The Purpose of Service Learning

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What Service Learning Is Not

“Service learning” is open to many interpretations depending on the intentions of the user. In what follows I will give my own interpretation beginning with what it is not.

First, it is not the solution to the lack of health care for the uninsured, poor, and disadvantaged. As we all know, that will take the reform of the entire health care system.

Nonetheless, the act of learning through giving service does fit into the equation, since medical education is the bedrock of medicine. That education must offer more than the process of acquiring biomedical knowledge and technical skills.

Second, service learning is not a series of programs (courses) run by the medical school administration. Seifer and others have stated that although we “encourage and support volunteerism . . . the learning that occurs . . . is not structural and may be quite accidental.” Further, Seifer and her colleagues suggest that service learning “linked to specific course-based learning objectives has a greater impact on students than do electives or voluntary programs.”

I am not alone in the belief that such programs in the hands of the administration fall short. Hafferty has stated that “For the most part, these types of curricular experiences remain in the control of the faculty and administrators, are electives and selected by those who least need them, and thus stand as isolated islands of ‘authenticity’ in a sea of egoism and entitlement.”

Third, previous voluntary experience is not a precursor to becoming an altruistic doctor. Of course we all want compassionate and empathetic people to go into medicine, but what applicants write on their personal statements (since everyone writes something about volunteerism) does not guarantee that “the spirit of volunteering” will remain with them throughout medical school. It has to be nurtured in particularly innovative and engaging ways.

During the time I was a dean, part of my duty was to be an ex-officio member of the admissions committee. The group took pains to try to capture the character of the total applicant, but in the final selection for admission, MCAT scores and grade point averages played the major role.

Fourth, the full impact of service learning on the morale and ethical behavior of medical school graduates is not readily evaluated in the short run. Most of these studies show lack of correlation between service learning and the type and style of medical practice.

The designers of such short-term studies use their results to debunk the influence of service learning experiences on the intellectual and moral maturation of the participants. They are looking for causality in the wrong places. Their misunderstanding is an unquestioning reliance on numbers as scientific proof. If a program doesn’t fit neatly into a statistical format, it is considered anecdotal at best. Too often the methods wag the program.

More than 40 years ago Peter Berger argued that the keen observer of social change “will be able to discover human values that are endemic to scientific procedures in both the social and the natural sciences.” Berger goes on to state that “Such values are humility before the immense richness of the world one is investigating, an effacement of self in the search for understanding, honesty and precision in method, respect for findings honestly arrived at, patience and a willingness to be proven wrong and to revise one’s theories, and, last but not least, the community of other individuals sharing these values.”

Learning Knowledge, Skills, and Values Through Giving Service

The proposition fundamental to my perspective—the guiding principle—comes from the work of the eminent child psychiatrist and author of The Children of Crises series, Robert Coles, who states...
that the “call of service . . . results in learning about the life lived by giving freely of oneself.”(By free he means not having to be told to do it; it is not a financial consideration.) Fundamentally, service learning is a way of fostering learning and development through experience in the real world—John Dewey’s experiential learning.6

The extent to which learning through doing is deemed critical to medical education is demonstrated by the existence of residency programs. But because it is virtually the sine qua non of medical schools, it is overlooked in the paradigm of service learning.

Yet, when the focus is strictly on clinical competence and technical skills, values like social consciousness, empathy, and compassion become secondary. It is assumed that the personal motivation to become a doctor is the psychological mechanism that leads to humane care. This assumption, however, ignores the fact that the process of acquiring biomedical knowledge and technical skills, particularly in residency, undermines or wipes out the idealism of students during their training.

There is, however, a body of thought in academic medicine that subscribes to the idea that values, such as altruism and dutifulness, can be taught like any other didactic topic. Yet a course in medical ethics does not automatically make one ethical. If values are learned this way, they become static and routinized. Martha Nussbaum refers to values as “emotional intelligence;” “Emotions involve judgments of important things . . . They alert us to what matters most.”7

As Jordan Cohen, former president of the Association of American Medical Colleges, has rightly stated: “The key to valuing the profession is to profess its values.”8

The study of values is deceptive. Dennis Goulet9 makes the point succinctly in An Ethical Model for the Study of Values: “To reduce the totality of these experiences to that mere portion of reality that is measurable is to deprive authentic development of its fullness and to falsify reality itself.” Further, he reminds us that “Values belong to the realm of synthesis, not analysis. To reduce this synthesis to an instrumentality of arbitrary ‘scientific rules’ is to lose its fundamental symbolic meaning.”9 In short, learning through giving service is an active process.

The Four Pillars of the Rush Community Service Initiatives Program

To add depth to my position on service learning, I turn to my book Doctors Serving People: Restoring Humanism to Medicine Through Student Community Service.10

Over the past 2 decades, medical students at Rush University in Chicago planned and implemented 24 clinical and social service programs in poor, urban communities—voluntarily and without academic credit. The four pillars of the Rush Community Service Initiatives Program (RCSIP)—student-generated, student-run, voluntary, and extracurricular—are the essence of the program. What differentiates RCSIP from most community service programs is that it is not run by the medical college administration. I cannot overemphasize this point. The programs were created by the students themselves. RCSIP is their innovation. This salient point is often overlooked when conventional assessments of service learning are applied to RCSIP. Of their own volition, RCSIP participants sought out areas of need (not only medical but social) and addressed them. Moreover, this process was renewed class by class on a yearly basis, and thus RCSIP has never become routinized.

In Doctors Serving People I created a conceptual schema showing the interconnectedness of service and learning (p. 111). The learning component is subdivided into knowledge and skills and values and beliefs. On the knowledge side the skills acquired by the participants are multifaceted: clinical (taking care of patients), interpersonal (teamwork), administrative (running a program), analytical (data analysis and publication), and leadership (leading through doing). On the values and beliefs side there is the moral growth and development (virtuous doctors) and social responsibility (active participation in health care reform).

The service component is more than volunteering at a free clinic. This perception is a prime reason for dismissing service learning as an an answer to the growing health care crisis. Planning, initiating, and assessing RCSIP programs required organizational skills on the part of the students that incorporated administrative, interpersonal, and assessment knowledge. In short, they discovered the health care system through their own ingenuity and resourcefulness. Moreover, the breadth and diversity of RCSIP is characterized by the different kinds of programs students initiated. Again, keep in mind that the context of what they learned rested on the service they gave. Some examples of the service activities follow.

Two of the free clinics where the students (led by clinicians) volunteered provide health care and support to the homeless. All the free clinic facilities contain pharmacies, diagnostic equipment, and other medical technology. Records are kept, referral networks are established, and social and psychological support is provided.

In the depth of Chicago’s notorious winters, medical students led by a committed physician go to the Wacker Avenue underground to care for the men, women, and, yes, children huddled together for warmth, providing medicine, clothing, blankets, and food. This is a world outside standard medical education in the most absolute.
sense, no doubt, outside standard service learning programs as well. No doctor will learn about this world in any residency program that currently exists.

In the early 1990s the AIDS epidemic expanded from the “gay plague” to transmission through IV drug use and heterosexual relations. Among the projects initiated by RCSIP was sex education and HIV prevention in Chicago’s inner-city schools. The Chicago school system continues to use Rush students in this program.

I took a group of students to the top of the parking garage where they could see the Henry Horner Housing Project on the other side of the Eisenhower Expressway. Henry Horner gained prominence through Alex Kotlowitz’s best-selling book There Are No Children Here. We went to the Boys and Girls Club where the students asked the director how they might be of help. He told them straight out that he was tired of “outsiders,” especially academic types, who always want to study life in the projects as the basis for writing papers or getting advanced degrees. He asked “What do you have to offer us?” One student sheepishly replied, “Since we know about science, math, and biology, perhaps we could be tutors?” This was the start of a long and lasting friendship.

After tutoring for about 6 months, the mothers of the children asked the medical students to help them with their number one health problem: their kids had asthma. At a meeting of the tenants’ organization I made it clear that we could not start an asthma clinic at Horner. But what we could do was conduct a survey of health care providers to find out where asthmatic kids could go for health care, instead of relying on the “Medicaid mills” on Madison Street. We could also train a cadre of “community asthma workers” (later referred to in the community as CAWS). The selection, training, and implementation of the community workers in the control of asthma program are detailed in Doctors Serving People. In our door-to-door canvassing of Horner, the CAWS found that about two thirds of the asthmatic children’s last visit to a health professional took place at the emergency room of Cook County (now Stroger) Hospital. CAWS have made a significant impact on the overuse of the hospital in dealing with asthma.

Another grassroots program that is described in the book occurred at Casa Guatemala. Based on documentation of health care needs and lack of access to medical services, a social action movement was started by the Guatemalan refugees (many of whom had escaped prison or death) with strong support (physically as well as spiritually) by RCSIP. There were also international health endeavors initiated by the medical students. Once again they did this from scratch. In the process of contacting faculty with international ties, raising money, dividing the dean’s summer fellowships resources equally, and developing a protocol for safety, cultural sensitivity, and individual commitment, they vowed never to become “cultural tourists.” They have volunteered in such varied places as Nepal, South Africa, Guatemala, Haiti, Serbia, and Indonesia.

Evaluating Program Efficacy

Despite all of the quantitative data we have collected over 15 years, the rich substance of meaning for the participants is found in the complex series of events, interactions, and experiences that constitute the convergence of structural, cultural, and political factors they had to confront. The greatest source of data for me was the student and faculty narratives. Of particular interest were the personal narratives of student activists who are now practicing physicians. I can’t overstate the value of these narratives. I concur with Rita Chapa, a general internist who teaches writing and interviewing skills to medical students and residents, who has stated, “Narrative knowledge . . . concerns motivations and the consequences of human action.”

Through participant observations over the course of my role in RCSIP and open reflections with students and faculty volunteers, it was possible to track the participants’ intellectual growth and moral development initially and subsequently. In these informal encounters, students often expressed recognition of the reality of life in a world where poverty and deprivation are social facts and one’s position in society has a direct effect on one’s state of health. The values that were instilled, reinforced, and sustained through RCSIP involvement were humanistic and ethical—the qualities of a virtuous doctor.

Such qualities cannot be taught in the lecture hall or on the wards of the hospital. Hafferty and Frank have insightfully differentiated between the formal, informal, and hidden curricula of medical education. Their construct of the “hidden curriculum” illustrates how and where much of the practical adaptation to the culture of medicine takes place. To propose a complete reorganization of health care by focusing on escalating costs of more than $2.2 million and rising, lack of access for more than 45 million uninsured and increasing due to the rise in unemployment, growing dissatisfaction with impersonal HMO clinics, and the specialization and technical procedures rapidly replacing primary care that continues to decline from 40% in 1995 to 18% in 2007 while giving “lip service” to the core values of medicine is a tragedy in its own right. Corporatization, commodification, and instrumentalization have driven medicine away from its inherent purpose—the prime responsibility of keeping individuals, families, and communities well.
Christakis, a physician and sociologist, performed a content analysis, beginning with the Flexner Report, on 19 of 24 reports that directly addressed undergraduate medical education. In the conclusion of his 1995 monograph, Christakis states: “The relative neglect of the students flows mostly from the emphasis that the reports place on patient care and research—rather than education—as the chief missions of medical schools. Indeed, the reports are relatively faceless . . . Only rarely do the reports refer directly to students or faculty concerns or to the duty owed by medical schools not so much to society at large but to their students.”

What service learning experiences like RCSIP offer at a time of chaos in medicine is a revival of moral principles. In particular, medical education must embrace these principles by making them part of the foundation of its mission. Effective reform requires a conception of medical services and health care that integrates culture as an interrelated pattern of beliefs and disposition with the context of structural factors such as social status, resource availability, and political empowerment as a basis for a more comprehensive health policy and humane profession. The results of such an innovation—learning through giving service—can be the catalyst for reconnecting medicine to society by producing clinically competent, ethically concerned, and socially conscious doctors who are committed to being change agents at a time when reform in medicine is urgently needed. Think of this type of service learning as residency in the real world.

Finally, I see RCSIP as an antidote to putting so much emphasis on professionalism as a privileged status and the exclusive focus on advanced technology and intricate procedures. The universe of health care has been almost completely reduced to the hospital rather than broadened to the community where care needs occur. This outcome traces directly back to medical education, which prefers to operate in its own limited universe. Hospital-centered medical education teaches itself. Health care happens in the community, where most medical students have never been. An awareness of this social fact must become the guiding force behind any proposed change. Clearly there is a difference between new skills and technical innovation and the health care provider behaving as a compassionate and dedicated professional. The integration of technical knowledge and humanistic behavior in the changing cultural context gives social meaning. To use Richard Horton’s phrase, we need to become aware that health and disease are “profoundly existential, policy, and geopolitical concerns.” Medical students so inspired are the future section heads, department chairs, center directors, and medical school deans. It’s the vision thing. The vision they bring is needed for influencing health policy that directly addresses the political and social implications of providing health for all.

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References