Panel Discussion by the KNA: Partners in Education-teachers and students.

Philosophical Stances for Future Nursing Education

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In order to place our discussions in proper perspective, it would seem appropriate to briefly review what's happening in the world surrounding us before going into the discussions of what future holds for nursing and nursing education and what stances should we take in the practices of nursing and nursing education.

I will briefly review the dilemmas we are faced with in the delivery of health services, characteristics of contemporary health problems we ought to deal with and the proposals which are made for changes in health care service delivery system. After describing the social context within which we have to operate I would like to go on to discuss their implications for nursing and nursing education and the philosophical stances we should take in preparing the future practitioners of nursing.

Dilemmas in Health care Services

The current decade has been characterized by the universal concern of every nation about how the best health care can be brought to all of its people. Practically every country in the world, each in a different developmental stage, is seeking in its own ways to expand its health care resources to reach its total population. The health care problems stem directly from the gap between the knowledge and medical technology available today and the delivery of the fruits of medical progress to the millions of people who have need of them. One can be proud of the progress the health professions have made in expanding medical knowledge and perfecting medical technologies. However, in the field of organization and delivery of health care, one also witnesses the dimensions of crisis because of its many inadequacies. This point has been emphatically made by Rogers when he said:

Despite having built the most impressive biomedical science technology programs to be found anywhere in the world and the training of a superb group of young men and women as physicians and nurses, we are confronted with a wholly inadequate fit between our fine medical technology and the health requirements of many of our citizens.

Inhibiting high cost, persistent health problems, inaccessibility of health care services and inequities in health levels and health care among different populations/are the features of health care problems which are heard worldwide.

The obviously simplistic belief, widely held up to the mid-1960s, that advances in medical knowledge and expansion of financing would automatically produce better services for the benefit of all has not been confirmed. On the contrary, according to Rogers, the crisis has been the widening gap between available knowledge and the delivery of that knowledge and skill in services, and the disparity between increasing public and private health expenditure /and the health benefits derived from these costs.

From the point of view of coverage and equitable distribution, advances in medical technology have acted as an interfering rather than a facilitating force. Production of service has been less per unit input. Additionally, expansion of public and private financing together with the increased potential of health services and a spreading concept of health care as a bithright, has provided an enormous increase in demand for health services, a demand which the current health care system could not satisfy. Although this phenomena was specifically pointed to the american situation, the implication would seem widely applicable.

Thus, boyond the era of great victory in the reduction of human mortality and preventable human ills, first by the results of agricultural, industrial and sanitary revolutions of the eighteenth to nineteenth century, and second by the development of preventive and curative medicine, the pendulum seems to have swung back to the original question of how the prevalent health problems of today may be solved. Medicine has leaped a great stride in the reduction of human suffering with preventive measures grounded in bacteriology and immunology and diagnostic and curative measures developed through the advancement of technology.

However, contrary to the expectations of mankind, health problems are still persisting worldwide-the developed societies with largely chronic diseases and the underdeveloped ones with variant acute and chronic conditions.

Health care problems of the world's population today vary from malnutrition, clean water supply, and sanitation to the multifarious health care problems of sophisticated medical technology, largely relating to the socioeconomic conditions of each country. Yet, health care, being an insatiable need, the world's nations, regardless of wealth, are confronted with the problems of budget and limited, capacity of health service systems. In spite of many situational differences, from the perspective of health administrators, there are many similarities. For one thing, it is becoming more clear to many expert health planners that regardless of the variations in the health problems they all seem to share

one common denominator, that is, their relation to cultural, environmental and genetic factors and the ways of life people choose to live.

Thus, Stephen C. Joseph of Harvard School of Public Health stated at an international conference on appropriate technology in health: "All of us are aware that the major determinants of health and illness are found far outside the boundaries of what is usually dealt with in a health care system." The health problems of today, therefore, needs to be tackled not from the medicine's perspective alone but rather from a broader perspective of the socioeconomic, cultural and political arena.

Proposed Changes in Health care Service

Thus improvement in the problems of access, availability, cost containment and the quality of health care has become the concern that is widely shared among the world's nations as a growing number or governments make their commitment to extend health services to their total population. Many alternative approaches to health care are being experimented with by various group in different areas of the world. Though each approach necessarily differs according to the varied local needs and the sociocultural contexts within which programs operate, there have been some discernible common elements across most of the recent innovative movements. The characteristic features of these innovations include: (1) community participation in the development and operation of health service programs; (2) systematizing of Health care services from the community level to urban medical centers with particular emphasis on primary health care networks for the effective channeling of services; (3) manpower strategies, including active recruitment and allocation of existing categories of health professions, and substitutions, exchanges and expansion of skills among existing health professions and a new cadre of health workers; and (4) strategies concerning alternative financing mechanisms, including various private and national insurance policies, propayment group medical practice arrangements such as The Kaiser Medical Plan and Health Maintenance Organizations in place of the fee-for-service arrangements prevailing so widely in medical practice.

Many examples of successes and partial failures have been accumulated as experiments matured. The major lesson from these seems to be that there is necessity for a rational approach to health care with the establishment of community-based, comprehensive, basic health care networks with sound referral systems.

Community Participation

The need for community participation and community-based health services is acutely elt in the realization that socioeconomic constraints would not allow us to do everything hat we know how to do for everyone, and also from the expanding recognition of the npact of the multiple techno-physico-psychosocial mix of factors on the individual's and roup's health statuses and their behaviors related to health care.

There has been some serious questions as to the effectiveness of health care services

today in relation to their power of influence on the general health status of the world's population.

The practical reasons for this need for community participation in health services, especially for developing countries, has been cited by Thorne of Johns Hopkins School of Public Health as follows:

1. Governement health budgets are low, usually $.50 to $5.00 per person per year, while the rural population spends 3 to 4 times as much on health care.
2. Most governments have very limited capacity to manage health services, but many variations at the periphery require local adaptations for services to be effective.
3. Health services are not effective unless communities use them well.
4. community habits, particularly of sanitation and nutrition, affect health status more than health services can.

Thus, either from the point of the view of the inertia of health services in tackling health care problems related to human values, life styles and environmental factors, or from the problems related to the advancement of medical technology and the distribution of the benefits of progress to the greatest numberof people, a shift in the health services strategy has become a mandate. A strategy aimed at groups and populations and their environments, rather than concentrating on individual health problems, with machinery for stimulating collaborations and participation of the consumer public in major health services decisions and program operations is believed to be the more appropriate strategy in this age.

Structuring of Health Services System

There has been a clear trend toward conceptualization of a regionalized health service system with a three-tiered hierarchical structure. The system consists of functionally distinguishable levels of care, namely, primary, secondary and tertiary health care. At the basic level, primary care has been conceived as the contact point between the client system and the health service system.

The usual source of primary care varies with the local resources of the health sector. A solo practicing physician, a medical group practice, a hospital outpatient department or emergency department, a health center, a nurse-midwifery clinic, or a neighborhood healthauxiliary post can be such a source. The content of services usually consists of an assessment of the problem through history-taking, physical examination, routine and simple laboratory tests, treatment of minor illnesses, and referral of patients with complicated problems for a differential medical diagnosis and/or for other medical or social services. The content and quality of services differ according to the qualifications of the health personnel involved and the availability of technological assistance. The trends also indicate an integration of preventive and curative services at the primary care level.

Secondary care is provided mostly at community hospitals and encompasses most medical and surgical diagnostic and therapeutic health services such as diagnostic radiology

and laboratory studies, general surgery, care of most medical and pediatric disorders requiring differential diagnosis and hospitalization, resolution of all but the most unusual obstetrical problems, and referrals for consultations.

Tertiary care is provided at major hospital centers, whose function combines education, research and service, to the patients requiring diagnostic, therapeutic, or rehabilitative services that are beyond the capabilities of average community hospitals.

Emphasis has been placed on primary health care, where the deficiencies are found most concentrated. Availability and easy access being the goals in this emphasis, primary health care service must necessarily be decentralized, whereas most secondary care needs to be relatively centralized, and all tertiary health care service must be highly centralized.

Of the total health service needs, about 70 percent to 80 percent will be covered by primary care service, 10 percent to 20 percent by secondary care, and about 5 percent to 10 percent is believed needing tertiary care. Thus, it is conceived that all health care needs must necessarily be filtered through primary care service, and most secondary and all tertiary care will deal with referred cases.

The American Public Health Associations Summary Study of 180 Health Projects worldwide on "The state of the Art of Delivering Low Cost Health Services in Developing Countries" and other individual reports indicate that the efforts for restructuring of the system of health services delivery is a global phenomena.

Health Manpower Strategies

Efforts to overcome the health manpower shortage can be viewed from two different vantage points; one from the perspective of equity in distribution of existing manpower, another from the point of view of augmentation of existing personnel. The kind of personnel required depends on the health care needs and the pool of manpower resources of each society and on other sociocultural and political factors, such as the level of cooperation of organized groups of health professionals.

In contrast to developed countries where primary care is traditionally provided primarily by physicians, dentists, nurses and other health professionals, in developing countries indigenous healers, village health workers, birth attendants and village volunteers are frequently the only ones available to provide primary care. These lay personnel, in the role of primary health workers, provide the first health system contact with the community at the peripheral level. They carry out simple curative measures and preventive and promotive services. Whereas innovative new health manpower strategies in the developed countries are focusing more upon distribution of physician services and development of physician substitutes or extenders, those in developing countries are, of necessity, focused primarily upon the training and use of community health workers and the development of self care attitudes and skills in the general population. These various areas of emphasis are however not at all exclusive; all require consideration in both the developing and developed countries.

Philosophical Stances that are implied in the emergent trends in health care services

Implications of the emerging trends in health services as previously discussed for nursing and nursing education are as follows:

1. The future health status of the world population will be largely determined by changes in socioeconomic, political and environmental factors lying largely outside the usual boundary of medicine. Thus there is a need for the health services to adapt constantly to the changing needs of the society. Changes such as improvement of living conditions, innovations in agricultural techniques, improvement in transportation, influence of mass media, increase in mobility of people, changes in family structure and changes in governmental policies all influence the society's need for health care.

2. The client participation and sharing of responsibility in health care decisions need to be sought after since each community has different aspirations, needs, values and economic resources and these community characteristics influence the health status of the people in general. Furthermore, communication gaps and differences in the perception of needs between consumers and elite health professionals have been identified as serious drawbacks in the provision of effective health services.

3. There is need for strengthening the self-care capabilities of individuals, families and communities and encouraging their active participation in their own health care and the health care services that most directly affect their state of well-being.

Rationale for this belief is that the ultimate practitioners of health care are the individuals, families and groups of people themselves, and not only the current tendency for self-diagnosis and self-medication will continue in the foreseeable future but also they make the decisions to use or not to use what outside assistance is available in cases of actual or threatened ill health. Furthermore Professional health care resources alone can never be sufficient to deal with all kinds of health care problems of every citizen, and these primary social groups, bound by loving and caring relationships, can be a rich resource in health care.

Another rationale is that the profession's ideal of social function is to help people retain, restore and promote their well-being through strengthening the self-sustaining power of individuals, families and groups and not to control and manipulate them. Thus a major role for the health professionals should likewise be one of assisting and facilitating self-care so as to help people become effective in dealing with health-related matters. In this helping relationship, the focus of assistance can vary, covering any area from assisting people to know what to want through explicitly defining needs which are not overtly felt or expressed to active search for needed care.

4. There is a need for systematizing a communication channel between the health service deliverers and client public for the dissemination and collection of health information basic to effective health services.

Rationale for taking this position is that a severe lack of health information on the

part of the general public has been a concern expressed by many health administrators.

A similar concern on the part of health planners is the severe lack of reliable data on which to base health service plans. It is my belief that man can be moved only as much as he understands and wishes to move, as psychological, sociocultural and cognitive changes modify human behavior, including health-related behavior. Thus, any knowledge related to the health of mankind should be widely disseminated in order to help individuals, families and groups make rational decisions grounded in modern sciences for the care of themselves and others. Any information concerning the health problems and local needs of the communities should be fed back to the health service system in order that the system can provide more effective and relevant services.

5. There is need for regionalization of health care planning. Rationale for this is that the health care resources in the country are not only limited, but also communities differ in their needs and problems, thus, duplications and gaps in services tend to render health services ineffective.

In addition, continuation of the trend toward specilization and urbanization in medicine in the face of perplexities of accumulating knowledge and technological progress seem inevitable. Therefore, instead of focusing on efforts to reverse the situation, efforts need to be made to effectively utilize the knowledge and skills acquired by individual specialists.

The currently predominant fee-for-service solo practice pattern in medicine has proven its economic, professional and social ineffectiveness insofar as the needs of the general populations are concerned. Thus, the pattern of medical practice is expected to be gradually replaced in the foreseeable future by some form of group practice with possible linkages to medical centers with a more scientifically oriented younger generation of medical doctors.

With general improvement in education, standard of living, and the networks of communication and transportation, there will also be a tendency to bypass ill-equipped local clinics and small hospitals for major health problems. However, increase in the need for informed guidance and initial screening is perceivable. Thus there is need for an easily accessible system of basic health care services at the community level, which combines self-supportive efforts of community people with assistance from available health professionals linked with supporting supra health structure of the country through an orderly system of referrals.

6. There is need for integration of more care-oriented preventive, promotive, and rehabilitative health services with cure oriented therapeutic services within the health system, as well as for integration of health services with the general developmental efforts of communities.

Rationale for this position is that current division between curative services and preventive services under each respective prerogative of private medicine and public health service is ineffective in providing comprehensive health service to all citizens. Need for

curative service is easily identified and the service is apt to be sought after, whereas need for preventive and promotive health care is not as readily realized and the service is not sought until crises become imminent. Instruction in prevention can sometimes be given more effectively in conjunction with the treatment of illness, since its importance is easily appreciated when the families are confronted with illness. By the same token, preventive consultation activities frequently alert families to cues and signs of pre-existing ill-health which requires treatment.

The increase in chronic adult diseases, mental illnesses and geriatic problems also indicate a future demand for more prophylactic, nurturative and rehabilitative care and adaptational guidance as well.

Furthermore the fact that health problems are related to the ways of life in the communities indicates the need for an integrated approaches to health care within the general community development framework.

Nursing As A Discipline

From the point of view of nursing as a practice discipline, nursing is still hardily pressed by the needs of defining what is the system of knowledge unique to nursing, what constitute the unique health care decisions that should be made by nurses and the missions that should be accomplished by nurses alone through filling what roles and functions amongst the perplexities of health care setting today.

Various theoretical models developed for nursing up to date suggest nursing as an interdisciplinary nature of science whose interest is focused on the conditions of total human being in relation to healthillness problems. Concepts such as stress, adaptation, life process, life rhythms, crisis intervention, systems of behavior, coping mechanism, etc. became important in nursing, however, these concepts need further clarification as to become operational in practice and research.

Whereas the discipline's need to control its practice is a common knowledge, nursing as a practicing discipline has obligation to fulfill an important social need, thus, it is essential for nursing to be responsive to changing needs of the society.

Expansion of nursing roles and nurse practitioner programs are some of the efforts to fulfill such responsibility. The Struggle to grow as an independent bona-fide professional discipline on one hand and the imperatives of responding to the changing social needs on the other nurses as a collective should carefully decide how best our efforts can be put together to enhance the growth of the descipline as envisioned and our service for the improvement of health and wellbeing of general public.

The most essential question we should pose at this stage seems to be whether we will follow the path to the extension of physician services and willing to risk the loss of identity as independent profession or find feasible alternative and willing to encounter multiple defenses.

I would like to propose a primary care nursing service system as an alternative for

community-based health services from the point of the view that nurses are best prepared for this function and the problem of underservice can be structurally resolved by the effective mobilization and organization of untapped health resources. Deployment of specially trained nurses and nurse-midwives as the first-line professional health workers to work with community people would have great impact on the improvement of the general health status of the population and contribute to the effective utilization of the world's health manpower.

Rationale for this position is that nurses are broadly educated to recognize and distinguish a wide range of normal and abnormal conditions of health and illness nature. Their knowledge includes identification of causative factors of most of the common diseases and appropriate preventive and curative measures to be taken to prevent or remedy each respective ill-health condition. Thus, nurses, by their training and with the back-up support of medical and other specialists and written protocols, should be able to effectively deal with most of the currently prevalent health problems of the worlds communities, the majority of which are relatively simple health problems.

Nursing education has also traditionally placed emphasis on health, rather than illness, with a focus on the normal growth and development of individuals, families, and communities and their interaction with the conditions of physical, social and psychological environments. Likewise it gives attention to factors that either impeds or facilitate normal growth and development and adaptive processes essential for the maintenance of health. Nursing also places importance on the development of skills of communication and human relationship as well as the knowledge of pathopsychology. Thus, nurses placed in local communities are expected to cooperate and work well collaboratively with others in the communities in finding ways to effectively respond to health needs.

Partners in Education, Teachers and Students

The notion of partnership between students and teachers in the future nursing education seems to be an appropriate topic to deal with especially when the client participation and partnership in health care are prominent social issues. When we postulate that students learn from experiences, the experiences of being participants in their own education, including the sharing of decision-making responsibilities in policy formulations and teaching-learning processes will be an essential learning experiences which will eventually enhance partnership practices in their future professional activities. Furthermore, today's nursing students are more assertive, inquisitive and science-minded than their counterparts in earlier days, thus, partnership practice in nursing education has a basic ground to flourish with accompanying changes in the roles and relationships of teacher-student are implemented with faith and mutual trust.

<국문요약>

미래를 향한 간호교육 이념

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오늘 저희에게 주어진 주제, 내일에 타당한 간호사업 및 간호교육의 향방을 어떻게 정하여야 하는가의 논의는 오늘날 간호계 주변에 일어나고 있는 변화의 실상을 이해하는 데서 비롯되어져야 한다고 생각하는 입장에서 먼저 세계적으로 건강관리사업이 당면한 딜레마가 어떠한 것이며 이러한 문제해결을 위해 어떠한 새로운 제안들이 나오고 있는가를 개관하므로서 그 교육적 의미를 정의해 보고 장래 간호교육이 지향해야할 바를 생각해 보려 합니다.

오늘의 사회의 하나의 특징은 세계 모든 나라들이 각기 어떻게 전체 국민에게 고루 미칠수 있는 건강관리체제를 이룩할 수 있느냐에 관심을 모으고 있는 사실이라고 봅니다. 부강한 나라에 있어서나 가장 빈궁한 나라에 있어서나 그 관심은 마찬가지로 나타나고 있읍니다. 보건진료문제의 제기는 발달된 현대의학의 지식과 기술이 지닌 건강관리의 방대한 가능성과 건강 관리의 요구를 지닌 사람들에게 미치는 실질적인 혜택간에 점점 더 크게 벌어지는 격차에서 발생한다고 봅니다. David Rogers는 1960년대 초반까지 갖고 있던 의료지식의 축적과 민간인의 구매력 향상이 자동적으로 국민 건강의 향상을 초래할 것이라고 믿었던 순진한 꿈은 이루어 지지 않았고 오히려 의료사업의 위기는 의료지식과 의료봉사간에 벌어지는 격차와 의료에 대한 막대한 투자와 그에서 얻는 건강의 혜택간의 격차에서 온다고 말하고 있읍니다.

균등 분배의 견지에서 보면 의료지식과 기술의 향상은 그 단위 투자에 비한 생산성을 낮춤으로서 오히려 장애적 요인으로 작용해온 것도 사실이고 의료의 발달에 따른 일반인의 기대 상승과 더불어 의료를 태생의 권리로 규명하는 의료보호사업의 확대로 야기되는 의료수요의 급증은 모두 기존 시설 자원에 압박을 초래하여 전체적 의료공급체제에 도전을 가해 왔으며 의료의 발달에 건 기대와는 달리 인류의 건강 문제 해결은 더욱 요원한 과제로 남게 되었읍니다.

현시점에서 세계인구의 건강문제는 기아, 영양실조, 안전한 식수 공급 및 위생적 생활환경조성의 문제에서 부터 가장 정밀한 의료기술발달에 수반되는 의료사회문제에 이르는 다양한 문제를 지니고 있으며 주로 각개 국가의 경제 사회적 여건이 이 문제의 성격을 결정 짓고 있다고 볼수 있읍니다.

그러나 건강 관리에 대한 요구는 영구히, 완전히 충족될 수 없는 요구에 속한다는 의미에서 경제 사회적 발달 수준에 상관없이 모든 국가가 공히 요구에 미치지 못하는 제한된 자원문제로 고심하고 있는 실정입니다. 또 하나의 공통된 관점은 각기 문제의 상황은 달라도 오늘날의 건강 문제는 주로 의료권 밖의 유전적 소인, 사회경제적, 정치문화적인 환경여건과 각기 선택하는 삶의 스타일에 깊이 관련되어 있다는 사실입니다. 따라서 오늘과 내일의 건강관리문제는 의학적 견지에서 뿐 아니라 널리 경제, 사회, 정치, 문화적 관점에서 포괄적인 접근이 시도되어야 한다는 점과 의료의 고급화, 전문화 일변도의 과정에서 소외되었던 기본건강관리체제 강화에 역점을 둔 다양하고 탄력성있는 사업전개가 요구되고 있다는 점 입니다.

다양한 건강관리요구에 적절히 대처할 수 있기위 한그간 세계 각처에서 시도된 새로운 건강관리

접근과 그 제안을 살펴보면 대체로 4가지의 뚜렷한 성격들로 집약할 수 있을 것 같습니다. 그 첫째는 건강관리사업계획 및 그 수행에 있어 지역 사회의 적극적 참여를 유도하는 일, 둘째는 지역단위의 일차보건의료에서 부터 도심지 신예 종합병원 시설 의료에 이르기까지 건강관리사업을 합리적으로 체계화하는 일, 셋째로 의료인력이용의 효율화 및 비의료인의 훈련과 협조 유발을 포함하는 효과적인 인력관리에 대한 제안과 넷째로 의료보험 및 각양 집단 의료유형을 포함하는 대체 의료재정 운영관리에 관련된 제안들을 들 수 있읍니다.

건강관리사업에 있어 지역사회 참여의 의의는 첫째로 사회 경제적인 제약이 모든 사람에게 가능한 최대한의 의료를 모두 고루 공급하기 어렵게 하고 있다는 점에서 제한된 정부재정과 지역사회가용자원을 보다 효율적으로 이용할 수 있게 하는 자조적이고 자율적인 지역사회건강관리체제의 구현에 있다고 볼 수 있으며 둘째로는 개인과 가족 및 지역민의 건강에 영향하는 많은 요인들은 실질적으로 의료권 외적 요인들로서 위생적인 생활양식, 식사습관, 의료시설이용 등 깊이 지역사회특성과 관련되어 국민보건의 실질적 향상을 위하여는 지역 주민의 자발적인 참여가 필수여건이 된다는 점 입니다.

지역단위별 체계적인 의료사업의 전개는 제한된 의료자원의 보다 합리적이고 효율적인 이용을 가능하게 하며 요구가 있을때 언제나 가까운 거리에서 경제 사회적 제약을 받지 않고 이용할 수 있는 일차건강관리망을 통하여 건강에 관련된 정보를 얻으며 질병예방, 건강증진 및 기초적인 진료의 도움을 얻을 수 있고 의뢰에 의한 제 2 차, 제 3 차 진료에의 길은 건강관리사업의 질과 폭을 동시에 높고 넓게 해 줄 수 있는 길이 된다는 것입니다.

인력 관리에 관련된 두가지 기본 방향으로서는 첫째로 기존보건의료인력의 적정배치 유도이고 둘째는 기존인력의 역할확대, 조정 및 비의료인의 교육훈련과 부분적 업무대체를 들수 있으며 이러한 인력관리의 기본 방향은 부족되는 의료인력의 생산성을 높이고 주민들의 자조적 능력을 강화시킨다는 데에 두고 있읍니다.

대체적 의료재정운영안은 대체로 의료공급과 재정관리를 이원화하여 주민의 경제능력이 의료수혜의 장애요소로 작용함을 막고 의료인의 경제적 동기에 의한 과잉치료처치에 의한 낭비를 줄임으로써 의료재정의 투자의 효과를 증대하는 법(cost-effectiveness) 그 기본방향을 두고 있다고 봅니다.

이러한 주변의료 사회적인 동향이 간호교육의 미래상에 끼치는 영향은 지대한 것이라 봅니다.

첫째로 장래 세계인구의 건강문제는 정치, 사회, 경제, 환경적인 의료권 밖의 요인들에 의해 더욱 크게 영향 받는다고 전제한다면 건강문제해결에 있어서도 전통적인 의료사업의 접근에서 더나아가 문제발생의 근원이 되는 생활개선이라는 차원에서 포괄적 접근을 생각하여야 하고 이를 위해선 정치, 경제, 사회전반에 걸친 깊이있는 이해와 주민의 생활환경에 직접 영향하는 교통수단, 통신망 mass media, 전력문제, 농업경영방법 및 조직적 사회활동 등 폭넓은 이해가 요구된다고 봅니다.

둘째로, 지역사회참여의 의의를 인정한다면 지역민의 자발적 참여를 효과적으로 유발시킬수 있고 의료집단과 각종 주민조직과 일반주민들 사이에서 협조적으로 일할수 있는 역량을 기르기위한 교육적 준비가 요구된다고 봅니다.

셋째로, 지역주민의 건강관리 자조능력 강화를 하나의 목표로 삼는다면 치료자에서 교육자로, 지도자에서 촉진자로, 제공자에서 지원자료의 역할의 변화 내지 다양화를 요구하게 될 것이므로 그에 대처할 수 있는 준비가 필요하다고 봅니다.

넷째로, 생각되어야할 점은 지역중심건강관리사업을 지향하는 보건의료의 이념적 방향과 그에 상응하는 구체적 접근방법을 효율적으로 적용하기 위해서는 종횡으로 연결되는 의사소통체제의 정립과 민활한 정보교환이 이루어질 수 있어야 한다는 점에서 의사소통의 구심체로서 역할할수 있는 역

량을 함양해야 할 교육적 과제가 있다고 봅니다.

마지막으로 생각되어야 할 점은 지역중심으로 전개될 건강관리사업은 건강증진 및 질병예방적 측면과 질병진료 및 회복과 재활에 이르는 종합적이고 포괄적인 사업이어야 한다는 점에서 종래 공공의료부문과 사설의료기관 사이에 나누어져 있던 예방의학과 치료의학의 통합 뿐 아니라 정부주축으로 이루어 지고 있는 지역사회개발사업 및 농촌지도사업과 종교 및 각종 민간인 집단이 벌이고있는 사업들과의 전체적인 통합적 접근이 이루어져야 한다고 생각하는 입장에서 종래 간호교육이 강조하지 않던 진료의 의무와 대외적 조직활동에 대한 보완적인 교육조치가 요구된다고 봅니다.

간호의 학문체계로서의 입장은 오랜 역사를 두고 논의의 대상이 되어왔으나 아직까지 뚜렷이 어떤 것이 간호 특유의 지식체계이며 건강문제에 관련하여 무엇이 간호특유의 결정영역이며 이 결정과 그 결과를 어떠한 방법으로 치료적 행위로 옮길 수 있는가에 대한 확실한 답을 얻지 못하고 있는 실정이라고 봅니다.

다만 근래에 제시된 여러 간호이론들 속에서 공통적으로 이야기되어지고 있는 개념들로선 우선간호학문을 건강과 질병에 관련된 인간의 전인적이고 전체적인 상황을 다루는 학제적 과학으로서보는 입장이 있고 따라서 생물신체적인 면 외에 정신심리적, 사회경제적, 정치문화적 환경과의 상호작용 속에서 인간의 건강과 질병문제를 생각한다는 지향을 갖고 있다고 말할 수 있겠읍니다.

간호교육은 간호계 내적인 학문적, 이론적 체계화의 요구에 못지않게 대민봉사하는 전문직으로서의 사회적 책임을 감당해야하는 중요과제를 안고있어 변화하는 사회요구에 효과적으로 대처해 나가야 할 당면문제를 안고 있읍니다. 간호역할 확대, 보건진료원훈련 등 이러한 사회적 요구에 대응하려는 조치가 되겠읍니다.

이러한 시점에서 간호계가 분명히 짚고 넘어가야 할 사실은 이러한 움직임들이 종래의 의사들의 의업무공급을 연장 확대하는 입장에 서서 간호의 특수전문직 명목을 흐리게 할수있는 위험을 감수할 것인지 아니면 가능한 대체방안을 갖고 간호전문직의 독자적인 진로를 개척하면서 다각적인 도전을 받아들일 준비를 갖추든지 그 방향을 뚜렷이 해야할 일이라 생각합니다.

저로서는 이미 잘 훈련된 간호원들과 조산원들의 교육적, 경험적 배경을 기반으로 지역사회 최일선 건강관리요원으로 사회적 효능을 다 할수 있는 일차건강관리간호조직의 구현을 대체방안으로 제시하고 싶습니다. 간호원과 조산원들의 훈련된 역량과 건강관리체제의 구조적 변화를 효과적으로 조화시킨다면 대부분의 세계인구의 건강문제는 해결가능하다고 보는 입장입니다. 물론 정책과 의료와 행정적지원이 활성화되어지는 환경속에서만 그 기대하는 결과가 확대되리라는 점 부언하는 바입니다.

마지막으로 언급하고 싶은 점은 바로 오늘의 주제 "교육의 동역자—선생과 학생"이라는 개념입니다. 특히 사회정의적 입장에서 보는 의료사업전개에 지역민 내지 의료소비자의 참여를 강조하는 현시점에 있어 교육자와 학생이 교육의 현장에서 서로 동역자로서 학습의 책임을 나누는 경험은 아주 시기적으로 적합하여 교육적으로 지대한 의미를 갖는 것이라고 생각합니다. 이에 수반되어져야 할 역할의 변화에 수용적인 자세를 갖고 적극 실제적용하려 노력하는 선생앞에서 자주적 결정을 행사해본 학생이야말로 건강관리대상자로 하여금 같은 결정권을 행사할수 있도록 촉구하여 주민의 자조적 역량을 기르고 의료사업의 민주화, 인간화를 이룩할 수 있는 길잡이가 될 수 있으리라 믿는 바입니다. ▩