Chapter 6: Teaching the Social Sciences in Residency

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Social Science Teaching

## Sample Curricula

The first two sample seminars are adapted from our curricular implementation in the academic year 2015-2016. The third sample seminar is adapted from other curricular materials that have been developed as part of our project. For these examples, we have created brief outlines of seminars (90-120 minutes) for further adaptation.

### 1 – Health Advocacy

We suggest involving a faculty member with personal experience in health advocacy activities to provide a personal reflection on incorporating advocacy as part of professional practice. The foundational social science content should include reflexivity (a key concept in the Self-Awareness theme), equity/justice, and power.

**Example seminar outline:**

1. Personal reflection by a 'professional' advocate – 20 minutes
2. Reflexivity exercise: the goal here is to have residents explore their own privileges and cultural identity as physicians. Though the default perspective has long been to consider the physician as 'neutral' of culture, this is clearly not the case. We use a

reflexivity exercise adapted from Peggy McIntosh's 'Invisible Knapsack'.[1] – 40 minutes, including time to debrief

3. Equity/justice: Various exercises or images can be used to illustrate the differences between equality (everyone gets the same treatment) and equity (everyone receives what is necessary to access the same opportunities). – 10 minutes
4. Power: To demonstrate the influence physicians can have as advocates, we suggest exploring the Pierre Bourdieu's concept of capital (see Box 7).[2] – 20 minutes
5. Advocacy project: On overview of a practical approach to an advocacy project should be presented. Residents then can form groups to plan an advocacy project. – 20 minutes
6. This project can be presented in a later session, where challenges and successes can be discussed. A second session would also provide opportunities to further explore concepts related to justice, power, and culture (especially since the 'recipients' of residents' advocacy are regularly marginalized).

**[INSERT BOX 7 HERE]**

Figure 3. Example slide exploring Bourdieu's concept of capital.

Suggested reading: Caragh Brosnan employs Pierre Bourdieu's concept of capital to conduct a comparative analysis of different medical schools. This paper can be a useful introduction to Bourdieu's conceptualization of power and its uses, making use of topics and contexts familiar to medical educators.[3]

**2 – Communication: Cultural Safety**

We strongly suggest considering the involvement of a faculty member who identifies as a member of a marginalized group (e.g. indigenous, LGBTQ, visible minority). The foundational social science content should include epistemology, power, and culture.

**Example seminar outline:**

1. Epistemology: Begin with a discussion of epistemological perspectives (ways of viewing knowledge), paradigms, and ontologies; the goal is to frame medical knowledge ('legitimate knowledge', 'truth') as socially constructed, one approach among others. – 30 minutes
2. Power-knowledge: To explore the Foucauldian concept of power-knowledge (that knowledge engenders power, and power makes use of and creates knowledge), we suggest focusing on the doctor-patient encounter.[4] Identify who has power in a doctor-patient encounter, and how that power is acquired, how that power is linked to knowledge, what types of knowledge are brought to the patient encounter by the doctor, by the patient, and the implications on the relationship. – 30 minutes
3. Critiques of un-self-reflective approaches to 'cultural competence': A discussion of the 'usual' and reductionist approaches common in medical education; useful to begin with residents' prior educational experiences. Critiques include: 1) assumption that 'normal' is white, heterosexual, cis-gender, Western, speaks the dominant language, a member of the dominant religion; 2) medicine 'has no culture', no reflection on enculturation throughout medical training, patients (especially culturally different patients) are Othered; 3) ignoring systemic barriers to equity to focus on individual attitudes in the formation of prejudice. More critiques can enrich discussion. Cultural

discourse where 'neutral' physicians *know* Others preserves traditional power-knowledge inherent in doctor-patient relationship. – 20 minutes

4. Cultural safety: A core component of person-centered care. Addresses historical developments and present systemic barriers that lead to on-going inequities in health care access and outcomes (e.g. racism, colonialism, policies as they impact indigenous health; developed in New Zealand in the context of Maori health care, cultural safety is often discussed in indigenous contexts, but has been applied more broadly). Reflexively examining one's own culture, beliefs, values, and experiences and the impact on one's approach to practice to explicitly address power relations between patients and providers (see Box 8).[5] We suggest including some role playing, with time for reflection. – 40 minutes.

**[INSERT BOX 8 HERE]**

Box 8. Example slide describing part of a cultural safety approach to doctor-patient power relations.

Suggested reading: Elaine Papps and Irihapeti Ramsden describe the emergence and development of cultural safety in nursing and midwifery education in New Zealand in the late 1980s and early 1990s.[6]

**3 – Professionalism: Self-reflection and Self-reflexivity**

We suggest targeting this seminar at trainees earlier in their graduate medical training, soon after finishing medical school. Habits and skills in self-reflection and self-reflexivity can be

useful for learning and clinical practice especially early in a resident's career. Foundational social science content should include concepts from the self-awareness and medical identity/culture themes.

**Example seminar outline:**

1. Self-awareness and reflective learning: A discussion of the concepts of self-awareness and reflective learning from their theoretical bases. – 10 minutes
2. Reflecting on learning: In pairs, residents will then work on a patient-oriented case, but are tasked with using the "Think Aloud Method" whereby on resident describes his or her thinking process and a peer transcribes, paying attention to reasoning, problem solving method, cultural perspectives, etc.[7] (The "Think Aloud Method" is a robust data-gathering method used in social science research requiring trained observers; in this exercise, residents are tasked with being attentive to their peers' thinking process.) Debrief focuses on how self-reflection during (in action) or after (on action) a clinical experience can help consolidate knowledge. – 30 minutes
3. Self-awareness and reflexivity: A discussion of reflexivity, contrasting with self-reflection, again attending to theoretical origins. – 10 minutes
4. Reflexivity writing exercise: Residents are asked to write a short item to practice self-location (see Box 9 for sample prompt questions). – 30 minutes, including time to share/debrief
5. Residents can be encouraged to produce self-reflective and self-reflexive writing over the course of their early clinical training with opportunities to review their understanding of these concepts and their utility for their learning and practice.

**[INSERT BOX 9 HERE]**

Box 9. Example slide with sample prompt questions for a reflexivity writing exercise. Suggested reading: Karen Mann, Jill Gordon, and Anna MacLeod conduct a wide-reaching and detailed systematic review that identifies important implications for the use of reflection in health professions education, with very relevant conclusions for medical educators and program directors.[8]

## References


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