

IV. IMPLICATIONS FOR COMPREHENSIVE HEALTH CARE

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The road ahead for preventive medicine seems clear. It is the delivery of high quality, personalized (as opposed to depersonalized) comprehensive medical care to all. The traditional skills such as epidemiology, statistics, case-finding, and health education are basic to future endeavors. To accomplish this delivery is laborious enough; to prepare medical graduates for skillful participation therein is even more difficult. Thus a text detailing the teaching practices current in preventive medicine is timely. A look at the past and present is appropriate before facing the future.

"The Teaching of Preventive Medicine in the United States"¹ is an independent study by outsiders, not an official study of or by any of the organizations devoted to medical education. The authors are William P. Shepard, M.D., M.A., D.Sc., formerly Vice President and Medical Director of the Metropolitan Life Insurance Company, and James G. Roney, Jr., M.D., Ph.D., M.P.H., who has had experience in community public health work as well as graduate study in public health and anthropology. Thus, although outsiders

in medical education, certainly they are experienced insiders in public health and preventive medicine at different levels of practice and application.

As the authors state in their introduction, the approach is descriptive and ecologic, not evaluative. This goal of objective description without subjective comment is achieved remarkably in this, the most detailed, review of preventive medicine teaching we have seen.

While initially the authors planned to study only a sample of medical schools, they soon found that the schools, their programs, personnel, departmental structure, concepts, and definitions were so variable that a detailed study of all schools was indicated. What might have discouraged some of us encouraged the authors to expand their study. In the end the results supported the validity of the original sampling procedure. As the authors state in their summary of Chapter 3, "The academic subject of preventive medicine is relatively recent in its development, is *remarkably diverse* [our italics] in its subject matter and in the professors who teach it, has relatively low status in the medical school scheme of things, and most recently has been emphasizing comprehensive medical care as one of its major topics."

Shepard and Roney consider three types of studies: "(1) The nose-counting type, concerned with details such as the number of faculty, number of hours of curriculum time, etc., (2) the philosophic view of preventive medicine and its teaching, without mentioning details," and (3) a third type which "combines both detail and generalization based on facts." The authors chose this third type as their model. While the factual data presented are exhaustive in detail and quite impressive, this detailed accounting of facts and figures tends to overwhelm any generalizations, especially when the diversity of the field makes such generalizations difficult to derive.

To "insiders" in medical education some of the findings in this book are not surprising, e.g., that preventive medicine departments have many names, diverse structures, and varieties of interests, or that preventive medicine retains its older interests and skills in statistics and epidemiology, and is now moving ahead rapidly into comprehensive care and comprehensive teaching programs. This

movement reflects its sensitivity to the major social and medical problems of the age—a sensitivity that far surpasses that of the standard clinician. Moreover, it is pointed out that teachers are increasingly recognizing the need to engage their students with material rather than merely to lecture at them or to demonstrate to them.

We applaud the publication of such a detailed objective study of the teaching of preventive medicine today. However, we closed the book with the hope that the authors will soon follow this publication with a monograph giving their subjective appraisal of preventive medicine teaching and will suggest guideposts for the future.

This review in a sense is a portrait of the teaching of preventive medicine and public health as it exists today in medical schools. It can be compared in a way with political polls. A political poll queries a sample of people on how they expect to vote for a candidate as at any one period of time, and then projects these findings, which are presumed to be statistically sound, to the entire population. A poll does not concern itself with the true cause or etiology—it merely samples attitudes and opinions. Neither does a poll give an insight as to how such personal opinions may be changed—what the attitudes and motivation behind an opinion are and how one can affect or manipulate them.

The authors have given us an excellent picture of preventive medicine and public health as it is taught, not what is right or wrong with it. This is a first step, but only a first step. We should like to know why this portrait is what it is, how it should be changed, and finally how it can be changed. We are now learning to use the knowledge and talents of the behavioral scientists in efforts to apply knowledge for the prevention and treatment of illness and disability more widely and effectively. Perhaps we might avail ourselves of these same scientists to help us proceed to the next steps. There is a definite relationship. A department of preventive medicine or community or social medicine must reach out into the community if it is to carry out what some of us believe are its distinct contributions. It needs a community base, a mass of people, and it needs to reach out to serve these people, as contrasted to teaching only in a clinic for self-

referred people who have complaints. Preventive medicine includes more than caring for persons who are ill, physically or psychogenically—it must go out into families and homes to learn why people act as they do, how this can be changed by sound educational programs, or, perhaps, how the health team can be changed to adapt to the cultural patterns of the community. It also needs a controlled community base in which to do research and evaluate objectively and accurately what has been done. How else can we determine how well we are doing, which approach is successful and which is not?

We have reached a critical point in time for the field of preventive medicine, and our efforts toward future development—or our lack of effort—may determine its fate. The great surge of medical and biological research of the past 15 years may reach a saturation point, a leveling off, due in part to drowning in the sheer mass of undigested information. This will not happen soon to efforts to improve and perfect the organization and delivery of health care services, their quality, comprehensiveness, and continuity, for we are already far behind in meeting the changes required, not only by new knowledge, but by changing political, social, and economic factors in the community.

The need to chart a new course is self-evident. Our efforts to do so have not been especially exhilarating or bountiful. Perhaps we need more mavericks and fewer standpatters. A balance is desirable, but the freewheeling, imaginative entrepreneur will move us forward if only because he overlooks the sheer complexity of organization, financing, and delivery of health services in tomorrow's complex society.

The electron microscope has brought us closer to the atom—the Space Age brings us closer to the moon. Hopefully, we are on the verge of the “Human Age” which will bring us closer to the person, the family, and the community. Maybe then we will understand their health care needs and be able to meet their demands more effectively.

Too long, in our teaching and practice, we have allowed the complexity of health care to impede progress, stifle new ideas and approaches. This explains in part our reluctance to use new knowledge,

to use the team concept, to include actively other professions such as the social scientists. This is resistance to change in a context wherein most of us should be active proponents of planned change.

Departments of preventive medicine exist to educate professional personnel for health care services, to help in planning and providing health care services, and to do research in the area of health care services. Of course, health care services make up only one facet of the multifaceted whole of human services and are interdependent with other factors of community life. Health problems when viewed in perspective are just one segment of the continuous spectrum of social problems. Delivery of health care, like that of other human services, is determined largely by society, and by the social, political, and economic climate of the culture.

We are learning that no human service, whether medical care, family service, a housing improvement program, a vocational retraining program, or a public assistance program, can be planned and operated as an autonomous isolate. It has been demonstrated repeatedly that people with problems usually have multiple problems, and that this very multiplicity of their problems acts as a deterrent for the medical, psychiatric, and social welfare problem-solving mechanisms.

Lately there has appeared in several places in our country a new caring-for-people concept and organism: the comprehensive health care unit. Recognizing the multiplicity of biological, psychological, and social problems faced by patients, these units offer medical, psychiatric, and social diagnoses and medical, psychiatric, and social therapy. In this manner, the comprehensive health care unit is oriented toward regarding and caring for the patient as a total human being and is able, when it is necessary, to treat the whole family.

Comprehensive health care, then, may be defined as the personalized, totally integrated family or individual biological, psychiatric, and social diagnostic, therapeutic, and follow-up services provided continuously in home, clinic, and hospital by professionals who are aware of their own culture and that of the patient, and who understand how cultural and subcultural differences between practitioner and patient may affect diagnosis, therapy, and follow-up.

This definition of comprehensive health care has implications for the organization and planning of services, utilization of service personnel, evaluation of services, and for the individual's or family's responsibility to seek care when needed.

The health-care planner can no longer be content, even in a municipal health service, to provide only basic mandated "traditional" health services such as well-baby clinics, tuberculosis clinics, and venereal disease clinics. Activities of these types still retain some importance, but today they are vestigial reactions to the public health world of years ago. These compartmentalized health department activities are a traditional response to history. These traditional public health services did originate solutions for problems of their times, but the solutions may not be effective for the problems of our times. The maternal and child health programs with their well-baby clinics originated when large numbers of European immigrant families were arriving in the United States. This service program, much like settlement house programs, was a method of acculturation, a process for transmitting to and instilling in these newcomers the middle-class folkways and mores of the United States. This was apparently a successful mechanism for the European immigrant families. Since then, however, the needs and problems of families have changed far more rapidly than have service agencies. The tuberculosis and venereal disease clinics, being responses to specific infectious disease problems, have functioned primarily as a method of protecting the "healthy" community members from the sickness. Each program has developed great skill in case-finding, diagnosis, biological treatment, and follow-up. Both programs have developed technological skill in screening processes, in diagnostic procedures, and in therapy. However, they are both still treating the disease and not the patient. They have shown little more than a token interest in the psychological and social factors which have such a great impact on the patients' lives and on the pathogenesis of the biological illness.

The history and organizational development of health care and public health services has led to compartmented, fragmented services and programs directed at a disease, a disability, a cause, an

immigrant group, etc. This approach to our medical problems is just as apparent in hospitals and outpatient departments where, for a variety of reasons, services are fragmented into specialties and sub-specialties—and where the over-all program is seldom based on a holistic concept of community needs or community service. Fragmentation of services is also the rule in voluntary groups concerned with multiple sclerosis, cerebral palsy, sickle-cell anemia, hemophilia, diabetes, arthritis, and rheumatism, and so on. But, though we have single-disease and single-disability agencies, we do not have single-problem people.

James Reston of the *New York Times*, in a recent column said, "The habits of the past are dominating the present and the future." This observation fits the health care services too well. We cannot afford to perpetuate the mistakes of the past any longer. We must face the future, not back into it.

In designing quality-controlled comprehensive medical care services we immediately find obstacles placed in our path by many present limitations. These are the complexity and sheer volume of medical technologies to be applied; the specialization systems in medical practice, in nursing, in environmental health, in social work; the categorical systems of care which we have inherited in health and social welfare agencies; the inadequate number of family physicians available; the lack of awareness and concern that physicians and others manifest in social and mental problems; and, most significant, the lack of sound interdependent planning by all concerned, including medical schools and hospitals—as well as official and voluntary health agencies.

There are also limitations in our present educational and training procedures for physicians and for other health workers. There is typically a lack of relationship, for example, between the medical school and other university departments, such as education, social sciences, law, and dentistry. The courses of preventive medicine in the medical school are usually taught as historical material and as abstract theory, without utilization of the community and the local health department as a laboratory for the teaching of public health practice.

John B. Grant, in his "Health Care for the Community," says:

"Satisfactory integration of theory and practice is necessary to provide adequate facilities for student participation and for investigation. The principle in providing facilities for public health should thus be the same as that applied in giving institutionally controlled laboratories to the biochemist, bacteriologist, or physiologist, and clinics to the internist, surgeon, or obstetrician. Such facilities should be of a nature to allow full exemplification and investigation of the subject as defined. The staff provided should be sufficient so that both teaching and investigation may be carried on effectually in a unit, the size of which is determined by the number of students and the method and theory of instruction and investigation. . . . The place of public health in the medical school, as in the case of other departments, should conform to the principle of a relationship to the whole, which would permit of either independence or integration with other branches as the problems of the moment would demand."²

We need a fresh approach in the provision of health care services. We must perfect our methods of planning, organizing, and administering services. We should move toward the reduction of fragmentation of services. We must introduce into the service complex an interest and competence in coping with the psychological and social problems of our patients. We must begin to make more full and effective use of rehabilitative services. We need to commit more effort and more funds to research in patterns of care, in planning for health care, and in the organization, administration, and evaluation of health care systems. We should change the present concepts in professional schools training physicians, dentists, nurses, and social workers.

We must, at the training level and at the operating level, learn acceptance of the full contributions of ancillary workers. It is paradoxical that the team concept of medical and paramedical professionals working as a tightly knit unit is accepted in the operating rooms during surgical procedures, but this same team concept is regarded as suspect in preventive medicine where a working unit of physician, social scientist, social worker, educator, welfare worker,

and nurse might be able to move toward solution of some of the basic problems of our times.

It is also paradoxical that we accept the *idea* of treating the patient and not the disease or faulty organ system, yet the organization of public and private medical care systems is still based on the organ system or the disease. It is simpler to treat the disease, to objectify the patient, and more difficult to conceive and implement a health care system centered around the patient as a person.

In order to make departments of preventive medicine viable, dynamic, and effective contributors to their universities and to their communities, it will be necessary to change their image and their practice. This can be accomplished in part by staffing the department adequately with professionally qualified people. We need skills in epidemiology, biostatistics, internal medicine, preventive medicine and public health, and social science. We need a clearer definition of the role of the preventive medicine department so that we all will realize we have responsibilities, in addition to medical student education, to the other departments of the school and to the community. These responsibilities within the department must be clearly assigned for, as the old maxim states, "if everyone has the responsibility, no one does the job."

The department of preventive medicine must be engaged in defining community health care and related problems, and should be involved in helping to evaluate present services and to plan future services. This requires a close working relationship with local governmental health services, area hospitals, and regional health and welfare service agencies. The role, image, and practice of the department of preventive medicine of the future may be to provide specific instructional courses, on the one hand, and, on the other, to provide leadership in making comprehensive care available in totality, by linking together and improving existing agencies and departments.

This concept is workable in practice. At Temple University Medical Center, we have tested it in a microcosm by developing a hospital-based comprehensive medicine clinic using clinically oriented internists, psychiatrists, and social workers who are accepted by their

counterparts throughout the medical center. Students actively participate in this clinic, so that we are fulfilling the tripartite function of teaching, service, and research. We are now developing a family-care clinic in which third-year medical students, working with internists, psychiatrists, pediatricians, and social workers, care for, and follow through the school year, families of patients. These activities allow and demand full utilization of all disciplines involved, not as appendages but as active participants. In addition, our Department of Community Medicine is working closely with the City Department of Health, the area Health and Welfare Council, and local health and welfare agencies in a project to define the health and related problems of our immediate community of 200,000 and to design a new health service center which will, as an integral part of the municipal Health Department, provide comprehensive medical and paramedical services to the community.

Fulfillment of the three functions of education, service, and research is the only justification for existence of departments of preventive medicine and the only way for them to remain functional, contributing members of the medical school. If the departments of preventive medicine do not function productively, the physiology of the medical school organization dictates that they will atrophy and eventually die.

In conclusion, impressed though we are with the completeness of the Shepard and Roney report, we cannot be satisfied with a poll of current status. These are times of rapid social evolution, and institutions must adapt in order to cope with changing times, changing technology, and changing clients. Where are the guideposts for those concerned with the new horizons in medical care systems? We close this review, as we closed the book, with the hope that these qualified and experienced authors will write a follow-up study in which, with their wealth of knowledge of what has been done and why, of what is being done and why, they will raise their eyes to the horizon—and tell us what they see.

REFERENCES

¹ Shepard, William P., and Roney, James G., Jr., The Teaching of Preventive Medicine in the United States, *The Milbank Memorial Fund Quarterly*, Vol. XLII, No. 3, Part 2, October, 1964.

² Grant, John B., HEALTH CARE FOR THE COMMUNITY, edited by Conrad Seipp, American Journal of Hygiene Monographic Series, No. 21, Baltimore. The Johns Hopkins Press, 1963, p. 95.