A Core Curriculum for Sociology in UK Undergraduate Medical Education (2nd Edition)

Behavioural & Social Sciences Teaching in Medicine (BeSST) Sociology Subcommittee

BeSST
Behavioural and Social Sciences Teaching in Medical Education

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A Core Curriculum for Sociology in UK Undergraduate Medical Education

Produced by the Behavioural & Social Sciences Teaching in Medicine (BeSST) Sociology Subcommittee

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Executive summary

The valuable contribution of sociology to medicine has long been recognised in the UK and since 1993 the profession's regulator, the General Medical Council (GMC), has reflected this in the learning outcomes required of all UK graduates in medicine. This recognition has created the need for support to those involved in student learning through programme design, development and delivery.

This 2025 core curriculum for sociology in medical education is an updated version of the original 2016 one. As with the 2016 version, our updated curriculum provides a robust, evidence and practice-based means of linking sociological knowledge, content and topics to the GMC's higher-level outcomes for graduates. It responds to continued calls from multiple sources for future doctors to have finely honed generic capabilities (GMC, 2017) including being able to deal with complexity and uncertainty, having excellent communication and interpersonal skills, demonstrating appropriate professional values and behaviours, taking into account the social and cultural context of medical care, working to prevent illness, safeguarding vulnerable groups and understanding the range of research and scholarship methods. Specifically, this updated core curriculum for sociology in UK undergraduate medical education takes into account recent social, economic and political changes that provide the context to and affect the way that medicine is practiced. These include:

- demographic trends, not least global mass migration and the ongoing growth in the ageing population (including increasing numbers of patients with multiple morbidities and long-term mental health conditions and a shift towards more patients in need of care at home and in community settings)
- political and economic trends such as community polarisation, the loneliness epidemic, rising poverty and widening social and economic inequality across society (including with respect to the allocation and distribution of resources and care)
- planetary health and continued threats to global environmental sustainability (for example, climate change, the rise of global pandemics)
- changes in the professional organisation of medicine (for example, continued privatisation and digitisation, the introduction of new professional practitioners and the shift towards lifestyle and personalised medicine)
- the growth of new technologies, especially artificial intelligence
- a greater awareness of, and commitment to, equity, diversity and inclusion in medical curricula and in particular, to decolonising the curriculum.

The development of the original core curriculum was an inclusive and collaborative process involving individuals responsible for teaching sociology in UK medical schools and a wide range of stakeholders including patient representatives, clinicians, students and medical educationalists. Our methodology was participative and orientated towards establishing consensus without sacrificing attention to diversity of views and experience. This consultation was coupled with reviews of materials and research relevant to the teaching of sociology in medicine.

The updated curriculum followed a similarly robust process. A wide range of stakeholders considered the relevance of the original work for medical practice and undertook reviews of recent sociological material. Workshops were then held to update the original version and the resulting document was reviewed further. Our stakeholder groups argued that the structure of the curriculum was fit for purpose but suggested some updates to the content. Thus, our emphasis has been on strengthening the wording of the learning outcomes and linking them to more current indicative content. All content has been mapped to the latest version of the General Medical Council's Outcomes for Graduates (2018) and cross references with the GMC's Generic Professional Capabilities Framework (2017). The curriculum also links with related recommended guidelines, for example with respect to widening participation in medical education and further equality, diversity and inclusion initiatives.

The core curriculum comprises 6 topics (see table 1). The first, entitled 'a sociological perspective', underpins those that follow. Taken together these topics represent a comprehensive, coherent and detailed guide to a curriculum. For each topic, the document provides a guide to core learning outcomes and indicative content.

The Sociology Core Curriculum	
A sociological perspective (Topic 1 is covered via topics 2–6)	
Topic 2	**Health inequalities**
Topic 3	**Lived experiences of health, illness, disability and healthcare**
Topic 4	**Knowledge about health and illness**
Topic 5	**Health policy and practice**
Topic 6	**Research and evidence**

The core curriculum recognises the diversity of approaches to pedagogy in medical education and the contexts and structures within which teaching and learning take place. It identifies a range of learning and teaching opportunities such as patient and public involvement and the integration of sociological content into the clinical aspects of medical education. It also highlights challenges such as preserving modes and methods of assessment relevant to the demonstration of disciplinary knowledge required of students.

Whilst primarily designed for UK undergraduate curricula, we have found that the BeSST Core Curriculum for Sociology in UK Undergraduate Medical Education can be a useful starting point for medical schools further afield. The 2016 curriculum has received support from medical educators, clinicians and students and has been widely used in the development of curricula in many UK medical schools and in wider international contexts (including the US and Japan).

We hope that you find the BeSST Core Curriculum useful to your practice.

BeSST Committee, July 2025.

Forewords

The doctors of tomorrow – today's medical students – will be practicing in increasingly uncertain and complex circumstances. We must ensure they are equipped with the knowledge and skills to understand this world around them and their role within it. For our medical students, this should be an exciting process of learning, if sometimes overwhelming. From my experience, I know these doctors of tomorrow are up to the task and, through a well conceived and delivered curriculum, will be supported to practice medicine well and to improve our health care system for the benefit of all. I am inspired by their problem solving attitude and concern about the pressing health issues we face as individuals and society. These latter include planetary health, new technologies, including AI, increased poverty, multiple morbidities, equity and inclusion – and this list is far from exhaustive.

Sociology has had a key role in medical education for decades and can help medical students not just in understanding the social determinants and context of health and care but also in understanding the complexities and uncertainties in the medical and clinical sciences themselves. Through rigorous use of evidence, application of theory and sensitive practice based learning, sociology gives a unique disciplinary perspective and contributes to generic skills and capabilities.

Yet, sociological understanding can both disturb and disrupt the way we think, see and understand the world. As medical educators, we must support our students to embrace such challenge, for it will be one of many that they will face in their professional careers. This second edition of the core curriculum for sociology in medical education aims to enable that, by providing clear guidance on curriculum content and suggestions about how best to deliver it and improve students' learning experience.

The development of the Core Curriculum models the kind of collaborative approach that we hope will help our students too, especially in their group and team work. The process was inclusive and iterative, and while it outlines elements of core content, it suggests a range of approaches to learning, teaching and assessment. It will be useful not only to those teaching sociology but to other medical educators who will increasingly want to integrate sociology into aspects of their teaching.

Professor Sarah Cunningham-Burley
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The Behavioural and Social Sciences Teaching in Medicine (BeSST) Steering Group made an important contribution to health professions education by publishing in 2016 a core curriculum for Sociology in UK undergraduate medical education. The curriculum for medical students is the heart and soul of a medical school and a wider recognition and attention to the social sciences in the curriculum is of the greatest importance and should be welcomed.

Over the last nine years since the first report was published, we have seen in response to pressures for change, important developments in the medical curriculum. These have included the acceptance internationally of an outcome-based approach with a specification of the expected learning outcomes and associated milestones and the definition of Entrustable Professional Activities. Other developments have been the use of new learning technologies, augmented and virtual reality and more recently Artificial Intelligence. Over the years we have seen a changing role of students from clients or customers to partners and collaborators in the learning process. There has been recognition too of the value of personalised learning which has been associated with a move to self-directed and self-regulated learning. Sustainability, international dimensions of education and education diversity and inclusion are now all on the agenda. Interprofessional education remains an important theme, but the optimum response is not certain. Most important of all is the need for an authentic curriculum related to the real world of medical practice and with greater on-the-job and workplace experience for the student.

All of these developments have important implications for the social sciences. A second edition of A Core Curriculum for Sociology in UK Undergraduate Medical Education is to be welcomed. This second edition provides a useful update on the first and reflects the revised learning outcomes for the medical curriculum specified in the 2018 guidance from the UK General Medical Council "Outcomes for Graduates". The GMC redefined the expectations that newly-qualified doctors will recognise social science principles and understand among other things the importance of sociological factors contributing to illness. Sociology has an important role to play in this reconceptualisation of the medical curriculum, recognising the myriad of social issues that can impact on medical practice and provision including demographic changes, health inequalities, health economics and the role of doctors in society. The second edition Core Curriculum does a service to teachers and students, administrators and researchers, the public and medical school deans by explicitly addressing how a medical school today can interpret and address, in its curriculum, the GMC expectations relating to the social sciences.

The teaching of the social sciences, as proposed in this report, should be embedded in the curriculum and aligned with the teaching and learning methods, student assessment and the school's education climate or environment. No longer, as I suggested in my Foreword to the first edition, can the social sciences be seen as window-dressing with little impact on what is taught and what students learn. The Core Curriculum document presents a powerful vision of the contribution that sociology can make when integrated into the medical education programme. In the past there has been a lack of appreciation of the relevance of the subject by teachers, many of whom have a predominant biomedical model mindset. This important second edition document contributes to the increasing recognition of the valuable contribution made by the social sciences to medical practice and demonstrates how this can be reflected in the medical curriculum.

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University of Dundee, UK
Editor-in-Chief, Medical Teacher

In a rapidly evolving healthcare landscape, where doctors must balance scientific knowledge with compassionate and socially informed practice, this curriculum provides an invaluable resource. It offers a solid foundation for understanding the interplay between healthcare and society, ensuring that graduates are not only clinically competent but also socially responsible practitioners.

As a General Practitioner in training, I have seen firsthand the importance of understanding patients' lived experiences, the social determinants of health, and the broader systemic factors that shape medical practice. This curriculum is particularly timely, addressing contemporary challenges such as health inequalities, demographic shifts, planetary health, digital healthcare, and the imperative for equity, diversity, and inclusion in medical education. By integrating sociological theory and insights, we enable medical students to develop critical thinking, adaptability, and a deeper appreciation of patient-centred care.

Additionally, the curriculum is both accessible and relevant, making it an essential tool for medical students navigating often complex and unfamiliar sociological concepts. As students progress through their training and into clinical practice, they will increasingly rely on sociological perspectives to reflect on patient interactions, navigate systemic challenges, and advocate for meaningful change within healthcare. This curriculum lays a solid foundation for fostering socially conscious, adaptable, and critically engaged doctors.

I wholeheartedly endorse it as a vital tool for medical education and commend the Behavioural & Social Sciences Teaching in Medicine (BeSST) Sociology Subcommittee for their commitment to ensuring that future doctors are equipped with the knowledge and skills necessary to navigate the complexities of modern healthcare with both clinical competence and social responsibility.

Dr Katy Stevenson
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Council Member Academy of Medical Educators (AoME), 2020-2024
Vice- Chair Trainees in the Association for the Study of Medical Education (TASME), 2021-2022

1. Introduction

This curriculum document for sociology in medical education has been written by the sociology subcommittee group on behalf of and in consultation with the wider network of sociologists within BeSST. It is a practical and flexible guide outlining a realistic, intellectually robust and engaging sociology curriculum in undergraduate medical education. It is intended to be of use to colleagues who deliver sociology and to those who manage and develop curricula within undergraduate medical education.

The core curriculum can be used in conjunction with core documents for Psychology (BeSST, 2010, forthcoming), Public Health (PHEMS, 2014, 2019), and Medical Ethics and Law (Stirrat *et al.*, 2010, Institute of Medical Ethics, 2019). Moreover, it aligns with areas of the UK Medical School Council documents: 'Education for Sustainable Healthcare, (Tun and Martin, 2022)' Active Inclusion: Challenging Exclusions in Medical Education (2021) and Decolonising Medical and Dental Curricula, 2025 as well as with aspects of the international, student led, 'Planetary Health Report Card' (Planetary Health Alliance, 2019). The core curriculum for sociology will enable educationalists to discern where content overlaps and is complementary. In addition, the core curriculum will help clarify the particular contributions that sociology can make.

This document:

- Describes what sociology is, its relevance to undergraduate medical education and approaches to teaching, learning and assessment
- Explains the rationale for the development of the core curriculum in medical education and the processes by which it was produced
- Provides a guide to a curriculum that supports medical schools in realising the learning outcomes detailed by the GMC in Outcomes for Graduates (GMC, 2018)
- Maps the learning outcomes to Outcomes for Graduates (GMC, 2018)

2. Sociology in Medical Education

What is sociology?

Sociology is a social science that seeks to understand our experiences and actions in relation to the local, cultural and wider economic and political contexts in which they take place. Through empirical and theoretical research at every level of society (from small groups of people, organisations, institutions and communities to entire societies), sociology examines how individual lives affect and are affected by wider social forces. By providing an understanding of these social contexts, sociological knowledge contributes to the development of policy and practice in a wide range of areas.

A key concept in sociology is 'the sociological imagination' (Wright Mills, 1959). Having a sociological imagination suggests that an individual thinks critically about the changing world around them, particularly in terms of the connections between individual experiences and public issues.

How does sociology apply to medicine?

Sociology applied to medicine seeks to understand the changing social contexts within which health, illness and medicine are formed, experienced and practiced. It provides a disciplinary framework for the teaching of empirical evidence and utilises relevant theories and concepts to enhance understanding of that evidence. It encourages students to think openly and critically about the intersection of medicine, health and illness with other social forces (for example, family, education, employment, inequalities) and to apply this deeper knowledge and understanding to clinical contexts in ways that enhance medical practice and build trust in health services.

Sociology and medical education

Over the past 25 years, there has been increased pressure on medical education from clinical and patient communities to demonstrate how contemporary challenges to health and illness associated with social phenomena are addressed (see, for example, Cuff and Vanselow, 2004; Frenk et al., 2010, Lechopier *et al.*, 2018). However, the need for UK medical graduates to have a broader understanding of the social world of patients, health, illness and healthcare to complement their technical and clinical competencies has been a core policy recommendation of medical education since the Goodenough Report (Inter-departmental Committee on Medical Schools, 1944) and more explicitly following the Todd Report (Royal Commission on Medical Education, 1968). Sociology outcomes have been included in the General Medical Council's policy guidance for medical schools Tomorrow's Doctors since 1993 (see GMC, 2009a, 2015) and in the most recent curriculum guidance: Outcomes for Graduates (2018).

3. Teaching and assessing sociology in UK undergraduate medical education

Where is sociology taught in the medical curriculum?

Sociology teaching in UK medical schools varies in relation to the style of curriculum used: traditional, integrated or a combination of these (Kendall *et al.*, 2018). In traditional curricula sociology tends to be taught in the earlier years of the medical curriculum although there is huge scope for teaching throughout the curriculum. Curriculum integration has provided opportunities for sociology to be delivered in new ways including integrated problem-based or case-based learning curricula. Sociology also contributes to optional parts of the curriculum including special study components/modules.

Who teaches sociology?

Sociological content in medical curricula is usually overseen by expert sociologists and/or anthropologists, reflecting the GMC recommendation (2009a, p69) that medical education be provided by a range of specialists. As well as teaching, sociologists work closely with a broad range of people who are especially well placed to demonstrate certain components of the sociology curriculum to medical students. These include patients, carers, members of public agencies and community organisations involved in healthcare, clinical colleagues from all areas of medicine and academics from relevant disciplines. To ensure sociology outcomes are met, sociologists increasingly have a role in faculty development.

What learning and teaching approaches are used?

Developments in medical education have created new opportunities in both clinical and non-clinical settings. For example, within the different curriculum models a variety of learning and teaching approaches can be used including interactive lecture-based classes, small group tutorials, guided independent study, problem-based learning, case-based learning, team-based learning, blended learning, flipped classrooms and community placements. Amongst the diversity of approaches, there is commonality in an emphasis on active learning and the application of sociological knowledge and theories to practical, clinical contexts.

'Co-teaching' is a popular model for emphasising a sociological perspective. For example, sociologists may teach with pathologists, physiologists, psychologists, patients and GPs in or outside of classroom settings on such topic areas as pain, alcohol use and dementia.

Patient and public involvement (PPI) is central to medical education (GMC, 2009b, 2018). Active patient and public engagement in medical education (in the classroom and at governance level for example) is recognised as essential for preparing current and future practitioners to deliver optimal health care, shaped by patients themselves (Towle et al, 2024). PPI opportunities include patient-led sessions and modules, shadowing patients, the use of patient-generated reading lists (for example blogs and videos), use of patient stories (ie healthtalk.org). In recent years, hybrid classroom technologies have increased opportunities for patients to participate 'remotely'.

Further opportunities to learn sociology can arise through the clinical context, for example during ward rounds, clinical feedback sessions and shadowing (although this is less well documented). Moreover, sociology teaching and learning aligns well with the agendas of those within medical schools who have a responsibility for equity, diversity and inclusion, widening participation, community engagement and interprofessional education.

Linking sociology learning and teaching to curriculum design and pedagogy

Individuals and groups interested in linking sociology to curriculum design and review might find it useful to consider the pedagogical basis of their curricula. In the UK context, medical schools working on curriculum review are beginning to recognise the importance of paying more attention to the core theoretical assumptions about teaching, learning and knowledge underpinning their courses. Useful work in this area has been undertaken at University College London. For example, in their 2021 paper, Wong et al. make the case for a wholesale faculty shift in the definition and understanding of 'knowledge production'. Wong et al. argue for a pedagogical framework that embraces epistemic pluralism (more than one perspective), cultural safety, critical consciousness, equity, decentring and intersectionality. Adopting these ideas will guide curriculum design and make it easier to incorporate sociology and more generally, person/patient-centred teaching across all areas of the curriculum.

How is sociology assessed in medical education?

The GMC expects all of the high-level outcomes listed in Outcomes for Graduates to be assessed. Outcomes for Graduates (GMC 2018, p 22) states that newly qualified doctors must be able to 'apply social science principles, method and knowledge to medical practice and integrate these into patient care'. While this guidance does not indicate what assessment methods should be adopted, it has been stated that '[a]ssessments will be fit for purpose – that is: valid, reliable, generalisable, feasible and fair' (GMC 2009a, p 48; see also GMC 2009c).

Undergraduate medical assessment globally continues to move towards machine-markable knowledge testing via multiple choice, single best answer questions (SBAs). Arguments for and against this and similar methods revolve around striking the right balance of utility, reliability, validity, educational impact, cost efficiency, capacity and acceptability (van der Vleuten, 1996). The trend towards assessing students' knowledge through multiple choice questions is set to continue. In 2024 the UK introduced the Medical Licencing Assessment (MLA). The MLA is a two part examination that all medical students graduating in the UK, and all international doctors seeking to practice in the UK, must pass to become licenced. The MLA comprises a multiple choice 'Applied Knowledge Test (AKT)' and a standard Clinical and Professional Skills Assessment (CPSA). In UK medical schools, final year students take the MLA alongside the final year assessments specified by each individual school.

In developing assessment tools for sociology outcomes, it is necessary to consider the nature of the constructs and competencies we are trying to assess and choose our evaluation tools accordingly (Kuper et al., 2007). While well written SBAs can be developed to assess some sociology outcomes, for other outcomes, such as those that require the demonstration of reflective skills, engagement with debates, understanding and application of concepts and ideas, free-text response questions (either in exam or in-course assessment contexts) are more appropriate. These include essays, reports, reflections, portfolios, short answer questions, oral presentations (individual or team) and targeted 'Observed Structured Clinical Examination' (OSCE) or 'Integrated Structured Clinical Examination' (ISCE) stations.

A BeSST survey of sociology assessment in UK medical schools by Harden et al. (2021) found that lecturers can feel constrained by the dominant assessment practices of each school and that the common form of assessment is multiple choice questions. However, teachers also incorporate sociology assessment into medical curricula in a variety of ways depending on the opportunities available, including through essays, case studies, presentations and 'OSCE's'. Further discussion of assessing sociology in medical education can be found in Harden et al (2021).

The curriculum in practice

Teaching sociology in medical education can feel like a daunting task especially given the need to consider curriculum balance, interdisciplinary working, student understanding and educational goals. Links to further support and information are given at the end of this document.

4. Developing the core curriculum: 2015 – 2025

The development of this core curriculum has been an inclusive and collaborative process involving the majority of individuals responsible for teaching sociology in UK medical schools and a wide range of stakeholders including patient representatives, representatives from regulating bodies, clinicians, students and medical educationalists. Below we outline the stages involved in this development.

Stage 1: Literature review

In 2015 an initial literature search revealed that there was no core curriculum for sociology in medicine and only the GMC curriculum guidance Tomorrow's Doctors (2009) gave any indication of broad social science outcomes. This was in contrast to the development of such documents by other behavioural science (and related) disciplines notably psychology (BeSST, 2010) and public health (PHEMS, 2014). Moreover, the literature search highlighted the suitability of timing of a core curriculum; in the shift towards integrated curricula there is a need for clarity in each disciplinary strand as it is woven into the whole (Atkinson and Delamont, 2009, see also Kendall et al., 2018).

There was a very limited literature discussing a core curriculum for sociology in medicine. Russell et al. (2004) identified a need amongst those teaching sociology in medicine for both a supportive network and some key guidelines about content. In 2006, a survey led by Peters and Litva of UK medical educationalists' views revealed significant agreement between clinical medical educators and sociology subject specialists about the requisite sociology content for medical education, although a detailed curriculum was not developed.

We took as starting point the sociology content identified as relevant by the respondents in the Peters and Litva (2006) study. Following this we undertook a review of GMC policy documents, articles in medical education journals and reports, as well as introductory and medical sociology textbooks. This process resulted in the identification of relevant outcomes and curriculum subject areas.

Stage 2: Consultation

We consulted with the British Sociological Association (BSA) Medical Sociology Group and held a workshop at their annual conference. We also ran a number of regional workshops (supported by the BSA, Birmingham, Durham, Peninsula, and Southampton medical schools and Cardiff School of Social Sciences) in order to gather the views of those involved in teaching sociology in medicine. The workshops, held in Dundee, Birmingham and London were attended by teachers from 27 of the (then) 33 UK medical schools. At the workshops participants reported that a core curriculum would be valuable for them in gauging what is 'best practice' for teaching sociology in medicine. Participants provided a list of their core teaching content which was then collated and discussed. We undertook a review of sociology in medical education formally with a group of students at Cardiff University and informally at the other universities in which we teach.

Stage 3: Developing the draft core curriculum

The consultation and literature review resulted in the production of an initial list of 30 broad topic areas, which was then grouped into a smaller number of more specific topics. The BeSST sociology subcommittee then met on several occasions to discuss and refine the topics.

Stage 4: Consultation of the draft core curriculum

The draft of the first core curriculum was initially presented to a regional BeSST meeting in Edinburgh, generating questions about content and the readability as well as usability of the document. The amended core curriculum was then sent for review to a range of expert stakeholders from the field of clinical medicine and patient and public involvement. In addition, we consulted with undergraduate medical students and colleagues in medical education. In September 2015, we held a core curriculum workshop with an international group of medical educators from clinical and non-clinical backgrounds at the Annual Conference of the Association of Medical Educators in Europe (AMEE). We engaged in feedback opportunities with students at conferences and through the Junior Association for the Study of Medical Education (JASME).

The insights from our consultation process strengthened the final original core curriculum produced in 2016.

The 2025 consultation on the 2016 core curriculum

Phase 1 of the curriculum update involved a community consultation with 13 sociology teachers working in medical schools across the UK and the BeSST student group comprising 4 students at different medical schools in the UK. Participants were asked to: check content for relevance and gaps, consider the curriculum through an equality, diversity and inclusion lens and offer suggestions for updates and resources. Written feedback from this review was imported into the qualitative management programme NVivo,12 (Lumivero) and analysed thematically. The results were fed back to the community via two workshops, to seek clarification and consensus on information received. Phase 2 took the form of a two-day writing retreat in which the project team worked together to update the original curriculum based on comments received. In Phase 3 we circulated the drafted curriculum for comment to the sociology teachers and students who had commented in Phase 1, to the BeSST patient group, as well as to colleagues in medicine, medical education and sociology (external to medical education). The final version was drafted and then circulated to the (Phase 1) sociology group for final approval.

5. Core curriculum for sociology in UK undergraduate medical education

It is intended that this curriculum is a guide to be interpreted by educators in ways that suit their particular institutional context and practices. The curriculum is divided into 6 topics. Topic 1 is the overarching topic because a sociological perspective underpins all sociology learning in undergraduate medical education.

Topic 1.	**A sociological perspective**
Topic 2.	**Health inequalities**
Topic 3.	**Lived experiences of health, illness, disability and healthcare**
Topic 4.	**Knowledge about health and illness**
Topic 5.	**Health policy and practice**
Topic 6.	**Research and evidence**

For each topic we have provided the following to support educators in developing their sociology teaching:

- **Core learning outcome:** the principal learning outcome for each topic
- **Key learning outcomes:** more detailed outcomes linked to the core outcome
- **Indicative content:** suggested content linked to each key learning outcome. Whilst all indicative content encourages the application of knowledge, the last key learning outcome for each of the 6 topics focuses specifically on application and offers up to 8 sample ideas for engaging students in that topic. Indicative content is intended to be suggestive rather than prescriptive and can be adapted by educators to suit the requirements of their particular contexts.

The green cross is the standard symbol for pharmacy and displayed at most UK chemist shops.

A core curriculum for sociology in UK undergraduate medical education

TOPIC 1
A sociological perspective

CORE LEARNING OUTCOME
Describe and apply sociological principles, concepts, theories and evidence to health, illness and medical practice

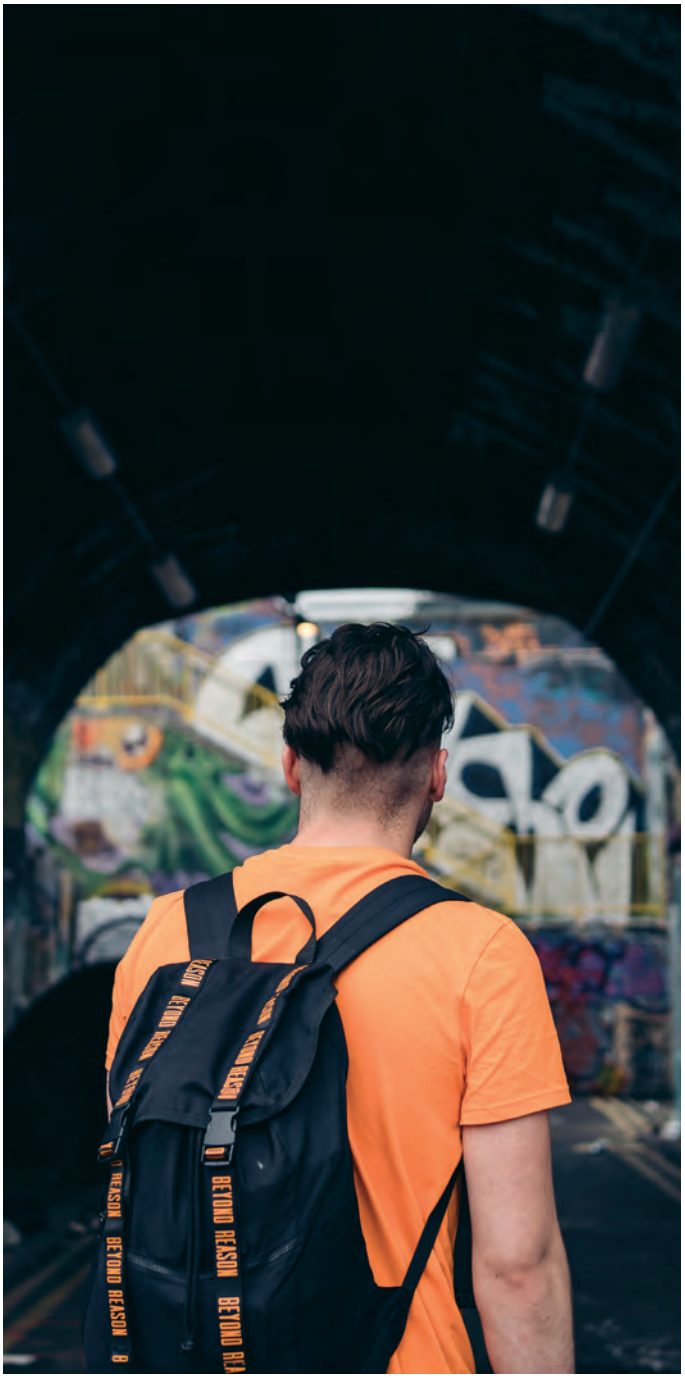
KEY LEARNING OUTCOMES*

* The learning outcomes listed in topic 1 can be addressed through the indicative content suggested for topics 2–6.

- Define and apply key concepts relevant to understanding sociology in medicine
- Analyse links between individual experiences and social structures/social forces
- Analyse the influence of social norms, values and structures on health, illness and medical practice
- Appraise the relevance of social, political, economic and cultural change for health, illness, and medical practice
- Apply sociological research and evidence to inform critical thinking and develop structural competence

TOPIC 2
Health Inequalities

CORE LEARNING OUTCOME
Demonstrate the ways in which health and illness are socially determined



KEY LEARNING OUTCOMES

Analyse inequalities between social groups and recognise how these intersect in the context of health and illness

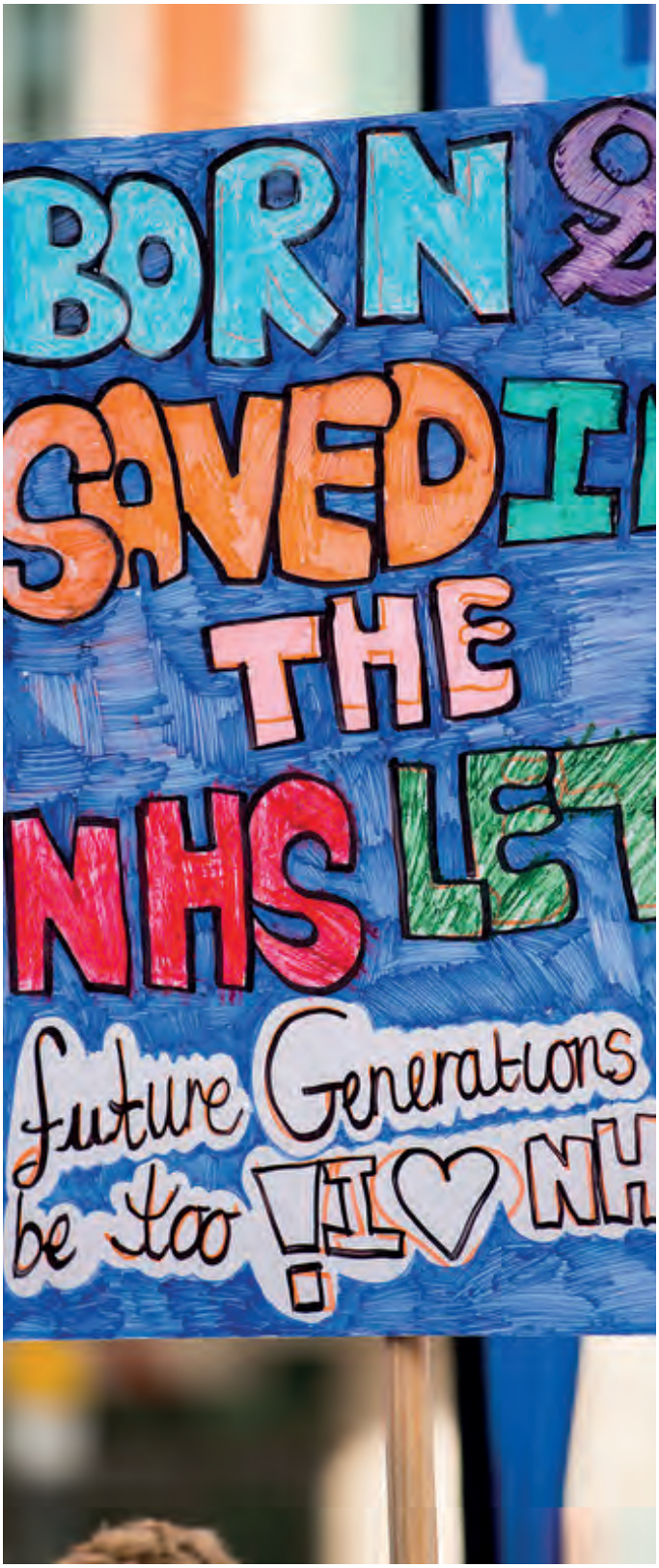
Evaluate explanations for health inequalities and identify implications for policy and practice

Apply knowledge about inequalities and inequities to medical practice

INDICATIVE CONTENT
Definitions of health inequality and inequity; and key social and political determinants: e.g. environmental, social class, poverty, gender, sexuality, ethnicity, age, faith and disability
Definitions associated with experiences of living on a low income or in poverty e.g. precariat, index of multiple deprivation, intergenerational living
The impact of key dimensions of inequality on health, illness and disease and access to health (and how they intersect e.g. older female migrants)
The ongoing impacts of discrimination and marginalisation on health and illness e.g. racism, sexism, homophobia, ableism, transphobia, ageism, and classism
Findings of key research and reports on health inequalities locally, nationally and globally (e.g. Darzi Report ,2024)
The concept of intersectionality and its relevance to health inequities e.g. The Wheel of Power and Privilege
How structure and agency interplay in health inequalities and interventions to address them
The link between health inequality and social care provision
Quantitative and qualitative methods for researching health inequalities
Key theories of health inequalities e.g. cultural, materialist, psychosocial, discrimination, structural violence, structural vulnerability, the Spirit Level and syndemics
Evidence of such theories in policy and practice
The functioning and funding of different healthcare systems from selected countries and the differences in relation to health inequalities
The relationship between social structures, power and privilege with respect to health inequities. (e.g. systemic bias and prejudicial discrimination in health policy and practice)
Place, and the differential impact of environmental degradation on the health of individuals and communities/ groups locally and globally e.g. in relation to toxins/pollutants, biodiversity change, land use change and climate change
Identify and critically evaluate a recent healthcare intervention designed to promote equity
Assess strategies for making healthcare provision more inclusive and just
Select a disease or public health concern, research its demographic profile and design restitutive, sustainable healthcare strategies
Develop a working understanding of relevant legislation e.g. The Equality Act and its application to medical practice
Undertake a piece of reflective writing to compare how the social positioning of doctors might impact on how they view patients (drawing on insights from literature, own experience and the views of others)
Explore the concept of 'race conscious medicine' and how it can inform medical practice
Discuss what doctors can do to reduce socioeconomic health inequalities and the role of health professionals as advocates
Profile a 'complex patient' then work to identify the barriers to their health through the lens of health inequalities
Consider the role that access to and deployment of digital technology (e.g., internet, smartphone apps etc.) can play to either exacerbate or ameliorate existing health inequalities and inequities, including displacement of employment by AI
Create a diagram of how climate change affects health via different exposure pathways (e.g., heat, air and water pollution, food insecurity, changes in infectious agents)
Drawing on your own experience or that of individuals within your immediate community, write a blog/journal entry/ reflexive essay (or create a piece of artwork) about the lived experience of poverty from a first person perspective. Cross reference the observations that you make with literature from the humanities (for example books, narratives, films that portray the experience of others in similar positions).

TOPIC 3
Lived experiences of health, illness, disability and healthcare

CORE LEARNING OUTCOME
Demonstrate an understanding of the lived experiences of health, illness, disability and healthcare



KEY LEARNING OUTCOMES
Explain the ways in which health, illness and disability shape identity
Identify the social, physical and emotional impact of living with illness
Discuss factors influencing experiences of health care
Recognise and demonstrate an understanding of the experience and the role of carers
Apply an understanding of lived experiences of health, illness and disability to medical practice

INDICATIVE CONTENT
How the intersection of factors such as ethnicity, gender, sexuality, socio-economic status, body size, and age mediate experiences of health, illness and disability
Stigma in relation to illness and disability e.g. how stigma is perceived and experienced; how multiple stigmatised identities intersect; impact on health and wellbeing; relationship between stigma, power and discrimination
Different models of disability – medical, charity, social, human rights
Negative impact of key stigmatising discourses on identity e.g. healthism, moralisation and victim-blaming
Concepts directed at understanding experiences of the onset of illness and living with long term conditions including biographical disruption, loss of self, delayed diagnosis, diagnostic journeys, medical merry-go-round, illness narratives and multi-morbidities
Chronicity as a dynamic social condition rather than an individual one; chronicity and ageing populations
Critique of individualised understandings of coping, recovery and resilience
Issues around pain management and co-morbidities e.g. ideas about cause and effect, contraindications of medications, the experience of suffering
Awareness of the ways in which people seek and act on medical advice via formal healthcare settings and lay networks
The nature and experience of relationships between patients and healthcare professionals e.g. influence of hierarchies, notions of expertise; influence of telemedicine in primary and secondary care; the role of digital technologies, such as the use of personalised medicine and other AI applications, in healthcare interactions
Managing long-term conditions e.g. medication taking, self-management and implications of concepts used, including compliance, adherence, and concordance; impact of 'shifts' in medical approaches to long term conditions (such as the turn towards functional medicine, wellness, nutrition and social prescribing) and patient experiences of co-morbidity management
Increasing focus on preventative, 'lifestyle' medicine and independent care; focus on sustainable and green care
Concerns related to particular social groups regarding their experiences of health care e.g. disability rights movement, impact of racism on healthcare experiences, homelessness, asylum seekers, LGBT+, appropriate informed lifestage care for women
The experiences associated with informal care or caring for a family member with a long-term condition or disability e.g. taking into account social factors such as stage of life, gender
The role of social media and its impact on engagement with health and social services
The link between informal caring and material wealth
The availability of public and private support for people who provide unpaid care
Awareness of the practical and emotional dimensions of caring and the problem of physical and empathy fatigue among informal and formal carers (including healthcare professionals)
Identify and describe key UK policies relating to person/patient-centred care or self-management programmes. Consider changes over time, the drivers for such policies and the implications for medical practice and patient experience (how are patients responding to such programmes?)
Explore the experiences of being a disabled medical student or working as a disabled healthcare professional
Draw on models of shared decision making and empowerment to reflect on consultations with patients; identify and reflect on aspects that are easier/more challenging to practice
Utilise an understanding of illness narratives to reflect on patient stories
Research a medical issue (e.g. cochlear implant, head and neck cancer, Huntingtons Disease) from only patient-facing sources
Review the evidence on social/green prescribing e.g from the Centre for Social Prescribing Research
Drawing on your own experience or that of individuals within your immediate community, write a blog / journal entry / reflexive essay (or create a piece of artwork) about the lived experience of illness or disability from a first person perspective. Cross reference the observations that you make with literature from the humanities (for example books, narratives, films that portray the experience of others in similar positions).

TOPIC 4
Knowledge about health and illness

CORE LEARNING OUTCOME
Explain how medical and lay knowledge are constructed

KEY LEARNING OUTCOMES
Describe how all knowledge is subject to human influence
Examine the development of medical knowledge within specific social contexts
Examine the social influences on lay and medical knowledge of health and illness
Analyse the intersections of medical and lay knowledge in the context of hierarchies of expertise
Apply understanding of the social construction of knowledge to medical practice and discuss the implications of this for health, illness and healthcare practice

INDICATIVE CONTENT
Concepts of objectivity and bias in scientific and clinical research (e.g. through consideration of clinical examples such as pain, heart disease, mental health, endometriosis and sickle cell disease)
The influence of social norms and values on scientific and clinical research (e.g. western, political, cultural with respect to significant undiagnosed conditions for minoritosed ethnic communities and women)
Critiques of evidence-based medicine
The colonial past of contemporary science and how the concept of 'race' was developed, utilised and critiqued
The racialised origins of contemporary medical practice
Historical and contemporary examples of how ideas about gender, class and sexuality are embedded in scientific and clinical research and medical practice
Examples of indigenous non-western health systems, philosophies and medical practice
The reciprocal relationship between modernity and medicine (e.g. bio-medicalisation, pharmaceutilisation and lifestyle medicine and how medicine has evolved alongside emerging problems of progress as well as social and ecological decline)
The influence of social, cultural and religious/spiritual discourses in shaping health and illness knowledge and practice (e.g. indigenous beliefs, practices and perspectives from the Global South, and the role of integrative healthcare)
The influence of evidence-based medicine in constructing hierarchies of knowledge and the implications of this for patient and practitioner
Comparison between lay and medical paradigms for understanding health, illness and disease and how social and medical groups (including patient support or advocacy groups) influence these paradigms
Historical and contemporary examples of the social construction of illness and the role of the medical profession in this process
The influence of social, cultural and faith discourses in shaping knowledge of health and illness (for example, normality, responsibility, risk)
The role of new technologioes in influencing meaning and knowledge around health and illness
The significance of structural position (for example, social class) and biographical experiences in shaping lay knowledge and medical practice
The value of integrating planetary and One Health thinking and ethics in medical knowledge and practice improvement
Find an artefact from the past about a particular medical practice (e.g. birth, mental illness, the medical profession) and consider how it was shaped by the social, cultural, political practices of the day. Look at the practice through a sociological lens such as equity or deviance. Now consider the same practice today - applying the same analytical framework
Select an example of a contested illness (aetiology, diagnosis and prevalence are unexplained and/or controversial) and explore the research literature, clinical guidelines, and information from patient groups to compare and contrast medical and lay views and discuss implications for practice
Analyse a piece of prose, medical literature, research article or image – (with trained facilitators). How (if at all) are protected characteristics represented? What are the implications for medical practice?
Find an account of cultural practice in a clinical setting. Discuss: what cultural practices do we take for granted? (Draw on ideas of cultural humility and narrative competence to structure your answer)
Reflect on examples from practice where patient and professional views may have differed and how this was resolved
Consider how your own experiences, beliefs and values may contrast with established social norms and explore resources that may be useful in protecting you from harm (e.g. support networks)

TOPIC 5
Health policy and practice

CORE LEARNING OUTCOME
Examine social influences on the development of health policy, systems, and medical practice

KEY LEARNING OUTCOMES

Discuss social, political economic and environmental factors shaping health policy and legislation

Describe the organisation of formal and informal health work

Discuss the impact of social and cultural factors on medical practice

Apply an understanding of health policy to medical practice

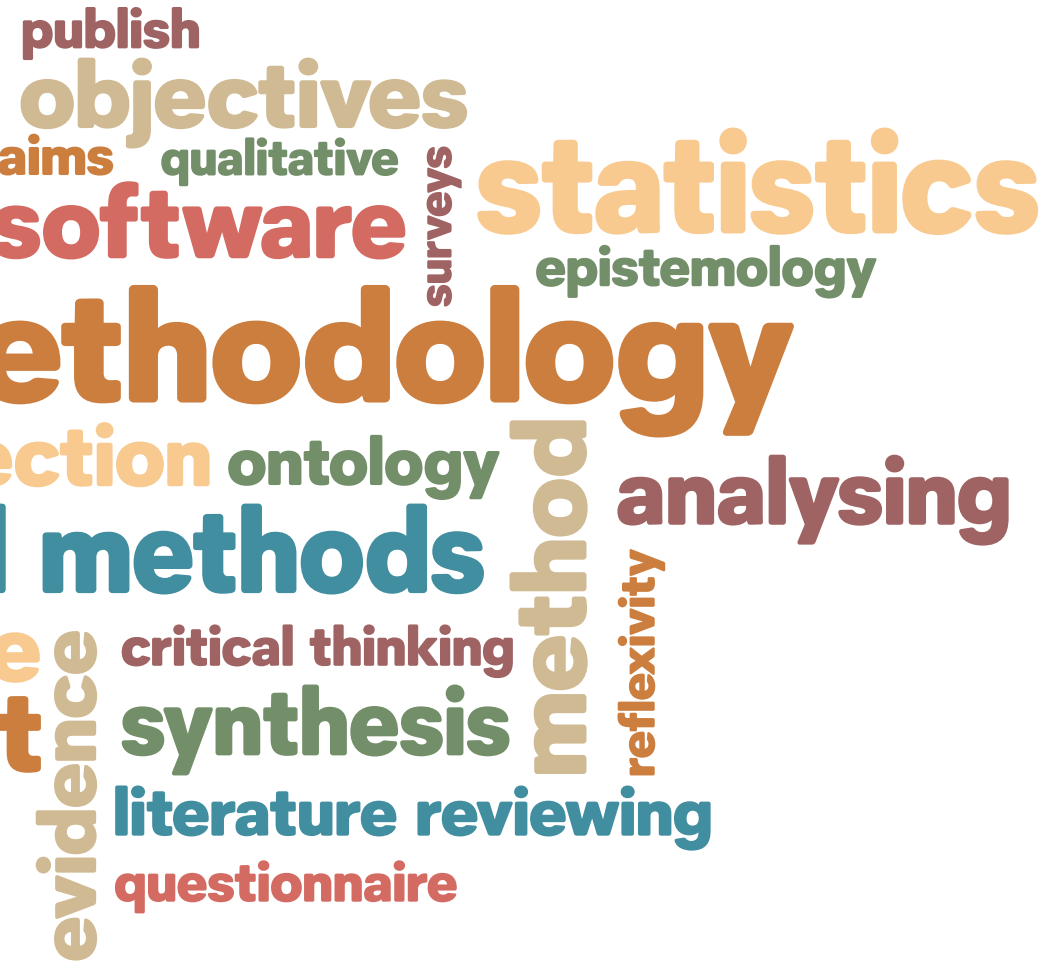
INDICATIVE CONTENT
The political and economic contexts within which specific health policies and legislation are formed e.g. austerity, privatisation, Brexit, devolution, the Sustainable Development Model and United Nations Sustainable Development Goals
Global challenges and changes and impact on local (UK/devolved nations) health policy and practice e.g. climate crisis, land use change, biodiversity loss, migration, conflict, pandemics, antibiotic resistance
The short and longer-term impacts of extreme weather events/disasters on health provision including e.g. emergency healthcare needs, long-term disruption to resources and services, physical and mental health implications for patients and providers. The significant risks to of climate change e.g. poor housing, food scarcity, energy and transport affordability, unprepared health and social care
Healthcare as devolved in the United Kingdom: how England, Northern Ireland, Scotland, Wales make their own decisions about health funding, structures, processes, and law
Unique challenges of healthcare provision in relation to rural, semi-rural and metropolitan locations e.g. Grenfell inquiry, health issues associated with rural areas of high unemployment
Landmark inquiries and reports concerning health that are relevant to how healthcare systems are structured and organised
The disparities between healthcare needs and the distribution of health workers both nationally and internationally, including the role of migrant workers in the UK
The organisation of health services and differences in effectiveness within and across the countries of the UK and internationally
The international composition of the healthcare workforce and the significance of this both within and outside the UK
The role and contribution of informal caring to healthcare
Gender and caring responsibilities (and implications for an ageing society)
The definition of professionalism, including debates around changes: de/re-professionalisation and new professionalism related to allied care provision and multidisciplinary healthcare teams/provision
Key regulatory frameworks relevant to medical practice
Medical error, whistleblowing and patient safety; impact of social, cultural and organisational factors shaping practice e.g. The Mid Staffordshire Enquiry
Forms of pervasive prejudice and discrimination e.g. racism, sexism, ableism
Inclusive care that applies a human rights perspective e.g. trans rights, impact of global events e.g. NHS Care for Refugees
Expansion of healthcare responsibilities to embed sustainable clinical practices that minimise environmental harms (reduce waste, promote circularity, limit exploitation)
Explore discussions within key organisations such as the British Medical Association to identify debates about the impact of regulatory frameworks on professional identity; reflect on what this has meant for students' clinical experiences
Explore the research literature to provide a critical perspective on the production of medical research evidence and identify the role of evidence in clinical practice
Reflect on your clinical experiences with regards to social, political, economic or global environmental factors that either inhibit or enable the application of evidence-based medicine and show how you can reduce barriers
Investigate the role of patient and student leaders in policy development
Discuss the role of health care professionals as advocates for health equity and social justice
Describe features of a health-promoting local environment, in community and healthcare settings to include funding and equitable access to green spaces, clean air and an affordable active travel infrastructure
Identify potential synergies between policies and practices that promote environmental sustainability and those that promote health sustainability
Contrast Bronfenbrenner's Ecological Systems Theory with Engel's Bio-Psycho-Social model. Which framework is most suited to understanding health care in the 21st Century?

TOPIC 6
Research and evidence

CORE LEARNING OUTCOME
Demonstrate understanding of the ways in which sociological research evidence is produced and used

KEY LEARNING OUTCOMES
Recognise philosophical underpinnings of different research approaches
Identify and evaluate research methods and methodologies
Apply an understanding of research methodologies and methods to medical practice

INDICATIVE CONTENT
Approaches to sociological research (qualitative, quantitative and mixed methods) and understanding of how each approach frames 'the truth' – positivism and interpretivism
Implications of philosophical debates for discussions of evidence-based medicine
Range of methods used in sociological research in health, illness and medicine: quantitative designs (for example, RCTs and surveys), qualitative designs (for example, in-depth interviews, focus groups, observations, Auto/Biography); mixed methods designs, interdisciplinary teams (i.e. working with experts in their own fields)
Aligning the choice of research methodology and method with research questions
Contribution of sociological research to understanding of health, illness and disease and the improvement of healthcare: for example to support service development and delivery; to facilitate awareness of social context and patient experiences
Select a topic and identify a small number of studies using different methods and for each, identify and critically discuss the research question, justification for the methodology and research methods and application to practice
Develop research questions relating to a topic that could be investigated using a variety of methods (for example, randomised controlled trials, surveys, qualitative interviews, observation). Evaluate how well the questions may be answered using these methods. Decide how questions can be adjusted to each method
Drawing on a clinical experience, reflect on how research might be used to inform practice
Explore the rationale, benefits and mechanisms for patient and public involvement (PPI) in research. How can co-production improve PPI?
Develop an idea for a research project which actively involves partnerships with marginalised or minoritised communities
Taking a topic of choice, critically analyse the kinds of understandings presented by papers that adopt a clinical trials approach and papers that adopts a mixed methods approach



Conclusion

This core curriculum draws together evidence with the expertise and experience of a wide range of people committed to ensuring that sociology continues to benefit medical students, those responsible for their training and, ultimately, patients and communities. It provides practical and coherent support to existing practice, a robust basis for the development of sociology teaching within medicine and guidance for future curricula and programmes.

We look forward to supporting its use and development as it becomes further embedded in medical education and we gain a fuller understanding of how it brings sociology to life for our students. There is continued work to do involving rigorous evaluations of its impact which may contribute to future reflections on the higher level learning outcomes expected of medical graduates. Subsequent work also includes a clearer understanding of how sociology overlaps with and is distinguishable from cognate disciplines including psychology, public health, global health, and the medical humanities. In addition, it will be important to review how sociology is assessed in medical education. Another area of work is the development of resources for medical schools. As part of a 2021 review we began collating resources utilised across UK medical schools that have been shown to bring sociology in medical education alive. This involved making links between sociological researchers whose outputs include teaching resources. A project to bring these resources together and present them to the medical and wider healthcare community is currently underway. Finally, it is clear that sociology has much to offer student learning in clinical and community contexts and we look forward to further thinking and activity around this to ensure that students have relevant and continuous exposure to the ideas and practices captured here.

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Appendix 1:
Mapping of the Sociology Curriculum to GMC Outcomes for Graduates (2018)

The core curriculum topics map to several areas in Outcomes for graduates, most notably Outcomes 3 – Professional knowledge, section 24: 'Applying social science principles'. In addition, they map to several outcomes within section 25: 'health promotion and illness prevention'; section 26: 'clinical research and scholarship' and Outcome 1 – Professional values and behaviours, section 6: 'Dealing with complexity and uncertainty'.

Core Curriculum Topic	Outcomes for Graduates
Topic 1: A sociological perspective Describe and apply sociological principles, concepts, theories and evidence to health, illness and medical practice.	**24. Applying social science principles** a. Recognise how society influences and determines the behaviour of individuals and groups and apply this to the care of patients b. Review the sociological concepts of health, illness and disease and apply these to the care of patients c. Apply theoretical frameworks of sociology to explain the varied responses of individuals, groups and societies to disease d. Recognise sociological factors that contribute to illness, the course of the disease and the success of treatment and apply these to the care of patients – including issues relating to health inequalities and the social determinants of health, the links between occupation and health, and the effects of poverty and affluence e. Explain the sociological aspects of behavioural change and treatment concordance and compliance, and apply these models to the care of patients as part of person-centred decision making.
Topic 2: Health inequalities Demonstrate the ways in which health and illness are socially determined.	**24. Applying social science principles** a. Recognise how society influences and determines the behaviour of individuals and groups and apply this to the care of patients b. Recognise sociological factors that contribute to illness, the course of the disease and the success of treatment and apply these to the care of patients – including issues relating to health inequalities and the social determinants of health, the links between occupation and health, and the effects of poverty and affluence **25. Health promotion and illness prevention** c. Evaluate the environmental, social, behavioural and cultural factors which influence health and disease in different populations

Core Curriculum Topic	Outcomes for Graduates
Topic 3: Lived experiences of health, illness and disability Apply an understanding of the lived experiences of health, illness and disability.	**6. Dealing with complexity and uncertainty** a. Recognise the complex medical needs, goals and priorities of patients, the factors that can affect a patient's health and wellbeing and how these interact. These include psychological and sociological considerations that can also affect patients' health **24. Applying social science principles** a. Recognise how society influences and determines the behaviour of individuals and groups and apply this to the care of patients b. Review the sociological concepts of health, illness and disease and apply these to the care of patients c. Apply theoretical frameworks of sociology to explain the varied responses of individuals, groups and societies to disease d. Recognise sociological factors that contribute to illness, the course of the disease and the success of treatment and apply these to the care of patients – including issues relating to health inequalities and the social determinants of health, the links between occupation and health, and the effects of poverty and affluence e. Explain the sociological aspects of behavioural change and treatment concordance and compliance, and apply these models to the care of patients as part of person-centred decision making **25. Health promotion and illness prevention** a. Explain the concept of wellness or wellbeing as well as illness, and be able to help and empower people to achieve the best health possible, including promoting lifestyle changes such as smoking cessation, avoiding substance misuse and maintaining a healthy weight through physical activity and diet c. Evaluate the environmental, social, behavioural and cultural factors which influence health and disease in different populations
Topic 4: Knowledge about health and illness Explain how medical and lay knowledge are constructed.	**24. Applying social science principles** a. Recognise how society influences and determines the behaviour of individuals and groups and apply this to the care of patients e. Explain the sociological aspects of behavioural change and treatment concordance and compliance, and apply these models to the care of patients as part of person-centred decision making **26. Clinical research and scholarship** a. Explain the role and hierarchy of evidence in clinical practice and decision making with patients b. Interpret and communicate research evidence in a meaningful way for patients to support them in making informed decisions about treatment and management c. Describe the role and value of qualitative and quantitative methodological approaches to scientific enquiry d. Interpret common statistical tests used in medical research publications e. Critically appraise a range of research information including study design, the results of relevant diagnostic, prognostic and treatment trials, and other qualitative and quantitative studies as reported in the medical and scientific literature

Core Curriculum Topic	Outcomes for Graduates
Topic 5: Health policy and practice Examine social influences on the development of health policy, systems, and medical practice.	**25. Health promotion and illness prevention** f. Outline the principles underlying the development of health, health service policy, and clinical guidelines, including principles of health economics, equity, and sustainable healthcare k. Evaluate the determinants of health and disease and variations in healthcare delivery and medical practice from a global perspective and explain the impact that global changes may have on local health and wellbeing
Topic 6: Research and evidence Demonstrate understanding of the ways in which sociological research evidence is produced and used.	**26. Clinical research and scholarship** a. Explain the role and hierarchy of evidence in clinical practice and decision making with patients b. Interpret and communicate research evidence in a meaningful way for patients to support them in making informed decisions about treatment and management c. Describe the role and value of qualitative and quantitative methodological approaches to scientific enquiry d. Interpret common statistical tests used in medical research publications e. Critically appraise a range of research information including study design, the results of relevant diagnostic, prognostic and treatment trials, and other qualitative and quantitative studies as reported in the medical and scientific literature f. Formulate simple relevant research questions in biomedical science, psychosocial science or population science, and design appropriate studies or experiments to address the questions g. Describe basic principles and ethical implications of research governance including recruitment into trials and research programmes

Appendix 2: Further Resources

Key text books

The following books contain syntheses of the empirical and theoretical work that have been undertaken in relation to each topic in the curriculum. They are a useful starting point for teachers. The resources here are not intended as an exclusive or exhaustive list.

- Annandale, E. (2014) *The Sociology of Health and Medicine: A Critical Introduction*. 2nd edition. Cambridge: Polity Press.
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For more information about and support for teaching and learning sociology in medical education see www.besst.info

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2016 Endorsements

As a practising clinician I think the core curriculum is completely relevant.

Louise Dubras, GP, Foundation Dean, School of Medicine, Experience, Ulster University

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Overall I feel it is an impressive document on a number of levels. It is remarkably accessible, succinct and relevant to the practice of medicine and importantly mapped to Tomorrow's Doctors 2009. I also feel you have achieved a remarkable consensus across the medical sociology community.

Bob McKinley, Professor of Education in General Practice. Keele University School of Medicine

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The core curriculum feels relevant because it picks up all the key modern issues in healthcare and society and the focus on patient experience throughout is excellent.

Anya de Iongh, Patient Leader
www.the patientpatient2011.blogspot.co.uk

This appears a very valuable document in ensuring that medical training includes the sociological aspects of health and social care. I think the paper is very comprehensive and I like the way it references patient participation groups and involvement.

Heather Eardley Director of Development. The Patients' Association www.patientsassociation.com

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