Revival of Scoliosis Screening
A Project of the NC Schweitzer Fellowship

by: Cherisse J. Thomas, Class of 2006

Cherisse Thomas, a 2006 Schweitzer Fellow, spent much of her free time over the past year providing scoliosis screenings for children and teens and founding a scoliosis support group in the Greenville area. Cherisse, a former scoliosis patient, felt a close connection with her project, “Because of my personal experience with scoliosis, I see these screenings as important in keeping the community aware of scoliosis and preventing children from having surgery or having debilitating spinal deformities.”

I remember being introduced to a woman who had such a severe case of scoliosis that she carried a tank of oxygen with her in order to breathe. She exemplified a tragic case of untreated scoliosis.

Scoliosis is the abnormal lateral curvature of the spine. There are several different types of scoliosis, such as idiopathic, neuromuscular, congenital, and others. The most common type of scoliosis, by far, is idiopathic, which usually develops during the growth spurt that accompanies late childhood or early adolescence. Treatments used for this include observation, bracing, and surgery.

At the age of six, I learned that I had scoliosis when my mother noticed an abnormal curve in my spine. When I turned ten, the curve in my spine had progressed so much that my doctor felt that I needed to wear a back brace to correct it or at least to prevent it from progressing any further.
Generalist Perspective:

Please, Put the Patient First

Several weeks ago I was returning from a board meeting and came through DFW airport. It was a rare day there. It snowed; not much, but enough to disrupt travel. At the gate the flight time came and went without a word from the agents about why we couldn’t board. Finally, we did board and left the gate 45 minutes late without explanation. That still gave promise for returning home on time, but the pilot dashed that hope (at least he gave us information) in letting us know that the plane was to be de-iced. It would take about 15 minutes per plane and we were number six in line. Two hours later we were still not being de-iced. Meanwhile the sun was shining and water was pouring from the plane in small rivers—and still we waited, because apparently once in the line to be de-iced no thought could be given to an alternative. Even the de-icing crews continued their lengthiest routine because it was policy. Such policy, unmanaged by reason, and unexplained to the passengers, kept almost 150 people closeted in a long narrow tube for more than three hours watching other planes take off all around us.

What has this to do with medicine? Substitute patient for passenger and it has everything to do with what we do. How often do we find ourselves willingly enslaved by patient unfriendly policy or routine (it’s always been done this way), or just plain stubbornness in the face of a difficult patient? You’ve no doubt seen it in the clinics where you work or maybe even experienced it as a patient. Is it rudeness or simply ignorance when someone in the office answers the phone while talking, laughing, or cracking gum? How are we different when we talk at length on the phone while a patient stands waiting to ask a question or simply register to be seen? And what about making room for a patient who calls needing to be seen today, or arrives a little late for a scheduled visit through no fault of his or her own? Do we accommodate them?

I’ve had the sad experience of coming to see a patient who’d been waiting a long time (two hours is not unusual in a busy ED) who had been given no explanation for the delay and during their anxious waiting, had seen others coming in later and leaving first. I’ve had the misfortune of watching doctors fail to offer even a simple apology for their lateness (often after having failed to even greet the patient by their proper name).

There is no doubt that every one of us, almost 100% of the time, provides high quality medical care, but at least a small part of the reason for the current medical liability crisis, is not bad medical care, but rather our indifference to the way people feel and feel about us. No tests, procedures, or sets of them, will make a patient respond as well as when we accommodate their needs, as when we call them by their proper name, greet them warmly, sit looking them in the eye, and showing by our words and body language that we care about them as people. The words please, thank you, I’m sorry, and sir and ma’am that our parents taught us years ago are as important a part of medicine as the immunology we learned last month. It is all part of putting the patient first. Please!
I’m sitting on an airplane, a “very full flight”, they called it, wedged comfortably (?) against a window, thinking. I had promised to write this article for The Generalist, but was waiting for inspiration. I got it from “the crazy engineer in the seat next to me,” (his words), who said I could also call him “Jim.” We began talking when he saw The-Brody-School-of-Medicine tag on my computer.

Jim lives in Charlotte now, but grew up in a very small town in New Jersey. He said I could interview him. He really got my attention with his answer to my first question, when I asked him what he knew or thought about family medicine. “It’s like a play on words, really”, he said. Gulp— that’s my specialty we’re talking about. Turns out Jim grew up with a family doctor; that is, a doctor who knew the family and all about them without an every-visit review of the family history. Jim’s family could always reach their doctor easily when needed—by phone or just go into his office. Jim recalled his bout with chicken pox when his mom called the doctor, got some medicine and advice, and that was that. “It was simpler then.”

Why was it simpler, I asked? For one thing, it’s hard to get an appointment when he wants it. He also thinks it’s because medicine is a business now, blaming “the almighty dollar.” He cited the current realities: we doctors must see more patients in a given time; pay for technology, and pay for the rising cost of malpractice insurance.

Actually Jim still sees a family doctor, the same one, now for 17 years. His health plan dictates that he must name a primary care provider. Would he go to a generalist if he didn’t have to? He believes he would, but then he offered the following thought: in the future, maybe all diagnosing and prescribing can be done with technology—by taking a diagnostic pill or going through a machine.

Dr. Seuss described such a scene in his 1986 book entitled You’re Only Old Once!: A Book for Obsolete Children. The picture accompanying the text shows the patient in a machine with the doctor peering in through a telescope.

And the next thing, you know, when you’ve finished that test, is somehow you’ve lost both your necktie and vest and an Ogler is ogling your stomach and chest.

Your escape plans have melted! You haven’t a chance, for the next thing you know, both your socks and your pants and your drawers and your shoes have been lost for the day. The Oglers have blossomed like roses in May! And silently, grimly, they ogle away.

Would the doctor be obsolete? Not for Jim. He would miss “the human factor.” Jim wants to interact with a doctor who will help him interpret the test results and give him personalized and lifestyle advice. What about the specialty of the generalist physician? That was not an issue, getting back to his original point, only a “play on words.” Whatever the specialty, he was looking for a doctor who would know him and take care of his general health needs. He understood that nurse practitioners and physician’s assistants did not have “an MD degree,” but fully accepted their role as part of a health care team.

So what can we make of this single interview, this series of one? Should it go unheeded? After all, this is just one person’s opinion. As it turns out, Jim’s opinion fits right in with some of the major findings of my discipline’s Future of Family Medicine project. This project is a very large, multi-year undertaking to understand (among many other things) what patients know and think about family medicine and family physicians. The results will be published this month in the Archives of Family Medicine.

Suffice it to say, most patients surveyed agreed with Jim. They would like to have a regular doctor who knows them personally, enabling the physician to help them navigate a complicated system of health care and offer them personal health care advice.
Revival of Scoliosis Screening

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four years after that, I wore a brace every day and had the support of my family and the Scoliosis Association, Inc. As a result of my treatment, I presently have a straighter spine and I realize more than ever that I am very fortunate that my scoliosis was caught early and treated.

Unfortunately, not everyone is fortunate enough to have parents who are knowledgeable about scoliosis and who regularly monitor the development of their child’s spine. Nor do all children have health insurance which enables them to have their spine evaluated by a pediatrician yearly. If scoliosis is not caught early, the twisting and curving of the spine can deform the trunk of a child’s body to the extent that it can result in pulmonary and cardiovascular problems. Additionally, cosmetic deformities, debility and pain from musculoskeletal problems can occur when scoliosis goes untreated. This is why in some cases the diagnosis of scoliosis in adolescents results in them having immediate surgery.

Over the years, the Pitt County School System has removed scoliosis screening from the public schools due to budgetary limitations. When screenings were conducted, the program enabled all children, despite financial barriers, to be checked for scoliosis. In addition, the fact that screenings were done at middle schools was ideal because most scoliosis patients are adolescents. Without scoliosis screenings a population of scoliosis patients still exists in our area.

Those children who go to their pediatrician yearly or have parents who are knowledgeable about scoliosis may not have been greatly affected by the removal of this screening. However, what about children who are not as privileged? These are usually children who only go to clinics for specific reasons like a cold, or broken arm. Physicians at these clinics do not routinely check for scoliosis because they usually concentrate on the specific concern. This is the focus of my project. I was most concerned with finding a means for disadvantaged adolescent children to be screened for scoliosis. To address this dilemma, I implemented The Revival of Scoliosis Screening.

Webster’s dictionary defines, revive, as to bringing back into use. My plan was to bring scoliosis screening back into use in the Pitt County community so that children without the means to be checked yearly by a physician would have the opportunity to be diagnosed and treated.

The Revival of Scoliosis Screening took place during the summer of 2003. This program involved an entire summer of traveling to different community centers in Pitt County, and forming a support group for adolescents with scoliosis. I focused my activity on community centers with larger populations of disadvantaged children from 11 to 14 years of age. The community centers and summer programs I visited included: Operation Sunshine, Impact 22, Impact 1, Pitt County Parks and Recreation, Thomas Forman Park, Greenville Aquatics Center, the Little Willy Center, and the Boys and Girls Clubs of Ayden, South Greenville and Pitt County.

The actual scoliosis screenings were performed on a volunteer basis by experienced physical therapists from the community, physical therapy students, and physical therapy program faculty members. I cannot tell you how thankful I was that these people helped me do this. I remember when I was planning this project and I had no idea who was going to help me do these screenings. During this time, I learned a great lesson about having faith. This faith in my project meant that I carried on as if everything was in place. In the end, for each site I scheduled a scoliosis screening, I had a physical therapist who was able to perform screenings.

Another interesting factor in my project was that it required parental consent. There were only a few problems with distributing the parental consent forms to the patients. The difficulty was in getting them back. Some sites, however, required constant reminding.

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Brody Students Sponsor Bone Marrow Drive

by: Brian C. Dawson, Class of 2006

Back, when we were interviewing for medical school at the Brody School of Medicine, many of us stated that we were interested in primary care in a rural area such as eastern North Carolina. Once school started and we were exposed to the vast array of options in medicine some of us changed directions to pursue other specialties. The Rural Health Interest Group, of which I am President this year, was formed to help keep the option of rural medicine alive in the minds of medical students and to provide opportunities for students to experience rural medicine. The Generalist Program has been instrumental in helping our group find the ways and the means to serve the rural communities surrounding our medical school.

I would like to share with you our most recent project and invite you to participate. First, a little background information. Last year as first year medical students we learned about the importance of bone marrow transplants for some individuals, the importance of finding an almost identical match, and we learned of the difficulty in doing so for some populations. As a white male my chances of finding a life-saving match would be better than any of my friends or their families who come from a minority background. This is due in part to the fact that I have a larger pool of individuals who are statistically likely to match my HLA-type, and perhaps in part to the cultural differences in organ donation. Based on this need in our surrounding rural communities, the Rural Health Interest Group chose to proceed with a service project focusing on bone marrow donation, placing specific emphasis on minority organ donation.

Last year we had participated with the Student National Medical Association (SNMA) on their minority organ donation project. When our group approached the Red Cross we discovered SNMA had also contacted them regarding the possibility of organizing a bone marrow drive at Brody. So once again, our groups are collaborating on a minority organ donation week with a special emphasis on a Bone Marrow Drive for Wednesday, March 31 in 2W-40 of the Brody Medical Sciences building.

So what can be done to help? First and foremost we would like to invite readers to consider being screened as potential donors. This involves attending the Bone Marrow drive on March 31 and having a small sample of blood taken to be typed. It will only take about 20 minutes. This HLA type will then be entered on the registry which individuals in need of marrow can search for a suitable match. There is no obligation to donate even if called. But we are asking that only those individuals who think they would be willing to donate actually be screened because we do not want to give false hope to those in need. Furthermore the testing costs are usually $65-70 dollars per person screened.

With the help of the Generalist Program, a grant from MedImmune, and grant funds secured by the Red Cross, we are able to offer this testing free of charge to a limited number of individuals. If interested, we encourage attendance at a lunch meeting on March 29 in Brody 2W-40 where a transplant physician, a bone marrow donor, and a potential recipient will give presentations and answer questions. Please RSVP for this event by March 22, 2004 to bcd0522@mail.ecu.edu.

Other events during the week include a lunch presentation about minority organ donation on March 30, the bone marrow drive from 8 AM to 6 PM on March 31 and a lunch presentation entitled What Next? on April 1. All of these events will be held in Brody, 2W-40. Please RSVP if you would like to attend any of these events. If you don’t feel that you can donate at this time, please help us by sharing information about this project with friends, family, churches, and others. Each individual on the registry improves the chances for those who are searching. Thank you, we look forward to seeing you soon!

If you would like more information or to schedule a time to be screened, please email Brian Dawson at bcd0522@mediec.edu or Cheryl Perry at cdp0508@mail.ecu.edu.
Scoliosis Screening

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to distribute the forms. I remember visiting one site on the day before the screening and seeing the unsigned consent forms sitting on the desk. Moments like these were very frustrating; but half way through the screenings I learned from my mistakes and begin to have parents sign their children up for the screenings in the afternoons, as they were picking them up, rather than sending a consent form home with them. This worked well because I was then able to educate the parents about scoliosis and they were able to ask any questions or share concerns they had about the screening. Many of the parents had never heard of scoliosis and some parents either had scoliosis themselves or had a family member who was treated for scoliosis.

At the end of the summer, my program successfully served ten community centers. We screened a total of 226 children and referred 26 to a physician for further evaluation. In addition, I helped some families who did not have health insurance to apply.

My screening program had a support group component with which I am still working. My hope in forming a group in Greenville was to provide a strong support network for scoliosis patients and their parents, the opportunity for adolescent scoliosis patients to meet others with the same condition, to promote self esteem, and to provide information about coping with, and treating, scoliosis.

The support group is sponsored by the Scoliosis Association, Inc. (with meeting support from Surgical Alternatives). This is a national organization with several chapters in the United States. Their mission is to educate, screen, support and research scoliosis as a service to the community. I have been involved with the Scoliosis Association, Inc since I was 11 years old and will continue to work with the support group even after my Schweitzer term is over.

Recently I hosted a meeting for the children who were referred to a doctor for further evaluation. The purpose of this was to educate them and their parents about scoliosis and what to expect. Dr. Scott Reeg, an orthopedic surgeon from the Center for Scoliosis and Spinal Surgery was the speaker for this meeting.

In January 2004, I held a more general meeting about using exercise to alleviate back pain. The speaker for this meeting was Dr. Margaret Maira, a physical therapist and faculty member from the Brody School of Medicine. This meeting primarily served patients with degenerative scoliosis although a large number of patients attended who had remnant back pain from surgery or a car accident.

At an upcoming meeting, a panel of scoliosis patients will explain what it was like for them during their treatment and how they coped physically, socially and emotionally. This meeting will cater to patients who are currently learning to live with scoliosis.

Though the Schweitzer Fellows at Brody School of Medicine all have different dreams and goals, we are all united by a strong belief about our role in improving health. We all wanted to implement a project that would work toward the goal of improving the health of the people of eastern North Carolina. My goal was to educate, at least some, eastern North Carolinians about scoliosis, to prevent children from needing spinal surgery, and to provide a supportive atmosphere for those who do have scoliosis. I feel so fortunate to be involved in this project. I remember feeling very different from others while being treated for scoliosis. As an adult, I truly embrace this segment of my life and I am thankful for the perseverance and discipline I was forced to learn. As this project continues to enhance my professional development, it has also encouraged me to accept my personal path in life.

If you would like additional information or would like to attend a support group meeting, please contact Cherisse Thomas. Her email address is CJT1031@mail.ecu.edu.
Brody Student Selected for Africa Fellowship

by: Dawn Hoffmann, Office of Generalist Programs

Since its inception in 1978, the Albert Schweitzer Fellowship has, each year, selected four senior US medical students to work at the Albert Schweitzer hospital in Lambaréné, Gabon. Benjamin Gilmer, a third year medical student at Brody School of Medicine has been selected as one of the four Lambaréné Schweitzer Fellows for 2004. He is only the second ever to be selected from a NC medical school.

Ben first became acquainted with the Fellowship as a North Carolina Schweitzer Fellow in 2002. He and his partner, Jennifer Farmer, worked in a rural Hispanic medical clinic and in rural Hispanic churches identifying families in need of health insurance, and enrolling them in various state and local programs. To accomplish this, Ben had to learn to speak Spanish and to delve into a culture that was foreign to him. In this way, he encountered a Lambaréné experience right here in eastern North Carolina.

The Albert Schweitzer Hospital has served as the primary health care resource in West Africa since Dr. Schweitzer founded it in 1913. The hospital is located in a tropical rain forest on the bank of the Ogooué River to allow access by boat as well as on foot or by car. Today the facility includes two operating rooms, inpatient wards for pediatrics, internal medicine, surgery and obstetrics, as well as a dental clinic. Ben will work with the French-speaking medical staff as a junior physician while on the three month rotation and will participate in village-based health care outreach.

SNMA Lecture on Integration in Eastern NC

by: Erica Quick and Sommer Knight, Class of 2007

On February 18, 2004, as part of the SNMA Black History Month lecture series, Dr. Andrew Best shared inspirational words with Brody School of Medicine students and faculty.

Dr. Best told about overcoming the racial obstacles he encountered during his long career. While serving in the army he had the experience of treating a woman who did not want to be seen by an African-American physician. With his gentle manner he was able to gain her confidence and upon subsequent visits she asked personally for him to be her physician.

With a combination of kindness and patience, Dr. Best became a key figure in several major segregation transformations. With Dr. Leo Jenkins, he selected the first African American student, Laura Marie Leary, to attend East Carolina University thus ending segregation without a court order.

Dr. Best continued playing pivotal roles in local events in the 1960’s and 1970’s and held state posts as a member of the UNC board of Governors and chair of the eastern division of Governor Dan Moore’s Human Relations Counsel. He was also the first African-American to serve on ECU’s Board of Trustees.

Dr. Best ended his presentation with a prescription for success: The Three F’s, Faith in yourself, Flexibility to change and overcome, and Fairness to all people. He said that, “In a world of workfare, warfare, and welfare, serving for gain and selfishness will lead to a decaying community.” He reminded students to not only make a difference in the lives of patients but to also take an active role in community improvement.
Generalist Calendar

Mark your calendars with these Primary Care Events!

March 2004

3–18 ECU Match - The Class of 2004 Annual Residency Match Ceremony held in the Brody Auditorium at 12:00.

3–20 Health for Life Fair at the Carolina East Mall from 10:00AM until 3:00PM. Come learn how to improve YOUR health and the health of others. Sponsored by the Brody School of Medicine Bone Marrow Drive Committee.

3–30 Deadline for Application to NHSC Scholarships. Please see Dr. Zanga if you would like more information.

3–31 Bone Marrow Drive cosponsored by the Rural Health Interest Group and Student National Medical Association from 8:00-5:00 in Brody, 2W40.

April 2004


4–02 Pediatrics Grand Rounds – Substance Abuse in Pediatrics with Dr. Hoover Adger, & Dr. Jake Lohr, 12:30 in 2E-92.


4–17 Healthy Kids 2004 sponsored by the Student National Medical Assoc. at the Pitt County Boys & Girls Club 9-1:00.