Commentary

How Can Medical Schools Meet the Expectations of Community Partners Over Time?

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Garrettson et al, the authors of the manuscript titled "New Medical School Engages Rural Communities to Conduct Regional Health Assessment," published in this edition of *Family Medicine*,[1] should be commended on a well-designed study that has relevance to other new emerging medical schools and established schools with similar missions wishing to assess the needs and strengths of community services related to the expectations of the medical school. The leadership of the Commonwealth Medical College of Pennsylvania should be applauded for supporting a needs assessment using a qualitative, informant focus group approach of multiple rural community stakeholders that simultaneously develops community relationships in the early stages of a new medical school. Not surprisingly, emerging themes include needs in primary care, prevention, mental health (especially substance abuse), and public health. The participating community stakeholders also want physicians with outstanding listening and communication skills. Does this assessment create unreasonable expectations for a new school that needs to develop a solid financial base and intensive Liaison Committee on Medical Education (LCME)-approved basic science programs and clinical clerkships in all major disciplines with capable and trained faculties? Should this type of assessment be performed sequentially over time to make sure that the medical school is addressing needs and fulfilling the expectations of community partners? How can medical schools meet the expectations of community partners over time?

According to the Association of American Medical Colleges (AAMC), as of July 2010, new "medical schools in the pipeline" include nine LCME applicant schools and seven schools with LCME preliminary accreditation status.[2] Many of these schools have public-private partnerships and expectations to "bolster a new local economy driven by the medical field."[2] Unlike the new schools started 30–40 years ago, the current new schools are being developed without federal assistance.[3-5] Due to the dominant fee-for-service payment system in the United States, high-tech, procedure-oriented care is valued over primary care, preventive care, mental health, chronic care coordination, and public health. If a major goal of these new schools is to bolster new economies, the major drivers will be economic outputs based on new procedure-oriented technologies (mostly provided in hospital-owned facilities) rather than greatly needed advancements in ambulatory, cognitive-based, longitudinal care of persons with complex medical and behavioral health problems. The new health reform law will expand coverage and expect millions of Americans to obtain coverage if they do not have it.[6] Will expanding the medical school class size of current schools and adding 16 new schools provide the medical workforce to address the needs of Americans today and into the future? Ingelhart quotes an upcoming report of the Council on Graduate Medical Education, which estimates that only 16%–18% of 2010 medical graduates are likely to practice in primary care, when there is a need for 40% or more.[6] The findings of a recent report on the social mission of medical education "raises questions about why some community-based public schools that seem well situated to have high social mission scores do not have them."[7] Four large research institutions in this report had top rankings in both National Institutes of Health (NIH) funding and primary care outputs.[7] How do they do both? The authors challenge all medical schools to examine "their educational commitment regarding the service needs of their states and the nation."[7]

How can a new medical school like the Commonwealth Medical College of Pennsylvania meet the needs of its rural stakeholders and stay focused on a clear social mission to train physicians who respond to primary care, mental health, and public health needs? New schools that plan to maintain a social mission of medical education by graduating physicians who practice primary care and work in underserved areas first need to admit the right students. Admissions commit-

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tees need to accept students from rural and underserved communities with intentions to serve the underserved and expand criteria to admit students with majors in humanities and social sciences.[8,9] A recent report of the Mount Sinai School of Medicine shows that graduates of a humanities and medicine program achieved clinical honors and were more inclined to enter primary care fields and psychiatry over bioscience majors.[9] New medical schools need to place medical students, early in their careers, in highly evolved clinical practices led by energized, primary care physician role models. Partner hospitals and communities need to fully support core residencies in primary care, especially family medicine and mental health. These programs are foundational for clerkship training of medical students and community campuses. New schools should engage their community partners to create scholarships to support students who will address the community's needs in primary care, mental health, and public health to defray high tuition costs that may influence care choice.[10] In Michigan State University's College of Human Medicine (CHM), which also has a strong community-focused mission, we have initiated an early admission program for undergraduates coming from colleges and universities located in our partner communities. In the Department of Family Medicine at CHM, we have initiated "The Integrated Program (TIP)," a variation of the University of Missouri program, where medical students commit to longitudinal training beginning in the fourth year of medical school through residency, supported through funding by our community-based residencies and partners.[11] Finally, if we are to seriously address such needs, as reported by the partners and stakeholders of the new Commonwealth Medical School, the US Congress and all medical educators need to recognize that shallow workforces in primary care and mental health are major public health issues that contribute to the US health system's 37th ranking in the world overall.[12] A 10% bonus by Medicare for performance under qualifying payment codes will not transform the workforce[6] and promote flocks of medical students interested in being family physicians. Profound and radical changes will be necessary to achieve the goal of a 40% physician workforce in primary care, such as full scholarships for students committed to primary care, indentured work experiences to defray tuition, incentive payment systems for coordination of care that really matters (over 30%–40% incentives), and a set ratio of primary care versus specialty care positions in graduate medical education (GME) based on community and public health needs.[13]

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