Community-Based Teaching and Academic Medical Centers: A Fragile and Uneasy Alliance

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Medical student teaching in primary care is moving into communities so quickly and so thoroughly that it could be causing the giant sucking sound Ross Perot always talks about. Academic medical centers (AMCs) have discovered the community as a resource for medical student teaching, although not always for the most salutary reasons. Here are a few of the less educationally sound motivations:

- Political pressure. "The legislature made us do it."
- Financial pressure. "We can't teach students in our faculty outpatient clinics, it affects productivity too much."
- Accreditation pressure. "The Liaison Committee on Medical Education says there are critical professional behaviors to be learned in community-based ambulatory and primary care settings, so I guess we'll have to move some of our students there."

Above all else, however, the move to community-based teaching is happening because of the Willie Sutton rule of medical education: We teach medical students in the community because that is where the patients are. The clinical systems of most primary care departments in AMCs are simply too small to support an increased emphasis on primary care teaching. The resulting move outside AMCs is an impending disaster much like the situation described by Yogi Berra when he said, "It's no wonder no one comes here anymore, it's too crowded." In our enthusiasm to move medical education in general, and primary care medical education in particular, into the community, we have created a number of serious problems. Major issues include:

- A lack of specificity in the educational objectives of such experiences
- Variability in the quality control of the medical teaching provided
- A lack of commitment to faculty development by both the academic institution and the community teachers involved
- Poor financial and institutional support for the teachers involved
- Excessive dependence on a set of educational and clinical resources whose commitment to the educational process may be transient

The study by Vinson et al[1] in this issue of the *Journal* provides some thought-provoking information with which we can discuss these problems. Vinson and his colleagues from the University of Missouri–Columbia used a two-stage survey methodology to assess the behaviors and opinions of community-based family physicians, general internists, and general pediatricians regarding teaching medical students in their offices. Despite an extraordinary methodological rigor applied to the identification and pursuit of potential responders, only approximately 18% of potential respondents provided data about teaching. This low response rate is one of the most telling findings. It is reasonable to assume that those who did not complete either the postcard or the questionnaire had less enthusiasm for, and less involvement in, office-based teaching. On the other hand, those active teachers who did complete the survey indicated a high level of enthusiasm for their teaching role and a high likelihood of continuing to teach. It seems unlikely that this enthusiasm resulted from the teachers' infrequent and unimpressive tangible benefits and remuneration. (Note that almost as

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many students received stipends for learning in the community setting as did the teachers for teaching there.) Thus, an important portion of the medical curriculum is dependent on the personal good will and individual commitment of an altruistic minority of community-based primary care physicians. Such altruism and enthusiasm are fragile commodities, however. Motivation may lessen with: increased financial pressures, the inability to teach as an employee of a large health care center, the loss of interest after several years of carrying a large share of the medical educational burden, a bad experience with a single student, or a personal life change that creates different professional demands.

These problems are particularly worrisome in light of the dramatic shift in practice patterns by recent family practice residency graduates from private solo or small group practices to large multispecialty clinics or health care systems.[2] Of particular note is the finding by Vinson and colleagues that there are roughly an equal number of community-based primary care physicians as there are full-time academic faculty physicians in the primary care disciplines, supporting the idea that a critical portion of education is dependent on the personal good will of a large, unorganized, poorly supported faculty for whom teaching is not a primary priority.

The support and rewards given to these 31,000 or so community-based teachers, roughly two such physicians for every student entering medical school each year, are modest, to say the least. The few tangible rewards include plaques, CME credit, and an occasional token stipend. One physician reported an annual reimbursement for teaching of $2750, but he had to teach eight students full time, for 6 weeks each, to receive it; this intensity of teaching commitment is made by few, if any, full-time faculty members in AMCs. The nontangible benefits of teaching were reported as satisfaction, stimulation, social interaction, and collegiality. Interestingly, nonteachers recognized the existence of these benefits to almost the same degree as teachers.

The study suggests that the decision to teach has less to do with tangible or professional rewards and more to do with some personal desire for the expected intangible rewards. Such a motivational system may lack permanence in the face of today's turbulent changes in the organization of medical care. The generally accepted 30 to 60 minutes of extra work per day associated with a student's presence[3] may become difficult to justify in the price-sensitive, cost-cutting environment that currently dominates much of medical care.

A final set of problems with this system may derive from the realtively small commitment made by these physicians, who teach three students per year for an average of 10 days each. Given the lack of quality control that pervades all medical education, as well as uncertainty about the value of and best methods for improving teaching, the situation in a community-based system becomes even more worrisome. The study by Vinson and coworkers does not address the degree to which the surveyed teachers ever participated in faculty development workshops, were given clear educational responsibilities, or were site-visited by full-time educators to evaluate and give feedback on the quality of their instruction. The usual response when such concerns are expressed about community-based teaching is that these activities are equally infrequent with teaching programs based in medical schools, so why should community-based teaching be subject to special criticism? This rebuttal is too easy, however, because it denies that most medical schools have a clear educational plan, even if it is not always followed exactly, and full-time faculty members are constantly evaluated for their teaching by sheer proximity and exposure to their peers. There is also increasing attention to candidates with teaching portfolios in promotion and tenure decisions, and most medical schools and departments value evaluation, feedback, and improved teaching, even if not consistently and precisely implemented.

Community teachers often say they have the best possible situation; they have all the benefits of full-time practice with the stimulation of teaching students as much as they choose, without all the meetings, hassles, evaluations, and bureaucracy of the AMC. They know that they are in a seller's market, and what they sell is so valuable they can package it to meet their personal needs, and participate in the traditions of medical education to the degree they choose.

I do not believe this is the way a critical and significant portion of the total medical education enterprise should be run. What is most troublesome about the picture of community-based pri-

mary care teaching painted by Vinson and colleagues is its fragile nature; a fragility that may succumb to massive disruption as the health care system goes through a painful and turbulent reorganization. The organization and financing of the health care delivery system has rarely accounted for the costs or logistical needs of teaching.

Is medical education unusual in the US educational system? Unfortunately, no. It is similar to secondary education in that society places great value on the highly trained graduates of the educational system, but does not value the process that leads to such graduates, namely teaching and teachers. Until this social value changes, we will remain dependent on a loosely organized and tenuous system of unsupported and unrewarded community-based teachers for an important portion of the medical education continuum.

REFERENCES

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