

## From the Classroom to the Community: Cultivating Social Responsibility in Medical Education

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### Abstract

This paper explores the experiences of two first year medical students through the Local Global Health Elective, a year-long clinical placement program developed through the Dalhousie Global Health Office. The article begins with a narrative exploration of the clinical experiences of the authors during their elective placements in two underserved local Halifax communities. The paper then explores the shifting paradigm in medical education around how learning objectives related to the social determinants of health are met in undergraduate medical education. The article concludes with a discussion about going beyond teaching the social determinants of health in a controlled classroom setting. The authors argue that in order for medical students to translate knowledge about the social determinants of health into behavior and action that reflects the unique needs of each patient, a participatory solution is needed.

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The patient sitting in front of us looked terrible; he was shaking, sweating, pale, and his face was clenched in pain. As an inexperienced first year medical student, my thoughts leapt to fears of a myocardial infarction. My preceptor, however, quickly assured me this was no cardiac crisis. This was panic and the cause was nothing a medical degree could cure: the patient had just been informed that he had been dropped from his drug plan and the medications he needed to control the chronic pain that racked his body would, in less than a week, become hopelessly too expensive for him to afford.

The story of what brought him to the clinic is one that is played out all too frequently, in Halifax and across Canada. Sitting in front of us was a patient who was patently unwell, but for all its remedies medicine had very little to offer him. Our patient was a labourer whose work had aggravated longstanding vertebral osteoarthritis. With three children to support and very limited alternatives for work, it was clear that the man in front of us had few resources to act on a prescription for rest and lifestyle change.

This story is played out in clinic offices across the country each and every day. While the patchwork may differ at first glance, the threads are one and the same. The social determinants of health – education, occupation, gender, ethnicity, social supports, among many others – matter a great deal and frequently matter a great deal more than any amount of medicine our healthcare system can offer.

### Shifting Paradigms in Medical Education

In recent years, it has become widely accepted that medical graduates should understand the relationship between the conditions in which people develop, work and age and the quality of their health and wellbeing.<sup>1</sup> Medical education curricula have undergone significant reform with the inclusion of learning objectives that focus on the social determinants of health, health inequities, and the needs of underserved populations. Indeed, identifying community needs, including barriers to health care access and the needs of society's most vulnerable, is a core educational outcome expected of MD graduates at Dalhousie.<sup>2</sup>

At a national level, the integration of a social determinants framework is supported by the Royal College of Physicians and Surgeons of Canada, which describes physicians as health advocates that “responsibly use their expertise and influence to advance the health and well-being of individual patients, communities, and populations.”<sup>3</sup> However, despite the strong push for incorporating a social determinants framework into medical education, health advocacy is regarded as one of the most challenging CanMEDS roles to integrate into medical training.<sup>4</sup>

**Reflections Between the Classroom and the Clinic**  
Dalhousie University's Global Health Office provides the opportunity for medical students to cultivate an interest in the social determinants of health through a community-based program, the “Local Global Health

Elective”. Drawn from our participation as first year medical students serving underserved and hard to reach populations in Halifax, this paper is a reflection of our year-long community experience. Over the year (2012-13), we experienced health through the lens of both clinical encounters and community programming. From street health outreach and Aboriginal advocacy to prenatal education and methadone replacement, this elective experience enabled us to actively participate in our community across a wide spectrum of health and social needs.

Having studied the social determinants of health in an academic setting before medical school, we were keen to apply our knowledge in a hands-on way through the lived experiences of real people. Practicing with compassion, physicians are expected to adhere to “the ethical and professional issues inherent in health advocacy, including altruism, social justice, autonomy, integrity and idealism”<sup>3</sup> The following reflections document the small measure of our experience in putting these ideals into practice:

“Un-biased, non-directive, non-judgmental.” These are terms that most medical students can recite and define by heart – and rightly so. Nonetheless, set against the noble goal of building a medical practice based on compassion and healing are the altogether imperfect realities of human nature. As medical students and physicians, we are privy to some of the most wrenching, frustrating, and heartbreaking of human stories. One of the important lessons that we’ve learned during our time with the Local Global Health Elective is that there are no perfect patients. This is not a value judgment; indeed, were it any of us on the other side of the Johnny shirt, we’d be far from perfect too. When you’re working with patients who struggle with addiction, IV drug use, opiate abuse, the occasions for disappointment, frustration, even anger, are many. The challenge, we have found, is finding ways to maintain that sense of openness and non-judgment when presented day-in and day-out with patients that face the realities of intersecting social disadvantage that lie outside the realm of personal control.

This challenge is compounded by the reality that, by virtue of our profession and the experiences that brought us to the point of an acceptance letter, as medical students and physicians we are in a position of power.

There is no denying that to be let into the doors of medical school, the steps before were paved with opportunity. Just as the social environments in which we are born, grow, work and age shape our health, so too they shape our access to postsecondary education, our ability to volunteer, travel, work and invest time in our hobbies and interests. While these experiences have fundamentally changed who we are as human beings and how we understand the world, it makes us wonder about the divide that such privilege creates in our relationships with patients.

It was a gap we both felt, probably most tenderly in those first weeks because we were so green to medicine - new to the idea of walking into a small room in which complete strangers are prepared to trust you with their most deeply personal of stories. Is it because I am educated? How I was brought up? Where I live? Because of my profession? My status? Suddenly, people trust you with important parts of their lives without knowing who you are. That one-sidedness was an entirely new experience.

In those early days, we were thrust into the quickly moving current that trailed behind our preceptors. As the weeks drew on, we grew less awkward and more confident in the fact that we were people worth sharing stories with. At the same time, our attention to the one-sidedness dwindled. We realized it was less of a question of us and them and more a way of interacting and communicating, that our preceptors demonstrated, in ways to generate an authentic connection to our patients amidst this dichotomy of power and privilege, poverty and injustice. We learned it was about meeting people “where they are.”

### The Challenge

Our intent here is not to make platitudes about the need for more compassion and less judgement in the medical system. Those needs and values are well established, if imperfectly practiced. The insight this elective experience gave us was that knowing these values in theory is not the same as experiencing them as you sit across the room from a patient. To us, it’s not enough to learn these values in a controlled classroom setting. Translating knowledge about the social determinants of health into behavior and action that reflects the unique needs of each patient is tough and there is no perfect

expression of these ideals. All the same, our experience last year showed us that the only way to learn is by observing preceptors, engaging with patients, trying (and failing) for ourselves, and continuously dialoguing about the process.

In practice, curriculum objectives that focus on the social determinants of health have largely been met in the context of didactic lecture-based learning and controlled case-based learning settings. With minimal explicit focus on recognizing and appreciating how the social determinants play out in the lives of the patients we encounter in real life, we are left wondering how a traditional classroom-based educational model alone can sufficiently prepare future physicians to understand and respond to health inequities. Having been exposed to an elective experience that encouraged us to engage with and reflect on these issues, we are curious if a participatory solution to developing a sense of social responsibility and accountability to address inequities in health and health care might bridge the gap between learning and doing.

Although curriculum development is a challenging undertaking, we believe that small tangible refinements could make a big difference. For example, elective objectives are student-driven and the requirement that at least one of these objectives focus specifically on the social determinants of health would be a simple change and one appropriate for every field of medicine. Another opportunity might be to build on the brief community immersive experience requirement in Dalhousie's second year Professional Competencies unit. Rather than spending a one-off evening with a community organization, students could be partnered with organizations that they meet with throughout the year. In so doing, students develop a sense of community needs, effectively preparing for their role as physician advocates.

Acknowledging the role of the social determinants in pre-clerkship classroom learning is an important start to continuous curriculum improvement that includes such objectives at the core of every elective and clinical experience. Finding ways to apply these ideas and engage in discussions about the lists of social determinants we have committed to memory will sharpen our ability to provide care. Furthermore, it will go beyond fixing current health problems, towards a culture of preserving and promoting health. If we are to practice what we are taught, that the social determinants play into all aspects of health and health care, we must consciously examine how and what it means for the patients we encounter

day-to-day. In doing so, we will emerge better prepared to steward our community's health.

Failing to grapple with the social determinants of health means failing to grapple with the needs of our patients and this is nowhere more true than in those patients who are most vulnerable. In cultivating an understanding of the broader social structures that can enable patients to thrive or impose barriers that they must struggle to traverse, we can find a place where authentic connections are possible and healing is empowered. Looking back on our own awkward first encounters, we feel that no amount of classroom based learning is going to prepare us for the sometimes grim realities of medicine in the community. This is not a bad thing, rather the chance to stumble and learn is a good thing; one we hope every medical student can experience in their curriculum.

## References

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