# Can Future Physicians Be Educated To Care for Underserved People?

HANS O. MAUKSCH, PhD

THIS PAPER COMMENTS ON THE ISSUES addressed in the accompanying reports of various programs which seek to attract and prepare medical students and young physicians to devote a serious component of their career to the care of underserved groups in the population. Concern about the absence of an equitable share of health care for certain portions of the U.S. population takes two programatic directions. Some programs—most notably the National Health Service Corps—seek to address geographic maldistribution of health services providers, while other programs, also including the Corps, focus on culturally and socially identifiable groups that by virtue of ethnic, racial, or social class background, neither receive an appropriate share of health services nor contribute significantly to the health care provider labor force. Every one of these programs is important, and they represent an impressive array of governmental, institutional, and individual initiative.

Without in any way diminishing the significance of the training activities and programs described in the preceding papers, it is advisable to step back and see them in the context of the macro health care delivery system and the educational climate in the medical schools. It is my unpleasant task to call attention to the fact that programs designed to improve the care of underserved groups in the population do not express the values nor the structures of mainstream health care services or of professional education.

## Programs Outside the Mainstream

Looking at three factors which affect the social role of these programs may serve here as a brief and, possibly, simplified analysis. One factor is typified by the heady but misleading implications of the fashionable use of the term "health" care service. The frequent use of this term over the last 10 years has almost succeeded in persuading our society that health indeed has become the predominant focus of medical concerns. This change simply has not occurred, and it is not altogether a critical comment to make this assertion. The predominant demands on the medical labor force, the overwhelming proportion of time and effort expended, and the preponderance of medical curriculum content are oriented toward "illness" care. This, in fact, still conforms to the population's mandate as expressed in its behaviors and expectations. The emphasis on illness has led to a preoccupation with

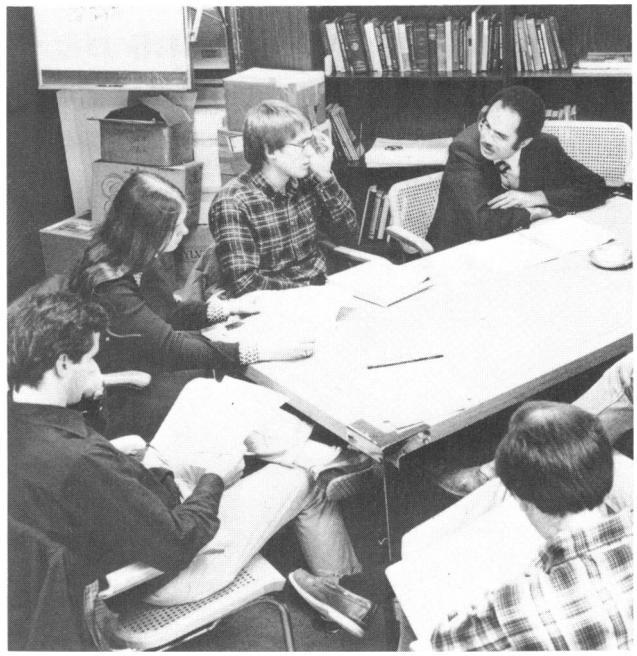
*Tearsheet requests to Hans O. Mauksch, PhD, Professor of Family and Community Medicine, Department of Family and Community Medicine, TD 3–West, Medical Center, University of Missouri, Columbia, Mo. 65212.*

patho-physiology and biological disease, thereby permitting the social and cultural issues in health to recede into apparent irrelevance.

The second factor mitigating against generally accepted and integrated programs for special populations lies in the tradition that medical care is sought by the consumer, rather than initiated and delivered by the provider. It is not too long ago that the prevailing opinion of the profession viewed medical care as a privilege and as a commodity to be bought if one could afford it. Although the norms of medicine have profoundly changed and although there is an abundance of sincere commitment to the care of those who need it, I must note sadly that the actual behaviors and habits of social institutions are agonizingly slow in following changed orientations of norms and desires. The structures of medical education, the organizational characteristics of the medical delivery system, and the reality of the medical workload all mitigate against actual efforts to seek out those who need care, but do not know how to enter through the gates of the delivery system. (One of the most valid excuses for not seeking out the needy is being so busy with those who have found the gate.)

The third factor which mitigates against care of underserved people lies deeply in the American value system. Out of the history of the American frontier, out of the Protestant tradition of the sacredness of work and success, and out of the American values of individual control of one's fate stem the persistent beliefs that those who are needy and those who are socially disadvantaged are somehow morally and socially less worthy. The history of American governmental and private programs can place care for the needy and the underserved either in the domain of charity or in that of guilt, but rarely, if ever, do these programs appear as an expression of a normal, pervasive social responsibility.

Since emotionally charged issues require continuous clarification, it might be well to reaffirm that this effort at placing programs designed to enhance health care for underserved people into a societal context is not intended either to criticize or to diminish their worth. On the contrary, if these programs are placed into historical and cultural contexts, those who devote their professional careers to them should gain the sense that even small successes are significant and gratifying in the light of the social forces arraigned against them. The very marginality of these programs makes them essential if one is committed to the belief that the focus of health care includes people and groups as well as diseases. Above all, the most significant dimension of programs like these lies in their potential for encouraging future physicians during their formative periods to cling to whatever commitment to human services they bring into medical school and to find support for their people-oriented goals.



*In a seminar, "The Rural Practitioner," at the University of North Carolina at Chapel Hill, second year medical students listen to Dr. Joseph Berry, founder and medical director of the Roanoke-Amaranth Medical Group, a nonprofit practice in Jackson, N.C. Dr. Berry came to Jackson in 1976 as a National Health Service Corps physician.*

## Undergraduate Career Influences

The importance of these programs in the formative years of the medical career cannot be overestimated. People- and community-oriented medicine is—in a dramatic, although oversimplified sense—in competition with organ- and disease-oriented medicine. The traditional premedical undergraduate curriculum encourages the students' anticipation of the latter and omits if not sneers at any curriculum content directed at the former. This orientation not only influences the selection of applicants to medical school, it shapes the values and expectations of those who prepare for a medical career. Notwithstanding this undergraduate gauntlet, research and informal observations across the country suggest that the last 10 years have seen a significant increase in the proportion of young people who enter medical school with a concern for people, for primary care, and for health-oriented programs. Yet the medical school is a powerful socializing institution. As we observe medical students marching through the avenue of their educational sequences, we must be dramatically impressed by the fact that, in general, it

is first the biological scientists and then the clinical specialists and subspecialists who stand at the curb waving the students on to the next station and cheering them for emerging in the image of the professor-role model. Those who represent programs serving people and populations, and those who represent behavioral and social issues in health stand in the second and third rows and, with much effort and an occasional bruise, succeed in thrusting their faces and their waving arms into the range of visibility of the passing students.

Medical students learn early a simple formula of educational power: "What is required is more important than what is optional, what has many hours in the curriculum should influence me more than anything with fewer hours, and to survive medical school means to navigate between competing pressures." Most medical schools are associated with medical centers devoted to tertiary subspeciality care. After the socialization into organismic science during the first 2 years, the medical student becomes the transitional property of medical specialties for short periods of different lengths of time. The clinical years, as several medical students expressed it, feel like enforced visits to a sequence of sales exhibits, each extolling the merit of its specialty and judging the transient by the degree of commitment to this specialty world. The overall objective of becoming a physician, the centrality of the medical role, and its universal capability and mission fade in the maze of laboratory data, specialization techniques and instruments, and inter-specialty rivalries.

The impact of the clinical years is aggravated by the fact that the overwhelming majority of the medical students' learning contacts are with the house staff rather than the medical faculty. The interns and residents, young people who have only recently made a choice and need to prove themselves, are not likely to be at the time of their life when they can view the universals of physicianhood as their foremost educational mission. On the contrary, they are likely, as new converts to their specialty, to be committed to their own world and to impart this subspecialty loyalty to the students. Not being regular members of the faculty and neither privy nor committed to the educational objectives of the school, they are educational forces frequently in conflict with the school's mission which may officially avow to prepare young people for primary care. With several colleagues at the University of Missouri-Columbia, I have studied the career choices of medical students over several years. Only half of those who entered medical school with a commitment to primary or people oriented care retained this career aim at the end of their fourth year (*1*). Even more significantly, hardly any students ever shifted *from* a specialty interest expressed at the outset of medical school *to* a primary care orientation 4 years later. In interviews with these students the importance of house staff as a formative force clearly emerges.

In describing these forces, the careful observer must conclude that the culprit is history rather than people. Those who have a claim on a curbside position in the medical school parade do what they think is best. Their location and claim is based on the logic of an earlier era, when the conquest of illness was indeed a bio-scientific breakthrough of the medical profession.

## Tactics to Promote Change

There are several implications of these paragraphs for those committed to active educational programs that would enhance the provision of care for underserved people. This essay suggests that within the current structure of the medical school those staffing the people- and community-oriented programs should fight for required curriculum time and other indicators of legitimacy in the dramaturgy of the medical student's experience. Fitzhugh Mullan comments elsewhere in this issue on the reluctance of medical schools to respond through curriculum modification to the increasing numbers of NHSC scholarship recipients. His observations are not surprising and must be viewed not merely as avoidance of service to specific students, but as an expression of the intransigeance of the current balance of power within the battle for curriculum territories. This battle is clearly one option for those who wish to remind medical students that knowledge and understanding about human groups is a legitimate area of a physician's concern.

What has been suggested in this paper could also lead to a different tactic. Those concerned with community-oriented health care programs could choose to bypass the medical school and concentrate on recruiting directed either at premedical school or post-medical school opportunities. Some aspects of the National Health Service Corps fit this tactic. Regardless of how these people-caring programs develop, we should be aware that their real enemies are not necessarily the voices of those who oppose or neglect them, but that these voices represent traditions and established patterns which need to be understood and even respected if they are to be effectively confronted and changed.

*Reference*

*1.* Mauksch, H.O., Brent, E., Diamond, J.T., and Elder, S.: Going through medical school and considering the choice of family medicine: prescription or antidote? J Health Soc Behavior. In press.