"I think you should be more explicit here in step two."
Overall description of SFM

Social foundations of medicine is applied social science. Along with rural health, indigenous health and research, it is one of the four frameworks that extend and interlink the four themes of the medical school. While rural health and indigenous health are perspectives that can be used in the four frameworks, and research can be applied across all frameworks, SFM enables us to provide a foundation for enhanced understanding, and informed practice across the four themes.

The overall aims of SFM are to develop

- the capacity for perspective taking, a key element of cognitive empathy
- the ability to synthesise and think critically and laterally across a range of medical disciplines
- the capacity to understand medicine as a practice, institution and knowledge system as socially and culturally based

SFM is founded on two key principles:

1. Medical practice, medical knowledge, and medical institutions are all rooted in our social world. This means that human cultural and social organisation influences the ways we practice as doctors, the medical knowledge that we choose to prioritise, and the institutions and policies through which medicine is delivered to populations.

    As doctors, our perceptions of who is worthy, or is being ill in the right way, or how we should behave in relation to patients (all of which reflect social and cultural perceptions and experiences) influence how we respond to patients.

    In medical science, the areas that are chosen to be studied, or incorporated into standard medical knowledge, often reflect social and cultural priorities.

    The institutions through which medical care is delivered are social organisations (that is, they reflect the larger society in which they are located).

    For patients, the ways in which people become sick and express being sick reflect their social position and opportunities and cultural beliefs.

    If we use a social and cultural lens to understand medicine then we will become more accepting and effective doctors, we will understand the
limitations of medicine, and we will be better able to navigate the institutions of medicine.

2. Medicine also helps create the social world that we live in. Medical innovations have led to improvements in health globally. Medicine has become a dominant frameworks used in everyday thinking.

We may describe things that we morally approve of as healthy, and things that we disapprove of as sick.

As a society, we may seek to use medical categories to describe some feelings or practices which are not socially acceptable, or are socially stigmatised.

Although health care is one of the resources through which countries and individuals improve economically, access to medical care is not equal around the world.

If we use a social lens to explore the impact of medicine we are able to respect the enterprise, and recognise where to responsibly advocate.

Structure

Year 1: UNDERSTAND Introduction to conceptual material. Practise applying them across all domains

Year 2: APPLY Advanced application of material to more complex clinical cases. Joint teaching in seminars

Year 3: ANALYSE Complex clinical situations that require judgement and analysis. Portfolio item on gender.

Year 4: EVALUATE Exercise in reflexivity: personal reflection on illness in one’s own life
Year 1 Learning outcomes

Block 1:
- Articulate the fundamental philosophical ideas and principles which underpin medical knowledge and medical practice in society
- Articulate the ways culture and social disadvantage may impact on the consultation and the distribution of illness

Block 2:
- Articulate the impact of medicine on the interaction between the embodied self and the social world

Block 3:
- Describe the social processes of institutionalising and mainstreaming medical knowledge

Teaching format

Lectures use illustrative material, with narrative material from clinical practice. This will usually be clinical material reflecting the overall learning focus of the week. Because of this, it’s best not to try too hard to remember the powerpoint slides, but rather to relax and listen. Feel free to ask questions in the lecture, and remember that usually in this area there isn’t one correct answer. There will be some test yourself questions at the end of the lecture to test your immediate understanding.

The readings in SFM are divided into tasters, which convey some key concepts and are written in very accessible style, and further readings, for those who wish to explore the lecture in further depth. Do the test yourself questions before each lecture to orient yourself to the areas where you may have knowledge or understanding gaps. I’ll put up the answers a few days after the lecture.
SFM LECTURE 1: Biomedicine as a sociocultural system

AIM: To introduce students to the socio-cultural foundations of health, sickness and healing.

OVERVIEW: You are about to begin studying the form of medicine called biomedicine, a term which signals its foundation in biological knowledge. The fact that biomedicine is a scientific endeavour should not blind us to the fact that it is also at its core a social endeavour, and it reflects (or can be used to reinforce) prevailing social and cultural mores and beliefs. Because it is such a pervasive cultural system, it can be difficult to see the way biomedicine channels cultural beliefs and practices, and reinforces or challenges social differences.

WHAT SHOULD I BE ABLE TO DO AT THE END?

- Define biomedicine.
- Identify key disciplines in biomedicine.
- Argue the case that biomedicine can (or can’t) be seen as a cultural system.

READINGS:

Starting up

The reading about Princess Diana’s management after her car accident contrasts the French “stay and play” and the US “scoop and run” approaches to emergency medicine. The difference between these two is presented as attributable to health system differences, but also draws on the heroic tradition of emergency medicine in the US. Deborah Lupton describes cultural aspects of many Western traditions that have been incorporated into biomedicine.


Deborah Lupton The cultural assumptions behind Western medicine https://theconversation.com/the-cultural-assumptions-behind-western-medicine-7533 2 January 2013
AIM: To outline the implications of mind-body dualism and materialism in biomedicine.

OVERVIEW: This lecture introduces the concepts of mind-body dualism and materialism and points to the way medicine - ostensibly a materialist discipline - oscillates in practice between both philosophical perspectives. This tension is fundamental to the practice and some of the ethical dilemmas within medicine.

The readings today begin with Descartes’ meditation on the nature of the human mind, read in beautiful if soporific fashion. An editorialist in the British Medical Journal two hundred years later suggests that medicine can, and should, move beyond dualistic thinking. Miresco and Kirmayer, both psychiatrists, suggest that this is an ongoing challenge for biomedicine, and that in their own discipline, psychiatry continues to use dualism in clinical reasoning. We will also talk in the lecture about whether the term "psychosomatic" is successful in its attempt to overcome dualistic thinking.

WHAT SHOULD I BE ABLE TO DO AT THE END?

- Distinguish illness and disease.
- Explain to someone what Cartesian dualism means in relation to medicine.
- Explain to someone what materialism means.
- Examine your own beliefs, and think about which philosophy seems most intuitively right to you?

Pushed for time?

1. Rene Descartes Meditation II from Meditations of First Philosophy. Read by DE Wittkower. [http://www.youtube.com/watch?v=QE8dL1SweCw](http://www.youtube.com/watch?v=QE8dL1SweCw)

2. Bracken P. Time to move beyond the mind-body split in medicine. British Medical Journal 2002;325:1433-1434

Stretch your mind:

AIM: To introduce the social and cultural determinants of biomedical nosologies of disease and illness.

OUTLINE: Nosologies are devices that are used to determine which diseases are legitimately part of the medical endeavour, and which aren’t. Nosologies are evolving entities. The two short readings provide two examples of nosological expansion. The New Republic article describes the development of the new category of ‘social phobia’. Emerging infections often pose problems for epidemiologists seeking to define the boundaries and the causes of illness. Feinsten’s paper discusses somatic sicknesses (e.g. Gulf War Syndrome) as conditions that cannot be understood independent of their social and cultural context. The extension reading by Gaines (an oldie, but a classic) outlines major changes in a psychiatric nosology over the last fifty years, and the impact of this nosology on notions of normality.

WHAT SHOULD I BE ABLE TO DO AT THE END?

- Describe and give some examples of a nosology
- For any one disease, invent at least two different nosological categories that it could be included under (e.g. glue ear could be classified using nosologies of (a) learning disorders, (b) disordered otolaryngology pathology, (c) infectious disease)
- Describe the implication of categorising a disease into different nosologies

Testing the water:


Going in deeper:

AIM: To describe modes of patient-doctor relationship within the medical encounter, and their relationship to context and therapeutic outcome. [This is an online interactive lesson. Make sure you test your understanding properly afterwards. Students who skip slip up]

OVERVIEW: The essay by Canberra GP Clara Tuck Meng Soo describes two patients who would be generally regarded as challenging. The first describes a successful use of the partnership mode. In the account of the second patient, Peter, Dr Soo first applies a parentalist mode, before back-tracking and using a very simple partnership mode. The text implies that the patient is so angry that a psychodynamic mode is unlikely to ever be acceptable to him. Larson’s paper raises the possibility that clinical empathy is not a moral character trait, but something which may be developed by acting like you care. Csordas and Kleinman present an overview of the conceptual terrain involved in thinking about therapy and healing.

WHAT SHOULD I BE ABLE TO DO AT THE END?

- Describe the four modes of patient-doctor communication.
- Give an example of a clinical situation where each of these would be used
- Mount a response to the proposition that saying that doctors “act” means that they are inauthentic with their patients (You may be in agreement or disagreement)
- Distinguish cognitive and emotional empathy. Which do you use?

Short cuts


Larson EB, Yao X. Clinical empathy as emotional labour in the patient-physician relationship. JAMA; 293(9):1100-6.

The long way round:

AIM: To explore the embodiment of sickness and disease in medicine, and the way this can embody socio-economic inequalities.

OVERVIEW: Both the rapid and in-depth readings for this lecture draw on the work of Havi Carel, a philosopher who writes of embodiment as a way of understanding her own bodily experience with a rare and fatal disease. Morstyn reflects on the experience of having an unpleasant procedure in hospital, again drawing on Merleau-Ponty. In a more theoretical vein, Krieger and Davey Smith discuss, using clear and concrete examples, the embodiment of socio-economic inequalities.

WHAT SHOULD I BE ABLE TO DO AT THE END?

- Describe embodiment to someone who doesn’t know any philosophy
- Describe what is meant by a culture-bound syndrome. Give some examples from your own culture
- Describe an approach to understanding how suffering or distress becomes embodied as feelings and/or illness
- Distinguish cognitive from emotional empathy

Openers:


Now read on:


SFM LECTURE 6: Suffering and social inequality: I

AIM: To articulate social explanations for the emergence of new infections or illnesses

OVERVIEW: Infections follow the faultlines in society (Paul Farmer). The short reading is a description from a blog written by a person diagnosed with multidrug resistant TB acquired in a Ukrainian prison. Prisons in developing countries and in the former Soviet bloc are major sites of transmission for multidrug resistant TB, a slow running international public health disaster. The video by Journeyman Pictures of a hospital in Guinea-Bissau is an unusually frank look at an impoverished hospital in an impoverished country. The “evening read” sketches out the role of an anthropological lens to understand (and predict) emerging infectious diseases in a time of social and ecological change.

WHAT SHOULD I BE ABLE TO DO AT THE END?

- Outline the elements of the epidemiologic triad
- Use the triad to identify reasons for outbreaks of disease
- Explain to a stranger why the poor are more likely to suffer outbreaks of disease and poor nutrition using some different explanatory frameworks
- Describe Malthus’ and McKeown’s hypotheses
- Define health and demographic transitions
- Analyse the characteristics of “countries that cope”

Morning read:

From Artem’s blog, TB and Me project (MSF) https://blogs.msf.org/bloggers/artem/tb-me-you-need-get-treatment-and-believe-yourself

Watch:


Evening read:

Alley C and Sommerfield J. Infectious disease in a time of social and economic change. Medical Anthropology 2014; 33: 85-91
SFM LECTURE 7: Suffering and social inequality II

AIDS and other catastrophes

AIM: To analyse the social histories and contexts of AIDS and famine.

OVERVIEW: Two doctors who observed the beginning of the HIV/AIDS crisis describe their experiences. Abraham Verghese describes the personal shame and isolation experienced by some of the early patients who died of AIDS in Johnson City, Tennessee. In Haiti, Paul Farmer describes the social inequalities, on both large and small scale, that resulted in the most vulnerable patients acquiring infection.

Can famine be regarded as man-made and socially produced rather than a natural disaster? Armatya Sen won the Nobel Prize for economics for his argument that humans make famines. One of his seminal papers is included here.

WHAT SHOULD I BE ABLE TO DO AT THE END?

• Outline the application of the epidemiological triad to the emerging response to HIV in the 1980s
• Explain to someone why Australia’s response to HIV is one of the great public health stories of recent memory.
• Identify the causes of famine, and how we can avoid them.

Beginnings:


Read further:


SFM LECTURE 8: Foundations of efficacy: The placebo effect and the locus of healing

AIM: To analyse and apply the concept of the placebo effect(s) and the nocebo effect to clinical care.

OVERVIEW: The efficacy of pharmaceuticals often extends beyond the efficacy of the active ingredients. In an email from an MSF post in Pakistan’s NorthWest Frontier, Dr Siobhan Reddel describes the potency attributed to pharmaceuticals, particularly injected ones. The ABC Health Report introduces us to the nocebo effect, “placebo’s evil twin”. Spiro provides an clinical perspective on placebos in practice. For those interested in the science of placebo, the paper by Benedetti describes the terrain.

WHAT SHOULD I BE ABLE TO DO AT THE END?

- Define placebo and nocebo
- Describe areas in medicine where placebo effects occur frequently
- Describe mechanisms by which placebo is thought to work to control pain
- Argue for and against the proposition that innovations in surgery should only be introduced after testing with a placebo arm
- Describe where nocebo effects may occur in medicine

Flickerfest

Reddel S. The most effective medicines in Pakistan, 2010 [email, January 2010]

ABC Health Report Nocebo effect could be making you feel ill November 2017

Any Star Wars film, the Director’s Cut:


Benedetti F. How doctor's words affect the patient's brain Evaluation and the health professions. 2002; 25; 369
AIM: To analyse the changing historical and social constructions of the good death, and to examine the change in locus of death from heart to brain.

OVERVIEW: Walter’s short article provides a historical overview of changing notions of the good death, challenging readers to consider their own personal constructions of the good death. As a clinician whose patient population often dies, Berry ponders the reluctance of professionals in his subspecialty to tell patients that they are dying. The New York Times paper outlines the tragic story of Japan’s first heart transplants. Lock’s classic paper contrasts constructions and loci of death in North America and Japan.

WHAT SHOULD I BE ABLE TO DO AT THE END?

- Outline the reasons why death is located in the brain
- Outline processes for determining brain death
- Identify personally what elements are important for the good death for you
- Describe cultural determinants of the location of death

The atrium


From the Archives: *Tokyo Journal: A transplant trauma - is soul-searching ending?* New York Times 1987

The left ventricle

AIM: To examine the legitimation and de-legitimation of types of sicknesses, and to explore the ways particular forms of sickness become ‘gendered.’

OVERVIEW: Being sick can afford some protection from social and cultural expectations. But not all sicknesses are equal. Some sicknesses are understood by both patients and doctors as being less legitimate than others.

The opening resources are author Maggie Stiefvater’s blog about her year with an illness without name. This is backed up by Dr Stone’s reflection on diseases with prestige and those without prestige.

For more about the gendering of illness, read Horton’s paper on illness expression in the Appalachian mountains, and reflect on your own experience of the ways illness in the community can be gendered.

WHAT SHOULD I BE ABLE TO DO AT THE END?

• Intelligently debate the proposition that some illnesses are conventionally regarded by patients and doctors as more legitimate than others
• Describe about the “sick role” and when it may or may not apply
• Outline the difference between gender and sex
• Use gender and sex to identify potential differences between health, illness and health care for men and women
• Explain the difference between gender, gender role, and gender identity

RESOURCES:

Begin here:
Maggie Stiefvater’s The Years Without Words (2019) http://maggiestiefvater.com/the-years-without-words/


On gender:

“Sex and Gender” Women’s Health Collaborative

"Men’s health 2018" Statement by the Australian Medical Association

Classic reads for rural Australians:

SFM LECTURE 11: Gender diversities

AIM: To analyse how biomedicine and medical institutions locate and frame the experience of gender diverse persons

OVERVIEW: Gender diverse persons are among the most marginalised in medicine, and are exposed to sustained institutionalised failures of imagination and knowledge among the medical profession, its institutions and its practices of knowledge. This lecture will take you through some of the challenges, conceptual approaches and priorities for good medical and social care for gender diverse persons.

WHAT YOU SHOULD BE ABLE TO DO AT THE END:

- Outline major health risks and considerations for gender diverse persons
- Explain the impact of cisnormativity in medicine
- Apply a minority stress framework to understand the experiences of gender diverse persons
- Explain intersectionality
- Make the case for pronoun sensitivity

As it really is: the world of difference

A map of gender diverse cultures: http://www.pbs.org/independentlens/content/two-spirits_map-html/

Medicine and the world as it really is:

Royal College of Psychiatrist: Position statement Supporting Trans and Gender Diverse persons 2018 https://www.rcpsych.ac.uk/pdf/PS02_18.pdf
SFM LECTURE 12: Sociocultural perspectives on the medical encounter

AIM: To provide a sociocultural perspective on issues of communication and understanding in the medical encounter

OVERVIEW: This session addresses the encounter with difference, and the example used is between non-Indigenous clinicians and Aboriginal and Torres Strait Islander peoples and clinicians and refugees. We will be exploring structural violence, patronage and power, the difference between guilt and shame, and the benefits of a medical student’s perspective to re-evaluate the medical consultation.

Aboriginal thought is very complex and layered. The paper by Grieves presents an accessible, respectful and well-researched overview of the field, introducing the reader to some fundamental issues to do with philosophical and spiritual approaches. Grieves presents a challenge for the clinician:

There is also a real need to develop approaches for dealing with Aboriginal clients based on Aboriginal concepts of personhood. More particularly, these approaches need to be locally based and developed according to the needs of the Aboriginal groups therein (p 48)

The other readings include an overview of structural violence and clinical medicine. The other reading is a discussion on the valuable insights offered by medical students watching consultations with fresh eyes.

WHAT SHOULD I BE ABLE TO DO AT THE END?

• Define reflexiveness
• Demonstrate that you can use these concepts:
  – Structural violence
  – Patronage
  – Agency
• Apply them to indigenous health/refugee health [as exemplary cases]
• Explain the concept of defamiliarisation, and identify a time when you have personally experienced this.

Short on time?

Prioritise the section on working across difference (pp 40-42) Make sure that you read the section entitled *What is Aboriginal spirituality?* some time this year.

**Read further**


Farmer P et al Structural violence and clinical medicine *PLOS Medicine* 2006; 3 (10): e449
AIM: To explore the social construction of disability, and how disability and chronic illness reflect and lead to a widening of social and political inequality.

OVERVIEW: The short readings for this week are animated by a concern for the human rights of the disabled, and take issue (in the article by Goggin and Newell), with the lionising of the disabled as heroic, and (in the film by Alexandra Codina) with the social exclusion of people with Down syndrome. The extended readings include an online history of the Deaf President Now campaign, a seminal period in the development of Deaf culture. Sarah Salway's research disconnects and examines the complex connections between ill health and poverty.

WHAT SHOULD I BE ABLE TO DO AT THE END?

- Distinguish disability and impairment
- Describe strategies used in the media to represent disability
- Outline impacts of different policy approaches on disability
- Critically outline the range of explanations for why poor people are sicker

Sand skimming

https://www.gallaudet.edu/about/history-and-traditions/deaf-president-now

Monica and David. (HBO Documentary, directed by Alexandra Codina, 2010, on the wedding of Monica and David, who both have Down syndrome)

Ocean surfing


Carey G, Dickinson L. A longitudinal study of the implementation experiences of the Australian National Disability Insurance Scheme: investigating transformative policy change BMC Health Services Research 2017; 17 (1): 570
AIM: To introduce the concept of medicalisation through an exploration of the evolving interest in defining ‘normal’ patterns of sleep and wakefulness.

OVERVIEW: Sleep and wakefulness are major and evolving sites of medicalisation. The readings for this week point to the technologies underpinning medicalisations (have a look at the DARPA website), how technologies can impede complete medicalisation (read CPAP Australia’s advice on how to get to sleep with a CPAP machine, which demonstrates how cumbersome the technology still is) and the unintended consequences of technologies in evolving fields of medicalisation. Talbot’s article in the New Yorker describes how the medicalisation of wakefulness and attention has spawned an interest in pharmaceutical neuro-enhancers for professionals.

WHAT SHOULD I BE ABLE TO DO AT THE END?

- Describe cultural and social determinants of “normal” sleep
- Describe the processes of medicalization
- Distinguish complete from incomplete medicalization
- Explain to someone how sleep disorders have become medicalised
- Identify another condition that is undergoing or has undergone medicalization, and identify if it is completely or incompletely medicalised.

Search a website:

DARPA (Defence Advanced Research Projects Agency) website: https://www.darpa.mil/our-research. Search through the drop down menu for research into sleep deprivation and performance enhancement. (Hint: it’s not where you think it would be)

Spare some sympathy:

CPAP Australia. Seven tips to falling asleep on CPAP https://www2.cpapaustralia.com.au/blog/7-tips-for-falling-asleep-on-cpap Read an article:

SFM LECTURE 15: ‘Your kidney on eBay’: the commodification of the human body and the trafficking of organs.

AIM: To introduce and illustrate the concept of commodification through an exploration of the social roots of organ trafficking.

OVERVIEW: Organ trafficking was dismissed ten years ago as being substantially urban myth. Interland’s Newsweek piece conclusively presents the counter-argument. Nancy Scheper-Hughes, the anthropologist who has been instrumental in bringing organ trafficking to the public consciousness, established the OrgansWatch website. The Lancet paper is simultaneously a briefing paper and a call to action issued to the medical community.

WHAT SHOULD I BE ABLE TO DO AT THE END?

- Define commodification
- Be able to apply it to the organ trade
- Articulate the arguments for and against the organ trade

Speed reading


Read an interview


Read more:

AIM: To outline the implications of the new reproductive technologies on notions of ideal and responsible parenthood.

OVERVIEW: Jessica Cohen describes her experiences in the world of commodified body parts, and how she fared as a seller in the market for students’ eggs. Margaret Lock provides a deeper analysis of the social desire for optimised children in a comparison with the approach used in Japan.

WHAT SHOULD I BE ABLE TO DO AT THE END?

- Describe the new reproductive technologies
- Articulate the process of commodification through new technologies
- Critically analyse arguments for and against procreative autonomy
- Describe new modes of parenthood.
- Have an informed debate with someone about the merits of a (a) free or (b) tightly regulated markets for surrogacy, or for germinal material (eggs and sperm) or (c) banning them altogether. Demonstrate your mastery by arguing for the side that you feel least personal aligned with.

A bedtime story


Get up early and read:
SFM LECTURE 17: Sex and Drugs: the medicalisation of sexual desire.

AIM: To describe changing views of sexual desire, and the emerging role of medicine in enabling, rather than policing, desire.

OVERVIEW: The medical profession has historically had a role in policing desire. In the latter half of the twentieth century, and increasingly in the 21st century, it has moved to a position of enabling desire. Hart and Wellings' classic overview describes this emerging medicalisation of sexual desire. Helen O'Connell's groundbreaking, and very recent, paper setting out the anatomy of the clitoris is also included here. If pushed for time, read the historical section on misunderstandings of clitoral anatomy.

WHAT SHOULD I BE ABLE TO DO AT THE END?

- Describe changing historical views of sexual desire, from policing to enabling
- Apply the model of medicalisation to understand the emerging position of medicine in enabling sexual desire

Easy reading


Because it's a classic (Or, Why Helen O'Connell was awarded the Gold Medal for Lifetime Achievement by the World Sexual Health Association, 2007)

AIM: To introduce students to a framework for communicating with people from diverse cultural backgrounds and to practise using this.

OVERVIEW: Australia has one of the world’s most multicultural populations, with more than a quarter of Australians being born overseas, or having a parent born overseas. This session provides a practical framework for cross-cultural communication, including how to use elements of the explanatory model to explore important aspects of the consultation. We will also look at communication styles and strategies that support and impede cross-cultural communication.

[NB: The country of origin of the patient-actor is kept deliberately vague. If asked, the actors will invent a country. The practice sessions with actors will be conducted in English. Working with interpreters is addressed in Year 2]

WHAT SHOULD I BE ABLE TO DO AT THE END?

- Describe speaking strategies that may impede clear communication (eg gratuitous concordance, parallel oration)
- Conduct an interview incorporating a modified set of questions to understand a patient’s explanatory model of illness and healing
- Recognise particular points in the life and illness history where cultural issues are likely to have particular importance
- Identify your own cultural communication strategies and identify ways to modify them where appropriate
SEMINAR 2: Clinical interviews with people at social disadvantage

AIM: To identify the impact of social disadvantage on patient's ability to access and use health care, and strategies of use in the clinical interview that can ensure that the doctor hears, understands and can respond to the patient's needs.

OVERVIEW: This seminar specifically addresses how social disadvantage impacts upon the clinical consultation. Students will be introduced to the breadth and types of poverty in Canberra, and the impact of those on patients being able to access and use health care. We will also discuss functional health literacy, and practise ways of being able to identify this as a barrier, and to respond to it.

WHAT SHOULD I BE ABLE TO DO AT THE END?

- identify key elements associated with being at social disadvantage, and how they impact on health
- describe and contrast transitional, life event poverty, intergenerational poverty
- be able to discuss the challenges of living at social disadvantage
- describe how “stating candidature” works and describe some situations you have observed where patients, or health workers on their behalf, have been obliged to do this
- conduct an interview which identifies and explores key aspects of social disadvantage and their impact on health.