



Bringing community oriented primary care into an academic training setting: A qualitative study

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ABSTRACT

Objectives: Identify patient-informed strategies through which an urban resident continuity clinic can implement the principles of community oriented primary care (COPC).

Methods: As part of a larger sequential mixed methods study supporting implementation evaluation of a new urban academic medical center in Cleveland, Ohio, semi-structured telephone interviews using a descriptive phenomenological approach were conducted spring 2021 with patients to explore perspectives regarding community involvement by healthcare providers and what they want clinicians to know about their community. A constant comparative analysis of emerging themes was used to analyze the thematic contents of interviews.

Results: Twenty-one participants completed interviews. Almost all thought clinicians' community involvement is important. Thematic guidance from participants highlighted that clinicians should be: (1) knowledgeable about the Black experience, (2) seen in the community outside the clinic, and (3) aware that "knowing my community is knowing me."

Conclusions: Design with a target community in mind is a necessary but not sufficient step to implement COPC in practice. The visibility of clinicians in community settings is essential for COPC.

1. Introduction

Since the enactment of the Affordable Care Act, population health management efforts have intensified at all levels of the health care system. Organizations are implementing population health management strategies ranging from using big data analytics to monitor and respond to epidemiologic trends, to investing more resources in primary and preventive care to screen for and address social determinants of health (Buehler et al., 2018). An early approach to population health, the Community Oriented Primary Care (COPC) model, underscores the health center's responsibility for engaging the community and interweaving primary care with principles and methods of public health (Mullan and Epstein, 2002; Geiger, 2002). A core tenet of COPC is to solicit patient input on how clinicians should engage with the community when making healthcare decisions. Instead of speculating or assuming knowledge of community needs, preferences, and priorities, COPC prioritizes asking people how they want to be helped (Fig. 1).

The COPC approach guided development of a new urban academic ambulatory medical center located in the midwestern United States (hereafter, "the Center") that also serves as the primary ambulatory

training site for Pediatrics and Obstetrics-Gynecology residents in a regional not-for-profit healthcare system. The result of a three-year community-engaged planning process, the Center was intended to serve as a strategic initiative by the system to address key gaps in community health. Programs and services offered at the Center aim to address whole-person care: women's and children's health services, mental health services, medical-legal partnership (Tobin-Tyler and Teitelbaum, 2019), and social needs services (Garg et al., 2007; Garg et al., 2012). Patients and families obtaining care at the Center predominantly identify as Black or African American (93%) and most (85%) rely on Medicaid as their primary insurer. This is compared to the staff members of the Center who identify 57% as white, 18% as Black, 7% as Asian, and 20% preferred not to say.

Center leadership solicits formal feedback from patients and families annually through a cross-sectional telephone survey. Survey domains include community-based needs, health care needs, and experience of care as assessed by the Person-Centered Primary Care Measure (PCPCM) (Ronis et al., 2021; Etz et al., 2019). The PCPCM measures the success of a primary care clinician using an eleven-question survey covering these broad scopes: accessibility, advocacy, community context,

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comprehensiveness, continuity, coordination, family context, goal-oriented care, health promotion, integration, and relationship (Ronis et al., 2021; Etz et al., 2019). In the fall 2020, more than 80% families reported that care at the Center “definitely” achieved goals for comprehensiveness, integration, coordination, health promotion, goal orientation, and accounted for family context (Fig. 2). Notably, families less often endorsed *relationship*, that their clinician knows them well as a person; *shared experience*, that they and their clinician had been through a lot together; and *community context*, that the care they receive is informed by knowledge of their community. The purpose of the current study was to investigate the discrepancy uncovered by the survey between the Center’s intent to address community context and families’ view of Center clinicians’ understanding of that context (Ronis et al., 2021).

2. Methods

2.1. Design

We completed one-time semi-structured interviews with a purposive subsample of Center patients and families who participated in the Fall 2020 survey. We applied a descriptive phenomenological approach to characterize participants’ lived experiences and perceptions regarding the relationship between understanding of community and other aspects of high-quality care.

2.2. Study team characteristics and reflexivity

The study team consisted of a female public health student (lead author), a sociologist with expertise in conducting mixed-methods studies on health disparities, and an academic pediatrician who also practices at the Center. The first author conducted all interviews. She was not previously known to participants of this research.

2.3. Participants

Participants who both completed the 2020 survey and agreed to be contacted again for research purposes were divided into two groups, based on how they responded to the *community context* prompt “The care

I/my child gets at this practice takes into account knowledge of our community”. The first group comprised those who responded “Definitely” (60% of all 2020 survey participants), while the second group responded “Mostly”, “Somewhat”, or “Not at all” (15%, 13%, and 9% of all 2020 survey participants, respectively). We aimed to recruit an equal number of participants from each group. Of the 232 families completing the fall 2020 survey, 212 (92%) agreed to be re-contacted for related research. After stratifying those eligible for participation into the two groups, email invitations to participate in interviews were sent in batches of 5 each, with invitations sent to new potential participants as needed to achieve balance in group size. In total, 34 people (all women) ages 18 years and older were invited to the study of whom 21 both agreed to participate and completed interviews.

2.4. Setting

All interviews were conducted via telephone between March 3 and March 19, 2021. To ensure privacy and confidentiality, participants chose the time for their interview and both interviewer (M.W.) and interviewee ensured that they were in a private space.

2.5. Data collection and storage

UH REDCap (Research Electronic Data Collection (Harris et al., 2009, 2019)), a secure, web-based application designed to support data capture for research studies, was used for all study data storage and management. The study was approved by the University Hospitals Cleveland Medical Center IRB STUDY20201833 on February 1, 2021.

Interviews were audio-recorded and lasted between 5 and 20 min (average length of 7:30 min). The interview followed a semi-structured guide designed to elicit narrative from the parent regarding selection and quality of the doctor, how their physician should interact with the community, and what their physician should know about their community (Interview guide in **appendix**).

Audio recordings were professionally transcribed verbatim. After reviewing transcripts for accuracy and de-identifying references to specific individuals, original audio was destroyed.

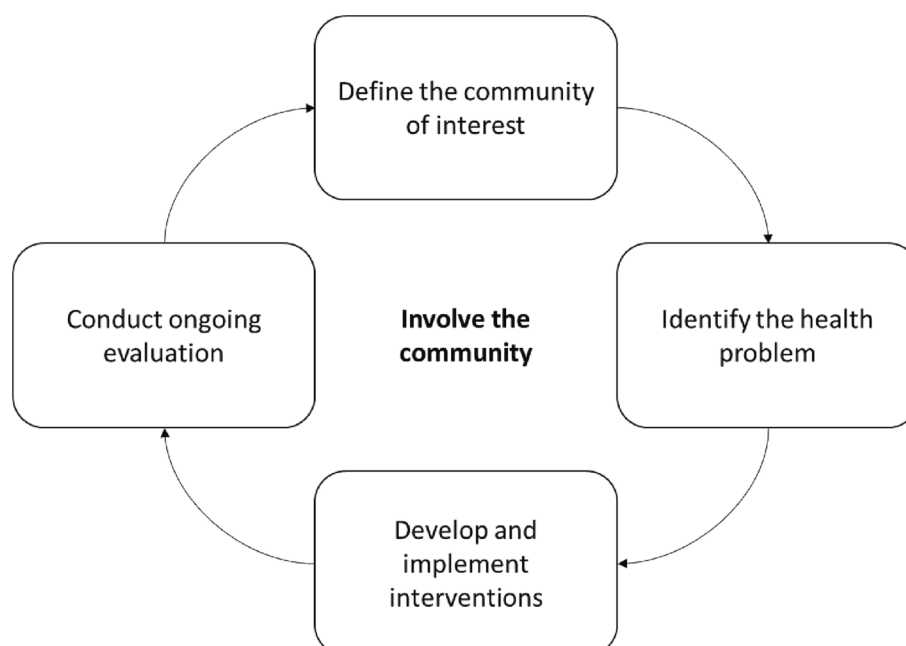


Fig. 1. The Community Oriented Primary Care Cycle, after Geiger et al. (2002).

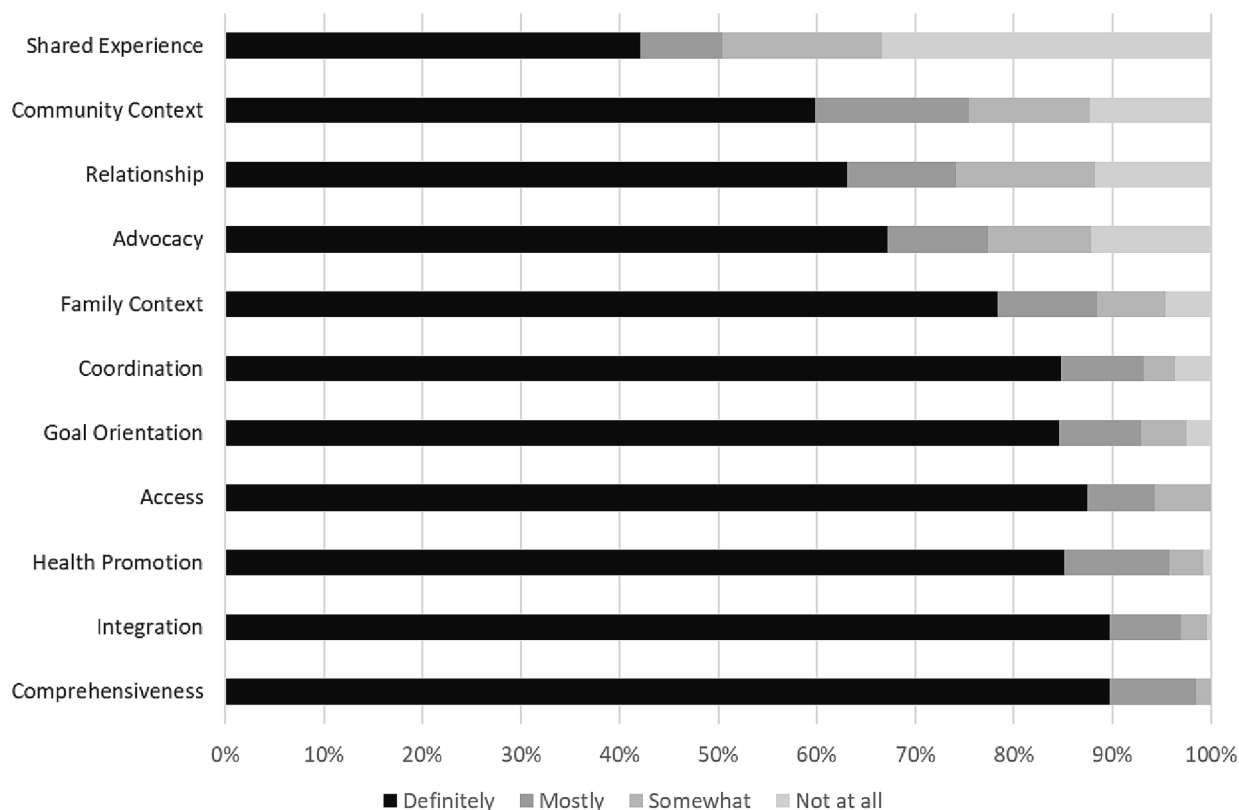


Fig. 2. Proportion of Families Reporting the Extent to Which Care at the Center Achieves Each of 11 Elements of High-Quality Primary Care, as assessed by the Person-Centered Primary Care Measure (Etz et al., 2019) Data Source: 2020 Local Inventory of Needs and Knowledge, n = 232.

2.6. Analysis

NVivo 11 (QSR International, 2015) was used to organize transcripts. First, an initial codebook was developed based on the content of the interview guide and findings from the fall survey, linking broad and fine codes with their consensus-derived definitions. Next, the lead author immersed herself in the data through detailed review of the complete interview transcripts and their accompanying field notes applying codes to the transcripts, documenting both emergent codes and themes in addition to *a priori* themes and codes. Code applications and emergent themes were reviewed regularly with the last author, moving iteratively between codes and text until thematic saturation was achieved. Lastly, to explore patterns and connections within the data, coded data were compared according to interviewee responses to the *community context* survey item group. Final themes and supporting exemplar quotes were audited by the second author for consistency.

3. Results

3.1. Participants in study context

Of those completing interviews, 12 of the 21 participants (57%) reported in the original survey that the care they receive at the Center “definitely” takes into account knowledge of community context, while 9 did not (two answered “mostly” (9%), five “somewhat” (24%), and two “not at all” (9%) to the *community context* prompt). Participants were also equally distributed amongst those from originally recruited from the pediatric practice (n = 10) and those patients recruited from the women’s health practice (n = 11). For demographic characteristics of participants, see Table 1. Given that the participants were mainly young parents who have many competing priorities, the interviews were brief but valuable in contributing to the ongoing conversation of COPC.

Table 1 Interviewee Demographics (N = 21).

	N	(%)
Age in years – median (range)	31.5	(19-62)
Residential location		
City	13	(62)
First-Ring Suburb	6	(29)
Other	2	(10)
Insurer		
Public	18	(86)
Private/Employer-based	3	(14)
Highest level of Education		
Less than High School	4	(19)
High School Diploma or GED	4	(19)
Greater than High School	13	(62)
Has children at home	18	(86)
Of those with children at home,		
Number of children – median (range)	2	(1-7)
Any children ages 5 years or less	16	(89)
Any school aged children	9	(50)
Any teens	9	(50)
Reported that care definitely accounts for community context	12	(57)

Theme 1: Clinicians build relationships through listening

Nearly all (19 of 21) participants agreed that their primary care physician at the clinic possessed the qualities they want in a good primary care physician. Two important qualities as defined by participants included: a primary care physician who listens to their patients and a primary care physician who can build a relationship with their patient.

One participant explained that her primary care physician makes her feel heard:

She listened to my concerns, all of them no matter what I googled or didn't googled and answered my questions...Because sometimes it could be farfetched but what we google might be it or it could be in our personal history and we're just so concerned about it and so I'm just like she really made me feel heard. She helped me understand what's important to pay attention to with my body and when [it could be] just be something at the moment but it never felt like she was sitting down looking, sitting up high looking down on me. It felt like she was a partner in my [corner] and that made me appreciate her [Participant 358]

Another participant highlighted the importance of having a primary care physician who tries to build a connection with each of their patients:

Maybe getting to know the patient, spending time, not rushing. Because sometimes you go to a doctor and you'll be in and out within ten minutes. They have a lot of patients and you don't get the personal time with them. Not saying they have to be in there for hours, but just to get to know about you. Or not me personally, but the kids. Building a relationship with them. I think they should be open. For instance, if a kid is hurt or something, or they're afraid to share something with their parents that they might not be afraid to share with the doctors [Participant 213]

Participants said that relationship building and being heard were critically important qualities of a primary care physician and almost all participants agreed that their physician fit the qualities they named.

Theme 2: Community involvement by clinicians influences quality of care

Most (16 of 21) participants said that it is very important that physicians are involved in the community they serve. These results did not vary in relation to responses to the *community context* survey item. Highlighting that community involvement by physicians is important to patients regardless of the participants' response to the statement, "The care I receive takes into account knowledge of my community".

A primary in-vivo theme that emerged early in the coding process and was present in many participants' interviews was "if you don't know about my community, you don't know about my needs". When explaining why community involvement by health care workers is important, one participant elaborated about how the lack of understanding between a doctor and their community affects the care she gets:

Just being knowledgeable about just the history of especially the communities that they're working. For example, you can't just say get fruit, because it's not just that simple or easy because there is no one for them to get fruit. And if they're just like, "Just eat more fruit" because if they had it, they probably would but it's not available to them. So, yeah, just being sensitive and aware of their biases I'd say they have. I know historically and statistically speaking, many doctors often brush off the feelings and the side effects that black women may be feeling which often leads to the death of black women when it comes to childbirth at a higher rate than white women. But even just the primary care doctor with other doctors, and it's important for all doctors to be on the same page about their biases and their privileges that they hold in their position [Participant 764]

Another participant agreed that the lack of community understanding can lead to worse health outcomes for the patient:

I think it's [community involvement by doctors] very important because the thing about life is, what you don't know can scare you. That is the biggest thing. That's why people are scared of faith. That's why people are afraid of the dark. That's why people have preconceived notions about other ethnicities because they lack understanding and so I always feel like if they knew more they could possibly do better...Everything you're not going to learn in school [Participant 358]

A related subtheme present was the (in)visibility of the clinicians in the community. Participants explained that more community

involvement by clinicians can lead directly to increases in healthy behaviors.

I want them to know that if they would participate a little more in the community, they would have better outcomes...in the community. Healthier choices, eating, engagement, healthy habits. Things like that [Participant 576]

Participants were asked, "If you were a healthcare provider, how would you interact with the community?". Over half of the participants gave a response like:

Getting out, getting to know their patients, really that's it [Participant 11]

Many participants would like to see the workers at the clinic be present at community functions or share their time at other neighborhood organizations. Participants also explained that they do not expect providers to create new programs to get involved in the community. One participant articulated that clinicians do not have to "reinvent the wheel" to be out in the community:

So different events like that it's already public. It's open. It's not like you have to go and speak. Just blend in seamlessly. I don't know. Pretend like you're somebody who needs something. Volunteer to help pass out clothes. It's not really deep. It's just getting out there [Participant 358]

One participant took community involvement by clinicians further and would like to see more clinicians living in the communities they serve.

I would say they live in the community. For example, my dad is a fireman. He's been a fireman for a very long time. When he first started, firemen had to live in the city they worked for, which he works in Cleveland so they live in Cleveland. But they live in the communities they work in, they do community geared events to maybe like market to where there are fresh foods available for them, or just reading to children. Just little stuff. Just being seen in the community, because you're supposed to trust your primary care doctor as your primary care doctor. If they only see you on those days but they live in the community, and you claim that you are community oriented, then how can you really be about the community and you're never seen in the community except when you go to work, and then drive all the way home to your very nice house in [suburb] [Participant 764]

Theme 3: Community involvement and shared humanity as a strategy to inform cultural humility

One of the most provocative discussion points during interviews addressed the question "What would you like your doctor to know or understand about your community?". Participants responded in a variety of meaningful ways that emphasize their humanity and unique lived experiences. One participant answered:

That most of us come from a tough background but we're still human. That's about it [Participant 213]

Another participant stressed their dignity and humanity:

That we're just people too and not – we're knowledgeable of our bodies so it's okay to listen to us [Participant 358]

Other participants explained that doctors need to understand the Black experience and how that is different from other people's experiences.

I would say that there are already so many things that we face, and we go through, and we struggle with on an everyday basis, and also already so many past traumas that we struggle from that we don't even know that we're struggling from. Our doctor is not something we want to have to worry about. And if someone is aware of the histories of medicine, of the government, they are less likely to go seek help from a primary care doctor or a doctor period. Just knowing that it's important that they took the time

out to come see you for their better well-being, and treating it as such. [Participant 764]

It is also important for doctors and providers to understand that Black communities in the United States are not a monolith with only one story. One participant elaborated:

We're not all the same because a lot of times they might have a bad experience, and they put us all in one category. So, we're all different. And understand that there's an underlying pain and hurt that a lot of us are going through in my community. So, just to be patient and understanding about that, whether it's financially, emotionally from childhood traumas and different things like that. Just be understanding of that and be patient [Participant 280]

4. Discussion

Among a group of patients with varied perceptions regarding the extent to which the care they received within the Center achieved the goals of community-oriented primary care, we found remarkable consensus among participants regarding (1) what makes a “good” primary care clinician, (2) the connection between clinician community involvement and delivery of quality care, and (3) the role clinician community involvement plays in facilitating cultural humility, particularly when clinicians are not “of” the community they serve.

Participants universally defined “good” clinicians as those who listen carefully, and who build a relationship with their patients. Key strategies identified by participants that clinicians can use to accomplish these goals include use of empathic communication (Mercer et al., 2016; McDaniel et al., 2007), and flattening power differentials by literally sitting/positioning themselves at the same level as patients and their families (Frankel and Stein, 1999; Nimmon and Stenfors-Hayes, 2016), which in turn may not only increase patient satisfaction but decrease patients’ sense of being rushed. These, and other tools promoting increased clinician mindfulness in the encounter may promote not only better partnership with the patients they serve (Epstein, 2013), but also benefit clinicians themselves (Beckman et al., 2012).

Nearly all participants stated that to build relationships, the clinicians need to know their community they serve. Importantly, participants indicated that community involvement is an essential component of how clinicians can build trust with that community (Benkert et al., 2019; Griffith et al., 2021; Sullivan, 2020). Participants emphasized that by getting involved in the community, clinicians can better understand the history, strengths, and norms that influence patient behavior but may not be apparent from within the walls of their own institution. Better understanding of the community may increase clinicians’ awareness of key coping skills and resilience factors within the community that they can help their patients to tap into for health and healing (Shonkoff et al., 2021).

Notably, participants framed community involvement as an ongoing bi-directional conversation between institution and community. In planning for the Center, and following the COPC model (Fig. 1), contributions from community members helped Center leadership to define the priority population(s) of interest, define the health problems most important to the community, and determine which programs and services should be offered at the Center to address those problems. Now that the Center is operational, these findings indicate that ongoing involvement by the community will require Center clinicians and personnel to contribute to the community from beyond its walls.

To do so, participants recommended that the clinicians be visible in the community. Strategies to increase visibility ranged from simply attending community events and patronizing community businesses, to volunteering with community organizations, to residing in the neighborhood itself. Regardless of which strategy might be applied, all involve some degree of physical presence in the community beyond the walls of the Center, which may allow clinicians and other personnel to

translate theoretical or received knowledge about the community into lived experience, and hopefully, greater cultural humility. Given the number of students and trainees at the Center, opportunities for applied learning is especially imperative. Learning in the community is essential to trainees to make them better clinicians (Habbick and Leeder, 1996). Participants recognized that effective high-quality medical care requires more than diagnostic efficiency and treatment decision making. Clinicians must be able to listen to and connect with the experiences of the people they serve. Too often this relationship-building aspect of clinical practice is not actively learned or practiced in medical education yet is vital to the delivery of effective care.

This study has several limitations. As a qualitative study aimed to explain unexpected quantitative survey findings from a single site, these findings are not expected to be fully or directly transferable to other settings. Recruitment aimed for equal participation by those who did and did not agree that their care at the Center accounted for community context and continued until thematic saturation was achieved. The interviews had an average length that was less than 10 min. Interviews were highly focused with only a small number of questions, but while the responses are rich and detailed, a series of longer interviews with more participants could likely reveal additional findings beyond what were discovered in our work. Recruitment and interviews occurred entirely via email and telephone without in-person interaction between the study team and participants. While it is possible that participants might have shared different information in a face-to-face setting, given the candor of participants, we believe the remote approach was a strength, where the telephone conversation may have provided participants with a degree of perceived anonymity and in fact made it easier to discuss potentially sensitive topics such as experiences of racism and discrimination in healthcare settings. Interviews were completed approximately one year into the COVID-19 pandemic: national conversations on social determinants of health, structural racism, medical mistrust, and the role of institutions in community health likely influenced interviewee perspectives (Ash et al., 2021, 2021).

5. Conclusions

Major improvements in population health will require care infused with cultural humility and community involvement by clinicians and healthcare personnel. Especially for those who are not of the community they serve, volunteerism, participation in community events, and patronage of local businesses or organizations can equip clinicians and personnel with “everything you’re not going to learn in school” but need to know in order promote health of individuals and communities.

CRedit authorship contribution statement

Mia Wang: . **Adam Perzynski:** Conceptualization, Methodology. **Sarah Ronis:** Conceptualization, Methodology, Supervision.

Declaration of Competing Interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: Ms. Wang and Dr. Ronis do not have any conflicts of interest to disclose. Dr. Perzynski reports book royalty agreements with Springer Nature and Taylor Francis, and equity ownership of Global Health Metrics, LLC outside the submitted work.

Data availability

The data that has been used is confidential.

Appendix A. . Interview guide

Introduction

Tell me about yourself and your family.

- Who gets care at the Center?
- What made you choose to get care at the Center [for your child]
 - o How long have you gotten care [in health system]?

Center experience

I'd like to ask more about your experiences with care at the Center
Can you tell me one thing the Center does well?

- Can you tell me one thing the Center needs to work on?
- What are some qualities of a good primary care physician?
 - o To what extent does your primary care physician fits those qualities?
- Describe the best interaction with a doctor you have had.
 - o What was the situation?
 - o What were things that the physician did to make it successful?
 - o What do you wish doctors would do similarly?

Community involvement

I'd now like to ask about community knowledge and involvement by health care providers.

- How important is it to you that your primary care physician has knowledge about your community?
 - o Can you tell me more about what you just told me?
- What does community involvement by health care workers look like to you?
 - o What should that involvement look like?
- What would you like your doctor to know or understand about your community?
- If you were a health care provider, how would you interact with the community?

Wrap-up

- Is there anything we have not discussed that you would like to talk about?
- Do you have any questions for me?

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