A few Questions for…

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Rural hospitals have long faced tight funding, declining resources, challenging recruitment/retention issues, and low volumes/reimbursements, yet they are expected to be ready to care for the full range of health issues including opioid / methamphetamine addiction, COVID-19, refractory mental health issues, farm machinery accidents, and high-speed vehicular trauma. Dr. Bruce Campbell, Editor-in-Chief of the Transformational Times*, spoke with Lisa Dodson, MD, Sentry Dean and Founding Dean, MCW-Central Wisconsin located in Wausau, Wisconsin this week about the challenges facing her campus and the future of rural healthcare…*

1. **How does a regional campus help address some of the challenges of rural health care?**

   Regional campuses play several roles as we address the unique challenges of rural health. First and foremost, a regional campus can directly impact workforce availability. Students who grow up away from large urban areas, train in smaller cities, and are accustomed to the lifestyle are more likely to practice in less densely populated, underserved counties. These students have the extra level of resilience needed to survive and thrive and will be ready for the constant challenges in both pathology and policy that have an oversize effect on rural communities.

2. **What can you tell us about students that are drawn to regional campuses?**

First of all, they are truly unique. Students coming from rural areas to medical school are unbelievably underrepresented. Nationally, medicine has the smallest percentage of students coming from rural backgrounds than ever before and most medical students in urban areas will never meet a rural mentor or have any rural experience. So, we actively look for students from rural areas, believing they have a greater likelihood of going back to theirs or similar communities.

The mentors these students meet are critical. They show the students that that they don't have to be "saints" or "missionaries" to go into rural medicine. These are great, fun, rewarding jobs. Working in these settings makes the students intrinsically motivated, curious, and pragmatic.

Because of their backgrounds and the backgrounds of their teachers, regional campus students might be less susceptible to the overt and subtle messages aimed at discouraging them from pursuing smaller community primary care careers. These students tell me that they are often subjected to comments asking them why they don't want to "aim higher." They hear that a lot but, fortunately, they also see how satisfied their mentors are. The students learn to say, "No. I want to do this." They learn to believe in themselves and their choices. Our goal is to support them to make the right choices.

Think about the challenge:

It is nearly impossible to convince a student to enter primary care in a small town if they have come to medical school from an urban/suburban background, have only seen urban medicine, and are convinced they want to be a subspecialist in a large city. The system is designed to take students who what to be family physicians and steer them toward specialties; rarely, does it work in the opposite direction.

Recruiting students from less populated areas isn't perfect, of course. Some students from small towns will see medical school as their "ticket out of Dodge." Finding students who will commit to return to a small

town after having been through medical school and residency training is special.

3. **What challenges do you see in the rural health care workforce and in rural health care in the coming decade?**

   Over the coming decade, we need to better understand and develop pipelines for all rural populations into health care professions. For example, we have an Advancing Healthier Wisconsin grant that is targeted to Hmong students. We hope to expand to other groups. One great example in Wisconsin is the UW-Madison Native American Center for Health Professions which was founded by Dr. Erik Brodt (view the We are Healers website here).

   To attract and retain rural students into our communities, we are partnering with Aspirus, a local health system. The Aspirus Scholars program provides full-tuition scholarships to medical students in exchange for a commitment to return to work in the area for at least five years. Currently, there are three Aspirus Scholars at MCW-Central Wisconsin.

   Political and policy changes are imperative. Policy makers must focus on community engagement, health equity, population health for all populations throughout the state. Unfortunately, the solutions that work in urban regions don't always work in smaller towns. Both areas need access to equitable public health. Both areas need access to quality care in trauma, medical emergencies, and obstetrics. Even though they might not be needed often, and the volumes of patients are low, the systems - and society writ large - need to make certain that these services and properly trained staff are available when needed. When someone is dying, you can't always just "drive to the next town." Keeping these services available is a larger problem than any one town or county and the loss of small-town hospitals across the region is a concern.

We need to think of the need for healthcare in the region the way our predecessors faced the need for electricity when it first became available. In those days, rural areas developed public utilities. There was a societal decision that everyone should have access to electricity because they thought the benefits outweighed the costs of getting wiring to remote regions – a concept with which we all agree. To reach rural areas, utilities required federal and state funding, but still maintained local control. Medicine, like electricity, should be delivered to all people in need, not to the highest bidder.

We need to advocate for our communities. If school systems are underfunded and failing, it will be hard to recruit physicians with young families. If infrastructure is not maintained, there will not be enough people to support practices and physicians will not have enough resources to provide care.

4. **What challenges do you see in your accelerated curriculum, and in medical school curricula, in general?**

We do need to build better curricula. A compressed medical school curriculum like ours does not fit for someone who intends to enter subspecialty surgery; there just isn't sufficient time for them to get the exposure they need. On the other hand, not every student needs the same length of time to master what they will need to succeed. We need to stop thinking of medical school duration as a series of "integers"; we should not design curricula as exactly three, four, or even five years. In competency-based curricula, students finish when they have displayed mastery. I have seen students who are close, but not quite ready, after their three years. Some would have needed a few extra months beyond three years to be prepared and not a full year. Curriculum reform should focus on using extra time to optimize student preparation and not as "remediation."

5. **What has surprised you most in your position?**

Being a dean is a weird job! It's like having a baby. You hit surprises. You hit roadblocks. Nothing is quite what you planned. For example, when I arrived, there were great physicians here, but we needed to launch into faculty development to turn them into teachers. It was harder than anticipated but very gratifying.

It has been rewarding to see how much our teachers clearly enjoy the opportunity to give back to the next generation. Since the classes are small, we find the chance to work with the students to be very engaging. They challenge us. They want to know, "Why do you do things that way?" The students bring ideas, keep us fresh, and keep the job rewarding.

I have been surprised by how difficult it can be to recruit. Wausau isn't that small of a town and we are close to major metropolitan regions. The area is amazing. We really need neurologists, but the system has been unable to get people to look. It's hard.

6. Any final words?

I have loved seeing how we all depend on each other in ways that aren't seen in larger urban areas. A small town will put you to work. The hospital hired my husband to install their first computer system. Once that project was complete, he was hired to do regional economic development. We all work together.

I think being part of a regional campus has given me a unique perspective on the current state of medical school education. Too often, schools focus on what doctors need and want. "We want more specialty training!" At a regional campus, we focus on what the community and society need. That is more rewarding and is, I believe, where medical education needs to turn. When we ask, "What do the neighbors need?" we think about where best to place our resources. Regional campus can demonstrate this. We listen and respond.

Lisa Grill Dodson, MD, is the Sentry Dean and Founding Dean at MCW-Central Wisconsin, a position to which she was appointed in August 2014. She completed her family medicine residency and fellowship at the Oregon Health Sciences University. Interview conducted by Bruce H. Campbell, MD.