



OPEN LETTER

REVISED

# Addressing complex societal challenges in health education – A physiotherapy-led initiative embedding inclusion health in an undergraduate curriculum [version 2; peer review: 2 approved, 1 approved with reservations]

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## Abstract

People who are socially excluded experience vastly poorer health outcomes compared to the general population. Inclusion Health seeks to directly address this health inequity. Despite the increased requirement for health care and the increased prevalence of complex health and social needs in socially excluded people, Inclusion Health features very little in health education curricula.

This letter has been written by a group of clinicians, academics, clinical education specialists and students with a common interest in Inclusion Health. In the absence of established guidance on how best to incorporate the broad topic of inclusion health in undergraduate education, we have developed a two-pronged approach within Physiotherapy. We are writing to highlight the following initiatives; firstly, the provision of a dedicated undergraduate clinical placement devoted to the area of Inclusion Health. Secondly, we have also initiated a step-wise process of introducing the topic of Inclusion Health into the formal undergraduate curriculum. This letter demonstrates the need to implement strategies to incorporate Inclusion Health into the curriculum and the approaches described are applicable to diverse health professions and settings.

## Keywords

Inclusion health, homeless, homelessness, education, clinical placement, curriculum

## Open Peer Review

Reviewer Status

	Invited Reviewers		
	1	2	3
<b>version 2</b> (revision) 06 Mar 2020			
<b>version 1</b> 02 Sep 2019	 report	 report	 report

- Patrick O' Donnell** , University of Limerick, Limerick, Ireland
- Serena Luchenski**, University College London, London, UK  
**Luke Johnson** , University College London, London, UK
- Joseph G. McVeigh**, University College Cork, Cork, Ireland

Any reports and responses or comments on the article can be found at the end of the article.

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**Author roles:** **Broderick J:** Conceptualization, Supervision, Writing – Original Draft Preparation, Writing – Review & Editing; **Waugh A:** Conceptualization, Supervision, Writing – Original Draft Preparation, Writing – Review & Editing; **Mc Govern M:** Conceptualization, Supervision, Writing – Original Draft Preparation, Writing – Review & Editing; **Alpine L:** Conceptualization, Supervision, Writing – Original Draft Preparation, Writing – Review & Editing; **Kiernan S:** Conceptualization, Supervision, Writing – Original Draft Preparation, Writing – Review & Editing; **Murphy N:** Conceptualization, Supervision, Writing – Original Draft Preparation, Writing – Review & Editing; **Hodalova S:** Conceptualization, Writing – Original Draft Preparation, Writing – Review & Editing; **Feehan S:** Conceptualization, Writing – Original Draft Preparation, Writing – Review & Editing; **Ní Cheallaigh C:** Conceptualization, Supervision, Writing – Original Draft Preparation, Writing – Review & Editing

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**REVISED Amendments from Version 1**

Person-centred language has been used throughout and we have ensured the heterogeneity of this group is emphasised. We have included Allport's contact hypothesis when describing purposes of the placement and made changes to clarify Table 1.

Regarding feedback obtained for future considerations and advice on running future inclusion health placements; we have included additional information as required. We have emphasised that information pertaining to Table 1 and Table 2 in this Open letter was informal and non-anonymised. As per HRB Open submission guidelines for Open Letters no data or analysis is to be included, therefore we feel this type of reporting is appropriate for this type of submission to give context to the initiative described. We also have improved the clarity of language throughout and ensured consistency with terms, more specific detail where requested has also been added.

Details of student numbers have been added. The inter-professional learning activity has not yet been finalised, so details were not included in this Open letter. As we were writing this Open letter with the aim for it to be applicable to a wide research audience (as per HRB Open submission guidelines for Open Letters), and in the interests of brevity, we did not link the developments to the CORU proficiency standards, but the following criteria would be relevant 'Curriculum design should reflect current evidence-informed and research based educational theory and health and social care practice. The curriculum model chosen should be dynamic and flexible to allow for changes in the profession, health and social care delivery and the development of evidence based/informed practice.

**Any further responses from the reviewers can be found at the end of the article**

**Disclaimer**

The views expressed in this article are those of the authors. Publication in HRB Open Research does not imply endorsement by the Health Research Board of Ireland.

**Introduction**

Inclusion Health is an approach that aims to address the extreme health inequalities experienced by socially excluded people<sup>1</sup>. Social exclusion is linked with poverty and low income, but is further characterised by poor access to employment, education, housing, health services and experiences of crime, incarceration and family breakdown. These experiences are linked, and often form part of an intergenerational cycle<sup>2,3</sup>. People with substance use disorders, prisoners, casual sex-workers, as well as Travellers and Aboriginal/First Nations people, frequently experience social exclusion<sup>4,5</sup>. The prevalence of multiple traumas or adverse events in childhood and adulthood is much higher in socially excluded people than the general population<sup>6</sup>. Social exclusion is also associated with increased morbidity and mortality similar to seen with that associated with poverty, but of a much higher magnitude<sup>3</sup>. Socially excluded people have a standardised mortality rate eight times higher than the average for men, and nearly twelve times higher for women<sup>4</sup>.

Homelessness predominantly affects people who have already experienced social exclusion and adversity since childhood,

and compounds the effect of social exclusion on health<sup>6-8</sup>. In Ireland, a shortage of public housing has led to homelessness becoming a national crisis<sup>9</sup>. Homeless people are predominantly located in the capital city, Dublin. Since 2013, the number of adults who are homeless in Dublin has doubled<sup>9</sup>. Homeless people in Ireland have rates of poor physical and mental health, chronic disease, and multimorbidity which are greatly increased compared to the general population<sup>10</sup>. A similar phenomenon has been reported in other high-income countries<sup>11</sup>. The median age at death for people experiencing homelessness in Dublin is devastatingly low at 44 years for males and 36 years for females<sup>12</sup>.

Unsurprisingly, given high rates of physical and mental ill-health, homelessness is associated with increased usage of unscheduled health care. The centrally located Dublin hospitals, including St. James's Hospital, have seen increasing prevalence of homelessness in patients. The effect of homelessness on usage of acute unscheduled hospital care is demonstrated in the recent report that, despite representing only 0.4% of the catchment people experiencing homelessness account for almost 10% of emergency department attendances and inpatient stays in St James's Hospital<sup>13</sup>. Homeless people, therefore, represent a significant proportion of patients requiring hospital care in St James's Hospital.

People experiencing homelessness and/or other forms of social exclusion may present challenges to clinical care providers<sup>14</sup>. In light of this, there is a growing appreciation for the need for cultural and structural competence to provide care to people experiencing homelessness and/or other forms of social exclusion. Cultural competence enables healthcare providers to provide care which accommodates differences in language and/or culture<sup>15,16</sup>. Structural competence has been defined as the trained ability to discern and address clinical presentations and individual behaviors which represent downstream implications of upstream socioeconomic, political, and institutional realities<sup>17</sup>. Structural competence promotes identifying and addressing stigma and aims to lead to advocacy as a means of addressing structural determinants of health. An example of cultural competency is clinician awareness of low levels of functional literacy in people experiencing homelessness resulting in an ability to provide verbal information suitable for someone with a low level of literacy. An example of structural competence would be awareness of the role of internalized and externalized stigma experienced by homeless people resulting in development of an outreach physiotherapy programme to be delivered in a setting which is more acceptable to homeless adults. Contact on an individual level between providers and patients belonging to different societal groups has been proposed to improve cultural and structural competency and to reduce stigma and bias<sup>18</sup>.

Undergraduate programmes for health care providers offer an opportunity to improve provider competency in providing care to socially excluded people<sup>19-21</sup>. However, integration of Inclusion Health in medical and allied health undergraduate curricula is often lacking and/or unmeasured<sup>21,22</sup>. We suggest a formal approach should be taken. This letter describes the development of an Inclusion Health placement and a step-wise method of

introducing this topic into the undergraduate Physiotherapy curriculum in Trinity College, Dublin.

**Inclusion health clinical placement**

St James’s Hospital has developed an integrated, interdisciplinary Inclusion Health team, with an initial focus on homeless adults<sup>23</sup>. The Inclusion Health team had noted that many of the homeless inpatients required physiotherapy. This opinion was supported by a report on the high incidence of frailty in long-term homeless adults in the catchment area<sup>24</sup>. Informal discussions between the Inclusion Health team and clinical physiotherapists in the hospital, facilitated by the the coach on the Quality Improvement project supporting the Inclusion Health team (a senior physiotherapist in the hospital), led to an awareness in the clinical and academic Physiotherapy Departments of the need for expertise on Inclusion Health in physiotherapists. This awareness prompted the development of a pilot Inclusion Health placement for undergraduate physiotherapy students.

A dedicated four-week pilot Inclusion Health placement was designed by key stakeholders in the Physiotherapy Department in Trinity College, Dublin (TCD) and the Physiotherapy Department and Inclusion Health team in St James’s Hospital (SJH). Key aims of the placement were to provide contact with homeless patients and to observe the provision of Inclusion Health care in the hospital and in the community. The placement included three key elements. The first element was observation of inpatient consult rounds, outpatient clinics, and weekly interagency case management meetings with the SJH Inclusion Health team, and observation of a general practitioner (GP) clinic for refugees and a GP clinic for Roma people. The second element was supervised clinical practice with homeless inpatients, and included the provision of clinical physiotherapy assessments and

treatments under the supervision of clinical tutors for an average of 3.5 days per week over the 4 week duration of the placement. The third element of the placement was supervised practice with a group of homeless adults in the community, and consisted of the design, set-up, and delivery of a weekly hour-long exercise class for approximately ten homeless adults in in a residential hostel in the local area

Two third-year undergraduate physiotherapy students of Trinity College Dublin completed the placement in June-July 2019 (SF and SH). The students were supervised by two clinical tutors who were senior clinicians with a dedicated role in clinical education (MMcG and AW). Informal written/verbal feedback about the placement was sought from the two students, the two clinical tutors, the inclusion health MDT and at some of the outreach clinics attended by the students. The students completed written post-placement reflections and compiled a guidance document for future students embarking on an Inclusion Health placement. Feedback was not anonymised.

Students and facilitators reported a number of considerations to inform setting up a clinical experience within the Inclusion Health area, which are applicable to future placements/clinical exposures. These are shown in Table 1. The guidance provided by students SH and SF for future students is presented in Table 2.

A total of 13 inpatients and 10 outpatients were assessed and treated by students during the placement, some of whom were treated multiple times over the 4 week placement. Nine people attended the exercise classes in the residential facility with an average weekly attendance of 4 residents. Data was not recorded on the number of patients who refused or participated in assessments/treatments.

**Table 1. Key success factors for an inclusion health placement.**

Key consideration	Reason
Conduct comprehensive orientation	This will maximise student confidence and preparedness, to optimise the learning experience
Allow additional time for placement planning	A comprehensive placement will consist of clinical exposure to off-site clinics and services to ensure breadth of inclusion health area is covered. Take time to build relationships with other staff and services in the area so students can be facilitated on placement
Consider interpersonal skills of students	Strong communication skills, a flexible open approach, and the ability to cope with the potentially unpredictable nature of the placement at times are needed
Peer placement recommended	A peer placement is recommended with two students placed together enabling students to undertake assessments and treatments together. Having two students together is also useful due to a number of reasons including high prevalence of physical disabilities necessitating >1 therapists to safely conduct assessments and treatments, and ability to debrief after encounters
Modify assessment	It is recommended that placement be graded on a pass/fail basis rather than a numerical grade as not all areas may be applicable to the standardised method of clinical assessment
Ensure sufficient support available for students	Due to the complexity of the area ensure there is sufficient support from senior clinicians/dedicated clinical education specialists
Arrange additional training	As the incidence of infectious diseases may be higher in inclusion health patients (for example higher incidence of HIV and Hepatitis C), infection control measures will need to be reiterated prior to commencing placement. Although the actual risk of injury is low, violence and aggression training prior to placement is recommended, mainly to learn de-escalation skills

**Table 2. Advice from students, ‘the student voice’.**

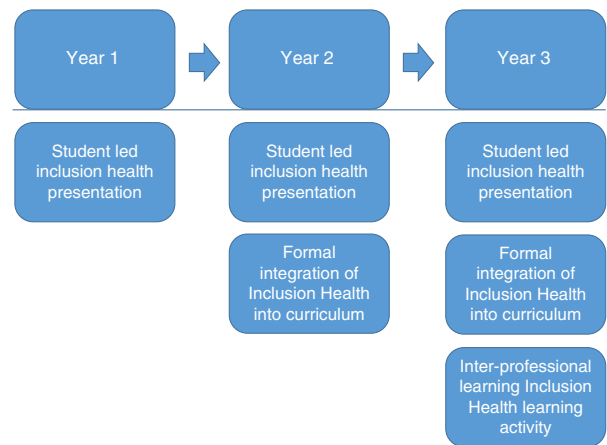
Key advice	Reason
Be empathetic & have an open mind	Have an awareness of the complex nature and difficult background of some of these patients and their co-morbidities. Speak to the nursing staff to ascertain if it is the appropriate time for treatment as patient’s mood and health status may fluctuate and will give you an indication of whether a patient is likely to engage with treatment at that time.
Communication skills are very important	Take time to build a rapport with your patient first. Assessment or treatment may need to be very brief, just talking to a patient & giving them advice may be the only treatment you will provide.
Know when not to intervene (patient unwell or not willing to engage, patient not listening to your advice)	If a patient is not on the ward or unavailable, try to get back later that day. If a patient becomes agitated or refuses to listen to your advice, it is best that you step back and try revisit the topic another day.
Plan in advance use a flexible approach	Have a plan before seeing a patient as to what you would like to get out of the session, but bear in mind that what you plan might not be what the patient would like to do. Ask the patient what they would like to get out the session/ what their priority is.
Speak to your senior clinician/practice tutor if you feel uncomfortable or unsure about a situation	Know that you should never feel out of your comfort zone when completing this placement. Speak to your senior clinician or practice tutor. Your peer is also someone you can speak to & reflect with about patients you have seen together.
You are in a safe learning environment. Generally, this patient cohort is approachable & happy to interact with students	From our experience, patients generally engaged well with assessments and treatments delivered by physiotherapy students & felt they were listened to. This patient cohort has multiple physical needs & were very receptive to input from therapies to help them.

The students and clinicians involved in the placement reported bi-directional positivity – of the students towards this placement and client group and of homeless clients towards meaningful engagement and cooperation with student physiotherapists. All clinicians involved in the placement reported that it was feasible and acceptable to themselves and, as observed, to socially excluded patients. Both students reported the placement was a valuable learning opportunity. We are planning to run this placement again in the next academic year 2019–2020. We plan to ensure adequate exposure to socially excluded groups which may have different cultural needs by specifically including contact with refugees and Travellers in the placement. Space constraints for placement with the hospital Inclusion Health team and in Inclusion Health settings in the community mean that this may not be feasible for all students in our institution.

**Curricular changes**

Inclusion Health is a complex topic which overlaps with mental and physical disease, as well as substance abuse and structural factors underlying the effect of social exclusion on health. An additional challenge to introducing it into the formal undergraduate curriculum is the lack of best practice guidelines or set of competencies. As demonstrated in Figure. 1, our approach is to introduce this topic in a step-wise fashion.

In the academic year 2018–2019, we commenced with group-based student-led presentations on Inclusion health. Groups were assigned titles including ‘‘Inclusion Health and physiotherapy in the homeless community’’ and ‘‘The role of physiotherapy in people who are asylum seekers/refugees, including special considerations post torture’’. In addition



**Figure 1. Step-wise approach of developing suite of inclusion health learning activities from Year 1 (Academic year 2018–2019) projected to Year 2 (Academic Year 2019–2020) and Year 3 (2020–2021) into formal undergraduate curriculum.**

to the title, students were signposted to key resource materials and subtopics to consider for inclusion in their presentations.

In 2019–2020, the topic of Inclusion Health will be formally integrated into a pre-existing learning module (a specialist rehabilitation module, delivered in third year) and to the curriculum document. Evaluation of Inclusion Health learning outcomes will take place in formal summative assessments. In addition to the student-led presentation, there will be scheduled



lectures on Inclusion Health, including homeless, traveller and refugee/asylum seeker health. In 2020–2021 an inter-professional learning activity, which is under development, will include third year students of 2–3 different health science professional students and will complement the suite of learning activities.

## Conclusion

Clinical practicum and curricula should be realigned to meet the needs of the 21<sup>st</sup> century of which the health of socially excluded groups is a pressing need. This letter describes a unique initiative to incorporating the topic of Inclusion Health in an undergraduate physiotherapy programme via development of a four-week elective clinical placement and integration into the formal undergraduate curriculum. Our experience, albeit with a small sample (two students) and with non-anonymised feedback, suggests that this is feasible and acceptable to students, service providers and patients.

Delivery of a universal basic level of knowledge and formal integration of Inclusion Health into the undergraduate curriculum as described in this letter would ensure all students are exposed to this topic with the aim to equip all future graduates

with the skills and knowledge base to work with vulnerable and complex socially excluded people to optimise health outcomes.

For deeper understanding, a dedicated clinical practicum or clinical placement including contact with a number of socially excluded people in a variety of settings is ideal. A dedicated Inclusion Health placement is likely to engage students as communication catalysts and agents of change in the health care delivery system of the future. These students may share their experiential learning with other students, professionals, educators and health care institutes; thereby enhancing future engagement from a wide range of professionals with socially excluded people.

We suggest the approach of a dedicated clinical exposure and formal integration into the curriculum could be rolled out to other health care students and applied pragmatically to other settings based on local needs and expertise.

## Data availability

### Underlying data

No data are associated with this article.

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# Open Peer Review

Current Peer Review Status:   

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## Version 1

Reviewer Report 30 September 2019

<https://doi.org/10.21956/hrbopenres.14019.r26787>

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### Joseph G. McVeigh

Head of Discipline of Physiotherapy, School of Clinical Therapies, College of Medicine and Health, University College Cork, Cork, Ireland

Thank you for the opportunity to review this open letter 'Addressing complex societal challenges in health education – A physiotherapy-led initiative embedding inclusion health in an undergraduate curriculum'. In this letter the authors argue for the need to implement strategies to address the needs of marginalized groups in the undergraduate physiotherapy curriculum. Specifically the letter describes the development of a physiotherapy clinical placement focused on the needs of socially marginalized groups such as homeless people, refugees etc. The letter also outlines some developments of the physiotherapy curriculum to include student led presentations and scheduled lectures on inclusion health. Future multidisciplinary/inter-professional learning developments are also mentioned.

Marginalized groups are poorly served by health care providers, the initiative described in this letter captures an important curricular development for physiotherapy and other Allied Health Professionals.

It would be useful to link the developments to the CORU Standards of Proficiency for Physiotherapists.

It would be helpful if the authors could give some indication of the number of students per year who experience the described placement.

Some further description of what future plans are e.g. how will the inter-professional learning activity mentioned be structured.

#### Is the rationale for the Open Letter provided in sufficient detail?

Yes

#### Does the article adequately reference differing views and opinions?

Yes

**Are all factual statements correct, and are statements and arguments made adequately supported by citations?**

Yes

**Is the Open Letter written in accessible language?**

Yes

**Where applicable, are recommendations and next steps explained clearly for others to follow?**

Yes

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Head of Discipline of Physiotherapy, UCC. Research interests: rehabilitation of long-term musculoskeletal conditions.

**I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.**

Reviewer Report 30 September 2019

<https://doi.org/10.21956/hrbopenres.14019.r26786>

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**Serena Luchenski**

Institute of Epidemiology and Health care, University College London, London, UK

**Luke Johnson** 

Institute of Epidemiology and Health care, University College London, London, UK

Dear Professor Broderick and Colleagues,

This peer review is in response to your recent open letter, “Addressing complex societal challenges in health education – A physiotherapy-led initiative embedding inclusion health in an undergraduate curriculum.” Your letter articulates the importance of inclusion health, an emerging discipline that seeks to prevent and redress the most extreme forms of health inequities among some of the most vulnerable and underserved members of society. It goes on to advocate for and describe novel clinical educational initiatives to train future clinicians working with inclusion health groups in the field of physiotherapy. It is highly impressive and inspiring that you have taken this on at your University – thank you for sharing your experience with us to encourage others to evolve their curricula in a similar manner.

There are two main areas for the authors to address to strengthen this article. Firstly, the section on feedback obtained for future considerations and advice on running the programme needs further expansion and detail. Additional description of the data that these are derived from, how you used that data to develop the considerations and advice that you present, and the limitations of this approach would greatly bolster the arguments you present. Secondly, the clarity of the writing and structure of the article needs improvement. We have detailed areas to consider changing below.



**1. The following section needs additional detail on the methodology, interpretation and limitations:**

Inclusion Health clinical placement

***“We found there were additional considerations to setting up a clinical experience within the inclusion health area, which are applicable to future placements/clinical exposures. These are shown in Table 1. The ‘student voice’ - physiotherapy student post-placement reflections and guidance specifically for future students embarking on an inclusion health placement are presented in Table 2.”***

This section needs the most work. The feedback or ‘results’ you collected after running the event need to show their validity for us to take note of them. We need far more detail on how you came up with these considerations in Table 1 and advice in Table 2. For example, how were there additional considerations decided? Who came up with them? What data did they use to come up with them? How was student feedback ascertained? Was it a questionnaire? If so, how was the questionnaire designed? Was it pre-tested? Or were these reflective assignments the students had to do? Were they given guidance if so? Were these marked pieces? What was the response rate for feedback from students? Was it anonymous to minimise bias? What else was done to minimise bias? How many/what proportion of students suggested each piece of advice? How was this advice extracted from the feedback provided by the students? How did you ensure quality and validity in extracting the considerations and advice – e.g. data credibility, transferability, dependability and confirmability of findings? A section is needed towards the end of the article explicitly discussing the limitations from the feedback you have obtained too.

**2. The following specific areas need addressing to improve the clarity of the letter:**

Introduction

***“Socially excluded populations have a mortality rate eight times higher than the average for men, and nearly 12 times higher for women (Aldridge et al., 2018).”***

Write ‘12’ as ‘twelve’ instead to keep consistency within the sentence.

***“In Ireland, a shortage of public housing has led to homelessness becoming a national crisis.”***

This statement needs citing.

***“Homelessness has predominantly affected people who have already experienced social exclusion and adversity since childhood, and this compounds the effect of social exclusion on health.”***

Both statements in this sentence need citing, either as one citation which covers both statements, or two separate citations.

***“Since 2013, the number of homeless adults in Dublin has doubled (Focus Ireland).”***

Reference ‘Focus Ireland’ needs a date too. Also, the link for this reference should be to the specific page for the source material, not just to the website front page.

***“In other areas country wide with high levels of deprivation, health care professionals will see homeless patients presenting across multiple services.”***

Please rephrase this sentence for clarity.

Inclusion Health clinical placement

***“The curricula of higher education instituted need to reflect these changing requirements for healthcare delivery (Dean et al., 2009; McMahon et al., 2016).”***

Statement might be stronger in the active rather than passive voice, and the word usage of “instituted” is confusing in this context – you might want to consider omitting it or changing it to “implemented”

***“Exposure of undergraduate students to patients from socially excluded groups is necessary so that graduates can become empathetic advocates and effective and innovative clinicians to help drive better health outcomes for vulnerable groups.”***

Change the ‘and’ to ‘as well as’ to clearly divide the two characteristics.

***“We suggest a formal approach should be taken and this letter will describe the development of an inclusion health placement and a step wise method of introducing this topic into the undergraduate curriculum which we have initiated in our setting.”***

‘Step wise’ should be ‘step-wise’ for consistency throughout article.

***“The team had reported a high incidence of frailty in homeless adults in the catchment area (de Paul, 2017), and had noted a high rate of need for physiotherapy in homeless inpatients referred to the service”***

Should be ‘The team has reported’ not ‘The team had reported’. Consider changing ‘and had noted a high rate of need for physiotherapy’ to ‘and noted a high need for physiotherapy’. Also, the citation ‘de Paul, 2017’ citation either needs to be moved to the end of this sentence, or a second citation needs to be added after the next claim.

***“Ongoing collaboration with the clinical and academic physiotherapy department led to the development of an inclusion health placement for undergraduate physiotherapy students.”***

State this as more of a responsive action to the previous statement so that they are linked.

***“We report the design and roll out of a dedicated four-week inclusion health placement delivered to 3rd year undergraduate physiotherapy students of Trinity College Dublin in Jun-July 2019 on a pilot basis.”***

You don’t need to reintroduce what you’re already reporting with ‘we report the design and roll out of’ – it’s already clear by this stage. Change ‘3<sup>rd</sup> year’ to ‘third year’. Please state how many students were involved in the pilot.

***“Students were supervised by two clinical tutors who were senior clinicians with a dedicated role in clinical education. The main client group were homeless in-patients of St. James’s Hospital who were referred due to diverse physical and mobility limitations. Students assessed and treated this group, facilitated by the clinical tutor. Another facet of the placement was the design, set-up and delivery, of a student led exercise class in a residential hostel for homeless adults in the local area. Students also attended GP-led clinics for refugees in direct provision and a dedicated clinic for Roma people in an observational capacity.”***

This could be restructured to be clearer/easier to read - perhaps in a list format of the different activities which students were involved with. E.g. the clinical placement involved three different facets. Firstly... Secondly... Finally.

***“The main client group were homeless in-patients of St. James’s Hospital who were referred due***

***to diverse physical and mobility limitations”***

You've used 'inpatients' before not 'in-patients'; try to keep consistency and use either "inpatients" or "in-patients" but not both.

***“Students assessed and treated this group, facilitated by the clinical tutor”***

How long did each student spend in this activity?

***“Another facet of the placement was the design, set-up and delivery, of a student led exercise class in a residential hostel for homeless adults in the local area.”***

What assistance were students given in organising this? How many homeless people attended the event? Also, should be 'student-led' instead of 'student led'.

***“Students also attended GP-led clinics for refugees in direct provision and a dedicated clinic for Roma people in an observational capacity.”***

How many GP-led clinics did each student attend? And how many clinics for Roma people? Also, what do you mean by 'direct provision'? I think you mean they provided physiotherapy at the GP-led clinic for refugees. This could be rephrased to be clearer.

***“Strong communication skills, a flexible open approach, and the ability to cope with the potentially unpredictable nature of the placement at times are needed”***

How are you going to ensure students have this?

***“Due to the complexity of the area ensure there is sufficient support from senior clinicians/dedicated clinical education specialists”***

How are you going to ensure there is enough support from staff?

***“Plan in advance use a flexible approach”***

Do you need an 'and' in between these two pieces of advice?

***“This inclusion health placement demonstrated bi-directional positivity – of the students towards this placement and client group and of homeless clients towards meaningful engagement and cooperation with student physiotherapists”***

Can you evidence this for us? Do you have feedback from students and homeless people (either quantitative or qualitative) to suggest this?

***“Students reported this was a valuable learning opportunity”***

Again, please show feedback to evidence this.

***“We are planning to run this placement again in the next academic year 2019–2010 with an increased focus on other socially excluded groups such as refugees and travellers.”***

Any idea how you would like to carry this out? What do you hope including these additional inclusions health populations would add in value to the students' experience?

Curricular changes***Figure 1***

The boxes in your diagram should have a hyphen to say 'student-led' instead of 'student led'. Also, is the box at the top of the third column meant to say 'year 3' instead of 'year 2'?

***“In the academic year 2018–2019, we commenced with group-based student led presentations***

***on the topic of inclusion health, entitled “Inclusion health and physiotherapy in the homeless community”***

You should have a hyphen to say ‘student-led’ instead of ‘student led’?

***“Role of physiotherapy in people who are asylum seekers/refugees, including special considerations post torture”***

You should have a hyphen to say ‘post-torture’ instead of ‘post torture’.

***“Students were given the topic as well and signposted to key resource materials and subtopics to consider for inclusion in their presentations”***

Please rephrase for clarity.

***“In 2019–2020, the topic of inclusion health will be formally integrated into a pre-existing learning module (a specialist rehabilitation module, delivered in 3rd year) and to the curriculum document.”***

Should be ‘third year’ not ‘3rd year’.

***“In 2020–2021 an inter-professional learning activity, which is under development, will include 2–3 diverse allied health professional students and will complement the suite of learning activities.”***

Rephrase this for clarity. Also, it would be interesting to know if you have an idea of what this activity would involve, and which allied health professional groups you would want to collaborate with?

#### Conclusion

***“This letter describes a unique initiative to incorporating the topic of inclusion health in an undergraduate physiotherapy programme via development of a 4-week elective clinical placement and integration into the formal undergraduate curriculum.”***

Should be ‘four-week’ instead of ‘4-week’.

***“Delivery of a universal basic level of knowledge and formal integration of inclusion health into the undergraduate curriculum as described in this letter would ensure all students are exposed to this topic with the aim to equip all future graduates with the skills and knowledge base to work with this vulnerable and complex group to optimise health outcomes.”***

Needs rephrasing for clarity. Consider splitting this up into two separate sentences.

***“For deeper understanding a dedicated clinical practicum or clinical placement would be recommended.”***

Should be “For a deeper understanding”. Also, consider rephrasing the sentence from passive to active voice for a stronger concluding thought i.e. “we would recommend”.

***“Due to the nature of the area it would not be feasible to offer this opportunity to all students.”***

What do you mean by this? Why wouldn't it be feasible? This is a new statement and so best not introduced in the conclusion, which should just be a summary of everything discussed in the main body of the text with thoughts on what should happen next. The conclusion is not the right place to address feasibility concerns. I would either more directly address these before the conclusion in their own paragraph - with recommendations on how to address them - or eliminate this statement altogether. It takes away from the strength of your conclusion.

***“Notwithstanding this, a dedicated inclusion health placement is likely to engage students as agents of change in the health care delivery system who can be communication catalysts and agents of change for the future.”***

You have ‘agents of change’ twice in one sentence – remove one of these.

We hope these suggestions are useful and look forward to reading up the updated article.

Dr Luke Johnson and Ms Serena Luchenski, FFPH

**Is the rationale for the Open Letter provided in sufficient detail?**

Yes

**Does the article adequately reference differing views and opinions?**

Yes

**Are all factual statements correct, and are statements and arguments made adequately supported by citations?**

Partly

**Is the Open Letter written in accessible language?**

Partly

**Where applicable, are recommendations and next steps explained clearly for others to follow?**

Partly

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Medical Education, Inclusion Health, Public Health.

**We confirm that we have read this submission and believe that we have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however we have significant reservations, as outlined above.**

Reviewer Report 16 September 2019

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**Patrick O' Donnell** 

Graduate Entry Medical School, University of Limerick, Limerick, Ireland

This is a well written and timely description of a novel initiative developed to introduce trainee healthcare professionals to concepts and situations that are sometimes considered challenging. It highlights well the

Irish context and the gravity of problems we have where social exclusion and health care concerned.

Suggestions:

- Consider person-centred language throughout e.g. people who are homeless, people who are socially excluded <http://www.homelesshouston.org/homelessness-101-person-centered-language/>
- The line "Homeless and other socially excluded people represent a distinct and significant population" could be altered - this gives the impression they are quite a homogenous group when we know this is not the case.
- Consider referencing Allport's contact hypothesis when describing purposes of the placement <https://www.sciencedirect.com/topics/psychology/contact-hypothesis>.
- For Table 1 the 'key considerations' - it is unclear to me if these are your findings or if they have been gleaned from existing literature.
- Table 1 - the term 'peer placement' is confusing.
- Table 1 - in the 'reason' column, can these be referenced to add weight?
- Table 2 - very nice to include this.

**Is the rationale for the Open Letter provided in sufficient detail?**

Yes

**Does the article adequately reference differing views and opinions?**

Yes

**Are all factual statements correct, and are statements and arguments made adequately supported by citations?**

Yes

**Is the Open Letter written in accessible language?**

Yes

**Where applicable, are recommendations and next steps explained clearly for others to follow?**

Yes

**Competing Interests:** I have given some advice to medical trainees & students conducting research with Dr Cliona Ni Cheallaigh.

**Reviewer Expertise:** Primary care, inclusion health.

**I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.**

Author Response 25 Sep 2019



**Julie Broderick**, Trinity College Dublin, the University of Dublin, Dublin, Ireland

Dear Dr. O' Donnell,

We would like to thank you for your very insightful and valuable comments. We will certainly take those comments on board and very much appreciate your time in reviewing this article.

Kind Regards,

Julie Broderick and co-authors

***Competing Interests:*** Nil

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## Comments on this article

**Version 1**

Author Response 26 Feb 2020

**Julie Broderick**, Trinity College Dublin, the University of Dublin, Dublin, Ireland

The authors would like to express their gratitude to the reviewers for the time taken to review this Open Letter and for their extremely insightful comments. We have made amendments in response to comments and hope this has improved the quality of this submission.

***Competing Interests:*** Nil

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