REGIONALIZATION; AN INTEGRATED EFFORT OF MEDICAL SCHOOL, COMMUNITY, AND PRACTICING PHYSICIAN*

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MEDICAL care in our country is undergoing a profound transformation, induced by two potent ideas long nascent in our society. The first of these is the awakening of our universities to the potential of their role in public service and community action. The second is the public decision to establish health as a major social goal and to take the means to define that goal and achieve it optimally. Recent and forthcoming legislative measures are facilitating enzymes in what promises to be a potent exothermic reaction. Whether the resultant heat can be transformed into useful work will depend largely upon how well the practicing physician and the medical school can coordinate their planning and their actions with those of the rest of the community.

The fact is that an informed public has already decided to devote a significant part of its material resources to the purposes of better health and has expressed its will in legislation and appropriation. It promises to go much further in this direction in the future. In so doing, it regards the physician and the university as instruments of social purpose. While the initiative has not been theirs, the university and the community of practicing physicians are now impelled toward a confrontation for which they have had little time to prepare and for which there is little precedent.

This confrontation will surely complicate the interrelationships of medical schools and practitioners. But the more pertinent issue is the responsibility of the medical schools to develop the great potentialities

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of a closer integration with the practicing community. Recognizing full well that the number of variables is large and all are not identified, it is nonetheless the university's mission to respond imaginatively and constructively to the current social and public mandates, especially those of its own region.

One may look on the new legislation and public pressures negatively, as unfortunate political eventualities, as threats to the quality of the present system of practice, or as mere passing annoyances. None of these reactions is reasonable nor is it in the best interests of our patients. This legislation is in fact the culmination of forces at work for a long time in our society. These forces are precipitating certain changes in medical care patterns that are the result of the advances of scientific medicine, our complex social structure, and the better education of an affluent public. The relationships of the medical center and the practicing physician in any new synthesis are best viewed in this latter context. It is unfortunate that more active leadership was not taken sooner by either the university or the practicing community in encouraging these changes and framing legislative action.

The fundamental social need expressed in the new legislation is to reduce to a minimum the lag between the discovery of new medical knowledge and its application. The maximum of new knowledge must be brought to bear for each patient, *in his own community* if possible, and independently of social or financial status. One cannot quarrel with this objective. Indeed it is a moral objective to which our profession would have been impelled to address itself more strenuously in any case. The new legislation, properly implemented, can accelerate the attainment of that objective.

It is surely obvious that its attainment is impossible without an integrated regional effort on the part of teachers and investigators as well as the members of the practicing community of physicians. The effort will of course involve more than physicians. All the institutions in which physicians function, hospital and university boards of trustees and administrators, the other university disciplines, and all the health professions will inexorably be drawn into it. But the essential relationship upon which the regional concept will turn is the integration of the practicing with the educational and investigative elements in the medical care system.

Before enumerating briefly some of the specific mechanisms that

can facilitate the cooperative efforts of practitioner and teacher, we should consider the two major obstacles to such cooperation: the uncertain state of relationships between medical faculties and their practicing colleagues, and the possible threats to the integrity of the university.

To begin with, a better climate of understanding than now exists must be cultivated between the practicing physician and his medical center colleague. The prevalent mood resembles a kind of respectful but wary and unstable equilibrium. The practitioner appreciates the benefits of medical research, the opportunities for continuing education, and the concentration of techniques and specialists the medical school affords. Nonetheless he is often deeply concerned that these very things lead to an overemphasis on research, a loss of interest in educating students for practice, and a deterioration of the clinical arts in favor of research esoterica. In some ways, he may regard the medical faculty as antipathetic to his way of life or even as a competitor with unfair advantages. The academic physician for his part is overly critical of the quality of medical practice and often undervalues the practitioner's contribution to the patient's well-being. He stresses scientific information, diagnostic accuracy, and therapeutic precision. He regards his practicing colleague as overly conservative and resistant to social change. He appreciates the difficulties of the practitioner's role but not enough to want to devote himself to it entirely.

There is a modicum of truth in both positions. It helps little to deny the existence of a cultural gap of some proportions between "town and gown." Recognizing this, how can we nonetheless meet the requirement of cooperative endeavor demanded by current social and political events? While the initiative may arise on either side, I believe the major responsibility lies with the university community, which must reach out to the practitioner.

The academic clinician is in a strong position today. His way of life, rather than being threatened, is strengthened by many of the changes in prospect. He has a duty to educate, to communicate, to try new patterns, and to make the resources of the medical center available to the total community. Society expects his leadership as it turns with greater frequency to the university for advice in the solution of social problems. Indisposed though he may be at present to extend himself into the community, the academician cannot remain indifferent to

the demands of society, as the recent history of the university in the United States so clearly shows.

The current demand to add service to the traditional university responsibilities of research and teaching carries certain inherent threats. No university has yet investigated its full potential as an instrument for social good nor, on the other hand, has any university perceived fully the price of compromises in its academic goals that such participation might entail. Can the university maintain its freedom for uninhibited inquiry and intellectual leadership and, at the same time, be deeply involved in everyday problems? No categorical answer is possible. However, a clear and discriminating choice of activities must be made. Resolution of the dilemma by inaction, fearful retreat, or defense of academic prerogatives will surely be lethal to the university. Like it or not, it must learn to live in the world, so to speak, and still not be entirely of the world.

Recognizing the full flavor of its dilemma, what are some steps the university and its medical center can take in establishing regional collaborative and integrated efforts with the practicing community?

Immediate Steps

The dialogue with the practicing community must begin at once from a constructive point of view, which emphasizes the opportunities in present legislation as well as the problems it creates. Representation on planning committees—local and regional—is assured for the practitioner by some of the legislation itself. I hope that in these committees the medical center representatives will learn to listen, and to hear at first hand the needs of the community as seen by practitioners as well as by laymen represented on these committees.

The university and its medical center should provide a resource of faculty members who are interested and capable in all phases of health care. This means adding substantially to medical faculties the types of persons not now found in great numbers—physicians trained in medical care administration and patient care research, in general and community medicine, in epidemiology and in family medicine. Such physicians will need assistance from nonphysician members of the university faculty—sociologists, economists, ecologists, behavioral scientists, and others. Members of nursing faculties of the allied health professions must participate, too. Clinical specialists will be involved, of course, for

specific problems. The scope of regional planning is such that the effort is of necessity a total university effort and not one confined to the medical school.

The medical center must begin now to acquaint itself more precisely with the community and the region it serves. Studies of the demography, ecology, health needs, and health resources of the contiguous community are essential if planning and action are to be based on verifiable data instead of mere hunches and hope, however sincerely motivated. Departments of community medicine charged with such research should be established expressly for this purpose in medical schools.

Medical schools, of late, have recognized more acutely their responsibility for experimentation in improving patterns of delivering optimal medical care. This responsibility is now an immediate one. Experimental procedures for hospital and outpatient care, for care in community hospitals and in smaller peripheral units should be designed, and their utility studied. Regionalization of personnel and facilities is a requisite if the maximum potential of modern medicine is to be available to all who need it. Experimental models and demonstrations of various types of regional health units are indispensable if the most satisfactory ways to deliver care are to be solidly based. Here is an excellent place for the practicing physician rooted in community needs and medical school faculty members with research sophistication to cooperate productively and with satisfaction.

The outpatient departments of medical schools must develop the interface with their communities more actively and productively. Better communication with community physicians, public health and visiting nurses, as well as better organized and more comprehensive long-range management plans are immediate necessities. Proper use of, and collaboration with, community health resources are rarities in even the best-run clinics today. The potentialities of the outpatient department as the essential link between community and hospital are yet to be fully explored.

One of the most important questions in medical care today relates to the gradual realignment of roles and functions within the health professions. Research into new roles—especially to help the busy practitioner—should be initiated. The practitioner can contribute to the redefinition of such roles as well as to his own and can participate in demonstrating the advantages and disadvantages of a particular innovation.

Continuing education can become one of the most effective instruments in improving relationships between medical faculties and practicing physicians. The extensive use of informal teaching based on care material that allows for informal interchange is most helpful. Visitations to community hospitals by faculty members can serve to acquaint them with people, problems, and the profile of the community in an immediate way. Closed circuit two-way TV, telephonic ECG and EEG, and other electronic teaching aids can bring the medical school faculty into more immediate contact with physician and patient and facilitate the regional concept. The most effective agent in dispersing suspicion and hostility is a dialogue between physicians about a patient's problem.

But the most important form of continuing education is that which occurs in the community hospital on a day-by-day basis. Medical schools can do much to make regionalization a functioning concept by establishing teaching units in the better community hospitals. Such hospitals, staffed by a core of full-time teacher-clinicians with faculty appointments at the medical school, can engage in the most productive kind of continuing postgraduate education of the hospital staff. They can also supervise students or house staff who may be rotated from the medical school for an experience with community medical care. Such plans are effective and have been in operation for some time.

A community medical clerkship experience with the relevance of social, geographic, and ecologic factors in disease as well as with the physicians' broad role in their resolution is indicated. As students carry out projects in community medicine on these clerkships, they also collect important data on the nature of the community and its health problems. These data, if collected with care and proper design, can be useful in acquainting medical schools with the needs of their region and can form the basis for planning endeavors.

Regionalized utilization of medical center information, data storage and retrieval systems, library materials, poison control and drug information services offer further opportunities for improving the tools available to physician and patient.

Some combination of these and many other mechanisms can and should be employed immediately by medical centers reaching out to fulfill their social and community responsibilities. In each of these activities there is an essential place for the cooperation, participation,

and contribution of the community physician whether he is a generalist or a specialist. Such cooperation will not only advance plannnig but will unquestionably redound to the benefit of the patient.

Long-Term Activities

The major emphasis in any long-term attempt to integrate the work of the physician and the medical school are two: critical assessment of the utility of the immediate measures already outlined, and the education of future physicians and faculty members for this sort of integrated activity as the ordinary way of life in modern medical care.

The university must be prepared to study on a continuing basis as many as possible of the experiments it initiates, so that future planning will be based increasingly on the verifiable needs of patients and communities. Experimental models are needed to validate a particular thesis in medical care and permit its extension while culling out false ideas, however dearly held. Here too, the experience of practicing physicians and academic investigators can be combined to arrive at scientific conclusions on how best to deliver optimal care in hospital, home, and community.

The education of future physicians and health professionals in the requirements of the emergent patterns of medical practice should of course be the major concern of university and medical school. A broader education than is now permissible is needed, especially in those sciences that give a better knowledge of the community and its needs: sociology, behavioral sciences, anthropology, and ecology as examples. A community experience built around the study of some problems in the social and ecologic dimensions of illness should be requisite for those contemplating clinical medicine. Earlier selection of a series of alternate curricular pathways to the M.D. degree would permit identification and preparation of students interested in the direction of the community. Better attention in every-day clinical teaching to the full dimensions of the patient's problems is increasingly a requisite–especially emphasis on the continuum of care from hospital, throughout the outpatient department to the community and back.

Many young faculty members spend a period as "Greek slaves" in the laboratory simply to earn a place on the faculty or to await the opportunity for some position more suitable to their interests. Little

would be lost if their energies were directed to some of the newer activities I have outlined instead of to the perpetuation of mediocre laboratory research. Many conversations with students have convinced me that we must allow for a more varied preparation than we now afford. A significant number of students would respond to faculty encouragement to pursue lives devoted to the interface between the medical school and its community.

Not all medical centers should undertake all these tasks. Fortunately there is evidence of the perceptiveness of the new medical schools, now in the planning stages, to meet some of these new eventualities. Training in the specialties and pursuit of laboratory medicine need not be compromised. We have the resources to expand the spectrum of education without compromising on *quality* basic research. We shall lose, I think, only some of the mediocre. Further, research in the social sciences is as basic and pertinent to medicine as research in the physical and biological sciences.

Summary

It is clear that practitioners and university medical centers today face unprecedented opportunities to complement each other for the benefit of the patient. Like any new venture arising out of potent social forces there are complexities and dangers. The university must guard against dilution of its academic responsibilities and loss of initiative in the intellectual sphere. The practitioner must guard against being swallowed up in a massive system in which his contribution, which is essential at every step, might be lost and even misinterpreted. Nonetheless, *each univerity* is compelled to engage some part of the wave front of change, and so is every practitioner. To fail to do so is to fail to meet the responsibilities demanded of medicine and the university today as instruments for social advance. Further, it means once again to lose the initiative, to respond, rather than guide, and to follow rather than lead in the generation of better patterns of care for all.

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