

## Clendening Summer Fellows, 2011 Directory

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**Proposals include the following sections:****Introduction:**

The project that I will work on this summer is a chart review for a larger project called Horizons Program, a program out of the University of North Carolina Hospital that was created for women who are substance abusers that are pregnant or have very young children. The goal of the chart review is to look for reports of domestic violence during counseling sessions they had while they were in the program. This information will be used to determine if there needs to be an increase in programming/counseling on domestic abuse for the women; it will help the Horizons Project when applying to funding, and may also help to contribute to the literature by helping define the connection of domestic abuse with substance abuse.

**Background:**

When I started thinking about my goals for this summer I knew I wanted to further explore different ways that being a public health worker can fit with becoming a doctor. Last May I graduated with my Masters in Public Health from KUMC and with that I gained a better understanding of how health interventions fit into our health care system and what role public health workers play in increasing their effectiveness. However I am still looking to gain a better understanding of how I personally will merge these two roles in my future. Since I am interested in obstetrics and gynecology for a career path I sought out both departments of OB/GYN and public health programs geared towards women's health. Dr. John Thorp M.D. at UNC introduced me to the directors of the Horizons Programs. For me, the Horizons program is a perfect fit for the summer.

Working with the Horizon's project I will be able to increase my knowledge of public health interventions geared towards women. During my MPH, I worked on interventions for childhood obesity and cancer prevention so working on a women's health program I feel like I would have a lot to gain. I am particularly interested in the aspect of counseling and long term intervention that Horizon's projects offer the women involved in their program. Learning about how they encompass the entire patient by incorporating both physical medicine and psychological medicine while working with these women with very complicated addictions and life circumstances.

Another reason why I am choose to do this project is that working with women with substance abuse problems is something I have never been exposed to. I think that this project will push me to empathize with women who suffer from substance abuse during a fragile time in not only their lives, but their children's as well. I hope to gain a better understanding of how and why they made the decisions they did and hopefully I can apply this understanding to my future patients.

Description:

The goal of the project will be to look for under reporting of domestic abuse among the women in the Horizon's Program. At the beginning of the program, each woman fills out an intake survey where one of the questions asks about past domestic abuse. Although there are women who have reported this during the intake, the directors and counselors began to notice cases where women were reporting 'no' at intake, but in later counseling sessions it would be brought to the counselors attention that they were victims of domestic abuse. The hope is that by doing this chart review and looking for these instances it would give Horizon's (and myself) a better understanding of how domestic abuse is correlated with substance abuse. In the literature domestic abuse and substance abuse have been correlated over and over again, however Horizon's project is seeking to determine at what extent they are correlated in their population. This information could be used to determine if further programming for the women in regards to violence abuse prevention should be incorporated into the Horizon's curriculum and also could help the program improve statistic reporting and gain funding in the future. There is also possibility that this information could further contribute to the scientific literature.

The time line for this project is the eight weeks of summer. I plan on arriving in North Carolina during the week of the 23<sup>rd</sup> of May and will stay until the last week in August. I will first begin by following a project participants around as they go through their daily routine. This could include going to visit the OB/GYN department at UNC hospital for a prenatal appointment, to then going to substance abuse or job counseling. I will do this for a few days in hopes to get a better understanding of the program. After that I will be reviewing charts looking for reports of domestic abuse. The goal is to finish

the chart review by mid July so that I can analyze the data to determine the outcome of the project goals and to be able to make recommendations to the program.

In addition to this project, I will also be spending a few days a month (dates to be determined) shadowing the obstetricians/gynecologists at the UNC hospital to gain a better understanding of the specialty and how the doctors there interact with Horizon's project.

#### Methods:

The plan to complete the project includes working forty hours a week for the eight weeks of the summer. The sample size of charts will be determined early in the summer and I will review them on the Horizon Project's campus. This will be about a thirty minute drive to and from where I will be staying and they both are on the bus route giving me options for transportation. Once I have reviewed the charts and have enough data for analysis I am told I will either stay on the Horizon Project's campus or I will go to the UNC Center for Women's Research where Kimberly Andringa, PhD, who is one of the directors works. We will analyze the data and develop recommendations for the program.

To develop this project, I communicated over e mail with three different doctors at UNC, Dr. John Thorp M.D. ([thorp@med.unc.edu](mailto:thorp@med.unc.edu)) who introduced me to Constance Renz ([Connie\\_renz@med.unc.edu](mailto:Connie_renz@med.unc.edu)) who is the director of the program. I have also worked over e mail and telephone with Kimberly Andringa ([krandringa@yahoo.com](mailto:krandringa@yahoo.com)) who develops programming for Horizon's project and writes grants.

#### Budget

My biggest concern for the budget is paying rent for the summer (as I have yet to find a sublet) and to pay for the gas I would need to get to Raleigh and to and from the Horizon's office. I will be staying with my fiancé who lives in Raleigh and will be helping him pay for the utilities.

Gas from Kansas City to Raleigh (1,077 mi) Fiance's house to Horizon's Office (26.4 mi each way)	\$400
Food (\$200 per month)	\$400
Lodging (will help pay for utilities)	\$ 200
Rent and utilities for Kansas City apartment	\$1200
Total	\$2200 *

\*I understand I would be responsible for the difference

#### Bibliography:

"Domestic Violence and Substance Abuse" National Coalition Against Domestic Violence. Ncavd.org February 13, 2011.

Lawerence, S., Chau, M., and Lenon, MC. Depression, Substance Abuse and Domestic Violence: Little is Known about Co-Occurrence and Combined Effects on Low-Income Families. Nation Center for Children and Poverty. Columbia University. June 2004. February 13, 2011.

Najavitis, L., Weiss, R., and Shaw, S. The Link Between Substance Abuse and Posttraumatic Stress Disorder in Women, A Research Review. The American Journal on addictions. (1997) 6(4) 273-283. February 13, 2011.

## **2011 Clendening Summer Fellowship Proposal**

### **Clinical Applications of Geographic Information Systems**

#### **Introduction**

The following proposal outlines my project for a 2011 Clendening Summer Fellowship. The proposed project is a study of the clinical applications of Geographic Information Systems (GIS). The proposal provides a description of the project, project objectives, the methodology that will be used to meet the objectives, and a timeline and budget for the project. My interest in this subject stems from my background in engineering. Prior to medical school, I was a consulting civil and geological engineer. Most of my projects involved the usage of GIS in managing spatial data, and I'm excited to gain a better understanding of how this tool can be used in clinical medicine.

#### **What is GIS?**

In a broad sense, GIS refers to the overlay or integration of spatial datasets, and the term is often used synonymously with computer-based mapping. At its simplest usage, GIS entails placing several overlapping attributes on a single map to visually evaluate their relationship. Alternatively, GIS can involve interrelating spatial data using complex mathematical models.

Much of the data used in health research contains a spatial component, including disease prevalence, patient demographics, and distribution of providers. GIS allows for the analysis of the interrelation of health statistics and provides a means for describing the spatial organization of health care. By linking patient and provider statistics through a common spatial variable, GIS can be used to evaluate the relationship between access to care and health outcomes (McLafferty 2003). Layers of different datasets can be intersected in a myriad of ways to create complex spatial models of the health care system. Health care data has been presented spatially for decades, but using GIS-based applications in health care is a relatively recent, but rapidly growing, technique (McLafferty 2003, Rushton 2003). GIS is now being extensively used to model health care need, access, utilization, and delivery (McLafferty 2003).

For example, statistics describing hospital admissions or discharges for different medical conditions can be linked to patient ZIP codes or census tracts (NBDPN 2004). By simply creating maps of these attributes, a researcher can highlight significant health disparity across a geographic study region. GIS can also be used to model provider shortages. Hospitalization for certain "ambulatory care sensitive" (ACS) conditions, such as asthma and diabetes, can indicate a need for primary care services, as the proper management of these diseases in a primary care setting typically prevents hospitalization (McLafferty 2003). Utilization patterns and primary care shortage can be

## References

- Billings, J, Anderson, GM, Newman, LS. 1996. Recent findings on preventable hospitalizations. *Health Affairs* 15:239-249
- Billings, J, Zeitel, L, Lukomnik, J, Carey, TS, Blank, AE, Newman, L. 1993. Impact of socioeconomic status on hospital use in New York City. *Health Affairs* 12:162-173
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- Rushton, G. 2003. Public health, GIS, and spatial analytic tools. *Annu. Rev. Public Health* 24:43-56
- Wang, F, Luo, W. 2005. Assessing spatial and nonspatial factors for healthcare access: towards an integrated approach to defining health professional shortage areas. *Health Place* 11:131-146

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mapped by examining Emergency Department (ED) utilization for ACS diseases across given geographic regions (Billings et al. 1993, Bindman et al. 1995, Billings et al. 1996, Dulin et al. 2010).

## **Project Description**

The overarching goal of this project is to explore how GIS can be used to describe healthcare environments. GIS has been shown to be an effective planning tool (Wang and Luo 2005, Luo and Qi 2009, Dulin et al. 2010), and through this project, I'd like to explore how GIS can be used in a clinical setting, as well. GIS is a tool that is becoming more and more available to the general public, with simplified web-based applications that use existing datasets. At the provider level, the aim of this project is to determine what kind of GIS applications might be useful for clinicians to understand the environment where their patients originate, to evaluate the quality of care they provide, and to highlight medical disparities that may exist within their patient population. At the planning level, this project will explore how GIS can be used to model regional health care systems to improve quality and efficiency.

## **Project Objectives**

The objectives for this project are summarized as follows:

- Describe existing spatial data sources with respect to their usefulness at both the clinical and planning levels. The project will include a discussion of the publicly available datasets that can be used to describe spatial variability in patient demographics, access to care, primary care and specialty utilization, quality of care, cost, and disease prevalence.
- Complete basic analyses that highlight various clinical and planning applications of GIS in healthcare. Compare the results between urban and rural locations in Kansas, Washington, Colorado, and Texas to evaluate regional differences in healthcare.
- Discuss the usage of GIS with practicing physicians in Kansas and Washington to better understand what types of applications would be useful in the clinical setting.
- Produce a document that describes the process of using GIS to describe patient care in these regions. The document will include mapping to graphically illustrate the results.
- Develop a presentation that highlights the findings from this research and serves as a primer on medical geography and GIS, as they pertain to clinical settings and health care planning.

## Methodology

This study will examine the following six areas of the United States: the Kansas City metro area; rural western Kansas; the Seattle metro area; the Puget Sound area of western Washington; McAllen, Texas; and Grand Junction, Colorado. The Kansas and Washington areas were selected to compare urban and rural settings within two different states. Applying this study to Kansas will provide a better understanding of the patient bases served by the University of Kansas Medical School system throughout the state. Washington was selected because of the coastal component of its rural population. I'd like to see if spatial data for this part of the state can resolve any unique aspects of patient access to care, given the geography of the area. Finally, I'd like to model McAllen, Texas and Grand Junction, Colorado, as these are two locations that were highlighted in the recent, and widely-cited article by Dr. Atul Gawande (2009) describing health care costs. In his article, Dr. Gawande described McAllen as "one of the most expensive health-care markets in the country" and Grand Junction as "one of the lowest-cost markets in the country." I'd like to use available GIS data to describe the patient populations between these two areas, as a means to evaluate the usage of GIS in describing healthcare efficiency.

This project will be entirely based on existing datasets that are publicly available. The principle data sources for the project will be the Dartmouth Atlas of Health Care ([www.dartmouthatlas.org](http://www.dartmouthatlas.org)), the U.S. Department of Health & Human Services Agency for Healthcare Research and Quality Healthcare Cost & Utilization Project (HCUP; [www.ahrq.gov/data/hcup](http://www.ahrq.gov/data/hcup)), and U.S. Census Bureau Topologically Integrated Geographic Encoding and Referencing System (TIGER; [www.census.gov/geo/www/tiger](http://www.census.gov/geo/www/tiger)). Raw data is available from these three sources, which will be imported into the computer program ArcMap (version 10, from ESRI). Using a common software package, instead of the web-based utilities at each source, will simplify overlaying data.

The units of spatial analysis will be hospital referral regions (HRRs), hospital service areas (HSAs), and primary care service areas (PCSAs) established in the Dartmouth Atlas of Health Care (1998). When available, data will be imported into the project directly linked to these geographic areas. Otherwise, data will be linked to the areas by U.S. Postal Service ZIP codes or by U.S. Census Bureau census tracts.

To characterize regional patient populations and healthcare delivery, parameters from the datasets will be selected to describe the following attributes:

- *Patient demographics* – the TIGER dataset includes pertinent demographic parameters such as age, gender, race, and income.
- *Access to primary care and specialty services* – the Dartmouth Atlas includes hospital and physician capacity data.
- *Utilization of primary care and specialty services* – the Dartmouth Atlas includes hospital usage, discharge, and procedure data, and the HCUP database includes state utilization data.

- *Quality of care* – the Dartmouth Atlas includes outcome indicators, ambulatory care statistics, and patient satisfaction survey results.
- *Payment for services* – the Dartmouth Atlas includes Medicare spending statistics, and the HCUP database includes charge data.
- *Disease prevalence* – spatial prevalence data are available in the HCUP database and from the U.S. Center for Disease Control (CDC) National Center for Health Statistics.
- *Mortality* – spatial mortality data are available in the HCUP database and from the CDC National Center for Health Statistics.

A collection of maps will be compiled for each study region describing the attributes above. The mapping for McAllen, Texas and Grand Junction, Colorado will serve as example applications of GIS in the study of health care planning and efficiency. The mapping for Kansas and Washington will serve as example applications of GIS in characterizing the patient care environments in urban and rural settings in the two states. Beyond simply comparing mapping of various regional healthcare environments, the goal of this part of the project will be to explore how GIS can be used in a clinical setting.

Once the mapping phase is complete, I will summarize the results from each geographic region, including compiling a draft list of potential clinical applications for GIS. The final phase of the project, and perhaps the most important, will be to present the draft GIS applications to clinicians and, in essence, “ground-truth” the results. The goal of this part of the project will be to elucidate the clinical usefulness of GIS by asking clinicians if and how they might use GIS, and what kind of data gaps they see in describing their patient populations and service areas. In Kansas, I will meet with Dr. Allen Greiner and Dr. Joshua Freeman in the KUMC Family Medicine Department to discuss the applications. In Washington, I will present the results to Dr. Mark Doescher at the University of Washington (UW) in Seattle, and Mr. Rod Dalseg at Island Hospital in Anacortes. Dr. Doescher is the Director and Principle Investigator at the UW WWAMI Rural Health Research Center. Mr. Dalseg is the Director of Diagnostic Imaging at Island Hospital, which serves western Skagit County, north Whidbey Island, and the San Juan Islands of Washington.

## Timeline

The following is a brief timeline describing the proposed progression of the project:

- *May 16 – May 27*: Explore the existing datasets of spatial health data and compile the applicable data for each study region. Summarize the available data for the final report.
- *May 30 – June 19*: Develop maps of the study regions describing the various healthcare landscapes to illustrate clinical and planning-level applications of GIS. Produce drafts of maps for the final report and list conceptual-level clinical GIS applications to present to clinicians.

- *June 22 – June 26:* Present clinical applications of GIS to physicians at the UW WWAMI Rural Health Research Center and Island Hospital (Anacortes, Washington) for their feedback on the usefulness of GIS in urban and rural areas of Washington.
- *June 29 – July 8:* Present clinical applications of GIS to physicians in the KUMC Family Medicine department for their feedback on the usefulness of GIS in urban and rural areas of Kansas.
- *July 11 – July 29:* Revise the project mapping to reflect GIS applications resulting from discussions with physicians in Kansas and Washington. Compile a final report describing clinical and planning-level usage of GIS, and develop a presentation to serve as a primer on medical geography and GIS.

## Budget

The following table is a summary of the anticipated budget for this project. The specific costs for the project are tied to software licensing and travel to Washington. Expenses for the analysis and writing phases of the project are overhead expenses that are not specific to the project and excluded from this budget.

Description	Estimated Cost
ArcGIS ArcEditor – Single Use License through the University of Kansas ESRI Site License	\$100
Round trip flight from Kansas City to Seattle	\$370
Rental car for 1 week in Washington	\$350
Lodging for 5 nights in Washington	\$520
Meals in Washington – based on a per diem rate of \$40	\$200
<b>Total Estimated Cost</b>	<b>\$1,540</b>

## Summary

This proposal describes a project to explore the clinical usage of GIS. The project will involve using available datasets and spatial analytic techniques to describe patient populations, access to health care, utilization of services, and health care outcomes. Basic clinical GIS applications will be presented to practicing physicians for feedback on how GIS can be made more useful in a clinical setting. The results will be summarized in a final report, and a presentation on medical geography and GIS will be developed.

Thank you for the opportunity to submit this proposal for a 2011 Clendening Summer Fellowship. I look forward to working on this project, and I am excited to discover how GIS can be used to better understand our current health care landscape.

## References

- Billings, J, Anderson, GM, Newman, LS. 1996. Recent findings on preventable hospitalizations. *Health Affairs* 15:239-249
- Billings, J, Zeitel, L, Lukomnik, J, Carey, TS, Blank, AE, Newman, L. 1993. Impact of socioeconomic status on hospital use in New York City. *Health Affairs* 12:162-173
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- Rushton, G. 2003. Public health, GIS, and spatial analytic tools. *Annu. Rev. Public Health* 24:43-56
- Wang, F, Luo, W. 2005. Assessing spatial and nonspatial factors for healthcare access: towards an integrated approach to defining health professional shortage areas. *Health Place* 11:131-146

# The Stories of Women's Reproductive Health in America

Rebecca Munro

University of Kansas School of Medicine

Date Submitted: February 11th, 2011

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## Introduction

Women's reproductive health in America is a complex issue involving social, political, and religious elements. These forces can sometimes be so loud as to overpower the quiet voices of the women themselves. It is these women and their stories that I am particularly interested in. I believe that literature and fiction give us a unique window into the truths of our own lives and culture. By listening to women's stories from various OB/GYN clinics, I am hoping to gain a better understanding and appreciation for the complex issues and emotions surrounding reproductive health, many of which we never hear or think about.

I have always been interested in people's stories and always loved writing. This summer I plan to create a collection of short stories surrounding the issues of women's reproductive health. Through creative writing, I hope to illuminate some of the quiet stories.

## Overview

My project consists of two main arms: a research component and the writing itself. The research component will provide me with the background and support necessary to carry out the writing. This research will consist of shadowing at various OB/GYN clinics in the Kansas City area and a reading list of fiction involving reproductive health (both fictional and non-fictional).

My mentor for this project will be Dr. Annie Reising, an OB/GYN physician at KU Medical Center. I shadowed Dr. Reising in her clinic and in the O.R. several times during the fall 2010 semester, and enjoyed working with her and learning from her. She has helped me to make contact with several specialty OB/GYN physicians for shadowing, and will continue to assist me as my project progresses.

### I. RESEARCH

I plan to shadow physicians at the following clinics for 2 days each to give me a well-rounded background in women's reproductive health. I have strategically picked a variety of clinics so that I will be able to write about a diversity of topics including infertility, unplanned pregnancy, high risk pregnancy, fertility preservation during cancer, and menopause.

#### Shadowing List

Center for Women's Health  
4840 College Boulevard  
Overland Park, KS, 66211-1601  
(913) 491 6878

Planned Parenthood  
4401 W 109th St #200  
Overland Park, KS 66211-1303 (913) 312-5100

KU Center for High Risk Pregnancy  
3901 Rainbow Blvd. 5th Floor DELP  
Kansas City, KS 66160 (913) 588-6259

KU Center for Advanced Reproductive Medicine & Fertility Preservation Program  
10777 Nall Avenue, Suite 200

Overland Park, KS 66211  
(913)-588-2229

KU Department of OB/GYN in the specialty of gynecologic oncology  
KU Medical Center Office  
3901 Rainbow Blvd., 5th Floor DELP  
Kansas City, KS 66160

Cancer Center  
2330 Shawnee Mission Pkwy.  
Westwood, KS 66205

In addition to shadowing, I have created a reading list, with help of Dr. Michael Pritchett (Director of the Creative Writing Department of UMKC). It includes both fictional and non-fictional writing in the area of women's reproductive health

### Reading List

#### *Fiction*

"The Handmaids Tale" by Margaret Atwood (novel)  
"Hairball" by Margaret Atwood (short story)  
"Play it as it lays" by Joan Didion (novel)  
"Voyage in the dark" by Jean Rhys (novel)  
"Prelude" by Katherine Mansfield (short story)

#### *Non-fiction*

"Ourselves Unborn: A History of the Fetus in Modern America" by Sara Dubow  
"The Girls Who Went Away" by Ann Fessler  
"Woman: An Intimate Geography" by Natalie Angier  
"Undivided Rights: Women of Color Organizing for Reproductive Justice" by Jael Silliman, Marlene Gerber Fried, Loretta Ross, Elena Gutierrez  
"Reconstructing Motherhood and Disability in the Age of "Perfect" Babies" By Gail Landman  
"Inconceivable Conceptions: Psychological Aspects of infertility and Reproductive Technology" edited by Juliet Miller and Jane Haynes  
"The Woman in the Body: A Cultural Analysis of Reproduction" by Emily Martin

## 2. WRITING

For the writing portion of this project, I plan to create a collection of short stories and poems, totaling around 100 pages with a unified theme that can be submitted for publication as a collection or individually. Stories will range from micro-fiction (several paragraphs in length) to the more traditional short story (5-10 pages), in addition to several short poems. I have attached samples of published writing in the style I would like to emulate by some of my favorite authors. Additionally, I have attached several of my own writing samples on the topic of medicine and women's health that have been written in preparation for this project.

To assist in the writing portion of this project I plan to enroll in a creative writing workshop and class at UMKC (English 432). The Mark Twain Creative Writing Conference is held from 9:30-12:30 pm daily from June 6-24 2011. This will give me a chance to get critical feedback on my work and get more information on the publication process.

## Timeline

Week	Dates	Tasks
1	May 22- May 28	Shadow Dr. Dave Jackson and Dr. Sacha Krieg; Reading List
2	May 29- June 4	Shadow Dr. Julia Chapman and Dr. Traci Nauser; Reading List
3	June 5- June 11	Mark Twain Creative Writing Conference and begin writing
4	June 12- June 18	Mark Twain Creative Writing Conference and writing
5	June 19- June 25	Mark Twain Creative Writing Conference and writing
6	June 26- July 2	Writing
7	July 3- July 9	Writing
8	July 10- July 16	Writing and final editing
9	July 17- July 23	Complete collection and submit for publication

## Budget

Item	Estimated Cost
Mark Twain Creative Writing Workshop	<b>\$424.49</b>
Copying and Shipping of manuscript for publication	\$100
Gas (for shadowing)	\$50
Books from reading list	\$250
<b>Total</b>	<b>\$824.49</b>

## Contacts

Dr. Julia Chapman  
OB/GYN physician in the specialty of gynecologic oncology  
University of Kansas School of Medicine

Dr. David Jackson  
OB/GYN physician in the specialty of maternal-fetal medicine  
University of Kansas School of Medicine

Dr. Sacha Krieg  
OB/GYN physician in the specialty of Reproductive Endocrinology and Infertility  
University of Kansas School of Medicine

Dr. Michael Pritchett  
Director of Creative Writing  
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Dr. Traci Nauser  
OB/GYN physician at the Center for Women's Health 4840 College Boulevard  
Overland Park, KS, 66211-1601

Dr. Annie Reising  
Department: General Obstetrics and Gynecology  
University of Kansas School of Medicine  
3009 Wescoe Pavilion; 3901 Rainbow Boulevard  
Kansas City KS 66160

### 3. Example of a short story

#### Indian Camp

By Ernest Hemingway

(originally published in "In Our Time" in 1925)

At the lake shore there was another rowboat drawn up. The two Indians stood waiting.

Nick and his father got in the stern of the boat and the Indians shoved it off and one of them got in to row. Uncle George sat in the stern of the camp rowboat. The young Indian shoved the camp boat off and got in to row Uncle George.

The two boats started off in the dark. Nick heard the oarlocks of the other boat quite a way ahead of them in the mist. The Indians rowed with quick choppy strokes. Nick lay back with his father's arm around him. It was cold on the water. The Indian who was rowing them was working very hard, but the other boat moved further ahead in the mist all the time.

"Where are we going, Dad?" Nick asked. "Over to the Indian camp. There is an Indian lady very sick." "Oh," said Nick.

Across the bay they found the other boat beached. Uncle George was smoking a cigar in the dark. The young Indian pulled the boat way up on the beach. Uncle George gave both the Indians cigars. They walked up from the beach through a meadow that was soaking wet with dew, following the young Indian who carried a lantern. Then they went into the woods and followed a trail that led to the logging road that ran back into the hills. It was much lighter on the logging road as the timber was cut away on both sides. The young Indian stopped and blew out his lantern and they all walked on along the road.

They came around a bend and a dog came out barking. Ahead were the lights of the shanties where the Indian bark-peelers lived. More dogs rushed out at them. The two Indians sent them back to the shanties. In the shanty nearest the road there was a light in the window. An old woman stood in the doorway holding a lamp.

Inside on a wooden bunk lay a young Indian woman. She had been trying to have her baby for two days. All the old women in the camp had been helping her. The men had moved off up the road to sit in the dark and smoke cut off range of the noise she made. She screamed just as Nick and the two Indians followed his father and Uncle George into the shanty. She lay in the lower bunk, very big under a quilt. Her head was turned to one side. In the upper bunk was her husband. He had cut his foot very badly with an ax three days before. He was smoking a pipe. The room smelled very bad.

Nick's father ordered some water to be put on the stove, and while it was heating he spoke to Nick. "This lady is going to have a baby, Nick," he said. "I know," said Nick.

"You don't know," said his father. "Listen to me. What she is going through is called being in labor. The baby wants to be born and she wants it to be born. All her muscles are trying to get the baby born. That is what is happening when she screams." "I see," Nick said. Just then the woman cried out. "Oh, Daddy, can't you give her something to make her stop screaming?" asked Nick. "No. I haven't any anaesthetic," his father said. "But her screams are not important. I don't hear them because they are not important."

The husband in the upper bunk rolled over against the wall. The woman in the kitchen motioned to the doctor that the water was hot. Nick's father went into the kitchen and poured about half of the water out of the big kettle into a basin. Into the water left in the kettle he put several things he unwrapped from a handkerchief. "Those must boil," he said, and began to scrub his hands in the basin of hot water with a cake of soap he had brought from the camp. Nick watched his father's hands scrubbing each other with the soap.

While his father washed his hands very carefully and thoroughly, he talked. "You see, Nick, babies are supposed to be born head first but sometimes they're not. When they're not they make a lot of trouble for everybody. Maybe I'll have to operate on this lady. We'll know in a little while."

When he was satisfied with his hands he went in and went to work "Pull back that quilt, will you, George?" he said. "I'd rather not touch it." Later when he started to operate Uncle George and three

Indian men held the woman still. She bit Uncle George on the arm and Uncle George said, "Damn squaw bitch!" and the young Indian who had rowed Uncle George over laughed at him. Nick held the basin for his father. It all took a longtime.

His father picked the baby up and slapped it to make it breathe and handed it to the old woman. "See, it's a boy, Nick," he said. "How do you like being an interne?" Nick said. "All right." He was looking away so as not to see what his father was doing. "There. That gets it," said his father and put something into the basin. Nick didn't look at it.

"Now," his father said, "there's some stitches to put in. You can watch this or not, Nick, just as you like. I'm going to sew up the incision I made." Nick did not watch. His curiosity had been gone for a long time. His father finished and stood up. Uncle George and the three Indian men stood up. Nick put the basin out in the kitchen.

Uncle George looked at his arm. The young Indian smiled reminiscently. "I'll put some peroxide on that, George," the doctor said. He bent over the Indian woman. She was quiet now and her eyes were closed. She looked very pale. She did not know what had become of the baby or anything. "I'll be back in the morning," the doctor said, standing up.

"The nurse should be here from St. Ignace by noon and she'll bring everything we need." He was feeling exalted and talkative as football players are in the dressing room after a game. "That's one for the medical journal, George," he said. "Doing a Caesarian with a jack-knife and sewing it up with nine-foot, tapered gut leaders."

Uncle George was standing against the wall, looking at his arm. Oh, you're a great man, all right," he said. "Ought to have a look at the proud father. They're usually the worst sufferers in these little affairs," the doctor said. "I must say he took it all pretty quietly."

He pulled back the blanket from the Indian's head. His hand came away wet. He mounted on the edge of the lower bunk with the lamp in one hand and looked in. The Indian lay with his face toward the wall. His throat had been cut from ear to ear. The blood had flowed down into a pool where his body sagged the bunk. His head rested on his left arm. The open razor lay, edge up, in the blankets.

"Take Nick out of the shanty, George," the doctor said. There was no need of that. Nick, standing in the door of the kitchen, had a good view of the upper bunk when his father, the lamp in one hand, tipped the Indian's head back.

It was just beginning to be daylight when they walked along the logging road back toward the lake. "I'm terribly sorry I brought you along; Nickie," said his father, all his post-operative exhilaration gone. "It was an awful mess to put you through."

"Do ladies always have such a hard time having babies?" Nick asked.

**"No, that was very, very exceptional."**

"Why did he kill himself, Daddy?"

"I don't know, Nick. He couldn't stand things, I guess."

"Do many men kill themselves, Daddy?"

"Not very many, Nick."

"Do many women?" "Hardly ever." "Don't they ever?"

"Oh, yes. They do sometimes."

"Daddy?"

"Yes."

"Where did Uncle George go?"

"He'll turn up all right."

"Is dying hard, Daddy?"

"No, I think it's pretty easy, Nick. It all depends."

They were seated in the boat. Nick in the stern, his father rowing. The sun was coming up over the hills. A bass jumped, making a circle in the water. Nick trailed his hand in the water. It felt warm in the sharp chill of the morning.

In the early morning on the lake sitting in the stern of the boat with his father rowing; he felt quite sure that he would never die.

## Samples of published writing from various authors

I am attaching an example of several published writings from various authors. I've included a poem, a micro-fiction story, and a short story that represent each genre's style. I selected these stories, not only because they are some of my favorites, but because they are written in a voice and style that I would like to emulate with my own writing this summer.

### 1. Example of a poem

#### What the Doctor Said

By Raymond Carver

(Originally published in "A New Path to the Waterfall" by Raymond Carver in 1989)

He said it doesn't look good  
he said it looks bad in fact real bad  
he said I counted thirty-two of them on one lung before  
I quit counting them  
I said I'm glad I wouldn't want to know  
about any more being there than that  
he said are you a religious man do you kneel down  
in forest groves and let yourself ask for help  
when you come to a waterfall  
mist blowing against your face and arms  
do you stop and ask for understanding at those moments  
I said not yet but I intend to start today  
he said I'm real sorry he said  
I wish I had some other kind of news to give you  
I said Amen and he said something else  
I didn't catch and not knowing what else to do  
and not wanting him to have to repeat it  
and me to have to fully digest it  
I just looked at him  
for a minute and he looked back it was then  
I jumped up and shook hands with this man who'd just given me  
something no one else on earth had ever given me  
I may have even thanked him habit being so strong

### 2. Example of a micro-fiction story

#### A Gentleman's C

by Padgett Powell

(Originally published in "Micro Fiction: An anthology of really short stories" by Jerome Stern in 1996)

My father, trying to finally graduate from college at sixty-two, came, by curious circumstance, to be enrolled in an English class I taught, and I was, perhaps, a bit tougher on him than I was on the others. Hadn't he been tougher on me than on other people's kids growing up? I gave him a hard, honest, low C. About what I felt he'd always given me.

We had a death in the family, and my mother and I traveled to the funeral. My father stayed put to complete his exams—it was his final term. On the way home we learned that he had received his grades, which were low enough in the aggregate to prevent him from graduating, and reading this news on the dowdy sofa inside the front door, he leaned over as if to rest and had a heart attack and

died.

For years I had thought that the old man's passing away would not affect me, but it did.

## Samples of my own writing

I am attaching several of my own writing samples (a poem, a micro-fiction story, and a short story), as an example of what I have been writing recently. These writings reflect my early medical school experiences with my preceptor, Dr. Martin Schermoly, as well as encounters I have had watching a delivery.

### 1. Example of a poem

(This poem was written after a visit to my preceptor, who primarily treats patients suffering from diabetes, hypertension, and heart failure)

Marshall

I saw Marshall again last  
Tuesday He comes in from  
time to time To follow-up with  
his diabetes To adjust his  
medication  
And check for sores he has failed to care  
for He is motionless in the examining  
room And stares somewhere past my  
shoulder  
Answering my questions in short, grunted breaths  
His flannel shirt smells like ham and soggy garages  
His nails are dry and split  
I ask about his weight  
Up from November  
And the numbness in his feet has begun to spread up to his legs  
He says he doesn't feel the sore on his toe  
But it isn't healing, and I think he will lose it  
I think he will lose everything very soon  
It's like the numbness is marching up his body  
Making his skin grey  
His lips grey  
His eyes grey  
I saw an old man and his dog crossing Lindell  
As I was coming home from the store on  
Sunday The car in front of me was giving him  
trouble On account of how slow his dog was  
And came very close to hitting the dog's  
hindquarters When the old man turned  
And brought his fist down onto the roof of the car  
And glared like a demon at the driver  
"Don't you rush him," I saw him growl  
It wasn't until two blocks later that I realized  
It was Marshall

### 2. Example of a micro-fiction story

(This very short story was written after I shadowed a pediatric neurosurgeon. I was interested in the way that a surgical patient is depersonalized in the O.R. as well as the effect that removing brain tissue has on a person.)

The Surgery

After the initial incision there was the drilling. There was the snipping back of bone and cauterizing of blood vessels, which always wanted to ooze open. The surgeons spoke, as they worked. The older one

gave short instructions to the younger, from behind his blue mask and cap.

"Neurosurgery," he said, "is the continuous attempt to minimize bleeding." The younger man nodded, then gently suctioned away the collecting fluid. They worked slowly together, moving deeper, checking the images taken earlier that morning until they had made their way down to where the tumor was supposed to be. It was there, as promised. Not sharp and clear as the images had suggested, but sticky and blurry, stretching tough gray roots into pink, healthy tissue. In some places, it was impossible to tell whether the tissue was cancer or just a place that stored a memory of a day in September when the young girl walked home from school with her mother.

They worked through the day, carefully picking their tools and precisely teasing gray from pink, tough from smooth. At times, they had no choice but to clip out good tissue. Cells that told the young girl when to feel proud or scared or shameful were sucked away. Neurons that told her to calm down when she was upset were removed. They spared the places that taught her how to speak, to listen, to move her arms and legs. These were far too important to risk damaging. Anyway, there was still a good chance that in several years, with luck, her brain would reorganize and find new places to learn what had been lost.

When they'd done all that they could do, they carefully stitched the skin back together, with a quick and skillful twist of the wrist, like whipping batter. They wrapped the head with bandages and finally removed their gloves, speaking in quick congratulatory voice. Then they left the room. The nurse pulled away the draping and was surprised to see that, despite the ugliness that had grown inside the girl's head and the things that had been taken away from her, she had a beautiful face.

### 3. Example of a short story

(This story was written because I am very interested in the identity of "mother" and the relationship between mother and child, a topic I hope to write about over the summer. When I shadowed Dr. Reising, I was able to see a baby being delivered. I was struck by the thought that the mother and her child had many years and experiences ahead of them, but at that moment in time, they had not yet occurred. For this story, I experimented with writing in future-tense.)

#### Faceless Mother

You are eight minutes old when they take this picture. They bundle you up in a light blue cloth and place you in my arms. Your skin is slick and red, and I'm amazed at how tiny your fingernails are. I run my finger over the fuzz on your head. And just as I touch my nose to your forehead the camera clicks.

In a day or so we will go home. Everyone will want to hold you. When Aunt Clair gets her roll of film developed she will give me a copy of this picture. It will grow to become my favorite, with a sacred spot in the left drawer of my desk. I will look at it the day you learn how to stand up, the morning after you leave for your first day of kindergarten, and the night when you stay over at a friend's. I will cry even though I am happy that you are becoming such a big boy. I will take out the photo and touch the spot where my nose meets your forehead. I will try to remember what you smelled like and how tiny your fists really were.

When you are six, we will set up the slip n' slide in the back yard. You will play and play until you are exhausted. Even though I tell you to come inside and put on more sunscreen, you won't. When your skin is hot and red I will pat it with ice and a cool washcloth.

When you are eight, you will ride your bike to a friend's house all alone, after I tell you that you aren't allowed to. When I ground you, you will become so angry that you open my desk drawer and grab this picture. You will take out a pen and scratch away my face, until it is white and torn scribbles. You will leave it there and go to your room. By dinnertime you will forget why you were mad. But when I find this picture at night, I will be hurt in a strange, severe way and quickly place the photo back in the drawer.

When you are eleven we will move to a new neighborhood. You will easily make friends, but will sometimes tell me that you just miss the old house. I will paint your new room blue while you are at school, so that when you come home it looks just like the old one. Sometimes I will ask you who your girlfriend is and you will get quiet and red.

When I bring your lunch up to the cafeteria you will get embarrassed and pretend that you don't see me, even when I wave. I will drive home and take the picture out of the drawer. I will wish I had another copy,

one where my face wasn't scratched out.

In a few more years I **will** lose both of my parents and the teacher's will tell me you have a reading disability. I will start drinking and sometimes, late at night, we will yell at each other. You **will** say you hate me, but I know you don't mean it. I will say that you are a monster, but I don't mean that either. In the morning the air **will** be thick and silent.

When you are sixteen I **will** catch you making out with your girlfriend in the driveway and pretend that I don't see. You will become secretive, and when you are at school I will go through your things, not knowing quite what I expect to find. I will drink more because things hurt worse. And when you say that you hate me, I will say, "I don't care." But that's not true either.

I will help you apply to colleges and encourage you to stay close to home, but you won't. On the day you leave we will drive separate cars full of boxes and furniture. I will slip the picture into my purse. After I hug you goodbye, you will say, "Thank you." And I will tell you how proud and happy I am. Then I will walk out to the car and take out this picture. I will sit in the parking lot and think about how you are your own person now. Think about how I wish I had done some things differently, but how you turned out alright despite that. I will look at this picture and try to remember what I used to be like. I will have trouble remembering how my face looked when I touched my nose to your forehead. And I will still be amazed at how tiny your hands were.

## Letters from Physicians regarding shadowing

### 1. Letter from Dr. David Jackson (maternal-fetal medicine)



THE CENTER FOR ADVANCED FETAL CARE  
OFFICE APPOINTMENTS — (913) 588-6255

January 28, 2011

ELAINE M. CARROLL, MD  
ACADEMIC OFFICE — (913) 588-6201

DAVID N. JACKSON, MD  
ACADEMIC OFFICE — (913) 588-6201

CARL P. WEINER, MD  
ACADEMIC OFFICE — (913) 588-6250

Re: Rebecca Munro

To Whom It May Concern:

I am writing with regards to first year medical student Rebecca Munro's request to shadow.

Ms. Munro has received my permission to shadow my clinical responsibilities on May 23, 2011 and May 26, 2011 for the purpose of gathering information to complete an independent research project.

If I can provide further information, please do not hesitate to contact my office at 913-588-6201.

Sincerely,

A handwritten signature in cursive script that reads 'David N. Jackson'.

David N. Jackson, M.D.  
Assistant Professor  
Department of Obstetrics and Gynecology  
University of Kansas Medical Center

DNJ:nbt

2. Letter from Dr. Sacha Krieg (reproductive endocrinology and infertility)



CENTER FOR ADVANCED REPRODUCTIVE MEDICINE

S. SAMUEL KIM, MD  
SACHA A. KRIEG, MD, PhD

OFFICE APPOINTMENTS — (913)-588-BABY  
(913)-588-2229  
ACADEMIC OFFICE — (913)-588-6261

January 27, 2011

To Whom It May Concern

Rebecca Munro, a 1<sup>st</sup> year medical student enrolled at KUMC, has been approved to "shadow" Sacha Krieg, M.D. in the specialty of Reproductive Endocrinology and Infertility during the summer of 2011. Tentative dates for her attendance are May 24 and May 25.

Please let me know if any further information is needed and do not hesitate to contact my office at 913-588-6261.

Sincerely,

A handwritten signature in cursive script that reads 'Sacha Krieg'.

Sacha A. Krieg, M.D., Ph.D.  
Assistant Professor  
Reproductive Endocrinology & Infertility  
Department of Obstetrics and Gynecology  
University of Kansas Medical Center

SAK:cat

Department of Obstetrics & Gynecology

• Mail Stop 2028 | 3901 Rainbow Blvd. | Kansas City, KS 66160 | (913) 588-6200  
• Corporate Medical Plaza, Building II | 10777 Nall Avenue, Suite 200 | Overland Park, KS 66211 | (913) 588-6200

3. Letter from Dr. Herbert Hodes and Dr. Traci Nauser (general OB/GYN)

**CENTER FOR WOMEN'S HEALTH**

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HERBERT HODES, MD, FACOG  
TRACI L. NAUSER, MD, FACOG  
COLLEEN O'DONNELL, ARNP, RN-C

4840 College Boulevard  
Overland Park, Kansas 66211  
Telephone: (913) 491-6878  
Fax: (913) 491-6808

January 31, 2011

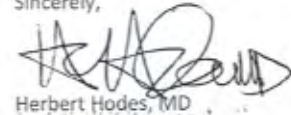
RE: Rebecca Munro

To Whom It May Concern:

This is to certify that we have agreed to allow Rebecca Munro to shadow our physicians and nurse practitioner on Wednesday, 6-1-2011 and on Friday, 6-3-2011. We are a private practice in OB-GYN in Overland Park. She will be with us from 8:30am to 4:30pm both days.













Thank You.

Sincerely,



Herbert Hodes, MD

4. Email correspondence from Dr. Julia Chapman (gynecologic oncology)- still scheduling a shadow time with her assistant.

Plain Text \* | Font ▼ Size ▼ **B** *I* U  ▼ |     |    |    

>>> Julia Chapman 01/31/11 7:22 AM >>>  
that would be fine.  
arrange with melissa james @ 588-6225.  
if it is the first 2 weeks of may, I am QOT

>>> Rebecca Munro 1/26/2011 3:14 PM >>>  
Dr. Chapman,

I'm a first year medical student here at KU interested in OB/GYN. I am planning to do some independent research over the summer with the Clendening fellowship. My plan is to write a collection of fictional short stories in the area of women's reproductive health. Part of my research for this writing, would be to hopefully shadow several OB/GYN doctors over the summer. Ideally, this would give me some experience for my writing. Just to be clear, the writing I am planning to do would be entirely fictional and I would not be retelling any patient's specific story (for confidentiality and IRB reasons). I was wondering if I could come to your clinic to shadow for 1-2 days in late May. I can contact your assistant for scheduling if it's alright.

I realize this is still several months off, but I have to submit my proposal for funding by February 14th, and they would like me to include written documentation that I have permission from physicians to shadow them. Let me know if you think this might work, and I hope to see you in May.

-Becca Munro

5. Planned Parenthood in Overland Park

- I have been in phone contact with both the volunteer coordinator as well as the clinical education director at Planned Parenthood in Overland Park. While they confirmed that it will be alright for me to shadow a physician there in May, I was unable to get written documentation from them in time for this application. I can forward this letter on as soon as I receive it.

Vietnamese Perspectives on the Role of the Physician

A Clendening Fellowship Proposal  
Barbara Nguyen

February 14, 2011

## Introduction

The social and economic reforms in Vietnam dating from the 1980s have arguably led to significant changes within this developing country's structure on many levels—healthcare is no exception. A need for state revenue sources eventually gave way to the creation of a healthcare system and, since its creation in 1992, has become an integral aspect of Vietnamese society (Ensor 1995). Like many other nations, the Vietnamese government has had, in its search for the optimal healthcare system for its people, its share of healthcare reforms throughout the years. Compared to the 15% of the GDP the U.S. used on its healthcare in 2008, Vietnam spent 6.6% of its GDP, with 97% of children immunized and approximately 50% of the population covered by insurance (WHO 2008). Similar to the United States, Vietnam has both public and private providers, as well as government-aided insurance for the disadvantaged. However, unlike the U.S., all insurance in Vietnam is government-owned, and the country's goal is successfully incorporate a universal healthcare system (Ekman et. al 2008).

Also important to note is that, as the Vietnam reforms stemmed from the events regarding the Vietnam War, so too did the immigration boom of the Vietnamese to the U.S. With over 200,000 Vietnamese immigrants in the 80s, that number has since increased to well over a million Vietnamese-born residing throughout the U.S (Terrazas, 2010). However, in the last decade, the population of Vietnamese immigrants in Kansas has declined by over 1800, with approximately 7100 in 2008 (Terrazas, 2010). Many of these immigrants arrived as a consequence of the Vietnam War, and has since established themselves within the American society. However, as with any ethnic group, cultural roots remain deep among the Vietnamese here, and it is not surprising that choices regarding their healthcare may be preferentially made based on racial ties. Studies regarding ethnic and racial disparities within medicine have frequently acknowledged the difficulties of adequate care to minorities by Caucasian physicians, due to such factors as language barriers and cultural misunderstandings (Cooper et. al 2003, Doescher et. al 2000). However, for those Vietnamese patients that do choose a Vietnamese physician, it remains that relationship may not be similar to that as in Vietnam, as the environmental and economic factors are much different.

The underlying factor, then, is whether or not there are preexisting underlying perceptions of the healthcare professional's role—in particular, that of the physician—among these Vietnamese patients. Additionally, whether or not these perceptions are similar to those in Vietnam will also provide information on an equally important topic: to what degree does the type of healthcare system play upon cultural beliefs? Through surveys conducted on Vietnamese immigrant patients in Kansas and Vietnamese natives in Ho Chi Minh City, Vietnam, my comparative study will hopefully provide an in-depth look at the cultural perceptions of the physician's role among the Vietnamese, and to what extent the context of the healthcare system affects them.

## Background: Interest

As a first generation Vietnamese-American, I have experienced firsthand how vibrant the Vietnamese culture exists within the American society. Having visited Vietnam twice, I also have experienced the vibrant culture in Vietnam. While there are undeniably many differences between the two, there are also many beliefs that have held strong within the Vietnamese population, no matter the location. I have learned it is common, like with

other ethnic groups, for the Vietnamese to preferentially make decisions based off an affiliation with one of their kind. This culturally-based link holds true in terms of healthcare. As my family practitioner is Vietnamese, I have observed this firsthand: rarely were there any non-Vietnamese patients in the waiting room.

I have frequently considered to what extent my cultural background will play in my future, particularly with my medical career. It is inevitable that several of my physician-patient relationships will have a cultural context embedded within them, as it did with my family's physician. Such a situation is frequently encountered everywhere, however, and it is a physician's responsibility to be as culturally prepared as possible. The cultural influence upon the perceptions of the physician's role is a complex yet vital component to provide effective healthcare, and ways to measure such a topic can be difficult. Recognizing that the Vietnamese healthcare system is much different than that of the United States, I believe that there may exist common themes in the Vietnamese culture that can be observed and explored. As I have always been interested in better understanding the Vietnamese culture, I believe this study would be an excellent way to combine both my personal and professional cultural interests.

### **Description**

To gain better insight into the Vietnamese attitude regarding healthcare, particularly on the physician's role, I would like to survey patients in Vietnam and those who have immigrated here in the United States. By getting a direct perspective on native Vietnamese people, I believe a more broad yet complete analysis can be achieved. I would first spend time interviewing patients at two predominantly Vietnamese patient-centered family medicine offices in Wichita. The criteria for being a subject in this study would be that he or she is a Vietnamese immigrant. This portion would span approximately two weeks.

Following this, I would spend the remainder of my research time—approximately five weeks—in Ho Chi Minh City, Vietnam. The structure of the Vietnamese healthcare system is predominantly built upon the use of hospital facilities. While all physicians are employed within these hospital facilities, they may also open their own clinics. Working with my contact in Vietnam, three clinics located in Dong Nai, a province neighboring Ho Chi Minh City, have been set up to perform my research.

When working with the subject, there will be three main areas of information collected. The first will be general data regarding the patient's background, such as age and gender. Secondly, information will be gathered on the patient's history with the clinic, mainly as a means to factor in clinic-specific opinions. The last portion, and the most important portion, will be a mix of open-ended questions and scale patient-satisfaction questions. This portion will be the main focus of obtaining the study's goals.

### **Goals**

My goal is to gain a better awareness of the possible cultural Vietnamese perceptions of the physician role, in particular the type of expectations they might have in the clinical setting. There are several important factors that play a part in the physician-patient relationship, and an affinity for healthcare providers of the same racial background clearly holds a role, thus making it an important component to be better understood and studied. By comparing the similarities and differences between those perceptions in native

Vietnamese and Vietnamese-Americans, a few different objectives can be explored. If there are similarities, this will provide insight on the impact of culture—the Vietnamese culture, to be exact—on the patient's views in medicine and the physician-patient relationship. Multiple clinics will be used to minimize clinic-specific opinions as a representation of cultural belief similarities. However, some questions, such as the time spent with the physician, will aid in obtaining a more accurate understanding of some of the subject's interview answers. Additionally, the degree to which the healthcare system structure impacts these cultural perceptions might also be considered. While there are many components that play a role in why a patient perceives the physician's position, and the conclusions reached in this study can only be suggestive of the possible underlying reasons, the results will nevertheless provide a wealth of information that can be helpful to future physicians and applicable to their careers.

#### *Hypothesis*

There are commonly-shared perceptions of the physician's role by the Vietnamese population, which can be observed through comparisons of patient views in the native population in Vietnam and Vietnamese immigrants in Kansas.

#### *Specific Aims*

- To find, if any, what the Vietnamese patients' perceptions are of the physician's role by identifying key similarities and themes
- To recognize, to what extent, the Vietnamese culture plays upon the patient's expectations, noting the impact of clinic-specific factors on patient opinions
- To note the influence of the different healthcare systems upon these perceptions

### **Methods**

This study will be conducted by use of surveys provided to patients in two primary regions—Wichita, KS and Dong Nai, Vietnam. Patients will be asked to participate at the time of arrival of their appointments. For privacy purposes, patients will be asked while waiting in their respective private exam rooms. Names and contact information will be not be collected for patient security. A script will be used to explain confidentiality and subject rights should the patient participate (Appendix A). This script, as a means for oral consent, is a way to protect patient rights (following KUMC-Wichita's IRB Expedited process) by having no written record of the patient identifiers. Patients will be informed that they will not be required to answer any question they are uncomfortable with, and that all raw data collected will be viewable only by the principle investigator and myself. For patients that agree, the interview will be done immediately and should take approximately ten minutes to complete. Patients will be provided the survey, and answers will be stated orally and recorded on my password-protected tablet. All patient surveys and data collection will be conducted by myself, in Vietnamese. In accordance with HSC regulations, patients will not be identified by province or city; however, requesting the province of residence for Wichita subjects is only for comparison purposes as collective numbers, as all subjects in Vietnam will be of the Dong Nai province. Subjects will not be identified within the context of the research by province—only as South Vietnam subjects; similarly, Wichita subjects will be identified as Kansas subjects.

As previously stated, the survey (see Appendix B), provided in both English and Vietnamese for the clinics in Wichita, consists of a few main survey portions. The first portion regarding the patient's office visit history will point to the depth of reliance

patients may have on their physician with their health concerns and maintenance. The last portion, the interview portion, is the primary focus of my research. Within this portion will be several open-ended questions, which will allow the patient to freely express his or her opinions. These questions are not meant for the patient to speak of a specific physician; rather, they are related to a general perception of physicians, and the patient will be asked to answer in general terms. Following this is a set of patient-satisfaction questions asked through a scale-grading format, as studies regarding patient interaction with the physician often use scales as a means to quantitatively indicate the level of patient satisfaction (Doescher et. al 2000, Cooper et. al 2003, Cook et. al 2005, Kaplan et. al 1996). This part of the survey portion is mainly used to factor in the influence of the patient's clinic in his or her perception of the physician's role. The entire process will thus provide a general depiction of the physician's role in the patient's health, and how the patient perceives the capabilities and need of the physician.

A minimum of 20 patient surveys will be collected from each research site. For surveys performed at the Wichita sites, patients that are not Vietnamese immigrants will be excluded from participation in the study. In order to minimize the impact of one particular physician's influence on patient satisfaction, patients of at least three physicians at each region will be surveyed. Collection of Wichita survey participants will span over about three weeks; Dong Nai participants, five weeks. Three different clinics in Dong Nai will be used as research sites—one week will be spent with every clinic. The reason for performing the surveys in Wichita first is for me to get a better hold of speaking Vietnamese in a medical setting more fluently. Although I was raised in a predominantly Vietnamese-speaking household, working with Wichitan Vietnamese patients, who understand at least some minimal English, will help strengthen my vocabulary, as they will be able to work with me on the appropriate diction. I will also be going to Vietnam with my grandfather, an immigrant himself and a native to Dong Nai. While he will not be working at the research sites with me, he will be my guide in the Dong Nai province and Ho Chi Minh City.

After all surveys have been collected, statistical analysis will involve categorization of results by various graphs: collective results by research site, comparisons between Wichita and Dong Nai. Points of focus in the interview portion will be common themes through similar answers. While no two subjects will have the exact same opinions, portions or comparable sentiments can be gathered and analyzed. Factors concerning clinic-specific influences will be taken into account by identifying how many subjects within a given number exclusively stated their respective clinic as part of the reason. Responses that might provide a more in-depth perspective on these common themes will be presented within the results (with no identifiers listed other than if the subject were from a Wichita site or Vietnam site), not for conclusive purposes, but for discussion.

#### **IRB status**

As part of my research will be in Wichita, I am completing my IRB forms to the KUMC-Wichita site. My application for HSC expedited status was submitted to Jason Rush, Research Compliance Coordinator (of KU School of Medicine-Wichita) on Feb. 1 for administrative pre-review and editing before actual submission to the HSC. It was returned with administrative notes on Feb. 11. The revised form will be submitted to Cindy Deveau, Medical Secretary for Dr. Moncure, on Feb. 14 for Dr. Moncure's approval and signature as Principal Investigator, and then will be sent to the Human Subjects Committee.

Thank you to the Clendening Committee for taking the time to read and consider my proposal.

### Sites

#### Wichita, KS

Thomas Tran, MD (Family Medicine office)	2620 E. Central Ave 67214
Dung Nguyen, MD (Family Medicine office)	2620 E. Central Ave 67214
Thanh Vu, DO (Family Medicine office)	2604 E. Central Ave., Suite B 67214

#### Ho Chi Minh City, Vietnam

Lê Nguyễn Đăng Khoa, MD, Clinic	72B Tân Hưng Viên, Quận Tân Phú, Biên Hòa, Đồng Nai
Lê Thị Xuân Lan, MD, Clinic	66/3 Tây Hòa, Lạc Hòa, Trảng Bàng, Đồng Nai
Thái Phạm Thị Hòa, MD, Clinic	15/15 Khu Phố 8, Tân Hòa Ward, Biên Hòa, Đồng Nai

### Contacts

#### Mentor and HSC Principal Investigator

Michael Moncure, MD, FACS  
 Director of Trauma and Associate Professor of Surgery  
 mmoncure@kumc.edu

#### Research and IRB Guide

Jessica McDonnell, RN, BSN, CCRP  
 University of Kansas Hospital Trauma/Burn Research Coordinator  
 jmcdonnell3@kumc.edu

#### Lodging

##### Wichita

Den Nguyen & Thuy Vu, parents

##### Ho Chi Minh City, VN

Sy Ba Vu, Grandfather

Xuan Lan Vo, Cousin (additional contact)

#### Research Site Contacts

##### Wichita

Drs. Thomas Tran & Dung  
 Nguyen's office, Family Medicine  
 Contact: Dr. Thomas Tran  
 2620 E. Central Ave, 67214  
 316-686-5555

Dr. Thanh Vu, DO, Family Medicine  
 Contact: Hien Nguyen  
 2604 E. Central Ave., Suite B  
 67214 316-684-9900

## Vietnam

The three sites were established and set up through communication with Dr. Tô Xuân Văn, MD, Internal Medicine. He works at Thông Nhứt Hospital, located at 234 Quốc Lộ 1, Tân Bình Ward, Biên Hòa, Đồng Nai. The physicians of the three clinics are his colleagues. He can be reached at cell phone: 09-0-7507-577. Dr. Van is the cousin of my friend Vi Leitenberger, a graduate student at KU. She can be reached at 316-218-8873.

Lê Nguyễn Đăng Khoa, MD, Radiology

Lê Thị Xuân Lan, MD, Gynecology

Thái Phạm Thị Hòa, MD, Cardiology

## Budget

Airfare (05/29-07/02) -Wichita, KS—Ho Chi Minh City, VN	~\$2000
Lodging -Wichita -Dong Nai	\$0 (Staying with my parents) \$0 (Staying with my cousin/grandfather)
Traveling (personal car in Wichita, taxi in HCMC)	~\$100
Food, miscellaneous	~\$300
<b>Total</b>	~\$2400
Note: I understand that the stipend provided through the Clendening Fellowship will only partially cover my expenses. However, it would only be through the aid of this program that I would be able to carry out this research, and I am prepared for the remaining costs to be covered by my personal finances.	

## Itinerary

May 18-June 3: Wichita site

May 18-24: Dr. Thanh Vu's office

Office hours: Mon, Wed, Fri: 8AM-5PM; Tues, Thurs: 8AM-3PM; Sat: 8AM-12PM

May 25-June 3: Drs. Thomas Tran and Dung Nguyen's office

Office hours: Mon-Fri: 8AM-4PM; Sat: 8AM-12PM

June 4: Leave for Ho Chi Minh City (with grandfather)

June 5: Arrive in Ho Chi Minh City (see Appendix C for proposed flight itinerary)

Take taxi to Dong Nai to grandfather's residence: ~20 minutes

June 5- July 2: Da Nang sites

Leave by taxi for site at 730AM; leave site at 2PM; Mon-Fri

June 6-14: Thái Phạm Thị Hòa's clinic

June 15-23: Lê Thị Xuân Lan's clinic

June 24-July 2: Lê Nguyễn Đăng Khoa's clinic

July 3: Leave for Wichita

### Resources

- Cook, Cynthia T., Kosoko-Lasaki Omofolasade, and Richard O'Brien. *Satisfaction with and perceived cultural competency of healthcare providers: the minority experience*. J Natl Med Assoc. 2005 Aug; 97(8): 1078-1087.  
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- Oanh, Tran Thi Mai, et. al. *Assessment of health system performance in six provinces of Vietnam: Draft report for comments*. Health Systems 20/20 Project, United States Agency for International Development. 2010 Jan 1.  
< <http://www.healthsystems2020.org/content/resource/detail/2737/>>.
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- Doescher, Mark P., et. al. *Racial and ethnic disparities in perceptions of physician style and trust*. Arch Fam Med. 2000 Nov; 9(10): 1156-1163. < <http://archfami.ama-assn.org/cgi/content/full/9/10/1156>>. PMCID: 11115223
- Kaplan, Sherrie H., et. al. *Characteristics of physicians with participatory decision-making styles*. Ann Intern Med. 1996 Mar 1; 124(5): 511-513.  
< <http://www.annals.org.proxy.kumc.edu:2048/content/124/5/497.long>>.  
PMCID: 8602709

## Appendix A

### Survey/Interview Patient Consent Script: Wichita patients

You are being asked to participate in a research study conducted by the University of Kansas School of Medicine-Wichita and Kansas City with Dr. Michael Moncure as principal investigator. Barbara Nguyen, a first year medical student, will be conducting the interviews in this study. The purpose of this study is to gain a better understanding of Vietnamese perceptions of the physician's role in the clinical setting. Questions will be asked regarding your opinion of what a physician means to you in general, and questions may be asked relating to your experiences with physicians. No questions will be asked about your personal physician. As a Vietnamese immigrant, you meet the requirements as a possible participant in this study.

Should you agree, this study will involve a series of open-ended questions and scale-rating statements. This brief survey and interview should take approximately 15 minutes to complete. Your participation is completely voluntary and greatly appreciated. You can choose to not respond to any question you are not comfortable with, and you may choose to withdraw from participating at any time. Your name or any identifying personal information will not be collected, and any information you provide will be kept in strict confidence. All data will be stored in a password protected file, accessible only to those involved with the research study. Your participation is very important to this study, and your privacy will be respected. You will not be contacted or solicited after the interview; however, if you have any questions regarding this study, please contact Dr. Moncure at [mmoncure@kumc.edu](mailto:mmoncure@kumc.edu) or Barbara at [bnguyen@kumc.edu](mailto:bnguyen@kumc.edu).

Bạn đang được yêu cầu tham gia vào một nghiên cứu tiến hành bởi Đại học Kansas hoặc Y-Wichita và Kansas City với Tiến sĩ Michael Moncure là điều tra viên chính. Barbara Nguyen, một sinh viên y khoa năm đầu tiên, sẽ được tiến hành các cuộc phỏng vấn trong nghiên cứu này. Mục đích của nghiên cứu này là để đạt được một số hiểu biết tốt hơn về nhận thức Việt Nam của vai trò của bác sĩ trong các thiết lập lâm sàng. Các câu hỏi sẽ được hỏi và ý kiến của bạn về những gì bác sĩ một phòng tiến độ bạn nói chung. Không có câu hỏi sẽ được hỏi về bác sĩ riêng của bạn, những câu hỏi về kinh nghiệm của bạn có thể đi lên. Là một người nhập cư Việt Nam, bạn đáp ứng các yêu cầu như là một người tham gia có thể có trong nghiên cứu này.

Nếu bạn đồng ý, nghiên cứu này sẽ bao gồm một loạt các câu hỏi mở và quy mô, đánh giá báo cáo. Khảo sát này ngắn gọn và phỏng vấn nên mất khoảng 15 phút để hoàn thành. Sự tham gia của bạn là hoàn toàn tự nguyện và đánh giá rất nhiều. Bạn có thể chọn không trả lời bất kỳ câu hỏi mà bạn không thấy thoải mái, và bạn có thể lựa chọn rút khỏi tham gia bất cứ lúc nào. Tên của bạn hoặc bất kỳ thông tin nhận dạng cá nhân sẽ không được thu thập, và bất kỳ thông tin bạn cung cấp sẽ được giữ kín. Tất cả dữ liệu sẽ được lưu trữ trong một tệp tin một khu vực bảo vệ, truy cập duy nhất chỉ những người tham gia với các nghiên cứu. Sự tham gia của bạn là rất quan trọng đối với nghiên cứu này, và sẽ riêng tư của bạn sẽ được tôn trọng. Bạn sẽ không được liên lạc hoặc tiếp xúc sau khi phỏng vấn, tuy nhiên, nếu bạn có bất kỳ câu hỏi liên quan đến nghiên cứu này, xin vui lòng liên hệ Dr. Moncure: [mmoncure@kumc.edu](mailto:mmoncure@kumc.edu) or Barbara: [bnguyen@kumc.edu](mailto:bnguyen@kumc.edu).

## Appendix B: Survey/Interview

### Survey for Outpatient Clinic Subjects

#### Part 1: Background Statistics

1. Province:
2. Gender:
3. Age:

#### Part 2: Patient Visit Statistics

1. How long have you been a patient at this facility?
  - a. 0-2 years
  - b. 3-5 years
  - c. 6-8 years
  - d. 9-11 years
  - e. 12+ years
2. Approximately how often do you visit your physician each year?
  - a. 0-2 times a year
  - b. 3-5 times a year
  - c. 6-8 times a year
  - d. 9-11 times a year
  - e. 12+ years
3. What are some of the reasons for your visits (please check all that apply):
  - a. Routine check-up/annual physical exam
  - b. Chronic condition
  - c. Cold/flu
  - d. Infection
  - e. Cuts/scrapes/injuries
  - f. Shots/vaccinations
  - g. Other: \_\_\_\_\_
  - h. More than an hour
4. On average, how long do you think you spend with your physician during your appointment?
  - a. Less than 15 minutes
  - b. Less than 30 minutes
  - c. Less than 45 minutes
  - d. Less than an hour
  - e. More than an hour

#### Part 3: Patient Interview

1. What is the first thing that comes to mind when you think of a physician?
2. What positive ideas do you have about physicians in general?
3. What criticisms do you have about physicians in general?
4. What criteria did you have in choosing your physician? What was the most important criteria?
  - a. (Examples: Convenience/Location; Nationality; Reputation; Gender; Age; Cost)
5. Of the following, please rate, 1 being the most important, the qualities of a physician
  - a. Professionalism/Personality
  - b. Competence in services
  - c. Types of services available
  - d. Physician-patient relationship (including patient confidentiality)
  - e. Availability
6. Please pick on the following scale, 1 being the most true, your opinion on the following questions:

a. I completely trust what my physician tells me about my health concerns.	1	2	3	4	5	6	7	8	9	10
b. I always do what my physician tells me regarding my health issues.	1	2	3	4	5	6	7	8	9	10
c. I would stay with my current physician even if he/she were more expensive.	1	2	3	4	5	6	7	8	9	10
d. I only go to the doctor's office if it is an emergency.	1	2	3	4	5	6	7	8	9	10
e. I expect my physician to know what my condition is.	1	2	3	4	5	6	7	8	9	10
f. My physician plays a big role in my life.	1	2	3	4	5	6	7	8	9	10
g. I believe the physician spends enough time with me during my appointment.	1	2	3	4	5	6	7	8	9	10
h. I feel rushed when I am with my physician for my appointment.	1	2	3	4	5	6	7	8	9	10
i. I believe the services provided are reasonably priced.	1	2	3	4	5	6	7	8	9	10

Kiểm tra cho bệnh nhân ngoại trú phòng mạch môn

Phần 1: Thông kê bệnh nhân

1. Tên:
2. Giới tính:
3. Tuổi:

Phần 2: Thông kê chuyên thăm bệnh nhân

1. Bao lâu bạn đã là một bệnh nhân tại cơ sở này?
  - a. 0-2 năm
  - b. 3-5 năm
  - c. 6-8 năm
  - d. 9-11 năm
  - e. 12 + năm
2. Khoảng bao lâu bạn ghé thăm bác sĩ của bạn mỗi năm?
  - a. 0-2 lần mỗi năm
  - b. 3 - 5 lần mỗi năm
  - c. 6 - 8 lần mỗi năm
  - d. 9 - 11 lần mỗi năm
  - e. 12 + năm
3. Những gì là một số trong những lý do cho các lượt truy cập (hãy kiểm tra tất cả mà áp dụng):
  - a. định kỳ kiểm tra lên/hàng năm vượt lý kỳ thi
  - b. tình trạng mãn tính
  - c. lạnh/cúm
  - d. nhiễm
  - e. cắt gọt/scrapes/thiết bị tích
  - f. mũi chích ngừa/tiêm chủng
  - g. khác: \_\_\_\_\_
4. Trung bình, bao lâu bạn có nghĩ rằng bạn chỉ tiêu với bác sĩ của bạn trong thời gian cuộc hẹn của bạn?
  - a. ít hơn 15 phút
  - b. ít hơn 30 phút
  - c. ít hơn 45 phút
  - d. ít hơn một giờ
  - e. nhiều hơn một giờ

Phần 3: Phỏng vấn bệnh nhân

1. Những gì là điều đầu tiên mà nói đến cái tâm khi bạn nghĩ của bác sĩ?
2. Những gì là ý tưởng tích cực đối với bạn có với các bác sĩ nói chung?
3. Những gì là lời chỉ trích nào bạn có với các bác sĩ nói chung?
4. Những gì là tiêu chí bạn đã có trong việc lựa chọn bác sĩ của bạn? Các tiêu chí quan trọng nhất là gì?
  - a. (ví dụ: Thuần thiện / Địa điểm, Quốc gia; Danh tiếng; giới tính; Age; Chi phí)
5. Của sau đây, cách đánh giá vui lòng, 1 đang là quan trọng nhất, những phẩm chất của văn phòng của bác sĩ
  - a. có thêm quyền
  - b. tôn trọng/chuyên nghiệp
  - c. hợp lý giá dịch vụ
  - d. kinh nghiệm
  - e. đáng tin cậy (bác sĩ, bệnh nhân mối quan hệ)

6. Hãy chọn trên quy mô sau, 1 đang nhất đúng, ý kiến của bạn vào câu hỏi sau đây:

a. Tôi hoàn toàn tin tưởng những gì bác sĩ của tôi nói với tôi về mọi quan tâm y tế của tôi.

1      2      3      4      5      6      7      8      9      10

b. Tôi luôn luôn làm những gì bác sĩ của tôi nói với tôi về các vấn đề sức khỏe của tôi.

1      2      3      4      5      6      7      8      9      10

c. Tôi sẽ tiếp tục với bác sĩ của tôi hiện tại ngay cả khi người đó hết hạn.

1      2      3      4      5      6      7      8      9      10

d. Tôi chỉ đi đến văn phòng của bác sĩ nếu nó là khẩn cấp.

1      2      3      4      5      6      7      8      9      10

e. Tôi mong đợi của tôi bác sĩ cho biết tình trạng của tôi là gì.

1      2      3      4      5      6      7      8      9      10

f. Bác sĩ của tôi đóng một vai trò lớn trong cuộc sống của tôi.

1      2      3      4      5      6      7      8      9      10

g. Tôi tin rằng bác sĩ dành đủ thời gian với tôi trong thời gian cuộc hẹn của tôi.

1      2      3      4      5      6      7      8      9      10

h. Tôi cảm thấy vui vẻ khi tôi với bác sĩ của tôi cho cuộc hẹn của tôi.

1      2      3      4      5      6      7      8      9      10

i. Tôi tin rằng dịch vụ giá hợp lý.

1      2      3      4      5      6      7      8      9      10

Appendix C: Sample flight itinerary (via Yahoo! Travel)

Flight: 1 Round-Trip Ticket

Thu, Jun 2, 2011


Kansas City International Airport (MCI) to Ho Chi Minh City (SGN)

Depart: 06:15am

Arrive: 09:50am

Kansas City, MO (MCI) to

Newark, NJ (EWR)

 **Continental Airlines**

Flight 2613 operated by EXPRESSJET AIRLINES INC DBA CO EXPRESS (on Embraer RJ135/145)

1 Stop – change planes in Newark, NJ (EWR)


Connection Time: 5 hrs 25 mins

Depart: 03:15pm

Arrive: 07:05pm

Newark, NJ (EWR) to

Hong Kong, Hong Kong (HKG)

 **Continental Airlines**

Flight 99 (on Boeing 777)

1 Stop – change planes in Hong Kong, Hong Kong (HKG)

Connection Time: 1 hr 35 mins


Depart: 08:40pm

Arrive: 10:05pm

Next day

Hong Kong, Hong Kong (HKG) to

Ho Chi Minh, Viet Nam (SGN)

 **Continental Airlines**

Flight 6019 operated by United (on Boeing 747-400)

Total Travel Time: 27 hrs 50 mins

Sun, Jul 3, 2011


Ho Chi Minh City (SGN) to Kansas City International Airport (MCI)

Depart: 11:55pm

Arrive: 07:45am

Ho Chi Minh, Viet Nam (SGN) to

Tokyo, Japan (NRT)

 **Continental Airlines**

Flight 4470 operated by AIR JAPAN (on Boeing 767-300)

1 Stop – change planes in Tokyo, Japan (NRT)

Connection Time: 8 hrs 10 mins

Depart: 03:55pm

Arrive: 01:50pm

Tokyo, Japan (NRT) to

Houston, TX (IAH)

 **Continental Airlines**

Flight 6 (on Boeing 777)

## Hope for the Economically Underprivileged in America's Urban Core

### Clendening Summer Fellowship Proposal

Andy Patton (KUSOM 2014)

February 14, 2011

#### Introduction

The project I propose for a Clendening Summer Fellowship involves researching primary care medicine in America's inner-cities. Specifically, my research will focus on prenatal care amongst the patient population served by the Hope Family Care Center in inner-city Kansas City, Missouri. Data will also be collected regarding demographic factors related to prenatal care, including rates of teenage pregnancies, unwed pregnancies, adoption and abortion rates, and parent demographics (including age, education level, employment, substance abuse, and gang membership). Information obtained will be included in a report submitted for the Clendening Summer Fellowship and given to the staff of the Hope Family Care Center to help them better understand the needs of their patient population.

#### A Word from Nathan Jackson of the Hope Family Care Center

As a new medical clinic that just recently opened our doors full-time, the Hope Family Care Center is very interested in further understanding the needs of our patients, especially in the realms of prenatal care and women's health. As Practice Administrator, I was excited about Mr. Andy Patton's proposal to assist in pursuing this knowledge, ultimately helping us provide the best patient care to our neighborhood. I've discussed the project with our Medical Director and Lead Practitioner, Dr. Jeremy Kirchoff, who is also excited and supportive of the project. We are prepared to assist and support Mr. Patton in his research endeavor while complying with HIPAA Privacy Rules. Feel free to contact me if you have any questions.

#### Background

The summer preceding my freshman year of college, I read Tracy Kidder's book Mountains Beyond Mountains which forever changed my life. The book told the story of a man named Paul Farmer, a physician who has given his life to serving some of the world's poorest people in Haiti. Since that time, I have had an ever growing desire to serve the world's poor as a medical missionary. This past November, I attended the Global Missions Health Conference in Louisville, Kentucky. The conference strengthened my desire to someday practice medical missions in a developing country, but it also opened my eyes to the tremendous potential for medical mission work in America's urban core. One of the conference's keynote speakers was a man named Rick Donlon, one of the founders of Christ Community Health Services, an inner-city medical clinic in Memphis, Tennessee. Dr. Donlon's stories, pictures, and videos of life at his clinic inspired me, and showed me that making personal and financial sacrifices to provide care for the poor is one of the most fulfilling career decisions a physician can ever make. He also showed that you don't have to give your life to doing either inner-city medical missions or foreign missions, but you can do both! At one point, he even mentioned that nothing can better prepare a person for medical missions in a developing country than doing inner-city work in the United States.

After looking into summer opportunities to do research on medical mission work in America and abroad, I decided that learning and working in an inner-city clinic in America would be the best option for me during the summer of 2011. I contacted Rick Donlon at Christ Community Health Services, told him about my interest in medical missions and the Clendening Summer Fellowship, and asked him if there were any summer opportunities for me at his clinic. He told me that they do offer 4-week elective

rotations for medical students during the summer. I then contacted the Hope Family Care Center (HFCC) about my interest in doing Clendening research on inner-city primary care. I asked if there was any research I could do that would somehow help the HFCC better understand the needs of its patients and provide better care.

The Hope Family Care Center opened in October of 2009, and is a subsidiary of a community development organization called The Hope Center, whose vision is to contribute to the betterment of Kansas City, Missouri's east-side community in a holistic manner through youth development, a charter school, housing, a neighborhood-based church, and the Hope Family Care Center. The Hope Family Care Center envisions all residents of its community receiving quality, personal health care, with preventive health care becoming the norm, regardless of one's income.<sup>1</sup>

### **Description**

Nathan Jackson (Practice Administrator) and Dr. Jeremy Kirchoff (Medical Director) of the Hope Family Care Center determined that a prenatal research focus would be helpful to the clinic. Specifically, they requested that data sets be collected regarding rates of teenage pregnancies, unwed pregnancies, adoption and abortion rates, and parent demographics (including age, education level, employment, substance abuse, and gang membership).

The aforementioned demographic factors have been shown to have profound implications on the health of both children and mothers in both the prenatal and postnatal periods. For example, teenage pregnancies have been correlated with premature birth and low birth weight,<sup>2</sup> pregnant teens are less likely to receive prenatal care,<sup>3</sup> and children born to teen mothers are more likely to suffer from health issues in childhood or be hospitalized than those born to older mothers.<sup>4</sup> Maternal substance abuse during pregnancy raises major concerns regarding long term health of children after in utero exposure, as well as being correlated to increased risk for placental abruption and premature rupture of membranes during pregnancy.<sup>5</sup> A better understanding of these demographic factors among the patient population of the HFCC would allow it to better meet the needs of patients and the community.

Additionally, I will spend four weeks this summer doing a non-credit rotation at Christ Community Health Services (CCHS) in Memphis. CCHS is one of the largest inner-city medical clinics in the country, and has done much to help the HFCC start the same kind of practice in Kansas City. While in Memphis, I will see patients in the clinics in the mornings, and do supervised discipleship and community outreach events in the afternoons. This rotation will be a great opportunity to learn about my broad interest of inner-city primary care medicine. Also, CCHS has years of experience providing prenatal care to the communities it serves. In 2008, CCHS launched an initiative called "Centering Pregnancy," a unique approach to prenatal care which includes self-care techniques, group prenatal care, and facilitated meetings. For this reason, I will pay close attention to learn as much as possible about CCHS's handling of prenatal care, and all findings that could be helpful to the HFCC will be carefully recorded. Because I will begin volunteering for the HFCC during February, I will be able to begin conducting my research during the spring semester, and will have plenty of time to finish interviewing patients and compiling results upon returning to Kansas City in June. The HFCC is aware that I will spend four weeks in Memphis and will not be volunteering or conducting research in Kansas City during that time.

### **Timeline:**

February – May 12	Begin volunteering bi-weekly at HFCC to become acquainted with the patient population and staff. Review medical literature and refine pre-interview
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	questionnaire and interview questions. Begin conducting interviews as time permits.
May 12	Academic year ends.
May 13 – May 28	Begin volunteering on a more frequent basis at HFCC and continue interviewing patients.
May 29	Drive to Memphis.
May 30 – June 25	Participate in rotation at Christ Community Health Services.
June 26	Return to Kansas City.
June 27 – July 23	Resume volunteering and research at HFCC.
July 24 – August 1	Compile data and finalize report for HFCC as well as Clendening report.

## **Methods**

Data will be collected through interviews with patients of the Hope Family Care Center who are willing to volunteer to be interviewed. Additionally, short pre-interview questionnaires will be given to interviewees in order to maximize time efficiency during the interviews. A draft of the questionnaire as well as interview questions can be found in Appendices B and C of this proposal, respectively. In order to become more familiar with the Hope Family Care Center's patient population, I will begin volunteering for the HFCC on a bi-weekly basis in February. My primary responsibility at first will be working at the clinic's front desk, which will provide great opportunities for patient interaction. Once classes get out for summer, I will be able to increase my time volunteering at the Hope Family Care Center, while also conducting my research.

Potential interviewees will include patients who are currently receiving prenatal care, or those who have received prenatal care in the recent past. Candidates will be approached, given a description of the project, and allowed to choose whether to participate. Written consent will be obtained; a copy of the written consent form can be found in Appendix A of this proposal. For patients who are not yet 18 years old, additional consent will need to be obtained from a parent or legal guardian. For the sake of brevity, that consent form is not included in the appendices of this proposal. The audio of interviews will be recorded to ensure accurate recording of the information, as well as to save patients time that would otherwise be spent waiting for their responses to be written down. Since calculating an adequate sample size would be difficult, as many interviews as possible will be sought. If it is determined that not enough interviewees are being found within the HFCC's patient clientele, opportunities to conduct interviews among the community's general population will be explored. Gift cards will be purchased through funds obtained from the Clendening Summer Fellowship and given to interviewees as an expression of gratitude for their participation. Medical literature pertaining to prenatal care in the inner-city will be reviewed, which will be obtained through databases provided by Dykes Library, such as PubMed and MEDLINEplus. Also, pertinent data will be obtained from local and state organizations, such as the Health Care Foundation of Greater Kansas City, the KCMO Health Department, and the Missouri Department of Health and Senior Services. This information will be included in the final report given to the Hope Family Care Center and submitted for the Clendening Summer Fellowship.

**Housing:** While in Kansas City, I will live at my current residence, a house at 4206 Cambridge Street in Kansas City, Kansas. In Memphis, I will live at Christ Community Health Service's guest house, where a spot has been reserved for me from May 29<sup>th</sup> through June 25<sup>th</sup>.

**Travel:** My 2004 Honda Accord will be my means of transportation to Memphis and for all research-related travel in Kansas City.

### Contacts:

<b>Hope Family Care Center</b> 3027 Prospect Kansas City, MO 64128 (816) 861-6500	<b>Christ Community Health Services</b> 2595 Central Ave. Memphis, TN 38104 (901) 260-8500
<b>Nathan Jackson – Practice Administrator (HFCC)</b> njackson@hfcckc.org (816) 547-6283	<b>Rick Donlon, MD</b> Associate Executive Director (CCHS)
<b>Judy Bodenhamer – Clinic Leader (HFCC)</b> judyb@hopecenterkc.org (816) 509-0685	

### Budget

<b>Housing:</b>	\$350/month in KC x 2 months	= \$700
	\$200/month in Memphis x 1 month	= \$200
<b>Utilities:</b>	Estimated \$60/month in KC x 2 months	= \$120
<b>Gas:</b>	Estimated \$108 for 900 mile round trip to and from Memphis	= \$108
	Estimated \$50 for daily trips to HFCC (~9 miles round trip)	= \$50
<b>Food:</b>	\$7/day x 84 days	= \$588
<b>Gift Cards:</b>		= \$300
<b>Audio Recorder:</b>		= \$50
<b>Total:</b>		<b>= \$2116</b>

The \$116 budgeted above the allotted \$2000 and any additional expenses incurred will be paid out of my personal savings. Money has been reserved for same.

### Conclusion

The stated mission of the Hope Family Care Center is "To honor God by providing quality, personal health care." Personally, if I were to write a mission statement for my medical career, it would sound very similar to that. As a follower of Jesus Christ, I believe it is my personal responsibility to use my medical career to glorify God and to love and serve the people He created, especially those who do not have the financial means to purchase the medical services they require. That is why I came to medical school, and that is why I'm applying to do research on medical work in America's inner-cities amongst her poorest people. Thank you very much for your consideration of this proposal.

### Bibliography

1. Hope Family Care Center "Mission and Vision" Statement. Obtained at <<http://hfcckc.org/about-us.html>>.
2. Scholl TO, Hediger ML, Belsky DH. "Prenatal care and maternal health during adolescent pregnancy: a review and meta-analysis." J Adolesc Health. 1994 Sep; 15(6):444-56.
3. Makinson C. "The health consequences of teenage fertility." Fam Plann Perspect. 1985 May-Jun; 17(3):132-9.
4. Guttmacher Institute. "Teen Sex and Pregnancy." 2011 Jan (<http://www.guttmacher.org/pubs/FB-ATSRH.html>)

5. Addis A, Moretti ME, Ahmed Syed F, Einarson TR, Koren G. "Fetal effects of cocaine: an updated meta-analysis." *Reprod Toxicol*. 2001 Jul-Aug; 15(4):341-69.

#### **Appendix A:** Consent Form

I am a medical student at the University of Kansas School of Medicine, and I am conducting interviews for a Clendening Summer Fellowship research project. I am studying inner-city medical care, with a specific focus on prenatal care and demographic factors.

If you choose to participate in this study, you will be asked to answer some questions regarding prenatal care you are currently receiving or have received in the past. You will also be asked questions about certain factors, including age, education level, employment, substance abuse, and gang membership. Please take as much time as you need to answer the questions, and feel free to expand on the topic or talk about related ideas. If at any time during the interview you are asked a question which you would rather not answer, please say so and we will either stop the interview or move on the next question, whichever you prefer. All the information will be kept confidential, and you will not be asked to give your full name, address, phone number, birthday, or other identifying information. All information will be destroyed or kept in a secure location once the research work is complete.

#### **Participant's Agreement:**

I am aware that my participation in this interview is voluntary. I understand the intent and purpose of the research. If, for some reason, I wish to stop the interview at any time, I may do so without having to give an explanation. I am aware that the information obtained in this interview will be used in a Clendening Summer Fellowship research project, and may be used in a presentation at the University of Kansas School of Medicine. I have the right to review, comment on, and/or withdraw information prior to the project's submission. The information gathered in this interview is confidential with respect to my personal identity unless I specify otherwise. I understand that the audio from this interview is being recorded, and if I say anything that I believe may incriminate myself, the interviewer will immediately rewind the tape and record over the potentially incriminating information. The interviewer will then ask me if I would like to continue the interview.

If I have any questions about this study, I am free to contact the student researcher (Andy Patton, [apatton@kumc.edu](mailto:apatton@kumc.edu), 913-961-6909). I have been offered a copy of this consent form that I may keep for my own reference. I have read the above form and, with the understanding that I can withdraw at any time and for whatever reason, I consent to participate in today's interview.

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Participant's signature

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Date

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Interviewer's signature

Form adapted from template provided by Bard College Institutional Review Board. <http://inside.bard.edu/irb/consent/>

## **Appendix B:** Pre-Interview Questionnaire Questions

1. What is your first name?
2. What is your age?
3. How many children do you have, and what are their ages?
4. What is your level of education? Please circle your highest level of education: No high school, some high school, high school graduate, some post-secondary education, associate degree, bachelor degree, graduate degree.
5. What is your current relationship status? Please circle one: Single, dating, engaged, married, other.
6. Have you ever had a pregnancy that was terminated? Yes/No.
7. If answer to question #6 was yes, how many pregnancies have you had that were terminated?
8. Have you ever adopted? Yes/No.

## **Appendix C:** Interview Questions

1. Approximately how many months into your pregnancy/pregnancies did you begin receiving prenatal care?
2. Where did you go to receive prenatal care?
3. How were you able to pay for your prenatal care? Was cost a factor that prevented you from receiving prenatal care you would have otherwise sought?
4. Do you feel that the prenatal care you received was adequate? Why or why not?
5. While you were pregnant what was your living situation?
6. During your pregnancy, did you smoke? Drink any alcohol? Use drugs?
7. Are you currently employed? If so, please describe the nature of your employment. If not, do you have some other means of income?
8. Do you know who the father of your child/children is? (Ask for all children listed in question 3 of the pre-interview questionnaire.)
9. Are you still in contact with your child(ren)'s father(s)?
10. How involved is/are the father(s) in the life/lives of your child(ren)?
11. Have you or the father of any of your children ever been involved in a gang?
12. If answer to pre-interview questionnaire question #6 was yes: What factors made you decide to terminate your pregnancy?

Clendening Fellowship  
Department of History and Philosophy of Medicine  
University of Kansas School of Medicine  
February 2011

Mariam Savabi  
School of Medicine  
Class of 2014

**Introduction:**

Prenatal care is very important in order to achieve a healthy pregnancy and try to avoid potential problems that may arise for the mother and the child. For immigrants, and particularly undocumented immigrants, the access to prenatal care is limited and can lead to infant and maternal mortality as well as preventable diseases that can arise in the child. In the private healthcare model found in the United States, access for all pregnant women in the United States to prenatal care is not equal. By analyzing a universal healthcare model found in Spain, determining access for healthcare by undocumented and immigrant patients can give insight into which type of model best meets the needs of all women in their prenatal care needs. During a time when discussions about what type of healthcare changes will occur in the United States, lessons from other systems and health models may provide guidance on how best to take care of and meet the needs of all people in that country – and possibly in a more efficient and less expensive way. By conducting a qualitative study on perceptions and behaviors of immigrant women during their pregnancy, indications of positive and negative prenatal behaviors will be recorded and categorized. The outcomes of the study can help determine satisfaction level and behaviors by the women in the two settings as well as find important differences that may guide healthcare policy changes, or perhaps behaviors of physicians when having contact with these populations. This type of data can then be used for further research and can give indications on what type of system may work most effectively.

**Background:**

My father left persecution in Iran to come to the United States as a refugee. During his long journey to the United States, he had to wait in Spain for two years until he received his Green Card. During that time he met my mother and they both decided to come to the United States and start a new life in a place where they knew no one, and had no money. Within the first year that my parents were in the United States my mother got pregnant with me. With very little access to healthcare and specifically prenatal care, I was born nine months later. Hearing my mother recount personal struggles with not speaking the language, not knowing her rights, not having information about clinics, or even how important prenatal care was shocking to me.

Leaving a universal healthcare system, my mother probably would have had appropriate access to prenatal care in Spain. Having come from a poor background and a middle school education, besides the information taught to her from my grandmother about what she needed to do when she was pregnant, she knew nothing else of the importance of regular check-ups as well as nutrition. Being a citizen of Spain, key word citizen, the assumption of the universal healthcare model is that she would have had access to the prenatal care needed. The barriers to my mother encountered as an immigrant in a private healthcare system were obvious. This then begs the question of whether or not immigrants in a universal healthcare setting are able to receive access to safe healthcare.

Before coming to medical school I worked in St. Louis, mainly in the urban and rural settings teaching sexuality health and diversity education. Having grown up speaking Spanish, and as the only Spanish speaker in my department, I taught the Spanish speaking immigrant populations of St. Louis. I had interactions with many women who feared the healthcare system. If the immigrants were

undocumented, their main concern was that the healthcare system was connected with the government and they would be found and deported. Even clinics that were created to be catered to Latino populations, that were culturally and language sensitive, the women feared and doubted. When trying to access healthcare in acute situation, often in the emergency room, poor care for chronic issues was given. If the women had to go to the emergency room for their pregnancy, the feeling that most of the women described was of being rushed with very little acknowledgement and consideration for the mother's concerns. Often the patients found themselves pushed away and discouraged in accessing care. It was my work with these women that really encouraged me to enter the medical profession, and especially to work with these oppressed populations. I hope to one day pursue my career goals to become an Obstetrician and Gynecologist and provide immigrant women with the prenatal and women's health that they deserve.

Being in medical school and working at JayDoc I get to see people, mostly Latino immigrants, come to the clinic and be triaged. Many people get turned away every night. As a free clinic that works after hours, many times this is the only opportunity for many of the patients to come in and be seen. Additionally, the patient care that the patients receive is subpar; the long wait, the indecisive students, the language barrier, and all with the possibility of being turned away. When they are turned away – where do they go? For the women trying to access prenatal and pregnancy care is a challenge. Additionally trying to establish a long term relationship with a healthcare provider gets complicated when on Women's Night at JayDoc the students and physicians are typically different every time. In the book Complications by Atul Gawande, he clearly describes that the medical dilemma of learning to be a healthcare provider. To teach the emerging healthcare providers what they need to know they need to practice, and often times it's on the poor and marginalized populations.<sup>1</sup> I have felt a personal conflict already in dealing with this situation and see clearly that the private hospitals and even certain patients will not be worked on for the benefit of the students to learn, but yet it is always the oppressed and those with little to no access that are often the one's that give us the gift of practice, and most of the time unknowingly. As far as prenatal care, patients need care that meets their needs, and is not optional or elusive. The level of prenatal care can indicate the health status of both that infant and mother after the pregnancy, and should be available readily for all patients.<sup>2</sup>

**Description:**

When dealing with my own personal experiences, my interactions, and work, I strongly believe that health care is a human right. Everyone fundamentally should have access to and the opportunity to safe health care.

While trying to research immigrant access to private versus universal healthcare models there is little information available.<sup>3</sup> When dealing with 'fringe' populations in the United States and abroad, discussing personal views about access and qualitatively analyzing the outcomes of healthcare are difficult to access when the populations are often hidden. When discussing with my mother all the struggles she went through while being pregnant with me, her perception and emotions around her healthcare were still so clear. Since the time when my mother arrived in the United States, anti-immigrant sentiments have continued to grow and targeted legislation occurring in the government

toward immigrants and undocumented immigrants has escalated, only adding to the barriers to health care access and prenatal care access. As far as pre-natal health is concerned, it affects the health of both the woman and a child. According to the projected goals of Health People 2020<sup>4</sup>, if there is increased prenatal and increased access to quality "preconception and interconception care" there would be a decrease in maternal and infant mortality as well as healthy birth outcomes and identification of health conditions that can be prevented in the infant.

Spain and the United States presently have a situation that taking many factors into account are surprisingly similar. Both 'developed' countries are currently dealing with serious economic recession. This has led to mass unemployment, particularly of civil servants.<sup>6,7</sup> Both countries also have nearly similar immigration rates – which is astonishing comparing the size of the countries.<sup>8</sup> The economic recession is affecting the healthcare and social service sector of each country, and particularly that of a large amount of undocumented or unemployed immigrants that are not paying into the social services programs.

As the national discussion in the United States on healthcare reform continues, the welfare of *all* the people in the country should be taken into account. The Universal Declaration of Human Rights, created by the United Nation in 1948 proclaims that, "everyone has the right to a standard of living adequate for the health and well-being of oneself and one's family, including food, clothing, housing, and medical care."<sup>9</sup> Spain has publicly signed this agreement, while the United States has not. Of course both countries certify that meeting the medical needs of its citizens is a priority; however immigrants and particularly undocumented immigrants are excluded from this classification. Since immigrants are not a priority in either country, analysis needs to be done on which provides for this human right best, and meets the needs of all the people that live in that country.

This is the root of my research proposal, to determine between the two healthcare systems whether one or the other is more able to meet the prenatal and health needs of immigrant women. This group especially is important since women, additionally pregnant women who are immigrants –based on their identity – are one of the most oppressed groups. The assumption could be that if this group does receive care that is quality, and safe that nearly all other groups of different oppressed identities can also access this type of healthcare.

#### **Timeline for Study:**

Apply for IRB approval and receive approval before June 1<sup>st</sup>.

Month of June will be spent in the United States, working with the family physicians at KUMC.

June 1<sup>st</sup> – June 8<sup>th</sup> – work with the family physicians of KUMC, and Dr Greiner's contacts in order to become more familiar with their practice and their patients clientele. This will involve rounding with and working with the patients of the practices as a medical student.

June 8-22<sup>nd</sup> – Identify, contact and interview approximately ten women that have recently given birth or are currently pregnant that have immigrated to Spain in the last five years.

June 22-July 4<sup>th</sup> – Compile analysis of the interviews, as well as analyze own experiences through journaling.

Month of July will be spent in Spain, working with Dr. Merino, or a physician in his practice.

Leave for Spain July 5<sup>th</sup>

July 7-13<sup>th</sup> - Meet up with Dr. Merino and round with and become familiar with his practice.

July 13-27<sup>th</sup> - Identify, contact and interview approximately ten women that have recently given birth or are currently pregnant that have immigrated to Spain in the last five years.

July 29<sup>th</sup> - return back to the United States

July 30-August 3<sup>rd</sup> - Compile analysis of the interviews, as well as analyze own experiences through journaling.

### **Methods:**

The research study will be composed of doing a qualitative evaluation of personal accounts from immigrant women in each healthcare setting. Working with Dr. Greiner, we are creating an in-depth interview, with a series of open ended questions that will last approximately 25-30 minutes. There will also be a short demographic survey for strict data and population analysis. An incentive will be provided for the women as a gift card to a local grocery store in the amount of \$30.

The population of interest will be immigrant women who are currently in their second trimester of pregnancy, or have given birth in the last six months. The immigration status of these women will not be taken into consideration (if they are undocumented or not), as long as they have immigrated to the United States or to Spain in the last five years. Ideally at least ten women in each country will be interviewed.

The question interview session will be recorded and transcribed. The questions will be delivered to the women in their native language. In the United States the immigrant population will most likely be Latina, and so I will conduct the interview in Spanish. In Spain the immigrant population will be more diverse (Eastern European, Latin American, Maghrebians), expected languages include Spanish, Romanian, Arabic and some African languages. In these situations I will ask friends and family in Spain to interpret the interview, or use the interpreting services of the hospital for the interview.

The questions during the interview sessions will be focused on behaviors, perceptions and emotions with personal healthcare around pre-natal care. A qualitative analysis of the information gathered from the interviews as well as the notes taken during the sessions will be conducted to elicit the factors that influence the patients in their personal health behaviors and perceptions of access to pre-natal care. Each factor will be itemized based on the categories listed by the Social Determinants of Health Model.<sup>4</sup> A distinction will also be made between factors that have a positive influence versus those that have a negative influence. The information will be kept privately and only myself, or anyone involved with analysis of the data will have access to it.

I will also journal throughout the study, particularly after each individual interview. I do feel that I am very emotionally vested in the stories of these women, and that many times I will be reminded of the struggles that my own mother had to endure. Journaling will allow me to have a healthy outlet to my emotions, as well as record any other factors that I may have felt were important to the study.

Upon approval of the study I will apply for IRB if needed in both institutional settings.

In the United States I will be working with Dr. Greiner and local family physicians in his practice network throughout the Kansas City region. In Spain, I will be working with the physician, Dr. Ricardo Picatoste Merino, who would be an equivalent of a family physician in the United States. His practice is in Madrid, Spain and my cousin, Henar Sanz, is one of his acquaintances. To ensure that the populations being analyzed are similar, certain controllable factors have been taken into account. First, I will be working with physicians that have similar practice and health services – family physicians that provide obstetrical care. Second, the city demographics of Madrid and Kansas City are comparable.

**Contacts:**

**Kansas City -**

Dr. Allen Greiner, and affiliated physicians  
Family Physician, University of Kansas

Dr. Sharon Lee  
340 Southwest Boulevard  
Kansas City, KS 66103-2150

KUMC Family Medicine residency – runs a prenatal care program for KCK Latina women

Dr. Yolanda Hewitt-Vaughan, and Dr. Miller at the Bethany medical office building.

**Spain -**

Dr. Ricardo Picatoste Merino c/ José Abascal, 48-7 dcha 28003 Madrid tel: 914 412 544/914 412 655

Professor Francisco Bolumar, Department of Public Health Sciences at the University of Alcala  
28871 Alcala de Henares (Madrid), Spain

(In current correspondence with Professor Bolumar to continue making contacts with more physicians in the event that I may not be able to interview enough immigrant patients through Dr. Dexeus)

**Budget:**

In Kansas City:

Incentives for the interviewees: \$30 gift cards to Price Chopper x10 interviewees = \$300

Living in same apartment, food and transportation – I have budgeted my loan money to last me until August regardless of Clendening scholarship so this should be negligible.

In Spain:

Flight to Spain: According to the most recent search for flights– US Airways has a flight from KC to Madrid, Spain for \$1242 (including taxes and fees) from July 5-July 29<sup>th</sup>.

Incentives for the interviewees: ~\$22 Euro gift cards to local grocer = ~\$300

While in Spain I will have room and board as well as inner-country travel with family and friends – Negligible costs.

If accepted for the Clendening Fellowship, any costs that go over the \$2000 will be covered personally.

**Bibliography:**

<sup>1</sup> Complications: A Surgeon's Notes on an Imperfect Science. Atul Gawande. 2002.

<sup>2</sup> Prenatal Care. March of Dimes. <http://www.marchofdimes.com/pregnancy/prenatalcare.html>

<sup>3</sup> Rio, I. et al. Cesarean section rates in immigrant and native women in Spain: the importance of the geographical origin and type of hospital delivery. European Journal of Public Health. June 2010. 1-6.

<sup>4</sup> Healthy People 2020. Maternal, infant and Child Health.

<http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=26>

<sup>5</sup> Spain and Immigration: Bad New Days. The Economist. Feb 2010.

[www.economist.com/node/15464909](http://www.economist.com/node/15464909)

<sup>7</sup> Spain's Immigrants Suffer in Economic Downturn. Cala, Andres. Time. Aug. 2010.

<sup>8</sup> 'Spain: Immigrants Welcome.' Business Week. May 21, 2007.

[Http://businessweek.com/print/magazine/content/07\\_21/b4035066](http://businessweek.com/print/magazine/content/07_21/b4035066)

<sup>9</sup> UN Declaration of Human Rights. Article 25. <http://www.un.org/en/documents/udhr/index.shtml>

February 14, 2011

Martha Montello, Ph.D.  
History and Philosophy of Medicine Department  
University of Kansas Medical Center  
3901 Rainbow Blvd.  
Kansas City, KS 66160

Dear Dr. Montello:

I am writing to submit the following proposal for consideration for the 2011 Clendening Summer Fellowship. My proposed project focuses on the public debate over medical care for the poor in London that was sparked by the dissolution of England's religious hospitals under Henry VIII.

The funding provided by the Clendening Fellowship would allow me to apply my interest and experience in the Humanities to questions concerning the provision of healthcare and the evolution of medicine during the sixteenth century. I believe that my project asks important questions that have not been answered by other scholars; I hope to have the opportunity to pursue them further.

Thank you and the rest of the committee for your consideration. I very much look forward to receiving your feedback. Please do not hesitate to contact me if you have any further questions.

Yours sincerely,

John Stroh

## INTRODUCTION

On September 30, 1538, Sir Richard Gresham, Lord Mayor of the City of London, wrote to King Henry VIII, pleading with the monarch to place three London hospitals under municipal control rather than dissolve them.<sup>1</sup> The hospitals, Gresham wrote, had originally been founded to provide charity for the poor. They should remain open to fulfill this mission for the sake of “the myserable people lying in the streete, offendyng every clene person passyng by the way with theyre fylthye and nastye savors.”<sup>2</sup> The situation in London was indeed dire; many English hospitals had been dissolved beginning in 1536. Although they were difficult to distinguish from other monasteries and religious houses and, like the monasteries, often harbored the abuses that Henry’s government sought to eradicate, hospitals had provided charitable relief to England’s poor and sick for centuries. As one after another disappeared, Londoners faced the dual problem of accommodating their own poor and sick along with those who flocked to London from outlying areas.<sup>3</sup> Even though Henry VIII later reopened several of London’s major hospitals and placed them under the management of the City of London, there was a period of at least six years during which London’s hospitals remained closed. While there have been some historical accounts of Protestant clergymen exhorting their congregations to give charitably to London’s indigents, very little scholarly work addresses the debate about institutional care for the poor and sick during this time. The fact that a prominent and powerful figure like Gresham wrote to the king indicates that the hospital question was one of great public importance. I hope to uncover and chronicle the role played by London’s powerful livery companies (descendents of the medieval trade guilds) and other civic institutions in the public discourse surrounding hospitals. My study would focus especially on the Mercers’ Company, which counted Gresham among its members and had several notable ties to London hospitals, and on London’s fellowships of ‘medical men’: the Barber-Surgeons, the Apothecaries – both members of livery companies with deep roots in the City – and the College of Physicians.<sup>4</sup>

## PERSONAL BACKGROUND AND EXPERIENCE

I earned an A.B. in History & Literature at Harvard University, where I completed several research projects, including the required Senior Thesis (approximately 15,000 words). My undergraduate work has given me the background in academic history and research experience necessary to undertake this project.

I spent a year between college and medical school teaching at St. Paul’s School, an independent secondary school for boys in London. I have always been interested in English history, and my year in

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<sup>1</sup> The City of London is a political subdivision within Greater London. The City, also called the Square Mile, is the small historic core of the metropolis. Greater London, or simply London, is a comparatively recent administrative amalgamation of the City of London and 32 surrounding boroughs.

<sup>2</sup> Quoted in William Gilbert, “The Abuse of Charity in London: the Case of the Five Royal Hospitals,” *The Contemporary Review* XXXI (December 1877-March 1878): 770-790.

<sup>3</sup> The wealthy could often afford to receive medical treatment privately from hired physicians or surgeons, while the poor relied on hospitals, which had been founded primarily for their benefit.

<sup>4</sup> Physicians, surgeons, and apothecaries of the time were not ‘medical professionals’ in the modern sense of the word. I shall, therefore, use the term ‘medical men’ to refer to them collectively. At this time, the Apothecaries were still members of the Grocers’ Company and did not constitute a distinct company until 1617.

England allowed me to gain a deeper understanding of the country's past. Working at the school attended by Edmund Campion, the scholar and Jesuit martyr, and visiting the Tower of London, Tyburn, and other sites associated with the religious turmoil of the sixteenth century sparked a particular interest in the English Reformation.

While in London, I also became fascinated by the role that the various livery companies have played in civic life, both past and present. John Colet, Dean of St. Paul's Cathedral and a member of the Mercers' Company, founded St. Paul's School in 1509. Upon his death, he bequeathed his estate to the Mercers to be managed as the school's endowment. Today, the Mercers' Company continues to manage the endowment and appoints 19 of the 21 members of the school's Board of Governors. As a Colet Fellow at St. Paul's School, I had the privilege of touring the Mercers' Hall and Chapel in the City of London.

My interest in early hospitals stems from two particular sites I visited in France when I was younger. The Abbaye de Cluny, a former twelfth-century Benedictine monastery northwest of Mâcon, was, at its height, one of the wealthiest and most powerful religious houses in Western Europe. The enormity and opulence of this monastery helped me realize just how prominent and influential the large religious orders were in medieval life. I also toured the Hôtel-Dieu de Beaune, a fifteenth-century almshouse and hospital in Burgundy that now houses a museum. I remember being surprised by the range and sophistication of treatments – especially surgical ones – that the hospital provided. Although it was not a religious foundation, religion pervaded the hospital; for example, the chapel, which featured a polyptych of the Last Judgment, was placed adjacent to the large open ward so that the bedridden could attend Mass without having to be moved.

Knowing that the clergy had provided care to the poor and sick in the Middle Ages, and that Henry VIII had dissolved the monasteries during the Reformation, the question of what happened to England's religious hospitals seemed a good starting point for my project. I have since refined my question to a much more focused and perhaps even more intriguing one. Researching how the City of London's livery companies and medical men contributed to the debate about the hospital issue in the late 1530s and early 1540s would allow me to combine all of these interests in a single project.

## PROJECT DESCRIPTION

Gresham's letter to Henry VIII in 1538 did not succeed in swaying the monarch's mind about the hospitals. In 1539, the mayor and aldermen again petitioned the king, requesting that the dissolved hospitals and several churches be placed under the management of the City and reopened for the benefit of the poor. The king either ignored or refused this petition. In August 1540, the Court of Common Council gave its consent for the mayor to purchase the properties for £700. Henry refused, calling the mayor and citizens "pynchepence."<sup>5</sup> The debate continued for another four years until June 23, 1544, when the king granted letters patent reestablishing St. Bartholomew's Hospital and assigning five Anglican clergymen to manage its operations. The appointments were made as political favors; the men made little effort to reopen the hospital. Angered by this, the citizens continued to lobby for the

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<sup>5</sup> Edward Geoffrey O'Donoghue, *The History of Bethlehem Hospital From Its Foundation in 1247* (New York: E.P. Dutton & Co.: 1915), 111.

hospital to be given over to the City of London. On December 27, 1546, the king placed St. Bartholomew's Hospital and the Hospital of St. Mary Bethlehem under the City's control.<sup>6</sup> This agreement came just in time; Henry VIII died only a month later, on January 28, 1547.

While historians have recounted the dissolution and, in some cases, eventual resurrection of the hospitals, none of them has chronicled the conversation during the years they were closed. The City of London's involvement is well known, and Gresham's petition has been reported in multiple sources.<sup>7</sup> What has been overlooked is the role that influential groups based in the City may have played in the dialogue surrounding the hospitals that resulted in the finalized proposals. One author goes so far as to say that "It would be tedious, and it is unnecessary, to trace the details of the negotiations. There was proposal and feigned withdrawal, there was counter-proposal and debate"<sup>8</sup> I disagree: this was an important issue that prompted the Lord Mayor to make repeated attempts to acquire and reopen the hospitals. Furthermore, the issue was a time-sensitive one, as well; Henry VIII was known to have given confiscated monastic lands and treasures to his political favorites as gifts, and the property that had once belonged to the hospitals was quickly being doled out to various people.

The importance of the hospital question and the stake that different groups may have had in it suggest that there was a lively and as yet unanalyzed discussion of the hospitals among London's livery companies and other influential groups of citizens. Each may have held discussions internally, or debated with other groups in a City-wide forum, or perhaps both. Whatever the case, my aim is to uncover and analyze the debate that went on in the late 1530s and early 1540s while London's hospitals were closed.

While the nature of the sources I find will ultimately dictate the parameters of my investigation, I initially plan to focus my attention on the Mercers' Company, the College of Physicians, the Barbers' Company, and the Apothecaries, who were at the time still part of the Grocers' Company. The Mercers were the most powerful of the livery companies and had several connections, both historical and contemporary, to London hospitals. Many of the company's members may have had financial interests at stake. Gresham himself profited from speculation on monastic lands and from stripping dissolved monasteries of their assets.<sup>9</sup> In analyzing its role in the hospital debate, I would pay particular attention to the financial motivations of the Mercers' Company, as well as those of its individual members.

The Mercers' Company had long been closely connected with certain London hospitals. Many of the hospitals, although they were run by the religious orders, had been founded by individual laymen or by lay organizations. The mercer William Elsyng, for instance, founded the Augustinian-run Hospital of St. Mary-within-Cripplegate during the 14th century. Nearly a century later, another mercer, Richard

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<sup>6</sup> Norman Moore, *The History of St. Bartholomew's Hospital* (London: C. Arthur Pearson, 1918), 23-24.

<sup>7</sup> Gresham's letter is mentioned in, among others, Blanchard, "Gresham, Sir Richard (c.1485-1549)"; Medvei and Thornton, eds., *The Royal Hospital of Saint Bartholomew 1123-1973*; O'Donoghue, *The Story of Bethlehem Hospital from its Foundation in 1247*; Orme and Webster, *The English Hospital 1070-1570*; Parsons, *The Story of St. Thomas's Hospital*; and Rawcliffe, "The Hospitals of Later Medieval London." See Bibliography.

<sup>8</sup> O'Donoghue, 111.

<sup>9</sup> Ian Blanchard, "Gresham, Sir Richard (c.1485-1549)," *Oxford Dictionary of National Biography* (Oxford: Oxford University Press, 2004), <http://www.oxforddnb.com/> (accessed February 2, 2011).

Whittington, founded and endowed a hospital that bore his name. In some cases, the laymen had to involve themselves with existing hospitals in order to keep them financially buoyant. The company formed an agreement with the Hospital of St. Thomas Acon that allowed them to conduct a biennial financial audit.<sup>10</sup> The Mercers were by no means the only livery company that had connections to London's hospitals, and one can only assume that there would have been interest among all of the livery companies in having some say in the City's plans to reestablish and manage the hospitals.

The physicians, surgeons, and apothecaries would have also had a special interest in the hospitals' fate. Firstly, they had a financial stake in the reestablishment of the hospitals. Gresham's 1538 letter outlined a plan for the new management of the hospitals. Significantly, it states that patients would be treated by "physicians surgeons and apothecaries which shall have stypende, salary and wages onely to attende for that entente and purpose."<sup>11</sup> That medical men would be salaried employees in the hospitals was a significant departure from the norm prior to the dissolutions. Although it was not unheard of, the permanent, or even regular, presence of medical men in late medieval hospitals in England was the exception rather than the rule.<sup>12</sup> Because the proposal called for their involvement in hospitals to increase so dramatically, and because the potential for salaried hospital work would be steadier and more secure than seeing individual patients only when called upon, London's medical men would have had a significant interest in the proposals that were being formulated.

The prospect of secular hospitals may have also been important to London's medical fellowships. The College of Physicians, for example, disapproved of licensing men who would ultimately become clerics but was largely unable to control the large numbers of "priest-physicians" that existed outside of, and competed effectively with the College.<sup>13</sup> By the sixteenth century, medical practice on the Continent had become secularized. Although England's progress was slightly slower, the sixteenth century was part of the period of transition between medieval and modern medicine. My study would consider how the attitudes held by specialist medical men about priest-physicians and about secular, 'modern', or 'scientific' medical care may have influenced their positions on the hospital issue.

My topic touches on many of the themes which engage social historians today, including attitudes about public health and improving care for the poor, religious and pastoral models of healthcare, the

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<sup>10</sup> When the hospital was dissolved, the Mercers purchased the hospital site in Ironmonger Lane and eventually converted it into their hall and chapel.

<sup>11</sup> Quoted in Rotha Mary Clay, *The Medieval Hospitals of England* (London: Methuen & Co., 1909), 236-37.

<sup>12</sup> In France, Italy, and elsewhere on the Continent, physicians, surgeons, and apothecaries held full-time posts in systems of municipal hospitals; however, no such formal scheme existed in England, where less-regularized religious hospitals still predominated during the early 1500s. The Savoy Hospital, founded in 1505 by Henry VII and opened in 1517 under Henry VIII, employed a physician and surgeon. It was, however, an exceptional case because it was lavishly funded by the king; other hospitals could not always afford to regularly pay medical men for their services.

<sup>13</sup> Margaret Pelling and Charles Webster, "Medical Practitioners," in *Health, Medicine, and Mortality in the Sixteenth Century*, ed. Charles Webster (Cambridge: Cambridge University Press, 1979), 199.

professionalization of medicine, financing healthcare, and the politics of healthcare. The primary source material I uncover will dictate which of these potential themes I investigate more fully.

## **SIGNIFICANCE OF RESEARCH**

I write in full support of Mr. Stroh's proposal. As an early modern historian of England, I can confirm that the closure of hospitals in London as part of the Henrician Reformation has not been researched in any detail. In fact it has barely been touched upon in works on Tudor medicine. Mr. Stroh's focus on this period and the complex negotiations that took place between various groups of concerned citizens and the king, promises to reveal much about the state of healthcare in a time of religious and political upheaval, attitudes towards the poorest of the poor, and the power of livery companies and medical men. Mr. Stroh's study will also add to recent research on the changing notion of charity as an ideal and a practicality during the Reformation. This is an intriguing and exciting proposal.

Lynda Payne, Sirridge Missouri Endowed Professor of Medical Humanities and Associate  
Professor of History, University of Missouri – Kansas City

## **SOURCES**

In order to uncover the debate about London's hospitals and medical care for the poor, I would rely heavily on the archival records of the Physicians, Barber-Surgeons, Apothecaries, and Mercers. These groups' archives contain, among other things, court records (i.e. minutes from meetings), financial records, and charities and estates records. I would go through these documents methodically, focusing initially on the ten-year period from 1536, when the dissolutions began, to 1546, when the king gave St. Bartholomew's and St. Mary Bethlehem to the City. As my research progressed, the direction that my project would take would become clearer.

I have been offered access to the Mercers' Company archives and Barbers' Company archives (please see Appendix A for further details). The Grocers (Apothecaries) do not have a library or archivist but have made their records available on microfilm at the Guildhall Library, which is open to the public. The Guildhall Library and the public access London Metropolitan Archives also contain the archives of the government of the City of London. The Royal College of Physicians Library is open to the public, as are the National Archives, which has records of the petitions and proposals made by the City to the Henry VIII, and the Wellcome Library, which holds many of the London hospitals' archives.

The British Library and the Clendening Library have a wealth of secondary sources that would allow me to further understand the historical context in which the debate took place and make a more informed analysis of the primary sources.

## **RESEARCH CONTACTS**

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Heritage Collections Assistant

Royal College of Physicians

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Jane Ruddell

Archivist and Curator

The Mercers' Company

Email: JaneR@mercercos.co.uk

Joy Thomas

Archivist

The Barbers' Company

Email: archivist@barberscompany.org

## **TIMELINE**

March 5-14: Spring Break in London (trip planned previously). Meet with archivists at the Mercers' Company and the Royal College of Physicians. Register for access to the Guildhall Library, London Metropolitan Archives, National Archives, and Wellcome Library.

May 14/15: Fly from Kansas City to London.

London, May 16-June 22: London. Research topic in various archives and libraries. Begin working on written report.

June 23: Fly from London to Kansas City.

June 24-July 31: Kansas City. Complete written report and prepare oral presentation.

## **LOGISTICS**

Two of my former colleagues at St. Paul's School live in Barnes, London, and have kindly offered to let me stay in their guest room while I am there (please see Appendix B). The walk from their home to the London Underground station in Hammersmith takes between ten and fifteen minutes. All of the archives I plan to use are accessible via the Underground (Tube). I also still own a bicycle that I keep at the St. Paul's School Boathouse and could use it as an alternative to the Tube.

## **BUDGET**

(Please see Appendix C for further details)

**Airfare:** \$940 (possible itinerary)

**Transportation within London:** \$270

**Room and Board:** \$480

**Miscellaneous Expenses:** \$310

**Total:** \$2,000

I understand that the Clendening Fellowship provides students with \$2,000 to fund their projects and that any expenses incurred beyond this amount must be covered by the student.

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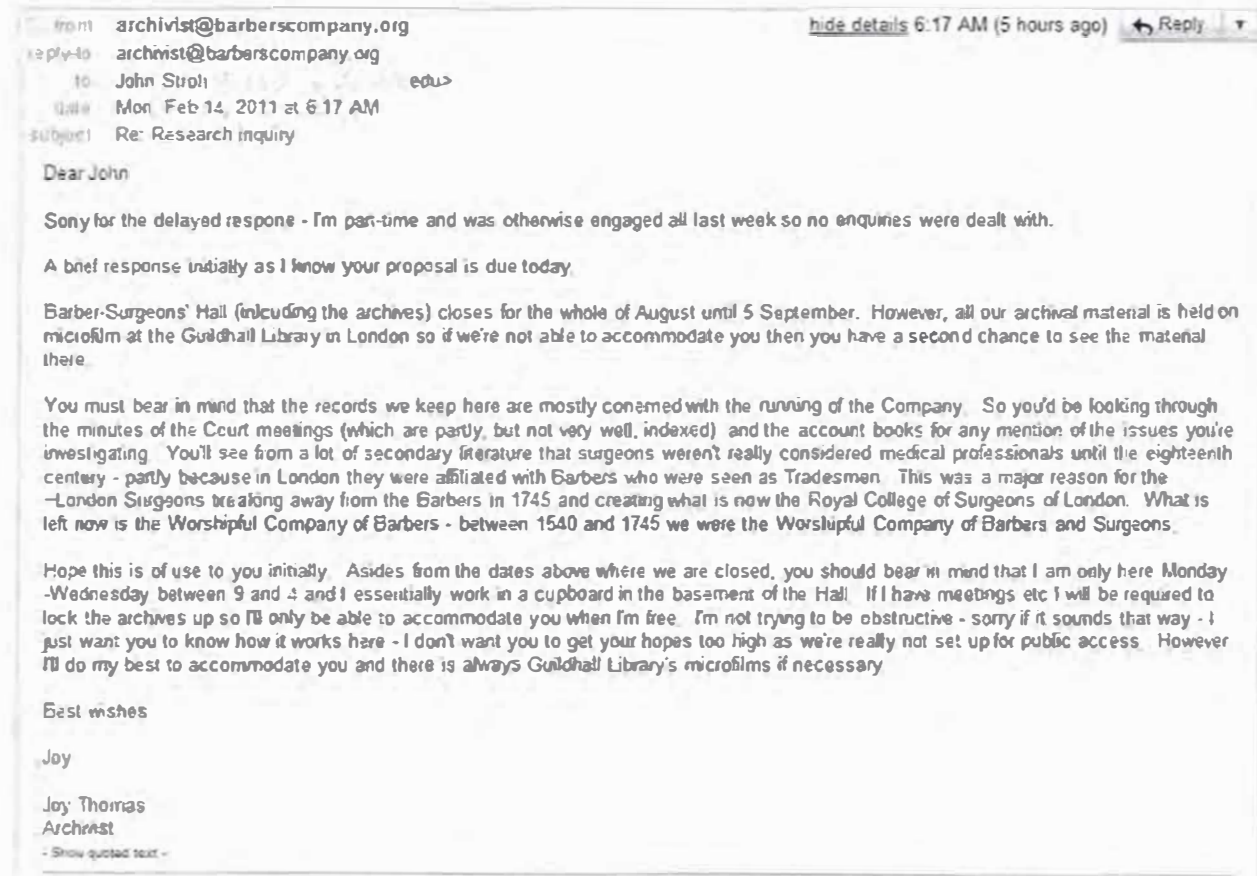
## APPENDICES

### Appendix A: Access to restricted archives and libraries

The Guildhall Library, the London Metropolitan Archives, the National Archives, and the Wellcome Library are all open to the public. Each requires completion of a registration form for admittance to their collections. I plan to complete these forms while I am in London over Spring Break.

#### Barbers' Company archives

The Barbers' Company archives are not set up for use by academic researchers; however, all of the company's records are available on microfilm at the Guildhall Library. Furthermore, Joy Thomas, the Barbers' archivist, said that she would try to accommodate me if I wanted to see any original copies of documents.



#### British Library

I applied for and was granted a British Library reader's pass in November. The pass expires on November 25, 2013. Please do not hesitate to contact me if you have further questions or need to see my card.

## Mercers' Company archives

from Jane Ruddell  
to John Stroh  
Fn. Feb 11 2011 at 8 16 AM  
subject Access to Mercers Archive

hide details 8:16 AM (1 hour ago) Reply

To Whom It May Concern

John Stroh has been in correspondence with me at the Mercers' Company Archive in the City of London to find out whether we hold archival records that may be relevant to his research proposal. The Mercers Company Archive holds records of the Company's activities from 1390 to the present day.

We do not have not have regular walk-in access arrangements because we are a private company and all access is by prior appointment but we prioritize those doing academic research at post-graduate level. We would be very happy to allow Mr. Stroh access to the archive if he requires it for his research.

Jane Ruddell  
Archivist and Curator

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FAX: (+44) 2076001158  
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[www.cleargate.com](http://www.cleargate.com)

## Royal College of Physicians

The Royal College of Physicians allows public access to its library and archives but admits readers by appointment only. I plan to meet with one of the librarians there in March to discuss a potential research schedule for the summer.

from Heritage <Heritage@rcplondon.ac.uk> [hide details](#) 9:31 AM (31 minutes ago) [Reply](#) 

to "jstroh@pos.harvard.edu"

Date Fri, Feb 11, 2011 at 9:31 AM

subject RE: #UM006424 John Stroh: Access to archives and research inquiry

Dear Mr Stroh,

You would be welcome to visit the RCP in March, and you can determine whether we indeed have sufficient relevant material for you to continue research in the summer.

We would need to make individual appointments for each visit, and booking entire weeks etc. may not be possible due to the limited staff availability.

If you can suggest a couple of dates during the period you are here in March, then we can register you as a reader (two forms of ID - one with picture one with proof of permanent address - recent bank statement etc.) and show you the catalogues etc.

Best wishes,

Peter Basham

Peter Basham | Heritage collections assistant  
Royal College of Physicians | 11 St Andrew's Place | London | NW1 4LE  
Direct line +44 (0)20 3075 1543  
Re-framing disability: portraits from the Royal College of Physicians  
An exhibition exploring four centuries of hidden history with responses from disabled people today

14 February - 8 July 2011  
For opening times phone 020 3075 1543 or visit: [www.rcplondon.ac.uk/heritage](http://www.rcplondon.ac.uk/heritage) Booking advisable.

## Appendix B: Accommodations in London

A letter from my prospective hosts:

London

11 February 2011

Dear Sir/Madam

I am writing to support John Stroh's application for the Clendening Fellowship.

John worked with us at St. Paul's School in London in the academic year 2009-2010. He has spoken to us about the possibility of his coming to London from mid-May until the end of June, whilst conducting his research in the British Library and at various other libraries and archives in the city. We have a guest room in which he could stay. Whilst we are not allowed to sublet, John has kindly offered to contribute £50 per week toward living expenses.

Yours sincerely,

Hilary and Anna







## Appendix C: Budget

Airfare: \$940

Possible itinerary:

### Trip Summary

You selected these flights:

OUTBOUND Sat 14 May 2011   1:43pm MCI to Sun 15 May 7:40am LHR   1 stop   DL 5820 <sup>1</sup> DL 6										 		<a href="#">Show Details</a>	
1:43pm	MCI	7:40am	LHR	1 stop	11h 57m	DL 5820 <sup>1</sup>	Economy (U)	View Seats					
		Sun 15 May		DTW	2h 13m Layover	DL 6	Economy (U)						
Operated by: Compass One Delta Connection													
RETURN Thu 23 Jun 2011   2:25pm LHR to 8:41pm MCI   1 stop   DL 41 DL 2637										   		<a href="#">Show Details</a>	
2:25pm	LHR	8:41pm	MCI	1 stop	12h 16m	DL 41	Economy (T)	View Seats					
				MSP	1h 45m Layover	DL 2637	Economy (T)						

Price per passenger:	\$751.60 (USD)
Taxes/Fees:	\$185.10 (USD)
Subtotal per Passenger:	\$936.70 (USD)
Total for all passengers (1):	\$936.70 (USD)

Transportation within London: \$270

I would plan to work in the archives and libraries every weekday, and on some weekends. In order to minimize transportation costs, I would confine my work to a particular area of London on any given day. The British Library, London Metropolitan Archives, Wellcome Library, and Royal College of Physicians' Library are within walking distance of each other near the King's Cross – St. Pancras Underground station. The Guildhall Library, Mercers' Company archives, and Barbers' Company archives are all in the City of London, near the Bank stop on the Underground. The National Archives building in Kew is a short bike ride from Barnes but can also be reached on the Tube.

My estimate includes round-trip fares for weekdays and weekends. All fares listed below are up-to-date according to the Transport for London website (<http://www.tfl.gov.uk/>) and are based on journeys between Hammersmith Station and the stops nearest to the aforementioned libraries and archives.

One-way tube fare Monday-Friday 06:30-09:30 = £2.50 = \$4.00

28 weekday outbound journeys from May 16-June 22 x \$4.00 = \$112.00

Note: One-way fare to/from Kew Gardens (National Archives) = £1.40 = \$2.24

One-way tube fare all other times = £1.90 = \$3.04

28 weekday return journeys from May 16-June 22 x \$3.04 = \$85.12

11 weekend round-trip journeys from May 15-June 20 x \$6.08 = \$66.88

1 round-trip journey from Heathrow Airport = £2.80 = \$4.48

Note: One-way, off-peak fare to/from Heathrow = £1.40 = \$2.24

Total: \$268.48

Room and Board: \$480

My prospective hosts are willing to accept up to £50 per week from me as my contribution toward food, utilities, and other living expenses.

£50 = \$80

6 weeks in London x \$80 = \$480

Miscellaneous Expenses: \$310

\$2000 – \$940 for airfare – \$270 for transportation – \$480 for room & board = \$310