Transforming Future Doctors Into Critical Thinkers: The Merits of UCSD’s Inaugural Pre-Med Undergraduate Sociology Course

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January 7, 2015

Abstract: Many educational initiatives for diversity and inclusion have been shown to run the risk of stereotyping; this is particularly the case in medical education, where a focus on differentiated identities results in the “Othering” of underrepresented groups. Undergraduate pre-medical education stands at a watershed moment for diversity and inclusion education. One of the integral components of the medical school application, the MCAT, will include sections on sociology in 2015. In anticipation of this change, the UCSD Sociology Department has created a course for pre-med students, expressly designed to teach the fundamental concepts and critical thinking skills in sociology. In this paper, I give an overview of why this course is important by placing pre-medical education within the wider framework of medical education and practice. Then, I describe how the placement, content, and goals of this course will work towards overcoming the issues that plague the instruction of social scientific knowledge across educational, research, and clinical practices in biomedicine. At the most basic level, this course brings attention to the multiplicity and intersections of identities within the institution of higher education and the institution of medicine, moving toward both an inclusive and differentiated understanding of diversity at the level of lived – or imagined - experience. More deeply, this course develops students’ capacity for an advanced sociological imagination that is attuned to implementing patient care, research, and health care advocacy without stereotyping or Othering.

Keywords: undergraduate education; medical education; diversity

INTRODUCTION

What makes a good doctor? Since 1928, the Association of American Medical Colleges (AAMC) has overseen the initial development and subsequent evolution of medical education. The AAMC’s interpretation of what it takes to be a suitable physician has been embodied in the Medical College Admission Test (MCAT), which has gone under 6 substantial revisions between 1928 and 2015. Integral to the medical school admissions
process, the content within the MCAT constitute a body of knowledge and skills that pre-
medical students must master in order to be competitive applicants.

The first version evaluated applicants’ knowledge of scientific concepts, memory
and logic, reading and comprehension ability. The second iteration launched in 1946,
while retaining the focus on verbal and quantitative skills and knowledge of scientific
concepts, added a section entitled “Understanding Modern Society”. This section on
liberal arts knowledge was expanded in the third version in 1962, yet eliminated in the
fourth iteration in 1977. The fifth update in 1991 introduced a writing sample section. As
medical educator William McGaghie (2002: 1085) notes, “the various renditions of the
MCAT demonstrate that the definition of aptitude for medical education reflects the
professional and social mores and values of the time.”

In 2008, the AAMC convened the MR5 Committee to conduct the 5th
comprehensive review and revision of the MCAT. The updated examination, appearing
this year, has four main sections; the first two test the applicants’ knowledge and use of
concepts in biology, chemistry, physics, biochemistry, cellular and molecular biology,
research methods, and statistics. The second two test the applicants’ knowledge, use, and
critical analysis of behavioral and socio-cultural determinants of health, ethics and
philosophy, cross-cultural studies, and population health. At the time, the AAMC
President and CEO Darrell G. Kirch, M.D., announced the change, stating that in surveys
“the public had great confidence in doctor’s knowledge but much less in their bedside
manner. Being a good doctor isn’t just about understanding science, it’s about
understanding people.”
Dr. Kirch’s remarks about good doctors needing to understand people speaks to a broader movement within medical education in the last twenty years. Medical educators, health services researchers, federal agency bureaucrats, social scientists, and patient advocacy groups have all pointed to the increased need for physicians to cultivate better communication skills, exhibit more professionalism, understand the patient as a whole person, and be sensitive to a wide range of beliefs about health, illness, and treatment. From race-based medicine, clinical trials, and genomics, to cultural competence curricula and community health, professionals in the health care sector have mobilized to address rampant health and healthcare disparities. These efforts in medical education have been diffused widely yet the content and depth have not been streamlined; the MCAT’s new sections on the behavioral and social sciences promise to help institutionalize a base-line orientation toward understanding people.

While the revised MCAT presents sections that would be welcomed by the medical education community, these sections – and the instruction of students preparing for these sections – would similarly be initiated into the fundamental challenge that medical educators face with these types of knowledge and skills. This challenge fills the pages of medical education peer-reviewed journals, often seeming insurmountable. Essentially, many research-, practice-, and education-based initiatives for diversity and inclusion have been shown to run the risk of stereotyping; this is particularly the case in medical education, where a focus on differentiated identities results in the “Othering” of underrepresented groups (Smith 2012; Wear 2003; Taylor 2003). Therefore, the challenge that lay before educators of pre-medical and medical students is: how do educators teach students to be inclusive while also being sensitive to difference?
This challenge is shared by educators within sociology, as well. As Cleary (2001: 36) noted, “the challenge of a sociology class addressing issues of inequality is to bring students beyond their stereotypical beliefs about those who differ from themselves, motivate them to question their underlying assumptions, and prevent them from distancing themselves from the subject.” Therefore, drawing upon pedagogical insights from the instruction of sociology can augment the instruction of pre-medical and medical students. The bridge from sociological instruction to medical education provides the pathway toward cultivating a critically engaged group of future doctors and citizens.

In anticipation of the revised MCAT, the UCSD Sociology Department has created a course for pre-med students, expressly designed to teach the fundamental concepts and critical thinking skills sociology has to offer. The objectives of the MCAT, which go beyond the usual social determinants of health, aim to give students a greater understanding of the social processes that influence behavior, identity, interactional style, and prejudice and bias formation; the structural distribution of resources and risks, according to class, race, ethnicity, gender, sexuality, age, ability, place, and their intersection; and, the institutional environment in which healthcare work occurs and from which disparities emerge. In this paper, I give an overview of why this course is important by placing pre-medical education within the wider framework of medical education and practice. Then, I describe how the placement, content, and goals of this course will work towards overcoming the issues that plague the instruction of social scientific knowledge across educational, research, and clinical practices in biomedicine. I will focus, particularly, on how the interplay between the student journal assignment and discussion activities are poised to alter how students perceive their lives and the social
world around them, solidifying an approach to critical thinking that they can carry with them into their future careers.

I argue that this Sociology course for pre-med students will not only enrich students’ approaches to medical practice, but will also help build each university’s institutional capacity for diversity and inclusion (Smith 2012). At the most basic level, this course brings attention to the multiplicity and intersections of identities within the institution of higher education and the institution of medicine, moving toward both an inclusive and differentiated understanding of diversity at the level of lived experience. More deeply, this course develops students’ capacity for an advanced sociological imagination that is attuned to implementing patient care, research, and health care advocacy without stereotyping or Othering.

FUNDAMENTAL CHALLENGE IN DIVERSITY-INCLUSION EDUCATION

The fundamental challenge in educating pre-medical and medical students stems from the issues surrounding the meaning and measurement of human difference. Health disparities research is ubiquitous, reflecting and constructing human difference – conceived as any deviation from the white, heterosexual, middle-class male – in health and health care as a social problem. This body of research embodies the tension between inclusion and difference; its goal is to promote a more egalitarian health care sector while simultaneously elevating the importance of human difference. This work promotes a conceptualization of human difference that states: understanding human difference is critical to the elimination of its salience.
This challenge has been addressed by sociologists interested in different areas of medicine. A blossoming group of scholarship in the science studies tradition has explored how geneticists, genetic technologies, and federal bureaucratic data collection standards have combined to reconstitute a biological, essentialized vision of race in pursuit of the elimination of race-based disparities (Duster 2005, 2006; Reardon 2005; Fullwiley 2007; Graves 2011; Kahn 2011; Krimsky 2011; Bliss 2012). Research building upon the science studies framework from an historical perspective has also shown how an eclectic assortment of clinicians, researchers, bureaucrats, minority groups activists, and pharmaceutical corporatists have collectively forged an institutionalized “inclusion-and-difference paradigm” (Epstein 2007), that prioritizes – and in turn reifies – race and gender differences within biomedical research protocols.

Under the rhetorical frames of benevolence and progress (Morning 2011), the inclusion-and-difference paradigm institutionalized concepts, practices, personnel, and infrastructure in biomedical research that prioritized the inclusion of previously underrepresented groups while claiming that the rationale for their inclusion was predicated on the realness of the biology of social categories like race. With biomedical research’s move away from the universal standard human research subject toward the inclusion-and-difference paradigm, Epstein (2007) argues, the human body was reconceptualized on a group-based level – the body was not universalizable, nor wholly individual, but understood according to the biological salience of group difference.

To understand how this tension is borne out in medical education, I will describe the challenges that medical education has faced with the instruction of cultural competence. Many scholars regard the point of contact between the patient and their
physician as significant (Parsons 1951; Balint 1957; Korsch and Negrete 1972; Byrne and Long 1976; Engel 1977; Cicourel 1981; West 1984; McWhinney 1989; Waitzkin 1991; Frankel et al. 2003; Stewart 2003). In the physician-patient encounter, social roles, social statuses, forms of knowledge and expertise, confront one another within the organizational and professional constraints of both the health care system and broader social structures. Cultural competence has been offered as a potential solution to many issues that occur in the physician-patient encounter, yet due to the organizational, professional, and knowledge-based values, practices, and identities within the biomedical system that physicians and patients are inevitably embedded in, such idealism often falls short.

FORMULATION OF THE PROBLEM AND SOLUTION IN MEDICAL EDUCATION & PRACTICE

The physician-patient relationship is analytically different, yet empirically connected to the physician-patient interaction. The former term refers to the social roles of physician and patients, in addition to their differential knowledge bases, statuses, and power. The latter refers to a behavioral and communicative exchange, that generally begins with opening remarks, proceeds through problem presentation, history taking, physical examination, and ends with a diagnosis and treatment recommendations (Byrne and Long 1976; Robinson 2003). While obvious, this interaction usually occurs in a biomedical environment, such as a hospital. Both the physician-patient relationship and interaction have been shown to have a substantial impact on diagnostic accuracy, treatment outcomes, patient compliance, patient satisfaction, and the illness experience.
Parsons’ (1951) formulated the classic portrayal of the physician-patient relationship, describing the social roles of physicians and patients, their inter-relationship, and their attendant behavior expectations. In this asymmetrical relationship, patients are configured as dependent upon the legitimized expertise of the authoritative physician; in turn, patients bear no responsibility for their condition if they want to get well by following their physicians’ treatment advice. Beyond objections to his normative bent (Foucault 1975; Conrad and Schneider 1980), Parsons has been criticized for overstating the commonality of interests between patients and physicians (Szasz and Hollender 1956), for equating interactional control with the ability to treat (West 1984), and for over-simplifying illness experiences to an over-generalized ideal type (Freidson 1970).

The physician-patient relationship, in general, has major implications for how the physician-patient interaction occurs. In the physician-patient encounter, the organization of talk lends sense and meaning to communicative exchanges in addition to creating situated identities and roles. Scholars have described the form and content of physician-patient interactions as problematic (Waitzkin 1991; West 1984; Cicourel 1981, 1992; Fischer and Todd 1983). The issues stem from a perceived disconnect between the status, class, ethnicity, and gender of physicians and patients, which fundamentally impact – and are constructed through – communication. These disconnects have consequences, as “a lack of mutual intelligibility between speakers have major repercussions (e.g., misdiagnosis, mistreatment, and even charges of malpractice)” (West 1984: 151). Moreover, these disconnects have implications for the patient’s satisfaction and comfort with health care, along affecting their values, practices, and self-understanding.
Communication is fundamentally embedded in regimes of power (Foucault 1975). To understand the dynamics of the physician-patient interaction, and the physician’s learned communication styles, its important to see how physicians are socialized. Medical socialization entails the process of instruction and internalization of a body of knowledge, set of skills, and encompassing value orientation that medical students undergo in a concentrated period – medical school – and that gets reinforced and challenged in everyday practice (Becker et al. 1961; Light 1978; Bosk 1979; Hafferty 1988; Berg 1995).

Biomedical socialization promotes a conceptualization of a patient as a compilation of anatomical parts that is assessed with insights from the basic sciences – a “reliance on chemistry and biology, reliance on quantitative measure, and a belief in the primacy of a physiological view of reality” (Chambliss 1996: 123; Nettleton 2004). This is reinforced with evidence-based medicine (Kirmayer 2012). One formal step in learning this approach to patients is through work in the anatomy lab; medical students learn to distance themselves from the patients with informal stories that dehumanize the cadavers (Hafferty 1988). Another step is the clinical narrative that medical students learn to write up (Good 1994; Good and Good 1995; Hafferty 1998). In practicing how to “en-case” the patient, medical students actively objectify patients with detached emotional comportment (Holmes and Jenks 2013; Fox 1957). As a result, scholars have described the physician-patient interaction as one that is constructed and negotiated in the physician’s terms – physician- and biomedically-centered (Byrne and Long 1976; Engel 1977; Cicourel 1981; West 1984; Heritage and Maynard 2006; Raz and Fadlon 2006).
Empirical studies of patient compliance and patient satisfaction have shown that the comprehension of medical jargon is ethnicity- and class-dependent (Korsch and Negrete 1972; McKinlay 1975), and that the length of time spent with the patient is less desired by the patient than the achievement of good explanation (Wallen et al. 1979). As such, Cicourel (1981: 71) contends, “the doctor-patient interview and history-taking, therefore, are like microcosms of larger societal patterns of information control and social stratification.” The standardized intake protocols and electronic-based input systems that are a part of technoscientific innovations only exacerbate this relationship.

Barriers to communication and information sharing are based on physician-patient differences in social class, education, gender, ethnicity, cultural background, language and age (Roter and Hall 1992). Fischer (1989) describes how women’s reproductive choices are often medically managed in a way that largely ignores the women’s voice. Waitzkin’s (1991) case summaries show that the uneducated and poor patients bear the largest brunt of the uneven physician-patient relationship, because they are less equipped to demand certain procedures and services. Moreover, Waitzkin argues, physicians who act uncritically end up acting as agents of social control, reinforcing the dominant ideologies governing major social institutions (such as work and family).

Medical educators and accreditation boards in the U.S. have recognized the need for communication and interpersonal skills to be integrated into American medical school’s formal curriculum (Silverman et al. 1988). One measure that has been introduced to try to bolster patient-centered communication and increased physician sensitivity to patients is cultural competence. For physicians, government agencies, and researchers from across disciplines, cultural competence has “become a byword endowed
with almost religious significance, a panacea for multiple and interwoven problems in health care communication” (Perloff et al. 2006: 835). There are two main problems that cultural competence has initially been configured to address. First, there are cultural differences in understandings of and approaches to treating health problems that diverge from the Western biomedical model that characterizes the health care environment wherein physicians practice and individuals receive care. Second, consequences of these differences have been shown to disadvantage racial and ethnic minorities, prompting a search for solutions that ameliorate these disparities (Brach and Fraser 2000; Chin 2000; Betancourt et al. 2002; Smedley et al. 2003). Culturally competent care, it is argued, will affect positive health outcomes by improving the transmission of information and the alignment of goals.

While some solutions may be targeted at different levels within the healthcare system (e.g., hospital-wide, agency-wide, or provider-level), others look for solutions to the structural inequalities external to healthcare (e.g., racial/ethnic and class-based disadvantages in educational attainment, employment opportunities, neighborhoods that negatively impact health) (Marmot 1991; Pescosolido 1991; Diez-Roux and Mair 1999; Fox 2005; MacIntyre and Ellaway 2005). One of the most common sites for the proposed intervention is the provider-level, encapsulated in the physician-patient interaction (Srivastava 2007; Bromley and Braslow 2008; Willen and Carpenter-Song 2013).

At the start of the 21st century, the federal Office of Minority Health published the first ever \textit{National Standards for Culturally and Linguistically Appropriate Services in Health Care} (National CLAS Standards) to enhance the provision of health care to an increasingly diverse America. Because there had been a “radical racial transformation” in
the United States over the last few decades, there were “strong implications for how social services and health care were delivered to people who may be unaccustomed to Western methods of intervention” (Walton et al. 2010: 441). In effect, these standards ushered in a new era in health care, whereupon “cultural competence” became not only a popular buzzword but also a legislated – if only formally – entity.

Cultural competence may take on many names, such as cultural humility, culturally appropriate care, and cultural sensitivity (Jenks 2011), yet the advocated practice remains similar: providing a level of responsiveness to a diverse patient population by cultivating an awareness of the “languages, histories, traditions, beliefs, and values” of “racial and ethnic minority groups” (U.S. Surgeon General’s Report 2001: 36). Admirable in intention, the application of cultural competence has proven to be a major challenge to legislators and healthcare providers alike, as “problem recognition and enthusiasm, however, are not enough to ensure effective change” (Tucker 2003: 859).

The theoretical import of cultural competence is disconnected from its practice. Some scholars blame the theorizing and contend that the confusion surrounding the concept of “cultural competence” or “cultural sensitivity” stems from the failure of researchers to consider patient perspectives in the definition or explanation (Tucker 2003: 860; Wear 2003). In a study of African American, Latino American, and European American patients at a primary care outpatient clinic, Tucker et al. (2003) found that, in general, patients wanted physicians that demonstrated good people skills (e.g., listened well, showed thoughtfulness, empathy, and concern, took tame with the patient, was not judgmental, was sensitive to privacy, and respected the patients’ perspectives), gave individualized treatment (e.g., had personal knowledge of the patient, cared for the
patient over the years, gave them special attention, and was sensitive financial issues), effectively communicated (e.g., explained procedures, tests, treatments without medical jargon and condescension, and was honest), and were technically competent (e.g., focused, thorough, simple, low error-rate).

Increased calls for medical education curricular reform voiced the need for medical education to teach social and cultural responsiveness. There is wide variation in educational settings (graduate, residency, and CME) and curricular activities (language programs, lectures, interactive sessions, workshops, clerkships, rotations, short immersion programs, elective courses, etc.). In addition, the assessment of learning outcomes remains limited (Crandall et al. 2003). Medical education has three interconnected curricular components: formal, informal, and hidden. Formal curriculum contains the explicitly stated and deliberate learning materials and courses, informal curriculum is composed of interpersonal relationships that transmit values, attitudes, and knowledge between individuals and super-ordinates, colleagues, and sub-ordinates, and hidden curriculum entails a “set of influences that function as the level of organizational structure and culture” (Hafferty 2000: 243). The transformation of the moral world is inbuilt to the fabric of medical education and the hospital; the transformation is from the lay world into the biomedical culture (Good 1994; Taylor 2003).

Scholars argue that this transformation is quite complete, with most physicians adopting the biomedical values, practices, and identities. As a result, medical students that have undergone two years of a cultural competence training series have reported being unaffected by their social location, characterized by Beagan (2003) as “social neutrality”; however, minority students were more likely to report that race and ethnicity
makes a difference, working class students were more likely to report that class makes a difference, and religious students were more likely to report that religion makes a difference.

Beagan (2003) argues that the student’s social group membership appeared to hold more weight than the exposure to the curricular material, which are findings corroborated by other scholars studying physicians (West 1984; Kellogg 2010). The central implication is that medical students see difference solely as a disadvantage, rather than reflexively as a privilege, constructing for the patient a “deficit identity” (Beagan 2003: 611). Her findings highlight biomedicine’s power, for “to assert that a given area of life – and the knowledge associated with it – is medical is, in our study at least, to claim that it has a technical status which removes it from all other intellectual activities and renders it immune to the principles which govern them” (Wright and Treacher 1982: 5-6).

Furthermore, Beagan (2003) argues that her findings reveal the inadequacy of a curriculum that does not integrate power relationships within cultural competence training, as “in this context, the experience of learning about ‘Others’ can be a type of voyeurism, stereotyping, exoticization, identifying the ‘deviant’ features of ‘those peoples’’ lives” (2003: 613). Many scholars agree with Beagan’s (2003) assessment (Jenks 2011; Shaw and Armin 2011; Kirmayer 2012), and Raz (2003) points out that the devaluation of cultural competence as compared to biomedical knowledge demotes cultural competence training to “lower status”, in turn becoming the task of auxiliary professionals.

Health disparities research both poses the problem cultural competence measures aim to address while contributing to it. Health disparities research, in their concern with
social causation external to the health care system, in turn, do not problematize the biomedical diagnostic and treatment protocols they are utilizing or recommending. This does not mean that their research is useless, however, as it reveals how individuals in different social contexts are subject to different degrees of inequality. They point out the simple fact that patients bring more to their physician’s appointments than their bodies. But even by pointing to the unequal variation in human experience, the problem with health disparities research remains, as biomedical knowledge – in the form of evidence-based medicine, for example – transforms this variation into generalized patterns according to race, gender, SES, etc., falling prey to ecological – and decontextualized – fallacies.

The issues with cultural competence at the provider level – and its training processes – reveal a problem with the formulation of cultural competence within curricular channels. Medical educators bemoan the failure of cultural competence – as a concept, practice, and educational program – to live up to its stated goal of reducing racial and ethnic disparities in health and health care (Betancourt 2003; Beagan 2003; Crandall et al. 2003; Wear 2003). These educators measure the success or failure of cultural competence by the evaluating the attitudes, skills, and knowledge of medical students – similar evaluation as the MCAT. Regrettably, the educators claim, medical students tend to reify minority stereotypes in these assessments, despite a widespread educational effort designed to combat this problem within the cultural competence curriculum.

The prolific community of medical educators blame curricular design, inadequate instruction, poor measurement criteria and methods in assessment, a subversive “hidden
curriculum”, and the values of biomedicine itself for the failure of cultural competence to impart a sophisticated understanding of human difference onto its students (CITES). In other words, “the use of culture in cultural competency work can decontextualize difference, drawing attention away from the power dynamics involved in health disparities and focusing it on individual personality traits” (Jenks 2010: 209). I build upon this tradition, and would like to show how the Sociology Department’s course for pre-medical students is poised to teach students about inclusion and difference in a way that avoids stereotyping – through the emphasis on the power-laden, socially constructed, yet wholly real, lived experience of difference (Shim 2014). Therefore, with pre-medical students, instructors have an opportunity to cultivate a critical perspective in students before they reach the all-encompassing world of medical school and practice. These students could help be catalysts for real change if they understand the complexities of how power and inequality are inbuilt to the social fabric of the United States.

**SOC. 70 COURSE OBJECTIVES & FORMATIVE ASSIGNMENTS**

Often, students perceive disadvantage at the personal level, and either think in terms of the meritocratic ideology, where disadvantage is seen as a result of personal failure (Johnson 2005) or only recognize racism and sexism when it is overt and interpersonal (Picca, Starks, and Gunderson 2013). Students have a difficult time conceptualizing the systemic inequality characterizing the contemporary U.S. landscape (Goldsmith 2006). The challenge that lies before the instructor is to make the invisible visible, to show how inequality is predicated on deeply entrenched ideas about difference and valuation that though socially constructed, have very real consequences in shaping life chances.
Cultivating a student’s sociological imagination can be difficult because students have been shown to lack an understanding of their own cultural lens (Schopmeyer and Fisher 1993). As such, students formulate etic, or simple, descriptive, and ethnocentric conceptualizations of human difference (Miller 2014). The goal of student instruction is thus to cultivate an emic orientation toward the social world, one that accounts for the histories, contexts, and processes that lend action and thought meaning.

This course aims to cultivate a sociological imagination (Mills 1957) in pre-med students, with the intention that not only will they be prepared for the MCAT, but that they will also become more aware of how our social world informs behaviors (Ballantine and Roberts 2014). Fundamentally, this course hopes for students to be able to de-personalize behaviors, identities, accomplishments, and failures, and instead place them within an interactional, group, and institutional context; in other words, we hope students can habitually situate themselves and others in a social world (Ballantine and Roberts 2014). The ultimate goal of the course is three-fold: to have students (1) conceptualize human difference as complex rather than reducible to single variables, (2) visualize human bodies within hierarchies of power, and (3) become comfortable with engaging in reflective practices.

The course material, and the approach to the course, allow us to situate the self amid a flurry of socialization agents: families, friends, education systems, religions, and so on. The purpose of building up from the individual (as opposed to teaching health disparities outright) is to show how each and every one of us has multiple selves. This is the first conceptual building block for seeing human difference as highly complex and multifaceted. As we trace the formation of the self across groups and institutions, too, we
begin to identify how some groups are disadvantaged by institutions, and how even arbitrary-seeming differences get translated into inequities, which fulfills the second objective. Finally, this processual and abstract approach to understanding the self provides ample fodder for reflexivity-based insights into students’ own lives. This “critical self-reflection encourages students to examine the connections between their experiences and the broader structural conditions of society and to develop a type of consciousness that leads them to behave with humanistic principles” (Rusche and Jason 2012: 339).

These objectives are reinforced through a complementary interplay between the reading material, discussion activities and assignments. The course text is Ballantine and Roberts (2014) *Our Social World*, which takes seriously the embedded nature of the individual, and shows how from dyads to nation-states, groups to global networks, an individual is conditioned as a social being. In addition to explaining an immense amount of sociological concepts, this textbook also actively engages students through “Thinking Sociologically” prompts (e.g., "Identify several dyads, small groups, and large organizations to which you belong. Did you choose to belong, or were you born into membership in these groups? How does each group influence who you are and the decisions you make?") (Ballantine and Roberts 2014: 7).

The central mechanism by which students will learn to comprehend and engage critically with the material is through the student journal. Writing is a process of learning and knowing, and student journals have been shown to activate the sociological imagination, through promoting active learning, connecting the course materials to life experiences, and fostering critical thinking and reflection (Mills 1959; Wagenaar 1984;
Chickering and Gamson 1987; Pavlovich 2007; Picca, Starks, and Gunderson 2013). At the outset of the course, students will be given the task of writing an entry, at least a single-spaced page in length, every week. Some weeks will be unstructured, others semi-structured; however, each week’s entry will be focused on the reading material and discussion activities of the week. Unprompted reflection allows students to find their own voice and style and play a very active role in their learning, whereas semi-structured reflection “insists that they process what they just read, not through summarization but application” (Rusche and Jason 2012: 346).

To demonstrate how the reading, discussion and journal activities are linked, I will use two examples of previously-established activities that have been integrated into the course. The first is derived from Larson and Tsitsos (2012) speed-dating exercise. Because the Ballantine and Roberts (2014) textbook opens with broad questions about the social self, it is easily paired with readings on the formation of meaning-making (Mead and presentation of self (Goffman 1959). Understanding one’s self as embedded in meaning-making systems starts with identifying one’s own meaning-making systems (Kebede 2009), and Larson and Tsitsos’ (2012) speed-dating exercise allows students to access the interpretive and interactive aspects of the presentation of self. Students set up their chairs in rows facing one another, and interact in pairs for 3-5 minutes before moving on to another student. After meeting between 5-7 students (depends on class duration), students record their impressions of their meetings. I ask them to think about what subjects they discussed and did not discuss, how their gestures held constant throughout the interaction and how they changed over time, how they decided what
information to share and not to share (Larson and Tsitsos 2012), and what they thought their answers to these questions were informed by.

Through this interactive exercise, the students began to see how the everyday activity of introducing themselves to other people is laden with a series of judgments that are dependent upon decision making processes and ideas that they may take for granted. This exercise served as a launching point to discuss some of the relevant sociological concepts and processes they participated in: socialization, social norms, presentation of self, impression management, and impression formation (Larson and Tsitsos 2012).

Students were asked to think through the types of socialization they have undergone in their lives, the sets of social norms they feel bound by, and where social norms come into conflict. By having the students focus on these conflicts between roles they may play, students begin to exercise their sociological imagination, by transforming personal problems into socially patterned conflicts.

The second follows Khanna and Harris’ (2014) approach to teaching students how to understand representation in the media. Students will be instructed to (1) visit the US Census, and record the ethnic racial breakdown of the United States, (2) watch a particular network (ABC, CBS, NBC, FOX) for the duration of one week during primetime (M-F, 8-11pm), and analyze the sitcoms, dramas, and reality TV shows on that network, (3) discuss the setting, character representation, role prominence, and characteristics of what they saw with a previously established partner in class. The questions below help students catalog what they saw (Khanna and Harris 2014):

 Character Representation: How many are White, Black, Latino, Asian, Native American?

After speaking in pairs, the pairs will share their insights with the classroom. The stereotypes will be aggregated for the students to write down. Then, they will watch the 18 minute video of Chimamanda Ngozi Adichie’s TED talk, *The Danger of a Single Story*, and think about how these stereotypes tell a single story. Their journal entry for that week will have them imagine how these stereotypes flatten the stories of the groups they represent. The goal of this in-class and written assignment is for students to engage with the hurtfulness that stereotypes provide. Learning through vulnerability, students will see how what is meaningful to individuals is not as simple as a single story, even though that is what is usually portrayed and consumed.

**DISCUSSION/CONCLUSION**

This course will move toward an understanding of human difference that is nuanced, contextualized, and oriented toward personal experience. In other words, this course will situate difference within a power analytic, making sure that difference is not synonymous with neutral, natural, and unavoidable. By employing the utility of the sociological imagination, students will enter medicine with an understanding of how difference becomes salient through socially constructed channels; how focusing on single broad social categories risks missing important ways in which these categories intersect, or how an individual makes meaning in relation to them; and how the lived experience of difference must be tackled holistically and cannot be reduced to categorical logic.
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