Advocacy through Medical Education

Scholarly Concentration in Medical Education

Senior Portfolio

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Introduction

The Medical Education Scholarly Concentration has been an unexpected gem of my Alpert Medical School experience. In truth, I entered AMS with clearer interests in global health. As an undergraduate in Brown's Program in Liberal Medical Education, I found myself engrossed in international relations, anthropology and Asian studies; as a medical student, I hoped to provide care for Rhode Island's sizable Cambodian (Khmer) and Hmong populations. Ultimately the Scholarly Concentration served as an ideal vehicle for exploring these goals. Through medical education I continue to discover opportunities to advocate for all patients, globally and locally.

My desire to teach and share ideas started with an internship at Asian Health Services, a California community health center that cares for a diverse refugee and immigrant community. During a month in southern Taiwan's villages, I learned how culturally appropriate concepts can be utilized when educating local populations on health. Such experiences in patient education and grassroots advocacy gave birth to the project, "Two Channels to Cambodian Patient Advocacy: Medical Student and Patient Education." At Brown, my advisors and peers in the concentration supported me as I developed the Cambodian Patient Advocacy pre-clinical elective, now in its third year at AMS as the Refugee Advocacy elective. Health screenings and educational workshops for elderly Cambodians provided fellow students and me with patient bonds that gave our work meaning. This project and its many moments of trial and error will always be highlights of my time at AMS.

Through third year, I continued to assist in curriculum development for the Doctoring course and pre-clinical units, drawing from experiences with refugee patients when called for. Contributing pieces to physician resources such as "5-Minute Clinical Consult" allowed me to explore educational writing for a wider peer audience.

In my final year, I collaborated with two classmates in the development of a resident course in cross-cultural communication and refugee health. Finally, a rotation at Angkor Children's Hospital in Cambodia provided me with a much richer context for understanding the struggles of Khmer underserved patients in the U.S., though impossible to ever fully comprehend.

Through this collection of projects and experiences as a Medical Education Scholarly Concentrator, I have found empowerment. For me, it has come in the form of teaching and continuous questioning. I hope I have done the same to empower my colleagues, and above all, the RI refugee patient community.

Summer 2009

Asian Health Services Patient Advocacy Internship

Rural Primary Care and Health Education in Taiwan

Asian Health Services: an internship in advocacy for Asian underserved in the U.S.

My goals for Summer 2009 were threefold: 1) To explore the issues healthcare providers face while caring for Southeast Asian refugees—a particularly challenging underserved population; 2) to gather materials for a health education/outreach program geared at Cambodian elders that will be implemented in the fall; and 3) to bring back resources that would increase awareness of refugee health issues among my colleagues at Alpert Medical School.

To achieve these goals, I first spent five weeks with physicians and behavioral health specialists at Oakland Chinatown's Asian Health Services (AHS), a community health center that serves Asian immigrants and refugees. By observing and assisting during Cambodian and Vietnamese patient visits with primary care physicians and mental health counselors, I experienced the challenges of being a provider for this patient group first-hand. In three weeks of shadowing, I gathered video footage with signed consent of patient visits for a provider education video. In the following two weeks of travel, I interviewed providers, community health workers and educators from California Asian/refugee centers to learn about the unique barriers to care for Asian refugees, and about existing approaches to bettering their health outcomes. My interviewees shared their thoughts for improving the health literacy of otherwise linguistically isolated elders, which I applied to outreach work for Cambodian seniors of Rhode Island. Another core project was a survey of AHS providers on their experiences with Asian refugee patients, researched and written in collaboration with my AHS mentor Dr. Daveena Ma.

The survey

Though AHS physicians were the targeted group this summer, the multiple-choice survey can be answered by any provider who has Southeast Asian refugee patients (with IRB approval). The questionnaire looks at the composition of each provider's patient base (in terms of ethnicity, refugee status and literacy level), provider awareness of refugee issues, perceived difficulties in working with Asian refugee patients (i.e. communication barriers, medication adherence, mental health), strategies for dealing with barriers to care, and recommendations for outreach. This tool was later useful in the production of a survey assessing Brown Internal Medicine residents' experiences in refugee patient care.

An educational video for providers

Because I shadowed doctors during visits with English- and Chinese-speaking patients in addition to Khmer- and Vietnamese-speakers, I was able to very generally compare the refugee group to the greater Asian underserved patient group. After reviewing my notes and footage of patient visits, I came up with a number of themes to highlight in the film:

1) *Mental health disorders* are extremely common among Southeast Asian refugee patients, and should be screened for at every visit. Indicators of post-traumatic stress disorder, depression and anxiety are not always obvious. Most commonly, patients will complain of headaches, insomnia, or being easily startled. It is important for the physician to work with the patient to discover the underlying cause (I found that many patients would admit after some calm discussion that their inability to sleep was due to recurring nightmares of family being killed by the Khmer Rouge, etc.). The AHS behavioral counselor, helped me interpret these common symptoms and their traumatic roots.

2) *Financial instability* in the U.S. is a continuous stressor for many Southeast Asian refugees; this is especially true for Cambodians who tend to have had more agricultural backgrounds and higher rates of illiteracy. Here are some examples of socioeconomic impact on Asian refugee health:

a. Some patients are so traumatized from their homeland and immigration experiences that they are not able to hold regular jobs (AHS can help them apply for disability).

b. Due to various socioeconomic factors, many of Oakland's female Cambodian minors are being drawn into prostitution. This affects their health and the health of their parents, who are often aware of their daughters' situations and feel helpless.

c. Many Cambodians live in crime-filled areas where even walking outdoors is unsafe—this impacts diabetes and hypertension management, as walking is one of the few exercises that some elders can do.

3) *Illiteracy or low literacy* affects the way a physician should discuss treatment and medications with a patient, even if an interpreter is present. Establishing literacy level at the beginning of a new patient visit allows the physician to adjust his/her dialogue accordingly.

4) *Adherence to prescribed regimens* is a major problem among the Cambodian patients, who may not understand what the medicines are, why they are taking them, or what the consequences are of skipping medications. The most common scenarios are addressed in the patient education video, which will be shown in the AHS patient waiting room and in a Providence health education workshop in the fall.

A Khmer-English patient education video

While at AHS, I also put together a patient education video in Khmer and English that addresses a major issue in the Asian underserved and refugee communities: medicine adherence. With Dr. Ma, an AHS Cambodian Health Educator and Patient Navigator as actresses, I filmed four brief outpatient scenarios that will help patients understand how to manage their medications.

The patient education video filmed at AHS depicts the following four scenarios (for full scripts, see Appendix I):

a. Patient comes in, doesn't bring meds, says “but you have it written in the chart!” Physician explains that we need to see all bottles so we know if some were lost, etc.
b. Next visit - Patient comes in, brings meds, but some pill bottles have multiple different colored pills in them. Physician explains why it's important not to mix pills into different bottles.
c. Next visit - Patient comes in, brings meds, but doc notices some are missing. Patient says she “ran out”, so she threw away the bottle. Physician explains the concept of chronic meds and refills. Patient says she has trouble remembering to take meds. Physician draws suns and moons on the bottles and shows her a pill box where she can fill a week’s worth of meds on Sunday to make it easier to remember to take them.
d. Next visit - Patient comes in, brings meds. Physician reviews them, sees that they are all there and that patient has been taking them. She congratulates patient and comments that her diabetes/high blood pressure are much better today.

Interviews with Cambodian community leaders

My interviewees ranged from a seasoned hospital interpretation services director to Cambodian psychotherapists and young cultural programming coordinators. Through our discussions, I developed a broad sense of why Cambodian refugees continue to be an underserved group across America. Health education outreach is a struggle to implement, my sources all said, but essential. Below is a sampling of potential barriers and solutions I noted at the time (based on interviews across RI and CA):

1) A good interpreter will be necessary to convey information effectively; written translations may be helpful for the usually few literate elders.
2) The most effective presentation will be filled with interactive activities, colors, pictures, video, humor, and less written text. Cambodian elders spend many hours watching Asian soap operas each day, and providers suggested I catch their attention by using clips from popular shows.
3) There are many myths about western medicine circulating among the Cambodian elders; it will be useful to address and debunk these myths using simple language.
4) Cambodians do not like to gather in large crowds. Targeting temples during holiday celebrations will be my best chance at a good turnout.
5) Any Cambodian population in the U.S. is likely to be divided between local temples; there is a strong sense of temple loyalty that often undermines attempts at Cambodian solidarity. People have said I will benefit from being a foreigner in this sense, since I will not have temple affiliations.

I learned about community and temple roles, and how it will be possible to make health interventions by working with authority figures (i.e. discussing salt content and sanitary preparation with the women who cook weekly meals at the temple; looking to the temple's head monk for a more specific needs assessment). I heard many peoples' versions of how they would solve the problems if they could. This is what prompted me to film the patient education video on med adherence, and what led me to expand the footage into more of a documentary-style project (which now includes interviews with my mentors Drs. Ma and Chang and information from meetings with community representatives). The video was presented at a multi-disciplinary conference on refugee health in Providence in September 2010.

Excerpts from scripts for Khmer Patient Education Video

Scenario 1: Patient comes in, doesn't bring meds, says "but you have it written in the chart!" Doc explains that we need to see all bottles so we know if some were lost, etc.

D: Hello Ms. Ly, how are you doing today?
P: I feel okay doctor, how is my blood pressure today?
D: It looks a little bit high—148/90. Let's take a look at your meds.
P: Yes, I need more of the pink one.
D: Do you have your medicines here?
P: I'm sorry, I did not bring them today. I just need the pink one.
D: Sometimes different companies make the medicines in different colors, so I don't know what the pink one is just by its color.
P: Ok, I'll bring that one next time.
D: Did you bring any of your other medicines today?
P: Can't you just look at the chart from last time?
D: I have them written in the chart, but it is still important for you to bring all the bottles, so we know if some of your medicines were lost, or if we need to refill them or stop them. You have so many medicines that you're taking, it's important to keep track of them.
P: Ok doctor.
D: I'm not going to make any changes in your medications today, but please bring them in next time, ok?
P: Ok.

Scenario 2: Next visit - Patient comes in, brings meds, but some pill bottles have multiple different colored pills in them. Doc explains why it's important not to mix pills into different bottles.

D: Hello Ms. Ly, I see you brought your medications in today, that's very good. (Starts looking through the meds and taking notes on them) Do you have your medicine for your blood pressure from last time?
P: (Patient takes bottle out of purse) Doctor, I need more refills of this one. I have no more after this bottle.
D: (Looks at bottle) Hmm, it looks like you have different kinds of pills in this bottle.
P: I traveled to visit my family in Seattle last week so it's easier to put them all in one bottle.
D: Actually, it's not good to mix medicines in the same bottle. Each bottle has instructions for how and when to take the medicine, and if you mix them together, you might take the wrong ones at the wrong time. Doing that could have bad effects on your body.
P: Oh, I see, Doctor.
D: Next time, even though it's a lot of bottles, let's try to keep them separate.
P: Ok doctor, I will try to remember.

Rural Primary Care in Taiwan: mobile healthcare delivery and patient education in a resource-limited setting

Following the AHS experience, I spent a month at National Cheng Kung University Hospital (NCKUH), a Tainan City medical center with a strong rural community health component. Here I experienced health outreach in a setting and style very different from that of the U.S., but discovered striking similarities between the U.S. Cambodian elderly and the Taiwanese elderly in rural Tianliao. Over the course of the month, I spent two weeks at Tianliao's country clinic and compared what I saw to the primary care delivered in NCKUH's urban-based family medicine clinic.

In the mornings, I assisted in an ongoing Osteoporosis research study, interviewing and measuring patients' heights and weights as well as their bone density. My afternoons were spent with the Tianliao Mobile Health Van team, a true highlight of the trip. Each week, we visited 20 sites spread across 10 villages; these were often temples or store fronts that were centrally located and accessible to Tianliao's elderly. The team was responsible for weekly health education workshops as part of their locally successful anti-smoking, anti-betel nut campaigns.

In NCKUH's Family Medicine Obesity special clinic, I observed my mentor Dr. Chih-Hsing Wu and the dietician as they counseled patients in an Obesity research study. The culturally appropriate diet counseling I observed in Taiwan would be well-utilized in my own outreach work in Providence. In my last week in the NCKUH Psychiatric outpatient clinic, I explored how mental health is perceived and managed in Taiwan. As mental health issues are extremely common among Southeast Asian refugees, but not dealt with in a traditionally "American" way, this was an experience that I planned to apply in Providence.

One particularly valuable lesson was understanding how feasible my original plans might be and what could be done to adapt them, to make communication as effective as possible. Dr. Chen, who ran the rural clinic in Tianliao, shared his ideas on how to implement effective health outreach with me:

1) **Concept**: healthcare workers must ensure that the patient audience can grasp the concept of health and preventative self-care. This is necessary before patients will make the effort to follow physicians' suggestions and comply with prescriptions. As Dr. Chen and his staff gave a talk on the effects of betel nut and tobacco to local, often illiterate elderly from the countryside, I identified techniques he was using to make the concept comprehensible (such as using pictures, giving many examples, showing the status of Tienliao's anti-smoking/betel nut campaign, giving out a simple T/F quiz, having patients sign an anti-smoking poster at the end of the talk).
2) **Access**: patients who have a concept of preventative health and want to make improvements should have access to the necessary providers and medications (financially, geographically, etc.). In Tianliao, this means bringing the doctors and pills to the patients, since they aren't able to travel to a clinic easily.
3) **Fulfillment**: patients need to feel welcomed and respected by their providers, so that they are satisfied with their healthcare encounters and continue to take their medicines and make their behavioral changes as necessary. If patients do not feel good about their healthcare providers and their encounters, they are unlikely to return.

That summer, I learned about the many mismatches between care offered by most physicians and the actual needs of Cambodian refugees, especially elders in the U.S. As I worked with providers and met community members, I was continually adding to the problem list, but began to recognize workable solutions over the course of the summer.

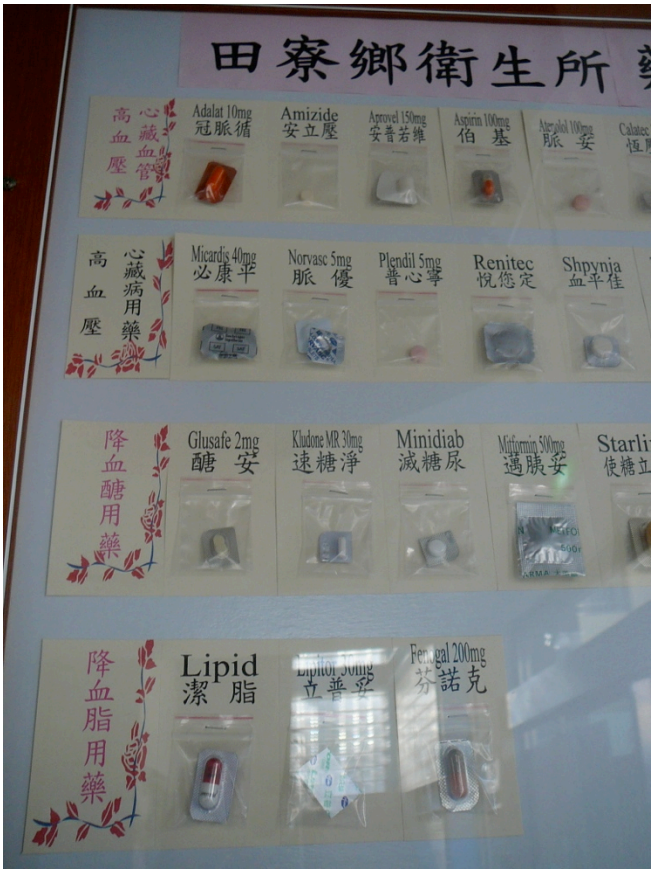
I learned that while I might not be able to control patients' experiences with providers, I could make concepts of diabetes management, dietary tools and hypertension control more accessible to the Cambodian elders via health education workshops. I could provide patients with information on physicians and resources in the area devoted to Cambodian refugee health; in this area, my relationship with Marc Harrison and Colin Hanrahan (founders of Independence Health Services, a then new organization bringing home care nurses to the Cambodian elderly in

Providence), proved very helpful. And by increasing physician/student awareness of Cambodian refugee healthcare needs (through the video and Doctoring course, and even the Takotsubo article), I hoped to increase the likelihood of positive encounters between Cambodian patients and local physicians.

(Top) A nurse from the mobile health team, administering a quiz at an educational workshop on the dangers of betelnut chewing to Tienliao villagers

(Bottom left) Audience at health education workshop

(Bottom right) A poster encouraging medicine adherence



Academic Year 2009-2010

Two Channels to Cambodian Patient Advocacy:
Medical Student and Patient Education
"Cambodian Patient Advocacy" Medical Student Elective
"How to Take Medications Correctly":
Cambodian Patient Education Workshops in RI

"A Woman with a Broken Heart" Case Presentation

Doctoring Curriculum Development
Cultural Competency Module
Informed Consent Module

"Cambodian Patient Advocacy" Medical Student Elective

The Cambodian/Khmer Patient Advocacy elective was a "final product" of sorts, drawing on previous work and research, but simultaneously a real starting point in my own development as a medical educator.

The idea came from a meeting with Dick Dollase, my Scholarly Concentration advisor, as we debriefed my summer in Oakland and Taiwan. I wanted a way of synthesizing and sharing what I discovered about barriers to care for California's Cambodian community, while also learning how these themes played out in Rhode Island. Though certain challenges of caring for Cambodian patients are unique to their refugee history, many themes can be generalized to all underserved patients, and a medical student working in any setting could benefit from such lessons. Through the elective, I wanted also to build a strong community outreach infrastructure that could be perpetuated by future students.

In developing the course, I outlined what I viewed to be major barriers to care and salient issues for Cambodian patients. What resulted was an eight-session curriculum of small discussion groups interspersed with a trip to a local temple (Wat) and visits to Cambodian elders' homes. Discussions included: history of Cambodian genocide and immigration; traditional Cambodian values and new Cambodian-American culture; the refugee experience as a risk factor for chronic illness; perceptions of mental health among Cambodians; a session at a Cambodian Buddhist temple to discuss spirituality and traditional healing; and home nurse visits to Cambodian elders' homes.

Guest speakers represented the diversity of issues affecting Cambodian patient health, and included family physicians, refugee mental health specialists, SEDC's Substance Abuse Programmer, the founders of RI's first Cambodian home healthcare agency, and Cambodian refugees of varying ages and backgrounds. By recruiting Cambodian speakers, my goal was to provide the Cambodian community with a direct voice in our understanding of their history and health. The outreach component included blood pressure and glucose screenings at local temples, as well as attendance at a Cambodian patient education workshop (a project which will be described further). I chose Anne Fadiman's *The Spirit Catches You and You Fall Down*, a narrative of a Hmong family's interface with western biomedicine, as a narrative to accompany the course. For each session, I also selected one or two articles pertaining to the topic from medical, psychology and social science journals. A written reflection was required at the end of the course for credit. Dr. Edward Feller served as the faculty advisor, and I was facilitator in the first year. The syllabus (Appendix) went through several iterations and was ultimately approved by Brown as an official AMS pre-clinical elective. We enrolled seven students, including one PLME undergraduate senior, five first year medical students and one second year, which was an ideal size for the round-table discussion format of the sessions.

Each course meeting was a true test pilot. For the Introductions session, I showed my provider education video and asked students about what drew them to the course. One student had spent extensive time in Cambodia, and was similarly eager to work with the RI Cambodian community upon entering AMS; another said that lack of any prior exposure to cross-cultural healthcare was his reason for signing up. With varying levels of experience in refugee health, but a mutual desire to explore these issues, I was optimistic that we would have rich discussions each meeting.

As with any experiment, there were unexpected bumps in the road. For the second session, I invited two Cambodian locals who had lived through the refugee experience to talk about cultural divides between older and younger generations; one man moved to the U.S. safely and now has a family with a woman from the U.S., and the other was an AMS student who grew up in a Thai border refugee camp before resettlement here. The student had to cancel on short notice, and as the session unfolded, we learned that our remaining speaker actually came from a very wealthy elite. This meant that he fled Cambodia before the worst devastation occurred, and he had the benefit of a prior education upon coming to the U.S., unlike the vast majority of Cambodian refugees. He in fact had little idea of the pervasive health problems and ongoing poverty of most of RI's Cambodians. Hearing this very different narrative was a surprise to me, as it was contrary to all my previous exposures, and I was honestly frustrated at moments by his complete lack of awareness. It was an excellent lesson, however, in the diversity of individual experiences that can come from one situation, and in working with the unexpected. For the most part,

the speakers and student experiences that came with the rest of the course suited the course goals very well, and added many layers of insight to those initial themes I had drawn up.

Serving as a discussion leader and coordinator, I learned a great deal from the speakers and community exposures. Throughout the course I experimented with various styles of facilitating, growing more comfortable with silent spaces towards the end and allowing discussion to flow more organically.

According to anonymous evaluations at the end of the course, students felt that all sessions were valuable to the course except for the "Debriefing" with Colin and Marc of Independence Health Services, which a few said was "interesting but didn't really enhance understanding." Several students noted that for the "Cultural Clash" session, having guest speakers with more "representative" experiences, or one to complement our speaker (described earlier, from the Cambodian elite) may have been helpful. Most felt that a few journal articles would have been beneficial, as the originally planned articles were never utilized as a supplement to *The Spirit Catches You.*

Reading student reflections was a highlight for me, as I could ascertain what lessons were most valuable for each student, and what action this spurred for each. For many, one of the most meaningful experiences was the visit to local Cambodian elders' homes, with nurses from Independence Health Services (the first home health service created for Cambodians). The students were sent in pairs with an English-speaking nurse who used her laptop computer to access Marc, interpreter and co-founder of the agency. Students noted the isolation of elderly Khmer who could not speak English nor relate to the society in which they'd been placed, as well as the quality of their living conditions:

> *One non-English speaking diabetic woman was wholly dependent on her son to take care of her, and their living situation was quite dire. Living on the top floor of a house without heat, they slept on a couple mattresses on the floor. It was hard to imagine how one could stay healthy in such a cold, dingy environment, but it was also hard to figure out what they could do to change their situation*. - MS2

Students commented on the barriers to care that were not cultural at all, but systems-based and logistical. Many wrote their final reflections about deficient interpretation services, a serious hurdle that all patients with limited English proficiency (LEP) face, as well as transportation, a problem for elderly patients and LEP patients in particular. Several reported that these themes, raised over the course of the elective, spurred them to do further research.

> *Since so many older Cambodians in the US do not speak English, and may not even be literate in Khmer, they are a hard group to reach, even by those with the best of intentions. At the patient education workshop in January, it seemed that many of the patients understood that seeing a doctor was important, but had trouble accessing care and finding a doctor with whom they could communicate in Khmer. If they could find a doctor, it would still be difficult to call and make an appointment.* -MS1

Several students highlighted that the course challenged their established understandings about "cultural competency." One commented on the complexity and the need for an advocacy component as part of "cultural competence."

> *Thinking back to the health screening, I enjoyed the immersion and the curiosity inspired by listening to a language – blasted over speakers – for which I had absolutely no point of reference to facilitate even partial understanding of what was being said. And then I left, because I had the choice to leave and return to something familiar. Now, having a better understanding of what life is like for Cambodian and other refugees resettling in Providence, I am struck by the fact that they often had no choice but to leave their homes and, once here, rarely have the choice of returning to what feels familiar.* –MS1

> *This elective was an exercise in praxis. It increased awareness among the medical school community about the rich culture of and issues facing a refugee population so that we can hope to meet their unique needs in the future as practitioners; it promoted community-wide education and preventative health screening; and it showed what it means to be an advocate in the health care setting to better the conditions in which people are living.* -MS1

Two students from the original group took over leadership in the following year, and had forty undergraduates and medical students attend the initial meeting. The course continues into its third year as the "Refugee Advocacy Elective", covering Cambodian and West African refugee populations in RI. Select student reflections have been included below**.**

Lastly, screenings and health fairs at Cambodian, Hmong and Laotian Buddhist temple celebrations drew substantial patient and student interest beyond the course. With near monthly community gatherings in the warmer seasons, screenings encouraged individuals to monitor their blood pressure and glucose, and also supplied information on nearby health resources and providing vision and glaucoma testing. This was a valuable experience for the students involved, as it garnered interest in the Southeast Asian communities and allowed for student-patient interactions outside of a time-restricted clinical setting.

Khmer Patient Advocacy Pre-Clinical Elective

An exploration of RI's Cambodian community healthcare needs and cultural sensitivity

Course Description

This pre-clinical elective is designed to: 1) educate pre-clinical medical students about the background and unique healthcare needs of the Cambodian (Khmer) patient population, and 2) to train students in immigrant/refugee patient advocacy through outreach projects targeting Providence's Cambodian elders. Students in the elective will learn about the Rhode Island Cambodian population (currently estimated at 10,000-13,000 people), its background and challenges in the U.S., and how to be "culturally sensitive" as providers for patients from immigrant and refugee backgrounds. The hour and a half long classroom sessions will feature film screenings and guest speakers from the Cambodian community, including cultural experts, physicians and refugee patients. These meetings will be supplemented by clinical and home care shadowing opportunities, a visit to a local Buddhist temple, regular community screenings and development of a health education workshop for Khmer patients and providers. The course will begin in Fall 2009 and extend into the Spring 2010 semester.

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Faculty Leader Dr. Edward Feller (Edward_Feller@brown.edu)

Credit Requirements

Attendance at classroom sessions and offsite visits (temple and home healthcare visit), as well as participation in SEDC patient education workshop and at least one screening or alternative community outreach project is mandatory (90% of final grade). One excused absence (requiring advanced notice to course leader) is permitted. Students will also write a 1-2 page reflection on a session of their choice, due at the end of the course (10% of final grade). Readings listed under each session will be discussed on that date.

Session 1 *Introduction to Cambodian Refugees in Providence and the U.S.*

Date/time: October 29, 2009 5:30-7:00 p.m. BMC 212

Objectives:

1. Define personal/shared goals for the course
2. Explore the background of Cambodian refugees and their settlement in the U.S.
3. Identify national data patterns related to Cambodian immigration
4. Identify barriers to proper healthcare among Cambodian patients

Agenda:

1. Introductions: What cultures do you come from? What brings you to the course?
2. Video screening: **"From Oakland to Providence"** and discussion

Readings: Chapter 3, *The Spirit Catches You and You Fall Down* by Anne Fadiman

Session 2 *Culture Clash: Traditional Values and Redefining Cambodian Culture in the U.S.*

Date/time: November 11, 2009 5:30-7:00 p.m. BMC 212

Objectives:

1. Identify cultural gaps between Cambodian elders and subsequent "Americanized" generations
2. Identify national trends in socioeconomic status, and the impact of poverty and illiteracy on health outcomes among Cambodian refugees
3. Discuss the role of family in decision-making processes, compare to American emphasis on autonomy

Agenda:

1. Guest speakers: **Cham Uth** and **Victor Long (Alpert MD '10)**
2. Video screening: "Monkey Dance" (A video about three Cambodian youth growing up in Lowell, MA and their relationships with their refugee parents)

Session 3 *The Refugee Experience and Body Dysfunction*

Date/time: November 18, 2009 6:00-7:30 p.m. BMC 212

Objectives:

1. Learn about the most common chronic diseases and syndromes affecting Cambodian refugees: Diabetes, Hypertension, Hepatitis B, TB
2. Discuss links between the traumatic refugee experience and chronic disease states

Agenda:

Guest speakers: **Dr. Soneath Pond** and **Margret Chang MD'10**

Reading:

1. Handelman, L. & Yeo, G. (1996). Using explanatory models to understand chronic symptoms of Cambodian refugees. *Family Medicine, 28*(4), 271-276.
2. Jackson, J. C., Rhodes, L. A., et al. (1997). Hepatitis B among the Khmer: Issues of translation and concepts of illness. *Journal of General Internal Medicine, 12*(5), 292-298.

Class 4 *Perceptions of Mental Health Among Cambodian Patients*

Date/time: December 2, 2009 6:00-7:30 p.m. BMC 212

Objectives:

1. Learn about most common mental health issues among Cambodian patients and manifestations of these illnesses
2. Explore substance abuse among Cambodian patients in the U.S. vs. Cambodia
3. Learn about counseling options for patients with mental health problems, in RI and beyond

Agenda:

1. Watch video of Cambodian patient R.S. from Asian Health Services (PTSD, Depression, Anxiety)
2. **Guest speaker panel:**
    a. **Dr. Martin Kerzer**, Family Medicine (one RI physician who opened his doors to Cambodian patients in initial immigration waves)
    b. **Chrisna Seng,** Socioeconomic Development Center for Southeast Asians (SEDC) Substance Abuse Prevention and Counseling
    c. **Psychiatry specialist (TBD)**

Reading:

1. Berthold, S.M., et al. (2007). U.S. Cambodian refugees' use of complementary and alternative medicine for mental health problems. Psychiatric Services, 58(9), 1212-1218.
2. Daley, T.C. (2005). Beliefs about treatment of mental health problems among Cambodian American children and parents. *Social Science & Medicine, 61*(11), 2384-2395.

Session 5 Art and Cambodian-American culture

Date/time: TBA (Spring)

Agenda:

1. **Guest speakers: RISD Anthropologist Lindsay French**, **Bristol Community College's Makna Men,** Cambodian refugee

Session 6 *Spirituality and Tradition: A Visit to Wat Thormikaram*

Date/time: Date in Spring TBA, Wat Thormikaram (177 Hanover St. Providence, RI 02907)
http://pluralism.org/research/profiles/display.php?profile=67685

Objectives:

1. Visit a Cambodian Buddhist Temple in Providence and meet monks and temple staff
2. Explore the roles of temple worship and spirituality in Cambodian refugee lifestyles and health choices
3. Learn about Cambodian alternative medicines and spirituality in healing

Agenda:

1. Head monk will discuss temple rituals, social services, and community needs
2. Dialogue on traditional medicines and healing rituals
3. Debriefing

Session 7 *Elderly Cambodian Visits with Home Healthcare Nurses*

Date/time: First week of December, two students per time slot

Objectives:

1. Visit Cambodian elderly patients with home healthcare staff from Independence Health Services
2. Take note of patients' living situations, neighborhoods, communication with nurses, adherence to prescribed regimens, daily lifestyles and dietary habits

Readings:

Ziner, Karen. "Trio's Healthcare Agency Focuses on Southeast Asians." The Providence Journal. April 18, 2009. (Link online)

Session 8 *Overcoming Barriers to Care*

Date/time: (Spring)

Objectives:

1. Compare the issues of Cambodian patient care with those of other underserved/immigrant populations
2. Learn about existing programs in RI that address Cambodian and immigrant healthcare needs
3. Discuss strategies and options for collaboration with local program coordinators

Agenda:

1. **Guest speakers: Marc Harrison** and **Colin Hanrahan,** founders of Independence Health Services (a home healthcare agency for Cambodian elders)
2. Discuss course topics and their applicability to non-Cambodian immigrant groups (from previous courses, experiences with patients, family, friends)
3. Reflection on course and personal discoveries, new directions
4. Evaluation

Readings: Chapter 1 (pp. 1-14) "Mexican Immigrants, Health Care, and Acculturation," in Reichman, Jill S. Immigration, Acculturation, and Health: The Mexican Diaspora. New York: LFB Scholarly Pub., 2006 (find in Josiah e-brary reader online)

Select Cambodian Patient Advocacy Elective Student Reflection Pieces

First Year Medical Student.
The most important thing I've learned over the course of the Cambodian elective rings true with nearly every experience I've had in medical school thus far: there is so much that I simply do not know.

My interest in taking the elective piqued last semester after I participated in a health screening that took place at a Hmong New Year festival. For lack of a better way to describe it, the screening was the first time in my life that I was surrounded by people who dressed and spoke in a way that was completely foreign to me. It's interesting: I certainly don't consider myself to be a sheltered individual, and yet somehow in my 25 years of life, I had never been immersed in a different culture as I was that day. What that experience helped me to realize was that my interest in and understanding of other cultures, while genuine, was largely academic. I've read about culture, studied ethnomusicology, and, though I've lived abroad, I've largely stuck to places like England and Italy where something familiar was always around the corner.

What I'm learning is that my understanding of cultural competency continues to grow. Prior to coming to medical school, I spent several years working in deeply impoverished communities on the south side of Chicago. My experience in those neighborhoods was largely one of culture shock; though there was a baseline of familiarity present via language and families and buildings, the pervasive presence of violence and extensive poverty was not something I had ever previously witnessed within my own culture. That said, my previous understanding of cultural competency was largely based in these experiences. Prior to taking this elective, I think I was overestimating the ways in which this intra-cultural competency translated into inter-cultural competency. There are, of course, ways in which the two overlap; many of the families with whom I worked in Chicago experienced barriers to health care and basic social services that parallel those faced by refugee or immigrant families. But salient differences exist – language barriers, the process of immigration, the threat of losing one's native culture – and I'm grateful to have had the opportunity to explore them.

This process of exploration through speakers and readings and home visits was filled with stark reminders of how much I do not know. I've never worked with an interpreter. I don't know how to teach someone who cannot read or write their own language the importance of adhering to a specific drug regimen. I cannot imagine what it is like to lose one's family or to experience trauma so severe that I don't speak of it to my children and grandchildren. I have no idea what it is like to live in a completely foreign culture, to be dependent on children for interpretation, or to be asked to navigate a new life according to foreign customs and systems.

This list is not at all meant to negate the fact that, over the course of the elective, I also learned a great deal about how to address many of these topics in my role as a physician and an advocate. It simply serves as a humble reminder that I have much to learn and that, as with most things at this point in my medical career, I am very much a beginner.

Thinking back to the health screening, I enjoyed the immersion and the curiosity inspired by listening to a language – blasted over speakers – for which I had absolutely no point of reference to facilitate even partial understanding of what was being said. And then I left, because I had the choice to leave and return to something familiar. Now, having a better understanding of what life is like for Cambodian and other refugees resettling in Providence, I am struck by the fact that they often had no choice but to leave their homes and, once here, rarely have the choice of returning to what feels familiar. I hope to continue expanding my understanding of how the process of resettlement affects individuals and families, and I'm very thankful to have a starting point firmly established by the Cambodian elective. Thank you, Geo!

First Year Medical Student.
One effect of taking this elective that I did not expect was that it greatly increased my interest in learning more about the growing field of medical interpretation. I have commented a couple of times in class about how introducing a third party into the equation inevitably affects the nature of the patient-doctor relationship. Not only

does the physician lose some of his or her own ability to actively build rapport with the patient, potentially vital information conveyed in the patient's tone and body language can easily be lost when they must communicate with the doctor through an interpreter. Patients may also be less likely to reveal certain personal information about themselves out of sheer discomfort due to a third party's involvement or because of concerns over confidentiality. Finally, as medical interpreters become increasingly available, one has to wonder whether this will negatively impact the willingness of physicians to learn and speak their patients' languages whenever possible. Access to interpreters may very well serve to reinforce reliance on their services and, thus, further widen the gap between physicians and patients who do not speak the same language. Regardless, the benefits of interpretation services clearly outweigh these unfortunate costs.

I believe that future students of this elective may benefit from having a guest speaker who works in interpretation come in to a class session and address some of the challenges of interpreting. It would also be an interesting opportunity to discover what kind of personal toll the occupation takes on the interpreter. According to an international survey on the interpretation field conducted in Sydney near the turn of the millennium, many interpreters at the time (regardless of the country in which they worked) felt that they received neither appropriate compensation nor respect for their services. Though the role of interpreters seems to be receiving increasing attention as time goes on, it is not hard to imagine that this situation has likely experienced little improvement. This must be particularly frustrating for interpreters as they are also exposed to many of the same emotionally stressful situations as others healthcare professionals. I believe that as future physicians, we all have the opportunity to do our part in helping interpreters gain the respect that they are due, and having a guest speaker share a glimpse of the day-to-day reality of their occupation might better empower us to do so.

First Year Medical Student.
I participated in this elective because I was interested in learning more about Cambodians living in the United States. The past seven years I worked intermittently with a documentary photographer and saw countless photographs of Cambodia. When I visited Cambodia last summer, I found the country sort of familiar in some ways—the hand painted signs in Khmer script, women selling noodles by the side of the road, rice paddies, water buffalo. The poverty was not unexpected. Despite this exposure to images of Cambodia, my first exposure to Cambodians in the United States did not occur until I visited the Cambodian consulate in Lowell, Massachusetts, to get a visa to enter Cambodia. There were whole streets of shops with Khmer signs, a Cambodian restaurant, Cambodian magazine and video shops. Later, when I knew I would be going to Brown, I became excited to learn more about the Cambodian population in Providence.

One of the strongest components of this elective was the way it highlighted a specific group of Cambodians—the older generation who came here as refugees in the 1980s and after. The Khmer Rouge time in Cambodia was devastating but acute, and meant that most refugees came here in the early eighties. While I have met some Cambodians who immigrated here after this period, t hey make up a different, better prepared, better-educated group. Instead of leaving their homes in chaos, making their way through refugee camps in Thailand or elsewhere, and then ending up wherever they were placed—Providence and Lowell with their New England climate likely felt particularly bizarre, these later immigrants had plans for jobs or education and are better able to navigate a new and foreign place. I have heard that adult Cambodians who arrived in Providence as refugees in the eighties went right to work, often in factories, where they did not need a formal education or English skills to get through the day and make a living to support their families. It seems that the older generation is now more isolated than ever as they are no longer working, their children are gone, and they are experiencing more health problems. Every Cambodian over the age of thirty or so has a terrifying story about how his or her family escaped Cambodia during the Khmer rouge time. Many lost most or all of their family. Even when I do not know someone well, I remind myself that no matter how healthy or happy someone seems, if she was in Cambodia in the 1970s, she has had thing happen to her in life that I cannot begin to imagine. It is hard to see people who I know have already been through so much struggling in a different way here in Providence.

During our home healthcare nurse visit, on a gloomy February day, we visited an elderly couple living off Elmwood Avenue. Their home was a typical providence apartment, in a wooden multi-family house. Their living

area was stark—an old couch, a folding table with two aluminum chairs. However, the many pictures of relatives, children and grandchildren, decorated the mantle and one wall. A small, colorful Buddhist shrine was in one corner. The card table was covered in orange prescription bottles, and packaging from a glucometer. The wife had recently been diagnosed with diabetes and the nurse was trying to set up her glucometer and make she knew how to use it. It was frustrating because the woman already knew how to do this—she had been looking after her husband, who also has diabetes for years. However the new glucometer was different than the husband's and the pharmacy had provided the wrong size test strips. To convey this to the woman, the nurse had to make a number of calls to Marc, at Independence Health Services. She would explain what she had figured out to Marc, who would then explain it in Khmer to the patient. Every time the patient spoke to Marc, at least four times during our short visit, she would greet him, "Lok Kmouy," ("nephew,") and then they would speak for a while.

This experience reminded me of an experience I had with a Cambodian family living in a slum outside Phnom Penh last summer. It was my first day in Cambodia, and I was invited to accompany a group from the hospital I was volunteering with, Sihanouk Hospital Center of Hope, to a site were they were having a house (brick, about ten by ten feet) built for a middle aged, HIV positive woman named Ly Nath. Her mother was a tiny, seventy-seven year old woman, with the shaved head of a widow. The situation was horrible. Ly Nath's husband was dead, they were all living in a wood shack that flooded when it rained, and because they were no longer in Phnom Penh proper (displaced by construction) it was very difficult for them to access medical care. The new house was a massive improvement, but not a solution to most of the problems. Despite the sickness and poverty, which I do not intend to romanticize or discount, I believe this family was in a better situation, at least mentally, than the couple in Providence. Both families are extremely poor, but the Cambodian family living in Cambodia was surrounded by family and friends, and in a place where their culture meant something to everyone. They were not isolated the way the Cambodian couple was in the United States.

Since so many older Cambodians in the US do not speak English, and may not even be literate in Khmer, they are a hard group to reach, even by those with the best of intentions. At the patient education workshop in January, it seemed that many of the patients understood that seeing a doctor was important, but had trouble accessing care and finding a doctor with whom they could communicate in Khmer. If they could find a doctor, it would still be difficult to call and make an appointment. Transportation also seems to be a major issue. If a younger family member were unable to help, it would be very difficult and scary to get to an appointment on public transportation. If the elder is isolated, without family or many friends, finding and getting to a doctor becomes even harder. It is only once these barriers are overcome that the actual cultural differences that make medical care confusing for both doctor and patient can begin to be addressed.

The patient education workshops are a great way to begin to disseminate information on healthcare services. It seems that there are at least some services available to low-income patients, and that with some planning translators can be arranged. Ideally, there would also be better transportation for these patients. Outreach workers from the Khmer community who could help patients figure out what doctor to see and how to reach the office would be best. However, just offering information on what is available and what patients have a right to expect is a start. I hope that the elders who attended the SEDC workshop at least left with a sense that they are not forgotten, and there are services even though they may be difficult to access. I would like to see, in addition to more patient education and assistance, better and more universal education for health care providers. Next year I hope to build on the patient education workshops and focus on some of the specific issues raised by this year's workshop.

First Year Medical Student.

I guess that I had never really thought about what it would be like to be a refugee before taking the Khmer Patient Advocacy Elective. It is certainly not a plight that is easy to imagine. Unless exposed to it either personally or via stories told firsthand by others who themselves have endured such hardship, the refugee experience can be an easy one to miss. Growing up in a small, suburban town, I never met any refugees. In college, much of my scholastic research and service focused on America's rural poor and again, I never came across the refugee experience.

During our first class, I remember being surprised by the degree to which refugees are forced into a kind of survival mode once they get to this country. I had seen my fair share of poverty in college but the survivalism forced onto refugees seems intrinsically different. Like American poverty, some of this survivalism is based on the acquisition of economic goods like food, clothing, housing, and employment. I guess what surprised me was the degree to which refugees have to make an effort to defend their cultural ways in the midst of American culture. Before that first class, I had never thought about American culture as necessarily being all that bad. Sure, we have fast food, legal protections for the possession of firearms, a hyper-sexualized media, a propensity for war, and the like, but we also have baseball and free education for all up to high school and some social protection programs. I guess I just never realized how intrusive mainstream American culture is into the lives of refugees, both for the good and for the bad. It was wonderful to learn about how people who had never had educations could pursue them in America; it was horrendous to hear about the intergenerational erosion of family life amongst the refugees as children became Americanized at the expense of their Hmong culture.

There is something to be said for learning to put yourself in someone else's shoes. More so than anything else, this elective has taught me that assuming this frame of mind is important in order to be "culturally competent." (I use quotation marks here because I think this term is so overused in medical education that its meaning and significance can sometimes become blurred.) By visiting a Cambodian patient at his house and by hearing refugees throughout the semester explain what they went through in losing family members during the genocide, surviving the camps, acclimating to the U.S., and trying to make a living here, it seems to me that "cultural competency" involves a lot more than what many medical students and physicians think.

I knew well before the start of the elective that the "culturally competent" health care provider is of course willing to listen to people. It is impossible to expect to understand people's life circumstances without hearing from them the conditions they are enduring; without an appreciation of a person's life circumstances, a physician is lost in trying to understand his or her health. Luckily, attentive listening is something that comes fairly naturally to me. I quickly realized through this elective, though, that listening is really only the first step of many that physicians must take in order to provide the best care for their patients of diverse backgrounds and cultures.

I had read my fair share of Paul Farmer books before taking this elective and understood that to be "culturally competent" also involves some measure of academic legwork in order to try to understand the cultures, histories, and value systems of patients. Books are useful, but again, listening is of paramount importance. The elective was helpful in emphasizing that allowing people to talk about themselves, their experiences, and their cultures is validating and cathartic for them at the same time that it reinforces your respect for them as the deferential listener. Though I know at times it was difficult for the various speakers we had to open up to a group of strangers, I really enjoyed hearing from everyone about everything they had been through. It is truly amazing what the human spirit is capable of overcoming.

The final feature of "cultural competency" – one that I did not realize prior to taking the elective – is advocacy. Listening to people and being understanding of their cultures and life experiences is not helpful unless that information and appreciation are translated into appropriate praxis on behalf of those same people. This elective was an exercise in praxis. It increased awareness among the medical school community about the rich culture of and issues facing a refugee population so that we can hope to meet their unique needs in the future as practitioners; it promoted community-wide education and preventative health screening; and it showed what it means to be an advocate in the health care setting to better the conditions in which people are living.

I thoroughly enjoyed the Khmer Patient Advocacy Elective. It taught me about the refugee experience in ways I did not expect and simultaneously helped me to recognize "cultural competency" for the crucial professional skill that it is, requiring both immense empathy and equally intense advocacy.

Undergraduate PLME Student.

This elective was created with the goal of educating future doctors about the specific issues that face the Cambodian population and other refugee populations. However, as sensitive as a doctor can be to a patient's culturally specific symptoms and his or her past, it is rendered useless if basic communication can't happen. This requires the use of a translator, which seems to be the biggest problem when it comes to treating the Cambodian population. The issue of having a good translator came up over and over again in our different sessions, which was surprising to me, considering how long the refugee population has been here and how large it is. One would think that because there are generations of young people that grew up in the United States, or at least mostly in the United States, that there would be a larger population of people available to become translators, or even becoming nurses and other health professionals.

There were seemingly good translators at the SEDC workshop (although because I don't speak Khmer I can't actually judge the level of translation) but seeing the way that Independence Health Services functions was a shocking and eye-opening experience. The nurse would call Marc every few minutes and he would do the translating over the phone. This seems like a broken and inefficient way to run a health services agency, especially when so many of the patients are Cambodian. This may provide more access to care then they would otherwise get but it is still severely lacking. Marc and Colin acknowledged the difficulty of this setup but said that after the experience of using translators from the community, they had decided that this was the best way to deliver their services. They couldn't find anyone who could translate as well as Marc could.

When I mentioned the lack of translators to a friend that works in the Cambodian community and she told me that the services for Southeast Asians in Providence and Rhode Island in general are severely lacking and that the last few translators were recently laid off from the Department of Human Services. When I looked further into this issue I found out that because of the lack of political involvement of the Southeast Asian community there is very little funding going to this population. Not only are the services already lacking but they continue to get weaker and weaker, especially with the economic crisis. However, the Spanish interpreters and other services that serve the Spanish speaking population have been left largely untouched, presumably because they have far greater political power.

This speaks to two issues – the need for a Cambodian voice in politics and the simple need for trained Cambodian translators, because even if there aren't any being hired by the government, they are still greatly in need for private services. I don't know enough about the situation to know why there is a lack of translators; it is possible that the younger generation wants more independence from the older generation and therefore has no desire to become translators, that translators are not paid well or not a stable enough form of work, or maybe that there are not accessible programs that train individuals to be professional translators. However, whatever the reason for the lack of translators is it is clear that it's a problem. Translators are important not only for health care but for many other crucial aspects of living a healthy and happy life. Although it may not solve the problem completely, an important step would be having more community programs directed towards addressing this problem. This may mean scholarships for bilingual members of the community to get trained to translate or maybe just specific encouragement to give back to the Cambodian community through translation services. With regards to the issues of a lack of political voice, if there are not enough members of the Cambodian community who feel comfortable or are able to participate in the political sphere and advocate for themselves, it may be the role of physicians and other groups to advocate for them.

"How to take medicines correctly": Cambodian patient education workshops

> *I met a woman who was taking penicillin and other meds. Her daughter sent the penicillin from Thailand to treat her allergies. But not only that, she was mixing meds. She was so desperate to get rid of her allergies, she was just taking whatever friends and relatives were giving her, with no idea what she was taking.* – Ammala Douangsavanh, Women and Infants Hospital Cancer Screening Initiative

Poor medicine adherence among Cambodian patients was a major source of struggle identified by physicians from Providence to Oakland. Dr. Margret Chang (AMS'10), my mentor in Providence, RI, had recently conducted a focus group of RI Southeast Asian individuals on what they viewed as health concerns and difficulty accessing healthcare. Because many participants in her focus groups specifically requested education on how to take medicines, adherence was the first topic covered as part of a health education program based out of Rhode Island's Socioeconomic Development Center for Southeast Asians (SEDC).

Working with a population with limited access to the healthcare system required a multi-disciplinary approach. Collaborators included SEDC; founders of RI's new home nurse agency targeting SEA patients; several RI Community Health Centers; RI Dept. of Health's Health Disparities & Access to Care team; as well as Brown University undergraduate and medical students.

The SEDC functioned as a central, familiar meeting place for our patients, as many Cambodians in the community participate in SEDC's other programming such as citizenship courses and meal site. Addressing logistical barriers to care, the workshops depended on a Khmer-English interpreter and free transportation for the audience. Approximately 100 patients were served over two 1.5-hour evening sessions, with community interest exceeding our anticipated total of 60 patients over two evenings. Each workshop involved:

1) Evaluation: a pre- and post-workshop test and demographic information portion;
2) Video Screening: "Taking Medicines Correctly", a Khmer-English patient education video that depicts common outpatient scenarios of medicine management (filmed during my internship at Asian Health Services in Oakland, CA);
3) Speaker panel: featured a Providence Community Health Center physician who serves many Cambodian patients, a Cambodian social worker, President of the local Cambodian Society as a patient representative, and the RI Dept. of Health Minority Health Team leader, who addressed the legal and structural issues affecting Khmer interpretation and access to care;
4) Q & A session: open questions from participants to the panel; and
5) Incentives: a prize round, rewarding audience members who answered questions aloud, as well as healthful Cambodian dishes for dinner and gifts of seven-day pill organizers and toiletries for all in attendance.

Assessing Workshop Efficacy

The Pre-Test collected demographic information and tested patient knowledge of medicine adherence prior to the presentation; this was offered in English or Khmer print, and the questions were read aloud in Khmer. The Post-Test included similar questions to assess any change in patient knowledge. There were limitations to this assessment: post-tests were not matched by patient to the pre-tests, and ultimately were not administered due to time constraints at both workshops. Ideally, these questions would also available for caseworkers to re-administer during follow-up visits with patients, to assess for change in understanding and practice of medicine adherence.

At the end of each workshop, we offered prizes to the three attendees who could answer aloud questions about reportedly common scenarios of medicine non-adherence, for example: *"You are staying the night at the Temple for weekend prayer, and have forgotten your blood pressure medications. Your friend offers to share her blood pressure medicine for the day. What should you do?"* Patients responded well to this round of questions.

Challenges
The planning process for these workshops was extensive, as they involved meetings with the executive director of the SEDC, multiple social workers and SEDC staff to ensure feasibility and maximum benefit to the patients.

Though SEDC was an ideal location for the workshops in many ways, space was limited and a major constraint in the number of participants we could accommodate. Because approximately 60 participants came to the second workshop when 30-40 were expected, it was difficult to maintain audience attention for as long as necessary to administer the post-test. Whether caseworkers at SEDC will use the quizzes to follow up with patients is questionable; the goal would be continuity, however patients may not be visiting the caseworkers frequently enough for the quizzes to be reliable, and caseworkers have limited time to administer such surveys. Moreover, it is difficult to assess how honestly and accurately patients answered the pre-test questions. Taken in close proximity to peers and SEDC staff, patients may not have responded to questions in the same way they would have was the quiz administered privately and with more thorough, individualized explanation. Whether the workshops have had a significant impact is hard to measure beyond post-test surveys and informal feedback.

In the future, the key changes would be to limit the agenda to fewer activities and points. A more interactive rather than lecture/video style workshop may also keep patients' attention better. Also involving RI public transportation was a suggestion by one community leader, who felt that transportation was identified as a major barrier to care, and having a representative present would be beneficial for both sides. Also, Incentives such as dinner and prizes are costly – seeking more donations and limiting prize expenses while still attracting audiences would be an important goal for workshop leaders.

"Two Channels to Cambodian Patient Advocacy" received "Best Poster" at the RI American Family Physicians Conference and was also presented at the local conference, "Celebrating Collaborations: Improving Services for Rhode Island's Refugees." The project was awarded the Alpha Omega Alpha Medical Student Service Prize (see below) and was also supported by a grant from the Petersen Educational Enhancement Fund.

"How to Take Medications Correctly" Patient Education Workshop Plan

Workshop Agenda
5:15pm – Participants arrive
5:30pm – SEDC caseworker gives welcome remarks; student leader gives introduction and agenda
Pre-test is administered (questions are read aloud for illiterate elders)
5:45pm – Dinner service; Patient education video screening
6:00pm – Speaker panel addresses the participants
6:30pm – Open discussion / Quiz for special prizes
6:45pm – Administer post-test
7:00pm – Participants are driven home

Patient Education Video

Assessing Workshop Efficacy
Pre-test and Post-test
The pre-test collected demographic information and tested patient knowledge of medicine adherence prior to the presentation:

1. Do you have a doctor who you can see for check-ups?
2. Do you bring your medicines to the doctor?
3. How many different medications do you take per day?
   None 1-2 3-5 5+
4. Can you afford to pay for all of your medications?
5. Do you know what your medications are for?
6. Do you follow your doctor's exact instructions on how to take medicines?
7. Do you make your own changes to your medicines against your doctor's advice?
8. Where do you get your medications? (Circle all that apply)
   Pharmacy Doctor or clinic Family and friends

The following questions were administered before and after the presentation as the pre- and post-test. These were not matched to each patient, and ultimately were not administered due to time constraints. Ideally, these questions are also available for caseworkers to re-administer during follow-up visits with patients, to assess if there has been change in understanding and practice of medicine adherence.

1. Do you know why the doctor needs to see your medications at each visit? Yes No
2. Do you understand why it is important to take your medications?
3. Do you understand how to take your medications?
4. Can you ask your doctor about how and when to take your medicines, or if there is something you don't understand?
5. Do you know what to do if you run out of pills?
6. Do you know that some medications can harm you if you do not take them correctly?

Workshop Anecdotal Quiz Questions

Scenario 1: *Your sister is on the same medication as you, but the doctor changes her prescription because she was having side effects. Should you stop taking yours too, or should you go to the doctor first and talk about it?*
Scenario 2: *You are taking a medicine for high blood pressure. Sometimes you feel like it isn't working, because you don't feel any different. Should you keep taking it as directed, should you double the dose, or stop taking it?*
Scenario 3: *You sleep over at the temple for the weekend and forgot to bring your medicines, so your friend offers you her medicine to take since it looks the same. Should you take it?*

Community leader feedback on Patient Education Workshops

What did the workshops accomplish? Were they effective?

I think the workshops helped to raise the level of consciousness about proper medication adherence and some of the consequences of noncompliance. Along with noncompliance, a problem in the Southeast Asian community (and I'm sure in other ethnic communities) is prescription drug sharing. These are issues that have never been addressed in the community so to have a place for that discussion with healthcare professionals available to answer questions was a great benefit, and I think opens the doors for further health education.
- Ammala Douangsavanh, Women's Cancer Screening Program, Women and Infants Hospital RI

I think they were very effective, the people had lots of questions, which is good. Even the simplest things like don't take someone else's medication are important to reinforce over and over. Our patients are getting better with the constant teaching that the nurses are doing, but once in awhile they still have problems.
- Colin Hanrahan, co-founder of Independence Health Services

Some participants get a sense of understanding of the available services in the community i.e. at the health centers, etc. that they can seek help from. Participants feel that there are staff that can support them i.e. doctors etc and they are not being bias, left out or being ignorant about their health, medications etc. Some participants were able to expressed their frustrations or not understanding of the importance of their health, medication and the consistancy of taking their meds. Some participants feels that there are organizations/staff who are SEA or not that care for them. Great support staff in providing transportation, recruiting etc. for the participants.
- Kimly Sao, Khmer Social Worker and Interpreter

What could have been done better? Any suggestions or ideas of how?

It's more difficult and time-consuming to do this but I think having smaller groups would allow for more comprehensive discussion and overall better understanding of the material. And I think that will help minimize repeat performers. ;) I think providing a baby-sitting service would be helpful to the parents who want to attend since it will allow them to concentrate on the discussion at hand. I would suggest having just one speaker (preferably Asian) who is a doctor. Naturally, you can have interpreters available. I know it's so superficial and reductive to say it like that, but it's the easiest and most effective way to get your message across. The focus and attention is on one person only, and since MDs are so revered in our community, having that healthcare expert there who looks like them, conveying the message to them appeals to this audience on many levels.
- Ammala Douangsavanh

I did not see the video that was played, it would be nice to be able to give each person their own DVD of any videos, that way they can go home and watch them, or even share them with people who did not attend. Repetition is how thing sink into their understanding. All the Cambodian households have DVD players because they watch the Karaoke and the Cambodian Soap Operas and they trade DVD's back and forth, because of the lack of Khmer TV programming on our cable systems.
- Colin Hanrahan

Not being able to have the agenda running smoothly due to lack of time. Translator staff not being effective in some way i.e. some participants not really focusing on her; and/or not clear when translating. Maybe should have fewer focus points rather a lot of what we have i.e video, presentation from staff and one by one...it seems that participants lose interest or too much info being presented. Eating and listening to the presentation, I don't think it works out well.
- Kimly Sao

What do you think would be a next step in achieving the goals of medical adherence and health education/awareness in the community?

I think follow-up workshops are in order. One that would be helpful is how certain folk medicines/teas/rubs/etc. may have adverse reactions with prescription drugs and reduce effectiveness or harm people; but I think included with that discussion should be SEA herbal/at-home remedies that ARE beneficial. Another good follow-up would be imported drugs from SEA countries. For example, I met a woman who was taking penicillin (of all things) and other meds. Her daughter sent from Thailand to treat her allergies. But not only that, she was mixing meds. She was so desperate to get rid of her allergies, she was just taking whatever friends and relatives were giving her, with no idea what she was taking. Discussing the potential dangers of imported drugs would be a great benefit.

I think it might be a good idea to create tools that will aid med-adherence. Maybe pillboxes in different languages? An SEA language brochure that lists and discusses common medications and the symptoms and conditions it's supposed to treat? I know medication is constantly changing but it's a start.
- Ammala Douangsavanh

Maybe involve them in a role play in small groups or even tell them that they can go out and tell others what they have learned, make them stewards for the commuinty, make them part of the process, involve them, give them a professional looking certificate for completing the class etc. some kind of hands on stuff.

"I hear...I forget
I see...and I remember
I do...and I understand"
Ancient Chinese Proverb

This applies to teaching somebody something. It means that if you simply tell (or talk) about something to a person/people, it is very likely that they will forget what was said. If you tell them **and** show them, they will more likely remember what was taught. If you involve them in a 'hands-on' activity/manner (where they 'do' what you are trying to teach them), they will fully understand- which means they will have totally "learned" whatever was being taught.

Also, it would be nice to involve RIPA and the RIDE program. I can go talk to them and have them provide Van's for the night. This will get people there and introduce people to the RIPA services, people that were afraid to use it before. Plus the state has very nice new handicap and RIDE Vans that our tax payer dollars are paying for. It would make the people feel special. It would be good to find out if RIPA has any Southeast Asian Drivers, this would make people feel better.
- Colin Hanrahan

Update on project for Alpha Omega Alpha Medical Student Service Prize

ΑΩΑ 1902 Alpha Omega Alpha Honor Medical Society

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Brown University: Two Channels to Cambodian Patient Advocacy

Above right, Brown student Geolani Dy (far right) addresses a group with a Cambodian social worker and an interpreter.

Since the 1980s, more than 20,000 individuals from war-torn Cambodia, Laos, and Vietnam have sought refuge in Rhode Island. Due to financial, cultural and linguistic barriers, many of Rhode Island's Cambodian refugees still lack proper health care and health education 30 years after arrival. Diabetes, hypercholesterolemia, and hypertension are pervasive and often go uncontrolled for years, as the tendency to seek preventive care is low among Cambodians. Doctor visits prove confusing and upsetting when providers lack the training to work within their patients' socioeconomic, linguistic, and cultural contexts.

Two Channels to Cambodian Patient Advocacy is an educational initiative designed to benefit Cambodian patients and future providers, through early awareness of a local group's health care needs and exercises in patient advocacy. Our project combines patient education and outreach with a medical student curriculum as a framework for the community work. With an ΑΩΑ Medical Student Service Project grant, we fulfilled our objectives of establishing a Medicine Adherence patient education program and an Alpert Medical School health screening team at Southeast Asian community gatherings. We created a new, Brown-approved pre-clinical elective course, Cambodian Patient Advocacy, which is sustainable as the Refugee Patient Advocacy course for future AMS students.

"A woman who died of a broken heart: causation or association?" Clinical Vignette

Dr. Kimberly Chang of Asian Health Services (AHS) has developed a large Cambodian patient base over the years. One of her patients was an elderly Cambodian woman who died of "Broken Heart Syndrome," or Takotsubo Cardiomyopathy, just before my arrival as an AHS summer intern. Takotsubo had been a subject of much attention in cardiology literature at the time, but this patient had a particularly interesting sociocultural history that we suggested contributed to her unusual outcome.

Takotsubo is characterized by transient left heart apical ballooning; the word literally translates to "octopus trap" in Japanese, for the heart's resemblance to the trap when in its ballooned shape.
With symptoms mimicking an acute cardiac event, its exact causes and mechanism are unknown. For most patients, it is preceded by an acute emotional or physical stressor—as simple as getting lost on the road to news of a death in the family—and most patients recover completely. Our patient, however, had a long-term history of psychosocial stressors and ultimately died of heart failure during her admission for Takotsubo.

The article explored the potential relationship between the patient's cause of death and her traumatic refugee past. The case report was a way of applying my knowledge of the historical, sociocultural and economic struggles of the Cambodian refugee experience to a case that was also a pathophysiologic mystery.

Abstract

A mimic of acute coronary syndrome, Takotsubo cardiomyopathy or "Broken Heart" Syndrome manifests with symptoms of crushing chest pain and diaphoresis usually following an acute emotional or physical stressor. Patients show a distinct left apical ballooning on ventriculography, and symptoms tend to resolve spontaneously. An unusual fatal case of Takotsubo cardiomyopathy is presented in this report of a Cambodian refugee woman, whose chest pain and dyspnea acutely followed epidural steroid injection, and chronically, a legacy of trauma from the 1970s Khmer Rouge genocide. Several diagnostic confounders—an imitator of acute coronary syndrome, patient history of trauma and adverse childhood events, and Cambodian culture-specific somatic complaints—are highlighted here. We suggest careful consideration of adverse exposures and culturally-determined complaints in refugee patients presenting for medical care, and propose that this patient's long-time exposure to psychosocial stresses contributed to development of her illness.

"A woman who died of a broken heart: causation or association?" was selected as a National Poster Finalist in the 2010 American College of Physicians (ACP) Internal Medicine conference's Student Clinical Vignette category.

A Woman with a Broken Heart: Association or Causation?

Geolani Dy, MS2; Kimberly Chang, MD; Edward Feller, MD, FACP

Asian Health Services, Oakland, CA; Department of Community Health, Alpert Medical School of Brown University, Providence, RI

BROWN
Alpert Medical School

Introduction

An association exists between myocardial infarction (MI) and severe emotional or physical stress such as war, earthquake or family death. A stressful event-related cardiomyopathy, variously termed Broken Heart, apical ballooning (ABS), or Tako-tsubo syndrome, has been described that mimics MI without anatomic coronary artery disease (CAD). ABS, which may account for 1% of cases of presumed MI, is characterized by marked female predominance and left ventricular (LV) apical ballooning and hypokinesis.

We report a woman with ABS and both chronic emotional stress and an acute antecedent physical stressor. Our dual goal: (1) explore an under-recognized and frequently misdiagnosed entity; and (2) highlight the problem of causation vs. association in individual case reports.

Case Description

A 56-year-old woman with 10 hours of anterior chest pressure and dyspnea. She was a refugee from the genocidal 1970's Pol Pot Cambodian regime. One day prior to admission, she had an epidural steroid injection for spinal stenosis. She had bipolar and schizoaffective disorders.

Physical exam: moderate distress; normal vital signs; chest: decreased basal breath sounds; cardiac: normal S1, S2 with S3 present, regular rhythm; CPK: elevated= 1129 ng/ mL with MB elevated= 224 ng/ mL; Troponin elevated. ECG: new right bundle branch block, ST elevation, T wave inversion and small Q waves in V1, V2. Urgent coronary catheterization: normal coronary arteries. LV ejection fraction was decreased (35%). Ventriculography: marked LV apical akinesia with compensatory basal hyperkinesis, producing systolic apical ballooning. Progressive, refractory hypotension and heart failure developed. She died on hospital day 1.

Proposed Pathophysiology of Takotsubo Cardiomyopathy

Adapted from Prasad et al.

*LVOT = Left ventricular outflow tract

Figure 1

Figure 1: "Takotsubo", Japanese octopus trap
Figure 2: Left apical ballooning

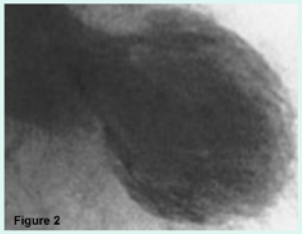
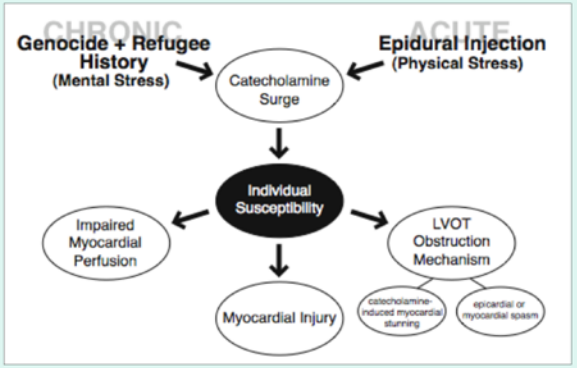


Figure 2



Reported triggers of ABS

Emotional stress
- Death, severe illness
- Receiving bad news
- Financial loss
- Public speaking
- Car accident
- Receiving bad driving directions
- Surprise party
- Move to new home

Physical stress
- Cholecystectomy
- Severe pain or illness
- Recovery from general anesthesia
- Cocaine use, opiate withdrawal
- Exercise stress test
- Thyrotoxicosis

Discussion

ABS pathogenesis is unclear. Catecholamine-mediated myocardial stunning, induced by preceding acute stressful events, is the most accepted mechanism. Preliminary data indicates that plasma catecholamines are significantly higher in ABS patients compared to MI patients.

Our patient is unusual because refractory heart failure and death are rare in ABS. Our case satisfies criteria for ABS, including absence of other disorders such as pheochromocytoma or myocarditis, but does not satisfy accepted WHO criteria for "definite" causation. We postulate that antecedent epidural injection, potentiated by chronic emotional trauma in Cambodia's killing fields triggered this episode. Triggering events are not always present or identifiable, nor do generally accepted definitions exist for "stress". Inciting factors in prior case reports are as varied as family death to receiving bad driving directions or colonoscopy preparation.

Our hypothesis is plausible and coherent, but temporal proximity implicating specific stressors is speculative as is documented absence of unmeasured confounding variables or reproducibility of this putative association. The nature and spectrum of stress causing a "broken heart" remains unclear.

The Cambodian genocide and traumatic refugee experience have led to permanent physical, social and mental dysfunction in survivors even three decades after the war. As manifestations may be delayed or atypical, the effects of past trauma must be considered when evaluating patients with such histories.

Causality Assessment

We postulate that antecedent epidural injection, potentiated by chronic emotional trauma in Cambodia's killing fields triggered this episode.

Assigning causality in this case: problems
- Our hypothesis, although plausible and coherent, is unproven
- Triggering "stress" may not be present in ABS
- No accepted definition of "stress" exists
- Reported stressor does not reliably produce ABS
- Dose-responsiveness is absent – Major stress (death of spouse) doesn't reliably produce ABS more than minor stress (colonoscopy)
- Temporal relationship of chronic stress to ABS "event" is absent
- Specificity and consistency of event are absent
- Unmeasured confounder or can not be disproven

How do we assess causality?

What causality assessment can do
- Decrease disagreement between assessors
- Increase or decrease relationship likelihood
- Improve evaluation
- Evaluate individual case reports

What it can't do
- Provide accurate quantitative assessment of likelihood of relationship; Describe the frequency of stress leading to complication
- Distinguish valid from invalid cases
- Prove connection
- Quantify contribution of stressor to adverse event
- Change uncertainty to certainty

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2. Regnante RA, Zuzek RW, Weinsier SB, et al. Clinical characteristics and 4-year outcomes in the Rhode Island Takotsubo registry. Am J Cardiol 2009; 103: 1015-1019.
3. Howick J, Glasziou P, Aronson JK. The evolution of evidence hierarchies: what can Bradford Hill's 'guidelines for causation' contribute. J R Soc Med 2009; 102: 186-194.
4. Mollica R, Donelan K, Tor S, et al. The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand-Cambodia border camps. JAMA. 1993;270(5):581-586.

Thank you to Asian Health Services and the Dept. of Community Health at Alpert Medical School.

Doctoring II "Cultural Competency" Module

During my second year, Doctoring course leader Dr. Iris Tong invited me to develop the "cultural competency" session for first year Doctoring. Though this topic was a long-standing interest of mine, it was a challenge to generate a curriculum session for many reasons. In the years since I have learned that this is likely the case for most teaching the subject. While cross-cultural communication skills and general "cultural competency" have been identified as an importance response to health disparities,[1] the best method of improving physician and medical student abilities in these areas is unclear. Three primary approaches to cross-cultural medical education have been suggested:

A. Awareness/Sensitivity approach (Attitudes): promotes attitudes of humility, empathy, curiosity and respect for patients and all the pieces that form "culture," as well as self-awareness. Though these tenets are exceedingly important in effective communication between patients and physicians, the ideas may seem abstract to clinically oriented individuals.[2] Efforts to change attitudes require a great deal of time and patience, and may not be the best approach when limited to a two-hour session.
B. Multicultural/Categorical approach (Knowledge): more traditional in its focus on specific information—attitudes, values, beliefs and behaviors of certain cultural groups are taught with "do's" and "don'ts". This approach can lead to stereotyping and oversimplification of culture, however, which can be very harmful.
C. Cross-cultural approach (Behavior): focuses on skills—providers are encouraged the adjust practice styles to the needs of individual patients, with specific interviewing or communication tools to elicit whether health beliefs differ.

These approaches each differ in feasibility of implementation, possible gains and dangers, but synergistically are very valuable in improving providers' ability to care for patients from diverse backgrounds. For the purposes of first year Doctoring, we started at a very introductory level, offering the following session objectives:

- Think about, challenge, and define the meaning of cultural competence and humility
- Recognize the broad scope of patients' "culture"
- Ask concrete questions to elicit information critical to a patient's care
- Recognize how physicians' attitudes and backgrounds can impact provider-patient communication

To use the three-hour block as effectively as possible, we began with definitions and presented the concept of racial and ethnic disparities in healthcare. We had students watch a film on cases of medical error that various degrees of a physician-patient cultural divide and followed this with a large group discussion. Then we followed with small group role-playing and concluded with a panel discussion featuring community members involved in reducing health disparities in RI.

This was my first experience in facilitating or teaching to a large group—with over 100 students and physician preceptors in the audience, there was much more diversity in the attitudes and ideas shared (probably more representative of the mean than what I had encountered in my self-selecting Cambodian elective group). Some relayed frustration that there may be an over-focus on cultural competency, when its principles should be common knowledge. This has been described as a common challenge to those teaching "cultural competency" with physician audiences—that amid a focus on more clinical aspects of patient care, the desire to devote time to topics such as culture are lost. Others related clinical experiences they had witnessed where cultural divides were apparent. Curriculum development in this area continues to be a work in progress.

[1] Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O., 2nd. (2003). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. [Research Support, Non-U.S. Gov't]. *Public Health Rep*, *118*(4), 293-302.
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Tuesday	**11.10.09**	**Session Content**

Topics

Cultural Competence/Cultural Humility: What Is It and Why It Matters

*The doctor told me that I have **tus mob hu ua ntshav qab zib** [sweet blood]. I never eat or drink sweet things. Why and how do I have the disease? Did I catch this disease by using public bathrooms or sharing utensils with other people who have diabetes?* **Hmong elder** Peterson KA, Vang ML, Xiong YM. Type II Diabetes in the Hmong Community. In Healing by Heart. 2003.

When I found out about the tumor—you know that it was cancer, I didn't know what to do. I didn't see much point in doing anything because you know they say all cancer will kill you. There ain't no cure for it. But the people here were so good to me and they told me not to give up—that my family would want me to fight to live and that they would help me. So I took my treatments and stuck with it. **Sallie age 53**. Mathews HF, Lannin DR, Mitchell JP. Coming to terms with advanced breast cancer: black women's narratives from eastern North Carolina. In The Social Medicine Reader. Duke University Press 1997.

A. Disparities in Health and Health Care

Quality health care means doing the right thing, at the right time, in the right way, for the right people—and having the best possible results.[i]

Quality health care is defined as care that is: **Effective, Safe, Timely, Patient-centered, Equitable, and Efficient.**[ii]

B. Cultural Competence—A set of knowledge, skills, and attitudes to address health care disparities

- Awareness of how one's own assumptions, values, biases, expectations and experiences influence one's behavior as a health care provider
- Recognition of and respect for differences among patients in terms of their values, expectations, self-care practices and experiences with health care
- Understanding of the culture-based practices of American medicine that can impact patients
- Ability to use specific strategies to adapt care so that it is congruent with the patient's expectations and preferences, and to guide interactions among patient, provider and organized medicine so that institutional barriers are lowered and access to care is maximized.[iii]

C. Cultural Humility—Full appreciation that cultural competence is a lifelong journey that requires ongoing learning and self-reflection to manage our assumptions, knowledge gaps and power imbalances that can undermine the delivery of quality care to every patient.

D. Definitions and Concepts *(Center for the Health Professions UCSF 2002)*

- **Culture:** The learned and shared knowledge, beliefs, and rules that people use to interpret experience and to generate social behavior. Culture is the guiding force behind what people think, say, expect and do. While there are many general characteristics associated with cultural

groups, there is significant heterogeneity among individuals within groups. Culture is dynamic. We all have culture.

- **Dimensions of Culture:** Health and illness beliefs; decision making style (individual vs. group/family or community); healing traditions; locus of control; status/hierarchy (Is status conferred by age, gender, kinship, education? What status is attributed to physicians?); privacy; communication (preferred mode and language); socioeconomic status (conferred based on family, vocation, wealth or education); immigrant or refugee status.
    - Disease vs. Illness
    - Folk Illnesses and Culture-bound syndromes
    - Self-Care strategies: alternative and complementary medicine, traditional healing
    - Traditional healers

[i]Agency for Healthcare Research and Quality. Your Guide to Choosing Quality Health Care. Rockville, MD: Agency for Healthcare Research and Quality; 2001. http://www.ahrq.gov/consumer/qnt/

[ii] Institute of Medicine Committee on Quality of Health Care in America. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academies Press, 2001

[iii] Components of Culturally Competent Health Care adapted from Cross Cultural Health Care Program Seattle Cultural Competency Curriculum, *1999;* Toward Culturally Competent Care: A Toolbox for Teaching Communication Strategies. *Center for the Health Professions UCSF 2002*

Doctoring III “Informed Consent” Module

For the Doctoring III course, I was able to integrate my knowledge of Cambodian cultural issues and healthcare needs into modules such as “Informed Consent” and “Ethics” for my peers. Previous to this experience I had thought about my work as fitting mostly under a “Cultural Competency” umbrella in medicine and medical education. Seeing the many layers of culture and communication as they affect the everyday practice of medicine, including informed consent, reinforced that these issues are indeed very generalizable. Through engagement with issues of Cambodian underserved patients, the ultimate goal is to develop an intuitive framework of awareness and curiosity by which all patients are better served.

Thursday, 10/8/09 Didactic session #6/BMC

CASE 2:
A 70-year-old Cambodian woman presents to the Emergency Room with involuntary weight loss of 20 pounds, frequent urination, and excessive thirst. She came to the US in the early 1980s after growing up in an agricultural community without access to formal education. She then escaped the killing fields and lived in a refugee camp for several years. She is widowed and currently lives in an apartment in Providence with her son and daughter-in-law who both work fulltime. In the ER, she is diagnosed by Dr. Baruch with hypertension, type 2 diabetes, and renal insufficiency and then admitted to Dr. Taylor's inpatient service for stabilization including the initiation of dialysis.

Physical Exam:
Afebrile BP 180/120 in both arms P 78 RR 18
Gen: well, NAD
Heart: RRR without M/R/G
Lungs: CTAB
Extremities: trace edema, pulses 1+

Labs:
Potassium = 5.6 (3.6-5.0)
BUN 98 (5-20) and creatinine 6.8 (0.5-1.2)
Glucose = 324 (70-120)

Information about chronic renal failure (from your Basic Science faculty) to inform this discussion:
1. Purpose: Dialysis only partially replaces kidney failure, and it does not cure the disease.
2. Logistics: It needs to be prescribed regularly (3 - 7 times weekly, depending on the type of dialysis) for the rest of the patient's life, until/unless the patient gets a renal transplant.
3. Risks: There are risks to dialysis, including hypotension, increased risk of a myocardial infarction, and a very significant risk of serious infection.
4. Benefits: However, without dialysis, in patients with chronic kidney failure, life is close to impossible, and death usually occurs within weeks to months.
5. Reality: Patients on dialysis have an annual mortality rate of over 20%.

It is likely that dialysis refusal will result in worsening renal function and life-threatening complications from uremia such as arrhythmias, uremic pericarditis, altered sensorium, eventual coma, and subsequent death within days. Alternatively, aggressive treatment of a patient's BP and diabetes may improve renal perfusion and may lower serum creatinine to < 4 and patient may survive for several months or possibly years before there is a subsequent deterioration of his kidney function leading to another life-threatening crisis.

Questions:

1. How would you go about discussing her diagnosis, the severity of the disease, and the need for dialysis with this patient? For example, who would be there from the medical team? Would the patient's family be involved or not? Where would this conversation take place? What level of information would you provide?
2. How do you think the patient's culture and past life experiences inform this situation?
3. How would you document this encounter in the medical record?

4. BONUS: What if this patient does not agree to dialysis?
5. BONUS: What if this patient does not speak *any* English? What if this patient speaks only *some* English? (Reminder: We will have an entire Doctoring session on Medical Interpreters next semester so this is merely foreshadowing.)

Informed consent discussion cases written by Jay Baruch, MD who can be reached at Jay_Baruch@brown.edu with assistance from Dr. Julie Taylor and the future Drs. Geolani Dy and Jamille Taylor. Many thanks to our student colleagues for their valuable input.

Thursday, 10/8/09, 1-3 pm Faculty Guide for Didactic Session #6/BMC

Topics

Advanced communication skill: Informed consent
Physical examination skill: Dermatology exam I

Readings/Resources

1. Baruch JM. Informed consent and advanced directives. *J Am Podiatr Med Assoc* 2004;94(2):198-205.
2. Chen PW. Doctor and patient: Treating patients as partners, by way of informed consent. New York Times Health Section, July 30th, 2009 at http://www.nytimes.com/2009/07/30/health/30chen.html
3. Required Bates readings:
   Skin, hair, and nails, pages 126-131.
4. Optional Bates readings:
   Relevant history, prevention, and counseling techniques, pages 121-5.
   Cool rashes, pages 132-151.

Objectives

- Understand the components of informed consent (both verbal and written)
- Review and practice the dermatology exam (skin, hair, and nails)

Schedule

1:00 - 1:30: Room 202:

The dermatology exam (Taylor)

1:30 - 2:00: Small Group Rooms: Physical Examination Skills, Oral Presentation / Communication Skills (MD + SBS Faculty)

Practice the dermatology exam (and the description of rashes).

2:00 - 3:00: Small Group Rooms: Medical Interview / Communication Skills, Written Documentation Skills, and Professionalism (MD + SBS Faculty)

Explore the components of informed consent using TWO paper cases.

Informed decision-making. Faculty Guide written by Jay Baruch, MD (and Julie Taylor)
Overview and take home points:

1. Informed "consent" is a process. Not a signature on a form. Refusal can be the result of a process done well.
2. Understand elements of informed decision making
3. Have a thorough understanding of **capacity** and how it differs from **competence**.
4. There is a power differential in the doctor-patient relationship. Physicians must be mindful of how they present information and caring enough to make certain that patients understand the decision at hand.

Objectives:

1. Understand the elements that comprise informed decision-making.
2. To develop a greater understanding of decision-making capacity as well as skills testing whether a patient has capacity.
3. Gain a richer appreciation of informed "consent" as a process that fosters communication, understanding, respect, and trust.

Questions for students:

1. What are the elements of informed decision-making?
2. What's the difference between capacity and competence, and how do you test whether a patient has decision-making capacity?
3. Explain how the manner in which information is disclosed can influence patient understanding and decision-making.
4. Is informed consent always necessary for treatment?

Outline:

1. Informed decision-making better term than informed consent
    a. Emphasize informed. The process and dialogue is central focus
    b. Consent (or refusal) is the result.
    c. Refusal can be the result of process done very well
2. Foundation of informed decision-making
    a. Ethics
        i. Self-determination
        ii. Respect for patient autonomy
            1. Two essential conditions to autonomy
                a. Liberty: independence from controlling influences
                b. Agency: capacity for intentional action
    b. Legal
        i. Protect individual liberties
        ii. Touching patients without their permission is battery
    c. Ethical foundations for autonomy
        i. Immanuel Kant
            1. Persons have unconditional worth with capacity to determine their own destiny
            2. Persons should be treated as ends, not means to an ends
        ii. John Stuart Mill
            1. Persons have freedom to shape their own lives, as long as they don't interfere with expression of freedom of others
3. The informed decision-making process derives from obligation to foster patient autonomy, and it shows respect, fosters trust, improves compliance.
    a. Failure to do so compromises their liberty and agency
4. **Elements of informed decision-making**
    a. Decision-making capacity
    b. Disclosure of information
    c. Understanding
    d. Voluntariness
    e. Decision

5. Decision-making capacity
    a. Not the same as competence—which is a legal term
    b. Task specific; relative to particular decision
    c. Process: determine over time
    d. Address reversible causes of questionable capacity
        i. oxygen for hypoxia, sugar for hypoglycemia, etc
    e. Critical test: does person understand nature of his or her condition, deliberate on risks and benefits or proposed treatment, including risks of no treatment, and then communicate a decision
    f. "Authenticity of choice"—is the decision consistent with person's history and values
    g. Sliding scale concept to capacity
        i. Capacity to consent may not equate to acceptable capacity to refuse
        ii. Adjusted to consequences of decision
        iii. Increased risks of decision relative to alternatives, greater the necessary communication, understanding and reasoning skills
        iv. **Refusal isn't necessarily a reason to question someone's capacity.** It does demand that the physician review the process to make sure it was done well.
6. Disclosure of information
    a. Medical condition
    b. Risks and benefits of procedure or treatment
    c. Alternatives to recommended procedure, including the option to do nothing
    d. How much information should be disclosed?
    e. Standards of disclosure
        i. Professional practice standard
            1. What would typical physician say?
        ii. Reasonable person standard
            1. What would the average patient need to know to make an informed decision?
            2. Standard in Rhode Island and Washington
        iii. Subjective standard
            1. Tailored to individual patient
                a. Can be very paternalistic
                    i. Paternalism: intentionally overriding of one persons known preferences or actions
                    ii. "usually" justified by goal of benefiting—or preventing harm to—the person whose will is overridden
        iv. I use the "Jay standard"
                a. What I would want to know if I was in the patient's situation
7. Understanding information
    a. Make medical information understandable
    b. Can the patient deliberate about personal values in relation to the medical situation
    c. Problems of information processing

i. Nondisclosure
ii. Information overload
    1. Lexicon of medical terms
    2. Information disorganized
iii. Framing errors
iv. Nonacceptance of situation
v. False beliefs

8. Voluntariness—independence from controlling influences
    a. Coercion
        i. Use of threat of harm or force
    b. Manipulation
        i. Deliberating managing information so other person agrees to what the agent intends
        ii. Lying or withholding information
    c. Persuasion
        i. Convincing of another through reason
9. Decision—consent or refusal
    a. Refusal doesn't equal incompetence
    b. Adherence to unusual belief system isn't in itself evidence of incapacity
    c. If refusal, review process:
        i. Patient has capacity
        ii. Patient understands illness and treatment/procedure
            1. Risks and benefits
            2. Alternatives
        iii. Communication
            1. Address any fears
        iv. Be nonjudgmental
        v. Remain open to other acceptable courses of action
10. Situations when informed consent may be waived
    a. Emergency rule
        i. Patient lacks capacity
        ii. Urgent circumstances
            1. Failure to treat outweighs risks associated with treatment
        iii. Insufficient time to obtain consent from family member or appointed guardian
    b. Patient wants doctor or family to decide.

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Academic Year 2010-2011

Small Group Materials for Human Growth and Reproductive Development Unit

***5-Minute Clinical Consult* and *Clinical Decision Support*:**
Writing for Physicians

Small Group Materials for Human Growth and Reproductive Development Unit

As AMS transitioned to electronic materials, scholarly concentrators in Medical Education had an opportunity to revamp existing preclinical lesson plans to incorporate new dimensions of Internet and interactive visual aides. I took on a case from the Human Growth and Reproduction unit on menstrual disorders.

It was first necessary to assess which areas would benefit most from inclusion of a web link, as it would have been possible to incorporate a link for every paragraph given the breadth of the Internet. What sort of link would drive a point home, or clarify a concept? I felt that visual aides, reference charts of background information, and algorithms took priority in this regard.

Another goal was to increase readability and clarity of the case as many originals had been written by faculty rather than students. I continually returned to the perspective of the second year student who would be seeing these concepts and vocabulary for the first time. On the other hand, we had the opportunity to revise the faculty guides as well, and putting myself in the position of the educator was especially useful as I transition from medical student to resident.

Sample page from Human Growth and Reproductive Development Small Group Case

PHYSICAL EXAM:

The patient's vitals are:

Weight: 150 lbs. Height: 61 in. BP: 120/70 RR: 20 HR: 76 Temp: 97.0 F (oral)

Her physical examination is:

General: Well-nourished, well-developed; awake, alert, in no acute distress

HEENT: Unremarkable, however skin shows moderate amount of coarse, dark, facial hair over the mustache area, cheeks, chin, and on the under surface of the chin. Moderate facial acne.

Lungs: Clear to auscultation bilaterally

Heart: Regular rate and rhythm, no murmurs, gallops or rubs

Breasts: Well-developed, no galactorrhea and no masses

Abdomen: Obese, non-tender, without palpable organomegaly.

Pelvic: Normal-appearing clitoris and labia majora and minora; Cervix has abundant amount of clear cervical mucus; Vaginal mucosa appears normal and is well vascularized without evidence of atrophy. On bimanual exam, the uterus is anteverted and normal in size. The ovaries are slightly increased in size bilaterally.

Neurologic: Unremarkable

Extremities: No clubbing, cyanosis or edema

Skin: Hair around areola bilaterally. Hair growing over sternal area on the midline and in a 2cm wide pattern from the umbilicus to the sternum. Hair growth from umbilicus to pubic hair, making a diamond shape to the pubic hair pattern. Dark coloration of the skin both at the posterior base of the neck and the axillary regions. The darker skin has a slightly textured surface which is soft to the touch.

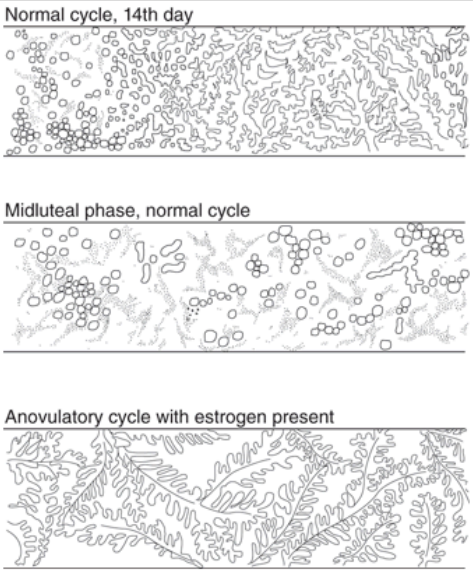
You pick up the cervical mucus with a swab for smear on a slide. The mucus stretches into a 10cm long string as you withdraw the swab. You allow the slide to air dry and inspect it in under low power under the microscope. It shows a fern-like crystalline pattern.

Discussion Questions:

1. What features of the physical exam are relevant to the patient's chief complaint?
2. What is the meaning of the following physical findings on gynecologic exam:
   a. Fine transverse folds in the vaginal mucosa?
   b. Cervical mucus which stretches to 10cm and shows a fern crystal pattern? *Please refer to the following link for an illustration of cervical mucus smears: http://www.accessmedicine.com.revproxy.brown.edu/popup.aspx?aID=5245136&searchStr=cervix%20mucus*
   c. Rough reddened area surrounding cervical opening? *Please refer to the following link for histologic slides: http://www.accessmedicine.com.revproxy.brown.edu/popup.aspx?aID=6183212*
   d. Hair growth on face, chest, abdomen?
   e. Acne?
   f. Darkened skin at the base of the neck and in the axilla? *Please refer to the link below: http://www.accessmedicine.com.revproxy.brown.edu/content.aspx?aID=5203004&searchStr=acanthosis+nigricans*
3. What clinical or laboratory tests should be utilized to evaluate and diagnose this patient's condition? Please be specific about the various conditions you are attempting to diagnose with each test ordered.

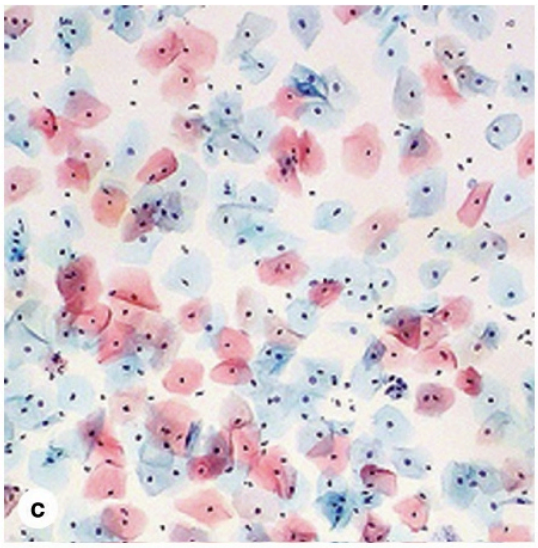
Images corresponding to links from above page

Figure 25–24

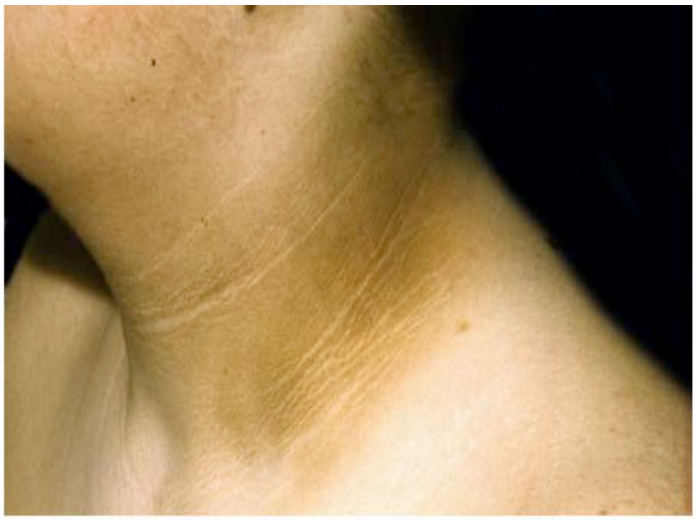


Source: Barrett KE, Barman SM, Boitano S, Brooks H: *Ganong's Review of Medical Physiology, 23rd Edition*: http://www.accessmedicine.com

Patterns formed when cervical mucus is smeared on a slide, permitted to dry, and examined under the microscope. Progesterone makes the mucus thick and cellular. In the smear from a patient who failed to ovulate **(bottom),** no progesterone is present to inhibit the estrogen-induced fern pattern.



Source: Mescher AL: *Junqueira's Basic Histology: Text and Atlas, 12th Edition:* http://www.accessmedicine.com

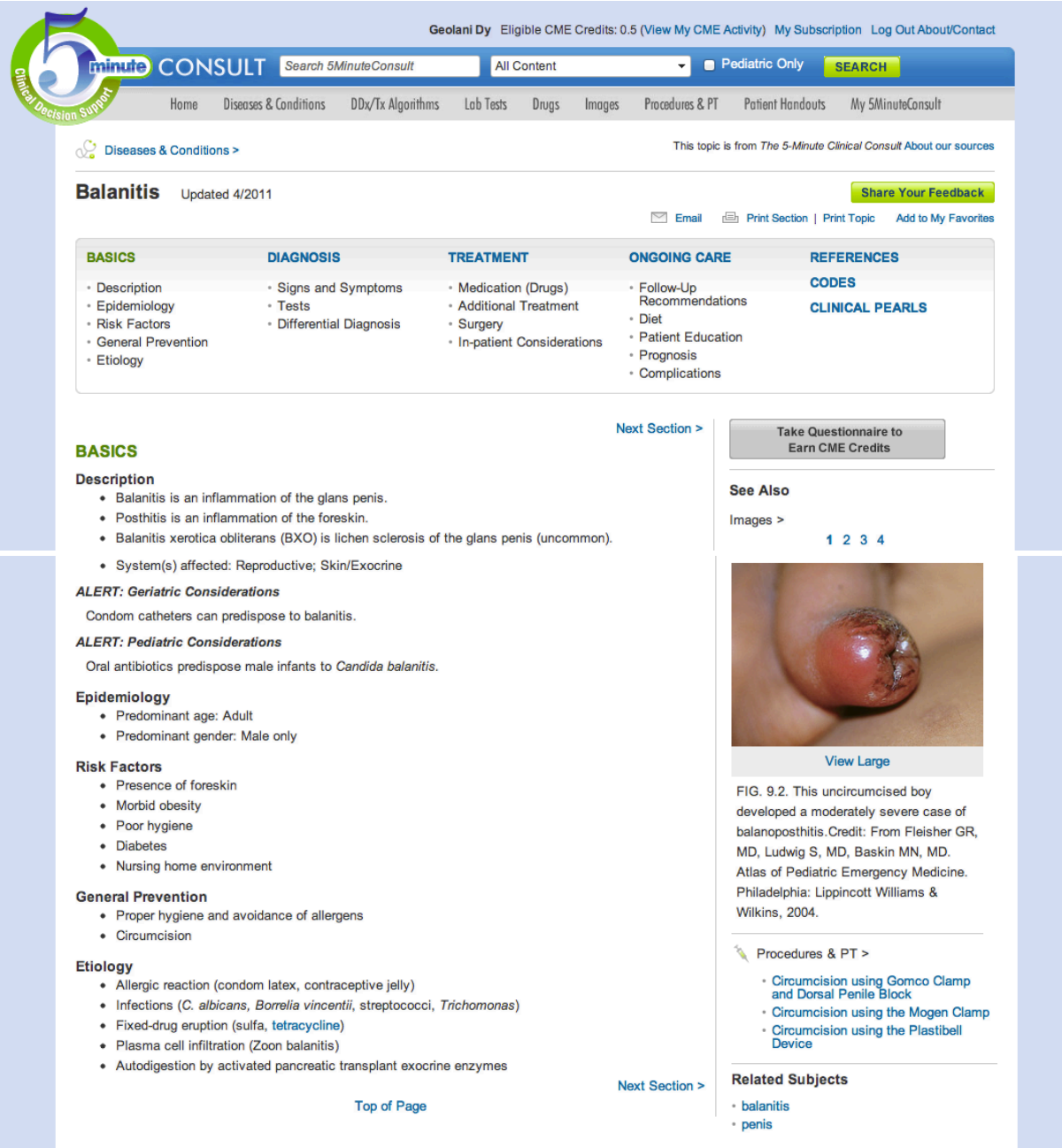


Source: Wolff K, Johnson RA: *Fitzpatrick's Color Atlas and Synopsis of Clinical Dermatology, 6th Edition:* http://www.accessmedicine.com

5-Minute Clinical Consult and *Clinical Decision Support*: Writing for Physicians

Amid my fourth year efforts to choose a specialty, I had the chance to author chapters of the physician clinical aides *5-Minute Clinical Concepts* and the new *Clinical Decision Support: Pediatrics*. For *5MCC*, I chose topics of Balanitis Xerotica Obliterans and Peutz-Jeghers Syndrome, as I was deciding between Urology and General Surgery. Eventually I decided on urology, with a strong interest in pediatric urology, and authored the Pediatric Nephrolithiasis chapter of *CDS:Peds* with one of my mentors in the field. Writing concisely while maintaining enough detail about recent additions to evidence-based protocols was a challenge.

***Sample page from* 5MCC: Balanitis (previous edition)**



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This topic is from *The 5-Minute Clinical Consult* About our sources

Balanitis Updated 4/2011

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BASICS
- Description
- Epidemiology
- Risk Factors
- General Prevention
- Etiology

DIAGNOSIS
- Signs and Symptoms
- Tests
- Differential Diagnosis

TREATMENT
- Medication (Drugs)
- Additional Treatment
- Surgery
- In-patient Considerations

ONGOING CARE
- Follow-Up Recommendations
- Diet
- Patient Education
- Prognosis
- Complications

REFERENCES
CODES
CLINICAL PEARLS

Next Section >

Take Questionnaire to Earn CME Credits

BASICS

Description
- Balanitis is an inflammation of the glans penis.
- Posthitis is an inflammation of the foreskin.
- Balanitis xerotica obliterans (BXO) is lichen sclerosis of the glans penis (uncommon).
- System(s) affected: Reproductive; Skin/Exocrine

ALERT: Geriatric Considerations

Condom catheters can predispose to balanitis.

ALERT: Pediatric Considerations

Oral antibiotics predispose male infants to *Candida balanitis*.

Epidemiology
- Predominant age: Adult
- Predominant gender: Male only

Risk Factors
- Presence of foreskin
- Morbid obesity
- Poor hygiene
- Diabetes
- Nursing home environment

General Prevention
- Proper hygiene and avoidance of allergens
- Circumcision

Etiology
- Allergic reaction (condom latex, contraceptive jelly)
- Infections (*C. albicans*, *Borrelia vincentii*, streptococci, *Trichomonas*)
- Fixed-drug eruption (sulfa, tetracycline)
- Plasma cell infiltration (Zoon balanitis)
- Autodigestion by activated pancreatic transplant exocrine enzymes

Next Section >

Top of Page

See Also

Images > 1 2 3 4

View Large

FIG. 9.2. This uncircumcised boy developed a moderately severe case of balanoposthitis.Credit: From Fleisher GR, MD, Ludwig S, MD, Baskin MN, MD. Atlas of Pediatric Emergency Medicine. Philadelphia: Lippincott Williams & Wilkins, 2004.

Procedures & PT >
- Circumcision using Gomco Clamp and Dorsal Penile Block
- Circumcision using the Mogen Clamp
- Circumcision using the Plastibell Device

Related Subjects
- balanitis
- penis

Academic Year 2011-2012

Cross-Cultural Communication:
Curriculum Development for Internal Medicine Residents

Pediatrics in a Developing Country:
Elective in Siem Reap, Cambodia

Cross-Cultural Communication: Curriculum Development for Internal Medicine Residents

For my Community Health rotation, I teamed up with classmates April Wilhelm and Marina MacNamara with a goal of improving refugee health education for Brown residents. After several preliminary meetings and literature review, we decided to start by surveying Brown/Lifespan Internal Medicine (IM) residents on their experiences and comfort level in working with "recently resettled" patients—immigrants and refugees who had come to the U.S. within the last three months. With the information that followed, we created a three-session curriculum to address gaps in comfort and knowledge. The curriculum has been piloted and integrated into the Brown General IM track with the help of Brown IM faculty, to address ACGME competencies of Professional and Interpersonal Communication skills. The sessions are geared specifically at cross-cultural communication, providing background context on RI refugee populations, and increasing utilization of resources that will benefit both parties.

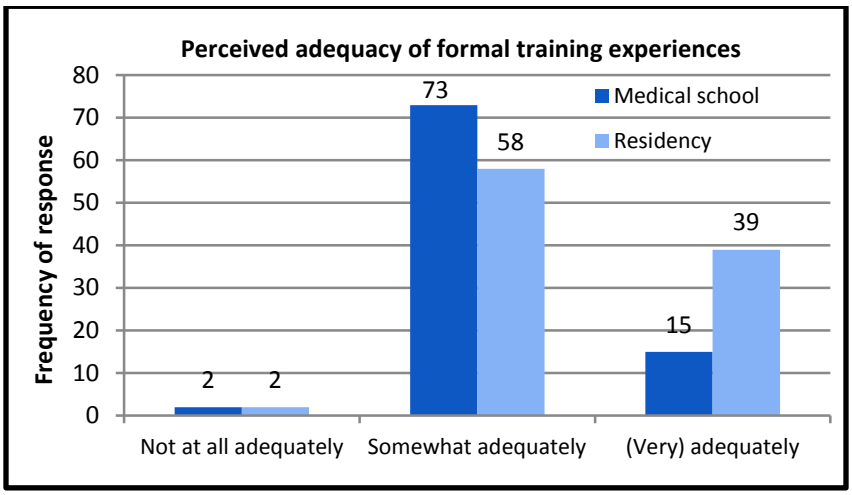
Data collection

The survey addressed the following key points:

- Perception of barriers among recently resettled
- Preparedness to care for these populations
- Use, perceived effectiveness of interpreting services
- Informal, formal training
- Resident demographics

Notable findings included residents' perception of barriers to outpatient care for recently resettled patients, with provider awareness of patient's social norms highest at 89% (see below). When asked about adequacy of formal training experiences in working with this population, only 39% responded that residency prepared them "very adequately," which should be the goal for all residents.

Perceived barriers to outpatient care	N	%
Provider's awareness of patient's social norms (e.g., gender roles)	87	88.8
Patient's ability to navigate the health care system	85	86.7
Patient adoption of preventive health care practices	73	74.5
Access to professional medical interpreters	70	71.4
Transportation to medical facilities	54	55.1
Access to telephone interpreting services	35	35.7



Curriculum development
With this data, we organized "gaps in care" into five categories to be addressed by the curriculum: context, analytical thinking, experience, communication and advocacy.

The first session was a general introduction to RI's refugee population: defining "refugee", exploring local demographics, and explaining the nuts and bolts of the refugee intake process. Session two focused on communication: an interpreter panel to explain their role as cultural bridges (featuring Liberian, Nepali-speaking Bhutanese and Burmese interpreters), as well as a local Med/Peds physician's experiences in her refugee clinic. The final session focuses on "Self Culture": the many dimensions of culture, personal biases, and concepts of cultural competence vs. cultural humility and transnational competence, and how they all overlap.

As existing formal training in cultural competency is variable in format and effectiveness, we seek to evaluate the impact of our own curriculum on residents' preparedness to care for patients from diverse sociocultural backgrounds. To do so, we will run a focus group following the third and final session. We are now entering the phase of curriculum assessment and expansion to the greater Internal Medicine residency program, the original group surveyed.

Strengths and limitations
This project's strength lies in its strong multidisciplinary faculty support, its sustainability as a course within the GIM curriculum, and its focus on a specific population with an identified need. Limitations were its non-validated instruments (the survey and curriculum being investigator-generated) as well as the small sample size. Ultimately, outcomes of our particular intervention are difficult to measure. Possible future directions are expansion to different residency programs, taking a further step in evaluating patient care outcomes, or capturing the curriculum in a multimedia format.

Health and culture profiles
In addition to the curriculum, my colleagues and I produced "health cultural profiles" on the highly represented refugee groups in RI; these provide brief geographical and historical context, as well as general information about diet, traditional views on medicine, and other special issues in healthcare. Though an important message of our curriculum endeavors is the importance of avoiding stereotypes, we have included certain generalizations (e.g. attitude towards biomedicine) from resources such as University of Washington's EthnoMed to provide some context. These have been published on the Lifespan Intranet and are available for all in the network to reference.

"Residents' Perceived Preparedness to Care for Recently Resettled Populations" was presented at the American Academy of Family Physicians (AAFP) Global Health Workshop in San Diego, CA. "Cross-Cultural Communication: Curriculum Development for Internal Medicine Residents" was recently presented at the Northeastern Group on Educational Affairs (NEGEA) Annual Retreat "Innovations in Medical Education Across the Curriculum: Looking into the future" in Boston, MA.

Cross-Cultural Communication

Curriculum development for Brown Internal Medicine (IM) residents

Geolani Dy, BA; Marina MacNamara, BA, MPH; April Wilhelm, BA
Depts of Internal Medicine and Community Health, Alpert Medical School of Brown Univ, Providence, RI

BROWN
Alpert Medical School

Lifespan

Introduction

Our patient population
- Rhode Island's (RI) population growing in diversity:
  - Foreign born 13%
  - Speak non-English language at home 21%
  - Speak English less than "very well" 9%
- Refugees resettled in RI, 2000-2011 2,234

Disparities in care
- Racial/ethnic disparities in healthcare well-described in U.S.
- Interpreters for patients with limited English proficiency (LEP) underused
- Patient health beliefs and values influence patient-physician decision-making but inadequately addressed by providers, contributes to health disparities
- Residents feel under-prepared to deliver cross-cultural care, due in part to lack of training and mentors
- *"Cultural competency"*: a provider-targeted solution

Goals and Objectives

Goal: Improve care for recently resettled populations in RI (moved to U.S. within past 12 months)

Objectives:
- **I. Assess:** Survey Internal Medicine (IM) residents on barriers to care, preparedness to deliver cross-cultural care
- **II. Empower:** Develop pilot curriculum for General IM (GIM) track residents
- **III. Adapt:** Run and analyze focus groups on effectiveness of pilot curriculum

Methods

I. Investigator-generated, IRB-approved survey to assess Brown IM residents' perceived gaps
II. Develop pilot curriculum based on survey findings
III. Focus group assessment, adaptation of curriculum

"Cultural Competency"

Two integrated curricular ideologies:
1. Cultural humility: recognizing perspective, biases of both patient and provider culture
2. Transnational competence: fostering *analytical*, *creative*, *emotional*, *communicative*, and *functional* skills.

I. Assess: Resident survey

Table 1. Basic Demographics.	
Gender	**%**
Female	55
Year of residency training	
Preliminary	3
First	29
Second	36
Third	32
Fourth (Med/Peds)	1
Residency track	
Categorical	67
General	20
Med/Peds	11
Plans to specialize	
Yes	57
No	21
Uncertain	8
Languages spoken	
English	55
1 language other	35

Questions on:
- MD perception of barriers among recently resettled
- MD preparedness to care for these populations
- MD use, perceived effectiveness of interpreting services
- Prior Informal, formal training

N = 101/147 (69%)

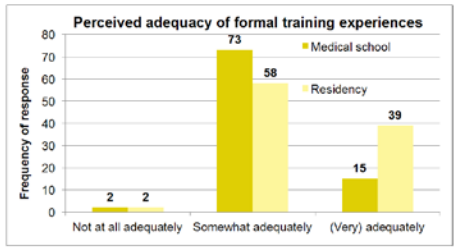


Table 2. Resident preparedness. Residents who reported being "moderately" or "very prepared" to deal with the following.	%
Deliver services effectively through a medical interpreter	91.8
Determine how to communicate with an LEP patient	84.7
Assess patient's understanding of the cause of their illness	79.6
Identify how well a patient can read/write in English	34.7
Identify cultural customs that might affect clinical care	31.6
Address religious beliefs that may impact health care	22.4
Discuss role of traditional healing techniques	20.4

Overall comfort in working with recently resettled patients:
- Minimal 30%
- Moderate 49%
- Very 8%

II. Empower: Curriculum development

Analytical Thinking • Sociopolitical and Cultural Context • Advocacy • Communication • Clinical Experience

Introduction to Refugees in RI
- What is a refugee?
- Where do our patients come from?
- Refugee intake process

Interpreters and Communication
- Interpreter panel
  - Liberian
  - Nepali-speaking Bhutanese
  - Burmese
- Experiences from RIH Med/Peds refugee clinic

Self Culture and Focus Group
- Self-culture, personal biases
- Cultural competence, cultural humility, & transnational competence
- Focus group

III. Adapt: Focus Groups

Questions on:
- What went well?
- What could be improved?
- Changes in survey "gap" areas?
- What lessons are generalizable to your non-refugee pts?
- Changes in methods, comfort in communicating with LEP pts?
- How to adapt curriculum for a broader audience (IM residents)?

Discussion

- This study describes IM residents' perceived barriers and preparedness to care for recently resettled patients
- Only 8% of residents feel "very comfortable" caring for this population, formal training experiences in residency lacking
- Pilot curriculum addresses gaps in knowledge and comfort through principles of cultural humility and transnational competence

Strengths
- Strong faculty support
- Sustainable
- Addresses identified need
- Tailored to RI demographics
- Based on data generated by this project

Limitations
- Non-validated components
- Small sample size
- Outcomes hard to measure
- Individual components difficult to assess
- Adds to bursting curriculum

Future directions:
- Focus group + analysis
- Expansion of curriculum
- Re-evaluate for long-term results

Conclusions:
- Lifespan IM residents feel underprepared to address issues of recently resettled patient care, similar to residents nationally
- Cross-cultural curricular initiatives are needed to fill these knowledge and comfort gaps, improve patient outcomes

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Liberian Refugees

Adapted from Charles Kemp's Refugee Health Page (Baylor) <https://bearspace.baylor.edu/Charles_Kemp/www/refugees.htm>

Introduction
Liberia is a diverse country, and one that has undergone rapid socio-cultural change in the last 25 years. This makes generalizations about "Liberian people" and "Liberian culture" somewhat difficult and overly simplistic. A Liberian from the capital city, for example, may feel much closer to American culture than to that of someone from the rural hinterland. All Liberians have, however, been touched in some way by the incredibly bloody conflict that was the Liberian civil war. The following is written in an attempt to share some of the common experiences Liberians suffered during their war and elucidate some of the social and cultural responses to it.

Liberia is located on the "grain coast" of West Africa, bordering Sierra Leone, Ivory Coast, and Guinea. There are approximately 16 different ethnic groups indigenous to the country, including Kpelle, Bassa, Gio, Kru, Grebo, Mano, Krahn, Gola, Gbandi, Loma, Kissi, Vai, and Bella. "America-Liberians" (descended from former slaves) compose about 5% of the population.

Infant mortality rates are high, estimated at 108.1 deaths / 1,000 live births. Life expectancy at birth is 56 years for men, 61 years for women. The average woman bears 6.23 children in her lifetime. Literacy rate for those older than 15 years is 53.9% for men, but only 22.4% for women (CIA World Factbook 1996). World Health Organization (WHO) data shows that in recent years the health status of Liberians has declined. Disability adjusted life expectancy (DALE) measures the "expected number of years to be lived in what might be termed the equivalent of 'full health'" (WHO, 2000). According to the WHO, Liberians have a DALE of 34 years, ranking 181st among 191 nations.

A Brief History of the Conflict in Liberia
The Liberian conflict has early historical roots when freed American slaves resettled on the coast of West Africa in the 1820's. The settlers generally regarded themselves as superior to the "tribal" peoples of the interior, and over time established civil controls (using the national army) to bring rural areas increasingly under centralized control, located in the coastal capital Monrovia. By the 1970's, Liberian presidents came under increasing political pressure to reform, yet the entrenched political patronage system that had developed, coupled with a depressed worldwide economy, made reforms ineffective.

In 1980, an uneducated junior officer in the army, Samuel Doe, led a coup with the support of his own Krahn ethnic base. Instead of instituting wide-ranging reforms, however, Doe began using the state solely as a means of personal enrichment. The Doe years are remembered by most Liberians as being particularly repressive – not merely brutal, but "marauding six years of rape and plunder by armed marauders whose ideology is to search for cash and whose ambition it is to retain power and accumulate and protect wealth" (Sawyer, 1995, p. 176). To maintain a personal grip on power, Doe armed the Krahn and Mandingo ethnic groups under the guise of the Armed Forces of Liberia (AFL) to spread terror into the countryside.

In 1989, Charles Taylor, an American-educated Liberian economist trained in guerrilla warfare in Libya and head of the National Patriotic Front of Liberia (NPFL), crossed into Liberia to overthrow the Doe regime, initiating the First Liberian Civil War. Taylor became one of the most prominent warlords in Africa following Doe's execution, and terrorized the public into electing him president in 1997.

During his term of office, Taylor was accused of war crimes and crimes against humanity, and domestic opposition to his regime grew, resulting in the Second Liberian Civil War in 1999. In 2003, Taylor lost much of his control and resigned after increasing international pressure and being formally indicted by the Special Court of Sierra Leone (SCSL).

In 2006, Ellen Johnson Sirleaf, a Harvard-trained economist, was elected as the first female president in Africa. Upon election, Sirleaf handed Taylor over to the SCSL for trial in The Hague. Liberia continues to suffer from a long legacy of civil war; many of Liberia's once 2.5 million people were forced to flee from their homes, *giving Liberia the largest percentage of refugees and internally displaced people in the world.*

Violence Against Women During the War
As is often the case in refugee-producing situations, women have been especially affected by war-related violence. Many were forced into sex during the conflict in order to feed themselves or their family, to get shelter or clothing, or for protection and safety. In one survey documented by the American Medical Association, 49% report experiencing one act of physical or sexual violence from a soldier or fighter during the war, 32% report they had been strip-searched; 17% report being locked-up, tied, or beaten; 15% report they had been raped; and 42% say they had witnessed a soldier kill or rape someone else (Swiss et al, 1998).

Extreme sensitivity should be taken in asking female patients about sex. Especially older Liberian women may even feel it inappropriate to be questioned about sex by a younger person. In addition, issues of "rape" carry considerable social stigma. The word itself may not be an exactly-translatable term into Liberian-English, hence one should use more general terms like "forced sex." Sensitive questioning should be prefaced by deferential remarks, such as "Excuse me, Ma, but . . ."

Communication and Health Care
Even though English is the "official" language of Liberia, important semantic differences exist between "Liberian English" and "American English" that necessitate extreme care in communication. For instance, seemingly simple and straightforward questions like "what has your child eaten today?" may often elicit a false negative answer. In this case it is necessary to understand the cultural context of "eating" in Liberia, in which the word "food" is often taken to mean "rice." Rice is THE staple food in Liberia, and "to eat" literally translates into Liberian English as "to eat rice." One researcher quotes a Gbande man: "A Gbande may eat bread, potatoes, cassava, plantain, or yams, and still consider himself virtually starved for lack of food if he has not had his bowl of rice" (Jarosz 1990).
It is recommended that, in case of any doubt, an interviewer use the most general term possible (Jarosz, for instance, in a nutritional survey, had to alter her wording to "Tell me everything you gave the baby from the time the baby woke up yesterday morning until the time the baby woke up today" (Jarosz, 1990).

Health Concerns and Beliefs
Infectious Diseases
Liberians in the U.S. or Europe are no more likely to suffer from endemic West African diseases than anyone else, although there is a high incidence of the sickle-cell gene. Liberians just arriving or visiting from West Africa, however, may suffer from a variety of tropical ailments, including latent schistosomiasis, chloroquine-resistant malaria, yellow fever, cholera, typhoid fever, hepatitis A or B, or STD's (especially gonorrhea, syphilis, Pelvic Inflammatory Disease/PID, or chancroid).

Nutrition and Body Weight
Liberians from rural areas may have different body-imagery than the "ideal" lean Western type. A "healthy" body in Liberia is perceived as a stout one, and is also associated with wealth and prosperity; the stereotypical Liberian "big man" politician would probably be seen as obese and at-risk for heart disease by a Western nutritionist. The palm oil that Liberians prefer to cook their food with is high in saturated fats, but also high in vitamins.

Traditional Medicines
The use of indigenous medicines in Liberia is extremely common, and most individuals have some knowledge of certain plants that may be self-applied in times of sickness. Liberians also have an assortment of indigenous healers, or "native doctors," including herbalists, Muslim holy men, bone specialists, and increasingly, faith healers. Liberian refugees may commonly combine indigenous and biomedical forms of treatment simultaneously, as the ailment may

Pediatrics in a Developing Country: Elective in Siem Reap, Cambodia

It felt only appropriate to spend my last rotation of medical school abroad, experiencing the homeland of the Khmer patients in whose health I have invested the last four years. Through Brown I arranged two weeks at Angkor Hospital for Children (AHC), a not-for-profit hospital in Siem Reap, Cambodia. AHC has one of two pediatrics residencies in the country, and provides services from dental care and nutrition education to intensive care and open heart surgery, free of charge to any Cambodian child.

My role as a medical student was to observe and assist in various settings, including the inpatient department, the emergency room, patients' homes for HIV/AIDS medication checks, and as a future surgeon, the operating theater. In the U.S., I have learned about the Khmer Rouge's genocidal regime and its devastating effects from undergraduate courses, documentaries and now refugee patients themselves. I have even taught about the lasting physical and psychological aftermath experienced daily by survivors. Even more than anticipated, I felt I was gaining an very new dimension of understanding.

As part of Pol Pot's vision for his country in the late 1970s, the Khmer Rouge eradicated all people with a semblance of education, killing even those who wore glasses as they were associated with intellectuals. Cities were evacuated and the entire country was made into an agricultural commune, where families were split and individuals were repeatedly told that their lives did not matter to anyone. It was not until the mid 1980s that Cambodia was "liberated," and since then it has been a rocky path for redevelopment. The lingering question is why Cambodians could inflict such harm upon their own people. For some who escaped to the U.S., the results are PTSD, body dysfunction and mistrust of others. In Cambodia, only ten minutes outside of more urban Siem Reap, families are subsisting on less than $0.75 US dollars per day. There is a lack of education in basic hygiene, and lack of access to education and healthcare in general. Thirty years later, the effects continue to be far-reaching for the global Khmer community.

After medical school, it is standard in Cambodia to practice medicine immediately. Residency programs are rare, and to practice immediately is the more lucrative path. It was inspiring to see AHC's pediatrics residents seek post-graduate training and to engage in research questions with their mentors. These are steps in our careers that I, among other U.S. medical students, take for granted.

Waiting area of Angkor Hospital for Children

Home visit sites outside of Siem Reap, Cambodia

Reflection

Two years ago, in our final Doctoring class, we were asked to write about our most valuable lessons in medical school thus far. I started my assignment with the following:

> *Some of the best experiences I've had as a med student do not stem from my time in basic science classes or even Doctoring, but from the "extracurricular" opportunities that have become open to me as a future healthcare provider. Of course, my new ability to learn a patient's full and intimate history, interpret lab values and symptoms, and advise on essential lifestyle changes is extremely meaningful, but I never thought that my ability to help others could change so drastically before even setting foot on the wards.*
>
> *Because I'm a medical student, physicians and community agencies open their doors to me and seem to value my observations more than they ever would have before. The social issues I cared about as an undergraduate, including my interest in Southeast Asian refugees, seemed limited to anthropology classes and midterm projects. Volunteer opportunities seemed ineffectual and unsatisfying. In med school, my draw towards SEA culture and history has emerged in the form of provider education materials and community health interventions…*
>
> *I am overwhelmed by the opportunities that will present themselves when I become a doctor—I will be able to travel to nearly any community, abroad or in the U.S., and have a useful skill to share. I will be able to create community health programs that have longevity and a serious impact for the people they serve.*

Having now entered the clinical realm, I can appreciate the incredible privilege it must be to be someone's doctor. Yet I continue to feel that opportunities in medicine beyond clinical practice will be an important piece of my career. The Scholarly Concentration in Medical Education showed me that to take an idea, to develop it in a way that others may learn from it, and to watch a lesson spark new thought in a student, is one of the most gratifying experiences one can have. Students from the early experiment "Cambodian Patient Advocacy" have shared that those sessions and temple visits generated interest in interpretation, patient advocacy and refugee health that is continued through their own outreach work and clinical practice. It is truly inspiring to see what can come from one idea if shared through education.

As I transition into residency, I leave medical school feeling extremely fulfilled. Through the Scholarly Concentration, I have met mentors such as Dr. Edward Feller, Dick Dollase, Dr. Margret Chang and Dr. Kim Chang, whose encouragement fueled my work. I have developed values and lifelong interests that I am sure will lead to more great adventures, and I could not be more excited.