



## Commentary

## What we might accomplish by engaging in our local communities

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## ABSTRACT

**Objective.** To describe the potential benefits of a clinician engaging in the same community in which her/his patients live.

**Methods.** Using a commentary format, the author describes the potential benefits of having clinicians engage in the same community in which her/his patients live.

**Results.** When we, clinicians, spend time in the same communities where our patients live, we have the opportunity to enhance our patients' lives and our teaching in three key ways. For one, we bring our medical expertise into the community. Secondly, we bring our expertise back to our practice and research inquiries. Finally, we teach trainees, who tend to be transient, about community assets and challenges.

**Conclusion.** As we learn more about the importance of social determinants of health—describing how poverty, neighborhood, access to healthy food, and education, all play important roles in health—having an educator who can teach about the specific local community assets and influences on health may be as important as teaching which antibiotic to use. Academia and funders could increase this kind of knowledge acquisition and dissemination by rewarding and valuing these clinicians.

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I sit at the edge of the soccer field on a beautiful New England autumn afternoon, watching my first grader and her peers run up and down the field. The clump of children hovering around the ball reflects the diversity of our community. They are daughters of fire fighters, taxi drivers, artists, administrative assistants, and physicians. They have skin colors of every shade. They speak English, Spanish, and Arabic at home. And they have a body mass index (BMI) that ranges from normal to overweight and obese.

When we, clinicians, spend time in the same communities where our patients live, we learn. We learn about demographics, we learn about challenges and assets. We may spend time on neighborhood governing boards, in local food co-ops, and sustaining local parks. We may do it to be with young children or older family members. We may do it out of a sense of religious or civic duty. Regardless, when we spend time in our patients' communities, we have the opportunity to enhance our patients' lives and our teaching in three key ways.

For one, we bring our medical expertise. When we get involved in our children's schools and child care settings, and, for example, help interpret the science of nutrition and physical activity, we can help

educators incorporate obesity prevention. Perhaps fewer elementary schools would have reduced physical education and recess time if there were engaged physicians on the school board or PTA.

Secondly, when we spend time in our community, we bring our expertise back to our practice and research inquiries. When we are recommending diet and exercise to our patients, we might do better if we know there is a new opportunity for fresh food because we have joined the recently formed food co-op or that the YMCA pool had expanded hours because we read about it in the local paper. But we're not just a well-informed person telling our patient about community resources. When we're knowledgeable about the local community, we combine our clinical expertise, our research knowledge, and community assets knowledge into information and recommendations that our patients can use.

Finally, we teach trainees, who tend to be transient, about community assets and challenges. As we learn more about the importance of social determinants of health—describing how poverty, neighborhood, access to healthy food, and education, all play important roles in health—having an educator who can teach about the specific local community assets and influences on health may be as important as teaching which antibiotic to use (Warnecke et al., 2008). In the fellowship program where I teach, the Robert Wood Johnson Foundation Clinical Scholars Program, each post-doc goes on walking tours of underserved neighborhoods, led by neighborhood leaders (Rosenthal et al., 2009). Faculty on the tour connect the assets and challenges of the

Abbreviations: BMI, body mass index.

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environment to the literature on the social determinants of health. After the walking tours, our post-docs report a new understanding of their patients and have new ideas for community-based participatory research inquiries that can translate into better patient care.

Influencing health-related policy in the community, enhancing patient counseling, and teaching trainees about community assets and challenges—might academia reward that as much as the latest cell biology discovery? And if not reward, at least facilitate the kind of career that encourages that kind of knowledge acquisition and dissemination?

While the concept of physician-advocate is not new, as we learn more about the value of patient-centered engagement and shared-decision making, it may be especially important now to have mechanisms that facilitate meaningful engagement in our patients' community (Stewart et al., 2000; Mirzaei et al., 2013; Armstrong and Arterburn, 2013).

One way may be to reconsider academic hierarchies. For example, when academic physicians seek to be promoted, a key criterion at some institutions is that they are known and respected nationally (to become an associate professor) and internationally (to become a full professor). What about including being known and respected in the community in which they practice? This could include the two-way street of contributing meaningfully to the local community as well as bringing knowledge of the local community to their practice and teaching. What if we rewarded the preceptor who says to the resident, "When we go back into the room, we should remind Mrs. Jones that they have bulk food at the grocery store that's a few blocks from her house. She'll find almonds there."

Additionally, more funding opportunities could give greater value to knowledge of one's community. Current community-oriented funding resources include the American Academy of Pediatrics CATCH grants (that encourage pediatric trainees to conduct meaningful health-related work in non-clinical settings), the Patient Centered Outcomes Research Institute, and other federal and foundation sources (CATCH Planning, 2014; Patient-Centered Outcomes Research Institute, 2014).

Finally, we could consider models that some cities use to attract city residents to apply for civil servant jobs. In some cities police officers and fire fighters get paid more if they live in the city where they work and in some cities residents taking the civil service exam are graded on a different curve. Both of these models recognize that there is an intrinsic good to the knowledge and skills that come from living and working in the same place.

It is the Willie Sutton theory of learning and teaching about our patients—we need to be where our patients are. In our professional lives we generally interact with patients in 15 minute intervals or more intensely for short in-patient intervals. When we are on the same soccer bleachers, PTA, and food co-op board, when we are trying to exercise on the same only moderately safe sidewalks, we may be learning at least as much, and probably more, about our patients as

we do in the hospital. Obesity prevention is only one example. Community knowledge and partnering skills could enhance patient care, research, and teaching about other challenges facing communities—including violence, homelessness and suboptimal schools.

With 10 min to go in the soccer game, my daughter scores. It is the wrong goal. The clumps of girls on both teams go wild. They do not know who scored and they do not know it was the wrong goal. I watch the coach cum volunteer parent retrieve the ball and then explain the mistake to the girls. Their joy is not diminished with the information.

As we, the grown-ups on the bleachers, recognize what has happened on the field, we share a smile that transcends all of our differences. In a few minutes we will get up, collect our children, and leave. But for now we will enjoy a few more minutes of community.

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### Conflict of interest statement

The authors declare that there are no conflicts of interests.

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