



Using Community Outreach to Enhance Professionalism Among Faculty Preceptors

Thomas P. O'Toole, M.D.
Assistant Professor of Medicine
Johns Hopkins University

A primary focus of discussions regarding community outreach has been on institutional change and initiative (Longest 1998, Verby 1991, White 1994, Levine 1994). This often reflects a philosophic need to become a better "neighbor," or more practical needs that include improving the safety and environment of the surrounding community and deferring expensive and uncompensated health care utilization by area residents. Alternatively, common externally defined needs include responding to a foundation-defined funding initiative. While institutional involvement clearly facilitates and can broaden the scope of outreach efforts, this "top-down" approach often neglects to appreciate and incorporate issues and agendas of persons who actually do work (e.g. faculty, students, community members), and those people who receive the services (e.g. clients, patients). An institutional emphasis and administrative approach minimizes specific needs of volunteers, which include fulfilling a sense of professional responsibility, exercising professional individualism and autonomy, and creating a sense of personal ownership and commitment to the process.

The need for and challenge to individualism and autonomy is seen most clearly in the health professions and within academic health centers. In response to market forces and in an effort to better control their financial destiny, health-care providers in the United States have become increasingly organized and integrated. This process of consolidation has come to define the employment structure of many physicians who have, either intentionally or unintentionally, traded their professional autonomy and individualism for financial security, workplace regularity, and previously unavailable personal freedoms. The result has not always been ideal, particularly from a societal perspective. Medical professionalism — defined as the practice of medicine with a patient-centered focus of advocacy and care unbridled by third-party fiscal mediators — is increasingly elusive in today's environment of managed care, restrictive covenants, gag clauses, and productivity quotas.

The impact of this paradigm shift in health care has also permeated the way we teach medical students and the values we impart to physicians-in-training. Where and when the corporate mission supplants the professional mission of a health provider is difficult to pinpoint or ascertain.

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However, with the intrusion of externally defined, market-driven standards of care and practice, the potential for influencing clinical decision-making, particularly for those patients with special circumstances or needs, is obvious. These decisions and their hidden value statements are relayed to students who may be "shadowing" at a clinical attending, presenting to a preceptor, or seeking feedback from a course instructor.

Community outreach and service opportunities can be a useful vehicle for influencing the exposure students have to the health professions (Seifer 1998). Not only are students removed from a health-care environment often defined more by fiscal and efficiency objectives than by patient care, they are exposed to a paradigm shift in priorities and motivations that reflect communities and clients. It also exposes them to a sense of reality that there are inequities in access to basic health services and that as individuals they can make a difference.

In 1993, the University of Pittsburgh, in partnership with the Salvation Army, created a volunteer effort to provide free medical care to area homeless persons. Over the next several years, the Program for Health Care to Underserved Populations grew to include care at a total of four community clinics and involve more than 400 students, eighty residents, and fifteen to twenty faculty and community physicians each year. PHCUP has been well supported by the university's Division of General Medicine and has received external funding from the Health Professions in Service to the Nation Program and the Corporation for National Service. In 1994, the U.S. Department of Health and Human Service recognized it as part of the Models that Work initiative.

Service-learning opportunities have been developed for students from medicine, nursing, pharmacy, public health, and dentistry that span their curriculum and include required and elective courses, volunteer experiences, and structured internships. Outcomes from this program have been reported elsewhere and include increased subsequent volunteering, positive attitudes towards care to indigent patients, and favorable rating of residency training in these areas (O'Toole et al. 1999, O'Toole and Freyder 1999).

In 1998, a non-scientific survey of ten PHCUP volunteer, physician preceptors looked specifically at reasons why they

volunteered and which elements made volunteering worthwhile. While it is not possible to draw statistically significant inferences from this survey, the ten responses highlight several important themes. Most respondents were university faculty and the average number of years out of residency was 10.2. Eight of the ten volunteered at least once a month and had been volunteering at least one year. When asked why they volunteer, seven of ten reported "it's an opportunity to give something back." The next three most common reasons cited by six of the ten were: "I like taking care of these patients," "I like teaching students in these settings," and "because there is an unmet need for this kind of service." The three most commonly cited elements for what makes volunteering worthwhile were: the patients (six of ten), "I am meeting an unmet need" (six of ten) and the students (five of ten).

While limited methodologically, the study's findings shed light on issues important to volunteer physicians in PHCUP. None of the reasons cited for why they volunteered or elements making volunteerism worthwhile refer to institutional missions, directives by department chairs, or statements by public officials. Instead, they refer to issues of personal importance and professional identity. "It's an opportunity to give something back" and "an unmet need" represent issues of self-perception and professional responsibility within a societal context. The responses also represent a personal response to a situation not remedied at a political, health system, or

organized health-care level. Patient care and student education reflect issues of personal and professional stewardship that cannot be achieved in other pursuits. Volunteerism becomes the vehicle for achieving personally defined measures of professional success and satisfaction.

This is not to imply that all physicians are unhappy and professionally disenchanting. It is also not meant to suggest that volunteerism is the only way to achieve this ill-defined success and satisfaction or that active volunteering implies a corporate

disregard for communities-in-need. However, the scope of issues defining physician satisfaction and professionalism, at least for some doctors, goes far beyond earning potential, disease management, or the specifics of patient care. These findings also remind us that the motivations to participate in community outreach will vary among stakeholders and any attempts at outreach must successfully address or negotiate all of them.

Issues of professional satisfaction, fulfillment, and exercising societal responsibilities are particularly important in the

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context of medical education (Crandall 1993). The molding of a professional identity begins long before the first paycheck with the process of medical education and residency training, usually the first formal indoctrination to the culture and ethos of the medical

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community. The power of role models and mentors in the health professions cannot be understated in their influence over how medical students view themselves and their societal and community obligations (Wright 1998, O'Toole 1999). However, as important as it is to have caring, compassionate physicians articulate their values and priorities, it is equally important to give medical students the opportunity to see those values in action in the community. Bringing students into the process of care outside of the "corporate box" of managed care and tightly integrated and regulated health systems legitimizes the values of individualism and autonomy within the medical profession. Seeing and being able to work with physicians who are exercising their moral prerogative is a liberating experience. It expands the definition of professionalism, moving it

beyond the artificial limits imposed by a litigious society, and a risk-adverse, return on investment-oriented health-care industry.

This individualist-focused process of community outreach and engagement does not end with the orchestrated act of community service. By exposing the student to an activist agenda that addresses the personal and professional needs for autonomy, individualism, and societal responsibility, we also forge a template for involvement that can then be applied to any number of causes or needs (Williams 1998). The result of what begins as a structured service-learning experience can then grow and mature into physician participation in community advocacy, system change, or more holistic efforts at addressing core problems.

It is important to distinguish between the physician autonomy and individualism captured by community outreach and service described here and individualism manifested in a reckless disregard for convention or safety. While the PCHUP volunteer initiative described herein is based on the professional development and enhancement of the physicians and students involved, it would not be possible without the support of the health system and lead administrators. Malpractice coverage would not have been extended to these sites, nor would the institution have contributed needed in-kind and logistic support, were the activities of the program perceived as dangerous to students or faculty, without academic merit, or not consistent with the goals and mission of the institution.

Appeasing the very real needs of multiple stakeholders requires drafting parallel objectives that address the needs of each group.

The challenge, then, becomes how to create a vehicle for physician activism and medical professionalism within the context of the "corporatization" of health care and health education. Here, knowing the needs and issues of involved stakeholders is crucial. For example, academic health centers operate in accordance with a three-fold mission: patient care, research, and education. The key to obtaining institutional support was structuring the PCHUP program as a vehicle for providing more efficient care to a marginalized population (e.g. homeless) and teaching medical students about community health in a capacity not available in traditional settings. Physicians whom we needed as volunteer preceptors articulated a desire to make a difference in the community and to teach students

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in this context. Of paramount importance to volunteer recruitment was ensuring physician autonomy and individualism that, in turn, leads to greater professional fulfillment and satisfaction. These two perspectives on the same project are not mutually exclusive, nor are they competitive. However, they hold different value with different audiences and it is important that they be matched to the appropriate stakeholders.

This discussion has heretofore focused only on the perspectives and priorities of volunteer physicians and the academic institution, with no mention of the needs of the other key stakeholders in a community outreach and service initiative: the community and students. While a complete discourse on their goals and objectives in community outreach is beyond the scope of this essay, it is important to note that their needs are intertwined with those of the institution and the faculty preceptor. A failure to address the needs of either the medical students or the patients would have eliminated elements of volunteerism that made the project worthwhile to faculty. The inability to recruit and retain faculty makes even the most eloquent and moving institutional commitment to service nothing more than a compilation of hollow statements.

In summary, an often neglected element of developing a community outreach and service initiative is the need to address stakeholder motivations and needs. This essay presents a discussion of volunteer faculty needs and motivators that have been pivotal to the success of the Program for Health Care to Underserved Populations. By emphasizing opportunities for professionalism, individualism, and autonomy among PHCUP's volunteer faculty — and concomitant values that may not have the same opportunities for expression in more traditional work settings — PHCUP was able

to recruit and retain physicians of the highest quality and commitment. In turn, these values were and will continue to be passed on to students who rotate through the service-learning sites, creating a new paradigm for expressing professionalism within health care. ■

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About the Author

Thomas P. O'Toole, M.D., is an assistant professor of medicine at Johns Hopkins University and program officer for the Open Society Institute Program on Medicine as a Profession, Soros Service in Community Health — Baltimore Initiative. He received his medical degree from the University of California-Davis. While at the University of Pittsburgh, he founded and directed the Program for Health Care to Underserved Populations described in this essay.