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## The US medical schools and health reform

"It is now realised that the needed changes in medical education should go beyond curriculum content and educational methods, and that the contribution of the medical school to the improvement of the health care delivery system should also be considered in the change process." [1]

Contemporary changes in American medical practice are attempting to keep pace with the demands of both individual patient consumers and their communities who search for equity and quality of health care services and delivery. The contemporary challenge for US medical education is not just in refining the content and process of medical education to enhance student learning (problem based learning, etc.); but whether medical schools can proactively set the pace for US health care reform and train physicians who will become competent field agents of change. They can thus influence the direction of American medical practice by actively addressing, within the context of the workplace and the community, the thorny issues of health care equity and quality.

US medical schools, in order to achieve this "new mandate", will need to train a physician, who, as a member of the health care team, will be competent not only in sciences basic to the practice of medicine but also have enhanced skills (the knowledge of social and behavioural sciences, clinical epidemiology, quality assurance, etc.) that are appropriate to provide the curative, promotive, and rehabilitative services necessary to meet the needs of the health care consumer and their respective communities.

If medical schools are to respond to this educational challenge ("from molecules to management"[2]) and become a driving force for health care reform - then the educational process must function within the context of influencing and changing the environment in which medical students learn and physician graduates will practice - in the community - not just in the locus of the hospital ward and outpatient department.

There are many models of community-oriented and community-based medical education in both developed and developing countries. Although some models may not be appropriate to every geographic and developmental setting within the US, a decentralisation of the medical educational process, rooted in the community, will not only provide the opportunity for community-oriented education, but by the nature of its locus, bring medical schools out of the ivory tower and into the trenches of health care service and, by necessity, reform.

If US medical schools are to produce the number of primary health care physicians required to meet anticipated US physician workforce needs, they will have to restructure how and where these physicians are trained as well as address the disincentives of physician maldistribution and the income disparity of primary health care physicians vs. their procedure driven specialist colleagues. The how and where of this process can be done through a decentralised educational scheme to train medical students and resident physicians in the community. Through this process there is the opportunity to develop the "community glue" - the professional satisfaction with community service, research, and training - which, if linked to income and ongoing CME and professional incentives, will keep physicians there, in the generic community, as instruments of ongoing change.

Other experiences: The John A. Burns School of Medicine (JABSOM) of the University of Hawaii has developed two decentralised medical educational programs in urban, rural, and isolated settings in Hawaii[3] and Micronesia[4]. Not only do these programs address the specific physician workforce shortage needs of those communities, but they are also vehicles for health care change and reform. Through its partnership with private and governmental health care service providers, JABSOM is educating future physicians whose training is suited for the special health care needs of these different settings and is positively influencing how the practice of health care delivery is provided in those communities.

## References

1. Boelen C. The Challenge of Changing Medical Education and Medical Practice. *World Health Forum*, 14:213-216 (1993).
2. The Robert Wood Johnson Foundation Commission on Medical Education: *The Sciences of Medical Practice. Medical Education in Transition*. Princeton, NJ: The Robert Wood Johnson Foundation: 1992.
3. Felleti G, Murry C. Ke Ola O Hawaii: promoting better health for the underserved. *Pacific Health Dialog*, 1995; 2(1): 155-160.
4. Finau SA. Pacific health: an analysis for training new leaders. *Asia Pacific Journal of Public Health*, 1992/93; 6(2): 46-53.□

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# Finau

PHD EDITOR

## PHD Matters

This is a mammoth issue of PHD! We have covered only a portion of the existing developments in medical education and health reform in the Pacific. Besides the training of doctors, innovative approaches in health worker development is underway in nursing, oral health, community work, food and nutrition, environmental health, etc.

It is in this milieu that PHD aims to function, providing a medium for exchange and CME, and encouragement to write up and be counted. In the last issue, subtle institutional censorship reared its ugly head but with uncharacteristic diplomacy, the editors withdrew papers without burying the issues. It was the fine line between altruism and strangling initiative and idealism with strict honesty. PHD sufficiently displayed the issues for others to take up elsewhere!

PHD is on the internet. The exchanges on Pacific health issues can now shift to cyberspace but we must not forget that people actually happen on earth. We must thank Peter Biggs for this innovation to expedite PHD matters.

In future issues we hope to focus on specific locations. The September 1997 issue will focus on Health and Pacific peoples in New Zealand and funded through the new Pacific Health Research Centre, Department of Maori and Pacific Health, University of Auckland. Discussions are underway on thematic issues about New Zealand Maoris, Pohnpei, Hawaii, Fiji, Tonga, Palau and Pacific peoples in the US. These of course depends on papers and funding. So if you have either or both let me know ASAP.

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The editor's job is unenviable and lonely. Through the coconut wireless it is said that PHD is a monologue. This is good because it takes two to dialogue. So as a reader, supporter, cynic, enemy or could-not-care-less receiver of PHD, do drop us a line. We also welcome advertising and marketing interests. It is only through dialogue and collective effort that PHD will matter! □

**" Pacificans are a heterogeneous and indigenous group of people who inhabit the islands within the Pacific Ocean proper and acknowledge a common biopsychological status and reciprocal obligations. "**

*S. A. Finau, Annual Scientific Meeting of RACP, Auckland, 1997*