Social Medicine, New Medicine? A curricular integration driving deeper learning with the social drivers of patient care.

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Abstract

In response to a curricular vision of improved social accountability, our Doctor of Medicine program launched a year-long integrated Social Medicine course designed and implemented for Year 1 medical school students. Our school is a moderate sized medical school serving a region of close to 2 M people in central Canada. The Schulich School of Medicine & Dentistry Doctor of Medicine Program at Western University, London, Ontario Canada, is grounded in a four-year curriculum, each year comprised of up to 171 students with a clinical clerkship in Year 3. Our curriculum is delivered in a distributed fashion between two campuses approximately 200 km apart: London (133) and Windsor (38) learners.

The vision of our leadership and learner partners was to provide students with an opportunity to concentrate early in their career on the impact of social, cultural and economic forces on medicine and patient care. Under the umbrella of this new Social Medicine course, we incorporated previous courses in population health, epidemiology, ethics and service learning to provide an exposure to cultural and societal roots; social inequalities; factors impacting treatment outcomes; ethical challenges and experiential community learning opportunities. This article, based upon our Short Communication, "Social Medicine, New Medicine? Redefining Social Medicine for Year 1 medical students", presented at AMEE in Barcelona, 2016, will discuss the origins of our course design as well as the rationale, objectives and caveats of this particular course.

Keywords: social accountability, social medicine, service learning, undergraduate medical education, curriculum design
Background

Schools struggle to create a context of learning around the community and societal needs that support students understanding the deep impact of the social determinants of health on patient presentation, progression and outcomes. Students are steered through social learning experiences such as service learning to rediscover what they cited as why they entered medicine. (Hunt et al 2011) However, while a traditional approach of offering individual courses in meeting the social values of care fulfills learner satisfaction in a traditional pedagogic model, it loses out on integration and presentation in the actual context of patient care. (Eckenfels 1997)

A mandate of our program leadership was a vision to advance social accountability in our curriculum. To do so in 2015, prior to the design and implementation of our Social Medicine course, we implemented "Service Learning" into our Year 1 curriculum. In designing this portion of our curriculum, we were aware this educational approach was rooted in the pedagogical theories of Dewey and Freire (Deans 1999, Ferrari & Cather 2002, Stewart & Wubbena 2015)

Canadian and American medical education is grounded in a national accreditation standard directing the mandatory implementation in curriculum of service learning. (Schools of CoAoCM 2015, Education LCoM 2015) Our mandate for service learning within our program was to follow a traditional model of uniting academic study and community service in mutually reciprocal ways. We strongly believed that through students' journey as medical learners, it is vital that these future physicians be socialized early in formal curriculum through a community of practice which included exposure to both medical knowledge as well as social interaction. While purposed not to be acting with patients and families within a medical capacity, we trusted that our service learning experience would foster their learning in four key domains: reflection, self and other awareness, engagement, and systems knowledge.

Our Service Learning course was introduced in Year 1 in response to an identified goal of early exposure to these topics within a generalist frame. Through confronting the issue, we had noticed learners drifting away from community service after matriculation. Our purpose was to deepen early in their studies, student understanding of the impact of the determinants of health in individual, family, group and community disease and wellness. The educational experience was structured to avoid any role as a medical expert and to allow learners to understand what patients were facing each day in barriers and lack of support or access to essential needs for improving their health and wellbeing.

Service Learning course was based upon the following objectives:

1. To identify the concept of service learning and recognize its importance to students' own professional identity formation.

2. To develop skills to engage in authentic community engagement in order to develop reciprocal relationships with community members and organizations.

3. To foster the examination of values, beliefs and social responsibility of future physicians within the context of a community and its needs

4. To aid in awareness in developing a deeper understanding of unconscious bias and the ways in which we make decisions based upon these biases.

5. To promote awareness of the activities of service agencies within the community and a focus on how they align
with health care systems including aspects of governance, health equity and health disparities.

While there is a body of robust literature on the challenges and merits of Service Learning in a medical curriculum, it is widely reported that many institutions of higher education are "reaffirming their dual obligations to educate students and provide benefit to the communities they service through a form of experiential pedagogy called service learning" (Cantor, 1997). Our requirements for our first year medical students were that they complete a minimum of 14 hours of service learning in a placement of their own choice and that they provide two reflections on their experiences. This experience could provide a paper of its own, however, the purpose of explaining this part of our curriculum is to inform on the rich information we gathered as we began to design our Social Medicine course.

A vivid stimulus for our innovation towards designing the Social Medicine curriculum was student service learning reflections. The most powerful reflection upon this experience was one student's prose which talked honestly about her feelings of sitting in a local community center auditorium counting and sorting through boots which had been donated for distribution to those with demonstrable need. Her initial thoughts focused around a disconnect between the manual task of sorting through used boots and her dream of what medical school would like look. But, after hours of sorting, she posed questions: "Who would donate these boots?" "Who, in this relatively rich city actually needed these boots?" This student then felt compelled to look at the social economic patterns of the community to see if there is a significant portion of the population who would actually need this type of service. She found surprising statistics that showed the high level of need while not previously visible to her and peers as community members.

Those two questions from this student's reflection weighed heavily on our minds as we held the debrief about our first year's implementation of Service Learning. It became clear that this particular student was able not only to critically pose these questions but also to actively seek answers to her questions. It was this type of experience that initiated our thoughts into a new direction for our curriculum. We felt that as service learning was a stand-alone experience for the students, there would be many who could ask and answer these questions on their own; however, there would be many who would neither ask the questions nor seek the answers. For this reason, it became clear that our service learning experiential learning component of our curriculum needed to be embedded into a more meaningful and guided pedagogy.

Summary of work

During the 2015 academic year and the summer of 2016, we began plans to design a new Social Medicine course – innovating from and with the content of previously separate courses. We were aware that social medicine was by no means, new medicine. From a historic perspective, Social Medicine owes a great debt to Rudolph Virchow, the liberal politician and founder of cellular pathology. Virchow postulated that there exist many correlates to disease: disease is related to the biological, behavior and social characteristics of the patient as well as the surrounding habitat in which both disease and patient exist (Porter 1996). We recognized that part of our planning was to design a framework that acknowledged an understanding of the interaction of biomedical and social medical forces in society and the lives of patients. Once again, our literature search indicated that we needed to meaningfully and intentionally create links between "these seemingly disparate worlds…of medical education that takes social medicine perspectives seriously" (Kasper et al 2016). We wanted our course to offer insight into the window of patients' rich social histories: language, housing, religion, immigration status, employment.

Our goal for this course is to provide an exploration of structural competency so students can begin to develop a discourse around the realities of a chosen demographic population while examining interventions which could
possibly reduce health inequality in patients at the level of neighborhoods, institutions, and policies.

The overarching objectives for our first iteration of the Social Medicine course are:

1. To introduce social medicine as a course which will provide a place for students to actively examine the social determinants of health.
2. To address the social dimensions and determinants of health and the health care system.
3. To focus on the sociopolitical and economic conditions impacting health, disease, access to care and the practice of medicine.
4. To provide an environment for students to begin to define their own roles as future physicians.
5. To provide active, experiential and scholarly learning opportunities for students to explore one demographic population.

Our curriculum had offered individual courses focusing on the social determinants of health: Ethics, Population Health and Epidemiology. While our assessment and evaluation processes demonstrated integration, student indirect feedback, consistently indicated that they failed to understand the inter-relatedness or relevance of the content in these courses in any meaningful way. We questioned a new state of a full integration that would drive deeper student learning and use of this critical area in patient care.

Based upon program consistent feedback, we decided to design and implement this new course upon a structural competency framework that included components of cited individual courses presented as one integrative course of study. Under the umbrella of Social Medicine, we have combined these modules with the purpose of establishing transparencies in order to bring these sometimes invisible structural determinants to the forefront for our first-year medical students:

Social Medicine: focus on culture and social roots

Population Health: focus on social inequalities (gender, class, environment, ethnicity) and how all contribute to the health conditions and access of care.

Epidemiology: focus on factors affecting treatment outcomes.

Medical Ethics: focus on ethical challenges: political, legal, social and economic realities

Service Learning: focus on synthesizing coherent narratives that illuminate the care provided to future patients and finding new meaning with individual encounters in order to place them within a larger context.

Within the Social Medicine course, students are required to complete a year-long project in teams of three. Student projects require submission of three reports throughout the year. They will be asked to identify what they perceive as some major obstacles for their chosen demographic population in order for them to achieve optimal health; they will be asked to participate in the scholarly activity of research using evidence based literature to more fully explore the health issues in terms of their chosen population; and they will be asked to develop a tool kit to demonstrate possible solutions to overcoming the major obstacles for their chosen demographic. Once the three reports are submitted, students will participate in a conference-like setting at the end of the year to present their findings to one another. The demographic groups chosen by the students (171 students) in this inaugural year were: People suffering with Addiction, Elderly, Disability, HIV/AIDS; Homeless, Indigenous, LGBTQ, Low Income, Mental Health, New Canadian, Palliative; Refugee, Domestic Violence, Youth.
Students were also asked to choose a Service Learning experience related to their chosen demographic. Overall, response in the community has been positive and we have seen overwhelming welcome from many agencies. We have worked closely with our school Indigenous Liaison to help us find placements within local Indigenous communities; some placements designed specific projects for the volunteering students; some placements have asked the students themselves to design their own project and plans for their experience with them; agencies that had capacity issues and could not accommodate all three members of each group often offered other placement suggestions. Students were provided with a list of placements from our last year’s iteration of Service Learning; many, however, choose to find their own placements based upon the theme of their projects. Integration of their service learning with the contexts of previous courses was purposeful, longitudinal and related to driving home the messages students were hoped to be experiencing at the time of their projects. We provided tools in previous siloed courses that seemed without anchors – now in the context of their project and related to what their community partner experience was demonstrating to them as future physicians.

Discussion

Our review in creating this innovation was guided by literature and this added value to what our program visioned for graduates – socially accountable team players who understood all aspects of patient care. Authors cite service learning in medical education as improving learning advocacy, communication, team work and social insight. (Essa-Hada et al 2015) Others have seen advancements in student competency with understanding impact of social constraints, economic challenges, culture and ethnicity, bias, interprofessional skills, lifestyle on health outcomes. (Smith et al 2013, Stewart & Wubbenza 2015) Studies cite that we do not have firm long term outcome data from implementing service learning in curriculum, however there is evidence in working in the community to building immediate improvement in health advocacy, awareness of community needs, working with other health professionals, leadership, discipline, enlighten of patient needs and more in-depth curricular experience. (Belkowitz et al 2014, Ferrari & Cather 2002, Hunt et al 2011) We propose that this lens in curriculum needs to be emphasized and broadened to reach our collective vision of social accountability.

Success builds from a principle of trust – trust in and between students, the program and community partners. (Ferrari & Cather 2002) This is not only trust in the learner growing from the curricular structure but also trust that community partners will meaningful engage with our students. All are vulnerable in this relationship and close attention to establishing and maintaining this trust is key to delivering an effective and meaningful experience for students, schools and the communities they serve.

Our course and school have experienced a split in student engagement between full and poor engagement in understanding social learning objectives. While many factors could be the root cause, the lack of previous similar events in curriculum may have bred a student hidden curriculum against implementation. While root cause is not clear, factors including hidden curriculum, the high representation in many school student composition from affluent families and understanding of value in their career is cited. (Stephens et al 2015, Smith et al 2013)

Medicine is not alone in using lessons from non-expert learning rooted in the context of societal drivers to improve graduates’ competency. There are lessons from other disciplines we can learn from others in adopting service and social learning as a prescribed experience or raising caution on learner alignment. Medical curriculum has moved to select and support learners who are more than experts. Business education point to service learning as an effective means of moving learners to approach their career from a broader perspective – working in teams to engage and understand their community while developing meaningful skills in critical thinking. (Sabat et al 2015) Other health professions have used service and social learning for over two decades to drive a deeper understanding in the
Determinants of health. Recent reviews of nursing, occupational therapy and pharmacy education cite this as gaining interest across all years of nursing education and serving to advance learner competency and understanding in: applying class content to careers, communication, team building, role awareness, civic awareness, leadership, determinants of health and personal growth. (Murray 2013, Taylor & Leffers 2016, Yancey 2016, Schlesselman et al 2015)

As with most experiential learning planned within a curriculum, the key issue for our course has been patience. There is a fair amount of documentation required as well as dialogue amongst the students, our undergraduate medical education office, and the partner community agencies. The feedback we have received from learners, community members, organizations and assessment outcomes has been encouraging and insightful. While some learners struggle to understand the complete context offered using the lens provided to them, most are keenly engaged and many have voiced a desire for a more prolonged engagement with partners across their years of study. Overall, from our early results, we feel there are great strides being achieved with our community as we build a meaningful and trusting relationship with our stakeholders. From this new experience, we feel confident in delivering on our curricular vision so that students will be able to reach our school and country vision of greater social accountability in our graduates.

Conclusion and Caveats

Medical education is moving rapidly in Canada and internationally to be transparent in improved social accountability. We present our results in structuring a new course, purposed to deliver early in medical school studies, the key driver of social forces impacting patient care. This course pedagogy combined didactic lectures, small group learning, independent study, group presentations, workshops, working in teams and service learning. The course center piece is a year-long project where students, working in groups of three, learn from and within community engagement. By studying how illness is socially constructed, students are able to integrate the knowledge from their Ethics, Epidemiology and Population Health courses, as well as their Service Learning experience, to examine how social forces shape our understanding of and actions towards health, illness and healing in care. The project was designed to provide an opportunity for each group to explore the political economy, institutional and professional structures and norms on health care of a specific local demographic population.

As we move through the first iteration of this course, we have come to realize that it can be challenge teaching first year medical students entering medical school who are coming from diverse backgrounds. Very few have a social science background and their experiences and exposure to these topics and this type of assessment is limited. Even for those matriculating with a social science background, it becomes evident that most students quickly learn to value the "medical expert" components of the curriculum and often see this type of course as "busy work". It will not be until our course evaluation is analyzed that we will know if we have provided a meaningful experience for our students or if this course will merely be perceived as a re-packaging of former courses.

Our Service Learning component of the course may be found to be more meaningful to students now that it is connected to their year- long project; however, we know from the literature that this type of experiential learning is dependent upon not only the chosen placement but also the student’s level of engagement. We will conduct a comparison of experiences from this year and our students’ experiences from last year. This will be a topic of future
research for our program.

While our goal is to integrate Social Medicine throughout the four-year curriculum, we see this new course as meeting head-on the challenge of deciding how to create and sustain a longitudinal curriculum of Social Medicine and how to imprint these key outcome objectives in our graduates to use throughout their careers.

**Take Home Messages**

Social Medicine is not new medicine. As we reviewed our own curriculum, we found that the invisible structural level determinants of health were inadequately delivered. During the pre-clinical years, we often see one or two objectives focusing on the social determinants of health; during the clinical years, often the only reference to social medicine is the obligatory "social history". As Westerhaus, et al, 2015 has stated, a curriculum "without explicit education about social context, our future physicians may struggle with recognizing and responding to the social factors that are often the root of patients' risk and experience with disease" p. 565.

We propose our educational innovation has not only provided a forum for our students to begin to develop the ability and the understanding of the importance of engaging in their patients' social world, but may also shape early values of team work, advocacy, empathy, communication and social accountability in a future generation of care givers whose career will require this discourse in each patient encounter.

**Notes On Contributors**

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Appendices

Declarations

The author has declared that there are no conflicts of interest.

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