Family Medicine Division at Meharry Uses Special Strategies to Meet Priority for the Underserved

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THE FOLLOWING EXCERPTS from the mission statement of Meharry Medical College reflect its institutional commitment to serving the underserved: "True to its heritage, Meharry must maintain its empathy for the disadvantaged of all origins . . . In light of its special concern for the health of minorities and the disadvantaged, Meharry will emphasize the amelioration of their problems . . ." This important theme within its guiding mission continually influences all of Meharry's functional units.

Whether by design or by some special destiny in the medical-health marketplace, Meharry medical graduates have traditionally served as primary physicians for the so-called underserved. According to "Meharry Today," an alumni magazine, as of 1978, more than 60 percent of Meharry's physician alumni were practicing in the five specialties (family practice, general internal medicine, general pediatrics, gynecology-obstetrics, or psychiatry) generally considered as most involved in delivering primary care. Further, an even higher proportion of Meharry's physician alumni have located in areas where practitioners of their specialty are in relatively short supply. This physician shortage in the areas where Meharry alumni practice is more evident when one examines the black physician to black population ratio which, in view of the general finding that the overwhelming majority of the patients visiting the offices of Meharry alumni are black, can be considered as another indicator of need for service.

Even if one considers the possibility that most black people might prefer or even seek a nonblack physician, the current cadre of all black physicians (constituting only 2 to 3 percent of all physicians) could not fill the client demand that would still be placed upon them. Therefore, although Meharry trains its medical-health practitioners to work for and with diverse groups of people (in fact, it allocates a significant portion of time and resources in training its students—only 75 percent of whom are black—to become high-quality practitioners who can serve and compete in any segment of contemporary society) most Meharry alumni spend a great deal of their time serving black people, the majority of whom appear to have limited access to medical and other health services.

Each of the four Meharry Schools (Allied Health, Dentistry, Graduate Studies, and Medicine) as well as its Division of Hospital and Health Services has demonstrated historically and continues to maintain a commitment to underserved people. Meritorious research, education, and service programs from these four schools have attracted the direct support of both the public and private sectors in Tennessee.

The senior school at Meharry, the School of Medicine (now 103 years old), has a remarkable record of service to the underserved. Of the living black physicians in this country, some 40 percent are Meharry alumni. And the number of Meharry alumni who are the "first black physician" or the "only black physician" to do a particular thing is a proud testimony to the commitment of one small school. Although these are laudable achievements, it is unforgettable that one small private school has had to provide such a disproportionately large share of the effort to produce this vital resource for the nation.

Although for several decades the Medical School's Departments of Pediatrics, Surgery, and Obstetrics-Gynecology have been providing training experiences in the field for students, other departments have just begun to demonstrate a more visible level of commitment to the underserved. Notable among the departments is the Division of Family Medicine, which was officially conceived after I began visiting Meharry (in 1973) to discuss and plan the initiation of family medicine training for medical students and residents.

Division of Family Medicine

Since its formal inception in April 1974, the Division of Family Medicine has given high priority to the training of medical and other health practitioners who

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could not only meet the special problems of the underserved but who also could compete in any segment of the medical-health system.

The Division of Family Medicine has used the following three main strategies to achieve its priority for the underserved.

1. Early identification of students who have positive attitudes toward working with underserved people, as well as the knowledge and skills needed to carry out such work.
2. Offering carefully selected mandatory experiences for all students through the regular core curriculum.
3. Offering relevant electives in all years of training.

Early identification of qualified students. During the first month of the division's course for first-year medical students (Introduction to Family Medicine-I), the division staff surveys the entire class to ascertain the following:

- Interest and experience in serving underserved populations. Have the students lived in an underserved area? Do they plan to live in an underserved area? How do they feel about living in such an area and serving its people?
- Interest in or feelings about family practice as a specialty. Who is biased for or against it? How much peer or kinfolk pressure influences their feelings about family medicine? How comfortable are they with the notion of being at increased risk of the unknown as they practice?
- Future plans—to what extent do they include family practice or service to underserved populations?
- Experience in the helping role. Which students have had prior experience? How much? How do they feel about it? Are they willing to share these experiences with their classmates?

Throughout their 4-year stay, all students receive printed information about family medicine and serving the underserved. However, the first-year students who indicate in the survey an interest in family medicine (about 20–30 percent of all those stating a specialty choice) and in working with the underserved are sent additional information about various elective courses that deal with family medicine and serving the underserved (see table).

In identifying students, special attention is given to those with positive experiences in underserved areas, those with positive regard for underserved people, and those who respond knowledgeably during exercises about the conditions of underserved populations (for example, socioeconomic stratification among black people and impressions about the role of the Indian Health Service or the National Health Service Corps).

Offering carefully selected mandatory experiences. Convincing arguments can be made for offering family medicine as a required course in medical school. Most of these relate to the relative credibility in the academic marketplace of required versus elective courses. On the other hand, when viewed as a somewhat revolutionary idea, the staff may not always wish family medicine to be identified in the mind of the avant garde student with the rest of the required (that is, "establishment") courses. However, in a university that has a living legacy of serving the underserved, the division staff believes that family medicine, a specialty still identified with the underserved in many respects, could profit from some required courses. The courses offered emphasize the following.

Family medicine (FM) courses offered at Meharry School of Medicine

Course	Years available	Hours per month	Length of time	Required
Introduction to FM-I	1	4	1 year	Yes
Introduction to FM-I (directed study)	1	12	1 year	No
Clinical correlations-I	1	3	1 year	Yes
Family Practice Club	All	4	4 years	No
Longitudinal elective	All	16	1–4 years	No
Journal Club	All	4	2 years	No
Family practice seminar	All	6	2 years	No
Family rounds	All	4	2 years	No
Behavioral medicine seminar	All	4	2 years	No
Introduction to FM-II	2	24	3 months	Yes
FM—preceptorship	3	250	5 weeks	Yes
Block elective I	1–3	200	2–12 weeks	No
Block elective II	4	250	4–12 weeks	No
Tutorial	2	24	3–12 months	No
Student fellowship	All	16–200	3–48 months	No

1. Didactic learning about the ecology or environment of health and of illness.

2. Experiential learning about families and communities using the processes of family diagnosis and community diagnosis. (Family diagnosis enables the student to visit a family repeatedly and get to know and diagnose its individual and collective problems, plans, and behaviors. Community diagnosis allows a student to visit repeatedly and examine a community to ascertain the status and behaviors of its health system and its various subsystems).

3. Experiential learning during a 4- to 6-week preceptorship experience with a prescreened family practitioner committed to underserved people.

A formidable task for the division staff is matching the experiential learning experiences to the interests of the students. This matching is easily done for electives; however, it requires considerable effort to assure that students' interests can be matched to the available sites. Using narrative descriptions, former students' evaluations, photographs, and faculty analyses of the sites' capabilities, the students select in order of preference six site choices. Ultimately more than 90 percent of the students in required courses get one of their first three choices.

Offering relevant elective experiences. The major challenge for any new optional course is generating and maintaining student interest. This is especially crucial when there is a concurrent required course in the same area. During the early and mid-1970s, official electives at Meharry's Medical School were offered only to fourth-year students. Recently, official electives have been offered to preclinical students as well.

The division offers two kinds of electives: longitudinal and block. For the longitudinal elective, a student spends 4 to 12 hours per week over a total period of from 6 months to 3½ years; each year, 2 to 6 students choose this elective. The longitudinal elective enables a first-year student to follow three or more families for more than 2 years, similar to the manner in which a family physician follows a family. Two faculty members are advisors and preceptors for the students, who attend regular structured and unstructured tutorial sessions and special-speaker sessions. We find that the students participating in the longitudinal elective tend to be "self-starters" and are generally inquisitive and concerned about the broader behavioral, social, and environmental matters that affect health and illness. This elective allows students to perfect their skills in family diagnosis (interpersonal dynamics and detection of health problems).

The division offers three kinds of full-time block electives. The first lasts from 2 to 12 weeks and attracts 8 to 15 students (from all years) per year. The activities occur in an underserved area where the student is preceptored jointly by a physician and a health services administrator and is given an opportunity to perfect community diagnosis skills (determination of the pluses and minuses in the various health system agencies). The second block elective is for fourth-year students who wish experience with clinical research in an underserved population. Two students yearly have elected this activity for 1 to 4 months. Finally, student fellowships have been used to involve students in research in the health problems of underserved populations and have attracted 1 to 2 students yearly for 4 to 12 weeks, full or part time.

The Family Practice Club is a recent addition to the division's optional activities. Run by students and residents with the assistance of faculty, the club is and promises to be a forum for significant interchange around issues of importance to underserved people. Some of the topics included are The Natural History of a Clinic in an Underserved Area, National Health Service Corps' Role and Impact, and Private Physicians' Role in Serving the Underserved. The club is an outgrowth of earlier student activities in which Meharry students have joined with other students in Tennessee and have initiated medical-health fairs and ongoing clinics in at least four sites. Faculty support of these activities has helped to interest many students in exploring further the issues of service to underserved populations.

Students are required to evaluate formally the courses they take in family medicine. Most do so readily. These evaluations are used in making yearly decisions about retaining a subject, lecturer, or a preceptor site as part of the learning environment.

Conclusion

The Division of Family Medicine carries out Meharry's commitment to underserved populations by training students to serve in any segment of the medical and health care systems, systematically exposing students and residents to underserved people and their needs, and helping students to acquire the special skills and sensitivities that are necessary in working with underserved people.

We have moved significantly toward a teaching mode that identifies promising students who are likely to locate in an underserved area. Our mode reinforces these students' positive attitudes and regard for people by allowing them to gain useful knowledge, skills, and practical experiences. Our division's continuation and expansion of these activities will add a new dimension to an old Meharry mission.