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It’s the evening of August 29, 2014 and a group of four Meharrians (myself included) pile into a car and make our way up to Ferguson, Missouri. Up until three weeks prior to this day, I had never heard of Ferguson and the event surrounding it. During the three days we spent there, we participated in a march with thousands of others as well as held teach-ins and strategic planning sessions on how to create change and combat the issues at hand in our home communities. The sense of spirit and unity I felt every second I was there was extremely moving. Although there were no longer police dogs, tear gas and rubber bullets being used, the experience was still emotionally-evoking. While in Ferguson we were able to engage in scintillating dialogue with members of the local community. The youth cried out in anguish, begging for their voices to be heard. It was gut-wrenching to hear that they felt their own community was failing them. How can I as a professional student take this emotionally passionate energy and apply it to my own community?

This event was not isolated to Ferguson, St. Louis, Missouri, or even the South. Look at John Crawford in Ohio, Oscar Grant in California, Eric Garner in New York, Trayvon in Florida, and Renisha McBride in Detroit. Police brutality and mistreatment of members of the minority community are prevalent throughout the United States. Current methodology to combat these issues such as conformity, assimilation, and respectability politics are frankly inadequate. Where do we go from here? We think that as we continue to climb the socioeconomic ladder we will receive better opportunities. The sense of spirit and unity I felt every second I was there was extremely moving. Although there were no longer police dogs, tear gas and rubber bullets being used, the experience was still emotionally-evoking. While in Ferguson we were able to engage in scintillating dialogue with members of the local community. The youth cried out in anguish, begging for their voices to be heard. It was gut-wrenching to hear that they felt their own community was failing them. How can I as a professional student take this emotionally passionate energy and apply it to my own community?

Taneisha Gillyard, GS-II

T-shirt and jeans. We, as black citizens, are still being harassed, still being undereducated, and still being underpaid. We’re not fighting for civil rights. We are fighting for human rights. Many think that if we ignore the issue of racism, it will magically work itself out and disappear. 500 years after the onset of slavery and we are still fighting to be 5/6 of a human. It may not be overt segregation as was once enforced in this country, but it still seems to exist in subtle and implied social relationships. As student activists and members of this society there is so much work to be done if we want to ensure change. We must harness the energy surrounding these recent events and fight a strategic battle to create a more equitable country. United we stand, divided we fall.


**“FREEDOM RIDE” TO FERGUSON, MO**

Taneisha Gillyard, GS-II

During Labor Day weekend 2014, a group of young activists and community organizers from around the country and Canada put together a national advocacy effort organized through the United States. Cur- rent methodology to combat these issues such as conformity, assimilation, and respectability politics are frankly inadequate. Where do we go from here? We think that as we continue to climb the socioeconomic ladder we will receive better treatment. But a suit and tie doesn’t make you any less of a target than a

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**Our Staff**

**Taneisha Gillyard, GS-II, Column Editor**

Taneisha Gillyard is a second-year PhD student in the Neuroscience and pharmacology department at Meharry Medical College. She is a native of southern California but completed her Bachelor’s of Science degree in cellular and molecular biology at Louisiana State University, Shreveport in 2013. Her academic interests include translation- and integrative approaches to research and medicine.

**Estevana Isaac, MS-II, Column Editor**

Estevana is a second-year medical student and alumni to the University of Pennsylvania, where she studied as a biology major and creative writing minor. Before medical school, Estevana worked as a team leader for Crisis Counselors in New York. She is currently seeking a career which will allow her to actively engage in health services research as well as help mold and shape national and international health policy. She shares her passion and ideas through spoken word, poetry and creative essays.

**Rian Cho, DS-II, Layout Editor**

Rian is a second-year dental student and RWJF Health Policy Scholar at Meharry. Following his undergraduate studies at Andrews University, in Berrien Springs, Michigan, Rian served in the military for six years before coming to Meharry. Rian is currently involved in research focusing on salivary biomarkers of Intimate Partner Violence. Rian worked as a freelance photographer and video editor before he joined The Pulse. He is a private pilot and enjoys flying over beautiful landscapes across the United States.

**Christopher Salib, MS-III, Editor-in-Chief**

Christopher received his BA in English from the University of Illinois-Chicago, and his MS in narrative medicine from Columbia University. Prior to medical school, he worked as a copy writer for independent Chicago-based newspapers and magazines and is the published author of several essays, fiction and poetry. Christopher is pursuing the field of orthopedic surgery, where he hopes to find the fusion between trauma, culture, language and healing.

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**Sherief Hussein, DS-II, Photographer**

Sherief Hussein is a second-year dental student. He moved from Tampa, Florida after completing his BS in biomedical sciences from the University of South Florida, home of the Bulls. Prior to attending Meharry, Sherief worked with a pediatric dentist as a dental assistant. His goal after earning a Doctor of Dental Surgery degree is to reach out to the underserved communities and provide services to those who are in need.

**Minoo Sarkarati, MS-III, Column Editor**

Minoo is a third-year medical student and RWJF Health Policy Scholar at Meharry. She completed her undergraduate degrees in psychology and integrative biology at the University of California, Berkeley. Before attending Meharry, Minoo worked at Lyon-Martin Health Services as a comprehensive patient support associate while volunteering for San Francisco Women Against Rape as a medical advocate. Her academic interests include health disparities, primary care and health policy.

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**Sherief Hussein Estevana Isaac Minoo Sarkarati Rian Cho Christopher Salib**
October is Breast Cancer Awareness Month. Join a local fundraiser by following The National Breast Cancer Foundation at: http://www.nationalbreastcancer.org/breast-cancer-awareness-month

Learn more about the ongoing services and research happening at Meharry’s Center For Women’s Health Research.

BREAST CANCER AND BLACK WOMEN

Studies show that one out of every eight women will develop breast cancer. Staggering statistics also reveal that black women are three times more likely to face death compared to Asian/Pacific Islanders and almost twice as likely to die from the disease compared to Non-Hispanic white women. One may ask two questions: 1. Why is it that more black women are dying from the same cancer other races face? 2. How should this issue be addressed?

The answer to the initial question is multifaceted, but part of the reason encompasses the late detection of breast cancer due to health illiteracies and socioeconomic status. Some black women are unaware of breast health screenings and other cancer prevention methods such as nutrition, physical activity and annual physical exams. The solution to the problem can begin with the Centers for Medicaid and Medicare Services (CMMS) and private insurance companies can later follow suit. As of now, the minimum age requirement for mammograms in each state ranges from 35-39 through CMMS. Tennessee’s baseline age is 35-39. Testing can occur every two years for 40 year olds and up. However, thousands of lives could be saved if CMMS lowered the baseline screening age to 30 while allowing women to get tested every year after the age of 35.

An additional answer involves primary care providers who should offer breast health education to women who are at least 30. This counseling could be as simple as handing out informational brochures or briefly discussing the importance of mammogram screenings and a healthy lifestyle in order to prevent breast cancer. By reducing the baseline screening age and implementing breast health interventions, early detection of breast cancer can become more prevalent which may result in successful treatment of the disease. Women may also increase their quality of life due to the presumable reduced time spent undergoing harsh cancer treatment methods such as chemotherapy and radiation.

Cheryl Onwu, MSPH-II

MEHARRY EVENTS

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Cheryl Onwu, MSPH-II

MEHARRY EVENTS
With the implementation of the Affordable Care Act (ACA) and wave of health care innovation we still face the stark reality that many of our patients are uninsured, underinsured and are facing the reality of high out-of-pocket costs. Federally Qualified Health Centers (FQHC) which serve over 20 million patients with most of the patients below 200 percent of the federal poverty level have been practicing with many of the major principles of the PCMH already in place[4,5]. One example of an FQHC that is moving toward becoming a PCMH, is one of our own training centers, United Neighborhood’s Cayce Clinic in East Nashville. Cayce Clinic has been recognized as an Innovation Center—one of the 469 sites across the country participating in the FQHC Advanced Primary Care Practice Demonstration. As a participating clinic in the program, the clinic is expected to achieve level three patient centered medical home recognition, help patients manage chronic conditions and actively coordinate care for patients[6]. This initiative was created by the ACA and is estimated to pay an overall $42 million to the participating FQHCs in the span of three years, ending on October 31, 2014. Medicaid and Medicare have also provided electronic health record incentive payments to clinicians practicing at FQHCs that have a high level of Medicaid patients or those who receive uncompensated care or sliding-fee scale for low income patients[7]. This means that eligible health professionals and hospitals can receive funding for adopting, implementing, upgrading or demonstrating meaningful use of electronic health record technology. Despite this support, financial and structural barriers have stood in the way of fully transforming into the PCMH[8].

What is in store for our safety net? The PCMH may be a promising model for delivering high quality primary care in the safety net. PCMH recognized practices have outperformed practices without recognition across many clinical quality measures in some studies. However, larger reviews have found that the current evidence is insufficient to determine effects on clinical and most economic outcomes[9]. Even with the implementation of the ACA, the Congressional Budget Office estimated 27 million people would be left uninsured by 2016[10]. There continues to be a need for the safety net, and a sustainable and effective model for quality primary care is still a project in the making.

References:

Minoo Sarkarati, MS-III

The Patient Centered Medical Home (PCMH) is one model of health care innovation that has its roots in the safety net and has permeated it as well. The criteria to be designated as a PCMH has evolved over time since the basic concept was first introduced in 1967 by the American Academy of Pediatrics[11]. The PCMH is defined differently depending on the organization and has morphed over the past decade. The Agency for Healthcare Research and Quality defines a PCMH by five major attributes. 1) Comprehensive Care including acute and chronic mental health care, prevention and wellness. 2) Patient-Centered Care, providing whole person care, including meeting the patient’s unique cultural needs, values and preferences, as well as recognizing and informing the patient as a partner in the care plan. 3) Coordinated Care that manages care across all elements of the broader health system including community services, home health, hospital care and specialty care. 4) Accessible Services, delivering services with shorter waiting times for urgent needs, increased in-person hours and around-the-clock telephone or electronic access to a member of the care team. 5) Quality and Safety with the use of evidence-based medicine, clinical decision support tools, engaging in performance measurement and improvement, measuring and responding to patient satisfaction and practicing population management[12]. Although the initial concept is not necessarily a new one, there has been a recent wave for clinics to become certified as a PCMH as a way to reduce healthcare costs and improve quality of care[13].

WHAT IS HAPPENING TO OUR SAFETY NET?: ATTEMPTING A PATIENT-CENTERED MEDICAL HOME

Health Policy Column

Minoo Sarkarati, MS-III
During the summer of 2011 I worked as an intern at the Women’s Health Clinic in Gaborone, Botswana where I can still vividly recall a young Batswana girl lying on a patient bed with her calves resting on the worn stirrups posted on each side. As a clinical assistant, I held a vinegar-soaked cotton ball with my tongs in hand. The attending Batswana gynecologist, Mimi, had her head stationed at the meeting of her thighs, while tears began to stream from the corners of the young girl’s eyes.

Mimi turned to me and explained, “She was referred here, but she has yet to know her HIV status.” She then handed the tongs to Mimi, where she proceeded to wipe the cervix of the patient and gently stated, “Don’t worry, we will talk in the next room when I am done. Everything will be okay.” I approached the young girl’s side and held her hand in the small, close-fit room. Mimi continued with Tswana words of encouragement. As I assisted the gynecologist in performing cryotherapy on the patient that day, I most clearly recall the tears that streamed down the young girl’s face, an entire community of healthcare workers in a patient bed with her calves resting on the worn stirrups posted on each side. As a clinical assistant, I held a vinegar-soaked cotton ball with my tongs in hand. The attending Batswana gynecologist, Mimi, had her head stationed at the meeting of her thighs, while tears began to stream from the corners of the young girl’s eyes.

Just at 16-years-old, my first job at New York state’s call center for federal assistance along with the onset of my sister’s condition, taught me that services are only as effective as those who provide them. I listened to the backed up line of low-income citizens unable to obtain their medication, access outpatient care or even afford to eat for the day due to the program’s lack of organization. As unsettling as the experience was, it truly became person when my sister, a Medicaid patient, was going through it as well. This led me to determine the empathy from the healthcare workers that filled the room. It was this moment that taught me that establishing an effective doctor-patient relationship is not exclusive to two individuals, but rather it includes an entire community of healthcare workers.

My passion for providing compassionate and coordinated care to low resource communities developed prior to my employment in Botswana. I know the problems faced in today’s healthcare system, at home or abroad, will not be solved with apathetic service providers. After my sister’s diagnosis of schizoaffective disorder in 2006, I became frustrated by the lack of support and encouragement that she received from her physicians. Coordinated effort focused on patient improvement is no longer a priority for her providers; instead, she has evolved into a stereotype with limited ability of success. As a result, I have dedicated my time to finding ways to improve quality care for the underserved.

In the summer of 2010, I independently proposed and conducted health services research under the direction of Dr. Nancy Hanrahan, concerning disparities in outcomes for patients diagnosed with schizophrenia. Our findings confirmed different treatment outcomes based on length of stay and readmission for different cultural groups. Unfortunately, patients such as my sister do not receive the proper physical, mental and emotional support needed to improve such health outcomes.

We are two voices. Two entities in one. Me and you - a hybrid Of downs and lows, Of ups that never got too high, Of cognitive and emotional. And we only speak the words of silence Because we are the dream of reality. We are the silent scream Everyone hears, but never truly heard. My sister’s predisposition I was made for you, But I’m what’s wrong with you. We are two in one - a hybrid “Schizophrenia and Bipolar” They like to call it “Schizoaffective Disorder” But – I mean, let’s be honest here. Mental disorders don’t really exist. Only White people pop pills because they are having a bad day. Let’s admit it, being Black every day is a struggle. So move on, suck it up. Depression, Schizophrenia, Anxiety – Are you serious? No need to visit a doctor or therapist, It’s called life, Sweety, get over it. Or so they say, But that belief has never gotten me far. Years after my tings with God, Denial can only last so long. Because she still speaks a distant language I can no longer comprehend. The voices are putting a curse on her, Reading her mind and now everyone knows her thoughts – Especially the Hispanics. The Spanish neighbors saw the photos taken by the construction workers Never leave the window open They can see you. Leviticus Ch. 24 v 16 says, “And he that blasphemeth the name of the Lord, shall surely be put to death. All the congregation shall certainly stone him”
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By print or online, we are medical storytellers.

The PULSE is a student-driven newsletter committed to educating the student body, highlighting its achievements and broadening its horizons.

The PULSE Mission Statement:
The mission of Meharry Medical College’s student-driven newsletter, The PULSE, is to provide the Meharry community and the healthcare community at large with powerful stories on the current development of the healthcare system from the perspective of Meharry health professional students. Our voice is our strongest character; with it we hope to speak about our experiences of medicine inside and outside the clinic, honor the stories of patients, generate provoking dialogue about healthcare issues and ultimately capture the truth of medicine today with the vision of improving medicine tomorrow.
From the first day of pre-clinical training, questions come in floods. By the time most students are done studying for their board exams, they will not be able to hold common conversation unless there are multiple choice answers given. Joking aside, it may not always be apparent the enormous presence that questions occupy in our lives. Most students know by now that answering difficult questions is the most active method of testing one’s knowledge base. Speaking for medical students, by the time we enter the clinic, most of us will have answered, studied and read through the explanations of well over 10,000 questions. At this point, when we begin seeing patients, we shift the responsibility from answering to asking.

Eliciting a thorough history from patients is a process that becomes more refined by practice. Many seasoned physicians at Meharry elicit a history from patients almost as if speaking in natural conversation, but with key questions that reveal much of the patient’s present condition. While we may not realize it at first, each question is a highly developed one and the order in which they are asked are organized to help guide the clinician through his or her differentials. Witnessing and working alongside them, it was clear the art of asking questions is a pivotal skill in our practice.

Before, I had never given a second thought to have a patient clarify such a question: Did you wake up with the headache, or was it the headache that woke you up? Is it burning you feel on urination or does it just feel hot when you pee? When you say “a lot of bleeding” exactly how much is a lot? Different answers to these questions may change the diagnosis entirely. We begin to qualify the subjective into the objective and that may help us pinpoint the origin of the disease process. Even when language becomes a barrier and a translator is necessary, direct questions become all the more pressing. And not only is it the actual question that becomes important, but how you ask the question. The best method is done with tact and compassion, removing any accusatory tone and paying attention to the volume and rhythm of one’s speech. All these nuances of conversation—this is what makes asking questions an art.

After developing this skill we can begin to extend the reach of our questions outward. Why aren’t some patients able to make it to their follow up appointments? Why do children from this school always have the highest rates of influenza each year? Why do women from low socioeconomic status still insist on formula feeding their newborns instead of breastfeeding? Addressing the answers to these questions may prove more socially involved, but still within the outreach and grasp of Meharry’s mission. It is inspiring to see many Meharry physicians who are unafraid to ask these questions, perhaps reveal some uncomfortable social truths, but become unwavering in their commitment as advocates for the community.

Physicians, dentists and researchers are some of the strongest social leaders any society can have. Especially Meharrians, where the populations we care for need our voices the most. Knowing how to question, who to talk to and how to elicit necessary information is the starting point for igniting change. We may change the course of an illness into health, a social conflict or disparity into a new movement for progress, or encourage improvement at the personal, local and national levels. All of this work begins with the simple focus on the question that will direct us toward revealing answers. With that, we should also be prepared for the questions that lead us to more questions. So, what do we need to do now?

Word,
Christopher Salib, MS-III
Editor-in-Chief, The Pulse