"Incorporating the Social Justice Curriculum into Medical Education: A Wicked Problem"

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1. Background

Shortly before the start of the pandemic, we embarked on a re-curriculation process of a 20-year-old didactic curriculum (School of Medicine 2019) that was content-heavy and lacked diversity; a process that was rudely and abruptly distorted and tangled by the pandemic. Developments in educational practices and curriculum strategies over the past 25 years, further call for a review and alignment of current facilitation, teaching and assessment practices. Tertiary education is moving towards a hybrid teaching approach with a competency and inquiry-based learning focus coupled with authentic assessment strategies; while a further emphasis is placed on self-directed and self-determined life-long learning skills (National Academies of Sciences, Engineering, and Medicine 2018). There is also a need to develop a well-rounded graduate that can function within the Fourth Industrial revolution (Penprase 2018); someone who is digitally fluent, and who have acquired transferable skills such as critical thinking, communication, and collaboration within a team (Frank, Snell and Sherbino 2015).

2. Aims and Objectives

This is an exploratory cross-sectional qualitative study with the aim to incorporate the social justice curriculum for medical students (MBChB) throughout their 6-years of study, thereby including competencies other than "medical scholar", that are important for being a globally competitive, well-rounded doctor upon qualification.

Objectives:

1. To define the medical school social justice curriculum
2. Evaluate the current experienced curriculum and identify areas for improvement.
3. Undertake a needs analysis to assess the local disease burden.
4. Determine the competencies required of South African undergraduate students and align these with the documented HPCSA competencies.

3. Methods

The TAU project purposively approached this task from within a human-centred, value-based, solution-focused, action-orientated and systematic reasoning process, with a specific emphasis on the social justice curriculum. The study was based on a design-thinking approach (Appendix 1). Design Thinking, as opposed to many other models and approaches, is not linear in nature (Dam and Siang 2022). It can best be described as structured but 'messy' where the process moves forward, just to backtrack to a previous stage, then again continues to a following stage(s), then backtrack again and so the process and loop continues. This back-and-forth approach makes the process much more cumbersome and laboured but yields better result. This study did not test the devised curriculum as development is ongoing.

The 'triple bottom line' (TBL) approach was applied throughout our curriculum development process. The TBL-concept, as coined by John Elkington in 1994, refers to sustainability in business (Elkington 1994). As a Higher Education Institution (HEI) our sustainability rests on the same three pillars of economy (prosperity or financial equity), people (or social impact) and environmental realities (planet).

4. Achievements

Stakeholder theory **("Empathise")** underpinned our departure point as it provides a theoretical framework for determining who we should consult with (Christiana-Kappo and Ogujiuba 2020). Freeman, from a business ethics perspective alludes to the various roles' stakeholders play and the prominence they have to take in our businesses, or in our context the higher education landscape (Stakeholders are people - R.Edward Freeman 2009)

To warrant the reputational legitimacy and the viability of the new program, we needed to ensure that all the relevant stakeholders were identified and their influence in and on the proposed new curriculum / program and then meet their realistic needs in a socially-responsible way (Saeudy 2015) (Klein, et al. 2021). In Appendix 2 we illustrate the interactions with the different stakeholders.

During the **"Define"** phase we analysed our document review, interview and survey data and observations made. Social justice in a medical curriculum is defined as the equal provision of healthcare despite social obstacles (Coria, et al. 2013). This enabled us to define the problem that would lead us to our third step. The survey results, as well as the informal personal

reflections emphasised the crucial principle of stakeholder involvement and the importance of a shared vision.

During the **"Ideate"** phase we had to think and dream-up solutions to each aspect of the problem. Our departure point here was to unpack the first day competencies of a newly graduated general medical practitioner. From the deliberations we isolated eight types of competencies. Together these competencies formed the CIRCULAR model of graduate attributes (Appendix 3).

Secondly, based on the burden of disease and projected health risks facing the South African population, a framework was developed to determine the core content. In addition, the pedagogy, a global perspective, and the social determinants of disease were incorporated into this framework (Appendix 4).

The concepts described above need to be taught to students in a tangible way so that they can be applied in practice. This will be achieved in two ways:

1. The concept of person-centred, values-based care underlies the curriculum. This approach to healthcare emphasises that the person is more than a mere patient, but has various roles such as being an employee, parent, citizen, or a student. Not all patients are the same but they are defined by their circumstance. This teaching will be incorporated into all theoretical teaching via case studies and clinical skills training via simulated patients in the first two years, and in the authentic work environment thereafter. Via this approach we hope to instil the idea that the practitioner has various roles (see Figure 3), other persons affect and are affected by the patient-practitioner dynamic, experiences of people are crucial, and both negative and positive health encounters are crucial (St Catherine's College Oxford 2022).
2. In consultation with the Gordon Institute of Business Science (GIBS) a leadership module for undergraduate medical students is being developed. This module spans the five years with larger stand-alone modules per year, and competencies incorporated into other learning modules and assessed via a longitudinal reflective portfolio. The learning outcome include:
    a. Critically reflect on **leadership theory** and the extent to which it has enabled (or disabled) leaders in the healthcare sector to become responsible leaders and their roles in **advancing social and environmental justice**.

b. Be aware of their **own leadership styles**, during normal conditions and under stress, as well as those of colleagues, with a view to strongly enhancing **collaborative management**.
c. Use **Emotional Intelligence** skills to lead and respond more skilfully as pressure, tension and complexity increase.
d. Use **Meta-Leadership** skills to strengthen leadership competence in **multiple fields**.
e. To understand and respect the **diversity of colleagues** and **leverage diversity as an opportunity** for leadership and enhanced performance.
f. **Build and lead effective teams** and gain an understanding of why teams fail and how to reduce stress in the workplace and embrace excellent and effective teamwork, leading to optimal productivity.
g. Use an approach e.g. "Walk in the Woods", to **resolve conflict** amicably.

5. Challenges

The development of a curriculum and the introduction of novel concepts is a wicked problem. Wicked problems are, per definition, not new concepts. Nearly half a century ago, in 1973 Rittel and Webber coined the term (Rittel and Webber 1973) with its subsequent ten defining characteristics, namely, interrelated, continuous, undetermined, untested, symptomatic, unique, approach, denial, understanding and responsibility (Appendix 5).

In addition, we have found that there were two distinct types of communities within this lecturer stakeholder-group, i.e. the **communities of practice** (CoPs) who have a shared vision and understanding about the necessity of the re-curriculation process. They work eagerly and relentlessly (mostly after-hours and over weekends) to drive the process and support one another and contribute greatly to the process; and the **virtual advocacy groups** who oppose the change (Dunham, Freeman and Liedtka 2006). These are 'members' who engage in extensive debate about the why and the how of the required and mandatory change, thereby delaying the process, but the process is seriously hampered without their contribution. There are also a third unofficial category within the lecturer group. They are not seen as a community, but rather as the apathy or "lack-of-interest" group. They are neither energetically involved in the process, nor are they openly opposed to the idea of re-curriculation. They just don't participate.

6. References

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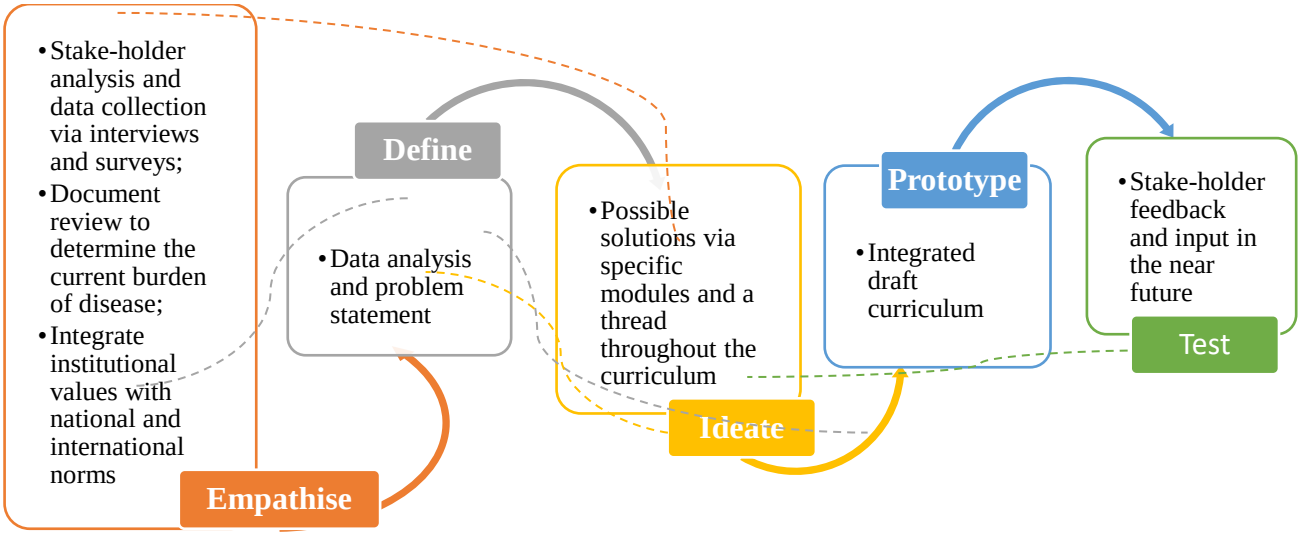
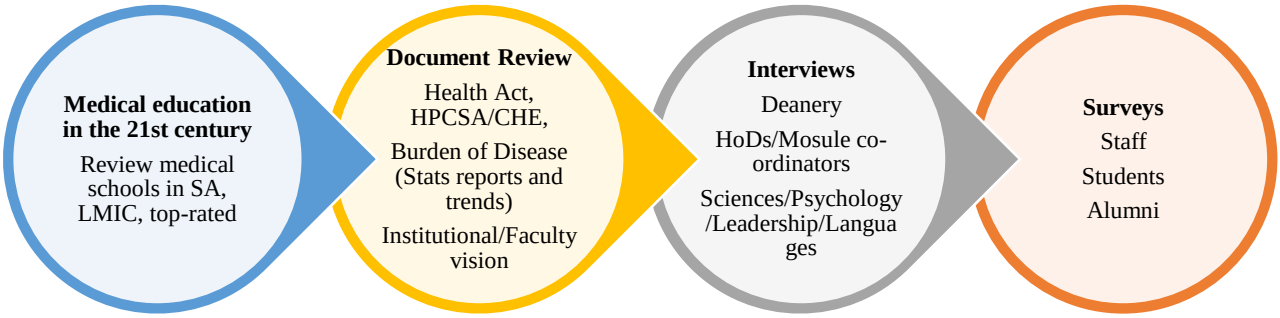
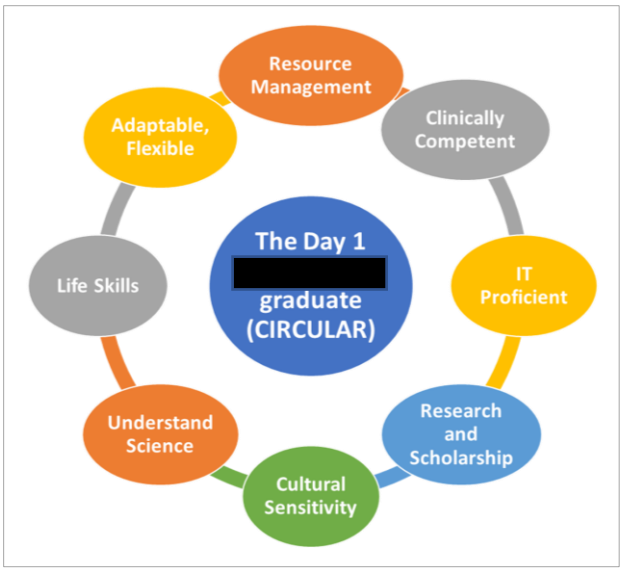
7. Appendices



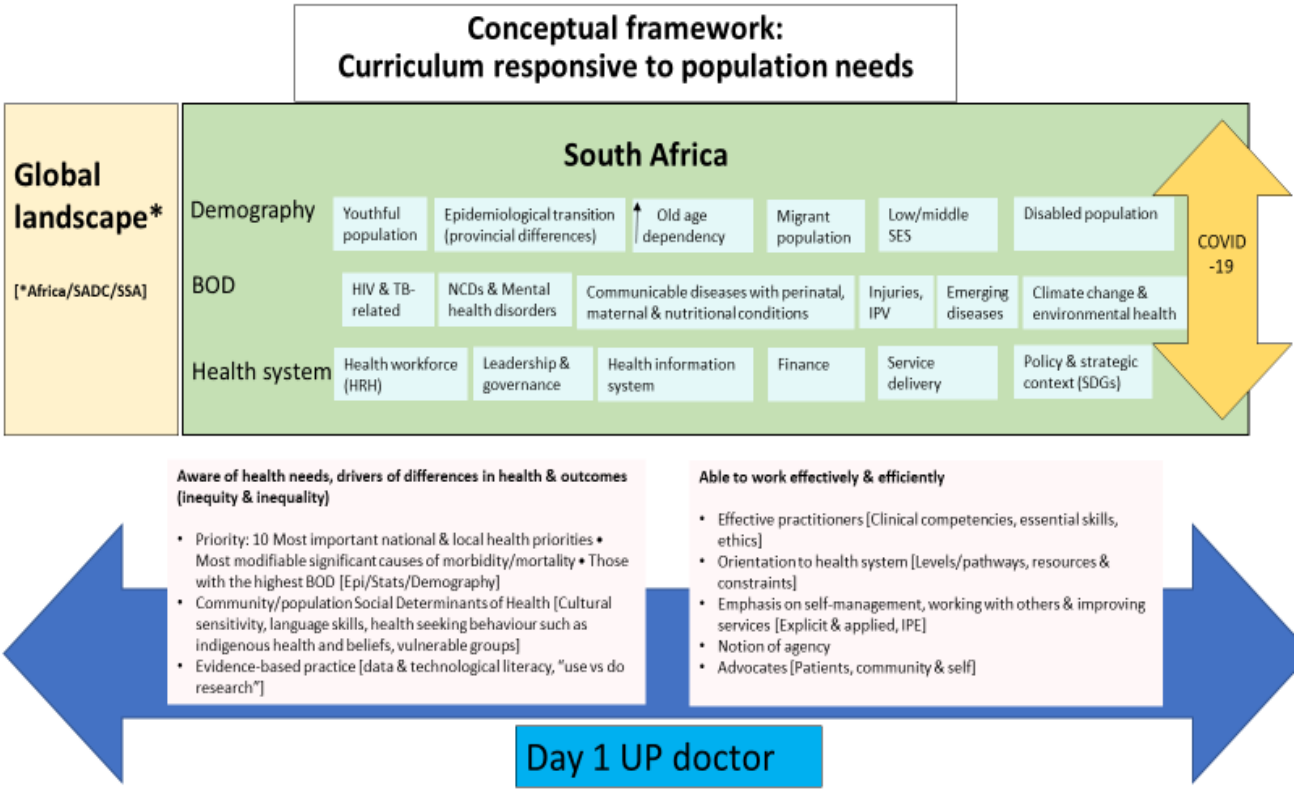
Appendix 1: Design thinking approach to define and integrate the social justice curriculum



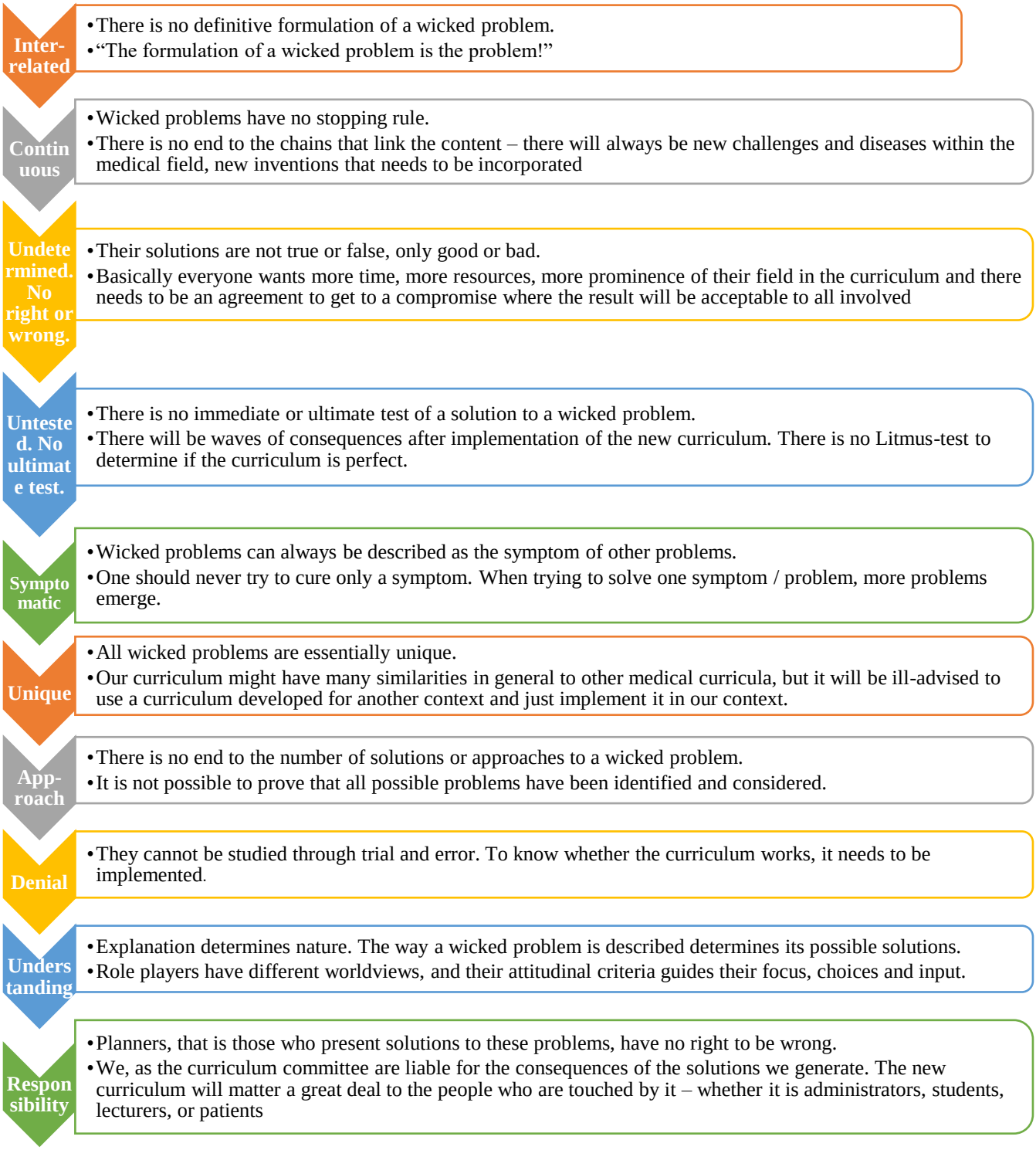
Appendix 2: Interaction with various stakeholders



Appendix 3: Circular model (as coined by Prof Adam)



Appendix 4: Constructive framework for social determinants of disease and the global landscape of disease



Appendix 5: The 10 characteristics of a wicked problem (Lubbe, Adam and Cordier 2022)