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The Social Mission of Medical Education

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Dr. Mullan has written widely for professional and general audiences on medical and health policy topics. His books include White Coat Clenched Fist: The Political Education of an American Physician (1977), Vital Signs: A Young Doctor's Struggle with Cancer (1983), and Plagues and Politics: The Story of the United States Public Health Service (1989). He is the senior editor of Healers Abroad: Americans Responding to Human Resource Crisis in the HIV/AIDS (National Academy Press, 2005). His articles "The Social Mission of Medical Education: Ranking the Schools" (F. Mullan, C. Chen, et al. Annals of Internal Medicine, 2011) and "Social Mission in Health Professions Education: Beyond Flexner" (F. Mullan, JAMA, 2017) have helped define the Beyond Flexner movement.

Dr. Mullan is the Founding President of the National Coalition for Cancer Survivorship, the Founding Board Chair of Seed Global Health, the Founding Board Chair of the Beyond Flexner Alliance, and a member of the National Academy of Medicine of the National Academy of Sciences.

I spent the summer of 1965 in Holmes County, Mississippi. I had just finished my first year of medical school and went south as a medical civil

rights worker. I lived on a small, poor farm that belonged to Magnolia Reed and her 17 year-old son, Cat. My work was to do whatever I could about local health problems and pitch in with the larger agenda of civil rights work going on across the state. I spent time going door-to-door to urge folks to register to vote and encourage parents to sign up their grade-schoolers to attend the white school that was to be integrated in the fall. I organized a health association, a chat group/ organizing cell in Durant, the near-by town, and paid testy visits to the town's three general practitioners and to the administrator of the local 25-bed, segregated hospital. I spent half a dozen nights with a shotgun on my lap, smoking cigarettes, taking my turn guarding a rural, black church that had been the target of an earlier firebomb. The community had decided to defend it.

It was an historic summer for the country. Not only was the Civil Rights Movement in full swing, but that same summer the U.S. Congress passed two pieces of legislation that were to have huge impact on Civil Rights and on health – the Voting Rights Act of 1965 and Titles XVIII and XIX of the Social Security Act, which established the Medicare and Medicaid programs.

It was certainly a momentous summer for me. I suddenly knew why I was in medical school. The son and grandson of physicians, I had gone to medical school with a general idea of doing something good but no real sense of what that was. I had been raised in comfort and had seen little of the world and the disparities in wealth and health that are the American reality and the global norm. The poverty, bravery, ignorance, brotherhood, racism, hate and love that I lived with for those months in the summer of 1965 called out to me. When I headed north again in the fall, I knew what I wanted to be. I wanted to be a Civil Rights doctor, a doctor for the people of Holmes County and others like them.

There was plenty to be done right away. When I returned to the University of Chicago, it was to a medical school riven by inequities like those in Mississippi, if perhaps less blatant. One in 10 medical students in my class was a woman. One in 72 was black - and he came from Nigeria. The main function of the Student American Medical Association at my school was organizing dances and running a microscope exchange. The American Medical Association itself was engaged in a last-ditch fight to block Medicare. A student didn't have to be a radical to conclude that medical school was preparing us for the past and not the future. We responded by organizing students around the idea of social justice. We started a student-run lecture series bringing speakers to the medical school to talk about health in Chicago's ghettos, racism in medicine, and the war in Vietnam. We got the dean of Harvard Medical School to talk about medical education reform. We raised $200,000 to run a summer project that placed 100 medical, nursing and dental students in service-learning projects in community organizations around the city. We built the Student Health Organization – a national alliance of activist

groups in medicine, nursing, dentistry and social work. We marched with Martin Luther King who, in 1967, was campaigning to end segregation in Chicago's suburbs. We intended to take on society's big problems even as our education ignored them.

This work raised an important question then, as it does now: why do we become doctors?

Medicine, we know, will guarantee us a good living. But, for many of us, the selection of medicine goes way beyond that. Idealism draws many of us into medicine – the opportunity of helping others, alleviating pain, extending life, and perhaps contributing new knowledge to the healing arts.

Social Mission in Medicine

For others there is something more - a sense of what I will call social mission that is more than the desire to heal. Social mission recognizes that there are inequities in the world and, more to the point, in access to health and health care. In ways articulate and inarticulate, many young men and women entering medicine hope to help in this regard. They hope to make the world not only a better place, but also a fairer place. This is social mission. So what is the role of the medical school in addressing these aspirations of its students?

Graduating competent doctors must be the number one concern. Many would also agree that it is important to go beyond technical proficiency by producing doctors who are compassionate, patient-centered, and good communicators. But what about graduating doctors who want to change the world by making it more just? What about the social mission of the school and its graduates? Here there is not uniform agreement among medical educators. Should the school concern itself with health disparities and the social determinants of health in its community, in the country, in the world? Should the school be concerned about equity of opportunity for disadvantaged students to study medicine? Should it be troubled about gaps in rural health or geriatric care? Should it be concerned that the US has one physician for every 400 of its citizens while Tanzania has one doctor for 100,000 people?

Social mission is a broad idea that speaks to what a person or an organization does to reduce disparities and promote equity. It is not about scholarship or board scores or numbers of students graduated. It is about what a person or a school does to improve society at large – the neighborhood, the community, the poor or the doctor-less.

Why should medical schools have a social mission?

First, medical schools and the universities in which they reside are the custodians of intellectual and professional development in our society. They are, by their nature, idealistic institutions. To that end, our society generously rewards medical schools with education and research funding and substantial tax benefits. They are public institutions and if they aren't the champions of social purpose, who would be?

Medical schools have a unique role to play in that they are the only institutions that can build doctors for our future. I say "build" because their role includes but goes beyond education. Medical schools select our future doctors and nurture them for four or more years. During that time, they teach them medicine, but they also mentor, mold, and motivate them. The culture of the medical school is a powerful influence on the values of its graduates and, ultimately, the physicians of the country.

So the articulated, cerebrated, strategized mission that a medical school selects for itself has powerful influence on who gets to be a doctor and what the values of that doctor are in the future.

The social mission of medical education has not received much systematic attention. U.S. News & World Report, for instance, ignores it entirely in ranking medical schools. Over the years and, increasingly, in this epoch of health reform, some educational leaders and some schools have focused more on social mission in medical education. But there is not a funding source, professional association, or consumer group that advocates for social mission or scores it in any regularized way.

This inattention to social mission in medical education stands in stark contrast to the rigor of teaching and repeated assessment that takes place in the basic and clinical sciences. We know, also, from published studies that social mission outcomes vary considerably among schools with some graduating high numbers into challenging practice settings while others continue to send more physicians to well-endowed specialties and localities.

The Flexner Report

These observations have a firm historical root. The most important single document ever written on American medical education was published in 1910 under the title of An Examination of the Medical Schools of the United States and Canada -- better known as the Flexner Report. Abraham Flexner was a distinguished educator appointed by the Carnegie Foundation to study the medical schools of the time. What he found and reported in 1910 was dismaying. The clear majority of the 155 schools he visited were of terrible quality, largely commercial, and graduating, as he put it, "ignorant men".

Flexner's proposed solution was that medical education should be limited to "research universities" that were, increasingly, the beneficiaries of European science and scientific methods. Science offered a quality control mechanism against commercialism, opportunism, and charlatanism in medical education. The Flexner report succeeded brilliantly in ransoming medical education from commercialism and bad science. Within 20 years, more than half the schools in the country were shuttered and virtually all that survived Flexner were sponsored by universities.

Medical education proceeded as a university-based enterprise rooted increasingly in academic health centers for which research and service delivery, as opposed to education, steadily became more important enterprises. The Report effectively guaranteed that medical education would become increasingly expensive and elite. Its emphasis on science, important as it was, promoted technical accomplishment over cognitive and communicative capabilities in practice and in scholarship. It bound medical education up in battleship institutions whose complex missions often did not prioritize the health of their communities or regions.

Beyond Flexner

We live in a world more than 100 years removed from Mr. Flexner's Report where, despite horrible events along the way, social justice has actually prospered. Since Flexner, the world has lived with and now rejected colonialism, apartheid, Jim Crow, and Nazism; in more and more of the world, women can vote, be educated, own property, and run companies and countries. Homophobia, female infanticide, and genocide are in retreat. We now dare to talk about health care as a human right. We have tools to measure health disparities, the social determinants of health, and Disability Adjusted Life Years (DALYs). Health equity is a vital and viable idea.

The question confronting American medical education now is how to move beyond Flexner. This is not to disown Flexner, science, or research but to re-think medical education based on the equity challenges that confront our population prevent our delivering the best care possible throughout the population.
Today, America is not compromised by quack medical schools. Nor is it suffering from a lack of research. Yes, we have not yet conquered cancer or found the vaccine for AIDS, but we have created a dazzling clinical armamentarium -- some of which is precise and well used, some of which is not. The proliferation of drugs, devices, and diagnostic tools we have invented is enormously costly; our system produces disappointing results when compared to other developed nations; and we still fail to provide health coverage for all our population.

We need doctors who understand these problems and are committed to fixing them. The call for social mission is by no means limited to primary care or for those who see themselves as activists. We need physicians of all specialties to work in rural areas and to treat poor and low-income populations. We need physician research scientists and policy leaders equipped to tackle these equity problems.

We need the hospital chief medical officer who opens a Disparities Solutions Center that turns hospital-wide attention to inequities within the institution. We need the anesthesiologist who is concerned about differential patterns of pain management in her institution that seem to fall along racial lines for no good or stated reason. We need medical school deans who will make it a personal priority to work to see to it that graduates of their local, inner city high schools are entering their medical school class four years later. Physicians and the institutions that train them need to see social mission as a living part of the medical skill set rather than an elective perspective exercised by some who are particularly compassionate.

Success, Failure and Opportunity

Writing this address challenged me to consider how medical education and the practice of medicine have evolved over the past 50 years since I was in medical school. How did the career of the "civil rights doctor" work out? Has the world changed as he had hoped?

In many ways, yes. Integration has proceeded; opportunities for minorities in America are much improved, as is the economic well-being of many. In medicine, 14% of our students are underrepresented minorities as opposed to 3% in 1960.

But in many ways, no, things have not gone as he had hoped. African Americans, Latino-Americans and Native Americans comprise 30% of our population meaning that our efforts at opening opportunities in medicine have only reached a halfway point. Residential and educational segregation remain in place everywhere. Huge disparities in income, net wealth, opportunity and longevity are the rule for minorities and the poor of all ethnicities. There is an enormous amount yet to do to build equity into our country and our profession. That is where our newly graduated physicians, as well as others who care about social mission come in to play.

Young people in medicine have a special opportunity and, I believe, a special mission. As with all generations of physicians, it is medical school graduates who inherit the future of medicine. The work, the practice style, and the priorities that

our newest medical professionals choose are all decisions that, taken together, can change public thinking about what it means to be a good doctor.

Choices newly graduating physicians will make about where to practice and how to practice will either maintain the status quo or extend the reach of health and health care to people who do not have it today. For those doctors who plan careers in academia, the selection of where and what to teach, what issues in the biopsychosocial world to investigate, and what sort of role model to be will have a lot to do with what kind of medicine we practice and what kind of country we become.

The Civil Rights Doctor may have worked hard and with purpose, but the world has not moved as far as he would have hoped. Racism is still very much with us as are massive and growing disparities in health and wealth. These disheartening realties account for tens of thousands of deaths and uncounted days of unconscionable pain and suffering every year.

We have left some work for our newest doctors do. They need to pick up the health disparities struggle where it is today and carry it forward, benefitting millions in their journey. Quite simply, they need to build a health system - including medical schools and teaching hospitals - that is not only a better than in the past but that is fairer than in the past.

Thank you.