GARY D. ROGERS AND DAWN FORMAN

4. THE CONTEXT OF HEALTH PROFESSIONAL EDUCATION TODAY

There is no doubt that graduates entering the health professions in the second and third decades of the twenty-first century will face an environment that is different in a range of important ways from that which most of their teachers encountered at the same point in their own professional careers. It is vital that we, as health professional educators, help our students to develop the perspectives and skills that will enable them to thrive and develop further in this changed context. We argue that foremost among these is a critical posture, where they are encouraged from the beginning to question the assumptions and culturally received knowledge that they will encounter in clinical and educational spaces. The fact that many of our students come to us after training in positivist scientific paradigms, at school or undergraduate levels, makes this a particular challenge

In this chapter we first survey the sociopolitical context of current health professional practice and education. Then we consider recent changes in the system of healthcare delivery with which our students will have to grapple, before examining recent trends in educational practice that will impact on us as health professional educators. We also reflect on how the world view of current healthcare students may differ from our own and the influences that these differences may have on the process of learning. Finally, we offer some suggestions for how we might best equip our students to become effective health practitioners at this point in history.

SOCIOPOLITICAL CONTEXT

Currently, hardly a day passes without the news media featuring some "crisis" in relation to healthcare (Sweet, 2010), leaving the average health professional student or educator in developed countries with an uneasy sense that something is deeply wrong with our health system, but no sense at all of what exactly that something is, or how it might be addressed. In this section we attempt to describe the sociopolitical currents that bear on the current state of healthcare delivery in the developed world.

Individualism, the Neoliberal Agenda and the Commodification of Health

Neoliberalism is a political philosophy that emphasises individual liberty and responsibility over community responsibility and the role of the state in improving human welfare. Coming to prominence during the 1980s under Ronald Reagan in

S. Loftus et al. (Eds.), Educating Health Professionals: Becoming a University Teacher, 35–48.

the United States (US), Margaret Thatcher in the United Kingdom (UK) and the Hawke-Keating governments in Australia, it remains the dominant paradigm underpinning health policy in most developed countries (McGregor, 2001).

Neoliberalism as an historical movement represented a resurgence of the "free markets" principle first proposed by Adam Smith in the Eighteenth Century. Pellegrino (1999, p. 245) summarised Smith's central tenet very succinctly as "if … everyone pursues his or her own interests, the interests of all will be served". Smith argued in *The Wealth of Nations* (1776, 1976, p. 356) that in the operation of an economy:

> every individual … intends only his own gain, and he is in this … *led by an invisible hand* to promote an end which was no part of his intention. … By pursuing his own interest he frequently promotes that of the society more effectually than when he really intends to promote it. (emphasis added)

This "invisible hand" of self-interest, re-worked and re-stated by many other thinkers, including Friedrich Hayek and Milton Freidman, forms the basis for a set of beliefs about the ability of unfettered economic activity – buying and selling in markets that are as free as possible from "interference" by governments – to solve all the problems of humankind. McGregor (2001, p. 84) described the basic elements of Neoliberalism as:

> (a) the necessity of [a] free market (in which we work and consume); (b) individualism; and (c) the pursuit of narrow self-interest rather than mutual interest, with the assumption that these three tenets will lead to social good.

In relation to health, pursuit of the free market philosophy by Western governments in the last three decades has led to a range of policy outcomes. First among these has been a focus on individual responsibility in the prevention of ill-health. This view is exemplified by the "just say no" drug use prevention campaign in the US (Elliott, 1993) and the pronouncements of former Australian health minister Tony Abbott on issues as diverse as obesity (2006) and blood borne virus infection (2003). It posits that all that is needed to reduce the incidence of diseases linked to personal behaviours such as smoking, unprotected sex with multiple partners, overeating or inadequate exercise is for informed individuals simply to decide to change their behaviour. In this view, state institutions have no role beyond simply informing citizens of the causal associations between the behaviours and the health outcomes. What individuals do with such information is considered entirely a matter for them. Such a view has been stringently criticised, since it ignores what is known about the complex causation of health and health-related behaviours (Krieger, 2001), including the deliberate efforts of the manufacturers of unhealthy products to influence behaviour through marketing.

A second outcome of the Neoliberal agenda in relation to health is the trend towards privatisation and corporatisation of healthcare delivery. The compulsory transfer of funds from one individual to another by governmental action, such as through taxation of the healthy to fund care for the chronically ill, is seen in the

Neoliberal model to be transgressive of the free market principle and "a type of discrimination for those who do not get to benefit" (McGregor, 2001, p. 85). Thus, the Neoliberal approach emphasises the responsibility of individuals to make personal provision for the possibility of accident or illness through savings or private insurance.

Related to this is the notion that, because of the absence of a profit motive, the delivery of services by state institutions inherently "lacks efficiency, while private markets are more cost-effective and consumer friendly" (Horton, 2007, p. 2). As a result, governments motivated by the Neoliberal agenda will seek to move responsibility for the provision of healthcare services from public institutions to private companies.

Pellegrino (1999) has argued that these processes amount to a "commodification of health care"; that is, treating healthcare as if it were a commodity like iron ore or coffee beans, with the intention that "quality" will be assured "through the usual mechanisms of competition"(p. 243). However, as Pellegrino further demonstrated, healthcare does not, in fact, have the fundamental characteristics of a commodity. It is not "fungible"; that is, instances of it cannot be mutually substituted. Rather, each episode of healthcare is, or at least should be, a unique and particular human interaction between provider and patient or client that is inherently different from any other. Nor is healthcare "proprietary", meaning that it is the property of the vendor. As Pellegrino argued, the knowledge and skills of health providers do not wholly belong to them, since they are based on the collective historical wisdom of their professions and the heritage of health research, much of which has been supported by the resources of the community. In this view, professionals are seen as "stewards" rather than proprietary owners of the wherewithal to provide healthcare (p. 251).

Additionally, as Kaveny (1999) pointed out, commodities are distributed within a market "to each according to their willingness (and ability) to pay" (p. 211), but there are ethical imperatives for healthcare to be provided according to other principles such as "to each according to need" or "to each according to the degree that his or her receipt of the good is likely to improve the general health status of the population" (p. 216).

Callahan (1999, p. 229) suggested that market-based approaches to healthcare will fail to benefit humankind because of "a fundamental, intrinsic conflict between market values and traditional medical values". He argued that healthcare is "explicitly altruistic in its formal goals, aiming for health" and thus fundamentally at odds with the market, which is "explicitly oriented to the maximization of choice and efficiency, aiming at satisfying individual self-interest." In attempting to answer the question of why, in the light of this conflict, many policymakers persist in attempts to use commodity principles to organise healthcare, Callahan further noted that "it is a matter of indifference to many market proponents that health care does not lend itself well to a … market model". He concluded that "the reasons for this appear as much ideological as efficiency oriented" (p. 229).

On the other hand, while Timmermans and Almeling (2009, pp. 24-25) agreed that the imposition of market mechanisms in health had a range of negative outcomes, they pointed out that it is possible that the commodification of some aspects of healthcare could have beneficial consequences for patients and clients, such as "bringing new products to market" or "raising awareness of treatment options".

Either way, it appears likely that, along with the predominance of Neoliberal ideals more generally in the developed world, market-oriented approaches to healthcare provision will continue to dominate for the foreseeable future. Thus it will be important for the health professionals of the future to have the understanding and skills needed to optimise outcomes for their patients, clients and communities in the face of the challenges they provide, while simultaneously applying a critical perspective to the Neoliberal model and its consequences.

Empowerment of Patients and Clients – Health Consumerism

Although, as has been discussed, the characterisation of healthcare provision as a commercial transaction between vendor and customer can have a range of negative consequences, one idea borrowed from the commercial sphere, that of the empowered consumer, has considerable potential to benefit the health of individuals. As Herrmann (1970) documented, consumer movements probably began in the 1880s with community mobilisation that ultimately led to "pure food" legislation in the US and, as early as 1938, following the death of more than a hundred recipients of a new preparation of sulphanilamide, healthcare issues have been among their foci.

As Hibbard and Weeks (1987, p. 1020) observed, the role of the empowered consumer for a recipient of healthcare "is in stark contrast to the traditional patient role". Under this model, they argued, a patient or client is "questioning, willing to make independent judgments on whether to accept [healthcare provider] advice, and seeks out alternative sources of information", rather than being "compliant, trusting, and uncomplaining". This shift in role has occurred in parallel with the organisational changes in healthcare already discussed. Kizer argued in 2001 that the shift had been driven by a range of socio-historical factors, namely:

> the aging of the "baby boomers" and greater prevalence of chronic conditions, the explosion of biomedical scientific knowledge and technology, changes in the prevailing method of health care financing, a recent prolonged period of economic prosperity, widespread community concerns about patient safety, return of disproportionate health care cost increases, and the democratization of medical knowledge consequent to widespread use of the Internet. (p. 1213)

The organised consumer movement in relation to healthcare has also been actively supported by governments in several countries, such as New Labour's reforming of the National Health Service in Britain around the turn of the current century (Newman & Vidler, 2006) or the establishment of the Consumers Health Forum of

Australia by the Hawke-Keating government in 1987, and its subsequent funding from government revenue since that time (Consumers Health Forum of Australia, 2012).

There is little doubt that the empowerment of consumers has led to an improvement in the quality of relationships between health practitioners and their patients or clients (Ouschan, Sweeney, & Johnson, 2006) and there is some evidence of associated improvements in health outcomes (Segal, 1998). Social researchers such as Lupton (1997) have pointed to complexity in real provider-recipient relationships, however, where health service users "may pursue both the ideal-type 'consumerist' and the 'passive patient' subject position simultaneously and variously, depending on the context" (p. 373).

Breen (2001, p. 21) emphasised the importance of reforms to health professional education so that graduates in the traditionally more directive professions such as medicine, in particular, are "better equipped" for these changed healthcare relationships. He pointed out that all medical schools in Australia have adjusted their programs to "emphasize the development of communications skills and appropriate professional attitudes" with these issues in mind. Improving educational programs to optimise acquisition of these critical skills may be more challenging, however, in less well-resourced health professional programs, with larger learning group sizes.

Patient Safety

Another major recent development that bears on health professional education is the "patient safety" discourse, which arguably began with the publication of the report *To Err is Human: Building a Safer Health System* by the Institute of Medicine of the (US) National Academy of Sciences in 1999 (Kohn, Corrigan, & Donaldson, 2000). The report estimated that more people died as a result of healthcare error in the US each year, at the time of its writing, than from motor vehicle accidents, breast cancer or AIDS. The patient safety agenda has focused on analysis of the systemic causes for healthcare error, in recognition of the extreme complexity of contemporary healthcare delivery, and the failure of a legalistic, blame-oriented, approach to prevent adverse outcomes.

A particular area of attention with the patient safety movement has been the importance of effective collaboration between healthcare workers from different professions in the safe provision of care to patients and clients. Interprofessional practice was defined by Freeth and colleagues (2005) as "two or more professions working together as a team with a common purpose, commitment and mutual respect". Enquiries into healthcare misadventure in multiple developed world settings (Bristol Royal Infirmary Inquiry, 2001; Garling, 2008) have highlighted the importance of high-quality interprofessional practice in the assurance of patient safety. Recently, the World Health Organization (2010), supported by a series of international conferences under the moniker of *All Together Better Health*, has sought to advance the approach as a solution to problems with healthcare delivery in both developed and developing countries. As a consequence there has been considerable work on how best to equip health professional graduates to become

effective members of interprofessional teams (see Interprofessional Education below and Chapter 16).

Changes in the Media

The advent of television stations dedicated to the continuous provision of news, which began in the 1980s, as well as the increasing use of the Internet to access information, especially on portable devices, has fundamentally changed the rhythm of information gathering by individuals across the world (Croteau, Hoynes, & Milan, 2012). Whereas formerly, information about current events was assimilated on a daily basis through reading a newspaper, or later through an evening television news bulletin, now "cable news, websites, and other sources of news are constantly updated throughout the day" (p. 301). Individuals seek to access new information on a continuous basis, but with little opportunity for analysis or reflection.

Similarly, gaining an understanding of the cause of health symptoms formerly required either a trip to the local library or, more commonly, consultation with a trusted practitioner. Now, more adults (59%) reported having accessed health-related information on the Internet in the preceding year than having consulted a medical practitioner (55%) according to Elkin (2008). In another study, 51% of adult respondents reported using the Internet to access health-related information "typically weekly" and 11% reported that they had discontinued prescribed treatment on the basis of information obtained online (Weaver, Thompson, Weaver, & Hopkins, 2009, p. 1376).

The impact of the "24-hour news cycle" on the quality of public discourse and behaviour of political leaders has also been the subject of considerable concern (Tanner, 2011), not least in relation to health policy (CBS News, 2009; Sammut, 2012). As a result of these developments, it is clear that health practitioners now have to work with patients and clients who are more informed, but not necessarily better informed, than those of their predecessors. Health practitioners will need to help patients and clients to be critical of the information they access. This is yet another important reason for practitioners themselves to have well-developed critical skills.

Alternative and Complementary Therapies

Another important trend in the sociopolitical context of healthcare practice in recent times is the increasing interest, on the part of citizens in the developed world, in understandings of health and disease that are outside of the Western scientific paradigm (Kessler et al., 2001). In a recent population survey of Australians aged 50 or more, Morgan et al. (2012) found that 46% of respondents had used a non-conventional medicinal product in the 24-hour period that was the subject of the study. Among the respondents, 87% had also used a conventional medicine within the same period, supporting the contention that non-Western interventions are not only very widely used but are now commonly seen by patients

and clients as "complementary to" rather than "alternative to" conventional healthcare. Comparison to earlier studies suggests that engagement with complementary health traditions continues to increase (Thompson & Feder, 2005) and there is little doubt that it will be a major feature of future healthcare practice.

Increased Scrutiny of Healthcare Practice

The shift towards a consumerist stance for patients and clients, as well as the changes in media usage, both discussed above, have also had a major impact on the degree of scrutiny to which healthcare practice is now subject. Widely publicised examples of criminal behaviour on the part of healthcare workers have also had a profound negative effect on public trust in the caring professions. Examples include Harold Shipman, the British general practitioner who is thought to have murdered 250 patients (Baker & Hurwitz, 2009), Charles Cullen, the US nurse convicted of murdering 29 clients (Associated Press, 2006) and surgeon Jayant Patel in Australia, who was found guilty and gaoled for three counts of manslaughter and one of grievous bodily harm in relation to injudicious and incompetent surgery (Burton, 2010), but was, at the time of writing, awaiting re-trial following a High Court challenge.

These influences have changed forever an environment where the healthcare worker can expect to be trusted implicitly, and it is important that we prepare our students for a world where they will be subject to continuous scrutiny and need always to be prepared to defend their clinical decisions and actions.

CHANGES IN HEALTHCARE PRACTICE

The changing demographics and consequent changes in the healthcare needs of people in developed countries (Crisp, 2010) have demanded significant reassessment of the ways in which healthcare is delivered. Recent reviews of health systems in Australia (Health Workforce Australia, 2012) and internationally (World Health Organization, 2010) point to the need for new models of healthcare delivery. Many aspects of healthcare have been called into question, including service inequalities, sociocultural issues with regard to refugees, geographical and regional aspects, aged care, a perceived need for greater efficiency, integration of primary and tertiary care, integration of private and public healthcare initiatives, clarity of communication systems, the impact of information technology, skill mix and new roles of health assistants. It is also interesting to compare the approach to these issues in developed countries with the innovations being implemented in developing countries (World Health Organization, 2010). Given that healthcare in any country is expensive, it is high on any government agenda to ensure efficient and effective use of the resources while maintaining quality.

Research comparing healthcare expenditure with outcomes is an ongoing enterprise in developed countries. Davis, Schoen, and Stremikis (2010) compared health expenditure with measures of healthcare quality and accessibility in a number of countries for the same year. They found that the United Kingdom had

the second highest quality ranking overall (after the Netherlands), with perhaps some further need to focus on patient-centred care, despite much lower per capita health expenditure than the US or Canada, which were ranked 7th and 6th respectively.

Perhaps it is unsurprising, therefore, that a British White Paper on the National Health Service (NHS) published in the same year (Department of Health, 2010) emphasised the need to:

- put patients at the heart of everything the NHS does
- focus on continuously improving those things that really matter to patients – the outcome of their healthcare
- empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services.

This emphasis on quality can be traced through white papers in the UK over the eight years from 2004 to 2012. Initially it was couched in the language of "key performance indicators", but in 2008 there was a shift to include more of the views of the staff working in the NHS – a result, many believe, of the influence of the then Parliamentary Under Secretary of State for the Department of Health, Lord Darzi. He researched health service provision in London and published *Health Care for London: A Framework for Action* (2008). The document was based on five main principles:

- Services focused on individual needs and choices
- Localise where possible; centralise where necessary
- Truly integrated care and partnership working, maximising the contribution of the entire workforce
- Prevention is better than cure
- A focus on health inequalities and diversity.

Inevitably, as these changes are implemented, health professional educators will need to adjust their curricula and pedagogies accordingly.

CHANGES IN EDUCATIONAL PRACTICE

Operationalising Workforce Reform

Internationally, developed countries have been reviewing health and education policy to ensure that they have a workforce ready for changing healthcare needs and an aging population (Crisp, 2010). Health Workforce Australia (HWA) has recently undertaken a review of that country's health professional workforce requirements with the intention of "preparing for 2025" (HWA, 2012).

To address the healthcare practice changes alluded to in the previous section, HWA contends that higher education institutions and health professional educators may need to:

- adjust the skill mix of practitioners being developed in higher education. For example, are sufficient support workers being educated? Are new types of health professionals needed?
- ensure that health professionals can work to their full, or even an expanded scope of practice and have an appropriate balance of specialism and generalism
- ensure that graduates are able to examine the current roles of each health profession and respond creatively to any identified need for role adjustments
- enable health professional graduates to work collaboratively in new and changing service models
- ensure that graduates are ready to work with emerging technologies, including e-health and tele-health.

The process of workforce reform has also led to a renewed focus on accurate delineation of the capabilities required by health professionals in particular settings. There has been increasing pressure from government agencies to define these in very precise terms, according to the approach developed by the "competency movement" in vocational education (Reeve, Fox, & Hodges, 2009, p. 451). Considerable controversy has surrounded this development, in relation to both the definition of the word "competency", as applied to healthcare, and the risk that complex, higher-level cognitive and human elements of healthcare practice will be ignored or undervalued because they cannot be easily reduced to short competency statements (Australian Medical Council, 2010).

Learning-Centred Pedagogies

The last three decades have seen significant advances in learning theory, as well as recognition of the critical importance of lifelong learning for health practitioners, in the face of continually developing human knowledge. This has led to a major shift in the orientation of educational practice from a focus on the transmission of information by teachers to a concentration on student-regulated learning and acquisition of the capacity to continue to learn throughout professional careers.

This change of approach has been manifest through a range of educational innovations such as problem-based learning (see Chapter 11) and simulation (see Chapter 22), as well as learning approaches that blend face-to-face and computer-based strategies (see Chapter 21).

Interprofessional Education

The importance to patient safety of collaborative interprofessional practice has been emphasised above. Interprofessional education (IPE) is defined by the World Health Organization (2010, p. 13) as occurring:

> when students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes.

Participation in IPE is generally agreed to be critical to the development of the skills, understandings and attitudes needed for interprofessional practice. A global movement, supported by the World Health Organization (2010), aims to ensure the inclusion of IPE opportunities in all health professional training programs.

Australia has recently undertaken a national review of IPE efforts and is in the process of developing a national curriculum framework to guide the implementation of the approach by educational institutions. The framework will utilise a four-dimensional model for health professional curriculum development developed by Lee, Steketee, Rogers, and Moran (2013). The methodology recognises the real potential for organisational and logistic barriers to impede the implementation of IPE, and provides the impetus for overcoming these problems by reconnection with the high-level societal purpose for change. IPE is explored more fully in Chapter 16.

CHANGES IN HEALTH PROFESSIONAL STUDENTS

Many of the societal changes discussed earlier in this chapter have had an impact not only on patients, clients and the public, but also specifically on the young (and often not so young) people who are our students. The learners of today are different in a wide range of ways that are explored more fully in Chapter 13. One aspect that many higher education practitioners talk about, in our experience, is the difference in the place of work and study in the complex lives of contemporary students compared with their forebears. Billett (2010) encapsulated this well when he suggested that:

> more than being time poor many of today's higher education students are actually time jealous. That is, they jealously guard and manage their time, including that allocated to their … studies. The difference between being time poor (i.e., not having enough time) and being time jealous is quite distinct. The latter means that students are more likely to actively and critically evaluate demands upon their time made by their university studies, and then respond according to those activities they view as being worthy of the investment of their time.

Billett's (2010) suggestion that "managing time jealous students' learning may become a key challenge" for contemporary higher education practitioners is particularly relevant in health professional education, where concepts are difficult, repetitive practice of skills essential and the welfare of the community depends on the outcome.

We may have to encourage our students to adopt a critical stance to their own education. Through this approach they might come to appreciate that the demands of a course are, in fact, worth the investment of their time and effort, because of the potential impact on their future patients and clients.

PREPARING OUR GRADUATES FOR PRACTICE

So how might we approach preparing our graduates for practice and further training in the complex and fluid environment that we have outlined in this chapter? Our collective experience suggests that among the most important tools that we can provide is a capacity for deliberation and reflection. We emphasise again that it is also vital to ensure that learners adopt a critical posture, through which they can, at all times, question the assumptions and culturally received knowledge that they encounter in clinical environments.

We find that early, examined, clinical exposure can be very useful for this purpose. Being able to observe healthcare delivery cultures with the "innocent eyes" of a neophyte, especially when accompanied by facilitated critical reflection, allows students to see the dehumanisation that is evident in many clinical settings but which becomes hidden from senior students and practitioners who are deeply acculturated in existing practices. We see this process as rather akin to "immunising" our students to the effects of acculturation to which they will subsequently be exposed as they progress in clinical training, with the aim of maintaining a patient/client-centred orientation in the face of the rigours of professional life.

An illustration from popular culture that one of us has found useful and engaging for contemporary students is the "red-pill/blue-pill" scene from the Australian/US movie *The Matrix* (Wachowski & Wachowski, 1999). In the scene, Keanu Reeves' character, Neo, is invited by Laurence Fishburne's Morpheus to make a choice between taking the blue pill and returning to the unquestioning but safe monotony of ordinary life or taking the red pill, which will lead to finding out how things really are and where "nothing will ever be the same again". If we liken the adoption of a critical posture to "taking the red pill", our students can come to understand that only if they are continuously vigilant, question all assumptions and think deeply about their clinical lives will they be able to have the greatest positive effect on the welfare of their patients and clients. It is also likely to result in a much more rewarding professional life.

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