The Community Corporation and its Implications for Education and Research in Health and Medical Care

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American medicine is facing a dilemma caused by its successes as much as by its failures—success in building the potential of its effectiveness, but failure to bring this effectiveness to fruition for all our people. If this dilemma is to be solved, the effort must have adequate direction. Direction will depend on research, education, and communication. And, in one way or another, since this will involve most of the population, the kind and amount of research, education, and communication that can help will be no small order.

I will deal with what I consider the most important of education's portion of the dilemma I have just mentioned. This portion I consider to be the education of the kinds and numbers of professional and supporting personnel needed to provide the personalized care that most people will require at one time or another. My principal concern will be for the medical care that is given, or should be given, at the grassroots community level—the points at which, and the manner in which, patients enter our system of medical care and, depending upon need, the care they receive in the local community hospital. To some, the growth of scientific medicine and of efficiency in its delivery makes my plea for personalized care sound like maudlin talk. I must disagree.

Much of the present preventive, curative, and therapeutic effectiveness of medicine has resulted from concern for the diseases of single etiology. Technical procedures and apparatus and drugs that help control the self-defeating aspects of certain disease processes have also added to this effectiveness. And, while it is important that such developments continue, it is my belief that the major reason for any continued effectiveness of medicine will be because of the ability to deal with causes of illness that are multiple and environmental, physical and physiologic, emotional and psychological.

This means that, while scientific facts and technical procedures will continue to increase the pos-

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sibilities of medicine's effectiveness, we must not forget that in medical care it takes a human being to apply a fact or use a technique to solve another human being's problems. No two human beings are alike, or respond alike, to the same situation. Scientific information and technical procedures therefore represent the only fixed quantities in an equation in which the human patient and the human health or medical professional are both variable considerations.

The Interpersonal Relationship

The ultimate situation in medical care is one in which human beings are working together on the basis of a close interpersonal relationship. This relationship is the atmosphere in which scientific and technical procedures are applied. And we now know enough about human behavior so that this relationship can be used as an instrument in the solution and management of clinical problems.

These emphases upon the interpersonal relationship should underscore the fact that the individual patient does not exist in a vacuum. Each patient is part of, and must fit into, a complex environment which constantly presents influences and situations to which the patient must make adjustments. These influences, situations, and adjustments are often implicated in illness, so that the environment must frequently be investigated for factors that can be removed or modified or factors to which the patient can be better adjusted. Also the environment must be explored for factors that can be used as resources in the interests of improving health and the prevention of illness.

And just as the personal and personality resources of the professional are necessary for the support and adjustment of the patient, so can environmental and community resources be turned to the same end. Using these resources demands of the health professional knowledge and understanding of the structure, organization, and function of the community of which both professional and patient are integral parts.

Thus, while a satisfactory interpersonal relationship is essential to the effective application of medical knowledge and technique, a satisfactory relationship between the health or medical professional and the community is also important. This requirement means that the working definition of

medical knowledge must be broadened to include information and concepts that are social and economic, as well as those that are scientific and technical. This broadening interest that includes a working knowledge of the patient's environment is important, not only from the standpoint of better diagnosis and therapy, but also from the standpoint of more effective preventive medicine.

A New Philosophy of Medicine

In the future, I anticipate that we will see an extension of interest from the mere prevention of disease to interest and activity in the promotion and maintenance of health. Like disease, health has its causes, and we are rapidly reaching the time when health will be subject to deliberate evaluation and management. Also like disease, the causes of health and, therefore, the factors important to its evaluation and management, are often to be found in the individual's personal and community environment. But health, unlike disease, is relative and therefore can be thought of as perfect, fair, or poor.

Finally, between the extremes of manifest disease on the one hand and good health on the other, preventive medicine must concern itself with the recognition and control of nonmanifest or asymptomatic illness and also with the possibilities or the risk of certain types of illness in persons who, as far as can be determined, are entirely well. (Since Collen's major paper in 1966 (*1*), the literature now abounds with suggestions and programs for screening for nonmanifest illness. Also Robbins and Hall (*2*) have placed predictive or "prospective" medicine upon what appears to be the beginnings of a sound actuarial base.)

If all these concepts are to be added to medicine's armamentaria, the basic philosophy of the continuing care of health should gradually replace that of the episodic care of illness and, as a consequence, in the education of health and medical personnel, emphasis will shift away from the patient on his back to the person on his feet and from the patient in the hospital to the individual person in his home and community. These are challenges that cannot be fully met unless education can be extended beyond the physical limits of the professional schools into the communities—into the places where people live and work, where people stay well and become sick.

The concepts and competences implied in what I am saying cannot result solely from teaching a special course or giving X number of hours to the teaching of another discipline. The needed knowledge and skills must be appropriately integrated throughout the professional's total educational experience and focused through more efficient methods of teaching and learning into practical frames of reference that involve the people to be served.

Now, except for minor rewriting, most of what I have said was published in 1952 (*3*). Before writing that paper I had taken an active part in the National Health Assembly. I had been on the Commission on Chronic Illness and had just spent a summer assisting with some of the work of the President's Commission on the Health Needs of the Nation; the University of Colorado School of Medicine, of which I had been dean, had just revised its curriculum, supposedly to lay great stress on the training of general practitioners. The school had also established a popular residency in general practice. Because of these events, in 1952, I had stars in my eyes; I actually believed that both medical care and education were going to move in the directions about which I had written.

Of course, I was wrong. I should have realized that the explosion of medical knowledge that was then already so apparent would rapidly expand specialization and create other conditions that would categorize, fragment, and depersonalize medical care in the ways we see about us today. But in 1966 (and in 1972) I still hope that the proper use of the interpersonal relationship in medical care can reverse these trends. And to be more realistic than I was in 1952, I called attention in 1966 to the inevitables with which all aspects—even the personalized aspects—of future medical care in the United States must deal (*4*). Aside from the inevitability of change itself, I listed these inevitables as:

1. Increasing knowledge
2. Increasing specialism
3. Increasing demands for service
4. Increasing costs of service, particularly the total national expenditure
5. Increasing shortages of personnel relative to demand
6. Increasing complexity and efficiency in data processing and communication
7. Increasing institutionalization (organization) for the delivery of medical service.

In that article, I did not elaborate upon these inevitables. Rather, I briefly stated the proposition that we should attempt to deal with them in such a way as to deliberately encourage the development of institutionalization (or organization) so

as to incorporate the use of increasing knowledge and specialization and increasing efficiency in data processing and communication to the end that we increased our capacity to cope with increasing demands, costs, and shortages of personnel.

Now from what I have said thus far, it may well appear that my past writings have me well boxed in. On the one hand I have pled for medical services and education that are primarily oriented to patients as people, but on the other, I have advocated increasing institutionalization. And I know that institutionalization encourages an approach to the individual person that is mechanistic, standardized, and impersonal.

As I attempt to work myself out of this box, I will turn to the consideration of what I think are the principal understandings that those in the total medical establishment, including those interested in patient care, must share. First I offer definitions of the terms and discussion of the goals and concepts that can provide the common ground for the development of these understandings.

I hope the time has come when the terms "medical care" and "medical education" can include the activities and education of all personnel in all disciplines and at all levels that are concerned in any way with the professional and technical aspects of our medical establishment. These terms must now mean much more than the activities and education of physicians, and their meanings must also include preventive, rehabilitative, and custodial aspects, as well as the diagnostic and curative aspects of medicine.

A Definition of "Comprehensive"

But more important than these questions of definition is the clarification of the goals and concepts that must direct our efforts in the field of health and in medical care and education. I believe we should aim for a system of medical care that is capable of providing every type of care and every amount of care that people may need. I suggest that we seek a system of personal and family-centered service, rendered by a well-balanced, well-organized core of professional and technical personnel who, by using facilities and equipment related both physically and functionally, can deliver effective service at a cost that is economically compatible with individual, family, community, and national resources. This is my definition of comprehensive medicine.

In 1963 a report, "Education for the Health Professions"—Dr. Lester J. Evans was the principal author—was submitted to the Governor and Board of Regents of New York by the New York State Committee on Medical Education (*5*). The report enlarged upon the concepts and goals of comprehensive medicine:

> . . . There is nothing new or complicated in the concept. Basically, comprehensive medical care is the kind of compassionate, personalized, birth-to-death attention —preventive, advisory, and rehabilitative, as well as diagnostic and therapeutic—that the ideal family physician used to give (and sometimes still gives), within the limits of his knowledge and facilities.
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> What is new and complicated is adapting the concept to the uses of urban society and specialized skills; so that medical care does not become increasingly an episodic, impersonal and even haphazard matter of a patient's shopping in bewilderment from specialist to specialist, none of whom may know the emotional and environmental problems interacting with his organic complaint. The aim should be to combine the concentrated knowledge and skills of the specialists with the broad understanding, wisdom, and continuing care of the generalist to the end that the patient receives precisely as little or as much care as he requires . . .

In my opinion, the combination of the "concentrated knowledge and skills of the specialists with the broad understanding, wisdom, and continuing care of the generalist to the end that the patient receives precisely as little or as much care as he requires" is the key to the effectiveness of comprehensive care.

In the concept of comprehensive care, it is essential that the patient have ready access to a system that will provide precisely the care he requires and that, at each and every point of entry into, as well as throughout, this system, he encounters the personnel qualified to render the judgments that the word "precisely" implies. Precisely as little or as much may mean diagnosis, treatment, and discharge on the spot, or it may mean further penetration into the system for varying degrees of study and care. The system must be so adjusted that all along the way the individual patient can have the benefit of judgments that take into account all of the factors, exogenous as well as endogenous, that have been concerned in developing his need for help; that episodes of illness are not routinely considered as isolated events; and that patients do not leave the medical care system except for good reason.

Laboratory determinations, other routine procedures, and computers may provide or organize information that may assist, but they cannot be substitutes for the judgments of which I speak.

Judgments in health and medicine, even quick ones, are entirely dependent upon human cerebration. The ability to form adequate judgments must be common to all health professionals, but at levels that are consistent with the responsibilities for which they have been trained.

I grant that such terms as "system," "point of entry," and "depth of penetration" suggest an assembly line type of activity. The introduction of the words "patient," "personnel," and "judgment," however, offers the opportunity to give life to such impersonal terms and, through proper combinations of personnel, facilities, and services, implies both efficiency and effectiveness in the various kinds and levels of care that any well-ordered community should have: care in the office, home, factory, or institution and care that is preventive, emergency, intensive, extended, convalescent, rehabilitative, or custodial.

And, as one looks at this broad range of services—services that deal primarily with people—it should be apparent that the medical care of the future, and also the education of its personnel, must be integrated with, contribute to, and draw upon other elements in society that also deal with people—the institutions of private and public welfare and education, churches, the world of business and industry, the systems of communication, and all divisions and levels of the systems and agencies of government. In other words, I believe the time has come when medical care must be recognized as an integral part of the structure and function of our total society and that, as such, it is time to provide the machinery that will permit the crisscross of the communications, planning, and programing that this integration implies.

A New Social Institution

The task of achieving such an integration is exhausting to contemplate. One could write books to document and discuss every consideration that would or could be involved. I will have to cut across all of this by saying that, in my opinion, because the limitations of specialism have trapped our social agencies and institutions just as they have our professions, we should create a new social institution that can coordinate all the elements in a given community that are actively concerned with, or that sponsor activities that are, should, or could be related to its medical care establishment.

Every community is different. I believe these differences dictate that each community should create its own institution which, for the purposes of this paper, I will call a "community corporation." Each corporation should be a legal entity that can make contracts, apply for and receive grants, employ personnel, and plan, sponsor, and conduct studies, research, and programs.

The corporation should have a self-perpetuating board of trustees that represents the most intelligent, farsighted, and fairminded persons the community has to offer. The board should be broadly representative of the rank and file of the community. The board should contain no one who is an official representative of any organized or established vested interest that is actively concerned with the conduct of welfare programs or medical care. This restriction will permit the board to be impartial in its dealings and, when necessary, to serve as a buffer between particularly influential agencies and interests, such as the many levels and agencies of government, academic institutions, the organized professions, volunteer health agencies, and the many other organized interests that are increasingly characterizing our society. Yet, through a system of consultants, committees, task forces, and commissions, the community can reap the indispensible benefits that such agencies and interests have to offer. This arrangement should prevent these agencies and interests from looking upon the corporation as any particular threat because the corporation would help all agencies or interests find the place where each can help the most.

Financing should be possible through contracts with and grants from the Federal, State, and local governments and through the support of projects that would appeal to voluntary health agencies, foundations, and private individuals. The general support of these corporations, particularly during the early phases of their development, should carry a particular appeal to those foundations that are required, or are dedicated, to use their funds for local purposes. Except for staff and overhead, much of the corporation's work would not involve the expenditure of funds. Many of its purposes would be served by bringing the right agencies together in the interests of the right programs at the right time.

It is generally recognized that recent Federal legislation, while not solely responsible, has created a climate in which community planning is now taking place, particularly in the interests of heart disease, cancer, and stroke. But as yet, I know of no instance in which the resulting organi-

zational plans cut a wide enough swath to meet a community's total medical care need. To organize itself to meet the total needs of the community would be the corporation's principal purpose. Any plans in the interests of these three diseases, along with the special activities of other health and welfare agencies and interests, could be a part of, but would not replace, the mosaic of the community effort of which I speak.

To be consistent with my introductory remarks, I believe that the community's attention should first be turned to improve its system of grassroots medical care. This will mean that judgments as to precisely how much or how little care will be of the first importance. Of course, there should still be grassroots interest in the facilities and services, most of them highly specialized, that lie deeper in the system of care. Certainly how and why patients had to reach these deeper levels of care, or why they did not reach these levels sooner, should be matters of grassroots concern.

Directions for Grassroots Research

This discussion of "how to do it" in the interests of medical and patient care has great relevance for education. For if our medical establishment is to grow in effectiveness, medical care and research in medical and patient care must unite to form the common framework within which education takes place.

I believe that the time has come when the medical establishment should not be subjected to further change without the sense of direction that research alone can provide. I further believe that if grassroots medical care is to be improved, it will depend upon grassroots research. This research will support the grassroots forums necessary if planning and programing are to make the most of research results. Therefore, using grassroots medical care as the principal point of reference, I suggest that studies start from the standpoint of the patients and their reasons for satisfaction, or its lack, as well as from the standpoint of the medical professionals and their judgments as to what is adequate and what is not. These findings should then be studied in the light of the organization of available personnel and the personal and professional limits within which these persons must work.

Every effort should be made to gather all other evidence, whether direct or indirect, that can be used to elucidate the quality or adequacy of care. Among the many questions to be considered from these standpoints would be those that have to do with access, freedom of choice, communications, delay, referral, continuity, and methods and amounts of payment. All opinions and data should be carefully analyzed and understood before trying to relate them to changes in the system of care.

Another early research activity should be analysis of the objectives, programs, and sources of authority and funds for all public and private health, welfare, and academic agencies and institutions that are, or could be, concerned with any aspect or facet of the community medical establishment. Instances of competition and overlap should receive particular attention.

Finally, research should concern itself with the continuing search of the literature; sorting out the data, information, and ideas that might be useful to the community effort in both medical care and social welfare. In addition to the standard periodicals and books, the importance of newspaper items, newsletters, unpublished speeches, reports of congressional hearings and committees, the Congressional Record, and special reports should be kept in mind.

There is a particular chain of reports that has relevance to the various ways in which a community can approach its problems of medical care: "Medical Care of the American People," published in 1932 by the Committee on the Costs of Medical Care (*6*); the 1949 report of the National Health Assembly (*7*); the 1952 report of the President's Commission on the Health Needs of the Nation (*8*); the Bayne-Jones, the Jones, and the Bane reports (*9–11*) published between 1958 and 1960; and the reports of the Commission on Chronic Illness (*12*), published between 1956 and 1959. More recently we have the DeBakey and the Coggeshall reports (*13, 14*) and the report to the Governor and the Board of Regents from the New York State Committee on Medical Education (*5*) as well as "Health Is a Community Affair" (*15*) and other reports of the National Commission on Community Health Services. I would also include the report of the White House Conference on Health (*16*) and of the AMA Citizens' Commission on Graduate Medical Education (*17*). The Carnegie Commission's report (*18*), issued in 1970, is the last item in this chain.

These kinds of research should provide the community with an understanding of its shortcomings and resources. This stocktaking should also generate the incentives that will lead a community to establish experimental systems or models of medical care in which both efficiency and effectiveness can be evaluated against various concepts and combinations of professional and supporting personnel and against different combinations of facilities and services, different patterns of organization, and different methods of financing.

It is important to recognize the distinction between medical care and patient care. To me, medical care concerns the functioning of the total medical establishment—all categories of personnel and facilities and all organizations for their administration and financing. Patient care is the principal objective of medical care. Therefore, while patient care is a part of medical care, the two are not necessarily the same. Patient care results from the exchange at the level of the medical professional and his patient. Research in medical care is primarily concerned with efficiency; research in patient care is only concerned with effectiveness. This distinction spells out the two broad areas of research with which a community corporation will be concerned. In applying research results, efficiency at the expense of effectiveness should be avoided.

The Community as a Classroom

Community study, research, and experimentation should provide the context within which the clinical aspects of medical education for the future takes place. The community itself should serve as the classrooms and laboratories. Early concern should be given to the continuing education of the practicing professionals so that they can keep in step with progress, not only for the sake of progress but also so they can plan their roles in research, teaching, and service that the overall community effort will require. Present programs of continuing education have far to go before they can meet expectations such as these.

Through the coordination of staff from the educational institutions with teachers that have become qualified in the community, the future clinical instruction of new professionals should take place in the environment and in the team situations in which they will practice. This change is particularly important if grassroots care is to hold its rightful place in the future of our medical establishment. Grassroots medical care in these terms is possible for only a few of the centers that sponsor professional schools in health and medicine; this is largely because the centers do not have access to the necessary resources.

Now before the educational activities of which I speak can have the incentive and receive the direction they will need, it is essential that all areas of health and medical education subject themselves to reevaluation and coordination of their basic educational goals. And, since we must anticipate the continuation of change, these goals, once established, must be kept under constant review. The goals should be determined in terms of the concepts, competences, and intellectual and technical skills that should be common to all medical professions, as well as those that should characterize the various levels and divisions of each single profession. Then, and only then, can the appropriate groups of educators determine the curricular content and teaching methods that should apply and devise the tools that will measure the various degrees of accomplishment of the goals that have been achieved. The implication here is an exercise the like of which medical educators have never faced before.

Some Possible Outcomes

I have considered only the most general of the research, service, and educational activities that can result from an all-out community effort in the interests of improving its medical establishment. I can see the possibility of many specific outcomes, most of them related to activities that are primarily educational. I will only give examples of these outcomes.

- The development of new kinds of personnel: specialists in ecology; administrators in medical care; and particularly, specially trained physicians, nurses, social workers, and possibly other assistants who would form the teams that provide primary care—care that would be person and family centered; comprehensive and continuous; provided as needed in the home, office, or community hospital.
- All-community internship and residency programs in all areas of medicine—not just for physicians—with the primary emphasis upon education, not on service. A special effort could be made in the interest of graduate and continuing education of physician graduates of foreign schools who come to this country on either a temporary or a permanent basis.

- On-the-job training, plus formal academic opportunities that would provide for upward mobility toward technical, subprofessional, and even professional qualification. This mobility could be particularly important in the field of nursing.
- Educational programs for lay people so they could help assume the responsibility for the custodial care of the chronically ill and the aged in their own homes and in foster homes.
- Surveys and educational programs that would make possible the recall of professional, subprofessional, and technical retirees to near-home, full- or part-time employment.
- Educational opportunities that would produce volunteers for communitywide as well as institutional service.
- Educational activities that would teach the public how to enter the community's system of medical care, the indications for entering this system, and, once in, the importance of using it properly. As part of these activities, there might be screening and automated clinics to discern asymptomatic disease; even begin to develop longitudinal data that might lend credence to predictive medicine and, this in turn, to community sponsored health education that would have highly significant relevance to individualized need.

I would be remiss in not suggesting prepaid health insurance as one method a community might use to program research and education for total medical care. To me, the population of a prepaid health insurance plan can provide an ideal laboratory group for the study of the efficiency and effectiveness of both medical and patient care. As well as improving the capacity for the early diagnosis and comprehensive, continuing management of disease, such an approach could give great visibility to the evaluation and maintenance of health.

Conclusion

In conclusion, I must express some special thoughts about the university. In the recent past, many persons, of whom I have been one, have indicated that the role of research and education in the activities we are discussing should involve the entire university, not just its medical school *(19)*. In other words, the university should take its resources in the social and behavioral sciences, as well as its appropriate professional schools and, in cooperation with the community, establish models within which it can conduct service, research, and education in medical and p ,tient care. Further, the implication has often be:n that the university should assume not only the general leadership, but also the major responsibility for administering programs and funds.

As I have given this matter continued thought, I now believe that this role would not be wise. The threat to the academic and fiscal stability of the university, and the chance that town and gown relationships will result in roadblocks rather than roads to success, are too great. Furthermore, the needs for academic and research resources are much greater than can be supplied by any one university or by a combination of universities. Every academic institution in a community, beginning at least with the high school, has something to offer and something that is needed in this enterprise. The coordination of all of the educational resources and the health and medical professions, plus the other elements from the community that are equally necessary, represents an enterprise far too complex for a university or other existing community institution to organize and manage. I propose, therefore, that each community meet its own peculiar needs by using its own peculiar resources, and create a new institution, the community corporation.

Addendum, 1972

In 1972 there has been considerable change in the national climate that pertained when I read this speech at the University of California in 1966. Much of this change is a reflection of legislation in the fields of health, education, and welfare that has been passed or is receiving serious consideration by the Federal Government. Four items of legislation are of particular importance. The success of the Regional Medical Programs now has considerable visibility. Any comparable impact from the comprehensive health planning legislation has yet to develop. But, in my opinion, this will happen, particularly as CHP will be related to legislation providing for area health education centers and health maintenance organizations.

As far as any one community or region is concerned, I see no reason why RMP's, CHP's, AHEC's and HMO's cannot be brought under the aegis of a single community or area corporation. The patterns of diverse community elements working together have already been set by RMP's. Many successful RMP's have been set up as com-

munity corporations, one good example of which is the Regional Medical Program, Inc., that involves nine counties centered around Buffalo, N.Y.

In 1970, I published two papers (*20, 21*) in each of which I added two "inevitables" to the seven I listed in 1966. One of these was the increasing "curse of bigness" and the other the increasing depersonalization of medical care. Also in these papers, I indulged in considerable elaboration of each of the nine inevitables, particularly upon the deliberate use of institutionalization or organization as a vehicle for adjusting solutions to problems. As a possible answer to the problem of depersonalization of care, I suggested a patient care team as an organizational unit that could offer person- and family-centered, continuing comprehensive care. Each team would be of such size and composition that it could be accepted by a person or family as the frontline echelon of service. A single team could incorporate as an HMO and function as an entrepreneur, or one or more teams could work side by side within the framework of a larger HMO, incorporated as a self-sufficient clinic or as the primary care units of an all inclusive community corporation.

As a final thought, I submit that the kinds of organization I am suggesting could serve as preparation for participation in almost any type of an overall national health plan—something that may well develop within the not-too-distant future. I like to think that community corporations, in addition to being the units that could help a national plan work, would still be sufficiently independent to accept grants from and make contracts with nonfederal agencies and also to foster the generation of earned income from within their own structures.

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