ORAL HISTORY INTERVIEW WITH LEONOR CORSINO
Duke University Libraries and Archives
Submitted 05 01, 2024
Researcher: Fiorella

COLLECTION SUMMARY

This collection features an oral history I conducted with Leonor Corsino on 03 18, 2024 for the Bass Connections Agents of Change oral history project. The 24-minute interview was conducted in the Duke School of Medicine. Our conversation explored her roles as a mentor and her impactful initiatives aimed to increase diversity at the Duke School of Medicine. The themes of these interviews include health disparities, research, and mentorship.

This document contains the following:

- Short biography of interviewee (pg.2)
- Timecoded topic log of the interview recordings (pg.3)
- Transcript of the interview (pg.5)

The materials we are submitting also include the following separate files:

- Audio files of the interview*
    - Stereo Corsino1.WAV file of the original interview audio
    - MONO Corsino2_01.MP3 mixdown of the original interview audio for access purposes
- Photograph of the interviewee (credit: Leonor Corsino)
- Scan of a signed consent form

*At the end of the interview recording, we recorded a self-introduction and room tone for use in a production edit of the interview.

BIOGRAPHY

Dr. Leonor Corsino's journey as a physician-scientist is driven by a genuine desire for change, rooted in her vision to address healthcare disparities, especially within Latino and Hispanic communities in Durham, North Carolina. Hailing from the Dominican Republic, her interest in endocrinology was sparked by her father's battle with diabetes, which led her to pursue a career dedicated to providing compassionate care to those with chronic health conditions. After completing her medical degree in her home country, she moved to the United States in 2002.

Since joining Duke University in 2006, Dr. Corsino has become a leading advocate for community-engaged research and Latinx representation. Through her various initiatives and leadership roles, she continues to advocate for a more representative and equitable future in medicine. "As an advocate, I'm always sitting at tables where maybe I'm the only one [raising] questions that I think might help minority populations -- or even majority populations. By feeling comfortable asking sometimes tough questions, I think I make other people think about them, and hopefully change systems to make it better for everybody," she states.

In her role as the Associate Chair of the Department of Medicine Minority Recruitment and Retention Committee, she launched the Latino Initiative, significantly increasing the number of Hispanic/Latino residents and fellows. Dr. Corsino also played a key role in establishing the Latino Faculty Group at Duke School of Medicine and serves as an advisor to the Latino Medical Student Association (LMSA). Additionally, she serves as the Associate Director for the Duke School of Medicine Master of Biomedical Sciences, actively shaping the educational landscape.

Reflecting on her career and personal growth, Dr. Corsino shares, "As I get older, I try to think less about the future and more about the present, about what I can do today to make a difference." Her journey stands as a testament to unwavering dedication to activism, education, and research, making a lasting impact on healthcare disparities and shaping a more inclusive future for the medical community.

INTERVIEW TOPIC LOG (Corsino2.wav)

00:00	Brief Introduction
02:16	Motivation to Pursue Health Disparities Research
03:28	Involvement in Durham Community
08:32	Projects and Initiatives (i.e. The Latino Health Project)
14:51	Role as Codirectors of the Community Engagement Research Initiative
20:04	Community Advocacy During Covid-19 Pandemic
22:24	Role in Latin-19

TRANSCRIPTION (Corsino2.wav)

Fiorella Orozco 00:01
Hello, my name is Fiorella Orozco, a third-year undergraduate at Duke University. Today is March 18th, 2024. And I'm here with Dr. Corsino in her office at the Duke School of Medicine. Thank you for meeting with us. For the second part of the interview, we were really excited to expand on some of your previous responses. In our previous interview, we focused on your roles as a mentor and your passions for increasing diversity at the School of Medicine. I really want to highlight your role as a community advocate in this part of the interview. I want to start off with your research at Wayne State University, where you first became interested in research in health disparities. Can you elaborate a little more on what that looked like?

Leonor Corsino 00:42
Yes, so thank you so much for having me again. It's a pleasure to see you. Yes, so actually that's where my passion for health disparities started. To be honest, I had no clue about health disparities until I was a resident and I started working with a mentor, who was a big, very well-known individual doing research on health disparities in African Americans and hypertension. So, during my work with him and in his clinic, is where I started to familiarize myself with all the existing disparities. Not everybody gets treated the same, or not everybody's impacted the same way by different conditions. So obviously, working with a mentor, that is an expert, you have to do a lot of reading. And then I came across other work and realized that it was not only health disparities, when it comes to hypertension in African Americans. During my reading, I recognize that some of the similar disparities also had a disproportionate burden in the Hispanic or Latino population. And I started doing my own research about it and identified very few people doing research in that area. And I contacted one of them that at that time was in Boston, and expressed interest in learning more about your work with the Hispanic or Latino population, and diabetes. He's an endocrinologist, also Hispanic and Latino. He was kind enough to share with me some of his papers and some of his initial work. And that's how all this passion about health disparities started.

FO 02:16
Where did your motivation come from to research health disparities, specifically in Latino populations?

LC 02:24
Well, the obvious one is that I'm Hispanic/Latina and I have a lot of family members with diabetes. So those two combined make me highly interested in this area. And then also realizing that as a one and a half generations, how I call myself because my mom migrated to the US when she was younger, and my grandparents live in New York for a long time, I realized that my family was part of the group that was being disproportionately burdened and was experiencing disparities as well. So, combining all of that is where that interest came. I also think I mentioned

during the first half of the interview that diabetes is very big for me because my dad had diabetes since I was little. And I knew I wanted to do diabetes. And then I realized, well, there's health disparities with diabetes, so it was kind of like the perfect combination for me to pursue. This is my area of interest for research.

FO 03:28
How did your research interests intersect with your community involvement? Were there moments when you felt that they clash with one another?

LC 03:35
I don't think they clash. I think one cannot exist without the other. What I mean by that is, when I started doing research here at Duke, back in 2006, I realized that I was not reaching the people that I wanted to help, for many reasons that is perhaps a little bit political. But at the time, there were not a lot of Hispanic and Latino patients coming to Duke for their health care. So in order for me to make a difference, I had to go to where they were. That's how I started working with El Centro Hispano and Lincoln Community Health Center, just to be able to see the people that looked like me that needed my help. When you try to ameliorate health disparities and working with health equity, you cannot actually assume things. You actually need to hear it directly from the people you're trying to help. And that's why working with the community is so critical. Because I could be sitting at my nice office and pretending that I know what people need, but it's usually very far off of what the reality is. And even though I'm Hispanic or Latino, I don't know the realities of my patients, right? I don't walk in their shoes. I don't live where they live, because of course there is this difference in privilege that I currently have, but some of the people I was trying to help don't have. They don't clash, they have to go hand in hand. That's how I see it.

FO 05:06
How did you first reach out to El Futuro? How did you first get to know more about the Latino community in Durham?

LC 05:15
Yeah. I started working first with El Centro Hispano. I'm gonna go to El Futuro in a minute, and Lincoln Community Health Center. So back in the day, my mentor had a person from Colombia, who was her research assistant, that is now the leading person at El Centro [Hispano]. So she was the one who started that initial connection with El Centro [Hispano] because El Centro [Hispano] is a well-known organization in Durham that serve the community, that Hispanic or Latino community at all levels, not only when it comes to health related challenges, but also education, finances, and so on. So that's how I got connected through them. Then Lincoln Community Health Center, my mentor also has strong connections to them, and we started connecting and offering some programs for weight loss and nutritional education through them. That's how we ended up working with those two organizations. When it comes to El Futuro,

which is a younger organization in Durham, it was kind of serendipitous, because I am part of the Project Access of Durham County Board. The founder of El Futuro is also part of that. He invited me to join them and do a tour of their wonderful facilities. We are now what I consider good friends that we connect with each other. I think they serve a different purpose in Durham because they focus mostly on mental health, versus El Centro Hispano has a broader reach, covering multiple areas of support.

FO 06:54
What does it mean to gain trust of the community? Like what ways did you gain trust with the Latino community in Durham?

LC 07:03
You know, that's a very challenging topic for me, because I don't think you gain trust, right? You have to be trustworthy. And then you actually build a relationship. It's like when you gain trust, you're asking people to give you something. When you work with a community, it must be collaborative and bidirectional. So, it should not be me expecting them to give me something and I don't know if that makes sense. But I think if you're honest, trustworthy, transparent, and straightforward with what you want for the relationship, people tend to be more collaborative. And if you're trustworthy by following with what you offer, and then that makes a more equitable relationship. I think the challenge that we face sometimes is that we don't align expectations early when we try to work with other people. And not only communities, but any relationship also that you build with someone. If you don't align the expectations early on, then misunderstanding comes and all those challenges. Then that's where the mistrust comes, right? It's like your best friend, or your partner or your family, right? If you're not honest with each other, and you don't share your true self. That's where things can get a little bit blurry. And to be honest, I think that's what has impacted our ability to have that trust from the community because sometimes we are not trustworthy.

FO 08:32
During your time at Duke, you've led various projects working on Hispanic /Latino populations, just to name a few: The Hypertension Improvement- Latino, The Latino Health Project, Patient Provider Management of Osteoarthritis- Latino, and A Transition of Care Model from Hospital to Community for Hispanic/Latino Adult Patients with Diabetes. What motivated you to partake in these projects or to initiate these projects?

LC 09:01
I think all of what they have in common is that we know what the evidence is to improve hypertension, to help with obesity, to improve diabetes care. But those evidence are not things that are implemented in the real world. We have a lot of wonderful things on paper that work, but how did that translate to people that perhaps don't have access to the food we are suggesting or

don't have access to a gym, or don't have the ability to buy medications where they've been discharged from the hospital? My goal with all the projects was like how can I see if what we know that works in other groups will work in the Hispanic or Latino population? Considering that we have the cultural aspects of things. We have a very heterogeneous population that although we group them as the same, are very different from each other. How can we adapt what we know in order to be able to say, it will work for someone from Mexico versus it will work for someone from Puerto Rico, or from the DR [Dominican Republic] and how we can pilot test that. I'm gonna use the last project you mentioned: Transition of Care from the Hospital to the Community for Patients with Diabetes. We know what works, right? And we know that people need to get a good list of their medications. They need to get follow-up with their providers in two weeks after they get discharged. But a lot of times that gets lost in translation. When you're Hispanic or Latino, perhaps you don't speak the language and you get a piece of paper that says, these are medications you're supposed to take. This is the way you need to go for follow-up. You don't understand what they're saying. You don't have a way or calling a phone number that could confirm the information they gave you. Or you go out in the community, and you don't have insurance to pay for the wonderful medication they gave you. So that's where we were trying to see how can we make that transition a little bit simpler? And take it to consideration the cultural factors and the socioeconomic factors that have an influence on how people do that transition successfully?

FO 11:11
Thank you. What were the outcomes of the projects, any meaningful interactions you had with patients?

LC 11:20
I have many, many, many, many meaningful interactions, right? Sure, but I can tell you, one thing that I learned that has been with me for the last 17 years was the fact that I was very ignorant when I started working in the Hypertension Improvement Project- Latino. I don't know why I had this assumption. It was probably lack of education on my part, that all Hispanics/Latinos speak Spanish. I think a lot of people have the same assumption. But when I started working in that project, I learned while collaborating with El Centro [Hispano], that we have a lot of people from Mexico that their primary language is not Spanish. I didn't know that. I don't know what I was thinking. Maybe because I'm from Dominican Republic, and we don't have natives. I have no idea. But I learned that a lot of the people we were reaching out Spanish was their second language. And that added another layer of complexity when you're trying to give people advice on exercise and changing your diet and all that. That is a lesson I'm taking with me forever. Another lesson that I learned from one of my projects that we were using the electronic medical record is that not everybody with Latino or Hispanic last name is Hispanic or Latino. Once again, lack of education or ignorance on my part, because I should know better. You could be married with someone who has a Hispanic and Latino last name. That doesn't

mean you are Hispanic or Latino. Or you can be from the Philippines, which we know a lot of people from the Philippines have Spanish last names, but they don't speak Spanish. So those things are things that I think were very meaningful for me. The last point I'm going to make is something I also learned, that actually talked about recently in a podcast I was interviewed in. That because race and ethnicity are very embedded into the U.S. culture. They have very different meanings from people from Latin America, or other countries, because there are social constructs, right? Those are invented in the U.S. by the census. But if you ask people from Latin America what their race is, they have a hard time answering that question. Also, ethnicity is not something we talk about, because we are all ethnically the same if you are from the DR [Dominican Republic] or Puerto Rico. And I'm being very mindful when I think about research and read research that reports race and ethnicity, because the data is usually not quite accurate. An example is there's a lot of randomized controlled trials with diabetes medication, that they say, oh we have larger percentage of Hispanics/Latinos. Then you look at where these people are coming from. They're from Argentina or Mexico or other countries in Latin America. And then they try to in that table demographic gives you the race. I'm [like] how reliable this is, if people really do not know how to answer that question. So those are lessons that I keep in my mind when I'm trying to think about research with this segment of the population.

FO 14:39
Yeah, that's something I'll definitely also keep in mind whenever doing research or interacting with a patient or anyone never to assume.

LC 14:50
Yes.

FO 14:51
I want to transition to your work within the Duke Clinical and Translational Science Institute (CTSI). What role do you hold as one of the codirectors of the Community Engagement Research Initiative?

LC 15:06
Yes. I've been working with the CTSI since 2017. As the co- director, we usually divide our programs, and each faculty will lead a group of programs. My team and the programs that I lead are the programs related to education, research, and others. We work on how we want to facilitate educational opportunities within the Duke community about what is community engagement and how to do community engagement well. Then I also lead what we call consultations. Anybody that wants to learn about community engagement, they will submit our consultation requests. And I'm the faculty lead for that program. I also lead community consultation studios. And the last program that I lead is the Population Health Improvement awards, which are small grants that we provide to community and researcher collaboration, in

order to do some community engagement type of research. So that's how I work with that team. Also, I don't want to get all the credit. I have a team that does a lot of work. As a faculty lead, we brainstorm ideas, how are we doing? Anything we need to change from the programs, anything that needs to improve? How do we evaluate the programs? Do we need to reinvent the programs as we move on and improve? So those types of things are what I'm doing with the CTSI in my role as co-Director for the Community Engaged research initiative.

FO 16:35
Can you provide specific instances where CTSI has played a pivotal role in enhancing health outcomes through community engaged research?

LC 16:46
Well, we have done a tremendous amount of work. There are many examples, I think of the Population Health Improvement [Awards]. We have collaborators with Lincoln, collaborators with Root Causes, and collaborators with El Centro [Hispano]. Many grants that we have supported through that Population Health Improvement Awards that had made meaningful changes in the community. We had one with the housing department as well. I think that's a way that we made some changes. Also, I think, with the educational part of what we do, we have a subset of programs called Examples From the Fields, where we have a panel of individuals from the community or researcher, to share a little bit about their experience of working together to make changes. I think that is also very meaningful because you have people that have never heard of community engagement or have no experience and they join the conversation and learn. This is something I should do [or] this is something I should not be doing if I want to do this right or not. I think those are some examples of meaningful things we have achieved with CTSI.

FO 17:58
In your research, a lot of it has to do with listening to the community's needs, how do you go about listening to your community's needs?

LC 18:08
There are many ways you can do that. And I must confess lately, I'm not doing a lot of listening. Because I'm doing a lot of listening to my students now. I haven't been engaging in a lot of the conversations in the last couple of months. But a way that I think we do that, well, for example, the Community Consultation Studios. The way they work is we have a researcher that has an idea. They come and present their idea to community members, and the communities will provide direct feedback of yes, this will work, or no the community doesn't care about this, or you should do this differently. Those things are very meaningful because that means you're going to be designing a research project that is in alignment with what the community wants. Another way I think we did very well during COVID was with the Latin-19 organization. we meet every Wednesday at noon. We just listened. We posted the challenges, and the community will talk.

And we learned so much from those interactions about the real reality of people. As I mentioned earlier, I don't think I can completely relate with someone that doesn't have a house, or someone that doesn't have food, or someone that is illegal and does have a legal status that allows them to access health care. By listening to the community, you can put yourself into their situation, realize maybe what I'm trying to fix with my idea is not going to be something that is going to be meaningful for someone that is having all these struggles. It's very eye opening to see how the realities of a lot of our community is so different than what we think it is. And how you really kind of change your mind of how to help and what to do differently.

FO 20:04
You mentioned the COVID-19 pandemic. How did your community advocacy look like during that time? Or what changes did you implement during that time to reflect the current situation?

LC 20:20
Well, I'm gonna reframe your comment. I don't think I made any changes. I think WE made a lot of changes. And what I mean by that is that LATIN-19, as I mentioned earlier, was an organization that emerged during COVID. And it was not the work of one person. The reality of what we achieved was a collective. I don't think anything that we did was the product of one individual. I think we all put our brains together. We all work very collaboratively. We all listen to each other. We all supported each other in many ways. We brought our strength, each of us whatever our strengths we had, and put it together. I always use COVID as a good example of when you work with other people, recognizing your strengths and your limitations, how much farther you can go. And I think that's something I will hold close to my life because we all just have the same issues. We worked long hours. We were not complaining about working weekends or nights. We had a mission and we all made it happen. Another example that I know is a little bit controversial is the COVID-19 vaccine. We know that when you put all the brains together, and all the money available, you can come up with a solution very fast. I think that is to me one of the biggest lessons from COVID, that if you work together, you can achieve more than if you compete with each other. And I hope people will remember that as a big lesson from COVID.

FO 22:03
I think that's a very valuable lesson, especially if you're doing community research. It takes a whole village to make a change. What was your role in Latin? 19? How did that look like in the beginning? What did you feel?

LC 22:24
So it's funny because I haven't had that question [asked] in a long time. But the reality we have a medical student, his name is Alex Villeda. Latin-19 started during COVID, but Alex actually had convened a group of faculty and students, even before COVID happened, immediately after the

shooting at El Paso. As a faculty advisor for LMSA [Latin Medical Student Association], I was invited and other individuals that subsequently started Latin-19, were also invited, and there was a meeting, just to brainstorm how we were going to help the community. That happened months and months before we knew COVID was a thing. Of course, when COVID hit my colleagues, [they] pulled the call for all the people they knew that were interested in Latino/Hispanic health, to join what was then named Latin-19. The Latin-19 name also came from a medical student, who was the one who came up with the logo. That student was Daniel Villalobos, who's now, I think, he's doing anesthesiology somewhere in New York. They were a group of students that were also doing a lot of the translation and PR stuff that Latin-19 was doing. So I want to give them all that credit too. And then I was invited to be part of the executive team just because my colleagues knew I was doing, already, a lot of this work before COVID. That's how I ended being part of LATIN-19. We all worked on our strengths. So in my case, I worked really hard into the MyChart in Spanish because I was already connected to the leadership in Duke Health and I knew people there and it was an interest of mine even before covid. I decided, okay, this is something I'm going to push because I've been trying to get this done even before COVID. So that's how I ended up doing all the MyChart in Spanish. Then also with LMSA, and a group of medical students, we saw this as a unique opportunity to also push forward into reimagining the medical Spanish course in the School of Medicine. We work really hard on that part as well. each of us did something different. And I think that formula worked really well, as well.

FO 24:45
Perfect. I think that's all the questions I have.

LC 24:50
Okay, great, thank you.

SS 24:54
Thank you. I'm just gonna record like 15 seconds of room tone to help with the calibrating level.