

Service Learning Helps Sustain the Status Quo

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The United States is vexed by the problem of providing care for a large number of individuals who do not have health insurance. Estimates from the National Center for Health Statistics indicate that in 2007, among individuals less than 65 years old, 17% of the population (43 million people) did not have any health insurance.¹ From a humanitarian standpoint, these individuals need care, and providing care can remedy the health deficits of the uninsured.² Leaving them without coverage actually increases the cost of care for society.³ Health care reform to address the issue of the uninsured is suggested and discussed, but comprehensive reform has yet to occur.⁴

Why don't we fix the problem? The answer is probably a mix of factors, but one contributing reason is that we have already created convoluted structures to help us live with the problem, rather than addressing it directly.⁵ This has led to a perception of addressing the problem but, in reality, we have only intervened at the margins, and the sense that we are addressing the problem permits the problem to continue.

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The movement to create socially responsible physicians is an example. Training of physicians who will provide uncompensated care to the uninsured is deemed to be a good thing. Indeed, having physicians donate time and resources to the care of those less fortunate is seen as an altruistic act and a benefit to society and also as a partial solution to the problem of people having no health insurance. But, this strategy is based on the assumption that there will always be a large pool of uninsured individuals.

Student-run Free Clinics

For those of us in medical education, a common example of how we teach physicians to volunteer their time is the medical student-run free clinic.⁶⁻⁸ Such clinics, often falling under the rubric of "service learning," are present in many medical schools and often operated by family medicine departments.⁷⁻⁹ Establishing these clinics as a way to deliver care to the uninsured is based on the current reality that there are uninsured patients who will use the clinic. Further, we provide this experience to students in the hope that these students will learn to deliver uncompensated care to the uninsured once they are out in practice—further emphasizing that we assume that a large pool of uninsured patients will exist in the future.

If there were no uninsured patients, the entire notion of altruistic work by physicians would be, and should be, very different. Service

learning and its use of experiences providing care to the community's underserved may have noble goals and underpinnings, but they are examples of adopting a system of care that obscures the need for radical health care reform to fix the problem of the uninsured. Now may be the time to move beyond tweaking around the edges and make a bold step to fix the problem.

The Pipeline Strategy

Another example of how we plan for a future with uninsured patients is the admissions policies of many medical schools, which now attempt to select for admission socially conscious applicants.^{10,11} Indeed, medical school admissions committees place a high value on applicants' premedical school community service activities.¹⁰ The assumption underlying this criterion is that by giving greater consideration to applicants with apparently altruistic inclinations, the future physician workforce will be caring and compassionate and also particularly oriented toward providing care to the underserved, defined in many circumstances as the uninsured.

Service Learning

Both student-run free clinics and the pipeline strategy are examples of how physicians are being trained to have values that will improve the health of the poor and underserved.^{12,13} Consequently, once individuals are admitted to medical school, the strategy is for these

medical students to participate in service learning activities as a way to foster their altruistic tendencies. Formal service learning experiences with a structured curriculum and community service activity allows students to gain an awareness and appreciation of underserved communities. In fact, the need for medical schools to provide community service learning opportunities has become codified in their accreditation through the Liaison Committee on Medical Education (LCME) standard: “STANDARD IS-14-A: (effective July 1, 2008). Medical schools should make available sufficient opportunities for medical students to participate in service learning activities and should encourage and support student participation.”¹⁴

Students value these service learning experiences.⁷ However, whether these service learning experiences make individuals better doctors is unclear. They are more likely to be socially conscious, but it is unclear whether they are more competent.¹⁰ One study found no statistically significant relationship between service learning experiences and election to Alpha Omega Alpha, election to the Humanism in Medicine Honor Society, or scores on year-2 or year-3 clinical exams.¹⁵ Another study found that students with service learning experiences had higher medical school grade point average, but there was no relationship with residency directors’ ratings of how these students performed during residency.¹⁶ Although one study showed how a required experience in a homeless clinic for primary care residents led many residents to continue volunteering after their rotations were completed, it is also unknown if these experiences lead to future provision of uncompensated care once the student enters medical practice.¹⁷ Most importantly, all of these experiences are based on the assumption that there will be future need to provide care to people who

have no medical insurance—as if we are accepting that situation as permanent.

Is This a Sustainable Strategy?

A large number of physicians currently provide uncompensated care. A recent estimate indicated that more than 67% of physicians in the United States provide some uncompensated care, spending a average of 7 hours per week doing so.³ This burden may also disproportionately be borne by primary care physicians who are the source of first contact care for undifferentiated patient populations but also have lower reimbursement.

However, there is mounting evidence that the proportion of uninsured adults in a community is negatively associated with physicians’ career satisfaction.¹⁸ Further, because physician services are only one part of the full health care process, simply encouraging physicians to provide uncompensated care can lead to many gaps in care. Indeed, appropriate medical care requires not just the work of an altruistic physician who volunteers time to care for the underserved. It also requires pharmacies, diagnostic laboratories, imaging centers, hospitals, operating rooms, and others.^{19,20} Thus, simply creating a pipeline of physicians who are willing to provide uncompensated care for the uninsured appears to be an inadequate response to a problem that needs a more comprehensive and radical change.

Experience in a Universal Access System

Countries with universal access health care systems do not need to train and encourage physicians to provide uncompensated care for uninsured patients. Because they don’t have to worry about covering the uninsured, policy debates focus instead on issues like geographic distribution of physicians, efficiency, quality of care, and other issues. For example, in the United

Kingdom, there is geographical disparity in the numbers of general practitioners and other primary care clinicians; there are fewer of them in areas that have the greatest need for primary care.²¹⁻²³ As those responsible for health care policy in the United Kingdom work on addressing the issue of geographic distribution of primary care services, the issue is not one of how to provide uncompensated care for the uninsured—because there are no uninsured individuals. Rather, this issue can be addressed head on by addressing factors that lead to geographic distribution problems. Universal access systems, combined with government leadership of health service policy, have an advantage over the current US health care system. It is possible for policymakers at the national level to focus on specific health care delivery issues without having to deal with addressing the radical changes needed in the United States.

Conclusions

The strategy of selective admission and creation of socially responsible physicians to provide uncompensated care for the uninsured assumes that we will not fix the problem of having a large segment of the population without health insurance. Volunteering and providing free care to uninsured patients is a societal good and should be applauded. But, these approaches to care are grounded in the assumption that a large proportion of the US population is and always will be uninsured. Perhaps a better approach is for the medical education system to encourage health care reform, rather than investing effort into strategies to help sustain the present, but ineffective, system that currently exists.

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REFERENCES

- Adams PF, Barnes PM, Vickerie JL. Summary health statistics for the US population: National Health Interview Survey, 2007. National Center for Health Statistics. *Vital Health Stat* 10 2008(238):1-104.
- Miller W, Vigdor ER, Manning WG. Covering the uninsured: what is it worth? *Health Aff* 2004;23:W4-157-W4-167.
- Hadley J, Holahan J. How much medical care do the uninsured use, and who pays for it? *Health Aff* 2003;22:W3-66-W3-81.
- Iglehart JK. The struggle for reform—challenges and hopes for comprehensive health care legislation. *N Engl J Med* 2009;360:1693-5.
- Ferrer RL. Within the system of no-system. *JAMA* 2001;286:2513-4.
- Jiminez M, Tan-Billet J, Babineau J, et al. The promise clinic: a service learning approach to increasing access to health care. *J Health Care Poor Underserved* 2008;19:935-43.
- Clark DL, Melillo A, Wallace D, Pierrel S, Buck DS. A multidisciplinary, learner-centered, student-run clinic for the homeless. *Fam Med* 2003;35(6):394-7.
- Haq CL, Cleeland L, Gjerde CL, Goedken J, Poi E. Student and faculty collaboration in a clinic for the medically underserved. *Fam Med* 1996;28(8):570-4.
- Seifer SD. Service-learning: community-campus partnerships for health professions education. *Acad Med* 1998;73:273-7.
- Elam CL, Stratton TD, Wiggs JS, Speck DF, Sayeed SA, Goodman NL. Gauging interest in community service: a retrospective review of admission files. *Acad Med* 2002;77:S-3-S25.
- Blue AV, Basco WT Jr, Geesey ME, Thiedke CC, Sheridan MEB, Elam CL. How does pre-admission community service compare with community service during medical school? *Teach Learn Med* 2005;17:316-21.
- McCurdy L, Good LD, Inui TS, et al. Fulfilling the social contract between medical schools and the public. *Acad Med* 1997;72:1063-70.
- Eckenfels EJ. Contemporary medical students' quest for self-fulfillment through community service. *Acad Med* 1997;72:1043-50.
- Liaison Committee on Medical Education (LCME). Accreditation standards. www.lcme.org/standard.htm. Accessed May 2009.
- Brush DR, Markert RJ, Lazarus CJ. The relationship between service learning and medical student academic and professional outcomes. *Teach Learn Med* 2006;18:9-13.
- Blue AV, Geesey ME, Sheridan MEB, Basco WT Jr. Performance outcomes associated with medical school community service. *Acad Med* 2006;81:S79-S82.
- O'Toole TP, Hanusa BH, Gibbon JL, Boyles SH. Experiences and attitudes of residents and students influence voluntary service with homeless populations. *J Gen Intern Med* 1999;14:211-6.
- Pagan JA, Balasubramanian L, Pauly MV. Physicians' career satisfaction, quality of care and patients' trust: the role of community uninsurance. *Health Econ Policy Law* 2007;2:347-62.
- Mainous AG III, Hueston WJ, Love MM, Griffith CH III. Access to care for the uninsured: is access to a physician enough? *Am J Public Health* 1999;89:910-2.
- Pisu M, Richman J, Allison JJ, Williams OD, Kiefe CI. Pharmaceutical companies' medication assistance programs: potentially useful but too burdensome to use? *South Med J* 2009;102:139-44.
- Sibbald B. Putting general practitioners where they are needed: an overview of strategies to correct maldistribution. University of Manchester, National Primary Care Research and Development Centre. 2005. www.npcrdc.ac.uk/PublicationDetail.cfm?id=139.
- Bloor K, Hendry V, Maynard A. Do we need more doctors? *J Royal Soc Med* 2006;99:281-7.
- Department of Education. Widening participation in higher education. London: Department for Education and Skills, 2003.