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When I Say…Social

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The 'social' was once known as 'a war fought between allies'[1]. The Oxford English

Dictionary currently lists 12 definitions, several of which are now obsolete, illustrating an

evolving understanding[1]. The term is derived from the Latin 'socius' meaning friend and

'socialis' meaning allied. Within clinical practice, one may consider it as referring to society

or non-medical aspects of a patient's condition. Within medical education the term is used

more broadly; in that context, there are two definitions that resonate most with us when

we say social: it's description as a marker of one's 'rank in society' and as 'interaction with

other people'. Unlike the use in clinical practice, these definitions imply meaningful

relationships and reflections upon one's place in the world. When we say social, therefore,

we mean learning and working cultures that foster companionship, distribute capital, and

facilitate communication.

To illustrate this, we will consider the example of a cardiac arrest team. These teams form

each day in hospitals, composed of different combinations of individuals, not infrequently

working together for the first time. They are brought together with a clear goal and defined

scope. In the ideal world, this gives them a shared purpose and connects them as allies

working together to achieve their goals. Communication is paramount as these high

adrenaline situations carry high degrees of risk. As such, techniques such as readback[2] are

commonly utilised and there has been considerable effort to create hierarchies that are

ideally flat so anyone can offer ideas about causes or potential treatments. It is not

uncommon, in our experience, for the 'team leader' to ask questions such as "is there

anything I might have missed?" or "does anyone have any suggestions?" to achieve that end

by ensuring junior team members feel comfortable speaking out. A well-functioning cardiac

arrest team is, therefore, an example of when the components of companionship, capital,

and communication align and is, arguably, the pinnacle of the 'social' within our healthcare systems.

Such harmony, however, is not universal within medical education or clinical practice. Rather, within complex systems, these three components reside in constant risk of conflict. Imbalance created by interference from just one of these three components may have harmful consequences for the entire system. We offer three examples to illustrate.

Firstly, consider the medical firm. While mostly discontinued due to working time reforms, this approach to postgraduate training has long been lauded for offering a strong sense of companionship and team identity. Did it really create a 'social' enterprise, however, or is this position somewhat revisionist? Hierarchical attitudes were endemic within these workplace cultures with junior colleagues being considered lower social class than seniors. Speaking out or raising concerns risked jeopardising one's relationship within the firm, inhibiting communication.

Second, consider the recent mass migration to distance learning. Despite decades of scholarly inquiry into effective technology enhanced learning, the medical education community was caught off guard by the physical limitations imposed by COVID-19. In response, numerous academics claim to have harnessed connectivism to navigate pandemic educational delivery through distance learning modules. Described by Siemens as 'social learning that is networked' and inspired by chaos, connectivism is about the curation of continuous connections formed through exploring genuine diversity of opinion[3]. Unfortunately, a recent BEME review[4] of technological adaptations demonstrated a relative

paucity of regionally or nationally organized collaborative work. That is, while technology removes physical limits from communication, the lack of companionship by which it is commonly accompanied can be devastating to achieving something 'social'. Distance learning has generally been affiliated with loneliness[5] and the full extent to which medical education and practice will suffer from immersion in a social environment where communication may have turned 'cold' remains to be seen.

This idea of loneliness triumphing over the social in such an interconnected world initially appears absurd. As alluded to, the rise of social media (SoMe) in theory has torn down power hierarchies and facilitated easier communication than at any point in human history. However, SoMe provides a fascinating exemplar of how disordered companionship distorts the third component of 'social', distributing capital. SoMe is inherently built upon Communities of Practice, with platforms such as Reddit hosting groups of shared interest networking in single environments bonded in common purpose[6]. In reality, however, too much intra-network companionship can be disruptive to wider societal unity. Instead, non-human algorithms combine with the very human instinct to avoid challenge, leading to both subconscious and conscious curation of social environments where genuine reflection is rare because echo chambers take hold. Further, some students live in fear of an ambiguous and outdated definition of 'professionalism' and, therefore, avoid open reflection and the expression of vulnerability. Equally, higher institutions, suddenly outnumbered, have been slow to adapt to this new social battleground as missteps rapidly become amplified. As society follows trends and compromise is increasingly compromised, our community is at risk of being shunted into silos where individuals feel too threatened to explore an unfamiliar world rather than distributing the intellectual capital they might share.

As is hopefully evident, many of these imbalances in medical education reflect wider

societal battles that it would be unrealistic to expect our community to solve. What we can

expect, however, is for educators to identify areas where they are able to make incremental

changes to mitigate against these disruptions for the benefit of their learners and the wider

community. Suggestions for these include meaningful involvement and engagement of

trainees in decisions about their education to share capital; co-constructing a shared vision

and purpose to foster companionship on SoMe and beyond; and, nurturing a healthy mix of

face to face and innovative technology enhanced learning that facilitates genuine

communication. Only then will we be able to truly take advantage of the strengths our social

lives afford to unity across the tribes of medical education.

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