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ABSTRACT
        The first part of the paper focuses on concepts and
ideas which can be used to discuss interface in any field or domain.
For example, meaning of words "community" and "university" are sorted
out. Attention is given to the idea of interface as expectations,
goals, attitudes, purposes and behavior. In the second part, these
same concepts are re-examined in the domain of medical and health
services in a community with a university medical facility. Many
issues are raised but no stand is taken. The paper is designed to
stimulate thinking about what an individual in the "university" or in
the "community" might do in reaching an interface. (Related documents
are SO 004 018 and SO 004 019.) (Author/VLW)

UNIVERSITY FORUM

BACKGROUND PAPER

THE UNIVERSITY AND THE COMMUNITY
IN THE DOMAIN OF HEALTH

DECEMBER 9, 1971

UNIVERSITY-URBAN INTERFACE PROGRAM

OFFICE OF THE SECRETARY
UNIVERSITY OF PITTSBURGH
DECEMBER, 1971

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UNIVERSITY-URBAN INTERFACE PROGRAM

UNIVERSITY FORUM

BACKGROUND PAPER

THE UNIVERSITY AND THE COMMUNITY

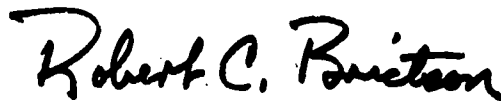IN THE DOMAIN OF HEALTH

DECEMBER, 1971

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OVERVIEW

I. PURPOSE

The attached paper presents concepts and ideas about what an Interface
is in the domain of medical and health services and how it can be created
and sustained. Our purpose is to stimulate your thinking about what you
the participant might want to say or do.

The paper is in two main parts. On the first part, focus is on con-
cepts and ideas which can be used to discuss Interface in any field or domain.
For example, emphasis is on sorting-out several meanings of the words "com-
munity" and "university". Attention is given to the idea of Interface as
expectations, goals, attitudes, purposes and behavior. In the second part,
these same concepts are re-examined in the domain of medical and health services.

There are few concrete examples in the paper. Many issues are raised
but no stand is taken on these. Our expectation is that you will exchange
with other participants in the day long seminar examples, ideas, concepts
and other issues which in your judgement are critical for the examination and
creation of an Interface in the domain of medical and health services.

II. SOME ISSUES AND QUESTIONS

As another means of stimulating your thinking about what you might say
or do, several issues and many questions are presented now.

1. One can conceive of many Interfaces where interaction occurs between
individuals who live in the community and individuals who work for the univer-
sity. An individual could be a patient in a university-medical clinic or a
consumer of services provided by a clinic, a prospective employee, a
student, etc.

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On another level, one can conceive of _groups of people_, _agencies and organizations_ in the community which interact with the university on issues or problems of mutual concern.

Taken together, there are many boundary points between university and community. At places, these boundaries are very vague; at other points, the boundary is quite clear. There are several specific and several vague boundaries in the domain of medical and health services.

2. Many in the university do not "understand the community" and many in the community do not "understand the university." Effort must be made to demystify the University and the Community.

3. Many in the community and in the university may hold unclear or unstated expectations of each other. In addition, there may be differences in goals, attitudes, purposes and style between individuals, groups, agencies in the community. There, differences can be seen at the boundary between University and Community in the domain of medical and health services.

4. Some foci for discussion of medical and health services might be the following topics:

> ---the availability and accessibility of medical and
>   health services
> ---what determines whether services will be offered
> ---who receives these services; who does not -, who
>   might want to receive these
> ---who pays for these services; who should pay
> ---who is accountable for the effectiveness, efficiency,
>   availability, accessibility of these services
> ---who decides what services should or will be offered,
>   where, when, how, by whom, at what cost

5. Some questions:

   (A) When I use the word "_community_", who or what do I have in mind?

   (B) When I use the word "_university_", what do I have in mind?

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(C) What groups or agency or organizations do I feel I represent?

(D) What are my expectations about this meeting?

(E) What do I (or my group, etc.) expect other groups or organizations to say about medical and health services; and to do about what they say?

(F) Do I believe that what I or my group say today will have any effect on what other people or groups or agencies or the university will do?

(G) I think that the most important barrier to the Interface between the university and or my group is....

THE UNIVERSITY AND THE COMMUNITY: THE SEARCH FOR AN INTERFACE IN THE DOMAIN OF HEALTH

INTRODUCTION

The interface between the University and the Community is elusive. This is so, in part, because each seems to believe that the other does not fully "understand" it, and, consequently, makes of it unfair and unreasonable demands. Our task is to facilitate the creation - or re-creation - of this much needed interface in the domain of health. The chosen approach is to suggest some issues which to us belong at the interface. In this paper, one view will be placed against another. Your task is to find what is acceptable in each. It is with this understanding and acceptance that an interface can be created by you. As a paper to stimulate discussion, ideas and issues, not solutions, are presented.

I. THE ELEMENTS: INTRODUCTION & DEFINITION

A. THE INTERFACE

To facilitate the search for an interface, a tentative definition of it is suggested:

An interface is those expectations of behavior held in common by those in the University and those outside of it on what each can offer the other and on how they can "work together." Second, the interface is the process of working together; third, it is the relationship which results from joint effort. At minimum, this relationship allows for and suggests open, on-going, joint discussion and evaluation.

The word interface as defined here includes shared expectations and beliefs on the value of joint action, the means of achieving this sharing and the acts themselves.

The interface which you hope to achieve is in part emotion, in part cognition and in part behavior. Clearly, emotion, cognition and behavior are attributes of people, not of organizations. How, then, can this definition of interface prove useful?

The definition of interface will be useful if a distinction is made between the University as a corporate entity and the University as its members -- faculty, staff and students. Similarly, there is a distinction between the word Community as an abstract term and the word community when it is used to mean people living in a certain place. We ask that you keep these distinctions before you. Both of the central words - university and community -- refer to things, to people, to ideas. It is imperative that the particular meaning you give to university or community be specified. Without such specification, the Interface will be even more difficult to achieve.

In order to make clear these distinctions, some examples are given.

B. THE UNIVERSITY AS A THING AND AS PEOPLE

A distinction is made between the University as a corporate entity and as the sum of the people and buildings which comprise it. In the first instance, the University is a legal "person" with certain rights and responsibilities. It is "more than" the sum of the people and the buildings which comprise it. In everyday discussion, this legal conception loses its specific, technical meaning, and people argue about the "role of the University", its mission, how "it" is governed.

The other meaning of the word university focuses on the people, equipment and physical plant. This is the University one "sees" when he goes to a campus or attends a class. Since the same word, university, means both the corporate entity and the people and buildings, it is often

difficult to discuss the Interface between the University and the
Community. The person speaking and the person listening could have
different conceptions of the university in mind. These different con-
ceptions of the term university contribute to forming a barrier to the
development of the interface.

C. THE COMMUNITY: SEVERAL MEANINGS

The word community also has many meanings. First, community
means place, a geographic area larger than a neighborhood. Second,
community means existing voluntary associations like ethnic and racial
groups or other associations of people who join in common effort for
pleasure, gain, identification, etc. Third, community means those people
who live in a given geographic area - whether or not they belong to
voluntary associations. Last, community means an ideology, a social philosophy,
a goal to achieve. This last meaning implies a commonality among people,
a binding belief or awareness which gives each person a sense of
belonging.

Taken together, these four categories are not inclusive of all the
meanings of the word community. They do suggest, however, that the word
means different things and its meaning for a particular purpose must be
specified. Without such specification the interface will continue to
be elusive.

D. THE COMMUNITY: SOME FURTHER DEFINITIONS

The concept community has come to mean something else recently.
It is used often as synonymous to poor people, specifically the "minority"
poor - the Blacks, Chicanos, Puerto Ricans and "ethnic whites" like "the
Poles." This meaning is so persuasive that many assume that a discussion

of the interface between the University and the Community will be
centered on the relations between poor people e.g., poor Blacks and the
University. Poor people are only some of those who live in a given community.

Some order is brought to these different meanings of community as
place, people, social groups and ideology by distinguishing between the
organized groups, business, etc., in the community - the organized community -
and the people in a community. i.e., the unorganized community. The un-
organized community refers to the people as a logical class - i.e. un-
specified people living in a specified geographic area.

II. TOWARD THE INTERFACE: PERCEPTIONS AND EXPECTATIONS

Basic to effective and acceptable joint action is an under-
standing, if not acceptance, of the perceptions and expectations that one
party or group has of the other. When perceptions are inaccurate, it is
difficult for expectations to be communicated effectively and to be met.
When expectations are not met, we see the consequences in un-intended
conflict, personal anger, etc.

The purpose of the following discussions is to make explicit
some of the perceptions and expectations held of each other by many in
the university and in the community

A. VIEWS OF THE COMMUNITY HELD BY MANY IN THE UNIVERSITY

One view held by many in the university is that the Community
is an underdeveloped or, a developing area. This might be called the
"foreign affairs" view. Implicit in this view is a definition of community
as poor, minority-group people living in "slums" which are "disorganized"
and "pathological". This meaning of community can be summarized as the
"them" definition.

In the foreign affairs view, is a colonial view. Those who
hold these views, and few do so publicly anymore, see and emphasise the

"bad", the "sick", the dysfunctional or the pathologic in the community.
Many who look at the community through the glasses of the foreign affairs
model feel fear and anger. They see poverty. To them, poverty means
"being poor, being powerless, being despised and being incompetent."
This view of the community is not a pretty one. Yet it is real, and thus,
it is a barrier to an interface.

A second view held by many in the University is that the
community is a laboratory for teaching, research and service. From this
perspective, community means place and people. It is a "natural laboratory",
indeed, a necessary one, in which one can do research and learn, can
"develop knowledge." It is a place to send students in order to expose
them to the "real world." Increasingly, it is a place where students
ask to be sent to "organize" and to give other services to low-income,
ethnic and racial groups.

A third view of community is held by many in the fields of
public health and community medicine: The community as the patient. We
return to this view later.

Last, many think only about the "organized community" - the
small business, corporations, and voluntary associations - when considering
the relation between the University (or their program) and the Community.
For many, it is easier to think about the organized community than the
unorganized community. Those who are organized are easily identified.
Their organization has form and structure; often, it has a telephone,
a letterhead, an address. And most important, it has identified "leaders" -
specific people to talk to.

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These "leaders" are important in the foreign affairs model.
With them, one can have "diplomatic relations", one can negotiate. How
does one "reach" or talk to an unorganized community?

B. VIEWS OF THE UNIVERSITY HELD BY MANY IN THE COMMUNITY

One can distinguish three views of the University held by
many in the community.

One view sees the University as an ivory tower. This view
holds that the "real world" is in the community and the University is an
"unreal world". In this unreal world are professors who have "theories"
but little "real knowledge", people who are not "practical", who could
not "survive on the outside" and thus they retreat to the ivory tower.
At Pitt, the tower is clearly visible, if not ivory. From it, one can
indeed "look down" on the community - pun intended!

A second view sees the University as a frontier post. This
view holds that the University is a place of scholarship. To some,
scholarship is the process of searching for "truth", to others, it is the
process of searching for "answers". Searching for "truth" goes along
with the ivory tower view of the University. Searching for "answers"
can go along with the view of the University as a service station.

A third view of the University holds that it is a service
station, a place where people think about answers to problems of concern
to people in the community and then work with community people to try to
solve these problems. In this view, the pursuit of "truth" and "answers"
is of value only in so far as this knowledge is used directly and immediately
for the benefit of people. The people who should have first priority for
service are those in the communities near the University.

C. SUMMARY

We have discussed briefly some of the views of the Community
held by many in the University and some of the views of the University
held by many in the Community. Those who hold each of these views also
hold expectations about how the people who comprise the University and the
Community will think, will feel, will behave. Some of the expectations
concern what problems people think exist in the community and what the
Community and the University will do to solve these.

The views that people hold of each other and the expectations
they have of each other determine in large part how people will behave
towards each other, whether they will work together and whether a
relationship between them will emerge. All of these together are the
Interface. There may be little interface now between the University and
the community because people hold different views of each other and
different or unclear expectations of each other. By examining the word
"problem", insight is gained on how different definitions of a word are
related to different expectations of behavior. And how these different
expectations of behavior can lead to confusion, to anger, to non-communication.
Without communication, there can be no interface.

III. SOME CONSEQUENCES OF THE DIFFERENT VIEWS AND EXPECTATIONS
   A. PROBLEMS: THEIR DEFINITION AND SOLUTION

Often implicit in University - Community relations are the
beliefs that problems exist in the community, that the University is aware
of these, that it is obligated to help solve these problems, and that it
frequently chooses not to. This is the view of the University as a
service station. It is also the University-extension model. This view and
this model are built on the expectation of service or aid, and on a

commonly held belief that if the University would only accept the fact that there are problems in the Community, it would and could help solve these; that is, the University would offer service and a solution would follow. Imbedded in the word "problem" are several issues which contribute to a major disjointedness between the University and the Community. This disjointedness, in turn, is a result of the different meanings given to the word problem.

When a word used by people talking to one another is used differently by each, confusion results: People talk past one another, and thus they can't get together.

What is a social problem and how does it "come to be?" We suggest that social problems do not exist "out there", somewhere, waiting to be discovered. Instead, these problems are "man made", they are brought into existence in a social process of problem creation. In this process, many actors with different views and expectations play a central part.

There are many different facts about various things. Alone, a fact does not have much meaning. It gains meaning and social significance through interpretation. Interpretation is a process of putting facts into a context and organizing them into combinations or systems of facts. A system of facts which we don't like, which we see as "bad", is called a problem. Problem means several things: It means that we dislike the system of facts; that we want to do something to change the facts - "solve the problem or cure it" - and we want to do it now; action has a high priority. This is how a problem is created.

For example, it may be a fact that 63% of the people who live in Oakland are under 60 years of age; another fact about these

people might be that 40% of them have family incomes of $15,000 or more

per year. And it may be a fact that 84% of them live in "good quality"

housing. We might look at these facts and conclude that most of the

people in Oakland are doing pretty well. Or we might conclude that some

of the people in Oakland are not doing too well - some may be poor, some --

the same people or others -- live in substandard housing, and some of the

people are over 60 years old.

We might conclude from these three facts that "Oakland has

problems"; that Oakland does not have problems; that some people living

in Oakland have no problems; that some people living in Oakland do have

problems; that some people living in Oakland are old, poor and poorly

housed, etc. We give the facts meaning by our interpretation. We

transform the facts into problems. We say we don't like it when some

people are poor or are poorly housed. A fact is only what is; not

what is bad or what should be.

If you accept that people can interpret the same facts

differently and can create different problems using the same facts,

then we can look at a second critical step in problem definition. Where

do these so-called facts come to use?

B. FACTS: THEIR DISCOVERY

There are different ways to "discover" facts, different

methodologies. People in the university and in the community often use

different ways to learn facts or "collect" facts. Often, those in the

University won't accept the methods to learn facts used by people in the

community; and often, community people will not accept the methodology

used in the University.

If there is no agreement on what is a "real fact", on how to learn real facts and on the interpretation of facts, the meaning of the facts, there can be little agreement on what <u>problems</u> exist, there can be little agreement on who will or should do what about these problems.

If problem solution is preformed by problem definition, and joint problem solution is an interface goal, then the social process of joint problem definition is critical for the interface. Without commonality at this point, the University and the Community will rarely be able to "solve" anything to its own satisfaction and that of the other. The interface, then, begins at the point where facts are brought and discussed and jointly interpreted as problems. Once a common acceptance of a problem is **achieved,** strategies for "solution" can be sought. Problem definition is, in short, a social process of negotiation. When this negotiation occurs, there is an interface.

C. <u>RESEARCH: A PROBLEM WORD</u>

There is another word which creates confusion because of the different meanings given to it. The word is research. We said that different people use different methods of learning facts. Another way to say the same thing is to say that different people use different <u>research</u> methods.

One point to consider is that the more similar the research method, the more likely it will be that the <u>same or similar</u> facts will be "discovered." There is still little acceptance by people in the university and in the community of the <u>research methods</u> used by the other.

Second, the word research itself is a bugabo which causes, because of the different interpretations given it, a major paradox: <u>Many in the university will not act without facts learned from research. Many in the community -- and increasingly in the university too--see research a cop-out from action, from doing something.</u>

D. ON KNOWING THE ANSWERS

If people in the University and in the Community can't agree on how to get facts, on what the facts mean, on what the problems are, there will be little agreement on how to "solve" the problems. There will be little agreement on the necessary strategies, tactics or resources.

Imbedded in the idea of problem solution often are three implicit beliefs: (1) that those in the University know the answers or solutions; (2) that knowledge, theory or skill can solve these social problems; and (3) that people in the university are just holding-out from using their knowledge to solve problems because they are sick, crazy, stupid, bad, dirty or whatever. One of these beliefs is examined briefly.

Most of the so-called social problems discussed at the interface are not amenable to solution simply by the application of knowledge, theory or technology.

By definition, these social problems are the creation of people who define a situation or a system of facts as "bad". Thus, personal beliefs and personal values (or group beliefs and values) are a source of the problem. Changing values create the stuff out of which more problems are created. The more men believe that it is their right and their neighbors' to have safe, decent, reasonably priced housing or universal, free health care, the more there will be a discrepancy between existing housing and health service and what is thought to be "basic" or "necessary". This perceived discrepancy is seen as problematic and it itself becomes the source of another social problem. More and more situations are thought to be undesirable -- hunger, the treatment of American Indians, urban slums, etc. -- and the demands for change are outpacing the efforts at remedial change, let alone major structural

and preventive change. This is precisely why knowledge, theory and technology are, paradoxically, <u>causes</u> of the discrepancies more than they are tools of amelioration.

The solution of a "social problem" is not an ability or skill held by those in the University. <u>It is not simply "they really don't know", it may be also that "they can't do</u>." Part of the demystification of the University, then, must be focused on the <u>limits</u> of knowledge, theory and technology in social problem solution. Attention and expectations might properly and profitably be directed to the social and political institutions of our country.

The belief that the University or its members can "solve" social problems is myopic. The belief that the University "could if only it would" solve these is naive. Most often, it can't.

The expectations that the University can and should and will solve social problems or that it is responsible for the casualities of these problems is a source of much acrimony expressed at the Interface. One task at the interface is to demystify the University and to learn about the Community. This is a first step in the process of interface - defining "realistic", i.e. valid expectations about the behavior and feelings of the participants.

This reality can result from bargaining among people, from joint negotiation. The Interface is in part this negotiation.

IV. <u>TOWARDS DEMYSTIFYING THE SERVICE WHICH THE UNIVERSITY CAN GIVE TO THE COMMUNITY</u>

The creation of an interface is the creation, recognition and acceptance of common expectations held by those in the University and in the community. One focus of these expectations is on what the University might give to the community. These expectations are often found in the view of the University as a service station.

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The University is a place of scholarship and education. Increasingly, these are put to the support of service to those outside the University's walls. This service may be <u>direct</u>, as when the University pays for and/or administers a health clinic in a neighborhood; or <u>indirect</u> as when the university buildings are used as meeting places for neighborhood groups. The following brief discussion of these direct and indirect services is intended to suggest categories for organizing this subject as well as ideas to fill them.

The distinction between direct and indirect services is not to be confused with the distinction between the University as a corporate entity and the university as its members -- the faculty, students and administrators. There can be <u>both</u> types of service for <u>either</u> the corporate or member conception of the University.

1.   <u>POTENTIAL RESOURCES IN THE UNIVERSITY: THE NEED TO DEMYSTIFY THESE</u>

The elements of both direct and indirect service are people, their knowledge, and space and money. These are the potential resources at hand in the University. The University's major resource is trained people, their ideas, expertise and, hopefully, their commitment. Second, the University has physical space, facilities and equipment. Last, the University has financial resources, and personal and organizational linkages to many people and organizations. All of these potential resources are elements of scholarship, education and service. Each must be the subject of demystification if the expectations held in the university and in the community are to facilitate the interface.

In one sense, scholarship and education are demystifying processes. They are the ordered search for and the transmission of facts and "truths". Often, these facts and "truths" are contrary to "common-knowledge". Conflict occurs frequently when these two "truths" or two facts are compared publicly.

In a similar way, the very process of scholarship and education must be the focus of demystification, for if they are not understood, many would continue to hold inaccurate expectations of their potential worth in problem solution and in service. One example of an invalid expectation already discussed is that the University could solve social problems if only it chose to do so.

There appears to be no consistent effort on the part of the University as an entity or by individuals within it to communicate, on a level appropriate to different people, what in fact goes on within a university, in its classrooms and laboratories. To demystify is not to devalue.

A second set of potential resources must also be demystified. It includes the University's financial resources and its "power" in the form of inter-personal and inter-organizational linkages.

2. THE UNIVERSITY IS RICH

Currently, most universities simply do not have nor can they get enough money to meet their current operating costs. For our purpose, note only that service is one of the three major functions of the university, and to most within it, not the most important.

This low priority is reflected in intra-university decision-making on the allocation of funds. Related to the amount of money available for service is the fact that most grant-money to the university is "ear-marked" for a particular purpose by the funding-source. Further, most designated funds are budgeted on a line-item basis, not on a lump-sum basis. The former is a barrier to the "flexible" use of funds. Last, most funds for the university are designated for research and teaching, not for service.

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Were the financial status of and funding process in the University
and its units demystified, Community expectations of the University could
be more valid. Most important, those who want service from the University
could choose other, appropriate organizations as targets to pressure;
for example the funding resources of the University itself.

3.   THE UNIVERSITY IS POWERFUL

The University's power in its actual and symbolic form must
also be a focus of demystification. Many, especially in low-income
communities, overestimate the power of the University or its members in
the day-to-day affairs of the city or country; many overestimate the
ability of the University to effectively challenge existing slum-housing,
narcotics pushing, environmental pollution, and similar patterns of social
organization. To demystify power requires a more delicate operation,
for one source of power lies in the viewer's eyes. Here, demystification
could lead to impotence.

4.   THE UNIVERSITY IS A PROVIDER OF DIRECT AND INDIRECT SERVICES

Each of the potential resources of the University can be
organized for either direct or indirect service. A basic policy decision
to be decided in the university and then negotiated at the interface is:
"What services should be in what form?" That is to say, what services
should be administered and staffed with people on university salary?; what
services should receive corporate sanction?; what effort should be made
to administer services heretofore administered by public or private
organizations?,etc.

Part of the answer to these questions lies in the word "service".
The word "service" is central to the expectation that the University will
"help the community". There are several meanings of service. First, the
word is used to mean something like "actively making available and using

the resources of the University and its members for the purpose of working
on issues of joint concern to people within the University and in the
Community". In another, more limited usage, "service" means providing
specific advice, treatment or intervention, for example advice on de-
signing a housing code, medical care for children in a specific neighborhood
or testimony by a faculty person at an air pollution hearing held by a
local voluntary association. Common to both uses of the word service are
the notions of "making available" and "of giving, of providing".

In direct service, the University or its members have direct
and major control over the service and directly do the service; in indirect
service, each party has more equal control and the person who does the
service is not on the University payroll.

5. TWO MODELS OF SERVICE

A. Urban extension

Urban extension is one model of a university-community service.
It could include direct or indirect services, on either the general or
on more specific levels. This model was created by analogy from the rural
extension programs of the land-grant colleges. It has been tried under
governmental and Ford Foundation auspices in several cities. In each, a
different kind of urban extension model was tried. For example, at Rutgers
University in New Jersey, seven goals were attempted:

1. Clearinghouse for data and sources of help
2. Counselor and Consultant
3. Convener of groups and individuals
4. Developer policy seminars and conferences
5. Provider of special education
6. Provider of general education
7. Developer of demonstration projects

This list suggests the variety of programs which can fit into any model.

B. UNIVERSITY AS A HUMAN SERVICE AGENCY - SURROGATE

A second, more limited model is the University as an agency-
surrogate. Here, human services previously thought to be the responsibility
of government or of private-sector organizations are administered by the
University. A neighborhood health clinic is an example.

This is surely not an inclusive review of what has been
done by different universities. Nor should it be, for the guiding
principle in the provision of services can only be to create the interface;
the model will be developed there.

PART TWO: THE DOMAIN OF HEALTH

INTRODUCTION

This introduction begins the second part of the paper. Here,
the general discussion of part one is focused on the domain of health.
The abstract issues reviewed above are specified here. The reader's task
is also the same: To find what is acceptable, if not common, to those
in the medical school, university-hospitals, schools of public health, of
dentistry, of health related professions and to those in the community.
As before, ideas, not solutions, are presented.

I.   THE ELEMENTS = INTRODUCTION & DEFINITION

A.   THE INTERFACE

The interface is those expectations of behavior held in common
by those in the university and those outside of it on what each can offer
the other, and on how they can "work together." Second, the interface
is the act of working together; and third, it is the relationship which
results from joint effort.

In health, these expectations are about direct medical
treatment, rehabilitation of disorder or disability and the prevention of
disease and disorder for an individual, for a large number of people
similar in some way (population group), or for the social and physical
environment. The expectations include questions of payment for these
services, and how, where and by whom these services are delivered.
These and similar expectations gain meaning when placed in a context
of the University and the Community.

B. THE UNIVERSITY IN THE DOMAIN OF HEALTH

Education, scholarship and service in health are carried out in several places in the University. Education, the primary function of the professional health schools, usually includes schools of medicine, dentistry, nursing, public health, and, increasingly, a school of health related professions or para-professions. There are other health-related professional schools or departments: Psychology, social work, speech and hearing counselling, vocational counselling, for example. For teaching purposes primarily, there are adjunct clinics and hospitals. For example: A university-hospital, an eye and ear hospital, a psychiatric hospital, a dental clinic. Scholarship and research is carried out by staff and students in all schools and departments, hospitals, and clinics on patients who come there; on people living in communities near the University, and on the environment. Within the health-complex of the University, service follows education and scholarship; service is primarily for teaching and research. This is the priority in the University; it is often in conflict with the priorities held by those in the community.

C. THE COMMUNITY: WHAT DOES IT MEAN IN THE HEALTH FIELD

The word community appears in several terms in the health field: The community as patient; community health; community health services; community of solution; community medicine. All but the last term appear in a report of the National Commission on Community Health Services entitled Health Is A Community Affair. It is now common to hear in the health field cries for "community control" and community participation, and discussions of community organization.

"Community" is increasingly an ideological word in the sense that when people hear the word in certain phrases their feelings are

stirred. Like a flag in war, the meaning of the word, if you will, "excites" some people. In this sense, the word community potentiates the emotional response some people have when they hear certain phrases. The word community has become a symbol of certain ideas. As a symbol, it is part of political rhetoric and political dialogue.

Once we recognize that words like community, neighborhood, citizen, and consumer MIGHT be used ideologically (as well as descriptively and analytically) we can begin to sort out some of what is meant and some of what is heard when the word is used at the interface. Some examples of phrases used in current medical and health discussion are discussed very briefly.

1. "The community as patient" is a public health aphorism. Unfortunately, it is misleading and in current public debate it has a connection many wish to avoid. The phrase is misleading because, as was shown, the word community can mean people, place, voluntary associations or an ideology. Which of these is the patient?

2. Community health is also a vague term. It implies that a health or illness status for a population group has been defined. Yet, the elements of this status are infrequently noted and, even more rarely, discussed. Moreover, and this is discussed below, community health (status) is built on the notion of "need" - another loose word.

3. Community medicine means providing individual health service in a community to people living there. Most often, the people are poor. Other distinctions between these terms could be made, but they would be "academic." The major purposes of presenting this limited discussion were realized.

It was shown that the word community is used frequently in the
health field and that the word is "in". As a consequence of its potentiating
effect on the listener, that is, its ideological function, many sloppy
and dubious proposals have been accepted. The creation of an interface,
however, depends on a clear idea of what the word community means and
how it is used often to "mobilize the emotions."

D. COMMUNITY: SOME OTHER CURRENT USES

1. The word community in the health field has come to be a
shorthand term for poor, "minority group" people like poor Blacks or
Chicanos. This shift in meaning follows a debate, increasingly public,
about the effectiveness, efficienty and costs of health care in America.
One topic in that debate is the relation between poverty and health.
This relation is summarized in the phrase, "The poor are sick and the
sick are poor. Without help, the sick get poorer and the poor get
sicker."

The shorthand use of the word community should not blur the
fact that non-poor live in the community and they too frequently receive
health care which is ineffective, inefficient and expensive. The
services for the poor are worse in most respects but, and this is critical,
the whole social institution of health is under public scrutiny and attack.
This includes private practitioners in medicine, the hospitals and clinics,
and public health departments.   The university-related
health complex is both part of the target and, to some, part of the
solution.

2. Community participation is a phrase in current use in the
health field. It means that people living in a given area want to
participate in these decision-making processes in which they think or
feel they have a stake. In political terms, clients of specific agencies

or people who are otherwise non-elites want to participate in those decision-making processes heretofore limited to elites. They want "in" on "who gets what, where, when or how", the ubiquitous political questions. This is the essential meaning of the phrase "community participation"; and of the related phrases "citizen or consumer participation" and "citizen or community involvement". In the health field, citizen and community have other, newer meanings.

3. Recently, these concepts have come to mean member of a voluntary association, part of the organized community.

Another new meaning is "lay", as in not-expert or not-professional. In this usage, a layman is a non-elite, someone or some group without power or control over certain decision-making processes. "Community control", then, is a phrase which means that non-elites want elite positions in these decision processes.

Such emphasis is placed on these meanings because the interface in health will be devoted largely to issues of "who makes or controls what decisions about which health services in which place, when and how".

II. TOWARDS THE INTERFACE IN THE DOMAIN OF HEALTH

    A. VIEWS OF THE COMMUNITY HELD BY MANY IN THE HEALTH PART OF THE UNIVERSITY

        1. The Foreign Affairs Model in the Health Domain

In the foreign affairs model, the community is an underdeveloped or developing area. In international affairs, health services have been a major focus of inter-national effort, and a means to developing on-going diplomatic relations among nations. In a socio-economic sense, health,

and environmental problems have been a major barrier to national socio-economic growth. Medical, health and environmental services have been a major source of social change. Overseas, ours is Western Medicine; in the ghettos and on the Reservations, it is White Man's medicine. The foreign affairs model is useful here at home, for understanding a major difference between the University and the Community in the domain of health.

There are many cultures: The medical and the lay; the professional and the lay; the academic and the professional; one profession and another; the University's and the Community's. Clearly, there are cultural differences between "us and them," between the practices of health professionals, their organizations and the people served. The foreign affairs model forces the recognition of these different cultures and the consequences of these differences.

One consequence is the different priorities assigned to different health and environmental problems by professionals and by those living in the community. Another consequence is the differential evaluation of how, where and when specific services are or should be given. A third consequence is the professional's propensity to assign or impute negative attributes to those laymen who do not follow his advice. The title of a recent book is illustrative: Public Health For Reluctant Communities.

There are cultural differences between the health worker in the University and the patient. These cultural factors vary by training, income, ethnicity and place. The foreign affairs model forces their recognition.

The model also offers a way to raise the issue of racism in health problem definition, service, scholarship and education. A majority of professional health workers are white and a probable majority of hospital workers are non-white. With the increase in racial selfawareness and it's sociopolitical-action consequences, unions have successfully organized in University-affiliated hospitals. Unionization has resulted in a greater delineation of the tasks performed in the hospital. The racial distribution of hospital staff by task performance now shows clearly, many if not most of the "menial" tasks are performed by non-whites. The issues of professional non-professional task allocation is thus highlighted by the addition of race as an issue. The resultant breakdown is professional-white and non-professional-non-white. The apparent in-hospital staff "harmony" which was thought to characterize staff inter-personal relations is now seen as a myth.

As a consequence, there are two "nations" within many university-affiliated hospitals. We have yet to see the consequences of this racial separation, though one could imagine a community group like the Young Lords in New York City attempting to link-up with their "brothers" in an effort to "liberate" a local, university-affiliated health facility. The New York Times has recently had a suggestive series on this.

2. THE COMMUNITY AS A LABORATORY

Another view held by many in the university is that the Community is a laboratory for public health and medical training, and research. The phrase "he is practicing medicine" points up the different perception of the laboratory model by those in the university and in the

community. The former use the phrase to mean "giving service;" the latter understand it to mean "training on us."

One purpose of research is to develop scientific theories about disease entities and the etiology of non-disease disorders of man and his environment like automobile accidents and air pollution. When theories are substantiated, primary prevention of disease and disorders are possible.

As University-Community relations have become strained, staff and students find in-community work more difficult, though students more often ask for it and faculty more often think it necessary. One response by university people to these "hostile" groups -- in most cases Black, Chicano or Puerto Rican - is to promise some "pay off" to individuals or groups from the research and "field work."

Too often these promises can not be met. This is especially true of research on mental health, mental retardation, drug addiction, alcoholism and other complex diseases or disorders. Research of this kind rarely has a direct service "pay off" for the individual or the Community in terms which he understands or, more important, he accepts.

B. SOME VIEWS OF THE HEALTH PART OF THE UNIVERSITY HELD BY MANY IN THE COMMUNITY

Because of the   condition of our national health system, or non-system, many of every social class and race see the university-affiliated health complex as a potential source of service for themselves, and as an ally in the effort to create a viable local and national health service system, i.e., to create services which are accessible, effective, efficient and reasonably priced. This national problem is most visible on the local level. There, social action efforts supported by the ideology of Localism are directed at creating "comprehensive, responsive, responsible, effective, efficient, low-cost service" - surely no simple task!   30

In this social action effort, those who do not actively support
the attempt to get the University-affiliated health centers to become
a primary source of medical treatment are seen as "enemies", the reasons
for their opposition notwithstanding. In other words, the university-
related health centers are being asked to become surrogate municipal or
what used to be charity hospitals by offering treatment to whomever
needs or wants it regardless of his ability to pay. This is a clear
request by many ethnic and racial groups, especially those composed of
poor people. The middle-class requests are somewhat different. But
many in both social classes do not understand and/or accept that the
patients accepted for treatment in a university-affiliated hospital are
there for either their "teaching value" - as in an esoteric case - or
because of the severity of their condition. This is so because these
medical centers most often are well-equipped and have highly trained
staff.

Many people do not understand the priorities of the hospital,
do not understand its relation to the purposes of the University and
of the medical school. Instead, they see a physical facility, usually
with a good reputation, closed to most of them. If they are poor, they
are asked to go or are forced to go to a usually more crowded, older,
less effective (in their eyes) municipal or charity hospital. Given
their position, what can they conclude?

The middle-class hold somewhat different expectations of the
university health center. These people want to retain the private practioner.
Thus, their demands on the university are different.

The middle-class does not seem ready yet to do away with direct
personal payment for treatment. There are several reasons for this beyond
the often latent belief that in medical care, personal payment enhances

personal control over the practitioner and over the quality of the care.
The belief that government payment would result in the loss of "the
freedom to choose" is surely related too. What these community people
want is access to the emergency room and to the specialized staff and
equipment thought to be in the university hospital.

The changing structure of medical treatment and the consequent
change in the role of that culture-hero - the personal, family doctor
has resulted often in the use of the emergency room as a middle class
clinic. Technological advances in medical care, and the publicity about
these, have focused on the role of the medical school and university-
hospital as a center of treatment research. Many of the technological
advances have resulted, in turn, in treatments for relatively rare
disease and disorders. The laymen, however, has come to believe that
any place which has people who can do heart transplants and other
relatively esoteric procedures must be good; indeed, must be the best
place to get treatment for any disease or disorder. Consequently, the
health conscious middle-class want to retain the scholarship, i.e.,
research, function of the university affiliated health center. This
emphasis could result in a relative scarcity of services and lower
priority for services.

Many factors beyond social class and health services utilization
patterns must be considered in the policy questions suggested by this
discussion. All of these will surely emerge again at the interface.

Note again the dysfunctional consequences of oversell, and
how the failure to demystify and the failure of professionals to clarify
what they have in fact to offer have resulted in ambiguous and overlapping
expectations of the University health center.

III. SOME CONSEQUENCES OF THESE DIFFERENT VIEWS AND EXPECTATIONS

A. THE DIFFERENCE BETWEEN NEEDS AND WANTS

In the context of the relation between the University health complex and the Community, the major public issue is the differential expectation held by each for University-affiliated medical care. The University sees the provision of medical care to people in the community as one minor responsibility proceeded in priority by education and scholarship. Individuals and groups in the community want medical care to be the University's first priority. They define services as a responsibility of the University and, further, they argue that they have a right to this service.

To better understand this crucial issue, one must distinguish between two key words - wants and needs.

In this paper, a want means a stated request by someone or some group for something. A need is someone's judgement that another person (or group or class of people) is deficient in some particular way.

Related to wants and needs is the idea of "having a right to something." Let us look briefly at how these three words and ideas are related often in discussions of services.

When I say (or we say) that I want you to provide a particular service that I can then choose to use, I may be saying several things:

(1) I desire this service.
(2) I demand this service.
(3) I have a right to this service.
(4) I "need" this service.
(5) I believe that it is your responsibility to provide this service for me (or to me).
(6) I should have this service. etc.

Each one of these phrases is somewhat similar. Yet, each is some-

what different too, and it may be the difference that is critical.

Each phrase can be heard to mean something different; and each phrase

is legitimated by reference to different values and "principles."

As Minoque notes (in the Liberal Mind)

> A need is an imperative form of desire. 'I desire bread'
> imposes no serious demand on anyone. 'I need bread' does
> impose such a demand. We may be justified in denying
> children, for example, what they desire, but we are not
> justified in denying them what they need. A need, there-
> fore, is a legitimate or morally sanctioned demand.

It seems that in the past, rights and needs were related while now

rights and wants and rights and demands are related. To connect this

now to the topic of services.

Health services and medical care in particular used to be

allocated on the basis of "need", that is, to the casualities or to

those at high risk to disease or disorder. When "medical need" was

present, a second level of "need" was introduced - economic. Government-

administered direct personal care and government-supported direct

personal care were available to the "sick who were poor". This is the

so-called charity medicine still available in municipal, state or

federal facilities depending on the person's health needs, his economic

needs and other "eligibility". As "needs" have become "rights",

demands are phased in the vocabulary of "rights". These demands have

focused on changing, e.g., broadening, the requirements for "eligibility"

and thus reducing the scarcity of these human services. Demands which

were heretofore focused on government are, in part, now focused on the

University. These demands appear as the right to have available to use

and _the right to in fact use_ university-affiliated medical treatment.
This transformation of needs into rights is reflected in another area
of health.

ON NEEDS

One focus of university sponsored health research has been the
determination of a "community's health needs". Another is the ranking
of different communities on the basis of these needs. Related is the
use of the concept need in the professional-patient or "community"
relationship. Last is the use of the word need as a measure of the
ratio of health workers and health services per size of the "community".
Each is commented on briefly in the belief that _the concept of need_
in its various meanings has profound consequences for an interface in
the domain of health. It is a main source of difference between those
in the University and those in the Community.

In the domain of health, discussion and negotiation is not
among equals, it is among professionals and laymen, professional and
citizens or among physicians and potential patients. _The concept need,_
in its various professional meanings in medicine, public health and
psychiatry, has the function -- _although not necessarily the conscious_
intent -- of prohibiting non-professionals from discussing and bar-
gaining with professionals. As a consequence, non-professionals and
non-elites require other sources of moral, legal, socio-political
legitimation for their demands. This is the legitimation of demands
as rights. How the concept need preserves this hierarchy is seen in
each of the four uses of the term noted.

The word need in the health field is used to mean that, "I, as
a professional, can determine the _difference_ between your condition and
some ideal or real standard of 'health'." This usage is built on the

idea that such standards exist, have validity and legitimacy within
the profession. Research on "community health needs", thus, is an
attempt to place a given population-group called a "community" on a
scale relative to a set of standards. To discuss health needs, then
is to talk about people as individuals - he is healthy or not healthy
or relatively healthy - or as population groups: Taken together,
collectively, they have an average health status of x relative to some
standard. Thus, communities are judged and ranked and the resultant
findings are called the "community health needs". Since professionals
define the standards and control the means of study, i.e., diagnosis,
only they can determine the needs. This is one acceptable, legitimate
social function of a profession. In this framework, "what I want or
what we want" has less validity in public debate than what the prof-
essional says I need c we need. This judgement on the health status
of a population group relates directly to recommendations on the amount,
kind and quality of services which these people need.

The determination of a "community's service needs" is made in
a similar social process. Here the standard is an explicit or, more
often, implicit ratio of numbers of practitioners to numbers of people
of a certain health status. ™ is ratio can be expressed in the form:
"one physician per 6,000 potential patients" or in some similar way.
Note again that the demand for "more doctors" has validity to prof-
essionals only when compared to this standard.

It should be clear now that the concept need is critically
important at the interface. It is an element in all attempts at "health
planning:, and in all discussions of "citizen, consumer or community
participation."

A parenthetical, though interesting idea, is that the concept need functions in the internal logic of medicine, health, and mental health like the concept "false consciousness" functions in classical Marxist thought. It is used to "devalue", to negate, to explain away one's opposition. Since neither needs nor false consciousness can be observed, it is used by imputation of the professional or "true" Marxist. The consequence of both uses is the same: He who is the true believer or the expert remains so. Discussion at the interface is rife with this form of the ad hominem argument, and, consequently, professionals become barriers to discussion and negotiation. Often, to paraphrase a current saying, "those who are the solution may also be the problem".

The purpose of this brief discussion of services, needs, wants and demands was to suggest first that there may be confusion at the interface about what community groups are asking of the University and what the University will or will not offer, can or can not offer, does or does not provide.

A second purpose was to suggest that these words may be clues to the kind of legitimation sought by groups and by the University for their positions. Clearly, certain kinds of legitimation enhance the probability of achieving one's goals.

Third, we suggested that bargaining in the domain of health is difficult for non-elite, i.e., non-health professionals, because the power to decide issues is administrative and technical and professional. Community groups have only their wants, demands or needs for service. These moral and political legitimations may not be enough.

One consequence of this discussion could be heightened
awareness of how these words produce political conflict at the inter-
face. Without clarity and understanding of who is bargaining for what,
how, the chances of winning are limited.

IV. PROBLEMS: THEIR DEFINITION AND SOLUTION - E.G. ENVIRONMENTAL
POLLUTION

It was suggested in the first part of this paper that social
problems are "man made", that they are "created" in a social process of
labeling. Implicit in that discussion was the idea that part of the
interface was the task of using knowledge discovered in the University
to focus public attention on facts and situations which are considered
problematic, i.e., for "creating" new social problems. The environmental,
ecological "crisis" is a recent example of how this process works in the
domain of health.

Dennis F. Miller has written in a recent issue of the Univer-
sity of Chicago Magazine:

> The idea of pollution is not new in America. Conservation-
> ists and ecologists have been warning the nation of the
> inherent dangers of the gradual poisoning of the environ-
> ment for years. But the widespread interest by the public
> in all aspects of pollution is a relative recent phenomenon.
> People at all levels of society have begun to be wholly
> aware of the connection between the heavy pollution around
> them...and the dangers to their health and that of their
> children born and unborn.

To paraphrase, the facts were known and viewed as "bad", as a "problem".
But this "problem" did not receive broad public legitimation until
recently. It was seen as a problem to those few professionals in
that field, to related voluntary associations like the Sierra Club
and the National Wildlife Federation and the professional groups like
the American Public Health Association. Recently and dramatically,
environmental pollution has become a broad-based social problem. Many
new groups and individuals throughout the country are "working on it".

University schools of public health have been a major source of
research in these areas, yet their effort is both little known to the
community and often it is little appreciated.

Many see the whole environmental issue as a way to <u>avoid</u>
acting on "more pressing" concerns of theirs. By extension, many of
these people see the University's efforts in pollution, as a "cop out",
for they want medical treatment for the Community to be the first priority
of the University-related health complex. These different constituencies
of the University in the domain of health, then, hold different expecta-
tions of the health complex and different priorities for each part of
the health center. The issue of environmental pollution is "real"
and surely worth your time to discuss. It is raised here as a <u>means</u>
to bring before you other areas of University-related health activity.

V.   <u>NEW SOCIAL PROBLEMS</u>

The problem of environmental pollution allows the discussion
of an issue which also belongs at the interface: The relation between
university-research on social problems, social action to prevent or
ameliorate the social problem, and political power. Reference was
made to these relations in the discussion of beliefs held by many in
the community on the political power of the University.

The domain of health includes the personal medical care
system with its practitioners and patients, and the field of public health --
health services for population groups, and social efforts to maintain a
"healthy" environment. As our concern shifts from the medical care of
an individual to the status of the "environment", the focus of prevention
and remedial action shifts to larger social organizations and social
institutions. These larger entities tend to be "more central, more basic"

units in the country, the more powerful ones. Action to change the

configurations of social and political power on these levels is surely

"radical". The prevention of environmental pollution will require changes

in the political structure of this country, in the relation between govern-

ment and industry, and between political and economic beliefs. These

changes may come about, as in the past, through incremental social change.

Thus, we participate in groups with a political and social philosophy

supportive of limited actions on prescribed issues. But these limited

actions on prescribed issues are somewhat ineffective vis a vis problems

like environmental pollution and "overpopulation". To prevent or

ameliorate these social problems, effort must be directed at institutional

power and decision-making in government, in industry and in the relation

between these. It is on these socio-political issues that the University

could find its Waterloo. Political "neutrality" on these issues is "impossible".

Inaction is viewed as complicity with those who are doing "wrong" and as action

in defense of the status quo. Findings from research done in the University

on these social problems will be viewed through the glasses of socio-political

beliefs. The boundary between scientific or technological face and the socio-

political use of these facts will blur. These are the issues and foci of the

seventies, of the Movement. These are some of the issues of the University and

its constituents in the community in the health domain. Unfortunately,

"selective inattention" too often precludes discussion of these. An example

follows:

Bill Kovach wrote a recent New York Times article on Calumet

Community Congress, a new community group in Gary, Indiana which is composed

of over 150 other community groups of "widely different social

and political colorations..." The purpose of the new group is "to bring
pressure on the giant steel mills to end pollution and on political
organizations which have controlled Gary for years". (My emphasis.)
(December 7, 1970, p.33) Several U.S. Senators publicly supported the
new group as did consumer advocate Ralph Nader. Observers were present
from Baltimore, Newark, Providence, Chicago, Cleveland, Detroit and
Philadelphia. The Congress organizers were trained at Saul Alinsky's
Industrial Areas Foundation Training Institute, Chicago. It is with
new community groups like this one that the University's relation to
the Community will be tested, for the different constituencies of the
University will hold incompatible expectations of University action.
Each of these expectations will be a stress which will appear at the
interface.

VI. FINAL NOTES ON SOME DIFFERENCES BETWEEN THE UNIVERSITY AND THE COMMUNITY

The differences between the University and the Community are
those related to the priorities for University service to people in the
community; to the focus of social change desired in the health sphere
within the University and beyond it; to the strategy and tactics of
these actions; to the use of knowledge and professionalism as sources
of power and thus of control over disease processes and social processes
and people; to the bureaucratization of health services and to the
control of these bureaucracies by professionals, faculty or "the community";
to the specification of decision-making domains in which groups outside
the University can participate in making decisions which were heretofore
made largely by those within the University; to the differential
definitions of what health services are needed and wanted; to the social

organization of these. These are scientific, technological, political,

ethical and moral issues with high symbolic and emotive meaning. That

is why the debates of the seventies will be complex and acrimonious,

One task is to make explicit those "inarticulate premises of action".

As Lamartine has written:

> These times are times of chaos; opinions are a scramble,
> parties are a jumble; the language of new ideas has not
> been created; nothing is more difficult than to give a good
> definition of one's self in religion, in philosophy, in
> politics. One feels, one knows, one lives, and at need,
> one dies for one's cause, but one cannot name it. It is
> the problem at this time to clarify things and men...The
> world has jumbled its catalogue.

VII. WHAT EACH PARTY HAS TO OFFER AT THE INTERFACE

A. WHAT THE UNIVERSITY HAS TO OFFER

In the domain of health, the University can offer scholarship,

education and service. The content, the form and the quality of these

will be determined at the interface. Some suggestions are made in

this proem.

1. Scholarship - What are some of the issues?

The focus of university scholarship in the domain of health

is determined by factors like the researcher's interest and competence,

financial support available, peer judgements on the "value" of a given

subject, considerations of the "utilitarian worth" -- the size and kind

of potential benefits to "Man" -- which might result, among others.

For each scholar, the factors determining the choice of subject to

study will differ. This is necessary and acceptable. The University,

however, may be pressured by its constituents to take a stand by develop-

ing "guidelines" and priorities in research. This is one possible con-

sequence of the severe cut-backs in federal money for research in the

health domain. A change in federal policy on medical and health research

could also push the University in this direction. An example of a policy change now beginning apparently is the switch from "project grants" to university-affiliated researchers to federal "contracts" made with the scholar and his department. If the University is pressured, so too will its members feel the pressure. Pressure will also come from different groups in the community, each asking or demanding University accountability for the actions of university-based researchers; and each asking and demanding a role in the decision-making process which will determine university-wide policy on research. These are but a few of the socio-political issues which could arise in discussion of university-based scholarship at the interface.

More specifically, emphasis will probably be placed on the content of medical and health research. One can anticipate research on the delivery of medical and health services rather than on new treatments for specific diseases. Such studies might focus on the evaluation of existing care and existing patterns of delivery. Such research would dovetail with the evaluations of existing services being made by many recipients and groups of recipients. It would bring to bear the resources of the University for the "benefit" of the Community.

On the other hand, applied research and scholarship could too easily come under the heavy-handed influence of its sponsors or of a politically powerful community group. Buried in the issues here are intensely discussed questions: the role of the researcher working for an organization, his claims to "objectivity", and the counter-claims of his partisanship. The researcher studying social problems in the health domain will be open to pressure from many sides, more so as his work becomes demystified, his methods and findings become open to scrutiny by a public with values different from his, and claims are

made on his freedom to choose his own subject for study. The pressure
to be "socially relevant", to work for "the general welfare" can be
extreme, however apparently noble "the Cause".

These are interface issues, and debate on them is expected to
replace the current deification of medical research. Open and active
debate can rarely take place in an atmosphere built upon faith and
symbols alone. Medical and health research itself can be evaluated.
And the self-conscious process of scholarship is one means to do, this,

2. Education

The recent report of the Carnegie Commission on Higher Education
in medicine and dentistry helps create a social atmosphere in which occur
interface discussion on what the University as a teaching institution
can offer the community. In the health complex, these discussions could
consider the amount and kind of education necessary to perform a job
in the health system. An important subject is the "kind of person"
who can be recruited, trained and employed. Here, race, social class
and previous education are central issues.

The University is a "societal gate-keeper" - a grantor of
credentials in a society obsessed with this means of people zoning.
These credentials, i.e., degrees, largely determine one's economic,
social and health life chances, one's opportunities. Because of this
credential granting power, the University can offer individuals and
groups means of gaining power too. This is an interface issue in the
global way it is presented here and in the specifics of accreditation,
academic and professional standards and the other myriad topics in-
volved.

motive or socio-political philosophy--yet to act without considering
the potential consequences--including those that might be dysfunctional
at a later point--is folly. Henri Bergson's famous quote is truly
applicable here: "Act as men of thought; think as men of action."

Beyond sending consultants out into the Community--to answer
a request or to stimulate a request--the University might make other
clear commitments congruent to its social roles in education and
research. For example, it could be the setting in which demonstrations
of innovative treatment practices could be developed and given public
exposure so that local groups could learn about these. These groups
can then use this knowledge to pressure other service deliveries to
adopt the innovation. This is one form of "community education".

Another form could be the education of individuals and
groups on matters heretofore within the province of "professional
expertise". This includes the issues of "standards of service", what
these are, how they are developed, how they are enforced, and by
whom; it includes education on the tasks performed by medical and health
practitioners and the professional rationale of the education necessary
to perform each. These rationales at some point might be shown to be
invalid; in short, the University could educate individuals and groups
on the inner workings of the medical and health system. In this way, it
could help to demystify these.

Clearly, providing opportunities for education in the medical
and health field is a major service to the Community. Other services
will emerge at the interface, for that is one of its reasons for being.
The interface in health is that process of joint exploring and bargaining
and deciding about service, scholarship and education.

B. WHAT THE COMMUNITY HAS TO OFFER

Individuals and groups in the community can offer themselves first and foremost. As thinking, feeling people, they must make their needs and wants known. This is not a shibboleth; it is a moral and socio-political imperative, for without the direct and constant presentation of their views, the University can too easily ignore their presence, can too easily become the sole voice of wisdom about "the people". It is apparent that at a time of vociferous and visible University-Community conflict, many of "the people" are quiet and invisible. Have the people become pacified?; or has futility replaced anger, self-respect and the politically and psychically "healthy" act of demanding what one feels is his right?

Second, the people can offer their ears and listen, for without learning about medical and health practice they can only defeat their ends. This knowledge will help them get what they want. And it will help them learn that what they have is too often poor. Alexis de Tocqueville put this point well:

> The evil which was suffered patiently as inevitable
> seems unendurable as soon as the idea of escaping it
> crosses men's minds. All the abuses then removed
> call attention to those that remain, and they now
> appear more galling. The evil, it is true, has be-
> come less, but sensibility to it has become more acute.

Third, the people can offer their own research findings, how-ever different the research methodology they used. They can offer to educate the academicians and the professionals to who they are, to what they believe, to how they live and to what they want.

IN CLOSING

Those in the University and in the Community have much in common. Often this is in the abstract like broad goals and broad values. It is in the concrete, the specific goal and specific means that differences appear. These differences in perception, cognition, attitude, etc., become barriers to common cause. These differences will be the stuff of discussion, negotiation and conflict in the seventies. To paraphrase sociologist, Robert Merton, we are living in a "context of distrust" and we "no longer inquire into the content of beliefs, assertations to determine whether they are valid or not". We in the University and in the community, we who are rational are together guilty of shrillness in our discourse, of a poorly articulated and somewhat frenzied anger and despair.

The task before you is clear, although the means to accomplish it are not yet fixed. At worst, try to reach an interface "authentically"--in Sartre's words--with "a true and lucid consciousness of the situation, in assuming the responsibilities and risks that it involves, in accepting it in pride or humiliation, sometimes in horror and hate."

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