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MAKING A DIFFERENCE

An Interview of Arthur Kaufman

Dr. Arthur Kaufman is Chair of the Department of Family and Community Medicine at the University of New Mexico School of Medicine in Albuquerque, USA. Last year he was elected Secretary General of The Network. He was one of the facilitators of the widely respected innovations at his school that began with a pre-clinical, community-oriented, problem-based track and led to changes in clinical clerkships, the creation of interdisciplinary learning teams, changes in the residency program and then changes in practice (McGrew & Kaufman, 1999). This edited, abridged report is based on an interview in Linköping, Sweden in October 1999, supplemented with a telephone interview in August 2000 and other exchanges.

Jane Westberg, PhD
Associate Editor, *Education for Health*

How did you get involved in medicine and medical education?
When I was in early high school, I read *The Scalpel and the Sword*, which is about Norman Bethune. He was a Canadian surgeon who served as a stretcher-bearer in World War I and a physician in the Spanish Civil War. He cured the ill on the fields of battle during the Chinese Revolution. I wanted to be like him. I wanted to go to China and cure the ill or something like that.

I grew up in New York City in a neighborhood near Chinatown. China always held a great deal of fascination for me. That's probably why I later did so much work in China. Ironically, I was more like Dr. Bethune than I bargained for, since we both developed tuberculosis. I was humbled by the task of taking medication for two years during my residency.

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Was anyone else in your family in the health professions?
No, my parents were artists. My brother and I went into the sciences, I think, just to be different. We basically liked the arts, probably better than the sciences, but we wanted to strike out on our own. My brother is an engineer.

I used to do a lot of art when I was younger. I did a lot of painting when I was in medical school. It's too time consuming though. I haven't done it since.

I went to medical school at SUNY [State University of New York, Downstate Medical Center, Brooklyn] from 1965 to 1969, during the Vietnam War. I wasn't a conscientious objector, but I disagreed with that war and was part of the anti-war movement. At that time the options for people of draft age were to go into public service (if you were lucky), go to Canada, or go to jail. During my internship year at St. Vincent's Hospital in New York, I was fortunate enough to be part of a group of protestors who were accepted into the Indian Health Service [IHS].

I worked for the IHS for two years, the first in South Dakota with Sioux Indians. My wife, Ellen, who was a senior medical student at Columbia University, and I had just gotten married. She took electives in places that were as close to me as possible. Then on weekends I'd drive to where she was studying. The next year I worked for IHS in Albuquerque and she did her internship at the University of New Mexico.

I had gone to medical school to become a psychiatrist. I didn't have an interest in any other field. But IHS changed my life. If you referred Indian patients to a psychiatrist they wouldn't go because of the stigma. There wasn't any stigma, though, attached to going to a doctor, so I combined counseling with working with my hands. This work as a primary care physician was very challenging and satisfying. You've got to do everything on a reservation.

In Albuquerque, I was the field health director of IHS. I was very young, but since I was one year older than the other Indian Health doctors, I was put in a leadership role. I enjoyed it. I reviewed health systems on different reservations, helped make policies, and ran my own clinics.

I decided that I wanted to continue this important, community-oriented work. I declined the psychiatry residency that I had been offered at Albert Einstein Medical Center, and I completed an internal medicine residency at St. Vincent's. (There were few family medicine residencies when I was in training.)

When I finished residency, I returned to Albuquerque and joined the new Department of Family and Community Medicine at the University of New Mexico. Most of the faculty were like me. They were young and had had some alternative career experience, such as Indian health, migrant health or health care in the developing world. These experiences had transformed all of our lives.

We all discovered that in our academic centers it's hard to become passionate about something that you don't see or experience personally. All of

us ended up choosing careers that were very different from what we had originally intended. What made us change? Well, it wasn't our formal training. It was real life experiences in the community that transformed us. Those experiences in the 1960s and 1970s were a consequence of war and alternative service, which is not a reliable scenario for change in peacetime. Most students move from medical school to residency to practice. So our young faculty wondered how we could give students this kind of influential, community experience in the middle of their formal training.

In the early years we experimented in many ways. Our department was allocated two hours a week of lectures to first year students. The students crucified us in their evaluations. We decide to get away from boring lectures and give them what they wanted. We taught them clinical skills and discussed common health care problems. We brought them to our houses and fed them cookies. Our little course became popular. We felt like heroes.

Now they had skills. What were they going to do with them? That led us to set up clinical experiences in the community for pre-clinical students. But our clinical options were limited. We had to take the students to rundown nursing homes, prisons, and homeless shelters—needy sites that the established health system avoided at that time.

By now our school had a team of young innovators that spanned different departments—pediatrics, family medicine, internal medicine, anatomy, and physiology. We had our own grants, so we were free to build upon our previous innovations. Our friendships were not bounded by any particular specialty. We were actually more bonded to each other than to the departments with which we were affiliated.

Our state needed primary care rural doctors. We felt that if we could get students who had rudimentary skills out into these communities, they could provide useful service and get turned on to rural health. Some of them might be transformed and decide to be rural doctors. We wanted to put students into the community for a more substantial period of time. We looked around for models.

From Ron Richards, who directed Michigan State University's rural Upper Peninsula program, we learned that we could start with a small experimental track that wouldn't force our institution to accept the entire innovation, sight unseen.

From the beginning some of our best models came from abroad. At the University of the Philippines' Palo Leyte Program, we learned about building career ladders. Students in the medical program were first trained as village health workers. They could continue their studies and become public health nurses. Then they could return and become midwives or, even later, doctors. They didn't have to become doctors. If they stepped off the ladder at any time, they'd be valuable health professionals in their communities.

Another big influence was the A-36 program at National Autonomous University of Mexico where, in their first two years, students were immersed in

the community far from the university. They worked in clinics in marginal, poor areas of the city. Right next to the clinics were classrooms where about 200 students were divided into groups of about 25 each. They worked on case problems in their own small groups, each group reporting back to a tutor. This 1:25 ratio of teachers to students in PBL seemed an important adaptation in the face of scare resources. Also, each student was assigned to about 10 homes where he or she did public health, immunizations, weighed the kids, made sure that they came to the clinic if they were ill, and looked after the elderly. The students were like mini public health officers. The students also adopted a local elementary school were they did health screening and conducted health education classes.

Can you describe your first contacts with The Network?
When The Network became known to us, we quickly joined because it was made up of schools like us who were also struggling with how to get students into their communities. Once we went to our first Network meeting, we were addicted. They were our kinds of people. In the States there were a lot of schools doing problem-based learning but they weren't doing community-based learning, so we had to look to the Third World for relevant models.

The next phase of our work was linked to the Rockefeller Foundation. John Evans was head of their board, and WHO and Rockefeller were fairly close. WHO was struggling with the fact that a lot of the most innovative programs in medical education in the Third World were not being emulated by other Third World programs because of a prejudice that caused them to assume that these programs must be of second-class quality. Rockefeller thought that North American or European schools needed to adopt important models from developing countries in order to legitimize them for Third World schools. This phenomenon was familiar to us. Much as New Mexico, McMaster, and others resented Harvard, a latecomer to PBL, for receiving so much publicity for their PBL program, the reality was that Harvard's adoption of PBL facilitated other schools doing it. If they did PBL, then PBL was regarded as legitimate.

At that time Tamas Fülöp was Director of the Health Manpower Development Division of WHO. WHO put a spotlight on our program because we were an innovative track in a traditional school, and WHO felt this might be a replicable model for change. Most of the schools at that time that had created groundbreaking innovations were new schools, like McMaster, Maastricht, Newcastle, and Suez. Their struggles were different than the struggles of traditional schools.

We were then designated as a WHO Collaborating Center. This encouraged us to make a stronger commitment to our visitors from developing countries and to visit their programs. We learned from each other. We now have visitors' weeks to which people from many schools around the country come to learn and to share their innovations and perspectives. We always learn as much as we teach.

Where is your program at now?
Some years ago, the innovative curriculum, with some modifications, became the curriculum for the whole school. It was no longer controlled by the ''Gang of Five,'' the designation critics gave to the originators of the Primary Care Curriculum—Stewart Mennin, Scott Obenshain, Martin Kantrowitz, Robert Watermen, and me. It was everyone's curriculum. While it lost some of its uniqueness, the change allowed a cadre of new, young faculty to assume leadership roles and create new, important educational innovations.

What has happened to the Gang of Five and the others who worked with you?
We've moved on to other things. We've been around so long that we have become chairs and deans and heads of other programs. We still are heavily involved in education, but spend more time training our successors and creating innovations in other realms.

Long ago I asked Kurt Deuschle, the father of community medicine in the US, ''How long do you have to stay with a program to institutionalize it?'' He said, "20 years.'' At that time, 20 years seemed like a lifetime. But that's about how long we were involved with the curriculum innovation before it became the school's established curriculum. I think that the longevity of the innovators and the fact that we stayed together is what held this program together.

One of your new responsibilities, of course, is serving as Secretary General of The Network. What are your reflections about The Network?
In the last eight years or so The Network has struggled. The Network was no longer unique in its focus on community. Every foundation in North America was funding community-based programs.

Then there was a big turnover in WHO. Tomas Fülöp left. The Network had been his baby. He nurtured it and gave it funding. Thank goodness the University of Maastricht is both community and globally minded. It has provided a great deal of support to The Network. The Kellogg Foundation, through Ron Richards, has also played a huge role with its substantial community partnership grants that funded programs not only in North America but also in Latin America and South Africa.

I think The Network has been influential, both as a network of innovative institutions and also through the individuals in The Network who aid and consult with other organizations. Our strengths are in helping to change academic centers so that they redirect resources toward community health needs. We used to focus only on one academic mission: education. We now realize we must incorporate all academic missions, including service and research.

The Network is no longer the sole repository of innovators who link academic centers and communities. Other organizations are making their mark. For example, COHRED (Council on Health Research for Development) is an

international organization that is looking at developing relevant research for development in Third World countries. The Network is interested in how academic health centers can mobilize their research efforts for community health. But we don't have to try to duplicate what COHRED is doing. We should work collaboratively with them as a sister organization. Similarly, WHO wants us to be a stronger partner with them, and The Network is helping them develop and disseminate their ''Toward Unity for Health'' program.

I think this era of collaboration is exciting and healthy for our organization. Recently we came up with the idea of a clearinghouse where innovators in all sister organizations and institutions could share their innovations through a common clearinghouse and website. WHO has helped support this effort, and an innovative primary care group in North America is developing a comparable website with which we can link.

What about encouraging more involvement in The Network by nurses and other health professionals?

The proportion of physicians in health teams is getting smaller and smaller because cases are getting so complex that adequate care in the clinic and community can only be provided optimally by a diverse health care team, including, nurses, doctors, social workers, dentists, behaviorists, and public health workers. Though our organization began as a doctor-centered network, we must broaden our base of support to increase our relevance for future health needs. To involve nurses and other health professions, we need to engage other professional organizations, such as those in nursing and public health. Medicine and public health is one of the themes of The Network meeting in Bahrain. Hopefully, when we go to Brazil in 2001, both nursing and public health will be strong partners.

Reference

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