Teaching Physicians-in-Training to Address Racial Disparities in Health: A Hospital-Community Partnership

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SYNOPSIS

Racial and ethnic disparities in health care continue to be a major impediment to improving the health of many communities in the United States. Efforts must be directed at the multiple social, economic, and historic determinants of health disparities. In addition, health care providers must be aware of these determinants and must have the tools to address them in their individual relationships with patients. This article describes a partnership that arose out of the mutual recognition by a community organization and public hospital of the need to (*a*) teach physicians how to recognize the root causes of health disparities, (*b*) improve their cross-cultural understanding and communication, and (*c*) enhance their awareness of the capacity of community resources to positively impact their patients' lives.

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Racial/ethnic disparities in health care have become one of the major public health concerns of the 21st century. Disparities have been documented in risk of disease, morbidity, mortality, access to health care, and receipt of health care services.[1] While the pervasiveness and persistence of these disparities have been clearly documented, their elimination is harder to envision. This is because the underlying causes of these disparities are complex, including socioeconomic, cultural, and language barriers at all levels of health care[2–5]; interpersonal and institutional racism[6,7]; and mistrust of the health care system on the part of members of "minority" communities.[8,9] Solving the problem of health disparities requires complex interventions that target each of these root causes and all levels of health care.

Efforts to address health care disparities at the level of the individual provider have focused on increasing providers' ability to provide equal and effective health care to all patients regardless of patients' racial/ethnic backgrounds. These efforts are growing in number and most often take the form of interventions to improve providers' "cultural competence." Culturally competent providers are defined as those who are "able to provide patient-centered care by adjusting their attitudes and behaviors to account for the impact of emotional, cultural, social, and psychological issues on the main biomedical ailment."[10] Interventions to enhance cultural competence are usually developed and taught by health care providers or other professionals and focus on how culture and language barriers impact patients' health and their understanding of health care. They rarely explicitly address the importance of social and economic factors that have been directly implicated as causes of health disparities.[11] Nor do they always reflect the actual concerns of the communities of patients served.

The partnership and educational intervention described in this article arose out of the mutual recognition by a community organization and public hospital of the need to teach physicians about the root causes of disparities and how they might be addressed in their individual relationships with patients. The teaching is shared equally between physician faculty and community teachers. The curriculum is structured to allow community members to teach physicians-in-training about their community and about how to best communicate with and care for patients whose background and experiences are similar to those of the lay teachers. The program has had a positive impact on both physicians-in-training and the partnering community.

THE TEACHING PARTNERSHIP

This teaching partnership developed from a 14-year relationship between a nonprofit community advocacy organization, the Westside Health Authority (WHA), and a large public hospital in the city of Chicago, Cook County Hospital. Both organizations serve economically distressed, predominantly African American areas of the city of Chicago and have similar missions to improve the health of people living in those areas. The partnership developed out of a mutual recognition of a problem highlighted by WHA research, that physicians' lack of familiarity with the socioeconomic and historical contexts of their patients' lives impaired their ability to provide them with the most effective care.[12] The two organizations decided to develop an intervention to address this problem, and the project began in 1999 with direct funding from the Cook County Board of Commissioners.

THE GOAL: TO PROVIDE PHYSICIANS-IN-TRAINING WITH THE UNDERSTANDING AND TOOLS TO BETTER CARE FOR THEIR AFRICAN AMERICAN PATIENTS

The overall objective of this teaching innovation is to provide physicians with the understanding and tools to better communicate with and care for African American patients at a public hospital. Community leaders and physician faculty recognized that the economic, historic, and social aspects of Cook County Hospital patients' lives impacted on their health and access to health care and yet were not being routinely recognized and addressed by their physicians. The focus of the curriculum is to increase physicians' awareness of each of these aspects of their patients' lives and provide them with the skills to address them in their relationships with patients. The four specific curricular objectives are: (1) Increase physician understanding of how socioeconomic and insurance status in the United States impact the health and health care of disadvantaged groups. (2) Improve cross-cultural understanding and communication. (3) Increase appreciation of the complexity of patients' lives and how it impacts on their health care and ability to access health care. (4) Enhance physicians' awareness of the capacity of the community and local services to impact positively on patients' well-being.

THE FACULTY AND STUDENTS

The core faculty members of the program are a sociologist employed by the WHA, four residents of the

community in which the WHA operates, and three physician faculty members from Cook County Hospital/Rush Medical College (see photo). The sociologist (Claire Kohrman) coordinates the course, teaches the residents the socioeconomic context of their patients' inner city communities, and trains the community members to be effective teachers. The five community teachers (Orlean Huntley, Adele Young, Bessie Wilson, Bonnie Bell, and Gennie Randle) are designated Citizen Leaders by the WHA because they have regular and frequent communication with their neighbors and considerable experience advocating and speaking for their community. The physician faculty includes the internal medicine residency director (Maurice Lemon), the chair of ambulatory pediatrics (Dennis L. Vickers), and a general internist with expertise in teaching cross-cultural communication (Elizabeth A. Jacobs).

The students include all internal medicine and pediatric physicians-in-training in the first year of their residencies. They typically come from very different backgrounds and communities from those of the patients they serve and have had little or no introduction to the cultural, social, and economic contexts of their patients' lives. This is especially true for foreign-born and trained residents, who have only recently come to the United States for graduate medical training (and who represent the majority of Cook County Hospital residents).

THE CURRICULUM

The curriculum is taught in four half-day sessions over a month-long period (see Figure). The first session is dedicated to teaching about the socioeconomic factors that impact the health of low-income people of color. The second session includes didactic teaching on cross-cultural communication followed by a facilitated discussion with the community teachers. In the third session, the physicians-in-training are hosted to lunch and a tour of the community by the community teachers. In the final session, the physicians-in-training are introduced to community-oriented primary care through a faculty member's personal experience opening a new clinic in a diverse, underserved Chicago community. The students also have two homework assignments. The first assignment is two readings about inner-city communities: an excerpt from Nicolas Lemann's *The Promised Land*[13] and an interview with William Julius Wilson.[14] These readings were chosen because they capture the experience of many African American families in the Chicago area. Nicolas Lemann's essay vividly portrays the migration from the

Figure. Curriculum structure

Week	*Length of session*	*Topic and sub-topics*	*Faculty*
1	3 hours	Socioeconomic Status and Health • Overview of health care financing in the U.S. (1 hour) • Interaction between socioeconomic status and health (1 hour) • Case-based discussion (1 hour) • Reading and homework assigned	CCH faculty
2	3 hours	Cross-Cultural Communication • Principles of cross-cultural communication (1 hour) • Discussion of cases from learners' personal experience (1 hour) • Discussion of homework (1 hour)	CCH faculty WHA faculty
3	3.5–4 hours	Westside Health Authority Community Tour • Lunch at local soul food restaurant (1.5 hour) • Tour of the neighborhood (1 hour) • Visit to WHA office and/or community home or business (1–1.5 hours)	WHA faculty
4	3 hours	Community-Oriented Primary Care • Interactive discussion of how to approach the planning and implementation of a community-based clinic in a diverse neighborhood (3 hours)	CCH faculty

NOTE: CCH = Cook County Hospital. WHA = Westside Health Authority. WHA faculty includes Citizen Leaders and a staff sociologist.

rural South to Chicago in the late 1950s and early '60s and the experience of the migrants who, in search of jobs and a better life for their families, moved from sharecropper shacks to the dense urban ghetto. The interview with Wilson, a prominent sociologist on the faculty of the University of Chicago for 24 years, examines the social and economic patterns that explain why there remains a persistently depressed black underclass even though some African Americans have prospered and integrated into a prosperous middle class.

The second assignment requires the students to have a discussion with several of their patients about how economic factors, geographic location, and family responsibilities influence their ability to access health care.

The curriculum is designed to focus on teaching by the community members. The faculty recognized that community teaching had the potential to provide great insight into patients' lives and improve physicians' communication with and treatment of Cook County patients. However, they also recognized that this type of teaching would be foreign to internal medicine and pediatric residents, who are used to didactic teaching by senior physicians, and could have little impact on the students if not appropriately introduced. To avoid this potential problem and lend further legitimacy to the curriculum, the faculty structured the program so that the initial meetings are didactic in nature and led by the internal medicine residency program director in his office. In addition, the first meeting of community teachers and students takes place at Cook County Hospital in a familiar environment for the physicians-in-training. In this way, faculty members introduce students to the concepts they want them to think and ask about as they get to know the community teachers and then visit their community.

MEETING CURRICULAR OBJECTIVES

1. Increase physician understanding of how socioeconomic and insurance status impact the health and health care of disadvantaged groups. Structured case studies addressing the dilemmas faced by individuals with private health insurance, Medicaid, Medicare, or no insurance form the framework for meeting this objective. Two themes are interwoven into the curriculum. The first theme draws attention to the fact that the U.S. system of health care relies on a patchwork of coverage, with many costs even for those with "insurance." The physicians-in-training are surprised by the gaps in their own insurance coverage. They also discover that even people with Medicaid and Medicare coverage, including elderly people living on fixed incomes and poor and working-class families, are economically vulnerable. One case study repeatedly astounds the students, the pricing of a sample patient's prescriptions at retail pharmacies. The physicians-in-training are also surprised by how many people in the U.S. are uninsured and are without any way to reasonably insure themselves or their families.

The second theme emphasizes racial/ethnic disparities in health care. The community teachers help physicians-in-training to understand common African American experiences of the health care system through their personal stories of encounters with public bureaucracies and public and private providers. Having health insurance is revealed to be no panacea for health problems. The discussion demonstrates that those with publicly funded health insurance do not necessarily obtain convenient access to medical care. The social impact of publicly funded programs is illustrated by one community teacher's experience waiting all day at a pediatric specialty clinic with her grandchild who had a Medicaid card, while privately insured patients went ahead of her. These discussions are very different from the typical doctor-patient conversations that are the basis for most residents' understanding of inner-city communities. Gradually they lead to personal connections between physicians-in-training and community members and lay the groundwork for the community teachers to discuss more sensitive areas of patient-physician communication.

2. Improve cross-cultural understanding and communication. Teaching on this topic is focused on raising physicians' awareness of the underlying problems behind cultural misunderstandings and cross-cultural miscommunication and engaging them to develop strategies to help them address such difficulties in the future. This is accomplished through didactic teaching followed by ongoing facilitated discussions between physicians-in-training and the community teachers. Each month there is a true cultural exchange as the diverse Cook County physicians-in-training and community teachers begin to share their family stories and cultural traditions. The resulting openness of communication and mutual understanding between residents and community members is remarkable. Both teachers and residents learn how to talk to one another about difficult topics in a sensitive and respectful manner.

Community teachers openly discuss the fears, distrust, and folk beliefs common to their community. The most frequent topic of discussion is the distrust and anger that the resident physicians sense in their African American patients. The community teachers are incredibly effective in helping the residents under-

stand this phenomenon as a legacy of slavery and segregation and persistent racism. They describe incidents in which they and/or their family members have experienced racism in health care and other contexts, and the residents immediately become engaged. They ask questions such as "Would you be fearful that I would treat you differently because you are black?" The community teachers ask similar questions of residents ("Do you look at black patients differently?"), and an open discussion about race, racism, and how different racial/ethnic groups regard each other ensues. The community leaders then work with the residents to understand how they might build trust and allay fears of racism in their encounters with African American patients.

Fear of experimentation is also a frequent topic of discussion. Residents are rarely aware of the Tuskegee experiment[9] and the frequent fear among their patients that they are being experimented on without their knowledge. Community teachers discuss these fears and how physicians can alter the language and explanations of treatment they use with patients to reduce these fears.

3. Increase appreciation of the complexity of patients' lives and how it impacts on their health care and ability to access health care. The physicians-in-training learn the most about the complexity of patients' lives during their afternoon in the community. During their visit, the physicians-in-training have lunch with the community teachers at a local soul food restaurant and are then introduced to some aspect of the community on a tour. The discussions at lunch and on the tours tell the story of the community and its evolution over time. The community teachers tell their families' stories of migration to Chicago for jobs and the subsequent recession, unemployment, and deterioration of their community. They describe the devastation caused by the influx of drugs to a community where people were looking for both income and escape from their problems through drugs. They go on to explain "the loss of a generation of young people to drugs" and how this left most of them and many of their neighbors to raise grandchildren. They discuss the problems for small businesses like the local restaurant where the group eats and point out the empty lots, torn-up streets, and boarded-up businesses. They also point out the frequency of storefront churches and beauty salons and the absence of good supermarkets offering nutritious and affordable food and of the kinds of businesses that bring significant income and jobs into the community.

In addition to a general tour, each group visits a home, business, or organization in the community that illustrates a particular teaching point. To understand why a 60-year-old patient may not be getting and taking her blood pressure medication regularly, a group of residents visits the home of an elderly woman who has custody of her grandchildren and must care for them as well as older relatives. To illustrate the impact of violence on the community, the community teachers take a group of students to a local funeral home, where the calendar is filled and the funeral director discusses how sad he is that now he so often buries young people. They also learn about the assets and strengths of the community and its members. One group visits a determined grandmother who provides care for her profoundly retarded granddaughter in spite of limited economic resources, transportation barriers, concerns about safety and crime on her block, and lack of support from other family members. Every group also tours the WHA office and learns how a community advocacy organization organizes the community and works with providers and clinics to establish health, exercise, and nutrition programs.

4. Enhance physicians' awareness of the capacity of the community and local services to impact positively on patients' well-being. One of the goals of the curriculum is to get the physicians-in-training to appreciate the potential positive and negative impacts of community structure and resources on their patients' well-being and access to health care. They are frequently unaware of what resources and/or barriers exist in patients' communities that might affect their health. This part of the curriculum is taught from a problem-based learning approach. The case discussed is based on one faculty member's experience of planning and implementing the start-up of a new primary care clinic in a diverse, underserved Chicago community. The resident physicians are given demographic data on the community from pertinent national, state, and local sources and then are encouraged to think through how to design and implement a community-responsive clinic.

The physicians-in-training enjoy the problem-based learning approach and become connected to the community and clinic through applying their own problem-solving skills to the case. The physicians-in-training are often humbled by the experience as the case evolves and they discover that the community members' multiple needs can only rarely be addressed by a traditional medical approach. The resident physicians come to appreciate the fact that the case community, while presenting barriers to the provision of effective care, also has many assets. This exercise gives them the

PHOTO: SOPHIA SHELTON

Curriculum faculty. Left to right: Dennis Vickers, Adele Young, Orlean Huntley, Bessie Wilson, Maurice Lemon, Elizabeth Jacobs, Claire Kohrman.

opportunity to apply what they have learned about identifying community barriers and assets. They recognize that the knowledge they have gained is very useful in solving real problems of delivering care to underserved populations. It is clear that the physicians-in-training come away from this module with a broader understanding of what role they can play in community health.

EVALUATIONS

Both community teachers and residents evaluate the curriculum highly. The community teachers are excited to be able to have an open, direct discussion with physicians-in-training about the importance of nonmedical factors, such as race, in their community and their lives. They are also appreciative of the opportunity to use their knowledge of their community to improve patient-physician interactions. The physicians-in-training are grateful for the opportunity to learn about factors that are important to the lives and health of their patients and about which most had little previous knowledge. Overall they view the curriculum, the visit to the community, and their interaction with community teachers positively. As stated in their evaluations, they believe the rotation is "very important," "a unique opportunity for insight into the lives of our patients," and a way "to understand some of the problems our patients face." They often comment on how the program has made an impact on their perceptions of their patients. The one weakness consistently remarked upon in the evaluations is that "there is not enough time." As one physician-in-training said, "I was just getting to understand and meet people and it was time to say good-bye."

BENEFITS TO THE COMMUNITY

This partnership benefits both the community teachers and their community as a whole. The community teachers receive a stipend and have gained teaching skills, recognition of the importance of their knowledge, and confidence in their ability to articulate and represent their community. Community teachers have learned more than they expected. They have learned that physicians are approachable and accessible hu-

man beings. They also have the opportunity to ask questions and learn about their own health care, general medical subjects, and the financing and organization of medical care. As a result, several of the community teachers have decided to seek long-needed medical care and have even developed doctor-patient relationships with some of the physicians-in-training.

There were unexpected benefits to the community as a whole. As a result of their experience in the program, these community leaders have become known as resources for health information in their community. When family and friends approach them about a bill or medical problem, they often find they have the knowledge to help them. They also share their newfound trust and confidence in doctors, encouraging family and community members to move beyond their fears to seek medical care. Finally, several of the resident physicians have decided to do primary care projects in the community, bringing broader health resources into the community.

BARRIERS AND CHALLENGES

While the teaching partnership and innovation described in this paper have been an overall success, this project has not been without its challenges. A major challenge has been the limited time available to both faculty and physicians-in-training for participation in the program. The intensity and irregularity of the hospital environment make it difficult to establish a consistent schedule and to draw residents' attention away from patient care responsibilities. This challenge is modified somewhat by scheduling the curriculum in an ambulatory block month, when physicians-in-training do not have hospital or call responsibilities.

Time limitations have also prevented the expansion of the program. Both physicians-in-training and faculty would like to increase the amount of time dedicated to this type of teaching. Ideally, an expanded program would teach about the culture, needs, and socioeconomic context of more than one community and increase the likelihood that this brief experience would have a lasting impact on the physicians-in-training. One of the faculty's future goals is to expand the curriculum to involve a Latino community and to extend the teaching program into the residents' second and/or third years.

Another big challenge is funding. Money is needed to pay the WHA to coordinate the program, to train the community teachers, and to pay them for their teaching time. While this is not a large amount of money, it necessitates that the faculty take time away from teaching and improving the program to focus on identifying funding sources and applying for grants.

FINAL THOUGHTS

This educational intervention has been very successful in teaching physicians-in-training how to address racial disparities in health. Its success is due, in part, to the fact that it is a collaborative effort between a community organization and a health care organization. The involvement of the WHA is critical to driving home the academic lessons introduced to physicians-in-training by the Cook County Hospital faculty. The physicians-in-training learn about the root causes of health disparities by witnessing them firsthand on their tour of the community. They learn strategies for addressing disparities through the relationships they build with the community teachers and the frank discussions that ensue. This experience has taught both organizations the critical need to involve community members in the development and implementation of interventions to address racial/ethnic disparities in health care, especially educational interventions directed at health care providers.

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