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ABSTRACT

While health services personnel in the United States receive the best technical training available, they are rarely exposed to a holistic health science curriculum which would enable them to develop the interpersonal competence needed in the delivery of health services. Indeed, the primary task of health services personnel is teaching patients to assume proper therapeutic behaviors. This requires understanding a patient's behavior patterns, the psychology of motivation, the patient's personal and cultural background, and the importance of including the patient in his/her diagnosis and treatment. In addition, health care personnel must learn the skills required of any organization member and be aware of the need to economize in a non-profit hospital setting, racial caste systems within job classifications, burn-out and other job-related problems, the inadvisability of socializing on the job, and management policies. Health personnel are also called upon to interact with people who are neither patients nor co-workers, for example, with patients' friends and family. They often need to teach families to assist with patient care and to deal with the sensitive topic of mortality. Clearly these interpersonal competencies cannot all be addressed within the short timeframe of formal study, but colleges have an obligation to incorporate general education into the curriculum to instill a spirit of critical observation and to motivate independent investigation. (JP)

HEALTH CAREERS Rx for 80's

The Other Courses: Nurses Cannot Live On Medical Terminology Alone

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ARGUMENT

Health Services Education is at a crucial point in the development of its own prescription for the 80's. The increase in the use of high energy powered technology, automated monitoring equipment, sophisticated diagnostic aids, pre-measured, pre-set medications and other examples of time-saving, labor saving and life-saving devices and procedures has created new problems with the new skills and new work.

The sub-fields of health services are not the "do what you can" of yesteryear, but rather what alternatives have we not tried as of yet. The number of personnel in health services delivery and related areas reflects the burgeoning development of specialization and departmentalization. Without overstating the situation, the delivery of health services is complicated, complex and multi-faceted. Health services educators have done a yoeman's job in teaching and training students so that they will be able to handle the complexity and complicatedness. But we've found that the multi-faceted aspect of our students' education is not adequately being met.

Health Services Education has in its very name the idea/goal of educating as well as training skilled technicians and professionals to assist people in maintaining and re-achieving emotional and social homeostasis along with their physical-organic systems equilibrium. Health services personnel in the United States receive the best training in their respective fields. The most up to date findings, drugs, methods, and technical equipment is quickly absorbed into both the content and process of their training. When they go out into their chosen careers they are as highly qualified technically as possible. If the total delivery of health services involved only up to date technical skills, health services educators could rest on their laurels. The picture though is not that clear.

Complaints about health services personnel do not appear to be in the area of technical competence, but rather in the areas of interpersonal, intergroup, authority, responsibility, emotional and psychological relationships. (The issue of initiative among technicians is one that health services educators still have to resolve.) We wince when we hear comments like "what he does is good work, but he can't seem to get along with his fellow workers," or "she has no respect for authority," or "she has a lousy bedside manner," or "he takes everything personally," or "she falls apart in a crisis situation."

Health services education has borrowed the term "holistic" from anthropology in an attempt to develop a broader, more realistic approach to meeting patient/client needs, but while significant strides have been made, much remains to be done. This paper is an attempt to point out some areas of deficiency and to suggest that within the established curriculum of most community colleges there are courses that can put the "w" back in the "whole" of holistic education of health services personnel.

The first and foremost task of health services personnel is to understand people, not just in a superficial way, nor in some general stereotypic categorizations, but really understand their behavior. Note that we say behavior, not attitudes, not values, not beliefs, nor any other psycho-emotional labelings. We proport that the primary orientation of health services is teaching; preventive, process, and rehabilitative. But how can we teach when we do not know the student.* We can warn them, admonish them, scare them, lecture (at) them, even train them, but we cannot help patients assume therapeutic behaviors if we don't know what would make them internalize these behaviors. We're not even sure we can treat them "holistically" if we don't understand them.

*The implications for health services educators should be clear.

A key word in psychology is motivation. Motivation, that which gets one moving, acting, doing, can be explained in a variety of ways. Motivation is probably the most multi-faceted concept with which we must deal both in our role as health services educators and our students' roles in health careers. Motivation is determined by gratification from previous experiences. For the new person in a health career, personal motivation and motivating patients/clients is often a hit and miss affair. The patterns used are often those we learned in childhood and in school, but they can be inappropriate and even deleterious in health services delivery. Appeals to authority, logic, right and wrong are not necessarily effective. Nor are screaming, cajoling, or even calm reasoning. What motivates one person does not do so for another.

Directly related are the facts of a patient's background. It should be noted that while socio-economic and socio-cultural factors must be considered as contributing to behavioral patterns, individuals may not have internalized these factors into their behavioral repretoire. Particularly in crisis situations, patients may resist acknowledging (to themselves and others) any association with their heritage. Health services personnel must be aware of these background factors, but from a social scientific verifiable perspective, not through pseudo-specification. Poor blacks, old Jewish ladies, spoiled white teenagers and middle aged

overweight salesmen are not categories for therapeutic intervention strategies.

In order to understand our patients, we must first correctly and objectively perceive and observe their behavior. Health services personnel are taught to observe their patients in a rather peculiar manner. The approach has been to look at and examine the patient/client in terms of systems. While this technique has certain advantages, it places certain systems as superordinate to others, namely the emotional and social systems. The patient becomes a fixed entity to be worked on and altered or changed, not a living behaving organism. The negativism of "what's wrong, how do we fix it, and how do we prevent it from going wrong again" doesn't really allow the patient to participate in his/her treatment.

There is the need to involve the patient more in both his/her diagnosis and treatment. While we commend health services educators for a good beginning in this area, there is much more to be done. There is still a tendency to "minister" to the patient with a set of rituals, both active and verbal, that reflect an accepted mythology that is known only to those expert in the cultic behavior.* It is still reasoned that the patient would find it difficult to understand what

*Horace Miner, "Body Ritual among the Nacerima," American Anthropologist, 58(1956), pp. 504-5.

is being done to and for him or her. There are even times where it is felt that if procedures were explained, it would make it more difficult for them to be effective.*

Beyond the interaction of the health services personnel and the patient/client, there are two general areas that compel our attention in the education of health services personnel. In lay language, they are learning the ropes and getting along. In social scientific terminology, they are organizational behavior and interpersonal relations. There are a cluster of behaviors that must be learned in any organization, be it a hospital, clinic, or industrial or home setting. We do not have the license anymore (if we ever did) to say, "leave me alone and let me do my job." With federal, state, and county governments, boards, and controls, we all deal with organizations.

Organizations prescribe certain behaviors, attitudes and interactions. These relate directly to the goal attainment, tension management, adaptation to the external environment, and personnel integration of the individuals within the organization and the organization itself with other organizations. The problems these tasks present could probably be solved separately by the new practitioner; but they must

*We should also mention that there are still "things" we do that we don't know whether they are going to work or why they do or don't.

be handled simultaneously. For the individual adapting to his or her new role as a practitioner, rather than as a student, these problems may seem insurmountable. This is not the time to have to learn how to deal with red tape, personality quirks, racial prejudice, and how you'll score on your provisional job evaluation.

Usually health services organizations are not for profit. In fact, the majority spend their time and energy trying to cut their deficit.* Capital equipment and "administration" are usually considered fixed costs and are the last things to be sacrificed or even reduced in cost-cutting economy actions. Direct service personnel (or salaries) and the "tools of their trades" are the early victims. Personnel have to be taught to conserve, efficiently utilize, repair, make do with less, and even "squirrel away." They also have to be taught how to offer cost-cutting suggestions in a manner that maximizes their chances of acceptance. Even at times when the resources are adequate, basic rules of efficiency and conservation should be observed. Hospital equipment whether paper, pencils, bandages, tubing, transistors or furniture are not meant to be taken home. Waste should be avoided. Lights should be turned off and while it is true that there are probably not enough personnel, the attitude that "its not my job" doesn't help at all.

*Health services organizations often were as guilty of overexpanding as our schools were and the consequences are just as severe.

Most health services organizations hire many different types of personnel who come from a variety of classes and cultures. In fact, there is probably no area where the outward appearances of desegregation ha existed for as long. If there were racial and cultural integration in our health services organizations, we would not even have to mention this item. The reality of the situation is that a caste system often reinforces the existing job category stratification. There is clearly a color gradation among the occupations and it is the unusual situation where there is even minimal socializing off the job and more than common amenities on the job. This issues must be dealt with in a directed manner in order to insure the well-being of all involved.

We have become acutely [sic] aware of the growing problem of mental health among health services personnel. In the field we work in a highly charged, tension producing and in many ways insecure environment. A milieu of noxious smells, electronic sounds, radioactive materials, drugs, threats of and actual violence, low salaries, fatigue, hostility, law suits, poor organization and vacilating management is not conducive to personal and professional development and growth, nor to the delivery of effective health services. Long before "burn out," debilitation begins to affect

efficiency and the more people complain to each other on the job, the worse the situation appears to become. Problems at work get taken home, home problems get taken to work and the least incident gets blown out of proportion, aggravating and exacerbating any temporary or situational personal, emotional, interpersonal or social problem. Because of specialization and departmentalization, the individual in health services is likely to view himself as only a small cog in a large wheel, unrecognized, unacknowledged, and unappreciated. He or she must learn to self-motivate, self-reinforce, self-evaluate, and self-improve. It is recommended that people in the health services learn to do somethings that provide both intellectual and emotional stimulation and satisfaction outside of work. Our students must learn that their whole life is not work and their whole work is not life.

While we are on the subject of work pressures, it is necessary to discuss the problems of mixing work and play. Stereotypes aside, socializing on the job must be kept to a minimum for everyone's sake, the patients, the participants, and all others. The shock of the work world, the pressures, tensions, anxieties, the ambivalences and the closeness with which people must work encourages familiarity, and the old expression about what familiarity breeds may not be too far from the mark, if not for the participants, then for those who might be jealous. Without being prudish, the dating

game, the mating game, or the bedding game interferes with the effective delivery of health services. While some people can carry on multiple roles in intersecting relationships, it is best to keep them separate. In fact, there may even be organizational policy to that effect, which brings us to the next bit of learning our students need to have.

Management decision making which may appear to be arbitrary, non-directed, at cross purposes, and even capricious impacts the day to day delivery of health services. Our students should understand the differences among policies, procedures, and actual performance and how they came about not just their specificity. Knowledge of the whole organization, how it operates, and the individual's place in it and skills necessary for survival are essential. Learning primary and secondary communications systems, how to procure "things" the proper way and the other way goes a long way toward the effective delivery of services and good mental health. Occasionally something doesn't operate properly and it should be changed. We must teach our students how to go about changing "S.O.P.'s" without getting themselves in trouble, without offending people and without disturbing the basic delivery of health services. Yes, we are talking about salaries, personnel practices, staff security, rotation schedules in addition to who can order medications, what forms have to be completed, how to get a better intravenous

drip tubing.

With a health services career comes multiple interactions with persons other than the patient and other professionals. If the patient/client were the only "outside" person with which we had to work, we would probably be much happier. We live in a mass-mediated culture with a profusity of lay medical knowledge, most of it incorrect or overgeneralized, but most people consider themselves experts. But families and friends are here, concerned, and honestly interested in the patient's welfare. What they do and do not do is often the stuff of which horror stories and comedy routines are written. Minimally, their presence or telephone calls can interfere with our doing our jobs. We must teach our students how to interact with these people as effectively as they should interact with patients and other health services personnel. We must also learn how to teach families and friends to assist us with direct patient care, rehabilitation, post care education and preventative medicine. We must also give them correct information and make them understand our limitations.*

One of our limitations is our mortality and the mortality of all those with whom we work, yet we are less prepared for dealing with this reality than any other with which we deal. The subject of death and dying which has had a wide press both in the health services and outside is one of the most

*We must also mention that our relationships with clergy could use improvement.

difficult areas that our people will be required to handle personally as well as professionally. It is also a good example of what is meant by being unable to deal with something that is too close. It also points to the clear need for humanizing technologies. A sensitivity needs to be learned so that emotionality does not get in the way of delivering effective services. A set of structured experiences with practical applications of philosophy, ethics, logic, argumentation, and all the humanities, not just lectures and units on the philosophy of nursing, bioethics, medical research taught by health services educators, must be designed for all the subfields, no matter how restricted the technician will be on his/her job.

Thus, all what we've said up to this point may be irrelevant to most of our students most of the time. While every organization is different, every department will have different policies and procedures, and every physician will permit technicians at different levels to do different things at different times, health services personnel need to know how to be a human being in a human situation working with other human beings.

We have pointed to what we consider the major deficiencies in health services education and there is much more to be learned than any of us can teach. There are constant developments in all of the fields for which we train our students. In addition, we only have them for a limited period of time. We have an obligation that goes far beyond the classroom instruction, evaluations, clinicals and graduations - we must teach our students to learn on their own and not incidently teach them to want to continue on their own. A spirit of inquisitiveness, critical observation and a passionate need for more knowledge for its own sake can and must be encouraged.

We must teach them to use libraries, how to ask questions, how to trouble shoot equipment, how to research new developments, how to apply existing knowledge to new problems, how to give and receive in-service, and to search for better ways of doing their jobs.

All these things cannot and will not be learned as content. They must be learned as processes. That which we indicated as deficiencies would be dismissed by adding a few lectures to a lecture course in a technical field though that should be done anyway, but our students must learn these within a general education framework.

General education is a process, that is, a pragmatic way

of manipulating the learning situation to bring it as close to the real world as is possible within a mass education system. General education is what John Dewey was talking about, make no mistake about it.

Some professional educators are apprehensive about general education, ostensibly because of its lack of discipline, sophistication and classical traditions; but really because somehow general education appears to convey an idea of going beyond the lecture room. General education includes all those ideas from field trips through simulations to internships, and even more, involves student directed competency based learnings.

This last idea means that students are continuously involved in deciding what it is they need to know to exist and prosper in and even change the world beyond the classroom walls. It is the teachers' job then to design, apply, and evaluate reliable and valid ways of learning and testing of that learning.

Ideally a student should learn skills where he will have to use them, but that is not always possible. General education must then get as close to that reality as is possible without restricting the students' learnings both in terms of content and alternative processes.

The essence of general education is keeping the process, learning, general enough to make sure the student has learned

as much as possible under the circumstances of being removed from pure learning by doing. In the '50's, general education was matched with general studies or liberal arts; that is, the way to appreciate poetry written about a fog was to go to a fog and try to write. To understand the ancients, or for that matter, the entire corpus of western civilization, travel abroad, was de riquer; it also taught you what dysentery was - something that previously was an experience restricted to soldiers and misguided rich folk. Sputnik put an end to all those frills and learning became once again force-feeding. It wasn't until those 90-day wonder engineers and scientists were found to be limited in their capabilities that the physical sciences began using, albeit minimally, a general education format. This is the problem we've returned to in technical education for health services. In the last third of the '60's, general education was the only "legitimate" learning for the social scientist. In the early days of the past decade the ecology minded natural scientists, too, adopted a general education component. But as all these experiences with general education have taught us, it is difficult to maintain the momentum of hard work, which is what general education is; physically, mentally, emotionally. It is certainly easier for all concerned to simply sit and listen to someone "tell it like it is" than going to find

out "where it's at." The health services educators in the community college have a unique chance to adopt general education as one main trust of their mission.

To paraphrase: "At general education, process is our most important product."

Postscript: Developmental education is the process of providing students with opportunities to increase under-developed skills in bridging the oftentimes "chasmic" gap between previous learning experiences and those necessary to profit from a general education approach. The failure of our technical career program graduates to pass stateboards may be a failure not of technical education, but of general (and developmental) education.

RESOLUTION

We have attempted to point out certain deficiencies in the education of health services personnel. We have pointed to certain areas in which a broader approach to our mission is required.

Rather than simply criticizing it has been our purpose to critically evaluate the training of health services personnel. But even that is not enough. We must go beyond that. We must together look to general education, to the other courses to develop a better prescription for health services education in the 80's.