

2016-12-16

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<http://hdl.handle.net/10026.1/8595>

10.15694/mep.2016.000152

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The history of sociology teaching in United Kingdom (UK) undergraduate medical education: an introduction and rallying call!

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Categories: Curriculum Planning, Medical Education (General), Teaching and Learning

Received: 13/12/2016

Published: 13/12/2016

Abstract

Based on a review of the literature, this article provides an introduction to the history of sociology teaching in UK undergraduate medical education. Aimed at an international community and at individuals either new to the field or with a general interest, our objectives are to situate sociology teaching in UK medical education within its broader historical and political setting, to highlight the work of past social science teachers, to draw attention to the modern day context and to ask: 'what now'? We are particularly interested in the changing role of the sociologist in teaching medical sociology. The behavioral and social sciences (BSS) were introduced to UK medical training in 1944, 34 years after the Flexner reforms (which although originating from the United States impacted significantly on the UK). From the 1970s UK academics with a responsibility for teaching medical students made significant progress with respect to: promoting sociology within medical education, designing teaching, and observing where barriers and opportunities to learning lie. This activity slowed however between the mid 1980s and late 1990s when medical training shifted from being discipline based to integrated and clinically focused. Following the 1990s' sociology teaching became dispersed throughout medical training and the responsibility of multiple stakeholders. Since the new millennium it has been recognized globally that trainees graduate from medical school unequipped to cope with the rapidly changing social context of medicine. Our paper concludes that coupled with new pedagogies, integrated curricula have given rise to many exciting opportunities for sociology teaching in UK medical education but also to new challenges including the repetition and misinterpretation of content. A systematic examination is therefore required of what works and what does not. Aspects of this activity are particularly suited to those individuals with an academic background in sociology who remain as teachers in medical education whom we argue have much to gain from working collectively.

Keywords: Sociology, Medical Education

Article

Introduction

The aim of this article is to increase awareness of the context in which sociology teachers working in UK medical education operate, by situating it within a broader historical and political setting and highlighting the work of social science teachers on whose legacy we build. Focusing in the main on the UK and with some reference to the US we provide an historical overview of the relationship between sociology and medicine and a brief description of the emergence of the sociology of health and illness as a subfield of sociology. We then describe successive policy developments in medical education in relation to sociology teaching in the UK and what has been said about which aspects of sociology should be included as content. We conclude with suggestions about the state of sociology teaching in UK medical education and comment on the role of the sociologist in undergraduate medical education today. Whilst this article is UK based we see the teaching of sociology in undergraduate medical education as an international project and therefore consider ourselves to be providing a significant insight into one aspect of the global picture.

Sources, searching and synthesis

Our article is based on a review of the literature that sought to explore more broadly what has been written about sociology teaching in medical education. The overarching question guiding our enquiry was, ‘what might be learned from the history of sociology teaching in medical education that might benefit our practice today’? Using the database EBSCO, we identified papers by combining the terms ‘sociology’, and ‘social science’ with ‘medical education’, ‘medical curriculum’ and ‘medical school’. In the search we considered titles only. We included texts that dealt specifically with the subject of teaching sociology in medical schools in the UK and the US. The final sample also included literature followed up as a result of our reading (e.g. texts on the history of medical education, the history of sociology, policy documents and records from the British Sociological Association Medical Sociology Group). We also draw on conversations with teachers of medical sociology (past and present) and our own observations and experiences as teachers of the social sciences in medical education. We have taken a descriptive approach to our analysis and our conclusions reflect this approach. Whilst we have sought to describe the data as closely and in as much detail as possible, responsibility for any omissions is entirely our own.

The connection between sociology and medicine

Recognition of the potential contribution of sociology to the field of medicine has been traced back as far as the 19th century, when in 1894 the US physician Dr Charles McIntire published a paper entitled “The Importance of the Study of Medical Sociology” (McKinlay, 1971). Indeed, during the late 19th century a number of physician-led projects focused on the link between social environments and disease such as Chadwick’s report on the laboring population of Great Britain and Neumann’s studies into the influence of poverty and occupation on the state of health (Bloom, 2002). The degree to which this medical work was located consciously in a social context by its practitioners is evident in the words of Rudolph Virchow who proclaimed in 1848 that medicine ‘is a social science’ (Rosen, 1979, p 62 in

Bloom, 2002).

During the mid-1800s, as social rather than biological or individual explanations for the aetiology of disease became more popular, the distinctive branch of medicine concerned with advocacy and reform known as social medicine emerged (Reid, 1976). However, whilst social medicine remained influential in the UK throughout the 20th century it had a short-lived impact in the US due to emergence in the 1920s of a bio-medically aligned approach to public health and the increased dominance of germ theory as the accepted antidote to widespread disease.

In North America medical sociology started to emerge in the 1930s following the restructuring of the university system. Whilst the focus was on the social nature of health and illness it differed from social medicine in that it was informed by a theoretical understanding of society and social structure, drawing on the work of European thinkers such as Durkheim, Marx and Weber. Within this academic context medicine emerged as a legitimate subject for scrutiny resulting in, for example, the theoretical work of Parsons (1951) on the sick role.

In Britain, medical sociology emerged between the 1950s and late 1960s (Annandale and Field, 2004). In contrast to the US, in the UK the stimulus came from social medicine (Cockerham, 1983). In 1944 the Goodenough Report called for sociological research that could be applied to improving patient care (Cockerham, 2007). Sociologists were subsequently employed within medical settings in a research capacity to contribute to addressing health inequities and the development of health policy (Reid, 1976). Since the 1970s medical sociology has become an international field of study and in the UK, following concerns that the term medical sociology implies the study of a 'narrow domain of the formal institutions of medicine' (Nettleton, 2006, p. xii), the term 'the sociology of health and illness' has been adopted as a more accurate description of the broad and critical work being undertaken by sociologists (Stacey & Homans, 1978).

The connection between sociology and medical training

Medical educationalists refer to the Flexner report of 1910 as the most influential development in western medical education. Primarily concerned with biomedicine, Flexner evidenced the then ad hoc nature of science training in US medical schools. The ensuing Flexner reforms ensured that all students, including those in the UK, were trained in schools affiliated with universities, and (during a two year preclinical phase) educated by academics with a background in the biomedical sciences.

Interest in the contribution of sociology to medical training in the UK was initiated some 34 years following the Flexner Report via the report of the 1944 Interdepartmental Committee on Medical Schools (Goodenough Report). According to McKinlay (1971), this report reflected a general belief within the medical profession that training in the basic medical sciences was insufficient to equip doctors of the future to cope with the socio-cultural and personal components of medical care and to discharge the role obligations and expectations placed upon them. Further statements calling for the inclusion of social sciences in the training of doctors are to be found in successive Reports of the Royal College of Physicians on teaching of social and preventive medicine (1943; 1953; 1966) and a report from the General Medical Council (GMC, 1957).

Despite repeated calls for a more socially oriented approach to be reflected in the content of medical education, social sciences did not figure in UK medical curricula until the late 1960s and early 1970s (Reid, 1976). A driver of change was a study commissioned by the Royal Commission on Education, the 'Todd Report'. The Todd report was scathing about previous attempts to include teaching about social aspects of disease into medical curricula and asserted that in order to treat 'human beings in trouble'

doctors need to understand social (and psychological) thinking and its application to medical care (1968, p. 86).

The Todd Report required that students be introduced, firstly to the rules of sociological observation and analysis; second, to the nature of sociological theories about the rules governing group behavior; and third, to empirical research to test such theories [1]. It was argued that these actions should be undertaken using illustrations that depicted the bearing of social factors on disease and on the medical profession itself.

Whereas in the US medical sociologists warned against the dangers that might be posed by working too closely with the profession that they were studying (Freidson, 1970), in the UK, many leading sociologists welcomed the Todd report and its critical engagement with questions of content and the practice of teaching sociology in medical education (Butler, 1969). Margot Jeffreys (1969), a key figure in UK medical sociology, argued that teaching both the methods of sociological observation and analysis as well as the findings of sociological research were highly relevant to practicing doctors.

Evidence of the impact of the Todd Report is clear. Prior to publication only the medical schools in Aberdeen, Edinburgh and Bristol were teaching sociology (Maclean, 1975). By 1977 32 of the 34 UK medical schools were teaching 'behavioral' sciences (GMC 1977). Jeffreys, (1974) was clear however that while success in establishing a role for sociology inside medical schools warranted acknowledgement, it was sociologists, rather than medical schools, who provided the impetus to implement the recommendations.

In many Schools medical sociology occupied less than five hours of a curriculum time (Maclean, 1975). Despite this there were numerous examples of excellent practice such as the development of community based programs, an intercalated degree in sociology and a Master's degree in the sociology of medicine in London (Stacey, 1999)[2]. Notably all teachers of sociology were also involved in or leading influential programs of social research. In the context of this progressive development however, challenges were apparent. In an illuminating paper, Field (1988), argued that sociologists teaching in medical education faced a number of interrelated challenges which affected the impact of sociology teaching on medical students (namely the characteristics of entrants and medical school organization), however sociology teaching in the UK maintained its emphasis on teaching theory as well as substantive topics.

The 1980s saw the publication in the UK of a set of text books written by teachers of sociology in medical education (Armstrong, 1979; Patrick & Scambler, 1982). These textbooks provided a range of accessible and directly relevant material for use with medical students and contributed to the establishment of teaching sociology in medical schools as an accepted practice (Field, 1988). The first generation of UK textbooks served to define core content from a sociological perspective in ways that remain largely unchanged to this day (see figure 1).

Figure 1: Substantive topics taught within 32 UK medical Schools (Field, 1977)

<i>Theme</i>	<i>Number of schools</i>
Relation of Medicine and Society	18
Doctor Patient Relationships	17
Social Stratification	16
Health Service and Welfare State	16
Social and Psychological Factors in Illness	14
Role Theory and Interpersonal Relationships	11

Tomorrow's Doctors

In 1993, the GMC published its first iteration of 'Tomorrow's Doctors', a document that marks a second major shift in the structure of medical education internationally. The impetus behind Tomorrow's Doctors was general agreement that medical education had become too cluttered and that students were overwhelmed by having to learn huge swathes of knowledge not relevant to medicine. At the same time technological advances, demographic changes and changes in patient expectations required new approaches not reflected in the old (Flexnerian) system. Tomorrow's Doctors advocated a more clinically focused and therefore integrated curriculum organized under the domains of 'doctor as scholar and scientist', 'doctor as practitioner' and 'doctor as professional'.

In comparison to the detailed Todd report little consideration was given to sociological content (the case for all subjects not just sociology). However, sociology was included under a specific knowledge (scholar) theme: 'man [sic] in society'. In addition, students were expected to achieve a number of attitudinal (clinical and professional) objectives that implied drawing on sociological understanding, including 'respect for patients in a way that encompasses without prejudice, diversity of background and opportunity, language, culture and way of life' (1993, p.15). In subsequent iterations of Tomorrow's Doctors (GMC, 2003; 2009; 2015) the subject of disciplinary integration has been pressed still more firmly, with sociology subsumed under the core knowledge themes of the 'individual in society' (GMC, 2003, p. 31) and the outcome of being able to 'apply social science principles, method and knowledge to medical practice' (GMC, 2009, p.16).

Somewhat paradoxically, whilst the regulatory establishment embraced sociology as a component of medical education, there has been a marked lack of investment in teachers qualified in sociology (Russell et al, 2004). This paradox is reflected in the publication of a second and third generation of sociology text books for medical students, but a lack of sustained critical engagement from sociologists with regards to sociology teaching in medical education (coupled with a rise in associated publications in teaching the social aspects of medicine from the fields of medical education and clinical medicine). In 2002 behavioral and social scientists, Russell, van Teijlingen and Stacy organized a workshop designed to bring together teachers of the BSS in UK medical Education (Russell et al, 2002). This marked the beginning of a new UK network known today as the Behavioral and Social Sciences Teaching in Medicine (BeSST), a group committed to offering a sociological perspective on the teaching of sociology in medical education.

A 2012 BeSST report suggests that currently sociology is taught in all UK medical schools although this appears to vary greatly in terms of depth, coverage and ‘amount of curriculum time’. Whilst the trend is towards integrated curricula, sociology is currently taught within a variety of curriculum structures including ‘traditional curricula’ (based on teaching individual discipline specific modules) and a combination of ‘traditional’ and ‘integrated’. Sociology lecturers within medical education are now more likely to be employed on teaching focused contracts within medical schools, rather than as traditional lecturers (with parallel research careers) working from within sociology departments (BeSST, 2012). Whilst a social science component has remained core to UK medical education policy, since 2010 there have been renewed calls internationally for educational curricula to better prepare students for the social circumstances and contexts within which they will practice. In the US, medical schools have been heavily criticized for ignoring the behavioral and social sciences (Wegar, 1992; Fox, 2010; Cuff et al, 2014) and following a US publication outlining core Behavioral and Social Sciences content for undergraduate students (AAMC, 2011) there have been moves to respectively audit behavioral and social sciences (BSS) teaching and ensure that all students are examined on their BSS knowledge. For the first time in history, Medical Education (in the US at least) is being held to account with respect to the behavioral and social science content of its curricula.

More relevant to the UK, in 2010, the Lancet published a report from a global commission on the education of health care professions arguing for complete educational reform as ‘contemporary education does little to equip professionals for unprecedented, socially mediated challenges faced by health care professionals in the 21st century (Chen et al, 2010).

[1] The appendices of the Todd report contain detailed indicative content for sociology teaching which are of notable interest

[2] This Masters course in sociology was recently described by the outgoing secretary for health in Wales as a key influence key health policy decision making in his career.

Challenges and opportunities

One disciplinary response to Tomorrow’s Doctors would be to criticize the reforms for stripping away content and to seek to ensure that it is restored. However, this would risk recreating the overcrowded curricula of the pre 1990s and ignore developments in pedagogy and teaching approaches. Perhaps it might be more constructive to think of sociology, medical education and sociology as applied to medical education as evolving projects. Taking this approach it might be possible to draw from each field to produce something erudite, coherent and efficient that addresses the need for socially minded and

appropriately skilled doctors.

A central tension with regards to training undergraduate medical education in social sciences revolves around integration. Since ‘Tomorrow’s Doctors’ (and spurred on by high profile cases demonstrating inadequacies in clinical care), there has been an explosion of interest in teaching modalities that lay claim to having a social dimension or focus. These include problem based learning, community based teaching, patient-centered teaching, teaching reflexivity, communicating with care or intelligent kindness and narrative based medicine. In addition, key social agendas have been identified for medical education designed to ensure a focus on, for example, widening participation, patient and public involvement, social inequalities, diversity, professionalism and interdisciplinary professionalism. Academic fields of interest have materialized based on concepts such as medical uncertainty, medical complexity and the hidden curriculum and there has been increased involvement in medical education from other socially oriented subjects such as public health, the medical humanities, communication skills, ethics and law. In many schools what was perhaps once seen as traditional sociology content has become distributed (or fragmented)[1] throughout the medical curriculum. This ‘dispersion of ideas’ serves arguably Todd’s original vision well. For example, community programs and reflective practice assist socio-cultural understanding through introducing aspects of sociological observation and analysis (Todd, 1968). It can also be argued that whilst sociology may have to vie for territory with other socially oriented subjects (Benbasset, 2003), more space than ever has been afforded to the social sciences within medical education. In addition, working together, healthcare professionals, patients, the public and academics from a range of disciplines have unprecedented opportunities with regards to embedding sociological ideas that benefit patient populations, into medical education and practice.

However, as traditional sociological content has become the business of multiple stakeholders, boundaries have become blurred (Delamont & Atkinson, 2009) and there is concern that sociology with its carefully honed theoretical tools and its rich legacy of empirically derived patient informed insights, has become ‘diluted’ within medical education and ‘relegated’ to the side lines or ‘made relative’ (Scambler, 2009; Russell et al 2004).

Shades of this argument, can be seen in the literature which suggests that teachers of sociology (and psychology) still perceive there to be a lack of time and space in the medical curriculum (Russell et al. 2004, and in the US, Satterfield, 2004). However, amongst students there is a view that sociology and relevant cognate disciplines are ‘over taught’ at the expense of basic science content (Litva & Peters, 2008): they are ‘nice to know rather than need to know’. Relatedly, Benbasset et al (2003) have found that students can find it hard to distinguish between individual subjects and perceive that social science topics are covered repeatedly but from multiple perspectives. Thus, ironically, in many schools, sociology is perceived as being ‘everywhere’ by the students and yet ‘nowhere’ by social scientists. It is this position of the social in medical education: of being everywhere and nowhere that most urgently needs unpacking. As sociologists working in medical education, we now need to move between academic, lay and professional fields in order to examine and make sense of how insights into health and illness that link to the subject of sociology are being interpreted and articulated. In addition, we need to ask: what is good about the current educational practices that are taking place? Where do they overlap? What resonates with students? How in the current educational climate can social scientists with a responsibility for ensuring good practice work with medical educators and students to ensure quality and consistency for students as they learn? This work has research implications and can link with the academic fields of sociology, higher education and medical education.

At the same time, because sociological research has a core role in addressing the pressing need for

socially minded doctors, in order to retain and build up a voice for sociology within our individual institutions, regardless of curriculum type, we need to maintain curriculum maps of sociology. We need to ensure that the delivery of teaching and learning is formative, not overly-repetitive, takes students' experiences as learners as well as future practitioners into account and is above all clear. Individuals employed to teach sociology within undergraduate medical education should play an important role in staff and curriculum development, ensuring, for example, that there is consistency in how sociological concepts are understood and employed within interdisciplinary teams. Importantly we need to make alliances with other academic and clinical lecturers in order to ensure support for the project of the social sciences and at institutional level, we should seek to actively serve on committees, attend working groups and gain promotion.

Such tasks are undoubtedly overwhelming for individual teachers tasked to undertake not only sociology teaching but also other generic responsibilities. Therefore, it is imperative to work together. This will help ensure support[2], assist in collaborative research, enable the sharing of practice and strengthen the position of sociology in undergraduate medical education nationally and internationally. (An example of how working together can assist the above objectives is shown in figure 2 below).

Figure 2: A case study of how working together can ensure better outcomes for sociology teaching in medical education

In 2016 following calls for the establishment of professionally endorsed, guidelines, (Russell et al. 2004, Litva & Peters, 2006), a core curriculum for sociology in undergraduate medical education mapped to the most recent versions of Tomorrows Doctors (2009, 2015) was created through collaboration between the majority of sociologists working in UK medical schools (BeSST, 2016). This clarification of sociological content has been welcomed by students, medics, the Patient Association and the Association of Medical Education in Europe (AMEE).

Core topics (or knowledge domains) in the UK core curriculum for sociology in Undergraduate Medical Education

- A Sociological Perspective
- The Social Patterning of Health and Illness
- Experiences of health, Illness, Disability and Healthcare
- Knowledge about Health and Illness
- Health Policy and Practice
- Research and Evidence

The core syllabus can now be used as a bench mark to examine the medical education literature exploring first what has been written about the different ways of teaching (for example with respect to each knowledge domain), second, how this links to other disciplines and third, the perceived efficacy of these approaches. This work would serve to expose the emerging blue print of sociology teaching within contemporary medical curricula and identify gaps in provision.

[1] For a discussion on the fragmentation of sociology into specialisms, the value of this and the importance of retaining a professional sociology, see Scott, 2005.

[2] Support is required for most sociologists whom are often alone within their medical institutions. Given that many sociologists are now employed on teaching focused contracts, networks including researching sociologists provide a particularly valuable link to Professional sociology (Scott, 2005)

Conclusions

This article has documented the emergence of sociology as a subject, the emergence of the sociology of health and illness as a subfield and the historical relationship between sociology and undergraduate medical education in the UK. It is abundantly clear from the literature that a narrative about the importance of the social context of health and illness has been prevalent in the discourse of medicine since the 1900's, yet this has been overridden by social and political shifts in thinking that have

emphasized a biomedical perspective and more recently new modalities of teaching. Presently however teaching sociology to medical students is arguably one of the most important issues in medical education today.

In the UK despite the relevance of sociology to medical education being evident since the 1950s, sociology teaching in medical education was perhaps at its most prolific and creative in the late 1970s / early 1980s, the impetus coming from sociologists themselves who pushed the boundaries of teaching and worked at creating innovative resources and sessions for students. In 2016, as medical education has changed, boundaries appear to have become blurred and in many institutions, sociology in undergraduate medical education appears to have become redistributed and at risk of fragmentation. Sociologists working in medical education today have a pivotal role to play in ensuring that the objectives of teaching social issues to medical students are properly addressed.

Take Home Messages

- Sociology has a rich history within medical education. However as policy has changed so the role of the sociologist has changed
- The link between research and teaching is now less common as sociology lecturers within medical education are more likely to be employed on teaching focused contracts
- Sociology is currently taught within a variety of curricula however, the trend is towards integrated courses.
- Within integrated curricula:

It can be challenging for teachers to follow what is being taught and by whom

For sociology to be successful teachers need to spend more time mapping, managing and organizing content

Teachers need to make alliances with other lecturers and clinicians in order to ensure support for the project of the social sciences

Sociology teaching is assisted when it is assessed

- In general

Sociologists should try and retain a voice within their medical school by engaging with activities, committees, and working groups

Sociologists working in medical education need to continue to network with each other, to collaborate, to disseminate models of good practice, host workshops, support colleagues and advocate for change where necessary

Sociologists might usefully engage with the field of Medical Education

Externally sociologists working in medical education need to build on and strengthen networks with

clinicians, students, the GMC, Deans and Heads of Medical Schools.

Notes On Contributors

Dr Tracey Collett is Associate Professor at Plymouth University Medical School. She is lead for the Sociology of Health and Illness and treasurer to the network BeSST (Behavioural and Social Science Teaching in Medicine). Her work with BeSST involves helping to facilitate workshops in the UK and internationally in order to learn about and spread good practice with regards to social science teaching and learning in medical education. Tracey co authored the core curriculum for sociology in medical education and is involved in other educational projects related to threshold concepts, identity development of faculty members and living anatomy. The thread of this research is integrating sociology in medical education for the benefit of the public and patients.

Dr Lauren Brooks has an academic background in the sociology of health and illness and until recently led sociology teaching at Keele Medical School. A key member of BeSST and co author of the core curriculum for sociology teaching in medical education, Lauren is currently working as an independent scholar based in Brighton, Sussex.

Professor Simon Forrest is Head of the School of Medicine, Pharmacy and Health at Durham University. Simon is chair of BeSST and co author of the core curriculum for sociology in medical education. Simon has an extensive background in sociology, specialising in health promotion and young people.

Acknowledgements

We would like to acknowledge the BeSST network for their support and insights into sociology teaching in medical education. In particular our thanks go to Oonagh Corrigan, Gill Bendelow and Sarah Cunningham Burley for supporting the idea to study sociology teaching in medical education. We would also like to thank Kathleen Kendall, Sara Macbride Stewart, Moira Kelly and Mariam Sbaiti for their encouragement and support in writing this article.

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Appendices

Declaration of Interest

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