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CONLEY ESSAY

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The Purpose of a Medical School

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State University Medical School's explicit, community-based mission is to educate primary care physicians for its home state, which comprises mainly small towns and rural areas.

As its fortieth anniversary approached, State U. Medical School administration reviewed alumni data and realized that the school had not come close to fulfilling its mission. The school required those who received financial aid to complete residency in a primary care specialty within the state. If they did so—and most did—their loans were forgiven. But the alumni data showed that, over the years, an average of 60 percent of residents had gone on to fellowships in subspecialties immediately after residency, and many of those had moved out of state to practice.

As a corrective to this “mission slippage,” a new policy for state-funded loans and privately funded scholarships was proposed such that students who declared their interest in practicing primary care in the state and received full tuition from state or private sources had to practice primary care in the state for 10 years after completion of their residencies to repay the cost of their medical education. There was a sliding repayment scale based on service increments of 1 year for those who practiced primary care in-state but did not fulfill their 10-year service agreement.

Several of the school's private funders objected to the proposed policy; at least one was outraged.

“I've always supported our mission,” he said, “but this new policy is coercive. It's social engineering, is what it is. Flies in the face of everything this country and this state stand for. When my grandfather came to this state in the early part of the last century, a man could make his living any way he wanted to, long as he didn't break the law.”

“What's worse,” the funder continued, “is that this policy hurts the middle- and low-income kids. The rich kids don't need our support, so they can practice anything they want, anywhere they want.”

Response

An impressive number of people have an opinion on the training of physicians. There are the educators, the faculty and deans and department chairs who live in academic medicine and have firsthand experience with the ways in which it falls short. There are public health officials and hospital administrators who predict changing disease patterns and envision workforce shortages 20 years hence. There are the patients who benefit from the latest innovations but may be inconvenienced by how things operate at teaching hospitals. And of course there are the students themselves, with exceedingly earnest personal statements about wanting to *save lives* and *help people* while also earning a living. Medical schools have to accommodate all these groups while still carrying out the core functions of a professional school: to “transmit knowledge, to impart skills, and to inculcate the values of the profession” [1].

Private medical schools are free to balance these interests as they see fit. Their public counterparts have the additional burden of accountability to the taxpayers of the state in which they are located. An unscientific survey of state medical schools’ mission statements suggests that they fall into two main camps. There are those that are centered around their students’ success, like the School of Medicine at University of Missouri, Kansas City, which strives to “prepare graduates so they are able to enter and complete graduate programs in medical education, qualify for medical licensure, provide competent medical care” [2]. Likewise UCLA prepares “our graduates for distinguished careers in clinical practice, teaching, research, and public service” [3]. Such schools define their purpose around their obligations to their students, the implication being that society benefits from the provision of well-trained physicians and the apparatus of the academic medical center.

On the other hand there are those schools with a community-focused mission, like University of Massachusetts, which begins by aiming to “advance the health and well-being of the people of the commonwealth and the world” [4], or Ohio State, which tries “to improve people’s lives through innovation in research, education and patient care” [5]. To such institutions, the teaching of medical students becomes almost a secondary goal, a means to a greater end.

State University Medical School (SUMS) falls squarely into the latter camp. With an explicit mission to educate primary care physicians for Home State, it has historically relied on a variety of financial mechanisms to encourage students to pursue careers in primary care. These incentives have been ineffective at best, with much of the funding going to support students who subspecialize or move out of the predominantly rural state. Now that SUMS has tried to remedy the situation with more rigorous criteria for loan forgiveness, it has been accused of social engineering by its outraged private funders, who are concerned that the proposed policy unfairly penalizes those students who rely on loan money to support their education, leaving those from wealthier upbringings free to pursue their vocational dreams.

To be worth implementing, SUMS's new loan forgiveness program should be both fair and effective. The first gets at the core ethical issue in this scenario, the justice of preferentially allocating a scarce resource (in the form of financial aid) in favor of those students willing to practice a specialty of benefit to the citizens of rural Home State. The intended effect of the policy is to shift loan forgiveness dollars to students who practice primary care. By doing so, SUMS hopes to better effect its mission and meet its responsibilities to state taxpayers. The implication is that students who formerly pursued subspecialties of internal medicine or pediatrics will no longer benefit from the program.

Students with full family support for medical training will be unaffected. For low- and middle-income students, who rely on loans to finance their education, the new policy removes their option to engage in fellowship training while also qualifying for loan forgiveness. The conflict emerges because the best interests of society, to have an adequate supply of primary care physicians, may not reflect the best interests of the students, to pursue their career of choice unencumbered by financial obligations.

SUMS has clear responsibilities to its students to prepare them for residency and licensure. But while students should rightly expect their training to allow them to become physicians, it does not follow that SUMS cannot promote certain specialties through mechanisms financial or otherwise. An outraged private funder is concerned that the proposed policy is unduly coercive; it is not. Applicants to SUMS who are not interested in primary care can apply to the numerous private medical schools that are not mandated to produce any particular flavor of physician. There are ample loans available that are unrestricted by specialty, courtesy of the federal government. If these students go to other medical schools, more positions would be available in the entering class for students who are truly committed to primary care. Moreover, students with an initial interest in primary care who discover other interests during training are entirely free to pursue their career goals. SUMS is asking only that Home State not be asked to bear the costs of their educational fulfillment. As the private funder's grandfather was indeed able to make his living any legal way, the students may do likewise. They are not entitled to receive their training on the taxpayer's dime, however.

The intent of SUMS's loan forgiveness policy has always been to encourage careers in primary care. The recipients who went on to subspecialize after accepting loan forgiveness were in effect gaming the system, following the letter but not the spirit of the program. Allowing the perpetuation of a system that rewards young doctors for completing a primary care residency without requiring that they ever practice primary care is an abuse of the public trust. SUMS is right to address this disparity and to consider changing the criteria for financial aid.

By the nature of a loan forgiveness program, the proposed changes will clearly affect low- and middle-income students more than wealthy students, who may be able to graduate medical school debt-free thanks to family contributions. In this way the new policy is similar to other programs such as the Health Professions Scholarship

Program or the National Health Service Corps, which exist to supply the nation's military and underserved areas respectively. In all cases students have some of their educational costs underwritten in return for providing a needed service. Students are no more coerced into entering primary care fields than they are into joining the military. Still, it seems unfair for students with more financial need to feel that their future debt loads limit their career options. Yet SUMS need not abandon its mission of training primary care physicians, or persist in a clearly suboptimal program in its pursuit. Rather, it is to create a source of financial aid for students who show aptitude for other fields in medicine. This approach—enabling students in need to follow their interests—is perhaps better suited to private funders, who are free to scholarship whoever they want. That way SUMS remains responsive to the needs of Home State, while allowing philanthropists to further the equally worthy goal of supporting medical students from low- and middle-income backgrounds.

To realize SUMS's goal of increasing primary care graduates, however, it is not enough for the proposed alterations to the loan forgiveness program to be merely fair. An acceptable solution will also be highly effective, and it is here that the new plan falls short. While a frequently referenced barrier to primary care careers, the absolute amount of student loan debt has not been shown to correlate with specialty choice [6]. The choice of a medical specialty is multifactorial, involving students' interests and how they perceive them to align with specialty characteristics, the medical school curriculum and experience, lifestyle and financial considerations, and others [7]. While many of these factors are outside of a medical school's control, there are a number of interventions that are consistently associated with student decisions to pursue primary care, such as a required third-year primary care clerkship, more weeks in family medicine clerkship, or a longitudinal primary care experience [7]. Such experiences additionally benefit all students in the class, promoting cross-discipline understanding and respect, key attributes in a team-based health care environment.

Finally, many of the factors discouraging students from pursuing primary care are structural. Perceived flexibility and “controllable lifestyle,” the desire for a well-paying job after completion of medical training, concerns about paperwork burden, malpractice environment, and physician autonomy [7] may all impact specialty choice, and are beyond SUMS's control. Nonetheless, as a public medical school in a mostly rural state, SUMS is well positioned to initiate a broader discussion of the primary care environment in Home State. Some reforms may require action by the state legislature; others by private health care organizations. Dollars to promote primary care careers should go where they can make the greatest impact; redirecting some of the funds should not adversely impact SUMS since they have been funneled directly to the loan forgiveness program.

SUMS is right to seek to alter an underperforming program to better serve the residents of Home State. Before implementing the proposed plan, however, a broader discussion of barriers to primary care in the context of specialty choice needs to happen. SUMS may find that other schools have found other mechanisms besides

loan forgiveness to achieve high rates of primary care-oriented graduates. By reallocating funds to those programs that show the most promise, SUMS can meet its responsibilities to both its students and Home State.

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