Now Is Our Time to Act: Why Academic Medicine Must Embrace Community Collaboration as Its Fourth Mission
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Abstract
In his Leadership Plenary at the Association of American Medical Colleges (AAMC) annual meeting, “Learn Serve Lead 2020: The Virtual Experience,” president and CEO David Skorton emphasized that the traditional tripartite mission of academic medicine—medical education, clinical care, and research—is no longer enough to achieve health justice for all. Today, collaborating with diverse communities deserves equal weight among academic medicine’s missions. This means going beyond “delivering care” to establishing and expanding ongoing, two-way community dialogues that push the envelope of what is possible in service to what is needed. It means appreciating community assets and creating ongoing pathways for listening to and learning from the needs, lived experiences, perspectives, and wisdom of patients, families, and communities. It means working with community-based organizations in true partnership to identify and address needs, and jointly develop, test, and implement solutions. This requires bringing medical care and public/population health concepts together and addressing upstream fundamental causes of health inequities.

The authors call on academic medical institutions to do more to build a strong network of collaborators across public and population health, government, community groups, and the private sector. We in academic medicine must hold ourselves accountable for weaving community collaborations consistently throughout research, medical education, and clinical care. The authors recognize the AAMC can do better to support its member institutions in doing so and discuss new initiatives that signify a shift in emphasis through the association’s new strategic plan and AAMC Center for Health Justice. The authors believe every area of academic medicine could grow and better serve communities by listening and engaging more and bringing medical care, public health, and other sectors closer together.

Academic medicine’s mission of serving the nation’s health has traditionally had 3 parts: (1) medical education, (2) research, and (3) clinical care. Recent events have clearly demonstrated that these missions are no longer enough, standing on their own. Something must change—and in a significant way. In fact, in his Leadership Plenary speech at “Learn Serve Lead: The Virtual Experience,” the annual meeting of the Association of American Medical Colleges (AAMC) in November 2020, president and CEO David Skorton’s refrain was, “Now is our time to act.” This message came in the wake of the theme of his 2019 speech: “The status quo is unacceptable.”

The need for change is clear and unavoidable. Long-standing discrimination against marginalized communities has contributed to dramatic health inequities in this country. Asthma, diabetes, obesity, and hypertension, for example, are more likely to affect Black adults than White adults. Native Americans are more likely to die from communicable diseases like influenza, pneumonia, and chronic lower respiratory diseases than the general population. And the pernicious effects of poverty affect the current and future health and prospects of many.

We can no longer ignore these inequities. All of us are part of one big community—whether we treat each other equally or not—yet many of us are not thriving. The problem is so complex that a single intervention or solitary action by any one sector or individual will not address it. When we understand that the fundamental causes of rampant health inequities involve intricate and long-standing factors like poverty and systemic racism, we recognize that we, in academic medicine, cannot solve this problem on our own.

Instead, to inculcate effective change, academic medicine must integrate with communities, collaborating and co-creating in more in-depth, ongoing ways. We must do more than we historically have done to share expertise, resources, and responsibility for achieving shared goals with communities and across sectors through interactions built on trust, mutual respect, cultural humility, and mutual benefit. A fourth and crucial component must join academic medicine’s mission areas: community collaboration.

The University of Puerto Rico’s response to Hurricane María is one example of what can be accomplished through successful community collaboration. When Hurricane María hit, the school drew upon its existing, deeply embedded relationships and resources within the community to respond to the island’s most immediate needs. With clinical guidance from faculty and residents, students organized a supply command center staffed by interdisciplinary teams who learned from community members they already had relationships with what supplies were needed and where. Such
efforts ideally unite all sectors of the health ecosystem (e.g., housing, food suppliers, infrastructure, the private sector, medical care, public health) to solve problems in an integrated way. Like the University of Puerto Rico, many institutions have made some progress, but we must do more and achieve more.

It is time for academic medicine to elevate this work as a core component of our mission and to expand what we can achieve through efforts like this. We must do more because the lived experiences of our patients who have been marginalized and harmed in society and in our health care system are not emphasized adequately within the traditional tripartite mission of academic medicine. We saw this clearly as educational, income, and criminal justice inequities were forced into the national spotlight during 2020, with health inequities prominent among the headlines. Community collaborations are more vital than ever.

Why Community Collaborations Matter

Health happens outside the exam room

Evidence suggests that much of a person’s health is related to many factors other than genetics and medical care—factors sometimes called social determinants of health (or, increasingly, “vital conditions for health”). These factors, like safe transportation, clean air and water, education, and job opportunities, significantly influence health. For example, Native Americans are 19 times more likely than White people to lack indoor plumbing, making handwashing as a disease prevention strategy difficult.

Because only roughly 20% of a person’s health can be attributed to the health care we provide, improving health equity does not end with what we can achieve through the traditional missions of academic medicine, as important as they are. In fact, research shows that 50% of a person’s health is determined by a combination of socioeconomic factors and their physical environment. If we wish to achieve health equity, we must ensure that no community is disadvantaged from achieving its full health potential because of social position or circumstances. In the mid-1990s, Link and Phelan suggested that, if the goal of public health is to improve the health of populations, it will never be achieved by addressing 1 individual risk behavior at a time. Rather, we should focus on what puts communities at risk of risk.

Solutions happen outside the exam room, too

We will never be able to ask the right research question, make the right diagnosis, fully explain the pathophysiology of disease, or develop the best treatment plan if we do not have the full story in mind. For too long, the medical community has chosen health goals for our patients, their families, and our communities. We have set standards influenced by our biases, our definitions, and our training. By default, our solutions can be 1-sided, and their salutary effects, however well intentioned, will not last.

There is a better way. When Michigan State University (MSU) College of Human Medicine built its Flint, Michigan, campus in 2014, the school recruited community stakeholders to make up half the research faculty search committee, along with representatives from the university, area hospitals, and government. Establishing partnerships with the community from the start of the school’s presence in Flint soon proved crucial when MSU researchers found alarming increases of lead levels in children’s blood and asked the state government to find a safer water source for the city. MSU continued to build on these mutually beneficial relationships with a collaborative public health program to mitigate the long-lasting health consequences of the water crisis.

Because MSU partnered with those who knew the on-the-ground realities best, members of the community and MSU faculty and researchers were able to navigate the most difficult obstacles together. This kind of disaster preparedness is especially crucial when our nation is faced with significant public health challenges, such as a novel coronavirus. If we approach community collaborations with a posture of humility and seek to value and appreciate the lived experiences of our patients and their families, our colleagues, and our communities, we create space for meaningful partnerships to achieve health equity.

Where Do We Go From Here?

The examples of community collaborations provided in this commentary are a step in the right direction. However, making one small impact in one individual community does not achieve health justice for our broader society as a whole. Instead, we need an expansive movement catalyzed by widespread community collaborations and framed by the local expertise and wisdom of the people we serve; those who experience health injustice are those closest to the solutions to that injustice. Because the obstacles we face are complex, those solutions must be multifaceted. We must pull together a multisector team to develop a long-term, aligned, mutually beneficial agenda to achieve lasting impact through policy and practice changes at all levels—organizational, tribal, local, state, and federal. Finally, these collaborations must embrace the reality that change is constant, and so we must remain vigilant, constantly evaluating and revising our strategies to adjust to evolving circumstances. Medicine, and academic medicine specifically, has unique and necessary, though insufficient, tools and resources to contribute to this effort. To achieve health justice, leadership is partnership.

Bridging the Gaps Across Sectors

To be successful in this effort, academic medicine must partner more, and more deeply, with public health, government, grassroots community groups, and the private sector. The medical care and public health communities have not always worked together optimally, but the AAMC and collaborating associations are beginning dialogue aimed at changing that. An ongoing, in-depth partnership is needed to fix what is broken in the U.S. health system.

AAMC efforts

The AAMC is dedicating significant resources and effort toward the community collaboration component of the mission of academic medicine. As part of the AAMC’s new strategic plan, we are prioritizing and deepening our efforts to advance this mission, committing the AAMC to national leadership in health equity and health justice. One way we are demonstrating this is by creating the AAMC Center
for Health Justice to make progress on initiatives advancing the moral, financial, and societal imperative of health justice. The center will focus on community-engaged, multisector efforts to co-create solutions to health inequities and improve population and community health. In May of 2021, the center released the Principles of Trustworthiness (www.aamc.org/trustworthiness) to help organizations of all kinds demonstrate they are worthy of their community’s trust—the necessary foundation for effective collaborations and partnerships.10

What institutions can do

Leaders of academic medical institutions can hold themselves accountable for weaving community collaborations consistently throughout the mission areas of clinical care, research, and education and for standing up the fourth mission of community collaboration. In this section, we offer recommendations to those at all levels of their institutions for incorporating community collaboration into each of the mission areas.

Clinical care. If you work on the clinical side, take the time to really listen to community residents and patients describe their experiences with the medical center. Find out what patients and their families truly need and want and use that information to train all those involved in clinical care. Familiarize yourself with relevant and granular data to understand the communities you serve and the upstream factors affecting their health.

Education. The medical students and residents at your institution should align their community health outreach or service-learning projects with the institution’s community health needs assessment and should partner with community-based organizations that have a sustainable commitment to eliminating health inequities. You can also partner with local schools and colleges to encourage health careers for students who are underrepresented in medicine and from marginalized communities, which will ultimately increase diversity and inclusion in the health workforce.

Research. To increase the relevance and impact of research discoveries for your larger community, think about the following questions:

- What makes patients, their families, and communities from marginalized groups concerned about participating in clinical trials?
- How deeply are community members and patients involved in the development of your research—from the development of the research question to the implementation, analysis, and dissemination of the study?
- Are you sharing study results with the community and engaging in a back-and-forth dialogue about what the results mean for them?

Community collaborations. You can work with community residents and organizations to advocate for policies that improve health and health equity locally. You can also integrate community collaboration into leadership-level decisions, as MSU did in Flint by involving community members on the research faculty search committee. Examine hiring practices, procurement, and investments according to community priorities and partner with community organizations to address the social determinants of health (e.g., invest in transportation infrastructure).

For example, the University of Wisconsin School of Medicine and Public Health integrates public health into its mission. Its Wisconsin Alzheimer’s Institute has spent years building relationships, engaging the community, and focusing on developing trust as its priority. It has since reaped the benefits of these efforts, now having grown the number of African Americans participating in the Institute’s Alzheimer’s disease research from 2% to 10%.11 As another example, Henry Ford Health System partnered with several institutions to revitalize local neighborhoods by improving transportation, updating façades, and rehabilitating housing developments for Detroit residents.12 Programs like these prove the power of genuine partnership.

Consider how you can collaborate more with those outside the walls of your institution and beyond its traditional boundaries. How can your organization build a strong network of collaborators across sectors? How will you seek out diverse insights and translate them into concrete, measurable actions that make a difference?

Taking Action to Achieve Change

Embracing community collaborations as academic medicine’s fourth mission provides an opportunity to reimagine what optimal health can be—together. Doing so is the only way to comprehensively fix what is broken in the U.S. health system and make meaningful progress toward achieving health justice for all.

Now is our time to act.

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References


Teaching and Learning Moments

Patient Dehumanization in Medical Education:
Reflections on Mr. E

We decided to pursue a career in medicine to serve and advocate for our communities and those who often live at the margins of our society. While this mission continues to be at the forefront of our medical endeavors, we have realized that our education in its current form can unintentionally contribute to the dehumanization of patients—especially those of marginalized and oppressed identities. Without special consideration of the forms of historical and sociopolitical oppression these patients face, we may unwittingly perpetuate the harmful stereotypes and forms of racism our education seeks to eliminate. One example of this emerged when we treated Mr. E.

“He is a 54-year-old African American male, a ‘frequent flyer’ with a long history of noncompliance. His diabetes has been poorly managed for over a decade and he has had multiple hospital admissions just these past 4 months. He denies using drugs, but the ER doctor found heroin in his system just 2 weeks ago. Safe to say, he might be an untruthful historian so we will take his words with a grain of salt.... Honestly, just looking at his previous notes, I am worried I will not be able to handle this case. I am sorry if things get out of hand.”

After my preceptor described Mr. E’s condition, I nervously looked around with a cloud of uncertainty hanging over my head. Just 3 months into medical school, I felt utterly unprepared for this. A prototypical image of a rude and noncompliant patient immediately entered my mind and questions quickly followed: Would Mr. E be willing to let me interview him? Would he yell at me? Would he disrespect the attending? Would he even show up? Would he…?

Thirty minutes later, my attending and I were standing face to face with the Mr. E I had pictured in my imagination over and over again. I nervously reached out to shake his hand and was surprised to be greeted with a firm handshake and a big warm smile. Mr. E respectfully asked how we were doing and said that he was excited to be in the clinic. In fact, he was so excited that he woke up at 5 AM to get ready and made it to the clinic an hour early and more excited to be in the clinic. In fact, he was so excited that he woke up at 5 AM to get ready and made it to the clinic an hour before his appointment. Mr. E told us that he had recently been going through a tough time, but after his brother died prematurely, he had promised to focus on his own deteriorating health and turn his life around.

At the end of the appointment, my partner and I stood in the preceptor’s office in shock. The Mr. E described in the hospital reports and the image of Mr. E painted by our worrisome preceptor were nothing like the kind and thoughtful man that we had just met. The disconnect was startling.

When we saw patients like Mr. E while volunteering in clinics before we started medical school, we sympathized with them. We saw more than just “noncompliant” patients. We saw our friends, our family members. Our conversation with Mr. E reminded us of loved ones from marginalized communities back home. How do physicians view them? Are they just another group of noncompliant and untruthful patients that few doctors could sympathize with?

As I left the clinic that night, an inexplicable feeling of guilt came over me. Even with all of my life experiences, I was still quick to judge Mr. E based on a few medical notes written by doctors I had never met. As the institution of medicine in the United States continues its reckoning with racism’s impact on patient care, it is imperative we consider the small, yet insidious ways racism and bias are baked into how we present our communities are portrayed. Their health depends on it.

Author’s Note: The name and identifying information in this essay have been changed to protect the identity of the individual described.

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