Letters to the Editor

To the Editors of *MEDICC Review:*

The fall 2008 issue of *MEDICC Review* (*Teaching for Health Equity: Changing Paradigms of Medical Education*) treats the rarely discussed topic of "teaching for health equity". Within medical education, there is discussion of medical ethics, professionalism, and, sometimes, services to the underserved. The broad issue of equity—health equity—receives little attention, either in the design of medical education programs or their content. Medical education systems in most countries are wedded to traditional social and economic structures that usually are geared toward producing physicians for that part of the citizenry that is economically and socially advantaged. The predominance of private practice and market-based economies in many countries facilitates the movement of doctors through medical school into practice among those with wealth and health insurance. In the process, health equity is not well served. Poor populations have fewer physicians (and other health professionals), less services provided, poorer outcomes, and greater morbidity and mortality.

The historical and current efforts of the Cuban medical education system to reverse these trends, both in Cuba and around the world, are global exceptions. The recent efforts to increase the output of medical education from Cuban schools for both domestic and global practice are well-described in "Cuban Medical Education: Aiming for the Six-Star Doctor" by Ileana del Rosario Morales Suárez, MD, MS, José A Fernández Sacasas, MD, MS, and Francisco Durán García, MD (see *MEDICC Review*. 2008;10(4):5-9). Of particular interest is the authors' description of the University Polyclinic Medical Training Program (UPMTP) in Cuba, which moves the principle site of medical education out of the hospital and into the polyclinic. They report that 292 of the country's 498 polyclinics are now engaged in the UPMTP program. Seventy-five to eighty percent of all educational experiences for students in the program take place in community primary care facilities. Only a quarter of students' six-year experience takes place in hospitals.

The benefits of this program are many, but two stand out. The successful use of an outpatient base for medical education would greatly increase the capacity of any institution or country. Secondly, the focus of education in ambulatory facilities is far more congruent with the population's experience with health, the vast majority of which does not occur in hospitals. Nonetheless, moving medical education out of hospitals has proved a Sisyphean task that has stigmatized the education, values, and perceptions of many generations of physicians. One of the reasons for the global crisis in primary care delivery is that physicians in many countries eschew ambulatory work in favor of hospital-centric specialty careers that minimize the role of health prevention and maintenance, and maximize expensive salvage strategies in medicine.

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In the United States, some 20 new medical schools were opened in the 1960s and 70s whose missions included community-focused education. Their curricula featured an emphasis on community medicine, greatly increased extramural and community-based rotations, an emphasis on family medicine, and a faculty committed to a new model of medicine. For the most part, these schools have modest research bases and do not fare well in prestige-based national ranking systems. Many of them, however, have remained constant to their mission and have produced large numbers of primary care graduates who are essential to rural and regional health and wellbeing.

In the American osteopathic school community, a number of experiments in community-oriented medical education have taken place over the years. The most notable one that has elements in common with the Cuban UPMTP program is the Mesa, Arizona-based campus of the A.T. Still University School of Osteopathic Medicine in Arizona (SOMA). This program, started in 2006, sends all of its students to one of 11 community health centers around the United States for all but their first year of education. Their educational and clinical home will be the community health center (similar to a polyclinic), and they will spend time "back-rotating" to hospitals for limited periods and specialty exposure. The school has yet to have any graduates or any emulators, so it is hard to speak definitively about how it will fare in the US medical educational and practice environment, but it does represent the boldest effort in the United States to depart from the traditional Flexnerian medical center-based model of medical education and, like Cuba's University Polyclinic Medical Training Program, it promises to graduate physicians for whom health equity is an implicit mission.

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To the Editors of *MEDICC Review:*

My compliments on the quality and content of the fall 2008 *MEDICC Review* (*Teaching for Health Equity: Changing Paradigms of Medical Education*). It is noteworthy, and I'm sure not coincidental, that those innovative medical programs which embrace social accountability as a major premise in developing their novel curricula are in countries that have a national health program or governments with a strong commitment to improving health equity. It is clear that all nations—developing or developed—need to use this approach in order successfully to address the healthcare challenges of the 21st century.

> **...those medical schools in the United States that are attempting to address the issues of health equity frequently are hampered by inadequate funding**

It is unfortunate that, in spite of the efforts of some US medical schools to establish innovative and model curricula such as those described in *MEDICC Review* (e.g. the University of New Mexico School of Medicine), the majority remain adherent to the Flexnerian model of medical education.

The consequence of this is the perpetuation of fragmented, costly, specialty-driven health care in what is effectively an illness treatment industry rather than a healthcare system. Moreover, those medical schools in the United States that are attempting to address the issues of health equity frequently are hampered by inadequate funding which, given the current economic crisis, likely will make it even more difficult to expand current programs or to develop new ones.

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To the Editor:

I read with great interest the article "Social Accountability: Medical Education's Boldest Challenge" by Charles Boelen in the fall 2008 edition of *MEDICC Review (Teaching for Health Equity: Changing Paradigms of Medical Education*). Dr Boelen provided an excellent viewpoint on the necessity of medical schools to meet the requirements of social accountability in order to train physicians to become active players in the development of healthier, more equitable societies.

I would suggest that the service-learning model is one method that can be used to address social accountability in the medical school curriculum. "Service-learning" is defined as a structured learning experience that integrates community service with preparation and reflection. Students engaged in service-learning provide community service in response to community-identified concerns and learn about the context in which service is provided, the connection between their service and their academic coursework, and their roles as citizens and professionals.[1]

Through the service-learning model, students can learn the tools of community health needs assessment and health promotion and also become more acutely aware of the social determinants of health. In medical education, service-learning opportunities are designed with the intention that students will continue to use these skills to address health issues on a community level throughout their careers.

> **...the service-learning model is one method that can be used to address social accountability in the medical school curriculum**

I would assert that an institution that is able to commit the faculty, staff, and financial resources to integrate service-learning into its curriculum is well on its way to meeting the three standards that Dr Boelen discusses in his article. Social accountability in medical education will continue to be an important issue as health systems across the world evolve, and medical schools must find creative ways to engage their students in this evolution.

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1. Seifer SD. Service-learning: Community-campus partnerships for health professions education. Academic Medicine. 1998;73(3):273-7.

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