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Community Partners' Experiences Teaching Undergraduate Medical Students

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Abstract

This research explores community partners' experiences of teaching undergraduate medical students. In collaboration with university faculty, community partners affiliated with a local non-profit organization drew from their own lived experience and expertise to teach students about determinants of health such as food security and low income. While feedback about educational sessions is often sought from students, this research addresses an important gap by seeking to better understand the experiences of community partners teaching health profession students. Semi-structured interviews with community partners took place to explore their perceived role in the educational session, their impressions of the overall session, and their reflections about sharing their personal experiences with medical students. Five community partners completed interviews.

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Thematic analysis of interview transcripts indicated community partners interpreted their roles in teaching about determinants of health to medical students were valuable in influencing future physician practice and rewarding on a personal level. The power dynamics of individuals with lived experience of food insecurity and/or low income engaging with medical students as "experts" rather than "patients," and the importance of being viewed by students and health care professionals as multi-faceted and intersectional people, were also important emergent themes. With connections to the literature, broader implications regarding community partner involvement in teaching health professions students are discussed including logistical and ethical considerations (such as provision of honorarium, supports before/during/after the session), diversity of learners, and distribution of power between university faculty and community collaborators. This research concludes that with thoughtful and deliberate planning, supports, and dialogue, community partner involvement in teaching can be a meaningful pedagogical approach to amplify the voices and expertise of community partners and, in doing so, can work towards informing the practice of future health care providers to address the priority health needs identified by these communities.

Keywords: community-academic collaboration; community partners; guest speaker; food security; session feedback; educational session

Introduction

Engaging in educational collaborations with teaching partners from outside of the academy is a well-established practice, and is increasingly common in health professions education.[1,2,3] Towle and Godolphin described early practices of individuals from outside of the academy engaging in health professions education that was largely limited to patients presenting as "living textbook[s]" (p. 496);[3] however, the scope and engagement of this work has expanded and can involve patients, caregivers, members of the community affected by the social determinants of health, and service-providing community organizations. The literature reflects considerable variation in the language used to describe teaching collaborators from outside of the academy, including service user, survivor, patient, lay person, client, non-professional, customer, and community partner.[1,3,4] For the educational collaborations discussed in this paper, speakers were recruited to engage with undergraduate medical students about their personal experiences in community programs, and in

regards to non-clinical dimensions of social determinants of health in their own lives. Throughout this paper, we will employ the term "community partner" with recognition that there can be overlap, nuance, and complexity in the types of teaching, nature of partnerships, and language used to describe educational collaborations involving guest speakers.

Educational collaborations with community partners can include initiatives such as representatives from community organizations coming to the university campus to teach specialized content or share their personal experiences, and/or may involve students engaging in off-campus initiatives such as service learning, community site visits, or completing practica in non-clinical settings (e.g., providing dental care at a shelter for people experiencing homelessness). Educational initiatives that involve the expertise of community members create valuable opportunities for students to connect and apply theoretical knowledge to "real world" contexts, people, and priority health needs identified by community members.[1] For example, reading about the impacts of housing as a social determinant of health is very different than hearing from a person who has lived the experience of housing insecurity. However, despite the important role of community partners in the education of health professions students, in many cases, formal mechanisms to collect feedback from community partners about their experiences of these community-academic partnerships are underexplored or are not in place. A body of literature does exist regarding community perspectives about some forms of collaborative educational initiatives such as pipeline/pathways programs,[5] civic engagement,[6] community outreach initiatives,[7] and an expanding body of research exists about community perspectives regarding service learning.[2,8] There are also bodies of literature that address patients as educators.[1,3,4,9,10] While some describe that an interest in the perspectives of community members involved in health professions education is growing,[5,8] others agree that a focus on community perspectives about non-clinical community-academic partnerships remains an area ripe for further development.[2,6,8]

Often the "success" or "impact" of an educational session is determined by the impressions of the session as articulated from the student perspective, or by the outcomes of student assessment measures such as exam results related to session content. Collecting student evaluations at the conclusion of a course, or in some instances after an individual session, can be common practice in higher education institutions. In this case, this project sought to better understand the experiences of Honoured Guests, community members with lived

experiences of low income and food insecurity, who collaborated with university faculty to co-teach interactive educational activities for second year undergraduate medical students.

Background

At the University of Manitoba, a mid-sized university in central Canada, the Food Security sessions are a component of the second year Population Health course for undergraduate medical students in the Max Rady College of Medicine. Complementing other undergraduate medical courses that often focus on health and body systems, the Population Health course focuses on the determinants of health and their impacts at individual, community, and population levels. In particular, due to their far-reaching impacts on many aspects of health and well-being, this session specifically addresses the determinants of health of income and food security,[11,12,13] the limitations of charity models of addressing food security,[14] and the role of physicians as advocates both for individual patients and at population/policy levels.[15]

Building upon a well-established 17-year relationship between the university and Harvest Manitoba, a community-based non-profit food redistribution and training center,[16] the format of the Food Security sessions underwent a significant renewal in 2017. Originally designed as a whole group lecture, over the years the session has become more interactive, with students engaging in more active learning strategies like small group discussion. Beginning in 2002, the sessions moved from the university campus directly to the community organization, allowing for students to learn about food security while immersed in a community setting. In 2017 a small working group of university faculty and organization staff partnered to further revise the Food Security sessions to include opportunities for students to engage directly with community partners with lived experience of these determinants of health. The revised session included didactic presentations from faculty and community organization staff/community advocate (topics included background on the community organization, an overview of the importance of physician advocacy,[15] and a discussion of the impacts of low income on health), student participation in active food sorting and food packing experiences in the warehouse, and small group work in which students (n=8) engaged in dialogue with a community partner, in this case called an Honoured Guest. "Honoured Guest" is a term chosen by organization representatives to describe the community volunteers who work with the medical students. The small group work with the Honoured Guests will be the principal focus of this paper. The primary objectives of these small group discussions were: (1) For

students to engage in dialogue with Honoured Guests, and to learn from them as experts with lived experience of low income, not as patients to diagnose; (2) For students to practice discussing topics such as low income and poverty as determinants of health with people who have related lived experience; and (3) As a result of engaging in dialogue with the Honoured Guests, for students to identify possible connections between the Honoured Guests' lived experiences and benefits/resources that are locally available in the "Get Your Benefits" resource.[17]

While Honoured Guests may be affected by individual health conditions, with the exception of experiences with low income and food insecurity, a shared health status or specific lived experience was not required for participation. All of the Honoured Guests volunteered at the community organization in some capacity; most if not all of the Honoured Guests have accessed food bank resources historically or at the time of the interviews. Honoured Guests were recruited by organization staff who approached organization volunteers to share information about the educational sessions, and to gauge their interest and availability to engage with the medical students. In 2017, a total of 10 Honoured Guests participated in small group dialogue with the students as part of the Food Security sessions. For each session they co-facilitated, the Honoured Guest received a $50 gift card to a grocery store, a thank you card, and a certificate of recognition. The Food Security sessions have continued in this format each year since the revisions were enacted in 2017.

Methods

Following the sessions in January 2017, all 10 Honoured Guests were invited to participate in interviews to provide feedback about their experiences working with the medical students. In addition, we facilitated a focus group with students who participated in the Food Security sessions and collected session evaluation feedback from students; this paper will focus on the results from the interviews with Honoured Guests. To arrange the interviews, an oral explanation and written information regarding interview recruitment was disseminated to the Honoured Guests by a staff member of the community organization. Honoured Guests were assured that they could decline participation without consequence. Eight individuals expressed interest in participating and scheduled interviews in March 2017. A number of the scheduled interviews did not take place due to participant illness and other extenuating circumstances. In total five semi-structured interviews took

place (Table 1). Ethical oversight for these interviews by the University of Manitoba was incorporated into a larger research project exploring the "Get Your Benefits" resource.[17]

Individuals experiencing low income are often subject to societal consequences such as social exclusion, marginalization, and stigma.[12] As a result, the perceived authority of the university conducting "research" with individuals who may experience discrimination and/or marginalization due to their socioeconomic status was an important consideration in arranging and conducting the interviews. University-affiliated researchers can carry perceptions of power and authority because they are viewed as "experts" who are well-versed in "legitimate" "scientific knowledge" (p. 315).[18,19] In order to help mitigate power disparities, participants were interviewed and audio recorded by an experienced research nurse (MO) who was not employed by the university. Interviews were conducted on site at the community organization -- a location familiar and comfortable to all of the Honoured Guests and physically accessible throughout. All interview participants granted informed consent to participate and received $30 cash honoraria.

Following the interviews, audio recordings were transcribed and reviewed by the authors to identify preliminary themes related to Honoured Guests' perceived roles in the educational sessions, their impressions of the overall session and small group discussions, and their reflections about sharing their personal experiences with medical students.

Table 1. Interview Participants

Pseudonym	Number of Sessions Led in 2017 (maximum 4)	Age	Gender	Participated in teaching this session prior to 2017	Participated in teaching this session after 2017
Flora	1	37	Female	no	no
Dan	2	65	Male	no	yes
Brad	3	45	Male	no	yes
Lori	2	48	Female	yes	yes
Stella	2	44	Female	no	yes

Findings

Honoured Guests were asked to comment on how they interpreted their role in the session. Of the three participants who directly answered this question, most expressed their role was to share about their lived experiences with the students in order to facilitate a better understanding of the realities people experiencing low-income face, and how those realities can impact their health. Two participants expressed that sharing this information is particularly important when there is a perception that learners may have a different socioeconomic positioning than the Honoured Guests:

> *"I guess just letting the students know basically how you're feeling when you're down…because I think most of us on the street have figured out that your health is based on how you're living, and basically to just let them know that there is a whole other side to life other than just having a house and a white picket fence and all that stuff."* (Stella, age 44)

> *"And those students, I don't know what their life was like or is like, but I'm envisioning them coming from their household of – well I say well-off household, but their household may have been poor and they're failing, struggling to do what they want to do. But my basic responsibility was to give them an idea of what I'm going through."* (Brad, age 45)

One of the participants commented that their role was specifically to help students become more comfortable discussing topics that might be uncomfortable, such as low income, in order to provide more effective care to their patients. More efficient care could include recommending resources or government benefits that the patient may not be accessing:

> *"My understanding [of my role] was to help with med students to try to get over the difficult questions…to help doctors to learn the questions to get the right information from their clients so we can utilize that benefit program [Get Your Benefits resource] to the max."* (Flora, age 37)

Small Group Discussions

To begin the small group discussions, the Honoured Guest provided some introductory information (such as age, source(s) of income, living situation, and any health or personal information they wished to share).

Following this introduction, students in the small group asked questions to the Honoured Guest and engaged in dialogue about the topics that were raised. All of the participants expressed that, following their introduction, the small group discussions were *"slow to start"* (Brad, age 45). Participants attributed this reluctance to a number of possible factors, primarily students' reluctance to discuss "taboo" or uncomfortable topics such as income (Flora, age 37; Dan, age 65), and also identified possible factors such as student shyness/reluctance to speak in front of the group (Brad, age 45; Flora, age 37), and/or students' feeling either disinterested or overwhelmed with the Honoured Guest's story (Lori, age 48).

> *"I think it's coming back to the taboo of not wanting to ask those hard questions on someone's social status… [The students] were really fearful to ask questions. They felt they were going to get into my business. And I almost wanted to say 'You guys are willing to touch people's genitals and don't know them…but you can't ask a simple question?'…We can find the way to form that question in a clinical, humane way. And getting into people's business, I think these doctors really need to know how to do it; we want you to do it. That's why we're here."* (Flora, age 37)

> *"I had a feeling to [the students] it almost felt like income is taboo…because 'I am not supposed to know how much [my patient] is making…I'm only supposed to treat'."* (Dan, age 65)

However, while all of the participants commented that the small groups took some time to establish open communication, they also agreed that after some time passed, students seemed to become more comfortable engaging in active dialogue about the lived experiences of the Honoured Guest.

> *"[Organization staff person] was in [the small group] with me and I think he just asked me a very general question and then I started talking… When I drew a blank or something, I would just go 'Okay, question about anything?' That's when [the students] would jump in and ask me a question and then I'd go on talking some more and stuff like that. So they really helped me too to direct the thoughts which way they wanted to go."* (Stella, age 44)

> *"[The students] were really reluctant to ask questions… And the point where they started seeing me as a human and hearing my story and going, 'oh wow, that's really interesting'…I was drawing them in and*

*they were now interested in me as a human and interested in hearing my story when every one of [their] patients has a story just the same." (*Flora, age 37)

"I thought the groups were slow to start but once they got rolling I was able to answer their questions, and I just did it honestly, like that's the only way to do things. And like it went well; I really enjoyed the opportunity to speak." (Brad, age 45)

When asked if they felt supported, respected, and/or heard during the session, all of the interview participants shared affirmative responses to various degrees.

[Did you feel supported?] "*[The students] were very, I guess, yes supportive in the way they asked the questions. They didn't make me feel put down or anything…And like they took me under consideration the way they asked their questions."* (Brad, age 45)

[Did you feel respected?] "Yes absolutely! Absolutely." (Flora, age 37)

[Did you feel heard? Respected?] "Maybe some of the students heard. Not all of them, but some of them…I would say about 90% of them at the end of the session kind of respected me, and about 10% they were sort of close minded." (Dan, age 65).

In Dan's case, he associated this "close mindedness" with students who might intend to pursue a career specialty, as opposed to Family Medicine, and therefore may have felt less sure about the relevance of this curricular content to their future practice.

Impression of Session: Reflections about sharing their stories

Several of the participants expressed the value of engaging in the session on a number of fronts: value that students are exposed to this curricular content, value in influencing the practice of future doctors, and personal value for themselves. In particular, a number of participants described the importance of people with lived experience teaching the students this content versus other forms of exposing students to this material. This seemed to be particularly important related to topics that may be uncomfortable/stigmatizing to address and that may be different from the students' lived experiences.

"*And I think the experiential people, if they get a chance to speak is the best thing you can do. 'Cause the experiential person is going to be the one who brings those doctors out of their shell."* (Flora, age 37)

"One thing I sort of would like to see is more of this [kind of teaching]…Because this way the [students] are seeing a different side of life than what they're being taught." (Dan, age 65)

In addition, two interview participants expressed that they appreciated the potential that their involvement in this session, and working with these particular learners, could have in influencing future doctors:

"I noticed some of the students walking away sort of thinking, 'Okay, how can I apply this to what I'm doing." (Dan, age 65)

"This experience [these sessions] I so look forward to; it was amazing. It is so needed, and you can just see it is going to bring that change, absolutely." (Flora, age 37)

Four of the five interview participants described feeling personal fulfillment from participating in the session.

"*I just want to add that being part of this has been so beneficial for me and built my confidence up, and I like walk around here, in the world today, with a smile on my face and feeling better about myself … The students were very good to me, and like I felt good about myself when I walked out of there. I was glad that I participated."* (Brad, age 45)

"*I think I did okay. Well yeah, sometimes I feel like I leave things out and forget to say something or whatever but generally I basically just try and get out what…I can remember. And I'm usually going to [staff organization person] or [university faculty person] or whoever was in there with me saying 'Was that okay?'. And they're usually like 'Yeah, yeah that was perfect' or 'That's great'… I liked it*." (Stella, age 44)

However, even the participant who did not specifically articulate feelings of personal satisfaction proactively offered to be involved in the session in future years.

> *"Just to let you know that I'm available if you guys need me in the future for anything." [So, you'd do this again?] "Oh yes."* (Lori, age 48).

Impressions of Session: Distributions of Power

The topic of power was not explicitly included in the interview guide, however, several interview participants shared comments about their experiences with power dynamics in general, and also how those dynamics were shifted during these sessions:

> *"[In general] sometimes people don't listen to us in poverty because sometimes it feels like they don't think we have anything real to say. Sometimes it feels that way."* (Stella, age 44)

> *"I enjoyed [teaching the session]. It's different. Especially when – because here we've dealt with doctors differently and now the tables have turned a bit and it's learning from us as opposed to us going to them for help. It's nice to be asked."* (Flora, age 37)

Related to the topic of power, one of the interview participants also discussed the importance of medical students not looking down upon individuals who may not be as familiar with clinical vocabulary and practices. This interview participant also expressed the importance of being viewed as a complex, intersectional and whole person.

> *"I don't need to be looked down because I don't know the clinical stuff. I need you to look beyond the clinical stuff and look at the person…I'm not just [an organ]… And I'm not just – I'm not just, you know… overweight. I'm not just [someone] with [a certain health condition]. You know what I mean?"* (Lori, age 48).

Discussion

The findings of this small-scale project are congruent with existing themes established in the literature. The literature supports that the benefits to community partners engaged in community-academic education

initiatives can involve personal benefits on an emotional level, such as feelings of empowerment,[1,9] competency, and satisfaction. In addition, Felton and Stickley identified that there may also be tangible benefits for community partners who engage in teaching, such as direct incentives like honorarium or other forms of compensation.[9] While none of the interview participants explicitly identified financial benefits as a motivator for involvement, it is noteworthy to consider that practical benefits, such as honoraria, may carry even more significance for community partners who are actively experiencing circumstances such as low income, lack of employment, and/or food insecurity. Deliberate care must be taken to ensure that coercion does not take place, that community partners have a clear understanding of what the teaching will involve in advance of the session, and that the learning environment is curated in a safe way. In the case of these sessions, an orientation was held at the community organization in which organization staff and university faculty met with a group of potential Honoured Guests to share information about what the sessions would involve (both through discussion and a written document), to introduce the "Get Your Benefits" resource,[17] and to address any questions or details related to the session. The phone numbers and email addresses of university representatives were also provided should any topics for discussion arise after the orientation. In addition to individual level impacts, if community partners are associated with a particular organization, the organization may also benefit in ways such as increased visibility, and connecting with possible allies, advocates, and supporters.

While an in-depth discussion is outside the scope of this paper, a present topic in the literature is the importance of fairly compensating community partners for their teaching.[1,4] To this end, it is important to recognize that there can be significant emotional costs for community partners engaged in this kind of teaching. While the literature acknowledges that there can be concerns with patient educators being "used," "poked and prodded" with physical exams in clinical environments (p. 380),[1] there are also important considerations regarding the emotional, spiritual, and psychological demands of teaching that draw heavily upon personal lived experience. For example, Rees, et al. describe that it was "traumatic" for "mental health service users to repeatedly tell their often harrowing stories to multiple groups of medical students" (p. 381).[1] The impacts of engaging in this type of teaching will vary based on the topic that is being discussed, the context/environment in which the topic is being discussed, and also the individual community partner's relationship to both the topic and broader contextual life factors. Adequately preparing community partners before the session, providing support during the session, and debriefing after the session, are critical considerations for university faculty to

undertake when pursuing community-university collaborative educational initiatives.[1] Prior to the session, transparently sharing logistic information with community partners such as location of teaching (how to get to the specific teaching location, if someone will be meeting them, who to contact if they are having any trouble), the number and educational background of students who will be present, in addition to clearly articulated expectations of what the teaching will involve are recommended practices.[4] The community partner's agency to decline discussing a particular topic and/or cease participation at any time, and transparency regarding if honoraria or other supports will be provided (such as reimbursement for parking expenses, provision of bus tickets, honorarium for teaching and how they can expect to receive it) also warrant pre-emptive consideration and clear communication. Depending on the level of comfort and teaching experience of the community partner, multiple conversations may be required to discuss this information, to ensure that emergent questions and considerations have been addressed as thoroughly as possible, and to problem-solve any potential challenges identified.[1]

Another theme of community partner engagement in teaching health professions students that can be found in the literature is the benefit of community partners learning more about their own circumstances or, in the case of clinical patient educators, their own health conditions.[1,10] Hatem, et al.'s account of individuals with HIV engaging as educators found that through the process of educating medical learners, the service users themselves learned more about their own health conditions.[10] While this was not a pervasive finding in our interviews, one interview participant described that having the opportunity to be present for the whole session – including the didactic lecture components prior to the small group work – was informative and shared useful information applicable to their circumstances and lived experiences (Brad, age 45). This blurring of clearly defined roles of "teacher" and "learner" is a hallmark of a critical pedagogy approach. Distinguished critical pedagogist Paulo Freire described that, "There is, in fact, no teaching without learning…Whoever teaches learns in the act of teaching, and whoever learns teaches in the act of learning" (p. 31).[20] Educational initiatives that involve collaborations between community, university students, and university faculty can create rich opportunities for all parties to learn from and with each other.

Disrupting the hierarchical roles of "teacher" and "learner" that are often present within post-secondary institutions is just one of the challenges to existing power structures that was evident in these Food Security sessions. The theme of challenging and inverting existing power dynamics is reflected in the literature about

university engagements with community,[2] and also patient/community educators engaging with health professions students. This sentiment may be particularly prevalent in circumstances where the community partner is usually positioned as the recipient of a service,[2] or has experienced oppression, stigma, and/or discrimination as the result of a particular health status[9] or social positioning. In their research exploring various stakeholder perceptions about service user involvement in medical education, Rees and colleagues described that "service users enjoyed having a voice and feeling listened to and this empowerment contrasted with the disempowerment they felt with qualified healthcare professionals" (p. 376).[1] Echoing the words of Flora (age 37) who described that in this session "the tables had turned", Felton and Stickley outlined that during learning experiences with service users as the educators, "the roles are reversed and the service user is in the position of authority" (p. 96).[9] In this regard, these sessions not only served as an opportunity for community and university members to learn from and with each other, but by engaging in the act of teaching, the Honoured Guests also overturned power relationships that often exist between people experiencing low income and health care professionals.

While it is an intended outcome that these sessions would interrupt existing hegemonic power structures and amplify the voices of individuals who often experience systemic disadvantage, it is also important to acknowledge that "community partners" and "students" are both heterogeneous groups. Undergraduate medical students are often perceived as highly privileged, and their future careers as high-income earners are affiliated with a significant amount of power, prestige, and authority. Certainly, there is privilege and power inherent in being a medical student and future doctor. Yet, it is also important to recognize that medical students are not a homogenous group. In recent years revisions to admissions policies have sought to increase the diversity of medical students in order to increase institutional social accountability and more effectively address the diverse health needs of individuals and communities seeking care.[21] As a result of these changes, diversity in attributes such as "ethnicity and religion, gender and sexual orientation, geographic origin, and socioeconomic status" (p. 10) may be considered as part of the application process, and these attributes may be more represented amongst recent classes of undergraduate medical students.[21] As one student shared in their evaluation of this session, educators should *"…not [assume] that students have no awareness of poverty…I have had to access food banks with my family. Just [be] cognizant of that when talking to students."* When planning educational sessions

involving community partners it is important for all individuals involved with a session to be aware of and to respect the diverse range of lived experiences of both facilitators and learners.

Building upon the recognition that groups such as "students" or "community members" are comprised of individuals with unique lived experiences that cannot be generalized, the importance of both "being humane" and "being human" were themes that arose from the interviews. "Being humane" involved the manner of engaging in dialogue about subjects that may be sensitive or challenging, and when disparate power dynamics may be at play, such as a doctor discussing if a patient is able to afford a prescription they require. "Being human" involved community partners engaged in teaching, and also patients seeking health care, being viewed by health care practitioners/students as complex and intersectional people. Patients and community partners who engage in teaching health professions students have most likely been invited to share their expertise as a result of a specific health condition or specific lived experience. It is important that the sessions do not isolate that one variable as the singular, or even the most important, identity marker of the guest educator. Rees, et al. described that the involvement of service users in the delivery of educational sessions "should help students develop a holistic perspective of patients" (p. 373).[1] This more holistic view can also help to challenge and dismantle stereotypes about people who have a particular health status or lived experience. For example, Felton and Stickley identified that involving mental health service users as lecturers can challenge negative assumptions about the abilities of individuals seeking mental health supports.[9] In the case of the Food Security sessions, harmful stereotypes about people experiencing low income and misconceptions of "deserving" and "undeserving" poor [22] are brought to the fore and challenged through dialogue and the personal narratives and experiences of the Honoured Guests.

While the focus of this paper is on community partner experience, it is worth pointing out that student session evaluations substantiated the value of the session from the perspective of the students. Of the 98 session evaluations received in 2017, in response to the statement "This experience broadened your understanding of community interventions and health problems related to poverty and food security issues" 16% of respondents indicated "somewhat agree" and 79% indicated "strongly agree." Narrative responses on the student session evaluations also underscored the value of integrating the expertise and experience of community partners into health professions education.[1] In response to the question "What did you find most beneficial about this

session?" 51 of the 84 comments (61%) identified the small group discussions with the Honoured Guests. Examples of these student narrative comments included:

> *"The human stories – very effective and impactful. Will never forget a story."*
>
> *"Listening to informative, inspirational firsthand accounts."*
>
> *"Getting a break from the sterility of [the] classroom to bring back humanity."*

Recommendations and Conclusions

Does the involvement of community partners in teaching sessions about social determinants of health, such as these Food Security sessions, ultimately help to shape doctors who are more compassionate? Aware? Effective? At present, there is not a mechanism in place to follow these second-year undergraduate medial students through the remainder of their four-year program, through their residencies, and into their respective practices to measure how, if at all, this type of education affects their practice. Towle and Godolphin expressed that it is largely undetermined how this type of education will impact the health outcomes for groups experiencing health disparities.[3] Others, such as Gelmon, et al. identified the impacts and described that the inclusion of community in the delivery of education "contribute[s] to improving the quality of higher education delivered to students, both today and in the future, and to ensuring their competency to better meet the needs of communities they will serve" (p. 99).[2]

It is important to carefully consider the ethics involved in asking people to share their stories, particularly stories that may be difficult to tell, or that may be told at significant personal cost to the sharer. Great care must be taken to ensure that individuals sharing their stories are imbued with as much authority as possible to decide what they wish/do not wish to discuss, to be fully briefed on what the session will involve in advance, to be adequately compensated for their emotional work, and to have access to aftercare supports as needed. In the Canadian context, essential consideration must be given to ongoing impacts of colonization and the principles of Ownership, Control, Access and Possession of Indigenous knowledges and teachings.[23] University members inviting community speakers to co-teach educational experiences must demonstrate a commitment to relationship building, and to an investment of resources such as time and financial support on

the part of the institution. It is important also to recognize that community engagement in university teaching often involves community members addressing learning objectives and priorities as identified by faculty.[24,25] In Rees and colleagues' work, "students explained that the information provided by service users sometimes contradicted their previous academic or 'book' learning…" (p. 375);[1] while this was framed as a positive in that these discrepancies aided students in critically reflecting upon and challenging the information taught, Felton and Stickley described that it can be challenging to "predict what a service user would bring to the classroom" (p. 93).[9] The autonomy of community partners when engaging in educational initiatives means that they may share messages that are different than university-messages, and/or the session may unfold in ways that are different than university faculty had anticipated. However, variances can also be framed as opportunities that may challenge learners and faculty to consider issues in new ways, and also to re-imagine what the learning objectives and activities of a session could and should be, as informed by community partner direction.

Throughout the span of his career, revolutionary educator, activist, and critical pedagogue, Paulo Freire shared many insights regarding the practice of education.[20,26,27] A foundational tenet of Freire's work is the recurring declaration that educating is never, and can never be, a neutral act.[27] Education can work to further entrench societal norms and systems, or to challenge, re-imagine, and re-build them. In the case of these Food Security sessions, inverting normative power dynamics and cultivating an educational experience in which community partners who have experienced low income are "experts" teaching medical students rather than "patients" seeking medical care can be a powerful experience for both community partners and health professions learners.

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