of the towns' old streets, buildings and houses remain, and their archives contain records from the years prior to World War II. Specifically, I would like to visit a small town called Bialobrzegi. This is the place where my Zaydie was from, where a Chasidic learning center once existed, and where 58 percent of the town's 2419 families were Jewish prior to the war (Mendelbaum, 1991). The opportunity to visit the places where my grandparents came from and to explore the country where much of the history affecting Holocaust survivors took place will greatly enhance my personal learning experience as well as my Clendening project.

As a final piece to the project, I will spend time in Israel to gain further background information about the Holocaust and Holocaust survivors. As many as 380,000 survivors are estimated to live in Israel, some of them in small communities started by and for Holocaust survivors directly following the war. I hope to discover the organizations and support centers available for Holocaust survivors in Israel and to learn about the ways in which they are working to accommodate the physical and mental health needs of the aging survivor population. In addition, I will make contacts and determine opportunities to conduct a future study in Israel.

There exist thousands of articles, books, memoirs, biographies, and websites about the Holocaust. Over the past few years alone, hundreds of studies have been conducted and books written about this topic. I plan on spending some time this summer doing extensive research on those studies that focus on the mental health status and appropriate healthcare of aging Holocaust survivors.

Method

A number of techniques will be used to both qualitatively and quantitatively assess the mental health status and needs of elderly Holocaust survivors. One stage of the project will be purely quantitative. I plan on submitting my research proposal to the IRB in order to receive approval prior to beginning this stage of the project. The research will involve giving standard questionnaires and interviews to a number of Holocaust survivors in three cities in the United States. In previous studies, questionnaires such as the PTSD inventory scale, SCL-90, and WHOQoL-Bref have been used to determine the psychological status and quality of life of study participants (Lev-Weisel).

I intend to survey 5 to 10 survivors from each of three cities: Kansas City, Chicago, and Boca Raton. Their current mental status will be evaluated on the basis of their quality of life, which will be assessed using the WHOQol-Bref, and their level of depression, which will be assessed using a geriatric depression scale to be selected based on the gold standard for this particular area of study. I will also assess their attitudes and feelings about death using a death anxiety scale also to be selected based on the gold standard. Many psychological scales for death anxiety assessment and general assessment of geriatric mental health are available. Some require additional training, and they vary in length and reliability. I am currently in the process of selecting which scales I will use.

In a more qualitative manner of gathering information, I will interview the participants about their experiences during the Holocaust. I will try to avoid going into detail in areas that will bring back difficult and traumatizing memories, and focus instead on specific pieces of information. Targeted information will include the number of years and setting in which they were forced to live during the Holocaust, family members whom they reunited with after the Holocaust, and any core personal beliefs or attitudes that were changed by the Holocaust. Based on my past experience speaking with Holocaust survivors, those who want to tell their complete story with all of its details will not hesitate to do so. Some of this information may also be gathered through videotapes of the survivors telling their stories.

Additionally, I will interview healthcare providers and social workers from the Holocaust Community Services Center in Chicago. This is an organization created

specifically to work with and aid aging Holocaust survivors. Through these interviews I hope to learn about survivors' mental health issues from the perspective of the healthcare providers.

Information from all of the interviews and questionnaires will be documented in detail. The interview scales will be scored and analyzed for statistical significance against non-survivor populations on whom the same scales have been used.

Time Frame

***Some preliminary time will be spent gaining certification in the necessary inventory scales that will be used and preparing for the interviews.

Weeks 1 and 2 – Kansas City

I hope to interview ten Holocaust survivors in this community. I have already spoken to some Holocaust survivors and have contacts that will allow me access to other survivors who are interested in participating.

Weeks 3 and 4 – Chicago/Boca Raton.

I hope to interview at least 5 survivors from each of these cities. I have contacts with survivors in Boca Raton and am in the process of finding a list of interested survivors in the Chicago area.

Week 5 – Poland

I will be gathering more background information about the Holocaust and visiting sites of old Jewish towns in Poland and any remnants which remain. I will be spending time with the Jewish community in Warsaw as well as exploring the towns of Radom and Bialobrzegi, where my maternal grandparents were from.

Week 5 – Israel

I will spend time learning about the various resources available for Holocaust survivors in Israel. I plan to meet with a researcher at Ben-Gurion University who has done previous Holocaust survivor studies to discuss the opportunity to do a follow up paper to my current project with the survivors in Israel. I also intend to visit the two Holocaust museums, one in Jerusalem and one in Lohamei Hagetaot to gain further background knowledge and explore the resources available at those locations.

Goals

The following are the goals of this proposed Clendening Project:

1) To learn about the needs and challenges of healthcare for aging Holocaust survivors so that I may be the most valuable asset possible to those survivors with whom I interact as a family member, friend, and future physician.
2) To conduct a study and develop a paper regarding the psychological impact of the Holocaust on end-of-life attitudes of survivors as they go through their own aging and dying process, and that of their loved ones.
3) To gain background knowledge about historical Jewish communities in Poland that were destroyed during the Holocaust and to discover some of my own family roots there.
4) To explore the possibility of conducting a future study in Israel on aging Holocaust survivors and to evaluate what further studies are needed to ascertain the best possible care and understanding of this population.

Budget

Flight to Chicago - $110

Flight to Boca Raton - $200

Hotel in Boca Raton - $300 (may not be needed)

Flight to Poland - $860

Flight to Israel - $950

Hotel in Poland - $300

Food - $300

Transportation - $200

Total - $2920

*Accommodations in Chicago and Israel will be with Friends and Family.

*Full responsibility will be taken to pay those charges that go beyond the fellowship allowance.

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PHYSICIAN-ASSISTED SUICIDE IN OREGON AND THE VIEWS OF A NEXT GENERATION OF PHYSICIANS

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Clendening Fellowship Proposal

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14 February 2005
Clendening Proposal
University of Kansas School of Medicine

Physician-Assisted Suicide in Oregon and the Views of a Next Generation of Physicians

Introduction

In 1997, Oregon voters passed the Oregon Death with Dignity Act (DWDA), a revolutionary piece of legislation which made Oregon the first and only state in the United States to legalize physician-assisted suicide (PAS). Despite controversy and efforts to repeal the act by the United States Supreme Court in 1997 and former US Attorney General John Ashcroft in both 2001 and 2002, the act has not been overturned and remains active as a part of Oregon state law. In the six years since legalization, 171 Oregonians have chosen to take their own lives using PAS. Although these numbers are small compared to other countries that have legalized PAS such as the Netherlands where 2% of all deaths are the result of PAS, the number of people that are choosing PAS as an alternative to a painful death due to a terminal illness is increasing each year. In 2004, forty-two patients died from PAS.

Physician-assisted suicide is defined by Oregon law as the ingestion of lethal medication prescribed by a physician to end one's life. These prescriptions consist of a lethal dose of barbiturates (secobarbital in most cases) which work by depressing the central nervous system. In order to make a request for such a prescription a person must meet the following requirements: the patient must be 1) an adult, 2) a resident of Oregon, 3) capable (has the ability to make and communicate health care decisions), and 4)

determined by both an attending physician and a consulting physician to be suffering from a terminal disease. For a patient to obtain the prescription he or she must: 1) make two oral requests and one written request within no less than 15 days and 2) have two witnesses present during the signing of such a request.

The physician must also meet a number of requirements in order to prescribe a dose of lethal medication in compliance with the act. He or she must: 1) make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily, 2) inform the patient of his or her diagnosis, prognosis, the potential risks involved in taking the medication, the probable outcome of taking the medication, and the feasible alternatives to PAS. Then the physician is required to 3) refer the patient to a consulting physician for confirmation of the diagnosis, 4) refer the patient to counseling if necessary, 5) recommend that the patient notify next of kin, 6) verify that the patient qualifies under provisions of the law and has completed the necessary documentation, 7) dispense the medication personally or deliver the request to a pharmacist, and lastly 8) file a copy of the dispensing record to the Oregon Department of Human Services. This department is held responsible for keeping records concerning PAS and releasing an annual report.

To further understand the Oregon law we must first consider the difference between PAS and what is referred to as Euthanasia. Euthanasia is defined as the act of intentionally and painlessly causing the death of a person suffering from a disease. It can also be described as a "mercy killing." While PAS may be considered a form of voluntary active euthanasia, in this context PAS differs in that the patient is directly causing his or her own death. The physician is acting only to prescribe the medication.

The law requires that the patient take the drugs on his or her own, and in most cases, without the physician present. In the context of the law, euthanasia is defined as the death of a patient caused directly by a second party (in this case, the doctor). Oregon law strictly prohibits euthanasia, mercy killing, and lethal injection.

The idea of physician-assisted suicide raises many bioethical questions for both the patient and the attending physician. Does a patient have the right to determine whether he or she dies? What is considered a terminal illness? When can doctors be sure of their diagnosis or prognosis? A previous study of Oregon physicians has shown that half of the participants were unsure in their ability to predict that a patient had less than six months to live. Furthermore, several studies have shown that primary care physicians overlook clinical depression about 50 percent of the time. This raises the question: when can a physician be sure that a patient is capable of making such a decision? How long should a physician know a patient before feeling confident that the patient is making a competent and informed decision? If a doctor's role is to heal, then when is harming a patient in this way permissible and can assisting in the death of a patient who wants to die be considered "harm"? How can we avoid the slippery slope argument that surrounds the legalization of PAS?

Description of Project

With little answers to these questions, the debate over the legalization of physician-assisted suicide continues. Several states have experimented with similar legislation to the Death with Dignity Act, yet to this date the only state where PAS remains legal is Oregon. As students of medicine, it is important to observe and

understand how the act is working in Oregon and the attitudes of physicians and patients towards PAS in a state where such an idea has become a reality.

This project with be an attempt to provide answers to some of these questions. In order to do this I plan on spending a portion of my summer in Oregon studying how the DWDA works by examining the views of physicians, bio-ethicists, and medical students who have experience the legalization of PAS in their state. I will compare and contrast the opinions of Oregonians to how Kansas physicians and medical students view the issue. I feel that it is especially important to understand the beliefs of medical students towards PAS. They are the physicians of the future and will ultimately decide the fate of PAS and the DWDA. While there have been several studies concerning the beliefs of physicians in Oregon as well as nationwide, no study to date has observed the views the next generation of physicians towards PAS. This study will examine the opinions of a younger and possibly more liberal generation in an effort to predict future changes in attitudes towards PAS.

Lastly, I would like to further explore how this legislation came to pass and speak to several groups that were involved in the passing of the Death with Dignity Act. If this law is working in Oregon, then it is important that other states examine their own policies towards PAS. Throughout the course of this project I will do a great amount of research on PAS with the ultimate goal being to propose an argument for and against the passing of such legislature in other states, especially Kansas.

Methods

In order to complete this project I will travel to Oregon in early June. Once in Oregon I will meet with faculty at Oregon Health and Science University and plan

several meetings where I can interview different faculty members. I will also distribute a survey to 200 Oregon physicians through the mail and a similar survey to the medical students of OHSU through email. This same survey will be sent to 200 Kansas physicians through the mail and the medical students at KUMC through email. I will aim for a response rate of about 70%. Once the data has been collected I will analyze this data using SSPS for Windows and compare Oregonian views with those of Kansans.

The second part of this project will involve a more subjective approach to PAS and the legislation behind the Death with Dignity Act. I will travel to Eugene, OR. In Eugene I will meet with the Hemlock Society, a group that has been very influential in the passing of the DWDA, and speak with them about their views and opinions. I will then travel to Salem, Oregon where I will meet with several other groups that have been influential in the passing of this bill. Lastly, I plan on spending about a month collecting data and doing research on PAS in order to produce a complete argument for and against PAS and whether or not the DWDA is something that should be passed in other states.

Timeline

May- Send Survey to Kansas Physicians and Medical Students
June 4 - Leave for Portland, Oregon
June 8 - Arrive in Portland, Oregon
June 9 - Meet with OHSU faculty
June 10 - Distribute Survey to Oregon Physicians and Medical Students
June 14 to 24 - Speak with bioethicists and physicians around Portland Area
June 28- Leave for Eugene, Oregon
June 28 to July 1 - Meet with Hemlock Society.
July 5 to July 7- Travel to Salem, Oregon
July 8 to 29 - Collect and analyze Kansas and Oregon data
July 30th- Leave for Kansas City

Goals

1.) To explore in detail how both Oregon physicians and medical students view PAS and the DWDA and compare and contrast that with the views of Kansas physicians and medical students.

2.) To explore the opinions of several bio-ethicists in both states in order to further dissect the arguments for and against PAS.

3.) To understand how the Death with Dignity act came to pass in Oregon, and what types of events have to happen in order for such an act to be passed in Kansas.

4.) To provide grounds for an argument on whether other states should pass the act and suggest future studies that might be necessary to insure that the legalization PAS is both effective and ethical.

5) To enhance my knowledge of physician-assisted suicide in order for me to make an educated stance either for or against it as a physician.

Budget

Travel to Portland and Eugene, OR	$500
2 months rent in Portland	$650
Survey expenses	$200
Food	$350
Miscellaneous Expenses	$250
Total	$1950

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Healing Touch:

Manifestations of the Doctor-Patient Relationship in Western Medicine Physicians and Costa Rican Curanderas

Clendening Fellowship Proposal
February 14, 2005

Submitted by: Brian Hollenbeck

Submitted to: Dr. Montello, Director of the Clendening Summer Fellowship Program
Department of History and Philosophy of Medicine

Rationale

Arthur Kleinman, a medical historian, wrote that western medicine is, "like all forms of medicine… an institution that over time develops its own unique form and trajectory." I believe that this trajectory has evolved, in part, to treat illness as pathology and as an entity that is often divorced from the patient's understanding of his or her condition. As such, it is often necessary for a western physician to balance the task of treating pathology with the less tangible responsibilities of relaying information to the patient and providing moral support. Indeed, with the mounting evidence of how depression and stress can affect health outcomes, the absolute necessity of patient involvement, enthusiasm, and trust in the healing process becomes increasingly obvious.

This trajectory that western medicine has taken stands in stark contrast to many indigenous non-western medical traditions, which emphasize (quite often with success) spiritual healing and plant remedies. These indigenous medical traditions tend to be locally based, and as a result are laden with the local population's culture, expectations, and understandings. In contrast, western medicine has spread its wings to encompass almost all parts of the world, and a large spectrum of cultures. It is not uncommon, in Kansas or anywhere else, to find patients who do not share the same agenda or beliefs as western medicine supplies. As an example in Kansas, any devoutly religious patient would find it unacceptable not to pray for their healing. By contrast, western medicine focuses on treating tangible pathology and, by definition of the trajectory it has taken, dismisses the need for such divine intervention. I do not mean to infer that religion and western medicine cannot co-exist (they often do), but rather that the methodology western medicine employs is based on measurable observations rather than spiritual enlightenment. One consequence of the dichotomy between western medicine's quest to conquer pathology and the socio-cultural understanding of many patients is the overwhelming emphasis and evaluation of the physician-patient relationship.

As a physician-in-training, I can attest that the importance of this relationship has been emphasized from the very first few hours in the lecture hall. We are conditioned and prepared for an endless amount of potential situations. We are given scenarios with no obvious right answer and we mull over what is the most ethical and appropriate course

of action. We practice our interactions with simulated patients long before we know what we are talking about clinically.

It is also part of my medical education to shadow practicing physicians. In doing so, I have observed how several doctors attempt to bridge the gap between their western medical training and their patient's expectations. Kleinman refers to these unique colloquial practices as the "indigenization of biomedicine." One country doctor I've shadowed has traded his white coat and tie for blue jeans and flannel shirts. He jokes freely with his patients and shares hunting stories. I have asked some of his patients why they always come back to him, and they tell me they return because he makes them feel comfortable; to his patients, he feels like one of their friends. While this approach works for one country doctor, it surely would not be as effective in an urban setting. Another doctor that I have observed offers silent prayer to his patients after each visit. At first I was surprised by this practice, but soon I saw that most patients are grateful for the offer, and even very secular patients don't get offended. His offering of silent prayer in a non-judgmental manner expresses to patients his desire to extend treatment past pure management of pathology. Both of these physicians have found ways to take western medicine beyond hard science and into the cultural paradigm of their patients.

Objectives

I propose this Clendening Fellowship as a supplement to my continuing medical education. The physician-patient relationship--as it is academically discussed-- fascinates me because of its uniqueness to western medicine.

In this proposal, I will travel to Costa Rica to interview and shadow an indigenous healer from the Boruca tribe. I will analyze how she relates to her patients in hopes of finding similarities and differences between the indigenous and western doctor-patient relationships. I will compare my findings of the indigenous "healer-patient" relationship with the indigenous medical tradition. These findings will be juxtaposed with what I learn about the western doctor-patient relationship and how it relates to the western medical trajectory. The comparisons I make will ultimately elucidate how the "trajectory" of a given medical tradition can help sculpt a particular physician-patient or healer-patient relationship.

Additionally, I will shadow and interview a physician practicing medicine in a Costa Rica. I will compare this vignette of the Costa Rican doctor-patient relationship with my past and future experiences shadowing American doctors. The summation of these findings, outside research, and my education at KUMC will be used to define the western physician-patient relationship for this project. Finally, I will be taking a medical Spanish class to help me overcome the language barrier that remains, and to prepare me for a future medical practice abroad and at home.

By doing this project, I will be gaining more knowledge about myself and future medical practice than is implicit in the objectives of the proposal. It has always been a goal of mine to practice medicine in an underserved developing nation. This project will give me the opportunity to view the day to day life of a physician in a developing country. Furthermore, I am ultimately in medical school because I have a desire to know and treat pathology. The indigenous medicine aspects of this project will help me to keep in mind the important role of cultural sensitivity in my future medical practice.

Methodology

I have spent six months in southern Costa Rica previously, and am able to speak Spanish fairly well. During my time there, I took a class in medical anthropology. As part of this class I interviewed the indigenous healer that I plan on visiting in this project. During my last stay there, I found the indigenous town of Boruca to be very welcoming and safe for American visitors. In the two years since I lived in Costa Rica, I have remained in contact with my medical anthropology professor, and she has helped me to organize the logistics of a stay in Boruca. Isabel, the Borucan curandera, has permitted me an interview and I found during my previous visit that she was very conversant and accommodating to the minor language barrier that persists. I will stay in Boruca in the small inn located there (5$ / night) or, preferably, with a local family (also ~5$ / night). It is not possible to know whether or not a family will have room for me until I arrive, but with the available inn (which never fills except during a festival in February), accommodations are secure. Everywhere in Boruca is within a 10 minute walk, so transportation within the village will not be necessary.

Upon arrival in Costa Rica, before going to Boruca, I will attend a three week medical Spanish class at the Institute for Spanish Language Studies in Turrialba, Costa Rica. This class will pair me with a physician in the local hospital in a specialty of my choosing (internal medicine). They will also provide me with additional hospital volunteer opportunities, should I feel that this would be helpful to my project. I have checked into legitimacy of the class (too often an issue in Latin America, unfortunately) and have found that it is reputable and accepted for credit at a number of American medical schools, including Colorado, Texas, Michigan State, New Jersey, Tennessee, and Mount Saini. I will be living with a host family during this stay for a price that is included in the cost of the medical Spanish program. Within the village, I will be able to get everywhere on foot. The bus system (with which I am familiar) will be used for transportation to and from the airport, and from Turrialba to Boruca.

My interviews of both the indigenous curandera and the physician will focus on uncovering the healer-patient relationship from their perspectives. Some questions I ask will be specific to either the curandera or the physician; however, I also hope to ask a set of the same questions to both people and compare their separate interpretations. This question set will shed light on their relationship with patients and also the framework of medicine within which they practice. Some potential questions that might be asked are:

- What level of knowledge do your patients have about their illness?
- What level of knowledge do your patients have about their treatment?
- Do you discuss options for treatment with you patients and allow them to participate in their treatment decisions?
- What do you do to handle patients who are skeptical about your treatments?
- Do your patients use pharmaceuticals or herbal medicines without your recommendation?
    - If so, which of the two seems to be used more commonly?
- Would you say or do anything differently if you were treating me (an American) than you would if you were treating someone from your village?
- To what extent do you utilize diagnostic tests or methods to help give patients confidence in their treatment?
- How far do patients travel to see you? Do you travel to see patients?
- Do you ever have to calm patients because they are uncomfortable with your treatment?
    - How do you calm patients that are uncomfortable with your treatment?
- Do you interact the same with children, adults, and elderly when treating them?

Obviously these are only a few potential questions that could be asked. Observations of the physician and curandera's interactions with patients will also provide insightful information into each healer's approach to the healer-patient relationship.

Timeline

I am continually gathering information for this project through my preceptor visits, my classes at KUMC, and individual research on both the physician-patient relationship and Boruca culture. As such, I should have a good foundation of information for this project when I depart for Costa Rica in the first week of June. Upon arrival, I will travel to the town of Turrialba. Here I will take a three week medical Spanish class and shadow a physician in the local hospital. After three weeks in Turrialba, I will travel to the indigenous town of Boruca for a week-long stay. This week should be sufficient to observe and interview Isabel, and get a feel for their culture. In all, I will be in Costa Rica for four weeks: three in Turrialba and one in Boruca. I have chosen to divide my time unevenly between the two parts of this program for several reasons. I want to get a solid foundation in medical Spanish, and feel that my level of Spanish could benefit from three weeks of class instead of two. Also, the Turrialba program better prepares me for the specific challenges that I may face as a physician practicing in a developing country.

Conclusion

My favorite aspect of defining the western doctor-patient relationship as a "trajectory" is that it implies past and future adaptation. This adaptation has historically been dependent on social climate and scientific understanding. Because recent scientific understanding shows us that patient moral and mental well-being can significantly influence health outcome, the western medicine trajectory is currently veering towards better accommodation of patient's wishes and needs. I believe the doctor-patient relationship plays a critical role in this process. By doing this project I hope to learn for myself and share with my classmates how this adaptation has occurred thus far, and where it can go in the future.

Budget

Plane ticket (on Travelocity)	$683
Bus tickets	$100
Accommodations in Boruca	$35
Food in Boruca $10/ day x 7 day	$70
3 wk Spanish Class, home stay, food	$1,325
Other (including gifts for host families)	$150
Total.....	**$2,363***

* That which is not covered by the Clendening fellowship will be paid for out of my pocket.

Bibliography and Contacts:

Contact for Medical Spanish Class and for shadowing the Costa Rican Physician:
Marjo or Dana Garrison
ISLS
http://www.isls.com/schools/medicalspanish.html

My past professor who has contact with the Isabel, the Borucan Curandera:
Natalia Carrillo-Padilla

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Educating for Change: The Impact of HIV/AIDS in George Compound, Lusaka, Zambia

Clendening Summer Fellowship
Proposal
February 2005

Beth Lawson Loney

Beth Lawson Loney
Clendening Fellowship
Research Proposal
February 2005

BACKGROUND:

Global

Twenty years after the appearance of HIV/AIDS, it continues to be a major cause of death on the world stage. There are 39.4 million persons worldwide living with HIV/AIDS, and it is estimated that AIDS kills more than 8,000 people every day, or one person every 10 seconds (WHO, 2004). HIV/AIDS has truly become a worldwi de disease, and is an example of an "equal-opportunity" infection.

The death toll is astounding. Since the beginning of the AIDS epidemic, 30 million people have died of AIDS, and more than 14 million children have lost one or both parents to AIDS. Of the three million people that die of AIDS year ly, 500,000 are children under the age of 15. Even those the disease is horrific, it is preventable. Unsafe sex is still the predominant mode of transmission accounting for 80-90% of infections (WHO, 2004). This statistic shows that education and availability of condoms is imperative in trying to stifle the spread of this disease. Some treatments are available after infection, but availability is sorely lacking. Nearly 6 million people in developing countries are infected with HIV and urgently need antiretroviral treatment to keep them alive (WHO, 2004). To this end, in December of 2003, WHO unveiled its "3 by 5" initiative, which aims to provide antiretroviral treatment to 3 million people with AIDS by 2005 (WHO, 2003).

Sub-Saharan Africa

The burden of this disease geographically is not equal. In this area of the world, it is estimated that 25.4 million adults and children are living with HIV, and the adult prevalence rate is 7.4% (for comparison, the rate is 0.6% in North America). It is estimated that in 2003 around 2.2 million persons died in Sub-Saharan Africa from HIV/AIDS, and around 3 million new persons were infected (WHO, 2004). Surprisingly, given the prevalence of the disease, world efforts in AIDS relief have not been directed to the area. Although sub-Saharan Africa has two-thirds of the world's HIV infections and 84% of its AIDS deaths, the region accounts for just 3% of global AIDS spending (FHI, 2004). Resources for education, prevention and treatment must be allotted to this region to aide in prevention of further spread of the disease and suffering of those living with this disease in this part of the world.

Zambia

As stated above, the disease bur den is concentrated within certain areas. There are varying levels of infection within Africa, but Zambia continuously ranks high on the

list of infected populations. With a population of approximately 10 million people, Zambia has an estimated 1.1 million people with HIV/AIDS (WHO, 2003). HIV prevalence in Zambia is 17.8% in females and 13% in males, thus yielding an adult HIV prevalence of 16%. Even within one country, the infection rate varies. The urban prevalence of 23.1% is double that in rural areas. Again, treatment is not widely available. In 2004 the Central Statistics Office of UNAIDS estimated that 775,080 adults and 90,218 children in Zambia are infected with HIV, and only 5,586 of these persons are on antiretroviral therapy (Office, 2004). Accordingly, the death toll is awful. One estimate is that 1.656 million children, or more than one-third of those under the age of 15, are orphans who have lost one or both parents. Due to these facts, Zambia has been deemed the most orphaned country in the world. Between 1996 and 1998, there was a national increase of over fifteen percent in the number of orphans. (Kelly, 2000) As a result of the AIDS epidemic, life expectancy in Zambia has dropped from 56 to 37 years (Kabsuwe, 2000).

Despite these bleak figures, there are some working to prevent the disease and help its victims. Zambia is attempting to aid with education and dissemination of information regarding HIV/AIDS, and on December 1, 2003, the government, churches, and charity organizations stationed there launched a nationwide HIV/AIDS telephone hotline that is run 24 hours a day to provide anonymous answers to questions and to aide persons in finding local resources (Zambia, 2003). Zambia has also begun a campaign funded by the U.S. Agency for International Development (USAID) known as the HEART campaign (Helping Each Other Act Responsibly Together). This campaign was designed with collaboration from young adults in Zambia to increase impact. The catch-phrase is "Abstinence. *Ili che*," or abstinence is cool. The program is targeted specifically for youth 15-19, and uses dramas and mobile video units in rural areas. The program has reportedly worked, with viewers of the campaign more likely to report abstinence or condom use than non-viewers. Former Zambian President Dr. Kenneth Kaunda has appeared in a series of TV and radio spots promoting HIV/AIDS awareness, abstinence, mutual fidelity, condom use, compassion for HIV positive people, and voluntary counseling and testing. (Making, 2003).

Lusaka and George

Lusaka, the capital of Zambia, was planned to be a garden city for British and South African settlers. Africans were considered only temporary workers in the town. Therefore, they were only provided with temporary housing, and employers arranged with land-owners for workers to be allowed to build their own huts in so-called compounds. These compounds were the basis on which squatter settlements, such as George, later developed. The growth of squatter settlements increased because the land-owners, often absentee and not living in the country, did not protect their land. George developed outside of the city boundaries in this way. George was incorporated into the city of Lusaka in 1970 (Schylter, et al. 1980).

Here again the burden of the disease is great. It is estimated that HIV adult prevalence in Lusaka is 23%. However, there is hope, as prevention campaigns show

some efficacy. A declining trend of prevalence is being seen in 15-19 year olds in Lusaka, with HIV infection dropping from 28% in 1993 to 15% in 1998 as a result of heavy education campaign occurring in urban areas (Family Health International, 2003). However, the situation is compounded by poverty and low levels of education. According to the 1990 census, in George 40,000 in the older parts of the community live in poverty. Total there are about double that number if adjacent areas of the community are also included. Less than half of the boys and less than a third of the girls attend school (Schlyter, 2003). Where HIV/AIDS education in most parts of the world is conducted widely in schools, this is not an option in this area where most families cannot afford to send their children to school. Due to this, other avenues of communication and widespread dissemination of information must be found.

Our project will be focused in this community. Within the George Compound, efforts are being made at a government clinic run by the Lusaka District Health Management Board. Contact with Pastor Joseph Malamba, a local pastor who also runs the La Espranza Orphan Ministry based out of his church in George has been made, and approval has been gained for us to spend time at the clinic. A second contact is Dr. Garth Myers, professor of Geography at the University of Kansas, who made this opportunity known to the potential fellows. He has conducted research in Zambia for several years and had direct contact with Pastor Malamba. These people have ensured contact with a Director of International Outreach at the Chainama Hills College of Health, John Mudenda, and with Bernadette Mumba, MPH, the Provential Health Officer for Lusaka. Through discussion with these officials in the country I hope to gain an idea of the perceived barriers to HIV/AIDS education and to the practice of safe sex in the Lusaka area. Through speaking with Pastor Malamba, a long-time resident of George, and his colleagues, I hope to gain insight to the living conditions and beliefs regarding sex and HIV/AIDS of persons living there. Most importantly, through interviews conducted with persons living with HIV/AIDS, who attend the George Clinic and churches of Pastor Malamba and his colleagues, I hope to learn their beliefs regarding the disease, how they contracted the disease, perceptions of treatment, and treatment they are currently receiving. In addition, I would like to discuss their perceptions of the education efforts regarding HIV/AIDS, their opinions regarding efficacy of the programs, and how the disease has impacted their lives.

MOTIVATIONS AND GOALS:

I have had an interest in HIV/AIDS and international efforts to stop the spread of this disease for many years. I began my high school and college career doing genetic research, much of which involved sequencing the bacterial and viral genomes of human infectious diseases. Breakthroughs in HIV/AIDS research were being made at an extraordinary pace at this time, and it was impossible to be in this field and not read about these new discoveries daily. I found the disease fascinating in its complexity, and seriousness as a truly a global disease, sparing no portion of the world. It was during my first two years of college that I also realized I did not want to spend my life in a lab, but had a drive to directly touch the lives of others through the health care field. I decided to

apply to nursing school, and the training I received served to further my desire to help not only those in my community but those in other parts of the world. I had the great opportunity to work in an HIV clinic in Kansas City while in nursing school as part of my rotations, and this experience increased my understanding of the disease and the effect it has on those living with it. After practicing as a nurse for a period of time, I realized I had the desire to return to medical school. Since realizing this, I have also known that I want to spend part of my time practicing in other countries, both to help those in other parts of the world and to aide in my growth as a person and a practitioner.

As a medical student I have had the opportunity to become a part of the Dramatic AIDS Education Project (DAEP) sponsored by KUMC, UMKC and the Coterie Theatre. I auditioned for this project and have since been trained as an AIDS peer educator. The other educators and I travel to schools in Kansas City and surrounding areas educating eighth through twelfth graders on HIV/AIDS through dramatic presentations and structured question and answer sessions. When this opportunity to travel to another country and use my interest and education relating to HIV/AIDS presented itself it felt like a perfect fit. I could think of no better way to spend a summer, giving to others and also learning so much myself. As a nurse I bring the experience of relating to people of varied backgrounds, of communicating one-on-one as a source of support and education, and of training in community health. A colleague of mine, Mike Oller, is also proposing a project to coincide with mine. Mike is a Master's of Public Health and also a member of DAEP.

Pastor Mulamba has had contact with people in the Kansas City area through Dr. Myers and others. He is very interested in DAEP and this project and feels a similar project could do very well in George. My goal for my time in Zambia will be to speak with health officials regarding what has been done in the area of AIDS education and how these efforts have fared. I also will make contacts through Pastor Mulamba with other pastors in the area, and have an opportunity to speak with leaders in the church community in George regarding the ideas and beliefs of persons living there regarding sex and HIV/AIDS. Finally, I wish to interview persons living with HIV/AIDS in George. My plan is to use tape recordings, with the permission of the subjects, to preserve these interviews. Mike is proposing an independent project that would coincide with mine, and he will be compiling a documentary-type video to be shown at this institution, a video record of how AIDS is affecting other countries. He will be documenting what we have experienced and the toll AIDS is taking in the George Compound. This will be done primarily in churches and the clinic in George. The compilation of our research will yield information on the daily life of those in George, what needs to be done to aid in education on HIV/AIDS, and how it is affecting those who live in George. The information will then be taken to a playwright associated with DAEP to produce a scene pertinent to youth in George, similar to those scenes we enact for youth in Kansas City.

Pastor Joseph has also asked for us to speak at a high level sensitization workshop for church leaders, such as pastors, reverends, bishops, and others, and community leaders, such as politicians, school teachers, civic leaders, medical

practitioners, traditional rulers, and others, on the effects, prevention, and control of the HIV/AIDS pandemic throughout the world and specifically in Zambia. He has also asked us to provide a course in AIDS peer education at the George Clinic. Mike and I would be working prior to the trip to compile information that we could present at these events and leave to aid with the training of AIDS peer educators. We hope to work with Dr. Chris Moranetz and Dr. Donna Sweet to create an effective HIV/AIDS education workshop, and to aide with my interview questions and techniques.

METHODS:

Four weeks will be spent in the compound of George in Lusaka, Zambia. Pastor Joseph Malamba will be our primary contact in George. Pastor Joseph Malamba runs the La Espranza Orphan Ministry based at a church in George. Dr. Garth Myer, professor of Geography and Director of Graduate Studies in the Department of African and African-American studies will be another primary contact. Research in the form of interviews and personal experience will be done in the four weeks in Zambia, but research and compilation of material to aid in education will be done in the month prior to leaving for Zambia. Following return from Zambia compilation of information will be done between Mike Oller and myself, and pertinent information and experiences will be communicated to the playwright to aid in the production of a scene to be used for education in George.

Once willing participants are found, I will be using a form of interviewing known as elite interviewing, where conversation is largely free-flow and questions are not all pre-planned. Elite interviewing is used when an individual has knowledge about the subject of study that is unique, requiring them to be given special, individualized attention. Any validity concerns can be compensated by never relying on a single respondent. Techniques are having a private interview, away from distractions and interruptions, interviewing one person at a time, and keeping the tone of the interview calm and reflective. Initial questions are planned, but much of the rest of the interview is allowed to flow with redirection as needed (Aberback, et al). This seems to be the most pertinent type of interviewing to be used with HIV/AIDS patients to allow me to get a true feel for how this disease has affected their lives. Initial questions I plan to ask include:

- When were you diagnosed with HIV/AIDS?
- Do you know how you contracted the disease?
- What prompted you to be tested?
- What treatment are you currently receiving?
- What education had you received, prior to contracting HIV/AIDS, regarding the virus?
- What do you see as educational method that do and do not work regarding this disease?
- Describe to me that progression your disease has taken since diagnosis, and how this has affected your life.

When taken together, Mike and my research will be able to provide a glimpse for persons living in the Kansas City area of the experience of HIV/AIDS in other countries.

It will also allow us to send something back to Pastor Malamba and other leaders in the George area to allow them, if implemented, to begin a program of peer education similar to DAEP.

ENVIRONMENT:

The Republic of Zambia is a land-locked country situated in central portion of the Southern Horn of the African continent. There are an estimated 10.9 million Zambians, and compared to neighboring African countries Zambia has a higher proportion of its citizens in urban centers. Mike and I will be doing our primary work in the settlement of George, a satellite community of Lusaka. Personal contacts have been made in both Lusaka, and George, as well as in the United States regarding the urban geography of the working environment. While most of the work will occur in George, Mike and I will live on the north-central or north-east portions of Lusaka. Temporary residence will be on the north-east corner of Lusaka at a boarding house near the University of Lusaka. This housing is only to be used until arrangements can be made to move to the north-central part of Lusaka. This move will be made with suggestions from contacts in country, and allow us to be closer to George, the primary work environment, while maintaining a level of required safety.

The Republic of Zambia is host to wide variety of cultures. The country speaks nearly seventy indigenous languages, although English is considered the official language. Eighty-four percent of citizens are of Protestant faith, 35 percent are Hindu, and 26% are Catholic. The currency is the Kwacha and currently trades at approximately 4800:1 on the dollar. The literacy rate is just over three-fourths. The average Zambian carries a life-expectancy of 37 years and the country has an infant mortality rate of 91.9 per 1,000 births.

TIME FRAME:

June 29th-July 31st 2005
Approximate time spent in country: 4 weeks

BUDGET:

Airfare:	$1200-$1800
(Round Trip from Kansas City to New York, & New York to Lusaka)	
Vaccinations:	~$190
Food:	~$330 ($10/day)
Room:	~$495 ($15/day)
Extra Travel:	~$250
Contingency:	~$500
Total:	~$2965-$3565

-expenses not covered by the fellowship will be paid out of pocket-

PROBLEMS AND BOUNDARIES:

Language may or may not present itself as a barrier. As mentioned above, the primary language is English. Effort will be made to find participants for interviews who do speak English so that an interpreter will not have to be used.

A great difference in culture will be a possible boundary to understanding those living in George. A meeting has already been conducted and further meetings are planned with Dr. Myers who has spent much time researching in the Lusaka area. This will assist in preparation for research conducted in an alternate culture, and for understanding of conditions found in George. Upon arrival to Lusaka we will be met by Pastor Malamba, who can further aid us in making the adjustment to a different culture. Communication with Pastor Joseph via email will continue to be made prior to our arrival to ensure understanding of what research goals will be in George, and to further establish what our roles will be.

A time frame of four weeks may also present problems. I will not be able to interview as many patients as I wish, and must work to make the interviews I do conduct as thorough as possible. It will also be difficult to get a feel of the culture in only a month, but with the help of contacts who are leaders within the community many barriers to open discussion with those in the community should be broken.

FINAL PRODUCTS:

During my stay in Zambia I plan to conduct interviews with health officials, community leaders and HIV/AIDS patients to put together the most comprehensive picture possible of the education efforts and successes occurring in Lusaka, and specifically in George. The compilation of my interviews with Mike's film and personal experience will help us to compile pertinent information to send back to George to aid with peer education and the production of a dramatic scene.

The opportunity to educate others while in George has also been presented. Mike and I will be able to use the training and education we have regarding HIV/AIDS and peer education to provide educational programs while in George at the request of Pastor Mulamba. This will allow information to be presented and left so that similar education can be continued after our departure.

Overall, I feel I will have gained an invaluable experience, allowing me to immerse myself in a culture so different from my own. I also feel I will be able to not only experience and learn for my own curiosity, but also use the knowledge I glean to aide in education of those who will be teaching me through their personal experience. I also feel it important that I will be able to bring back my experiences and share them with fellow medical students and faculty.

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Zambia Launches Free HIV Telephone Advice Line to Respond to Growing Need for Accurate Information in Confidential Setting; Hopkins CCP Helps Implement New Hotline. www.jhuccp.org/pressroom/2003/12-03.shtml

On-Line Resources:

www.emro.who.int/asd/pdf/inserts%20english.pdf
www.who.org

Contacts:

Judith Reagan
Director of International Programs, University of Kansas Medical Center

Garth Myers
Director of Graduate Studies for the Department of African and African-American Studies, University of Kansas.

Joseph Malamba
Pastor, and co-founder of Laesparanza Orphanage Ministry

John Mudenda
Head of International Outreach, Chainama Hills College of Health

Bernadette Mumba
Provential Health Officer for Lusaka, Zambia

Recording the Health of George: A Video Documentary

Clendening Summer Fellowship Proposal

Michael Oller

BACKGROUND:

World:

Since its discovery, HIV/AIDS has claimed an estimated 30 million people. It kills its victims at a devastating velocity of 1 person every 10 seconds; 8,000 people every day; 3 million people per year. HIV/AIDS like other sexually transmitted infections is one-hundred percent preventable through the use of abstinence, unfortunately unsafe or unprotected sex is still the leading cause of transmission. And with nearly 40 million people living with HIV/AIDS right now, it seems that HIV has secured its future. (WHO)

Africa:

Africa, the theoretical home of HIV, bears witness to awesome lethality of HIV. Nearly 25.5 million people, adults and children, are currently infected and in 2003 it is estimated that for every two deaths caused by HIV/AIDS complications three people were infected.
The lack of education and access to antiretroviral medications has been proposed as the leading reasons why Africa is under a disproportionate siege by HIV. (Highlights)

Zambia:

Approximately 1 out of every 10 Zambians is infected with HIV. The prevalence in females is 17.8% and 13% in males, while the urban prevalence is 23 percent—double that of the rural areas. (WHO) In 2004 the Central Statistics Office of UNAIDS estimated 775,080 adults and 90,218 children infected with HIV, only 5,586 persons on antiretroviral therapy. (Office) One estimate is that 1.656 million children, or more than one-third of those under the age of 15, are orphans who have lost one or both parents. Zambia has been deemed the most orphaned country in the world. During the late 1990's there was a national increase of over 15 percent in the number of orphans. (Kelly) Apart from orphans there are also 75,000 to 90,000 street children who are very vulnerable. (Kabsuwe) Zambia is attempting to aid with education and dissemination of information and on December 1, 2003 launched a nation wide HIV/AIDS telephone hotline. (Zambia)

George:

It is estimated that HIV adult prevalence in Lusaka is 23%. A declining trend of prevalence is being seen in 15-

19 year olds in Lusaka, with HIV infection dropping from 28% in 1993 to 15% in 1998 (Family Health International). Lusaka was planned to be a garden city for British and South African settlers. Africans were considered only temporary workers in the town. Therefore, they were only provided with temporary housing, and employers arranged with land-owners for workers to be allowed to build their own huts in so-called compounds. These compounds were what squatter settlements, such as George, later developed. The growth of squatter settlements was enabled by the land-owners not protecting their land, as they were often absentee landlords not living in the country. George developed outside of the city boundaries in this way. George was incorporated into the city of Lusaka in 1970 (Schlyter, et al). According to the 1990 census, George has a poor population of 40,000 in the old parts and about double if adjacent areas are included. Less than half of the boys and less than a third of the girls attend school.

MOTIVATIONS AND GOALS:

There was a time, not to long ago, that I wanted to live my life as a physician who worked with children, specifically those with disabilities. I worked a number of summers at a camp for children and adults with disabilities, and it was my hope that one day I could give back to the people who helped shape my life. Following my final summer I pursued my Masters in Public Health. It was during my study of public health that I discovered the knowledge and virtues that will ultimately define my life. And now, while studying Medicine I have learned that one day I will have all the mental tools to heal individuals, villages, states, and maybe countries. Hitherto, my knowledge and experience have been derived from books, and that alone is not enough to teach. I need real-world, hands on, first-hand experience.

Africa is the defining realm of inadequate healthcare. Most of the tribulations that I will face as a physician exist and thrive in Africa: poverty, disease, health disparity, and social stratification. Since the discovery of HIV Africa has carried the lion's share of the disease. Industrialized nations have dealt with, and even managed to control HIV/AIDS, but not Africa. The reality of HIV/AIDS has faded. Once a mighty virus with the ability to rival early twentieth-century influenza for the title of "Doom's Day Bug," HIV/AIDS has been socially quarantined to Africa

and south-east Asia. People accept that the poor and meek in the world must bear the burden of disease and healthcare inadequacy, but they too often forget about these people. Casting them under the bed, in the closet, over the balcony. These people are forgotten, their lives not recorded.

I choose not to forget. This summer I hope to accompany Beth Loney to the Republic of Zambia to live for a month in the northern part of Lusaka, near the squatter settlement of George. The settlement currently houses ancestors of rural Zambians who moved to the urban center to find work; in addition to a wide variety of health-related problems. We will focus specifically on HIV/AIDS. Together Beth and I will provide educational workshops for local clerical and civil leaders. We will assist in functions of the Laesperanza Orphanage and will have the opportunity to see patients in various clinics. While I will be assisting Beth in her project—the collection of statements from HIV affected or afflicted people with the hope of creating a peer education program similar to the Dramatic Aids Education Project here in Kansas City—my project will focus on the creation of a video documentation of life in George, with a primary focus on HIV/AIDS. I believe that this record will serve as a source of inspiration for me and other future physicians at the University of Kansas Medical Center. I hope that it will constantly remind us that our pursuits in healthcare are eternal and without borders. I hope that this document will never allow us to forget.

METHODS:

Beth and I heard about the Zambian opportunity through Judith Reagan. Judith received the information from Garth Myers, who in turn was asked by Pastor Joseph Malamba for the opportunity to have two medical students spend a month in Zambia working on various projects. Pastor Malamba informed us that the Laespranza Orphan Ministry (LOM) will be organizing a high level education workshop for church leaders and community leaders on the effects, prevention and control of HIV/AIDS. He feels that we could assist, and possibly run the workshops for the first two weeks. He also informed us that the LOM is looking to do peer education in George. In his first correspondence, Pastor Malamba suggested that we do peer education, in addition to

the workshops. Beth and I are planning on doing the workshops, as well as peer education; however, we will also be gathering information to help construct a self-sustaining peer education program for the LOM. In addition to Pastor Malamba, we will also be working in country with Bernadette Mumba, the Provential Health Office of Lusaka and John Mudenda, the head of International Outreach at Chainama Hills College of Health in Lusaka. We have also contacted the Peace Corps to obtain the names of local volunteers to help ease with cultural transition.

During the month of June we plan to work with members of the Dramatic Aids Education Project to construct a standard interview that will provide enough information for the construction of scripts by the playwrights once return. We hope to work with Dr. Chris Moranetz and Dr. Donna Sweet to create an effective HIV/AIDS education workshop. While Beth and I will work together on workshops and peer education seminars, she will primarily focus on interview collection, while I will primarily focus on video documentation.

I plan to collect video and photographic records of life in George as it relates to relative health of the compound, with a specific focus on HIV/AIDS. I plan on taking my personal digital camera and digital camcorder to record life in George. When I return in August I plan on working closely with KUMC Instructional Support Technicians to help me compile the video records into what I hope will be a long lasting tribute to healthcare at KUMC.

ENVIRONMENT:

The Republic of Zambia is a land-locked country situated in central portion of the Southern Horn of the African continent. There are an estimated 10.9 million Zambians, and compared to neighboring African countries has a higher proportion of its citizens in urban centers. Of these, the capital of Lusaka is of the most interest. The Clendening fellow will be doing a significant amount of work and learning in the settlement of George, an impoverished, satellite community of Lusaka. Personal contacts have been made in both Lusaka, and George, as well as in the United States regarding the urban geography of the working environment. While most of the work will occur in George, the fellow will probably live on the north-central or north-east portions of Lusaka. Temporary

residence will be on the north-east corner of Lusaka. This housing is only to be used until arrangements can be made to move to the north-central part of Lusaka. This move will provide the fellow closer quarters to George, the primary work environment, and maintain a level of required safety, whilst completing international work.

The Republic of Zambia is host to wide variety of culture. The country speaks nearly seventy indigenous languages, although English is considered the official language. Eighty-four percent of citizens are of Protestant faith, 35 percent are Hindu, and 26% are Catholic. The currency is the Kwacha and currently trades at approximately 4800:1 on the dollar. The literacy rate is just over three-fourths. The average Zambian carries a life-expectancy of 37 years and the country has an infant mortality rate of 91.9 per 1,000 births.

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Room:	~$495 ($15/day)
Extra Travel:	~$250
Contingency:	~$500
Total:	~$2965-$3565

PROBLEMS AND BOUNDARIES:

There are a number of problems and boundaries that I may encounter while in the Republic of Zambia; however, the most significant will be a lack of time, damaged equipment, and culture differences. All of the projects will be pressed by time. We will have adequate time to prepare, but I imagine small changes will cause a deviation from our original plan and may cause us delayed or deviated programming. In addition, I may not have enough time to film and photograph everything I need for the completion of my project, but I doubt this will be a significant issue;

however, lost or stolen equipment will pose a serious problem and may disrupt my progress until the equipment can be replaced. The transition from this culture to the Zambian culture will be a change; although, I imagine the change will be a positive revelation and foresee long lasting problem for the completion of the project. With adequate preparation, in addition to our established contacts I feel that any problems or boundaries encountered will be minor and temporary.

FINAL PRODUCTS:

In August, when I return to Kansas City with my video data I will begin construction of the documentary of George. I envision the final product to be approximately one hour in length, and to portray and accurate depiction of life in George as it relates to overall health, with particular emphasis on HIV/AIDS. In addition to the documentary, I will continue to work with Beth on her project. When both products are finished I hope that we will have created a good foundation for a peer education program for the citizens of George, and an inspirational, documentary that can be shown to medical students at the summer electives workshops. These are the tangible products. I will also return with a different perspective on life. I will return having lived in poverty; having felt disease; having bared witness to social stratification. I will return having had an experience that will compare to none other, and it will be that experience that will make all the difference to my future.

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Confidential Setting; Hopkins CCP Helps Implement New Hotline. www.jhuccp.org/pressroom/2003/12-03.shtml

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www.who.org
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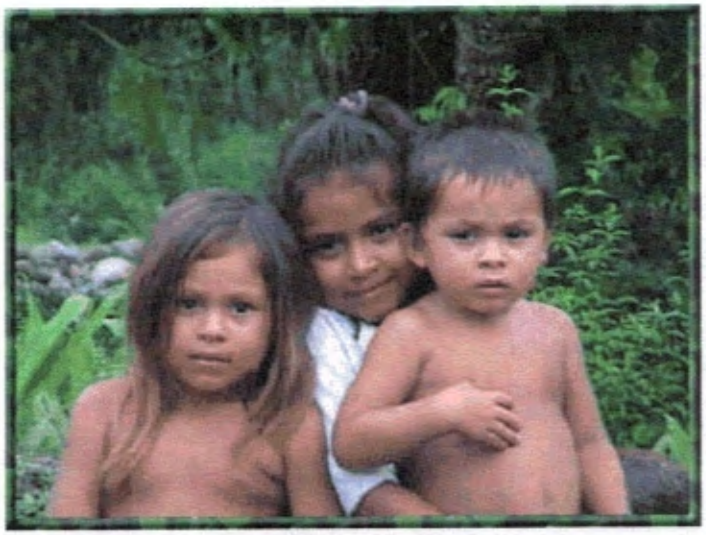
A Vision of Hope

in

Buenos Aires, Honduras

Summer 2005 Clendening Proposal



Ashley S. Robbins
February 14, 2005

Introduction

After returning from a ten day mission trip to Honduras in August of 2003, I knew that someday I would return. My return however, would not be simply for a vacation or to enjoy the beautiful mountains and the laid-back style of life led by the people that live there. Rather, my return would be to participate in the lives of people, to engross myself in the Latin American culture, and learn about what I, a young female from Kansas, can do to participate in the global movement toward better health and quality of life for all people. During that trip my heart had been touched and my sense of social responsibility heightened. It was my dream to become a physician; and not only did I receive confirmation on that dream while I was in Honduras, but I also realized the far-reaching effects I could possibly have practicing medicine. Today, I sit in amazement that I am carrying out my dream. It is the thought of returning to Honduras that sustains me through every late night of studying and stressful test block that comes with being a first-year medical student.

Background

Honduras, one of the poorest countries in the western hemisphere, is located in Central America. It is situated between Guatemala, El Salvador, and Nicaragua, with the Caribbean Sea forming its northern border. Of the 6,941,000 people living in Honduras almost a quarter of them live on less than $1.00 per day. The unequal distribution of wealth is incredible; and there is massive unemployment. In 1998, hurricane Mitch devastated the country, killing 5,600 people and causing $2 billion in damage. All of the lowland agriculture was damaged and much of the infrastructure of the country, including schools, medical clinics, and other vital community centers, were destroyed. The reconstruction after Mitch is still underway, despite other tropical storms and droughts, and will take years to complete.

Most of the population lives in rural areas where the majority of homes do not have the necessary resources to produce or obtain daily food requirements. There is also limited access to basic services such as health, education, safe drinking water, and proper sanitation. Malnutrition is a serious problem in these areas. An estimated 25 percent of all children under the age of five suffer from malnutrition; thirteen percent of children between the ages of one and three years are affected by clinical vitamin A deficiency and 30.2 percent are iron deficient. Over a quarter of women who are of childbearing age and more than 30 percent of pregnant women are classified as anemic.

Many Hondurans do not relate their poor health to the actual causes. Their experiences of constant tiredness, stunted growth, and infectious diseases are so common and have been part of life for so many generations that they believe that such things are normal. In addition, they may not have access to any medical services. Most health care professionals are located in the cities; and many Hondurans cannot afford doctors, drugs, or transportation to reach medical care. Some Hondurans have never seen or experienced healthy living conditions, so they do not understand what it feels like to be well-nourished and healthy.

Despite all this there is hope. Lisa Armstrong, a registered nurse from Chanute, Kansas (that's my hometown) moved to Honduras permanently in 1998 following Hurricane Mitch. Since then,

through her mission, Lisa has established a medical clinic and agriculture program, among other projects, in the village of Buenos Aires, Santa Barbara, Honduras. The clinic was constructed in a remote mountain range in the northwest portion of Honduras in response to the overwhelming need of the poor for access to adequate medical services. It offers services which include: general medicine, dentistry, laboratory services, labor and delivery, and minor surgery. Serving over 120,000 people, it is the only complete healthcare facility of its kind. On a monthly basis, over 800 people receive medical attention at the clinic. A visit, which includes a physical exam and all medicines needed to treat the illness, costs 40 lempiras ($2.16). However, if the patient is unable to pay, the exam and medications are provided free of charge, no questions asked. Clients are educated as to the actual cost of their healthcare and are encouraged to participate in any way they can. This promotes a feeling of ownership and responsibility for the success of the project among the communities served and stresses the importance of eventual self-sufficiency.

The agriculture project established by the mission coordinates and distributes healthy foods and offers technical assistance related to agriculture. This is in attempt to combat disease brought about by malnutrition. After being instructed in a variety of agriculture techniques, clients of the project are encouraged to exchange their cultivated fruits and vegetables for meat, egg, and milk products offered through the mission's barter system/trade store. This provides incentive for the people to produce more than they can consume, introducing and stressing the importance of variety in their diets. It also allows them to save their cash resources for other necessities which they are unable to produce for themselves. In addition, all excess produce of the agriculture project, such as organ meats, vegetables, and fruits are donated to the school in Buenos Aires. The teachers have organized groups of volunteers who prepare school lunches several times a week in recognition of the importance of good nutrition and its impact on the learning process.

As eluded to before, in August 2003 I visited Lisa's mission in Buenos Aires with other members of my church in Chanute, Kansas. We were able to take and distribute clothing and school supplies to many villages in the mountains of Honduras, worked on the construction of the new kitchen for the school, and helped organize the clinic with new medical supply donations Lisa had received, as well as prepare it for the new dentist that would be arriving soon. In addition, we utilized some of the produce from the agriculture program to make healthy breads and snacks for the people of Buenos Aires and had a community party for them at the clinic. My experience can be simply stated as amazing! Seeing my passion and interest during the trip, Lisa extended an open invitation for me to come back and spend an extended amount of time there. In September 2004, Lisa returned home to Chanute for a visit and I was able to speak with her. Since then, we have been in contact over e-mail and the plans for me to come to Honduras this summer are becoming a reality. Both Lisa and I are very excited.

Goals

While in Honduras this summer I will have a four-fold project:

1) Collect and transport supplies needed at the clinic

- Communicate with Lisa about what supplies and pharmaceuticals are needed at the clinic

- Seek-out and contact potential donors, including local businesses, individuals, and non-profit organizations
- Collect items that are needed but not generally brought by mission teams

2) Shadow and assist Dr. Marco Tulio Dominguez

- Observe, practice, and gain new skills while acquiring an understanding of the practice of medicine in rural Latin America
- Examine the effects of culture, poverty, and climate on health and wellness
- Compare the similarities and differences of practicing medicine in rural Honduras with that in rural Kansas
- Practice skills learned in the first year of medical school

3) Compare the nutrition and health status of the people affected by the mission to their prior condition

- Assess the effects of the clinic and agriculture program on the surrounding population over the last few years
- Interview Lisa, other employees of the mission, and individuals/families that live near the mission and have taken part in its programs

4) Increase my proficiency in the Spanish language.

- Begin a Spanish home-study before leaving for Honduras
- Become comfortable conversing in the language
- Ultimately be able to translate at the Jay Doc free clinic upon arriving back in Kansas City

Methods

Lisa returns to the United States once a year and during that time is very busy raising money for the mission, visiting family and friends, and giving presentations about the progress that has taken place at the mission. In addition, it is her only time to collect supplies that are needed at the clinic. During the remainder of the year she primarily depends upon donations brought by individuals and mission teams that come to Honduras. Lisa is aware that I am planning on bringing supplies and is compiling a list of things that are needed at the clinic; I will continue to be in contact with her through e-mail. This spring I will also make contacts at KUMC, local businesses, and organizations such as Heart-to-Heart for possible donations, and will utilize resources that I already have with physicians, the Ashley Clinic and other businesses in Chanute, and pharmaceutical representatives. Thus, before leaving I hope to collect supplies, instruments, and/or medications that are needed but may not otherwise be attained by visiting mission teams.

Dr. Marco Tulio Dominguez is the bilingual, native Honduran doctor that works at the clinic in Buenos Aires. At the time of my arrival he will have worked at the clinic just under one year. He is a very good physician with a passion for the people of the area. This summer I will have the opportunity to shadow and work with Dr. Dominguez as well as with Lisa. I have already spent a

great deal of time shadowing doctors in Chanute and Manhattan, KS, and my current preceptor is in Atchison, KS. Thus, I have gained an understanding for rural practice in Kansas and making a comparison will probably come naturally. I plan to document the experiences that I have in the clinic in a daily journal as to record the things that I learn, the knowledge that I gain, and the ways that I grow.

Nutrition has been an interest of mine for many years and was my major at Kansas State University. Thus, I have a background knowledge and great concern for this subject. I have studied marasmus and kwashiorkor (types of protein-energy malnutrition) and have an academic understanding of vitamin deficiencies. Thus it will be incredibly interesting for me to actually see the effects of these conditions. It also has the potential to have a great impact on my personal appreciation of life. However, my primary goal will not be to focus on the negative aspects, but rather to assess the effects of the clinic and agriculture program on the surrounding population over the last few years. To do this, I will interview Lisa and the other employees of the mission, as well as the people living near the mission to find out if and how health, wellness, and quality of life has changed. I will be living with Lisa and working closely with others at the mission, thus access to these individuals will not be difficult. In addition, Lisa often visits families around the village on a regular basis. I met many of these families the first time that I was in Honduras and will be able to make these "rounds" with Lisa again. It will also be feasible to have at least one community party at the clinic, in which I will have an opportunity to talk to groups of people. This will also allow them to receive some sort of health information, watch a movie, and enjoy snacks prepared by the mission. It will be interesting to view what has and has not been effective in combating malnutrition and what it takes to promote and implement health programs in that setting.

- Potential questions that I would like to ask and document from Lisa:
    - Why have you stayed in Honduras since 1998?
    - What changes have you seen in the population since your arrival? Starting the agriculture program? Building the clinic?
    - What methods have been the most successful to make a positive impact on the wellness of this community?
    - What strategies have you tried at the mission/in the clinic that have not worked?
    - What is the most important factor in keeping you healthy both mentally and physically?

- Potential questions that I would like to ask individuals that work at the mission:
    - What changes have you seen in the surrounding population since Lisa's arrival? Starting the agriculture program? Building the clinic?
    - What is the most critical factor affecting the health and wellness of these people?
    - What priorities have changed for you and for the surrounding population and how have they changed?
    - What, if anything, needs to be done to further promote health in this region?

- Potential questions that I would like to ask individuals living near the mission:

- How has your/your family's health changed since Lisa arrived? Starting the agriculture program? Building the clinic?
- What is different in your life now as compared to before the mission?
- What was the state of your health and living conditions before the mission? How about now?
- What is one piece of advice that you would give me to stay healthy?

Finally, because I see myself continuing to return to Central and South America as a medical professional, I find it necessary to be able to be somewhat proficient in Spanish. I took four years of Spanish in high school and in preparation I plan to work through a home-study medical Spanish book purchased from the KUMC bookstore. Still, there is no better way to learn the language than by immersing myself in it. Although Lisa and Dr. Dominguez are bilingual I will communicate with them in Spanish as much as possible; almost everyone else I interact with will only speak Spanish, forcing me to learn and understand. I also look forward to living by the rules of a different culture, thus broadening my worldview.

Time Frame and Budget

Leave Kansas City: Sunday, May 29, 2005 Continental Flight 711, 6:30am
Return to Kansas City: Saturday July 23, 2005 Continental Flight 1969, 12:26 pm
Airfare: $608
Personal expenses: $300
Gifts: $100
Room and board: $0 (provided by Lisa)
Vaccinations: $0 (up-to-date)

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Role of Faith and Spiritual Healing in Northern India

Seth Sheldon
Clendening Summer Fellowship 2005 Proposal
February 11, 2005

Introduction

What is healthcare? Many people view healthcare as merely a science involving doctors and medications. An often neglected aspect of patients' well-being, however, is their mental and spiritual health. A recent survey indicated 45% of psychiatric patients in a hospital in southern India as having visited Hindu, Muslim, or Christian healers (Campion et al.). This summer I will be volunteering with Child Family Health International (CFHI), the mission of which is to build and strengthen healthcare services for underserved communities worldwide. During my time in India, I will study the role of faith and spiritual healing in India.

Background

The experiences that lead me to service in international medicine started during my undergraduate years at the University of Kansas. Majoring in chemical engineering left me little opportunity to learn about international healthcare and public medicine. A European study abroad experience in international history and politics, however, provided an initial view of the differences in medical care and health policy between the United States and other areas of the world. This prompted me to explore questions about international medicine.

Later in college, as I contemplated a combined career in research and medicine, I realized that my skills and passion were geared more towards the clinical setting. I started to develop an interest in mission work after attending church services where medical missionaries spoke about their experiences in Africa, Russia, and South America.

My lifetime goal is to volunteer two weeks to a month every year as part of a medical mission either domestically or internationally. As a medical student, I am receiving an amazing education that only a limited number of people receive. It is important that I share this knowledge with those in underserved regions. CFHI's program in India is an excellent opportunity for me to serve patients internationally in a program that focuses on underserved communities while catering to 1st year medical students.

Past service experiences prepared me for this summer. In high school, I went with my church on a mission to inner-city Chicago where I learned how to relate to people in circumstances about which I knew little. In the spring of 2003, I participated in my second Alternative Spring Break, volunteering with a team of six other students (whom I had not previously met) in an inner-city school in Philadelphia. Having grown up in a small town, I found it nearly incomprehensible that these children could attend a school where over 50 languages were represented. Nevertheless, I learned to relate to the kids and developed some amazing relationships and memories on the trip – rapping with them, working on homework, playing games on the playground, and learning about their lives. The children in the school instilled tremendous hope in me – they had a profound ability to make the most of the limited resources available to them. Together with my time in Big Brothers Big Sisters and Jubilee Café (a breakfast center for the homeless), I have

had a chance to meet and get to know a variety of people. These experiences provided me with the foundation I need to go to India.

Description of Project

Faith often plays a central role in patient care. A patient's faith affects everything from the comfort and mental health of the patient to the types of treatment sought out. A dramatic transformation occurred in India in the 20th century as Western medicine became more accessible. The modernization of healthcare and implementation of public health in India have likely been major factors in the tremendous increase in life expectancy. The average life expectancy in India went from 32 years in the 1930's to 64 years in 2000. Nevertheless, the average Indian life expectancy is 15 years less than that of the average citizen in high-income countries (Sivakumar).

The people of South Asia are learning to integrate traditional medical practices with Western medicine (Mercer et al.). In addition to treatment from doctors and hospitals, patients often have contact with spiritual healers of various faiths (Hindu, Muslim, Christian, etc.) or seek various forms of traditional medical treatment, such as massage therapy (Hentschel et al.).

The people of India are extremely religious and philosophical. It is the birthplace of many major world religions including Hinduism, Buddhism, Jainism, and Sikhism. About 80% of the population is Hindu, 12% Muslim, and 3% Christian (*Republic of India*). The high value placed on religion and the variety of beliefs should make India a great place to study the role of faith in medicine.

The CFHI program I will be participating in involves a variety of experiences. I will spend two weeks in Dehra Dun, one week in Anjanisen, and one week in Than Gaon. Dehra Dun is the capital of Uttaranchal. There I will participate in a variety of rotations including pediatrics, plastic surgery, and geriatrics. Anjanisen is a village high in the Himalayas where I will be working at a community hospital with Shri Bhuvneshvari Mahila Ashram (SBMA), a non-governmental organization dedicated to serving the poor. Than Gaon is a small village in the Himalayan Mountains where I will be following the local doctor, Dr. Paul, at his clinic and hiking several hours to villages to provide health camps to those who cannot come to the main clinic. My primary role in these clinical experiences will be assisting the local doctors, observing them, and distributing medical packages from CFHI.

Methods

I will gather information through observation and informal interviews with patients and doctors. I will keep a daily journal of my experiences and of the information I obtained. Some of the questions that I will ask the doctors are:

- What role does spiritual healing and faith play in a patient's health?
- Do you believe spiritual healing/religion can have an impact on a patient's health emotionally? Physically?
- How has reliance on faith changed over time as medicine has become more modernized? (if relevant)
- What spiritual/religious restrictions have you faced in treating patients?

If provided the opportunity in my daily interaction with patients, I will ask them questions related to the following:

- Have you ever sought spiritual healing/intervention?
- Where did you seek this healing/intervention?
- Do you believe this treatment has been of benefit?

I will obviously be unable to ask these questions of all the patients I see and I do not feel that it would be appropriate to conduct a formal interview with patients. I do, however, think that I will be able to gather the information in these questions from patient histories and when the opportunity is available.

Goals/Objectives

1. Learn more about and immerse myself in Indian culture (people, language, faith, lifestyle, and professions)
2. Learn about alternative medicine (herbal medicines, treatments, etc.)
3. Adjust to conditions that will take me "out of my comfort zone" – strict vegetarian diet, accommodations
4. Develop and improve my clinical skills
5. Observe and learn from the local doctors (challenges faced, advice)
6. Learn to recognize relevant issues in public health and find the best solutions and methods for education on these issues
7. Use lessons learned in India to relate to people of different backgrounds at home

Budget

Roundtrip Airfare (Makemytrip.com)	$1640
Tourist Visa	$60
Immunizations/Rx	$100
CFHI Program Fee (accommodations, 3-meals/day, intercity transportation, orientation materials)	$1675
CFHI Application Fee	$35
Miscellaneous (Food, books, activities)	$300
June Apartment Rent (KC)	$420
Subtotal:	**$4230**
Clendening Fellowship	-$2000
Total Out of Pocket:	**$2230**

Contacts

CFHI provides a medical director and local coordinator that we will have weekly contact with. CFHI's contact information is as follows:

Child Family Health International
995 Market Street, Suite 1104
San Francisco, CA 94103
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Phone: 415-957-9000
Website: www.cfhi.org

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Ghana: The Role of Traditional Healers as Primary Care Practitioners

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Clendening Fellowship Proposal 2005
Mitra Tabidian
February 14, 2005

I. Introduction

Known to both its proponents and opponents as TM, traditional medicine is composed of ancient practices, current therapies and future possibilities. Incorporating everything from mineral, plant and animal derivatives to spiritual belief systems, TM is utilized by individuals around the world to sustain well-being and treat numerous ailments. The popularity of TM has been maintained in Asia, Africa and South America, and is quickly gaining favor in industrialized nations, where these practices are grouped as complementary alternative medicine (CAM) therapies. Once slighted as outdated and dangerous, unconventional remedies are becoming more widely accepted. The World Health Organization estimates "In Africa, 80% of the population uses traditional medicine for primary health care."[1] The high cost of westernized health care and lack of access issues are primarily responsible for this astonishing percentage.[2] One cannot help but wonder about the substantial impact on the overall health of Africans, and have interest in what can be learned from these age-old therapies. As we enter into the 21st century, it is our responsibility as a global medical community to understand what impact non-westernized practices may have on our patients and to determine what benefit or detriment various CAM treatments may hold.

II. Background

My interest in holistic healing began concurrently with my passion for medicine. Although I was a biochemistry major in college and believe strongly in scientific answers for the many chronic and acute health problems that exist today, I also recognize that the traditional therapies used for the past thousands of years also hold high value for patient treatment. What is most impressive to me is that many non-Western healers utilize methods to cure the entire person; body, soul and mind. I was able to take a course at UCLA entitled "The History of Childbirth", a class that focused on women and their care takers, changing expectations before and during labor and the progression of the birthing process into the hospital from the home. Although I had read about acupuncture, meditation therapies and other comprehensive treatment options, this course and its insight into early and modern midwifery practices showed me the past capabilities of traditional medicine and the potential for incorporation of many of the principles into classical treatment plans. I feel that the more I learn about alternative therapies, the better comprehensive medical practitioner I will become, both in understanding what options are available and also what patients may have attempted before coming to my me for assistance. I have a unique opportunity to study traditional medicine in Have, Ghana, and am excited about the possibility of exploring another dimension of health care.

Ghana is located in Western Africa, situated along the coast at the Gulf of Guinea, with Cōte D'Ivoire to the west, Burkina Faso directly north and Togo eastward. Lake Volta carves into the landscape, running over half the length of the country. Have is a small agricultural village in the Volta Region, located nearly 300 km north of the capital city of Accra. Villages in the region are governed both by chieftains, who receive their position through family lineage and also by other elected committees, each performing specified duties. Villages are generally far from licensed hospitals and westernized doctors, but most have at least one traditional healer who is relied upon for primary medical care.

Local village practitioners generally come to their profession in one of three ways: 1) an unofficial education by relatives, 2) an internship or residency with an already reputable healer and 3) by a divine calling.[2] As a result, traditional healers have either a primarily spiritual or non-spiritual based practice, although both categories overlap a great deal. Healers treat multiple illnesses including malaria, asthma, hypertension and *tukpoe* (a supernatural gun thought by Ghanaians to cause physical pain).

In Ghana, the majority of traditional healers are men, although women do practice to some extent.[3] This reflects the general attitude towards women in the patriarchal Ghanaian society. As stated in World Bank IK Notes, "…women, if they openly practice traditional medicine are termed witches and every misfortune is blamed on them."[3] However, the majority of birth attendants are women, and are accepted in this capability.

Currently there are multiple concerns regarding traditional medicine in Ghana. Preservation of indigenous customs and practices is an issue at the forefront, as most are passed through oral tradition and are therefore in danger of being lost. There is also great concern about the conservation of and access to native organic remedies that are becoming increasingly popular among non-locals and are more and more tightly regulated each season. International health care organizations are also interested in utilizing traditional healers in Ghana as wide-spread educators in combating disease.

III. Description of Project

I plan on going to Have, Ghana to study traditional healing in a native setting. While there I intend to observe traditional medicine in Ghana, both as an academic field and as a practice in rural areas, the impact of westernized care on traditional remedies, the role of a traditional practitioner in a small village and the impact of these medical practices on the women and children of Ghana. I am primarily interested in the care of women and children, although due to the patriarchal nature of the Ghanaian society, I am not certain to what depth these investigations can be carried out, especially in smaller villages. This does present a difficulty in the development of my proposal, but I am certain that I am capable of dealing with any challenge I come across. I am curious about why individuals (specifically women) choose a specific healer, what aliment has caused them to make a visit and what type of treatment they receive.

I plan on arriving in Ghana with an armament of background research and multiple contacts, to assist me in my studies. I have already been in touch with many individuals involved with traditional medicine and am continuing to accumulate links both here in the U.S. and abroad. I will devote one week (or more, as necessary) before departure to research here in the U.S. My investigations will continue in Accra where I will spend one week doing research at the University of Ghana, including interviews with traditional medicine researchers, library searches and a visit to the main market in the city utilized by traditional healers to purchase ingredients for procuring remedies. I have been in contact with professors both in the Department of Religion and the Department of Medicine and am confident that I will gain a solid foundation in both the theoretical and practical aspects of Ghanaian traditional medicine. I will be met by a friend who has been living in Ghana for two years and can help me navigate the streets of Accra with

minimum difficulty. Accommodation in Accra will be arranged prior to departure, but as it is the capital city, it should not be a formidable task.

The remainder of my visit (two weeks) will be spent in Have and surrounding areas, where I will learn the true customs of Ghana, experience village life first hand and meet local traditional medicine practitioners and their patients. I have requested the opportunity to shadow the conventionally trained Peace Corps doctor assigned to Have and other nearby villages, and hope to investigate his views on traditional medicine. Through this experience I will learn how he integrates alternative therapies with western practices and I also hope to observe his direct interactions with natives. I have also arranged a meeting with Have's 72 year-old traditional medicine practitioner who has been a healer since adolescence. Public transportation between villages is available, and I intend to visit nearby locations such as Kpeve, Tsate and Gagbefe, all of which are small but accessible by the main road. In visiting multiple locations I will be able to gain a broad perspective of traditional healing, especially since many practices are unique to one particular village. Accommodation is provided by a close friend, in a house in Have.

IV. Methods

In order to develop an understanding of the role of traditional medicine in Ghana, I will first investigate the academic components including the history of spiritualistic and non-spiritualistic practices, the theoretical models for the utilization and integration of westernized medicine and the efforts made by governmental and non-profit organizations to best preserve these traditional practices. These studies will mainly be done at the University of Ghana, in Accra (Ghana's capital city) where I will meet with Dr. E. Amoah and Dr. Pobee, from the Department of History and the Department of Medicine, respectively. The library at the university will also provide a great resource. I will take the bus, which is easily accessible though cramped at times, to the main market, to see first-hand where many of the modern traditional healers purchase the ingredients for their remedies. I will record my personal observations as well as what I learn from written resources and interviews in journal format. All of these direct experiences will provide the groundwork for the observations I make in smaller villages.

I will be accompanied on public transport to Have where I will spend two weeks, to begin observation of and investigation into the practice of traditional healing. I hope to learn what integration there is with western medical practices and how these treatments affect Ghanaian women and children. I will accomplish this task first by speaking with healers in Have, Kpeve, Tsate and Gagbefe. Have will serve as my home base for the remaining time, as I already have accommodation provided there and have been able to indirectly contact the healer in the village. Each of the villages outside of Have are easily accessible, as they line the main road, and I will be able to make day excursions to each village in the morning and return to Have in the afternoon. It is extremely difficult to contact any of these healers from the U.S. before departure. However, I will locate each of them on the national registry of traditional medicine practitioners, which is available to me at the University of Ghana though not accessible here or online. This listing is fairly complete and will provide a good starting point, although I will definitely discover more by going into the village of interest and inquiring about the local healer. I plan on asking

each traditional practitioner about their history and what they think of westernized medical practices. Simple observation of spiritualistic therapies will also provide me a great experience and insight into traditional practices, both on the side of the healer and the patient. In speaking with individuals, specifically women, who are being treated, I would like to learn what motivations they have in visiting a particular healer, what they expect out of the visit and how they feel about the care of their children. I also have contact with the Peace Corps doctor assigned to the Volta Region (including Have) and I am working on setting up a shadowing experience with him.

All interviews will be conducted on a voluntary basis and although will be limited to those who speak both English and Ewe, a large portion of the population speak both. I also have access to a translator if necessary and hope to digitally record interviews for later reference.

I recognize that this project will require extensive preparation time and a lot of leg work while in Ghana. The email and telephone systems are much different to those here in the U.S. and thus make some arrangements difficult ahead of time. However, I am prepared for the task at hand and am looking forward to the challenge with anticipation of all that I may see and learn.

V. Timeframe

My project will take approximately four weeks to complete, including one for preliminary research in the U.S. I will arrive in Accra, Ghana on June 21st from LAX and return to Los Angeles on July 12th. The first week in Ghana will be spent in Accra, including visits to the university's Department of Religion, where I will meet with Dr. E. Amoah who specializes in spiritual African healing, and to the Department of Medicine where I will talk with Dr. Pobee who received an M.D. in London. I will then depart for Have, where I will talk to local traditional healers and also local medical doctors. I will spend the remainder of my time stationed in Have and venturing out to surrounding communities. Speaking first with academic specialists in traditional medicine and then going out into the practicing world, I will witness the broad spectrum of the world of traditional medicine in Ghana.

VI. Goals

1) To investigate traditional medicine in Ghana, both as an academic field and as a practice in rural areas.
2) To learn what role westernized medicine plays in both primary care and as secondary means to treatment.
3) To determine to what extent westernized medicine and traditional practices are integrated into a cohesive treatment for patients.
4) To understand how the women and children of Ghana utilize and are affected by traditional medicine.
5) To obtain an understanding of Ghanaian society and culture.

VII. Budget

Airfare: Round Trip between Los Angeles International (LAX) and Accra, Ghana (ACC):	$2117.85*
Travel while in Ghana:	$50.00
Lodging (in Accra):	$100.00
Food:	$50.00
Total:	$2317.85

*I have a valid U.S. Passport and am on a working schedule for necessary immunizations. I take full responsibility for costs above the allotment from the Clendening Fellowship.

VIII. Contacts

Dr. E. Amoah, University of Ghana, Department of Religion
Dr. Winston Anderson, Howard University
Abena Dove Osseo-Asare, Harvard University, Department of History
Zena Herman, Peace Corps Volunteer

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   The Authors and Researchers at WHO, of which Bagozzi is one, utilize reputable sources and direct investigation to compile summary information about global health issues for health care professionals and the general public. Bagozzi gives a comprehensive definition of traditional medicine and discusses many issues related to traditional medicine in general such as use, safety and sustainability.
2. Tsey, K. (1997) Traditional Medicine in Contemporary Ghana: A Public Policy Analysis. *Social Science in Medicine* 42, 1065-1074
   Tsey is a native Ghanaian who grew up in Botoku (which is also in the Volta Region along with Have) and explores the public health aspect of traditional medicine in Ghana from a village perspective. Although the results and conclusions are of more interest to those in public health than in medicine, Tsey is able to provide native insight to traditional practices throughout the article and specifically in the case studies.
3. Naur, M. (2001) World Bank IK notes, No. 30
   At World Bank, the writers and investigators are concerned with imparting important information regarding health care development to professionals and interested individuals. Naur focuses specifically on the HIV/AIDS crisis in Ghana and Zambia, but delivers an interesting perspective on the role of traditional healers as primary care practitioners.

Cover Art: Nesbitt, C. (2001) AP Photograph

"INSPIRATIONAL MEDICINE":

Motivational Factors of Volunteer-Doctors

Proposal By Kristin Wong
Clendening Fellowship
Dr. Martha Montello
February 14, 2005

INTRODUCTION:

When does a doctor's responsibility reach beyond the clinic? Many have often wondered how active a doctor should be after hours, whether they should make an effort to answer house calls, act as managers, lobby to congressmen, speak out to the public, etc. In this day and age, to have a medical doctorate puts one instantly at a higher status within the U.S.; doctors are well-respected, intelligent leaders of the scientific, rural, and urban communities. Does this status inevitably endow them with the responsibility of using their influential position to its fullest and most beneficial extent? One could argue that any work or help done outside of a doctor's pay is considered volunteer work; hence, it could never be considered mandatory. Nonetheless, there are many doctors and organizations that thrive on their efforts to help those in need at any cost, inside or outside of the office. Child Family Health International is one such organization. Based out of San Francisco, CFHI's mission is to "build and strengthen sustainable healthcare services for underserved communities worldwide" (CFHI.org). The Jaydoc Free Clinic has a similar goal for the surrounding Kansas City area. So what motivates them? Should all doctors feel a sense of obligatory community service like those who volunteer regularly or is there a different motivating factor that only some possess? For my project, I want to get the full story: I want to ask doctors to share their volunteer experiences and what motivated them to pursue that path. Kate Fincham, a Health Volunteers Overseas spokeswoman, states, "People really need to ask [why they want to do this]. They need to honestly assess what those answers are and figure out the best match" (Zeigler 25).

BACKGROUND:

As an undergraduate at Duke, I was extremely interested in expanding my premedical education to include key medical issues not covered in the basic sciences. As a result, I majored in political science and pursued a health policy certificate. During my studies, topics such as the fairness of drug pricing and the ownership of organ donations became the focus of my writing and research. I also took courses in international health care and health equity, which developed into an interest for how various countries allocate care to the underserved.

One summer I spent three weeks with People to People International touring the urban and rural hospitals in China and experienced phenomenal differences that a textbook could never have taught me. In Beijing, its military hospital was well equipped with virtual reality dissection programs, language centers, and high-tech medical tools. However, just outside of the city, small villages without basic plumbing had one doctor who only owned a stethoscope. Despite the obvious differences in medical supplies, one problem did remain constant; the people of China just did not have enough doctors to treat everyone. Throughout the world many people lack access to basic primary care and one of the most important resources that I have seen to be limited in one way or another, is direct doctor-patient contact.

Now, as a student at KUMC, I have become an active volunteer at the Jaydoc Free Clinic and am constantly amazed at how many patients come in just looking for basic medical advice. Not only is it a rewarding experience for myself, I can see how thankful many of the patients are to be able to speak to someone about their problems. Jaydoc has given me an excellent introduction to the way free clinics operate and how much time and effort it takes to volunteer. With this, I feel that I have a good base to compare and build upon when visiting my project sites.

Because of the importance of the doctor-patient relationship and how limited that access can be, I want to take the opportunity to understand what makes doctors go out of their way to volunteer their limited time and energy. For some doctors it is a release from their usual routine; "Docs tired of practicing medicine in the defensive U.S. style look outside the country for

rejuvenation" (Zeigler 20). In many rural areas, however, doctors may feel obligated to help outside the clinic; "For a family physician in a rural area, often the only limit to practice is geographic; everyone within a one- or two-hour driving distance may be the doctor's responsibility" (Flannery 294). Still others volunteer for completely spiritual reasons; "God has called [Dr. John Greene] to use his medical skills to attend to the world's physical and spiritual needs." He states, "Personally, I wouldn't go on a trip…unless it had some spiritual value" (Zeigler 26). Whether it is for religious, personal, or business reasons, volunteer-doctors have incredible stories to share and I want to be there to catch every word. It is in their stories that move future doctors like me to lead similar paths.

GOALS:

By speaking with doctors in India and Boston, I have the opportunity to learn about their motivations and limitations, furthering my understanding of the stresses and rewards that come with practicing medicine. This information not only will help me to become a more open-minded doctor, but will possibly assist me in influencing other doctors to volunteer as well. Besides this new insight, I will also gain valuable skills in managing doctor-patient relationships. In India, complete submersion into a culture that I have never experienced before will improve my clinical skills across language, cultural, and economic barriers. Boston will also introduce me to a diverse population and give me a perspective on urbanized healthcare. The more aware I become of the obstacles doctors face everyday, the more prepared I will be as a physician. The following is a list of learning and service objectives for my project:

Learning Objectives:
- Understand my own and doctors' motivations for medical aid
- Improve patient assessment techniques
- Understand the prominent healthcare issues in India/rural and Boston/urban communities in general
- Learn about and treat various diseases affecting India

Service Objectives:
- Distribution of healthcare to underserved communities
- Assist doctors with patient exams and treatment
- Help patients understand their health problems and the importance of health maintenance

Lastly, with my experience, I hope to be able to pass on what I learn to those also looking for the right motivation to go beyond a doctor's typical duty.

DESCRIPTION & METHODS:

In order to collect a variety of responses and experiences, I wanted to get international and domestic, rural and urban, perspectives of volunteerism. Thus, I decided to spend a month with CFHI in India and a second month in Boston, Massachusetts. In India, CFHI is giving its students the opportunity to work with several rural doctors who dispense health care to the underserved in small communities. For four weeks, we will be assisting local physicians in Than Gaon, Anjunisen, and Dehra Dun. In Than Gaon, Dr. Paul travels to nearby villages to conduct health camps. We will be assisting him for one week by trekking medical supplies to and treating patients in the villages. In Anjunisen, we will be spending another week observing doctors at the community hospital, Shri Bhuvneshvari Mahila Ashram (SBMA). SBMA is a non-governmental organization dedicated to serving the poor and initiating community development programs. At Dehra Dun, we will spend two weeks assisting and observing various doctors serve middle to low-income families. These doctors have specialized in pediatrics,

emergency care, gynecology, and other medical fields. Each week the students will also be meeting with the local coordinators and medical directors on the program for further orientation and evaluation.

In Massachusetts, I will be spending another four weeks volunteering and visiting a few of the free healthcare clinics around Boston. Many of these clinics need the extra help during the summer months since the students that they depend on are out of the area. The Sharewood clinic (www.sharewood.info), started by medical students from Tufts University, welcomes any medical student in the vicinity to help interview and assess patients. It serves mostly urban populations of Chinatown and the greater Boston area. Another clinic focuses its care on the homeless populations in Boston at the Boston Medical Center while a few Rhode Island clinics within driving distance serve the general community at local churches. By comparing the responses from urban doctors with those in India, I will be able to look at any differences in motivational factors, if any. The following includes a few of the contacts at my program sites:

Dr. Sanjay Gandhi
Medical Director of "Rural Rotation, India"
www.cfhi.org

Aaron Summers
Sharewood Administrator Director
administrator@sharewood.info

Program Staff at CFHI
students@cfhi.org
(415)957-9000

Rhode Island Free Clinic
(401)274-6347

Boston Medical Center Homeless Clinic
(617)414-7779

Providence Community Health Centers Inc
(401)444-0400

At all of these sites I plan to speak with and ask the doctors and medical students to share their volunteering experiences including the when, what, where, and why. To keep a record of my travels, I will keep a written journal of interviews, daily/weekly tasks, and any compelling events or thoughts that I may come across. I will also keep a photographic journal with pictures and video clips of my surroundings and encounters (with permission) to add to my presentation for the following school year. Aside from the presentation and the research, I have an interest in art and painting and if inspired, would like to paint or photograph a representation of my experience. The following is a list of sample questions that I will be asking the doctors and medical students on-site:

Why do you volunteer?
What do you feel you get from volunteering?
How & why did you choose to volunteer in this way? (as opposed to donating money, etc.)
What other volunteer efforts have you pursued?
What influenced your decision to volunteer?
Did you expect to be doing this when you first started practicing?
Do you wish you could do more?
Do you expect other doctors to do the same? Why?
How would you convince others to join your efforts if you could?
What makes you continue to do this specific volunteer effort?
Do you feel that it is a doctor's responsibility to volunteer? Why?

BUDGET:

Roundtrip Airfare (Makemytrip.com)	$1640
Tourist Visa	$60
Immunizations/Rx	$100
CFHI program fee accommodations, 3-meals/day, intercity transportation, orientation materials	$1675
CFHI application fee	$35
Boston Living Arrangements*	$0
Boston Gas & Transportation	$250
Boston 1 month of meals	$250
Miscellaneous (research materials, activities, etc.)	$240
Subtotal:	**$4250**
Clendening Fellowship	-$2000
Total Out of Pocket:	**$2250**

*All accommodations in India and Boston have been confirmed. In India, housing will be through guesthouses or host families arranged by CFHI. For more detailed information see www.cfhi.org. Housing in Boston will be with a friend working in the area.

Even though my project costs are estimated to be more than what the Clendening Fellowship can contribute, I have no problem paying for the rest out-of-pocket. The experiences that I will gain are worth more than the money. By studying medical topics like this, I gain a better understanding of the situations and patients that I encounter as well as the doctors that I work with. While helping migrant workers, a medical student at Michigan states, "As future physicians, we must ask ourselves what we can do for these kids. How can we help them break free of the migrant workers' cycle?" (Rangaraian 34). Many volunteer-doctors have made this essential step and are getting involved with activities that they feel help their cause. As some doctors call volunteering a "pure medicine," I consider their efforts as "inspirational medicine."

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