Message from the Director

It has been a very busy and productive year for our PRIME-HEq community. Our students continue to make great strides academically and have remained fully committed to our surrounding underserved communities through advocacy and leadership. Students have participated in numerous community engagement activities, pre-health conferences, scholarly projects, as well as our Border Health Project.

It’s hard to believe that the academic year is almost over! As always, our students are at different transition points. Our Master’s degree students have been fully integrated into their respective programs, and have been involved and undertaken leadership roles in numerous initiatives addressing health disparities and social justice. Many have also had the opportunity to travel. We look forward to welcoming them back within the next few months. Our second year students are busily preparing for entry into the clinical world, and our third year students are making final decisions about their Master’s degree training.

As we prepare to bid farewell to our fourth year students, I recognize how fortunate we are to maintain such strong PRIME-HEq Alumni presence. As predicted, they are all doing amazing work. Featured in this newsletter are Drs. Anne Chmilewski, Juliet Okoroh, and Jacob Bailey. I hope that you also enjoy our new ‘Diversity & Community Partnerships Corner’

I wish you all a happy spring!

All the best,

Lindia

Lindia Willies-Jacobo, MD, PRIME-HEq Director
Lincoln High School – Health Equity

By Christian Lopez, MSII and Nicole Tantoco, MSII

Lincoln High School – Health Equity was born out of a desire to provide greater mentorship for Lincoln High School students and to learn more from the Lincoln Park community. This program seeks to engage students to explore health care fields by emphasizing their capacities to improve outcomes in underserved communities. One component of LHS-HEq are two TED-style assemblies in which health care professionals from diverse backgrounds share their stories, struggles, and motivations. The first assembly kicked off the program on October 16, 2014 and was attended by 500 LHS students. The second, closing assembly will be held on February 24, 2015.

After the kickoff, the main component of LHS-HEq has been a series of biweekly after-school sessions in which UCSD students facilitate discussions and teach clinical exam skills. The emphasis of LHS-HEq is cultural humility, health disparities, and social determinants of health. Our first few sessions explored the impact that various spheres of influence had on each person and how these affect health.

LHS-HEq has six clinical cases in which students are introduced to a patient, their health needs, their backgrounds, and physical exam skills. In one case, LHS-HEq participants learned about Miguel, an 8-year-old boy from Barrio Logan who was having trouble keeping up with his friends on the schoolyard. Participants learned that he likely had asthma, a chronic condition that disproportionately affects Barrio Logan’s residents as a result of the high rates of pollution from the shipyards. As a part of the case, they were guided through the basics of a pulmonary lung exam.

In the most recent after-school session, participants met Tom, a 66-year-old homeless veteran with a laceration requiring sutures. Dr. Toussaint Mears-Clarke, a family medicine resident from Chula Vista Medical Plaza, led a suturing workshop, as we discussed the challenges veterans face upon reintegration into civilian life.
A portion of each after-school session is dedicated to a student-led project. Participants identified a community need (greater access to healthy food options at lunch) and how they can positively change their campus environment.

LHS-HEq will conclude with a field trip to UCSD with a tour, practice multiple mini interviews (MMI), and a standardized patient encounter on February 21, 2015. The goal of the full-day field trip is to show the students that they belong at a university and at a medical school. The MMI and standardized patient counters are aimed at giving the students a safe space in which to practice communication skills.

This mentorship program has strengthened an existing partnership with Lincoln High School. Though this was the first year of the program, mid-point focus groups of the mentors and mentees showed tremendous support for its continuance. We are now working closely with Dr. McKennett to see how LHS-HEq can be supported by the Blue AC so that we can continue to learn from and with the Lincoln Park community.
By Nicole Tantoco, MSII

"I feel like America is not home for me," Naeemah Munir (MSI) shared with a group of about 35 UCSD undergraduate, graduate, and medical students, as well as some UCSD staff members.

The evening it was announced that there would be no indictment in the shooting of Mike Brown, Dr. Shaun Travers, a Campus Diversity Officer and Director of the Lesbian Gay Bisexual Transgender Resource Center, posted to Facebook that he would be facilitating a discussion on race. Word at the School of Medicine quickly spread, such that half of the people present were medical students. We arrived with heavy, angry hearts that were seeking ways of processing our emotions. Each of us shared our motivations behind our attendance—confusion, outrage, guilt, profound sadness—and it became evident that medical students sought spaces to explore race in America, our duties to fight entrenched systems of discrimination, and steps we could each take to deconstruct oppression.

Within a few days, we hosted a brown bag lunch discussion on race at the MET. Over 50 medical students attended and challenged each other: Would you be willing to put your privilege on the line, knowing the implications for your future as a clinician? What can be done by any individual to change racism in medicine? Why is the Ferguson case causing a big fuss? Why wouldn’t we want to say all lives matter? Opinions and emotions were very diverse, but one thing was evident: our peers wanted time to explore race and other oppressive forces, but the safe spaces for these discussions were largely absent.

An email from the SNMA regional listserv came to our attention: UCSF was calling for a protest in the form of a die-in to show solidarity with the rising #BlackLivesMatter movement. At UCSD, a powerful team assembled to organize our #WhiteCoats4BlackLives protest. While the devaluation of certain members of our society is an erasure of our humanity, it was incredibly humbling and comforting to see the collective energies of my peers come together. We developed a plan, recruited peers, and informed administrators. Medical students are often pigeonholed as socially apathetic because of their intense workload. #WhiteCoats4BlackLives was evidence that this assumption lacks veracity. It is easy to be cynical; the difficult task is to positively channel that energy into meaningful action that will result in change.
On December 10, 100 students marched and chanted from the School of Medicine to the Silent Tree in front of Geisel Library, “No justice, no peace.”
We began the protest with a statement of our purpose: “Medical schools across the country have selected a die-in to be the focal point of our nationwide demonstration because it is an image of the dehumanization black and nonblack bodies of color undergo on a day to day basis. From microaggressions to profiling to workplace and employment discrimination to housing discrimination to prison pipelines to hate crimes to the compound magnification of marginalization of black individuals with multi-tiered oppressed identities: black women, black queer women, black trans women, black Muslims.”

The die-in lasted for 11 minutes, one minute for each time Eric Garner said, "I can't breathe."

People walking by stopped to observe or ask questions, and several of our core organizers passed out flyers and spoke with them about our purpose. Our protest was not only meant to disrupt, but also to promote honest conversations based on facts. We used our platform to provide context for our fight.

During the open mic portion of the protest, participants shared their frustrations and hopes. We recited again the Hippocratic Oath--our promise to society that we will "remember that [we] remain a member of society, with special obligations to all my fellow human beings."

In our closing speech, we recognized that our white coats have been invested with a trust and power that we must use responsibly. Staging a die-in while wearing our white coats was meant to honor our profession by continually fighting alongside the oppressed.

Since December, a new organization at the School of Medicine called Medical Students for Justice has been formed. Students are working to partner with the San Diego Police Department to understand how police officers, fellow professionals dedicated to serving our communities, are trained to care for diverse populations. We are forming a bridge with the larger UCSD community to show that its medical students are social justice warriors.

#WhiteCoats4BlackLives was not a one day protest. It is a commitment that medical students have made to consciousness-raising and it is an invitation for all to listen, learn, and fight.

#WhiteCoats4BlackLives asked medical students to fight the discrimination that exists within our field. Biases permeate the medical establishment, contributing to health disparities and glass ceilings. Though at the bottom of the medical hierarchy, it falls under the purview of all health professionals (current and future) to initiate challenge conversations in order to effect change.

#WhiteCoats4BlackLives increased visibility of the intersectionality of marginalized identities. We are past the die-in, and we are changing the climate at the UCSD School of Medicine.
Inclusion of Surgery in Universal Health Coverage as a Matter of Social Justice

By Vicki Chia, PRIME Masters student completing MPH at Harvard University

The right to health and well-being was declared in the 1948 Universal Declaration of Human Rights (Article 25) and has been institutionalized by the World Health Organization (WHO). The implementation of universal health coverage (UHC) through national health insurance is one step that many nations have taken towards realizing this right, including nineteen low-middle income countries (LMICs) as of 2013. Although surgery is not traditionally seen as “cost-effective” compared to traditional global health interventions focusing on infectious disease and maternal-child health, from a social justice standpoint, it is unconscionable to ignore a rising global prevalence of preventable deaths due to non-communicable disease, including surgical conditions such as ruptured appendicitis, cancer, or traumatic accidental injury, especially because the prematurity of these deaths is related to poor infrastructure resulting from centuries of systemic global inequities in the flow of economic capital.

One day after Surgery Grand Rounds during my third year clerkship in summer 2013, Dr. Juliet Okoroh (UCSD PRIME-HEq Class of 2014, now a general surgery resident at UC San Francisco) and I were discussing the need to strengthen health systems in a way that reflects these shifting patterns in the global burden of disease. Juliet had recently finished her MPH in Health Care Policy at Harvard, the same program I will be completing in May. She had met several physicians in Boston, including a surgeon who works on surgical capacity-building in Rwanda. All of us were struck by gaps in the global health and surgical/medical literature on access to surgery as essential to global health systems strengthening.

Over the next year we conducted a review of the literature on coverage of and access to surgery in nineteen LMICs with established UHC plans. We examined policy documents, institutional reports, and national health insurance operating plans of these countries to determine what benefits and conditions were covered, and analyzed data on enrollment rates and cost-sharing in each of these plans and polices. While we found that many LMICs’ health insurance plans included coverage of conditions that are surgically treatable, we also found many challenges to de facto access to surgery, from low enrollment rates in the health plans themselves to the persistence of catastrophic levels of out-of-pocket payments even when services were ostensibly covered. This indicates that there is much work to be done on expanding financial risk protections, optimizing cost-sharing and identifying barriers to both utilization and delivery of surgical care.

Juliet and I presented some of our findings at the American College of Surgeons 2014 Clinical Congress in San Francisco, and I will be presenting more results at the Society of Black Academic Surgeons Annual Scientific Assembly in Chapel Hill, North Carolina, this April. This research supports the idea that discussions about UHC cannot exclude access to surgery. Working on this research has been enlightening, and through it I have gained access to a small but growing community of physicians that is dedicated to surgery access as a matter of social justice at a global level.

References:
2. Defined by the WHO has health care expenditures exceeding 20% of total household expenses.
Poster Presentations:

Ferrel, Vanessa (MSII), **Tantoco, Nicole, PRIME MSII**, Baseline Knowledge and Attitudes of Medical Students Towards LGBTQIA Communities, poster presentation at the Innovations in Medical Education Conference, USC, Feb 22, 2015

**Lopez, Alexis, PRIME Masters, Bailey, Jacob, PRIME Alumni**, Powell, Tamara, PhD, Garcia, Katherine, MA, Willies-Jacob, Lindia, MD, Program in Medical Education—Health Equity (PRIME-HEq): Training Future Physicians to Care for Underserved Communities at Risk for Health Disparities.

Conference Sessions:


**Fonseca, Silvia, PRIME MSII**, Thayer, Syney, MSII and Martins, Adeola, MSII, Hotspotting in a Student-run free clinic: A Pilot Project of a Medical Student Care Management Intervention for Complex Patients, presented at the Society of Student-run Free Clinic National Conference, Georgia, Feb 8, 2015.

Publications:

SUMMA Conference at Stanford

MLK Community Health Fair

PRIME-HEq Community Engagement

PRIME-HEq Retreat

MEDS Conference
Every year the PRIME community comes together at the PRIME Statewide Conference. This is an opportunity for our PRIME students to connect with other PRIME students from UCSF, UCI, UCLA and UCM. The 6th Annual PRIME Statewide Conference was hosted by UC Irvine and the theme was United for Advocacy. Highlights from the conference includes, Advancing Advocacy Workshops, Humanitarian Crisis Relief at the Border by Border Angels, keynote address by Assemblyman Don Wagner, Senator Lara, and Tony Iton, MD, JD, MPH, Senior Vice President for Healthy Communities, The California Endowment.

Save the Date
UC 7th Annual PRIME Statewide Conference
October 17-18, 2015, UC San Francisco
By Anne Chmilweski, PRIME Alumni, Class of 2013, Family Medicine Resident

I graduated from UCSD Prime in 2013 and am currently a second year family medicine resident at Scripps in Chula Vista. Essentially all my days are spent serving underserved patients in Chula Vista and National City, most of whom have Medi-Cal or are uninsured. Now that I’m in my second year and my schedule is a little lighter, I’ve had time to visit some projects in neighboring communities as well.

I recently had the opportunity to visit Calexico with the UCSD Border Health Project. This new location was pioneered by a medical student from Calexico in partnership with the women’s tennis team at the high school there. Calexico shares the border with the Mexican city Mexicali.

The health fair was set up in the flea market. Patients got diabetes and cholesterol screenings and then would meet with me to discuss their results. I learned that some women and men get in line to cross the border every morning around 3 am and can’t get across until 8 am. They then work in the fields on the US side until dusk and return home at 8 pm. The next morning, they get up and do it all over again! Some of these people are actually allowed to live in the US, but have family members who aren’t; cost of living is also lower in Mexico and some families just can’t make it on the poverty wages of the fields if they reside in Calexico.

Pay for such jobs is low. One of my patients, a woman in her 40s, had a blood sugar of 458—dangerously high. She had previously used insulin, but had run out of money to pay for it. Lantus costs about $400 a month and even suboptimal NPH or 70/30 is about $120-$300. She doesn’t have insurance through her US employer and because she doesn’t work in Mexico it seems she doesn’t qualify for insurance there either. She is very likely to be placed on dialysis, have a heart attack or stroke, go blind, or have an amputation by age 60 if she doesn’t have access to insulin.
My church recently started a relationship with a sister parish in Mexicali and for those who can’t cross the border, the situation is even worse. Workers in the maquiladoras make about $10 a day and are fired every 3 months so that the employer can circumvent Mexico’s law that requires employers to provide health insurance. Quality of care in the under-resourced clinics and hospitals can be variable.

I got another view of health care in Mexico a week later when I went with the Flying Samaritans to a clinic in Ensenada. This clinic is working to try to partner with local health agencies; for example, the day we went, the urgent care center was overwhelmed and we were able to see 150 or so patients that weren’t going to be able to be seen at the urgent care center. Only three of the eight doctors with Flying Samaritans were trained in family medicine and could see children, and there were many children, so they were quite grateful to have us family docs. I was grateful that there was a group of women volunteers from the Ensenada community, especially when we had a bulimic 5 year old patient. They were able to assist with a referral to child psychology services, although I will not be able to follow up to know if the referral works out.

I’m not sure what I will do after residency, but I’m glad to have a chance to stay involved with neighboring communities on both sides of the border. There is of course also the HFIT clinic and one of my residency cohort has worked with Partners in Health in Mexico and ultimately wants to set up rural residency programs there. He is currently working on setting up a partnership whereby we can help mentor Mexican interns. It’s not easy to take on very much during residency, but keeping some connection with these communities helps guide my current training and prepares me to be helpful to these communities after residency.

Anne Chmielewski, MD—PRIME Alumni, Class of 2013

Prior to medical school, Anne was involved with Americorps “Health Corpos: at SJP Health Center, Boston. She assisted in the development of JP Fit, part of a citywide campaign to address childhood obesity among the underserved. Anne received a Masters in Peace and Justice Studies from University of San Diego. Anne’s Masters project topic was “Protecting the Mental Health of Immigrants and Asylum Seekers: The Ethical Dilemmas of Locking Up a Vulnerable Population,” Anne received the Arnold P. Gold Humanism in Medicine Award. Her Hobbies include religions, social justice, global health, and hiking.

Anne is currently a second year resident in Scripps Chula Vista Family Medicine.
By Vanessa Ferrell, MSII

In August 2014, I began working with a few faculty from the Department of Psychiatry - Arpi Minassian PhD, Brian Buzzella PhD, and Jeri Muse PhD - on an LGBTQIA+ cultural competency module for the American Medical Association’s Introduction to the Practice of Medicine curriculum. The opportunity presented itself through one of my contacts from the Intersections of LGBTQ Health elective, and I jumped on it - it was the kind of impactful, educational work that really interests me.

Having just finalized the Intersections elective, I pushed for an intersectionality-focused module that would incorporate fundamental knowledge - through terminology review of identities and behaviors, clinical skills - through sensitive history taking, thorough screening, and non-judgmental interventions, and provider attitudes - through mindful checking of subconscious bias and counter-transference.

Ultimately, we settled on focus areas of 1) cultural competency, 2) differentiating between sex, gender identity, sexual orientation, and sexual behavior 3) health care disparities, and 4) strategies for screening and intervention.

We collaborated on a PowerPoint presentation and a few short clinical vignettes to highlight doctor-patient interactions, and wrapped up the project in late February by filming the module in its’ entirety. Each of us delivered different topics from the module, and I took on the task of differentiating between sex and gender, and defining aspects of gender expression, gender identity, and biologic sex.

This has been an incredibly rewarding experience for me, and I hope it is meaningful for people who view the module and has a positive impact on the health outcomes of our patients, especially those who self-identify as LGBTQIA+.
By Rosalind Streichler, Director of Cognitive Sciences

For many years, medical students recorded notes by hand. For those who were not fast enough or whose poor handwriting made it difficult to study from their notes, taking notes on their computers seemed to be a panacea. The notes were definitely easier to read, and for most students, keyboarding was faster than writing by hand. So why even think about handwriting your notes?

It turns out that there may be very valid reasons for writing notes by hand. The results of several studies have indicated that writing notes by hand strengthens the learning process. Anne Mangen at the University of Stavanger reports on an experiment where two groups of adults learned to write in an unknown alphabet (one group writing by hand and the other group keyboarding). After three and six weeks, their recall of the alphabet was tested. In both tests, the recall of the handwriting group was superior. Additionally, for this group, fMRI brain scans revealed an activation of the Broca’s area.

Further research by Pam Mueller and Daniel Oppenheimer supports these findings. Results from their studies indicated that "students who took notes on laptops performed worse on conceptual questions than students who took notes longhand." (Psychological Science, 2014, 1159). However, additional research has indicated that “typing as a method of note-taking may be an influential factor in memory retention, particularly in a lecture context.” (Schoen, I. 2, 2012).

It is important to note that none of these studies included medical students as subjects. While these studies provide important information upon which to base decisions about notetaking, it is suggested that students decide for themselves which method works best for them.

For some, the ability to take more notes when keyboarding may provide a comfort level when preparing for tests that is not obtained by writing notes longhand. For others, practice for many years of handwriting their notes and conceptualizing when taking notes may be a superior method. To help with this decision, students may review the sources below.

References:


Happy Birthday Wishes to our PRIMErs!

January
Jonathan Barboza 1/2
Nadine Patton 1/9
Katherine Garcia 1/9
Elizabeth Elman 1/19

February
Lue Lao 2/3
Lorenzo Gonzalez 2/3
Rene Garcia 2/4
Thomas Onyia 2/6
Ryan Huerto 2/12
Shonte McKenzi 2/26
Christopher Evans 2/27

March
Naeemah Munir 3/19
Kristin Parinella 3/22

April
Nicole Tantoco 4/13
Kim Nguyen-Ta 4/21

May
Diana Garcia 5/7
Richard Kow 5/16
Jessica Cruz Whitley 5/18
Dami Soyode 5/23
Christian Lopez 5/15

June
TC Robbins 6/23
Phuong Tran 6/25

For more information about UCSD PRIME-HEq:
https://meded.ucsd.edu/index.cfm/asa/dcp/primeheq