Kern Grand Rounds Preview

Creating Physicians Where a Medical School Should Not Exist

by Dan Hunt, MD, MBA - Liaison Committee on Medical Education (LCME) Field Secretary and Secretary Emeritus

1. What are the main benefits of regional campuses?

First, let's take an unofficial tour of the history of regional campuses that will set us up for ways to reflect upon answers to this question and the next three. Keep in mind, this author is not a historian and mainly draws his conclusions from personal observation that is occasionally supported by actual evidence.

Both the Indiana University and the University of Washington have legitimate claims of being the first schools to establish regional campuses. This was in response to the early 1960s manpower studies that predicted major shortages of physicians and nurses, and led to the federal government capitation funding to incentivize the expansion of enrollment of existing medical schools and/or the creation of new schools. In response, by the early 1970s, 27 new medical schools were created (1). As an example, Ohio doubled their number of medical schools going from three to six (2) during this period. This is when Indiana and Washington began the expansion of their programs by developing regional campuses. Indiana University created their regional campuses in their own state, but the University of Washington contracted with Alaska, Montana, and Idaho (and later, Wyoming) to be that state's medical school while also adding a first-year regional campus on the east side of the state of Washington to blunt efforts by legislators to create a second medical school in Eastern Washington.

Thus, one benefit of having regional campuses is the ability to add students without building costly classrooms at the university-based "Mother Ship." The U of W sold this concept to legislators as the "School without Walls." A second benefit for both of these early regional campus adopters was to eliminate future competition for state resources that happens when you have another hungry medical school at the state budget table.

Over time, as students trained in their own state for the first year and then did many or all of the clinical rotations in smaller communities in the region, more and more students sought residencies and, ultimately, sites of practice in rural underserved settings. The curriculum was designed so that only half of the required clinical rotations could be completed in Seattle which required all students, regardless of home state, to experience practice sites such as pediatrics in Pocatello, ID, surgery in Fairbanks, AK and – one of my favorites – Family Medicine in Havre, MT. Thus, a third benefit of regional campuses is that, by training students with faculty who have chosen to live in small communities and making sure those students learn the skills needed to work in less resourced areas, rural underserved areas gain new healthcare manpower. (3,4)

Let us also not miss a fourth benefit, amongst many more, that community pride and community engagement should not be underestimated in regional campus towns that have "their own medical school," particularly when it is time to convince funders or legislators that additional funding is needed.

2. **Do you anticipate a significant increase in the number of regional campuses over the next 10-20 years?**

No. Just a guess here, but I think that the heydays of expansion of regional campuses is slowing down. In 2011, forty-five medical schools reported having at least one regional campus, and this peaked in 2016 at fifty-four and has plateaued at fifty-three for 2017 and 2018 (5). I don't know the exact number of regional campuses, but with well over one hundred, I don't see that many more communities that can support a regional campus unless

there is a major breakthrough in how medicine is taught. I do have some ideas on how that breakthrough could be done, but that is a story for a different time.

3. **Have regional campuses resulted in an increase in the diversity of medical school applicants and graduates?**

   Sadly, no … but hold on, as there are a number of assumptions to this knee-jerk answer. Remember, each school defines their diversity categories. So, if we define "diversity" solely as ethnic minority populations, then the sad answer is that, while it is true that the numbers of minorities have expanded as the overall enrollment has grown, unfortunately, this rate of expansion is less than the growth rate of the majority population. However, if we define diversity as those coming from rural environments, then my guess and hope is that this type of diversity has increased, and can be traced back at least, in part, to the growth of regional campuses.

4. **Do regional campus graduates pursue different residencies compared to traditional one campus schools?**

   I hope someone in the audience of the Grand Rounds has an answer to this, but my first reaction is that with over one hundred regional campuses, it is hard to draw conclusions. There are certainly many medical schools with regional campuses that take pride in demonstrating that their graduates are more likely to select primary care residencies and, especially, those in rural settings, but there are also regional campuses that are an extension of the culture of their Mother Ship, and their graduates compete for the same residencies as their classmates from the main campus. Again, I do hope someone in the audience can clarify this for us … I would like the answer to be that, on the whole, they are more likely to pursue primary care; but my gut reaction is that culture trumps curriculum.

Dan Hunt, MD, MBA, served as the AAMC Co-Secretary of the LCME for nine years. He has also served as the Founding Academic Affairs Dean for two new medical schools, one in Canada and the other in New York. Prior to that he served as the Associate Dean for Academic Affairs at the University of Washington School of Medicine, overseeing the five state WWAMI program for seventeen years.