# Understanding Deficiencies of Leadership in Advancing Health Equity: A Case of Pit Bulls, Public Health, and Pimps

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## Abstract

Market- and legislation-driven health reforms are being implemented across the United States. Within this time of great change for health care delivery systems and medical schools lie opportunities to address the country's long-standing health inequities by using community needs assessments, health information technologies, and new models for care and payment. In this Commentary, the author, a university regional campus leader, shares several difficult personal experiences to demonstrate that health equity work undertaken by academic institutions also requires institutional leaders to pay attention to and gain an understanding of issues that go beyond public health data. The author reflects on lessons learned and offers recommendations that may help academic health center and university leaders be more effective as they take on the complex tasks involved in improving health inequities. These include reflection on personal strengths and deficiencies, engagement with the community, recognition of the historical roots of health disparities, and the development of trusting relationships between the institution and the community.

With the implementation of market- and legislation-driven health care reform in the United States, physicians and hospitals are being asked to do more than provide patient care; they are being asked also to improve health care safety, efficiency, and quality.[1] This time of great change offers opportunities for health care delivery systems and medical schools to use new models of care and payment, health information technologies, and community health needs assessments to address long-standing health inequities.[2] The expectation that the academic medicine community will advance health equity is highlighted in the Association of American Medical Colleges' (AAMC's) Areas of Impact: "[T]he AAMC will work to promote … a culturally competent, diverse, and prepared health and biomedical workforce that leads to improved health and health equity."[3]

Health disparities in the United States are significant, with age-adjusted death rates between neighborhoods ranging from 7 to 25 years in several urban centers.[4] Health disparities are driven by a complex web of issues, including access to care, health literacy, crime, drug abuse, poverty, and histories of racial discrimination and violence.[5,6] As health care providers and leaders, we must ask ourselves, Are we currently prepared to be effective contributors in addressing such complex problems, and if not, can we take corrective actions during this health reform "window of opportunity"?

I received an outstanding medical education, yet the following case illustrates how poorly prepared I was to lead the University of Oklahoma–Tulsa's (OU's) efforts to address health disparities in a local, chronically underserved population. The lessons learned from this case, which I will share in this Commentary, emphasize the need for academic health center and medical school leaders to be attentive to our existing leadership skill sets as well as to the historical events and current levels of mistrust among underserved populations within the communities we serve.

## A Case of Pit Bulls, Public Health, and Pimps

An hour after my 19-year-old son returned home from college in May 2010, I suggested we take a bike ride through north Tulsa, to see the progress being made on the construction of our new university clinic. When Sam and I reached the clinic site, I beamed with pride. "I think things are going well in north Tulsa and this clinic will help," I proclaimed.

As we headed back home from the construction site, I noticed the two pit bulls. They were asleep on either side of the bike trail, just ahead of us. As we approached, the sleeping dogs both awoke and lunged for my thighs. I steered to get away but my rear wheel caught on Sam's front wheel. Both of us flew over our handlebars, and I heard the loud crack of my son's bicycle helmet hitting the pavement. When I rolled over, I saw that his helmet, still strapped to his head, was in pieces. Sam sprang to his feet and used his mangled bicycle to shield me from the attacking dogs. Within seconds, the dogs' owner arrived and called them off. He was immediately apologetic, explaining that the pit bulls were his protection in the rough neighborhood.

After assuring him that we were fine despite our scrapes and torn clothes, we calmly began to walk our now-useless bicycles along the trail. I called my wife to ask her to pick us up. While we waited for her to arrive, Sam commented softly, "It's hard to be healthy in north Tulsa if it is unsafe to simply ride your bike on the trail."

We had moved to Tulsa nine years earlier. Our introduction to north Tulsa was when we were looking for our new house and were advised, "Make sure you do not go north of Interstate 244." Interstate 244

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roughly divides the north, east, and west sections of Tulsa from the midtown and south sections. That warning about not going north of Interstate 244 stuck with me for four years, until I experienced a change of heart while attending a September 2005 summit discussing solutions for caring for Tulsa's uninsured population. At one point, a local health executive announced, "We have the best health care in the United States in Tulsa and I see no need to meet further."

At the time, I knew the executive's claim to be false but had no statistics with which to counter it. That day, I asked OU's College of Public Health to compile data on the health of the Tulsa region. We soon learned that the life expectancy in the north Tulsa zip codes was 14 years shorter than in the zip codes just 5 miles away. Although 40% of the Tulsa region's population lived in north Tulsa, only 4% of the region's physicians practiced there.

With help from local philanthropy, our campus leadership team set out in 2006 to build a comprehensive clinic in north Tulsa that I thought would solve the community's dramatic access and physician shortage problems. I was so bold as to call the project a "super clinic," a term I quickly learned was a bad choice. North Tulsa leaders shared with us their concerns that a large university clinic would drive the few existing clinicians in the community out of business. Our leadership team took these concerns to heart and devised a plan for OU to provide care only in specialties that were not currently available in north Tulsa.

All involved seemed to be happy with OU's digging up data on Tulsa's health disparities, our clinic plans, our fundraising, and our responsiveness to concerns regarding clinic scope. After raising $20 million for design and construction of the 50,000-square-foot OU Wayman Tisdale Specialty Clinic, we planned a ground-breaking celebration to coincide with the area's 2010 Martin Luther King, Jr. Day celebration. I was even asked to be the master of ceremonies for the community-wide holiday parade. I was confident that we were doing the right thing in every way.

However, just days before the January 2010 festivities, the following headline appeared in north Tulsa's newspaper, the *Oklahoma Eagle*: "Is Tulsa North Being Pimped by OU?"[7] After acknowledging the community's need for medical care, the editorial answered the question posed in its title:

> Our answer: Pimps use the bodies of women to make money. For whatever reason, the women are vulnerable. The residents of Tulsa north are very vulnerable because of their poor health outcomes. Hundreds of millions of dollars will be spent ostensibly for better health care for Tulsa north residents. Who gets the money for such an endeavor? OU will.…
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> A medical facility should have a significant economic development benefit to our community. If a healthy community is the goal of OU, does it not recognize that a healthy community involves more than improving traditional healthcare facilities and services? A healthy community must have a good economy and a chance for good jobs for its residents.…
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> ... When will OU learn that the elimination of healthcare disparities among population groups is not a zero sum game?[7]

After reading this piece, I was flooded with emotions. How could someone compare us to pimps when we were doing such a great thing? Within a few days, OU and north Tulsa leaders met. When we asked the newspaper's editor to explain the editorial during this meeting, he responded, "OU has enormous resources. This clinic can be more than a clinic. I am asking you to bring the full resources of the university to help us."

## Lessons Learned: New Directions for Our University

These difficult experiences led me to engage in a significant amount of reflection and to develop a list of lessons learned that may be helpful to other institutions' leaders and physicians as they engage in work to address community health disparities. These lessons learned led us to begin moving in a new direction, coordinating our strategies and attitudes with the community we hope to serve.

### Be open to ongoing learning

Despite my years of leadership experience, I had the erroneous belief that I had learned enough and could handle any difficult task, including conquering health inequities. The fact is that we must be open to ongoing learning, particularly about our own shortcomings, as we take on complex tasks.

### Seek a new level of university–community engagement

The newspaper editor's comments put many things in perspective for me and for other OU leaders. We realized that a new $20 million clinic in an underserved area was indeed an opportunity to extend our mission beyond health care. Through outreach efforts, the university encouraged the north Tulsa community to participate in bidding for clinic construction projects. Previously, according to city leaders, the highest percentage of minority participation on a major construction project in the Tulsa area was 4%. In our clinic project, we had 24% participation by local minority talent, and the first workers were able to walk to the site.

We then recruited local talent to staff the clinic, including specialists who had grown up in north Tulsa. In addition, the OU College of Architecture placed an urban design studio in the clinic, creating a local site for community members to work with us on long-term urban planning and economic development for north Tulsa. From those efforts, we worked with the city of Tulsa to have the neighborhood around the clinic placed on a priority list for focused redevelopment, and north Tulsa will soon receive $5 million in infrastructure improvements. The university has embraced this expanded community revitalization role and, in doing so, has been recognized by the broader Tulsa community as providing significant return on investment for both public and private financial support.

### Consider the past

Moving these projects forward successfully has depended not only on working through current issues but also on gaining an understanding of the historical roots of those issues. For Tulsa, 1921 was the year of one of this nation's worst race riots. More than 35 blocks of north Tulsa, then a thriving African American neighborhood, were burned to the ground, and as many as 300 people were killed. The survivors, their children, and their grandchildren continue to live and work in north Tulsa. A sense of mistrust of public entities—such as the city government and universities—and of area business leaders continues among some African American residents, although it has improved. Early on, I was so focused on the compelling public

health data regarding health disparities that I was blind to the history that created those disparities in Tulsa.

### Develop collective trust

Researchers in education[8] have identified "collective trust" as a key factor in determining public school academic performance. Collective trust describes the trust that must exist between and among groups of students, parents, teachers, and administrators to create significant improvements in school performance. Looking back, I realized that we initially did little to build collective trust between OU and the important constituents of north Tulsa.

## Closing Thoughts

To physicians, data are often the primary drivers of clinical decisions. Data-driven, evidence-based medicine has provided great benefits by getting the right treatments to patients and protecting patients from ineffective treatments. Reviewing public health data moved me from a state of fear about working with north Tulsa to a state of blind ambition. The public health data, however, could show me just part of the need and part of the solution. Only by riding my bike through north Tulsa and coming face to face with two pit bulls and their owner was I able to understand north Tulsa's issues of safety. Only by choosing a bad term to describe our new clinic did I come to realize the importance of protecting existing jobs in north Tulsa. Only by being compared to a pimp in a public forum was I able to understand the need to provide assistance that goes beyond direct health care to affect the social determinants of north Tulsa's health and the community's economic development. Over these past years, I have learned that getting something done in a complex urban environment requires that we pay careful attention to the data and, just as important, to history, to building a sense of trust, and to what those most affected are telling us.

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