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The Evolution of College Health: A Story of Education for Justice

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ACKNOWLEDGEMENTS

Thank you, Susan Hochman, for that introduction. And thank you, especially to all of the members of the Health Promotion section (and specifically the Program Planning team) for the invitation to be here with you. I also want to acknowledge the generous support of the American College Health Foundation Endowment Fund and the Health Promotion in Higher Education Fund for their recognition of this session. This is a sort of homecoming for me to rejoin a community that I have considered a professional home for several years now, and I regret that I have not been able to participate in these annual meetings since 2005. It’s so nice to be back. Thank you.
INTRODUCTION

When I started to prepare for this session a few months ago, I wrote those words “a sort of homecoming” in my journal and of course that made me think of one of the first albums that I ever owned on vinyl, cassette, and CD (simultaneously), *The Unforgettable Fire*, by U2. I always need music to inspire my thinking or at least give it a good start, so I listened to the song “A Sort of Homecoming” again, and heard these lyrics:

And you hunger for the time
Time to heal, desire, time
And your earth moves beneath
Your own dream landscape

In this presentation, I hope we will be able to discuss time, healing, changes, and dreams (or at least the hopes and ideas we can imagine).
HOW DID WE GET HERE?

I am curious to know why you are here, especially considering the interesting titles and abstracts of the other concurrent sessions. So I would like to begin what I hope will be a kind of conversation with this question: “What brought you here today?”

Audience responses (paraphrased):
- To look at health in the very broad sense of social justice and not just individual health topics like alcohol
- To address the health needs of minority and underrepresented groups; to look at old or existing paradigms and explore how social justice can be brought into the work of health promotion, or even more broadly into all of health
- To understand the “evolutionary liminality of ecotones” (learning objective #3 in the program description)
- To learn more about the evolution of health promotion: where we’ve been, where we are going in the timeline of health promotion; learn new vocabulary relevant to health promotion.

As I stated in the title of this program, I intend to discuss the evolution of that which we call college health. And I will do so with a story. I think it’s a good story. And as with many good stories, this one good story actually includes layers of other stories within its narrative. Along the way, I hope to discuss future directions for health leadership, drawing from multiple disciplines and sources of information.

Are you interested in taking that storytime journey with me? Okay, then let’s go.
You were kind enough to entertain my question, “What brought you here today?” Now I would like to tell you the story of what brought me here today.

Late last year, maybe October or November, my colleague Susan Hochman sent me a message on Facebook asking me to call her so we could talk some time. Well, we hadn’t been in touch for a while, but we certainly had some very good mutual friends, so of course I thought it would be fun to schedule a phone call to catch up some time. Maybe she had some good juicy stories about those mutual friends or maybe she just wanted to talk about the theater scene in my hometown of New York City. Well, we scheduled the call and when we connected we enjoyed some of that chit-chat, but then she told me that she really wanted to talk to see if I might be interested in speaking at the 2011 annual meeting of ACHA. I thought, “What? That’s what this call was all about? Really?” Of course I would love to come back to ACHA – I always found this to be a great conference with cool colleagues.
And then Susan told me that the planning group wanted me to address “college health/public health and social justice.” Well, I thought I immediately understood that topic, and we discussed it a just a little bit more, and then laughed and chit-chatted again. Soon after that phone call, the enormity of my task hit me: how in the world was I going to do this – talk about college health and social justice? What was I thinking? Those are huge issues that I am being asked to address. Here is just a sampling of social justice-related health news that I have read and mused over during the last several months of preparation:
• There was a story in *The New Yorker*, about new technology that is much more accurate at diagnosing tuberculosis (TB), and yet is out of financial reach for use in India, which has 2 million new cases of TB each year, 1,000 deaths every day from TB, and which counts TB as the leading cause of death in people between the ages of 15 and 45 (the most productive workforce population in a nation that our interconnected global economy relies on far more than many people can imagine) (Specter, 2010).
There was a story in *Newsweek* that documented a disparity in publication progress of drug trials: trials that showed no effect in treatment took an extra two to four years to get published (compared to trials that showed any kind of positive effect), so the biomedical community and the general public, have a skewed sense of advances in pharmaceuticals (Begley, 2011).

Of course there have been numerous continuing accounts and debates about health care and health care reform in the United States.
In my new hometown of Saint Louis, the local press reported on the debates about social class, food choice, and healthy diets –were they connected? (Joiner, 2011).
• And then just under two months ago, there was the report in *The New York Times* about the controversy surrounding comments made by the president-elect of the American College of Surgeons in a Valentine’s Day editorial that raised issues of gender bias and heterosexism in that medical field (Chen, 2011).

Needless to say there have been moments since that phone call last year when I have felt woefully ill-equipped to discuss the topic at all.

Well, in that phone call, Susan and I did find that in addition to our mutual friends and random fun stories, we did have some professional catching up to do. I had graduated with my Doctor of Education degree in Organization and Leadership from the University of San Francisco just a few months prior to this call, in May 2010. And even before my dissertation defense, back in January of 2010, I had engineered a plan to cut my own job in what we expected would be the ninth round of budget cuts in two years.
So I was wrapping up this degree, finishing work projects, and job searching and as often happens in life, those timelines do not always line up, and I was unemployed for four months before I packed up my car, drove out of San Francisco on December 1, arrived in Saint Louis on December 4, and showed up to my first day at work at Saint Louis University on December 6.
THE MOVE...

December 4, 2010
That phone call with Susan came near the midpoint of that period in between jobs, and was a really welcome affirmation for me. One of my best friends told me that I should enjoy being unemployed for a bit, I should consider it a time of personal growth and reflection and maybe explore more of my city, live frugally, but smile a lot. Looking back now, it really was a very happy time in my life, and the invitation to come speak here was a nice reason for a very big smile.

In that same phone call, Susan Hochman and I discovered two more points that converged on my being here. One was a favorite book. The other was my dissertation.
I'll start with the book. Susan and I confessed to be academic geeks, the kind who enjoy reading journal articles or usually read more non-fiction at the beach than paperback novels. I hope this doesn't embarrass her, but Susan told me that this was one of her favorites: George Rosen’s “A History of Public Health.” First published in 1958, the book traces the development of the public health field from ancient civilizations through the modern scientific age of the mid-/late-50s. While the book does not directly address race/ethnicity or gender, it does offer a sweeping history of the public health profession and makes a consistent argument that economic class is a major cause of disease (or of health promotion): from the earliest understandings of sanitary conditions that factored into access to clean water or safe housing to the more current understandings of disease transmission through animal vectors or pathogens like bacteria and viruses.

Well, I thought I could leave it at that, couldn't I? If someone in 1958 already wrote that socioeconomic class provided someone access to health and health care or exposed someone to disease or pathogenic
conditions, then my whole presentation was already done, wasn’t it? Didn’t that cover social justice enough? Nope. Too easy, and not what Susan asked me to do.

But I did go back to this book, which is one that I had read before also (but probably would not have made it to the tip of tongue if someone asked me to name a favorite book or some favorite books). I asked myself, aside from this summary statement about what George Rosen argued about poverty being a determinant of health, what did a history of public health have to tell me about social justice? And then I rediscovered two passages that impressed me: one in the 1958 preface and the other near the book’s conclusion.

A STORY OF PUBLIC HEALTH

“History performs a social task. It may be regarded as the collective memory of the human group and for good or evil helps to mold its collective consciousness. It creates an awareness of oneself in relation to the world around one, including both our yesterdays and our tomorrows. A meaningful understanding of the present requires that it be seen in the light of the past from which it has emerged and of the future which it is bringing forth.” (Rosen 1958/1993, p. 1xxix)

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In all countries there are problems of community health that require social and political action guided by available knowledge...Furthermore the horizon of health workers today can no longer be limited to the local or even the national community but must extend to the international community. Today we are all members one of another; and so each in our own community, we must strive toward a goal of freedom from disease, want, and fear.” (Rosen 1958/1993, p. 471)

So even in our recent past of 1958, we had pronouncements that we must understand our history and move towards a future where everyone in the international community could live freely. But what read like an orientation towards social justice was not the only reason why these proof texts appealed to me. The language of past, present,
and future, of social and political action, and of horizons also matched the language in my own dissertation research.

HOW DID I GET HERE? ACHA & ME

PERSONAL JOURNEY...

I was surprised that when we spoke last year, Susan Hochman knew that I had finished my doctorate degree but did not know the subject of my research. So I explained to her then, as I will explain to you all now, that I actually studied ACHA. Perhaps it is more appropriate to say that I studied how an organization adapts and changes and develops and grows, and the case study I really examined was ACHA, over the time span of the AIDS pandemic. All of my friends, colleagues and mentors told me that I should pick a dissertation topic that would hold my interest enough to sustain my working on it for a few years. Well, ever since my undergraduate coursework in genetics and virology, I have been fascinated by epidemiology. My identity as a gay man living in San Francisco at the time ignited a sense of obligation for me to conduct research that was relevant to me as a person and to a community that I
claimed as my own. Prior to my dissertation defense and my graduation, the San Francisco AIDS Foundation started a fundraising campaign in anticipation of June 2011 – this month that we are meeting here in Phoenix, Arizona, because this is the month that also marks the 30-year anniversary of the first cases of AIDS being reported (on or around June 5, 1981).

So now you are probably wondering what my dissertation could possibly have to do with this past-present-future theme that I wrote about in my article for “College Health In Action.” My dissertation chair and faculty advisor is one of those professors we all love and sometimes envy: very sweet and caring, committed to her students, an activist in her research, and she has not one, but two Ph.D.s after her name: one in organizational development and another in anthropology. After toying with some topics and methodologies, I decided to study organizational change from an anthropological approach. The specific research method I followed was a narrative approach that used the philosophy of critical hermeneutics. If you are like some of my more snarky friends, you are
probably shaking your head now asking yourself, “Critical hermeneutics? Isn’t that one of those overly inflated academic terms that gets tossed around postmodern liberal arts circles just to sound more intelligent and added to dissertation titles to make them sound better, especially after the prerequisite colon in the title?” Not really, well, at least not for me.

Critical hermeneutics is a paradigm, a worldview, that life is a narrative. It has its origins in philosophy and linguistics but is used now in anthropology, critical theory, sociology, leadership and education. (Leading philosophers who have contributed to this field are Heidegger, Habermas, Gadamer, Ricoeur, and Kearney.) In this perspective, each of our lives has a past, present, and future, we tell a story with our actions, words, thoughts, apprehensions, thoughts, fears, loves, and hopes. Our lives as stories are populated with characters, conflicts, dreams, tasks, challenges, and victories. All of the characters in our stories live in the contexts of settings and scenes and a narrative allows us to recall the past, consider it in the present, and then imagine a future to move
towards.

Look, I think there are two great fears that many doctoral students have about their research: (1) that nobody will ever care about it when it’s all done; and (2) that the research itself will be an impossible process. Conducting anthropological research using critical hermeneutics means collecting stories, and interpreting those collected stories through your own (the researcher’s own) revealed story. There is a subtle and significant difference between critical hermeneutics research and qualitative research in the Cartesian positivist tradition of science and research. That critical difference is the interweaving of the researcher’s personal story and the collected stories of the research. Because of the need to disclose these stories truthfully, there is no attempt made in this research to hide or make anonymous the people who choose to partner with the researcher (the way qualitative research might describe the experiences of people with pseudonyms at vaguely described large public universities in the mid-Atlantic region of the United States with 6% undergraduate female student enrollment). When I started planning my research, I was worried that nobody would want to speak with me and tell me their stories.

But I was very happily surprised that everyone was more than willing to do so. In fact, a few of my research conversation partners said it was a bit of a fun project for them to experience research in a whole new way simply by narrating their personal stories. That article I wrote as a bit of self-promotion for this session played with the language of “once upon a time.”
I recently saw the Werner Herzog documentary about 30,000 year-old prehistoric paintings in Chauvet Cave in France, “Cave of Forgotten Dreams” – quite stunning to see in high-definition 3D. And all jokes about Werner Herzog’s style of documentary narration aside, it is evident in this movie that there is something quite fundamentally human about stories: we inscribe our lived experiences in our art and then use stories to teach and remember and in many ways, those stories can transcend the space of a nearly inaccessible cave and cross the expanse of centuries of time. I think this universal appeal of storytelling as a human way of knowing and learning is what may have been so attractive to the colleagues I engaged in my research.

So I spoke with 12 colleagues and worked with their stories. Most of the 12 have some strong connection to ACHA, but two have none. Those two have experience in higher education research, public policy development, or teaching in graduate preparation programs for higher education administration.
The story that they wove together moved the history of ACHA from its founding 91 years ago in 1920 to what was the present-day of my research period 2007-2008. In that history, there is a strong connection between college health (first generally recognized as the health service at Amherst College in 1861) and medical science. Colleges organized health and hygiene, physical education, athletics, and natural science together. It was not until 1957 that the sections we know today in the association were established. In 1984, ACHA established its AIDS Task Force, and two years later it received its first HIV-related cooperative agreement from the CDC, and in the late 80s it also established a task force on human dignity (Quirolgico, 2010). Fast forward to more recent history and in last year's April/May/June issue of “College Health In Action,” I read the association president's reflection on cultural competency which included recognition that illness and healing are culturally based, the national office essay on the 10-year anniversary of the ACHA National College Health Assessment, a viewpoint reiterating this field’s professional and ethical obligation to “promote and protect the public's health,” a call for collaborative interventions on our
campuses, and an exploration of team-centered approaches in caring for students to have a positive impact in treatment and prevention (Hiller, 2010; Kalifey, 2010; Pecci & Laursen, 2010; Randol, 2010; Turner, 2010). So the association has come a long way from its start in managing public hygiene on college campuses to truly serving as health advocates for the greater public good.

ANOTHER HISTORY: MEDICAL EDUCATION

But pre-dating this association’s founding was another kind of professional revolution. No, I’m not going back 30,000 years to cave paintings of prehistoric rhinos and mammoths. I’m just going back to 1910. Does anyone here know what happened in April of 1910?

On April 16, 1910, The Carnegie Foundation for the Advancement of Teaching published a truly game-changing report that is commonly referred to by the name of its author, Abraham Flexner. (Please signal me if you know about “The Flexner Report.” Audience response = 3 people recognize “The Flexner Report.”)
Abraham Flexner was an educator who was asked by The Carnegie Foundation to research and write a report about medical education. He later shared his anecdote that when he was asked to do this, he was certain that he had been confused with his older brother, Simon Flexner, who was the first director of what is now The Rockefeller University in my hometown of New York City. For two years, Flexner visited each and every one of the then 155 medical schools in North America and his resulting report, *Medical Education in the United States and Canada*, basically created medical education as we know it today (Cook, Irby, & O’Brien, 2010).

Prior to Flexner’s report, in the narratives of medical students or doctors, there was no accreditation, no standard curriculum, no admission requirements, no patient contact, no laboratory instruction, and no licensing requirements (Cook, Irby, & O’Brien, 2010).
This was, after all, the era in which barbers could be surgeons and vice versa, and barber/surgeon services such as bloodletting by leeches are what gave barber’s poles their characteristic red stripes. The Flexner Report completely transformed medical education (and contributed to the closing of approximately one-third of those 155 medical schools within a decade of its publication) (Cook, Irby, & O’Brien, 2010).
Some of the reforms that Flexner proposed (that we think are standard now) included:

- High admission standards including a bachelor’s degree and strong academic preparation in the sciences (a required high school diploma was the standard at the time);
- University-based medical education to include two years of basic sciences (instead of the 8 months of lectures);
- Two years of supervised clinical practice in a university-based teaching hospital;
- Supervised laboratory and clinical training;
- Instruction by physician scientists. (Cook, Irby, & O’Brien, 2010)

Although Flexner did not address the narratives of health disparities that we understand today (Giles & Liburd, 2007), his report was nonetheless sweeping in many ways. In addition to fundamentally shaping medical education, “The Flexner Report” also led to the
The establishment of licensing, accreditation, and review boards – again, all part of Western medicine as we know it today. And all from the work of an educator who was an “outsider” to the medical world.

In anticipation of the 100th anniversary of “The Flexner Report,” The Carnegie Foundation for the Advancement of Teaching commissioned another study of medical education that was just published in 2010. They must have known that even if cave paintings can survive unchanged for 30,000 years, a lot can happen in just 100 years in the life of North American medical education.

The foreword of this new publication, *Educating Physicians: A Call for Reform of Medical School and Residency*, is subtitled “On the Shoulders of Flexner.” (The Carnegie Foundation commissioned similar comparative studies in its “Preparation for the Professions Series” - in medicine, nursing, law, engineering, and preparation for the clergy.) This 2010 report (that many people are already calling “Flexner 2”) looked at the history of medical education after 1910 and recognized that medical
education has become more specialized, has expanded in presence and access (some of the schools that closed because they could not meet the recommendations of the 1910 Flexner Report were the only schools that were admitting African American or women students), we have improved patient care, and health care has become a $2.1 trillion-dollar business in the United States, consuming approximately 16% of the gross domestic product.

The recommendations of this 2010 report include:

- Standardization of the curriculum’s learning outcomes through assessment of competencies;
- Individualized learning plans to permit flexible learning processes within and across levels, and learner-centered electives;
- Integration of formal knowledge and experiential learning including early clinical immersion (i.e., before the third year) and more reflection and study;
- Integration of basic, clinical, and social sciences;
- More comprehensive experience in patients’ experiences of illness and care (i.e., longitudinal connections with patients beyond diagnosis and start of treatment);
- Provide opportunities for learners to experience all professional roles of physicians including educator, advocate, and investigator;
A STORY OF MEDICAL EDUCATION

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(Cook, Irby, & O’Brien, 2010)

...Recommendations of this 2010 report (continued)...
Incorporate interprofessional education, collaboration, and teamwork into the curriculum;
Engage learners in routine and adaptive forms of expertise;
Develop learners’ habits of inquiry and improvement, focused on population health, quality improvement, and patient safety;
Locate clinical education in settings where quality patient care is needed and delivered, not just in university teaching hospitals;
Promote formal ethics instruction, storytelling, symbols, and rituals;
Make the hidden curriculum of professional work settings explicit and advise learners (as mentors) on the development of their professional identities. (Cook, Irby, & O’Brien, 2010)

These are bold visions, and the authors of this “Flexner 2” report acknowledge that enacting such breadth and depth of changes will require not only curriculum changes by the medical faculty and deans, but also changes in admissions; testing; patient care and clinical care;
community outreach; advocacy for funding reforms so that medical school graduates do not have the debt burdens they currently have; funding innovations to support mentoring, collaboration and faculty development; and public policy advocacy to support the development of fair and just health care systems and also a fair and effective medical workforce. So the report recognizes that there is work to be done and that the work is complicated and will take many communities much time and energy and resources. (And that’s just one of these professional preparation reports: good luck to all lawyers, nurses, engineers and clergy too!)

NARRATIVES AND CRITICAL HERMENEUTICS

THE DISSERTATION STORY

• 12 conversation partners (college health and higher education)

• History of HIV and AIDS:
  • Emergence ➔ Submergence

Let me go back now to my dissertation research that really focused on those years in the 1980s and 1990s when ACHA was leading national efforts to educate about HIV and do something to address the AIDS pandemic. As I mentioned, I had the great pleasure and good fortune to speak with twelve different people who shared with me their stories of
public health, higher education, college health, and social justice from those years through 2008 (and in some cases we traveled farther back in time to our childhoods). Several consistent themes emerged from these collective memories of our history with HIV and AIDS: the fear of the unknown; the recognition of stigma that was ascribed to specific populations; the emergence of new medications; and the new conceptualization of AIDS as a long-term manageable chronic illness. They also told me stories of ACHA taking the lead in understanding HIV and AIDS as something more than a virus or disease pandemic but as a human experience that had emerged at a particular moment in human history, perhaps a once-upon-a-time genetic mutation that jumped across a species barrier as long ago as the Abraham Flexner's original report and the founding of ACHA in the early 1900s.

What the members and leaders of ACHA understood in the 1980s was that addressing HIV and AIDS in higher education required an approach that was not just biomedical; necessary and effective interventions had to pay attention to individual identity, family structures, faith traditions, cultural norms, laws and public policies, international economics, privilege, status, oppressions, the protection of universal rights of women, children, and men, social activist movements, immigration, technology, and politics.
I titled my dissertation, *The Emplotment of Human Dignity and Social Responsibility: College Health Promotion Comes of Age in the Time of AIDS* because of this emergent understanding: that all health matters were human issues that affected human dignity and required social responsibility to preserve and promote the health of all individuals and all communities. This social justice orientation to health was arguably ahead of its time, and certainly predated the “Flexner 2” report of 2010.
An orientation to both health and social justice is also markedly evident in The Ottawa Charter for Health Promotion, presented at the first international conference on health promotion in November of 1986. This charter states, “Health promotion is the process of enabling people to increase control over and to improve, their health...Health is, therefore, seen as a resource for everyday life, not the objective of living” (Canadian Public Health Association and the World Health Organization, 1986). The Ottawa Charter goes on to state that the fundamental conditions and resources for health are:

- Peace
- Shelter
- Education
- Food [and, I would add: clean water]
- Income
- Stable ecosystem
- Sustainable resources
- Social Justice, and Equity
Over 20 years later, recognition of the significant social and economic changes we have experienced in our world (including the globalization of trade, the development of Internet and mobile communications technology, and emergent health threats like the AIDS pandemic) forced a reiteration of the imperative of healthy public policy. This includes an ecological understanding that we must have clean and safe environments and deftly organized community actions (Nutbeam, 2008).

But ACHA is a living organization, a character in its own narrative storyline, and like other living systems and characters, it changes. Less than 10 years after it established the HIV Task Force and the Task Force on Human Dignity, both of those work groups were dissolved or subsumed into other committees. It would be unfair to judge such changes as good or bad – every professional association changes over time. But we should consider what such a past tells us in the present-day: a present day that has already been described once upon a time in the “Flexner 2” report and in many other higher education publications. We know that our higher education landscapes have changed a great deal and our professional associations must do the best they can to keep up or even get ahead of those changes.

I think everyone I’ve ever known who has successfully defended a dissertation takes a step away from it and either thinks it’s just terribly boring writing (and thank goodness that’s over with!) or thinks it’s great earth-shattering innovation (and why doesn’t everyone want to publish this?). I might be in a happily humble middle stage right now, but I do think that one of the benefits of the research method I used is that the narratives of critical hermeneutics might at least stand the test of time.
“SCHOLARSHIP”’ PLAY

- Critical Hemeneutics
- Mimesis and Imagination (Kearney, 1999; Ricoeur, 1992)
- Oneself as Another (Ricoeur, 1992)
- Narrative Identity (Kearney, 2004; Ricoeur, 1992, 2004)

In higher education, people refer to the dissertation (or any graduate education or a thesis or comprehensive exams) as “scholarly work.” The root of that word, “scholarship” is the same word that gives us “scholar” and “school” and it is the ancient Greek word, “schola,” which means “to play.” You see, the ancient Greeks believed that after you work and worshiped, then you were free to play with ideas. And those who played with ideas were scholars and wherever they played with ideas was a school.

In my program proposal for this session, I promised to introduce new vocabulary, new authors, and maybe even new disciplines of learning in this session, so permit me now to review some of the concepts I played with in my research (and I’ll keep this part brief because nobody here wants to be at a dissertation defense):

- Mimesis and Imagination (Kearney, 1999; Ricoeur, 1992)
- Oneself as Another (Ricoeur, 1992)
- Narrative Identity (Kearney, 2004; Ricoeur, 1992, 2004)
Mimesis and Imagination

Putting together characters and settings into some kind of story is the act of what the philosopher Paul Ricoeur called “emplotment” – making the plot. Another scholar, Richard Kearney, says that assembling a storyline provides context and meaning to an identity or action. Knowing the historical context of what happened once upon a time can provide context in the present and allows us to imagine future possibilities. Like the ancient Greeks who played with ideas, the critical hermeneutics philosophers and anthropologists of today play with imagined futures. And this is also a very human experience. Long before my job at the University of San Francisco was eliminated, I was already imagining future possibilities and my present-day actions moved me toward those possibilities – we call that a job search. Mimesis is what Ricoeur termed this stitching together of past-present-future. An additional concept that comes from this narrative orientation is that of horizons: we look to the horizon to greet new days and say goodbye to passing days. In critical hermeneutics, horizons are formed by the
Intersection of narratives and lead to new understandings. So when the story of your life interacts with the story of someone else’s life, there is possibility for change, growth, new knowledge, and especially new questions.

Oneself as Another

A classic storytelling character of a doctor and patient might describe one as the expert and the other as someone who needs expert help. This might be a scene you have witnessed in a teaching hospital or two. In his book, *The Illness Narratives*, Dr. Arthur Kleinman (1988), describes meanings for illness (the personal experience and the experiences of any individual patient’s social network), meanings for disease (the health professional’s experience), and meanings for sickness (the societal/social experiences of health). He also makes the point that these meanings are all shaped by ethnicity, race, class, gender, and global pluralism. In describing a possible future for clinical education, the authors of the recent Carnegie report imagined, “Perhaps what is needed is not a science expert at the bedside, the person with
the answers, but a culture that values productive questions. The solution to this problem may lie less in bringing the expert with the answer to the resident and more in encouraging the resident and his or her teacher to ask the questions” (Cook, Irby, & O’Brien, 2010, p. 153) Expanding this notion beyond the doctor-resident relationship, Paul Ricoeur’s philosophy called for the elimination of the separation between oneself and another. This interrelated existence is also part of the social ecological approach that is espoused in health promotion (McLaren & Hawe, 2005; O’Donnell, 2011) and orients the profession towards a shared obligation to advocate for social justice. Another philosopher in critical hermeneutics wrote that although health might be defined as the absence of illness or disease, it is not a quality or experience that one can impart onto another (Gadamer, 1996). The ecological perspective of health requires interdisciplinary thinking about interconnectedness: of people to each other, of body and mind, of individuals and communities, of children and families, and of cultures and ecosystems (Cloitre, Stolbach, Herman, van der Kolk, Pynoos, Wang, & Petkova, 2009; Emerson, Sharma, Chaudhry, & Turner, 2009; Johnson, 2007; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).
Narrative Identity

When we tell the stories of our lives and when we interact with the stories of the lives of others, we are compelled to construct narrative identities. At one point in the “Flexner 2” report, the authors stated that they “believe that transformation of identity should be the highest purpose of medical education” (Cook, Irby, & O’Brien, 2010, p. 65). They specifically describe a need to create professional communities of learning, where questions are asked freely in the process of lifelong learning. To establish such communities of practice, some medical schools have already started teaching how to take narrative patient histories (instead of just compiling diagnostic criteria). Some of the latest paradigms in student development encourage a similar approach throughout our campus communities: where the responsibility for student learning is shared by all campus stakeholders, shared by all disciplines, diffused throughout the environment, and committed to students developing their own stories, in the process of self-authorship (Baxter Magolda, 2001). Another trend in higher education has been the application of critical theory. One example of this is critical race theory,
which includes these tenets:

- **the centrality and intersectionality of race and racism**, which puts race at the center of all analyses (Solórzano, 1997; Solórzano & Yosso, 2000), while acknowledging that other social identities must also be considered to fully explain the multiple oppressions one may face (Solórzano, Villalpando, & Oseguera, 2005);
- **the challenge to the dominant ideology**, which calls for scholars and practitioners to question race-neutral concepts such as objectivity, meritocracy, and equal opportunity within education (Solórzano, 1997; Solórzano & Yosso, 2000);
- **the commitment to social justice** (Solórzano, 1997; Solórzano & Yosso, 2000), which states that researchers and educators must be committed to eliminating racism and other forms of oppression that exist within education;
- **the centrality of experiential knowledge**, which recognizes the importance of legitimizing the personal stories and histories of People of Color (Solórzano, 1997; Solórzano & Yosso, 2000); and
- **the interdisciplinary perspective**, which requires a historical and contemporary outlook using cross-disciplinary methods (Solórzano, 1997; Solórzano & Yosso, 2000).

Our personal narratives have become richer and deeper as our understanding of human experiences has expanded. And a rich deep understanding of human experiences also orients all of us to a horizon where we must each act not only for our self-preservation but for the full health capacity of all communities to achieve the greatest possibilities of learning, adulthood, freedom and dignity.
And I hope you can begin to see that multidisciplinary thinking, shared ownership, community responsibility, care and compassion expressed as genuine connectedness to others, and a concern for the individual’s rights and privileges to oneself and to all other communities are themes that have emerging now in health promotion, medicine and education (and perhaps many other disciplines that our own siloed experiences have not yet begun to imagine).

WHERE IS HERE? WHAT IS NOW?

So now I have shared with you some of my personal narrative about my research, a narrative about ACHA, a narrative about medical education and physicians, and a narrative from higher education and student development. I apologize to those professions represented here now that I have failed to mention. But those combined narratives that I did mention tell us how we got here. Now I have to ask, where is “here” and what is “now?” This is the logical step in any story that starts out in the once-upon-a-time past; we must move the narrative into the
I have not spent much time in Arizona, so I had to look up some information to give myself some biogeographic and sociocultural context. For one kind of health perspective, here is the Arizona Department of Health Services list of leading causes of mortality and number of deaths in 2009:

<table>
<thead>
<tr>
<th>Rank</th>
<th>Cause of Mortality</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Diseases of heart</td>
<td>10,151</td>
</tr>
<tr>
<td>2</td>
<td>Malignant neoplasms</td>
<td>10,147</td>
</tr>
<tr>
<td>3</td>
<td>Accidents (unintentional injury)</td>
<td>2,887</td>
</tr>
<tr>
<td>4</td>
<td>Chronic lower respiratory diseases</td>
<td>2,808</td>
</tr>
<tr>
<td>5</td>
<td>Alzheimer's disease</td>
<td>2,086</td>
</tr>
<tr>
<td>6</td>
<td>Cerebrovascular diseases</td>
<td>2,010</td>
</tr>
<tr>
<td>7</td>
<td>Diabetes</td>
<td>1,078</td>
</tr>
<tr>
<td>8</td>
<td>Influenza and pneumonia</td>
<td>1,007</td>
</tr>
<tr>
<td>9</td>
<td>Suicide (intentional self-harm)</td>
<td>1,060</td>
</tr>
<tr>
<td>10</td>
<td>Chronic liver disease and cirrhosis</td>
<td>818</td>
</tr>
<tr>
<td>11</td>
<td>Septicemia</td>
<td>528</td>
</tr>
<tr>
<td>12</td>
<td>Nephritis, nephrotic syndrome, and nephrosis</td>
<td>532</td>
</tr>
<tr>
<td>13</td>
<td>Parkinson's disease</td>
<td>446</td>
</tr>
<tr>
<td>14</td>
<td>Essential primary hypertension and hypersensitive renal disease</td>
<td>475</td>
</tr>
<tr>
<td>15</td>
<td>Assault (homicide)</td>
<td>360</td>
</tr>
</tbody>
</table>
Would anyone like to guess which causes of death out of these 15 were not on the list 10 years prior, in 1999? The answer is none: the rank order has changed slightly but the same causes of death were the top 15 in 1999. Does that (lack of shuffling of top causes of mortality) say anything to you now?

Let’s consider a health topic that is no stranger to our past or present and will surely be a factor in our future: alcohol. The College
Alcohol Survey has been coordinated by colleagues at George Mason University and West Chester University, sampling hundreds of colleges and universities, every three years since 1979. For better or worse, longitudinal comparisons of survey data show very little change from baseline years to 2009 in campus policies, prevention and education efforts, resources committed to such efforts, treatment and referral services, or effectiveness and adequacy of efforts (D. Anderson, personal communication, 2011). Perhaps since our campus environments have changed so much in the last 30 years, this is a significant achievement. But perhaps in light of those 30 years of significant changes, we now need to listen to new and different stories and radically change our approach to addressing any campus issue like alcohol use and abuse, and do so in collaborative teams that draw from multiple disciplines of research and intervention.

PRESENT-FUTURE

Let me now segue to two works of non-fiction that are noticeably much more compelling than my own dissertation (what a friend called a “big book report” in her efforts to encourage me that the task was a manageable one). I’m not being falsely humble here: these are two books that have been bestsellers and award-winners. And I think they speak to the enlarged concept of health as a social justice reality that goes far beyond disease pathogens or biomedical research.
Guns, germs, and steel: The fates of human societies, a Pulitzer Prize-winning work by Jared Diamond. In this book (which was also made into a PBS/National Geographic documentary), Diamond describes the rise and fall of civilizations, dictated by warfare, disease, and industrialization. But he also expands this history by taking into account the role of geography of landmasses, migration and trade routes, and environmental climates. If such forces are beyond the influence of any health educator or medical or nursing professional or health insurance coordinator, then it will really take a global commitment to universal health and human dignity to facilitate the growth and wellbeing of all people. That vision reinforces the call for a social justice orientation to health inequities and health, in general.
Next, I want to mention another rare non-fiction science reportage book that topped bestseller and critical lists, *The immortal life of Henrietta Lacks*, by Rebecca Skloot. Many of you may have read this one, so I will just summarize it by saying it describes how HeLa cells came to exist in biomedical research, and it describes the one life of the woman who gave those undying cells to cancer research (or from whom those cells were stolen). I met the author at a book event in Saint Louis earlier this year that included a live interview, an audience talk-back, and a reception. In the interview, Rebecca Skloot said that “we are a storytelling species” and we need histories and stories to understand the importance of things (R. Skloot, personal communication, March 23, 2011). When asked if she would describe her own book as science reporting, she nodded but added that the book “is about class as much as race” and also stresses the importance of equal access to education and scientific literacy (R. Skloot, personal communication, March 23, 2011). Her book is not just a biomedical history.
Addressing health issues requires addressing health disparities and addressing health disparities calls upon every health professional to serve as educators and advocates in all the public policy, law, and culture narratives we have. Doing anything less would simply fail our identities as health professionals who have a duty to care for the dignity and freedom of all people or as educators who have a duty to free the self-authored narratives of all students. So what can we imagine for the future of our leadership in the narrative of health and social justice? Critical hermeneutics suggests that we must place our own stories at the horizon of that larger narrative, and that intersection of pasts and presents, we can imagine future possibilities. The body of knowledge in public health recognizes that health practice and health improvement are individual and community realities that involve health promotion, disease prevention, and clinical care (Cohen, Chavez, Chehimi, 2007).

The reality of our work as advocates for socially just individual and
Community health realities will require complex understanding of complicated issues and a sharper informed perspective on organizational change, systems and capacity building, organizational development, and leadership. We will need new colleagues and new collaborations to form networks of social change (National Public Health Leadership Institute, 2007).

I told you that the invitation to come speak here came to me at a time when I was job searching and luckily when I was interviewing for jobs on different campuses. Whenever I was asked to describe my management or supervisory style, I described myself as a narrative leader – a leader who tells a story with his life, values the language and emplotment of other people’s personal stories, and lives to intersect horizons of other human stories.

If you read the article I wrote for the most recent issue of College Health in Action, then you might have guessed that I have a love of non-fiction science reporting and writing.
One of my favorite authors in that genre, Richard Preston defined the concept of “ecotones:” the boundaries and edges of environments or ecosystems and these are the regions where life thrives (Preston, 2002). This concept was borne out in another natural history book I read that documented that the areas of greatest life in the Antarctic are the places where the cold water and warm water currents meet (Bortolotti, 2008). So if we want life to thrive in the most robust and healthy way, we should look for those boundaries and edges in our professional narratives (the horizons, if you will), or create opportunities for new horizons to be discovered.

My time for prepared remarks is just about up because I do want to engage in a conversation with you too. Soon this presentation will just be part of history. And I know I can take comfort in that, not only because our modern technology has many ways of preserving this content (should anyone ever want it) but because “history” (the word itself) has the word “story” in it (i.e., “h-i-story”). As a matter of fact, the
word “history” was not differentiated from the word “story” in Modern English until the 15th century, and derives not from the word for “histology” which means “standing tissue,” but from the ancient Greek word meaning “knowledge gained from inquiry and investigation.” So my story, that includes many other stories, will simply join a larger human history of questions and answers.

The New Normal

“Every sickness is a musical problem...
Every cure is a musical solution.”

- W. H. Auden

You may remember that near the beginning of my presentation, I referenced a song by U2. Apparently I’m not the only person who looks to music for inspiration. In his Pulitzer Prize-winning book, The emperor of all maladies: A biography of cancer, Siddartha Mukherjee, says that cancer is now our new normal: an inescapable part of our present-day reality of developed nations, environmental domination, global interchange, medical research, and patient care. If that’s true, then I believe that many health realities (disparities and all) are now also our new normal. Near the conclusion of his book, Mukherjee quotes the poet W. H. Auden’s eulogy for a doctor he knew (1969, as cited in 2010):
“Every sickness
is a musical problem...
...and every cure
is a musical solution.”

The reality of health is complex and complicated and will require concerted action in a culturally literate and educationally relevant context.

If that is the new normal and that new normal is its own musical problem, then I turn to a different kind of Pulitzer Prize-winning work, the musical theater work, “Next To Normal” for my proposed musical solution. If you have seen this pop/rock-opera, then you know that it has been described as a musical unlike any other – it narrates the story of a mother, a father, a son, a daughter, the daughter’s boyfriend, and a number of doctors who are all dealing with the mother’s long clinical history of depression, therapy, and medication.
Near the end of this musical, the mother sings a song to her daughter lamenting any possible mistakes she made as a parent, and in that song, she tells her daughter:

“We tried to give you a normal life /
I realize now I have no clue what that is.”
The daughter responds:

“I don’t need a life that’s normal / 
That’s way too far away / 
But something next to normal would be OK / 
Yes, something next to normal that’s the thing I’d like to try / 
Close enough to normal to get by…”

Together they sing: 
We’ll get by... 
We’ll get by...

CONCLUSION

I think this is a remarkable association made up of amazing professionals, committed to both health and also to social justice. I trust that your narratives will fuse with the horizons of our new health realities and I am eager to see what our collaborative partnerships will
I am confident we will do more than just get by – I hope we will all be next to our new normal(s) and then on those narrative horizons we will live successfully, we will live freely, and we will live healthfully.

I welcome the opportunities for continued conversation in the future, and of course right now with the time that remains.

[Audience Q&A – paraphrased/summarized]

Question 1:

The CAS research that was referenced showing very little significant longitudinal changes – where is that available?

Answer 1:

One of the lead researchers of CAS gave me that data and he hopes to develop at least one manuscript describing his 30-40 year history working with CAS for possible publication very soon.
Question 2:
So many injustices we experience are the various “-isms” in our society. In the mental health side, so many of those “-isms” appear acceptable to individuals. What is the present and future in mental and physical health to lead on that edge and model a different way for new generations to achieve a greater good?
Answer 2:
I am often reminded that the body of knowledge that informs my own professional existence in student affairs – student development theory, learning theory, etc. – is all less than 50 years old (half the lifetime of the original “Flexner Report”). So a lot of the work in adult development theory and research (in personal identity development, ally development, faith development, etc.) is still quite young and emerging. We have to look at many other disciplines to look at how we might engage students in new, innovative, different ways.
Many of our own students think that “diversity” has already been covered so we have to do things differently. For example, my dissertation advisor does anthropological research in Thailand with a specific population known as the Mlabri (the “Yellow Leaf People”). The entire counting/numerical system for the Mlabri is this: one, two, many (just three words). That kind of understanding is not being published in popular scientific reports or journals that we might be familiar with, so we need to be aware of new opportunities to engage our understandings of ecology, history, culture, and people and communities. We should do more than look to student development theory or social justice research for those insights to the future.
*The Chronicle of Higher Education* even gives glimpses of the kind of cutting edge liminality in disciplines other than our own (for example, in service learning or transborder learning) – that might help expand our thinking. At my own new campus, Saint Louis University, there are interprofessional degrees in many of the health sciences academic programs. But we are even seeing the call happening now in the medical profession that doctors must do more than simply diagnose and treat; they must investigate and serve as public policy advocates for individuals and communities. So let’s think about how we can partner with centers on our campuses that push those disciplinary borders of liminality to get us moving our communities in new and interesting ways. I also acknowledge that we are each pushed to do a lot within our own work roles and disciplinary specialties, but sometimes we also fall
into patterns that are comfortable. We may need to push beyond those comfortable boundaries of what is comfortable and seek out information from other disciplinary perspectives.

Question 3:
What’s next for health education? Considering these new perspectives and new lenses to look at things, where do we go from here? What’s the starting point when we go back to our home campuses to start to address inequities and social justice?
Answer 3:
If you have a new lens or new vocabulary or new perspective, that “present” now becomes a new “past” – that becomes the history that informs your work. There is no one single path. If you are now newly informed, what does that do to your story and how does that change the person you are? How do you engage your full personhood and engage other personal stories? Critical hermeneutics theory challenges us to cross-disciplinary boundaries, engage communities, and consider where we have responsibility to change things, name our assumptions and biases, and share our privileges. There is another concept in critical hermeneutics called “communicative competence” which clarifies that in order for there to be a meaningful exchange in a fusion of horizons (to generate new knowledge at that liminal border of different narratives), there must be common vocabulary. So if any of this is new, your next step might be to share this new vocabulary with your colleagues. You may find that your campus colleagues (for example those in student affairs) were looking for this new vocabulary or that they had similar new vocabulary (from another discipline) and they had no idea that they could approach you with similar perspective. If you can approach your work as “stories lived,” then you should continue to live your story.

Question 4:
As an undergraduate studying health promotion, what do you think is my future work in this field? How can we address all those issues of oppression and social justice?
Answer 4:
Welcome to you and thank you for studying this important field. To answer the other earlier question (“What is the future of health promotion?”), I think you should ask this person that same question: his
story is the answer, so engage this person’s narrative with your narrative and discover new directions and generate new knowledge.

If you consider the storytelling concept of “epitomation,” you can look at any topic (like the topics being covered at a conference like this or in the journals that we may read), and ask, “What is the story being told here?” And then you can go beyond that to look at characters (who is included in that story and who is excluded; what other characters – like legislators or non-profit agencies – could be included?) and context (what does that story have to say about socioeconomic class or privileges or social advantages?). I think there are some other new works being published that look at things from that kind of multidisciplinary and community responsibility contextual perspective, so we just have to be on the lookout for them.

I hope you enjoy the rest of your meeting here in Phoenix. I appreciate the work you do! Thank you all so much for this time.
REFERENCES


Pecci, M, & Laursen, M. (2010, April/May/June). A shift in college sports medicine services under the umbrella of student health. *College Health In Action, 49*(4), 1, 29


