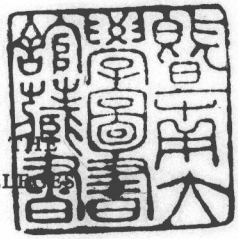
Widening Horizons in Medical Education

A Study of the Teaching of

SOCIAL AND ENVIRONMENTAL FACTORS IN MEDICINE

1945-1946



A REPORT OF THE JOINT COMMITTEE OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES AND THE AMERICAN ASSOCIATION OF MEDICAL SOCIAL WORKERS

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PREFACE

The formula for spontaneous generation is the Creator's secret. We mortals have not shared it. Our creations are slow and frequently painful. They evolve usually after long deliberation and uncertain groping along tangential paths. The evolution of this Study has been no exception.

Though this Study of the Teaching of the Social and Environmental Factors in Medicine had its beginnings in 1941, it may be said to have actually originated a number of years before.

Until about seventy years ago the teaching of the social aspects of medicine was largely confined to the self-instruction that comes to every physician with his experience in practice. Paracelsus and Sydenham recognized the importance of knowing the patient as a human being in relation to his physical and social background. Their teachings, however, were not translated into a formal inclusion in the medical curriculum.

Five years before Johns Hopkins opened its medical school, Dr. John Shaw Billings advocated the novel plan of sending medical students under competent supervision into the homes of patients to learn how environmental factors complicate illness. This was the first effort to formalize the teaching of social and environmental influence on illness. Osler and Welch followed this lead in the 1890's by assigning two third year students to investigate the home conditions of consumptive outpatients. Thus the student had an opportunity to study disease not only in the hospital where it made its last appeal, but also in the environment where it had its origin.

Osler's influence was evident in the contributions of one of his assistants, Dr. Charles P. Emerson. Under his direction, twenty-seven Johns Hopkins students volunteered as home visitors for the Baltimore Charity Organization Society in 1903. Later, while Dean at the University of Indiana School of Medicine, Dr. Emerson enlisted the aid of the Social Service Department of the hospital in teaching the social aspects of medicine. Students visited patients in their homes

and subsequently reported on the conditions they had found at weekly "medical-social clinics."

At Harvard Medical School in 1912, Dr. David L. Edsall instituted a study of lead poisoning in Massachusetts General Hospital patients. The occupational environment as a factor in disease was thus brought forcibly to the attention of the student. In 1913 Dr. Edsall called upon Miss Ida M. Cannon, Chief of the Social Service Department, to assist in arranging a series of lectures to medical students. The social aspects of tuberculosis, heart disease, syphilis, alcoholism, feeblemindedness, and occupational diseases were formally discussed. Later, the lecture method was abandoned and replaced by the more interesting and instructive technique of case teaching. The trail blazed by Dr. Edsall was capably followed by Dr. George R. Minot, and his assistant, the late Dr. George P. Reynolds, and this teaching has been carried on up to the present day at the Boston City Hospital. At the Beth Israel Hospital in Boston, Dr. Harry Linenthal elevated social case teaching to a status of equality with instruction in physical diagnosis.

In the beginning most of the medical-social teaching was done by clinicians, usually from the Department of Medicine. But since then a new trend has developed in medical schools. Departments of Public Health and Preventive Medicine began to spring up in one school after another. The very nature of the instruction given by these departments demanded the study of social and environmental factors as they affected community and personal health. Consequently, in a number of schools where no program had existed formerly, the teaching of these factors was introduced by the newer departments. Prominent among these were the developments at Yale University by Dr. Ira V. Hiscock, and at Vanderbilt University by Drs. Waller S. Leathers and Henry E. Meleney. In other schools a collaborative effort between Preventive Medicine and other clinical departments was evolved.

Further attempts to orient the student to the patient in his natural environment took the form of domiciliary and other extramural services. The adaptation of extramural teaching ranged from simple visits by medical students to patients' homes in order to observe environmental conditions, to actual domiciliary care of the sick.

It is apparent from the foregoing and from a survey of the literature on the subject that a new school of thought in medical teaching has developed and has grown to impressive proportions. Almost every new member of this school has contributed either a variation of an already accepted technique, or has introduced a method of his own. One of these variations put into practice by Kerr at California and by Bardeen at Wisconsin was the assignment of students to private physician preceptors for actual observation of the social aspects of the practice of medicine.

The trend toward the recognition and teaching of the social and environmental factors in medicine was expressed both here and abroad in various other ways. In 1932 the Commission on Medical Education of the Association of American Medical Colleges took an official stand on the importance of these factors and the physician's obligation to become acquainted with them. At the 1938 meeting of the Association, a symposium on medical-social teaching was presented. The following year the Education Committee of the American Association of Medical Social Workers published the results of a ten-year study of the participation of its professionals in teaching medical students. Then in 1941 the first steps that led directly to this Study were taken.

By 1941 our society had felt the impact of several successive social upheavals within a short span of years, and the immediate future threatened to provide more. The devastating economic depression of the thirties was followed by the rise of the foreign aggressors. Their "war of nerves" eventually developed into a shooting war in which death and destruction reached incalculable proportions. Numerous other factors in our rapidly changing society, such as the widespread trend toward urbanization of the population, also contributed to the problems of an overburdened people. One adjustment to change had hardly been made before another was required. Insecurity and anxiety were manifested by a rise in mental and emotional disturbances. The effect of this social turmoil on the physical health of mankind can only be surmised, but it must have been profound.

Medical educators had been becoming more cognizant of their obligation to create in students a social consciousness in the care of the

sick. Accordingly, in 1941 the Association of American Medical Colleges appointed a subcommittee of the Committee on the Teaching of Public Health and Preventive Medicine under the chairmanship of Dr. Curran to explore the subject of medical-social teaching. At the October 1942 meeting of the Association, the chairman presented a progress report based on data obtained from questionnaires sent to seventy-six medical schools of which sixty-eight had replied. A continuation of the Study was voted, and the subcommittee was made an independent body.

In 1943 the Study became a joint effort when the American Association of Medical Social Workers was invited to collaborate. A committee from this Association joined the original committee and began active participation, with Miss Cockerill as co-chairman. It was decided that the prosecution of the Study could be more favorably advanced if its executive functions were delegated to a smaller group which could plan the program and formulate policy. Accordingly, a Project Committee was designated under the chairmanship of Dr. Rhoads.

At the outset the Project Committee was beset with difficulties. Medical schools were operating on an accelerated schedule because of wartime necessity, and the question arose whether the Study should be undertaken under these circumstances. The Committee was impelled to move ahead, however, by its conviction that the results of such a study might contribute significantly to medical-social teaching in the postwar period, when social problems could be expected to be most acute.

The Project Committee's first problem was to devise a method of study that would be practical and effective in obtaining the desired information. Accordingly, two "pilot" studies were undertaken. It was hoped they would guide the Committee in shaping a future program, test the method of approach, and indicate the feasibility of continuing the Study during the war. These trial studies led to the conclusion that the prosecution of the Study was practicable. Approval of the program was given by the Association of American Medical Colleges and the American Association of Medical Social Workers and a grant

was obtained from the Milbank Memorial Fund to underwrite the Study in 1945 and 1946. Miss Harriett M. Bartlett, who had been Educational Consultant of the Social Service Department at the Massachusetts General Hospital, was appointed Executive Secretary in January of 1945.

The Scope of the Study

Briefly stated, the general aims of the Study were: (1) to gather information in this country and Canada on present-day teaching of the social and environmental aspects of medicine; (2) to analyze the data obtained; (3) to evaluate the methods and techniques of instruction in use; and (4) to offer recommendations based on conclusions drawn from the Study.

Only undergraduate teaching has been covered. Instruction that extends into the postgraduate years might well be the subject for another study. The fields of medical sociology and medical economics also warrant investigation.

In relation to psychiatry, the Committee has limited its consideration to those aspects which are closely related to the subject of the study. The emphasis is upon the utilization of the knowledge and skills developed chiefly by the field of psychiatry which are felt to be an essential part of the equipment of the general practitioner and which are fundamental in acquiring the capacity to recognize, evaluate, and treat the social and environmental aspects of illness. It is significant that the Study indicated that the help of the psychiatrist is extensively employed in this teaching.

This monograph is a report of the Study made by the Joint Committee. General considerations, a summary of the findings, and conclusions are presented in Part I. For those who want more detail, a second part has been included to provide much of the source material. The case study outlines and case reports presented in Chapter Five have been submitted and approved for inclusion by the schools visited. The case reports have been carefully disguised.

We wish to express our indebtedness to many persons at the various medical schools and hospitals without whose cooperation this Study

would have been impossible. Special appreciation is due Dr. Louis D. Zeidberg for his invaluable assistance in the preparation of the manuscript.

The members of the Committee have obtained a rich educational experience from this Study. To us it has meant broader vision, greater skill, and an increased capacity for teaching medical students. We hope that this volume will serve the same constructive purposes for its readers.

J. A. C.
E. C.

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PART II

PART I

CHAPTER ONE

INTRODUCTION AND STATEMENT OF PRINCIPLES

"Consider the patient as a person!" This highly implicit precept was generally offered to the medical student of twenty years ago as his sole introduction to the social aspects of medicine. In most schools it was an empty platitude except in isolated instances, and naturally so, because it was left dangling without the support of generally applied instruction by clinical teachers. If it had any meaning to the medical instructor himself, he seldom revealed a sense of responsibility for its elucidation. The social implications of the phrase acquired significance only after years of private practice during which the physician for the first time faced the realities of social and environmental factors in relation to his patient.

If it is true that Man is a biological and social being (and how can it be denied?), then it must also be true that medicine is a natural and social science. Why, then, was the teaching of the social aspects of medicine so much ignored in the past? The answer probably lies in the spectacular advances in the natural sciences in recent years. The focus of attention of medical teachers, and inevitably of students, was irresistibly drawn to them, to the detriment of the social sciences. As knowledge, specialization, and concentration increased, the tendency of medical scientists was to dissect the human being into his component parts, or even into his individual cells. In their thirst for a better understanding of the human mechanism, they became so preoccupied that they couldn't see the man for the cells.

The goal of medical teaching is to develop physicians who are capable of dealing with all the health needs of human beings. The objective can only be achieved if Man is studied in relation to his external, as well as internal, environment. Dr. Henry E. Sigerist (1946) has very aptly written, "The picture society has of its ideal physician—the goal of medical education—is determined primarily by two factors, the social and economic structure of that society and the technical means available to medical science at that time." In the past, medical teaching

centered on the "technical means." The modern trend is toward a proper balance between the teaching of the physical and the social factors in medicine.

Since the greater part, if not all, of clinical instruction has been confined to the hospital, it has been difficult to emphasize properly to the student the importance of the factors in the patient's home and community having a bearing on his illness. The patient comes to the hospital with his medical complaints, but leaves his environment at home. The clinical clerk sees the patient dressed in a fresh hospital gown, lying in a clean bed in the hushed atmosphere of the hospital. Unless the diet is restricted, the patient is served three times a day with nourishing food that contains a scientific balance of all the nutrients, minerals, and vitamins required. What the student has difficulty visualizing, however, is that the patient may come from a crowded, dirty home; that the family diet may be totally inadequate because of economic limitations; that the patient's spouse may also be ill with tuberculosis or another chronic disease and unable to work; that school-age children are being denied education and a carefree childhood because the illness of the parents requires them to shoulder domestic responsibilities prematurely (see Part II, page 148, for actual illustrative case). It is small wonder then that the medical student does not become aware of the social aspects of medicine unless a conscious effort is made by his teachers to awaken him to the importance of these factors. Attempts to close this gap in medical teaching have taken interesting forms. In the succeeding chapters it will be shown how the problem has been attacked in some schools by extramural teaching and the use of a variety of techniques (see Chapter Two, pages 35–38).

The accumulation of knowledge becomes a sterile hoarding of facts unless that knowledge is applied. This is true of all education, and is no less true of medical education. It is not enough for a student to learn that social and environmental factors influence the health of people. Nor is it enough for him to know what these factors are specifically, if he will not apply his knowledge in the care of his patients. It is the responsibility of the medical educator not only to teach the facts, but also to provide his students with an opportunity to use them. The instructor must consciously bring these problems into every