

Beyond Opening Doors: Valuing Community Voices While Rethinking Curricular Design

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The ivory tower, as a metaphorical image, has perhaps persisted in culture due to the relatability of institutional oppression. The institution of academic medicine has often wielded its exclusivity as a tool to define knowledge for those not traditionally welcomed in through the tower doors. However, the communities existing outside of the world of academia foster their own collective wisdom. When academic and community perspectives conflict, truth must be negotiated. Within medicine, that negotiation has historically been tilted towards the supremacy of institutional power. This exclusion of voices in defining truth restrains medicine's ability to achieve the very health outcomes for which it strives. Communities become more ill, unheard despite speaking to what ails them.

As the field of medical education research has matured, so too has the realization that research paradigms rooted in positivism, more characteristic of biomedical research, are often insufficient to explore questions regarding individual and community attitudes, beliefs, and values.¹ Underlying this change is an appreciation for epistemologies such as constructivism and social constructivism, where truth is subjective and negotiated within individuals, between them, and by intersecting sociocultural forces.² Significant work using subjectivist frameworks now exists within the medical education literature. This work advances an understanding of "truth" beyond what is solely owned by the educator to also include that which is defined by learners. However, these investigations still confine truth within the institution and those who comprise it, particularly when defining *what* should be taught and *how*.^{3,4} Those outside continue to be denied ownership through their exclusion from the negotiating process. If academic medicine exists, at least in part, to equip trainees to provide the best care they can, then it is necessary to consider every voice that could enrich our understanding of what that best care could look like. To modernize an old metaphor, we can use subjective epistemologies to respect that any individual student or educator may describe an elephant in a dark

room differently, depending on the part to which they have access. However, currently we are often neglecting the voices of those who can tell us what the elephant is intuitively, no matter what part they are offered—because they have lived experiences with elephants and others in the room often do not.

Questions regarding truth, its definition, and its ownership are vital to the work of the medical education curricular designer, as the designer's answers to these questions will both implicitly and explicitly be present within the curriculum.⁵ By extension, these answers may reify differences in the value of certain voices—itsself a reflection of broader systemic imbalances in power—and perpetuate them. Put another way, students can detect the perspectives included and excluded in curricular design, which provides a tacit lesson regarding the relative importance of those perspectives. Alternatively, consider an approach in which efforts are taken to include previously unheard voices in the curriculum development process, and the different underlying messages contained within.

In their manuscript "Incorporating Community Member Perspectives to Inform a Resident Health Equity Curriculum," Lichtenstein et al provide an example of how to include perspectives from members of their community in the creation of a longitudinal health disparities curriculum for a pediatrics residency program.⁶ They argue that a major contributor to systemic health disparities is a lack of resident education on this topic or, when implemented, education that is "often ad hoc and does not address the specific populations served by the institution." As part of the needs assessment for this new curriculum, they detail utilizing principles from community-based participatory research to incorporate the voices of local community members.⁷ By opening the door for ideas from outside their institution, the authors created an opportunity to broaden their understanding of the need for a health equity curriculum. In assessing what to teach, they in fact were negotiating a sense of truth with the lived experience and wisdom of the community.

If the physician's goal is the *health* of their patients, then medical training must seek to include patient and community understandings of health and provide

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trainees with the skills to negotiate shared meanings of health with their patients. Medical training offers a foundation of knowledge regarding disease and infirmity, but the definition of *physical*, *mental*, and *social* well-being⁸ lies outside the institution of medical education and within individuals and their communities. This point may be most salient when considering health equity, as Lichtenstein et al point out.^{6,9,10} However, the lessons learned by the authors in this study exemplify the power of this approach for rethinking all medical curricula. By standardizing the incorporation of the patient voice into all curricular design, we can both enrich trainee understandings of health and begin addressing some of the power imbalances built into the system itself.¹¹

As we strive to do better, to educate better, to include the voices of those for whom we care, we must be mindful of the pitfalls that can undermine our very purpose in doing so.^{12,13} We must safeguard against tokenization by including multiple patient voices and accommodating the unique intersectional identities individuals hold. We must practice reflexivity and acknowledge the privileges afforded us as representatives of academic medicine. We must be intentional and humble in our approach and committed to continued partnership. We must continually demonstrate that the institution is not merely “serving,” but working together with the community towards a shared goal. Rather than extending an invitation into the ivory tower, we can rebuild it together as a community-based system with the duty to advance health in all its forms.

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