

"The principal factors responsible for increasing life expectancy from less than 50 years to more than 70 years in wealthy countries are to be found outside the health care system as it is traditionally defined and, instead, in the broader socioeconomic environment."

Hertzman C. Health and human society. American Scientist 2001;89(6):538

POSITION STATEMENT

Canadian Physiotherapy Association position statements address political, ethical and social issues that impact patient welfare, the role and practice of physiotherapy, the Association and its members.

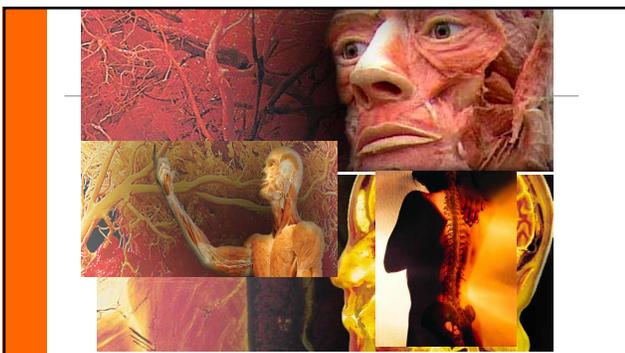
POPULATION HEALTH

STATEMENT

The Canadian Physiotherapy Association (CPA) endorses a population health approach to address the present and future health needs of Canadians. Physiotherapists, as essential primary health providers, must consider population health needs and incorporate population health approaches into program planning and treatment interventions in order to have the greatest impact on clients' and communities' health status and health outcomes.

Physiotherapists understand the effect of the determinants of health on health outcomes, as well as how they can positively affect the determinants of health in their daily professional practice. Using a client-centered approach, physiotherapists are sensitive to their clients, and adapt their assessment and treatment approaches to include the range of life experiences each client brings to the therapeutic relationship, including employment, family environment, education, and physical and mental health.

A population health approach shifts the emphasis from solely treating disease/disability/injury to include promoting health and considering all the factors which influence the health of both individuals and communities. The CPA believes that by integrating a population health approach in planning for and developing physiotherapy services, physiotherapists will make an additional important contribution to improve the health outcomes of Canadians.



Competence and Conscience

"In many fields, skills have become ends. Scholars are busy sorting, counting, and decoding. We are turning out technicians...."

But the crisis of our time relates not to technical competence, but to a loss of social and historical perspective, to the disastrous divorce of competence from conscience....

Once professionals begin to practice, they stop thinking beyond the technical aspects of their work....

Professionals must be able to make judgments that are not only technically correct but also ethically and socially considerate."

College: The Undergraduate Experience (1987)

Ernest Boyer
1928-1995

Accreditation Bodies Calling For Greater Attention to Social Accountability -

"healthcare disparities and the development of solutions to related burdens,

the importance of meeting the healthcare needs of medically underserved populations ... and

core professional attributes, such as altruism and social accountability..."

"Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being."

"For God sake, Jim, I'm a Doctor!!



"This is important but we really need to develop proficiency in clinical and surgical skills...the other 'stuff' we can figure out later, once we get going in our careers."

Woo JKH, Ghorayeb SH, Lee CK, Sangha H, Richter S. **Effect of patient socioeconomic status on perceptions of first- and second-year medical students.** CMAJ 2004;170(13):1915-19.

Medical students from high SES backgrounds are less inclined to want a patient from low SES background in their practice than high SES patients.

Physicians with low SES backgrounds (low parental income and education) showed significantly higher levels of service to poor patients than physicians with high SES backgrounds, even after adjustment for physician race, ethnic background and sex.

Health Professionals' Attitudes Towards Homelessness

26. I believe that those who enter medicine or other health disciplines want to help those in need.

Strongly disagree	3.1%
Disagree	16.4%
Neither agree nor disagree	18.8%
Agree	37.5%
Strongly agree	24.2%

Total Respondents 101 (Year 1 MD Students)

Health Professionals' Attitudes Towards Homelessness

33. I believe that health professionals are too pressed for time to investigate psychosocial issues routinely.

Strongly agree	10.2%	13
Agree	46.5%	59
Neither agree nor disagree	22%	28
Disagree	16.5%	21
Strongly disagree	4.7%	7



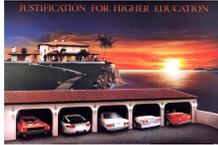
"You'll have students tell you that what you're trying to teach me is a waste of time.

" The curriculum is so focused on... getting students through the process... the currency to graduate... is not social responsibility but [passing] tests and [getting] clinical credits."

Dharamsi S, Pratt DD, MacEntee MI. How dentists account for social responsibility: economic imperatives and professional obligations. J Dent Educ 2007;71(12):1583-1592.

**Becoming a Doctor: A longitudinal study
Sherlock and Morris (1972)**

“students are highly motivated to achieve economic and professional status....they adopt a rhetoric of altruism in order not to disclose these motives.”



Crandall SJ, Volk RJ, Loemker V. Medical students' attitudes toward providing care for the underserved. Are we training socially responsible physicians? JAMA. 1993;269(19):2519-23.

The MS-IVs are less favorably inclined toward caring for the medically indigent than MS-Is

Crandall SJ, Reboussin BA, Michielutte R, Anthony JE, Naughton MJ. Medical students' attitudes toward underserved patients: a longitudinal comparison of problem-based and traditional medical curricula. Adv Health Sci Educ Theory Pract. 2007 Feb;12(1):71-86.

Longitudinal findings revealed that commitment to caring for the medically underserved was greater when students entered medical school than when they graduated.

Transformative Education



“...curricula that is immunized from the human condition and devoid of story, attachment and meaning.”

Phelan 2004
Rationalism, complexity science and curriculum: a cautionary tale



Nurturing social responsibility through community service-learning. Dharamsi et al. Med Teach 2010.

“I wanted to tell you how excited I am to see [that] school is not all about long hours of studying and feeling disconnected from society...thank-you for firing this interest in us...”

“...When you are lectured on things like socio-economic status, it doesn't quite sink in, you really need that personal experience to kind of realize [and] to see those communities and be out there... It is just different than being told in a classroom.”

The REVOLUTIONS framework Mnemonic	
Individual Focus Local focus, research, grant, prior service	R = RECRUITMENT Identify and cultivate potential students with a strong ability to practice medicine as a socially accountable physician focused on socially identified needs?
Clinical Determinants Individual pathogenesis	E = ENVIRONMENT Inherent issues of culture, context of care, history, and geographic place— all social determinants of health? (social, individual?)
Technical Biomedical, evidence-based, patient centered	V = VOCATIONAL DEVELOPMENT Cultivate a sense of social contract through identity development recognizing how medical practice can and does contribute to finding priority health concerns?
Patient-Centered Medical expert to individual patients	O = ORGANIZING SYSTEMS Promote a commitment to medical practice that serves societal needs, focused on marginalized populations and best addressed by interdisciplinary systems founded on a respect of primary care?
Prescription Biomedical treatment	L = LEADERSHIP Develop connection by expanding competencies from traditional physician-patient communication to community-based advocacy?
Knowledge Evidence-based practice	U = UNDERSTANDING Foster practice of wisdom, broad based, context-based reasoning, predominantly over the learning of top-down-based knowledge?
Traditional Conventional, career-oriented	T = TRAINING OF FACULTY Refocus faculty members toward participatory methods of education, research, and mentoring?
Bioethical Bioethics research	I = INVESTIGATION Foster inquiry using community- and population-based methods?
Disease Model Biological-based, reductionist	O = ORIENTATION Support active and ongoing processes for identifying priority needs and developing action-oriented responses. (and a systems model of disease evaluation?)
Medical Competency Quality patient care	N = NURTURANCE Nurture physicians in socially accountable practices through suitable continuing education, mentorship, training, and support networks?
Individual Obligation Accountable to single patient needs	S = SOCIAL RESPONSIVENESS Enable teachers and learners proactively to address community needs, integrating social health with all levels of disease treatment?
	Global Focus Social justice, pipeline programs
	Social Determinants Priority care, gender, and environment?
	Professional Practice-oriented, Primary care and public health settings
	Community-Centered Resource to a defined practice population
	Advocacy Advocacy empowerment
	Wisdom Practice-based medicine
	Collaborative Interdisciplinary, community and basic research
	Participatory COPR, CARE, and GPCR
	Systems Model Complexity-oriented, open, self-organizing
	Health Citizenship Citizenship empowerment
	Social Need Accountable to public priorities

COPR indicates community-oriented primary care, CARE, community-based participatory research, OADR, qualitative action-oriented research.

Organizational Structure

“Every system is perfectly designed to get the results it gets. If we keep doing what we have been doing, we'll keep getting what we've always gotten.”

Paul Batalden - on the healthcare system and quality improvement.

“The definition of lunacy is to keep doing what you've always done and expect a different result.”

Albert Einstein

**Seek to transform yourself, your students and
the lives they will touch.....**



"A troubled world can no longer
afford the luxury of pursuits
confined to an ivory tower;

[Our work] has to prove its worth
by service to the nation and the
world."

Oscar Handlin