How a Community-Based Organization and an Academic Health Center Are Creating an Effective Partnership for Training and Service

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Abstract

Community–academic partnerships in the training of doctors offer unique learning opportunities of great importance. Such partnerships can induce a paradigm shift such that physicians view community as a teaching resource and partner rather than as a passive recipient of services or solely as a placement site.

The authors describe a model of a community–academic partnership in New York City, begun in 1995, in which, for training and service, pediatric residents are integrally involved in a community-based program. Principles adapted from the Community-Campus Partnerships for Health's principles of partnership provide a framework for portraying the essential elements of developing and maintaining the partnership. The authors explain the clashes that may arise between partners and show how the principles of partnership guide partnership members in working and learning within a setting that by its nature entails conflict and inequality.

This report is based on the knowledge gained from the structured reflections of both members of this partnership: the residency program at a large academic health center and the community-based social service organization. Such partnerships provide the training ground for the development of physicians who understand the social and cultural determinants of health and constructively use community agencies' input in promoting child health and well-being. Within this framework, community-based organizations are not solely service providers but become educators of physicians-in-training who, with new knowledge gained through the partnership, more effectively contribute to the overall health of the communities they serve.

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The origin of pediatrics as a specialty began with practitioners training in community settings. However, over the years, education for practice shifted to the university and its teaching hospitals.[1] In the mid-20th century, community medicine was based on a concept of the community as a patient to be diagnosed and treated.[2] However, at that time, the idea of a partnership between a medical center and a community-based organization, by which both direct services and service-based learning could be mutually negotiated and ongoing, had yet to be developed, even though such a partnership would be beneficial for both the education of professionals and the health of target populations.

The partnership concept emerged later. Numerous programs were—and continue to be—created to enhance the training of physicians in community settings.[1,3–5] As stated in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, published by the National Center for Education in Maternal and Child Health, optimal health depends on a trusting relationship in which the health professional, the child, the family, and the community all become partners in health care practice.[6] The development of community–academic partnerships in the training of doctors offers unique learning opportunities of great importance. Such partnerships can induce a shift to a paradigm in which physicians view a community as a teaching resource and partner rather than as a passive recipient of services or solely as a placement site. They also provide the training ground for the development of physicians who understand the social and cultural determinants of health and appreciate the input that community agencies can have in promoting child health and well-being. However, the partnerships between academic institutions and community-based organizations can also give rise to tensions and conflicts that must be confronted.

In this article, we describe a model of a community–academic partnership in which, for training and service, pediatric residents are integrally involved in a community-based program. This partnership began in 1995. The partners are the pediatric residency program at a large academic health center—the Children's Hospital of New York Presbyterian at the Columbia University Medical Center (CHONY)—and Alianza Dominicana, a community-based social service organization, both located in Washington Heights in northern Manhattan, New York City. "We" are the director of the community pediatrics training program (DM), a Columbia faculty member with an expertise in curriculum development (AA-C), and the co-founder of Alianza Dominicana who is also the community liaison for the community pediatrics training program (MB). Our article's content represents both partners' perspectives. In developing this academic–community partnership, we have adapted the Community–Campus Partnerships for Health's principles of partnership[7] and will refer to them in describing the partnership and its successes and chal-

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lenges. We will describe four of these principles whose applicability has been substantiated in the CHONY–Alianza Dominicana experience. These principles, in fact, have proved essential in creating a productive community–academic partnership. They are implemented within a context characterized by three dimensions of power and inequality: (1) the institutional dimension, extending between a large research university and a grassroots organization, (2) the professional dimension, spanning physicians at one end and community activists and workers at the other, and (3) the ethnic and socioeconomic class dimension, ranging from mostly white upper-class physicians to minority working-class community members.

We will portray the clashes that arose between the partners and show how the principles of partnership guide the members of this partnership in working and learning within a setting that by its very nature entails conflict and inequality. Residents' experiences in a true partnership, in which tensions and disagreements are openly probed and examined rather than ignored, as occurs typically in a hierarchical relationship, will be described as a critical part of the successful training of residents. Their exposure to such a partnership provides a basis for the development of knowledge, skills, and attitudes necessary to become a competent community pediatrician.

This report is based on the experiences accumulated during the past nine years since inception of the program and the knowledge gained from the structured reflections of all members of this partnership. Such reflections have been elicited at monthly debriefing sessions with the residents and biannual focus groups with community partners.

The Community and the Partners

Washington Heights

At the time of the 2000 census, 208,328 people lived in the New York City community of Washington Heights. Of this total, 74% were Latino, of whom 72% described themselves as Dominican.[8]

Most of this community's Latino immigrants come from rural areas and are working class. The community is economically disadvantaged, with 77.3% of children born into poverty, according to 1999 data; the comparable New York City average was 53.2%.[9] Nevertheless, this is a vibrant community with multiple assets, including numerous community-based organizations (CBOs) addressing the diverse needs of the people in the community.

CHONY's pediatrics residency program

Community pediatrics has become a key part of the pediatric residency program at Children's Hospital of New York. CHONY, a 256-bed pediatric hospital founded as Babies Hospital in 1887, is part of the Columbia University Medical Center, a large, highly ranked academic medical center. It trains an average of 60 residents, two chief residents, and 76 fellows each year. In 1998, the residency program was restructured to give greater emphasis to primary care. As a result, residents now spend 25% of their time delivering primary care in one of five hospital-affiliated, faculty-run, community-based practices. These practices are where residents' continuity clinic experiences occur. The community pediatrics program is mandatory for all residents and is integrated into all three years of training. Most of the community pediatrics training experiences take place outside of the clinical setting—they occur within the community under the auspices of the community agency and do not involve traditional clinical work. These experiences will be described later in detail. The general pediatrics faculty are the core teachers for the residency training program; 30% of them lead the efforts of the community pediatrics training program.

Alianza Dominicana

Alianza Dominicana, Inc., founded in 1982, is the largest nonprofit community development and social service organization in northern Manhattan and the Bronx, with an annual budget of over $12 million and more than 350 full-time and part-time staff. Annually, Alianza serves more than 17,000 individuals throughout the City of New York. To address the community's multiple and complex needs, Alianza has developed dozens of innovative neighborhood-based initiatives. The organization currently provides services of more than 20 distinct types, including multidisciplinary cultural activities, neighborhood economic development projects, employment and training programs, family-focused and youth development projects, as well as health and mental health services. Alianza has become the leading national authority on Dominican immigrant communities and is considered a pioneer in many program areas. It has served as a catalyst to the development and creation of many programs and initiatives of both local and national scope.

The Partnership

The relationship between the Department of Pediatrics and Alianza Dominicana began in 1994, when these two groups joined together with the New York Society for the Prevention of Cruelty to Children to create a service called Best Beginnings. Best Beginnings is a voluntary, home-based service for high-risk expectant families and new parents that employs community workers to promote optimal child health and development, prevent child abuse and neglect, support positive parent–child bonding and relationships, and enhance parental self-sufficiency.[10] This program is based on the Healthy Families America model.[11] Best Beginnings provided the foundation for a partnership to be created between CHONY'S pediatric residency program and Alianza Dominicana in 1995. Initially, Best Beginnings was physically based in Alianza Dominicana's community home, but to improve the model, the program decided a "medical home"[12] was needed for all enrolled babies and families. A community-based practice affiliated with CHONY was located two blocks from Alianza's headquarters and the pediatric faculty practicing at this site committed to providing the much-needed "medical home." Fifteen percent of the hospital's pediatrics residents received their primary care training at this site and became the primary care providers for babies enrolled in the program. Currently all 60 CHONY residents participate in various programs offered at Alianza Dominicana, where a productive partnership for service, education, and training has developed.

The Training Experience

The overall goal of the community pediatrics training program is to prepare pediatric residents, upon completion of their education and training, to relate to, be advocates for, and remain committed to the community and the children for whom they care. The curriculum organizes residents' educational and training

experiences to enable them to achieve competency in three categories: community health, cultural competency, and advocacy. The overarching methodology used to achieve these goals is service–learning. In service–learning, community partners are integrally involved in the design, implementation, and evaluation of the curriculum so that the academic goals are aligned with the service needs. The model stresses an approach that builds from the communities' self-perceived assets rather than from outsider-perceived deficits. It emphasizes the value of reciprocal learning between residents, community partners, and multidisciplinary academic faculty. Structured reflection on these experiences and on specific objectives ensures that the experience meets programmatic and educational goals for the residents.

A critical prerequisite of service–learning is a mature community–academic partnership, one in which the partners can resolve major differences for the sake of the program. Through the partnership, residents not only provide service but also learn about the context in which the service is provided, the connection between the service and their curriculum, and their roles as citizens.[13] The critical elements of the partnership are the establishment of institutionalized mechanisms for interaction and dialogue between—in this case—the community pediatrics program and the community-based organization, significant community participation in program development and implementation, and provision of an arena for changing stereotypes and misperceptions. The pediatrics residents are taught the skill of reflective practice whereby structured reflection on their experiences in the community-based organization facilitates the connection between practice and theory and fosters critical thinking. In addition, this program addresses community-identified needs through the integral involvement of community partners.

Initially the partnership's focus was on health care delivery, providing primary care for all children enrolled in Best Beginnings. Integrating a focus on residents' education and service came as a second step. All residents now provide service at Alianza Dominicana. During their first-year ambulatory block rotation, residents receive an introductory session from a community pediatrics faculty member where the purpose of the program and the residents' roles as teachers and learners in a community agency are described. Residents then go to the Best Beginnings facility to learn about the program's services, meet the family support workers, and participate in a case conference. Together with the family support workers, residents choose a health care topic to be discussed at their scheduled visit during their last week of the rotation. Throughout this block, residents join support workers in home visits of newborns enrolled in the program. During their second year, residents return to the program to teach prenatal classes to expectant mothers. They also participate in monthly "narrative medicine" sessions with agency staff, which will be described later in detail.

Principles of Partnership

The four principles of partnership described below provide a framework for reflecting on our partnership. They portray the essential elements of developing and maintaining the community–academic partnership between the CHONY residency program and Alianza Dominicana. Each principle is based on critical concepts described below; see Table 1 for a summary of the principles and these concepts.

Principle 1: Build a relationship between partners characterized by mutual trust, respect, genuineness, and commitment.

Although most residency programs in pediatrics use many community sites as training grounds, we at CHONY decided to embrace the richness and depth that come with establishing a partnership with a single community agency. Our relationship with Alianza Dominicana took years to develop in an ongoing, labor-intensive process. It offers an incredible array of opportunities for all parties involved. Different areas of our curriculum are taught within this agency: domestic violence, cultural competence, and early childhood support. While enjoying the commitment to one partnership, we have had to struggle with the discontent that

Table 1

Principles of Partnership*

The principles	Critical concepts	Outcomes
Build a relationship between partners characterized by mutual trust, respect, genuineness, and commitment.	• Partner with one institution • Establish personal relationships between leaders • Foster awareness of stereotypes	• Strong commitment • Reversal of stereotypes
Build agreement on mission, values, and goals for the partnership.	• Negotiate agendas • Embrace partners perspectives • Respond to community-identified needs	• Awareness of shared mission • Integration of training and service
Balance power and share resources among partners.	• Exchange complementary resources between partners • Foster active participation of community in program development	• Creation of a zero-sum situation • Ability to take advantage of community assets
Create an open, accessible communication between partners, and develop a common language	• Share knowledge about the other partner • Recognize and accept different perspectives	• Clarification and redefinition of perceived roles of partners • Improved relationships

* These principles of partnership between community-based organizations and academic health centers, and the critical concepts upon which they are based, have been shown to foster positive outcomes, as described in the text.

this brings to other agencies in the community and to those individuals within the hospital system who for political reasons are not comfortable with our agency of choice.

Our relationship and perceptions of one another have evolved over time. Initially, the university faculty was perceived as the "Ivory Tower," arrogant and all-knowing, as our community liaison reported. There was mistrust of the university's intentions, the community seeing itself historically as being poorly served or having its members exploited as subjects of research. Faculty did not trust the community members' ability to understand the culture of the medical center and its training methodology. They viewed the community as impoverished and lacking in resources and knowledge, and rarely acknowledged the community's assets and strengths. As a first step there was a fundamental need to change these perceptions, for they created barriers to working together to improve children's health.

Although the institutions in our partnership had a formal partnering relationship for the Best Beginnings program, it was of critical importance that a pediatrics faculty member committed to community child health and a leader at Alianza Dominicana involved in women's and children's issues were able to engage on a personal level and share the commitment to the educational endeavor. The latter leader, a social worker, became the community liaison for the community pediatrics training program and now has a faculty position within the Department of Pediatrics. As the partnership evolved, members of Alianza Dominicana have had to respond to the community's hesitation and mistrust of having one of its leaders work within the medical center. Questions of loyalty arose that put the university and the community in opposite camps. Pediatrics faculty had to withstand criticism from within the university about their bringing outside agencies to participate in physicians' training. For example, members of the hospital's Department of Social Work expressed anger that one of their own staff was not fulfilling the role of community liaison. The faculty member and the community liaison conducted a painstaking, slow process of confronting both residents and community workers with their own biases and misperceptions and with the negative consequences of holding to stereotypes.

An essential outcome of this personal relationship was its clear, emphatic message to all participants that a genuine collaboration would facilitate all participants' work and maximize community health. This message was conveyed through workshops and with in-depth training led by the community liaison and a pediatrics faculty member.

Through this process community workers gradually took on leadership roles within the community pediatrics program, allowing them to share with residents their own health beliefs and perceptions of the medical center. For example, a dialogue about the prevalence of home remedies used in the community developed. Community workers encouraged patients to share with physicians their use of complementary and alternative medicine. As a result, pediatrics residents developed a booklet of the most common home remedies used in the community, their known efficacy, and their side effects. The booklet is now given to incoming interns during orientation week when interns visit a local "botanica" as part of their introduction to the community. The goal is to apply this knowledge in the patient–doctor encounter.

The residents now perceive community workers not only as service providers but also as their educators, whose input and beliefs they value. Our community liaison rotates through the continuity clinic and gives noon lectures to residents on topics related to community health. She then acts as a co-preceptor to whom residents can present cases for comment. Through such experiences residents come to understand the importance of the community context in child health. They become willing to leave the hospital walls not only for service but to enhance their own education. In turn, this has allowed community members to demystify physicians and value them as peers.

Principle 2: Build agreement on mission, values, and goals for the partnership.

The original individual mission of both the community pediatrics program and Alianza Dominicana was to serve the community in an integrated way, viewing the family in its totality and offering high-quality services. However, it was necessary to bring both partners to a full awareness of their shared mission. This allowed the community pediatrics program to embrace the community's perspective and Alianza Dominicana to incorporate physician training and medical services into their programs.

Best Beginnings, as noted, understood the importance of offering a "medical home" to all babies enrolled in the program. The medical practice located near Alianza Dominicana offered primary care services. Each resident assigned to continuity clinic at this site (nine out of 60 residents) was assigned a baby, performed a newborn home visit with the family support worker from Best Beginnings, and then followed this baby throughout the three years of training. Based on positive feedback from both partners, all 60 residents now go to Best Beginnings twice: once to learn about the program and participate in a case conference, and the second time to give a health education talk to the family support workers. This offered Best Beginnings a unique opportunity to enhance the medical knowledge of their workers and at the same time to allow the family support workers to share with the residents their local health beliefs and practices related to topics of interest. The goals and objectives both for residents and for the community workers at Best Beginnings evolved over time. The partners needed to negotiate agendas and be open to changing them, always giving preference to the community's needs rather than those of the training program. Though fearful of overwhelming the practice, the practice administration committed to accepting all Best Beginnings' babies and their siblings for primary care services because this fulfilled both partners' missions. While the training program would have benefited greatly from having all residents at all practice sites partake in the medical home portion of Best Beginnings (i.e., newborn home visit and three years of continuity of care), this was not feasible for the Best Beginnings staff or the families involved in the program. However, the community pediatrics faculty recognized the educational value of this experience and therefore arranged for all residents practicing at the other hospital-based, community-based practices to perform a newborn home visit with a Best Beginnings family support worker without becoming the child's primary care provider.

As we defined our goals, we realized that it is complicated to meet the inherent demands of each partner in terms of time and continuity of experience. Community needs are addressed over a long period of time, while an individual resident's training is a brief window within the community's life. Taking this into account, we came to define our goals as follows:

- To provide needed services—for the most part, health education and anticipatory guidance at the community site to maximize the health of participants and/or staff
- To enhance residents' knowledge and skills in working in community settings with diverse populations
- To foster and strengthen a working relationship between the medical center and the community
- To ensure and develop an informed, community-sensitive "medical home" for the Best Beginnings target population

Principle 3: Balance power and share resources among partners.
The balance of power is key to a thriving relationship free of resentment and misunderstanding. This is hard to establish in a situation in which structural imbalances of resources and power are inherent.[14] Broadly speaking, the communities in which residents train often are underserved, impoverished, and culturally diverse. These factors add complexity to establishing partnerships, sharing decision making, and allocating resources. Elements that contribute to the academic health center's power and resources are physicians' salaries, which are almost double those of leaders in community-based organizations; power and prestige associated with faculty appointments; control over grants where the university is the leading agency; and control of local real estate. Elements that contribute to the community's resources and power include grassroots social service agencies; human resources; knowledge of the community's culture, strengths, and needs; and trust bestowed on the CBO by the community.

In our particular partnership, these varied resources allowed for an exchange between the partners. The partnership generated a zero-sum game, moderating the imbalance of resources and promoting a shift towards optimal use of the partners' complementary assets to attain common goals. Seven years after Best Beginnings' creation, Alianza Dominicana became the lead funding agency for this initiative; a board of directors was created with equal representation of all parties involved.

Often universities approach CBOs for letters of support attesting to collaborations in order to obtain grant funding, frequently having no history of a partnership and having little intention of truly involving the CBO in the program design and implementation. As a result of the positive experience of the partnership with CHONY described here, Alianza Dominicana now does not get involved in any collaboration or partnership unless the benefits are clearly defined from the outset. Unfortunately, although much of the community pediatrics faculty feels they have come to understand this, the community liaison must continually teach them what community participation in this process should be.

In the community pediatrics training program, the community liaison was integrally involved in curriculum design, implementation, and evaluation. For example, it was the community liaison who initially advocated including training in domestic violence screening as part of our maternal child health curriculum unit. The community pediatrics faculty were reluctant at first, as it was an area where the faculty themselves lacked competency. The liaison's knowledge that our community had the highest rates of homicide due to domestic violence in New York City made the university partner realize the need to create a curriculum that incorporated both the community and the hospital perspectives on domestic violence and begin intensive faculty development in this area. Both a community member and a pediatrics faculty member are now part of a hospital-wide initiative to review our domestic violence screening and referral practices in all pediatric settings.

The family support workers benefit from a hospital ID and library access. Representatives of the CBO participate in scholarly activities, give lectures, participate as professional equals in workshop settings and national meetings, and share authorship on publications. Historically, the faculty had never considered including the community members in these "academic" endeavors because of perceptions that the community members did not belong side by side with educators in these venues. The community partner's open and abundant sharing of knowledge about the culture and values of the patients from the community has helped make the faculty and residents more responsive to patients' and families' needs. The residents' exposure to family support workers has allowed them to gain an appreciation of their impact on children's health and well-being.

Principle 4: Create open, accessible communication between partners and develop a common language.
Community-based education takes the resident into someone else's territory. This experience can be humbling to residents, who are often struggling to develop an identity within a traditional model where doctors carry a sense of entitlement in the hospital setting. On the other hand, community members now empowered to participate in physicians' training need to be sensitive to the issue of "MD bashing," that is, anger sparked by the community's view of the medical center expressed in such a way as to make residents defensive and unwilling to participate in training. Furthermore, overworked and overcommitted residents may feel they are already giving everything they can in serving their patients. Asking them to learn about patients' culture and health beliefs may generate anger and frustration. Thus, the emphasis has to be on teaching them the skills to elicit patients' perspectives rather than on learning facts about practices of other populations.[15]

This principle has been key on many levels, and its importance recognized more and more over time. Our faculty, residents, and community members are often from markedly different backgrounds. Recognizing such differences from the onset of our partnership and reminding ourselves of our common goals prevented the demise of a potentially fruitful relationship.

Preparation for the encounter between all parties involved in the educational process is vital for success. To create a common language, we developed forums for doctors and community members to talk about cultural differences in an open and respectful dialogue. An example is our "Narrative Lunches" activity—a venue

where community workers, residents, and faculty discuss cultural clashes that occur in a medical narrative. In preparation for such meetings, all participants read a designated chapter from Anne Fadiman's book *The Spirit Catches You and You Fall Down,*[16] that describes the colliding worlds of Western medicine and Hmong culture. With a community worker and a faculty member as moderators, participants are encouraged to describe real-life encounters involving cultural clashes. One of Fadiman's chapters focuses on the topic of the medical world's reporting the child's family to the state's child welfare system. Extensive, emotional discussions have occurred during the Narrative Lunches devoted to this chapter. The Best Beginnings staff felt that families from the community were often reported for unjustified reasons and spoke of instances where families suffered great burdens as a result of such reports. Residents explained their professional obligation and possible loss of medical license should they not report when appropriate. There is now a better understanding of this process—the roles and obligations of the medical staff on one side and the sequelae to a child and family should a report be unjustified. Residents now include the staff from Best Beginnings as a resource in helping to make decisions of when and when not to report a family, and the family support workers are more respectful of the medical staff's decision in such cases.

An early need was for community members to learn the hierarchy of who's who within medical training. For example, it was important that they understand that interns are recent medical school graduates and are unaware of the long-standing tensions between the community and the medical center. Lacking such awareness, interns at a community site might feel threatened and discouraged by the "MD bashing" to which they are exposed. Where residents were perceived as disinterested or bored at times, there is now more empathy from the CBO staff who recognize the residents' yawns and tired appearance as a possible byproduct of their schedules at the hospital.

Pediatricians in training need to know who the family support workers are—women from the community trained to work with, and be advocates for, the families the partners serve. Emphasis is placed on the role of agencies in maximizing the health and well-being of the patients we serve and on the learning value of spending time in community agencies in an educational rather than a clinical role. Without this understanding, residents question the value of community-based education, and often become angry when they feel that their "doctoring" skills are not being utilized.

Outcomes

To assess the impact of our program, four years ago we developed two qualitative instruments: biannual in-depth semistructured interviews with our community partners and monthly written "reflection cards" (described below) for evaluating the self-reported educational impact of community experiences on our residents.

Semistructured interview with community partner

When interviewed, the program directors at Best Beginnings agreed that all goals were being met by the ongoing activities; they wanted the partnership to continue and believed the program was benefiting from it. At Best Beginnings, residents' participation in the case discussions and monthly Narrative Lunches with the family support workers were regarded as important contributions to staff development. Staff education was seen as a way to improve service to clients. "Staff can now reinforce basic medical knowledge about child health care issues during the home visits made by the family support workers." For example, when discussing families' expectations versus actual medical practice in the treatment of upper respiratory infections, family support workers can explain to mothers why antibiotics are not effective, avoiding an emergency room visit or a visit to another provider. The personal relationships between medical providers and family support workers have changed over time. As a result of sharing their own personal stories regarding their childhood experiences and paths to becoming doctors, residents have become demystified as physicians and valued as colleagues and peers. This creates an atmosphere in which all parties can learn from one another. Reflecting on the Narrative Lunches and residents' role, a family support worker stated: "They had very good communication skills and delivery style. They were modeling how to discuss in a composed way. Not like us, all emotional." The improved relations have a direct impact on patient care. As a CBO staff member said, "To treat me you need to know me." Family support workers have open access to medical providers, are familiar with the clinical setting, and can be advocates for improved services to meet families' needs. Although not predicted at the outset, each resident's involvement in Best Beginnings is fulfilling a state requirement for staff development and cultural competency training for home visiting programs.

Written reflection cards for residents

At the end of each block of community-based activities, residents completed preformatted "reflection cards" asking them to identify new lessons learned and ways they could apply this new knowledge to patient care. Major areas where residents described how they could apply the knowledge gleaned from their experiences included (1) paying more attention to social and home-life issues that affect family health, (2) improving the ways doctors communicate with patients, and (3) being knowledgeable about community resources that could help their patients and families. One resident stated, "Closer interactions between physicians and staff of such community programs may be an effective way to accomplish specific goals for families and also broad public health goals." Residents describe ways that they have changed their own patient care practice, such as utilizing community resources to help support their patients and their families or spending more time getting to know the families. One resident reflected,"Sometimes the personal support given by staff through programs like Best Beginnings can be more effective than the best medical advice we can offer." Residents found their home visits enlightening—"I realized that things I take for granted (for example, a steady source of income) can be a real obstacle in attaining medicine, food, and adequate supervision." As a result of this, residents are now incorporating into their medical history questions about source of income and housing status and making appropriate referrals.

For both the community partner and the residents, a major obstacle was the difficulty in scheduling. Community program directors reported that scheduling issues prevented residents from participating consistently in support groups, depriving

them of the "full experience." Some residents expressed frustration that the CBO staff did not understand the residents' schedules and their lack of flexibility.

For some residents, their training imposes a perspective that they are not willing to embrace. For example, as one resident reflected, "When I am told how important it is for me to learn more about the cultures of my patients (meet them half way, develop working relationships with them), the conspicuously *absent* corollary is that the patients need to do the same! In other words, I felt that I was being told that I have a responsibility to change my practices to be more appropriate, but never are patients expected to do the same. I do understand the learning value of this–our positions put us in a more adaptable and observed position, but I think it's overdone."

Over the years, as community pediatrics became ingrained in the culture of the pediatric residency program, the residents' reflections have become more positive. There is less questioning of the value of community-based education, and a majority of residents embrace the opportunity to partner with community members.

What Partnerships Contribute

By attending to the principles of community–academic partnership and embracing the long-term relationship built on trust and common goals, the partnership we have described has been a fruitful and valued venture for all parties. We were able to achieve this partnership, despite the structural inequalities and tensions that typically characterize the relationships between academic institutions and CBOs. Throughout the country, there are similar models of successful partnerships, such as those selected to be a part of the Anne E. Dyson Community Pediatrics Training Initiative.[17] Community-based education provides residents with a comprehensive view of issues affecting our patient population and an understanding of the different disciplines and organizations that must be involved to improve the health of the children we serve. It empowers the CBO by giving it an active educational role within the health profession, thus enabling it to strive to equalize the power of the medical center and the community. Moreover, the partnership provides community workers with knowledge of health care topics, confidence, and cultural capital that allow them to fill an educational role in the community. These effects suggest the value of community–academic partnerships for serving all communities and for providing future physicians with the knowledge, skills, and attitudes necessary to become truly competent community pediatricians.

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