WHAT DOES THE FLEXNER REPORT SAY TO ASCD?

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OVER the past eight to ten years the Association for Supervision and Curriculum Development has been formally concerned about the professionalization of supervisors and curriculum workers. The past work of the Commission on Professionalization, the present purposes of the Committee on Professionalization, and the ASCD 1965 Yearbook [1] all attest to this major interest. Within the total family of educators — teachers, administrators, teacher trainees, and specialists, the question of how we relate to the definition of a profession has been a historical issue as well as one of contention with the lay public.

What are some of the major problems in the upgrading of performance of all educators, especially of the group known as supervisors and curriculum workers whose ranks are growing each year?

Regardless of a general definition of a profession, there are agreed-upon characteristics, be it in the fields of medicine, law, theology, architecture, dentistry, pharmacy, or others. Some of these common factors are: entrance requirements, preparatory training, clinical or field experiences, accreditation, licensure or certification standards of performance, and ethical practice. Generally, all these component parts constituting a profession are controlled and policed by the membership.

As educators pursue the professionalization of educational workers, they turn to other professions for analysis as a base for comparison, hoping that from such study we may better understand the qualities that illustrate desired standards common to all. The medical profession is considered to be the classic example with overtones of the ideal as a pattern for emulation.

The history of the development of the medical profession both in America and Europe supports the "test tube approach," for the quality level of modern day medicine is the result of much research and action within its ranks. It is a colorful story, filled with much soul-searching and self-criticism. The use of its experience in total and direct application to the educational profes-

[1] Association for Supervision and Curriculum Development. *Role of Supervisor and Curriculum Director*. Washington, D.C.: the Association, 1965.

sion is not suggested or implied here, rather, it is recomended that in describing the progress of medical education, we achieve a perspective for our own.

Observer and Critic

Much credit for the professional upgrading of the medical profession is given to one man, Abraham Flexner, who at the time of his death in 1959, at the age of 92, was revered for his contribution to medical education and to education in general. In this fact there is a modern day parallel, in that even as the educational profession has its critics outside its ranks, so A. Flexner, a prime observer and critic, was not a member of the medical group. In reference literature he is identified as an educator.

Mr. Flexner gained some national attention in 1908 for a report entitled, "The American College: A Criticism," which brought him to the attention of the Carnegie Foundation for the Advancement of Teaching. At the invitation of the Carnegie Foundation that he undertake such a project, he published in 1910, after two years of visitation and study, a report, "Medical Education in the U.S. and Canada." This document is known as the "Flexner Report."

The reading of his autobiography[2] is interesting and of value to all educators, for Flexner spent more than seventy years of his life contributing to American education and research.

In 1908, at the time Mr. Flexner launched his study of medical schools, the calibre of medical practice and the preparation of medical training attributed to the medical schools in the U.S. and Canada were being questioned. "The practice of medicine, long a professional calling in Europe, was then (1910) still a trade in America."[3] The well known motive of the founders and operators of medical schools was profit making. Cutthroat competition for students was unbounded.

As Flexner approached his visitation of operating schools centered mainly on the east coast and in the midwest, two factors characterized his efforts. One, Flexner went totally unprepared as to survey methods and instruments. Two, his point of view was that medical training was a form of education and not a mysterious process of initiation or professional apprenticeship.

He found that a lack of basic training

[2] Abraham Flexner. *Abraham Flexner, An Autobiography*. New York: Simon and Schuster, 1960.

[3] John Lear. "Who Should Govern Medicine?" *Saturday Review* June 5, 1965. p. 39.

due to inadequate facilities and teaching aids was universal. It was not uncommon for Flexner to discover classrooms completely devoid of charts, apparatus and equipment.

Flexner thought it necessary that clinical training be obtained through contact with patients in local hospitals. He found this need either not being provided for or hospital facilities and staff for this purpose, in his own words, "in wretched condition."

Working upon the assumption that a medical school related to a college or university should measure up to the institution's standards for training, he found these standards only weakly integrated and correlated.

After a number of visits to medical schools, Flexner began to approach his inspection in an organized manner and he shortly formulated a set of criteria. In his report, Flexner summed up what he called the decisive points, which when known, were conclusive as to the quality and value of a medical school.

First, the entrance requirements. What were they? Were they enforced?

Second, the size and training of the faculty.

Third, the sum available from endowment and fees for the support of the institution, and what became of it.

Fourth, the quality and adequacy of the laboratories provided for the instruction of the first two years and the qualifications and training of the teachers and the so-called preclinical branches.

Fifth and finally, the relations between medical school and hospitals, including particularly freedom of access to beds and freedom in the appointment by the school of the hospital physicans and surgeons who automatically should become clinical teachers.[4]

[4] Op. cit., Flexner, p. 79.

Parallel in Education

With slight modifications of this list, mainly by changing a few words and terms such as "preclinical branches" and "relations with hospitals" to "research and demonstration centers" and "field experiences," one can readily apply the decisive criteria to any aspect of the training and practice of teachers, administrators or curriculum workers.

The American Medical Association, through its Council on Medical Education and Hospitals and the American College of Surgeons, is the influential watchdog of medical training in medical schools and hospitals. Accreditation of these institutions is crucial to their existence. Also, the number of such schools is controlled through the rigid standards set.

Through the professional organizations, state standards for examination before a board of examiners and the granting of a license to practice all hinge upon meeting the requirements set by the profession. Such conditions also exist in other professions mentioned earlier, i.e., law, pharmacy, dentistry.

In an earlier generation it was practically necessary for a physician to go to Europe for postgraduate work. Today the U.S., along with England and Scandinavia, is outstanding in postgraduate studies and medical research. The influence of the Flexner Report can be credited also for this development.

The study of the history of the medical professionalization and the career of A. Flexner is exciting and informative. However, drawing direct implications from the evolution of the medical field for a professional group in education is fraught with danger.

Nevertheless the history of fifty-plus years of conscious analysis and improvement of medical training does supply us with clues as to major factors involved in professionalization of any group of workers.

As supervisors and curriculum workers, we should give serious attention and united effort in analyzing our own professional growth in the following areas:

1. We need a nationwide systematized study of current conditions hindering professionalization.

2. We need to consider setting standards for recruiting and selecting future supervisors and curriculum workers.

3. We should work to strengthen preservice training specialization programs to insure concreteness in the program which needs both the theoretical classroom studies and field work.

4. We should ask for and assume a definite role in setting standards for certification by working with certification agencies.

5. The association should take steps to study taking direct responsibility for policing the rank and file membership for violations of acceptable practice.

6. We should develop a specific program nationally, statewide and locally to improve the public image of supervision and curriculum work.

7. We can note the fact that professional preparation is an expensive venture in which the amount of financial support and investment in training is directly related to the quality of such preparation.

To those who seek a fresh viewpoint and one that is substantiated by experience, especially as they probe the progress of instructional workers' self-evaluation and efforts to professionalize themselves, we suggest that the foregoing summary of medical professionalization may offer a perspective and a hopeful direction.