The Application of Social and Adult Learning Theory to Training in Community Pediatrics, Social Justice, and Child Advocacy

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ABSTRACT. The Issue. Perhaps the greatest challenge we face today in medical education is how to establish a conceptual framework for conveying the context of community pediatrics and issues related to child health equity and social justice to practicing pediatricians and pediatricians in training. This will require a new infrastructure and approach to training to allow pediatricians to think and practice differently. The application of social and adult learning theory to the development and implementation of community pediatrics curricula will be necessary to succeed in these endeavors. In particular, we also will need to understand the educational processes required to motivate adult learners to acquire knowledge, attitudes, and skills outside the context and framework of their previous experiences and perceived professional needs. Pediatrics 2003;112:755–757; adult learning theory, social learning theory, community pediatrics, social justice, child advocacy, curricula, competency.

ABSTRACTIONS. RRC, Residency Review Committee; AAP, American Academy of Pediatrics.

Traditional pediatric training in the United States and the United Kingdom remains predominantly hospital based with a biomedical focus. Although there has been some increase in the understanding of the relevance of population and community health training to pediatrics, there remains a paucity of community health instruction and community-based experiences in traditional pediatric training in both countries. This is despite that 80% of pediatricians in the United States practice in community settings and the recognition of the impact of social determinants on child health outcomes.

Before 1980, virtually no training occurred in community settings. In the 1980s and early 1990s, the momentum for training in community settings slowly progressed. In 1996, this movement gained strength in the United States with the implementation of the Accreditation Council for Graduate Medical Education Pediatrics Residency Review Committee (RRC) requirements for community-based training. Currently, 80% to 90% of residency programs in the United States have continuity and/or other primary care experiences in the community and, given the RRC requirements for certification, all have at least a 1-month community-based experience. However, a disconnect remains between community-based experiences and rigorous training in community pediatrics, preventive medicine, and population-based health and child advocacy.

In this context, a current challenge confronting medical education is to define priority competencies in community pediatrics and to create training initiatives that provide the knowledge, attitudes, and skills to fulfill these competencies. An initial framework to structure these educational initiatives can be found in the principles of community-oriented primary care and child advocacy, as well as the American Academy of Pediatrics (AAP) policy statement “The Pediatrician’s Role in Community Pediatrics.” In addition, creating certification requirements in community pediatrics for training programs can provide a mechanism for ensuring continued efforts to bridge the gaps between training and proficiency.

It will be impossible to achieve these competencies with training that is principally hospital based. The involvement of the AAP in the Future of Pediatric Education II initiative and its policy statement on community pediatrics, the Community Access to Child Health Program, and other similar efforts all have contributed to our shift in perspective in the United States related to training in community pediatrics. Thus, there is impetus and ample opportunity to redefine pediatric training in the United States in the context of community pediatrics, including knowledge and skill development in issues related to equity, social justice, and child advocacy.

Of note, this also applies to the training of subspecialists, including hospital-based subspecialists, who need to understand the realities of children and their care in the context of the communities in which they live. Subspecialists need to understand the broad social implications of the care that they provide for the child and the family. They may not provide primary care, but they need an in-depth appreciation of the role and function of primary care and that of the health system as a whole.

The acceptance by regulatory and professional organizations such as the Pediatrics RRC, the American Board of Pediatrics, and the AAP of the need for community-based training in pediatrics is necessary but not sufficient to ensure the transfer of the knowledge, attitudes, and skills involved in the practice of
People do things for their own reasons, not for yours. People cannot be told that they have to be motivated. However, all people can be motivated. The challenge is to ensure that pediatricians’ motivations are oriented in the direction of greatest relevance and significance to child health endeavors.

People do things for their own reasons, not for yours. It thus is incumbent on program directors to understand the motivations and needs of each adult learner as they relate to his or her individual background and personal and professional plan. With this understanding, curricula can be modified/tailored to meet the needs of the individual, especially as it occurs in experiential community-based elements of the curriculum. Program directors also can work with learners to modify/change their perspectives. One effective way to modify an individual’s perspective is to expose him or her early in his or her career to competencies that have been developed by individuals and institutions for which he or she has respect and that are deemed necessary to become a competent pediatrician.

Create a need and develop a sense of personal responsibility on the part of the learner. One effective approach to this, in the context of helping adult learners think about and understand the issues of equity and advocacy, is to have individuals consider these issues for each patient they see. Have them identify and chart this assessment with an advocacy plan through this process. Advocacy then loses its abstraction and becomes a tangible component of the care for the individual patient and his or her family.

Structure experiences to apply to the content of life. Adult learners have evolved through a process of personal and professional differentiation and have a large inventory of experiences that have influenced their lives. For them, theoretical, didactic, and experiential elements of curricula must be applicable to their perceived future professional needs, fit into this personal history, and be practical, or they will not integrate the desired knowledge and attitudes into the skill set that is meant to be imparted.

Give choices. We all are motivated by choices and will respond to those that resonate with our past and plans for the future. Provide choice in the curriculum, and be prepared to modify the curriculum to respond to changes in the environment or interests of the learner. Presumably, each component of the curriculum will have an impact on the learner, and, as a result, their interests and perceived needs may change. Be prepared to respond to these changes—especially for trainees early in their career development.

Provide positive feedback. Recognition, encouragement, approval, and positive reinforcement will help to sustain the motivation of the learner. The mentor’s enthusiasm for the discipline of community pediatrics and issues related to equity and advocacy is extremely important. It is equally as important that the adult learner see your internal motives as sincere and value driven. Do you feel strongly about the need to incorporate this knowledge, attitude, and skill set to become the best pediatrician you can be and to provide your patients the best care and opportunities they need to succeed?

Establish a personal relationship. The relationship between mentors and learners is important. Showing concern about him or her and his or her future, in particular what he or she will be doing in the near future, is a powerful tool to motivate. Engage the learner in your own professional and, if appropriate, personal endeavors in community pediatrics and child advocacy.

Create effective communication experiences. For some students, the topics and experiences that will be addressed in community pediatrics (in particular, those dealing with equity, advocacy, and children’s rights) may seem foreign and irrelevant to their current or future professional pursuits. The
adult learner must be provided context to process and integrate information and experience. This is an important principle for experiential learning. Adult students, regardless of their level of training, must be provided insight as to the relevance of the experience, priority focus areas, what questions they should ask themselves, and what they want to accomplish before they are sent into the community. After their time in the community and periodically if this is an extended period of time, their experiences must be processed individually or in group settings to reinforce and integrate them into their knowledge base, attitudes, and skill set.

- **The experience should relate to desired competencies.** Community-based experiences should be structured to relate to the competencies that are to be addressed, and the adult learner should be able to see the relevance of the experience to these competencies. Experiential learning requires ongoing definition of the learner’s responsibilities and the relevance of the related activities of the experience to the responsibilities that will be undertaken by the learner. Passive learning does not work in terms of community-based experiences. The learner must participate, and the community-based experience must be structured to ensure that this happens. Discussion and dialogue about the experience must incorporate the concepts that are to be imparted in a context that is relevant to the learner.

In addition, following the principles of experiential learning, every community pediatrics educational experience should have structure. What is to be taught in the larger context of the overall curriculum and goals, how it is to be taught, and how to measure the impact of the training also must be defined before implementation of any community pediatrics program. This is especially important in relation to the elements of the curriculum that deal with imparting attitudes and skill sets related to child advocacy and the application of the principles of social justice and children’s rights to practice. This can be done, and even a 1-minute interaction with trainees can impart these desired curricular competencies. However, all faculty must be oriented to these competencies, including those related to child advocacy and ensuring equity in child health, and must understand the basics of social and adult learning theory if the full potential of the community pediatrics curriculum is to be realized.

**CONCLUSIONS**

The challenge we face is how to accomplish the formidable tasks related to developing and implementing community pediatrics curricula that integrate the breadth of what we know about social and adult learning theory. Perhaps the point of departure for this journey could be a joint initiative by the AAP and Royal College of Paediatrics and Child Health to delineate:

- **The competencies required by trainees in community pediatrics to respond to the social, political, economic, environmental, behavioral, and health systems determinants of child health.**
- **The content and structure of curricula to develop these competencies and instill the knowledge and inculcate attitudes and establish the skills required to practice community pediatrics, including social justice and child advocacy.**
- **The needs of adult learners with respect to training in community pediatrics.**
- **How to apply social and adult learning theory to motivate and train new and practicing pediatricians in child advocacy and the integration of principles of social justice and children’s rights into clinical practice and health systems.**
- **How to structure and integrate community pediatrics curricula into community-based educational experiences using experiential and adult learning concepts and the practitioners trained as outlined previously.**

The opportunity is here and now.

**SUGGESTED READING**


Blanchard KH, Johnson S. *The One Minute Manager*. New York, NY: Morrow; 1982


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