

PERSONAL STATEMENT

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My career in community pediatrics has been guided by two principles: (1) improving access to quality health care services for underserved populations and, (2) teaching health professions students to deliver culturally competent and compassionate care. I have not followed a typical academic path. Each work experience in academia, government and communities has broadened my knowledge base as well as my sphere of influence. Like building blocks, each experience has served as the foundation for the next phase.

After receiving a National Health Service Corps scholarship during medical school and completing a pediatric residency, I was assigned to work as a school physician in federally designated health manpower shortage areas in the District of Columbia. With a DC map in hand but without a fixed office, I delivered school-based care to mostly African American and Latino patients. Poor health outcomes, lack of health insurance, poverty and school failure were but a few of the challenges I faced as a school pediatrician who worked out of the trunk of a car. As I crisscrossed the city on a daily basis, I met an impressive array of community leaders, principals, teachers, parents and patients. Exposed to overwhelming social, educational, housing and health needs I reflected, questioned and learned. I marveled, for example, at some families' resilience as they survived and even thrived under austere socioeconomic circumstances. I was unarguably marked by these early career experiences and subsequently instilled the lessons learned into the academic setting.

My first foray into academia was as a community preceptor leading a sex education practicum for third year medical students from George Washington and Howard University in DC Public Schools. As the students ventured across both geographic and metaphoric bridges from Northwest to Southeast DC, from affluent to poor communities, they struggled with their unfamiliarity and unease speaking with children from other cultures or from different socioeconomic classes. I was struck by the obvious cultural divide and the ensuing communication challenges between mostly poor, minority elementary school students and soon-to-be physicians often from privileged backgrounds. I reasoned that this dissonance could adversely impact physician-patient interactions. Additionally, I concluded that medical students could and should be taught to provide health care services to *all* patients within the context of the patients' culture and community.

In the late 1980's and early 1990's, the medical cultural competence field was in its infancy. Not surprisingly, there were very few curricular resources or models available to medical educators. As somewhat of a pioneer in a nascent field, I began filling this void by developing and teaching cultural competence curricula to medical students, residents and faculty. Locally and nationally, the response from learners and academic educators was stunningly positive. Soon after a presentation at GWU, I was invited to join the medical school faculty. My role as an educator was merely transformed from a community platform to a new academic platform. But in this new role, I would serve as a portal for students to expand their educational experiences to

include underserved communities in the District of Columbia. While at GWU, I developed interdisciplinary, community-based clinical rotations for residents, medical, physician assistant, nurse practitioner and public health students. My community partners at Clinical del Pueblo, Mary's Center for Maternal and Child Health, Upper Cardozo Health Center and others opened their doors so GWU students could learn and serve. These students learned to work in interdisciplinary teams, identified community resources, improved their cross cultural communication skills, implemented health promotion interventions in Head Start centers, developed asthma health education materials for almost illiterate Latino immigrants, provided clinical care to needy patients, and engaged in many other service-learning activities.

The knowledge gained during my early career work in communities also prepared me to play a pivotal role at GWU when their health plan (now defunct), along with several DC managed care organizations, was awarded a Medicaid managed care contract. I was asked to assume a leadership role in preparing the academic health center to deliver health services to an at-risk Medicaid population and in developing a network of community providers. My interest in the business of medicine was peaked by this unexpected assignment and I decided to pursue additional graduate studies. As my oldest of three children was about to finish college, I earned a Master of Business Administration degree from Johns Hopkins University.

My current capstone position as Executive Director of the Goldberg Center for Community Pediatric Health at Children's National Medical Center builds upon my previous experiences as a community pediatrician, educator and leader and takes it to a new level. From an academic perspective, my trajectory has been atypical. Rather than following a mentored residency-fellowship-faculty sequence of carefully planned events, I have traversed and learned from the often conflicting worlds of community, academia, health services, policy and financing. Along the journey, I have taught students and published, lead and managed, developed, obtained funding and implemented educational and clinical programs. While weaving together my role as a clinician, teacher and leader in both academic and community settings, I have made a difference in the lives of students and communities.

Community scholarship has been defined as "learning that combines rigorous academic curriculum with meeting needs of communities, discovery that emphasizes community-oriented research, and engagement that moves beyond the concept of service to the formation of strategic campus-community partnerships to improve health".¹ My future goal is to demonstrate improvement in pediatric health disparities in the District of Columbia through the on-going application of community scholarship principles.

¹ Maurana C, Wolff M, Beck B et al; "Working with Our Communities: Moving from Service to Scholarship in the Health Professions, *Education for Health*, Vol 14, No.2, 2001

