THE HEALTH PROFESSION AND THE CHANGING COMMUNITY

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Two hundred years ago an American physician and professor of medicine, Dr. John Morgan, shocked the medical world by advocating specialization, applied science, and affiliation of medical colleges with universities.[1] At about the same time Adam Smith shocked the political and economic world by advocating free trade specialization and free competition on a market. Both started a first revolution—Morgan, a professional revolution which was slow in coming, and Smith, an industrial revolution which was slow in coming.

In the decades around the turn of the century we saw the second industrial revolution, with the use of electricity, new ideas of production, and the end of laissez faire. Parallel to this great upheaval, 55 years ago Abraham Flexner published his famous Bulletin Number Four,[2] an evaluation of medical education in the United States. Out of it came a profound professional revolution; medical colleges changed, health professions moved into new work rhythms and work processes as different from the old ones as those of the second industrial revolution were from the first, when 60 years ago electricity and mass production changed man's work life. In the work life, we are now facing a third industrial revolution, marked by computers, electronic impulses, and new theories of human relations. We are also facing a third professional revolution, marked by closed circuit television teaching, data retrieval, and interdisciplinary research and study.

We have moved from hand power and horsepower to steam and oil, and from there to atomic power. In medicine, we have moved from the power of magic to the power of medical science, and from there to human science. Who would approve an education or preparation that stopped with Euclid or with the invention of the wheel or the light bulb? Who would approve medical education that stopped with Hippocrates, Harvey, or Pasteur?

Dr. George Packer Berry, in an address to the Association of Medical Colleges in 1958, threw light on the dramatic consequences of change: "The environment of today's generation of physicians is very different from that prevailing fifty years ago. The whole atmosphere has changed, yet the medical curriculum has not evolved to meet these changes." Several years ago, the sociologist Robert Merton, in his classic, *The Student Physician,* painted the environment of those past days in which the student physician could predict what he would find when he opened up his first practice: "The structure of the society and the organization of medical practice were such that many practitioners would intuitively and almost automatically take into account both the stresses and the potentials for therapeutic support which the environment afforded the patient." One might add ". . . and the help and hindrance he might find himself in that environment."[3]

INTRODUCING TWO PROPOSITIONS

My first proposition is that health is the core of the steadily changing human community. The crucial difference in the future will be the extent to which the science of medicine can be effectively used in that community. For this reason I need a second proposition, stating that the effective use of the science of medicine depends on the extent to which the medical scientist can work productively with the social scientist whose task it is to explore and understand the human community.

These two propositions have personal, everyday aspects. Doctors and their helpers—nurses, sanitarians, nutritionists, psychologists, social workers, hospital administrators—are all *makers of the en-*

vironment, the human community. With them, of course, are others—politicians, teachers, newspapermen, architects, workers, businessmen, artists. The health professions daily make communities with other professions.

The role of the health people is rather specific. They are the ones who daily introduce science into a world of magic. Their professional role is to change illness to well-being through medical science. Their role touches those of other scientists—the political scientist, the economist, the sociologist, the anthropologist—all attempting to apply science to the making of community.

The other human aspect of the two propositions is that the doctor and his helping health professionals also are *mirrors* of community. They are all citizens, clients, friends, patients, neighbors, taxpayers, leaders, members. Their clinic or hospital or waiting room is a mirror of the many forces and interests at work and play in the surrounding community. At their side are other institutions, also mirroring community—the school, the church, the city hall, the bank, the welfare agency.

A social scientist would say that *the health professional belongs to two kinds of reference groups*—the makers and the takers of health, the producers and the consumers. A social scientist would go on to say there is a possibility that the health professional will find himself, or herself, in *role conflict*. This afternoon representatives of both reference groups are present: One is concerned with the professional competence of doctors, nurses, and paramedical personnel; concerned with scientific facts of medicine, laws and legislation, administrative arrangements, professional proficiency, knowledge about diseases and their prevention. The second group is concerned with interests and ideas from the nonmedical world: ideas and motivations, needs and resources, people, processes, programs, and plans in countless reference groups—families, churches, clubs, associations, cities, neighborhoods, and political parties.

In both of these reference groups there are pictures and images of what medicine is, what it was, and what it should be; of what medical education is, was, and should be. We all have pictures in our minds of what a doctor, a nurse, or a good clinic is. Our refer-

ence groups have such pictures. They are not the same as ours. Patients, neighbors, taxpayers, politicians, and members of health associations have pictures of what medicine is and what the health professions are. The tough practical question for the practitioner—and for the professor who is teaching the future practitioner—is: How can one get to know the two sets of reference groups around the physician, and how can one have a clearer idea of the picture in the minds of all of us of the physician, including the picture the doctor has of himself?

If the doctor and his supporting health professionals are mirrors and makers of community, the two propositions have direct impact on medical education—indeed, on medical research: First, if health is the core of community then in education and research the physician must be prepared to face the community. Secondly, if the medical scientist is to be best utilized in the human community through skillful interdisciplinary co-operation between medical and social science, then the student physician in his university must have ample opportunity to meet and discuss the problems of environment with his fellow scientists—the sociologist, the economist, the anthropologist, and the psychologist.

It is not my right either to question or prescribe anything that touches the professional science core of medical education, but I should like to offer some thoughts on the professional problems which I believe the medical scientist is facing in today's community. In doing this, I should like to ask three questions:

1. What kind of preparation does the medical profession need in face of the new and changing environment?

2. How do we prepare the doctor and his helpers for the new dimensions of the health profession?

3. How can we prepare the physician for his future work *with* other professions?

THE NEW ENVIRONMENT

The first question is whether we are educating for the past and for a situation that has already changed. In ordinary vocational

training, the leaders keep saying that when students walk out of the classroom the things they have learned are already "old stuff." Is that the case in the professions, too? One of the leaders in public health work in this country has said that the public health professional today is educated for the work of 35 years ago. Even with allowances for a bit of exaggeration, the physician, the public health nurse, the health educator, the educational psychologist, the nutritionist, and the sanitary officer are moving out of their professional courses with reasonable preparation for *today,* suddenly realizing that they are facing *tomorrow.* The society described in textbooks or in professors' notes is changing or has already changed. What implication does this have for our professional preparation?

Dr. Leroy E. Burney, former Surgeon General of the United States Public Health Service, now Vice-President of Temple University, recently spoke at the dedication ceremonies of the University of North Carolina School of Health concerning the kind of education people in public health need at this very moment. "Why does your school exist?" he asked. "What are you educating or training for? What is your purpose, your mission? Basic," he said, "is an understanding of how social, economic, and political factors will affect society in the future."[4]

In 1961, Dr. George Rosen presented a paradigm on health education to the Institute on Community Education for Health. In his statement, he called for instruction of public health educators in public health, sociology, psychology, cultural anthropology, political science, history, and some natural science. These, he said, are core subjects for health educators. Are they not also core subjects for physicians, nurses, social workers, and sanitary officers? They all are aimed at making health workers at home in society.[5]

I have neither the competence nor the right to offer specific criticism of existing programs. But it may be my business to raise questions. So here goes: In the curriculum designed for the medical health professional, what do we now have to give him specific knowledge about the community in which he is going to work? What kind of professional courses should he have to make a physician fully acquainted with the social and economic develop-

ments of which health is one facet? Has he been introduced not only to medical research findings but also to social and economic research findings which will make him appraise his environment with more than frustration? When should he hear about the community—early or late in his university years?

In her present professional education, what equips the future public health nurse to understand the community in which she is going to work? Lyle Saunders, in his article "Culture and Nursing Care," says poignantly, "Cultural factors, along with physiological and psychological factors, are omnipresent influences in the work of the nurse, and they need to be understood, assessed, and, where possible, controlled for the mutual advantage of the nurse and the patient, just as the more familiar organic and emotional factors are."[6] What is the professional role of the modern nurse in the community where there are long-term health needs, not just crises and accidents?

These are several questions arising out of a concern which practitioners express when they leave the safety of the classrooms in colleges and professional schools. These are questions about the bridge from the textbook and the theory to the living community.

Several years ago a survey was made under the auspices of the Canadian Association for Adult Education. In a nation-wide inquiry on the training needs of field workers, it was found that the majority felt they lacked professional preparation in the field of adult learning, community organization, human relations, and communication. "Field workers do recognize common educational needs (adult psychology, human relations, community organization, and communications) which are over and above those in their areas of specialization. The most important elements of the job and the ones where field workers spend most time require a high proportion of . . . knowledge and skill in these areas."[7] There is no reason to think that practitioners in the field of health are very different from field workers in co-operative organizations or in educational or social work. Nor is there any reason to suggest that Saskatchewan is different from British Columbia or the state of Washington in these basic concerns. We are not talking here

about the necessary general education that all of us need. We are talking about additional education, education in the community aspect of a professional's life.

THE NEW PROFESSION

The second question focuses attention on the health profession itself. Medical care in the last decades has changed in purpose, in clientele, in potential power, and in methods. The new dimension to the patient in a community is *the learner*. The new dimension to the citizen who is supposed to be involved in various stages of medicine is the learner. The new dimensions to the health profession—the physician, the nurse, the health educators, the social worker, the sanitary officer—are *the teacher, the instructor, the leader*. The crucial change in the program as we see it is the relationship between an agent for change and the person who is supposed to change. It is in this teaching-learning relationship that new findings of social science have immense importance.

Let me ask some more questions: What is there in the physician's professional background that makes him move past the powerful education of an individual specialist? How well has he been prepared in medical college to accept the role of a member of a team? True, he has been taught things about the patient—but has he been taught about himself? Learning is a two-way affair. Interaction is of the essence. What has taught the physician that he is no longer the father of all health, but that he is an agent, a teacher, a team leader? How well is he equipped and how willing is he to work with the men and women of the community who will be members of his hospital board? To work *with* the patient, not just *on* him?

"The prime challenge to medical education today," Samuel Bloom says, "is to prepare future physicians for a deeper understanding and skill with the interpersonal part of the doctor-patient relationship. In other words, the art of medicine is striving for the discipline of a social science of medical practice."[8] More than 20 years ago, L. J. Henderson said that the physician "can do harm

to the patient with words as surely as he can do harm by prescribing the wrong drug or making a false cut with a scalpel."[9]

In a discussion of national health grants for the years 1948–1961, the Canadian Department of National Health and Welfare pointed to the appreciation of the need to work with people. "This new concept is a tribute to the advances to be made in social sciences which are concerned with such areas as the modification of behavior, theories of learning, working with minor groups, group process facilitating learning and group productivity."[10] At present, then, the doctor has new tools and more than magic and intuition to work with.

How does the nurse understand her double task as "mother surrogate and healer" that medical sociologist Sam Schulman calls her "basic functional roles"? How has she been prepared to collaborate with the people whom she is serving, even letting them decide some of the features of her program? Lyle Saunders suggests that nurses "are going to have to take account of values, expectations, status, roles, norms, social class, ethnic membership group and similar matters from the province of the social scientist." Are they prepared to do this?

And what of the health educator? Are we giving him tools to work with adults, not only with young people? How well are we equipping him for an educational program in a classroom without walls (in a world with TV, teleconferences, and programmed learning)? Is he sufficiently flexible and imaginative in his philosophy of education to take into account not only the knowledge and skills people need to change, but also their values and attitudes?

THE NEW TEAM

This leads us to the question of the health team. The third major need facing the medical profession today is shared by the rest of us professionals. The future will, indeed, depend on how imaginatively we can use what Robert Oppenheimer once called "the creative intersections." The extremely fruitful explorations in our

time of interdisciplinary research and study lead one to state that the great discoveries and, indeed, victories of the future will be those won by persons who cross over lines of disciplines to discover together what they could not find alone. Look at biostatistics, for example, and medical engineering, economic history, and astrophysics.

This third question is possibly a more touchy one: What are we doing to prepare the physician for teamwork—across lines of disciplines and, within his own profession, across lines of specialization?

Recent studies of communication in a hospital—to mention only one kind of evidence—have shown that people talk with their colleagues much more than they do with personnel up and down the organizational ladder. Horizontally we talk with ease but vertically with difficulty! How can we prepare all public health professionals to talk with each other more easily and with less reticence? Much of modern medicine has built on rigid, at times unbending, discipline—not only in hospitals. How can we prepare the medical professional to play other roles than those of giving or obeying orders? How can we, for example, use the new findings by scientists like Jack Gibb on climates of communication (and co-operation) which are supportive rather than defensive? Studies of how groups operate point to the great importance of creating confidence. If there is a hierarchy in salaries and education—and there is—how can we prepare doctors for building creative co-operative teams from people in the different ranks? How can a university education give insight into human relations? Communities do not ask for piecemeal individual actions; they ask for health and medical care for which many are responsible. Such things as health and medical care are whole, not partial; they are tied together in human relationships.

With sociologists like Charles P. Loomis, we can point out that the members of a public health unit and the patients and customers are parts of a social system. If they are, what is there in the background of the professionals to help them understand what a social system is? What are the processes which maintain the sys-

tem? How can they be improved? What are the conditions for effective action? How can we master them?

In 1963, Dr. Burney drew attention to the fact that "we are critical of the splintering of services in the community among a growing number of private and official health and welfare agencies, the so-called social fabric which doesn't approach grandmother's patchwork quilt in functional design and unity. But take a look," he says, "at our own universities and the autonomy and lack of functional relationships among their many schools and you may decide you have a job cut out for you in your own family, close at home." Let us paraphrase this and say, "take a look at our health teams." Let us remember that all of them come from separate parts of a university or a professional educational system. "The professional base of these people is unimportant—what is important is the educational environment and training you can give them in organization and administration, biostatistics, health education, and an awareness that no one program or speciality stands alone in tomorrow's complex problems."[11]

Health is a major concern in the community of man. The doctor and the health professional are central figures in that community. We are, therefore, all concerned with the excellence they may develop before, in, and after their university training.

A great English philosopher wrote the words I will use in conclusion. Fifteen years ago Alfred North Whitehead said: "The fixed person for the fixed duties who in older societies was a godsend in the future will be a public danger." So he asked us to prepare our professions "to face novel situations which find no parallel in the past." Whitehead also warned that "each profession makes progress, but it is progress in its own groove."[12] We need grooves to make more perfect our professional knowledge. But in this professional drive for excellence we may be too narrow in our cultivation of effort. We may lose our vision of the whole field.

"Wisdom is the fruit of a balanced development. It is this balanced growth of individuality which it should be the aim of education to secure."[12] The balance we are asking for in our call

for a renaissance in professional education is flexibility and fresh imagination about the unpredictable future and, at the same time, professional excellence with the wisdom and skill to co-ordinate the resources of the many professions man has invented.

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