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Metropolitan universities have an obligation to work with their communities to address infrastructural problems related to health care, education, and economic opportunity. Parkland Hospital in Dallas, Texas, part of a campus shared with the University of Texas Southwestern Medical School, instigated its successful Community Oriented Primary Care COPC) program to deliver primary and preventive care to local communities at risk. Like Parkland, metropolitan universities should lead in attacking health care problems, starting by re-examining their medical schools' policies. Other challenges include community involvement; seeking solutions to community problems; fostering partnerships for change; discussing social issues; helping the community; and encouraging community-oriented disciplines.

Challenging The Darkness:

Metropolitan Universities in Today's Society

In the Middle Ages, universities stood as a fortress against ignorance and bigotry as they fanned the flames of civilization through research, learning, and the search for truth. Universities served as citadels to house scholars, scientists, and philosophers who later led the world into a renaissance of freer thinking, greater freedom, and better living conditions.

Five hundred years later, metropolitan universities are still at the forefront of research to improve the lives of people around the world. But institutions of higher learning must now cultivate something other than the ivory-tower approach to learning that separates them from the streets and ghettos of the cities in which they are located.

This is particularly true in the United States where the fabric of society is threatened from unaddressed infrastructural problems related to health care, education, and economic opportunity. Here, the expertise of university thinkers and doers is sorely needed to find solutions. The location and academic disciplines of metropolitan universities provide these institutions amazingly varied opportunities to effect change in their communities.

This article will focus on health care, a primary element in maintaining the health and welfare of every community. Only an intensive, comprehensive, and disciplined approach can be successful in attacking the myriad of societal and behavior-related health care problems now devouring inner cities. Solutions to conditions that breed ill health will not be found in test tubes and think tanks. Universities must also

get out of the laboratory and become partners to help areas of society under siege.

Desperate Need

Such assistance is desperately needed by most inner-city hospitals who daily witness the staggering impact of violence, malnutrition, and behavior-related problems such as AIDS and teenage pregnancy. Parkland Memorial Hospital in Dallas, Texas, a 940-bed institution whose roots extend to nearly 100 years of caring for the sick and destitute, is one such hospital.

Today, in addition to treating the health care needs of the poor, Parkland's expanded mission includes teaching and research as well as community service to fill the gaps in care left by private and non-profit hospitals. In particular, Parkland is renowned for trauma and burn care. Parkland is the primary teaching hospital of The University of Texas Southwestern Medical School and is dangerously near capacity. It has an inpatient volume of more than 41,000 patients, and a trauma center that handles roughly 70 percent of all serious injuries in Dallas County, which has resulted in a near doubling of the hospital's trauma cases in the last three years. The hospital's outpatient caseload is exploding. There were 735,000 patient visits last year, and this number is expected to reach one million within three years. This is in addition to delivering more than 15,000 babies each year, representing 40 percent of all babies born in Dallas County.

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Parkland is part of a microcosm of the societal issues nationwide where more than 37 million Americans have no health insurance and only limited access to treatment. This is a problem that has taken decades to develop, but the cumulative effects are shattering lives and the economy. The impact on the poor and the largely inner-city hospitals that care for them has been overwhelming. The nation has increased its spending on health care to nearly 14 percent of the Gross National Product, and yet is not any healthier.

More Than Think Tanks

Many of the most difficult health problems such as teenage pregnancy, violence, AIDS, hopelessness, or helplessness are also social problems that are behavior-related. These kinds of problems are not solved in hospitals, but rather in the community. It is vital to get other types of practitioners besides doctors involved in the larger health care issues. The schools of business, law, education, social sciences, engineering, theology, public health medicine, and social work should lend their expertise and resources in addressing the many critical issues facing society today.

These kinds of social health issues are a whole area for research that has been totally untapped. Just as universities conduct traditional scientific research to develop vaccines for polio or for AIDS, there should be comparable research for "vaccines" for teenage pregnancy or for violence.

Take, for example, today's theory of managed competition. How does the theory work out in the inner city or in rural America? How do we not destroy the current structure of the public system—with many of the most competent and committed, although outdated hospitals—in a competitive environment? An issue like this needs the best thinking of the allied health fields, as well as assistance from other disciplines to provide strategic planning and outcome assessment. No matter what national or state policies may become, there is a need to work them out through local community efforts. The solutions have to come from universities that are disciplined in studying, developing, and implementing creative approaches that are assessed by their outcome.

Modern metropolitan universities have an opportunity and an obligation to be more than think tanks. Rather than simply analyzing issues and theories, universities should develop and implement solutions. In health care, this means a paradigm shift from hospital-based work to community-based work. Universities can use community-based programs to teach, to do research, and to help out the community.

No Easy Solutions

As universities lead the way in addressing health care problems in their communities, they need to take a careful look at some of their own traditions, especially those of their medical schools. Most medical education is conducted at large, centralized medical centers and campuses. During the last century, health care delivery underwent a process of involution, bringing the components of health care geographically closer to the medical classroom and the hospital bedside, but away from the community. At the same time, medical training has been compressed into subspecialty organ and sub-organ specific departments. Medical students often see patients only when they are ill in a hospital setting. Instead of seeing the motion picture, they see a Polaroid snapshot of the patient's life.

Current patterns in medical student applicant pools, residency selection, reimbursement strategies, and the organizational structure of the academic institutions have amplified the effects of involution and compartmentalization. Financing, research grants, and tenure policies tend to favor the bench research or highly specialized investigative disciplines, and these same pressures tend to de-emphasize primary care, preventive medicine, and health systems research.

Perhaps part of the problem lies in the success of modern medicine which, over the years, has focused on medical care, not health care. We virtually practice "resurrection medicine," and we do that well. This "curative" approach to health care delivery is powerful, yet limited and disease focused. We need both preventive and curative components to bring a health orientation to American medicine. The medical model

excels at treating terrible disease and injury, in bringing patients back from the brink of death. It is necessary but not sufficient for an adequate approach to health reform. Bottom line, the current medical model is egregiously expensive to society and not sustainable without a shift that includes incorporation of public health, preventive medicine, and population-based delivery systems.

Preventive medicine and public health, with their related disciplines of epidemiology, bio-statistics, demographics, and others are critical to the synthesis that creates community-responsive medicine. The medical or disease model needs to make room for prevention. In this way the medical schools of metropolitan universities can begin to implement successful and relevant programs to address the stubborn societal issues related to health care.

Addressing The Problems Through Community-Responsive Medicine

In 1986, Parkland defined an ambitious strategy to better serve the health care needs of the residents of Dallas County through a community-responsive health care system. The Community Oriented Primary Care (COPC) program delivers comprehensive primary and preventive care to communities identified as suffering high morbidity and mortality rates.

Community-responsive medicine traces its roots to health care for the poor. Ancient Rome created hospitals for the care of slaves, and European cities in the 13th century established hospitals for the poor. In modern times, Israeli physician Dr. Sidney Kark developed a preventive model of a community based primary care program for poor, South African blacks in the 1940s and 1950s. He carried his model to the kibbutzim in Israel, and the strategy was adopted in 1977 by the World Health Organization for a global health strategy.

With local tax support, Parkland's program was implemented in 1989 in Dallas County communities that were targeted through a county-wide needs assessment that identified them as at-risk. Seven health centers were established and now extend care into such nontraditional settings as homeless shelters, schools, churches, and senior citizen centers.

In 1991, these health centers generated more than 175,000 patient visits. More than 200,000 visits are anticipated this year. Eventually, more than 400,000 visits will be provided annually. Additional benefits of the COPC program will be decongesting the central campus by decentralizing ambulatory care and patient education to the centers, which also will provide curricula for primary care practice and community public health practitioners.

Some of these health centers were built from the ground up while others expanded existing community clinics. Each center offers one-stop health care services including general medicine; family medicine; women and children services, particularly prenatal care, pediatrics, and well and sick baby care; laboratory studies; radiology; dentistry; social and psychological counseling; nutrition; and patient educational services. In

designing these services, we employed a life-cycle approach, from conception to death, and defined some 26 points of preventive health care intervention.

The one-stop concept is important for our patients who often have difficulty finding transportation, or who can't afford to take off a full day of work for a doctor visit. Other convenience factors include location on the city bus line, a play pit where children can play while their family members are being treated, and community volunteers who often read to the children while their parents or siblings are being seen. Patients pay a basic $5 per visit and nominal costs for prescriptions.

The mission of the COPCs goes beyond simply providing health care for the people who come through the doors. Broader public health concerns are addressed as well, such as teenage pregnancies, sexually transmitted diseases, cancer screening, nutrition, and so on. Each COPC is responsible for the health of three or four census tracts.

To create an appropriate mechanism and atmosphere for the physicians practicing and teaching in COPC, a unique group practice was established. This multi-specialty group, Community Health and Medical Primary and Preventive Services (CHAMPPS) had, as its original challenge, the need to recruit 20 physicians during the first year. This recruitment goal was met and surpassed, as 23 physicians were hired during fiscal year 1990. The group is ethnically diverse—African American and Hispanic physicians account for 56 percent of its membership; women account for more than 65 percent of the group, and five members possess advanced degrees in public health. The group also fills a critical void by role modeling primary care and public health to medical students, residents, nursing students, and allied health professionals. The cultural and ethnic diversity of the group provides an additional opportunity for role modeling within the minority communities served by the program.

Clinical faculty status was negotiated for the CHAMPPS group members in their primary specialty and in the Department of Community Medicine because only University of Texas Southwestern faculty and housestaff can admit to Parkland.

One way we ensure that public health goals are addressed is through our compensation plan. Our professionals are paid in three ways, including salary plus merit payment for meeting operational standards such as productivity, quality assurance, or collections. The third component is for outcome. We work with each COPC health center to set public health goals and then we compensate based on achievement of those goals. Because of this incentive, COPC employees as well as a host of volunteers reach out aggressively into the community to provide screening and education programs at schools, churches, community centers, shelters, and so on.

Parkland and Dallas County commissioners believe that the COPC program has been quite successful. The program is still too new to provide evidence of the gain we anticipate in health status, but they are very encouraging. Many of the public health interventions require years or even a generation to achieve maximum impact as demonstrated at our West Dallas COPC health center which has a 20-year history as a children

and youth clinic under a federal program. As a result of that facility's long-term public health services, the age-appropriate immunization rate of the infants the center treats is about 95 percent, compared to a county average of only 30 percent. In the same community where we've conducted an active program with teenage mothers to prevent second pregnancies, the population-adjusted rate of teenage pregnancies has decreased by about one third over the last decade.

Another important measure of success is the reduced utilization of Parkland's emergency room facilities by patients living near the health centers. The cost of care at a COPC center is considerably less than if that same primary care were rendered in an emergency room. It is also less costly than Parkland's outpatient centers, where costs are approximately $126 per patient visit, compared to $77 at a COPC.

But more important than broad public health goals or even financial advantages, the COPC program is making a material difference in the lives of the people it serves. People of all ages and with all sorts of infirmities are for the first time receiving the benefits of compassionate, continuous, and comprehensive primary care. The poor and working poor served by COPC are receiving preventive health care as a routine and fundamental part of their lives.

Challenges To The Universities

Community-responsive medicine in the form of Community-Oriented Primary Care is a single example of how a major metropolitan university can, and, I believe, must use its resources to address community problems. Health care is just one strut of the infrastructure that supports total community health. Much remains to be done in public health, and much remains to be done in the areas of crime control, housing, education, and employment. Metropolitan universities can and should be involved in all of these areas in order to make a difference in the communities they serve. To do otherwise, through apathy or omission, is to shirk a time-honored responsibility of service to people and community.

The consortium of metropolitan universities should issue a call to arms that challenges each entity to renew its commitment to community service and to search for solutions to societal problems that affect us all. It is clearly within the purview and mission of metropolitan universities to accept these as challenges:

- ***Make community involvement a priority.*** Resist the temptation to remain in the ivory tower. Universities can provide invaluable services to the inner-city community such as special education opportunities or literacy training. On a larger scale, universities can establish research and academic programs in numerous and interrelated disciplines that address social problems. As the COPC example has demonstrated, these can have outstanding benefits for the community, as well as for the university's educational programs.

- ***Actively study the problems to seek solutions.*** With their rich resources of academic disciplines, universities are eminently prepared to investigate the connections between education, job opportunities, housing, crime, and health care delivery. From the study, create recommendations and plans for action.
- ***Help create partnerships to effect change.*** Universities in major cities have immense opportunity for interaction with business, government, non-profit, and other entities. By bringing these together and fostering their cooperation for a common goal, a wealth of resources can be brought to bear on social issues.
- ***Be a forum for discussion of social issues.*** The whole concept of a university is the confluence of ideas and opinions for the purpose of expanding the total body of knowledge. What other social institution is as well poised to engender thoughtful give-and-take discussion on the evils that plague society? Discussion, enhanced by research and carried out through education, is the mission of universities at its finest.
- ***Help your community.*** Just as COPC tries to impact the health of non-enrolled persons, not just patients, extend your goals to your community's education, not just to your students.
- ***Restructure administrative procedures and tenure policies in order to encourage and reward community-oriented disciplines.*** The work that has been done by academicians for years for the good of their communities is seldom glorified to the extent that bench or clinical research is. The highest levels of administration need to "give permission" to students and faculty alike to reach out in community service.

The Middle Ages were a terrible time of ignorance, prejudice, violence, disease, and death. Only through the labor and vigilance of universities were the arts and sciences preserved. Had the universities of the great European cities shirked their responsibilities, had they bowed to the terrific social pressures to give up on their mission, civilization may well have taken a tragic turn forever. Instead, although they were citadels, and detached from a world in chaos, they persevered and succeeded in bringing about a renaissance.

Ignorance, prejudice, violence and disease still plague society and are getting worse in the inner cities of our nation. Metropolitan universities could galvanize their significant resources of medicine, social science, law and jurisprudence, education, engineering, and other disciplines to accept the challenge of fanning the flames of social justice, and carrying light into the darkness of our cities. At the same time, they would become better institutions of higher learning for their efforts. This time, however, they can only be successful if they leave the citadel and become relevant to their communities.

Suggested Readings:

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