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**AN ABORIGINAL MEDICAL PRACTITIONER:

THE NATIVE AMERICAN EXPERIENCE

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During my six months stay in Australia I have viewed with admiration the quality of the Aboriginal Health Worker Training Programs in Western Australia. They complement the growing control by Aboriginal people over their destiny, including their health care. It is inevitable that there will soon be Aboriginal physicians. The first formal step to this end was taken by the University of Newcastle declaring its intent to accept four Aboriginal medical students a year.

I am a white physician and a faculty member at the University of New Mexico School of Medicine. I have worked for a number of years with Native-American communities and I see many cultural and historical parallels between the Aborigines and Native Americans. I therefore think it is important to consider our experience in educating Native American medical students.

My State of New Mexico has many minority peoples - 40% Hispanic, 10% Native American (primarily Pueblo, Navajo and Apache tribes). The under-representation of minorities in medical careers in the United States contributes to the lack of doctors serving minority communities. It also means that the design and conduct of health services are often ill-suited to the socio-cultural needs of minority groups. Studies show clearly that minority medical graduates are far more likely than white graduates to work in minority communities. Thus, our medical school has made special efforts to recruit minority students. Now, about 20-25% of each class is minority, primarily Hispanics and Native Americans.

To do this, however, we broadened our ideas about what is required for entrance into medicine. For example, many schools admit students solely on the basis of grades and test scores. The low scores of many minority students would usually exclude them from consideration. These low scores, however, reflect their economically disadvantaged background without school opportunities enjoyed by most white applicants. The low scores also reflect a discomfort with a competitive approach to learning and test-taking which is socially repugnant to many minority students. These same minority applicants who have low test scores have often made major

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contributions to their communities, and have completed their prior schooling having to simultaneously support themselves and their families. Finally, the traditional criteria for medical school admissions - test scores and grades - have been shown to have little to do with becoming good doctors.

Over the past ten years we have come to understand certain principles of education concerning Native American medical students that would, I believe, apply to future Aboriginal medical students.

1. Success in medical school has more to do with social support networks than academic ability.

2. The white health care system can be alienating for Native Americans and the student who goes to medical school is seen as "joining the system" and may be rejected by the tribe.

3. Competitiveness is not a virtue among most Native Americans, so the very skills that are often praised in the "cut-throat" environment of medical school are odious to the Native American student for whom co-operation is a far more compatible value.

We have therefore designed a different kind of curriculum which not only suits many of our minority students but, we have happily discovered, is far more enriching and challenging for white students as well. Called the Primary Care Curriculum (P.C.C.) it has no traditional courses or lectures. All learning of medicine is done in small discussion groups, concentrating on health problems of real patients and communities. Students are rewarded for co-operating rather than competing with each other. While they learn on campus, students give health care in the community every week and then spend four months at the end of their first year in a rural setting caring for patients and working on community health problems. Native American students have returned to reservations where they have re-established community contacts and support.

The importance of these contacts is illustrated by the experience of a Navajo woman medical student when she was confronted with the dissection of a dead human body. Tribal custom does not permit such conduct. She consulted with a Navajo Medicine Man who proposed she could dissect the body, but not the face. Thereafter she would return to the reservation where the Medicine Man would conduct a religious healing "sing" to cleanse her for having violated tribal codes. Our Medical School supported her in this decision. This incident took place seven years ago. This same student has just been accepted as a top applicant to the University's Family Medicine Residency Program. She plans a career back out on the reservation.

Another Native American student talked about what medical education in this new way meant to her:

> Navajos think about things a lot before they do something. They weigh things a lot. For example, when someone dies in a Navajo family there is no will. Everyone gets together to discuss how things should be done. Another example is that there are chapter house meetings for tribal government. At these meetings people sit and weigh things. So sitting back and looking at problems makes sense to me. Trying to determine what is involved and what to do is just what we do in P.C.C. I see my father doing the same thing taking care of the cows when they are ill. P.C.C. fits better for me.

In Australia, Aboriginal health workers can determine the best way in which doctors should serve the Aboriginal communities. They are, therefore, best qualified to identify promising applicants to medical school. They will choose them on more important criteria than grades and tests. They will assess their compassion, flexibility, adaptability, maturity and capacity for community service. When this day comes, medical education will become more humanised for all students.

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