Vive la Difference

Under Graduate Teaching Experience

in Inner-City Challenges

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ABSTRACT

Physicians meet clients with special challenges and life styles in their daily practice. Vive la Difference, a selective program offered at the University of Toronto to First year medical students, aims at increasing student awareness of their own attitudes toward their inner city clients. The paper outlines the content and process of this teaching experience.

Vive la Difference

The streets are exploding. People are getting hurt. There is poverty, racism, violence. Single parents, kids, gangs, drugs, booze - families - all are part of the explosion of life on the street - life in urban war zones.

Modern medicine - like most other institutions - is ill equipped to deal with this new reality. But it is here. There is no choice. Next week it will be more intense. Crack babies and multiple addictions will haunt all our corridors.

"Vive la Difference" is an optional course for a select group of 1st year medical students at the University of Toronto to explore the implications of these issues. It was developed by Dr. Yves Talbot, (Head of Family Medicine at Mount Sinai Hospital in Toronto), Jack Pearpoint (then President of Frontier College) and Dr. Marsha Forest, Founding Director of the Centre for Integrated Education.

It began late one night in 1985. The three met to discuss how medical students could become more familiar with the reality that they would be facing in cities - a reality that was untouched by the vast majority of their course work. Five years later, Vive la Difference recruitment is by word of mouth - from previous students. The limit of 12 has always been exceeded by students demands. A healthy sign.

OBJECTIVES:
The original course objectives:
To increase awareness of one's own values and attitudes toward people with disabilities and to confront issues such as illiteracy and different lifestyles.

> The description explained:
> Family physicians working in the community deal with patients with various ailments and lifestyles. Because of this, the physicians' values are constantly challenged. Being aware of one's own biases and understanding the patients' needs are essential to the delivery of care.
>
> We specified that "Students participating in this course should be prepared to come away with attitudes that will never be the same."

Our original focus was on issues affecting people labelled mentally retarded. However, in discussing how to sensitize and expose students to these issues, we confronted our own biases. Similar issues were faced by many "so called deviant" populations. We decided to expose the students to the broadest possible spectrum of life that they would encounter in an inner city practice.
The time available was 10 two hour blocks in the spring. We decided that following the first meeting at the University, all other "encounters" should be closer to the "home turf" of some of the people we wanted students to meet.

Our focus was to "introduce" the students to people - to sub cultures who will require medical care, and who are at risk of being gravely misunderstood and thus mistreated.

The list of "labels/issues" we tried to expose people to included:

* Mentally Handicapped
* Physically Handicapped
* Street People
* Aging People
* Chronically mentally ill
* Gay, Lesbian and Aids
* Addiction Problems - drugs and alcohol
* Prisons
* Prostitution
* Illiteracy

Many of the people overlapped several categories - but the pattern is clear.

PROCESS:

The Structure was experiential. We wanted to affect attitude - and our assumption was that to cut through to raw attitude,the approach had to be experiential. But experiences in isolation have minimal impact. Thus, we designed each unit to include time for:

1. a presentation
2. processing.

The presentation was "real life", by real people on their own turf, about issues those people considered important in their experiences with the medical system. We encouraged question and answer time - pushing people to ask the questions they were afraid/embarrassed to ask.

We followed this with our "processing" time. We withdrew as a group to discuss the presentation without the guests present. This processing tended to have two components. Firstly, the students talked to each other about their reactions - their values - their beliefs. Again and again, the students reflected that this was the only opportunity they had to actually get to "know" their fellow students. They worked long hours together, but seldom did they ever actually get to "know" how another student thought. Informally, the faculty would join in and guide the discussion to a second stage. Invariably, students would make remarks like, "It would never happen like that...", at which point, it was absolutely essential for the physician to report that these things happen - in the emergency ward, etc - and thus introduce "reality". Similarly, Marsha and I added lateral examples, so that it did not become simply a "show", but rather a sampling of broader more complex societal issues.

A SAMPLE COURSE:

An afternoon with Judith Snow - in her apartment. Judith became part of our core faculty. Judith is an amazing woman, and one of the leading authorities on the continent on deinstitutionalization and building support systems for people. But on

first encounter, the students only saw a "quad four" - not a person - but a diagnosis of profound disability. In fact, Judith has no controlled movement except in her face and 1/4 inch in her right thumb - which is how she drives her wheelchair. She types 35 words a minute on her computer using a "sip and puff" attachment. She travels the world lecturing. But like almost all of us, on first encounter, the students could only see a wheelchair - and disability.

A student's written journal recorded the following:

> "The first thing I noticed about Judith was her wheelchair. My feelings were mixed. I felt sorry for her. I felt curious about her and I couldn't understand how she could possibly live outside an institution.
> After the session, and after leaving,Judith's apartment, I felt mad both at the community at large, and at myself for knowing so little and having such preconceived notions. I started questioning everything as I never had before. What was my role as a doctor anyway?"

The whole situation was traumatic for them. Judith is one of the most physically disabled persons in Canada - and she lives independently - in her own apartment - with her own attendant care system. She works - full time - and travels internationally. All our predispositions suggest that Judith should be dead - and if living - on a nursing ward. And then she lectures. She tells her own story of medical experimentation that lost the use of her arms; of being malnourished almost to death in a geriatric hospital, the only place for her after finishing her Masters Degree in Counselling. We always arrange the room so that people have to feed Judith snacks, and help her drink her tea. No one ever thinks about "the handicapped" quite the same after spending an afternoon with Judith - drinking tea and helping her eat a muffin. Part of the power of time with Judith is her amazing capacity to include people. She is not alone.

This gives the flavour of the course. Week after week, punctuated with regular "rest stops" for reflection and always - treats from a bakery, we led each new group forward.

SELECTION OF CO-FACULTY:

The range of communities we introduced people to varied - slightly. The list of topics was easy to generate. The presenters were a more delicate selection. Some have become "regulars". Others we dropped after a try-out. The selection criteria to be co-faculty were:

* a personal interaction with the medical system in the past.
* being in control of the frustration/anger from that experience
* an acceptance that the "students" had done nothing to them..
* a willingness to contribute to medical training
* a willingness to tell their own story publicly
* a capacity to articulate their experience to a group without being intimidated.

We learned a great deal in selecting co-faculty. Initially, we were worried that we would have trouble finding individuals and/or groups to teach about their various communities. We were wrong. We are lobbied constantly by various people to add them/their issue into the course. A more delicate problem was the issue of hostility to the medical profession which is substantial in many communities on the street. It was healthy for the students to see "hostility" - but not too much. The individuals had to be controlled enough to "explain" their feelings - not just explode at "doctors".

THE STREETS & ILLITERACY:
As the weeks passed, different street communities told their story. Each year, we toured Beat the Street - and went on a guided "street walk" led by young people - who live on the street - or in nightly hostels. Our guides were young kids - troubled, articulate, yearning for a future. They were also pimps and prostitutes and addicts. To survive, many were involved in crime. Aids was part of their reality. Violence was everywhere. But at Beat the Street, these kids were students and tutors - teaching each other to read and write. Almost all had been scathed by school, but their formal skills were limited. As the constantly changing cast on the street told their stories, our students heard about abuse, neglect, rape, abandonment. They heard kids tell how their "community" on the street was their "family" - they had friends. None glorified the street, but few were ready to "go home". That was even more dangerous. Most wanted a way out - but they didn't know where to begin.

> "I definitely live in a sheltered world. Today we met the people at Beat the Street. It was the first time I had ever seen a hooker or met a street person. I found out "they" were people - not stereotypes. I'll be a more sensitive doctor as I'm starting to question my own narrow world and open it up."
>
> - a student

These two sessions - at the beginning of the course usually took a whole day to "process". The experience was so staggering to most that it challenged their values - their beliefs - assumptions they had made about systems, people, and medicine. Invariably, "horror stories" of neglect and mistreatment arose. These were hard for students to hear. It was a painful listening, and they needed to talk out their feelings and the information.

INSTITUTIONS:
And so the course continued. Another "constant" was a presentation from "People First" - an association of people labelled mentally handicapped. Peter Park and Pat Worth, Presidents of associations in Ontario always left people in stunned silence. Peter spent 17 years locked up on a back ward. He is now married and working full time. Pat spent almost as many years in institutions after being abandoned by his family. He jumped through a window to escape - and now heads the provincial association. Their stories shatter student confidence in "institutional support". People cannot believe that they were "labelled" mentally retarded. One student

commented that Pat's lecture was perhaps the most brilliant he had ever heard - and he specifically compared Pat to his university lecturers.

This is where the role of the faculty becomes critical. Independent of what has actually been said, some students begin to get very defensive. They rally to protect "medicine" and social values. They don't want to believe what they are hearing, but they have no alternative. Debates ensue. They want to rationalize that every guest is a "special case". They want us to tell them that what they have heard about is not real - that it is an aberration - a quirky exception. The role of the physician here is vital. Someone in authority has to say to the students, "They are telling the truth. ... This happens all the time. ... I have made decisions that were mistakes - like what happened to these people." And in the same breathe, it is essential not to idolize the presenters. Street people can and will also be miserable, abusive, violent, etc. The picture is far from all "sweetness and light". But, on Saturday night when a beaten up, single mum arrives in emergency smelling of booze and filth, it is absolutely essential to remember that she is a person and deserves to be treated like a decent human being. It will be hard, but if you remember that every person has another side. The patient is BOTH a loving mother, and a woman who has hit hard times and the bottle to deal with her agony. It will be easier to listen for relevant symptoms - which may well be more complicated than a hangover, if students remember...

One of the messages that came from almost every community was their shared terror of the medical system. They begged, without exception, to be treated like people - and to be preserved from arbitrary abuse and mechanical treatment. They wanted to be well, to see doctors, but preferably on their own turf.

DIFFERENT SEXUAL PREFERENCES:
Our afternoon with gay and lesbian families was shattering without exception. Most of the students "knew about gays" from television or a walk on Yonge street on Saturday night. They had no knowledge of "families" - but most important - they thought they did. Our meeting was at a very middle class apartment. Four co-faculty talked. Two men and two women - both of whom are raising families. Preliminary discomfort dissipated quickly as the students discovered that Neil and Dale were extraordinarily competent and caring professionals - who loved each other very much. They were a stable couple - in a society with very little family stability. They had teenage sons who were "straight" but comfortable with their "parents". The details varied from year to year, but the session was about shattering myths. No one denied that there were flamboyant gays - much like there are super macho men. But we all learned that one must not operate on grossly inadequate stereotypes. And the pain of rejection by many doctors - when people are genuinely ill was a story that the students did not want to hear - but they listened.

PEOPLE IN PRISONS:
All of us have strong opinions about the people we label criminals. But, most of us will only see these people through the glare of television. We seldom encounter the real people. Doctors are more likely to meet all types. The urban street scene

includes extensive crime - gangs, violence. One of our sessions on alternate years was to spend a block of time with a individuals who had spent their lives - largely in jail. These sessions were fascinating in that they forced the students to think about - and articulate another packet of largely unexamined beliefs. Spending a block of time with a man who has been convicted of murder - and is unrepentant is sobering. But it was particularly disturbing because most of the people we met were charming. They were "sales people" and could sell you a bill of goods - any bill of goods. And as gentle and pleasant as they were with our students, clearly there was another side - of danger, violence and the excitement of all that. Fortunately, by choosing carefully, our co-faculty didn't spend all their time telling entertaining stories. A lifer left the students with a homework assignment. "If you want to know what its like in prison, go home, take the door off your bathroom, move the television in if you want, but stay there - just for a long weekend. And remember, no door, no leaving." We never checked to see if any of the students actually locked themselves in, but the example conveyed meaning. Gradually, the students came to understand the meaning of "institutionalization" and the profound impact it has on people.

DINNER WITH FELICIA & MARIA

The closing session of the course was always very special. Our food theme moved into high gear as we had a dinner with a family - like the Galatis - in their home. Rose and Dom Galati are teachers. Their two beautiful teenage daughters, Felicia & Maria are both medically fragile and labelled profoundly mentally and physically handicapped. They live at home with their parents and go to regular schools. That is what is special. The historical pattern would have been (and was for Maria) "life" in a series of care giving institutions. But Rose and Dom loved their children and wanted them to experience all of life they could. They fought and worked and have integrated their children back into their community - their church, their neighborhood. The children have friends. This seems so simple, but it has been a massive battle. It involved changing the basic belief systems of school boards, and others - to see that Felicia and Maria are human beings. They too have contributions to make, and the right to be full citizens.

As people sat over dinner, feeding Felicia and Maria, and feeling the warmth of a healthy Italian family, the discussion about the power of physicians to sign children into institutions for life took on a crystal clarity. The impact deepened as each person gradually realized that all of us age and become "imperfect" and thus could become victims of a medical sentence to "institutionalization. Rose talked about the pain of the well intended remarks of physicians as they informed her that her second new born would also be a "vegetable". Good intentions don't make up for the months of grief that ensue from that kind of remark. The discussion always returns to people - recalling individuals they have met - people new to their consciousness.

The students recall Norman Kunc, born with cerebral palsy. Doctor's told Norman's mother to let him die - or to put him away. Today, Norman still has cerebral palsy. Medicine cannot fix that. But he was a gold medal winner at York University. He is a practising family counsellor, and of all things, an internationally renowned speaker.

People with cerebral palsy aren't supposed to be "speakers". Organizations pay to have Norman speak. He is also an expert sailor (solo racing) and a master chess player. It would have been so much better if the physicians had been brutally frank with Norman's mother and said, "We think your child has cerebral palsy. We simply do not know what that means in terms of his potential, but take your child home and love him." Our concept of "normality" needs to be broadened - and more inclusive.

Rose and Dom give the same message over dinner. It is hard to eat at someone's table and not remember that they are people first - not just "cases".

DELICATE ISSUES:
There are many hard discussions in Vive la Difference. Two of the issues that are constant are "deinstitutionalization" and "power". A sub theme for almost all the co-faculty - regardless of their community is the destructive power of institutional containment - and the counter-veiling need to be recognized as a person - a whole person. It remains a delicate balance to understand and remember that when you are medically sick, a hospital (institution) is a very helpful and important asset. But, the profound impact of the institutional reality can be so intimidating and upsetting to many people - and almost all of the people we encounter, that to have a positive net impact, those institutional encounters must be minimized.

The second issue that is a struggle for student doctors was a surprise to us. The issue is power. On average, the students did not want to accept the reality that they would be very powerful people. They wanted to be "nice and caring". They wanted to avoid the fact that doctors are powerful in our society. A doctor's signature can commit a person to treatment - to surgery - to procedures that can save a life. But the fact is that a doctor has power of life and death over many patients - at the very time when we are most vulnerable. Coming to terms with that power and influence, and still remaining sensitive and caring was an issue that students struggled with.

EVALUATION:
The evaluations on this course are fascinating. The most negative comment is actually a positive. Students complain that this is not available to all students. "It should be compulsory". On their own initiative, classes have written to the Dean and proposed it. Students write about the fact that they have been forced to think about issues they never thought about - and to come to terms with their own values. Almost to a person, they say they will never be the same. The rate it as one of their best classes ever.

The fact that the students from previous years recruit students from the new crop says a great deal. We have another informal measure. Our course has recently been on Tuesdays. On Wednesdays, there is a formal gathering of all the 1st year students. The Wednesday gossip has been, "What did Vive la Difference do yesterday?" The word is getting out. Some students even organized extra additional sessions with some of our speakers - for their fellow students - evenings. That is a very clear evaluation message.

We attribute our success to the excellence of our co-faculty - who have been hurt badly, but have turned the hurt into helping. They want to produce a generation of professionals who won't make the same mistakes that caused such agony in their lives. But, their energy was to build a partnership of trust - and to support the caring competence of these students - who desperately want to be caring and competent.

Students are required to write a page after each session on the impact of the session on their own life. The authors are currently reviewing 5 years of this data through content analysis.

We hit a chord. We assume that these students want to be good doctors. We appeal to their best instincts. We give them an opportunity to examine their own values, and to meet co-faculty who can genuinely help them to be better professionals. To practice good medicine in the inner city of the 90's, you need to understand the enormous variety of communities that will cross thresholds. Vive la Difference gives students and introduction to those realities - and skills and knowledge that allows them to go further if and when they are ready.

The last words go to the students:

> "This course has been a fantastic learning experience. It has taught me that although I though I was open minded, I wasn't. This is the first course I've taken that encouraged me to participate and discuss my values. Everyone should have to take this course."
>
> - a student

> "Vive la Difference" certainly worked! you took a naive young group of medical students and actually made them think about themselves and issues they will be facing every day in the future."
>
> - a student

> "I have not had to think about my values, dreams, etc. I was too busy studying for medical school and getting A's. "
>
> - a student

> "I won't simply accept things now like the need to put people in institutions, segregated schools, etc. I want to learn more, think more and I know I'll be a better doctor because of this course."
>
> - a student.