Connections: Partners in Health
Contributing Authors

We would also like to acknowledge the support and contribution of Dr. and Mrs. Philip Pumerantz; Debra Nelson, Graphic Designer, WesternU Communications/Publications Department; university photographers Jess Lopatynski and Jeff Malet; Jeff Keating, Executive Director of Public Affairs; and all creative individuals who submitted photography and artwork. Without them, this issue would not have been possible.

Cover photo by Jackie Pham, DPM '13
Suliman Rastagar, DO ‘12

As I gaze across our ever expanding campus, it strikes me over and over again how we students and faculty have maintained our principles of humanism and service to humankind throughout this supercharged evolution of sorts. With new colleges and the constant buzz of even more colleges to be added to Western University of Health Sciences, nowhere is the spirit of cooperation and service more apparent than right here in the pages of the Humanism Journal. It is with this perspective that I welcome the new colleges to the already existing family and take pride in the knowledge that together we are well underway to fulfilling our promise to our community.

Angeline Ng, PharmD ‘12

This is my second year as co-editor for Humanism Journal, and as a pharmacy student at WesternU. In the past two years, I’ve become a part of the WesternU family, learning from professors, working with teammates, and interacting with students from other schools. Appropriately, our theme this year is “Connections: Partners in Health,” and it incorporates not only how we interact and work together at school, but in our profession. With WesternU’s opening of the Health Education Center and initiation of the Interprofessional Education (IPE) program, our school is still growing, and expanding interprofessionalism in our daily lives. I’m excited with this year’s issue, as it reflects our school, and allows our WesternU family to get a glimpse of what other students and faculty have to share from their fields.

Lana Grinberg, DO ‘13, Editor-In-Chief

A very wise friend of mine once said that “Power without humanity does not make a hero, but a thug.” Humanity is not simply our species, it is our creed, and we must protect the humanity within us all, or perish in the darkness of ego and malaise. It is a battle fought daily within us and among us. We must rise each day anew, bracing ourselves, and bonding with our fellows to look wrong in the eyes and send it on its way. We are stronger together, united as a profession of healers, realizing that alone we are but one drop, but together we can create a tidal wave. It is a fascinating time of great change and debate. Throughout these times we must believe in that one universal and uniting truth – humanity is within us and among us. We must choose to embrace it completely and wholeheartedly. It has been an honor working on this issue of Humanism magazine and witnessing the humanity among the WesternU community and my peers. I deeply hope that you enjoy our efforts!

Huyenlan Nguyen, DO ‘13

This year has truly been a remarkable year for WesternU. From our new building to the new professional programs, the WesternU family has had a busy year. Through it all, one thing remains unchanged: a strong commitment to humanism. As a first year co-editor, I was impressed with the number of submissions we received from students, staff and faculty members. Every time I came across a beautiful photograph, an intriguing poem or a heart-warming story, I was reminded of why I joined the Humanism magazine team. Being able to appreciate the fine details of a piece of art, or share in one’s personal journey, is essential when approaching life in a humanistic way. It is easy to get caught up in the hustle and bustle of an academic lifestyle, so I hope this year’s magazine allows you to take a moment to relax, learn and enjoy.

Beth Boynton, DVM

Professor of Wellness, Director of Hill’s Wellness Center, College of Veterinary Medicine

We live in a world intricately connected. As health care providers, we have enhanced connection with our Interprofessional Education curriculum, where students from every college converge to solve issues relating to individual, family, and community health. The One Health Initiative mission states, “that human and animal health and mental health are inextricably linked and to promote, improve, and defend the health and well-being of all species by enhancing cooperation and collaboration between physicians, veterinarians, and other scientific health professionals and promoting leadership and management to achieve these goals.” We are making profound steps in this direction. We seek to go further. We celebrate the humanistic outreach by so many on these pages, in this community and around the world. As individuals and as a country, we must address the myriad of factors affecting health, including environment, access, population, and economics. We cannot escape the face that the health of this planet affects our health and future profoundly. As we enjoy the beautiful images and prose in these pages, we celebrate the humanistic efforts by so many at this university, and continue to work and advocate for a better tomorrow.

Thank you to all the editors who made this publication possible.

James Martin, Dr.rer.nat.

Professor of Physiology and Behavioral Sciences, College of Osteopathic Medicine of the Pacific

Humanism and empathy, combined with science, are the cornerstones of modern health care. Humanism is, obviously, all about us—the most successful and dominant species on the planet. Does universal health care or One Health mean we are a healthy species? Probably not. As human populations have expanded, human endeavor is increasingly in conflict with the biological and ecological foundations that sustain our existence. Should we continue in this direction, all human endeavor including art, architecture, literature, and science, will decline and ultimately end. Harvard professor E.O. Wilson argues that a new way of understanding human endeavor is needed—a way to unify humanism and science and a way to embrace nature as a part of our identity. He called these concepts *consilience* and *biophilia*. The health of our species can improve, if we can extend empathy for other individual persons or empathy for individuals of other species and to concern for the living world around us. It is the responsibility of all health care providers to embrace a concept of human health that recognizes the dependence of human health on environmental health. Not to do so represents a failure of science and humanism. In this magazine, we hope that Wilson’s ideas of consilience and biophilia will resonate in the essays and photographs and will find expression in the lives of all of our students. We hope you will enjoy this effort by our student editors and contributors.
WesternU is firmly connected on several levels with its home community of Pomona, as well. Our Pomona Community Health Action Team (PCHAT) participates in health fairs and visits schools to provide glucose screenings, blood-pressure checks, and a variety of other health-maintenance care to anyone in the community. The Pomona Homeless Outreach Project offers similar services targeting the city’s homeless population.

Connecting with young people – tomorrow’s health-sciences professionals – also is an important part of WesternU’s mission. The Pomona Health Careers Ladder, a partnership between WesternU, Pomona Unified School District and California Polytechnic University-Pomona, offers monthly, on-campus workshops for sixth- and seventh-graders to acquaint them with health-careers options and to put them on a path to graduating from high school, earning a bachelor’s degree from Cal Poly, and ultimately earning a health-sciences degree from WesternU.

Our University also is making connections far beyond the boundaries of our Pomona campus. In addition to the many partnership agreements we have struck with sister universities throughout the United States and across the globe, WesternU is establishing an altogether new osteopathic medical school in Lebanon, Oregon. This institution, COMP-Northwest, will train doctors from the Northwest, in the Northwest, to practice in the Northwest. WesternU’s presence in the region re-affirms its relationship – its connection – with the Northwest osteopathic medical community, which was so important in the establishment of COMP in Pomona more than three decades ago.

All of these connections are important, and are keys to the continued growth and success of WesternU. But none are more important than the connection all of our graduates must make on a daily, sometimes hourly, basis – the bond between patient and caregiver. This one-on-one connection between a caring, compassionate, expertly trained health-care professional and the person seeking his or her care is paramount, and is the foundation for all that we teach and all that we do at Western University of Health Sciences.

Provided by Michael Corpuz, DPM ‘13

Connections: Partners in Health

The theme of this year’s Humanism magazine, “Connections: Partners in Health,” is one especially fitting one for the WesternU community. The connections between our students, faculty and staff are paramount to the successful operation of an institution that produces the very finest health-care professionals, and to creating an environment that fosters teamwork, innovation and compassionate care.

But our campus is only the most visible outward sign of how WesternU is “connecting” each day. Countless other critical connections – less obvious to the casual observer, but important nonetheless – are being made here and everywhere WesternU students, faculty and staff carry out our mission.

On campus, we have embarked on an Interprofessional Education (IPE) curriculum that perfectly captures the essence of “Connections: Partners in Health.” WesternU’s IPE program is putting students from the University’s various disciplines together in the classroom, in small group venues, and in clinical experiences with patients. The goal is for WesternU graduates to demonstrate an understanding of other health professions, and to provide and promote a team approach to patient care and health management.

On a global scale, WesternU is establishing an altogether new osteopathic medical school in Lebanon, Oregon. This institution, COMP-Northwest, will train doctors from the Northwest, in the Northwest, to practice in the Northwest. WesternU’s presence in the region re-affirms its relationship – its connection – with the Northwest osteopathic medical community, which was so important in the establishment of COMP in Pomona more than three decades ago. All of these connections are important, and are keys to the continued growth and success of WesternU. But none are more important than the connection all of our graduates must make on a daily, sometimes hourly, basis – the bond between patient and caregiver. This one-on-one connection between a caring, compassionate, expertly trained health-care professional and the person seeking his or her care is paramount, and is the foundation for all that we teach and all that we do at Western University of Health Sciences.

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“Forget the light, head toward the music at the end of the tunnel.” Barcelona, Spain

“Camels (do or don’t spit) — true story.” Sahara Desert, Africa

“You can stand under my umbrella.” Madrid, Spain

“Ready for takeoff.” Central Park, New York

“Not much further.” Croton-on-Hudson, New York

“Not much further.” Croton-on-Hudson, New York

“Not much further.” Croton-on-Hudson, New York
Connections: PARTNERS IN HEALTH

By Joan Sandell, DMD
Assistant Provost for Strategic Operations and Clinical Services

At Western University of Health Sciences, because we understand the connections of a complex physiologic system, our health care providers are taught to have a knowledge, appreciation and understanding of what the other health care professions can offer their patients toward all of the benefits of optimal health.

A successful global economy needs experts that know how to connect and partner as they integrate the multifaceted aspects of economics. A successful health care system and team demands the same. Not only is disease a complex web of systemic factors, optimal health is also a product of complex and interrelated factors, many of which can be controlled by daily lifestyle choices. At the WesternU Patient Care Center, we embrace and practice patient education that allows individuals to learn and encourages them to make the right lifestyle choices for a healthier existence. We also recognize and put into practice the necessary partnering and connections of both the patient and other appropriate health care providers that will result in optimal health care solutions and management for each of our patients.

The Patient Care Center houses five distinct centers where patients will receive specific services. The Eye Care Center and Pharmacy are on the first floor. The Medical Center, Foot & Ankle Center, Interprofessional Suites and Pomona Valley Imaging Center are on the second floor, and the Dental Center is on the third.

While the faculty and students in each of these centers are examining and providing care to their patients relative to their specific professions, they are doing so with the discerning knowledge and perspective of partnering with the other professionals in the building, a natural step toward providing the finest health care for their patients.

So when President Pumerantz asks, “What will the patients in our Patient Care Center get that they might not get elsewhere? Why will they come to us instead of going somewhere else?” I answer him in his own words.

“By living the founding philosophy of this institution — medical excellence through science and humanistic, compassionate care — we will never go out of style. Indeed, what we offer will become more critical with each passing day. We are here with the overarching goal to improve the lives of our community.”

At the WesternU Patient Care Center, we know that the ankle bone is connected to a whole lot more than the leg bone.
IPE allows us to work collaboratively, communicate, discuss, and assess health care issues.

By Huyenlan Nguyen, DO '13

When I first came to WesternU, I thought it would be like any other typical medical school. Medical school would be a challenging endeavor consisting of hours of lectures, library dates with classmates, coffee, studying, stress and Apreso. Little did I know that WesternU had something different planned for all first-year students: an interprofessional curriculum. This year the colleges of Optometry, Podiatry and Dentistry welcomed their first classes. Since some of our courses overlap, we are taking them together. Through this integration, we are able to learn together and build friendships with one another. However, the concept of combined classes is not where the interprofessional curriculum ends; instead, it became an introduction to WesternU’s newest course, Interprofessional Education (IPE).

The IPE course incorporates nine colleges from the WesternU family: medicine, optometry, dental medicine, podiatric medicine, veterinary medicine, physical therapy, physician assistant, nursing and pharmacy. Western University is the first school to ever incorporate an interprofessional course consisting of this many professions. More than 80 faculty members, headed by Vice Provost/Academic Affairs and Chair of IPE, Dr. Sherre Aston, developed the course.

Students are broken up into small groups and presented with case studies that we must all work through together, bringing to the table knowledge from each of our respective backgrounds. I initially thought IPE would be an extension of what I was already experiencing with the combined classes, except that it would include more students from the other health professions. However, after the first meeting with my group, I soon learned that IPE incorporated more than just general knowledge and awareness of each other’s professions. IPE allowed us to collaboratively work, communicate, discuss and assess health care issues.

The first case study involved a patient who came in for a dental appointment. It was later revealed that many other health issues needed to be addressed, such as primary care, optometry and podiatry. The case also shed light on cultural, ethnic, and socioeconomic differences that we, as future health care providers, would need to be sensitive to.

As a team, we were encouraged to research any learning issues that we thought would be pertinent to the patient’s background and community affect the treatment plan?” to “What caused that specific symptom?” and to “How does the patient’s personal background and community affect the treatment plan?”

This opened the door for each of us to express our opinions, personal experiences, and ideas as to what could be done. Through the discussions, it was evident that there is an advantage to approaching health care in a team-based manner.

Dr. Susan Mackintosh, the course director of IPE, expressed the importance of open communication and establishing relationships with different health care professionals in order to create community-based medicine. This was not something that she was taught in her first two years of medical school; it was knowledge that she gained through her residency training and experience in public health. The IPE course was created to allow students to gain this vital experience early in their professional education.

Given that this is the first semester of IPE, student feedback has been central to assess perception of the course. Students are encouraged to give honest opinions as to what they have learned and what aspects of the course could improve. Lea By Dr. Orzoff, collection of this data is important in determining whether the course objectives are being met.

Some of the objectives include communication and collaboration, knowledge of health professions, awareness, and resolving ethical conflicts. Continued communication from students will help faculty members make the necessary adjustments to the curriculum.

All in all, IPE has been a refreshing experience in our busy and packed schedules. It is meant to be a stress-free, Apreso-free course because we are simply graded on attendance and participation. It is more than just another class weaved into our curriculum; IPE is an opportunity to grow in our knowledge of the connecting health care system and to establish relationships with one another.

The small group environment especially fosters this relationship. Similar to how osteopathic physicians are trained to treat patients holistically, emphasizing that all systems of the body are interrelated, IPE trains ALL of us to approach patient care together, as partners in health.

I would like to thank Dr. Aston, Dr. Mackintosh, and Dr. Orzoff for sharing with me their insights on IPE and for allowing me to use his photos. Below left: IPE Grand Rounds, January 27, 2010. Below right: IPE Day One, January 13, 2010.
Interprofessional Education:  
HISTORY IN THE MAKING

By Drs. Sheree J. Aston, Susan Mackintosh and Jordan Orzoff  
Photos by Jess Lopatynski and Jeff Malet

Wednesday, January 13, 2010, marked an important date in the history of Western University of Health Sciences (WesternU). This day saw the launch of the Interprofessional Education (IPE) program at WesternU, with the much-anticipated unveiling of IPE 5100 – Patient Centered Cases – An Interprofessional Approach.

For more than two years, teams of faculty from all nine health professions programs at our university tirelessly collaborated to develop and test the unique IPE cases.

Since a picture is worth a thousand words, we offer you a “behind the scenes” look at the preparation and implementation of IPE 5100.

Orientation for the initial pilot study in the spring of 2008 set the stage. First-year students from all nine health care programs participated in the study.

Faculty from all nine programs, acting as first-year students, field-tested the cases in February 2009.

Final revisions for the three cases were tested with actual students in the summer and fall of 2009.

In the fall and winter of 2009, 182 faculty and administrators completed large and small group facilitator training.

Week one: 851 students and 94 faculty facilitators begin IPE case-based learning on January 13, 2010.

Week two: the case continues and concludes. Students can still anticipate Grand Rounds for Case 1 and two more cases for the 2010 spring semester course.

While this may seem like the culmination of years of work, the IPE journey has just begun for WesternU. As a stone dropped in a pond creates a ripple effect, we believe the ripple of WesternU’s IPE program will help change the face of health care.

The end of this picture-book story is really just the beginning...
Photo Gallery: Tim Snyder, DPT '10

“The Copper Sunset”

“San Clemente Pier”

“Splash”

“The Red Sunset at Dana Point”

“Oceanside Sunset”

“Butterfly in Admiration”

“The Red Sunset at Dana Point”
At medical school orientation last year, University staff explained that although the next four years of training may feel daunting and challenging at times, we must remember what the end goal is: the patient. Health care is about the patient.

On January 11, 2010, you could hear the boasting chants of “Hey hey, ho ho, health care greed has got to go!” ringing out throughout most of the day around the capital building in Sacramento. Well over 1,000 health care students, health care workers, and supporters met in Sacramento for Lobby Day to promote SB 810, the single payer universal health care bill. This bill, which had been vetoed twice by the governor, called for a drastic overhaul of the California health care system, ensuring complete coverage for all California residents.

The opposition argued that the proposed bill was indicative of a socialist system. This is far from the truth. The bill would implement a single public insurer with the existing private delivery system. In other words, everyone would have the freedom to choose health care providers without the limitations of private insurance plans. Under this bill, administration and prescription drug costs would drastically decrease, and California families would have more money in their pockets thanks to the extinction of skyrocketing premiums and monthly payments.

Lobby Day was a great way for students to get involved with, and express their ideas about, the non-medical issues in medicine. The event was organized by the California Health Professional Student Alliance, which successfully united advocates from around the state in order to express a basic idea: health care is about the patient, not about profit. As student health care professionals, it is important to go beyond our studies and become involved with policy, reform, and improvement of the health care delivery system. Great practitioners need to understand how to treat a patient’s disease and how that treatment will impact the patient’s life, including their wallet and financial well-being.

During Lobby Day, we were able to meet many victims of the failing health care system, who chanted along with us on the Capitol steps. Some of these victims were thousands of dollars in debt due to health care bills; others had ailments they could not afford to treat. These mothers, fathers, brothers, sisters, neighbors and friends were fighting for change. We as students of health professions need to fight for what we believe in and stand up for our professions and our patients, whether it is in support of SB 810 or a completely different issue. Not only is it necessary to train to be the best physicians, podiatrists, optometrists, dentists, physician assistants, physical therapists, nurses, health care administrators, pharmacists, veterinarians and researchers we can be, but we must also critique and improve the professions we are joining and the health care system as a whole.
There are countless interested parties, not the least of which is the medical industry has become in the United States. It is obviously not a simple undertaking to disassemble and subsequently reassemble the machine that clients outside of delivery rooms, and the politics of big organizations.

A BRIEF HISTORY OF HEALTH CARE REFORM IN AMERICA

REFORM:

HEALTH CARE

A WesternU Perspective

Introduction by Lana Grinberg, DO ’13

For the past year, we have all watched as Congress has struggled to decide the fate of medicine in this country. It is obviously not a simple problem to unravel the impending changes, we solicited comments from several deans. We at Western University of Health Sciences have nine programs, which provide health care needs by addressing community health, health promotion, and the underinvestment in uninsured Americans, and the political system to promote healthy lifestyles.

To meet the growing health care needs of the United States, the health workforce must change in size, distribution and preparation to better reflect the diversity of our population. Increasing student and faculty diversity in the health sciences is critical to the success of any health care delivery strategy. Traditionally, most come to health care education through clinical disciplines. However, Department of Health Sciences Education graduates excel in the art of adult education, program planning and implementation, and educational research, and can address health care needs by addressing community health, health care administration, and systems management needs.

The changes that the president recommends are already coming to pass in the physician assistant profession. Ninety percent of physician assistant (PA) students in clinical rotations are already using electronic medical records. One key issue in the President’s plan is preventive health care, and the PA profession continues to lead this charge. Accreditation standards for PA schools require preventive health care and health care delivery systems in their training curriculum. WesternU’s Department of Physician Assistant Education has taught students health promotion and disease prevention as a formal topic for more than 15 years, and within the health promotion context, believes in the importance of reaching out to local schools to address health care concerns. Over the years, our PA students have provided informative talks on health issues to many of the elementary, middle, and high school students in the Pomona Unified School District.

The changes in the president’s health package are many, and the PA profession will be among the practitioners ready to take health care to the next level.

The American Physical Therapy Association (APTA) represents 72,000 members and their patients, and stands ready to assist the administration and Congress in achieving reform that will enhance patient care, access and value. As a bipartisan health care provider association, the APTA has identified the following top priority areas: repeal of the therapy cap, direct access, adequate workforce, and student loan repayment.

The House of Delegates of the APTA hopes to see the elimination of payment policies that impede patient access to cost-effective rehabilitation services provided by physical therapists. Further, it supports provisions that ensure rehabilitation services enhancement, and that a distinct physical therapy benefit is available to all. Finally, the APTA would like to see the development of a national strategy to ensure that an adequate health care workforce exists to meet the needs of patients. This entails incentives such as student loan repayment.

A BRIEF HISTORY OF HEALTH CARE REFORM IN AMERICA

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<td>1929 – A local teachers’ union in Dallas, TX, contracts with Baylor Hospital to create a pre-paid program in what is thought to be the nation’s first example of modern group health insurance. The model becomes popular across the country and is the predecessor of Blue Cross organizations.</td>
<td>1934 – President Franklin D. Roosevelt signs the Social Security Act as part of the New Deal. The Act provides benefits to retirees and the unemployed, and a temporary benefit at death, but does not include a health insurance component that was initially proposed.</td>
<td>1946 – Congress passes the Hill-Burton Act to provide federal grants and guaranteed loans to finance the construction of hospitals. The Act requires hospitals receiving funds to provide a “reasonable amount” of charity care, and prohibits discrimination based on race, religion or nationality.</td>
<td>1946 – President Truman proposes a system of public health insurance. It is denounced as a socialist approach to medicine by the American Medical Association (AMA) and does not pass.</td>
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commitment to educating the next generation and caring for the active duty family created such a wonderful sense of belonging and service that our weakest links became stronger and more engaged in their responsibility as health care providers and not just health care workers.

How can we salvage or move in an incremental way toward this type of care for all Americans? Does the current legislation move us along that continuum? Will the final product, if there is one, just be a reshuffle of the chairs on the Titanic? Until we get answers to health care professional education financing, loan repayment opportunities, residency development funds and an understanding that the practice of health care delivery cannot be legislated, it must be inspired and rewarded in the “place of care” both financially, and more important, emotionally. Otherwise, we will only have health insurance reform, not health care reform.

From the College of Dental Medicine

James J. Koehl, DDS, MS, MJ, Founding Dean

While the prospects for a complete overhaul of the health care system are uncertain, there are still elements in legislation being proposed that could have an impact on dental education and the dental profession at large.

Increasing Teaching Capacity: This legislation would provide grants for teaching health centers to establish new accredited or expanded primary care residency programs. General and pediatric dental residency programs would be eligible.

Community-Based, Interdisciplinary Care: This legislation would help fund community-based teams to support patient-centered medical homes. This would include grants aimed at the following: to primary care providers for support services; to community-based, interdisciplinary, interprofessional teams to support patient-centered medical homes; support collaboration with local providers to coordinate disease prevention and case management and to develop and implement interdisciplinary care plans; and to provide resources to local primary care givers to provide cost-effective, patient-and-family-centered culturally appropriate care. Programs would need to include all stakeholders in program design and oversight.

This legislation would also fund a new program to support Community-Based Collaborative Care Networks to provide coordinated, integrated health services to low-income and medically underserved populations through a consortium of health care providers.

Oral Health Prevention Program: Funds would be provided to the Centers for Disease Control to implement a national prevention program. This would include demonstration grants to community providers for research in management of dental disease. It would also provide grants to 50 states, territories and tribal governments for oral health leadership; to build oral health data systems; to improve oral health delivery; and to implement dental sealants, water fluoridation and other prevention programs.

Training Programs: This legislation would fund grants to facilitate the development of cultural competency training programs and interdisciplinary training programs to promote cultural/linguistic competency training for health professionals to address health disparities and to promote delivery of care through an interdisciplinary, team-based model that coordinates care across settings.

From the College of Osteopathic Medicine of the Pacific

Karen Hanford EdD, MSN, FNP, Founding Dean

From the College of Graduate Nursing

Karen Hanford EdD, MSN, FNP, Founding Dean

While the recession has made it difficult for new registered nurses to find an entry level position, this is temporary. The future of nursing is very bright, and nursing is considered to be the No. 1 job for employment nationally. National health reform, if passed, will only increase the number of jobs for advanced practice nurses to provide primary care.

Despite these challenging times, this is an exciting time for the College of Graduate Nursing (CGN). Enrollment in all CGN programs continues to expand, and graduates are highly sought after. Since 2008, we have offered a Doctor of Nursing Practice degree. These graduates will be the change agents that will drive transformation in health care. Due to the complexity of health care, nurses who are prepared at the highest level will be in greater demand. Quality and safe health care is America’s agenda, and nursing is key to the success of our health care system.

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The ultimate structure and potential impact of health insurance reform legislation remains uncertain. And we know from the sage philosopher Yogi Berra that “It’s tough to make predictions, especially about the future.” So instead of making predictions, or discussing a snapshot of current legislative initiatives, I will take this opportunity to share some of the work being done to frame the “ideal future” of a health care system. We here at Western University of Health Sciences are used to approaching complex problems with optimism and idealism, so keeping our eyes on the best and most desirable future can serve as a valuable guide.

I would like to share the perspectives of two national associations, both of which are dedicated to improving and protecting the health of the public, while supporting collaboration between health disciplines. I am proud to say that I am a member of both organizations. I find the information that I receive from the associations to be extremely helpful, and I would encourage every member of the WesternU community to learn more about what these organizations have to offer.

The first perspective comes from the National Academies of Practice (NAP). The NAP is an interdisciplinary organization of health care professionals representing 10 disciplines, and its mission is to serve as distinguished advisors to health care policy makers in Congress and elsewhere through the development of public policy papers, interprofessional dialogue, and interprofessional forums. Through its analysis process, the NAP has put forth a recommendation for an accountable, coordinated health care system that promotes and supports a variety of health care professionals in providing integrated patient-centered care and optimal outcomes across all settings, types of care, and throughout a patient’s lifespan.

The NAP has several recommendations regarding the steps necessary to achieving an accountable, coordinated health care system in the U.S. Most relevant to WesternU are recommendations for federal investment in “cross-professional” training within health professions schools and through graduate internships and the development of interdisciplinary teams.

The second perspective comes from the American Public Health Association (APHA). The APHA is the oldest and most diverse organization of public health professionals in the world, and has been working to improve public health since 1872. APHA represents a broad array of health professionals striving to promote the scientific and professional foundation of public health practices and policy. The Association has 27 primary sections that represent major public health disciplines or public health programs, including each of the different disciplines working together at WesternU.

Through its analysis and advocacy processes, APHA has also developed recommendations for health care reform. Its policy states that we must ensure coverage for high-quality, affordable health care for all, emphasizing that this means covering the more than 46 million individuals who are uninsured, while also improving the quality and safety of the health care system and building a modern health information infrastructure.

The association makes a number of recommendations for reform, including several that have the potential to impact WesternU. APHA asserts that health reform legislation must significantly increase support and funding for programs that provide loan repayments, scholarships and other grants for the training of public health personnel, primary care physicians, nurses and other health providers. It must also improve the distribution and diversity of health professionals in medically underserved communities, as well as ensure there is a capable health workforce able to provide care for all Americans and respond to the growing demands of our aging and increasingly diverse population.

I don’t know what to expect as we continue to observe the legislative process, but I do know that I have the opportunity to stay informed about what is happening in Washington. I also have the opportunity to work toward a brighter future, where we are able to make these recommendations a reality through our ongoing interprofessional collaborations here at WesternU.
Children

“Daddy’s home, Daddy’s home, Daddy’s home,” is a ditty I hear almost every night, sung by Aiden (6) and Thomas (3), silhouetted in the door to the garage. I stir up a frenzy screaming “Aiden, Thomas, Aiden, Thomas, Aiden, Thomas” as fast and as loud as I can. In the background, my wife, carrying a near-term baby boy, sighs in relief that their energy is directed at someone else. Life lesson #1 is to show proper enthusiasm.

On Tuesday nights, we go to a local pool an hour after dinner for a bit of family time. My wife taught the kids to jump into the pool on the command “butter, butter, pop.” On Saturday mornings, I am sitting in lecture learning about the task at hand: becoming a doctor.

On Sunday morning we make colored waffles in the waffle iron. Each child alternates putting in an ingredient. Sometimes we mix up all the batter without making a food coloring mess, but Mommy is usually still sleeping, so we have plenty of time to clean it up before she wakes. Then we pour our colorful creation into the waffle iron and wait in total silence for about 3 minutes for the light to turn green. My children are always very excited, but this moment is a little sad for me because after breakfast I go to school and study for the rest of the day. Any kid can teach you life lesson #4: Enjoy the moment.

Monday morning, I am sitting in lecture learning about the numerous ways genetics and our immune system can let us down. My focus is up a notch, knowing I need to learn much of this information the first time because there might not be a chance to learn it later. My mind drifts back home; the little baby kicks my wife from the inside and reminds her that it is almost time for him to come out and play with us. I repeat the cardinal motions of labor over and over in my head. Then I return my attention to the task at hand: becoming a doctor. Life lesson #5: With proper balance, you can have it all.

On Saturdays we go on family adventures. We’ve been to almost every Southern California beach, Sea World, Disneyland and Palm Springs. But a quick drive up Mr. Baldy with a lunchbox full of peanut butter and jelly sandwiches brings me close to heaven. I think playing with stones in a creek is a microcosm of life. The never ending stream of water shows us that there are powers greater than ourselves. But the careful placement of river stones teaches us life lesson #3, that we may not change the whole world, but with hard work we can make a difference.

AIDS WALK

Dennis Andrew Ancheta, PharmD 2013

A number of WesternU students came out to support the 25th Annual AIDS Walk on October 18, 2009. It was a spectacular event to see different organizations, health care providers, and students unite and walk 6.2 miles to raise funds for AIDS research. From the College of Pharmacy, the Class of 2013 and one of its respected faculty members, Dr. Khassawneh, worked together and donated well over $400.

TOY DRIVE

Ronald Armado, PharmD 2012

During the month of December, I had the pleasure of working with Mike Trillanes, PharmD 2013 Class President. We took part in a toy drive for Pomona Valley Hospital Medical Center, benefitting the Sick Baby and Hospital Assistance Fund. Combined, our two classes filled each of our donation boxes and collected more than 35 toys and stuffed animals. The toys were distributed to children coming out of surgery because they are soft items for them to hug and to hold while they are recovering.

As future pharmacists, we are the front line of the medical profession, as we are the most accessible to the community. When we are in lecture or working on SOAP cases, we are often so caught up in treating the disease that we forget that our priority is to treat the patient. We were both fortunate to take part in this philanthropy because we were able to deliver the toys to the hospital. We were greeted by Lindsey Medina, the volunteer coordinator, who explained what the toys were for and how much they appreciated our efforts. We thought we were just collecting toys for children to play with; we did not realize that these toys were given to children coming out of surgery, and ultimately, how much these toys could impact these vulnerable children. Through this experience, we gained a new perspective that the diseases we are treating are actual people, with real feelings and real fears. Realizing this, we were enlightened to know that these toys would help these children, who might be lying in that hospital bed afraid of their surroundings. We learned that the best thing for these children to do is to smile, to know they have a friend, and be assured that they are in good hands.
The American Pharmacists Association (APhA) was the first established pharmacist association in the nation, and the root of many pharmacy organizations that branched off thereafter. Composed of pharmacists, pharmaceutical scientists, pharmacy students and technicians, and others dedicated to advancing the profession, we have become partners in health. As WesternU students, we would like to remind the community that pharmacists are educators, health care providers, and an important connection to the health profession, and not just pill counters.

**MRM 2009**

On October 16-18, 2009, members of WesternU’s APhA attended the APhA Midyear Regional Meeting (MRM) in Albuquerque, NM. This student-focused conference was a great opportunity for students from several states to meet and learn from each other. The main highlight was the legislative component. The APhA-ASP Policy Process was initiated here, with students given an opportunity to debate their positions on a variety of proposals, then vote on the measures. The proposals dealt with issues pertaining to pharmacy students, practicing pharmacists, and the medical profession as a whole. Proposals accepted will move on to be debated at the APhA Annual Meeting & Exposition this year in Washington, D.C.

**AIDS AWARENESS**

UNAIDS estimates there are now 33.4 million people living with HIV, including 2.1 million children. During 2008, some 2.7 million people became newly infected with the virus, and an estimated 2 million people died from AIDS. Around half of all people who become infected with HIV do so before they are 25, and are killed by AIDS before they are 35.

On Dec. 1, 2009, we promoted World AIDS Day by encouraging students to participate in a “Wear Red” campaign. The idea was simple: Everyone just had to wear something red. We passed out red ribbons to spread awareness of the ongoing devastation that is caused by HIV/AIDS, and a photo was taken of everyone wearing red ribbons. The red ribbon is an international symbol of AIDS awareness to demonstrate care and concern about HIV and AIDS and to remind others of the need for their support and commitment.

**ONGOING GOALS**

We are focused on elevating our community work by incorporating innovative ways of educating our community about various health problems. We have four subcommittees that are focused on specific health issues (Diabetes, Hypertension, Heartburn and Immunizations) and a subcommittee on a project called Chapters Helping Advocate Needy Communities Everywhere, or CHANCE. CHANCE allows us to collaborate with a 340B-eligible facility (STD or TB clinic) to design a plan to help patients receive counseling, as well as medications at a reduced cost rate.

Health events are an integral part of our organization, and our goal is to be as interprofessional as possible. We want to collaborate with other student organizations on campus to bring about a more unique experience for patients. By reaching out to the community through health events and being more “hands on,” we hope that our services will motivate people to live healthier lives and be aware of the risk factors that can lead to disease.

Our health events are also great opportunities for student pharmacists to practice their skills and work within their community. We encourage our students to provide patient education that is more interactive, to ensure that it is memorable for patients. As always, we are focused on showing the community that pharmacists are great health advisers and caretakers due to our accessibility and medication knowledge. We hope to further build that bond with our community through our health events.

**APhA IN THE COMMUNITY**

Nogie Demirjian, PharmD ‘13  
Stephanie Gleiberman, PharmD’12  
Hazel Hang Tran, PharmD ‘13  
Charles Lam, PharmD ‘13  
Angelene Ng, PharmD ‘12  
Nichelle Nguyen, PharmD ‘13
Andrew Ayre, DVM ’11

It’s 5:30 a.m. The first of our alarms rings violently, resounding off the concrete walls of the garage where we are sleeping. With stacks of wood and tools piled near a large garage door, this home away from home was one of many where we laid our heads during the Arizona trip with Rural Area Veterinary Services in May, 2009. RAVS provides veterinary care for animals in communities where no other animal services exist, including communities on Native American reservations. Unfortunately, this alarm was mine. The sun had yet to rise, but I needed to start my day early to prepare for the rush at 7:30. After a very swift, cold shower (since there was no hot water) I dressed into scrubs. As I began across the hardwood floor of the meeting hall where we had set up our clinic the night before, I noticed other clinic volunteers beginning to stir. We all had similar responsibilities that morning — caring for overnight patients and those animals who were coming to California to find new homes.

Each day we interacted with many families and their animals. Dogs, cats and sometimes horses were treated, and while most were pets, others were working animals whose families relied on them for their livelihood. They came to our free clinic to receive wellness exams, vaccines, parasite control, and surgery for spays and neuters. Community members visiting the clinic were reaching out for help, hoping we could provide comfort to their sick animals. Many individuals were concerned with protecting their families from zoonotic diseases, while others recognized the tribe’s dilemma with pet overpopulation and the need for a solution. These sites were hand-picked by RAVS with the intent to serve communities most in need of veterinary support. While the premise seems simple — giving medical care to animals — the group of volunteers gave so much more.

As each owner came with their animal, we sat down with them to ask questions about the animal’s history, but also to create a dialogue and establish a relationship of trust. This individualized attention often allowed us to discover stories about how the families interacted with their animals and, in turn, we shared stories about how we view animals. This mutualistic relationship permitted us to expand our perceptions of our cultures and connect with people from different backgrounds. One evening, sitting on the bleachers of the high school gymnasium, a father and his daughter presented the history of their people – the Apache tribe. His daughter wore a traditional dress and a baby basket, both hand-made with materials from the land. He described their history, their triumphs and how they dealt with modern life. This gesture by a father and his daughter was the highlight of our trip. It showed us how grateful the community was to have our help, and allowed us the opportunity to better understand the Apache people.

Reflecting back on my RAVS experience, some of my favorite interactions were with the children in the community. I distinctly remember a group of three boys who came by so often on our second week that we knew them by name. All of the children were curious about our lives and would visit just to see what was going on, asking us questions like, “Where are you from?” “Why are you helping the animals?” “Why do you care so much about the animals?” “Can you play basketball with me?” Several times, after a hectic clinic day and before dusk, we would join the children on the basketball court to throw a ball or play jump rope with them. As we battled with lack of sleep and exhaustion from the excitement during the day, our interactions with the children fueled our enthusiasm to continue reaching out to new people and helping their animals.

I cannot imagine a more fulfilling way to spend my free time. These short trips present meaningful opportunities for us to connect with people through their animals. The information we learned from being in that environment not only improved our ability to practice medicine, but it also increased our understanding of American culture and enhanced our spiritual growth.

Kimberly Bridges, DVM ’11

In the sweltering heat, they walk their two canine companions to our clinic with their man-made rope leashes and collars. This may be the only chance for this family to obtain veterinary care for their pets. I notice that one of the children isn’t wearing shoes; the mother states that they have walked two miles so their dogs can get medicine for their skin. Both dogs are covered in ticks; I notice patches of hair missing as my eyes glide over their emaciated frames. It is evident that neither dog has been seen by a veterinarian or ever received any medical care.

As a RAVS volunteer, this is your chance to make a difference in this family’s life. Your dedication to the long hours, your caring heart, and your passion to educate others on animal husbandry takes over as you evaluate this family and their pets’ needs. This experience is once in a lifetime. What you take away from a RAVS trip will stay with you forever. Your connections made here with the veterinary community of students, technicians, and veterinarian volunteers will influence your life-long goals. We work together as a devoted family, a well-oiled working unit, to provide veterinary care and relief to animals in need.

As a veterinary student volunteer, I learned how to practice good medicine with limited resources. This aspect of veterinary medicine is often overlooked in vet school and practice because many veterinarians believe that in order to practice “good” medicine, you must offer the best diagnostic tools and services. After serving as a RAVS volunteer and extern, I now understand that high-quality medicine begins with educating the family on how to provide “basic” care for their pet. Through the connections you establish with these families and their pets, you realize that simple topics such as nutrition and shelter need to be addressed. This family and I bonded over a small plastic measuring cup that I used to demonstrate how much food each dog should receive every day.

As a RAVS volunteer, you are also assigned to administer vaccinations, flea/tick preventative, deworming medications, etc. Many of the community members are burdened with providing care to 10-15 pets, and you provide relief to these families by performing spay and neuter procedures. Your dedication and assistance to the pets do not go unnoticed by the community members. Many times they ask to shake your hand, present you with a thank you and offer you a piece of hand-made jewelry.

As you can see, RAVS is more than just a social experience, more than just an opportunity to perform surgery. As a RAVS volunteer, you feel empowered to make a difference, to change the life of a family and pet in need. If there is one piece of advice I could offer to a student colleague, it would be to volunteer one summer with the RAVS program. The experience is invaluable, one that will strengthen you as an individual both mentally and physically.
I was curious about how people and vehicles going across the border were managed and controlled. Having never been to the border, I learned that the Laredo, Texas-Nuevo Laredo, Mexico border plays a huge role in imports and exports, and learning about it gave me a much better idea of what goes on. I never knew that border traffic was so complex. Many people, agencies, organizations, government groups, and rules and regulations are involved in dealing with what comes in and out of the country.

One thing I definitely did not expect prior to STEER was the number of animals and wildlife I would see and learn about during the rotation. We learned a lot about wildlife and domesticated animals in South Texas through visiting the river, the ranches, sessions at Laredo Community College, and visiting Mirango City. Learning about the Oral Rabies Vaccination Program was an eye-opener. I never even knew that such a program existed in the U.S., and I never knew about the scope of problems from different animals (foxes, dogs, raccoons, coyotes, skunks and bats), extensive border crossings, and rabies. I realized how implementation of the program was crucial toward controlling rabies within the area.

The water quality segment was fascinating. Not only do we have to worry about contaminants that edible fish may have, but we also have to be concerned about the contaminants in the smaller fish and sea organisms the edible fish may consume. Our natural ecosystem works in a cycle that encompasses cause and effect, and this concept was also demonstrated in other areas of the course. The Rio Grande River plays a tremendous role at the border, as it separates the two countries. We learned about protecting this great source of water, which has been susceptible to heavy pollution in the past.

Through visiting ranches and learning about local plants and their medicinal uses, I was amazed that such a variety of herbs exist and how they play an important role in Hispanic culture. Many patients rely on these herbal medicines, and it is crucial for us to know about them. Through the overview of Mexico’s health care system, I found it interesting that many people cross the border into Mexico to receive faster and more affordable health services compared to the U.S. I don’t think many people are aware of how Mexico’s health care system, in many ways, is pretty strong.

Learning about proper sanitary waste disposal, landfills, air quality, water pollution, drinking water safety, lead and pesticide exposure, and food quality was a great part of the experience, as we need to know more about how these things affect us on a daily basis. With an interest in primary care, preventive medicine, and public health, I can better educate my patients about these issues, and I can try to gather information from my history-taking of patients. I also have a better idea of possible programs that may help patients. Wherever I end up practicing, I will be sure to explore the programs available that can help my patients and their families in terms of providing them with additional resources.

People from various parts of the community taught us, and this connected with the Humanism theme of “Connections: Partners in Health.” Actually getting out into the community and learning directly with firsthand, on-site individuals was amazingly effective. The “take home” message that I learned from STEER is that I want to be a physician who is community-friendly, one who is aware of public and environmental health issues facing the community, and one who wants to become involved in these issues.

Program:

STEER (South Texas Environmental Education and Research) transformed me as an aspiring health professional, as it provided me with a community-based educational experience, allowing me to learn about public health and environmental health issues facing the border communities of U.S. and Mexico. Offered through the University of Texas Health Sciences Center at San Antonio, STEER has been running for more than 14 years, and more than 500 health professions students have completed the program. A dedicated team of faculty members, instructors, and community health workers work together to make the course very successful. We learned about different topics, including health and economic issues facing the border, pesticide exposure and subsequent health effects, binational health programs, barriers to health care access, food sanitation and inspection, and indoor and outdoor air quality issues.

I enjoyed the program from day one! Many of the issues covered in STEER affect communities elsewhere, as well. Thus far, my health experiences have been in California, where there are numerous clusters of immigrant and underserved communities. I did my OB/GYN rotation in Santa Maria, where most patients were Spanish-speaking, and where there is a large community of migrant farm workers and their families. Teenage pregnancies, prevalence of sexually transmitted infections, pesticide exposure, and air quality were all of concern in this particular city. Many patients were raising children in low-income families, and many were pregnant teenagers. Just like we learned at the city of Laredo Health Department, programs need to be implemented to encourage healthy sexual behaviors and precautions, screening for STDs, hotlines for information, and resources for HIV patients. I did not know that communities like the colonias existed along the U.S.-Mexico border. Visiting the colonias made the experience more real, and I could see the obvious challenges in accessing basic services like health care, water, electricity, and sewage disposal. We visited the community center and learned how they managed to run certain aspects of their system on a small budget. Visiting a family in the colonias and addressing their dietary issues also helped me learn about how diet, income, and food perception play a role in the lives of people in the colonias and in other low-income families.

The message that I learned from STEER is that I want to be a physician who is community-friendly, one who is aware of public and environmental health issues facing the community, and one who wants to become involved in these issues.
Photo Gallery: Gina Johnson, DVM ‘12

“Proboscis,” Los Angeles, 2009


“This Modern Grime,” Claremont Hills Wilderness Park, overlooking Los Angeles, CA, 2009

Pastel drawing, “The Colors”
A
fter driving up the central California coast, through a 17-mile drive in Monterey, into the Santa Cruz mountains, and along a windsly single-lane road to Ben Lomond, I finally arrived at my destination. I wheeled my luggage across a dirt trail to my A-frame cabin, humbly nestled within the majestic redwood forest. This was home for a month for me and 24 other privileged medical students from U.S. medical schools as we embarked on the HEART elective. Appropriately named, this fully accredited elective is offered annually by the American Medical Student Association (AMSA). It stands for Humanistic Elective in Alternative Medicine, Activism, and Reflective Transformation. Little did I know I would rediscover my heart at HEART.

I settled into my cabin, laying my sleeping bag out on the bed that promised the most abundant morning sunshine, since I was sure this rotation would let me sleep past sunrise. Excited to meet the other participants, I quickly followed the aroma of dinner to find the lodge where the group was beginning to gather. The kitchen crew directed me to the dining room, where folks were making name tags, placemats, and mailboxes. Flashbacks of kindergarten rushed to me as I toiled over whether to use glitter, puffy paint, beads, pipe cleaner, or buttons to decorate my items. I could not even remember the last time I indulged in a chuckle. Had I lost my sense of humor? Fortunately for me, I rediscovered the ability to laugh by the end of HEART, but I had to release all of the grief and sadness I encountered during medical school that was overshadowing my ability to celebrate joyfulness. Give yourself permission to be happy, because nothing is more refreshing than a happy person.

1) Have an agenda for self care. First detox. Find a way to restore a healthy body and mind. It took at least two weeks for me to identify the negative habits and thoughts that developed during medical school. I needed to relearn how to treat myself a meal, instead of the typical Starbucks run. I needed to remember how easy it is to exercise for pleasure, and how to recognize my own prejudices when meeting a new person. Then create a plan for achieving balance. I had to ask, “What am I like at my best, and what is preventing me from being there?” One morning we had a spontaneous session of laughter yoga, and I found myself surrounded by a group of hyenas but unable to laugh myself. I quietly smiled, which comes naturally for me; but my complete silence shocked me, as I painfully realized that I had nothing to laugh about. I could not even remember the last time I indulged in a chuckle. Had I lost my sense of humor? Fortunately for me, I rediscovered the ability to laugh by the end of HEART, but I had to release all of the grief and sadness I encountered during medical school that was overshadowing my ability to celebrate joyfulness. Give yourself permission to be happy, because nothing is more refreshing than a happy person.

2) Know your limits. One person can make a difference, but one person is just one part of the larger picture. In our lecture, “Green Medicine,” we learned the Intergovernmental Panel on Climate Change made a recommendation for ways that each person can help combat global climate change: ride a bike, be a frugal shopper, and refrain from eating meat. Not everyone can do those, not everyone can buy a hybrid, not everyone can convert their homes to solar power, but everyone can do something. Similarly, we cannot always cure our patients, but we can play a part in helping to reduce suffering in every patient encounter. As physicians, we are just one member of the global team for health care. Use your energy to move in the right direction. Know when it is your responsibility to act, pass it on or let it go.

3) Sleep well but wake up and be present. Sleep, sleep, sleep. You will look better, feel better, learn better, and drive better! Sleep so you can be present with your patients. Learning to be present was the most difficult skill for me to acquire, since my mind is always in the future, anticipating the next task. My body seems to be in constant motion, running from rounds to surgery to clinic and back to rounds. The ability to be still and quiet is a persistent struggle for me; sometimes the only time this happens is when Mother Nature calls. I try to make a daily practice to slow down, connect to my surroundings, awaken all five senses, and remember who I am, where I am, and what I am doing. In doing this, you will ground yourself so you can be present to make the human connection and fully offer yourself as an ally to your patients.

4) Be thankful. We are incredibly privileged to have our education and training. We are freely granted trust and respect from most of our patients and their families. We are given the autonomy to make life-changing decisions for others. As a whole, we are generously compensated and will likely never struggle to feed our families. However, we are not entitled to any of this. You may have hundreds of thousands of dollars in student loans, sacrificed your hobbies to make time to study, and missed celebrations with friends and family to be on call. We all have. But never forget that you chose this path, and thus accepted these responsibilities. Our degree does not define us; rather, we define our degree as a Doctor of Osteopathic Medicine. We are no more important than other health professionals or the patients we serve. Be thankful for the amazing opportunities you are given each day and for the people who support you.

osteoopathic and homeopathic medicine, a silent day for reflection, a video stream lecture on green medicine, a day of gardening at the local homeless shelter, discussions on racism and poverty, art therapy...the list continued. Every day, I recorded the day’s events and lecture notes in my journal, and in the evenings I articulated my reflections. Without publishing the entire journal, I wanted to share a few of the most enlightening moments from my month at HEART. I wish all medical students had the opportunity to experience the HEART elective, because it provided me with the tools and enlightenment I needed to practice medicine the way I intended when I wrote my personal statement four years ago. Thus, I pass along these “top ten” insights that I learned from medical school, clinical rotations, and the HEART elective.

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5) Make a plan but allow for flexibility. One of the exercises at HEART involved writing a life mission statement and a five-year plan to begin fulfilling these goals. For most of us, that started out simply as graduate medical school and complete residency. We were probed to go deeper. If your vision is to maintain loving relationships and a healthy weight, you must create a plan to make it happen. Both of these require a conscious effort and action now, not later. Making a plan is generally not difficult for medical students and physicians, but flexibility remains a challenge. When we are faced with an interruption, we must choose to continue to move forward toward a goal, or create a new goal. This sounds simple, but is much harder to practice. Remember that a more flexible muscle absorbs shock more readily.

6) Being a healer does not always require providing a treatment or a cure. Health is achieved by the coexistence of happiness, vitality, and wholeness, not just by the absence of disease. One speaker emphasized this point by stating “My healthiest patients are dying from cancer.” Being a healer requires one to be a team player with all persons involved in patient care. It means ignoring the ranking and respecting all members of the team for their helpful contribution.

“Being a healer requires one to be a team player with all persons involved in patient care. It means ignoring the ranking and respecting all members of the team for their helpful contribution.”

7) Contribute to your community. Just as a chain is no stronger than its weakest link, we are no stronger than the community where we practice. On our last day at HEART, while discussing our excitement and fears about residency, the speaker shared, “Residency is about learning to be one spoke in the wheel so it can continue turning.” I think about this often, mostly when I am exhausted. It reminds me that I am not alone, nor am I the first person to work so hard. It reminds me to smile, lend a hand to my fellow residents (like doing a discharge summary on a patient they discharged over the weekend but you followed the preceding week), and thank others for their help. Never forget the power of a compliment. Outside of medical school or the hospital, find a way to meaningfully connect to your community. For me, it is doing events to support patients with breast cancer and raise money for breast cancer research.

8) Keep an open mind. This one is simple to explain but complex to practice. Do not assume anything. Ask questions when it is relevant and apologize when you make an inaccurate assumption. The first step toward being non-judgmental is acknowledging the judgments we make.

9) A lifelong learner is always learning. We cannot know everything, and there will always be someone who knows more. As a medical student, this frustrated me greatly, because I constantly felt my knowledge was inadequate. I never knew more than the person who was “partnering” me, but then again, why should I? The entire purpose of medical school and clinical rotations is to learn! And the learning does not end when you graduate, since the practice of medicine is constantly changing. The modalities for learning are changing also, as more journals are published online and simulation labs are established for practicing technical skills.

10) Remember why you chose this path. To me, this is the most important insight of all. At the end of the day, after phone calls to pharmacists, requests for authorizations, and endless paperwork, I chose this path for the patients. Though each day presents new administrative hurdles, it also provides more opportunities to help a patient discover wellness. As physicians, we are not promised success because of the rigorous education, laborious training, or prolonged work hours. That is part of the job description. And as long as I can still remember why I am on this path, I will continue the journey. ■

Coming from Southern California, the clean piercing air of Vernal, Utah, came as something of a shock to me. Being back in my hometown for the first time in a year, I found myself going to the nearest 7-11 and, like some forgotten actor. We go through the awkward first words and introduction, but then slowly transition into conversation, and learn that making small talk makes a big difference. Now, in advanced classes, I still can’t help but chuckle when I receive a card from the actor’s back pocket that reads “you hear wheezes, rales and rhonchi.” I find myself half-heartedly wishing that the patient did have these findings so I could actually know what they sound like! Conversely, the true value of those encounters comes from rapport-building in that first uncomfortable moment.

I have read books and editorials that make it evident that it often isn’t possible to have evocative conversations with patients, given the limiting time restraints. This is an obstacle that appears difficult to circumvent or alter. However, the lesson I learned while being back in my hometown was that our humanistic skills must be developed because that is what people can relate to and are comfortable with. I find no common ground with my father when I tell him I scored well on my 130-question respiratory exam, but I discover my footing in discussing basic principles that govern our daily lives. It is my hope that throughout my professional training I will be reminded that little triumphs inside and outside the medical field are what can unite us and help us to form meaningful, lasting relationships.

WesternU has greatly expanded, including dental, podiatry, and optometry programs that started this fall. I have confidence that students will receive a high-quality experience because of those little early encounters with actors. What I have come to appreciate is that first rapport-building exercise, when taken in the right mind, could奠定 my foundation in humanism and could prove to be my greatest tool in assisting in overall health.

By Allan W. Belcher, DO ’11

Western University of Health Sciences

Photos by Jin Lopatynski and Jeff Male

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Mt. Shasta off 5 Freeway

October in St. Helens, Oregon

Rancho Santa Ana Botanic Garden

Sunset in Alta Loma, CA

Washington Coastline off 101 Freeway
Interprofessional Health Care:
Pomona Community
Health Fair

By Lana Grinberg, DO ’13

I am one of the lucky ones. I have been chosen to be part of the first group to participate in WesternU’s phenomenal interprofessional learning module. Throughout this year, I have thoroughly enjoyed working side-by-side with future physician assistants and health care professionals from podiatry, dentistry, optometry, and veterinary medicine at many different health clinics and events held by university clubs. My favorite event, however, has to be the Pomona Community Health Fair held in January of this year on our own campus. The event was put on by students and organized by students, and many students received hands-on experience consulting and examining the community. In addition, a few of us were given the opportunity to make presentations to the community on topics such as the flu, diabetes, and nutrition and exercises. Thank you, WesternU, for the many opportunities that you extend to us. It was a monumental experience that I will treasure for the rest of my career.
THE CASE OF THE STUDENT AND THE PATIENT WITH PREECLAMPSIA

I was seven a.m. and time for “change of shift” on the OB service. The night call team had been inundated with new admissions. On Labor and Delivery, all the rooms were full, and cesarean section deliveries were underway in each of the two operating rooms. Across the hall on the ante-partum ward, I was making rounds with a new team of medical students and residents. Most of the new admissions were for preterm labor or preterm ruptured membranes, and I was having difficulty distinguishing between the individual patients admitted with these diagnoses. The way the cases were being presented, none seemed unique. Oh well, I thought — I’ll go back after rounds and sort them out. Things changed when we got to Patient X’s room. A third-year medical student who had been on the night before asked if he could present her case.

“She is a 24-year-old primigravida at 25 weeks of gestation who was transferred from a midwife clinic to the hospital yesterday because of recent swelling of her hands and feet, an elevated blood pressure of 150/80 and a urinalysis showing proteinuria ...” he said, reading from his note. I paid close attention because this case was different. This was not another case of preterm labor. This was preterm preeclampsia. The immediate clinical questions were: Was the disease severe enough to be life threatening to the mother or fetus? Did the patient need to be delivered? If delivered at this stage of pregnancy, the baby would be extremely premature, and even if it survived was likely to suffer from major complications. With these thoughts in mind, I peppered the student with questions—both to test his knowledge and because I needed the answers in order the make the right management decisions. The student was prepared. He had clearly taken a careful history and done an exam, reviewed all the lab data and had tried to formulate an assessment. I was impressed.

After rounds, I went back to see the patients myself. When I got to Patient X’s room, I asked the student to come in with me so I could determine if his presentation was accurate. It was spot on. “Are you interested in Ob-Gyn?” I asked.

He laughed, “Well, I’m interested in it, but I’m going to apply for a residency in orthopedics.”

What a shame, I thought, and proceeded to review with him the signs and symptoms of severe preeclampsia: headache, visual changes, right upper quadrant pain and severe hypertension, and heavy proteinuria, among others, as well as potential effects of the disease on the fetus. We discussed how a patient with severe preeclampsia should be stabilized, the role of magnesium sulfate for seizure prophylaxis and the use of betamethasone to accelerate fetal lung maturity. The student had clearly read about the problem and was eager to apply his knowledge to the care of the patient on hand. He then asked if he could follow the patient. I was pleased that he asked but wasn’t sure if he would actually follow through.

Continuity of care is frequently missing from the clinical training of students and residents. Often, when I ask students (or even residents) for follow up information regarding a particular patient in whose care they have been involved, I am told, “Oh, I don’t know the details of what happened to the patient? Did the patient need to be delivered? If delivered at this stage of pregnancy, the baby would be extremely premature, and even if it survived was likely to suffer from major complications. With these thoughts in mind, I peppered the student with questions—both to test his knowledge and because I needed the answers in order the make the right management decisions. The student was prepared. He had clearly taken a careful history and

consequences of their clinical decisions if they don’t know what happened to the patient?

This particular medical student seemed oblivious to these all too common barriers to patient care. For the next few days, the student rounded on “his” patient twice a day; in the morning, before rounds, and again in the evening after he finished whatever else he had been assigned to (clinic, labor and delivery, etc.). He was always knowledgeable about what was going on with the patient medically — symptoms, blood pressure, labs, and fetal heart rate tracing. Even more important, he got to know the patient in a way that no one else on the team did. He found out that she had immigrated to this country only a few years ago and, although her husband and some of his family were with her, her own parents were still in their native country and she longed for her mother’s support and presence. She was afraid — afraid of what was going to happen to her and her unborn child in what to her was a cold, strange place filled with unfamiliar faces. The student was able to spend the time required to rephrase many of the things we said on rounds so that she had a clearer understanding of what was going on. In addition, he listened to her, allowed her to express her concerns and tried to be a comforting presence. After a few days she came to expect to see him each morning and evening and considered him “her” doctor as much as anyone else on the team.

After about four days later the student reported on rounds that the patient’s repeat 24-hour urine collection now contained six grams of protein. There was no longer any question about the diagnosis. She clearly had severe preeclampsia and the renal manifestations were worsening, although otherwise she and the fetus seemed relatively stable. We discussed whether or not the patient should be delivered.
I was hesitant. Although delivery is the only “cure” for preeclampsia, in this case it appeared that delivery would benefit the mother potentially to the detriment of the fetus. Such is the conflict one faces in the management of high-risk pregnancies — there are two patients, the mother and the fetus, and with multiple gestations there can be even more. One has to consider the implications of any clinical decisions on both. In this particular case the patient was still less than 26 weeks gestation and the estimated weight of the fetus was only a little over a pound. All of our tests of fetal well-being were reassuring, even the fetal heart rate tracing. Each day the fetus could remain in utero at this stage of gestation increased its chances of survival and, even more important, it’s chances of survival without severe disability. I explained that we were walking a tightrope and had to watch the mother and fetus even more vigilantly for signs of deterioration if we were to time the delivery correctly — in other words, deliver the mother before any permanent damage occurred to either herself or the fetus from preeclampsia, but not so soon that the baby was more preterm than necessary.

We decided to get laboratory studies twice a day on the mother, looking for signs of the HELLP (hemolysis, elevated liver function tests, low platelets) syndrome, increase the frequency of her blood pressure monitoring and follow the fetal status more closely with continuous fetal heart rate monitoring. I reminded the team that one feared complication was placental abruption — or premature separation of the placenta. This unfortunately could occur with minimal warning. The clinical signs of vaginal bleeding and abdominal pain do not always present until late. One of the only signs might be a change in the fetal heart rate pattern — a decrease in fetal heart rate variability, change in baseline, or the onset of decelerations, which are often subtle and difficult to detect early on. We wrote the orders, reviewed the plan with the patient and her nurse, and then left the hospital to see patients in the Women’s Health Clinic.

About five hours later, when everyone went to lunch, the student went back to the hospital to see his patient. When he returned to the clinic he had a worried expression on his face and a copy of the fetal heart rate tracing in his hand. “Are these the changes you were talking about?” he asked as he put the copy down on the desk. I stared at the tracing — there they were! — shallow “u” shaped decelerations of the fetal heart rate, accompanied by a rise in the baseline from 150 to 165 beats per minute and a decrease in variability. The changes were subtle and had just recently begun. Neither the patient’s nurse nor the automated alarm system detected them. We had time to get this baby delivered before there was a full-blown placental abruption and hypoxia ensued, but we had to move fast. We both ran back to the hospital, and notified the L&D team and the neonatal intensive care unit. We then went quickly to the patient’s bedside to explain to her what was going on and why she needed to be delivered by an emergency cesarean section. It helped tremendously that the patient had seen both of us every day for the past four days. She knew us and trusted us to make the right decision.

Everything went like clockwork. The Labor and Delivery team — consisting of the Ob attending, the resident, the OR nurse and the anesthesiologist — worked with speed and care. The patient was delivered expeditiously — a 700-gram male — and handed off immediately to the neonatal team standing by. Exam of the placenta showed the beginning of an abruption. The baby was very premature, but did better than expected because, in the opinion of the neonatologist, of the additional days spent in utero combined with the ante-partum administration of betamethasone and magnesium sulfate. The mother improved rapidly. Post-partum she had a significant diuresis, her blood pressure returned to pre-pregnant levels and her proteinuria resolved. We had waited as long as we could, but not too long. I could breathe a sigh of relief.

Before she was discharged, the patient thanked everyone on the team for the care they gave her and would continue to give to her baby. In addition, she and her family gave special thanks to the medical student. I also thanked him. His role was as important as mine, the obstetrician, the neonatologist and everyone else on the team involved in the care of this patient and her child. The student’s behavior exemplified the saying attributed to Sir William Osler, “The secret in the care of the patient is in caring for the patient.” It was also a clear illustration of putting into practice WesternU’s motto: “The discipline of learning, The art of caring.” Because of his interest, caring and commitment, the student found a way to provide continuity of care to “his” patient while she was in the hospital, even though it was not something strictly required of him. This allowed him to learn a great deal about preeclampsia, not just from articles, chapters, lectures and rounds, but directly from the patient with the disease. It also gave him the all-important opportunity to “give back” to the patient he learned from by positively contributing to her care.

Students in the health care professions need to recognize early that clinical training offers the privilege of learning from the patient and the team caring for the patient. Along with privilege comes responsibility. Students have the responsibility of making the commitment to try to contribute to the care of the patients they learn from, as well as the team they are a part of. Put more succinctly, clinical training is a balance between taking and giving. When a student puts that principle into practice, wonderful things can happen, even if they decide not to specialize in Ob-Gyn.
In the Face of Change There is One Constant

Story and photo by James A. James III, DO ’12

It is health care’s very nature to be in constant upheaval as it strives to fit new, better treatment paradigms. New technology begets technology that seemed new only yesterday. New treatments are offered up as addendums or replacements of the old. New evidence becomes the basis of new practice. Change is one of the quintessential traits of health care that makes it appealing to many who seek its rewards.

Change is one of the quintessential traits of health care that makes it appealing to many who seek its existence and remains the beacon for its bright future. It is health care’s very nature to be in constant upheaval as it strives to fit new, better treatment paradigms. New technology begets technology that seemed new only yesterday. New treatments are offered up as addendums or replacements of the old. New evidence becomes the basis of new practice.

While everyone is justifiably focused on this change, I consider a part of health care that deserves more vigilance and focus than any form of change. This one thing, this one constant, is humanism. Often overlooked and under-practiced, humanism is the foundation for medicine’s existence and remains the beacon for its bright future. It directs us to be ever mindful of our obligation to treat the patient and not just their presenting illnesses. Without humanism, health care becomes a cold, machine-like industry, speeding through and pumping out sub-par results and poorly cared-for patients. No matter how inconsequential it may seem at times, humanism should guide every thought, every evaluation, every conversation, and every cut.

A few weeks ago, I was working at a clinic for the underserved. One of the patients I met was in her late fifties and was impressively applying to join the Peace Corps. For this she needed a physical, but had no insurance and no provider. In fact, she informed me that she had not seen a physician in longer than she could remember. As we began interacting I noticed that she appeared timid and a bit preoccupied. As I performed and explained my examination, I began to also inquire about her interest in the Peace Corps. The conversation moved to her family and then on to diabetes. Her uncle was recently diagnosed with diabetes as well. Being a fit marathon enthusiast who makes impeccably healthy lifestyle choices such as abstaining from the use of any intoxicants and maintaining the most un-American of diets, I assured her that such a diagnosis for her was unlikely. At that point a wave of relief surged across her face. As the exam continued, she proceeded to share other health concerns apparently bottled up for years. Most of her concerns were diffused through my modest range of knowledge. By the end of the appointment, instead of appearing burdened by irrational worries of illness, she presented with a comfort more warranted by her healthy lifestyle.

Through a simple demonstration of humanism, I nurtured an atmosphere of trust and honesty. In response, the patient allowed me to provide her with a service that would otherwise have been overlooked. The patient would still have received the reassurance of a healthy physical, but an examination remiss of humanism would not have allowed treatment of the whole patient. Though no court or ethics committee would find me guilty of negligence, nor would any tangible adverse outcome likely precipitate from a lack of humanism in the above example, it is my belief that an interaction devoid of true humanism would have been negligence nonetheless. Treatment of my patient in such a way would have left her burdened with unreasonable doubts about her well-being and health, thereby reducing her ability to live a life as rich and fulfilling as she deserved.

Humanism must be at the core of everything we do as physicians. It is central to a fully functioning patient-physician relationship. When humanism is removed from this interaction, one can expect incomplete reporting, misinformation, mistrust, the overlooking of patient needs, and non-compliance. On a global level, such interactions blemish the medical community and diminish the trust and respect the public has for our profession — a trust and respect I believe our profession both deserves and requires.

I know each of us has chosen this profession because we seek the challenge of medicine, the excitement of change, and the satisfaction of healing. To fulfill this role, I hope that each of us is devoted to humanism and caring for each patient individually and holistically. Our ability to stay true to this devotion will be challenged time and again by busy schedules, stressful encounters, and personal matters. This is all the more reason that we must consciously center ourselves. I recommend that each of us find that inspiration for humanism in life, whether it is a personal experience or a patient encounter. Hold on to that memory and use it to remind yourself during those rough patches to the work that we do. I nurture and use it to remind myself during those rough patches to the work that we do. I nurture it to remind myself during those rough patches to the work that we do. It is our duty as humanists to be ever mindful of our obligation to treat the patient and not just their presenting illnesses.

By giving to those who are going there.

People have traveled from around the planet to ease the Haitian hunger, pain and panic. For we are all creatures of man.

We can lead a helping hand.

As partners in health, joy and sorrow. We should help those people to have a better tomorrow.

Call the Red Cross and give what you can. You may not be able to visit the Haitian land. But, you can show that you care. By giving to those who are going there. God bless us all.

By Carrie E. Charles, DNP ’10

Photo courtesy of shutterstock.com

Partners in Health

A cry goes out from across the sea
An earthquake has ravaged little Haiti.

Images appear around the world on TV
On cell phones, computers Xbox and Wii.

Tens of thousands are dead, 6 million displaced

The images show many horrible sights.
Where will these people sleep tonight?
Who will comfort them and ease their pain?
When there is little access for airplanes?
Who will bring them food and care?
Many wish that they were there
To help those in despair.

Some wish to help from origins of poverty and wealth.
They know that we are all partners in health.

It does not matter your station in life.
Helping those in need may ease strife.

Photo courtesy of shutterstock.com
We’re walking in through the doors of cadaver lab
Blank white sheets as they’re covered row by row
Cause of death, unknown words and bewildered looks
Lift the shroud, and we see that
The world slows down
But my heart beats fast right now
I see the skin, feel shivers
Down my back
I can’t take it any longer
Thought that we were stronger
Adipose and fluids
Slipping through our fingers
I don’t wanna try now
All that’s left is learning
Coping as I can tell you
I hate this part right here
I hate this part right here
Remember all my fears
I hate this part right here
Everyday, everyday, every single day
Learning muscles, bones, nerves, and blood supply
I forget that you once walked among us
And that you have a family grieving

The world slows down
But my heart beats fast right now
I see the skin, feel shivers
Down my back
I can’t take it any longer
Thought that we were stronger
Listen to the sniffles
Slipping through our fingers
I don’t wanna try now
All that’s lefts good-bye
Coping as I can tell you
I can’t take it any longer
Thought that we were stronger
All we do is linger
Slipping through our fingers
I don’t want to try now
All that’s lefts good-bye
To find a way that I can tell you
I thank you from my heart
For all your precious parts
No matter where you are
I thank you from my heart

I’m holding on P-site
Get a peptide bond away
I’m ready for attack
And I wait for tRNA
I have an ester waiting
Peptide transferase, but wait
RF1 reaches
The UAA stop codon, and now
It’s too late to translocate, it’s too late
Yeah it’s too late to translocate, it’s too late
Water takes a shot, makes a break,
in the peptide chain
Release factor 3
GTP
binds RF1
Hydrolyze and release RF1
And now you have GDP, on RF3
Ribosome Recycling Factor, and
EFG –GTP
are coming in
So it’s too late to translocate, it’s too late
Yeah it’s too late to translocate, it’s too late
So it’s too late to translocate, it’s too late
Yeah it’s too late to translocate, it’s too late
Yeah it’s too late to translocate, it’s too late
All the factors release and now I’ve
Got a free ribosome

The day has shifted now, the morrow in new plight.
Circling red and white around witnessing embers
My shadow was to precede this faulty lead.
An ancient practice in all seven rounds.

In first my sustenance shall stem from you alone.
A second my strength through you.
Third, my wealth and warmth be your embrace.
At quarter, all sorrow and joy take your form.

A fifth, of progeny, a rouse of destiny.
For sixth of wish-less longevity
In finally, my step is first in accepting eternity.
Through love of friendship we two shall turn to one.
Photo Gallery: David Nguyen, PharmD ‘12

“Scars of Survival”

“Paper Brilliance”

“Bo vo”

“Maternal Instinct”

“Ông”

“Ba”
During this past summer, I had the opportunity to travel to the city of Bangkok, Thailand. It was a unique city and very different from the typical American city. Food carts, malls, stores, and McDonalds lined the city streets. And of course, being a pharmacy student, I decided to check out the local pharmacy because I ran out of mosquito repellent. This pharmacy was like a mini-Walmart, because everything and anything could be sold there, including cosmetics, fresh produce and beer. Although all prescribed medications are kept behind the counter, some medications like antibiotics, which require a prescription in the U.S., may be bought without one in Thailand. Also, there is no requirement that a pharmacist be present in every pharmacy. Obviously, the laws are different in Thailand, but one thing is for sure—the people trust their local pharmacy to help them with their problems and needs. Many of us, including me, take for granted our neighborhood pharmacy, but the people of Thailand rely on them to cure and heal the ailments that they or their loved ones may have. I believe that they are the most critical providers of health care service there because many people cannot afford to see a doctor when they are sick, but they can go to the pharmacy they trust. The dynamics were certainly different from what I have seen in the U.S., but I know that as health care providers, we should not stop at providing medical care for our patients, but we should also take the time to care for their well-being and be that person who can make a difference in their lives.
With its fields of plush green vegetation and immense banana plantations, with its frantic, busy cities, with its handsome and strong women and men and its playful children, with its hope and its beauty amidst cries of hunger and sickness, Cameroon has wrapped her fingers around my heart and drawn me in.

I had never experienced Africa nor had I observed health care in a developing nation until the spring of 2009, when I joined a team of physicians, dentists, hygienists, nurses, and their families on Health Team International’s (HTI) twelfth trip to the West African nation of Cameroon. HTI is a Christian organization that brings free medical aid and Christian teachings to impoverished nations throughout the world, focusing on Southeast Asia, China, South Africa, and Cameroon. HTI seeks out the most remote areas and this past trip brought us far into isolated villages outside of the major city of Douala.

Drs. Dan Wiklund, MD, and John Ngo led this mission trip. Dr. Wiklund has served as an incredibly inspiring mentor to me throughout my pursuit of medicine, and it was due to his encouragement and care that I was able to take part in this wonderful experience. He has been trained as a specialist in tropical medicine and is thus an expert on tropical diseases. We encountered many tropical diseases in Cameroon, such as tinea versicolor and onchocerciasis (river blindness). Dr. Ngo is a pastor who started out in Cameroon, growing up in a small crowded house with a dirt floor. After moving to the United States and becoming a Christian pastor, he realized his true calling was to return to his roots and serve the people of Cameroon. Hence, HTI was developed, an interdisciplinary group of health care professionals came together, and the work began.

In each village, our team worked in either the local clinic or a schoolhouse. The conditions were not exactly ideal, but we did the best we could. In one village, we performed surgeries inside the chief’s small meeting room, with a dusty table as the bed and one miniature window and our headlamps for light. I often assisted the team’s surgeon, a Cameroonian who runs a busy hospital in Nigeria and works ceaselessly. We removed lipomas and did many hernia repairs, and it was amazing – I will never forget my first suture!

The most powerful part of the trip, however, was simply the chance to touch these people and be touched by them. Looking into the eyes of the woman whose baby cries of burn wounds or the man who has been suffering abdominal pain for years, one can see the oppressed pain and the faith and strength within. After using our very basic supplies, our education, and our own hands, all of which we take for granted, we watched their hope grow. They would say thank you to us and mean it in a way more sincere than we can comprehend, and we’d watch them go while hoping, deep within our beings, for the best for each and every one, wishing only that we could do more.

This experience taught me the value of working as a team, a value that is emphasized at WesternU with its interprofessional curriculum. With each of us having different strengths and expertise, we were able to bring effective, comprehensive health care to those needing it most. This experience also reconfirmed my choice to pursue osteopathic medicine, where the whole human being is considered and not merely his symptoms. Moreover, I witnessed more poignantly than ever the resilience of the human body and spirit, and I will carry this appreciation with me into my career and throughout all of life.
On July 14, I arrived at the airport in Belize. The weather was the most humid I have ever experienced. The airport was about half the size of a supermarket with only one baggage carousel. As I walked through customs, I had a hard time conversing with the lady, as she did not understand English and I did not understand Spanish. After ten minutes of miscommunication, I figured out that she wanted to hold on to my passport until I figured out where I was actually going. The people who were going to pick me up were not arriving for two hours, so I took the risk. Next, I went to baggage claim to find my luggage, only to find my luggage missing with no one to help me figure out where it was. I now realized I was in a third-world country with my luggage missing and my passport being held. Luckily, my baggage arrived several hours later and I was able to retrieve my passport.

As we drove to our destination, I came to realize that Belize did not have many roads made of tar. Most of the roads were composed of dirt and rocks, and every bus trip required travel at 30 mph. If it rained, we would go even slower and take alternate routes to get to our destination to prevent the bus from getting stuck in mud. It took us two hours to get home, a trip that would have taken us less than 30 minutes in the U.S.

The walls of the place had holes to the outside which allowed easy access for all creatures, including scorpions and lizards. The mattresses were just one big piece of sponge. It was like sleeping outdoors. I went to take a shower only to find out there was no water, something that was common to the lower class of Belize. It was time to go to sleep, and I was having a hard time shutting my eyes because of the fear of a creature coming to bite me, not to mention the humidity made me feel like I was sleeping in a warm bath. When I went to use the toilets, the toilets would not flush if you put toilet paper in them, since the pipe system was not strong enough.

The next morning we had water! Thank God. I turned on the power knob and there was absolutely no water pressure. Basically, the faucet was spitting out a few sprinkles of water. In addition, the shower floor was dirty, and most mornings I showered with toads. To add to our fun, we had no hot running water and no mirrors. Throughout the two weeks, no matter how much mosquito repellent I sprayed, I still got bit, and Belize’s humidity caused me to sweat profusely. The second day of my trip we had a crash course in taking a patient history, performing a physical exam and diagnosing the patient’s complaint. While performing the physical exam on these patients, I gained exposure to taking blood pressure/pulse, using a glucometer to screen for and monitor diabetes, performing eye/ear/throat exams, and listening for abnormalities in the heart and lungs using a stethoscope. We also learned suturing techniques, giving injections, and writing out and filling prescriptions.

On the third day, we went to our first village to let them know of the free medical services we would provide them the next day. Walking through this village was very difficult for me, as I had not seen poverty like this before. Most houses had families with more than seven kids all enclosed in a space as big as a standard U.S. family room. One of the homes had 29 kids! None of the houses had running water, the toilet was not very hygienic, and they did not have showers, so they washed where they got their water – the river. This is also where they washed their clothes. We inspected the river and found it to be full of parasites and worms. What affected me the most was not seeing these people living in these harsh conditions, but the fact that they were still so happy.

We came back to their community center to set up our clinic the next day. We arrived at 9 a.m., and there was a long line for “Transformers” on opening night. Each patient came in, and we took down their history and did a physical exam. Most of the people we met had parasitic, fungal and bacterial infections. Some of the people we interacted with had never seen a physician. I could tell we were making a difference because before each patient left, they would give us a hug.

The next day, we set up clinic again, and once again there was a long line. People wanted to get into the clinic to get free medications. One of the patients I examined was a mother who had a fungal infection that had lasted more than four years. The infection had travelled, taken over her body, and she could not afford to get a CT scan or to fix his problem. Most of the patients we saw were kids between two and 10 years old, who were covered in rashes and infections from head to toe. Some of the kids had never seen a flashlight before.

Overall, the trip was a life-changing experience. I realized that in America we take things for granted. I realized that little things make a big difference. I also realized how fortunate I am, and I have learned to stop complaining about minor things! Thank you to everyone who sponsored me! Your donations provided the people with medication and care as well as contributed to my own personal growth.
A group of six DO ‘12 students — Christine Ayoub, Chelsea Chung, Morgan Faggard, Sheetal Patel, Radhika Sood and Jessica Weiss — and attending physician Zuhra Musherraf, DO ’04, Assistant Professor of Family Medicine, COMP, went on a 16-day medical trip to the northeast state of Bihar, India. We set up camps in three villages. All three of these villages are close to the border of Nepal. The villages, along with hundreds of others, suffered major flooding in August 2008 when a dam on the India-Nepal border breached its walls and submerged everything in its path. During the five days that we held our clinic, we saw about 1,500 patients. The most common patient diagnoses besides malnutrition were respiratory illnesses, gastrointestinal infections and musculoskeletal dysfunctions.

The population in this part of India is well below the Indian poverty line. Going to these villages and providing them with medical care is the least we could do. Unlike the United States, their problems are a lot bigger than just being unable to pay for medical care. Getting to a doctor itself becomes a problem, because the closest clinic is four hours away and the only way to get to it is by walking for over an hour to catch a very unreliable public bus. It is hard to avoid illness when the animals live on the front porch and children play with the animals’ excrement because parents are uneducated about the diseases they can catch. One cannot expect these people to support themselves and each other when fields that once grew crops to feed the family are covered in sand brought in by the flood. Malnutrition is endemic in these regions, and health understandably loses its priority over hunger. Paying for a pair of shoes to cover and protect a 1-year-old septic wound is not an option when one cannot even manage two meals a day. Two out of the three villages we went to still do not have electricity in every home. The only way to get to them is on dirt roads that diverge away from the paved road long before the village. The concept of running water might as well be unknown in these regions.

Being born and raised in India, I thought I had seen the tough life some people have to live. My perception of their condition would have been luxury compared to what I saw in these villages. The experienced humbled me. It reminded me of the power I have, we all have, to make a small change, bring one smile and touch one heart. These villages screamed for help from people like us. We fortunate few have the skill and resources to do something for people who literally do not have anything other than a lot of faith and some hope for their better future hanging from a fine thread.
OUT OF AMERICA: Ah, Where All Things Are Possible, A Fulbright Finds Home

By Judge Maureen Duffy-Lewis, Western University of Health Sciences Board of Trustees

Judge Maureen Duffy-Lewis was a Fulbright Lecturer at Sofia University Law Program. She took a sabatical leave for the full semester of 2009 from her position as a U.S. District Court Judge in Los Angeles. A jurist for 23 years, she has handled a wide variety of cases from major felonies to complex civil cases. While in Sofia, Judge Duffy-Lewis was requested by Tom Peble, a representative of the United States Department of Justice, to assist with developing the 2004-2005 International Human Rights Law Program. She took a sabbatical leave for the fall semester of 2009 to explore democracy and its legal implications, in Bulgaria's leading legal system. Judge Duffy-Lewis was a featured speaker at the Europe-Africa Union Model Courts Program and guest lecturer at other law programs in Bulgaria. Judge Duffy-Lewis, a legal author, also published “Lost in a World of Social Networking,” an article on the perils of social networking and its legal implications, in Bulgaria’s leading legal magazine, Law World (June 22, 2009).

The following article is a snippet from Judge Duffy-Lewis’ first day on campus, thousands of miles from home.

As I crossed the campus quad at Sofia University, I was amazed at how at home I was on this faraway campus. Of course, smiles and hand signs passed for language (since my Bulgarian was sparse at best) but things felt familiar. As I tried to put my finger on it, it happened right in front of me. It was opening day of the fall semester, and students were arriving on campus, some with their parents. Some excited parents appeared to lead me. It was opening day of the fall semester, and students were arriving. Some students had already turned down for, I immediately approached them to see if they were, and I could pick out all the future lawyers in one second. If they were eager for knowledge that I quit registering students and just let them slide out the classroom door. I require an immediate answer, as long as it is a good faith attempt, I throw candy.

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Then I dropped a bomb. “Well, learning can be fun. We are going to have fun learning this semester. I had already tripped in a hole on the street, I was wearing high heels... enough said. I was a little wet from spilling coffee on my pants and then trying to wash it off in the bathroom when I was unexpectedly attacked by the cold water faucet. But there I was, in front of 50 students who could have been from Any University USA, including my beloved alma maters USC and Loyola Law School, Pepperdine University, and Western University of Health Sciences, where I have strong board affiliations, were equally on my mind as I viewed this fresh-faced group of exuberant learners. Each face was eager with anticipation. I took a deep breath and said that I could not tell them apart from students back in the United States, and that we were going to have fun learning this semester. A look of confusion crossed their faces. “Fun?” one of the students asked. “How that could be, since this class is required for law school credit?”

A postscript: As a result of my Fulbright experience, I have a greater appreciation of the knowledge gained by participating on various court committees. Working with colleagues on approximately 30 committees throughout the years provided me with an understanding of many aspects and considerations of major court operations. This information and a wide perspective has proved very valuable in my ability to advise and assist the Bulgarian courts.

It was very clear to me that because I came from the world’s largest country, my opinions were held in very high regard. I was often asked to participate and assist in programs due to my long tenure on the Los Angeles Superior Court, and many Bulgarian judges whom I regards as colleagues in justice, were grateful I was able to share my perspectives. I have enjoyed meeting colleagues from around the EU and Bulgaria, all working simultaneously to improve justice.

I have gained a renewed sense of the enormous importance of justice as it is dispensed on a day-to-day basis to the average citizen and business looking to fairly resolve disputes. When justice is delayed to a degree that it inhibates a timely resolution of disputes, the public begins to question the fairness of the system, and asks the question “For whose benefit does the justice system exist?” The Bulgarian courts suffer from a public perception of corruption because the public is suffering from a “Justice delayed to justice denied” syndrome.

One of the accomplishments of which I am most proud is being associated with and assisting with the founding and opening of a wholly Bulgarian-funded and supported Mediation Center. The Mediation Center provides services to the Sofia Regional Court, the largest court in the country. It occupies a historic building in Sofia and has more than 30 mediator judges and lawyers participating. The goal of the Mediation Center is to assist the court in case management issues, and to improve the public’s access to early dispute resolution. The grand opening occurred on Jan. 27, 2010, to much public fanfare and substantial press coverage. I, along with my judicial colleagues in Sofia, are hopeful that this center can be a first step in addressing the public’s negative perception of the judiciary in Bulgaria.

My Fulbright was truly a gift from the American people. The Fulbright Program is the premier flagship international academic and cultural exchange program of the United States. Its purpose is to “increase mutual understanding between the people of the United States and the people of other countries.” The Fulbright Program was established in 1948 by Congress at the urging of Senator J. William Fulbright. Initial funding was derived from the sale of war-related materials. The Fulbright Program is sponsored by the U.S. Department of State’s Bureau of Educational and Cultural Affairs. The Scholarship Board is composed of 12 members from the academic and public arena appointed by the president of the United States. They set the policies and criteria for candidate selection. The program has many world leaders as esteemed alumni. My selection was truly a humbling honor.
Photo Gallery: Coleen Galindo, Office of Medical Education, COMP

"Napali Coast Aerial View," Napali coastline in Kauai, Hawaii

"HPC Bldg Flower Bed," Outside the HPC building on WesternU campus, Pomona, California

"Opaekaa Falls Kauai," Kauai, Hawaii

"Hindu Monastery Kauai," Kauai, Hawaii

"Red Footed Boobie in Flight," Crater Hill / Kilawea Point Lighthouse in Kauai, Hawaii

"View from a Cruise," Pacific Ocean along the Mexican Riviera
A Journey from Ultrasound to Pathology: Connections: Partners in Health

By Roslyn Davis, Library Clerk for Harriet K. & Philip Pumerantz Library

Monday, day one… In the fourth month of pregnancy carrying my third child, my life was literally interrupted while lying on a hospital ultrasound table. Spotting the day before had caused me (on the advice of a physician assistant) to go in for what I thought would be a normal ultrasound examination. During the exam, the technician began to move the ultrasound probe away from the lower part of my abdomen upward to the top of my rib cage area, all the while snapping pictures. Then she asked me the strangest question, one I had never been asked before. “Do you have two uteruses?” I replied, “No.” The technician then asked, “What are we going to do with her?” Then, not waiting for the doctor I was a little on edge, a little nervous, I replied, “No, I’m not going to have an abortion.” I walked out of his office, got on the crowded elevator, and tears began to stream down my face. With each descending floor this sobbing continued. For the next 24 hours, I was numb; and my appetite for food had left. I couldn’t eat, I couldn’t think, I couldn’t breathe. I had no idea of the journey I was about to embark upon. I did as I was instructed and went upstairs. After drinking some thick stuff, I was slowly rolled into the CT scan. While I was still partially inside the machine, I could see the doctor across the room as he viewed the images. Soon one of the other technicians turned into two doctors, then three, then four… all viewing my images. They were pointing at the images and pointing at me, quickly turning away to avoid making eye contact with me and shaking their heads. It was at this point I knew something was seriously wrong with me. Finally, they decided to come out and speak with me. I came face to face with another doctor who gave me little eye contact (I really knew then that something was wrong). Nobody wanted to look me in the eyes as they searched for the correct words to say. He finally said to me, “We have made you an appointment for tomorrow with the high-risk OB-GYN… You have to go see him immediately.” There was that word again, “immediately.” I then replied, “I’m not going to see the Physician Assistant.” “No,” he replied back, “you won’t be seeing any more physicians. You have the high-risk OB-GYN now, immediately. He will explain everything to you.” I went home that day a little on edge, not fully knowing what to expect. It would be on the following day that the full weight of my medical condition would hit me like an uncontrollable nightmare.

Tuesday, day two … Other than the fact that I was going for my appointment to see the high-risk OB-GYN, the next day was like any other normal, cool San Francisco afternoon in March. I sat in the examination room waiting for the doctor I was a little on edge, a little nervous, just not sure how to feel. Then the doctor walked in and remained standing as he spoke these words after greeting me. “Yesterday I looked at your CT scan, and I also showed it to the urologist. He says by what he can see, there is a large tumor growing on your right kidney, and he highly suspects that by the looks of it, it is cancerous. Since you are only in the first trimester of pregnancy you need to get an abortion, because if we have to give you chemotherapy the baby will be affected. I’ve made you an appointment for tomorrow to see the urologist, but now I want you to go downstairs to get a chest X-ray to make sure the cancer is not in your lungs.” By now my head was swimming in all the words this doctor was speaking to me, swimming around and around my head. I felt like I was spinning on a merry-go-round in an unbelievable story, like the ones you’ve seen on television where the doctor tells the patient they are going to die and you sit there in your living room watching and wondering just what that person must be feeling. Well, for me, at that moment, it was a great FEAR … FEAR like I had never felt before, a force gripped my heart. So overwhelmed and stunned with shock, the only thing I could manage to say to the doctor was, “No, I’m not going to have an abortion.” I walked out of his office, got on the crowded elevator, and tears began to stream down my face. With each descending floor this FEAR-GRIEF grew tighter and tighter around my heart.

For the next 24 hours, I was numb; and my appetite for food had left. I couldn’t eat, I couldn’t think, I couldn’t breathe. I had no idea of the journey I was about to embark upon. I did as I was instructed and went upstairs. After drinking some thick stuff, I was slowly rolled into the CT scan. While I was still partially inside the machine, I could see the doctor across the room as he viewed the images. Soon one of the other technicians turned into two doctors, then three, then four… all viewing my images. They were pointing at the images and pointing at me, quickly turning away to avoid making eye contact with me and shaking their heads. It was at this point I knew something was seriously wrong with me. Finally, they decided to come out and speak with me. I came face to face with another doctor who gave me little eye contact (I really knew then that something was wrong). Nobody wanted to look me in the eyes as they searched for the correct words to say. He finally said to me, “We have made you an appointment for tomorrow with the high-risk OB-GYN… You have to go see him immediately.” There was that word again, “immediately.” I then replied, “I’m not going to see the Physician Assistant.” “No,” he replied back, “you won’t be seeing any more physicians. You have the high-risk OB-GYN now, immediately. He will explain everything to you.” I went home that day a little on edge, not fully knowing what to expect. It would be on the
he reminded me that He was that “perfect love.” And these words to my spirit “Perfect love casts out all fear.” beautifully arrested my FEAR completely by speaking was in prayer, and God before I left the house morning of the surgery, and it produced tangible miracles learned minds of caring doctors in line with God’s plans. That morning, I placed myself into the skilled hands and heal me through physicians. Therefore, He had chosen to ultrasound to pathology. nurses — all of them, from anesthesiologist and the everyone I had met along my journey — the technicians, the doctors, the urologist, the the final pathology report findings: “Removed was a clear-cell carcinoma tumor along with the right kidney and a cluster of involved lymph nodes.” Afterward, I continued on with my pregnancy and delivered a healthy baby boy.

In conclusion… I know we all go through different things in life, some good things, and some bad things. We all get our share of them, and no one is exempt. That’s a fact of life we can’t avoid. But in the end, it will always be the connections we forge with one another in our journey that will define the outcome, when we remember that everyone of us has an appointed part to play. And so, today, 24 years later, I remain cancer free thanks to God and the connected partners in health dream team He used!

In 1995, I was approached by Western University’s administration to build the curriculum for a new College of Graduate Nursing. I wanted to give back to the profession that I loved, and helping to create the nurses of the future seemed just the thing. I had been a nurse for 25 years and my mother had just celebrated her 50-year anniversary as a registered nurse. I was halfway there. She wrote this poem when I was young, and the sentiments she expressed inspired me to be that person … a nurse. She was at my first code blue in ICU as the nursing supervisor. Years later, she volunteered at a community clinic as my nurse, assisting me with procedures that I performed as a nurse practitioner. Now, she is my role model of how to mentor those who follow in our health care footsteps, and I hope I make her proud.

Diana Lithgow, RN, FNP, PhD
Professor of Nursing, College of Graduate Nursing
Assistant Dean of Distance Education

I Am A Nurse
I am a Nurse and I am Special because...
I rejoice with you when you hear your baby’s first cry,
I help you when you are in pain,
I wash you when you cannot help yourself,
I cry with you when you lose your loved one...
From birth, through illness, through death,
I am your support… I am special…
I am your Nurse

By Helen Georges, RN
50 years a Registered Nurse

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Consequently, TVP is modeled upon an ancient teaching aptitude toward society: to build character, not merely careers. Individuals with moral courage and a sense of duty inspire students to strive to become humanistic beings. TVP’s goal is not only to teach philosophy, but also to develop skills, but rather for what purpose a person would use those skills. Athavale’s thinking echoed Einstein, who told teachers and students at New York University, “It is essential to know more closely resembles a well-trained dog than a harmoniously developed personality.” Similarly, TVP’s goal is not only to teach philosophy, but also to inspire students to strive to become humanistic individuals with moral courage and a sense of duty to society; to build character, not merely careers. Consequently, TVP is modeled upon an ancient Indian practice called “tapovan” which seeks to develop character through simple living and high thinking.

The Struggle: Simple Living, High Thinking

From the very first night at TVP, I slept on the hard tile floor. After waking up at five in the morning, I took a freezing cold shower, and until lunch, my stomach hungered for food. During class, I sat on the floor. While in my room, I sat on the floor. My right arm felt drained after I individually scrubbed each piece of clothing for one hour. When I walked into my room, I met my five roommates, who spoke five different languages that I did not understand. There was no TV; there was no computer; there was no mp3 player; there were no electronics whatsoever. It was hot, really hot, but there was no air conditioning. Within my first day, I had at least 10 mosquito bites on each limb. All I could think is, “What the heck did I get myself into?”

The challenges I faced for the first three months made me realize that through struggle one develops character. I had never truly pushed myself before coming to TVP. I had underestimated my capacity to adjust and grasp, and I found that if I truly push myself, I can accomplish what seems impossible. Education means “to draw out.” The education of TVP, living simply, drew out of me the confidence to overcome any situation I may face. As Aristotle claims, the goal is to “actualize the potential.” TVP gave me the opportunity to realize my potential. It is a potential which exists within us all.

Unity in Diversity: Residential Education

“Where are you from?” I asked my roommate.

“A village in Maharashtra (India). You are from America, right?” he asked as he saw me fumbling with my mosquito net.

“Yeah. As you can see, the last time I came to India was nearly eight years back.”

“It’s OK. The last time I went out of my state was … never.”

His native language was Marathi; I spoke Gujarati. We continued the conversation, barely understanding one another. As time went on, we became very close, sharing our family backgrounds, what we would like to do in the future, and what kind of life we would like to live. He came from a family of farmers who earned less than $170 per month. He had never seen an iPhone, never had a computer, and never owned a car. On the other hand, my other roommate from south India came from a family of millionaires. He was used to having servants do everything for him — cooking, cleaning, washing. He spoke Malayalam.

TVP brings together 160 students from at least four different countries, and 15 different states, who speak more than a dozen different languages, have studied in a variety of fields, and have household incomes ranging from hundreds to millions of dollars per year. TVP is the embodiment of diversity. It opened my eyes to a world beyond America, teaching me that every background and culture produces a unique individual. TVP emphasized the importance of making a connection with every person, regardless of the fundamental differences each of us possesses. This process made me realize my own faults and strengths, and that there is something to learn from every human being. The key to living together in harmony, to make a connection with another individual, is to focus on similarities rather than differences. This was one of the most valuable lessons I learned in my two years at TVP.

Along with living together, every one of us worked together. Part of the residential education included fulfilling duties. The entire institution was maintained by us — everything from cooking and cleaning to electrical work. It was inspiring to see a farmer cutting...
It cultivated in me a way of thinking that helps me value others' views rather than discounting them, so that as a physician I remain open to my colleagues and my patients. I was taught the importance of taking responsibility for my actions, sincerity in work, and what it takes to thrive in a group. Each individual fulfilled the duty given to him with honor. No duty was ever considered superior or inferior than another. What I found most amazing at TVP was that no single teacher was more important than the other. There was a strong emphasis on cultivating the best qualities and ideas found in the world's traditions. For example, the search for truth has been common to all civilizations. The West has looked to the outside world to find truth, cultivating the spirit of scientific inquiry. The East has looked within, developing the practice of spirituality. Each one contributes greatly to society and the development of man. Through ideas such as these, TVP embedded in me a mutual respect for each culture, religion, and philosophy.

The classes were not strictly academic. They were more like a philosophy to live by. Through the classes, lifestyle, and interactions with a diverse group of individuals, TVP instilled within me the philosophy that to be human means to make connections. It cultivated in me a way of thinking that helps me value others' views rather than discounting them, so that as a physician I remain open to my colleagues and my patients. It ingrained within me the value of relationship, bringing man closer to man, man closer to nature, and man closer to a universal power.

Pandurang Shashi Athavale, the founder of the school, began the Swadhyaya (Sanskrit for “self-study”) movement, inspiring millions of people to live by the philosophy of building connections with others, regardless of race, religion, or status, simply because we all arise from a common cosmic energy. Once we come to realize the connection we all share, the quality of humanism will simply have to follow.

I would like to express my deepest gratitude to Pandurang Shashi Athavale (Dadaji) for giving me the thoughts to develop my life and showing me what it truly means to be human. I am equally grateful to Dhanashree Talwalkar (Dadi) for giving me the opportunity to be a part of TVP. I would like to express my gratitude to the teachers of TVP for dedicating their lives to this school and to students like me. Finally, I would like to convey my sincere thanks to Dr. Clinton Adams, DO, Dean of the College of Osteopathic Medicine of the Pacific, for his advice, motivating words, and cooperation; without him, my journey to medical school would not have been the same.

The teachers were vital to this education. They would inspire us students to observe and analyze our own actions, to think about what moral courage means, and to ponder about spirituality, true happiness, and the goal of life. Every professor took a special interest in every student, developing their confidence, making them mentally strong, and instilling in them a will to live. The main thing the classes and the character of the teachers gave to us is the attribute of being a student for life, so that after two years, one continues to develop spiritually, building character and understanding what life is truly about. This was a cornerstone lesson of TVP.

**Conclusion:**

In my small experience of stepping into the medical field, I have witnessed much disconnect between health professionals, their colleagues, and patients. This observation became confirmed when during one of our Interprofessional Education sessions, a discussion arose regarding the issue of health professionals not being open to listen to or believe in one another, especially in regard to different types of treatment options for a patient. Dr. Lester Jones, Executive Associate Dean of the School of Podiatric Medicine, commented that “this problem arises due to philosophy, and it’s difficult to change one’s philosophy.” This reminded me of Tattwajnana Vidyapeeth. TVP gave me a philosophy to live by. Through the classes, lifestyle, and interactions with a diverse group of individuals, TVP instilled within me the philosophy that to be human means to make connections. It cultivated in me a way of thinking that helps me value others’ views rather than discounting them, so that as a physician I remain open to my colleagues and my patients. It ingrained within me the value of relationship, bringing man closer to man, man closer to nature, and man closer to a universal power.
INFORMATION FOR AUTHORS AND ARTISTS

Humanism in the Health Sciences (HHS), an award-winning journal of Western University of Health Sciences (WesternU), accepts the work of students, alumni, faculty and staff of WesternU or their families. Friends of the university also are welcome to submit their work. HHS is managed and edited by WesternU students and faculty. It is published annually and distributed free of charge to interested individuals and institutions worldwide. The next issue is scheduled for publication in May 2011; deadline for submissions is February 15, 2011.

HHS publishes essays, short stories, art, photography, poetry, case reports, literature reviews, and letters. All articles are reviewed by the editorial board; content experts review scientific and other appropriate submissions. Stories, articles and essays should be relevant to the theme of the journal, health care practice, or WesternU. Letters to the editor may address new topics or respond to subjects presented in previous issues of HHS.

Manuscripts should be submitted as a Microsoft Word file. Photographs, illustrations and artwork may be submitted in Adobe Photoshop (PSD), Adobe Illustrator (AI), EPS, JPG or TIF format on disc or via email.

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