Working with the medically underserved

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An imbalance between rich and poor is the oldest and most fatal ailment of all republics.

Plutarch

Working with the medically underserved is not for everyone. It can be difficult to gain the perspective necessary to understanding the vicious cycle of indigence and social injustice. Many socially disadvantaged groups were born into the lower social strata of the population and struggle to climb up the ladder. Their rates of obesity and cardiovascular and pulmonary disease, coupled with learning difficulties and poor quality of life, create a ladder with widely spaced and slippery rungs. The diseases borne by socially disadvantaged groups do not create a compelling medical practice for everyone, as compliance remains low and treatment failure rates are high. And yet many physicians (along with other providers) are drawn to work with the medically underserved as a tradition of service.

Who works with the underserved?

What we know about physicians working with the underserved is limited. Rabinowitz and Paynter[1] identified 4 independent predictors of US physicians providing care to underserved populations: being a member of an underserved ethnic or minority group, having participated in the National Health Service Corps, having a strong interest in practising in an underserved area before attending medical school, and growing up in an underserved area. Eighty-six percent of physicians with all 4 predictors were providing substantial care to underserved populations, compared with 65% of those with 3 predictors, 49% of those with 2 predictors, 34% of those with 1 predictor, and 22% of those with no predictors. Sex, family income while growing up, and exposure to underserved populations during medical school were not independently related to providing care for the underserved.[1]

In a qualitative analysis of providers working with medically underserved patients, Li and colleagues[2] identified a group of health professionals committed to working with the poor. Their study included 12 physicians, 3 physician assistants (PAs), 8 nurse practitioners (NPs), and a dentist. The investigators found that these providers had a strong sense that they were serving humanity and took pride in making a difference. Each appeared to thrive on the challenge of creatively dealing with their patients' complex human needs with limited health care resources. The authors identified factors critical to survival in an urban, underserved setting: a hardy personality style, a flexible but controllable work schedule, and a multidisciplinary practice team. The camaraderie and synergy of successful teams generated personal support and opportunities for continuing professional development.

Challenges of serving the underserved

The United States, with its patchwork quilt of health care, leaves many citizens medically stranded. In the 1960s, during a time of considerable social change, the PA, NP, and a safety net of community health clinics (CHCs) sprang up around the country, modeled after community-oriented primary care clinics in South Africa.[3] These CHCs serve as refuges for the medically underserved and are staffed by physicians, PAs, and NPs.[4] Not only are CHCs adequately staffed, but these 3 providers also remain committed to working with the poor and their retention rates are high (Henry and Hooker, 2013, unpublished data). Such cultural work points to a social commitment on the part of physicians and others, but does not answer why those working with the underserved do so.

An understanding of why those working with the medically underserved and economically disqualified do so is needed because the demand for services often extends beyond what is typically distributed in usual health care. Food, shelter, and clothing lead the list, but other requirements can involve protective services, mental health needs, telephone access, transportation, legal services, and advocacy. These issues can increase the requirement of time and resources for a busy clinical practice. But they also bring together a sense of team-based care and a need to meet the demand head-on (Henry and Hooker, 2013, unpublished data).

In a study by Muldoon and colleagues in this issue of *Canadian Family Physician,* the authors found that those in the lowest 2 quintiles in terms of economic status in Ontario neighborhoods increased the workload of primary care providers, as reflected in the providers' panel sizes (**page 384**).[5] What was surprising was that the increased workload seemed almost entirely the result of the medical comorbidities of the patients, and not some other feature intrinsic to "being poor." How the providers met the nonmedical needs of their poor patients could not be determined in the study, but it might be that other services delivered by CHCs, such as community-level programs, contributed to the care of these patients.

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The fact that patient poverty did not add stress in this study is surprising, as physicians have indicated that patient socioeconomic status often affects their clinical management decisions.[6] Bernheim and colleagues[7] interviewed physicians about the effect of patients' socioeconomic status on clinical management. The authors showed that when physicians undertook changes in their management plans (in an effort to enhance patient outcomes), they experienced numerous strains. The strains arose by trying to balance what they believed was feasible for the patient with what they perceived were established standards of care. Muldoon and colleagues commented as much: "We were surprised … as we expected that dealing effectively with the social challenges of poor patients in the primary care setting would create a lot of work for [primary care providers]."[5]

Muldoon and her colleagues advance a few potential explanations for the unexpected findings.[5] One is that some factors might not have been accounted for in their regression models. Another is that perhaps changes are taking place in Ontario communities that reflect provincial and cultural effects of addressing poverty and access to care. Then again, as the authors pose, panel sizes might not be accurately reflecting the actual workload of providers.

In the end more will need to be done to examine whether poverty and income equality are covariants of medical care that drive up the workload of primary care systems. Does the health sector have a role in raising the issue of poverty and income equality? As Raphael states, "It appears, at times, that the answer to that question depends more on the values being expressed by institutions concerned with health than by the research evidence. From an evidence-based perspective there is no doubt that poverty and income inequality are the key determinants of the health of Canadians."[8]

Creative solutions

As the evidence narrows in on the case that it is the economically disadvantaged that shoulder the bulk of chronic and comorbid illnesses, it is apparent that this burden strains physicians and health care systems as well. Some solutions are at hand. To be more creative in delivering scarce resources to needy communities is a clarion call for expanding the variety of personnel to work in team-centred care systems. A diversity of providers is needed for a diversity of patient needs. Although Canada is running short of doctors, at the same time it has PA and NP resources trained, able, and ready to expand health care service delivery: we wait for the political will to make the changes needed.

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Competing interests
None declared

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