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ACCREDITATION STATEMENTS

Genesys Regional Medical Center, an organization accredited by the Michigan State Medical Society Committee (MSMS) on Continuing Medical Education Accreditation, designates that this activity meets the criteria for a maximum of 20 hours in Category 1 Credit toward the requirement for Michigan relicensure and of the Physicians Recognition Award of the AMA, provided it is completed as designed. This activity has been planned and implemented in accordance with the Essentials and Standards of the MSMS through the joint sponsorship of Genesys Regional Medical Center and the Association for the Behavioral Sciences and Medical Education.

The Association for the Behavioral Sciences and Medical Education is approved by the American Psychological Association to offer continuing education for psychologists. The Association for the Behavioral Sciences and Medical Education maintains responsibility for the program. ABSAME is offering this activity for 20 hours of continuing education credit provided it is completed as designed.

Program Overview

Ethnic, gender, and socioeconomic disparities exist in health status in the U.S. Disparities in health status have been attributed to biological predisposition, environmental factors, socioeconomic status, insurance status, race and ethnicity as well as to the distribution, access, utilization, process (diagnosis and treatment) and cost of care. Of critical importance is the role of culture specific health beliefs that encourage traditional health practices and health behaviors, which may delay acceptance of evidence-based care. These factors have been identified as critical sociocultural components for educational programs designed to enhance our understanding of disparities in health status that exist for immigrants, racial and ethnic minorities. While understanding of the biological and psychosocial bases of disease and illness has increased in recent decades, much less discussion has centered on sociocultural factors as determinants of illness. The challenge of preparing medical students to treat an increasingly diverse patient population demands a focus on the influence of cultural and sociocultural factors on health.

The conference goals are to examine methods for integrating knowledge on sociocultural factors and health disparities in medical education; to emphasize educational methods for integrating epidemiologic data on ethnic, gender, and socioeconomic disparities in health status; and to highlight related knowledge concerning sociocultural influences on health in the following areas:

- Health Behaviors (eating, activity level, substance abuse, violence)
- Health Conditions (illnesses, such as Type II Diabetes, Cancer, HIV-AIDS)
- Health Care System Factors (access, diagnosis, treatment)
- Health Beliefs (illness interpretation, folk beliefs, spirituality, family role in health)

Presentations will focus on the contribution of sociocultural factors not only to illness but also to optimum health, as well as on current information and trends from multiple specialties and disciplines within the medical school and hospital settings.

Objectives

At the end of this conference, participants will be able to:

- Determine sociocultural influences on health behaviors, health conditions, and/or health care system issues
- Discuss sociocultural factors that contribute to optimum health, as well as illness
- Design model curriculum to address health disparities in medical education
- Identify funding for curricular and research efforts to address racial, ethnic and gender disparities in health.

Program Highlights

- Over 50 presentations, workshops, seminars, and poster presentations for gaining new ideas and vital information to help you be more effective in your medical education efforts.
- Opportunities to network and camaraderie with your colleagues in the behavioral sciences through meetings, informal gatherings, and social events.
- Lake Tahoe- a beautiful location to relax and enjoy the sights, sounds, food, and fun!

Schedule at a Glance

Thursday, October 10	
12:30 PM - 2:00 PM Plenary Session - Squaw Peak A Opening Remarks: <i>Alicia Monroe, M.D.</i> PL1: Reflections on Roads Not Taken <i>Cyril M. Worby, M.D.</i>	
2:15 PM - 3:30 PM Concurrent Sessions	
<i>Emigrant Peak A</i> Brief Paper Presentations BR1 - BR4 Moderator: <i>O. J. Sahler, M.D.</i>	<i>Emigrant Peak B</i> S1: Marcus Welby Meets the 21st Century Family Doctor: Home Visits Redux
3:45 PM - 5:45 PM Concurrent Workshop Sessions	
<i>Emigrant Peak A</i> W1: Cultural Diversity Matters: A Summer Elective for First Year Medical Students	<i>Emigrant Peak B</i> W2: Looking for Tools to Design or Refresh Your Cultural Competency Curriculum?
6:00 ABSAME Dinner (Cash Bar)	
Introductory Remarks: <i>Alicia Monroe, M.D.</i> Keynote Speaker: ABSAME'S Rich Heritage: Using the Past to Illuminate the Future <i>DeWitt C. Baldwin Jr., M.D.</i>	

Friday, October 11

7:30 - 8:30AM **Breakfast Plenary:** (*Grand Sierra Ballroom A*)

PL2: The National Breastfeeding Awareness Campaign: The Role of Medical Education
Suzanne Haynes, Ph.D.

8:45 - 10:30AM **Plenary Session:**(*Grand Sierra Ballroom A*)

PL3: Funding Strategies to Eliminating Racial and Ethnic Health Disparities
Tuei (Jean) Doong

PL4: Health Disparities and Substance Abuse Among Populations
H. Westley Clark, M.D., JD, MPH., CAS, FASAM

Moderator: *Charlotte Kennedy, Ph.D.*

10:45AM - 12:00 PM **Concurrent Seminars**

Emigrant Peak A

S2: Black Domestic Violence: Teaching Gender,
Race, and Class (GRC) Intersections

Emigrant Peak B

S3: Addressing Access Issues for Underserved
Minority Populations

12:15 - 2:00 Poster Session (*Grand Sierra Ballroom A*) Box lunch provided

1:00 - 6:00 PM Special Workshop Session (*Emigrant Peak A*)
W3: NCI Grants Workshop

Dinner on Own

8:00 - 11:00 PM ABSAME Coffee House (Dessert Served)

Special Thanks to the Program Committee: This year's program committee has worked to insure a quality educational program. Their efforts are greatly appreciated.

Charlotte, Kennedy, Ph.D. (Chair)
José L. Calderón, M.D.
Amy Ellwood, Ph.D.
Lynn Epstein, M.D.
Ann Flipse, M.D.
Liva Jacoby, Ph.D.

Alicia Monore, M.D.
Joao Nunes, M.D.
O. J Sahler, M.D.
Dorris Tinker, Ph.D.
Mark Vogel, Ph.D.
Kenneth E. Wolf, Ph.D.

Saturday, October 12		
7:30 - 8:30AM Common Interest Breakfast - <i>Squaw Peak A</i>		
B1: Expansion of a Clinically Based, Interdisciplinary Service Elective: How Can Behavioral Students Be Integrated? B2: Crossing the Communication Divide B3: Using Humanities to Teach Multicultural Sensitivity		
8:45 AM - 9:45 AM Pleenary Session - <i>Squaw Peak A</i> PL5: Transcultural Principles Applied to Medical Education <i>Ann Hubbert, Ph.D. & Gail Harris, Ph.D.</i> Moderator: <i>Amy Ellwood, MSW, LCSW</i>		
10:00 AM - 11:45 AM Concurrent Seminars		
<i>Papoose Peak</i> S4: The Biomedical Lecture as Opportunity to Inculcate Biopsychosocial Perspective	<i>Castle Peak</i> S5: Substance Abuse: The Impact of Sociocultural Factors and the Role of Medical Education	
12:00PM - 1:30PM ABSAME Membership Meeting (<i>Cascades</i>) lunch provided		
1:45 PM - 3:45 PM Concurrent Sessions		
<i>Papoose Peak</i> Brief Paper Presentations BR5-BR10 Moderator: <i>James Campbell, Ph.D.</i>	<i>Castle Peak</i> W4: Using Multi-vocal Case Narratives to Explore Multicultural Ethics	<i>Pyramid Peak</i> W5: Malice in Genderland: Reducing Disparities in the Care of Transgender Persons
4:00PM - 6:00 PM Concurrent Seminars		
<i>Papoose Peak</i> W6: Developing Written Communication for Vulnerable Patients Having Limited Literacy Skills	<i>Castle Peak</i> W7: Teaching Prevention in a Sociocultural Context: The Case of Type II Diabetes	
Dinner on Own		

Sunday, October 13

7:30 - 8:45AM **Student Scholars Breakfast - Squaw Peak A**
Moderator: José L. Calderón, M.D.

BR11 - BR14

9:00 AM - 11:00 AM Concurrent Sessions

<i>Papoose Peak</i>	<i>Emigrant Peak A</i>	<i>Emigrant Peak B</i>
Brief Paper Presentations BR15 - BR19 Moderator: Ann Flipse, M.D.	S6: Addressing Health Disparities Through Faculty Development: A Course in Survey Research for Clinical Faculty	S7: Biomechanical Thoracic Restriction Technique for Teaching Diaphragmatic Breathing

General Information

Registration Desk Hours:

Thursday	11:00 am - 4:00 PM
Friday	7:00 am - 1:00 PM
Saturday	7:00 am - 3:00 PM
Sunday	7:00 am - 9:00 am

Meal Functions: Please wear your name tag and present the appropriate ticket for each meal function you attend. Additional tickets for guests can be purchased at the ABSAME registration table. Please check at the conference registration table if you have any questions.

CME/CE Certificates: Continuing Medical Education credit and Continuing Education credits are available for participants who select in advance and pay for this option. Certificates will be handed out at the end of the conference. *It is the responsibility of the participants to complete an evaluation of each session they attend to receive the credit.*

Conference Evaluations: Please fill out and return the conference evaluation forms. These assist us in planning future conferences in order to meet the needs and concerns of all members and participants.

Disclosure Statements: In order to comply with ACCME and APA requirements, all faculty for this conference have been asked to fill out a Disclosure Statement. These have been reviewed by the Program Committee and are on file at the Registration table for viewing on request.

Special Needs: If you have special needs to participate fully in this conference, please make those needs known to someone at the registration table or to a member of the planning committee.

Non-Smoking Policy: Smoking is not permitted within conference meeting rooms.

Special Activities

ABSAME Dinner: This event will be held on Thursday evening beginning at 6:00 PM, in *Squaw Peak Ballroom B*. Each registrant will receive one dinner ticket. Additional tickets are available at the registration desk at a fee of \$30.00 each. Dress is casual.

Traditional ABSAME Introductions: Following the dinner and keynote address, everyone is invited to join in one of ABSAME's nicest tradition of introducing ourselves to the group and speaking briefly about why we have chosen to attend and what we hope the meeting will provide.

Poster Displays: Posters will be displayed on Friday starting at 12:15 P.M. and the authors will be available to discuss their material at this time. A box lunch will be served at this event.

ABSAME Coffee House: An evening of informal networking , poetry, and musical participation is the tradition of the Coffee House. Desserts will be served. Please come and enjoy.

ABSAME Annual Business Meeting: Please join Alicia Monroe, M.D., President, and other members on Saturday following lunch for the annual ABSAME meeting. The business meeting offers members the opportunity to learn about key ABSAME activities, address issues of concern to the board of directors, and plan the future of the organization. Everyone's input and participation is welcome.

Book Exhibitors Table: Publishers participating in this years combined book exhibit have sent sample copies of books along with order forms. Please come by and review the books. These books will be raffled off after the Sunday morning Student Scholars Session. Winners must be present to win.

Activities and Adventures: No meeting at Squaw Creek would be complete without an outing or adventure. Golf, tennis, hiking, horseback riding, and mountain biking are all enjoyed. Neaby Lake Tahoe provides a wide range of water spoorts, sightseeing, and the non-stop entertainment of the Nevada shore-line casinos. Please check with the hotel concierge for more information or to schedule an event.

Sponsorship

Book Exhibitors

Hogrefe & Huber Publishers
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Special thanks to Batiz.com who has been a valuable supporter of ABSAME.

Plenary Speakers

**Thursday, October 10
12:30 - 2:00 PM**

“Reflections on Roads Not Taken”

Cyril M. Worby, M.D.



Following graduation from Antioch College Cy Worby completed medical school, a split internship in medicine and pediatrics, and psychiatric residency all at the University of Rochester. After 3 years at the 97th General Hospital in Frankfurt, Germany Cy returned to Roch-

ester where he directed an innovative inpatient unit and began a program in family theory and therapy. While at Rochester he was imprinted with George Engel's biopsychosocial model, which influenced his teaching, writing and clinical work to the present day. Rochester was followed by a 10 year period at Michigan State where he initiated the psychiatric residency and, with colleagues in psychology and psychiatry, began a Family Life Cycle Studies Program and Referral Clinic which trained psychology interns, psychiatric residents and medical students who fulfilled their psychiatry clerkship requirements in that interdisciplinary setting. He also had curricular responsibility for the first term of medical school which featured a Focal Problem on Cystic Fibrosis, integrating biological, psychological and social aspects of the disease. Next venue was Jack Medalie's Department of Family Medicine at Case Western Reserve as Director of the new Division of Family and Behavioral Sciences. At CWRU Cy developed a popular interviewing program for the first year class. Final stop: University of Nevada School of Medicine with appointments in Psychiatry and Family Medicine. With departmental colleagues he completed and published a Robert Wood Johnson funded study of the impact of a coronary on the family system. In 1995 he became emeritus professor of psychiatry and behavioral sciences. He has

continued teaching medical students and residents and is a consultant and facilitator to Cystic Fibrosis teams in the US and Scandinavia.

**Friday, October 11
7:30 - 8:30 AM**

“The National Breastfeeding Awareness Campaign: The Role of Medical Education”

Suzanne Haynes, Ph.D.



Dr. Haynes serves as Assistant Director for Science in the Office on Women's Health in the Department of Health and Human Services. In this position, she coordinates science initiatives for the Office. For the eight years prior to her appointment, Dr. Haynes was Chief of the Health Education Section of the National Cancer Institute, where she launched several community breast cancer screening programs, physician early detection intervention programs, and dietary change and skin cancer prevention programs. Trained as an epidemiologist, she has published 70 articles on women's health, including papers on women and heart disease, cholesterol levels, smoking, hypertension, diabetes, and breast cancer screening. She has edited the Book, *How to Increase Breast Cancer Screening in Your Community*. Dr. Haynes has contributed to the work of the National Action Plan on Breast Cancer, the Canada-USA Women's Health and the Environment Interagency Committee, and other women's health initiatives of the OWH.

Friday, October 11
8:45 - 10:30 AM

“Funding Strategies to Eliminating Racial and Ethnic Health Disparities”

Tuei (Jean) Doong

Captain Doong has been with the Office of Minority Health (OMH), PHS since 1989 and is currently the Deputy Director of the office. As the Deputy Director, she assists the Deputy Assistant Secretary for Minority Health in the organization and management of the OMH to assure achievement of the Department of Health and Human Services’ goals for minority health.

Prior to joining the OMH, she served in the Health Resources and Services Administration (HRSA) in various capacities, including Chief of Compliance Monitoring and Acting Deputy Director of the Division of Facilities Construction in the Office of Health Facilities.

Captain Doong began her career in the Public Health Service in 1979 as an analyst for the Health Careers Opportunity Program, HRSA. Prior to joining the Public Health Service she was a community health planner for Montgomery County, Maryland and a State health planner for the District of Columbia State Health Planning and Development Agency.

Captain Doong has received numerous awards, including the Surgeon General’s Exemplary Service Medal, Meritorious Service Medal (the second highest award in the Public Health Commissioned Corps), Outstanding Service Medals, Commendation Medals, Unit Commendation Medal, and PHS Citation.

Education: MA in Health Care Administration from George Washington University, Washington, D.C.; BA from University of Rochester, Rochester, NY.

Health Disparities and Substance Abuse Among Populations

H. Westley Clark, M.D., JD, MPH., CAS, FASAM



Dr. H. Westley Clark, Director of the Center for Substance Abuse Treatment under the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, leads the agency’s national effort to provide effective and accessible treatment to all Americans with addictive disorders.

Dr. Clark was the former Chief of the Associated Substance Abuse Programs at the Department of Veterans Affairs Medical Center, San Francisco (DVAMC-SF). In addition to his duties at the DVAMC-SF, Dr. Clark served as a Senior Program consultant to the Robert Wood Johnson Substance Abuse Policy Program, as well as a co-investigator on a number of National Institution Drug Abuse-funded research grants in conjunction with the University of California at San Francisco (UCSF). He is currently on leave of absence as an Associate Clinical Professor of Psychiatry, Department of Psychiatry, UCSF. Dr. Clark’s areas of expertise include substance abuse treatment, methadone maintenance, pain management, dual diagnosis, psychopharmacology, anger management, and medical and legal issues.

Dr. Clark is a noted published author in the field of substance abuse and medical and legal issues. He has written chapters in *New Treatments for Chemical Addictions*, *Promoting Cultural Competence in Children’s Mental Health Service*, *Principles of Addiction Medicine*, *Review of General Psychiatry*, *Treating Coexisting Psychiatric and Addictive Disorders*, and *Occupational and Environmental Reproductive Hazards: A Guide for Clinicians*. Dr. Clark has also published in the *Journal of Pain and Symptom Management*, *Journal of Substance Abuse Review and Treatment*, *Journal of Mental Health Administration*, *Journal of Psychoactive Drugs*, *Valparaiso University Law Review*, and other journals.

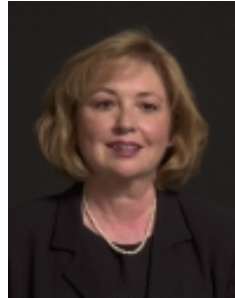
Dr. Clark received the Vernelle Fox Award from the California Society of Addiction Medicine for excellence in Addiction Medicine, Education and Public Service in October 2000. He received the 1999 Solomon Carter Fuller Award at the annual meeting of the American Psychiatric Association. The award is given in honor of Solomon Carter Fuller a renowned Liberian scholar who taught neurology, pathology and psychiatry at Boston University for more than 30 years. In 1996, Dr. Clark received the Honored Teacher Award from the University of California, Berkeley Extension, for his contributions to curriculum development and his commitment to teaching students in and out of the classroom. He is also the recipient of the Martin Luther King Award from the University of California, San Francisco, which recognized his extraordinary leadership and inspiration in advancing the goals of social and economic justice.

Dr. Clark is a Fellow and former member of the Board of Directors, American Society of Addiction Medicine. He served on the boards of the California Society of Addiction Medicine, East Bay Community Recovery Project, and the California Advocates for Pregnant Women. Dr. Clark was a trustee and board member at Pacific Graduate School of Psychology. He also was a member of the National Medical Association, the American Psychiatry Association, American Academy of Addiction Psychiatry, College on the Problems of Drug Dependence, the National Institute on Drug Abuse's National Advisory Council, and the San Francisco Treatment-on-Demand Planning Council. Dr. Clark received a B.A. in Chemistry from Wayne State University in Detroit, Michigan; he holds a Medical Degree and a Masters in Public Health from the University of Michigan, Ann Arbor; where he completed a Psychiatric Residency at University Hospital, Neuropsychiatric Institute. He obtained his Juris Doctorate from Harvard University Law School and completed a two-year Substance Abuse Fellowship at the DVAMC-SF. Dr. Clark received his board certification from the American Board of Psychiatry and Neurology in Psychiatry and sub-speciality certifications in both Addiction and Forensic Psychiatry. He is also a member of the Washington, D.C., Bar Association.

Saturday, October 12

8:45 - 10:15 AM

“Transcultural Principles Applied to Medical Education”



Ann Hubbert, Ph.D.

Dr. Hubbert is an assistant professor in nursing at the University of Nevada Reno. She is one of 65 worldwide Certified Transcultural Nurses, and the Vice-President of the international Transcultural Nursing

Society. Her doctorate in nursing research emphasized transcultural nursing theory and research. She was a nursing administrator for 16 years, and administrator of the award winning, “Traditional Indian Medicine, Spirituality in Healing” program, attended by over 7000 people from 17 countries. She has been a student of traditional Indian medicine for over 25 years, and was sponsored as a Comanche, by Comanche medicine man and Indian Health Services traditional medicine specialist, Edgar Monetathchi Jr.

Gail Harris, Ph.D.

Dr. Harris is a certified speech language pathologist and fellow of the American Speech and Hearing Association. She is the director of Fetal Alcohol Prevention for the State of Arizona. She is the former director of the Native American Research and Training Center, the University of Arizona, and has worked in transcultural settings for 30 years. She is now an independent scholar of traditional Indian medicine. She lives in Tucson and Flagstaff, Arizona and San Carlos, Mexico.

Keynote Speaker

**Thursday, October 10
7:30 PM**

“ABSAME’S Rich Heritage: Using the Past to
Illuminate the Future”

DeWitt C. Baldwin, Jr. M.D.



A pediatrician, family physician, and psychiatrist, Dr. Baldwin was educated at Swarthmore College, the Sheffield Scientific School at Yale, Yale Divinity School, Yale Medical School, and at the University of Minnesota and Yale Graduate Schools.

He is a diplomate of the National Board of Medical Examiners, the American Board of Pediatrics, and the American Board of Family Practice. He is certified by the American Association of Psychiatric Clinics for Children. He has held professional appointments in pediatrics, psychiatry, family medicine, community medicine, behavioral sciences, medical education, social dentistry, and human behavior and child development at eight medical schools, two dental schools, three graduate schools,

and two schools of social work. He was a member of the founding faculties of the University of Connecticut and the University of Nevada Medical Schools. He served as President of Earlham College in Richmond, Indiana before coming to the American Medical Association in 1985 as Director of the Division of Medical Education and Research Information.

Currently Dr. Baldwin is Professor Emeritus of Psychiatry and the Behavioral Sciences, University of Nevada School of Medicine; Adjunct Professor of Clinical Psychiatry, Northwestern University Medical School; and Senior Associate, Institute for Ethics and Scholar-In-Residence, American Council on Graduate Medical Education. He recently received the McGovern Award for Distinguished Service in the Health Sciences from the Association of Academic Health Centers.

During his academic career, he has lectured and provided leadership in the fields of higher education, health professions education, medical ethics, child development, psychology, dentistry, behavioral sciences, humanistic medicine, rural health, and interdisciplinary education. He has published over 150 articles and three books.

Session Abstracts

Thursday, October 10

12:30 PM - 2:00 PM Plenary

PL1: Reflections on Roads Not Taken

Cyril M. Worby MD

Reflecting on 40 years of teaching medical students Cy Worby will describe several paths along the curricular road he wishes he had explored more fully before retirement. He hopes some of these paths will be of interest to others who may consider exploring them further. He will invite audience dialogue and discussion after each presentation of a particular path. For example, one path will focus on a more comprehensive approach to teaching aspects of the doctor - patient, doctor - dyad (i.e. patient & spouse, child & parent) and doctor - family relationship. Another path will suggest a means of integrating at the end of each clerkship important variables relevant to that specialty and the patients seen by the student. Examples of issues to be considered are ethnicity, sex and gender disparities, ethical dilemmas, legal issues, family dynamics, and access to care and resources.

2:15 PM - 3:30 PM Brief Papers

BR1: "Learning From Experience": Using Clinical Experiences of Third Year Medical Students to Teach Sociocultural Issues in Patient Care

Tricia Tang Ph.D.

Objective: To develop sociocultural training cases based on the clinical experiences of third year medical students. These cases will be used in small group discussions and other educational experiences for the first and second year medical students. The purpose of sociocultural case vignettes development was three-fold: to encourage reflective skills and practice as it relates to cultural issues, to expose pre-clinical students to sociocultural issues they will encounter prior to starting their 12 month clinical clerkships, and to equip students with the skills to consider and incorporate social and cultural factors in patient care.

Description: At the end of their clinical clerkship year, third year medical students were invited to write-up two case vignettes that highlighted social and cultural factors that had a significant impact on patient care or treatment outcome. Sociocultural factors were broadly defined including gender, race, ethnicity, sexual orientation, economic circumstance, spirituality, etc. Student-generated "sociocultural case vignettes" reflected 1) the broad spectrum of social and cultural groups represented in the UMHS patient population, 2) the most frequently encountered sociocultural issues, and 3) the different clinical specialties (e.g., Pediatrics, Surgery, Internal Medicine, etc.) and situations (e.g. death and dying,

informed consent, treatment planning, etc) in which these issues frequently emerge. A structured case vignette format was provided for students to write-up cases. Format components included 1) clinical rotation where the case was seen, 2) patient care issue/clinical situation, 3) brief case description, 4) reflection of case outcome and, 5) generation of alternative approaches to addressing the sociocultural issue (if outcome could have been improved).

Results: A committee of medical educators selected 12 students whose cases were judged to be excellent training cases. These students were requested to follow-up the written cases with a videotape production of the case to be used as a teaching tool in future educational forums. Selected cases represented a diverse range of sociocultural factors in patient care including patients economic circumstance, language barriers, cultural belief systems, sexual orientation, spirituality, effective use of language interpreters, etc. Student cases also reflected a wide range of clinical specialties such as neurology, surgery, pediatrics, psychiatry, internal medicine, OB/GYN, and family medicine. To date, these cases have been utilized in educational programs such as the "Orientation to sociocultural medicine" for the first year medical students, "Culture and bioethics Session" and "Considering belief systems in the treatment and management of significant chronic disease" for the second year medical students. Evaluation of attitudes related to sociocultural issues in patient care following some of these educational experiences demonstrated significant changes in the positive direction.

BR2: The Integration Of Culture And Behavior In An Undergraduate Medical Curriculum: Potential Impacts on Health Disparities

Jason Satterfield Ph.D., Nancy Adler Ph.D.

A radically new undergraduate medical curriculum was launched by UCSF in Fall 2001. The conceptual framework for the curriculum, "the interaction of biology and environment in determining health," provided a unique opening and an important foundation for integrating social, cultural and behavioral factors with biology across the curriculum. Such integration was thought to be essential for several reasons: (1) Given the changing health care needs of a diverse and aging population, future physicians need to become more skilled in facilitating health-related behavior change, (2) As our ethnic and cultural diversity increases, training culturally competent physicians becomes essential to provide quality care and reduce health disparities, and (3) The rapid pace of medical advances and the need for more interdisciplinary disease management models necessitates a shift in the problem-solving and collaborative style of future physicians with both patients and other professionals allowing greater access and increased patient involvement. In the overall UCSF curricular redesign, the traditional structure consisting of two years of basic sciences plus two years of clinical rotations has been replaced by a multidisciplinary approach to instruction divided into three stages: the Essential Core, the Clinical

Core, and Advanced Studies. The Essential Core lasts 16 months and consists of nine integrated segments called “blocks” organized around clinical cases. Class time has been shortened to a maximum of four hours per day and a new emphasis has been placed on learner-centered and technology-based instruction.

Newly developed culture and behavior materials have been integrated throughout all blocks using web-based materials, lectures, small group experiences, integrative cases, independent learning modules, “teachable moments,” and significant faculty development. The “basic science” of behavior is taught mainly in the Essential Core while applied clinical and behavioral skills are taught in an ongoing course called “Foundations of Patient Care.” Comprehensive longitudinal plans of essential cultural and behavioral knowledge have been developed and were designed to both build chronologically and integrate with the relevant clinical and basic sciences of each block.

We provide an overview of this curricular approach and philosophy including examples of teaching methods, learning objectives, and special exercises. The potential impact on health disparities will be illustrated by a detailed look at the instructional methods and materials used in select Essential Core classes. Important classes include basic epidemiology on health disparities, socioeconomic status, applying the biopsychosocial model, patient non-adherence, and stress/coping.

Important lessons in curricular design and faculty/student “buy-in” have been learned as UCSF nears the end of its first new curriculum year. (1) Students are receptive to the inclusion of more culture and behavioral sciences in the curriculum and can readily grasp its clinical and societal significance. (2) Significant, collaborative curriculum development time is required for multidisciplinary faculty to do meaningful and integrative teaching. (3) Traditional examination methods do not reflect our objective to create active learners and cannot adequately assess disparity-relevant constructs such as “cultural competence.” Future work will surely include further integration and developing improved ways to assess students, the curriculum, and the eventual impact on patient access and care.

BR3: Hearing the Minority Voice: Experiences in Emergency Departments

Robert Wolosin Ph.D., Sabina Gesell Ph.D.

Objectives: The chief objective of this study was to discover what, if any, disparities exist in the experiences of patients in various types of emergency departments (ED’s). Specifically, do the patients of inner-city ED’s (who are likely to be members of a minority group) rate their satisfaction with various aspects of their care differently from patients of non-inner city ED’s? If so, how do the ratings differ, and what are the implications of such disparities for medical education? A sec-

ondary objective was to demonstrate the use of patient satisfaction data to examine substantive issues.

Methods: A national database of surveys collected from patients of nearly 1000 ED’s was partitioned into sets representing those that characterized themselves as located in an inner-city environment, (n=63) and those self-characterized as not located in such an environment (n=590). These 653 ED’s had over 1,000,000 patient surveys returned from visits in 2001. Surveys of patients from both types of ED’s were analyzed for differences in reported experiences with such things as waiting times and treatment by registration personnel, physicians, nurses, and technicians. Most data take the form of satisfaction ratings transformed to a 100-point scale. In addition, for each facility type, an index (the “priority index”) was calculated which combines the importance of an item with its overall rating. These indices can help ED’s target their improvement efforts in a more efficient way, by calling attention to issues of greatest concern for their type of facility.

Results: Inner-city ED patients were similar to non-inner-city patients on a number of respects, including gender, arrival by ambulance, and whether they were treated by their own personal physician. They differed with regard to age, the person who accompanied the patient to the ED, whether it was the patient’s first visit, and number of hours spent in the ED. Mean ratings of satisfaction with various aspects of the ED experience showed very large and consistent disparities, with patients of inner-city ED’s reporting worse experiences on every question than those of non-inner-city ED’s. Priority indices showed that overall, inner-city ED’s could improve their satisfaction scores the most by taking their patients (and their patients’ complaints) more seriously, while non-inner-city ED’s could improve their scores the most by concentrating on issues of information about, and timeliness, of service.

Conclusions/Discussion: The minority voice is loud and clear: Treatment in inner-city ED’s leads to a much worse perceived experience than treatment in ED’s outside the inner-city. Surely, some of these disparities are amenable to intervention on the level of graduate medical education. For instance, simple decency of treatment is neither hard to understand nor to model. On the other hand, some disparities may prove to be less tractable, as they are probably rooted in economic circumstance and non-medical discrimination against minority individuals.

BR4: Helping Students Gain an International Perspective from Elective Clerkships Abroad: Design and Implementation of an International Health Rotation

*Carol Elam Ed.D., Lois Nora M.D., J.D.,
Todd Cheever M.D.*

Objectives: Since 1988, the University of Kentucky Medical Center (UKMC) and Shandong Medical University (SMU) have maintained an affiliation agreement that allowed for the exchange of faculty between both institutions. Recent overtures have been made to include medical and public health students in the exchange program. This presentation will address the necessary steps and considerations in building an international health elective.

Methods: At the University of Kentucky College of Medicine and its School of Public Health, individual students have arranged to take elective experiences abroad on an ad hoc basis. However, the institution has not developed an international electives program or regularly offered its own sanctioned international elective at an affiliated institution abroad. Student affairs officers at UKMC were charged to travel to the People's Republic of China in May 2002 and meet their counterparts at SMU to examine the educational, social, and cultural benefits of an international health rotation and student exchange program. Proposed clerkship objectives included exposure to community health and public health issues, identification of health behaviors and health beliefs that contribute to health conditions, and comparison of U.S. and Chinese health systems.

Outcomes: In designing an international elective, many factors need to be considered at the site abroad: What is the educational environment like? Can a faculty mentor/preceptor onsite be identified? In what clinical and didactic activities will students be able to take part? What are the student life facilities like, including accommodations and food? Are there safety or security issues? What types of cultural opportunities are available? Is language fluency essential? Travel considerations also need to be reviewed: How do students go about getting the necessary visas and travel documents? What immunizations are necessary? What student health and insurance needs must be addressed? At the home institution it must be decided: How are students selected for participation in the international elective? What office will coordinate student travel and what level of staff support will be given to coordination of student travel plans? How will the clerkship performance be evaluated, graded, and incorporated into transcript data? What types of orientation or de-briefing programs should be developed for students and who will offer those? Does the institution have funds to support international travel and, if so, how will those funds be allocated? Can students obtain financial aid for international rotations?

Evaluation: Medical and public health students often seek international health experiences to enrich their education and allow them to see how medicine is practiced in other parts of the world. For both U.S. and Chinese students, the opportunity to meet colleagues from other institutions contributes to the understanding of global health issues. The educational goals of students as well as the institutional missions of both the UKMC and SMU along with local and national political concerns will impact the success of this international rotation program. Collaboration and collegiality between student affairs officers at both institutions will be necessary to negotiate an agreement that will be viewed as advantageous to our students and institutions. This session will present general lessons learned in the development of this international rotation and a timeline for its implementation.

2:15 PM - 3:30 PM Concurrent Seminars

S1: Marcus Welby Meets the 21st Century Family Doctor: Home Visits Redux

*Patricia Lenahan MA, Wadie Najm MD,
Mark Giglio MD*

Historically, family physicians have recognized the importance of home visits as an extension of care. Educationally, home visits offer an unparalleled view of families. Yet, physician interest in conducting home visits is variable. According to a 1990 AMA survey, nearly one half of the primary care physicians who responded said they made house calls. They acknowledged, however, that these visits occurred on an infrequent, if not rare, basis. Numerous factors that contribute to the infrequency of home visits have been cited: time, reimbursement, fears of liability, etc. At the same time, physicians have cited the benefits of home visits—for themselves and for their patients—enhanced quality of the doctor-patient relationship through a more egalitarian partnership, greater understanding of the patient in his/her own environment, increased care for the patient who has difficulty getting to the physician's office.

From a biopsychosocial viewpoint, the home visit presents countless opportunities for teaching students and residents to understand individual and family dynamics. The therapeutic home visit can be one of the most powerful tools the family doctor has at his/her disposal. It offers the physician a chance to observe the family in their own environment, to improve the quality of the doctor-patient relationship, and to provide both preventive care and education to the patient and the family. Since home visits shift the balance of power in the doctor-patient relationship, a breaking down of barriers may occur, leading to a greater understanding of family dynamics and improved patient care.

Home visits also demonstrate the impact of culture and ethnicity on the family structure, their belief systems, their use of traditional healers/practices, and their access to care.

Clearly, home visits provide excellent psychosocial teaching opportunities, including: a focus on the physical environment of the neighborhood/home (is it an “ethnic” neighborhood, safety/crime, access to transportation, etc.), identification of functional problems (ADL’s/IADL’s for older/disabled persons), observation of the role of the family in helping/hindering patient compliance, etc.

This seminar will explore the value and the “teachable moments” of home visits through a series of case examples and videotaped excerpts from home visits that addressed: cross cultural health beliefs/practices, issues of disability in a young Asian male, marital and sexual concerns of a gentleman with COPD, and the significance of spiritual beliefs among the family of terminally ill young woman.

3:45 PM - 5:45 PM Concurrent Workshops

W1: Cultural Diversity Matters: A Summer Elective for First Year Medical Students

Mary F Smith Ph.D., Mary Jo Fink MD

Objective How do language and thought, ritual and belief, religion and ethics, gender and family structure enter into the realm of health and the meaning of illness? The dynamic of the doctor-patient encounter, a central theme of medical school education, provides an excellent opportunity for students to explore cultural diversity. Demographic changes in the population of the United States are not mirrored within colleges of medicine; furthermore, student profiles continue to under represent the poor and working class. To compensate for these disparities, it is critical to get students sensitized to cultural differences and to better understand how beliefs and traditions influence health care. Providing students with an opportunity to reflect on personal assumptions enhances their ability to understand inherent power relationships within the context of the medical relationship. This medical elective serves as a critical review of cultural influence on patients’ health so that this self-reflective, self-directed process of education occurs.

Method: In order to promote a way to critically view culture/ethnic background and its influence on basic assumptions, a curriculum was developed using pedagogical methods described by Paulo Freire. Centered on two basic tenets, power and values, this perspective provides an excellent backdrop for a course on cultural diversity. Reflection is the key element to achieving critical consciousness. Eighteen medical students participated in a 6-week elective held during the summer between the first and second year of medical school. During week one, a curriculum was selected from literature, film, games and role-plays to foster reflection and students were expected to journal. Use of small groups and use of the Native American tradition of the Talking Stick in the large group, created a safe environment where key questions emerged. These questions became central to the group dis-

ussion and continued beyond the first week through an Internet Focus Group.

For four weeks, students were paired with a physician mentor from diverse communities, including inner city and rural areas, Indian Health Service, Prison Health and an HIV designated center within the United States. Throughout this four-week period, students and faculty continued the dialogical process through the Internet, sharing reflections in response to questions from faculty and fellow students. During the closing week, a debriefing was followed by a college-wide presentation of the students’ experiences and reflections.

Outcome: In the first year offering, 18 students participated and completed the entire course. Using a self-directed reflection model of learning, students posed questions raised by their experiences to the Internet focus group and responded to one another’s queries. This process was beneficial to the individual as well as the group’s understanding how power and values affect the doctor-patient relationship in the context of culture and diversity.

EVALUATION Students evaluated all aspects of the course, as well as being evaluated by their preceptors. Overwhelmingly positive evaluations were received by both constituents. In addition, students made several suggestions including modifications on the curriculum, more flexibility for the timing of the course, assurance of confidentiality in the Internet Focus Group and clearer objectives for the debriefing week.

W2: Looking for Tools to Design or Refresh Your Cultural Competency Curriculum?

Kenneth E. Wolf Ph.D., Sunita Mutha M.D., H. John Blossom M.D.

Changing national demographics make the need for culturally competent physicians and health care clinicians imperative. Medical school faculties have asked for assistance in developing and implementing cultural competency curricula to address MSOP, ACGME and individual RRC core competencies, as well as ongoing faculty development. Medical school educators must design and implement (or periodically revise and refresh) curricula in cultural competency that are educationally effective and attractive to busy students, residents and faculty.

This workshop is intended for individuals who have an interest in teaching issues of cultural diversity and cultural competency in health care to medical students, residents or faculty. This workshop will be interactive. Although intended as a vehicle to present elements of successful curricula for teaching cultural competence, this workshop is also designed to allow the learners to have an opportunity to experience an array of tools for teaching specific content and skills in this arena. Using a variety of teaching modalities (individual activities, large and small group exercises, mini-lectures) along

with a mixture of presentation formats (paper and pencil, power point, video tape demonstrations), some effective tools for delivering successful cultural competency curricula will be modeled. References to all resource materials will also be provided.

Participants will be encouraged to share their personal experiences, and provide feedback. Participants will also be given an opportunity to develop their own action plans for teaching cultural competency. Time permitting, they may share those action plans with the workshop presenters and other participants to obtain feedback and commentary.

7:30 PM - 8:15 PM Keynote

ABSAME'S Rich Heritage: Using the Past to Illuminate the Future

DeWitt C. Baldwin Jr. MD

The recent death of Donald A. Kennedy PhD., founding and long-term Secretary-Treasurer of ABSAME, brought to a close a largely unrecognized phase of what has been a truly remarkable "happening" in medical education: the introduction of the behavioral and social sciences in medical education. Don was one a very few far-sighted and energetic persons who foresaw the need for developing a new perspective and knowledge base in medicine and patient care nearly 50 years ago. Until then, the focus of medical education had been largely on the exciting new developments in scientific knowledge and technology rather than on the equally important social and behavioral aspects of health and disease. Due to the efforts of Don and others, some of whom were among the founding fathers of ABSAME, within a very few short years, this new perspective and knowledge base was fully recognized by its acceptance as a basic science of medicine in the Part I Test of the National Board of Medical Examiners, and to a fairly large degree integrated into the undergraduate medical curriculum nationwide. The story of this early effort and the factors that have affected the subsequent development and future of ABSAME, as well as of the behavioral sciences in medical education will be described.

Friday, October 11

7:30 AM - 8:30 AM Breakfast Plenary

PL2: The National Breastfeeding Awareness Campaign: The Role of Medical Education

Suzanne Haynes Ph.D.

8:45 AM - 10:30 AM Plenary

PL3: Funding Strategies to Eliminating Racial and Ethnic Health Disparities

Tuei Doong

PL4: Health Disparities and Substance Abuse Among Populations

H. Westley Clark MD, JD, MPH, CAS, FASAM

This presentation will discuss and document the health disparities in the United States as they relate to substance abuse and its treatment. It will also address the implications and consequences of health disparities and SAMHSA/CSAT's support of efforts to reduce health disparities.

10:45 AM - 12:00 PM Concurrent Seminars

S2: Black Domestic Violence: Teaching Gender, Race, and Class (GRC) Intersections

William Conwill Ph.D.

Over the last two decades, the health care community has acknowledged the devastating impact of domestic violence. Nearly half the estimated annual 4,400 intrafamily murder victims in the U.S. are spouses (McCoy, 1996). A significant percentage of couples seeking help for their relationship reveal some evidence of domestic violence (Cascardi, Langhinrichsen, & Vivian, 1992). Black domestic violence, however, presents special problems for health care providers due to the influence of structured systems of inequality, such as gender, race, and class (GRC). There are striking GRC variations in domestic violence. Females are 13 times more likely than males to suffer serious injury in mixed sex domestic violence (McCoy, 1996). Salber & Taliaferro (1998) It has been reported that the spousal homicide rate among African Americans is 8.4 times higher than among Whites. In addition, significant class-related social contextual factors influence the degree of domestic violence (Browne & Williams, 1992; Kumpfer, 1999; Straus, 1979).

Single-factor theories of domestic violence, such as psychiatric disorder, psychobiology, patriarchy, or domestic violence in the family of origin have fallen short in explanatory power (Bitler, Linnoila, & George, 1994; Bland & Orn, 1986; Bograd, 1999; Cazenave & Straus, 1979). Additive models of domestic violence, wherein the effects of GRC factors are considered in a cumulative fashion, have been criticized for presenting ethnic minority women with limited forced choices (Collins, 1998; Crenshaw, 1996). Gender, race, and class factors, however, do not operate independently from each other, but interact simultaneously and mutually, creating an impact on the lived experience (Ellis, 1987) of persons depending on their location in the social order. Hence, an additive model can be faulted for neglecting to recognize the simultaneity

and mutuality among GRC factors (Harrison, personal communication, September 1, 2001). The dynamic nature of these axes of inequality as they intersect with each other can be investigated through the metadisciplinary theoretical paradigm of intersectionality, which interprets GRC as systems of privilege and oppression rather than as independent variables. Intersectionality denotes a variety of specific analytical strategies of exploration into the interrelations of multiple axes of difference, inequality, and power. Intersectionality elucidates the interaction of social stratification systems and hierarchies, to clarify their effects on the lived experience of persons.

Bograd (1999) The intersectionality paradigm has been proposed a useful tool for strengthening domestic violence theory. This workshop addresses GRC intersections in the assessment and management of Black domestic violence. The leader will introduce a complex interactional model of intersectionality to iterate ecological environments circumscribing the lived experience of persons according to GRC; to address some experiential aspects of lower-class Black domestic violence; to describe appropriate communicational exchanges for health care providers, their clients, and other knowledge agents in the ecological environment of the lower-class Black couple; and to guide prevention policy for Black domestic violence.

S3: Addressing Access Issues for Underserved Minority Populations

Georgiana Herzberg Ph.D., Stan Cohen Ed.D.

Based on Mezirow's transformative learning experiences, health professions students and faculty went through a life experience with a group of homeless people who lived at the local Salvation Army. This provided an opportunity to change some stereotypical beliefs and perspectives concerning the underserved. It was a collaborative effort of several health professional groups which enhanced their respect for each other and increased cultural sensitivity, communication skills, and non-judgmental attitudes. The project was funded by a HRSA grant and ran for six months. After six months post graduation, a survey was conducted to assess the effects of the shelter experiences on student interest in working with the underserved and minority populations. There was a significant improvement in attitudes and perspectives toward these people and a willingness to seek jobs in these areas.

12:15 PM - 2:00 PM Poster Session

P1: Do Patients Understand Instructions on Their Prescribed Medication Containers?

Membere Bahru MS-3, Celia Mercado MS-3, Kenneth Wolf Ph.D.

Background and Hypothesis: Communication barriers between patients and health care professionals impact upon effective health care. The inability of patients to comprehend

directions on prescription containers places them at-risk for preventable adverse outcomes. Task performance is dependent on understanding the instructions of the task. Therefore, the instructions for the task's procedure must be communicated in the language and literacy level of the person who will be performing the task. Likewise, effective communication, i.e. written and/or verbal, between health care professionals and patients is an essential tool that contributes to a patient better understanding of prescribed medications. Written communication is an efficient and inexpensive method to inform and instruct patients, however, available material is often provided at a level beyond most patients' literacy level. It has been estimated that the average reading level of the American public is no greater than the level of 7th to 8th grade. Because it is impossible to guarantee proficiency at the same level as patient's education level, patient's reading abilities are estimated to be 3-5 grade levels below what patients report as grade completed. In general, it is recommended that brochures be written at or below the 6th grade level. The reading level of people whose primary language is other than English is often lower than the 7th grade level. Moreover, adults with low literacy skills have poorer health status and estimated average health costs that are 6 times higher. Patients with low literacy level are less likely to understand their illnesses and less likely comply with their medication regimens as compared to patients with adequate literacy level. Thus, pharmacy/physician educational material/medication instruction should be communicated at the level and in the primary language of the population they serve. The purpose of this study is to assess the level of comprehension of instructions on medication containers in the underserved adult population in South Central area of Los Angeles (LA) County, to determine if primary care professionals are effectively providing verbal and written medication instructions to patients and to determine factors that contribute to patients understanding of medication instructions.

Methods: Prospective study evaluating ~300 randomly selected subjects, ages 18 and older, filling prescriptions at hospital-clinic associated pharmacies in LA County. Information regarding subjects' demographics, prescribed medications and instructions received both orally and from the pharmacists and/or clinician will be recorded.

Results and Conclusion: Results will be presented demonstrating subjects ability to comprehend written and oral instructions for their prescription medications. Recommendations for changes in the delivery of services and student, resident, and faculty education will be considered. Results are expected to enhance culturally appropriate clinician-patient communication and improve quality of care to underserved populations.

P2: Religiosity and Spirituality: Implications for Public Health Practice, Policy, and Medical Education

John Bomar M.D.

Public health officials and health care providers have devoted countless time, energy, and resources to uncovering the many and disparate determinants that positively and negatively affect American public health. Such seemingly unrelated factors as environmental influences, biologic effects, and lifestyle choices and practices have been shown to profoundly affect the rates of preventable morbidity and premature mortality. The impact of smoking, sedentary lifestyle, and poor nutritional practices has been intensely scrutinized and their adverse effects on public health widely publicized. More recently, public health research has looked into the more “intimate and personal” habits of the citizenry by focusing on areas such as sexual practices, domestic violence, marital contentment and strife, strength of social contacts, and others to determine the impact these issues have on public health. Thus, the public health researcher has entered our homes, bedrooms, automobiles, and social circles in search of positive and negative determinants for individual well-being.

Yet for all their apparent thoroughness into the lives of Americans, there continues to be one institution that has not been sufficiently investigated; that is our churches and other places of worship. A recent Gallup Poll discovered that 96% of Americans adults believe in God or a universal spirit and more than 40% attend church weekly, 90% pray, and almost a quarter read religious literature at least several times per week. With such a large participatory population, it seems somewhat myopic to not study the possible physical and psychological influences of religiosity and spirituality on public health and include this as a topic in the education of future physicians. This paper reviews the findings of recently published mainstream medical journal articles, enumerate some of the difficulties and confounding data inherent in such research, and propose a role for religiosity/spirituality in future public health practice, policy development, and medical education.

P3: Teaching Medical Students About Health Care Disparities in a Longitudinal Clinical Care Curriculum

*Katherine Au MS-3, Noah Rodriguez MS-3,
Ronald Edelstein EdD*

Longitudinal continuity of care clinical training has been proposed as a method of teaching critical aspects of medicine by integrating primary health care, prevention and bio-behavioral sciences into the training of medical students and allowing them to have multiple interactions with patients over time. A number of programs now have elective and required longitudinal programs incorporated into the more traditional clerkship based medical education program. The Drew UCLA Medical Education program is one such novel program that

has integrated a unique longitudinal Primary Care continuity experience in the third year core clerkships phase of the clinical curriculum.

The Primary Care program has integrated throughout its clerkship, the importance of addressing the various health disparities seen in minority communities. The Monday conference series, clinic didactic sessions, and the continued emphasis on preventive health care during the continuity clinic experience further highlights the importance of reducing health disparities in vulnerable communities. Yu, Hawley and Towns (1997) and (Yu 1997) reviewed the trends in ambulatory care medical education and reported on an inner city program designed to teach third year medical students in a comprehensive community health center linked to a public hospital /academic medical center. A five year follow up to that report will be used from the medical clinic 2001- 2002 academic year and published national reports to: evaluate trends within a primary care continuity clinic during the 5 year period; compare patterns between inner city primary care and national health care data; discuss findings with respect to national reports on health care disparity; compare longitudinal continuity of care programs in medical schools in the United States; and recommend specific curricular modifications based on findings. In addition, student feedback regarding the knowledge gained through exposure and education regarding health disparities will further enable specific improvement in the clinical curricula.

Student perceptions from a AAMC questionnaire from the year 2001 for the Drew/UCLA program suggest that strongly emphasis (>80%) is placed on the importance of reducing health disparities throughout the clinical curricula compared with national data (~60%). Preliminary analysis suggests that the clinical curricula of the Drew/UCLA medical education program in general, and the longitudinal Primary Care clerkship in particular, has effectively integrated the teaching about health care disparities to medical students. Continued improvement based on feedback will further enhance such programs at Drew.

P4: Analysis of homelessness: Results from a Regional Survey of Homeless Assistance Clients

*Patrick Hardigan Ph.D.,
Georgiana Herzberg Ph.D.*

Homelessness remains one of Americas most complicated and important social issues (Burt et al., 1999). According to the National Council for the Homeless (1999), approximately 700,000 people are homeless in the United States on any given night. Chronic poverty, physical and other disabilities, and rapid changes in society, the workplace, and local housing markets are all factors contributing to this complex problem (Burt et al., 1999). In South Florida, the large number of immigrants coupled with the considerable proportion of people of color, add a unique aspect to the study of

homelessness. This presentation reflects the findings of a comprehensive survey for the homeless conducted in South Florida.

P5: A Study of Self-Efficacy in Medical Education

LJ Perrot MD, JD, Linda Deloney MA, EdD(c)

According to Bandura's social cognitive theory, students' judgments of their capability to perform academic tasks (self-efficacy beliefs or cognitions) predict their potential to accomplish such tasks. Behavior can often be better predicted by the beliefs students hold about their own capabilities than by the knowledge and skills they have acquired.

Perceived self-efficacy is an important concept in education because it can enhance or sustain student motivation. Self-efficacy beliefs affect one's level of accomplishment in several important ways. They influence the choices students make, the amount of effort, persistence, and resilience they will expend to complete a task, and the stress and anxiety levels they will endure in the process.

Pajares suggests students who have high self-efficacy will approach difficult tasks with feelings of serenity and see them as challenges to be mastered. They have greater intrinsic motivation and will set challenging goals for themselves. They can recover from failure more quickly and will attribute their failure to insufficient effort or the need for additional skills and knowledge. The purpose of the current study was to extend self-efficacy research to medical education. Three classes of entering medical students were surveyed as they progressed through their preclinical curriculum to determine their self-efficacy for self-regulated learning, self-efficacy to meet other's expectations, and self-assertive efficacy. The survey was administered as they entered medical school, at the end of the first academic year, and near the end of the second academic year. Results will be reported.

P6: The Effect of Direct Physician Counseling of High-Risk HIV-Negative Adolescents on the HIV

Raul Sepulveda MS-3, Jorge Magallon MS-3, Chancellor Daniel MD

Background: Since the beginning of the HIV epidemic, certain known factors have been associated with increased risk of acquiring HIV infection i.e.: illicit drug use; injection drug use; needle sharing; alcohol consumption; exchange of sex for money, drugs, food, protection, or shelter; unprotected sexual intercourse; anal sex; multiple sex partner; and a sexual partner known to be HIV positive. Many modalities have been used to modify or decrease high-risk behaviors for acquisition of HIV infection. Counseling and education are two such modalities. Evidence suggests that direct physician counseling alone leads to changes in high-risk behavior. Adolescents (ages 18-24) in particular, are at an increased risk for acquiring HIV and other sexually transmitted dis-

eases. Despite this increased awareness, adolescents are still engaging in high-risk sexual behaviors.

Methods: King/Drew Medical Center in collaboration with G.L.A.S.S. (Gay Lesbian Adolescent Social Services) provides a mobile health care clinic (MoHCC) that provides primary and preventive health care services along with educational information to homeless adolescents. We plan to conduct a prospective study in which 100 subjects will be followed over a 3 and 6 month period to determine the impact of direct physician counseling on rates of HIV sero-conversion. Oral-HIV testing will be done confidentially at the initial visit. A repeat oral-HIV test will be done at 3 and 6 months following the initial encounter. Repeat testing in 3 and 6 months will allow us to evaluate HIV status of the subjects as well as an opportunity to evaluate the effectiveness of the counseling. Any subject testing HIV-positive will be referred for further testing to confirm their initial test results and for counseling.

The effect of direct physician counseling and testing will be assessed by a questionnaire that will be given at day 1 of initiation into the program, at 3 months, and at the end of 6 months. Incentives (Health Kit, condoms, transportation tokens) will be given to reassure that subjects will return to maintain follow up. 50 control subjects will be counseled by non-physicians and evaluated along with study subjects to be able to analyze all variables with similar incentives as the study group.

Conclusion: Based on prior experience, the effectiveness of direct physician counseling on such high-risk adolescents is likely to yield beneficial results. This will hopefully translate into lower rates of HIV seroconversion in such patients. Such a study will re-emphasize the importance of counseling and education of high-risk populations regarding preventable infections with high morbidity and mortality such as HIV disease.

P7: Integrating Tuberculosis Training in Medical Education Programs

Shobita Rajagopalan MD, Ronald Edelstein EdD, Bobby Bryant MS-3

Background: Tuberculosis (TB) is an important infectious disease or worldwide significance infecting a third of the world's population killing 2 million persons each year. Although with effective TB control measures, the rates of TB are declining in the United States, there is a disproportionate increase of TB in foreign-born individuals; this in turn has contributed to the increased rates of TB in minority populations. In developing nations, TB continues to be rampant because of increased poverty, overcrowding and easy transmissibility of tubercle bacilli. The importance of integration of TB education into training programs of medical schools and residencies cannot be overemphasized. Likewise education of nursing professionals and other allied health practi-

tioners regarding TB is important. The National Institutes of Health through its Heart, Lung, and Blood Institute recently initiated the TB academic award (TBAA) program offered to various Medical Schools including partnering Minority Schools such as Charles Drew University of Medicine, in order to enhance TB education within the curricula of its various academic programs.

Methods: The TBAA received by Drew in 2000, enabled the development of various educational initiatives. Such initiatives included regular lectures on the approach to TB, access to internet based virtual clinics supported by various universities e.g., UCSD, the sponsorship of on-campus Continuing Medical Education (CME) symposia on TB with several experts. In addition to evaluating knowledge gained by such programs, a needs assessment of TB in the community was conducted with the department of health services in Los Angeles County. Recommendations for TB clinical care and infection control were highlighted using national guidelines. Based on the assessment and community data, an educational plan was developed for hospital and community faculty and healthcare team members. A follow up is planned to assess implementation of recommendations and quality assurance data.

Conclusion: Since the integration of focused and regular educational activities within the curricula of the medical student, resident and allied health programs at Drew, the awareness regarding the importance of TB in high-risk communities has been enhanced. National reports such as the institute of medicine studies on medical errors and health quality suggest that improvement in healthcare requires coordination of change across the practitioner, team, community, organization and system levels of support. This TB education project combined these multiple elements to improve education and health outcomes.

P8: Mucho Gusto! Reducing Health Disparities Through Cultural Competency

Alicia McClary Ed.D.

The growth of the Hispanic population in our community has been rapid, unexpected and unprecedented. It has changed a region long characterized by its biracial composition, into a multiethnic and multilingual community. Unfortunately, it has caught many sectors of the community unprepared for the impact of its size, its language, and, less visibly, the attitudes, knowledge, customs, and beliefs that have come with it. While growth in itself can be expected to put a strain on community resources, the strain generated by this Hispanic population explosion is even greater because it has brought with it a culture and language that differ significantly from those of the mainstream community. These cultural and linguistic differences can and are acting as major barriers that are preventing Hispanics from accessing even the most basic community services and resources. Although many Hispanics live near hospitals, clinics, and other healthcare facilities, they

often forego health care for a number of reasons including: (1) their limited command of the English language; (2) a fear of reprisal related to undocumented status; (3) the inability to deal with the complexity of a specialty-oriented health care system and (4) innumerable logistic obstacles such as unfamiliar appointment procedures, unreadable signage, and transportation problems. For these reasons, many Hispanics, often with advanced diseases and complications, find themselves seeking last minute care in public facilities such as hospital emergency rooms that are overloaded and overextended. They are thus put at greater risk for even more serious health problems problems that can be averted through early preventive intervention.

To increase the access of these Hispanics to meaningful and appropriate health care, students and faculty have developed a community outreach program called *Mucho Gusto!* *Mucho Gusto!* Is comprised of a potpourri of community-based activities designed to increase the cultural competency of both the students and the members of the Hispanic community. Neither the providers nor the members of the community are expected to become linguists just good communicators able to demonstrate cultural competency in thought, word, and deed. Culturally sensitive and linguistically appropriate activities, many of which try to simulate typically border town encounters, include both English and Spanish language skills, health education, preventive services, and assistance in exploring some of the most common barriers to health care access. To increase our chances of being successful in our approach to increasing cultural competency, we have set the following guidelines. *Mucho Gusto!* activities (1) are based on a community needs assessment and ongoing input from the Hispanic population; (2) are at the learning level of health professional students and residents and an Hispanic population with little or no exposure to a second language or a another culture; (3) are community-based and interactive; (4) meet the time restraints of health professionals in training; (5) meet the work schedules of the Hispanic participants; and (6) must be practical, doable, and FUN!

P9: Qualitative Analysis of Providers Perceptions of Health Care Barriers Across Cultures.

*Ali McGaw , Joelle Friedman ,
Hayden Bosworth Ph.D.*

Purpose of Study: The disparities in health status for immigrants, and those of ethnic and racial minorities, continue to be influenced by sociocultural factors. The purpose of this study was to identify providers perceptions of barriers regarding the provision of medical care for individuals of different cultures.

Methods: Surveys were sent by e-mail in January 2002 to 1,141 Durham, North Carolina community providers using the Physician WebLink of North Carolina. The responses were then reviewed for common and recurrent themes using

the methods of constant comparison.

Results: There were 83 physicians who responded to the survey; they had practiced in Durham County from 0.5 43 years. Over 36 attributes were identified that characterize physicians perceptions of healthcare barriers. These attributes composed thirteen broad domains: language problems, prevention, compliance, sensitivity, knowledge, transportation, financial difficulties, lack of services, problems with existing services, cultural problems, differences in religion, gender differences and unmet expectations. Of these domains, 62 physicians (74.6%) cited language problems and 34 physicians (40.9%) cited cultural problems as the two most common barriers that arise in treating individuals of different cultures.

Implications: Physicians serving patients from different cultures must acknowledge the range of barriers that affect the care they provide. The findings suggest that lack of language commonality between patient and physician can result in a lack of communication and provide a barrier to appropriate care. A number of physicians also believe that they do not understand patients cultural beliefs and values. Better means of educating community physicians about patient beliefs might address these issues.

P10: "Limit the Whites, Leave a Bite"

Anna Mies Richie M.D.,

Cynthia Ledbetter M.S., CFNP,

Matthew Yociss M.D., Sherry Simmons, MD

Millions of Americans find it difficult to lose weight. "Limit the whites, Leave a bite," focuses on limiting refined flour and sugar (the whites) while learning how to gain control over food (leaving a bite). The goal is weight loss focusing on dietary changes. There is a cohort and non-cohort population. Patients attend an introductory session, then are followed at scheduled intervals. Laboratory investigations and measurements are collected at each visit. Statistical analysis is done at scheduled intervals. "Limit the Whites, Leave a Bite" is a weight loss program that patients find effective and easy to incorporate into daily life.

P11: In and Out of the Comfort Zone: Boundaries and Emotional Responses in Behavioral Science Learning

William Elder Ph.D.

Behavioral science curricula frequently include attitudinal change objectives. Emotional responses, via personal experience of the exercise or meaning of the material, may enhance this change. However, in some circumstances boundary violations may occur and learners and faculty may become too uncomfortable emotionally, to learn or teach. After a brief introduction to concepts and focusing on teaching sexual health and responding to resident mental health issues, participants in this seminar will: 1) identify teaching

methods that are frequently and variously experienced as uncomfortable 2) describe how this discomfort may be related to boundary violations 3) discuss what constitutes boundaries in behavioral science teaching; 4) discuss how transference, countertransference, role, expectations, and trust may influence boundary violations; 5) identify teaching techniques and methods that may titrate emotional responses.

1:00 PM - 6:00 PM Special Workshop

W3: NCI Grants Workshop

Sabra F. Woolley Ph.D.

The Behavioral Research Program of the National Cancer Institute (NCI) offers a workshop for behavioral and biomedical scientists who are interested in applying for research and training grants. Much of the information offered is pertinent to all the institutes of the National Institutes of Health, which have fairly uniform grant application procedures. The discussion includes an overview of the NCI and NIH, details about the application procedures and mechanisms, and analysis of the peer review process. Common pitfalls in grant writing for the NIH are highlighted as are the strengths that make for a winning application. Discussion and questions are encouraged.

Biosketches will be required of all participants; notebooks with NIH and NCI information will be distributed.

Saturday, October 12

7:30 AM - 8:30 AM Common Interest Breakfast

B1: Expansion of a Clinically Based, Interdisciplinary Service Elective: How Can Behavioral Students Be Integrated?

Terry Stratton Ph.D., Jean Wiese Ph.D.,

Wanda Gonsalves MD

Service learning (SL) holds potential as a valuable and effective means of educating health professionals while providing services to medically, economically, and socially disparate populations. At the University of Kentucky College of Medicine, a community SL elective initially targeted to M1-M2 medical students has grown to encompass students from allied health, nursing, and pharmacy.

The Department of Behavioral Science (BSC) is a multidisciplinary training environment for graduate students - typically non-clinicians - interested in some aspect of medical behavioral science. This discussion will explore integrating BSC students into the SL elective focusing on disciplinary roles, learning objectives, and other desirable outcomes.

B2: Crossing the Communication Divide

Sheila Rettig RN BS, Gerri Navarre MSW

The challenge of training residents to LEP (limited English proficient) patients provides opportunities for exploring approaches to bridging the communication divide. Recently, Metropolitan Hospital was awarded a federal grant to research the use of video conferencing technology and interpreters in a medical setting. This innovation involves a community partnership and will evaluate this approach to training physicians, interpreters and staff.

Residency programs have the capability of participating in a grant project that establishes best practices associated with interpreter utilization, setting a community standard and lobbying for financial reimbursement for essential services not currently covered.

B3: Using Humanities to Teach Multicultural Sensitivity

Kathie Culhane-Pera MD MA

Poetry and prose written by and about diverse populations can assist physicians to understand the current disparities of health by increasing awareness to people's life experiences with racism and discrimination in society and in medicine. This type of non-medical literature conveys history and present-day conditions, illustrates moral values, and depicts cultural symbols. And by evoking emotions in readers, it increases empathy and understanding of people's life conditions. In this common interest breakfast, the leader will share the readings we have used in our residency program — both by reading some selections and by passing out a list of readings. Depending on time and interest, brief descriptions of a qualitative evaluation of residnets; writings, in response to the readings will be presented. Participants will be invited to share their humanities readings with the group.

8:45 AM - 10:15 AM Plenary Workshop

PL5: Transcultural Principles Applied to Medical Education

Ann O Hubbert Ph.D., RN, CTN,

Gail Harris Ph.D., CCSP

Medical educators are challenged by increasing demands to provide knowledgeable and competent transcultural expertise in order to teach and mentor students who in turn, will be able to provide culturally competent care. Many critical transcultural health issues, impacting health care, and must be incorporated into medical educational curricula and clinical experiences as society shifts to multiculturalism.

The workshop's objective is to address specific strategies of faculty preparation in transcultural theory and evidence-based research knowledge. Current educational dilemmas concerning cultural diversity/disparity that which are exam-

ined include: (1) academic ethical issues of cultural impositions among and between faculty, students, and clients, (2) the diversities and similarities of culture care values as shown by Leininger's culture care diversity and universality theory and research, and (3) curricula application of transcultural theory in the classroom and clinical contexts. Workshop participants are asked to participate in small groups in order to apply transcultural theory's action and decision modes as solution methods for educational transcultural challenges. Upon completion of the workshop, participants will have a foundational knowledge base and resources for the creative incorporation of transcultural health care knowledge into curricula and clinical practice.

Leininger, M.L. (1995). Teaching transcultural nursing in undergraduate and graduate programs. *Journal of Transcultural Nursing*, 6, (2), 10-26.

10:30 AM - 11:45 AM Concurrent Seminars

S4: The Biomedical Lecture as Opportunity to Inculcate Biopsychosocial Perspective

Greg Troll MD

Medical students begin their professional training with a range of attitudes on issues of social disparities of care, valuing patients input and perspective, the role of physicians in addressing unmet social and biomedical needs, and related issues. As they proceed in their training, they often fail to learn or even unlearn a desire to integrate these perspectives into their practice as physicians. The reasons for this are many, but an important step in the process is learning to think of other people as objects of clinical knowledge, to some degree divested of personhood. Part of this is a deliberate effort to help physicians be objective and emotionally protected, part is due to the cognitive discomfort of thinking clinically and culturally about the same person.

Although inculcating humanitarian and patient centered values has been the subject of small group teaching activities, the bulk of a preclinical students time is spent in bio-medically oriented lectures. As a biomedical lecturer, the leader has evolved techniques to embed the understandings of disease mechanisms and clinical reasoning in the stories of people who are part of a family, members of a social and international human milieu and memorable as people, not merely clinical examples. This seminar explores these techniques, with specific suggestions on their application. Although the biomedical lecture may not be the ideal method for transmitting patient centered perspectives and values, it is nonetheless an excellent opportunity, and an important cognitive link to the developing professional intellect. If these perspectives are not integrated into the biomedical aspect of training at this level, these concepts may remain as xenografts and fail to motivate the future professional behavior of these physician students. Some qualitative feedback from students about this approach will be presented.

S5: Substance Abuse: The Impact of Sociocultural Factors and the Role of Medical Education

Kimberly Sutton Ph.D.

The role of medical education in reducing health disparities are to enhance the understanding of these disparities and to expose medical students to the impact of sociocultural factors as determinants of illness. Opportunities for developing strategies to address health disparities do exist in medical education. By encouraging medical students to integrate a biopsychosocial model, identification of how and where health disparities occur can be maximized. Drug addiction, while acknowledged as a disease like any other, remains highly stigmatized with very strong sociocultural factors influencing the course of the disease, motivation to accept treatment and access to effective treatment. Data exists on ethnic and racial, gender and socioeconomic variables that influence substance abuse factors. There remains a need for medical professionals to receive improved training in identification, assessment and referral of substance abusing behaviors. Increased classroom knowledge on drug addiction, specific clinical vignettes utilized as teaching tools and more practical applications through internships and practicums will aid in bridging gaps in the knowledge about identification of substance abusing behavior looks and how it is shaped by sociocultural factors and what that means to the physician in training.

1:45 PM - 3:45 PM Brief Papers

BR10: Culture, Patient Advocacy and the Community

Alicia D. Monroe M.D.

Demographic trends and documented disparities in health status and health care have created an imperative for health care providers to enhance their knowledge and skills needed to deliver culturally responsive health care. Increasingly, medical educators are concerned with teaching students not only to diagnose and treat disease, but also to understand how complex social, economic, and cultural factors influence each persons concept of health, illness, and quality of life. This brief paper presentation will review the design and evaluation of a pre-clinical medical school elective devised to enhance students understanding of the role of race, culture and socioeconomic status on health status, provider-patient communication, and access to health services. An effort was made to help students connect current and past life experiences including their work as community volunteers and advocates with the key concepts of the course. Students community service experiences often involve work with vulnerable members of society who are disproportionately impacted by environmental pollution, poor health, and lack of information about and access to culturally appropriate health care services. An interactive seminar format was utilized to enable students to interact with community and faculty presenters

and to discuss a variety of public health and health service delivery issues. The discussions incorporated information on the role of culture and class in communication, and strategies providers can utilize to improve effectiveness in working with individuals, families and community service providers. Readings were drawn from several sources including the medical literature, government publications, the social sciences and periodicals. The course provided opportunities for students to increase self-awareness, to develop greater insight into the social and community context of health care, and to refine communication skills.

The Course Objectives can be summarized as follows:

At the completion of the course participants will be able to:

1. Recognize how culturally based beliefs, values, attitudes, practices and life experiences can influence expectations, communication, and trust;
 2. Appreciate how biologic, social, cultural and economic factors contribute to the impact of health problems on individuals or communities;
 3. Identify the skills needed to develop partnerships with patients, families, and community agencies to promote optimal patient outcomes;
 4. Gather data regarding patients needs and perspectives to support culturally-responsive counseling;
 5. Discuss the importance of self-awareness, communication skills and feedback skills in advocacy and patient care.
- Eighteen students completed the course and their evaluation of the content and design of the course will be presented.

BR5: Health Information Disparity in Spanish and English at a Core Safety Net Public Hospital System

Jose Calderon MD, Richard Baker MD, Ron Hays PhD

Background: Since written health information is a cornerstone of primary and secondary disease prevention efforts and most Americans lack the literacy skills to comprehend most written health information there exist health information disparities that further contribute to health care disparities. This problem is particularly important for vulnerable racial and ethnic minorities who tend to have limited English proficiency (LEP) and limited literacy skills. We investigate the readability of documents available to Latino and African Americans with primary grade level literacy skills (< 5 grade) accessing healthcare from a safety-net public hospital. Preliminary data from this project were presented at ABSAME in 2000. However, the completed data set revealed characteristics of health information disparity not previously reported. Methods: Fifteen documents (English and Spanish versions) representing clinical, research, hospital and Internet patient information were assessed using reading grade level and reading ease measures. Results are compared to readability of medical journals, popular press, and children's books (difficult, average and easy readability).

Results: One of 30 documents studied had a readability match-

ing primary grade level literacy skills. Mean reading grade level difficulty, range 10-13, and mean reading ease, range 15-68 (>80 for primary grades), exceeded primary grade level in all categories (see tables below). The readability of corresponding English and Spanish versions was similar and that of consents form was not different from that of medical journals.

Conclusions: According to the Hospital and the Research Bill of Rights people have the right to be informed. Contrary to the ethics and edicts for practicing medicine, information provided at the public hospital studied in this project is too difficult for it's vulnerable patients and the average American to understand. This represents a barrier to communication that may result in non-compliance, difficulties with self-care, patient harm and contribute to disparities in health for vulnerable populations. Patient information targeting vulnerable ethnic/racial minorities should be written at a grade level compatible with children's books. Over the last 3 years a seminar on the implications of health information disparities on health has been included in the cultural competency curriculum at Drew. The reading grade level of this abstract is >12.

BR6: Perceptions of Career Choices, Assignment of Specific Faculty Mentors and the Residency Match

Shobita Rajagopalan MD, Vanessa Ngakeng MS-3, Monica Tillis MS-3

Background: Since the curricular reform initiative in 2000, the restructured clinical curricula within the UCLA and Drew/UCLA medical education programs have provided a better focus toward academic and patient care excellence. The clinical curricula at Drew in accordance with the unique mission of this University of service to the underserved, has integrated and highlighted the importance of reduction in health disparities throughout the third and fourth year. The third year or core clerkships phase provides the foundation for clinical experiences and knowledge enhancement in the fields of Family Medicine (FM), Internal Medicine (IM), Obstetrics and Gynecology (ObGyn), Pediatrics, Psychiatry, Neurology, Radiology and Surgery. The fourth year or college phase provides career guidance, mentorship, an interactive dinner seminar series and specific courses to enable students to refine their clinical skills further enhance their knowledge and meet their eventual professional goals. There are five such colleges at UCLA and Drew/UCLA respectively: the Acute Care, Applied Anatomy, Medical Science, Primary Care (PC) Colleges at UCLA and the Urban and Underserved College at Drew. The PC Research Thesis requirement at Drew in the fourth year adds strength to its College phase.

Methods: Students from the Class of 2002 and 2003 from the Drew/UCLA Medical Education Program conducted a survey of career choices for their respective classes in March of their third year. The intention of this survey was to enable

assignment of appropriate faculty mentors in the fourth year to provide career guidance, discussion of specific topics in the given field of interest, to strengthen faculty-student relationships and to enable support based on student career goals. From this preliminary and voluntary survey of the Class of 2002, presented to the Drew Educational Policy and Curriculum Committee, the first career choices indicated that: 64% selected PC (inclusive of FM, IM, ObGyn, Pediatrics and Psychiatry) and 36% selected non-PC specialties; of the second career choices: 58% selected PC and 42% selected non-PC specialties. Based on the result of the National Residency Match in March 2002, 54% of the Class of 2002 matched in PC specialties indicating that student perceptions of their career goals at the latter part of their third year may correlate to some extent with eventual residency choices. The Class of 2003 presented a similar survey suggesting that 40% selected PC and 60% selected non-PC for their first career choices and 53% PC and 47% non-PC for their second career choices. Consistency with national trends need to be further assessed.

Results and Conclusion: The preliminary career choice survey suggests that there may be a correlation between student-perceived career choices and their eventual residency matches. Such surveys could help determine the career interest dynamic of each individual class and enhance the development of focused groups of mentors, seminar series and recommended courses that will support student goals. The addition of an international experience is also likely to further strengthen the uniqueness of the Drew/UCLA Medical Education Program.

BR7: Writing as Therapy: A Summary of Literary and Psychology Research

Linda Garcia-Shelton Ph.D., MHS, Ann Hudson Jones Ph.D.

BR8: Using Case Studies in Small Discussion Groups To Teach Medical Students About Health Care Access and Availability For Vulnerable Populations

Gary Myers Ph.D.

At last count, over 43 million Americans-almost 20 percent of the population under age 65-lacked health insurance coverage. The ranks of the uninsured include the usual vulnerable populations, the poor and working poor, inner city and rural populations, the elderly and the mentally ill, but the recent economic downturn has added a new group-the newly unemployed. As a result of the large numbers of uninsured in the patient population, the quality of health care for many Americans will depend on physicians' ability to recognize and to address this barrier to accessing treatment.

Being that it is sometimes difficult for medical students to appreciate the impact of these access issues to their future

patients, we have developed this case study/discussion group approach to learning in order to help students become more existentially engaged with these issues. This paper introduces conference participants to a method of instruction that incorporates the use of case studies in a directed discussion group: to teach medical students to identify barrier to access issues; to identify their impact on treatment; and to develop strategies for providing adequate health care to these vulnerable populations. Specifically the paper describes the learning activities of the students, presents sample cases for a brief discussion by the participants, and reports student response to this method of teaching.

Learning Objectives Participants will be able to: 1. Identify the core elements of a case based approach to teaching about issues related to access 2. Experience the methodology through discussion of a brief case 3. Identify additional educational materials that address barriers to access.

BR9: Student Perceptions of a Focus on Healthcare Disparities in Medical Education

Shobita Rajagopalan M.D., Susan Baillie PhD, Harmony Crutcher MS-3

Background: The Drew/UCLA Medical Education Program has a unique mission to train students to provide service with excellence and compassion to underserved communities. A recent survey of graduates suggested that students from Drew were more likely to provide service to the underserved compared with colleagues from non-minority institutions indicating that the Drew mission is being met. Teaching students about various healthcare disparities has been an integral part of several components of the clinical curricula both in the core clerkships (third year) and college phases (fourth year) respectively. The innovative longitudinal Primary Care Program has continually provided strong emphasis on educating students regarding healthcare disparities in the third year, through its Monday conference modules, clinic didactics, and supervised clinic continuum. The mandatory research requirement investigating diverse aspects of healthcare disparities is another fourth year component of this Primary Care Program. The fourth year or college phase at Drew has been named the Urban and Underserved College in concert with the school's mission. The objective of the college is to further emphasize knowledge regarding healthcare disparities with focused mentorship, career guidance, recommended courses and a dinner seminar series on topics such as alternative medicine, nutrition, cultural diversity etc.

Methods: The AAMC graduation questionnaire given to all graduating medical students, was examined to review student perceptions of their educational experience upon completion of medical school. UCLA and Drew UCLA data from 2000 were compared with national data. Overall, if the 14,094 students completing the survey, 137 were UCLA students and 17 were Drew UCLA students. This study examines and

compares student perceptions on markers for health disparities education including health behaviors, health conditions, health care system factors and health beliefs.

Results: The survey data suggests that Drew students perceive that they are receiving significant levels of instruction in topics related to health disparities. For example, Drew UCLA students overall felt that their instructional time devoted to health issues for underserved populations was appropriate (88.2%) compared with UCLA students (65.7%) and US overall (61.7%). Drew UCLA and UCLA students both indicated that they had participated in delivering health services to underserved populations Drew (88.9%), UCLA (84.4%) and US overall (69.4%). Discussion: The data suggests Drew students do perceive that in most disparity topic areas they are receiving instruction at a more appropriate level than do students at many other schools. Capturing the impact of a health disparities curriculum is complex, as students recruited to this type of program often have heightened interest in the underserved.

Conclusion: This data suggests that education regarding health care disparities is being effectively accomplished in the Drew program. Medical Education curriculum that specifically addresses disparities is more likely to train professionals competent in integrating knowledge, skill and attitudes to work effectively with underserved populations.

1:45 PM - 3:45 PM Concurrent Workshops

W4: Using Multi-vocal Case Narratives to Explore Multicultural Ethics

Kathie Culhane-Pera MD MA, Dorothy E. Vawter PhD

Health disparities are partially based upon differential treatment in the medical care setting. Disparities in treatments may be due to cultural differences in beliefs, values, and behaviors, which can lead to miscommunication, misunderstanding, disagreements, and conflicts between culturally diverse patients and health care professionals. Understanding the multiple contributors to these issues may allow health care professionals to improve their care delivery to patients of all cultural backgrounds.

The presenters have edited a Book of cases soon-to-be published by Vanderbilt University Press: *Healing by Heart — Clinical and Ethical Challenges in Cross-cultural Health Care: Case Studies of Hmong Patients and Western Practitioners*. The book includes 14 stories of Hmong children and adults with such problems as diabetes, infection, cancer, depression, difficult pregnancies, organ failure, and traumatic injuries. Multivocal commentaries (written by Hmong and non-Hmong professionals, patients, and community members) about each case discuss the cultural and value issues raised by each story, as well as offer suggestions about improving care for similar families in the future.

In this workshop, we will present a culturally responsive health care model, particularly focusing upon the ethical framework to approach multicultural disagreements or conflicts. We will read and then discuss several cases, applying the multicultural values of the audience and the culturally responsive model to discuss optimal ways to provide culturally responsive care. We will read selected parts of the commentaries, which provide the participants with multiple perspectives of the cases. Finally, we will discuss the educational implications of using multivocal narratives to teach culturally responsive care, and to discuss whether these efforts will reduce health care disparities.

W5: Malice in Genderland: Reducing Disparities in the Care of Transgender Persons

Amy Ellwood MSW, LCSW,

Jane Heenan MS, MFT,

Transgender persons are an underserved community in need of primary care. Disparities in their health status spread across race, ethnicity, biology, and access to care. Transgender persons are often the victims of violence from within their families, intimate relationships and society. These experiences can lead to self-abusing and reckless behaviors such as the abuse of alcohol, illicit drugs, hormonal medications, suicide attempts, and unprotected sex with multiple partners and self-mutilation. Further, many transgender persons have suffered from inadequately trained and sometimes disrespectful providers of medical and mental healthcare. Physician and mental health clinicians are responsible for providing transgender persons with comprehensive medical and psychological care that they need and deserve. Behavioral science educators in academic medicine are in a unique position to teach about the needs of the transgender person and to be role models for that care in their clinical practice.

This workshop will address the needs and experiences of transgender persons that are important to medical students, residents and faculty alike. These include gender identity, gender expression, gender role, sexual orientation, impact of the disclosure on the family, sexual practices, common mental and physical health issues, legal issues, confidentiality concerns and the Harry Benjamin Standards of Care.

4:00 PM - 6:00 PM Concurrent Workshops

W6: Developing Written Communication for Vulnerable Patients Having Limited Literacy Skills

Jose Calderon MD, Sandra Smith MPH, CHES

Written health information is a cornerstone of primary and secondary disease prevention efforts aimed at improving the public health. Yet the majority of Americans lack the literacy skills needed to decipher and comprehend most written health information. This problem is magnified for immigrants and other vulnerable groups. These groups are culturally diverse,

comprise more than 30% of the general population and are disproportionately represented among those who have poor literacy skills, limited English proficiency (LEP) and poor health. They can be expected to benefit the least from written health information despite having the greatest need given their disparate burdens and health outcomes from chronic disease.

As cultural groups, immigrants and other vulnerable minority groups differ in their explanations for disease and its physical, emotional and social manifestations. Consequently, illness coping mechanisms are revealed as culture-specific health seeking behaviors that are appropriate in the context of the social, cultural and physical environment of that culture. However, these behaviors often contradict evidence-based practices for preventing and treating disease. Delayed care for cancers by uniformed and uninsured immigrant Latinos is noteworthy in this regard. They tend to seek biomedical health care only when self-treatment and folk-healing practices have been unsuccessful. Matching health information to literacy skills, language preferences, and health beliefs may help to improve appropriate utilization of biomedical health services by immigrants and other vulnerable groups. As such, using linguistically appropriate and culturally relevant health information may help to diminish the sustained disparities in health status they experience.

The purpose of this workshop is to bring an awareness of the readability/literacy gap that exists for immigrants and other minorities and to teach participants ways of producing written communication that is culturally appropriate and very easy to read. We will accomplish this by imparting on workshop participants some of the basic skills needed to simplify existing patient information (research and clinical consent forms, disease specific information, etc.) and to develop written patient information at < 5th grade level. Simplified information is useful cross-culturally because the language translation of easy to read English language documents results in easy to read target language documents. Five key workshop objectives correlate with the five skills that will be imparted.

W7: Teaching Prevention in a Sociocultural Context: The Case of Type II Diabetes

Charlotte Kennedy Ph.D., Beverly Williams-Cleaves M.D., Dorris Tinker Ph.D.

Non-insulin-dependent diabetes mellitus (NIDDM) or Type II Diabetes affects more than 7% of the adult population. There are approximately 600,000 newly diagnosed cases each year. Multiple health consequences such as blindness, renal failure, and amputations illustrate its wide-spread impact on quality of life. In addition, diabetic patients are at higher risk for other life-threatening illnesses (i.e., cardiovascular disease and stroke).

Type II Diabetes is disproportionately represented in ethnic minority populations. This illness may be found in 10% to 50% of the adult populations of Native Americans, Latinos,

African Americans, and Asian and Pacific Islanders. A major factor in the development of Type II Diabetes is obesity. Thus, prevention efforts must focus on life style interventions that target weight reduction. Recent surveys of practicing physicians indicate that education on approaches to weight management is often lacking in medical school and residency training programs. At the same time, this is vital information for reduction of health disparities related to obesity. Since there is an increased prevalence of Type II Diabetes in ethnic minority populations, an effective approach to prevention necessarily addresses weight management in a sociocultural context.

Sociocultural information related to specific ethnic minority populations provides guidance for the development of problem-based illness prevention education. This workshop will demonstrate an educational model based on sociocultural components of a weight reduction program. Patient case studies will illustrate consideration of sociocultural issues as a major component in weight reduction strategies. Application to patient care will be achieved through small-group, problem-based tasks and discussion.

Sunday, October 13

7:30 AM - 8:45 AM Student Scholars Breakfast

BR11: Is it Social Phobia or Social Oppression? A Case Description of Social Phobia Symptoms in Closeted Non-Heterosexual Female

Jodie Eckleberry Ph.D., Anne Dohrenwend Ph.D

Our literature review, covering the last 20 years, yielded only one in-depth study specific to social phobia in a non-heterosexual, and there was no consideration given to sexual orientation. We believe it is a leap to generalize theoretical assumptions about social phobia from heterosexuals to non-heterosexuals because the social context of the two populations differ. In this case study, we explore the relationship between symptom presentation and the social context of a closeted, non-heterosexual female diagnosed with social phobia. Our conclusions suggest that closeted, non-heterosexuals may display protective social withdrawal as a result of internalized homophobia and rational fear associated with the risks of

BR12: Depression, Health Beliefs and Compliance: Relationships to Glycemic Control in Hispanic and African-American Diabetics

Arriana Moreno

Background: Chronic illnesses (diabetes, cancer, AIDS) account for approximately 80% of deaths in Western countries. Diabetic patients may suffer from depression and the medical complications associated with poor glycemic control. It is

well established that Hispanic and African Americans are more likely to have increased prevalence of diabetes and poor glycemic control compared with Caucasian patients. As a result of poor glycemic control, these populations have increased incidence of medical complications such as nephropathy, neuropathy, retinopathy, myocardial infarction and stroke, all risk factors for higher mortality. The reasons for such increased morbidity and mortality in Hispanics and African-Americans are multifactorial; in addition poor glycemic control has been well documented in these groups. However, very few studies have examined the prevalence of depression, health beliefs and compliance in Hispanic and African American diabetics. As the prevalence of diabetes in these two groups increases and demographic expansion continues, Hispanic and African Americans can be expected to represent a growing and important segment of the diabetic population. By understanding specific health beliefs of diabetic patients, and their possible relationship to depression, different explanatory models of diabetes may be used to increase compliance and decrease the rate of developing devastating medical complications.

Methods: This will be a cross-sectional study. Patients will be recruited from the Diabetes Clinic located at the King Drew Medical Center. The study will involve informed consent and patient completion of the Beck Depression Inventory (BDI), a Health Belief Scale (HBS) and a CompThe HBS attempts to measure the perception of who or what is responsible for an individuals health. The sense of responsibility for health may be directed internally or externally, with external responsibility involving those of powerful others and chance. Health beliefs will be measured using a validated, 25-item questionnaire entitled Measurement of Beliefs of Diabetic Patients. Responses to questions are given in a Likert scale format with five possibilities ranging from 1 to 5, wherein, the higher the score on an item, the stronger the belief. The CS is a validated tool that assesses patient compliance to medical, diet and exercise regimes. After completion of the three questionnaires, a chart review will be conducted. Ethnic and gender variations will also be evaluated. Glycemic control will be defined by hemoglobin A1C levels: good <7.5%, fair 7.6-9.0% and poor >9.0%. Renal function and lipid profile will also be recorded.

Conclusion: This important study is likely to provide critical information regarding health beliefs, compliance and depression as contributing factors to the increased morbidity and mortality in diabetic Hispanic and African-American patients. Furthermore, addressing these issues earlier on in the disease, can help decrease complications.

BR13: Medical Student Workshop: Teaching Sociocultural Issues Related to HIV-AIDS

Darren Johnson, Charlotte Kennedy Ph.D., Thorpe Edwin MD

Racial, gender, and age disparities exist in the rates of HIV-AIDS in the US population. Center for Disease Control statistics indicate that approximately 339,000 persons were infected with AIDS as of December 2000. Of these, 41% were African American and 20% were Hispanic. The rates of AIDS among Asian Americans/Pacific Islanders and American Indians/Alaska Natives were reported to be of concern, as well. The rate of HIV infection in women of color is growing. The prevalence of the virus is 19 times higher for African American women and seven times higher for Latina/Hispanic women in comparison to Caucasian women. Likewise, age differences exist. Most women diagnosed with HIV are between the ages of 16 and 44 years. With respect to adolescents and young adults, half of the 5.8 million persons diagnosed annually are in the 15-24 year age group. The 10-year period between initial infection and clinical manifestations of AIDS suggests that most of these persons were infected during their teens. This paper describes the demographics and self-reported knowledge, attitudes, and interest level regarding HIV-AIDS for a third-year medical student class. Further, it describes an educational workshop for third year medical students at the University of Tennessee Center for the Health Sciences, which integrated information on the biomedical and psychosocial/sociocultural approaches in addressing the complexities in caring for HIV-AIDS patients. Pre-post measures of perceived "comfort-level" in discussing HIV-AIDS in patient encounters are reported. In addition, student responses on a "Training Session Reaction Form" indicated their perceived usefulness of the workshop, satisfaction with the content, and recommendations for future educational activities.

The goals and objectives for the student workshop were: 1.) to provide current information regarding the changing local, national, and global epidemiology of HIV-AIDS with a focus on populations considered to be at disproportionately higher risk for contracting HIV, 2.) to review information regarding HIV-AIDS transmission, signs and symptoms and complications, including perinatal transmission and opportunistic infections, 3.) to provide information regarding sexual behaviors, lifestyles, practices, and culturally/ethnically-sensitive issues that contribute to HIV-AIDS risk, and 4.) to provide a demonstration and discussion of communicating pertinent and appropriate information to patients with HIV-AIDS regarding test results, risk reduction, partner-notification, and support. The workshop included lectures with audiovisuals, student discussion, patient interviews, and patients' descriptions of their reactions and experiences with illness.

The psychosocial and sociocultural components and effectiveness of the workshop will be the primary focus of the presentation. Student involvement was significant in devel-

oping the workshop, which was introduced into the curriculum in response to a Center for Disease Control initiative (HIP-Corps Project) that provided funding to the Student National Medical Association. The University is a HIP-Corps Project site.

BR14: Perceptions of Breast Cancer Risk in Second Generation Asian American Women

Melinda Chen BA, Rowan Chlebowski MD, Kenneth Wolf Ph.D, Linda Lillington

It has been historically well documented that breast cancer incidence rates are 4-7 times lower in Asian countries than in the United States. Much of the research exploring this lower incidence focuses on possible environmental differences between women living in Asia versus the United States. In part because of the publicity surrounding this documented lower incidence, studies have indicated that Asian females perceive themselves to be at lower risk; accordingly, there have not been as many educational or preventive efforts in Asia as compared to the United States.

The Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute documented in its study of breast cancer incidence from 1990 to 1996 that, similar to their counterparts in Asian countries, Asian American women too have a lower incidence of breast cancer compared to other ethnic groups. However, Asian Americans are also the only ethnic group with an increasing incidence, while whites, blacks, Hispanics, and American Indians/Alaskan Natives have either maintained steady or shown decreasing breast cancer incidence. This increasing incidence has aroused concern, especially because the protective environment enjoyed by women in Asian countries may not continue once these women leave their native lands for American soil. In fact, in a study of the association between migratory patterns and breast cancer risk, it was found that Asian women who have lived in the US for greater or equal ten years or longer have an overall 80% higher risk than more recent immigrants. Furthermore, Asian American women born in the US had a 60% greater breast cancer risk than women born in Asian countries.

This finding leads one to question whether perceptions of Asian American women's own risk of developing breast cancer differ from their predecessors in Asian countries. The purpose of this study is to probe how second generation (and beyond) Asian American women perceive their risk of breast cancer specifically, whether and to what extent they still share in their predecessors beliefs that they are unlikely to get breast cancer. This is a two-phase prospective study of Asian American females at Harbor-UCLA Medical Center and satellite clinics over the period of March 2002 to September 2002. The two phase study involves:

1) 10 focused one-on-one interviews with second generation and beyond Asian American patients to gain preliminary data and information to produce a working ques-

tionnaire to assess breast cancer risk perception

2) Questionnaire development and administration to 100 second generation and beyond Asian American patients with subsequent data analysis

Through administration of the focused interviews and questionnaires, we will explore whether second generation Asian American women realize that they are at greater breast cancer risk than their predecessors in Asian countries. We will also gain insight into factors Asian American women believe predispose one to breast cancer. This may lead to increase screening and preventive efforts within the Asian American community, which may ultimately promote earlier detection of breast cancer and better disease prevention and treatment.

9:00 AM - 11:00 AM Brief Papers

BR15: Medical Students' Participation in a First-Year Community Service Elective: Preliminary Evaluation Results from a Pilot Program

Terry Stratton Ph.D., Carol Elam EdD

Objectives: As part of the American Medical Student Association's (AMSA) Promoting, Reinforcing, and Improving Medical Education (PRIME) initiative, the University of Kentucky College of Medicine in 1999 piloted a service learning (SL) elective by integrating community-based experiences into portions of a pre-existing small group-based course in the M1- M2 curriculum. Sixty-one students in the entering class of 2000 (n=99) opted to take a first-year elective — 23 of whom enrolled in the newly created SL program. An evaluation was undertaken to examine changes in students' attitudes that may have resulted from participation in the PRIME elective. For these analyses, their remaining classmates (n=76) served as the comparison group.

Methods: With IRB approval, pre- and post-test versions of the AmeriCorps service learning survey were given to all incoming students prior to beginning the elective (Year 1) and again following its completion (Year 2). This confidential, self-administered instrument uses 36 Likert-type items to assess attitudes toward community service, altruism, and professional development. **Outcomes:** Eighty-seven students including 23 PRIME students completed the pre-test administration (response rate = 88%); 70 of whom 19 are PRIME students completed the follow-up post administration (response rate = 74%) . Pre and post responses were matched for 61 students (42 non-PRIME, 19 PRIME). Overall reliability (a) of the pre-test scores was .89, indicating a high degree of internal consistency.

As a data reduction technique, an exploratory factor analysis was conducted on the 36 scale items. After visual examination of the resulting scree plot, a two-factor solution was

determined to best fit the data, with factors tentatively labeled as: pragmatism/social conscience/racial and ethnic diversity (Factor 1) and service/experiential learning as a pedagogic framework (Factor 2). Factor 1 consisted (loadings > .40) of 8 items (a = 0.87), while Factor 2 included 5 items (a = 0.79). Together, the two factors explained 31% of the variance.

Using summated scales of unweighted items, a 2 X 2 (Group X Time) repeated measures analysis of variance revealed no significant between or within differences on Factor 1. Factor 2 showed statistically significant main effects for Group and Time, with scores increasing for each from pre- to post-test, but with PRIME students exhibiting higher means. However, these latter findings should be interpreted cautiously in light of a significant departure from the equality of covariance matrices assumption (M = 8.92, F = 2.83, p = .037).

Evaluation: The lack of remarkable findings may be attributable to several factors. First, the self-selection of service participants corresponded with elevated baseline scores indicating many PRIME students were already highly vested in the concepts measured. While we purposely designed the course as an elective, more dramatic changes may have resulted with the participation of less service-oriented students. Second, the relatively small sample was further compromised by less-than-ideal response rates and, subsequently, attrition limiting the power of many statistical tests. Lastly, key measures performed only adequately, and may have been of too general a nature to tap more specific changes in students attitudes toward service learning. As part of a comprehensive evaluation, we plan to triangulate these findings with supplemental data.

BR16: Children and Adolescent Type II Diabetes

Ryan Nishihara MD

With the increasing prevalence of obesity in our society, its association with Type II diabetes has dramatically increased. The "Westernized" lifestyle is a major contributing factor to the increased prevalence of Type II Diabetes. "What was once mainly diagnosed as a problem with adults is now a major health issue in children and adolescents. The prevalence, suspected pathophysiology, and clinical and diagnostic evaluation of a child thought to have diabetes will be discussed.

BR17: "Brainwashing" and "Battering Fatigue": The Role of Psychological Abuse in Domestic Violence and Its Impact on Healthcare Disparities

Lesly Mega MD, Jessica Mega MD,

Benjamin Mega M-2, Beverly Moore Harris, MD

The amount of intimate partner violence (IPV) in the United States is substantial and involves an interrelated combina-

tion of physical, sexual, and psychological abuse. The psychological aspect of the abuse deserves special attention since victims of IPV commonly lose their independence, self-esteem, and dignity and therefore remain in abusive situations. Because of the psychological aspects of their condition. The health issues of this population are often missed or misunderstood.

This paper presentation will explain that the abuse these people experience is perpetrated by a domestic partner who aims to maintain power and control over a relationship. To accomplish this control, the abuser uses “brainwashing tactics” similar to those used with prisoners of war, hostages, or members of a cult. Common features of brainwashing include isolation, humiliation, accusation, and unpredictable attacks. This environment produces real and anticipated fear that contributes to the battered woman’s belief that her situation is hopeless and that she must depend on her abuser. She develops coping strategies to deal with her oppressive environment. The battered woman eventually exhibits symptoms of “battering fatigue,” resembling the battle fatigue of soldiers in combat, since, like these soldiers, they live in fear of being killed or severely injured. Understanding the state of mind of battered women can help medical students see how it is difficult for these women to escape their traumatic environment, to obtain appropriate health-care, and to choose other alternatives beside suicide or homicide. It is imperative that medical students appreciate these complex, devastating psychological aspects of domestic violence to adequately screen and treat their patients and to understand the healthcare disparities this population experiences because of their psychological and social situation.

BR18: Investigating Healthcare Disparities Research Through a Required Primary Care Thesis Initiative

Dotun Ogunyemi M.D., Ronald Edelstein EdD, Mohsen Bazargan PhD

Background: In 1995, the Charles R. Drew University of Medicine and Science, College of Medicine, Primary Care Clerkship developed an innovative curriculum requiring medical students to develop, design, and implement a research project during their two-year Primary Care longitudinal clinical experience. The research project was to address medical conditions commonly encountered in Primary Care practice. Because the majority of such student research projects have been clearly demonstrated to be at a caliber equal to that of thesis quality, methods were explored to make the Drew research project and UCLA medical thesis a synchronized process. The Drew Educational Policy and Curriculum Committee (EPCC) and the Drew Primary Care Subcommittee have recently approved the development of this outstanding initiative, advancing the research project to a thesis requirement for all Drew graduates beginning with the graduating class of 2004.

Methods: Early in the 3rd year, students select a research topic and faculty mentor. The thesis research prospectus is presented to the Thesis Committee for approval prior to implementation. The final research product will be presented as a formal bound thesis during the fourth year and must fulfill the following minimal requirements: Title Page; Abstract; Hypothesis (Research Question); Introduction (Background); Materials and Methods; Data Analysis; Results; Graphic Presentation; Discussion (Conclusions); and a Bibliography. Students may work jointly on a research project, however, each student must analyze a unique aspect of the research project and produce a unique thesis.

Conclusion: Students will be recognized formally for their research work at graduation. In addition to presentation at the Annual Student Research Colloquium on campus, students are expected to formally present their thesis at regional or national meeting(s) and/or publish in peer reviewed journals. The theses will also be published as part of the library thesis filing process for listing at the electronic thesis clearinghouse. This initiative will: provide additional training and encouragement for students to become leaders in academic endeavors; provide competitive residency and career options; and provide students and faculty members with have publication incentives that enhance their careers and foster the Drew mission of service to the underserved. The student Research Project is evolving from a third and fourth year group project and presentation to a formal written medical thesis requirement. We have demonstrated that all students are able to conduct and present Primary Care Research as part of their medical training.

BR19: Diabetes and Science Education in Tribal Schools

Sanford Garfield Ph.D., Lawrence Agodoa MD, Marilyn Nichols MS

There has been a six-fold increase in people known to be living with diabetes in the United States in the past four decades. Almost all of these cases can be attributed to Type II diabetes, which is increasing globally. Diabetes brings with it the potential to cause serious complications, including blindness, kidney disease, cardiovascular disease, periodontal disease, and lower extremity amputations. Diabetes was rare among American Indian and Alaska Natives until about 50 years ago. Since that time, diabetes has become one of the most common and serious illnesses in tribal nations of North American and, alarmingly, it is now affecting children. Diabetes is also an especially relevant model for teaching biology of organ systems, since it affects so many body systems. Diabetes is an especially relevant model for teaching biology to younger students, particularly in communities highly impacted by this disease. Moreover, education focused on diabetes could serve several purposes in such communities: fostering science education, encouraging students to select science and health related career paths, and providing information that may influence healthy lifestyle choices in chil-

dren and families with and/or at risk for diabetes. The NIDDK in collaboration NCMHD, CDC and IHS, has initiated a diabetes-based science education program to develop diabetes-based science education programs for tribal elementary, middle and high schools serving American Indian/Alaska Native (AI/AN) communities. Towards this end, a planning grant targeted to Tribal Colleges and Universities (TCUs) was awarded. The purpose of this award was to begin development of a program to enhance understanding and appreciation of the problems of diabetes in AI/AN communities and to stimulate general student interest in diabetes-based science in the early years (pre-college) of education. The goal is to increase AI/AN representation in diabetes related biomedical sciences. This planning phase will be followed by a curriculum development and pilot testing phase open only to TCUs. The ultimate objective is wide scale implementation affecting all AI/AN youth.

9:00 AM - 11:00 AM Concurrent Workshops

S6: Addressing Health Disparities Through Faculty Development: A Course in Survey Research for Clinical Faculty

*Kenneth E. Wolf Ph.D.,
Richard W. Lindstrom M.A., Margaret Govea ,
Richard S. Baker, M.D.*

A campus-wide faculty development program was designed to increase the total research productivity of the faculty, residents and students in the College of Medicine at Charles R. Drew University of Medicine and Science and develop mentors for student research. The research themes addressed issues of health and health disparities among members of minority and underserved populations. The first offering of the course focused on selected faculty members with the intent of providing skills, knowledge and attitudes necessary to conduct independent research, and to mentor students, residents and colleagues in their future research endeavors. The focal point of the course was instruction in survey research methodology that could be used to directly study issues of health disparities and provide strategies for developing research and clinical solutions. To ensure that the benefits of this research course were distributed throughout the University community, each department in the College of Medicine was assured that at least one of their faculty members could participate in the program. Two positions were also available for faculty members in the College of Allied Health. Participants were required to have signed commitment from their respective Department Chair, allowing the faculty member to participate in the program, and assuring that they would be provided with the opportunity to share their experiences at regularly scheduled department events such as faculty meetings or Grand Rounds. The course was designed to support participants to develop a research protocol, completing a manuscript, and submitting it a peer-review journal. The course is expected to prepare participants

to develop and continue their research careers in areas related to minority health disparities. Equally important, they will be expected to actively support and mentor post-docs, fellows, and other faculty in the College of Medicine. The course will also be considered a pre-requisite for those who wish to take on the role of a mentor for the Primary Care Research Thesis project, now a mandatory requirement for graduation from the School of Medicine.

The 30-week course is divided into two 15-week phases. Phase I of the course is a comprehensive series of classes addressing the development of a survey research project (clinic survey/questionnaire, secondary data analysis, or chart review) from developing a research question to submission of a protocol to the IRB. Phase II of the course will provide research guidance, technical assistance, expert consultation, and workgroup sessions to facilitate completion of the research project and manuscript (including data collection/analysis, manuscript writing and editing, etc.). At the end of this phase, participants will have a finished manuscript ready for submission to a peer-reviewed journal. This seminar session will be interactive with the audience. The scope of the seminar will be presented and issues highlighted. The discussion will address considerations and challenges including curricular development, access for departments and faculty, scheduling logistics, release time, homework, consultant access, developing and sustaining interest, departmental and College support. Results from the first course will be used to illustrate particular obstacles, observations, and solutions.

S7: Biomechanical Thoracic Restriction Technique for Teaching Diaphragmatic Breathing

Albert Eaton Ph.D., Michael Walsh M.D.

Relaxation therapy is an integral element in the primary prevention of life style related disorders and is useful in the prevention and therapy of biophysical and psychological illness. Diaphragmatic breathing is foundational to most relaxation methodologies and is an independent management technique. For many people, learning to breathe in a relaxed manner from their diaphragm is a challenging task. Diaphragmatic training routines utilize passive trial-and-error strategies with active monitoring for the target behavior. We propose a simple, active technique that decreases time to behavior acquisition, increases the degree of response, overcomes many cognitive and cultural impediments, and may increase utilization outside the providers office. Clinical and pilot-research data will be provided to support its efficacy. Seminar participants will be trained in this techniques and its variants. The group will discuss implementation strategies and limitations.

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Goals of ABSAME

ABSAME exists to:

1. Promote the application of social and behavioral science knowledge, skills and perspectives in the education and training of physicians and other professionals working in the field of health;
2. Improve the effectiveness, efficiency and quality of health care through the application of social and behavioral science knowledge, skills and perspectives;
3. Encourage the broadening of educational and training practices in the preparation of physicians and other health professionals; and
4. Aid in the continuing education of teachers, clinicians, researchers and administrators involved in carrying out the above activities.

Objectives

The contributions of the behavioral sciences to the areas of health and illness include the following:

1. Extend the scientific orientation of medicine into the field of human behavior at the individual, group and collective levels of analysis and predication;
2. Help physicians improve and extend their preventive, diagnostic, therapeutic and rehabilitative skills;
3. Improve the learning process for student physicians during all stages of their professional care;
4. Assist physicians' adaptability to rapidly changing organizational community and cultural environments;
5. Bring the perspectives and expectations of consumers of healthcare into the realm of medical education so that students and faculty can more effectively solve patient care problems;
6. Identify more precisely the behavioral patterns that interact with biological process in human health and illness so as to increase the effectiveness, efficiency and quality of the services provided by physicians and other health care professionals;
7. Develop sensitivity in observation, validity in interpretation and accuracy in predication of one's own behavior and the behavior of others;
8. Strengthen physician's teaching skills so they may more effectively educate themselves, their patients and their colleagues on a continuing basis; and
9. Provide instruction in management and leadership skills essential to the provision of health care for individuals, families and populations at reasonable levels of relevance, quality, convenience and cost.

Past ABSAME Conferences & Topics

<u>DATE</u>	<u>SITE</u>	<u>TOPIC</u>
Oct. 13-16, 2001	Cape Cod, MA	Beyond Competence: Altruism, Advocacy, and Public Health
Oct. 12-15, 2000	Santa Fe, NM	Integrating Culture and Complementary Medicine: Challenges to the Biomedical Paradigm
Oct. 1-5, 1999	Savannah, GA	Promoting Healthy Behaviors: Changing Institutions, Teachers & Learners
Oct. 10-14, 1998	Jackson Hole, WY	Expanding Our Horizons: Educational Innovations in Behavioral Science
Oct. 18-21, 1997	Cape Cod, MA	Outcomes Research And Evaluations: The Ecology of Assessment in Medical Education
Oct. 19-22, 1996	Eastsound, WA	Managed Care Challenges to Medical Education
Oct. 7-10, 1995	Naples, FL	Behavioral Science in Education for Primary Care
Oct. 2-5, 1994	Santa Fe, NM	Cultural Diversity in Medicine: Challenges and Opportunities
Oct. 2-5, 1993	Myerstown, PA	Implementing the Process: The Complementary Roles of Curriculum and Evaluation in Behavioral Sciences Training
Oct. 1-20, 1992	Smugglers' Notch, VT	Ideas in Process: The Role of the Behavioral Sciences in Medical Education and Training
Oct. 19-22, 1991	Palm Springs, CA	Preparing Physicians for a Changing Society
Oct. 20, 1991*	Rancho Mirage, CA	Panic Disorder in the Clinical Setting: Diagnosis and Treatment
Oct. 7-10, 1990	Thompsonville, MI	The Making of the Physician
Oct. 9, 1990	Thompsonville, MI	Anxiety Disorders in Primary Care: Meeting the Challenge
Oct. 15-18, 1989	Tuscaloosa, AL	Preparing Clinicians for the Future: Behavioral Science and Ambulatory Care
Oct. 9-12, 1988	Andover, MA	Approaches to Wellness: Health, Maintenance, Behavioral Science, and the Clinical Teacher
Oct. 18-21, 1987	S. Lake Tahoe, CA	Behavioral Sciences and Chronic Illness
Oct. 5-8, 1986	Bethesda, MD	Training Physicians for the Future: Changing Health Care Patterns and Their Impact on Behavioral Science Medical Education
Oct. 13-16, 1985	Chevy Chase, MD	Applied Behavioral Science in Residency Training
Oct. 14, 1984	Boiling Springs, PA	
Fall 1983		
Spring 1982	Taos, NM	Training for Medical Practice in Multi Ethnic Society

Fall 1981	Val Morin Station, CAN	Canada/Quebec - USA: Contrasts and Comparisons in Health Care Systems and Behavioral Science/Medical Education
Spring 1981	Lake Quinault, WA	Family Medicine and Behavioral Science
Fall 1980	Boiling Springs, PA	Behavioral Science and Health Policy
Spring 1980	Estes Park, CO	Rural Health Care and Medical Education
Fall 1979	Boiling Springs, PA	The Role of the Behavioral Sciences in Medical School Admissions, Selection and Survival
Spring 1979	Lake Tahoe, NV	The University as a Resource to Medical Education
Fall 1978	Boiling Springs, PA	Relationships between Psychiatry and Behavioral Sciences and Internal Medicine
Spring 1978	St. Simon Island, GA	Training for Primary Care Part III: Behavioral Sciences and Internal Medicine
Fall 1977	Boiling Springs, PA	Medical Student Perspectives on Behavioral Science Teaching
Spring 1977	Snowbird, UT	The Role of Behavioral Sciences in Training for Health Care Delivery in Rural and Underserved Areas
Fall 1976	Boiling Springs, PA	Training for Primary Care Part II: Pediatrics and Behavioral Science
Spring 1976	Toronto, Canada	Teaching Medical Students about Health Care Systems
Fall 1975	Boiling Springs, PA	Training for Primary Care Part I: Collaboration between Behavioral Science and Family Medicine
Spring 1975	Columbia, MD	The Planning, Management, Delivery and Evaluation of Health Services: An Interface Between Behavioral Science and Medicine
Fall 1974	Boiling Springs, PA	Continuing Education Experience for Faculty in The Fields of Behavior Modification, Marital and Sexual Health, Problem-solving Skills, Coping With Death and Teaching Interpersonal Communication Skills.
Spring 1974	Lexington, KY	Faculty Roles and Responsibilities in a Medical Setting
Fall 1973	Boiling Springs, PA	The Relationships Between Behavioral Science Teaching and the Clinical Specialties of Internal Medicine, Pediatrics, Family Medicine and Psychiatry
Spring 1973	Hershey, PA	The Development of Self-Instructional Materials in Medical Behavioral Science and the Use of Multimedia Approach
Fall 1972	San Diego, CA	Role of the Behavioral Sciences in Relation the Fields of Community, Social and Preventative Medicine
Spring 1972	Boiling Springs, PA	Testing and Measurement of Learning Performance (with the staff from the National Board of Examiners)
Fall 1971	Boiling Springs, PA	The Development of Educational Objectives for Teaching Programs in Medical Schools

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32th Annual Meeting -Squaw Creek Resort, Lake Tahoe, CA

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