Family Practice Forum

On Minority Student Programs in Medical Schools

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Increased numbers of minority students have been admitted to medical schools in recent years and represent an effort toward correction of the disparity that has long existed between the number of students who have been recruited from the medically deprived poverty areas of our country and those from the medically well served, affluent communities. Simply to increase the number of minority students, however, is not enough, for the evidence already suggests that this policy of itself does not improve the lot of the medically underserved. Studies show that despite the increase in the number of ethnic minority students admitted to medical schools, physician shortages in medically deprived areas continue to grow.[1-6]

Research such as that by Kaufert et al[7] supports a contention that in the isolation of the medical school environment a reorientation occurs that dissuades students from their original goals of service to their communities or ethnic groups. Medical school training covertly (and, not infrequently, overtly) denigrates the patients, health-care workers, and the health-care systems of impoverished inner city and rural America. Many medical educators imply that the physician can only be true to his or her profession by being trained within the confines of the university's laboratory model, the university medical center.

Those who strive to improve the lot of the medically deprived do not wish the medical schools of America to discontinue the practices that have given our country research and teaching supremacy; however, they desire to see a greater proportion of the energies and money of our major medical institutions of learning directed toward improving the health services of those who are not, at present, on the health-care delivery route. Pauli has stated that, "Health-care demands made by society or by the patient in search of health care not only are directed toward institutions exclusively delivering health care, but also are now directed toward medical schools. There is an increasing public awareness of the relationship between undergraduate medical education and health-care delivery."[8]

Nowhere is the relationship between undergraduate medical education and health-care delivery needs more critical than in the development of meaningful medical school admission programs. An integrated program is needed that spans the pre-medical, medical school, and postgraduate training periods of individuals who are involved in affirmative action recruitment. Such a program could well have the following components:

1. Recruitment of the best possible students for affirmative action programs in medical school. This could be facilitated by support to Mentally Gifted Minor Programs for outstanding ethnic minority and rural students, as well as replication of special programs such as the Biomedical Science Program at Meharry Medical College.[9] Under the Meharry program, outstanding black college students have been involved in an intensive training program in mathematics and the biomedical sciences during every summer since 1969. This program has allowed educationally deprived ethnic minority and rural students the opportunity to gain competence in basic sciences and compete on more equal terms with the educationally privileged, and a majority have gone on to medical school, dental school, and other graduate education.

2. Increase of student awareness of community needs and maintenance of a liaison between the students and the communities of their choice. The following kinds of experiences during medical school are recommended: *first year* – one half day per week or one weekend per month spent as patient advocate, office assistant, or health survey participant in the student's community of choice; *second year* – one half day per week or one weekend per month spent in introduction to clinical medicine in the student's community of choice; *third year* – five to six-week clerkship in primary care to include full-time clinical experience in a medical school satellite clinic in a rural area or an inner city setting; *fourth year* – six to twelve-week preceptorship/clerkship in an approved community primary care clinic with the student gaining full-time clinical experience in all facets of primary care; and *postgraduate years* – resident physicians in primary care assisting in medical student training programs in rural and urban community satellite clinics.

It is my contention that if any state is to increase the number of physicians who will serve its medically deprived areas, affirmative action recruitment of educationally, economically, and culturally handicapped students from ethnic, poverty, and rural areas must continue. In addition, improved care to the medically deprived will occur only when enlightened medical school admission policies are combined with medical school education policies that allow well-prepared and motivated students to participate in community or neighborhood health-care delivery throughout their medical training.

This paper is based on a presentation before the California Legislature, Senate Select Committee on Health Science Education, in Los Angeles, December 9, 1975. Requests for reprints should be addressed to Dr. Gabriel Smilkstein, Associate Professor, Department of Family Practice, University of California, School of Medicine, Davis, Calif 95616.

References

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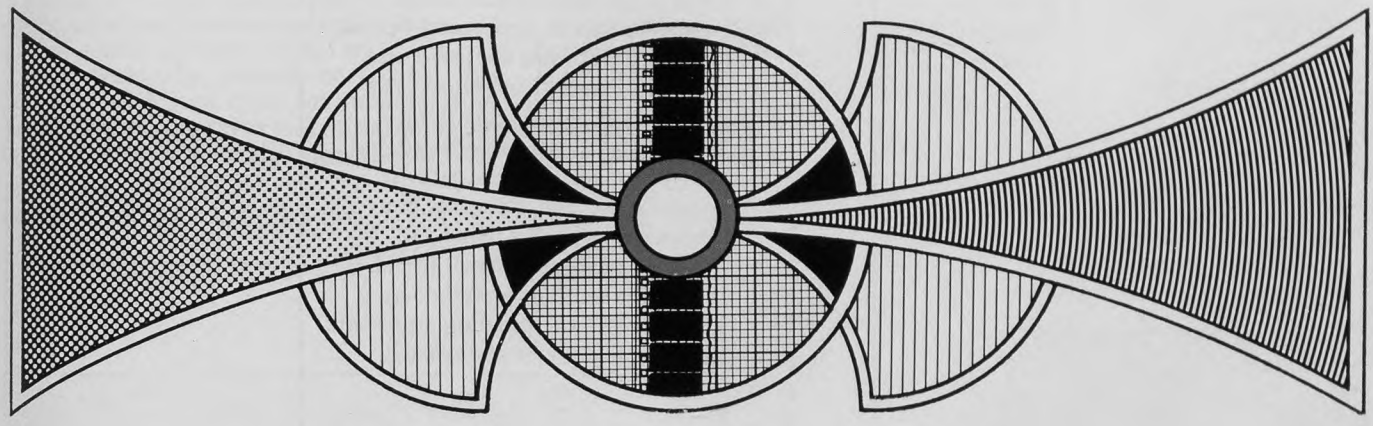
Reviews of Audiovisual Materials

AUDIENCE
1 Family physician
2 Family practice resident
3 Family nurse practitioner/Medex
4 Medical student
MEDIA
A 35 mm slides
B 16 mm film
C Video tape
D Models

The following audiovisual materials have been reviewed by the Audiovisual Review Committee, an *ad hoc* group of the Education Committee of the *Society of Teachers of Family Medicine.* Membership: John P. Geyman, MD, Chairman (University of California, Davis), Richard M. Baker, MD (University of California, San Diego), Thomas C. Brown, PhD (University of California, Davis), Thornton Bryan, MD (University of Tennessee, Memphis), Laurel G. Case, MD (University of Oregon Medical School, Portland), Wendell B. Garren, MD (Geisinger Medical Center, Danville, Pennsylvania), James L. Grobe, MD (Phoenix, Arizona), Warren A. Heffron, MD (University of New Mexico, Albuquerque), Brian K. Hennen, MD (Dalhousie University, Halifax, Nova Scotia), Thomas L. Leaman, MD (Pennsylvania State University, Hershey), I. R. McWhinney, MD (University of Western Ontario, London), Donald C. Ransom, PhD (Sonoma Community Hospital, Santa Rosa, California), Philip L. Roseberry, MD (York Hospital, York, Pennsylvania), Rafael C. Sanchez, MD (Louisiana State University, New Orleans), Robert Smith, MD, (University of Cincinnati, Cincinnati, Ohio), William L. Stewart, MD (Southern Illinois University, Springfield), John Verby, MD (University of Minnesota, Minneapolis), Raymond O. West, MD (Loma Linda University, Loma Linda, California), Hiram L. Wiest, MD (Pennsylvania State University, Hershey). Reviews of each type of media were carried out by subgroups of the committee.



SOURCE	PROGRAM	MEDIA	AUDIENCE	COMMENTS	OVERALL APPRAISAL
Network for Continuing Medical Education 15 Columbus Circle New York, NY 10023 ($50.00)	**Clues to Congestive Heart Failure**	C	3 4	The objectives of this program are clearly stated. The subject is treated in a somewhat basic manner and the program is particularly geared to medical students and allied health professionals. The program reviews information from the history and physical examination relating to the various causes of congestive heart failure. A particular emphasis is placed upon early diagnostic clues to congestive heart failure. The content is comprehensive, definitive, and accurate.	Recommended