Training and Education as a Means of Increasing Equity in Child Health Teaching of Undergraduates

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ABSTRACT. The Issue. Several primary sources of influence shape pediatric curricula in the United Kingdom and the United States. The national guidance given by the General Medical Council1 in the United Kingdom and by the Future of Pediatric Education2 document in the United States focus on developing a group of physicians who respond to the relevant needs of contemporary children. The competition among interest groups for time in curricula, including our interests in advancing community pediatrics, determines what is taught and the extent to which it is taught. Strategies to engage and motivate students so that they learn what we want them to learn ultimately will define our success in medical education and as medical educators. In approaching the above noted challenges, I have made 3 assumptions about learners. First, most students come from middle-class backgrounds and have little exposure to what life is really like for our patients and their families. Second, there is good evidence now that students’ learning styles are set from the time they enter medical school.3 Contemporary students are very assessment driven, and our residents are adopting these same sorts of attitudes. It is a protective mechanism for survival in a very crowded curriculum. The third assumption is that students have a wealth of experiences and creative energy, and there is much that we can do to harness them. Pediatrics 2003; 112:747–748; life experiences, international health, pyramid of care.

LIFE EXPERIENCES

To raise students’ awareness of different life experiences, it is important to start at home, where they live and where they come from. Helping students to become aware of the communities around them will help them to appreciate the less-than-ideal living circumstances from which some of our patients come.

Awareness is the first step in trying to develop sensitivity in students. It is important that they be encouraged to consider the environment in which they are living and to ask what is it really like to live in this neighborhood all the time. A question posed to a group of students about the characteristics of the area brings out the issues of poor transport and play facilities; crime; vagrants; poor-condition housing; dampness and substandard safety; lack of leisure facilities; and corner shop stores with overpriced food, produce, and a paucity of high-quality fresh foods. This is the first step in trying to develop an awareness in the student in terms of how these environmental factors can affect child behavior and health status. An additional consideration locally is for students to consider their own demographic structure and how representative this is of the general patient community in the area around the hospital. There are still marked disparities and inequalities in student intake at medical school that need to be addressed and about which few students are really aware.4,5

INTERNATIONAL HEALTH

Another approach to raise awareness of these issues is to engage students in international health. I ask students to think about their home countries, if they are from abroad, or just to consider the mortality rates of children younger than 5 years and other indicators of child health from developing countries.6 The awareness of students of this global perspective is a very useful tool to encourage them to think about health inequalities.

It also is instructive to have students consider the relevance of approaches to health in developing countries to developed ones, especially as they relate to the contribution of socioeconomic issues to improved child health outcomes. There has been an extraordinary drop from approximately 7000 to 2000 infant deaths per 100 000 births over the past 40 years in the United Kingdom. Asking students to reflect on the causes for this decrease in infant mortality enables them to think carefully about the relative contribution of nutrition, sanitation, immunization, and curative and hospital-based medicine to this vastly improved outcome.

PYRAMID OF CARE

The pyramid of care model7 is an instructive tool to teach students about our health system. As much of the students’ training is focused on the acutely sick and takes place in the hospital setting, I ask them to think about the broader context of where and how health services are delivered. We ask them to consider such questions as, “Who are their patients?” “Where do they live?” “Which parts of town do they come from?” “Have they themselves experienced similar sorts of personal problems and challenges in their homes and environments as those with which their patients contend?”

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Another related set of questions to ask students is, “Who is more likely to get ill: is it people living in that nice house, or the people living in less-than-ideal circumstances?” “What are the social inequalities experienced by families from each of these areas?” Most students are unaware that the most common disabilities in our society relate to behavioral problems and that there is a necessity for physicians of tomorrow to be able to respond to them.8

In addition to the above, we discuss and place some numbers into the inverse care law.9 For example, if we have an at-risk population of approximately 50,000 children, then there will be approximately 3500 hospital admissions a year, but the outpatient attendance will be 7 times that, and the general practitioner consultations are 4 times greater than the outpatient consultations. This provides insight into where health services are delivered in a community. As a great deal of health is generated in and by families, we also work with students to develop skills in developing genograms and taking family histories. Because the social context of health and illness is changing, it is important to understand family structures that are not the typical nuclear family and their potential impact on the well-being of children.

SETTING OBJECTIVES

It is important to start undergraduates off in a wide range of experiences. They have 2 weeks of acute pediatric experience, 1 week in outpatients in the community and hospital settings, and 1 week of social and behavioral pediatrics that includes going to a local nursery. They pass through social services, a specialist under-5 behavioral clinic, and a psychosocial meeting on the ward and spend a week learning about development, disability, and neonatology. It is planned so that they see common disorders. It is important to frame these experiences with learning objectives and test them at the end of the rotation if they are to learn from these experiences.

CREATIVITY

How do we unleash the creativity of students? By the time they get to year 4 of training, they have lost much of the creativity with which they started. By engaging them in projects, we can rebuild some of their awareness of social issues and give them back some of the creative force that they have lost. These are very small projects but ones that are instructive.

CONCLUSIONS

There are 3 areas that must be addressed in putting equity and advocacy on the agenda in pediatric training. First, awareness raising of students—helping them take a wider view of child health—will provide perspective and insight into the health and social issues confronting children and families. Second, these concepts must be institutionalized in the core structure of curricula and the assessment of curricula and student competencies. Finally, we need to empower students to believe that they are able to contribute to child health outcomes in their own right. The Equity Project proposed by the American Academy of Pediatrics and Royal College of Pediatrics and Child Health to carry this meeting forward could design, implement, and assess strategies to meet these challenges.

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