*Director's Corner*

# Improving Rural Health and Transforming Medical Education: Two Peas in a Pod

By Adina Kalet, MD, MPH

*In this issue of the* Transformational Times *devoted to the MCW regional campuses, Dr. Kalet muses on how centering the social mission of medical education to address physician workforce maldistribution creates a hotbed of innovation which pays off in the long haul …*

When I was 17 years old, I signed a contract to serve a medically underserved community as a primary care physician for five years in exchange for an innovative, excellent, highly subsidized, accelerated medical education. Committing to that path was the most consequential decision of my life up until that time (admittedly I was young). I was the first in my family to get on this path. I was so terrified about what I was getting myself into, I didn't sleep for the full week before signing that document. Not certain I wanted to be a physician, I was not sure whether skipping two years of my life to get there fast was the good or right thing to do. The one person in my life who knew anything about medical school thought taking this non-traditional academic path was too risky. We were both wrong.

Taking that "road less traveled" opened a path for me that was more eclectic, creative, flexible, and optimistic than it might have been. I have had a lifetime of meaningful work, and this was almost entirely due to early exposure to passionate, risk taking, innovative medical educators on a mission to ensure all people, especially those with less, had access to physicians prepared to do the job. "And that has made all the difference," to quote Frost.

Sound familiar?  It should. This is exactly the magic happening on MCW's two regional campuses.

**Mission Possible: Preparing physicians to serve rural communities**

People who live in rural Wisconsin are more likely to be older and less likely to have health insurance. They have fewer resources and poorer health outcomes than their fellow citizens who live in metropolitan and suburban areas. They are more likely to suffer from chronic diseases such as diabetes, heart disease and cancer. Rural youth suicide rates are almost double that of urban counterparts.

There is a huge, unmet need. Almost 20% of Americans live in rural communities, yet only 6% of our country's physicians practice in such communities. Put more starkly, there are about 65 primary care physicians per 100,000 rural Americans, compared to 105 for the same number of urban and suburban Americans. This primary care gap is the "tip of the iceberg." All medical specialties, especially those that provide mental health care, are especially scarce in rural communities.

Addressing rural health care workforce shortages is a challenge all over the globe. Therefore, the very detailed 2018 report by the Wisconsin Council on Medical Education & Workforce is sobering but not surprising. There will be an estimated shortfall of 745 primary care doctors in the state by 2035, leaving many rural communities with no easy access to medical care. There is a perfect storm of reasons for this situation, including the fact that forty percent of family doctors are expected to retire, and fewer younger physicians are choosing to settle in these communities despite the high quality of life and beautiful surroundings.

In general, medical schools are located in—and attract students from—urban areas. As a result, students and residents develop their personal and professional identities entwined with urban regions. They are more likely to find work in such areas.

While the causes and solutions are complex and multidimensional, medical education can play an important role in addressing the maldistribution of physicians. As a result of Abraham Flexner's 1910 report critical of the American medical education, we embraced a highly Germanic, hyperrational and structured approach to physician training. Attempting to standardize medical education, almost half of the existing medical schools, especially those serving poorer Americans and racial minority groups, shut down. In many ways, we have spent the last 100 years recovering, building a network of schools that prepare excellent physicians who have been trained to thrive professionally in settings which provide great satisfaction and many challenges. These schools serve as laboratories for transformative practices, challenging traditional medical schools to up our game.

**The value of community-located medical education**

At the same time, as medical expertise became concentrated in urban settings, rural health was neglected. The emergence of community-based medical schools has had to address many recalcitrant challenges, including:

- How do we attract and select students more likely to spend their lives in rural locations?
- How do we train physicians with the broadest array of skills, temperament, and courage to be generalists when payment models and debt burden incentivize physicians to specialize?
- How do we attract and retain physicians in communities with fewer options than urban communities?
- How do we work with community assets, technology, population health data science and the human touch to reduce maternal and fetal death, drug, tobacco and alcohol use, and motor vehicle accidents?

Most successful models, and there are many, combine locating in and recruiting students from such communities, ensuring vibrant, talented, and creative medical educators are front and center, and providing a range of incentives to those who stay. Such medical schools always have too few resources, but with novel public-private partnerships, these schools are "hotbeds" of innovation that are often decades ahead of their urban colleagues when it comes to transformative medical education.

**MCW creates two remarkable regional campuses**

Sensing the impending concurrent crises of physician shortages, critical rural health issues, and growing physician debt burdens, Medical College of Wisconsin President John Raymond and Dean Joseph Kershner, launched two regional campuses, aiming to bolster the generalist and psychiatric workforces for central and northern Wisconsin. They were generously supported with funding from multiple community partners including the Advancing a Healthier Wisconsin Endowment.

MCW-Green Bay accepted its first class of twenty-five students in July 2015 and MCW-Central Wisconsin, located in Wausau, launched the following year. Each campus, in its own way, deeply engages with local and regional community members on selection and admissions processes. Both have a three-year, "calendar-efficient" curricula, that are tightly linked with the MCW-Milwaukee curriculum but delivered, in a technology enhanced way, by local faculty and staff. Each campus has built unique, locally relevant clerkship training models. Neither program limits the residency pathways of their students and both groups have done well "matching" graduates to the residencies of their choice (Raymond and Kerschner, 2015). Evidence collected over many decades finds there are no serious down sides of similar accelerated medical curricula. These models are informing the MCW School of Medicine curriculum reform efforts currently underway.

**Lambeau Field, College Baseball, and Door County? What could be bad?**

The regional MCW campus communities are tight knit. One of the loveliest weekends I have spent in the past year started in the Luxury Suite at Athletic Park cheering on the Wausau Woodchucks, while drinking beer surrounded by MCW-CW medical students. The campus's small size provides social cohesion among students, staff, and faculty that should be the envy of the Milwaukee based program. Our regional campus students work hard, most completing a four-year curriculum in three (with an option to elect a 4th year if the need arises). Both MCW regional campuses are set in beautiful, mid-size cities with cultural amenities in proximity with rural communities that welcome them. By nature, faculty at new medical schools tend to be pioneers, adventurous, and committed to the work, making for inspiring mentors and role models.

**In it for the long term: the outcomes will take decades to manifest**

The World Health Organization has challenged all medical schools to embrace a social accountability framework which acts to produce a "fit for purpose" medical workforce which takes responsibility for rural health medical education across the entire continuum of training. The international rural health community is vibrant, politically involved, and very scholarly, making for many career opportunities for rurally engaged medical school faculty. Medical educators who are ready for a challenge couldn't find more meaningful work.

Deans Lisa Dodson (MCW-CW) and Matthew Hunsaker (MCW-GB) have assembled top notch education teams and launched highly novel curricula. These are early wins because building a medical school does wonders for attracting and retaining good physicians in rural communities, even though it will be decades before we will see the longer-term fruit of their labor on the careers of their students and the health of the public.

**A tear of pride and no regrets**

About twenty years after I signed that contract, I was serving as a primary care physician in a public clinic on the Lower East Side of Manhattan. One evening, I was invited to have dinner with the dean of my medical school. This academic physician-scientist with an Ivy League pedigree was on an alumni listening tour (and, yes, he was raising money). Knowing I was a medical educator, he let it slip that although he was passionate about the school's social mission, he was getting push back about the "funky" curriculum and was under pressure to roll it back and replace it with a more a traditional, easier to defend, one. This stately, grey haired, Black man looked pained.

I explained to him that I had also once been a skeptic. I was not convinced of the need for the intense, time consuming, core "community practice" curriculum with its focus on public health, community engagement, epidemiology, service-learning, and early clinical experiences that competed for attention with all the required foundational sciences course work. But, I explained, in hindsight, it was clear that it was exactly those aspects of the curriculum and the

committed educators who delivered it that prepared me to thrive as a clinician and educator in one of the poorest urban communities in our country.

A tear of pride rolled down his cheek. He said, “My work is done.”

*For more reading:*


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