Perspectives of Excellence: A Multimedia Exploration of Institutional Diversity

by V. Faye Jones, MD, PhD, MSPH
Assistant Vice President for Health Affairs/Diversity Initiatives

When others talk about diversity, can you see yourself in the diversity spectrum? Do you feel at times that you are invisible or may not have a voice in the direction of your career? Do you have a sense of belonging or community at the university?

I have asked myself these questions and more in the 24 years I have been at the university. Sometimes I have a clear picture of what I see and feel but at other times it is a little fuzzy. The Perspectives of Excellence: A Multimedia Exploration of Institutional Diversity project was created to allow everyone to have a voice and be recognized for the unique, diverse person that you are. We want to celebrate when possible, but also explore themes and ideas and, perhaps, come up with solutions on how to stay on the road of excellence for our institution.

The HSC Office of Diversity and Inclusion’s (ODI) mission is to advance the university’s priority of promoting and supporting a diverse community by fostering an environment of inclusiveness through the understanding and celebration of the many differences in perspectives, thoughts, talents, rich histories and experiences, belief systems and cultures of our students, faculty and staff of our the HSC community. It is our vision that we will be an innovative force that drives excellence as we integrate diversity in education, clinical service, community engagement and research by enhancing partnerships across the schools.

We wish to have this moment in time to shift our thinking beyond the idea that diversity and engagement is only a way of helping others to have the opportunity to reach their potential to a concept that helping others is the key to helping ourselves and the institution reach the level of excellence. The need for this new paradigm is essential in our changing environment to seize future opportunities which can be used to leverage and ultimately be able to respond strategically utilizing the diverse human talents and aptitudes that we are or will be fortunate to encounter. We need to see diversity more broadly. It has to go beyond numbers to include the development of a culture of inclusiveness. It has to be an interconnected component of the institution’s mission. Diversity has to be a key component of strategic planning.

The first step in advancing this model is developing and communicating a shared understanding of diversity and its relationship to excellence. The process has to begin by defining diversity and inclusion to provide a focal point for all constituents.

In a prior Celebrating Diversity...
John Chenault, Associate Professor at Kornhauser Library, defined diversity as: “the normative condition of human existence; it defines the complex nature of human society at the level of the individual. Inclusion is used to describe the active, intentional, and ongoing engagement with diversity—in people, in the curriculum, in the co-curriculum, and in communities (intellectual social, cultural, geographical) with which individuals might connect—in ways that increase one’s awareness, content knowledge, cognitive sophistication, and empathic understanding of the complex ways individuals interact within systems and institutions.”

We need to encourage and foster all our constituents’ growth and development to allow for everyone to be successful on our campus. The concept of inclusion is critical in the process. The ability for everyone to have a voice and feel appreciated is vital for the overall mission of our institution. This was best stated in a poem by Charles Bennafield entitled, I Am Diversity, Please Include Me.

By augmenting a culture and climate that demonstrates its belief that diversity and inclusion adds value to intellectual development, academic enrichment, patient care, research and community engagement, we believe we are at a decisive moment to be an innovator for other institutions to follow. The ODI in partnership with the HSC Diversity Chairs and the Muhammad Ali Center invite you to participate in the creation of a multimedia exhibition and educational program entitled, Perspectives of Excellence: A Multimedia Exploration of Institutional Diversity, focusing on perspectives of diversity and belonging on the Health Science Center (HSC) campus. We specifically wish to showcase our institutional perspective on diversity through self-reflection, demonstration of activities aligned with our mission and/or providing a critical look at areas of opportunity on the campus. This collaborative multimedia project will use platforms of photographic images, video clips, written materials and original art work.

Through a multimedia medium, we can transcend barriers of language, cultural difference, educational inequity, job description, ethnicity and age. As such, the Perspectives of Excellence exhibition will fulfill three purposes. First, using the broad definition of diversity, the exhibition tells the story through reflection of how you see yourself in the diversity spectrum and how this increases/decreases your feeling of belonging within the HSC campus. Second, we wish to showcase examples of the work of individuals, groups, departments, organizations and/or the institution who are engaging in actions to enhance the concept of diversity as a component of institutional excellence. Finally, the exhibition itself will serve as a form of institutional activism, educating and motivating all to become agents of change and provide a venue to provide solutions or actions that the individual, group, department or institution can incorporate to influence the sense of belonging on the HSC campus.

Check out our website to see videos and examples of some of the submissions.

For more information about the Perspectives of Excellence project and contest, please contact the HSC Office of Diversity and Inclusion at hscodi@louisville.edu.
DMD Students Receive Scholarships to Serve Others

by Barbara Dagnan
ULSD Financial Aid Coordinator

The University of Louisville School of Dentistry is proud to have a service driven student body. We currently have eight students who are recipients of the National Health Services Corps Scholarship, as well as 41 students who are receiving military scholarships through three branches of the U.S. Armed Forces.

ULSD’s military scholarship recipients will serve our country upon graduation of the DMD program. In return, the military pays tuition, fees and a monthly stipend. Among our students who are receiving these scholarships, 19 are Army recipients, 12 Navy and 10 Air Force.

The University of Louisville School of Dentistry is also proud to announce that four new recipients have been awarded the National Health Service Corps Scholarship. This highly competitive scholarship is awarded to service driven individuals who wish to work in medically underserved areas. For the 2014-15 year 192 new scholarships were awarded nationwide across five medical disciplines.

The new recipients of this scholarship are Nate Einerson of Blanding, Utah; Matthew Free of Jonesboro, Arkansas; Logan Schuiteman of Rogers City, Michigan and Colten Butler of Hurricane, Utah.

The National Health Services Scholarship Program pays tuition, fees, other educational costs, as well as a living stipend to recipients in exchange for a commitment to work at an approved NHSC site for each year the scholarship is received.

Additional information about the National Health Services Corps Scholarship can be found at http://www.nhsc.hrsa.gov/scholarships/.
Diversity means different things to different people. To me, as a long time practitioner and clinical teacher of Internal Medicine, it means that different patients have different needs. But, a patient’s needs are not always obvious. This is especially true for patients who have a native language, sexual orientation, enculturation, ethnicity, or religious creed that is substantially different from those of the health care provider. As I reflect on how diversity has complicated my efforts to provide effective care, many patients come to mind. Here are a few examples that animate my point.

**Case 1**
The first visit of a spry 60-year-old patient, who emigrated from Eastern Europe as a child, comes to mind. His wife had died years before, but he had two adoring daughters, one a grade school teacher and the other a secretary, whom he had raised with his earnings as a “handyman”. He had a delightful sense of humor and spoke English quite well. His principle medical problem was ischemic heart failure. We agreed upon a treatment approach that included some dietary changes, and I gave him a printed handout of the key points. After that visit, my office staff mentioned that the patient had signed in using an “X” and that one daughter had discussed and filled out his medical history form. The patient was unable to read or write! I confirmed this with his daughters, and they became quite involved in helping him follow our plan.

**Case 2**
An African American woman, a single mother with a meager income and three children to support, had been diagnosed with “refractory hypertension” before she became a patient in our teaching clinic because she could no longer afford to see her previous physician. We repeatedly discussed the need for adherence to her medications but she always stated that she took her medication exactly as directed. She was able to give the name and timing of all of her medications. So, we changed the doses and types of her medications, reviewed factors that can make hypertension more difficult to control, and ran some tests to screen for an underlying cause that might respond to a very different approach to treatment. Despite these efforts, her blood pressure control was still poor and her renal function began to deteriorate. When we admitted her to University Hospital for observation and possible additional testing, we found that her hypertension was easily controlled on a simple regimen of relatively inexpensive generic medications. Non-adherence was the cause of her “refractory hypertension” and poverty was the cause of her non-adherence.

**Case 3**
During the civil war that followed the collapse of Yugoslavia in the 1990’s, many refugees found their way to Louisville, a federally designated site for refugee support. One of those was a Bosnian man who became a patient in our teaching clinic, in part because some Internal Medicine residents in that clinic had emigrated from the same area. The patient was a life-long heavy smoker with reactive airway disease, which had progressed to the point that moderate physical activity caused him to become short of breath. This problem would progress all the more rapidly
These vignettes underline two important points. First, the issues of miscommunication, poverty, poorly understood patient values, and health care literacy are quite common and impede our efforts to help our patients. Second, as the diversity of our patient population increases, cultural differences, unfamiliar languages, restrictions related to immigration status, and other factors increase the challenge of delivering effective health care. And, make no mistake about it; there is substantial diversity right here in “River City”, with more to come.

Some practitioners, especially new practitioners, are beginning to understand how quickly our Louisville patient base is diversifying. For example, more than 80 languages are now spoken within Jefferson County Public Schools; and the University of Louisville’s international student body represents 91 different countries. The need to include diversity awareness and communication skills in healthcare education is becoming more obvious. Formal training, such as programs described by Staton et al., is important, and new modules and materials are being developed and shared. But implementation will take time.

Interestingly, Hendelman and Byszewski looked at medical students’ perceptions of “slips” or lapses in professionalism made by their attendings and found 26.6% of them were related to cultural or religious insensitivity! If students can spot those lapses in physician behavior, does that mean that they may be more aware of some of the issues than faculty? Perhaps, but those findings also illustrate the importance of modeling behavior.

The most effective approach to addressing challenges related to patient diversity is likely to involve not only education (including role modeling), but also increased involvement of families, and cultivation of community organizations that can provide outpatient support in the form of home visits, transportation, and more. However, for several reasons, large-scale adoption and implementation of such an approach would probably take considerable time.

The good news is that some important changes are already occurring both locally and nationally. First, the Yale Office Based Medicine Curriculum is available to residency programs for small-group, faculty-moderated resident education. This curriculum is used by a number of residency programs across the nation, including the UofL Internal Medicine Residency, and includes several topics related to diversity awareness. Second, Always Use Teach-Back offers free, online training in an approach to provider-patient communication that is being incorporated into some of our residency training and faculty development activities.

Clearly, modeling awareness of and sensitivity to diversity issues by health care providers is a potentially powerful tool for changing attitudes. Just as clearly, effective communication skills are critically important to providing effective health care.

Case 4
My ward team admitted a 25-year-old Hispanic man for severe kidney failure. We diagnosed the underlying disease and provided renal dialysis during his hospital stay. He had a wife and several young children, whom he supported by working as a manual laborer, at least until he became so ill. This situation would be tragic for anyone, but for this patient and his family, the tragedy was worse because he was an undocumented immigrant, which we did not know initially. This meant he could not receive scheduled dialysis as an outpatient or even obtain needed medications. Because of the lack of outpatient treatment and, perhaps in part because he continued to try to work to support his family, he required frequent readmissions and his condition rapidly worsened.
School of Nursing

My Experience in the International Service Learning Program in Botswana

by Ruth Wooten
Upper Division BSN student

I had the amazing opportunity to travel to Botswana, Africa in early May of this year through the International Service Learning Program, here at the University of Louisville. I had never been across the Atlantic and going to Africa had always been a personal dream of mine. Not only was it a marker of accomplishing one of my personal goals and dreams, I ventured on that journey with a group of peers and faculty that I had the privilege of working with and greatly respect.

While ISLP is about having a service experience abroad, it was just as much about collaborating with students and faculty from other academic units to serve the global community. Our service, in Botswana, manifested itself as teaching in local schools that were in and around the capital of Botswana. With all of the planning and time we devoted to our lesson plans, I had no doubt that we would successfully be able to implement our teaching plans. All the while, our teaching plans allowed for the freedom to be flexible and teach most effectively.

I had two experiences that were particularly memorable from my time in Botswana. First, was the night we spent with college students from BOTHO University. We played volleyball, basketball, handball, and giant chess with them. It was so fascinating to see how similar we were. We had the same priorities, and life experiences as those students. Our lives were just taking place in different countries. The BOTHO students shared some of their cultural traditions with us that ranged from cuisine to dancing. It was such a joy to completely immerse myself in the rich culture of the “Batswana”, citizens of Botswana.

My second most memorable experience was teaching and interacting with the children at a middle school in Molepolole, an area outside the capital of Botswana. One of the first activities we completed with the students was to create a “confidence tree” in which the students traced their hand and wrote inside of the hand something about themselves that they were confident in. They were very quiet during the beginning of the exercise, but as I continued to answer and ask questions, the students were much more forthcoming with their input. My small group of students explained to me how no one had ever asked them questions about what they are confident in, what their goals are, and what they want in their lives. This was surprising to me. I remember being asked those questions all of the time, when I was their age. People, who prompted me to find my goals, when I was younger, made a big difference in my life and I was humbled to be able to have that conversation with the students at Molepolole.

The ten days I spent in Botswana are ones that I will never forget. I learned that no matter the differences or language barriers, the things that make us who we are and drive us to accomplish our goals are more powerful and will bring people together.

For more information about the International Service Learning Program, go to louisville.edu/islp.
Public Health and Information Sciences

The Ebola Epidemic in West Africa: From the Outside Looking In!

by Muriel J. Harris, PhD
Associate Professor, Department of Health Promotion and Behavioral Sciences

When I decided to write this piece it seemed so natural to say “from the outside looking in” since in so many ways I have felt like an outsider, not standing in the midst of an epidemic that has consumed the imagination of not only three countries in West Africa but the rest of the world. As I settled on the title, it occurred to me that maybe it had been used before, and then I came across this quote, "From the outside looking in, you can never understand it. From the inside looking out, you can never explain it." (Unknown) and it just seemed so poignant! So, I ask myself, which is it really, looking in or looking out? Given that I was in Sierra Leone for three months as the Ebola epidemic unfolded, but far away from where it was all happening and therefore I was on the outside looking in for sure! I will never understand why it took so long for people to realize what was happening, and having realized what was happening, it took so long to respond. Taking the other part of this quote, “from the inside looking out, you can never explain it,” the questions we must always ask and answer first in any situation like this is, what is it? How is it spread? What do we need to do to protect ourselves and those around us?

These were the questions that guided my earliest responses to the Ebola Virus Disease (EVD) and the questions that I answered over and over again for many people who were also scared of what people came to recognize as a virulent disease that was set to change the way people relate to each other, the way doctors view their patients, the way men and women are forced to view anybody who has a fever, aches and pains or diarrhea and vomiting, including their children with suspicion. The simple act of touching one another became taboo.

It has been a difficult time for the people of the three countries at the center of this epidemic and the only three counties largely affected. Africa is a massive continent made up of fifty-one independent counties so the fact that only three counties have borne the brunt of this disease is a testament to the resolve of many people to end the epidemic, quickly and decisively. To put it into perspective it is four times larger than the US. See Figure 1.

The three countries most affected by the Ebola Virus are in West Africa and they are Guinea, Sierra Leone, and Liberia. See Figure 2. The three countries have common borders and are generally referred to as the Mano River Union Countries. In Sierra Leone the first evidence of the epidemic emerged in the Kenema and Kailahun districts in the East of the country where the people mix and mingle with folks from Guinea and Liberia. They share families and goods with little regard for geopolitical borders. The people that live in this region move freely across the three countries and speak the same language. Guinea also shares its borders with Cote d’Ivoire and Mali while Liberia shares its border with Cote d’Ivoire. Mali has only recently identified cases of EVD and Cote d’Ivoire has no reported...
cases.

Only a few other counties including the US have any experience of the epidemic, most of that experience being from individuals who were taken back to those countries for treatment (France, Germany, Spain and the US). See Figure 3.

In the US and Spain, health care workers who treated patients with Ebola and who were exposed to the virus were infected, but they were treated and they all survived. The only means of transmission of the virus from person to person is from direct contact with a person who not only tests positive for the Ebola Virus but also has symptoms of the disease. The infection is ONLY transmitted through contact with body fluids. It is thought that a person who recovers from the infection will transmit the virus through sexual intercourse for about 3 months following recovery. It is important to understand the facts!

In the wake of the epidemic and the recognition of its effect on not just West Africa but also its likely impact to other countries around the world, the response from the US, Great Britain and countless others came as a welcome relief. It included treatment centers, health care providers and public health personnel. We even got a war ship sitting out at sea!

It was President Obama who said, "Ebola is a horrific disease. It’s wiping out entire families. It has turned simple acts of love and comfort and kindness -- like holding a sick friend’s hand, or embracing a dying child -- into potentially fatal acts. If ever there were a public health emergency deserving an urgent, strong and coordinated international response, this is it."

Yes, it needed a massive amount of financial input and human resources to stop the spread of the virus across fourteen districts in a country that has a population of approximately six million people, but why did it take so long to get treatment centers in each district? Persons suspected of having Ebola were taken 3-4 hours by ambulance to the only holding and treatment centers in Kenema and Kailahun, and then wait 3 days for Reverse Transcriptase Polymerase Chain Reaction and the Ebola test result. In many cases, they did not survive long enough to get the diagnosis, yet they were taken away from their families and friends who were left to wonder if they had in fact died of Ebola or malaria, typhoid or some diarrheal disease. We will never know! What we do know is that they were buried within 24 hours, with many families not knowing how they died and...
In West Africa the countries leadership also recognized the threat the epidemic posed to the health care system, the economy, and the agricultural sector, and they began to take action to build advocacy for taking on what some people in Sierra Leone have called a “situation worse than war”! Most said that with the war, one knew the enemy. However, as individuals have understood more about the infection and have sought health care as soon as the symptoms of infection appear many more have survived and the death rate has dropped. It is why the epidemic is slowing down and while vigilance is still recommended after the last case is seen, the projections made earlier in the epidemic are unlikely to be realized. In addition to improved health care people have learned quickly what it means to be infected, although I will also add, not quickly enough. Old habits and traditions are not easily changed! I know that!!

Thousands of families have seen firsthand how deadly a virus this is, they have witnessed family, friends and patients die, and sadly have also watched health care workers, our doctors and nurses, die in the line of duty. Sierra Leone and Liberia have both experienced many years of war and political instability and it seemed just when the countries were beginning to realize significant growth in their economies, this epidemic has set them back again.

The deaths that all three countries have experienced are one thing but what lingers long after the last case is seen is the devastation that it leaves in its wake. Many families lost as many as ten people sometimes in less than one week! What is even more distressing is the number of orphans who have been left behind: a figure that may be anywhere from 2,600 (Ministry of Social Welfare) to 7,000 (UNICEF). What is left behind is a people who have endured untold suffering; a school system that has shut down for six months (so far), fields that have been left untended since May, mining industries that have shut down operations, and an economy that has had to use all its reserves as it contributes its fair share while it loses revenue daily as a result of policies that are intended to keep its people safe.

Guinea, Liberia and Sierra Leone will recover from this, and whether we are on the inside looking out or on the outside looking in, what we all must support is a resolve that this should never happen again. Never again should a people experience such loss. Public health has a duty to protect; we must protect all people and especially the most vulnerable women, children, the poor and the disenfranchised. We must think locally and act globally. Whatever our vantage point, from the inside looking out or from the outside looking in, my late grandmother would have said, “It is in caring for others that we care for ourselves.”

I would like to express my deep appreciation to the students of the School of Public Health and Information Sciences and those of the School of Medicine, Global Health Track for their kindness, thoughtfulness and generosity. Thanks for showing that you care!!
HSC Office of Diversity and Inclusion

Caregiving: An Unselfish Act of Love
by Katie Leslie, M.S.
Program Director

In celebration of National Caregivers Month, the University of Louisville Office of Community Engagement, Kent School of Social Work, and the HSC Office of Diversity and Inclusion sponsored a free celebration at the Muhammad Ali Center to honor and recognize the hard work lay caregivers provide in service to others. Nearly 100 people who tend to relatives and others attended the November 7 event during National Family Caregivers Month.

“This event was done for no other reason than to say thank you to caregivers...to honor and celebrate people who unselfishly give of themselves to people who cannot do for themselves what they would normally,” said Dr. Sharon Moore (Kent School of Social Work), who chaired the organizing committee.

Other committee members were Dr. Faye Jones (HSC Diversity and Inclusion), Dr. Karen Kayser (Kent School of Social Work), Kenyatta Martin (President’s Office), Katie Leslie (HSC Diversity and Inclusion), and Sandra Malone (Canaan Christian Church).

Civic leader Alice Houston, co-founder and president of Louisville-based logistics services provider Houston-Johnson Inc., spoke at the luncheon about her personal experiences in caring for parents. Health care agency vendors ResCare, Baptist Health Louisville, Elmcroft of Oaklawn, Gilda’s Club of Louisville, Helping Hands Companion Services, Inc., Hosparus, Kentucky Cancer Program, and MD2U provided information about their services and products.
Upcoming Diversity Events

- “Binding Wounds, Pushing Boundaries: African Americans in Civil War Medicine”
  Exhibit on Display November 24—January 2
  Location: Kornhauser Library

- “Game Theory: The Politics of Race and Sport”
  Part of A&S All Star Series
  Presenter: Ricky Jones, PhD
  Saturday, November 29 at 10:00am
  Location: Gheens Science Hall Rauch Planetarium

- “Religion and Holidays”
  Part of the Cultural Competency Series
  Wednesday, December 3, from 12:00 — 1:00pm
  Location: Cultural Center, Belknap Campus
  Lunch Provided

- Safe Zone II Training
  Friday, December 5, from 9:30am —12:30pm
  Location: Human Resources, 103A
  Contact: Brett Steele

- “Understanding Hanukkah and Kwanzaa”
  Part of the Cultural Competency Series
  Monday, December 8 at 6:00pm
  Location: Cultural Center, Belknap Campus

- Student Volunteers Needed for Community Health Screenings
  Wednesday, December 17, from 8:00am—12:00pm
  Location: Redeemer Lutheran Church
  Register [here](#)

World AIDS Day December 1, 2014

- Around the world, about 34 million people are living with HIV. In the United States, about 50,000 people get infected with HIV every year. World AIDS Day is a global initiative to raise awareness, fight prejudice, and improve education about HIV and AIDS.

- In the last 2 years, US efforts to create an AIDS-free generation include advocating antiviral therapy for all HIV+ individuals at risk of sexual transmission, implementing PreP (Pre-exposure Prophylaxis guidelines) for discordant couples and HIV negative people at risk, and continued use of PeP/ nPeP (occupational and non-occupational Post exposure Prophylaxis guidelines) [http://aidsinfo.nih.gov/guidelines](http://aidsinfo.nih.gov/guidelines)


- Did you know? African Americans are the racial/ethnic group most affected by HIV. Learn more: [http://1.usa.gov/MZ9oSe](http://1.usa.gov/MZ9oSe)

- Women account for about 1 out of every 4 new HIV/AIDS cases in the U.S. Learn more: [http://1.usa.gov/1o3IBjb](http://1.usa.gov/1o3IBjb)

- Help Put an End to the Stigma!
  - Talk to parents about teaching their kids the basics of safe sex
  - Address discrimination
  - Help promote HIV/AIDS education
  - Encourage proper health care
  - Affirm support for people living with HIV/AIDS
  - Wear a red ribbon, the symbol of HIV awareness and support and tell people why you are wearing it.