HUMANISM
in
MEDICINE
Season’s Greetings and Happy New Year! There is much to celebrate and reflect on for this season: being thankful, being generous, celebrating family traditions, and embracing the new year. This season is also an opportunity to reflect on what it means to have humanism in medicine.

William Osler stated: “Let us know what kinds of people have a certain disease, instead of discovering what kind of disease a person has.” A good doctor-patient relationship is the foundation of good medical care and allows physicians to address the more nuanced, human, non-technical factors in patient care. Inherent in this relationship is empathy: the ability to see life through another’s perspective. Research suggests that empathy levels are high in the basic science years of training, and drops in the third year and again in residency, at two transition points when trainees gain increased exposure to patients. The stresses of limited time, high volume of patients, and limited control of one’s schedule may result in burnout, decreased empathy, and disillusionment with medicine. The great news is that empathy certainly can be taught, as it is necessary to build a strong therapeutic alliance.

One way to strengthen the provider-patient relationship is to have strong communication skills. For example, listening is a crucial communication skill in understanding the patient’s story and taking a good medical history. Medical students admit in the early months that taking someone else’s sexual history was one of the most awkward parts of learning clinical medicine. However, to be more comfortable with taking ANY part of a medical history requires the knowledge to be a good listener. On behalf of National Sexual Health Awareness and World AIDS Day in December, Publications Committee Vice Chair and JSNMA junior editor Jonathan Batson addresses sexual education reform as a way to increase the health literacy of the young population. Imoh Ikpot addresses why it is important to take a good medical history. Invited contributor Isaiah Yerima addresses misdiagnosis. Martha Ayewah addresses how her experiences will allow her to develop humanism in surgery.

We also revisit the topic of curriculum, but this time with the humanities, as Rosemary Attor advises all to “Stay on Track.” Adriana Prado and Juan Oves demonstrate how their passion for service fuels their desires to be humanistic healthcare providers. The American Medical Student Association has also included resources to further develop the humanistic physician.

New for this edition are several book reviews for books that further discuss empathy and the doctor-patient relationship. One is from the international student trainee perspective, one is from an attending physician’s perspective, and another is from a patient family’s perspective.

SNMA members are certainly ready to be humanistic, compassionate doctors. Jessica Edwards provides insights from the osteopathic residency interview trail. Your Story Matters returns for this edition, as SNMA Publications Co-Chair Cortlyn Bown uses her superb rapport-building skills to interview an SNMA member. (Think about which parts of the interview allowed for relationship-building with interviewee Tony Fuller).

The mental health professions have a great need for rapport building. Our letters to the Editorial Board have brought increasing attention to mental health in African Americans. January was National Mental Health Awareness Month.
Health Awareness Month. In line with topics for our letters this publication includes research the “Healthy Minds Program,” which includes findings to further spur discussion on mental health in African Americans. In addition to our varied research selections, this publication includes the introduction of the 2013-2014 Satcher Research Fellows.

Finally, the SNMA Publications Committee and the JSNMA Editorial Board have nearly tripled in membership since last spring. I am very, very thankful to have had the opportunity to work with several driven individuals on the JSNMA and other SNMA Publications. Look forward to our next edition of the JSNMA, celebrating 50 years of rich history. The SNMA looks forward to seeing all of you at the Annual Medical Education Conference in April!

Yours in SNMA,

Oluwakemi Eniola Tomobi
SNMA Publications Co Chair
Editor-In-Chief
Journal of the Student National Medical Association

How can we address mental health in the black community?

Issues relating to mental health remain a topic that, until recently, is lacking from public discussion. Among those with insurance, there is lower coverage for mental health services than coverage for conditions such a hypertension and diabetes. Violence as reported in the news has now brought renewed national attention to the need for mental health services. Yet, to this day, the discussion on mental health is lacking in the black community. African Americans cynicism in the health care system and mental health steams from long history of inequities in accessing education, employment, and health care. According to National Institute of Mental Health, 1 out of 3 African Americans who needs mental health care receives it. According to the Medical Expenditure Panel Survey from 2004 to 2009, 40% of whites who needed mental health care initiated treatment as compared to 24% of African Americans. Minorities also suffer higher mortality rates related to substance abuse. This is disturbing, because members of racial and ethnic groups are expected to grow to 57% of the U.S population by 2060 and need their health needs met. Barriers to addressing mental health conditions can affect the treatment of other co-morbid conditions, such as hypertension and diabetes.

Many African Americans underestimate issues dealing with mental health. As a result they usually turn to family, church and community to cope with issues dealing with mental health.

However, with the Patient Protection and Affordable Care Act, more will have access to health insurance. The health care reform sets a minimum standards for health insurance policies that can be purchased by individuals and businesses. It also makes significant enhancements to Medicaid including increasing the number of people that qualifies for the extensive mental health services covered by Medicaid. Under this new health care reform, childless adults who are not considered as having a disability qualify for the Medicaid program. This new reform also creates several options for long term-care for people with disabilities and mental illnesses. This increased access to health insurance covers substance abuse and mental health services on a par with the coverage for medical and surgical care. Several other provisions in the new health care reform will aid people with mental illnesses, such as prevention programs, improvements to Medicare’s drug benefit and a new insurance plan for long-term community care.

Reforms in medical education can also allow for revisions to training of all providers to be able to provide mental health care as a part of comprehensive health care. Additionally, in considering that minorities may have stronger therapeutic alliances with providers of a similar background, medical education efforts can help increase minority interest in pursuing psychiatry and other mental health professions. Finally, the other relationships that African Americans are able to establish in the community may also prove therapeutic and may lend themselves to refining and expanding the definition and scope of the mental health workforce.

Therefore, the steps towards healthcare reform, changes in education and training of healthcare providers, as well as opportunities for community support, will help to further address mental health in the African American population.

Work Cited
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http://www.psychiatry.org/african-americans
The Student National Medical Association is the nation’s oldest and largest independent, student-run organization focused on the needs and concerns of medical students of color. Membership includes more than 6,000 medical students, pre-medical students, residents, and physicians. Established in 1964, SNMA is dedicated to both ensuring culturally-sensitive medical education and services, as well as increasing the number of African-American, Latino, and other students of color entering and completing medical school.
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HUMANISM IN MEDICINE
Dear SNMA Family,

Welcome to the winter edition of the JSNMA and to the anniversary year of the Student National Medical Association! 2014 has great things in store for the SNMA – namely our 50th Anniversary celebration! Throughout the year, we will celebrate this historic moment for our organization starting with our annual conference. If you haven’t ready registered for the 50th Anniversary Annual Medical Education Conference, what are you waiting for? With over 70 workshops and 125 exhibitors representing medical schools, residency programs, and medical institutions, this conference is sure to be a spectacular event.

Over the last year, our chapters have worked to truly fulfill the mission of our organization, which is to address the needs of the underserved communities. Many chapters across the nation have participated in the “The Weight of the Nation” Obesity Campaign to promote healthier lives throughout our community. In this issue of the JSNMA, I had the opportunity to share what some of these chapters have done. If your chapters has yet to participate, there is still time! Schedule a viewing of the Weight of the National video documentary, host a guest speaker to discuss the obesity epidemic, or host a physical activity with your community. There are many ways to be involved in this campaign.

Finally, to celebrate the work of our chapters, we will culminate our efforts with a conference plenary session at AMEC 2014 entitled: “The Weight of the Nation: The SNMA Response.” This plenary session will highlight the work of several chapters and provide an opportunity for the SNMA to discuss a plan of action for helping to eliminate the obesity epidemic. Our communities thank you for all your efforts in this campaign and I look forward to welcoming you to conference in DC for a more in-depth discussion.

Yours in SNMA,

Courtney M. Johnson
2013-2014 National President
The SNMA has risen to the challenge of tackling the nation’s obesity crisis through its “Weight of the Nation” Campaign. As a part of this year’s Presidential Initiative – The 50 Years Forward Campaign – chapters around the country were encouraged to celebrate our history of service and advocacy by developing programming centered around ending the obesity epidemic in our communities. Via our established national protocol on Obesity Education and a partnership with the Institute of Medicine, chapters were equipped with the facts, knowledge, and resources to share with our communities to help them work towards healthier lifestyle.

According to recent statistics, more than one-third of U.S. adults (35.7%) are obese. (1) Obesity-related conditions include heart disease, stroke, type two diabetes, certain types of cancer, and some of the leading causes of preventable death. (2) The estimated annual medical cost of obesity in the U.S. was $147 billion in 2008 U.S. dollars; the medical costs for people who are obese were $1,429 higher than those of normal weight. (3) When we look at minorities in our country, blacks have the highest age-adjusted rates of obesity (49.5%) compared with Mexican-Americans (40.4%), all Hispanics (39.1) and non-Hispanic whites (34.3%). (4)

Adults are not the only ones affected by this epidemic. Approximately 17% (or 12.5 million) of children and adolescents aged 2–19 years are obese. Since 1980, obesity prevalence among children and adolescents has almost tripled. There are significant racial and ethnic disparities in obesity prevalence among U.S. children and adolescents. In 2007–2008, Hispanic boys, aged 2 to 19 years, were significantly more likely to be obese than non-Hispanic white boys. Similarly, non-Hispanic black girls were significantly more likely to be obese than non-Hispanic white girls. (5) These are frightening statistics and, as future physicians, we must commit to playing an active role in the health of our future patients.

As an organization aiming to address the needs of the underserved community, it has become apparent that we must take action in this area of need. By partnering with the IOM and HBO, we were able to distribute the award winning “Weight of the Nation” documentary to each of our chapters across the nation to provide a vehicle by which to start the conversation in their communities. Our chapters truly embraced the Obesity Campaign. For example, the University of Toledo SNMA Chapter and University of Michigan both hosted WOTN viewing and discussions within their communities. Other chapters went above and beyond this request. Drexel University College of Medicine, for example, hosted Dr. Anthony Rodriguez for a talk entitled: “Dealing with Obesity in Primary Care and Ensuring Patient Compliance.” The Florida State University SNMA chapter conducted the SSTRIDE Summer Institute Fitness Fair with the purpose to teach high school students about ways to live a healthy lifestyle and prevent obesity. Some chapters used their creativity to really show our community how to live healthier. For example, the University of North Carolina – Chapel Hill engaged in physical activity hosting a Salsa Dance Lessons with Latino Medical Association. We are proud of the work our chapters have conducted over the year and we encourage our chapters on continue to promote our Obesity Campaign.

There is much work to be done and our chapters are truly rising to the challenge. If your chapter has yet to participate, don’t delay. There is plenty of time to contribute to the SNMA’s WOTN campaign. We are so excited about the impact that our organization has had, and will continue to have, in our community. We will continue to work to become the leaders and change agents that our patients, neighbors and families can depend on to address this vital issue.

http://www.cdc.gov/nchs/data/databriefs/db82.pdf
http://content.healthaffairs.org/content/28/5/w822.full.pdf+html
http://www.cdc.gov/nchs/data/hestat/obesity_child_07_08/obesity_child_07_08.htm
Interview with:

Tony Fuller
Duke University School of Medicine
MD Candidate, class of 2016

Interview performed by Cortlyn Brown
Publications Committee Co-Chair

Please tell me about your background (cultural, religious, ethnic, etc)

I am mixed with African-American, Mexican, and Caucasian.

Could you please describe how your multiracial heritage has influenced how you view the world?

Growing up being multiracial was always interesting and challenging for various reasons, especially pre-adolescent years. It always felt like there wasn't a group I totally belonged to. I was light skinned so didn't fit totally with the African-American community, I couldn't speak Spanish so I didn't fit in with the Hispanic community, and then again I was light-skinned so I didn't fit in with the Caucasian community either. As I grew up I embraced my multi-races and realized that I didn't need to pick one community. I ended up identifying with all of the communities on some level. This allowed me to feel comfortable with a wide variety of people and gave me a lot of knowledge of different cultural groups. This fueled my passion to be involved in student groups during Undergrad as well as during Medical school. It has also helped me to relate to a wide population of people that I have taken care of in the hospital during my clinical rotations.

Do you think there are any disadvantages to being multiracial (I am biracial and just got asked that by an attending after I gave a presentation on being biracial so I would be very interested in hearing your thoughts)?

Besides what I stated above, about feeling like you don't belong to any group, I don't think there really are any other disadvantages to being multi-racial.
If somebody were to ask you, "What makes you special/unique?" what would your answer be?

The thing that makes me special is my upbringing and the perspective that it gave me. Growing up in a single parent household with 5 siblings and no health insurance really helped me understand the complexities of the healthcare system. It is one of the reasons why I always wanted to be a physician.

When did you decide you wanted to go into medicine?

I decided to go into medicine when I was a little kid. It was the only thing I ever wanted to do. That idea never changed and allowed me to refine my decision over the years.

How did you decide you wanted to go into medicine?

I decided on medicine so early in life that it is hard to explain that reasoning. My current reasons for sticking with the conviction all these years are multi-factorial. One of the biggest reasons is the desire to impact the health of the community around me, especially those who are uninsured. Growing up in that environment I learned the challenges and the hardships that families face when their health becomes an issue. I hope to impact that, but as well as impact the health of people overall.

Did/do you have any other career interests and, if so, do/how do you plan on combining those with medicine?

I'm currently dual enrolled in the medical program at Duke as well as the Masters of Global Health program. I hope to tie my medical career in the states with work in other parts of the world, so that I can help impact health on a global scale.

How did you find out about the SNMA?

I found out about SNMA right away when applying to medical school. During undergrad I was the president of the Black Student Union and the Latino Student Association all four years, so I knew that once I got to medical school I would like to stay involved with minority concerns. SNMA was the perfect fit and I began working with SNMA people day one.

Why did you decide to join?

I decided to join because I have a vested interest in main goals of the group and thought the mission really fit into my personal values.
What is your favorite thing about the SNMA?

My favorite thing about SNMA has been the diversity of experiences that it has afforded me over the years. From working with high school students interested in health care through HPREP to working in the local community interacting with the people of Durham.

Have you ever felt out of place in the SNMA, if so, please describe?

I have never felt out of place within SNMA, nor do I foresee that feeling ever occurring.

Have you ever held a leadership position within the SNMA, if so, please describe?

I have been part of the executive board every year. My freshman year I acted as the first year student liaison. My second year I acted as the HPREP coordinator and the Educational Resource Officer. This year I am the HPREP coordinator and the MLK Banquet dinner coordinator.

Could you please describe below any advice that you would give to undergraduate minority students interested in medical school.

I would tell them that they have to shoot for their dreams. Being a minority is not a disadvantage when applying for medical school. On the contrary, it is beneficial. You have a chance to distinguish yourself just by who you are and the way you were brought up. It gives a perspective to medicine that is sorely lacking. Further, I would tell them that they need to go into each aspect of the application process with passion. Put passion into the personal statement, to secondary essays, and during interviews. Schools can see that passion for medicine and they want those types of students. Medical school is challenging, but those that go into it with a passion and something behind why they choose medicine will succeed.

Is there anything else that you would like to tell me?

SNMA has been a great experience and one of the reasons I came to Duke. I think it is one of the best and most active organizations that I have had the opportunity to be involved with. When I finish my medical training I know that I will be better for having been a part of SNMA.
From Jessica Edwards, Region 3 Director, Osteopathic Committee Member; University of North Texas Health Science Center DO Candidate

The Osteopathic Residency Application Process and How to Excel Part 2: Surviving Interview Season

So now that interview season is finally over, I applied to a total of 29 programs, was offered 20 interviews and accepted 9 of them.

Let me start off by saying that interview season is crazy. I am going to keep it real with you. It is overwhelming, exhausting and most of all expensive but with planning and making smart decisions early on, you will be fine just like I was.

1. A cool preceptor or central location is a MUST

Most Osteopathic Programs start interviewing at the end of September and commence through the end of December. I chose to do my audition rotations in August and late October to mid-November. Here was my interview schedule: I interviewed at the program I rotated at in August, completed 6 interviews from the end of September to the middle of October and completed 2 additional interviews while I was on an audition. I would suggest setting up a rotation or two with private physician(s) when you plan to interview the heaviest and when you ask to work with them, ask to only work 2-3 days per week (and no it doesn’t matter if they work all 5 days in the work week) and arrange your interviews accordingly. This will save you the awkwardness of having to miss too many days to interview at other places while you are rotating at one of your top programs.

2. Rank your programs in tiers.

I had 3 tiers of Residency Programs based on the factors that I mentioned in the previous article (location, unopposed vs. opposed and curriculum). For instance my tier 1 programs were unopposed family medicine residency programs that provided lots of exposure to every part of medicine. My tier 2 programs in a moderately desirable area with moderate exposure to every part of medicine. My tier 3 programs were in an undesirable area but had a good curriculum and were pretty much “safe” options that I could interview at if I was low in numbers for my tier 1 and 2 programs.

3. Don’t be too picky

I feel like this is a double-edged sword. Often times, we get in mind the certain type of program we want and decline offers from programs are not that. When it came to interview offers, I accepted offers from all programs and cancelled if I needed to at least a week in advance. Don’t feel bad about declining interviews if you just absolutely know that you do not want to go there. Think of it this way, you don’t want to keep an interview spot from someone who really wants to be there. A trick to this is to schedule less desirable programs later on in the interview season so that if you have interviewed at your top programs, you can cancel them and still have enough programs to rank when that time comes.

4. Residency and Relocation Loan

I would highly recommend getting a loan like this because unless you plan to only interview in a certain, very limited geographical location, your financial aid is by no means enough. That’s the honest truth. Sallie Mae, Discover and PNC bank have these loans available. Several friends of mine (including me) were not approved for the loan without a cosigner. So keep that in mind as you begin to prepare.
5. Try to group interviews together by geographic location

I was interested in going to the Midwest or northeast for Residency. So I grouped all of my interviews by location. For example, I interviewed in RI, CT and NYC for one set. My next set of interviews included NYC and Maine. After that, I was completing a rotation in the Midwest and just drove to an interview in a different city. This really helped finance-wise because I was able to either drive a couple of hours to the next destination or hop on a cheap flight to the next destination. Another good option is to ask to interview while you are rotating at the program. I would ask midway through the rotation after you know how they feel about you. I did this for my first interview in the NJ area while I was rotating there in August.

5. Use different lodging options besides hotel

I used websites such as airbnb when I interviewed in large cities. However, it is SO important to look at reviews of the hosts before you book. If you see anything negative or below 4 stars, don’t book it. For instance, when I interviewed in the Bronx, I rented a room in Harlem and it was $60 a night. If there is not an airbnb location where you are interviewing that meets your standards, be sure to use hotwire.com. The rates are greatly reduced and the website does not tell you the name of the hotel but will give you the general area location and the ratings. I would recommend hotels that are 2.5 and higher. You don’t need the luxury of a 5 star hotel but you definitely need to feel comfortable. Also, include the cost of food while you are traveling (some programs do not have an interview dinner the night before) and rental car if applicable. Do not forget the cost of parking at the airport if you drive yourself and/or getting to and from the airport as well as around the city when you are in a city and don’t get a car.

6. Important questions to ask during the interview

- How happy are the residents
- Accessibility of the program director when/if you have concerns
- Lecture schedule (is it noon conference? Half day? Is that time protected?)
- Call schedule (Do you work any 24 hour shifts? Is it 6 days on, 1 day off? How do they handle holidays?)
- Where the residents live in the area and the cost of living
- Health insurance coverage
- How time off works (do you have to take a mandatory week(s) off? Or can you take 1 day off here and there as needed)
- Moonlighting opportunities and timing (i.e. are you only allowed during 3rd year or can you moonlight in 2nd year)
- Rotations out of state (you may laugh but one residency program that I interviewed at sends their residents to 2 different states for certain rotations during their 3 years)
- Evaluation System (are they done on paper, online? What’s the turnaround time in getting them back?)
- Do they have any residents who have done fellowships? What are some of the residents doing now?
Opportunity for volunteerism and international mission work (if this applies to you)

- In the case of Family Medicine specifically: Do they have Pediatric and Obstetric patients in their outpatient clinic? What are the opportunities for procedures in clinic? Are family medicine residents scutted out other services?

*Most programs address some of these things during their overview of their program, but just in case they don’t address them, I would for sure at least ask a faculty member or a resident at some point.

8. Go with your heart

I rotated at one of the top family medicine programs in the country (which shall remain nameless) during my 4th year because of their exposure of their residents to full spectrum family medicine. That month was kind of miserable. The faculty members were great but the patient demographic was not what I was interested in working with and some of the Residents were not very friendly. I say all that to say that they expressed interest in me but instead of going off of name alone, I decided to not even rank them due to knowing that I would not be happy there. Trust your feelings and write down how you felt after each interview. Write down your pros and cons and when it’s time to submit your rank list, trust your heart. If you are religious, seek your higher power for direction. Talk to your mentors but do not talk to classmates and even colleagues. They very well could be going for the same position that you are. Some of that advice could be skewed. If you have a HUSBAND or WIFE (notice my emphasis on that), then consult with them about their line of work and ask them to look into job opportunities in that area to see if they would do well there. Do not choose a program due to a significant other who may or may not be there in the long run.

I hope that this article helps you along the way while you are applying for residency and interviewing. Always remember to be yourself. Don’t try to group too many interviews together. I got burnt out after 3 back to back interviews at one time. I spaced them out a couple of weeks apart.

Once again, if you have any questions about the interview process or application process, please feel free to contact me at region3director@snma.org
Go to www.snma.org to register.
Let’s Talk About Sex

By: Jonathan Ryan Batson, Vice-Chairperson of the Publications Committee, Junior Editor of the Journal of the Student National Medical Association (JSNMA)

As we recently celebrated the 25th annual World AIDS Day celebration this past December 1st, I reflect on the images of how a virus that was first thought to be a “homosexual condemnation” by some and at that time a death sentence, to now an afterthought in some people’s minds. Human Immunodeficiency Virus (HIV) has arguably been one of the most pervasive viruses of the past quarter century; however, today, it still haunts millions around the world. Even with the atrocities of mass death due to the convergence of HIV into AIDS and with the need for more public health intervention to promote healthy sexual education, sadly, the United States as a whole has not done as good of a job as they should; which hurts our youth. Though all can be at risk for contracting HIV, there seems to be a disparity amongst the youth which may be due to various social and economic factors that influence higher risk activities that promote the contraction of the virus. According to the Center for Disease Control, among men having sex with men, there seemed to be a 12% increase in new infections in 2010 in comparison to 2008. In accordance with the youth population, which is regarded as the population between the ages of 13 to 29, they accounted for approximately 39% of the new cases of HIV infections in 2009 and in terms of young men having sex with men, 27% of new cases of HIV infections (and 69% of new HIV cases amongst people between the age group of 13 to 29 years). These may be due to various practices such as unprotected sexual contact, rape and other sexual abuse related cases, drug and substance abuse which may impair judgment, and lack of education, the presence of which would demystify stereotypes and create negative attitudes towards sexual health.

“We tend to educate children in mathematics, language arts, English language and literature, and the basic sciences, but we cannot talk about sex. The question we have to ask ourselves is ‘why?’”

As with seeing the same trends of the youth affected by HIV more-so than the older population, one has to wonder what can be done to promote the education necessary to decrease rates of transmissions at faster rates? When looking at abstinence-only education in comparison to teen pregnancy rates, we tend to see a higher incidence of teen pregnancy in those that lack comprehensive sex education. Also, states that had positive attitudes towards teaching comprehensive sexual education to teens had not only lower HIV rates, but lower pregnancy states in comparison with states with abstinence-only sex education laws that promote abstinence until marriage. This may indicate the major driving force that continues to plague HIV prevalence amongst the youth; not enough holistic sexual health education at an early age that can influence positive sexual health practices and attitudes in the event an individual may participate in sexual intercourse in their teen years. When looking at European models of sexual health efforts targeting teens, there seems to be a progressive stand of not “babying” the adolescent population but rather educating them with the right information to make the best decisions for themselves. In America, we tend to see that this is the complete opposite. Some schools, due to pressures by their congressional members in their districts prohibit comprehensive sex education by the use of condom demonstrations and educating the youth about not only how to access free condoms to protect themselves from sexually transmitted infections, but also not promoting something that is as natural in the animal kingdom as breathing. We tend to educate children in mathematics, language arts, English language and literature, and the basic sciences, but we cannot talk about sex. The question that we have to ask ourselves is why?
When looking at a wide range of issues that may influence our sense of “awkwardness” when speaking about sex, one has to look at two drivers that are possibly huge factors in why the American society (at least in some communities) does not speak more about sexual health and awareness: the effect of sex in mass media which can create attitudes and judgments about sex, and family history and parental impact on teen sexual behavior. When assessing a study done on college freshmen on their attitudes of sex after watching television drama shows, there seemed to be a correlation of positive and negative attitudes of sex respectively when the shows exposed positive or negative consequences of premarital sexual intercourse. As we have learned from research from multiple disciplines, imagery can create some effect on people’s perception over time. Though we cannot definitively conclude that there is causation to the correlation due to added effects possibly due to socio-cultural norms, financial stability, educational level, and other societal pressures, there may be some effect in combination with the prior list that can influence attitude towards sex. With many commercials on television increasing with sexual imagery and promoting a certain portrayal of women, they not only perpetuate stereotypes of over-sexualizing women, but one can assume that it can influence sexual desires without education that can promote positive and honest attitudes towards sexuality and bodies. In terms of parental impact on the youth, we tend to see that when parents guard their children more, teens have tended to be more likely to partake in higher sexual risk activities which can possibly increase the likelihood of those youth to contract sexually transmitted infections; risk level can increase or decrease depending on education about sexual health, peer pressure, attitudes towards certain behaviors and assessing their peers risk taking behaviors, etc.

“When looking at a wide range of issues that may influence our sense of “awkwardness” when speaking about sex, one has to look at two drivers that are possibly huge factors in why the American society . . . does not speak more about sexual health and awareness: the effect of sex in mass media, which can create attitudes and judgements about sex, and family history and parental impact on teen sexual behavior.”

With looking at all avenues of comprehensive health, we as a nation need to do more better in educating the youth on preventative measures to protect themselves from not what could be a death sentence, but a life sentence. Though HIV/AIDS attitudes have decreased over the years due to increased research that debunk myths and stereotypes, in many communities and different age groups, some of the same stereotypes still exist. In order to change the prevalence of HIV/AIDS and decrease the amount of new cases of infection, we have to not only educate our children holistically and be honest with them about sex, but we may have to start earlier with promoting honest images about their bodies. It should not be acceptable to talk about sex to a 17 year old but not start the conversation at some point earlier. We have to accept the truth... people are having sex. Though the youth, due to increase internet access to information has made some strides on educating themselves about sex, we must have the courage to speak to them about the very thing that allowed us to exist. Sex is real and sex is here to stay. However, just because we do not want our youth to have sex without the mental capacity to understand the responsibility of the act, does not mean we should lie to them and promote abstinence only, for we cannot expect them to do what many adults cannot withhold themselves.

Citations:


I believe being human gives us a moral obligation to help others. The way in which we accomplish this can be very diverse for different people. As social beings, we strive for relationships, family, and friends who we can go to for many moments in our lives. To share emotions and experiences is something we all hope to gain through these social interactions. During the holidays, we feel a special need to congregate together with our friends and family and share a special time with them and helping our loved ones. It is also a great time to give to and help others.

I am a senior pre-medical student at Florida International University in Miami, Florida. I come from a Latino background; my mother was born in Havana, Cuba and my father was born in Guayaquil, Ecuador. My two brothers and I are the first generation in our family to be born in the United States. As I was growing up, my parents kept their cultural heritage and showed us the value of family and how important it is to take care of them. As such, this value will be with me for the rest of my life and would later grow to include others outside of my family.

“Students can get caught up in their own lives; worrying about exams, organizational clubs, social media, friends, sports, and passing classes takes up much of their time. I’ve spoken to several students about the local and national news and many of them don’t feel the importance or need to read or hear about it.”

As a college student, I know how easy it is to forget how people in poverty-stricken countries live their everyday lives. Students can get caught up in their own lives; worrying about exams, organizational clubs, social media, friends, sports, and passing classes takes up much of their time. I’ve spoken to several students about the local and national news and many of them don’t feel the importance or need to read or hear about it. “It’s depressing” or “I’m a bit busy studying for my exam next week” are things students hear often. I myself have felt this way many times. I would spend hours studying, writing papers, or researching. Often times my family and friends would wonder if I have lost myself in my books.

Helping others has always been in my nature. As I came to realize my wish to help beyond my family, I wanted to help my community in any aspect required of me. I began a quest towards providing aid for others.

In December of 2011, I took the opportunity to volunteer as a counselor at a sleep-away camp in Eustis, Florida located in the center of the state. The camp, called Camp Boggy Creek (CBC) is designed for children who have chronic and/or life-threatening illnesses. The idea is for children to spend one week of their summer to gain the experience of being at camp and enjoy being a kid. Since these kids can’t attend a regular camp because of the restrictions brought upon them by their disease, CBC is a place they can be safe while having fun. At CBC, they have a place called “The Patch” where they have a working medical facility with health care personnel. Whenever the campers need any medical attention, they have a place to go and be taken care of immediately on the campus grounds. I chose to volunteer at Camp Boggy Creek as a counselor because I wanted to experience what it would be like to have to take care of children who needed a little extra care and companionship.
During the summer, every week was dedicated to a particular disease. This would encourage those children with the illness to attend at the same time. Some examples of diseases the camp caters to are cancer, spina bifida, epilepsy, heart disease, and asthma. The week I volunteered at the camp was sickle cell anemia week. As a counselor, I was assigned to take care of a group of girls between the ages of 10-13 who have the illness. Four other female counselors were assigned to my cabin as well and we had fifteen girls come stay with us. I had never had a role in which I had to take care of so many young girls. We made sure they went to bed early and woke up on time in the morning, were fed properly as we ate every meal together and most importantly, we had to make sure the girls were comfortable and not in any pain while doing regular camp activities. With sickle cell anemia, patients can go into what is called a “crisis” or episode where they feel intense pain in certain areas of their body which may be due to cold temperatures, strenuous exercise, or other activities.

“From then on, she always held my hand. I felt such relief and happiness to be able to help her take her mind off of her pain. My heart was touched and changed forever. Even though I did not help her medically, I was there with her and that was something she needed. Sometimes even being just a friend or a hand to hold can make such a difference in the world.”

The experience was more than I expected. As cabin counselors, we were sort of like a temporary guardian for these girls. This was a very touching experience for me. Usually, you see children playing in a playground with no care in the world. Giggling and bouncing around the yard with toys and playmates. They are healthy, active, and have tons of energy. Being a part of CBC made me realize how ill children can get and how much more care they need to still be a kid. Having sickle cell anemia, some of my campers would tire easily and become dehydrated. Many of the campers were afraid to do certain activities because most of their lives they were told not to because of their illness. At CBC, they were able to partake in activities that were especially sensitive to their illness. Even with so many precautions, several of them endured a sickle crisis while at camp and were treated at The Patch. I felt a wide range of emotions as I watched the campers go from having fun and playing to getting a sickle cell episode and in pain. One of our girls had to stay at The Patch for three days and had asked me to stay with her all the while. I played cards with her, made drawings, watched Disney movies and played board games. After she felt better, we joined the rest of the group. From then on, she always held my hand. I felt such relief and happiness to be able to help her take her mind off of her pain. My heart was touched and changed forever. Even though I did not help her medically, I was there with her and that was something she needed. Sometimes even being just a friend or a hand to hold can make such a difference in the world. With that feeling, I was invigorated to continue finding more ways to provide service for others.
As I learned of the hunger and poverty around the world, I understood the need for self-less service and care in developing countries like those in Central and South America, Africa and others. I realized they all needed help just like our own communities from people who had the ability to give it.

One of the most fulfilling life experiences I have ever had was with Medlife. Medlife is an international organization that schedules mobile medical clinics in several parts of the world including Peru, Ecuador, Tanzania, and India. College students volunteer to participate in these medical clinics as assistants to the physicians and nurses who volunteer as well. Students help conduct physical exams, perform triage, dentistry, gynecological exams, and provide prescriptions along with educating the community on health. Volunteers also take on developmental projects to help their communities grow and be safer. The ultimate goal of Medlife is to give medicine, education, and development to impoverished communities with little to no access to medical care.

Medlife returns to the same communities every few months to follow up with the families. With my future plans of becoming a physician, I felt especially inclined to this experience because we were offering medical care to communities lacking access to any clinics or hospitals. Every day for one week, my group traveled to a different poverty-stricken village or “pueblos” on the outskirts of Lima, Peru. One of the stations I worked at was the tooth-brushing station where we taught children the importance of brushing teeth and how to do it. I observed several kids take the tooth brushes we gave them and use them to dig in the dirt to play. It dawned on me then how important it is for us to continue working to help them. The dentistry station showed the effect of this lack of knowledge of dental hygiene. The amount of cavities that were beyond repair was plentiful. Dozens of teeth were pulled out because of how rotten they were from all the candy the kids eat and no knowledge of dental hygiene.

The experience was nothing like I expected. The huts or “favelas” people lived in on the mountains, the ground holes they used as bathrooms and the dozens of stray dogs running around was all very eye-opening. I felt a sense of awe at how much the people in the communities cared for one another. I had never seen anything quite like the communities I visited on my trip to Peru.

I have become quite involved in my passion of giving to others since attending these trips and others the past few years. I made plans for another Medlife clinic in Ecuador this past December 2013. It gives me a sense of peace and satisfaction knowing the people I help have some comfort in knowing someone else cares. Someone who, to them, probably has everything one needs and has come to their community to help their people. It also gives me a motivation to persevere and continue working on this path because there is so much need in this world. Many people do tend to think there are far too many people that need help in the world and that one person couldn’t change it much. I disagree with this statement with all my heart. I now understand how significant it is to touch one person’s life and come out with both of your lives changed forever.

Being immersed in all these communities and cultures has given me a sense of understanding—an understanding of how many people live the way they do and why. I believe it is extremely important to be able to appreciate and empathize where people come from, especially as a physician. Patients come from different backgrounds, geographic locations, races, ethnicities, languages, cultures, and religions. You don’t just treat a human being; you treat a person who has a history, a family, emotions and beliefs. It is important to be sensitive to the way people live their lives to be able to treat them holistically and thoroughly and most importantly, with respect.

The holidays are an especially great time to reflect on what we are grateful for and then go out and show we are grateful by helping others. There is a lot of need in this world and it isn’t just monetary. There are so many around us who have forgotten to be grateful for their life and the wondrously simple blessings we receive on a daily basis. So go out there and lend out your hand.
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Understanding Community Health through Philanthropy
—Juan Oves, Jr., MPH Candidate FIU

The world is in a continuous change and everyday different communities are exposed to a variety of environmental and behavioral factors that affect community health. Currently, as a public health graduate student at Florida International University (FIU) Robert Stempel College of Public Health & Social Work my area of concentration focuses on health promotion and disease prevention. The understanding of different populations and their health disparities including social and behavioral causes is of great significance to future physicians and public health professionals. Establishing a clear understanding of these health disparities and their social determinants will assist in effective planning of interventions and programs to improve community health.

Understanding the health of a community requires understanding the context of the community. From the individual patient to the patient’s social network, having an ecological perspective of the health issues is essential in improving community health. Volunteering and philanthropy are essential components in developing a deep understanding of community. The act of giving to and promoting the welfare of others allows us as future physicians and public health practitioners to immerse ourselves in the community. While volunteering at Miami Children’s Hospital for Radio Lollipop, a non-profit organization dedicated in providing education and entertainment for children at the hospital, I gained valuable experience through patient and hospital interaction. Radio Lollipop is a radio station located in the hospital that provides care, comfort, play and entertainment for children during their hospital stay. Volunteers are able to interact with patients, family members, friends, and hospital staff. This program creates an enabling environment where children can utilize their imagination and creativity while contributing to their well-being. You may ask yourself why this interaction is important. This interaction is an intricate part of improving health. Understanding the patient’s beliefs, attitudes, behaviors, social needs and cultural norms are essential in improving their health.

“Understanding the health of a community requires understanding the context of the community... Understanding the patient’s beliefs, attitudes, behaviors, social needs and cultural norms are essential in improving their health.”

Volunteering is powerful and not only provides us with medical and patient interaction, but also with a driving force to change community health. The three hours a week I volunteered at Radio Lollipop allowed me to truly discover the value of life. I recalled when I first started volunteering at Radio Lollipop; I instantly became committed to the Pediatric Intensive Care Unit. I felt that this unit in particular really needed that burst of good energy and company, not only for the patients, but also for the family and friends. I recall the first time I walked into a room and saw a mother sitting in a chair looking into a crib and speaking in a smooth and calming voice. At that moment, my heart sank, as I realized how delicate the situation truly was. I did not know how to react, but I smiled at her and asked if I could come in. She introduced me to her child and I saw the excitement in the child’s eyes when I presented the child with an arts and crafts activity. The child stayed in the hospital throughout the year, so I naturally developed a relationship not only with the nurses and staff, but also with the mother and child. I realized how important a few words and a conversation could be to a patient and their family while staying in the hospital. It was that weekly social support that distracted the child from the daily routine of administering medicine and doctor visits. After a year of seeing the child in a crib supported by medical equipment, you could now see a beautiful little boy that was constantly smiling and his health continuing to improve. I learned that to improve health, love and compassion can be an intricate component of the healing process. Essentially healing can come from a soft voice of a mother whispering to her child, a nurse caring for a child, a doctor giving a child hope, and a volunteer comforting the child and family members. You realize how important it is to understand your patients’ community and their social needs, just as important as the medical treatment a patient receives while they are at the hospital.
During the four years of volunteer experience I was able to not only expand my knowledge, but also leadership skills through becoming a volunteer trainer and fundraising chair of the organization. As a fundraising chair for the organization, we were able to raise a total of $67,000 at one of our major fundraising events.

“I learned that to improve health, love and compassion can be an intricate component of the healing process. Essentially healing can come from a soft voice of a mother whispering to her child, a nurse caring for a child, a doctor giving a child hope, and a volunteer comforting the child and family members. You realize how important it is to understand your patients’ community and their social needs, just as important as the medical treatment a patient receives while they are at the hospital.”

This volunteer position allowed me to obtain knowledge and experience from current health professionals in the hospital and community. The Radio Lollipop experience expanded my horizon and provided the foundation for me to pursue a graduate degree in public health and further develop the necessary leadership skills as a public health professional. Currently as president of the Stempel Public Health Association I continue to provide service and hours to our local community and develop relationships with current public health practitioners and physicians. As future physicians and public health professionals, we must commit and become involved in our communities in order to understand the underlying factors that affect community health.
Staying on Track: The Non-Traditional Pre-medical Student’s Perspective

By Rosemary Attor, MS, Region VIII MAPS Co-Liaison, University of Pennsylvania

During my first meeting with my pre-medical advisor, I was informed of the numerous courses required as prerequisites for medical school. As I sat in the office reviewing the pre-medical course requirements worksheet, structured by each academic year, I thought to myself, “This is going to be the next four years of my life.” The worksheet included courses in the social sciences, chemistry and humanities. Despite being overwhelmed, I embraced the initiation of my journey and planned accordingly.

Generally, undergraduate students aim to fulfill the pre-medical requirements in order to be deemed the “cookie cutter pre-medical student.” At this critical time, aspiring doctors are under the impression that they have to be a biology major, have no social life, volunteer at a local healthcare facility, shadow a physician and excel in their coursework, especially the science courses. However, many tend to disregard the fact that a significant percentage of medical students were not biology majors, but majored in the humanities and social sciences.

In Anemona Hartocollis’ article, Getting into Med School without Hard Sciences, she sheds light on the pre-medical curriculum and illustrates ways to bypass the pre-medical requirements and still gain admission into medical school. This article features a Brown University student who discovers the Humanities and Medicine Early Assurance Program (HuMed). The Icahn School of Medicine at Mount Sinai-FlexMed Program (an expansion of HuMed), is a competitive program, which provides second year college students the opportunity to apply for early assurance of admission to medical school. Accepted students are then at liberty to pursue any area of interest and are not required to take any of the pre-medical requirements, including the MCAT. If standardized testing is not your strength, the FlexMed program may be for you. If you are an initiative-driven college sophomore who yearns to explore his or her creative side, this may be the program for you. Or is it?

Hartocollis further discusses the medical school success rates of traditional pre-medical students who studied the “hard sciences” versus students of humanities and social science backgrounds. Apparently, medical school performances amongst the two student groups are equivalent. Surprised? Well, this finding contributes to the rationale for the changes being implemented in the MCAT in 2015 (i.e. the addition of a social and behavioral section). A study by Mount Sinai’s Nathan Kase, MD and David Muller, MD shows humanities and social science majors are more sensitive, and thus, more empathetic than their biological science major counterparts. Empathy fosters life-long relationships with patients and enhances patient care. In contrast, humanities and social science majors were more likely to prolong their time in medical school by taking leave of absences for non-academic reasons. In addition, these students do not perform as well on the United States Medical Licensing Exam (USMLE) in comparison to their colleagues that were science majors.

Regardless of their major, medical students will face both disadvantages and advantages, due to their respective educational backgrounds. Both empathy and scientific knowledge are critical in medicine. In college, pre-medical students have to make a sacrifice by taking science and math requirements in exchange for humanities and social science courses. The majority of pre-medical requirements are revisited in medical school. However, medical students rarely have a second chance at taking courses such as art history, anthropology, etc. No matter the track you choose, it is imperative to enjoy the journey to and after medical school.


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Born and raised in San Diego, California, Ms. Milele Bynum travelled to North Carolina to complete her post-secondary education. After graduating from Duke University with a Bachelor of Arts in Sociology and Public Policy, Ms. Bynum continued her studies at North Carolina Central University where she received her Master of Public Administration. In August 1999, she entered the University of North Carolina, School of Medicine.

Her life as a person and a future doctor was forever changed on November 5, 2001. At 28 weeks pregnant, she gave birth to a little boy and girl, who together weighed less than five pounds. Faced with the challenges of caring for two premature infants, she withdrew from medical school. Although the circumstances leading to her withdrawal were life altering, they did not deter her from pursuing her goal of becoming a doctor.

Turning perceived obstacles into opportunities, Ms. Bynum continued to pursue her passion for medicine and public health. As a Study Manager with Social & Scientific Systems and a Clinical Research Associate with The Parkinson’s Institute, Ms. Bynum accumulated almost a decade of epidemiology research experience. In the Fall 2011, Ms. Bynum returned to UNC School of Medicine with an even deeper desire to reverse disparity trends by working with underserved, high-risk, and vulnerable populations to empower them to live healthier lives and have improved health outcomes.

Ms. Bynum’s project seeks use a community based participatory model to examine the effects of a faith-based intervention on weight management and healthy behaviors amongst church-going African Americans. Her interest in health disparity research is based on personal experiences and a genuine desire to empower and improve the health of underserved populations. As a person who has and continues to struggle with weight, Ms. Bynum understands the health consequences that are associated with being overweight. As a mother and future physician, Ms. Bynum wants to serve as a model for her children and patients. Her proposed intervention offers a culturally relevant approach to addressing obesity, changing health behaviors and improving health outcomes.
Jerrine R. Morris, MPH
Virginia Commonwealth University School of Medicine, M.D. Candidate 2015

Jerrine R. Morris was born and raised in Brooklyn, New York but relocated to Richmond, Virginia to complete high school. After matriculating to Virginia Tech for post-secondary education, she developed an indubitable passion for maternal and child health, specifically within underserved populations. As a certified nursing assistant at a local free clinic, she met a young woman who needed a colposcopy with biopsy after being diagnosed with cervical dysplasia. This young woman cried incessantly not because of the pain or agony associated with her diagnosis but because she did not want her boyfriend to find out and leave her. The emotional journey experienced during that encounter has remained a key factor in Jerrine’s desire to serve as an advocate for women.

Upon completion of a B.S. in both Psychology and Biology with minors in Chemistry and Medicine & Society, Jerrine ventured to New Orleans, Louisiana to complete a Masters in Public Health in Epidemiology. While learning the foundations of survey methodology, biostatistics, and epidemiology, she began an internship with the Family Planning Office of the Louisiana Office of Public Health. Here she cultivated her interests in women’s health but more importantly, gained insight into public policy and health disparities. She cites her internship with the Family Planning Office as pivotal for her attainment of a subsequent internship with the Maternal and Child Health Program; during this second internship she investigated biologic mechanisms for excess fetal and infant mortality among women in Louisiana with race as a key determinant of adverse birth outcomes.

Since her matriculation to medical school at Virginia Commonwealth University School of Medicine, she has taken many lessons with her. She have an extensive repertoire in data analysis yet an undeniable passion for maternal and child health. After working in conjunction with her current mentor, Dr. Saba Masho, on several smaller projects using data from the Pregnancy Risk Assessment Monitoring System, she was offered an opportunity to serve as a coordinator on Masho’s Centering Pregnancy Project. Jerrine reflects on how this project was perfect for her as it combines her passion for women’s health, her recognition that disparities are best prevented in utero, and her fondness for data analysis in public health. Throughout the past year, her Project Team has successfully recruited over 200 women and has been following them in this longitudinal study to identify how prenatal care influences postpartum behaviors. Specifically, she and her team are interested in how Centering Pregnancy, an innovative approach to prenatal care held in groups with facilitative leadership, affects breastfeeding initiation, postpartum attendance, rates of contraception usage and rapid repeat pregnancy, and weight gain. Developed in 1993, Centering Pregnancy has slowly risen as a lofty and essential approach to prenatal care. Despite its limited research, benefits have been shown in areas such as gestation and birth weight, two outcomes that have notoriously been influenced by health disparities. Jerrine’s ultimate goal is to show the importance of Centering Pregnancy in decreasing adverse postnatal outcomes especially within a racial and socioeconomically diverse population prone to health disparities.
Healthy Minds: Cost-Effective Method to Promote Mental Health in At-Risk Minority Youth

Judy-April Oparaji, RD, SNMA Region VIII Director; MD Candidate, University of Pittsburgh School of Medicine; Enyinna Nwachuku, BS; MD Candidate, University of Pittsburgh School of Medicine; Jason Rosenstock, MD.

Objective:

There are many factors contributing to the prevalence of mental health issues in minority youth. These include increased stressors and limited funding for community mental health programs. The objective of this study is to create a low-cost, effective and reproducible program that promotes mental health amongst at-risk minority youth in underserved communities.

Background:

Studies show that over 80 percent of urban youth experience trauma compared to 25 percent in the general population of children (1). Urban youth in underserved communities are disproportionately faced with increased stressors including violent neighborhoods, substance abuse, poverty, lack of support, and limited resources. These youth are also at increased risk for entry into the juvenile justice system (2). Despite this increased need for mental health services amongst urban youth, a 2007 analysis of two national data sets found that half of minority adolescents were not receiving needed mental health care while only less than a third of their Caucasian peers were not receiving needed care (2). Some of this disparity can be explained by differences in income and insurance status and a disconnect between those delivering care and those receiving care (3,4). This program, if effective, aims to provide the guidelines for an easily reproducible, cost-effective method to increase mental health awareness and positive self-conception in minority youth living in underserved communities. The study hypothesis is that medical student volunteers provided with only minimal training can teach school-age children a series of well-received mental health workshops that will increase their knowledge and positive self-conception.

Methods:

This is a University of Pittsburgh IRB approved research study conducted at University Prep Middle School at Millions for middle school participants in the Zone! afterschool program. Eighteen University of Pittsburgh medical students were recruited to teach one-hour workshops on one of the following four topics: (1) Stress Management & Ways to Cope with Trauma (2) Family Planning & Sex Education (3) Body Image & Dealing with Depression (4) Skills Workshop: Professional Development. Professional representatives from medical clinics and community organizations volunteered to facilitate one-hour trainings for medical students on each workshop topic. At the beginning of the program, each student participant was consented into the program by either of the co-investigators (Judy-April Oparaji and Enyinna Nwachuku). In addition, a parent consent form was also required. The following evaluation measures were administered: (1) quizzes before each workshop to measure increase in knowledge (2) satisfaction surveys (3) Rosenberg Self-Esteem Scale. This scale is one of the most widely used self-esteem measures in social science research with good reliability and validity tested in many settings (5). See Figure 1 below for program timeline.

Results:

Twelve students initially enrolled in the program. Seven students received parental consent to participate, with 1 female dropout due to circumstances unrelated to workshop interest. There was a 4:2 male to female ratio. Average student age was 13 years old. Results show an approximately 5% increase from pre-test to post-test scores (n=6).

In addition, data trends suggest that increased workshop attendance positively affects post-test scores. On average, students that attended at least 75% of all workshops did 46% better on post-test quizzes than those students that attended less than 75% of all workshops (Figure 2).
Medical student volunteers receive a one-hour training from community professionals.

**Weeks 1-4: Mental Health Workshops at University Prep at Milliones Middle School**
*Study Group: 4 boys, 3 girls; African-American; 6-8 grade*

Voluntary Participation; Self-Enrollment in Healthy Minds elective of Zone After School Program

Wk 1: Ways to Cope with Trauma Pt. 1
Wk 2: Body Image & Dealing w/ Depression Pt. 1 (1 dropout)
Wk 3: Family Planning & Sex Ed Pt. 1
Wk 4: Skills Workshop: Professional Development Pt. 1

*Pre-test before each workshop; Satisfaction Survey after each workshop.*

**Weeks 5-8: Mental Health Workshops**
*Study Group: 4 boys, 2 girls; African-American; 6-8 grade*

Voluntary Participation; Self-Enrollment in Healthy Minds elective of Zone After School Program

Wk 5: Ways to Cope with Trauma Pt. 2
Wk 6: Body Image & Dealing w/ Depression Pt. 2
Wk 7: Family Planning & Sex Ed Pt. 2
Wk 8: Skills Workshop: Professional Development Pt. 2

*Post-Test before each workshop; Satisfaction Survey after each workshop*

*Rosenberg at weeks 5 & 8*

*Overall Satisfaction Survey at Wk 8*

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Figure 1. Healthy Minds Program Timeline
Figure 2. Average Pre-test & Post-test Scores for all Student Participants. Student 2 Dropout. No data recorded.

Figure 3. One-Month Rosenberg Self-Esteem Scores. Data shows an average 7-point increase in scores. Rosenberg Scale ranges from 0-30. Normal Self-Esteem: ≥ 15. Low Self-Esteem: < 15.

Figure 4. Student Satisfaction Survey Results (n=6).
Also, average post-test scores for students that attended both workshops in the 2-part series were 19% higher than those that only attended 1 workshop in the series.

The students’ Rosenberg Self-Esteem Scale scores increased by an average of 7 points in a 1-month time frame (Figure 3).

The average overall student satisfaction rating of the program was 9.2 out of 10 possible points (Figure 4).

Conclusions:

Result trends support the hypothesis that minimally trained medical student volunteers can teach school-age children a series of well-received mental health workshops that will increase their knowledge and positive self-conception. Improvements in learning appear to be based on attendance rates. A six-month follow up survey will be administered to assess long-term program outcomes.

Underserved minority youth are at increased risk for mental health dysfunction. Affordable primary prevention programs in communities are needed to prevent emotional and behavioral dysfunction and promote overall mental health. Underserved minority youth are also at increased risk for entering the juvenile justice system. The average cost for a child in the Pennsylvania juvenile justice system is about $360/day, plus an additional $50/day for youth with mental illnesses. In comparison, the average cost per child for this community-based mental health program was approximately $60/day (including training). Thus, this could result in large potential savings for communities.

If this low-cost program can result in increased skills, self-esteem and self-efficacy, it may lead to decreased child behavioral disturbances and lower costs for underserved communities. There is a limit to the statistical significance of this pilot program due to the small sample size; however, this program shows promise. A larger study needs to be completed to more accurately assess program effectiveness and to generalize research findings to a larger population.

Acknowledgements:

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Bibliography:


Neuronal Regulation of Regenerative Bone Growth in the Zebrafish Fin

Anthony M. Recidoro, Amanda C. Roof, Brandon J. Ausk, Sundar Srinivasan, Edith M. Gardiner, Ted S. Gross, Steven D. Bain, Christopher H. Allan, Ronald Y. Kwon

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Disruption of the nervous system (e.g., via brain, spinal cord, or peripheral nerve injury) has been widely associated with aberrant bone function. Zebrafish are small, optically accessible, genetically manipulable vertebrates whose tail fins possess a relatively simple neuroskeletal structure (~18 bone rays each associated with intra-/inter-ray nerves, Fig 1A). The capacity for zebrafish to undergo rapid bone regeneration following fin amputation confers unique opportunities to examine neuroskeletal signaling within a highly tractable experimental system.

In this study, we developed a model of cholinergic disruption in the regenerating tail fin using intramuscular injections of Botulinum toxin B (BTxB). The tail fin is muscularized only at the base. By administering BTxB into the base, we were able to examine remote effects of BTxB at the distal tip while minimizing the influence of impaired muscle near the regenerate (Fig 1B). BTxB resulted in multi-faceted effects on bone regeneration in adult zebrafish (9dpa, ~30mm S.L.). For example, BTxB fish exhibited a significant decrease in the % length of bone regrowth compared to saline controls (sal: 74.8±8.1%, btx: 35.2±4.6%, p<0.001 for treatment, n=5). The degree of inhibition was significantly more pronounced in the middle of the regenerate compared to the dorsal/ventral regions (p<0.05 for region:treatment), suggesting that the trophic influence of fin base nerves can be spatially focused to distinct fin regions. We also found that bone ray bifurcations were significantly reduced in BTxB fish (sal: 9.4±1.0, btx: 6.7±0.3 p<0.05), indicating a role for the nervous system in guiding bone patterning. Finally, when fish were calcein stained, we found that BTxB dramatically decreased osteoblast activity in regenerating bone. Interestingly, the effects of BTxB appeared to be spatially restricted within individual rays, as evidenced by marked differences in osteoblast activity between adjacent rays (Fig 1C). This suggests a potential role for intra- and/or inter-ray nerves in mediating the effects of nerve disruption in the fin base on osteoblast activity in the distal tip. Collectively, these studies demonstrate the capacity for focal cholinergic disruption to remotely alter bone regeneration in a multi-faceted manner. Given the genetic and optical tools for dissecting neural pathways in zebrafish, this model provides a powerful platform for identifying novel mechanisms underlying neural control of bone growth.
A Survey of Young Adult Attitudes towards American Healthcare System and the Affordable Care Act
Vihoale Kpadenou and Oluwakemi Tomobi, SNMA Publications Co-Chair

Abstract: The generation of health professional trainees will stand to be the most affected by the Affordable Care Act, the healthcare reform law passed in 2010 under President Barack Obama’s first term. In addition, the young adult population ages 18-35 are a necessary component of the ACA. A survey was taken by epidemiology students to determine their stance on American healthcare, whether the ACA was considered good health care policy and which items should be covered under the plan. Results revealed that more than half of the respondents (80.5%) suggested that healthcare was a problem in the U.S, and of this group, only 30.6% of them thought that the ACA was good for the country. The top prioritized items were emergency care, while the least prioritized items included hospice care and birth control. These findings suggest that young adult needed to be more educated about the Affordable Care Act and about health insurance in general, and this lack of knowledge may be a barrier to getting other young adults enrolled in a health insurance plan.

Introduction:
America ranks at number 1 in the world, when it comes to the amount of money spent per person for healthcare (Berwick & Hackbirth, 2012). Figures from 2009 show that more than $8000 per capita is spent on healthcare; healthcare spending is 17.3% of the gross domestic product, or GDP (Berwick & Hackbirth, 2012) with 2014 projections at 18.3% (Berwick & Hackbirth, 2012). Despite all this spending, the quality of healthcare in the U.S. is lower than in other developed countries. There is no doubt that healthcare reform will be needed to address today’s healthcare needs, including health disparities, funding for and changes to the training of healthcare providers (Hoge et al, 2013), coordination of care among different healthcare providers, and an increase in the aging population due to increased life expectancy. Reform includes provisions for increased health insurance, because it is evident that people with healthcare insurance are more likely to seek regular, preventive care than people without health insurance (Flaura, Winston, Zonfrillo, Garcia-España, & Miller, 2013). Such reform also includes increased coverage of services with health insurance, such as with women’s health services.

The Affordable Care Act (also known as the ACA, and as “Obamacare”) was passed in 2010 as a way to expand coverage to those who do not currently have insurance. The ACA is expected to be implemented fully in 2014 to expand coverage via the following: extended dependent coverage, expanded Medicaid, new health insurance marketplaces, premium subsidies, and the individual mandate. However, the ACA has raised some controversy. While the plan mandates that every U.S resident get health insurance, many people do not agree with the policies. In addition, Medicaid expansion has been left to the individual states to implement as each state desires. This raises the question as to whether the ACA is worth the substantial cost of implementing this new health insurance plan for the country.

The opinions of the young adult population, ages 18-35, are particularly useful because this age group tends to be healthier and of low cost; at the same time, this group is currently the least insured group in the U.S (Neinstein & Irwin, 2013). Unlike adolescents and older adults, young adults don’t fit neatly into well defined health needs and services, and there is a lack of coordination of care in this age group, leading some to believe that young adults are even worse off than adolescents (Nienstein & Irwin, 2013). Young adults are interested in getting health insurance; cost is certainly the main barrier to enrollment (Cunningham & Bond, 2013). What are some of the other factors to consider in enrollment?

Our study aimed to identify the factors that may be included in the health care coverage that would influence student attitudes towards the ACA. We hypothesized that those who agreed that healthcare is problematic and needed urgent attention would agree with Obama’s health care changes.

Methods:
Thirty-six students from an undergraduate student epidemiology class answered a survey questionnaire related to Obama’s health care policy formulated by our group. Therefore, we asked students to assign to each variable one of the following: 1 for those that they thought significant, and 0 for those that they thought were insignificant.

A list of the following variables were provided: emergency care, ambulance rides to emergency room, nursing home care, hospice, prescription drugs for chronic conditions, vaccination, cosmetic surgery, weight loss programs, mental health counseling, psychiatric therapy, birth control, infertility treatments, dental care, and eyes and prescription care. Some other demographic information were collected as part of the survey, such as gender, student’s major, whether students have insurance and if they are the policy holder, and whether they think that the health care change is good for the country.
Table 1: Stance on health care, attitudes on ACA, and priority of items for healthcare insurance (n=36).

<table>
<thead>
<tr>
<th>Social demographics</th>
<th>Case (29) U.S Healthcare is problem</th>
<th>Control (7) U.S Health care is not problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>Female</td>
<td>14</td>
<td>3</td>
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<tr>
<td>Have health insurance</td>
<td>29</td>
<td>7</td>
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<td>Covered under parents</td>
<td>29</td>
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<td>Covered under Plans:</td>
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<tr>
<td>Emergency care</td>
<td>27</td>
<td>7</td>
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<tr>
<td>Ambulance rides to emergency room</td>
<td>27</td>
<td>7</td>
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<tr>
<td>Nursing home care</td>
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<td>2</td>
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<td>Hospice</td>
<td>3</td>
<td>1</td>
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<tr>
<td>Prescription drugs for chronic conditions</td>
<td>25</td>
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<tr>
<td>Vaccination</td>
<td>18</td>
<td>4</td>
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<tr>
<td>Cosmetic surgeries</td>
<td>2</td>
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<td>Weight loss programs</td>
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<tr>
<td>Mental health</td>
<td>18</td>
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<td>Psychiatric therapy</td>
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<td>Birth control</td>
<td>3</td>
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<tr>
<td>Infertility treatments</td>
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<tr>
<td>Dental care</td>
<td>15</td>
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<tr>
<td>Eye care</td>
<td>12</td>
<td>5</td>
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<tr>
<td>Prescription care</td>
<td>24</td>
<td>7</td>
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</tbody>
</table>
Results:

Out of the 36 participants (n=36), 29 (80.5%) recognized that health care coverage is a major problem among citizens of the United States, while the other 7 (19.5%) did not believe so. Only 11 of the 36 participants (30.6%) agreed that Obama’s healthcare changes are good for the country. The 29 respondents were the cases and other 7 were the control. Out of the 29 students who recognized that healthcare is a significant problem in the United States, only 8 of them (27.6%) agreed to the Obama healthcare changes while the other 21 students (72.4%) disagreed with it. Out of the 7 students who did not recognize healthcare as a major problem, 3 of them agreed with Obama’s healthcare changes (42.9%) and other the 4 (57.1%) did not.

The top five ranked variables that students thought should be incorporated in the healthcare plans were: emergency care, ambulance rides to emergency room, prescription drugs, mental health, and dental care. The lowest ranked variables were: cosmetic surgeries, nursing home care, hospice, psychiatric therapy, and birth control. Findings are displayed in Table 1.

Discussion and Conclusion

The results were surprising. The 29 students in the case group may not think that Obama’s healthcare is a good change because all of them have health insurance and are covered under parents’ plans. As a result they do not know the needs or the demand for the health insurance especially for those with financial difficulty. This finding is in disagreement with the hypothesis that “Obamacare” would generate more positive attitudes.

The irony is that if not for the ACA, many of these students would not be allowed to continue on their parents’ plans. One of the earliest provisions of the ACA is that regardless of school or employment status, people can be a part of their parent’s insurance plans as a dependent until age 26.

One finding that stood out is the discrepancy between rankings for mental health and psychiatric care. Psychiatry is a part of mental health; perhaps the discrepancy has to do with mental health to broad interpretation of prevention. Mental health was ranked with a higher priority, while psychiatric care was ranked very low. Perhaps it is also the stigma that mental health still has today, as it is one of the most underfunded aspects of healthcare, compared to conditions like hypertension. Birth control was also ranked low, and it could reflect American ambivalence towards the discussion on sexual health and women’s health. However, the ACA makes provisions for increased coverage of services for women.

It is surprising that nursing home care was ranked very low, with only 5% of participants viewing it as significant. One of the reasons for the high costs of health care in the United States is the increase in the elderly population as people live longer today. This population has unique healthcare needs. Perhaps societal perceptions of the elderly reveal little interest or knowledge about the needs of the elderly population, or perhaps the students do not have a loved one who lives in a nursing home. Perhaps the majority of those who selected a nursing home care as a priority were found to be nursing students. Perhaps the choices of preferred variables have to do with students’ majors, interests, and knowledge about that topic.

These findings suggest that young adults need increased health literacy to learn more about the ACA. Further studies are needed to identify what else influences the attitudes of health professions students and other young adults towards the ACA, and to further assess how health professions students are educated about the components of the ACA. Also, better exclusion criteria and a much larger sample size may be needed to select participants for future studies, to include young adults without health insurance. Finally, more effort needs to be made on outreach to get young adults enrolled in a health insurance plan.

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This I Believe: A Surgeon’s Scalpel

by Martha Ayewah

DO Candidate, TCOM

I BELIEVE IN THE BLADE OF A SCALPEl. It is sharp, thin, sterile, untouched. It pierces its way into deep and forbidden places, exposing to all what is hidden beneath the surface. It is wielded with deft precision in the hands of a surgeon, and guided by years of experience to its target – that foreign or defective entity that must be removed. I believe that the blade of a scalpel gave me a second chance when it cut away that which would have taken life from the woman who gave me life.

In April 2004, my mother had a seizure and lost consciousness in the middle of a train station. The seizure was caused by a meningioma which was compressing the right frontal lobe of her brain. Only fifteen years old, the prospect of losing my mother was fiercely terrifying. My only hope rested on whether the blade of a scalpel could remove a threat that lay in one of the most delicate parts of the human body. Two surgeries later, I got my mother back and, together, we continued on with a fresh appreciation for life.

Now on the path towards becoming a surgeon myself, I have sought out several medical experiences with the intention of getting some meaningful exposure to the field of surgery. One summer, I stood in the operating room and watched as a surgeon carefully cut open the bulging stomach of a pregnant mother; a piercing cry erupted as the tiny infant exhaled her first lungful of air. It all came to me in that moment: I believe in the blade of a scalpel because it protects and preserves that which I hold to most dearly – life.

“It all came to me in that moment: I believe in the blade of a scalpel because it protects and preserves that which I hold to most dearly—life.”

Tiny breaths, cheery smiles, hearty laughs, and salty tears – that is life. My life is colored with all these expressions, the most prominent being the joy that I have found in my faith in God. He protects me. He preserves me, and teaches me to use healing words and loving actions to give life to others. I believe in all other things because I believe in Him. You see, much more than a sliver of sharp metal, the blade of a scalpel symbolizes my God. He is the most important expression of all my beliefs.

So when I embrace and kiss my mother, who I love so dearly; and trace my fingers across the faint scar on the right side of her head, I remember. When I one day become a surgeon and find myself standing in some future operating room, I will remember. When I look into the face of a patient, someone else’s mother, I must remember that the blade of a scalpel may cut away that which brings death, but my God will be the one who chooses to give life.
An Appreciation for a Humanistic Approach to History Taking

Imoh Z. Ikpot, SNMA Chapter Secretary, M.D. Candidate, Cooper Medical School of Rowan

My enthusiasm for attending Cooper Medical School of Rowan University was based on their mission and dedication to service. The mission aligned directly with my previous experience as a volunteer at the Health Disparities Collaborative in Rochester, New York. During this time, I witnessed diabetic patients suffering from life-threatening complications, many of which could have been prevented. All too often, these patients were members of my own community and I wanted to help those who needed it most. Since becoming a member of the inaugural class, I have sought out opportunities to continue my commitment to service. Biweekly, we have a unique opportunity to serve as primary care student physicians for the underserved Camden, New Jersey community. This experience is part of a four year clerkship that provides the opportunity to utilize and further develop my skill set as a future physician.

Through this clerkship, I have had the opportunity to meet, treat and learn from a variety of patients. During my initial patient encounters as a first year medical student, I was very eager to begin “playing doctor: with my brand new stethoscope and freshly pressed white coat”. I diligently prepared and, under the supervision of a licensed physician, recited questions and performed physical exams during these patient encounters. Surprisingly, my first few patients did not return for follow-ups. This was especially disturbing in cases where patients had exhausted a lot of their medicine.

“This personalized approach provided more than just patient retention. I established a better rapport that led to more in-depth discussions which revealed medically relevant information. Now, I understand the importance of a detailed history.”

While there were many reasons preventing these patients from returning for follow ups, I was not satisfied. Perhaps there was an important part of the patient history missing. In order to create a better bond, I attempted another approach that focused on understanding a patient’s family, living situation and work life. Through this new strategy, I noticed an overwhelming amount of patients suffering from not only family stressors, but also drug addiction, violence and legal troubles. As patients described these circumstances, I began to appreciate the depth of their misfortune and the resulting health ramifications.

This personalized approach provided more than just patient retention. I established a better rapport that led to more in-depth discussions which revealed medically relevant information. Now, I understand the importance of a detailed history.

The population we serve in Camden, New Jersey mirrors the Rochester, New York population that first propelled my interest in medicine. Therefore, in order to continue making strides in servicing the community, it was imperative to couple science with humanism when obtaining a history. This has led to a better student doctor-patient relationship and thus retention. Additionally, I have become more aware of the challenges that exist in a disadvantaged community. As I progress through medical school, I intend to utilize and build upon these experiences.
Science of Medicine

Medical practice is based on the application of science for the improvement of human health. It is an art, which mandates empathy and compassion. It requires much more than the coldness often associated with analytical minds. Entrusting physicians with human lives demands a combination of humaneness and sound scientific temperament.

Medicine centralizes on health maintenance through diagnosis, treatment, and prevention of disease. The proper treatment of a disease and its prevention anchors on a correct diagnosis. Diagnosis which is the act of identifying a particular disease by a physician involves the consideration of a patient’s symptoms of illness or injury and the arrival to a reasonable conclusion about the name and cause of the disease.

This diagnostic act is carried out by trained health professionals known as physicians. Diagnosis is the domain of the physician, and part of what gives physicians their unique health professional identity today.

Role of Humanism in Medical Diagnosis

Proper diagnosis goes beyond the consideration of symptoms of diseases and arriving at a conclusion about the name and cause(s) of the disease. Physicians are to take into consideration human factors; the variations in patients that may diversify or complicate disease presentation, such as health belief system, lifestyle, gender, age, and ethnicity. If a proper therapeutic alliance is lacking, then it may be hard to incorporate the human factors in patient care.

Proper diagnosis about a particular disease and its eventual management is strongly backed upon by a good physician-patient relationship. Thus, to provide patient-centered care; physicians must be well trained in the concepts and methods of humanistic practice. Humanism goes a long way into the maintenance of the health condition of the patient. Physicians who focus on patients total wellbeing and health end up to treating a patient’s body, mind and soul. Such physicians see beyond the physical symptoms of diseases and dig deeper into the patient’s life to develop a reliable diagnosis. They treat both the individual and the disease.

Gradual Extinction of Humanism in medicine

The gradual switching off of humanity seen in physicians may be attributed to various factors ranging from the medical school system, attitude of medical instructors/mentors and the nature of students admitted into medical schools.

Factors such as the rigorousness of the training, the unhealthy competitive attitude exhibited by medical students and the cost of medical education might act as erosive substances that erode the humane aspect of young physicians.

Today, the loss of humanism in medicine has really ripped patients of the empathetic and compassionate care they need from physicians. One may wonder if humanistic training is no longer included in medical schools or are medical schools admitting the wrong candidates for the profession.
Effect of the Egression of Humanism on Medical Diagnosis

Most physicians today fail to establish a physician–patient relationship. This makes him/her careless of the about the patient’s individuality, and put focus on treating the scientific components of disease presentation only. As a result they may end up with wrong diagnosis as they put little details about the human factors of the patient’s life into consideration. Others may be able to treat the symptoms but fail to rescue the individual from the causative factor as the physician patient relationship is lacking. They succeed in treating the diseases but leave the patient and their challenges as irrelevant entities.

The way forward

Like patients, physicians are also human, and are prone to making mistakes. There is increased interest and focus on patient safety, with diagnostic errors making 10-15% of all medical errors. Diagnostic errors can be costly; they are hard to measure. But they can be reduced.

Diagnosis, though a complex mental process, can be learned and improved. One way is to establish a systematic approach to challenge and refine diagnostic skill.

Another is to cultivate the environment of openly discussing the mistakes, and not be afraid to discuss when things go right and when they go wrong. It becomes hard to improve unless there is a culture of safety that allows one to openly discuss mistakes without shame.

Next is to engage patients in the pursuit of a definitive diagnosis. Physicians should discuss their preliminary findings, describe the treatment decision and what they expect to occur, and urge patients to contact them with evidence that confirms or refutes that expectation. Also, physicians should elicit additional feedback at each visit until either the symptoms have fully resolved or they have gathered enough information to arrive at a definitive diagnosis.

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Towards a holistic medical education experience - trends and advice to improve your training

By Aliye Runyan, M.D, Education and Research Fellow, American Medical Student Association

The American Medical Student Association is the oldest and largest student-run medical student association in the country - we represent over 30,000 medical and pre-medical students from coast-to-coast, as well as allied health members and international medical students. AMSA's mission is to improve health care and healthcare delivery to all people; promote active improvement in medical education; involve its members in the social, moral and ethical obligations of the profession of medicine; assist in the improvement and understanding of world health problems; contribute to the welfare of medical students, premedical students, interns, residents and post-MD/DO trainees; and advance the profession of medicine.

Part of this mission is to contribute to a well-rounded medical education experience, in which the physician-in-training has greater exposure and understanding of the "social, moral and ethical obligations of the profession of medicine", is tuned in to his or her own well-being as another tool in the practice of safe and healthy medicine, and is aware of the constant learning process of medical training - including feedback, communication, and working well within a team.

Pre-medical liberal arts focus

A well-rounded path to medical training includes the formative years of undergraduate learning - a time that has been traditionally filled with the usual 'pre-med' classes, and along with that, 'pre-med' or 'pre-health' majors, and/or the default biology or chemistry major. While this trend is slowly dying off, it is still important to point out that the undergraduate years are the prime time to truly benefit from a liberal arts education, which will ultimately pay off in a service-and people-oriented profession.

Classes, majors, and minors in subjects like literature, psychology, sociology, anthropology, music, and languages help to develop communication skills, perspective on different cultures and ways of life, and insight into human behavior.

Furthermore, the number of 'non-traditional' applicants and enrollees into medical school are rising, in part because schools are realizing the many benefits that varied backgrounds (finance, non-profit work, the Peace Corps, musicians, etc.) and the maturity and perspective of life experience which these students bring to the field of medicine.
Inter-professional medical education (IPE)

Medicine, and the technology which accompanies it, is growing and changing at a more rapid pace than ever before. Health care systems and protocols are complex and require team care - from the hospital inpatient wards to the patient-centered medical home. Medical and allied health schools are now making it a priority to teach students in allied health professions side by side, especially on clinical rotations where clear communication among doctor, nurses, pharmacists, and other professions are vital to patient safety and continuity of care. The World Health Organization definition states that "Interprofessional education occurs when students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes. Interprofessional education is a necessary step in preparing a ‘collaborative practice-ready’ health workforce that is better prepared to respond to local health needs.” The Institute of Medicine is exploring competencies and outcomes for IPE (1), and published a report (2).

If your school does not offer these opportunities or you are interested in learning more, apply to AMSA's Primary Care Interprofessional Leadership Institute when the application season arrives for the following year (3).

Humanities in medical education

The use of humanities (literature, creative writing, reflective practice, music, theater, improvisation) teaches critical skills that physicians and allied health trainees must learn to effectively care for patients and families. Literature teaches health care providers how to analyze and share stories of illness with the goal of improving diagnostic skills, facilitating healing, and improving education of patients. Music is often used to assist healing in patients with neurological disorders, and is also used for relaxation and pain control, especially for patients with chronic illness. Creative writing and reflective practice can allay physician burnout, as well as give patients and caregivers an outlet to deal with the emotional burden of disease. Theater and improvisation are often used to teach effective communication and how to give feedback, as well as how to explore controversial ethical topics in a safe environment.

Humanities in medicine as a concept began in the UK, made its way to Canada, and is now becoming more utilized in academic centers around the US (4, 5). Consider applying to AMSA's Medical Humanities Institute (6) for the following year!

Wellness and burnout prevention

It is no secret that physicians endure physical and emotional stressors, most famously during medical training. Physicians have some of the highest depression and suicide rates of any profession. And now, more than ever, doctors are choosing to leave medicine, citing factors which include career dissatisfaction and moral distress (the conflict of what the physician knows is "the right thing to do" versus what is done or established in the medical system).
Physician well-being also impacts patient care - physicians and health providers who are tired, irritated, and feel defeated tend to make more mistakes (7), have less patient retention, worse communication, and lower patient satisfaction with the quality of their care.

There are solutions, however. Warding off burnout can begin in training, by learning to encounter the medical system from a perspective of mindfulness - recognizing the moments when change can be made, developing a greater awareness of the meaningful interactions with patients, and the ability to let go of systemic issues that might not change in the near future, so that more effective work can be done. There are several links to address approaches to mindfulness (7-11).

AMSA resources
AMSA has resources for medical education, leadership, and advocacy into the issues discussed above, and more (12-15). Come to one of our regional or national meetings, attend an institute, join a scholars program, or get involved in national leadership - make a difference in the future of medicine!

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Aliye Runyan, M.D.
Education and Research Fellow

Join Us in New Orleans for
AMSA’s 2014 Annual Convention!
March 6-9, 2014
www.amsa.org/conv

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Physical and emotional exhaustion derived from intensive hours of studying, completing clinical rotations, and balancing demands from friends and family highlights an experience medical students in the United States endure. If one were to envision the experience of a medical student working in a third world country, their mental image may entail greater levels of stress inflicted upon them due to impoverished circumstances. The idealistic model of the doctor who saves lives and alleviates the suffering a patient may be going through, suddenly dismantles when confronted with challenges that makes delivering quality health care appear impossible. Contrary this conjecture, many medical students in third world settings combat challenges through maintaining their joy and commitment to serving people. In Claire Wendland’s, *A Heart for the Work: Journeys through an African Medical School*, she shares the narratives of prospective physicians attending medical school in Malawi, one of the poorest countries in the world. At the commencement of *A Heart for the Work*, Wendland figuratively recounts a conversation she has with a third year Malawian medical student enrolled at the University Of Malawi College Of Medicine. According to the student, accommodating to gravely ill patients, whose conditions vary from parasitic diseases to witchcraft related illnesses, presents extreme difficulty when working in a clinic that is limited in biomedical resources. Working in a clinic where there is a massive shortage in physicians and on average, two nurses tending to the needs of sixty or more patients, presents an obstacle many people in western countries may find unfathomable. Acquiring the knowledge necessary to treating patients is another hurdle that the Malawian medical student mentioned in her conversation with Wendland. Because two textbooks on medically related content and twelve microscopes are shared among fifty students, students not only have to “wait their turn” to get access to the books, but they have to “deal with the competition”. In spite of these hardships, Malawian medical students cope creatively with the resources they have. Just like medical students in the west, Malawian medical school students experience stress. They experience fatigue and frustrations. They experience doubt. What keeps them going is their happiness and pledge to assisting to those in dire need. Claire Wendland states that the stories of Malawian medical students are not articulated in the social science literature on medicine and medical education, an extensive and rich body of scholarship limited by its geographical confinement with wealthier countries (Wendland 2010: 23). In *A Heart for the Work*, Wendland creates a space to delineate their experiences and encourage readers to critically examine the effectiveness of biomedical institutions in places that are at a financial disadvantage. One of the doctors in the ethnography states, “Even with the little we have we can do a good job for people” (Wendland 2010: 18). *A Heart for the Work* is a moving piece that shows how the transnational mobility of biomedicine can be a source of devastation and hope. Most importantly, this book exemplifies powerful ways in which genuine compassion is manifested in relationships between physicians and patients.

http://www.ssrc.org/publications/view/11C267BD-DA7F-E011-9A1B-001CC477EC84/
I opened to the first page of this book with both excitement and consternation. I thought to myself, “Is this a book about how having emotions can affect physicians’, as well as physicians-in-training’s, decision in medicine?” or “Is this another book about the conundrum of being a caring physician versus being too emotionally involved in a patient’s care?”

As I skeptically turned the page, I became riveted by Dr. Ofri’s stories—the stories her first experience with a homeless woman who presented at the rape crisis center, of an intern traumatized when she is forced to let a newborn die in her arms, and of a physician whose daily glass of wine to handle the frustrations of the ER escalates into a destructive addiction.

Danielle Ofri’s newest book, What Doctors Feel, is not about the negative side of having emotions in the practice of medicine but is rather a look at the emotional side of medicine—the shame, fear, anger, anxiety, empathy, and caring that impact patient care. It is about the quality of medical care that is influenced by what doctors feel—a critical aspect of medicine that is usually left out of discussions of health care today. Her way of vividly telling of the stories puts you in the midst of the situation and stirs up the emotions that most of us in medicine have experienced. She carefully dissects the hidden emotional responses of physicians, and how these directly influence patients. She examines and reexamines the daunting range of emotions that permeate the contemporary physician-patient connection.

Drawing real-life stories from her own experience and other physicians, Dr. Ofri investigates the impact of emotions on medical care. And with incredible insight, lyrical beauty, humor and consideration, she effectively portrays the processes of diagnosis and treatment as more human than clinical. She takes us into the eddying hub of patient care, telling stories of caregivers caught up and occasionally torn down by the whirlwind life of doctoring. These stories in her book reveal the undeniable truth that emotions have a distinct effect on how doctors care for their patients. For both clinicians and patients, understanding what doctors feel can make all the difference; and they are all here: disgusting patients, entitled patients, lovable patients, somatizing patients, litigious patients, patients with a terrible diagnosis that you know about but they do not. Burnt-out doctors, bullying doctors, alcoholic doctors, frightened doctors, embarrassed doctors. Exhaustion, grief and mourning, fear of looking stupid, fear of harming one’s patient and getting sued. “What Doctors Feel” is filled with heartfelt examples of all of these.

I kept reading with a building sense of fulfillment. While the book did force me to reevaluate some of my own feelings, I felt a sense of validation. These stories remind me that it is okay to feel anger, joy, shame, relief, and peace. Accepting the emotional side of medicine will make me a better physician.

There are moments I wonder if one of the reasons that many of the young physicians-in-training lose their empathy is because the suppression of emotions becomes a useful defense mechanism for them as they are repeatedly exposed to awful things during prolonged periods of stress and sleep deprivation. With time, suppressing emotion can become second nature. However, it is only possible to bottle up emotions for so long before they erupt without warning and creating a destructive cascade. Dr. Ofri truthfully describes in simple yet heartrending detail how this happened to her and to her colleagues.

Ofri further notes that “the medical student observes that even the most thoughtful and humanistic intern operates under the brutal calculus that every minute spent on nonessentials simply prolongs the work.” And what, exactly, are these nonessentials?, she asks. “An in-depth conversation with a patient . . . a more thorough physical exam, to patiently explain the disease process to a family member . . . let[ting] a patient ramble on without interruption,” she pointed out.

I closed the last chapter full of emotions. I revisited the feelings during my patient encounters in my last rotations. As the author pointed out throughout her book, how doctors (and doctors-in-training) feel matters. She pointed out that those emotions impact care. Learning more about what physicians feel can help, not only the medical profession, but patients as well. What becomes increasingly and alarmingly clear is that little is done to help physicians (and physicians-in-training) deal with the range of emotions that they experience daily in their profession. As a result, physicians suffer burnout, patients are treated with more distance, and the medical profession as a whole suffers. And as Dr. Ofri points out again and again in her
Collateral Damage

By Oluwakemi Eniola Tomobi

Health care reform calls for more coordinated care among the different health professions, including medicine, pharmacy, nursing, nutrition, physical therapy, and others. Each of the above categories of providers is trained in different professional schools and thus contributes unique perspectives to team-based or multidisciplinary healthcare. Collateral Damage reveals that to truly achieve patient-centered healthcare, we need the input from all professional members of the healthcare team. One perspective that is often missing is that of the patient. Patients have to navigate a complex healthcare system. Providers may struggle to understand things from the patient perspective. Therefore, patients and their advocates deserve a place on the interprofessional team, just as students have a place in the parent-teacher-student association.

In Collateral Damage, author Dan Walter offers a unique education from the patient family perspective. His wife undergoes a cardiac ablation procedure for atrial fibrillation. Walters provides the details surrounding the entire process, from the confusing informed consent and signature process, to the focus on the corporate side of medicine, and the “learning curve.” Walter illustrates that patient safety becomes compromised, and that the culture of safety would allow for physicians to more openly admit their errors and learn to prevent further collateral damage – not just the physical damage from a cardiac procedure gone awry, but also the resultant damage that miscommunication and corporate greed does for healthcare in general, and the doctor-patient relationship in particular.

Walter fills in the care gaps and provides a picture of continuum of care that is often missing when the patient perspective is not considered. Trainees and providers alike have much to gain from Collateral Damage to become leaders in promoting patient-centered care. Patients and other non-providers in the community also have much to gain from Walter’s quest to educate all about navigating the healthcare system on behalf of his wife.
MAPS Minutes
Spring 2014 Call for Submissions

Do you have any experiences about your premedical education that you would like to share?
Unique course innovations at your school?
Public Health/Sociological/Psychological/Basic Science Research Experience?
Admission to a summer academic enrichment program?
Community service or volunteer experiences in your local community or abroad?
A humbling experience during your clinical shadowing experience?
Artwork or creative writing responses to a classroom or clinical experience?
Mentoring experiences?
Share it with the MAPS nation in the MAPS Minutes!!!
Maximum is 2000 words per submission.
All submissions welcome, with preferences for submissions on the theme.
Submit all works to maps@snma.org.

Would you like to submit something but not sure where to start? Need ideas to get started? Other questions?
Contact the MAPS Committee at maps@snma.org. Deadline for submissions is February 20th, 2014 at 11:59pm.
Humorously Healing

—by Oluwakeini Eniola Tomobi, SNMA Publications Co-Chair, Editor-In-Chief, Journal of the SNMA

One day, I had started attending an aerobics dance class at the local gym. The gym was rather small, with only four exercise rooms. I looked straight ahead as I pushed past the double glass doors. I walked down a long corridor to the open gymnasium and saw that the dance class was not starting for another twenty minutes. So I wandered up and down the hall of the small gym, and then stopped to look at the bulletin boards. I wanted to look at the schedules, and become familiar with each of the exercise class rooms in the gym. The door near the exit of the gym was closed, while all the others remained open. I decided to take a peek through the closed door, just at the end of the display. I noticed five people in a circle, just laughing. I tried to catch on. What was so funny? Were they laughing at the teacher? Or at a fellow classmate? Where was the punchline? Perhaps it was an inside joke. I waited for the laughter to subside and for the “joke” to gradually declare itself. But the group just kept on laughing. I scratched my head. I then stepped back into the hallway to get a better look at the titles and schedules of the exercise classes.

*LAUGHTER YOGA 4:30-5:15 PM.*

Oh I see, I thought. At that moment, I wanted to laugh. Not because the previous laughter was contagious, but because at the time, I could not fathom the concept of an exercise class based on laughter.

Laughter is shared. When it is not forced, laughter can be an audience’s expression of humor gone well. This is important, because humor is a crucial communication skill that really gets at our humanness, and humility. Consider the root “Hum”.

But what is humor? What makes something funny? Why are some things humorous to some and not to others?

Humor is the tendency of particular cognitive experiences to provoke laughter and provide amusement. The extent to which a person will find something humorous depends upon a host of variables, such as age, ethnicity, gender, profession, religion, interests, and other beliefs. Humor can occur without laughter, and, as with laughter yoga, laughter can occur without humor.

For humor to be effective, there has to be some shared common knowledge between the communicator and the audience. The writer or presenter of humor needs to be aware of "what does the audience know, think, or believe right now?"

Humor skills are useful for the workplace, for example, to increase office bonding. Humor allows people to let down their defenses, so that the communicator allows the listener to be more receptive to the message. It draws people together.

Humor and laughter can certainly be useful in medicine.

For example, humor can be educational. Humor can increase motivation. Students say that when humor is infused into the lesson, in small doses, and relevant to the material taught - that they retain and learn more. Thus, appropriate use of relevant humor positively affects student test performances.

Even “gallow” humor – humor that pokes fun at aspects of healthcare, as with Samuel Shem’s *House of God* can help trainees bond and better acclimate to the rough times in training.
Humor can heal. Laughter, including forced belly laughter, as seen in Laughter Yoga, has health benefits. Because most visits to the doctor are based on conditions exacerbated by stress, belly laughter fights stress, and relaxes the muscles. Laughter also reduces pain, acting as morphine does. Furthermore, laughter boosts the immune system cells against infection.

How can one approach humor? Consider holding off on jokes until you have a better idea of the person’s sense of humor. For example, gallow humor would certainly be inappropriate and offensive for patients, and for anyone who does not understand the complexities of healthcare training.

Even better than gallow humor, however, is humor that crosses cultures, builds bridges, and diffuses tension. After all, to be a more humanistic physician, one has to make a connection with patients and others from different walks of life. The humor can be more inclusive than that of gallow humor. Such tasteful humor can open lines of communication to discuss more difficult issues.

If you are not interested in making humor, you can still enjoy and recommend the benefits of laughter from attending comedy shows, reading humorous material, or even taking a laughter yoga class.

So reach into that belly, because laughter is the best medicine for everyone. It reveals physiological benefits, allows for bonding, and there are absolutely ZERO side effects.

1. The Use of Humor in Patients With Recurrent Ovarian Cancer A Phenomenological Study. Rose, Stephen L. International journal of gynecological cancer; 05/2013 23 Issue: 4 Page: 775 – 779
2. Howard Bennett, MD – Humor in Medicine