CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

AN ECOLOGICAL ANALYSIS OF ROLE SYMBIOSIS
IN A MEDICAL PRACTICE SETTING

A Thesis submitted in partial satisfaction
of the requirements for the degree of

Master of Public Health

by

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DEDICATION

This thesis is dedicated to my parents for their love, encouragement, and lifelong support. Further, it is dedicated to my Grandparents for the heritage they have instilled in me.
ACKNOWLEDGEMENTS

This thesis is an outgrowth of many significant individuals in my personal, professional, and educational experiences. I am indebted to all of them and wish to reaffirm my gratitude to all these individuals.

To a number of very special individuals at Northridge Hospital for providing the opportunity and stimulation from which this concept has evolved. I would like to express my sincerest gratitude and appreciation to Dr. Lennin Glass who has served as my committee chairman and graduate advisor. His professional advice, guidance, and contribution during my entire graduate education have been invaluable.

A very special acknowledgement and appreciation should go to Dr. G. B. Krishnamurty for it has been his sincere interest in me that has guided and inspired the fruition and culmination of this thesis. His expertise in research methodology has provided the critical analysis which was so essential in the articulation of this abstract concept.

To Linda Choate, who has been an inspiration and continually provided support and encouragement during the entire process of this study.
I wish to dedicate this thesis to my Parents and Grandparents. Without their heritage, love, and support this paper would have not been possible.

Alan Y. Hayashi
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPROVAL</td>
<td>ii</td>
</tr>
<tr>
<td>DEDICATION</td>
<td>iii</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>iv</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>ix</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>x</td>
</tr>
<tr>
<td><strong>Chapter</strong></td>
<td></td>
</tr>
<tr>
<td>1 INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>STATEMENT OF THE PROBLEM</td>
<td>3</td>
</tr>
<tr>
<td>ASSUMPTIONS</td>
<td>4</td>
</tr>
<tr>
<td>IMPORTANCE OF THE STUDY</td>
<td>5</td>
</tr>
<tr>
<td>THE LIMITATIONS OF THE STUDY</td>
<td>5</td>
</tr>
<tr>
<td>THE DEFINITION OF TERMS</td>
<td>5</td>
</tr>
<tr>
<td>2 REVIEW OF THE LITERATURE</td>
<td>10</td>
</tr>
<tr>
<td>EVOLUTION OF PUBLIC HEALTH</td>
<td>10</td>
</tr>
<tr>
<td>CURRENT STATUS OF HEALTH EDUCATION</td>
<td>15</td>
</tr>
<tr>
<td>HOSPITAL SETTING AND HEALTH EDUCATION</td>
<td>20</td>
</tr>
<tr>
<td>SOCIOLOGICAL CHANGE THEORY</td>
<td>25</td>
</tr>
<tr>
<td>CONCEPTS OF ECOSYSTEM SUCESSION</td>
<td>31</td>
</tr>
<tr>
<td>SUMMARY</td>
<td>36</td>
</tr>
<tr>
<td>3 NORTHRIDGE HOSPITAL: THE EVOLUTION AND DYNAMICS OF THE PRIMARY COMMUNITY</td>
<td>38</td>
</tr>
<tr>
<td>Chapter</td>
<td>Page</td>
</tr>
<tr>
<td>---------</td>
<td>------</td>
</tr>
<tr>
<td>4 NORTHRIDGE HOSPITAL: THE INTRODUCTION OF THE HEALTH EDUCATOR'S ROLE AND SUBSEQUENT EVOLUTION OF THE SYMBIOTIC RELATIONSHIP</td>
<td>49</td>
</tr>
<tr>
<td>INTRODUCTION OF THE HEALTH EDUCATOR'S ROLE IN THE ECOSYSTEM</td>
<td>49</td>
</tr>
<tr>
<td>PROPOSED APPROACH SEQUENCE AND PROFILE</td>
<td>50</td>
</tr>
<tr>
<td>FUNCTIONS OF THE DEPARTMENT OF EDUCATION</td>
<td>50</td>
</tr>
<tr>
<td>ANALYSIS OF ECOSYSTEM</td>
<td>52</td>
</tr>
<tr>
<td>CONCRETE COMMUNITY</td>
<td>52</td>
</tr>
<tr>
<td>DIVERSITY INDICES</td>
<td>52</td>
</tr>
<tr>
<td>ECOLOGICAL ROLE DOMINANTS</td>
<td>53</td>
</tr>
<tr>
<td>ECOLOGICAL AMPLITUDE OF THE HEALTH EDUCATOR</td>
<td>54</td>
</tr>
<tr>
<td>ECOLOGICAL NICHE</td>
<td>55</td>
</tr>
<tr>
<td>EVOLUTION OF THE SYMBIOTIC RELATIONSHIP</td>
<td>56</td>
</tr>
<tr>
<td>PHASE 1: COMMENSALISM RELATIONSHIP</td>
<td>58</td>
</tr>
<tr>
<td>PHASE 2: COOPERATION RELATIONSHIP</td>
<td>59</td>
</tr>
<tr>
<td>NATURAL CHILDBIRTH EDUCATION CLASSES</td>
<td>59</td>
</tr>
<tr>
<td>PROGRAM FOR PROBLEM DRINKERS</td>
<td>61</td>
</tr>
<tr>
<td>PHASE 3: MUTUALISM RELATIONSHIP</td>
<td>64</td>
</tr>
<tr>
<td>5 SUMMARY AND CONCLUSIONS</td>
<td>68</td>
</tr>
<tr>
<td>CONCLUSIONS</td>
<td>75</td>
</tr>
<tr>
<td>Chapter</td>
<td>Page</td>
</tr>
<tr>
<td>---------</td>
<td>------</td>
</tr>
<tr>
<td>6 APPLICABILITY OF THE MODEL AND RECOMMENDATIONS</td>
<td>78</td>
</tr>
<tr>
<td>BIBLIOGRAPHY</td>
<td>80</td>
</tr>
<tr>
<td>APPENDIX A</td>
<td>86</td>
</tr>
</tbody>
</table>
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>PRIMARY COMMUNITY OF NORTHRIDGE HOSPITAL (1955-1975)</td>
<td>71</td>
</tr>
<tr>
<td>2.</td>
<td>SECONDARY COMMUNITY OF NORTHRIDGE HOSPITAL (1975 to present)</td>
<td>72</td>
</tr>
<tr>
<td>3.</td>
<td>POSSIBLE CLIMAX COMMUNITY OF NORTHRIDGE HOSPITAL</td>
<td>73</td>
</tr>
<tr>
<td>4.</td>
<td>EVOLUTIONARY DEVELOPMENT OF EDUCATIONAL FUNCTIONS (1955 to present)</td>
<td>74</td>
</tr>
</tbody>
</table>
ABSTRACT

AN ECOLOGICAL ANALYSIS OF ROLE SYMBIOSIS
IN A MEDICAL PRACTICE SETTING

by

Alan Y. Hayashi
Master of Public Health

The purpose of this study was to identify, analyze, and articulate the factors and processes involved in the ecological evolution of a health educator's role in the setting of Northridge Hospital.

Four subproblems were stated: (1) The first subproblem was to articulate a model for an ecological description and analysis of the evolution of a health educator's role in the setting of Northridge Hospital. (2) The second subproblem was to document the ecological factors and processes involved. (3) The third subproblem was to analyze and interpret the ecological factors and processes involved. (4) The fourth subproblem was to provide recommendation and implication for the future
evolution of the health educator's role symbiosis in a medical practice setting.

The review of the literature provided the basis for the construction and articulation of the model. The search extended into four areas: (1) The history and evolution of public health. (2) The current status of health education in the medical practice setting. (3) Social and institutional change process. (4) Ecological theories and concepts regarding ecosystem analysis and evolution.

The evolution and dynamics of the Primary Community of Northridge Hospital was documented. In order of sequence, they were: (1) The external environmental factors which affected the ecosystem. (2) The concomitant growth pattern of services and departments at Northridge Hospital. (3) The generation of educational ideologies and services culminating in the change of function in the Department of Education.

Finally, the introduction of the health educator's role and subsequent evolution of the symbiotic relationship were analyzed. The areas analyzed included: (1) The introduction of the health educator's role. (2) The author's proposed approach sequence and profile in the Secondary Community. (3) The functions of the Department of Education at Northridge Hospital. (4) Ecological
concepts related to the evolution of role symbiosis. (5) The organizing activities in the evolution of the health educator's role symbiosis in the Secondary Community of Northridge Hospital.

As a result of this study, the author provided the applicability of the model and further recommendations for research.
CHAPTER I

INTRODUCTION

Early in the history of mankind there was a preoccupation with public health practices. This has been documented in a variety of art and literature forms. The first sanitary codes were established by the Hebrews, and Moses, the codifier, who has been called the first teacher of preventive medicine. Time and understanding have not dimmed the validity of Mosaic laws (8). Along with this biblical reference other types of documentation seem to indicate that public health practices have occurred for many eons.

Recently the discipline of public health education has appeared to be in a state of metamorphosis with new areas of concern and involvement emerging in the health care delivery system. These geometric growth patterns have pushed the health educator either into or to the verge of specialization. Thus, persons in the field find themselves in a state of anxiety. The practitioners are faced with a multiplicity of frontiers and the resolution of conceptual and methodological approaches seem nebulous, at best. The health educator's role in a medical practice setting is an area of most recent emergence.
Cecilia Doak has pointed out in her essay, "The Health Educator: Building Credibility in the Medical Practice Setting," that it seems highly desirable to explore the variety of ways in which the health educator as a change agent can build credibility in a setting less familiar than the traditional public health agency . . . the medical practice setting (14:1). She goes on to point out that the proliferation of occupations in the field, now counted in hundreds instead of dozens, has increased the focus on "team development." As a result, the health educator has an opportunity to develop and mold realistic expectations of what can be accomplished through a multidiscipline or interprofessional approach (14:9).

Read (1973) has suggested that rapid changes in modern life have thrust to the forefront issues that were hardly, if ever, considered in the past. On the heels of these changes has come a proliferation of new ideas and theories to meet the challenge for education (46).

Science is growing in many directions, including a growing together. Consequently, a need to examine the knowledge of various disciplines has emerged in order to develop concepts that encourage and assist interdisciplinary cooperation (40:viii).

The existence of different philosophies, approaches and procedures within any field of endeavor
is often regarded as a sign of energy and creative purpose. Thoughtful expression of disagreement, proposal, embodying alternatives and exploration of new approaches all contribute to the type of environment necessary for a profession's continued growth. "Such differences, however are most constructive when they are focused on means of operating, rather than on the ends toward which one is striving" (46:95).

Daniel Bell states in, "The Year 2000-The Trajectory of an Idea":

Time, said St. Augustine, is a three-fold present: the present as we experience it, the past as a present memory, and the future as a present expectation. By these criterion, the world of the year 2000 has already arrived for in the decisions we make now, in the way we design our environment and thus sketch the lines of constraint, the future is committed (46:252).

STATEMENT OF THE PROBLEM

As indicated, the role of the health educator is changing. New opportunities have arisen in the area of medical care. In order to better understand the role of a health educator in such a setting, this paper proposes to identify, analyze, and articulate, in a retrospective manner, the factors and processes involved in the ecological evolution of a health educator's role in the setting of Northridge Hospital Foundation.
The Subproblems

1. The first subproblem. The first subproblem is to articulate a model for an ecological description and analysis of the evolution of a health educator's role in the setting at Northridge Hospital.

2. The second subproblem. The second subproblem is to document the ecological factors and processes involved.

3. The third subproblem. The third subproblem is to analyze and interpret the ecological factors and processes involved.

4. The fourth subproblem. The fourth subproblem is to provide recommendations and implications for future planning and analysis relative to health educators in the medical practice setting.

Assumptions

1. The first assumption. The discipline of health education and the health-care delivery system is in a state of evolution.

2. The second assumption. The need for health educators in various health care delivery systems will continue.

3. The third assumption. The health educator will evolve as an integral part of the health-care delivery system and will necessitate the utilization of a model
for institutional intervention points in the evolution of such a role.]

[4. The fourth assumption. The articulation of a role-evolution model will be utilized in the medical practice setting by health educators.]

IMPORTANCE OF THE STUDY

There is a need for a timely conceptualization and articulation of the evolution of health educator's role in the medical practice setting. There seems to be no suitable model in the literature examining the factors and processes involved in such a role evolution. The model should provide criteria and methods for future implementation, alteration, or further refinement in a variety of settings.

THE LIMITATIONS OF THE STUDY

The study was limited to the concept, factors, processes, and analysis of the evolution of a health educator's role in the setting of Northridge Hospital Foundation. The time period in which the evolution occurred was April of 1975 to January of 1976.

THE DEFINITION OF TERMS

The definitions which follow are stated in the context of the proposed study. The ecological concepts
are redefined in a social-institutional sense. However, they have been derived from Clifford B. Knight, Basic Concepts of Ecology (1967), Eugene P. Odum, Ecology (1963), and Richard A. Pimentel, Natural History (1963).

Abiotic. Abiotic simply refers to without life. Abstract Community. An abstract community is a mental image of a particular type of community or assemblage that does not exist except in one's mind.

Adaptation. Adaptation is an adjustment to new or different circumstances.

Biotic Factors. Biotic factors refer simply to life.

Climax Community. A climax community is the last aggregation in a successional series. Also refers to the community of Northridge Hospital Foundation as it exists at the end of the study.

Commensalism. Commensalism is a relationship between different roles of individuals in which one role or individual definitely benefits from the association, but the other individual or role is not benefited or adversely affected under normal conditions.

Community. Community refers to two or more individuals existing together or in close proximity to one another.
Concrete Community. Concrete community is a specific area or roles one can observe directly.

Continuum Concept. The Continuum Concept implies that there are no distinct communities with well-defined boundaries, but rather there is a gradual change in space and time along a gradient of some sort.

Ecological Dominant. An ecological dominant is the most common role in a particular community.

Ecological Niche. An ecological niche refers to the functional role an individual plays within a community or ecosystem.

Ecological Succession. Ecological succession refers to an orderly sequence of community changes: these are directional therefore predictable.

Ecology. Ecology is a field of study concerned with the relationship between the environment and living organisms.

Ecosystem. Ecosystem refers to the systematic, orderly combination or arrangement of living organisms mutually interacting with a shared environment (36).

Grounded Theory. Grounded Theory developed by Glasser and Strauss in 1967, proposes generating a theory from data means that most hypotheses and concepts not only come from the data, but are systematically worked out in relation to the data during the course of the
research. Generating a theory involves a process of research.

Homeostasis. Homeostasis is synonymous to ecological regulation and/or may be defined as checks and balances that dampen oscillations all along a line of succession.

Interspecific Competition. Interspecific competition occurs when two or more closely related roles adapted to the same or similar niche, inhabit the same community.

Mutualism. Mutualism is a relationship between two roles or individuals in which each benefits from the other.

Obligatory Mutualism. Obligatory mutualism is a relationship of two or more roles or individuals in which they must remain together in order to survive.

Periodicity. Periodicity are regular and recurrent changes of any distinct community. These changes may be of two distinct types (1) abiotic fluctuations and (2) biotic variability.

Pioneer Community. A pioneer community is the first group of roles and/or individuals to become established in a community.

Secondary Community. A secondary community refers to all aggregations that follow a pioneer community.
**Synecology.** Synecology is primarily a community-type approach, in which all life, including individuals and roles as well as pertinent abiotic elements, are studied.
CHAPTER II

REVIEW OF THE LITERATURE

The review of the literature provided the basis for the construction and articulation of the model for the synecological analysis of role evolution in a community hospital setting. The search extended into four major areas: (1) The history and evolution of public health. (2) The current status of health education in the community hospital setting. (3) Sociological literature relevant to social and institutional change process. (4) Ecological theories and concepts regarding ecosystem analysis, and evolution.

EVOLUTION OF PUBLIC HEALTH

Many public health practices have been ascribed to past civilizations. Evidence, and a variety of documentary sources have inferred that the concern for public health practices were evident throughout the history of mankind. References from biblical doctrines through the Hippocratic challenge reveal the desirability of a total ecological approach.

The physician was taught to evaluate the patient in the total context in order to arrive at a correct diagnosis with proper therapy (8:46).
Other references to public health practice have been attributed to civilizations such as Greek and Roman concerns. However, these practices appeared to be episodic in nature and fluctuated in direct proportion to the emergence of a variety of communicable diseases.

Blakey (1974) has indicated that in the 1800's there was a growing concern in both Europe and the United States over the need for public health (8:47). Relative to these concerns in America, Smolensky (1969) has pointed out that the growth of public health is closely linked to the disease patterns of different historical periods and the success with which medical science was able to cope with these threats (57). Illustrative of this point he has stated that the concerns for public health are characterized by the following:

Although tuberculosis and typhoid fever claimed many lives, small pox instilled fear and terror in the public mind because of its loathsome appearance and disfiguring consequences. Its extreme communicability, and its high fatality rate. Mass vaccination were not conducted until the 1920's because many individuals were slow to accept the preventive measure. With the application of measures for community population, sanitation and health education and with an increasing proportion of the population protected by immunization against typhoid fever, diphtheria, and smallpox, the number of cases and deaths from these communicable diseases gradually decreased (57:27).

(In 1850 the Shattuck report to the Sanitary Commission of Massachusetts provided a basis for sound
public health practices. Heavily influenced by European experience the report listed some 50 recommendations. The following is a list of those recommendations which have, for the most part, been realized: (8:47)

1. Establishment of state health departments.
2. Provision for local boards of health.
3. Conduct of sanitary surveys of particular communities, chosen for cause.
4. Vital statistics registration: including:
   a. Decennial census.
   c. Registration of data by age, race, sex, occupation, economic status and locale.
5. Environmental sanitation.
6. Food and drug control.
7. Communicable disease control, with stress on vaccination.
8. Well-child clinics.
9. School health programs.
10. Mental health program.
11. Smoke control.
12. Alcoholism program.
13. Town planning
14. Teaching of preventive medicine.

During this era, U.S. history repeatedly reveals the many facets in the consciousness raising of the public. The issue is characterized by the introductory address given by the first President of the American Public Health Association, Stephan Smith in 1873. The address "On the Limitations and Modifying Conditions of Human Longevity, the Basis of Sanitary Work" began:

We inaugurate today the American Public Health Association, the objects of which are "The advancement of sanitary science, and the promotion of organizations and measures for the practical application of public hygiene . . . the science which we cultivate, and which this
Association is organized to promote, discarding the traditions of the past and the teachings of false philosophies, interprets the laws that have been set for the guidance and control of man's earthly existence by the exact demonstrations of true physiology. This science of life reveals to us the stupendous fact that man is born to health and longevity, that disease is abnormal, and death, except from old age, is accidental, and that both are preventable by human agencies (60:161).

Legislation was accepted slowly and dealt primarily with sanitation and communicable disease control (57:26). In the latter part of the 1800's changes in concepts, priorities, and issues were evident. By 1921, the American Association of Public Health was addressing such issues as maternal and child health, the midwifery problem, prevention of rickets, undernourished school children, the hygiene of cardiac children, and school health supervision (60:162). The creation of state boards of health brought about a great improvement in public health. Services were rapidly expanded (57:28). The establishment of public health laboratory services, statistical services, environmental sanitation services, immunizations, antibiotics, public health nursing services, and health education contributed to health improvement (57:33).

Commenting on the expansion of the scope of public health, Terris (1975) pointed out some of the
concerns of the 1947 (75th) Annual Meeting of the American Public Health Association:

Fluoridation and other aspects of dental health, nutrition, health education, and industrial hygiene problems were discussed. Curiously, there were no reports at all on chronic disease epidemiology, while medical care was represented by a single paper by Surgeon-General Thomas Parran on "New Problems in the Field of Medical Care," and a single session on hospital relations (60:163).

Compare this to the bewildering array of subjects presented at the Centennial Meeting of the American Public Health Association in 1972:

The epidemiological sessions were concerned, in the infectious disease area, with rubella, diphtheria, measles, hepatitis, venereal disease, tuberculosis, diarrheal disease, acute lower respiratory disease in children, nosocomial infections, foodborne diseases, and serological epidemiology. Other subjects included cancer of the cervix, cancer of the mouth and pharynx, occupational lung cancer, childhood leukemia, coronary heart disease, diabetes mellitus, hypertension, stroke byssinoisis, asthma, psoriasis, radiation, air pollution, obesity, nutrition surveys, drug abuse, pregnancy outcomes, prematurity, and fetal infant, and maternal mortality (60:163).

Terris (1975) went on to point out the concomitant changes in health personnel. In 1897, 80 per cent of the 568 members were physicians. By 1968, 29 per cent of the members were physicians; nine per cent held PhD and Doctors of Science degrees; Registered Nurses comprised six per cent; dentists three per cent; and Doctors of Veterinary Medicine, two per cent. It is
worth noting that 26 per cent of the members held a public health degree, and of these, 83 per cent of these held the Master of Public Health (60:165).

CURRENT STATUS OF HEALTH EDUCATION

The great increase of nonphysicians among public health personnel appears to be a general phenomena in the health field. Commenting on this phenomena Blakey (1974) pointed out that "We, as public health professionals, may know our mission but we need to broaden our concept for application of our basic function" (8:51). He further implied that the public health professionals must develop a sense of mission and of means. "They must form concepts of goals and standards for achieving them, in short, get busy to help create the climate in which they must function" (8:51). Health educators fall within this realm and Dallas (1972) asserts that:

Health educators and the health education profession may well be at a crossroads. We can either bury our heads in our program guides and choose not to be excited by current concern for quality of life, hoping it will go away so we can get back to the real world of educating, or we can examine our profession and our practice in light of these people vibrations (13: 918).

Means (1971) has suggested that a need may represent a lack or a deficiency too, and it frequently reflects a problem. In health education there are a
number of such perplexing and challenging situations that demand inquiry and solution:

(1) A greater recognition of the value of health education.
(2) Improved interrelationship with other fields, especially the health related sciences.
(3) Developing administrative support for health education and related program activities.
(4) More and higher quality evaluative instruments for use in appraising health programs and behavior (46:261).

Means further pointed out what seemed to be trends in health education. It should be noted that a trend is not necessarily a common practice. Some trends may not be reflected in actual practice, while being accepted in theory. Most trends, however, are habits of action as well as thought, and usually are expressed in events. Accordingly, the following have been listed as trends in health education:

(1) The acceptance of health education as a discipline and a field in its own right.
(2) The development of new and improved research studies and projects to advance the field.
(3) The recognition of health as a multi-disciplinary entity, with physical, mental, social and economic implications.
(4) The employment of specialists in health education, including teachers and coordinators (46:259).

Throughout the essays of Rene Dubos one can identify several recurrent themes. One of course is the dynamic nature of man and his environment. Dubos has
implied that static solutions will not work in a dynamic environment that continues to present new and different threats to one's health status (46:107). It is evident that Dubos is one of the most articulate at reminding us that today's world can not solve its problems with yesterday's programs:

The greatest improvements in health during the past century have resulted from the continuous rise in our standards of living. But we may now be coming to the phase of diminishing returns. Our prosperity creates a new set of medical problems. Environmental pollution, excessive food intake, emotional deprivation, lack of physical exercise, the constant bombardment of unnatural stimuli, man's estrangement from natural biological rhythms--these are just some of the many consequences of urbanized and industrialized life that have direct or indirect pathological effects (13:914).

It is obvious that the growing concern for the quality of life has had a marked effect on health education. Quality of life appears destined to become one of the most talked about yet least understood topics of the seventies (13:910). Dallas (1972) has suggested that:

There is no "one" definition for the quality of life. There are, in fact, many qualities of life. What should be paramount to health education is not the isolation of "a" quality of life, but a determination of life in terms of the people being served, the client population (13:913).

He further pointed out that the quality of life is characterized by various components:

(1) Quality of life implies choice-knowledge of all the available options, freedom to
choose any option, and an understanding of the effects once a choice has been made.

(2) Quality of life implies increased individual responsibility.

(3) Quality of life implies the development of new skills and roles for health educators as well as the full use of existing strategies (13:914).

While there is little doubt that health education has an effect on the quality of life, it is less clear what effect a concern for quality of life will have on health education. That it is already having an effect is indisputable. At least four trends are now apparent:

(1) A continuing shift in public interest from a focus on the prevention of premature death, excessive morbidity, and disabling injury to an ascending concern for the total quality of human existence, for the maximum development of human potential, and for the development of environments in which such human capacities may flourish.

(2) An increasing public demand, not simply for the delivery of such environments and life-saving circumstances, but for participation in the framing of the end state and instrumental decisions necessary to their delivery.

(3) A shift in institutional behavior from a commitment to "process" to a focus on "purpose."

(4) A trend toward the practice of public health in a variety of institutional settings, rather than in agencies that carry "public health" in their official titles (13:912).

Health education's effects on the quality of life can be broadened through political and social interventions as well as through the educational process, through interaction with consumers of all background and through
a deeper understanding and sensitivity to the
determinants of the quality of life (13:912). The role
of the health educator is not to dictate the way life is
to be lived. The way of life is clearly the perrogative
of the individual. The educational process can, however,
be used to inform people of how their choice of life
style affects them, their families, and others around
them (13:914). Furthermore, it can develop more choices
for those who have limited options and allow persons to
make their own choices and assist them with meeting the
consequences (13:915).

Perhaps for the first time health educators as
a group realize the full impact of this concept on their
own efforts. Appropos to the current concerns and state-
of-affair of public health, Dallas (1972) suggests:

Health maintenance, comprehensive health care,
prevention, and the other emerging priorities
of this era will not be achieved solely through
administrative mandate or governmental fiat.
The individual person needs to be educated not
only about health problems but also about what
he should reasonably expect from the health sys-
tem. If peoples' expectation continue to rise,
they will leap even farther ahead of the system's
ability to respond. It is becoming increasingly
clear that mass infusions of new health manpower
and mass building programs will not improve
health unless they are coupled with health edu-
cation at a personal level. The individual per-
son needs to be educated to accept the responsi-
bility that goes along with increased freedom
to make decisions concerning his health and the
health of his family (13:915).
Currently the health care system finds itself in a socio-economic dilemma. The taxpayers of this country spend approximately $126 billion in federal funds for human services, but both those who pay for these services and the intended recipients are not receiving $126 billion worth of good out of them (10:891). The system is wasting human resources at a colossal rate and with few exceptions it is not working. Greenberg (1974) has declared that:

No problem can take precedence over the delivery of health services and medical care. This encompasses the whole spectrum of medical, dental, nursing care, drugs, nursing homes and extended care facilities, physical therapy, hospitalization, outpatient dispensaries, laboratory tests and also the services of state and local health departments. Health services are probably one of the fastest growing industries, for its size, in our nation and the most rapidly changing (24:534).

One realizes, of course, that little substantive change will occur in the overall health care status in the nation until the emphasis is changed. Such change will require major efforts by all segments of the health care industry, including those responsible for health education (65:27). For many years there has been an uphill battle to make prevention of disease as important as its cure. Currently the fruition of the prevention issue can be seen in institutional changes as the need
for health education of the patient and his family, employees, and the community is recognized. Simonds (1973) has indicated that the impetus has been given to patient education components of hospital health education by the adoption of the "Patient's Bill of Rights" by the American Hospital Association:

The Patient's Bill of Rights clearly requires that information be provided to the patient in order that he make an "informed consent," and it is clear that this has important administrative and legal implications, as well as philosophical implications. The increased uses of medical audits and quality assurance efforts lead inescapably to the conclusion that sound, well-planned programs for education of patients are a requirement for high-quality health care (56:60).

The learners are no longer passive recipients of information but have become active participants in the determination of their needs and goals and in the evaluation of their success in attaining them (63:22).

Hospitals and other health care institutions should recognize the opportunity to exercise a role of leadership in health education. The educational equation points out the need for various health care organizations to organize with the appropriate staff in order to carry out the projected multifaceted functions. Simonds (1973) has poignantly suggested:

If hospitals are to take an increasingly more complex educational functions not only of patients but also of consumers in the community at large, it is clear they must go considerably
beyond their function as providers of care for the acutely or chronically ill. Although being providers of care for the sick will continue to be the major role for hospitals in the future, their role in relation to health maintenance organizations, convalescent facilities, and long-term care institutions will need to be reassessed. It is apparent too that as hospitals take on expanded educational functions generally, the linkage between such organizations as area health education centers will need to be developed more fully. The need for educational specialist who can work effectively across the board in patient education, employee health education, and consumer health education in the community becomes increasingly more urgent (56:60).

Appropos to these trends and projections Peters (1975) has formulated a model for a comprehensive hospital health education program.

The Department of Health Education has four major divisions:
(1) Patient education.
(2) Inservice and employee health education.
(3) Community health education.
(4) Multimedia (44:13).

The model includes recommendations for the following:

(1) Administrative-organizational pattern for health education programming.
(2) Personnel for health education programming.
(3) Inpatient and outpatient education programming.
(4) Inservice and staff related education programming.
(5) Community health education programming.
(6) Methods for health education programming.
(7) Facilities for health education programming.
(8) Equipment for health education programming.
(9) Materials for health education programming.
(10) Evaluation for education programming (44:1, 3).
Formerly, when efforts in continuing medical education were directed toward the production of information, the educator's role was minimal. But now with the focus on the application and utilization of knowledge and skills, the educator's role is highly strategic. Of all the changes occurring, the most significant one for the health educator is the recognition of education as a process (14:1). The need for professionals skilled in educational methodology; the need for time and administrative support for education within the system itself; and the need for supporting the development and use of educational materials and media have become glaringly apparent (55:60). Thus, the health educator should be a person with an appropriate educational background with the responsibility for coordinating the total range of hospital health education programs, whether it be hospital-wide program or a program directed to a specific population.

Shapiro (1975) has provided an excellent characterization of the qualifications of health educators:

All educators have, to a varying degree, been educated in selected biological and social sciences, and in psychological and sociological foundations of education. Working in the field of health, whether in school systems or other agencies in the community, the health educator adds an understanding of health functions, organization, and practices related to health services and goals. With extended training, the health educator learns to analyze educational needs, to design programs, mobilize
resources, and evaluate efforts. He learns to participate in program planning with other disciplines (54:472).

Zimmering (1975) has defined the new player on the health care team as the clinical health educator:

Working within the extant patient-care system, these "clinical health educators" will seek to introduce concepts of prevention and health maintenance into daily, routine patient care activities; to sensitize other health-care professionals to the need for prevention and patient education; and to develop feasible programs for patient education with the organizational structures of hospitals (65:28).

He further indicated that:

It must be stressed that the clinical health educator will not enter the patient-care arena to replace any other health professional nor to relieve any practitioner of his or her educational responsibility. Rather the health educator joins the team to bring the previously-lacking expertise which leads to positive behavioral changes on the part of the patient, and to increase the effectiveness of the professional-patient interaction. Thus, although the clinical health educator will directly plan, supervise, and perhaps conduct a wide variety of educational programs aimed directly at the patient (or potential patient), his family, and other consumers; perhaps one of the most important roles of the new professional will be to assist the other members of the team in understanding, enhancing, and improving the effectiveness of their own roles as educators—as well as therapists.

Clearly, the clinical health educator must possess an image as a completely-credentialed health professional in order to gain the respect and acceptance of the other members of the patient-care team (65:30).

Ulrich (1973) distinguished the role of the health educator as one of consultation. The role is a
preparatory and evaluative one which includes planning the program content; developing the educational processes; developing the teaching capabilities in a variety of health professionals; and assessing the effectiveness of the entire operation.

It is the health educator who acts as a catalyst and coordinator in planning and arranging the program, working out appropriate materials and methods to meet the educational needs determined, setting goals, and finding teachers (63:25).

The exciting challenge for health educators is the opportunity to plan on a long-term continuing basis for behavior change, rather than limiting efforts to episodic educational experiences (14:4). Relative to these trends and projections Doak (1974) has provided a stirring charge:

The challenge ahead of us is to find ways and means to keep the educational cycle in focus, and prevent fragmentation from occurring. The credibility of the health educator as a change agent in the medical care setting has passed the demonstration phase. Collaborative relationships are a reality. As a bridge between the two social systems of education and health, the health educator as a change agent lives in the ambiguity of doubt and certainties (14:13).

SOCIOCLOGICAL CHANGE THEORY

Within the realm of sociological literature there exists an abundance of constructs, theories, and models proposing a variety of categorical methodologies and
classification for social change. Appropos to the evolution and production of social change models, Glasser and Struss (1967) have provided a prototype called the "Grounded Theory" from which suitable models may be synthesized. Thus, "Grounded Theory" is a method of arriving at a principle suited to its supposed uses. It proposes that generating a theory from data means that most hypotheses and concepts not only come from the data, but are systematically worked out in relation to the data during the course of research. In essence, generating a theory involves a process of research (22:23).

Relative to the phases of planned change, Lippitt, Watson, and Westley (1953) have provided the following model:

Phase 1. The Development of a Need for Change: The problems which are creating stress in a system must be translated into "problem awareness."

Phase 2. The Establishment of a Change Relationship: The success or failure of almost any change project depends heavily upon the quality and the workability of the relationship between the change agent and the client system.

Phase 3. The Clarification or Diagnosis of the Client System's Problems: In order for the problem to be diagnosed the change agent must first be able to obtain information.

Phase 4. The Examination of Alternative Routes and Goals: Establishing Goals and intentions of action. In this second phase of "moving," the diagnostic insights gained in the preceding phase must be translated into ideas for action and then into intentions to carry out the ideas in a certain way.
Phase 5. The Transformation of Intentions into Actual Change Efforts: It is during this final phase of "moving" that plans are put into action, and that innovations are adopted.

Phase 6. The Generalization and Stabilization of Change: For a change to be considered successful it must remain a stable and permanent characteristic of the system.

Phase 7. Achieving a Terminal Relationship: The terminal phase is the dependency of the client system on the change agent (25:10-55 to 10-59).

Everett Rogers (1962) has conceptualized a model which has been utilized in studying adoption through the process of social interaction:

(1) Awareness: The initial stage is Awareness in which the individual is exposed to the innovation but lacks complete information about it. The individual is aware of the innovation, but is not yet motivated to seek further information.

(2) Interest: The behavior of the individual during the second, or Interest stage is characterized by active information-seeking about the innovation.

(3) Evaluation: The third stage of Evaluation is a period of "mental trial" which is a necessary preliminary to the decision to make a "behavioral trial."

(4) Trial: If the results of the individual's "mental trial" are favorable, he is ready to move on to the Trial stage. At the trial stage the individual uses the innovation on a small scale in order to determine its utility in his own situation.

(5) Adoption: The final stage is threat of Adoption. It is at this stage that the results of the trial are considered, and on the basis of this the decision is made to adopt or reject the innovation (25:10-30 to 10-33).
In reference to the diffusion of an innovation, Havelock (1971) pointed out that one is actually dealing with a collectivity of adoptions by individuals. Though the individuals all belong to a single social system, the system will affect each person differently (25:10-7). He has suggested that innovations may pose a threat to the established social structure. A general finding is that resistance is roughly proportional to the amount of change required in the social structure and the strength of the social values which are challenged (25:10-24). In essence the social structure acts to impede or facilitate the rate of diffusion and adoption of new ideas through what are called "System Effects" (15:110). Thus, the underlying theme or construct of the "Diffusion Effect" is that the social system generates increasing pressures toward adoption as an innovation gathers momentum (15:110).

Moss (1973) suggested that three of the most commonly encountered concepts in discussions of social change are adaption, equilibrium, and homeostasis. Equilibrium or homeostasis refers to the system's processes for preserving continuity, whereas adaptation refers to the changes of the system's processes in such a way that continuity in that milieu is enhanced (40:187). Utilizing a biosocial model, Moss distinguished steps in social-system change:
(1) Invalidation: The first phase of the social-change sequence, in which new information is sought and/or examined and new communication relations tried.

(2) Exploration: The second phase of the social-change sequence, in which new information is sought and/or examined and new communication relations tried.

(3) Innovation: The third phase of the social-change sequence, in which selected information of the exploration period is accepted, refined, and applied, and new communication patterns established.

(4) Habituation: The fourth and final phase of the social-change sequence, in which the new information becomes established, new communication patterns become more routinized, and the network's control over information is solidified (40:243).

Nyswander (1956) cited six pragmatic principles illustrative of a health educator's role as a change agent in a medical practice setting:

(1) In every problem-solving situation there are two major processes at work. One process is dependent on the dynamic impacts of personality needs, perceived threats, and protective reactions of the members present. The second is the understanding of the dynamics of the group process.

(2) The perception of those who are to be taught furnish important data to be used in program planning.

(3) The planning process itself is an educational method which has the potentialities for stressing the major psychological factors which bring about change.

(4) Bringing people together to work on problems (often called community organization) is a complex process involving (1) Analysis of the validity of the objectives for the group (2) Relation of objectives to the various levels and kinds of power structure in the community, and (3) The concepts of leadership held by professional workers.
The social distance between the educator and the group taught is a significant factor in education.

Evaluation of educational programs and methods by staff provides a supporting structure for introducing changes in content and methods (15:4-13).

Commenting on the basic entity of social-system change, Laing, et al. (1966) pointed out that experiencing one's self is also a function of how others experience us and communicate that experience to us (15:80). This also appears to be closely linked to the issue of the credibility of social-change agent. Commenting on credibility Doak (1974) stated that "Credibility is a product of personal qualities, knowledge, skills, and abilities in a chosen field, and acceptance by co-workers (14:2).

In summary, one finds three appropos statements regarding the concept of social-system change. Doak (1974) pointed out:

It seems highly desirable, therefore, to explore the variety of ways in which the health educator as a change agent can build credibility in a setting less familiar than the traditional public health agency... the medical practice setting. The demand for health education expertise in the medical practice setting may increase at a greater rate than the health educators may be able to respond to the demand (14:1).

Further evidence was provided by Rogers (1969):

"Social Change" is the process by which alteration occurs in the structure and function of a social system. The impetus for such
change may be planned or unplanned and its source may be internal or external to the society (15:81).

Commenting on a general method of comparative analysis, Glasser and Strauss (1967) stated: "For in generating theory it is not the fact upon which we stand, but the conceptual category that it was generated from" (22:23). Further explanation is provided by pointing out:

The interrelated jobs of theory in sociology are: (1) To enable predication and explanation of behavior, (2) To be useful in theoretical advance in sociology, (3) To be useable in practical applications—predication and explanation should be able to give the practitioner understanding and some control of situations, (4) To provide a perspective on behavior—a stance to be taken toward data, (5) To give and provide a style for research on particular areas of behavior. Thus, the theory in sociology is a strategy for handling data in research, providing modes of conceptualization for describing and explaining. The theory should provide clear enough categories and hypotheses so that crucial ones can be verified in present and future research; they must be clear enough to be readily operational in quantitative studies when these are appropriate (22:23).

CONCEPTS OF ECOSYSTEM SUCCESSION

"Ecology" is a word derived from the Greek root "oikos" meaning "house." Thus, literally, ecology is the study of "houses" or more broadly "environments." Knight (1965) further differentiated ecology as a field of study concerned with the relationship between the environment and living organisms (31:2). Kogan (1971)
declared that the ecosystem is a systematic, orderly combination or arrangement of living organisms mutually interacting with a shared environment (33:9).

Implicit in the study of ecology is the concept of "community." The community concept dates back to the time of Theophrastus. He recognized the existence of plant communities or associations of species in different environmental areas (31:229). Thus, a community is a group of several species living together in the same locality. Any distinct community is a dynamic entity, constantly changing in various respects to cycles and factors (31:236). Ecological factors are said to fall into two categories, biotic and abiotic (45:300). Pimentel (1963) suggested that the environmental factor or factors that cause such restriction of functions and partly determine the distribution of a species are called "limiting factors" (45:299). This distribution can be closely allied to the concept of adjustment or adaptions to an environment (ecological amplitude) (45:299). The success or failure of an individual species is the consequence of the reaction of ecological amplitude to the environment (45:356). In addition Pimentel (1963) pointed out:

No organism is so narrowly restricted to a unique set of environmental conditions that it can occur only at one point in an overall environmental gradient. Rather, each species, and each individual within a species, possesses an ecological amplitude that determines its environmental distribution (45:356).
Furthermore, for success, ecological amplitude must permit the organism to become a part of its total environment and to obtain its requirements there. This "becoming a part" is a very intricate thing, requiring integration within processes and relationships of extremely complex and dynamic phenomena. Therefore, success is dynamic rather than static (45:336). Generally, the physical factors of an environment are the governing forces within an ecosystem. However, certain activities of living organisms have direct and to some extent governing effects upon other species and the environment. The strongest forces exist when different species display close contact with one another, a phenomenon called "symbiosis" (45:333). In essence, the term symbiosis means "living together." Pimentel (1963) characterized many possible reactions when two species are in intimate contact. The most important interrelationships are:

1. Neutralism, in which neither species is affected.
2. Mutualism, in which both species are benefited and both require the relationship.
3. Cooperation, in which both benefit but neither require the relationship.
4. Competition, in which both are harmed in the sense that each strives for the same materials.
5. Commensalism, in which one is benefited and the other is unaffected.
6. Amensalism, in which one is harmed and the other is unaffected.
7. Exploitation, in which one is harmed and the other is benefited (45:333).
Commensalism, cooperation, and mutualism are symbiotic phenomenon in which only benefit occurs. These are called positive interactions.

One of the most dramatic and important consequences of biological regulation in the community as a whole is the phenomenon of ecological succession (42:77). Succession, from the ecological standpoint, refers to an orderly sequence of different communities over a period of time in some particular area (31:271). Odum (1963) defined ecological succession in terms of the following three parameters:

(1) It is the orderly process of community changes; these are directional and therefore, predictable.
(2) It results from the modification of the physical environment by the community.
(3) It culminates in the establishment of as stable an ecosystem as is biologically possible on the site in question (42:78).

Odum (1963) has summarized the basic types of ecological succession:

The "pioneer community is the first group of organisms that become established in an area . . . The aggregations that follow are called the "secondary community" . . . The "climax community" is the last aggregation in the successional series (42:272, 273, 280).

In addition, he added that:

An "Abstract community" is a mental image of a particular type of community, an assemblage that does not exist except in one's mind. A "concrete community" is a specific area, that one can observe directly (42:229).
Further differentiation may be provided by considering the comments of Pimmentel (1963) in regards to ecological succession:

The distribution of individuals, species, and communities must be dealt with in terms of the dynamic relationships between the environment and organisms through time. The dynamics appear to proceed in an orderly sequence of events that can be termed a kind of succession. Although any segment of the over-all biogeographical succession varies according to the nature of a particular environment and its organisms, it is possible to assume certain general tendencies in the events of most restricted sequences. These restricted events, or biogeographical seral stages, here are arbitrarily termed:

1. Abiotic area: Any area without life.
2. Primary Biosere: An unstable organism congregation lacking clear community organization.
3. Consolidating Biosere: Presence of a definite community organization but at the seral level.
4. Biotic Climax: A climax community as considered in biotic succession.
5. Biome: A group of similar climaxes.

In regards to successional stages, one finds that the climax is a phenomenon in which environmental factors are relatively stable and species composition is relatively fixed. Furthermore there is a tendency for equilibrium. The more complex the replacing communities become, the greater is the tendency for equilibrium conditions to be approached. Commenting on the significance of ecological succession Odum (1963) stated:
The achievement of a measure of stability or homeostasis, rather than a mere increase in productivity, in a fluctuating physical environment may well be the primary purpose of ecological succession when viewed from the evolutionary standpoint (42:88).

Since we are capable of altering our environment and yet are at the mercy of many of these changes, a more thorough understanding and appreciation of basic ecological concepts could alleviate possible future environmental problems (31:1).

SUMMARY

The literature was reviewed in four major areas. The first part of the review traced the evolution of public health and the current status of health education in the United States. In addition, the second area reviewed was the status of health education in the hospital setting.

The third area of review focused on a variety of sociological theories regarding social-system change. Analytical processes were defined and a linkage to social evolution and sociological change process was inferred.

The fourth area of the literature review was directed towards biological concepts of ecosystem succession. Conceptual models were defined and evolutionary models of ecosystem succession were provided. Finally,
the role of individual adaptation to environmental changes was implied.

Thus, it is apparent that the discipline of public health, health education, and the role of the health educator are integrally related in an evolutionary continuum. Furthermore, there appears to be a vast similarity in the possible application of ecological concepts of community evolution and the possibility of its application in the diagnosis of role evolution in the medical practice setting.
CHAPTER III

NORTHRIDGE HOSPITAL: THE EVOLUTION AND DYNAMICS OF THE PRIMARY COMMUNITY

The following historical perspective is provided as a chronological overview in order to characterize the external and internal environmental factors which have affected the evolution of the Primary Community of Northridge Hospital. In order of sequence they are (1) The external environmental factors which have played a role in the evolution of the Primary Community of Northridge Hospital. (2) The concomitant growth pattern of services and departments at Northridge Hospital. (3) The generation of educational ideologies and services culminating in the change of function in the Department of Education.

EXTERNAL ENVIRONMENTAL FACTORS AFFECTING THE EVOLUTION OF NORTHRIDGE HOSPITAL: THE PRIMARY COMMUNITY

In 1955, the role of the physician was indeed simplistic as compared to the complex system of roles that must be assumed today. Not only is the physician a diagnostician, healer, counselor, and family friend but an integral force in the organization and development of an evolving medical system characterized by a striving for more effective patient care. This change in physician
role has had an impact on the hospital. Northridge Hospital began expanding its services over 20 years ago in order to provide quality medical care for the inhabitants of West San Fernando Valley. In the mid 1960's Northridge Hospital began to feel the impact of the newly-emerged physician specialists. The first type of new specialist were the Obstetric-Gynecologic physician. This was followed by such specialists as the neurologist, the cardiologists, and specialty fields. Currently, the medical staff at Northridge Hospital numbers 420 physicians representing some thirty fields of specialty.

The mid 1960's also brought about the "Third-Party Payor" in the form of Medicare and Blue Cross. Thus, hospitals had to be approved or certified in order to receive reimbursement for service. Along with this certification came the implied edict that in-service education be available for all nurses. Terms such as "Utilization Review," "Medical Chart Audit," "Joint Commission on the Accreditation of Hospitals," and "Quality of Care" became commonplace issues which inevitably forced the development of criteria, documentation, and evaluative measures. The occurrence of these terms emphasized the need for educational efforts aimed at patients and that these efforts be documented and evaluated. Accountability, therefore, provided a natural external force which
changed the evolutionary direction of many roles and for many professional disciplines. By 1972 "Continuing Education" of staff became an ordinary term in the everyday language of the hospital. That year also marked the adoption of the "Patient Bill of Rights" by the American Hospital Association. This seemed to be in keeping with the increasing general awareness of consumer rights and privileges. The general populace was questioning not only the services they received but also the fees they were charged. It was at this point historically that the hospital physicians, and the entire medical-care system began to be enmeshed in the national struggle of federal, state, and local government regulations which fluctuated frequently. Mass media, especially television, had a tremendous effect on the consumer. Health programs, television series about physicians, and periodicals like Reader's Digest began to expose the citizen to various aspects of medical practice.

Socio-economic changes also had a marked effect on the changing medical scene. Along with these changes came new technologies and new machines. The role of the provider was changed and a need for continuing education became glaringly evident. Too, new disciplines began to emerge and older disciplines such as physical therapy, occupational therapy, social work, recreational therapy, and inhalation therapy began to become more distinct
disciplines within the medical care institution. These events also occurred at Northridge Hospital. In addition, students in training began to bring in progressive and innovative ideas and the hospital soon realized that this vital input was a necessity. The professional staff and administration began to realize the urgency of staying abreast of rapid changes in trends, knowledge, and technologies through the implementation of some form of ongoing educational program.

HISTORY OF NORTHRIDGE HOSPITAL

Northridge Hospital is a non-profit, non-sectarian community medical center. It is governed by the Northridge Hospital Foundation's 21-member Board of Trustees. The Trustees include civic and business leaders from the community and physicians from the hospital's medical staff.

The original 49-bed hospital was founded on September 18, 1955, as the first general hospital in the West San Fernando Valley. In 1957, 50 more beds were added in a new unit. By 1961, a children's pavilion opened to provide 28 more beds.

The Outpatient Psychiatric Department, opened in 1967, was the first phase of a modern psychiatric center for the treatment of the mentally ill. Nineteen hundred
and sixty eight marked the completion of a new five-story, $5 million tower, housing the Intensive Care Department, Coronary Care Unit and complete new Surgery and X-Ray Departments.

A 20-bed multi-disability Rehabilitation Center was opened in 1970, providing comprehensive services in the field of physical restoration. This was the only hospital-based rehabilitation program within the confines of the San Fernando Valley.

Expansion of the Laboratory service area in 1971 and the addition of a modern new Renal Dialysis Center that summer provided the community with a vital scope of critically-needed diagnostic and treatment services.

The Pediatric Unit which was remodeled in 1972 resulted in the separation of services for pediatric and teenage patients. That year also marked the opening of a 24-bed Mental Health Institute which offered inpatient, outpatient, and day treatment care for all of the Central and West San Fernando Valley. No other general hospital in the Valley offered such comprehensive mental health services.

In 1973 remodeling and expansion of the hospital included modernization of the Psychiatric Inpatient Unit and the addition of an Activities For Daily Living Center in the Rehabilitation Center.
A five-story, ultra-modern structure called the Frederick Gruneck Tower was dedicated on June 1, 1974. The structure featured a 24-bed Critical Care Center, and additional medical, surgical single-occupancy patient rooms. Additional services included in the Gruneck Tower included a new Obstetrics Department, expanded space for Medical Records, Education and Administration. The Gruneck Tower, was named in honor of the hospital's Founder and former administrator, Frederick Gruneck, M.D. This marked the beginning phase of an expansion program which would total $30 million at completion.

Concurrent with the completion of the Gruneck Tower were several projects of major proportions. The Emergency room was expanded, and Radiology became a specialized treatment center. The opening of a pilot Paramedic Base Station, which provided a communication network for the Paramedic Emergency System in the San Fernando Valley, also took place in 1974. This needed service for the Valley added a new dimension to the emergency medical system for the San Fernando Valley community.

Construction began in December of 1974 for a $17 million expansion program at Northridge Hospital. The projects represent the continuation of a comprehensive patient service program unparalleled in the San
Fernando Valley. The hospital, currently at 266 beds, will be expanded to 319 beds at the conclusion of the present construction program. The projects include the Institute for Living, and a Diagnostic and Treatment Center. This Center is designed to house a comprehensive spectrum of outpatient services and inpatient diagnostic facilities. The Institute for Living will expand the present services of Mental Health and The Rehabilitation Center.

In February of 1975, the Critical Care Center expanded and centralized two departments of Coronary and Intensive Care. Also included in the Critical Care Program was a Respiratory Intensive Care Unit. This expansion provided the West San Fernando Valley with one of the largest and most comprehensive acute care centers in the Western United States.

Northridge Hospital has been fully accredited by the Joint Commission on Accreditation of Hospitals, comprising the American College of Physicians, American College of Surgeons, American Medical Association, and the American Hospital Association. The hospital holds membership in the International Hospital Federation, the Association of Western Hospitals, the California Hospital Association, and the Hospital Council of Southern California.
INTERNAL EVOLUTION OF THE EDUCATIONAL SYSTEM

The growth of Northridge Hospital's educational concerns and functions appear to be directly proportional to the evolution and sophistication of hospital services. Over the years, there was an increasing concern for patient education, staff in-service education, and finally a concern for community health education.

Current efforts in health education appear to have evolved during the last five years. Initially, nurses had been provided one-to-one patient teaching on an informal basis. Basic nursing training had instilled in these nurses a frame-of-reference for teaching patients about their specific disabilities. It should be noted that as late as 1969, there were no formal patient education programs within the institution. With the realization that this informal education was inadequate there was a natural evolution towards more formal education and the need to promote patient responsibility for themselves. Paralleling this concern was a felt need by the nurses to acquire skills for effective educational functions. Slowly the parameters emerged and the realization was made that the physician was not the sole deliverer of educational services. Nurses began to expand their role in patient management and established an ecological niche by providing valuable medical judgments regarding patients.
Various disciplines and roles were recognized as an integral part of a multidisciplinary team which contributed to the care of the patient.

The first formal education programs were accepted by the medical staff in the early 1970's with the advent of an outpatient program in November of 1971. Educational programs for patients included the Myocardial Infarction program instituted in 1972 and the Cardiac Catherization teaching program which started in 1972.

The Department of Education also began to feel the necessity of change. Prior to 1970 the Department of Education was identified as the Department of In-Service Education. With the advent of continuing education for all professionals; the emergence of new specialities and discipline; and the issue of patient education, the Department of Education began planning for different roles and functions. Thus, the Department of Education, formerly under the auspices of the Director of Nurses was placed in the organizational structure as a staff position directly under the Assistant Administrator in July of 1972.

Currently a wide range of community education programs are offered by Northridge Hospital. The Program For Problem Drinkers assists individuals to develop better means of coping with the stresses of everyday living without alcohol dependencies. The Diabetic Teaching Program,
in effect since 1971, aids diabetics and their families to more effectively deal with and understand the nature of their disease. The Stroke Resocialization Program provides the support of a group to assist post-stroke patients in their re-entry to normal living. Northridge Hospital also offers an annual Heart Symposium to the community. Its objectives are to clearly define the causes and preventative measures of heart disease. Other community education programs include Natural Childbirth Training, Classes for expectant parents, Post-coronary education program. There now exists a pre and post educational system for many of the in-patient disabilities.

As a teaching institution, the addition of the Paramedic Program to the San Fernando Valley and the subsequent designation of Northridge Receiving Hospital as the Paramedic Base station added a new dimension to nursing education. This requires the certification of Emergency and Critical care nurses. An on-going educational program is now available to all nursing personnel. Specialized areas of patient care and relicensure requirements now require continuous training to keep up with the new trends of medical science. A major goal was the certification recently from the American Medical Association to offer credits for continuing education for
physicians. Secondly, the approval was received in 1976 from the American Medical Association's Council on Medical Education which resulted in the launching of a graduate medical education program for future physicians in the field of Family Practice.

Northridge Hospital appears to have maintained a constant training atmosphere through an organized Department of Education. Community, professional, and patient education has been a special emphasis for many years. Over 20 educational affiliations exist with five universities, three community colleges, and the Los Angeles City School District, offering training and clinical facilities for the education of medical, nursing, and paramedical students in the community.
CHAPTER IV

NORTH RIDGE HOSPITAL: THE INTRODUCTION OF THE HEALTH EDUCATOR'S ROLE AND SUBSEQUENT EVOLUTION OF THE SYMBIOTIC RELATIONSHIP

The following chapter is a description of the ecosystem and Secondary Community of Northridge Hospital in relation to the evolution of role symbiosis: (1) The introduction of the health educator's role in the Secondary Community. (2) The author's proposed approach sequence and profile in the Secondary Community. (3) The function of the Department of Education at Northridge Hospital. (4) Ecological concepts related to the evolution of role symbiosis. (5) The organizing activities in the evolution of role symbiosis in the Secondary Community of Northridge Hospital.

INTRODUCTION OF THE HEALTH EDUCATOR'S ROLE IN THE ECOSYSTEM

In April of 1975, the author began his involvement as a health educator in the Department of Education at Northridge Hospital. The ecosystem of Northridge Hospital had evolved along a continuum and was considered a Secondary Community relative to its successional status. It possessed a variety of complex dynamics internally and the effect of external variables
were quite apparent. The historical evolution of the institution was traced in the previous chapter.

PROPOSED APPROACH SEQUENCE AND PROFILE

With the initial exposure to the ecosystem, the author was acutely aware of the current successional status of Northridge Hospital. Furthermore, it was evident that the role of the health educator was rather vaguely defined and that a more viable-functional relationship could be developed within the Department of Education. Thus, the most immediate priority was to become totally familiar with the departments, key personnel and roles in the hospital, and the functions of the Department of Education. Of equal importance was the diagnosis of the probable direction for further evolution of the ecosystem; the design and execution of appropriate activities in order to enhance the development of role symbiosis in the hospital; and finally the total development and sophistication of the health educator's role to culminate in a "mutualism" relationship.

FUNCTIONS OF THE DEPARTMENT OF EDUCATION

At the point of introduction of the author's role as a health educator, the Department of Education professed the following philosophy and functions:
The Department of Education of Northridge Hospital Foundation recognizes and supports the contention that each patient has the basic right to receive those services that will help restore the patient to health or support him and his family in their acceptance of stress with dignity. The Department seeks to provide an atmosphere of creative approaches in problem solving to facilitate the acquisition of knowledge and skills, so that each member of the staff has an opportunity to achieve his own potential in his role in the provision of health services; and also to cooperate with other agencies in coordinating and providing educational programs in the community that are informative and educational.

The Department of Education attempts to meet and adhere to this philosophy through the following functions:

1. Provide on-going education of employees through staff development and continuing education.

2. Provide training and consultation to middle management in order to enhance staff development.

3. Provide orientation for all new employees.

4. Expose employees to workshops, seminars, and academic courses.

5. Evaluate and document workshops, seminars, and academic courses attended by employees.

6. Evaluate and document continuing education activities.

7. Schedule hospital education programs.

8. Coordinate affiliated community education programs.

9. Provide library research studies.

10. Produce management manuals.
11. Provide and coordinate the Diabetic Education classes.

12. Provide and coordinate the Prepared Childbirth Education Classes (41: 12,000-12,001).

ANALYSIS OF ECOSYSTEM

The author provides the following concepts and factors in order to establish a framework with which to analyze the successional stages in the evolution of role symbiosis in the ecosystem of Northridge Hospital.

CONCRETE COMMUNITY

The "Concrete Community" of Northridge Hospital was one which the author and others could observe directly. Thus, the "Concrete Community" was the pre-existing and documented aspects and factors recognized by the hospital, departments, and key staff personnel. Also, such items as job descriptions, policies, procedures, inter-role relationships and communication lines were considered as aspects of the "Concrete Community."

DIVERSITY INDICES

In the basic analysis of the evolution of Northridge Hospital, from a "Primary Community" to the stage in which the author's role was introduced, it was observed that the "Cumulative Number of Individuals" had
increased and thus a corresponding "Cumulative Number of Roles" had developed concurrently. In the sense of the study, these "Cumulative Number of Roles" were considered taxonomic or ecological grouping of functions. It could generally be assumed that the advantage of a high diversity of roles was of survival value to the community in that it lent towards increased stability. That is, the greater the number of roles and individuals, the greater was the possibility for adaptation to changing conditions, whether in a short-term or long-term sense. In essence, the greater the diversity the greater was the adaptation potential. It should be noted, however, that a description of an ecosystem consisting of a list of component roles, its relative diversity indices, and numbers was not sufficient information to determine the dynamics of an ecosystem. For a full understanding of an ecosystem, the structure and function had to be studied together. Thus, the relationship of function-to-role was a central problem at all levels, a fact that was apparent and emphasized in this study.

ECOLOGICAL ROLE DOMINANTS

Of importance to the evolution of all roles, but particularly that of the health educator were the "Ecological Role Dominants" in the ecosystem of Northridge
Hospital. These "Dominants" were the most common role to be found in the hospital setting. They generally reflected the ecology of the community, since they appeared to be best suited to survive in a continuously changing environment. Furthermore, these "Dominants" regularly influenced the rest of the community. In this sense, these "Dominants" functioned in a critical way, since their success could determine the subsequent success or failure of subordinate roles that were introduced into the system. Therefore, the author's analysis concluded that the nurse was the obvious "Ecological Role Dominant" in the ecosystem relative to the "Cumulative number of Individuals and Roles." Nurses, in fact developed complex relationships, roles and functions and thus had a greater effect upon the ecosystem.

ECOLOGICAL AMPLITUDE OF THE HEALTH EDUCATOR

"Ecological Amplitude" was defined as a set of expertise or adaptation potentials which could enhance the health educator's likelihood of role success in the ecosystem. In regards to this "Ecological Amplitude," the health educator possessed by nature of his educational training, a set of expertise which provided viable survival mechanisms for the newly-introduced role in the ecosystem. Specifically, these areas of expertise were
in the planning, consultation, and evaluation of health education programs.

The most common reason why new roles did not survive was because of "Competition." That is, there were pre-existing roles of a similar nature or individuals in ecosystem that possessed similar "Ecological Amplitude" or potential. Thus, new roles became obsolete through "Extinction."

It was evident that the success or failure of an individual role was the consequence of the reaction of "Ecological Amplitude" to the environment. For success, "Ecological Amplitude" must have permitted the role to become a part of its total environment and to obtain its requirements there. This was an intricate process, requiring integration within processes and relationships of extremely complex dynamics in the ecosystem. Success was dynamic rather than static and the degree of success of any role fluctuates through time and history.

ECOLOGICAL NICHE

The role an individual played within the community or ecosystem of Northridge Hospital was called the "Ecological Niche." When the term niche was used to designate a particular place or setting it was necessary to use the term "Functional Niche" to refer to the
functional position of a role in a community. Thus, the fundamental workings of the ecosystem included the operation of "Functional Niches." The main advantage of this system of analysis was that it could maintain the dynamic aspects of the ecosystem scheme. Furthermore, the ecosystem analysis focused upon the potential centers of new evolutionary development for health educators.

Of particular importance to the evolution of roles in an ecosystem was the phenomena of "Interspecific Competition." Where there were two or more closely-related roles adapted to the same or similar niche, "Interspecific Competition" became important. If the competition is severe, one of the roles may be eliminated completely, or forced into another setting. Therefore, evolutionary analysis was extremely useful summarizations of what has occurred and was happening through time.

EVOLUTION OF THE SYMBIOTIC RELATIONSHIP

The following is a description of the evolution of the symbiotic relationship of the health educator's role at Northridge Hospital. Certain activities of roles had direct and to some extent governing effects upon other roles in an ecosystem. The strongest forces existed when different roles displayed close contact with one another, a phenomenon called "Symbiosis."
Symbiosis is a term with many definitions and many possible reactions when two roles are in intimate contact. The symbiotic phenomena in which only benefit occurs are Commensalism, Cooperation, and Mutualism. These are called positive interactions and are presented in their probable evolutionary sequence. The more important relationships are (1) Neutralism, in which neither role is affected. (2) Cooperation, in which both benefit but neither requires the relationship. (3) Commensalism, in which one role is benefited and the other is unaffected. (4) Mutualism, in which both roles are benefited and both require the relationship. It should be noted that Neutralism is a relatively rare phenomena. The harmful, or negative interactions, in their probable order of evolutionary origin are Competition, Amensalism, and Exploitation. These relationships may be defined as: (1) Competition, in which both roles are harmed, in the sense that each role strives for the same functions or activities in the ecosystem. (2) Amensalism, in which one role is harmed and the other is unaffected. (3) Exploitation in which one role is harmed and the other benefited.

The author has focused on the evolution of the positive interactions and relationship of the health educator in the "Secondary Community."
PHASE 1: COMMENSALISM RELATIONSHIP

For approximately one and one-half months, after the author's role as a health educator was introduced to the Department of Education, the relationship remained one of Commensalism. The author's primary duties and activities were ill defined and commensal in nature. These activities focused primarily around attending meetings as a representative of the Department of Education, Evaluating various workshops and educational events in the hospital, and finally in assessing a variety of needs relative to Continuing Education in the hospital setting.

The assets of this initial exposure were two fold. First, there was very little in the way of competition with other roles. Secondly, this gave the author a brief orientation period in which to diagnose the successional status of the ecosystem and thereby determine "key" individuals in order to develop a profile and approach sequence. This approach sequence and profile thus lent toward a more successful evolution of a symbiotic-role relationship.

It was evident to the author, that the primary role, in terms of viability for a health educator, was in the area of educational planning, design, consultation, and evaluation.
PHASE 2: COOPERATION RELATIONSHIP

At approximately the end of a two-month period the author had identified two major areas of role evolution and definition which were congruent with the functions of the Department of Education. One dealt with providing educational consultation to the Program For Problem Drinker. The other dealt with the Natural Childbirth Education classes (provided by the Department of Education), where there was a need for redesigning and evaluating the entire program.

At this stage in the evolution of role symbiosis, the "Cooperation" relationship was evident. Both the Department of Education and the author benefited from the relationship. However, it was evident that the role was not an integral component of the ecosystem nor was there a perception that the role was a requirement of the ecosystem.

The following analysis was made by the author as to possible areas of evolution and role definition for the health educator.

NATURAL CHILDBIRTH EDUCATION CLASSES

I. The author found the following needs within the program:
a. The development of a more efficient communication system between the Natural Childbirth instructors and the Department of Education.
b. The development of a Natural Childbirth Training Manual.
c. A class registration system.
d. An educational evaluation system.
e. A program documentation system.

II. These needs were made evident by:

a. The lack of knowledge, communication, and continuity in the hospital delivery system.
b. The political and attitudinal problems of the staff surrounding the use of the Bradley book, "Husband Coached Childbirth."
c. The lack of accountability in not having a class registration system.
d. The lack of a method of assessing educational effectiveness.
e. The lack of program visibility in the hospital system due to lack of documentation.

III. To meet these needs, the author recommended and implemented the following measures:

a. Periodic meetings and coordinative sessions between the Natural Childbirth instructors, the Department of Education and the author.
b. The development of a Natural Childbirth Education manual for Northridge Hospital.

c. The development and implementation of a class registration system which included the following items:
1. Patient information request forms;
2. Patient information letter; and
3. Class registration policies and procedures.

d. Development of knowledge and attitude tests (pre and post).

e. A telephone documentation system.

f. A more sophisticated Annual Report to the Ob-Gyn committee.

g. The redefinition of educational objectives for the classes.

h. Consultation with the Natural Childbirth instructors relative to a variety of educational methodologies.

PROGRAM FOR PROBLEM DRINKERS

This program was offered to the community on an outpatient basis and specifically oriented towards counseling the problem drinker/alcoholic and his family. It was under the auspices and administration of the Department of Mental Health.
Initially, the author was requested to consult with the director of the program in regards to the client education component. This request was made by the Administrator of the Department of Mental Health and the Director of the Department of Education. By the end of August of 1975, the author had been assigned to develop and implement the educational, community outreach, and staff development component of this program.

I. The author found the following needs within the program:

a. An effective educational component relative to:
   1. Assessment methodologies.
   2. Educational methodologies.
   3. Evaluation methodologies.
   4. Policies and procedure for the proper articulation with treatment modalities.

b. Development of a community outreach and education component relative to:
   1. Referral and coordination-linkage system.
   2. Community education for high risk target groups.
   3. Consultation with other professionals and agencies.

c. Staff development and inservice systems for hospital staff.
d. Development of public information system.

II. These needs were made evident by:
   a. Initial consultation with the Administrator of the Department of Mental Health and the Director of the Program For Problem Drinkers.
   b. Lack of continuity and coordination of patient service delivery system.
   c. Lack of knowledge and misconception by the hospital staff regarding alcoholism and the Program For Problem Drinkers.
   d. The lack of awareness by the general community to the Program For Problem Drinkers.
   e. The necessity for educational sessions and materials for all clients involved in the program.

III. To meet these needs, the author recommended and implemented the following measures:
   a. The development of an education program for clients including:
      1. Assessment tools.
      2. Instructional objective and an education curriculum.
      3. Coordination of education program with treatment staff and other modalities.
      4. Evaluation tools.
b. Community outreach and education system on an on-going basis for advocacy, referral, and coordination services.

c. In-service education program for Department heads in the hospital.

d. Production of program brochure in coordination with the Director of Public Relations.

e. Production of educational material for clients.

PHASE 3: MUTUALISM RELATIONSHIP

By January of 1976, the author had been transferred to a full-time position in the Program For Problem Drinkers and the symbiotic-role relationship had evolved to one of "Mutualism." In essence, the health educator's role and other roles benefited and required the relationship within the context and current status of the ecosystem of Northridge Hospital.

The following description of the author's health educator role is provided in order to describe the "functional niche" that evolved in terms of role symbiosis. It delineates the responsibilities that had become an integral part of the system of the Program For Problem Drinkers.

I. ROLE: Under the guidance and supervision of the Director of the Program For Problem Drinkers,
the health educator consults, develops, implements, and evaluates the prescribed components of the Alcohol Education Unit.

II. COMPONENT RESPONSIBILITIES:

1. Client Education.
2. Outreach and community education.
3. Northridge Hospital staff in-service regarding alcoholism.
4. Educational materials for clients, community, and staff.
5. Supervision of undergraduate health education student.
6. Educational activities and materials for Drop-In Center.
7. Development of grants, policies, and procedure.

III. SPECIFIC RESPONSIBILITIES:

a. Program Planning.

1. Identifies and compiles information on existing alcohol education problems in component areas.
2. Develops methods for record keeping, documentation, and collection of data.
3. Determines priorities for alcohol education services in component areas.
4. Develops achievable and measurable objective for alcohol education in component areas.

5. Participates in joint program planning with program staff.

b. Evaluation.

1. Develops criteria for evaluation of alcohol education component.

2. Involves all appropriate staff in on-going evaluative efforts.

3. Evaluates appropriateness and effectiveness of all educational materials used in program.

4. Evaluates the effect of educational methods utilized in educational components.

c. Community Organization.

1. Develops and implements methods for community organization activities.

2. Serves as a liaison between institutions and agencies regarding alcohol education activities.

d. Education Training.

1. Provides for training of staff in specific skills relating to the education process.

2. Coordinates alcohol education in-service for Northridge Hospital staff.
e. Consultation.
   1. Upon request, provides consultation to schools and other agencies interested in alcohol education components of the Program.

   1. Develops alcohol education materials for component areas.

g. Group Work.
   1. Conducts Alcohol Education groups for clients.
CHAPTER V

SUMMARY AND CONCLUSIONS

The purpose of this paper was to identify, analyze, and articulate, in a retrospective manner, the factors, processes and concepts involved in the ecological evolution of a health educator's role in the setting of Northridge Hospital.

The importance of the study lie in the fact that the role of the health educator is in a state of change. New opportunities have arisen in the area of the medical care institutions. Furthermore, there is a need for a timely conceptualization of the health educator's role in the ecosystem known as the medical care institution. The model provides for the analysis, criteria, and methods for future implementation or refinement in a variety of settings.

The first subproblem was to articulate a model for an ecological description and analysis of the evolution of a health educator's role in the setting of Northridge Hospital.

The second subproblem was to document the ecological factors and processes involved.

The third subproblem was to analyze and interpret the ecological factors and processes involved.
The fourth subproblem was to provide recommendations and implications for the future planning and analysis relative to health educator in the medical practice setting.

The following assumptions were the basis for the paper and the model:

1. The first assumption was that the discipline of health education and the health-care delivery system is in a state of evolution.

2. The second assumption was that the need for health educators in various health care delivery systems will continue.

3. The third assumption was that the health educator will evolve as an integral part of the health care delivery system and will necessitate the utilization of a model for institutional intervention points in the evolution of such a role.

4. The fourth assumption was that the articulation of a role-evolution model could be utilized in the medical practice setting by health educators.

The review of the literature provided the basis for the construction and articulation of the model for the synecological analysis of role evolution in a community hospital setting. The search extended into four major areas (1) The history and evolution of public
health. (2) The current status of health education in the community hospital setting. (3) Social and Institutional change processes and theories. (4) Ecological theories and concepts regarding ecosystem analysis, and evolution.

The evolution and dynamics of the Primary Community of Northridge Hospital were provided in a historical perspective in order to characterize the external and internal environmental factors which effected the evolution of the community. They were: (1) The external environmental factors which had played a role in the evolution of the Primary Community. (2) The concomitant growth pattern of services and departments of Northridge Hospital. (3) The generation of educational ideologies and services culminating in the change of function in the Department of Education.

Finally, the introduction of the health educator's role and the subsequent evolution of the symbiotic relationship was analyzed. It consisted of (1) The introduction of the health educator's role in the ecosystem of the Secondary Community. (2) The author's proposed approach sequence and profile in the ecosystem. (3) The functions of the Department of Education at Northridge Hospital. (4) Ecological concepts related to the evolution of role symbiosis and (5) The organizing activities in the evolution of a symbiotic-role relationship in the Secondary Community of Northridge Hospital.
This was the era of the construction and expansion of services. The effect of external and internal variables on the ecosystem resulted in greater role definition.
SECONDARY COMMUNITY OF NORTHRIIDGE HOSPITAL (1975 to present)
This was the consolidation era. It is characterized by the introduction of the health educator and subsequent evolution of role symbiosis.
Figure 3

POSSIBLE CLIMAX COMMUNITY OF NORTHRIEGE HOSPITAL
Since there is a tendency towards equilibrium in a stable ecosystem, the dynamics of a climax community are probable.

Evolution Complexity-Isolation-Recombination-Competition-Extinction

Overlapping of Related Climax Communities

Transition → Stable Ecosystem → Tendency Towards Equilibrium → Exit of Certain Roles From System

Possible Increase in:
- Extinction
- Role Speciation (definition)
- Greater Complexity in Isolated Units

More Extinction → More Role Speciation → Even Greater Complexity → Recombination of Isolated Units and Roles → Barrier Breakdowns
1955-1969 'Recognition of Need for More Formal Health Education of Patients''

1970 Institution of Various In-Patient & Out-Patient Health Education Programs

1970 Department of In-Service Education Becomes the Department of Education

1975 to Present More Patient Education Programs; Consumer Education Programs; Community Outreach

1972-1975 Concern & Development of Community Health Education Programs

1971 New Specialties and Technological Advances - Requirements for Continuing Education of Professionals

Figure 4
The growth of Northridge Hospital's services and disciplines was equaled by the concomitant growth of educational services. (1955 to Present)
CONCLUSIONS

The conclusions contained in this section were derived from the author's experience and analysis of the selected evolution of role symbiosis in the ecosystem of Northridge Hospital.

1. The role and functions of the health educator are currently in a state of metamorphosis and there are many opportunities within the medical practice setting to establish viable roles.

2. The traditional models of social-institutional change seem to lack an analysis of role and ecosystem evolution on a continuum basis. Furthermore, they appear to be rather static in nature.

3. An ecological model of role evolution, in terms of successional status of communities, offers a more practical model for the analysis of the medical practice setting.

4. The ecosystem model emphasizes the dynamic interaction between roles and within systems. Furthermore, it emphasizes the immediate consequence of past history in terms of major units of evolution as defined through adaptations within the context of the ecosystem.
5. Since the ecosystem approach is one of relationship analysis, the development of role symbiosis is a key issue.

6. As an ecosystem becomes more complex so does the increase in the "Diversity of Roles." Thus the possibility of role adaptation in terms of positive symbiosis become greater.

7. Of particular importance to the survival of any newly introduced role are the "Ecological Role Dominants" for they often times determine the survival possibilities of such roles in an ecosystem.

8. In order to survive a new environment the health educator must be able to diagnose an ecosystem from a holistic-ecological stance. Furthermore, he must be able to direct his efforts in the development of functions in order to enhance the evolution of positive-role symbiosis within the context and pecularities of the ecosystem.

9. The "Ecological Amplitude" of a health educator provides an excellent set of expertise with which to become an integral-functional role in the ecosystem of the medical practice setting.

10. The health educator role can not survive alone. Therefore, the "Functional Niche" to strive for
in an evolving ecosystem is one of "Mutualism" in role symbiosis.

11. "Extinction" of a health educator role is a possibility if "Competition" with other "Role Dominants" in the ecosystem becomes involved.
CHAPTER VI

APPLICABILITY OF THE MODEL AND RECOMMENDATIONS

The author recommends the following in the application of the ecological model of role symbiosis:

1. The model should be applied to similar medical practice settings, in order to test the validity of the concept in relation to the evolution of the health educator role.

2. If the model is applied to similar medical practice settings, it should focus on the factors and dynamics mentioned in this study. New factors may appear as a result of the analysis and interpretations of each stage of community succession in different settings.

3. These new factors should be utilized to modify the ecological model of role symbiosis.

4. The model may be utilized as a tool for diagnosis, evaluation, and the prediction of the factors involved in the evolution of the health educator's role in an ecosystem.

5. An alternative focus for research might be an analysis of particular factors and dynamics which
would shorten or lengthen the evolution of role symbiosis for the health educator.

6. The ecological amplitude of the health educator should be examined to determine whether the amplitude provides a viable survival mechanism in the development of an ecological niche and role symbiosis.

7. The model should be further applied to the ecosystem of Northridge Hospital in order to monitor the evolution of the Secondary Community in relation to the health educator's role.
Bibliography


northridge hospital foundation
medical center

ADMINISTRATIVE ACTIVITIES REPORT
Chronological Summary of Services & Programs

1970

Administrative Change Announced by Board of Trustees
Board of Trustee Committees Established
20-Bed Rehabilitation Center Opened
Preliminary Master-Plan Studies Completed
for Phase-Designed Expansion Program
Personnel Department Re-structured
Inservice Education Department Expanded
Materials Department Organized
Food Service Department-Systems & Management Re-organization

1971

$70 Million Master Plan Expansion Program Approved
New $300,000 Clinical Laboratory Expansion Completed
Heart Catheterization Laboratory Added
Renal Dialysis Center Opened
Groundbreaking for 5-Story Grunewald Tower
Maternity Department Remodeling Project - Pavilion Building
Classroom Addition - Pavilion Building
Pavilion East Psychiatric Unit Opened with 11 inpatient Beds
Earthquake Damage & Construction Repair - $254,000
Trustee Committees Expanded
Volunteer Services Coordinated and Expanded
Outpatient Diabetic Teaching Program Introduced

1972

Respiratory Rehabilitation Program Initiated
Laboratory Automation Program - Acquisition of Hycel Mark X & Coulter "S"
New Central Power Plant
Coronary Care Unit Re-equipped and Expanded
Teen Unit & Pediatrics Remodeled - Pavilion Building
New Employee Cafeteria Opened
Day Treatment (Mental Health) Evening Program Introduced
Selective Menus for Patient Diets Developed
Employee Evaluation Program Revised
Annual Heart Symposium Initiated
Patient Care Committee Established
Library Lounge Remodeling - Pavilion Building
Expansion & Re-location of Renal Dialysis Center
Nursing Services Re-structured
Assistant Administrator Appointed
Central Services Department Re-organized
Electro-Diagnostic Laboratory Established
Employee Blood Bank Organized

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ADMINISTRATIVE ACTIVITIES REPORT
Page 2

1973

Personal Health Program Revised
Employee Orientation Program Revised
Emergency Center Opinion Survey Developed
Diet Manual Completed
Pavilion East Expansion from 11 to 24 Inpatient Beds
Satellite Radiology Unit Established, Providing Massonography System for Breast Examinations
Modernization of Autopsy Room
Laminar Flow Surgical Suite Added
O.B. Suspect Nursery Completed
Inpatient Questionnaire Program Introduced
C.A.S.H. Program Initiated (Development & Utilization of Management Skills)
Health Conference Center Opened in adjacent Shopping Center Property
Administrative Assistant Appointed
Accounting Department Implements Systems Change
Capital Budget Program Initiated
Respiratory Services Re-organization away from Contract Service
Emergency Center Medical Director Named
Rehabilitation Center Medical Director Named
Laboratory Services Re-organization & Pathologist Change
Preventive Maintenance Program Introduced
Employee Coffees Initiated with Administrative Staff
Job Description Procedure Manual Completed
Position Control Program Established

1974

Establishment of Employee Credit Union
Emergency Center Designated as Paramedic Base Station for Valley
Auxiliary Gift Shop Re-construction, Expansion and Opening
Respiratory Rehabilitation Treatment Center Opened
Dedication, Frederick Gruneck Tower
Gruneck Tower Occupancy of First, Third, and Basement Levels
Begin Construction of Gruneck Tower 2nd & 4th Floor Projects
24-bed Critical Care Center -- 2nd Floor
32-bed Medical/Surgical Unit -- 4th Floor
Retractive Pension Plan Approved, effective July 1, 1974
Chapai Fund Raising Program Inaugurated
Activities for Daily Living Center Opened in Rehabilitation Unit
Investigation Toward Family Practice Residency Program Begun
Patient Van Transportation Program Introduced for Rehabilitation and Day Treatment
Completion of Satellite Parking Facility to be used during Construction Period
Laboratory Acquisition of Dupont Automated Clinical Analyzer (ACA)
Alcoholism Treatment Program Introduced on an Outpatient Basis - Funding Provided by $45,000 County Grant

(continued)
1974 (cont.)

Establishment of Utilization Review Department

Dedication and Opening of New Hospital Library

Mobile intensive care certification program for Emergency Room, Critical Care Center Nursing Staffs

Adolescent Mental Health Program introduced

G.I. Laboratory Opened in Pavilion Building

Emergency Center Expands to portions of Pavilion Building

OB Remodeling in Pavilion Building includes Fathers' Waiting Room

Introduction of "Candlelight Dinners" for new parents in O.B.

Construction begins on 7-level Parking Structure

Vocational Evaluation Unit Approved for Rehabilitation, through $75,000 Grant from State Department of Rehabilitation

Nuclear Medicine Expands to include Gamma Camera Capability

Pediatric Patio Donated by Northridge Kiwanis Club

Division of Cardiology Established in Medical Staff Organizational Structure

Community Relations Department Established

Fund Development Department Introduced

Education Programs Expand to Provide for Increasing Involvement in Community Education, Personal Training and Specialized Educational Projects

Affirmative Action Program Established

Management Study Task Force

Employee Service Awards Established as Annual Luncheon Event

1975

Construction Begins for 5-Story Institute for Living Building

Remodeling Programs for Accounting and Business Office Areas Completed - Main Tower

Rehabilitation Center Implements Six-Month Pilot Study on Team Approach to Patient Care (Grant received through SFV Health Consortium)

Construction of Diagnostic & Treatment Center Begins

Completion of new 24-bed Critical Care Center (2nd Floor - Gruneck Tower)

Remodeling Programs for Expanded Admitting Area Completed - Main Tower

Construction of new Maternity Center Begins (5th Floor - Gruneck Tower)

Relocation of Personnel Department to Expanded Suite of Offices, adjacent to Main Tower Lobby Area

Public Relations Committee Organizes Pilot Educational and Orientation Program for Foundation Membership and Prospective Membership

Critical Care Center Opened for Patient Service Development Association Incorporated

Supervisory Development Program Inaugurated

JCAH Awards Full 2-Year Accreditation

(continued)
1975 (cont.)
Vocational Evaluation Unit Opened - Satellite Service of Rehabilitation Center
Stroke Resocialization Center Opened in Conjunction with Easter Seal Society
32-Bed Medical/Surgical Nursing Unit Opened (4th Floor - Gruneck Tower)
Establishment of Cardiac Rehabilitation Program
CMA Approval for Continuing Medical Education Program
Housekeeping Services Established as Hospital-Based Department, with
Management Supervision Provided by Servicemaster, Inc.
Addressograph System Donated by Auxiliary
20th Anniversary Fund Raising Dinner-Dance, Universal Studios
Telemetry Unit Opened
Construction and Remodeling of Orthopedic Unit Completed (4th Floor-Main Tower)
Video Tape Equipment Donated by Auxiliary
Opened Hospital-Based EEG Department
Pediatric Pacio Donated by Northridge Kiwanis Club
Parking Structure Opened (7-levels, 481 cars)
Dory Previn Concert, a Benefit for Mental Health Institute
New Maternity Center Opened (5th Floor Gruneck Tower)
Social Service Department Expands Coverage

1976
Establishment of Pharmacy as Hospital-Based Department
Diagnostic Computer Acquired by Respiratory Department for Automated
Pulmonary Function Laboratory
AHA Approval Received for Establishment of Family Practice Residency Program
Development Association Elects First Board of Directors and Officers
Sliding Glass Doors Installed in Lobby, Donated by Auxiliary
Remodeling completed on Third Floor Medical/Surgical Unit (Main Tower)
Director of Medical Education Named
Patient Van Transportation Program Expanded
Financial Department Re-structured
Continuing Medical Education Program Approved for Second Year by AHA
Spring Bazaar Raises Funds for Chapel
American Heart Association "Award of Merit" Presented to Northridge Hospital
for Annual Community Education Program "An Affair of the Heart"
Emergency Department Designated as Medical Emergency Center for Presidential Visit
Family Practice Residency Program Initiated
Family Practice Center Opens
Remodeling of Elevator Lobbies (Areas Connecting Gruneck & Main Towers)
Community CPR Training Classes Inaugurated
Northridge Hospital Foundation Membership Open House and Tours of Current
Construction Projects
(continued)
ADHINISTRATIVE ACTIVITIES REPORT
Page 5

1976 (cont.)
Laboratory Expansion Program Partially Completed
Alcohol Services Expanded and Relocate to Satellite Facility in Reseda
First Annual Employee Picnic
Rehabilitation License Increased from 20 to 33 Beds, and Transition Unit
Established in Pavilion Building Area Formerly Occupied by Maternity
Associate Administrator Named
Northridge Hospital Approved as a Provider of Continuing Education for
Registered Nurses
Establishment of Tumor Registry
Employee Benefit Fund Committee Expanded
Employee I.D. Program Inaugurated
CHA Seminar for Senior Administrative Personnel, Board of Trustees and Physicians
Approval Received for Capital Fundraising Feasibility Study
Hospital Fund Raising Events Mark 21st Anniversary
— Magic Castle Party in the Institute for Living
— Magic Castle Party at the Magic Castle in Hollywood
Dedication Ceremony for the Institute for Living
Mental Health Institute Occupies 1st & 2nd Floors of new IFL Building
Master Plan Committee Established
Autologous Blood Donation Program Inaugurated by Blood Bank
Pharmacy Initiates Streamlined Discharge Procedure (NHFTE-Northridge Hospital
Foundation Time Efficiency)
Auxiliary Sponsors First Annual Fashion Show Luncheon Fund Raiser
Center for Rehabilitation Medicine Occupies 3rd & 4th Floors of IFL Building
Pediatric/Teen Unit Re-located from Pavilion Building to 3rd Floor -- Main Tower

1977 (First Quarter Only)
Coopers & Lybrand Named as Consultants for Four-month Health Care Projection
Survey
Microfiche System Introduced for Patient Accounts
Medical Director Named for Intensive Care Unit
Specialty-A-Month Program (Continuing Medical Education) Inaugurated, Including
Physicians from Throughout the Community
Health Services Fair Developed to Update Physicians on Hospital
Departmental Activities
Materials Department, General Stores and Mail Department Occupy Basement
Level of New Diagnostic and Treatment Center
Employee Credit Union Increases Services to Provide for Dividends
Construction and Renovation of Alexander's Market in Adjacent Hospital-Owned
Shopping Center
Central Service and Linen Departments Move to Basement of Diagnostic &
Treatment Center

(continued)
1977 (First Quarter, cont.)

Grant Application Submitted for further Expansion of Patient Van Transportation Program
Construction Plans finalized for 7-story Medical Office Building
Construction Plans finalized for Mental Health Institute Remedial Pool
CETA Program Coordinator Named

Projected Plans for 1977

Opening of New Diagnostic and Treatment Center, including a phase-by-phase Occupancy by the following Departments and Specialty Service Areas:

- Pharmacy
- EEG Department
- Radiology
- G.I. Laboratory
- Nuclear Medicine
- Respiratory Services
- Ultra Sound
- Surgery Center
- Special Procedures Section
- Pathology
- EMI Scanner
- Materials Department/Purchasing
- Cardiac Catheterization Laboratory
- Central Service/Linen Departments
- Cardiology Department
- Duplicating Center
- Emergency Center
- Environmental Services
- Roof-Top Heliport
- Dialysis Center
- Paramedic Communications Base

Introduction of Cardiovascular Surgery Department
Inauguration of EMI Body Scanner

Commence Construction on the following Projects:
- Laboratory Addition
- Pediatric/Teen Unit Re-location to Fifth Floor of Main Tower Building
- Chapel/Family Room
- Engineering/Maintenance Building Expansion
- Cafeteria and Kitchen Expansion
- 7-Story Medical Office Building
- Further Development of Medical Park Plaza (Adjacent, Hospital-Owned Shopping Center)
- Open Definitive Observation Unit
- Expand New Education Center Facility
- Open Inpatient Alcoholism Treatment Unit
- Expansion of Residency Programs