



The Rewards of Faculty Engagement

Judy Lewis
Associate Professor of Community Medicine
University of Connecticut

As the director of Community Based Education (CBE) at the University of Connecticut School of Medicine, I am involved in a wide variety of public service and outreach activities. In my twenty-six years at UCSM, my participation has ranged from spending 100 percent of my time directly developing and evaluating community health programs to spending 100 percent of my time working with students in community health educational activities. These projects have included development of school-based health clinics in Hartford (supported by a grant from the Robert Wood Johnson Foundation), and the areas of adolescent health, teen pregnancy prevention, primary health care for children and youth, and breast cancer prevention.

Today, my major professional responsibility is directing the CBE program for 336 medical students in all four years. The students work with more than 300 community programs in sixty-two Connecticut towns; their activities include providing health education, community service and program development, and learning about community resources. CBE also works with graduate students in public health and dentistry. The staff of community programs works with CBE in curriculum design, implementation, and evaluation. Communication is maintained through visits, telephone, newsletters, feedback forms, annual workshops and receptions, and community representation on the CBE planning committee.

CBE activities are part of the institutional fabric of the medical school. The formal program was established in 1984. It was based on earlier relationships I developed when serving as project director for the school-based clinics, working at an Area Health Education Center, and filling the position of co-director of the Primary Care Clerkship. From the start CBE, institutional support in terms of funding for the faculty, staff, and the programs has been in place; economic support expanded as the programs required. The only state medical school in Connecticut, UCSM endorses the public

service mission of the university. CBE is based in the Department of Community Medicine with direct support from the dean's office. While the university and the medical school have faced financial difficulties and staff reductions in the past few years, the commitment to support CBE has continued.

The institution provides malpractice insurance and donates materials and supplies for clinical treatment and health education. When the medical school curriculum was completely revised in 1995 after five years of planning, CBE was identified as an important element to be maintained and the school's commitment to teaching medical students about community health persisted. Many community-service projects involve faculty as well as students. Students contribute hundreds of hours to community service projects each year and volunteer clinical faculty must be present to supervise if clinical care is being provided. This work is rewarded by the institution. Public service is recognized as an element of professional contribution for academic promotion.

My own interest in public service and outreach is long standing and at the core of my professional development as a medical sociologist. While in graduate school, first in Illinois and then in Connecticut, I was involved in community mental-health programs. In the late 1960s, I was a caseworker whose primary responsibility was to keep mentally ill people in the community and out of mental hospitals. It was an era of de-institutionalization of people with mental illness, the short-stay "zone center," and community

intervention. I learned lessons from working with patients, and those lessons have stayed with me throughout my career, but the most important thing I learned was that I wanted to work to change the systems of care. I realized that real change could occur only by improving funding, services, and provider and community attitudes. I decided my "therapeutic" relationships would focus on social change, in particular how to develop organizational structures that support positive outcomes in health. Therefore, my

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early graduate research was on the structure of community mental-health centers and health-maintenance organizations. I used this experience in designing the organizational structure for collaboration between health-care delivery, medical services, and educational systems when I developed the school-based health clinics in Hartford. This attention to organizational structure (including financing) contributed to the expansion of a pilot program to other schools and a program that would exist for more than twenty years. Organizational structure was also a key element in the development of CBE. The challenge inherent in educating the doctors

of the future was to create and support collaboration between the medical school and the communities it serves.

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Learning about the elements — socio-demographic, cultural, and economic — which sustain this disparity led to my participation in many coalitions and programs that focused on improving the life situation and health of Hartford residents. These have included expanding school-based clinics to other urban areas of Connecticut, developing programs to provide training to school nurses so they could provide expanded services in the schools, working with community-health clinics, working with parents and adolescents to improve health and education outcomes, developing health-provider coalitions, and working with parents to advocate for better health-care access. My “clinical practice” area became the community. My personal and professional commitment to these activities enabled me to serve as a role model for my students in the area of community relationships and involvement. Because I have worked in the same institution and community for so long, I have been able to create and build on relationships with people and organizations. In addition, I have had the privilege of seeing my students finish their training and take their place as health professionals who are involved in their communities.

The benefits of faculty involvement in public service and outreach are many. First, faculty derive satisfaction from direct participation in social problem-solving and connection with community residents from many different backgrounds. A second benefit is the enrichment of teaching and research through insights and experiences afforded by these projects. I gained an interest in international health as a direct result of my engagement in local communities. The international work is a natural complement because it gives me the opportunity to examine how countries and communities with many fewer resources than Hartford creatively address problems and develop solutions. The main lesson is to understand the perspective of community residents and directly involve those affected in the problem-solving process. A third benefit is watching communities and individuals grow over time. I have seen the health of school children improve and the resulting increase in their ability to focus on learning. I have seen students develop skills in working with diverse communities and the resulting increase in their ability to provide high-quality care to patients. I have seen the joy of medical students who struggle to begin a project, and watch it grow and succeed. Faculty who work together in these projects are often able to cross traditional disciplinary boundaries and develop bonds which would not otherwise exist.

The institution also benefits from faculty involvement in public service. Visibility and goodwill in local communities are especially important for public educational institutions, which are supported by tax dollars. After the only city hospital in Hartford closed to make available beds for a new academic hospital, it was goodwill, engendered in part by creation of a clinic at the old city site, that eventually overcame residents' resentment. Hartford residents did not have a very high regard for UCSM's academic tower on a suburban hill at some distance from the city. It took many years of public service for the university to establish credibility and community connections.

Constituents benefit both directly and indirectly from faculty involvement in public service and outreach. When services are provided, in the form of consultation and development work, the

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community benefits directly. Residents are relieved of the responsibility to raise funds necessary to purchase these services. In most cases, the community can obtain these services only if they are donated; therefore, an important project may not materialize. However, I would argue that both the community and the university benefit more from the indirect exchange of collaboration, communication, and relationship building. These provide the basis for responding to issues of common concern in constructive and powerful ways. Trust and partnering do not happen without familiarity and respect. Public service and outreach are effective ways of developing trust and

collaboration. Familiarity, respect, and trust are inherently valuable and provide the keystone to all other interactions.

Faculty who are interested in becoming involved in public service and outreach should seek out faculty who are already engaged in these activities. These individuals exist in most institutions. Faculty who are committed to public service know the needs of local communities and are usually willing, if not eager to share strategies and information. They can serve as mentors for new faculty and introduce them to community programs and colleagues. Probably the most important advice for faculty who are just beginning in public service is to remember to listen and observe *before* offering to share their expertise. While academics may possess a formal knowledge base, we usually lack real-life experience in the communities in which we work. Knowledge and expertise are of no value if they are not shared in a manner that is valued. The process of working in collaboration is more important, especially at the

beginning, than creating a product based on the academic's professional knowledge. This is often difficult to remember. A corollary to this is that "giving" is not the same thing as "collaborating." Collaboration requires negotiation and compromise, which is rarely a component of a scholarly endeavor. The rewards from learning these skills far outweigh the disadvantages. ■

About the Author

Judy Lewis is Director of Community Based Education (CBE) and an associate professor in the Community Medicine Department at the University of Connecticut School of Medicine. Lewis is a medical sociologist. She has conducted research on medical education, school health, maternal and child health, and a variety of other topics in the United States, Sri Lanka, Haiti, and several other countries.

Lewis has played a leadership role in educational program development in community health and has directed several key parts of the medical school curriculum, including the Primary Care Clerkship, Introduction to Community Medicine, International Health, and the Selectives. She developed a four-year CBE program as part of a major curriculum revision.

Lewis received an award from HRSA in 1997 for her research on academic-community partnerships in medical education. Locally, she has served in leadership positions in many child and adolescent health programs and is president-elect of the Connecticut Public Health Association.

Nationally, she served as president of the International Medical Education Consortium, chairwoman of the Cross Cultural Education Special Interest Group of the American Association of Medical Colleges, and provided consultation and training to many groups. She is the author of several books and articles on medical education and community health.