Open Society Institute

Medical Education in the Public Interest

Soros Service Program for Community Health: Mission and Program Description

DURING ITS OPERATION from 2000 to 2003, the Soros Service Program for Community Health strove to foster in medical students a commitment to serving the community and advocating on behalf of vulnerable populations. To this end, SSPCH worked with medical schools and a variety of community-based organizations to develop a community-based and community-led, service-learning curriculum that was responsive to the needs and cultural diversity of the communities served. Students participated in an intensive professionalism curriculum that explored issues of service, community, advocacy, leadership, and ethics, relative to the medical profession. Community organizations operated as training sites, and staff members served as mentors and educators for medical students who participated in SSPCH.

Student activities varied at each community site, and participants were assigned to specific sites based on their expressed interests and unique skill sets. When admitted to the internship, clerkship, or fellowship program, participants focused on one of the following issues:

- Adolescent Health
- HIV/AIDS in the Community
- Health and the Uninsured
- Homelessness and Health
- Immigrant Healthcare
- Mental Health
- Substance Abuse and Addiction
- Violence and Health

SSPCH offered two educational opportunities for medical students in Baltimore and New York City—a summer internship program and a clinical clerkship program. It also offered a preclinical fellowship to students in New York City.

Participants began the preclinical fellowship in the second semester of their first year and spent an entire calendar year with a community-based organization. Students in the fellowship program were also required to participate in the eight-week-long summer internship program during their first and second years of school. To fulfill the requirements of the fellowship and internship programs, students completed research projects related to their community placement sites.

The collaboration with community sites, which provided mentors from a number of fields, including public health and social work, allowed medical students to explore broad concepts of health and develop an appreciation for the multidisciplinary nature of healthcare in the preclinical portion of their education. These students' sustained interest in community health pointed to the need to also offer educational opportunities during the clinical stages of medical education.

A number of alumni from the summer internship and preclinical fellowship programs went on to participate in the clinical clerkship program. The clinical clerkship was offered during the third and fourth years of schooling, when students' professional interests and understanding of healthcare are generally well developed. The program, generally a one-month rotation, was designed to develop clinical skills in a community setting.

This publication is rooted in the varied experiences garnered by the Soros Service Program for Community Health (SSPCH), which is an initiative of Medicine as a Profession (MAP), a program of the Open Society Institute. MAP has worked with the medical community in Baltimore and New York City since 2000.

The booklet contains three sections. The first is an essay examining the history of professionalism within medicine. The author argues that, by grounding the concepts of professionalism—including service, community, advocacy, leadership, and ethics—in a community context, medical educators can provide students with an understanding of the importance of working in the public's interest. Community-based endeavors promote a strong ethos of medical professionalism and reinforce these essential principles for students during their preclinical and clinical years.

The second section of the booklet is a tool kit, designed to provide educators with a flexible framework that will help them develop additional community-based learning and service programs. The tool kit is intended to serve as a guide for creating meaningful learning experiences for students, not as a definitive step-by-step manual. We at SSPCH recognize that each effort is unique and will present its own specific challenges and opportunities.

The final section of the booklet is an informal survey of the views of SSPCH alumni in medical school and residency programs throughout the country. The alumni's responses to this voluntary survey provide an anecdotal but powerful glimpse into the challenges faced by medical students and residents who would like to engage in professionalism and advocacy activities during their education and training.

We hope that these three perspectives will together provide medical educators with a road map for developing community-based professionalism initiatives, present the reasons why it is important to develop them, offer insight into how to set up such programs, outline the challenges that continue to exist in promoting an ethos of professionalism within medical education, and, finally, present an overview of the positive effects of establishing professionalism within a community context.

American Medical Education:
The Value of Learning in a Community Setting

The process of defining the standard for medical education and practice in America has had a long history—from the country's earliest days, when methods and training were informal and often haphazard, to the mid-nineteenth century, when a formal curriculum was established in schools within university settings. Although the process is still far from complete, the gradual evolution toward today's standard of education and care has been a cumulative process that has not yet led to the creation of a curriculum that fully addresses the role of the medical professional within society. Today, in light of the current challenges to our healthcare system, the ethos of medical professionalism should include not only those traditionally accepted values of ethics and service to others, but should also help define the role of the physician as an advocate for the public's interest and a leader in improving healthcare.

Early Medical Training

Today, most people assume that the medical profession is limited to physicians. In a historical context, however, this assumption would not be true, especially when one considers the colonial period, when other types of healers were considered part of the medical profession. During that time, the elite among healers were the physicians. They usually had university degrees and sometimes apprenticed at the start of their careers. Surgeons trained through apprenticeships and hospital instruction but rarely held degrees. Until the late eighteenth century, midwives accounted for the majority of obstetrical practice, although they lacked practical training.[2] Colonial practitioners were a miscellaneous lot, and reformers championed attempts to address the inadequacies in their education. If one were to pick an event that marked the beginning of reforms in medical education, the founding of the medical school at University of Pennsylvania in 1765 might be a good choice.

Throughout the eighteenth and nineteenth centuries, proprietary schools were more common than university-based schools. A disorganized system of proprietary schools, which were owned and operated by independent practicing physicians, trained a number of physicians who treated soldiers wounded in the Civil War. The schools had no admission criteria, and, consequently, applicants were not required to have prior education. A budding physician only needed to pay a fee to begin training. A four-month program focused on the practical aspects of care, such as anatomy, physiology, pharmacy, surgery, and obstetrics. Medical education consisted of lectures, and students graduated without any practical experience in treating patients. The proprietary nature of these schools, whose owners depended on the income generated by student fees, provided an incentive to inflate class size and enforce low graduation standards. Students received no grades, and were only required to complete a short oral examination to graduate.[3]

A medical student could supplement his education if he had the financial means to pursue additional training opportunities (women were not considered fit for the medical profession until the mid-twentieth century). Some doctors in training availed themselves of an informal apprenticeship system, which provided meaningful work in a medical setting under the close supervision and tutelage of a practicing physician.[3] Although apprenticeships offered valuable learning opportunities, they provided an informal system of instruction in which students struggled to learn without books and equipment.

Medical students could also supplement their education at a number of non-degree-granting schools that operated during the summer vacation months. These extramural schools provided students with the hands-on clinical experience not available in a degree-granting institution. Students were given opportunities to develop concrete skills, such as dissection, the

bandaging of wounds, and minor surgical procedures. Without this type of experience, an American doctor in training during the early nineteenth century usually entered the field without any practical bedside experience.[3]

During the 1820s and 1830s, medical students could also pursue a position as a house pupil, a role established by a number of hospitals that allowed students to reside in a hospital and closely manage patient cases. A predecessor to the clinical clerks, house pupils spent two months in rotations at different hospital wards gaining intensive clinical training at bedside. These coveted yet demanding positions grew more popular during the mid-nineteenth century.[3]

Finally, students who could afford to often pursued additional study in Europe, particularly in Paris where new scientific and medical developments were occurring. European study was a popular, although elite, experience that allowed American medical students to obtain personal instruction from professors seeking additional income. Medical students who traveled to continental Europe benefited from hands-on exposure to new advances in pathology, physical diagnosis, and statistical research methods.[1,5]

The American system of medical education evolved into one that closely mirrored that of Europe: Training centered around two years of nonclinical training and two years of clinical teaching. The decentralized nature of American medical education in the nineteenth century and early twentieth century, however, produced a disjointed system of professional standards. Rules and regulations on medical teaching and practice varied from state to state, posing many challenges for unified curriculum reform.[3]

An American Model

Efforts to increase the skill and professionalism of the medical field to create a distinctly American system started in 1847 when a group of physicians (who later formed the American Medical Association) made a series of pronouncements calling for the lengthening of the period of instruction from four to six months, the establishment of preliminary education requirements, and the mandatory completion of an apprenticeship with a qualified preceptor. Later curricula reform occurred because of teaching innovations independently introduced at a number of medical schools around the country and eventually incorporated at other schools. In 1857, for example, the New Orleans School of Medicine introduced a system of assigning patients to medical students who would closely follow the case from admission to discharge—another precursor of the clinical clerkship, which would later be adopted by all schools of medicine.

In 1859, the Medical Department of Lind University in Chicago (later to become Northwestern University Medical School) was the first school to establish a graded curriculum. In the 1870s, this innovation was followed by similar changes at Harvard University, the University of Pennsylvania, and the University of Michigan. Between 1885 and 1920, proprietary schools were replaced by large teaching hospitals, which are the norm today. By the late nineteenth century, full-time professors assumed teaching roles and academic medicine was gaining professional legitimacy and prestige.[3,4]

The Flexner Report, Abraham Flexner's famous report published by the Carnegie Foundation in 1910, revolutionized American medicine. The report documented the inadequacy of medical education and promoted an "ideal" school of medicine: university-based schools with full-time faculties and a commitment to medical science. The highly publicized report galvanized the medical establishment and obliged schools to raise students' entrance standards, create teaching hospitals, hire full-time professors devoted to teaching, and institute vigorous research programs.[6,7,8]

American medical education reached full maturity by the 1920s. New subjects have since been introduced to the curriculum as a result of advancements in knowledge, but the philosophy and structure have essentially remained the same. One of the most influential forces shaping contemporary medical education, however, is research. Initially, the medical establishment was slow to integrate research into teaching and practice. Physicians throughout the nineteenth century were profoundly influenced by French medical philosophy, which characterized medical science as a process of keen observation.[1] American physicians distrusted the acquisition of knowledge through experimental investigation and manipulation of nature, a school of thought

promoted by clinicians in Germany. Pure science was overshadowed by practicality, and, therefore, medical research by American physicians lagged far behind that of their European colleagues.[2]

Shortly after the publication of *The Flexner Report*, schools began to view research as an opportunity to strengthen their institutions and shape medical science. A commitment to research soon created specializations within the field of medicine. Practitioners were no longer generalists who were called upon to provide care and train the next generation of physicians. From the 1920s, research provided legitimacy to the medical field and divided the nonclinical and clinical departments of medical schools across the country.[3,4] Students studied nonclinical and clinical subjects individually until the 1950s and 1960s, when schools nationwide made efforts to integrate laboratory and clinical training. The 1950s saw the disintegration of these knowledge "silos" in medical education.[3,4]

No significant structural change has occurred in medical education since the introduction in the 1970s of accelerated programs that combine undergraduate and graduate medical training.[7] Curriculum changes have been minor, primarily mirroring sociopolitical trends. The 1970s saw an emphasis on holistic health, patient-centered care, patient rights, and gender-specific care.[3,4] In the 1980s, debates on the role of ethics, such as bioethics and the ethics of care, burgeoned with advancements in biogenetics.[3,4,10] In the 1980s, 1990s, and today, medical education pedagogy promotes the development of well-rounded, critical-thinking skills with a focus on patient-centered care, rather than the rote memorization that has traditionally characterized medical education. Medical education today balances intensive training in acute care and in outpatient-oriented holistic standards of care.[11,12]

The medical establishment has not caught up with American economic and sociological trends, which are fueled by a recent political/philosophical shift that views medical care as a natural right.

Medical research brought vast amounts of federal funding (and, in the 1980s, corporate funding) that established medical schools as complex bureaucratic structures and "big businesses."[3] One may argue that the expansion of and emphasis on medical research has isolated academic medical centers from strengthening student training in clinical practice and patient-centered care. Critics may further argue that such a research-dominated system, driven by funding for scientific advancement, creates an economic disincentive to investigate and train students on the diverse clinical needs of an American society that is growing ever more complex. The medical establishment has not caught up with American economic and sociological trends, which are fueled by a recent political/philosophical shift that views medical care as a natural right.[13,14] Americans are demanding good care regardless of ability to pay.[13,14]

The Soros Service Program in Community Health (SSPCH), founded in 2000 as part of the Medicine as a Profession initiative of the Open Society Institute, offers the medical establishment a model opportunity to achieve a new standard in medical education by grounding the concepts of professionalism in a combination of formal curricula and experiential learning.

The SSPCH Curriculum

The Soros Service Program in Community Health is driven in theory and intent to help medical students explore the role that physicians play within a larger societal context and to encourage their greater involvement in issues concerning the public's interests.

How can physicians provide effective medical care in ways that acknowledge the realities of substance abuse, intimate partner violence, homelessness, and HIV/AIDS? What does it mean to provide medical care in communities where recent immigrants and the working poor face significant economic, geographic, linguistic, and cultural barriers to obtaining primary and preventive care? Such issues endemic to medically underserved populations are not adequately addressed in the traditional medical school curricula, but they are intrinsic to a physician's practice. The SSPCH curriculum was designed to engage medical students in an intensive exploration of the complex relationship between self and society, to encourage them to explore issues when confronted with the imperative, and to work toward a greater social good as an intrinsic aspect of the medical profession—in

other words, to ask, how can a commitment to social change manifest itself in a physician's career?

To answer such questions, the program sought to collaborate with community-based organizations that would expose students to a cross section of the societal issues (including race, gender, and economics) that impact an individual's ability to maintain physical, mental, and emotional health. SSPCH did not expect all its alumni to pursue a career devoted to serving low-income, medically underserved populations. Rather, the program presented different types of social action to provide students with a range of options for serving a community larger than themselves.

A student's decision to pursue a career in community health frequently depends on his or her stage of medical training and development as an individual. Medical students are motivated by a range of professional goals—from idealism on one end of the scale to pragmatism on the other. In the early stages of their careers, students are focused on doctor-patient dynamics and interactions. Students then often move onto concerns regarding the ethics of delivering care—for example, how to present bad news and how to work with noncompliant patients. Finally, students face important decisions about which specific field to enter, frequently balancing personal interests with the realities of paying off school debt. SSPCH sought to engage students at every stage and expose them to the many choices they have for practicing idealism and pragmatism throughout their careers.

THE CORE CONCEPTS OF PROFESSIONALISM:

SSPCH strove to focus on issues of professionalism in clinical practice, issues to which medical students are rarely exposed. How professionalism is defined and articulated has been the subject of increasing debate and discourse over the past several years. Much of the debate is fueled by the sense that professionalism within the medical community faces challenges, in part due to the growing corporatization of healthcare delivery, the disengagement of physicians from critical decision-making roles, and the increasingly intrusive role of financial incentives and disincentives on patient care. At the same time, technological advances, patient empowerment, and the realities of rationed access to care and services have all placed greater demands on physician behaviors and actions.[15,16,17] The answers to how and where a physician develops the capacities to respond to these challenges have traditionally rested with medical schools and have shaped the content and focus of undergraduate medical education.

The SSPCH professionalism curriculum formally addresses what it means to work among a team of professionals in the care of patients, communities, and society. Although medical schools provide students with superior practical knowledge and skills, few students have the opportunity to explore their full potential as community and social-justice advocates. To train and inspire the next generation of physicians, SSPCH organized its curriculum around the five aspects of professionalism: service, community, advocacy, leadership, and ethics.

Service is defined as direct care to patients, particularly to disenfranchised and vulnerable individuals and population groups. This concept encourages exploration of the relationship between the self and the collective good, between the individual and the profession. For some, service may be motivated by a purely altruistic intent that defines one's entire career. Physicians may choose to devote their entire professional lives to serving the poor or may become involved in discrete service-oriented initiatives—even if their areas of specialization do not directly concern the needs of an underserved community. For example, many physicians remain committed to social good throughout their careers by devoting limited time and talent to nonprofit organizations, such as Doctors Without Borders or Operation Smile.

During weekly seminars, students explored various aspects of service. What does it mean to provide free care to people in need? Would mandating all physicians to provide pro bono service to the poor be a legitimate policy solution? Students were asked to reflect on how they, as physicians, will balance the need to care for the underserved with the need to care for their own well-being. How much of a physician's time do the poor "deserve"? One day, six weeks, one year? Is short-term service "medical voyeurism"? Further, students discussed the institutional barriers to providing service. How do malpractice and state licensure issues prohibit physicians from working with medically underserved populations? Should a medical institution support those physicians who choose to devote time to community service, despite the organizational and financial constraints placed on the institution?

Community refers to the broader role played by the physician and the need for accountability to not only the individual patient but also to the

community. SSPCH students explored what it means to be a part of various communities—whether demarcated by geography, profession, race, religion, or gender. Students were asked a number of questions. How do you (as members of a health profession) define a community? How do community members define a community? How do these differences compete with each other and reflect different priorities or agendas? By presenting students with an exercise in mapping resources, such as libraries and social service organizations, the program in Baltimore sought to teach students to view the communities they served as assets rather than liabilities.

Students in the SSPCH program gained exposure to the community setting, and their collective work reflected the desires of a group to address the unmet needs of particular communities. Within that context, students explored what it means for people outside of a community to work with that group. Medical students also learned that, for many individuals, community-based organizations (CBOs) are a critical part of a fragile safety net. They began to understand these organizations' unique niche within the American healthcare system and the valuable contributions that CBOs make.

Advocacy is driven by an individual's concern and passion for a particular issue. The advocacy activities of medical students and physicians may include both individual patient advocacy and systemic advocacy efforts. Advocacy, which has a distinct skill set, should be an integral part of the professional ethos within medicine. It should also be—first and foremost—informed by the principle of service to others rather than by self interest. Based on the experience of SSPCH, the concept of advocacy is best taught by combining classroom exercises and discussions with experiential learning and reflection—especially because many advocacy efforts require collaboration with a variety of individuals both within and outside of the medical profession.

The SSPCH curricula included an exploration of advocacy and service to emphasize the importance of working in the public interest rather than in self-interest. "Bedside advocacy" promotes patient interests within the context of the doctor-patient relationship. "Systemic advocacy" addresses unmet needs on a broader level, and advocates can utilize legislative efforts or the media to engender changes in policy.

Advocacy is not generally undertaken in isolation, and, consequently, the SSPCH program emphasized the need for collaboration with rather than on behalf of community partners. In New York, students' research projects were developed in concert with staff at community sites, and the results of the research were shared with mentors. In Baltimore, students undertook collective, advocacy-based research, and, since 2001, their research served as an annual report card on the status of Baltimore's safety-net providers and the marginalized populations they serve. Their work also received attention from local press and legislators. Consequently, through their own research and presentation of the findings, students learned how informed research could eventually impact policy.

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SSPCH also grounded the concept of advocacy in experience and discussion, often at the request of students who wanted to develop a concrete set of skills not generally taught in medical schools but much needed in their professional lives. Program participants explored the concept with physician advocates who served as role models. During one year of the program, students interviewed congressional legislative aides about how health policy is developed and how physicians can effectively advocate for their patients' interests. Students were also confronted with complex questions. For example, should a physician take action when insurance or hospital guidelines indicate a life-saving medication is too expensive? If a physician advocates on behalf of a patient to get needed medication, how can he or she then initiate institutional change to make sure medications are available to all patients at the hospital despite the individual's socioeconomic level? And finally, what is the physician's role in affecting larger societal reform to ensure that life-saving prescription medicines are available to all Americans in need?

Although individual and systemic advocacy have not been traditional aspects of the professional ethos of medicine, the complexity of our current healthcare system and the demands of students for a related skill set suggest the need to develop curricula pertain-

ing to the topics. Advocacy curricula should be rooted in classroom discussions and in experiential learning. To be effective advocates, students would also be well served by developing an understanding of the tenets of collaboration with those who need their help.

Leadership, or the capacity to inspire and direct others, complements the concept and supports the work of advocacy. Students explored the idea of effective leadership primarily through role models and discussions. The discussions centered on the students' expressed concerns: the fear of burnout; the difficulty of juggling family obligations with professional obligations while also assuming a leadership role; and the question of whether or not advocacy and leadership activities are valued and rewarded within the medical profession, particularly in academic medicine.

Ethics, distinct from advocacy and leadership, encompasses both individual and institutional decision making and behavior. A number of topics fall under the umbrella of ethics, including professional behavior. Should pharmaceutical companies be allowed to give gifts to physicians? Should medical schools provide pharmaceutical companies with access to their students and residents? Should physicians "game" the system when faced with an indigent patient who needs medication? Ethics is an essential part of professionalism, and the students' exploration of the topic was grounded in their experiences as medical students, in their observation of physician preceptors and colleagues, and in an examination of institutional behavior. Students also explored these aspects of ethical behavior through articles and in discussions.

THE CURRICULUM STRUCTURE:
The development of a formal curriculum to address the nuances of SSPCH's core values was essential for the success of the program. The professionalism curriculum had three core components, each one meeting the needs of various participants in the program: readings that relate to a weekly theme; structured lectures and discussions led by community/academic leaders in the field to provide context; and a community-based research project to be completed during the program.

LECTURE SERIES:
A core element in the SSPCH experience was the weekly seminar series. The seminars encouraged active participation and dialogue among students and faculty. The format included an opening session in which students shared their experiences at their community-based host sites. Next, an individual or panel of speakers made a formal presentation, which was followed by a discussion of a topic reflecting the core values of professionalism. Seminars were cofacilitated by mentors or staff from the participating CBO sites along with guest faculty, including individuals from other OSI-funded programs. Seminars often took place at the participating CBOs to provide students with direct exposure to diverse community settings.

SSPCH is a collaborative, cost-effective model that could be adapted to a variety of settings, including medicals schools and nonprofit institutions that seek to improve healthcare. Unlike most other service-learning initiatives, SSPCH explores the core concepts of professionalism—service, community, advocacy, leadership, and ethics—both through formal curricula and experiential learning.

In evaluating the program, we have found that alumni of the program express a sustained interest in serving the public interest in a number of ways, including individual and systemic advocacy efforts and service to individuals or particular communities. Unfortunately, the burden of student debt and the lack of protected time for service or advocacy have made it difficult for these individuals to explore their interests during their years of medical school and residency. We hope that institutions will adapt the SSPCH program and curricula to provide future generations of medical students across the country with the opportunity to engage in activities that will benefit the public's interests and, by extension, promote professionalism in medicine.

ENDNOTES

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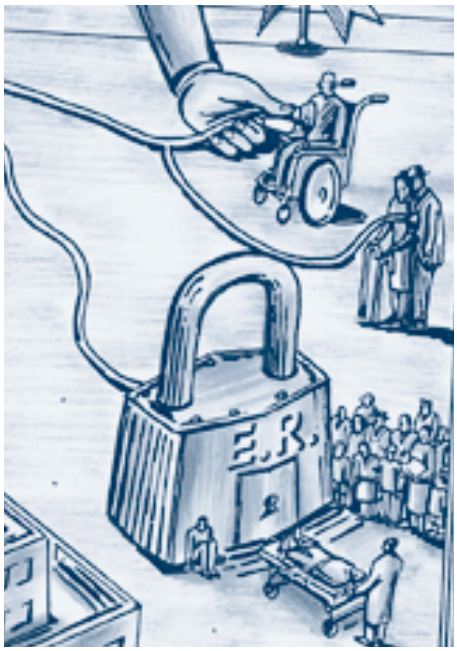
THE SSPCH TOOL KIT

Teaching Professionalism in the Community



The process of moving medical education out of the classroom or academic health center and into a community setting can be fraught with challenges and uncertainty. What will the teaching be like? Will the experience be consistent across sites? How do we balance teaching and learning objectives in settings where providing a clinical or community service takes precedence? Can the safety of participants be assured? Will the students' experiences (and expectations) match their skill sets or will they be "in over their heads"? Potentially volatile issues, such as levels of professionalism and the relationship between the community and the academic health center or university hospital, may need to be addressed when creating a community-based learning experience. Medical educators need to consider their objectives and decide how to convey messages in a manner that recognizes historical or existing tensions. What biases or potential misrepresentations do they need to watch for?

These questions are representative of the types of concerns that medical educators may have as they consider whether or not to develop community-based learning experiences. Additionally, they will need to find extra time and resources to coordinate the program, which includes a complex organizational matrix of activities, locations, and capacities. Ultimately, however, teaching medicine and establishing professionalism within a community context can be extremely rewarding and can add value to students' educational process. Community-based learning opportunities can be tailored to specific skill sets and made available to students in both their preclinical and clinical years in order to reinforce notions of professionalism that may otherwise be eroded at different stages of their education and training.

This tool kit offers guidelines on how to develop a community-based learning experience and presents the kinds of issues that educators need to be aware of when establishing a professionalism curriculum in a community setting. We have developed this kit based on the experiences, mistakes, and successes garnered in developing and running the Soros Service Program for Community Health (SSPCH), which has operated in Baltimore and New York City since 2000. If you are interested in additional service-learning or community-oriented learning experiences, we recommend perusing the list of resources found on the Community Campus Partnerships for Health (CCPH) website (http://depts.washington.edu/ccph/). You may also want to refer to the *Collaboration Handbook: Creating, Sustaining and Enjoying the Journey* by Michael Winer and Karen Ray (Saint Paul, Minn.: Amherst H. Wilder Foundation, 1994).

This tool kit is not meant to be an exhaustive resource or step-by-step manual describing how to design your own community-based educational experience. Rather, the tool kit shares information gained through the combined experiences of SSPCH and several other community-based initiatives and projects that predate it. We hope that the kit will serve as a general guide for developing the next generation of initiatives for learning. Every effort is unique and has its own issues, challenges, capacities, needs, partnership opportunities, and personalities. The essential traits in a successful collaboration are the ability to stay flexible, to "keep your eye on the prize," and to never lose sight of why you are developing the program and what you want to accomplish. Most important, remember that it can take time to establish a thriving, sustainable community-oriented or community-based learning program, and it is important to enjoy the process along the way.

Laying the Groundwork

What is it that you want to accomplish?

Consider student objectives, community objectives, and institutional objectives.

When designing a program, it is always important to take time at the outset to think about what you want to accomplish and for whom. Too often, projects fail because of a mismatch between what the project's initiators want to do, where they want to do it, and what they actually can do with the available time, resources, and skill sets. To develop a sustainable initiative, medical educators need to understand what resources—both human and experiential—are available to them. In addition, they should have a sense of the stakeholders' requirements for participation. It is important to demonstrate flexibility in working with all the parties involved and to avoid the all-too-easy trap of "doing to" a community rather than "doing with" a community.

One simple trick that helps when engaging in negotiations with stakeholders is to reduce your objectives to one or two sentences with broad appeal. In our professionalism project, we described our program's goals this way: "We want our medical students to see what it is like for XYZ population or group to try to get healthcare and what role they as health professionals can and need to play." If you cannot explain the essence of your objective in one or two sentences, chances are you are not yet clear yourself as to what you want to do. One proviso to keep in mind is that you may need to modify your statement slightly to relate more directly to the different stakeholders—students you are trying to recruit into the program, community agencies and providers that you need for placement sites and mentors, or your deans and department chairs, who have their own benchmarks for endorsing a new project.

How can you keep the process informed?

Establish a well-balanced advisory board.

The creation of a group of informed advisors who will guide you along the way is critical to avoiding mistakes that can sink a project before it gets started. You should also know what questions to ask these advisors—and when to ask them. For example, you may need to ask for their input if, after launching your program, you suddenly realize that you need to make modifications to your program. For this reason, you need to select individuals who are equipped to offer informed and intelligent advice.

You also want to be sure to select board members who do not have hidden agendas or vested interests that may conflict with the development of your program. Avoid choosing people who only "look like you." In other words, avoid stacking the board with fellow academics or others who share your viewpoint. Avoid, too, those people who may be more likely to rubber-stamp whatever you propose for their own reasons. This mistake is easy to make and especially common when a program initiator reaches out beyond his or her base or comfort zone to seek colleagues and advisors. Medical educators should interview potential board members in order to determine whether or not the candidates share the educator's commitment to a set of objectives and to ascertain whether the individual's experience and expertise will add or detract from the program's development.

Medical educators should also carefully consider their communications strategy. It can be difficult to convene individuals who have multiple commitments. So, in order to facilitate meetings and keep the program development moving forward, educators should establish a set schedule of meetings and, in advance, should provide the advisory committee with written background information and briefings on critical issues. At the same time, the educator will need to establish clear guidelines as to how the advisory group can best inform the process of program development, as well as explicitly state any important ground rules for the committee's work. If the advisory board is effective, members will not only help guide you but, in the process, often will also become proponents of your program. And, as you may find, you can never have enough allies when trying to work "out of the box" or challenge the status quo.

There are a few additional questions to consider as you establish an advisory board and approach community partners. Is your advisory group representative of the people you want to serve in the community and of the disparate stakeholders in the project? Are both you and the members of your advisory group able to be self-reflective? To be an effective advocate or to serve others, educators and advisors should be able to consider and discuss

their own biases and needs. How do the members of the board work best? What biases—relating to socioeconomic background, religion, etc.—do they bring to the table? What is their comfort level when discussing difficult topics? Medical educators should be able discuss sensitive issues both with advisory board members and stakeholders.

How do you find the right community partners?

Know what it is you are looking for in a partner.

Establish explicit expectations.

Create an agenda with shared objectives.

Define clear spheres of responsibility.

Identify your intended outcomes and benchmarks—and how they will be measured.

Create a Memorandum of Understanding.

Establishing community partnerships can be one of the most daunting aspects of the process, but also one of the most rewarding. You may find that wearing your academic badge out in the community can be a rather humbling experience, particularly when your institution does not have the best reputation for working in collaborative community partnerships. You can start engaging community partners by being a good listener. If you expect a potential partner to believe in your commitment to truly serving the community's needs, you have to show your sincerity by actively listening to individuals from the community explain what they need, rather than telling them what you think they need.

If you do hit it off with a community agency or director, however, that does not always mean that that partner is a right fit. Understanding and appreciating the needs, expectations, and capacities within that community agency (and clarifying who will be doing all the work) are important steps in determining whether a partnership with that organization is likely to succeed. When considering a community partner, understand that many of these groups are struggling to "keep the lights on" and may not be able to take on students or may need extra help, either as an in-kind exchange or in the form of resources.

It is extremely important that you are very clear as to what you expect from the partnership, what each side can expect to gain (and expend) in making the partnership and project work, what each entity is responsible for, and what the benchmarks and indices of accountability are. Spelling out these details in a Memorandum of Understanding is one approach that several groups have taken—most notably, the Greater Flint Community Association and the University of Michigan. Too often partnerships go awry when an implied benefit or a delivery of resources doesn't come through or when work expectations are not shared by both parties. Make sure everything is on the table from the beginning.

There are many types of potential community partners, and you will likely work with groups that are start-ups, well established, or somewhere in between in their own development. Although it can be difficult for start-up staffs to devote their limited time to your meetings, these organizations may be committed to your goals. Be careful that other agencies with greater resources do not overshadow their entrepreneurial perspective and input, however. This type of competitive dynamic may play itself out in an advisory board or in meetings with community partners. You may also witness interagency conflict among community partners or competition for limited resources—particularly if your sponsoring institution offers a stipend or grant.

Program administrators should know how to effectively address these issues as tensions surface and before they adversely affect the collaboration. Early in the development of a collaboration, it is best to devote time to a frank discussion about conflicts of interest or prior relationships among agencies (whether they are competitive or not). Administrators should also consider talking about whether sites may want to work together. The Baltimore program attempted to partner clinical sites with nonclinical sites in order to provide medical students with a broad understanding of health and to link social service agencies with those providing medical services.

How do you keep lines of communication open?

Schedule meetings and maintain regular contact with all the stakeholders.

A lack of communication among program administrators, community partners, and advisory board members is one of the most common pitfalls—and a potential Achilles' heel—in creating and running these types of programs. You need an advisory group to help you stay on course, but you also need to make sure that you remain informed as to how things are going on the ground and that you continually inform your stakeholders and partners where you want the program to go.

Meeting with your community partners, students, and deans and department chairs at regularly scheduled intervals is important. If it is not always possible to schedule meetings, you should make sure that there is a mechanism in place that ensures two-way communication and that you are actively initiating it in regular intervals. Unfortunately, projects like these rarely make it on autopilot. Staying informed (so that you can inform) and regularly communicating with those around you is far preferable to being caught off guard if things go awry.

Setting Up the Curriculum

How do you match experience to the agenda?

Match students' skills and capacities with their duties and responsibilities.

Make your activity relevant to the current curriculum.

Provide required, elective, and volunteer options for the students.

Creating the curriculum is the fun part of the project—and the area in which your creativity is rewarded with experiences and teachable moments that cannot be found elsewhere. During this stage of program development, be sure not to assume that your own fervor, drive, and vision are shared by the students, community mentors, or even other faculty members.

Make sure the curriculum requires a level of engagement that matches the level of enthusiasm and commitment shown by the students. Students who sign up for elective courses will have a different set of expectations and energy than those signing up for a required course. In required courses, you are more likely to be working with students who are not indoctrinated or sensitized to community-based work or who are reluctant or resistant to the more socially oriented objectives of a professionalism curriculum. This is not to say that a proactive professionalism curriculum—which addresses issues of service, community, advocacy, leadership, and ethics—should not be required. Nor does it presume that conversions and epiphanies do not take place among students during their medical education. Rather, we raise this point to suggest that it is probably better to view a required course as an opportunity to lay a foundation and create a base from which more involved and intensive experiences can subsequently develop.

It is also important to consider where and how a community-based curriculum will fit into and/or blend with the established medical school–based course offerings. This consideration is important in terms of how the experience will be viewed by students and legitimized by the rest of the faculty and academic leadership, and how it can complement and potentiate other curricular experiences. Sometimes, it is better to have lectures, in-service sessions, and community-based modules that are incorporated into existing courses and clerkships rather than offering stand-alone courses.

Keep in mind, however, that curricula change, and it is probably more important to focus on where you end up rather than worrying too much about where you start.

How can you make professionalism relevant and real?

Keep the program local.

Connect with real people.

Know your stakeholders and make sure your curriculum also connects with them.

Keep the program community-driven.

A hallmark of SSPCH was the emphasis on making professionalism relevant to students, and, for that reason, it was grounded in experiential learning to the greatest degree possible. The importance of this approach to teaching professionalism, especially in a community setting, cannot be emphasized enough. In order to foster the retention of these essential principles in your students, the edicts of professionalism, which are espoused in your curriculum, should be real and relevant, rather than abstract and removed. This approach is also critical to legitimizing your education efforts to your community partners, students, faculty, and the broader audiences for whom the quality of medical education has meaning. You will have an advantage in teaching students the ethos and tenets of professionalism by basing the curriculum in a community setting and grounding it in the experiences of a specific vulnerable or traditionally disenfranchised population. A community-based experience makes medical students starkly aware of the inequities in access to healthcare and aware of their responsibility as physicians to address the healthcare needs of all patients.

One caveat to the exhortation to ground professionalism in experiential learning is that the process must be informed by your community partners and your advisory board. Too often, we in the medical community impose our own ideas upon, rather than work

with, disadvantaged and indigent patients and communities, although these individuals and communities already know what is wrong and what needs to change. Good healthcare goes beyond the blood pressure screenings, flu shots, and lectures on good eating habits that we bring. We need to learn to address the health problems created by poor schools, lack of jobs, inadequate housing, environmental hazards, and low expectations of quality of life—or at least learn how these issues contribute to poor health.

Often we walk away from the problems of our patients and their communities when we realize that the answer isn't within our prescription pad. This type of curriculum offers us the opportunity to listen, to become a part of a bigger process moving toward better healthcare and social change, and to realize that change is an empowering force. We need to become comfortable with not always leading, but instead, becoming involved in the process of change for the greater good. Robert Coles, in his seminal book, *The Call to Service*, provides a strong intellectual basis for what we in medical education can realize through a community-based proactive professionalism curricula.

How do you design an effective curriculum?

Identify objectives.

Identify teachers and determine how well prepared they are to teach what you want students to learn.

Consider the many ways in which students learn.

It is important to remove all traces of self-righteous pedantry in favor of promoting a reality-based curriculum that is engaging, challenging, and fulfilling for the students who take part in it. Just as minimizing the importance of community perspective, input, and leadership can have disastrous consequences, so too can taking the student for granted or assuming that he or she is little more than an indentured servant or an extra hand for scut work.

A rigorous curriculum with clear, measurable objectives and expectations does not have to be stuffy or stiff. Rather, it can set the bar for what is expected of the student and establish expectations among community mentors and faculty facilitators for a high quality of education. Some course directors worry that by letting their students loose in the community they lose the opportunity to ensure consistency and quality of content within the curriculum. To some extent, they are right. What is lost by moving students out of a lecture hall, however, is more than made up for in the community settings where they are exposed to a reality impossible to recreate in the classroom and where they are given the opportunity for experiential learning they are much more likely to retain.

What is necessary to ensure that the benefits outweigh the risks is a hands-on approach to off-site learning. This oversight requires four key components. First, the learning objectives need to be clearly delineated for both students and community mentors. The expectations need to be explicit and appropriate to the setting and the anticipated experience. Second, the learning and teaching approaches needs to be defined from the outset. We have employed a service-learning pedagogy in our work, which is particularly well suited for this type of effort. In brief, service learning consists of three core components: a preparatory stage, an experiential stage, and a reflective stage.

It is naïve to assume that all of your learning objectives will be achieved from experiences garnered in a community-service agency setting. This assumption also does not take into account students' different starting points, the different experiences they are likely to have, and their different approaches to processing those experiences, based on their personal histories, cultural and family influences, and other factors. This is why it is crucial to take the time to prepare your students for what they will encounter and equip them with a framework (and the time) to process and reflect on their experiences.

How do you ensure successful mentor training?

Educate mentors.

Establish clear expectations.

Provide and solicit feedback.

Obviously, it is critical that the people teaching and facilitating the learning of the students be well prepared. Once again, the notion of relinquishing teaching responsibilities to community partners who may lack academic credentials can be a source of angst to course directors. We have found that what may be perceived as a deficiency in the formal pedagogic training of community mentors, however, is more than made up for in their life experiences and real-world perspectives.

That being said, we have also

found it is critically important for community mentors to be brought up to speed in terms of the nuances of service learning and what is expected of them in the teaching and facilitated learning of students. It is equally essential for medical educators to provide community mentors with a list of explicit expectations, and such information must be conveyed in a timely manner, as should ongoing feedback about performance and progress. Likewise, the sharing of student feedback with the community mentors can be both validating and informative. Feedback from students legitimizes their role in the shaping of the program and is important to the development and quality control of the curriculum.

It is also important to give the students the opportunity and the latitude to frame their experiences within their own set of values and judgments. They need a venue for reflection, one separate from their community placement sites. Having a "safe haven" where one can speak openly, honestly, and sometimes critically of a community experience is important to the process of evaluating the program. The presence or participation of one's community mentor, who may be vested in a specific outcome or interpretation, can stifle this process. We have found it to be most effective to hold the reflective sessions at a neutral site, facilitated by a faculty member.

How do you design students' final projects?

Decide what you want to accomplish and for whom.

Evaluate the advantages and disadvantages of group and individual efforts.

Determine whether the project is relevant to the community.

Determine if community partners will be satisfied with the outcome.

A significant component of our initiative—and one that has proven extremely popular with students and community partners—is the linking of a final project to the curriculum and course work. This hands-on, outcome-defined activity is critical to engaging students as adult learners and also provides them with a sense of accomplishment and contribution in settings and situations in which they often feel overwhelmed.

Community partners appreciate this feature for two reasons. First, the final project motivates a student to take initiative and work independently when staff are consumed with day-to-day operations and cannot directly supervise. Second, student projects can be crafted in such a way so that, when completed, they actually benefit the community agency hosting the student and participating in the program. Although this approach is somewhat trickier to arrange, it holds great promise as a means to keep stakeholders vested in the process and engaged as participants.

Some of the pitfalls and problems we have encountered while creating our programs can be sorted into two broad categories:

1. Students (or faculty) try to tell the community what it needs rather than listening and responding to what they are told. This harkens back to the innate tendency within academia to "do to" rather than "do with" and speaks to the importance of clear and ongoing communication that covers all facets of the curriculum.

2. The scope of the project requires more time than the students can devote to it or more skills than the student brings to the table—or the projects are not ambitious enough, leaving the students looking for things to do during their rotation. The scope and complexity of the project can also be so great that the student is never able to get a "big picture" perspective on what they are doing and why. In these cases, students never achieve the sense of accomplishment that comes with meeting a goal. Some community-based research projects fall into this category—the student may be involved in data collection or data entry but never sees where the data goes or understands what the data ultimately describes. The medical students we have had in this curriculum are bright, energetic critical thinkers who need to be challenged. A clerical role, or even an administrative role, often does not effectively challenge them, nor does it stimulate their thinking or foster engagement—frustrating both student and mentor alike.

Within the Soros Service Program for Community Health, students have worked on both group and individual projects in three broad categories: advocacy-based research, health education, and primary-based research. There are pros and cons to individual and group projects. Deciding which approach to take depends on what the partnership identifies as important, the amount of time the students have to work on it, the type of oversight and technical expertise needed, and how

much can be accomplished and when. The Bridging the Gaps website, (http://www.cce.upenn.edu/btg/btg.html)which describes a long-standing and well-developed community service initiative in Pittsburgh and Philadelphia, is another excellent resource for examples of what can be done.

How do you evaluate your program?

Think about how you will evaluate before you start.

Remember (and remind yourself and your partners) of your objectives.

Share your findings along the way.

Target and match your findings to those of your stakeholders and other audiences.

Share credit along the way.

Celebrate your successes and learn from your failures.

One of the often-overlooked elements of a program is the need to remember that it is a collective process from beginning to end. Everyone involved needs to be recognized and rewarded for their contributions and also held accountable for its deficiencies. You can address this need in an end-of-project event or a ceremony that brings everyone together. The logistics of pulling this off are often outweighed by the benefits of allowing everyone to put aside their day-to-day struggles and celebrate the cause and the process. In Baltimore, we hosted an annual press conference at which students presented a "healthcare access report card." The community agencies had the chance to speak with one voice (an alarmingly rare occurrence) on an issue that affected all of them. It also allowed us to publicly recognize the positive things that were happening and the good work being done.

Sharing a deliberative and thoughtful evaluation is another way to keep the process transparent and keep everyone involved. A formal evaluation also provides a context for talking about what works and what doesn't. When presented in a constructive, objective, nonaccusatory way—with input from all parties—an evaluation can build teams and strengthen partnerships. All too often evaluations are top-down, resulting in defensive posturing and "silo building," which are hardly conducive to effective collaboration and improved motivation.

Finally, it is important to share the credit when presenting your program's accomplishments to the general public through professional journals, media releases, and other events. You can make a big difference by simply acknowledging community partners and students who have made significant contributions to the program. This small gesture is often the defining moment that fosters ownership and a commitment to sustaining and building the community-based curriculum. It is also important to remember that the credibility of the message is often driven by the student or community voice that delivers it. Keeping the program a partnership from beginning to end is key.

How can you serve as role model?

Have fun.

Finally, and perhaps most important, it is essential that you have fun and try to ensure that all the other people involved enjoy themselves, too. This program presents an opportunity to do the right thing and have a good time doing it. Students will pick up any feelings of cynicism, burnout, or drudgery. If one of your goals is to engage these medical students in a lifelong commitment to serving the most vulnerable individuals and communities in society, you have to make sure that they see and feel the value and benefits of the pursuit. In our surveys, students repeatedly expressed concern about how practicing professionals, which they soon will be, can sustain the necessary energy and commitment to do this work. This concern is why role modeling is so important and why keeping the process fun, exciting, and rejuvenating is critical. Enjoying the process also makes our own jobs a lot easier and more satisfying.

For additional information or for guidance in adapting this tool kit to specific needs and circumstances, please contact the authors (see page 23).

Outcomes: *Viewpoints from SSPCH Alumni*

In late summer of 2004, the alumni of the Soros Service Program for Community Health (SSPCH), an initiative of the Open Society Institute's program Medicine as a Profession, were asked to voluntarily complete an 11-question survey about professionalism and their current advocacy activities. The responses listed here are from a cross section of SSPCH alumni who are completing medical school and residency programs across the country. Although anecdotal, these responses highlight certain themes, including the lack of time allotted to medical school students and residents to explore issues that are in the public's interest. In their responses, students and residents also revealed that they appreciated the mentoring they received from colleagues both within and outside the medical profession.

Q. How do you currently define professionalism, advocacy, and service?

"Interacting with your patients and colleagues with respect, honesty, and empathy. Doing everything you can within reason and without ignoring other parts of your life outside of your career to be the best provider for your patients. Doing no harm and

providing, at the very minimum, standard care."

"Working for the greater good of my patients and community."

"Professionalism is acting in accord with the standards put forth by your profession. A profession is a 'stand-alone' group of people that defines its own membership and values. So, specifically, one must uphold those values/moral obligations of the profession. One must also maintain the competency required to be an effective member (through continuing medical education). One must be a watchdog for other members of the profession, making sure they remain competent and uphold the values of the profession.

Advocacy is lending your voice or time or any resources you have to help another or a group and usually is not self-serving. Usually you are giving someone or some other group power/presence/a voice. (As opposed to just giving money, you are giving something more substantive.)

Service is giving of yourself to help/aid others. It usually connotes some type of selflessness. Giving of yourself for a salary is a service, as in the service industry, but the word "service" to me usually means giving above and beyond what benefits you—military service (risking your life) or community service (for no money)."

"A commitment to improving health—on an individual, community, and national level."

"Acting in the best interest of your patient defines all three."

"Professionalism is respect for our profession, colleagues, and patients. Acting with maturity and dignity. Allowing our actions to reinforce our words. Advocacy is dedication to empowering others to better help themselves. Service is helping those who need help, giving back to society."

"My definition of professionalism includes a larger concern about the medical system and infrastructure and a significant devotion to teaching."

"Professionalism is developing empathy for our patients and their social situations and caring for them with this in mind; working for our patients' trust, in us both as individuals and as physicians; behaving in ways to earn respect from our colleagues, especially within an interdisciplinary team of providers; teaching others in the profession to strive for this trust and respect as well.

Advocacy is recognizing the needs of our individual patients and communities and working to create policies and systems of care that support and serve them better.

Service is giving of self beyond what is required to care for a patient and his/her family and the community."

"Professionalism means maintaining a sense of responsibility toward your job and profession and working to meet your responsibilities and duties in such a way that you are respectful to those around you.

Advocacy means speaking on behalf of a person/persons whose voice may not be heard for whatever reason to ensure their needs (whatever they may be) are met.

Service is a type of duty or activity that one does in order to meet the needs or expectations of someone else."

Q. What, if any, professional and/or advocacy interests have you developed during medical school and residency?

"I guess the major one has to do with pharmaceutical gifts. During our second year, we were given a textbook for one of our classes courtesy of two pharmaceutical companies. I wrote an email to the class asking them not to take the book and giving reasons why. I then organized a talk afterward with a panel of speakers about pharmaceutical gift giving.

Because of that talk, a couple of students and myself decided to try to draft a policy for the medical school regarding its relationship with the pharmaceutical industry. After talking to the dean, we surveyed a great portion of the student body about what their opinions were on pharmaceutical companies' gifts to students.

There has also been talk of trying to do more research, put a paper together, etc., but right now we just have the policy submitted and are waiting on that."

"Cover the Uninsured Week, public health research, educating seventh-graders about HIV/AIDS, and international health experiences in Nicaragua and Ecuador."

"I have been asked to be a trustee-elect nominee for the residents in training division of the American Psychiatric Association."

"In medical school, I co-chaired and taught in a program that matched med students with local classes to teach health. Designed, co-chaired, and piloted a curriculum on cancer prevention at a rural high school in Vermont. Spent a month in South Dakota teaching health to middle/high school kids living on a reservation and learning about their culture, their beliefs, and their struggles. Volunteered as a judge in the Rhode Island State science fair. Provided physical exams to middle school kids."

"I have found that in many instances patients who are mentally challenged don't receive adequate care or they face challenges because of communication barriers, and this has created in me an interest to be a better advocate for those types of patients."

"My commitment to the problem of the uninsured population of New York. Helped organize a conference for medical students entitled "Free Clinics for the Uninsured: A How-to Guide for Medical Students." Member of the NYC Free Clinic steering committee, organizing the pharmaceutical aspects necessary to run the clinic."

"Issues of healthcare access."

"While in medical school, I developed an interest in practical research that gives advocacy groups access to traditionally academic research methods. I worked on a project with the American Civil Liberties Union (ACLU) of Pennsylvania's Reproductive Freedom Project as part of my master's of public health (MPH) thesis, in which we surveyed provision of emergency contraception at community pharmacies. The results from this study were immediately presented to professional societies of pharmacists to improve quality of care and were used in recent Food and Drug Administration (FDA) hearings to make emergency contraceptive methods available over the counter. The study was also published in a more

traditional venue, the journal Contraception.

In residency, I have developed interests in understanding how our systems of healthcare may adversely affect patient care and outcomes. At JH-Bayview, I am participating in the Achieving Competence Today (ACT) program to learn to create quality improvement programs (mostly focusing on barriers to access to care) and to integrate curriculum changes, which will teach other residents about systems and quality improvement.

Also, in residency I have continued to have an interest in exploring ways to incorporate women's health into primary care internal medicine. I am working with faculty to identify areas within our own curriculum that need to be improved."

"During medical school I learned to always be professional in my attitude and appearance at all times, no matter who I am interacting with. I have not yet found a passion to serve as an advocate for."

Q. How is professionalism defined in your medical school curriculum or within your residency program? And, is that definition congruent with your current views of professionalism?

"It is not clearly defined. The student handbook has guidelines that no one looks at. It is, rather than defined, implied via what examples your teachers and mentors set and via course offerings. One set of classes we have, "Patient-Doctor," explores many parts of professionalism, although not explicitly. The rest of the curriculum focuses on knowledge, which is a part of being a professional (competency). Then there is a socially defined aspect to professionalism, which is taught by example (what to wear, how to act on the wards, etc.).

But in my opinion, our school does a poor job of addressing professionalism. I feel that a lot of my classmates feel entitled. There is too much focus on knowledge, grades. I think the faculty should emphasize that going to medical school doesn't just mean you got the grades and now you are accepted, but that you have agreed to try to work to uphold the ideals of the profession (patients first, community first, giving of yourself). My friend is currently putting together a course on professionalism. It will be interesting to see how far it gets."

"Professionalism has been directly addressed by students to a greater degree than faculty; however, we have had some discussions of the topic within the first- and second-year curricula."

"Commitment to professional responsibilities, primarily to patient's needs. Adherence to ethical principles, sensitivity to patient diversity, commitment to excellence."

"Our program has developed a lecture series focused on professionalism during noon conferences. We also have a month during internship devoted to the doctor-patient relationship (Med-Psych), which emphasizes professionalism."

"Personally, I had a difficult time coming to an understanding of the idea of professionalism. It is a difficult topic, and if the medical college does have a clear definition, I was unable to understand it."

"It's not directly defined, but we have been taught to act in the best interests of our patients, and that is congruent with my definition."

"Don't know where it is explicitly defined at my residency, however we discussed it during orientation. Emphasized the fact that as doctors we provide a service, that we should remember to conduct ourselves in a way of which our fellow residents and staff would be proud."

"In medical school, we have an honor code that emphasizes honesty, integrity, and respect for all students, residents, and attendings. This code, in my opinion, defines all the crucial behaviors that are necessary for one to maintain professionalism."

Q. Is advocacy or are notions of social justice explored within your medical school curriculum or within your residency program?

"[My school] offers master scholars groups offering extracurricular seminars on the issues of public advocacy and public health."

"Yes, there is a whole social medicine department and kind of paracurriculum. So there is a subset of students who take these courses and are interested in this."

"Opportunities to explore this field are available."

"Yes, we have an ethics class in my residency program."

"We have several lectures on community-oriented primary care, which teach advocacy, but I think it would be great for our residents to take more tangible actions as a group. We have some efforts underway."

"Superficially. The best part about Cornell was that such options were available to those students who wished to pursue issues pertaining to social justice."

"We have a REACH program, in which a half day a week in second and third years is spent exploring a special interest. Many people do advocacy projects."

"Not really but sometimes on rounds we do discuss advocacy in terms of some of our patients."

"In medical school, we have several student interest groups about a wide variety of topics, many of which perform free services for citizens in the surrounding community. All types of people, races, religions, cultures, and lifestyles are targeted by the various student groups. No one is discriminated against."

Q. If you developed any professional and advocacy interests while in medical school or residency, how did/do you manage your responsibilities as a student/resident and still manage to pursue your interest in advocacy?

"Difficulty. The hardest part was not the time commitment, but that I had to continually motivate myself, as things would move slowly and I would have so much else going on. I constantly felt like I was starting at the beginning, and that momentum was against me."

"Make time! It's an energizing activity for me, so I don't mind committing some of my free time to it. I've also done international rotations as a part of clinical rotations and over spring break."

"It's tough to juggle everything!"

"The two are intertwined. By becoming involved in the school's free clinic, I bettered my understanding of clinical medicine, while shaping my own future interests as a physician. There is never enough time to do everything, but somehow, things just work out."

"I do not feel as though I managed it well. Medical school was a difficult period of balancing large responsibilities, and often I felt my interest in social justice had to be set aside (mainly in my third year)."

"I set aside time for things that were important. It was much easier in the first two years of medical school when my schedule was more predictable. The last two years it was easier to participate in one-day events."

"I would communicate with physicians and nurses who were more familiar with the system as to how I can act on my patient's behalf."

"During medical school, I devoted an extra year to completing a master's of public health degree, which allowed time for me to explore many of my interests and complete a research project.

During residency, the Achieving Competence Today (ACT) program is a funded program with a faculty preceptor. I will have a one-month elective devoted to course work and then will fit in the other time I will need during my lighter outpatient months."

"Working on my interests in women's health, especially curriculum redesign, has been a very slow process, probably because I do not have any protected time for this project, although I have been my own experiment by trying out some of the opportunities."

"I have not yet found a cause to advocate for. I am interested in student interest groups that provide wellness checkups for underserved areas—people without insurance or access to good healthcare."

Q. If you have engaged in advocacy work during medical school or residency, what brought you into advocacy work or how did you become interested in the topic you chose to pursue?

"I developed an interest in emergency contraception through my work in medical school with Medical Students for Choice. I found it very inspiring to work with this advocacy organization, to lead the group at my medical school, and through this group I created a medical student elective on reproductive health. This led to my work with the American Civil Liberties Union (ACLU) of Pennsylvania on several of their advocacy programs and projects. Also, in medical school, I worked in a clinic for uninsured, mostly immigrant populations, which

helped to shape my interest in primary care and public health."

"Participation in the Soros Service Program for Community Health's Pre-Clinical Fellowship Program provided me a platform to get involved, and I used those contacts to continue on."

"Extracurricular fairs at the beginning of medical school, encouragement from other classmates. Makes me feel good about myself. Have always loved working with kids and enjoyed teaching. Putting the two together was perfect!"

"I first learned about the term "advocacy" through Medicine as a Profession (MAP) and have only heard it used occasionally in medical school. But, during my rotations, I actually meet some physicians who genuinely care about their patients and have become advocates."

"All through college I've been interested in the health needs of the indigent population. Choosing to go to school at NYU, where one of the major teaching hospitals is Bellevue, was largely due to my interests in community health. Patient advocacy comes hand in hand with working in a community hospital, so the NYC Free Clinic was just an extension of that."

"Via my time at the Soros Service Program for Community Health, a talk we had by Bob Goodman on the pharmaceutical industry."

"Health insurance (and lack of health insurance) has a tremendous effect on the care available to my patients and the financial impact that illness has on their lives."

"I want to be a leader in my field."

Q. What challenges did you or do you currently face with your advocacy efforts?

"During my internship, it was difficult to keep up with many of my interests, especially advocacy issues. I am hoping to continue to develop them as I figure out the next steps in my career. Because I am so busy and at times overwhelmed, it has been difficult to consistently work on projects, stay involved, and maintain awareness about the important issues."

"Not enough time. I am in early in the morning and I am often out after dinnertime. Lack of consistency of schedule. Inpatient months with longer hours than outpatient months. That initial step to get involved is always the hardest."

"I am going abroad for a year, so it will be difficult to do anything. During the past year, I have been dealing with the administration, which is totally confusing, and the fact that I am working with two other students, and between our commitment on the wards, we never seem to have time to meet, and things move really, really slow."

"I may be interested in a career in pediatric cardiology, which is less public-health oriented than some other fields. I will work to balance this interest with broader interests in public health and advocacy."

"Finding the time."

"Insurance companies are a great hindrance."

"The most significant challenge for me is to find the appropriate opportunities that can be incorporated into my busy schedule."

Q. Have you found an individual or multiple people—either within or outside the medical profession—who have provided valuable insights and/or served as mentors to you? If so, please provide a brief description of the support you have received.

"Yes, mostly one doctor in the school. Also a couple of students. They are just people to go to for advice on how we can best achieve our goals. They support our work, send emails for us, give us contact information."

"I have found a research mentor in public health who is guiding me in a project."

"Not really—yet!"

"The attendings I have met through the clinic are all inspiring. They give insight into how to balance advocacy work in your clinical careers, while providing examples through their own work. The leader of my seminar "Physician as Advocate," a master scholars program, was full of suggestions as to where to go and how to do more. In general, it seems that the initiative to become involved is largely self-motivated, but once you decide you want to get involved, there are many physicians who are there for support."

"Many of the faculty at my residency program are involved in research or advocacy projects and are always encouraging us to either help with theirs or develop our own."

"Constant reassurance and examples of the different paths physicians have taken. It has been important to have mentors support my decisions and help me understand the opportunities open to me in the future."

"I have a strong mentor in Carol Petraitis, the director of the American Civil Liberties Union (ACLU) of Pennsylvania's Reproductive Freedom Project. She has been a tireless supporter of me personally and professionally. I worked closely with her and the organization during medical school and have continued to stay involved with some of the projects. I am also developing mentors and advisors at my residency program, especially around career planning."

Q. Although courses and individuals can expose students to the concept of advocacy, what has it been like to implement such ideas, and what types of advocacy skills have you developed through your work. What is the most important lesson you've learned while serving as an advocate?

"It is easy to be exposed through individuals and course work, but implementation can be impossible. With school being so busy, things have just moved so slow and many things have fallen apart."

"Skills I have developed? Hmm, not nearly enough. Well, how to put on a big presentation/talk. How to write a policy. The power of doing a survey. Acting out on a plan immediately (not waiting). Trying to find unique ways of communicating/meeting since it is hard to meet on such busy schedules.

"Most important lesson I have learned. You need a group of people who share your passion, interests—or at least it helps a lot—since you constantly need to be motivated."

"Be persistent. Network. Find people who share your interests and will pursue them with you. The best teams include alliances with people who are not MDs, too—social workers, public health educators, etc."

"Listen to the people you are advocating for. Really listen. This is harder than it sounds."

"I've learned it is tough being an advocate and that there are obstacles. It has been both a challenge and a learning experience implementing advocacy efforts, and I've learned that in some situations you just cannot give up and efforts do pay off."

"Acceptance, understanding, and patience. When I teach I learn a new way of thinking—so that I can not only understand it myself, but also explain it to someone else. Every time I find myself involved in advocacy, I realize more about the people around me as well as becoming aware of how I interact with those people. I've become a better listener through advocacy work, more aware of the world around me, and more understanding of different groups of people."

"There are few instances when there is a clear and appropriate issue for advocacy, and I am learning that I must keep reevaluating my positions."

"I have been an advocate in several different ways. In the Elder House Call, as part of the primary care tract at JH-Bayview, I have been working to help my homebound patients and their families navigate the confusing medical system and find appropriate services for them. I have also been an advocate for women's reproductive health and access to contraception through my research at the American Civil Liberties Union (ACLU) of Pennsylvania. The most important lesson learned? People are very resourceful, and it is important to empower but not to take control and do something for someone."

Q. How, if at all, have your interests and efforts been reinforced or nurtured through more structured/curricular activities, including clerkships, clinical encounters, and courses within medical school and residency?

"One of the reasons I chose to go into pediatrics is because there is a stronger focus on family, community, and social determinants of health."

"My residency directors are encouraging me to pursue a career in community mental health and advocacy."

"Not at all. There is an ethics class that would have helped, but I did not take it."

"The best rotation I have had is the rural med program (RMED) that I am currently involved with, and it includes a lot of patient advocacy, and this program reinforces my interests."

"I worked on a reservation in South Dakota and realized the needs of this population."

"I am not sure my medical school experiences have nurtured my interest in social justice."

"The SSPCH clerkship was a great opportunity for me to work in a non-profit safety-net clinic and to begin to understand the responsiveness a clinic shows to its community. I chose my residency program because it had a general internal medicine track and was committed to teaching advocacy and professionalism. I have been having a great experience."

The following is a small sampling of publications by SSPCH alumni, documenting the service, advocacy, and research work conducted during their medical school and residency programs:

Bennett, W., Petraitis, C., D'Anella, A., and Marcella, S. Pharmacists' knowledge and the difficulty of obtaining emergency contraception. *Contraception* 68, no. 4 (October): 261–67.

Mcullough, Marie. Study: Pharmacists not informed on morning-after pill. *Philadelphia Inquirer*, October 21, 2003.

"Medical Student visits Tiospa Zina." Tribal paper, *Sota Iya Ye Yapi*, 34, no. 40 (October 15): 4.

INFORMATION on the Soros Service Program for Community Health (SSPCH) is available on our website, www.soros.org/initiatives/map. The website includes information on professionalism within medicine and the SSPCH tool kit on developing community-based educational opportunities.

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