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Community Perspectives in Medicine: Elective for First-Year Medical Students

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Abstract

Introduction: Recently, stories depicting social injustices and inequities have gripped the US, leading to protests and other demonstrations of student activism. In response to current events, students at Weill Cornell Medical College identified the need for more diversity inclusion components in the newly developed medical school curriculum. Thus, we developed a student-initiated, student-run elective, Community Perspectives in Medicine, which provides a forum for first-year medical students to interact, and have open discussions, with members of communities most impacted by social and health inequities. **Methods:** During five weekly 2-hour sessions, representatives of different community-based organizations (CBOs) speak with 15 first-year medical students. Invited CBOs represent diverse populations, including LGBT, chronic illness, disabilities, religion, and immigrant health. For each session's first hour, a second-year student facilitates a semistructured interview of the CBO guests focusing on health disparities within their community, challenges experienced with the medical system, and what they wish doctors did differently. Students are encouraged to ask questions, often resulting in a rich dialogue. The session's second part is a debriefing by the student facilitator over a relaxed dinner (without CBO guests). **Results:** Fourteen of the 16 enrolled students attended all five sessions and completed the course evaluation. Satisfaction with the course was high, as 93% of students enrolled rated the course as excellent. The course format, content, and diversity of speakers were rated as excellent by 79%, 86%, and 93%, respectively. Similarly, 71% of students believed there to be excellent applicability to medical practice, and 100% of students thought the timing during first year was excellent. **Discussion:** We emphasize the importance of a partnership between CBOs and medical students, thus increasing students' cultural awareness as well as formally involving traditionally disenfranchised communities in medical education. Our project's unique format of safe-space discussion forums and session debriefings enhances critical thinking. Though used with multiple CBOs as an elective, our model can be easily adapted for one session on a specific health disparity.

Keywords

Health Disparities, Student-Run, Cultural Competence, Peer Teaching, Diversity Inclusion, Cultural Humility

Educational Objectives

By the end of this session, learners will be able to:

1. Identify health disparities seen in diverse populations, specifically within LGBT, chronically ill, disabled, religious, and immigrant populations.
2. List the biggest challenges a community faces within the health care setting.
3. Articulate challenges diverse patients have faced within the medical setting and identify ways medical practitioners could have improved the patient experience.
4. Participate in the creation of a safe space where others can express their thoughts freely without feeling judged.
5. Recognize the variability and individuality of each person's beliefs on diverse populations.
6. Set the intention to create a practice of medicine more inclusive and respectful of minority needs.

Appendices

- A. CPIM Syllabus Template .docx
- B. Sample CPIM Syllabus.pdf
- C. Facilitator Guide Template .docx
- D. Sample Facilitator Guide .docx
- E. Student Session Evaluation .docx
- F. CBO Session Evaluation .docx
- G. Course Evaluation.docx
- H. Leadership Roles.docx

All appendices are peer reviewed as integral parts of the Original Publication.

Introduction

Racism, sexism, homophobia, and xenophobia are universal challenges, but in the medical setting, they can be associated with concrete health disparities. Many minorities are disproportionately affected by certain health conditions, such as diabetes, obesity, HIV/AIDS, cancer, tobacco usage, and alcohol abuse. Treatment for chronic medical conditions is often compromised for patients from racial and ethnic minority backgrounds, as research shows that they are less likely to receive appropriate medication compared to their White counterparts.¹ These inequalities of care are concerning for physicians, as they are real obstacles in optimizing health for all patients.

Through the Patient Protection and Affordable Care Act and expansions of Medicaid in some states, including New York, many patients who previously were unable to access medical providers are now able to seek out care. In 2014, there were 1,319,239 individuals who applied for health insurance in New York, 53% of whom had an income at or below 200% of the federal poverty level. Twenty-one percent of these individuals identified as Hispanic, 13% as Black/African American, and 9% as Asian/Pacific Islander. The patient population is clearly becoming more racially, ethnically, and fiscally diverse.²

It is essential that health care providers are trained to communicate effectively with individuals who may have different health beliefs or life experiences. To best prepare medical school students for their careers, they must learn about the challenges that patients from different backgrounds face when seeking health care. To meet this need, medical schools across the country have programs designed to integrate diversity inclusion into medical education, with many aiming to provide medical students with cultural competency skills.³⁻⁵ Often, the information about diversity is presented by describing cultural practices of different racial, ethnic, religious, and sexual groups. Many resources are available for this purpose, such as those following the ETHNIC (explanation, treatment, healers, negotiate, intervention, collaboration) mnemonic.⁶ Other programs focus on health disparities and provide lectures with important information on ways specific minorities are disproportionately impacted by certain illnesses. Fewer resources exist, however, for the development of cultural humility curricula, which incorporate “a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations.”⁷ Teaching cultural humility introduces students to a way of thinking—rather than solely providing a knowledge base—that has evidence of effectiveness. The Columbia University College of Physicians and Surgeons used the cultural humility model in its LGBT health curriculum for medical students,⁸ and the University of California, San Francisco, School of Medicine used the same model in its clinician and community perspectives alignment training.⁹

Like many other programs on cultural sensitivity, we chose to include the course in the first year of medical school.^{10,11} However, we deviated from the small-group, case-based discussions used by some¹² and opted for an open, reflection-based, small-group format, which is generally reserved for clinical years.¹³⁻¹⁵ To ensure an environment in which open self-reflection was encouraged, a safe-space model was used. Students were explicitly told before each session that any information disclosed by other students was to remain confidential and that students should feel free to speak their minds without feeling judged by others. The safe-space model and its benefits have been well described elsewhere.¹⁶⁻¹⁸

Our elective sought an innovative way to inform students of specific obstacles by allowing them to hear from community-based organizations (CBOs) representing entire communities of diverse populations. Some programs have diverse perspectives represented through cases written by physicians or other medical school faculty.^{19,20} This approach has limitations, as the actual emotional experience of interacting with patients from different backgrounds is lost. Similarly, medical students may make light of the challenges during role-play, resulting in culturally insensitive dialogue. To prevent this, other curricula invite specific patients to speak about their experiences in medicine.²¹ While this brings a more realistic account of the challenges experienced, there is still a dependence on one patient to represent an entire population. By inviting CBOs to present specific issues their members face, students are able to hear a collective viewpoint from those impacted by disparities. CBOs often serve as advocates for patients and

thus have experience articulating the needs of the population they represent. Many CBO members see educating others (including medical students) about their community as part of their organization's overall goal.

Based on the literature review, we created this course and the conceptual model shown in Figure 1. A key aspect of the student-initiated elective is including community members in teaching medical students the knowledge, skills, and attitudes needed to provide care for a diverse patient population. While many programs of this kind are taught within the general medical education curriculum and are mandatory for students to attend, we opted for an elective model where students choose to sign up for the course. Creating Community Perspectives in Medicine (CPIM) as a student-run course was beneficial as it meant it could be formatted by course leadership to best address the educational goals without the time, space, and administrative constrictions often experienced by other curricular innovations. This was similar to the format of Wake Forest School of Medicine's Transitions in Medicine course.²² However, there is also benefit in identifying a faculty member as a mentor for the project in order to help reserve space on campus. Dr. Carla Butin-Foster provided this mentorship and served as an advisor throughout the development of the course.

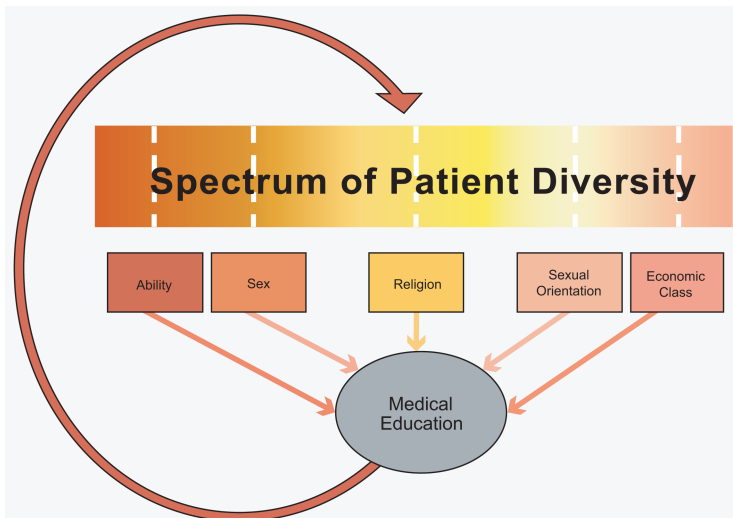


Figure 1. Community Perspectives in Medicine conceptual model.

CPIM was first run as a pilot session with a \$500 grant from Weill Cornell's Medical School Executive Council's Health Equity Fund. The pilot session was moderated by an outside social worker who volunteered her time to help with the session and was attended by 20 students. Through surveys administered at the pilot session, students expressed dissatisfaction with the number of students in the course, feeling that 20 students were too many to allow for an enriching conversation. Similarly, the post-pilot session evaluations indicated a strong preference for student moderation, as participants felt it would allow for a more relevant and less guarded discussion. After the pilot session was completed, a formal proposal for the course was written, and an application for funding was submitted to and accepted by the Weill Cornell Medical College Alumni Association. With this annual budget, this course is now run each year as described in the sections that follow, and we are continuing to make progress on the overall goal of creating a space for students to critically analyze their own actions and perceptions, with the long-term goal of improving health experiences and outcomes for minorities.

Methods

As an elective at Weill Cornell Medical College, CPIM facilitates student-community conversations about health disparities. The 5-week series occurs 1 evening per week for 15 first-year medical students. Each session is designed to provide a conversation with a specific CBO, represented by two speakers.

The course is run with a grant of \$2,500 (an average of \$500 per session). The budget breakdown is approximately as follows:

- \$100 to each community organization speaker (usually two per session) to compensate him or her for travel.
- \$25 each on thank-you gifts (framed stethoscopes) for the speakers.
- \$250 on dinner for each session for all of the students.

The first full iteration of the course was organized by a second-year medical student, Eric Kutscher, who had been trained previously as a peer educator for multiple prior extracurricular activities. Planning should be expected to be very time intensive, requiring 3 hours a week for the 2 months prior to the course (24 hours total) and an average of 7 hours a week during the course.

CBO Recruitment

Recruiting CBOs to speak should begin at least 2 months before the start of the course and may require a variety of avenues in order to reach organizations. First, course leadership can use personal connections to reach out to local organizations. Second, faculty members who work with diverse patient populations can be contacted for suggesting CBOs and providing e-introductions. At our institution, this is how the majority of speakers have been found. Lastly, some speakers can be recruited through blind emailing. CBOs invited for the inaugural year of the elective allowed for discussions on LGBT health, immigrant health, women's health, care for patients with special needs, and care for patients of a variety of religious backgrounds.

Once a representative from the CBO indicates interest, the course leadership should set up a phone call to further clarify the goals of the session and confirm participation. Once a CBO agrees to send speakers, the speaker biographies need to be collected and compiled into the syllabus, along with CBO-recommended prereading. A course syllabus template is available in Appendix A, and a sample full-course syllabus is available in Appendix B. In some cases, CBOs might request an in-person meeting at their site to provide the speakers with the opportunity to get additional information and guidance on the expectations. These can be very helpful.

Student Recruitment

Medical students should be recruited to participate in the course at the beginning of the year. We recruited during the annual student activities fair for first-year medical students. CPIM had a table with information on the course and a sign-up sheet for students interested in hearing more. Of the 100 students in the first-year class, 41 students signed up for the Listserv. One month prior to the start of the course, an email with the finalized syllabus and a link to sign up for the course (e.g., Google Forms) should be sent to those interested. To sign up for the course, students should provide their name and email and indicate if they will be able to attend at least four of the five sessions (dates need to be provided). At our institution, students were also given the option to be on a waiting list to attend certain sessions in case there were openings due to course attendee absences. Priority should be given to students on a first-come, first-served basis.

Session Organization

The course outline is described in [Figure 2](#). All students are expected to have completed the CBO-recommended prereading prior to the session. During the first hour of each session, community groups speak with students to address the following questions:

- What is the goal of your organization, and how is health included in this goal?
- What are the greatest health disparities your community faces?
- Describe the challenges you or your members have faced with the medical system.
- Is there anything you wish doctors did differently?



Figure 2. Session outline.

Each community prepares for this section of the course differently. Some may come with formal presentations, while others provide a brief introduction and overview addressing the above questions. Appendix C offers an example of what this may look like based on the facilitator guides for the five CBOs that most recently presented at our institution. A modifiable facilitator guide template (Appendix D) is also included. Regardless of the format, students are always encouraged to ask questions, and there should be time allocated for discussion between the students and the speakers.

Keeping the session running on time is the responsibility of the second-year student facilitator. Two other second-year students should also be present to take notes during the discussion to help capture lessons learned. After 1 hour, the speakers are thanked for their participation by providing them with a symbolic token of their role as educators of future physicians, a framed Cornell-red stethoscope. This also represents their role as healers of the health system as they listen for problems and report them back to students and physicians.

Once the speakers and other community members leave, the debrief session begins. Students are provided dinner and should sit around a table or in a circle for a more relaxed atmosphere. Each debrief session should always begin with the facilitator establishing the room as a safe space. The facilitator specifically prompts students to reflect on the following:

- Their thoughts and feelings on the presentation and CBO.
- The generalizability to a wider population of the experiences discussed.
- The improvements to the medical field suggested by speakers.
- Any modifications they would make to their practice of medicine.

While most of what the students say remains confidential, any takeaway points should be recorded by the two second-year note takers and shared with the entire class during the 10-minute wrap-up at the end of the session.

After each session, both students and community members fill out an end-of-session evaluation (Appendices E & F, respectively). As determined through a sign-in sheet, students who attended four or more of the five discussions are given elective credit for their attendance and participation. At the end of the course, students also complete a course evaluation (Appendix G). This assessment instrument was designed by course leadership as a way of monitoring the course and was not taken from a standardized source. It was, however, used consistently throughout all the sessions of the course, including the pilot session.

Results

The course overenrolled to 16 students, and all 16 students successfully received elective credit for the program by attending at least four of the five sessions. Fourteen of the 16 students attended all five sessions and completed the course evaluation. Of those 14 students, 57% agreed that capping the course at 15 students was necessary.

Satisfaction with the course was high, as 93% of students enrolled rated the course as excellent, and 100% of students would recommend the course to students for next year. The course format, content, and diversity of speakers were rated as excellent by 79%, 86%, and 93%, respectively. Similarly, 71% of students believed there to be excellent applicability to medical practice, and 100% of students thought the timing during first year was excellent. The evaluation tool itself was rated by 86% of students as above average or excellent.

Selected quotes from participants include the following:

- “I learned so much from the course. The discussions provided for a richness of understanding that the presentation wasn’t capable of eliciting.”
- “The discussions were EXCELLENT, especially when people got less guarded.”
- “I loved hearing all about how we can help improve the quality of care for marginalized groups. I believe that this class really helped me improve as a medical student and future physician.”
- “Make the course longer so we can survey more communities that face disparities.”
- “Absolutely excellent course. I feel like I have learned something.”

In terms of questions regarding possible modifications to the course, 71% felt that speakers should not be asked to give a more formal presentation, 64% felt that a practicing physician should not be present for the debrief portion of the course, 93% agreed that it was important to provide dinner to students at the sessions, and 50% of students felt the course should be required for all first-year students.

Discussion

CPIM provides a model for meaningful involvement with CBOs outside of service-based learning models. Like some other programs (e.g., the University of North Carolina at Chapel Hill’s community-based participatory research program), we emphasize the importance of a partnership between CBOs and medical students. In this way, we not only increase medical students’ cultural awareness but also provide traditionally disenfranchised communities with a formal involvement in medical education.²³ This resource also demonstrates how student-developed and student-led courses can be integrated into medical education, allowing for enriching experiences for student leadership and cross-class relationship formation. Our project uses a unique format of safe-space discussion forums and session debriefings to enhance critical thinking, similar to a model used at the San Francisco Veterans Affairs Medical Center during their longitudinal rotations program.¹⁷ Early in the elective, we realized we needed to provide students with prereading materials to enrich the discussion. The 10-minute wrap-up was also added at the end of each debriefing to provide continuity across the sessions. Another lesson learned was the importance of team-based planning for the elective. The leadership structure for CPIM thus has changed for the second year of the course to spread out the level of responsibility. Looking forward, seven of the 16 students are currently working to plan the course for next fall, following the leadership format discussed above. The new leadership roles and responsibilities are outlined in Appendix H.

We hope our program can be an easily adaptable model for other medical schools to increase community perspectives in medical education but realize there are limitations to the CPIM program that must be considered. First, time requirements to coordinate the course were quite high. Second, only 15 students were able to benefit from the program. To expand the project to reach a larger audience, one could consider allowing more students into the discussion with the community groups but then splitting into groups of 15 for the debrief portion. Third, evaluations were based on a small number of students, and all students assessed had volunteered to partake in the course. Similarly, the evaluations used did not evaluate for concrete knowledge points but instead allowed students to provide their own takeaway

lessons. Looking forward, we hope to formally study the impact of our course on students' attitudes towards diverse communities either through pre- and postcourse self-assessments (e.g., Harvard's Project Implicit program) or through standardized questionnaires (e.g., Crandall, Reboussin, Michielutte, Anthony, and Naughton's Medical Student Attitudes Toward the Underserved questionnaire²⁴). Lastly, the course relies on participation of community organizations, which requires the commitment of multiple organizations to partake in the course, and may be more difficult in medical schools in less urban areas.

In the future, we hope to create additional sessions for second-year medical students to help prepare them immediately before they begin their clerkships in the second half of their year. In these additional sessions, we hope to hear best practices from physicians working for community health centers. A physician from the Weill Cornell Medical College community would help moderate the sessions and the debriefings. We also hope to add a third-year program that allows CPIM course graduates to volunteer in CBOs that provide clinical services.

Eric Kutscher: Second-year Medical Student, Weill Cornell Medical College

Carla Boutin-Foster, MD: Associate Professor of Medicine, Weill Cornell Medical College

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Disclosures

None to report.

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Ethical Approval

Reported as not applicable.

References

1. National Research Council. *Understanding Racial and Ethnic Differences in Health in Late Life: A Research Agenda*. Washington, DC: National Academies Press; 2004.
2. 2014 Open Enrollment Report. NY State of Health Web site. <http://info.nystateofhealth.ny.gov/2014OpenEnrollmentReport>. Published June 25, 2014.
3. Coria A, McKelvey TG, Charlton P, Woodworth M, Lahey T. The design of a medical school social justice curriculum. *Acad Med*. 2013;88(10):1442-1449. <http://dx.doi.org/10.1097/ACM.0b013e3182a325be>
4. Bakshi S, James A, Hennelly MO, et al. The Human Rights and Social Justice Scholars Program: a collaborative model for preclinical training in social medicine. *Ann Glob Health*. 2015;81(2):290-297. <http://dx.doi.org/10.1016/j.aogh.2015.04.001>
5. Vela MB, Kim KE, Tang H, Chin MH. Innovative health care disparities curriculum for incoming medical students. *J Gen Intern Med*. 2008;23(7):1028-1032. <http://dx.doi.org/10.1007/s11606-008-0584-2>
6. Blue A. Cultural competency interviewing case using the ETHNIC mnemonic. *MedEdPORTAL Publications*. 2009;5:155. http://dx.doi.org/10.15766/mep_2374-8265.155
7. Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *J Health Care Poor Underserved*. 1998;9(2):117-125. <http://dx.doi.org/10.1353/hpu.2010.0233>
8. Grubb H, Hutcherson H, Amiel J, Bogart J, Laird J. Cultural humility with lesbian, gay, bisexual, and transgender populations: a novel curriculum in LGBT health for clinical medical students. *MedEdPORTAL Publications*. 2013;9:9542. http://dx.doi.org/10.15766/mep_2374-8265.9542
9. DeFries T, Rodrigues M, Ghorob A, Handley M. Health communication and action planning with immigrant patients: aligning clinician and community perspectives. *MedEdPORTAL Publications*. 2015;11:10050. http://dx.doi.org/10.15766/mep_2374-8265.10050

10. Kodjo C, Lee B, Morgan A, et al. Twist on cultural sensitivity. *MedEdPORTAL Publications*. 2014;10:9931. http://dx.doi.org/10.15766/mep_2374-8265.9931
11. Colley P, Cai J, Ofshteyn A, et al. Improving interdisciplinary collaboration in first-year health professional students through a learner-developed and learner-driven IPE curriculum. *MedEdPORTAL Publications*. 2012;8:9284. http://dx.doi.org/10.15766/mep_2374-8265.9284
12. Goldberg C, Tanabe T, Plato M. Can we talk? - Case studies in communication challenges and conflict management for clinicians. *MedEdPORTAL Publications*. 2011;7:7957. http://dx.doi.org/10.15766/mep_2374-8265.7957
13. Elliott D. Cultural self awareness workshop. *MedEdPORTAL Publications*. 2009;5:1128. http://dx.doi.org/10.15766/mep_2374-8265.1128
14. Gaffney M, Galvin M. Techniques in conscience sensitive medical education. *MedEdPORTAL Publications*. 2012;8:9166. http://dx.doi.org/10.15766/mep_2374-8265.9166
15. Elliott D, Schaff P, Woehrlé T, Walsh A, Trial J. Narrative reflection in family medicine clerkship - cultural competence in the third year required clerkships. *MedEdPORTAL Publications*. 2010;6:1153. http://dx.doi.org/10.15766/mep_2374-8265.1153
16. Holley LC, Steiner S. Safe space: student perspectives on classroom environment. *J Soc Work Educ*. 2005;41(1):49-64.
17. Chou CL, Johnston CB, Singh B, et al. A "safe space" for learning and reflection: one school's design for continuity with a peer group across clinical clerkships. *Acad Med*. 2011;86(12):1560-1565. <http://dx.doi.org/10.1097/ACM.0b013e31823595fd>
18. Llerena-Quinn R. A safe space to speak above the silences. *Cult Med Psychiatry*. 2013;37(2):340-346. <http://dx.doi.org/10.1007/s11013-013-9321-3>
19. Lucia V, Joyce B, Farr A. An integrated community health and behavioral health group project. *MedEdPORTAL Publications*. 2014;10:9698. http://dx.doi.org/10.15766/mep_2374-8265.9698
20. Allwardt D. Culturally competent health care practice with older adults. *MedEdPORTAL Publications*. 2006;2:254. http://dx.doi.org/10.15766/mep_2374-8265.254
21. Mehringer J, Bacon E, Cizek S, Kanters A, Fennimore T. Preparing future physicians to care for LGBT patients: a medical school curriculum. *MedEdPORTAL Publications*. 2013;9:9342. http://dx.doi.org/10.15766/mep_2374-8265.9342
22. Strowd R, Borgerding E, Kittner S, et al. Transitions in medicine: four-year complementary process-oriented curriculum for medical student guidance. *MedEdPORTAL Publications*. 2014;10:9904. http://dx.doi.org/10.15766/mep_2374-8265.9904
23. Cene CW, Peek ME, Jacobs E, Horowitz CR. Community-based teaching about health disparities: combining education, scholarship, and community service. *J Gen Intern Med*. 2010;25(suppl 2):S130-S135. <http://dx.doi.org/10.1007/s11606-009-1214-3>
24. Crandall SJS, Reboussin BA, Michielutte R, Anthony JE, Naughton MJ. Medical students' attitudes toward underserved patients: a longitudinal comparison of problem-based and traditional medical curricula. *Adv Health Sci Educ Theory Pract*. 2007;12(1):71-86. <http://dx.doi.org/10.1007/s10459-005-2297-1>

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