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REFLECTIVE STATEMENT

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NOTE ABOUT REFLECTIVE or CAREER STATEMENT: This reflective or career statement was part of Dr. Landis's portfolio for her promotion and tenure to Full Professor at the UNC-Chapel Hill Department of Family Medicine.

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More than a century ago, in her novel *Middlemarch: A Study of Provincial Life*, George Eliot described the medical profession as “the finest in the world, presenting the most perfect interchange between science and art, offering the most direct alliance between intellectual conquest and the social good.” I believe her; you can satisfy your intellectual cravings and help improve the life of your community. My medical passion has always focused on enhancing the social good. It started with my National Health Service Corps work in Appalachia where I recognized a need for public health training that would enable me to better care for populations rather than only individuals or families. Thus my journey began with working for the Palm Beach County Health Department in Florida, to my Clinical Scholars years, my short stint as a researcher in the School of Public Health, and finally to my destined role at the Mountain Area Health Education Center in Asheville, NC.

Look at Buncombe County, NC, where I live and work. Together with representatives of the organizations that deliver health care and additional interested community people, I helped start Health Partners, a community-wide coalition dedicated to improving health and health care access in Buncombe County. Through the generous contributions of several foundations, Health Partners has been able to identify and quantify the scope of the medically underserved and design and implement solutions to the health care access problem. One program entitled Project Access, of which I am the volunteer medical director, provides medical services for free for patients who are uninsured and earn less than 200% of federal poverty level. Local physicians donate their medical services, seeing patients in their offices or at a local free clinic; hospitals donate laboratory, radiologic, and hospital-located services; the county commissioners provide financial support for a low-cost prescription program for patients; and the pharmacists waive their prescribing fees. Project Access is coordinated by the county medical society and has provided free services for more than 18,000 of the 20,000 eligible patients. Project Access has received numerous national awards and is now being replicated in more than 30 communities.

Maintaining a clinical practice, teaching students and residents, and working with communities can produce a somewhat schizophrenic existence. In order to help me better meld all of these potentially disparate aspects of my professional life, I searched for a philosophy or book to guide me. Mary Catherine Bateson's book *Composing a Life* highlights the lives of five women, each of whom achieved personal and professional success yet, who like me, did not traverse a traditional career path. I certainly relate to

these women because with my move to Asheville in 1987 I started on a path where few traditional academic physicians tread; I had a vision of integrating clinical work/teaching with collaboration with communities to improve the communities' health status. Bateson describes certain personal characteristics that allowed her women to develop well-balanced and rewarding lives; I subscribe to these.

"... the central survival skill is surely the capacity to pay attention and respond to changing circumstances, to learn and adapt, to fit into new environments beyond the safety of the temple precincts." My academic and clinical training took place in Chapel Hill, but once I moved to Asheville, I was challenged to adapt my clinical, teaching, and standard epidemiological skills to the benefit of my community and the region of western North Carolina. I revised my traditional public health skills to fit the needs of the mountain communities, to listen to their concerns and to help them in their quest for better health. Rather than develop a program to improve cardiovascular risk factors, since coronary artery disease is the major cause of death here, I helped one community who was concerned that new parents were unprepared for raising children to design an in-home parental support program using volunteer community helpers. In another county concerned about the high cost of medical care for low income people, I worked with the medical society and the physicians to design Project Access that provides comprehensive medical services for free for low income uninsured patients. In another clinical setting concerned about how to improve the quality of health care, I helped to develop a program to better screen and treat depressed patients. In each of these situations, I listened to the needs of the people and used my research skills with the resources of the groups to design successful programs.

Bateson discusses the concept of conservation; i.e., holding onto skills and relationships that may be repackaged at a later date. Some people view me as a better doctor because of my role as a Girl Scout leader. And vice versa. My skill in dealing with adolescent sexuality issues helped me better guide my adolescent Girl Scout troop. The same partners who helped to build a successful Project Access are the same people with whom I now work to redesign mental health services in the primary care sector. Because of our previous relationships, the primary care-based depression program was developed in record time.

I aim for synergy, where my many activities actually enhance other portions of my professional and personal lives. Several years ago I wrote and received funding for a residency training grant where I spent one half-day per week helping the residents teach health promotion to children. For five years I was able to provide valuable teaching experiences for residents, obtain financial help for our residency program, develop important professional relationships with the school system and the community, publish for my CV, all while spending time with my children in their classrooms.

As a teacher I aim to encourage students to become leaders. I support the president of the Carnegie Foundation, Ernest Boyer's, paradigm of leadership: "one that not only

promotes the scholarship of discovering knowledge, but also celebrates the scholarship of integrating knowledge, of communicating knowledge, and of applying knowledge through professional service.” This statement rings true to me, for as physicians we are viewed as leaders in our communities. And as leaders we assume a responsibility—a responsibility to use our talents and skills to improve the health of our communities.

All of these programs described above positively impact on my ability to work with students and especially with residents in different learning environments, such as the outpatient continuity care setting, the inpatient services, as an advisor over several years, and in a community setting like an elementary school or in a health coalition. Our residents witness first hand the ability of physicians to improve the health of their community. This is an important lesson in leadership, one that is otherwise hard to teach, but is crucial to their own personal success in their future medical practice, and also to the survival and good name of our medical profession.

In the individual teaching situation I try to select a teaching method that fits both the needs of that learner at that time and the particular situation at hand. In general I support learning that is active; problem-based; goal directed; and multi-dimensional (i.e., acquiring facts, problem solving skills, motor skills, and attitudes). Over my now seventeen years as a teacher I have seen myself move from the exclusive use of prescriptive teaching and mini-lectures to more diverse methods including the use of questions to encourage critical thinking; discussion to review information, issues, and/or implications of information; role modeling; coaching; and active listening.

I have the most difficult time with allowing residents to totally manage patients who are admitted to our Family Practice Teaching Service. I have been cited as being more of a “presence” than other attendings. I love caring for patients in the inpatient setting, and in my excitement to provide the best care, I sometimes have trouble allowing residents to be the one “more in charge.” This has been a recurring theme in my evaluations from the residents. I hope, and am often told, that my passion for teaching overrides this flaw and that the residents “forgive” me for becoming more involved in patient care issues. Nevertheless, I will continue to strive to blend the right amount of direct oversight and latitude to residents.

Over the past fifteen years at MAHEC, I have used my skills as physician, teacher, and a clinical researcher to enhance our mission of improving the quality, geographic distribution, and retention of health care professionals in western North Carolina. With funding from the Kellogg Foundation, the Academy of Family Practice, and residency training grants through HRSA, our residency program has developed curricula in the areas of preventive medicine, community-oriented primary care, school health, AIDS education, sexual history taking, and now continuous quality improvement and quality indicators. In 1996 I developed, funded, and directed a Rural Health Fellowship for primary care physicians who desired additional training in community health planning, office-based procedures, and teaching learners. This program has supported seven

fellows, all of whom are practicing in rural areas.

From my many years of working with communities, I recognized the great need for MAHEC to develop training and consultation services in community health planning. From some initial grants in the early 90's, I started the CHRS (Community Health Resource Services) Department which now provides training and consultation services in community health assessments; health coalition building; grant writing; and planning, developing, and evaluating community-based health programs. CHRS is now self-sustaining and is the recognized regional leader in evaluating health programs and supporting health coalitions. I work closely with many of the CHRS projects providing the clinician/epidemiologic perspective, especially with projects dealing with chronic illnesses such as depression and asthma.

I have found a home at MAHEC; they support my belief that medicine offers the most "direct alliance between intellectual conquest and the social good." I have been able to visualize my passion to enhance the "social good" and have found colleagues who support, encourage, and work with my vision of a healthier community. Each partner in this journey brings a skill that when blended together becomes more than merely a sum of the parts. I have no doubt that we can continue to achieve great strides towards being known as the healthiest region in North Carolina.