MEDICAL HUMANITIES AND SOCIAL SCIENCES: THE INTRODUCTION OF SOCIO-MEDICINE INTO THE MEDICAL EDUCATION CURRICULUM

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I am delighted to be here today as a representative of the University of Illinois College of Medicine at Urbana-Champaign (UICOM-UC) at this International Symposium on Health Conduct and Health Care in the Modern Welfare State and acknowledge, with thanks, the support of the four institutions underwriting this symposium, the University of Aachen, the University of Cologne, UICOM-UC and last but certainly not least, the Werner-Reimers Foundation.

The problem I intend to discuss today is that of introducing an adequate appreciation for the Medical Humanities and Social Sciences (MHSS) into the education of a physician. As this conference considers medical sociology problems, we should recall that the M.D., the physician, remains at the apex of medical care. Ultimately, it is the physician to whom the patient turns in distress. The physician therefore must be a healer and with the modern-day burgeoning of scientific knowledge, the physician is perceived in an ever stronger healing role. Therefore, the educational thrust of medical education, particularly in the United States, has focused on hard science. Science is king, and good science is the basis of good medical education and

ultimately good medical care. In the public mind, science holds the key to the "Fountain of Youth," and ultimately the key to that still distant but much desired victory over death which mankind has sought throughout the ages. In fact, the fear of death within society is the ultimate driving force escalating costs of health care around the world. In this atmosphere, medical education cannot compromise precious educational time to socio-medical topics.

However, the dominance of science poses problems to the medical educator. Scientific knowledge is virtually infinite; time is a finite commodity. Regardless of discipline and regardless of curricular goals, choices must be made. Every medical school faces the threat of unbridled curriculum growth from the varied sources of knowledge that abound within its faculty. My staff at UICOM-UC once reviewed the reading assignments for our first year students in the basic medical sciences and concluded that if our students read at a rate of 500 words/minute for 18 hours per day during the entire first year, they could not complete the reading assignments demanded by the faculty. The curriculum expansion which faced our students is best illustrated by the observation that when our school began the published curriculum objectives and guidelines for the basic science year were printed on three inches of paper. Eight years later, the curriculum was 14 inches thick. Despite document expansion at the rate of more than one inch per year, there was no evidence students learned more or performed better on standardized examinations. Science faculties are very skilled at adding timely elements and new information to a curriculum, but they are completely unskilled in the selectivity necessary to weed out duplications and

obsolescence.

Science also has very powerful constituencies clamoring for educational time. In the basic sciences are biochemistry, microbiology and physiology, etc. and in the clinical sciences one has the competing demands of internal medicine, surgery, pediatrics, and so forth. New disciplines and new topics are forever arising. For example, AIDS is almost a field of its own at the present time. Every "good" medical school must have a course in AIDS. Computers are making massive inroads into medical care, medical imaging, and medical decision making, and the adherents of these special interests, if you wish, are demanding curricular time to "make doctors computer-literate."
Each discipline, having a body of knowledge that is expanding and proud of its achievements, desires to transfer that information to the next generation of physicians. In short, comprehensive medical education is a contradiction in terms; an oxymoron. In the crowded marketplace of molecular biology and double-blinded clinical trials, there is little time allotted for "soft science" unrelated to healing.

We are left then with the problem of incorporating adequate sensitivity to MHSS issues into this fact-oriented educational environment. To our benefit, the social problems of medicine are beginning to make inroads into the medical polity. Drawing attention from all quarters are the escalating costs of health care. The demography of our society shows that we are now harvesting the "benefits" of high technology and high science. We are an aging society and that's expensive. The increased sickness and extended disability that attends aging will lead to unending cost escalation that is

independent of inflation. Noting that perhaps as much as 50% of health care expenditures are spent on the last year of life, we have a peculiar situation reminiscent of ancient Egypt where powerful pharaohs collected inordinate amounts of wealth throughout their lifetime. After death, they were buried in tombs surrounded by their gold and silver, which for practical purposes represented a drain on societal resources. Nevertheless society, in the form of grave robbers, broke into the pharaohs' tombs, removed the loot and provided for its redistribution in a continuous economic cycle. To a certain extent we, in the United States, do the same thing in our health care system of 1982. Men and women accumulate whatever wealth they can during a lifetime in order to save it for the medical care of old age. At this point the health care system serves the same function as the grave robbers of ancient Egypt except that the redistribution of wealth is done in the last year of life.

Furthermore, society is often unprepared to face the ramifications of "good" health initiatives that are undertaken in its behalf. For example, everyone will agree that smoking cessation is a useful societal objective. It's hard to find people today who are pro-smoking. But we are not yet certain what the long range effect of a smoke-free society means. Formerly smokers were the true "good citizens." They would smoke their two packs a day during a productive lifetime, contribute billions in cigarette taxes to the political coffers and then conveniently, about the age of retirement, die of lung cancer or heart disease. They were rarely a burden on the Social Security System and their terminal illnesses were relatively short and less expensive. How will society compensate for the compound stress of the loss

of cigarette tax income as our non-smoking, longer-lived citizens begin the unplanned drainage of our Social Security coffers for 25 to 35 years?

Or take the example illustrated by the real promise of cholesterol control in the area of cardiovascular disease. We already know that a one percent lowering of serum cholesterol reduces the risk of heart disease by two percent. Should these drugs, now on the horizon, which have the potential for lowering cholesterol between thirty and fifty percent be proven effective, the result could be an unprecedented fall in the incidence of heart disease and stroke in the older populations. This will inevitably be followed by a burgeoning number of older members of society who will rightly demand "quality health care" in their ever-lengthening lifetimes. Therefore, as physicians prove more clever in mastering diseases of aging, they trade early health problems for later ones together with an unknown quantity of concomitant social problems. Is this a suitable subject for the medical curriculum? It better be.

Attention to the new age of geriatric generated social problems only scratches the surface of topics relevant to the training of MDs in Medical Humanities and Social Sciences. Ethics, informed consent, health care policy, medicine and religion, professional socialization and, like the hard sciences, a virtually infinite amount of topical material can be envisioned. One begins to sort out options with the premise that the modern physician must be prepared to meet his obligations as a member of society as well as a scientist. Nevertheless, this element of medical education is usually given more lip service than clout. Clout in medical education lies in the

examination, licensing and certification process, I took a "re-certification" examination in Internal Medicine a few years ago administered by the American Board of Internal Medicine. While the examination proved rigorous in the usual aspects of the scientific practice of Internal Medicine, it was void of content related to its social aspects. This is significant in that 25-30% of all U.S. medical school graduates specialize in Internal Medicine and internists form the major group which cares for the geriatric population.

Recently the National Board of Medical Examiners has included some elements of MHSS into their examinations but the process has been slow and halting. I've served on medical school accreditation site-visiting teams that scrupulously surveyed scientific curricula in great detail, but hardly gave lip service to socio-medical issues. Rather than ask the medical schools whether they teach MHSS topics, such teams should ask "Do you rigorously examine future physicians concerning their MHSS knowledge?" Not until broad knowledge of the impacts medicine has upon society and vice versa are demanded for graduation, licensing and accreditation will medical education fully respond to the societal challenges before it.

We had the opportunity at the UICOM-UC to begin a MHSS or socio-medical curriculum from scratch in 1978. Indeed, we hired a medical sociologist as our first behaviorally oriented faculty member. The sociologist was given responsibility for teaching behavioral medicine, assisted by psychologists and psychiatrists, and introduced the first elements of medical sociology into the medical curriculum. We were also blessed by being located on a campus with strong humanities and social sciences programs; a campus which was not

overwhelmed by a resource-devouring medical school. The problem many medical schools encounter as they interact with colleges of liberal arts and sciences is that the resources required for medical education are astronomical compared to those required for arts and sciences. This generates envy and suspicion. The circumstances of our development were such that this was not a significant issue although it took several years and the successful development of our dual-degree, Medical Scholars Program, to convince the other disciplines on the campus of the University of Illinois at Urbana-Champaign that this was the case.

The Medical Scholars Program (MSP), an M.D.-Ph.D. program not only reduced the barriers between medicine and the rest of the campus, it affords us, by recent count, 100 student messengers to 35 different department on the campus. While many of these departments are in the usual scientific areas, the MSP has dual degree students in medicine and second disciplines as far ranging as philosophy, history, sociology, social work, political science, business administration, and law. The MSP, therefore, is a vibrant link between medical education and the remainder of academic society.

Using faculty contacts enhanced by the MSP, we have developed a multidisciplinary eight week summer program in MHSS which serves both the College of Medicine and the several departments that contribute lectures to the program. The MHSS program has a didactic element, practical requirements, and a requirement for a mini-thesis in some sociomedical subject. The program was launched in 1978 and has gathered momentum since. Students, who initially greeted the program with expected skepticism,

have warmed to its content over the years. At the same time, the MHSS faculty have become more proficient in delivering the "soft sciences" to a medical student and graduate student audience.

The MHSS curriculum has not been without its critics both from the students and from the more traditionally oriented faculty. Every time the cumulative average of National Board Part I (the national basic science examination) scores fall a notch, one is certain to hear a cry to fault the "time wasted" by the MHSS curriculum. However, with persistence the program continues to grow and at the present time is burgeoning. The course is designed for all students in the health professions (particularly medical students), for advanced undergraduate students, and for graduate students training in the medical humanities and social sciences. It has been divided into two relatively independent segments, each lasting eight weeks. The two course segments are (1) a Medicine and Society lecture-discussion course and (2) individual student projects to apply the methods and topics. The former meets two hours daily during the summer and includes a trip from Urbana to Cook County Hospital and Cook County Jail. The latter includes volunteer participation in a local health setting, ethics case discussions and student presentations, and a research paper and presentation in conjunction with one of the course faculty.

The course offers a multidisciplinary approach to the social aspects of medicine and health care and draws upon faculty from the social sciences, economics, the humanities, medicine, and other fields to present such topics as the evolution of human disease, culture and social aspects of illness,

ethical issues in health care delivery, communication in medical settings, the history of medicine, medical economics, health care organization, and the study of medicine as a profession. The lecture/discussion sessions are intended to introduce sociomedical theory and research in a variety of content areas. Students are expected to analyze and reflect upon their own professionalization process and within the in-depth project component, to demonstrate the applicability of sociomedical theory and research to the realities of disease and treatment in an area of their interest. Supporting the didactic elements of the program are the field trips to an inner city hospital and a county jail to look at the social and medical problems as they interface in two public institutions.

The course has experienced increased growth and success. Through the careful use of evaluation techniques, student feedback and review of similar curricula elsewhere, the course director has incorporated subjects and activities that now bring generally positive feedback from medical students and others. Some comments from recent evaluations are pertinent: "This course could be the difference between my being an aware, sensitive well-adjusted physician or being one who is suddenly shocked at the experience of medical education"; "The health care system, as a social, cultural and historical entity, makes more sense now." The course has also been praised by a number of distinguished visitors.

In summary, I have focused on the breadth of problems faced when trying to introduce a non-perfunctory MHSS curriculum into medical education. Like it or not, the medical profession will be increasingly pressured by the

societal environment in which it functions. As medicine becomes more effective, changes in human demography and ecology that follow medical success will inevitably be associated with concomitant social issues. These issues will likely multiply more rapidly than either society or the medical profession can handle. Medical schools which ignore these trends in their Sisyphean quest for scientific excellence within the educational process do their students a serious disservice.