Achieving Health Equity This Generation: The Case for Social Medicine Education

A Consensus Statement by the Social Medicine Consortium

There is extensive evidence that a patient's social context has a dramatic impact on health, yet integration of social medicine into clinical education is uncoordinated and inconsistent. An emphasis on basic science, pathophysiology and biomedicine overall, continues to be the crux of clinical training and practice. Ignoring the reality that the causes of illness and premature death are rooted in inequities: economic, educational, and power, is to perpetuate a system of care that is both unjust and ineffective.

Social medicine is the practice of understanding the social context in which our patients live, and working to remediate the impact of grossly unequal social context on the life and death of the poor and marginalized. Not to be confused with socialized medicine, a health policy that defined by centralized management of a health system by the state, social medicine involves improving the health of communities using a model to correct the inequities that cause poor health. Rudolph Virchow, an early scholar in the field of social medicine wrote, "physicians are the natural lawyers for the poor". We believe this imperative—that we must collect evidence and use it to advocate for justice—is tragically as true today as it was in Virchow's time. While in his time Virchow wrote of physicians we see this as the role of a constellation of care givers at the forefront of social medicine. We see this coalition of clinicians as the drivers of change.

At a time when zip code is far more influential than genetic code, most clinicians enter the workforce ill-equipped to promote structural change to improve patients' health that comes from applying critical lessons about the construction of their society. Many complete their training uninspired or uniformed to challenge the status quo despite being the natural advocates for health equity. As a result, our global communities don't reach their full potential and the poor continue to carry the greatest burden of disease and premature death.

We have an unprecedented opportunity to achieve global health equity in this generation, but it will not be possible without reimagining education for physicians, nurses and other essential clinicians.

Here are the actions that we can take now to realize global health equity through social medicine:

1. Restructure health professional curricula around the world to promote models that expand beyond singular biomedical explanatory models. We must promote models that are biological and psychosocial. We most expand understanding the context of health.

Why?

Despite broad and influential support for social medicine curricula, practice has not yet shifted from a traditional biomedical model. The WHO Commission on the Social Determinants of Health (WHO), the Lancet Commission on Health Professionals for a New Century (Frenk), and the Institute of Medicine report on a Framework for Educating Health Professionals to Address the Social Determinants of Health (IOM) all advocate for a social medicine approach to medical education. Despite this broad support from these and other well-respected entities, the traditional biomedical model remains the foundation of current medical education. Curricula are often based on curative disease treatment, under the assumption that behavioralism and individualism are the dominant determinants of health status rather than social factors and systemic forces. Social epidemiology and other research suggest that this is not the case, and education of health professionals must shift significantly to reflect these truths. Social medicine is considered a marginal abstract concept in relation to biomedical causation. In this way students don't feel implicated in solving social problems. Students may feel that social medicine is not within the scope of health professionals and is rather the job of social workers. Some faculty and students therefore may not

see the value in social medicine education since it may be implicating, while biomedicine creates formal distance between patients and providers, between causation of health and outcomes.

Action needed:

- Integrate social medicine principles longitudinally throughout the education of health professional students, including theory and practice through focused content and experiential learning.
- Restructure competency assessments, exams, and licensing processes to reflect the importance of social medicine knowledge and practice. (See Appendix A)

2. Transform cultural competency curricula into social medicine curricula that incorporates cultural humility.

Why?

Recent initiatives for health professional students to become culturally competent as the means to improve patient care may lead to inaccurate generalizations of patients based on their cultural, tribal, or ethnic background. This approach may oversimplify the social determinants of health and fail to recognize the structural forces that lie at the source of health disparities. In contrast, curricula guided by social medicine principles teach students to appreciate individuals living in societies, listen to deeper narratives of illness, explore psychosocial stressors, and identify what is uniquely at stake for each patient. Informed by principles of anthropology, these curricula teach students to recognize their position in a unique culture of biomedicine and the resulting interactions and conflicts with the values of their patients (Kleinman 2006).

Action needed:

Phase out the cultural competency framework and phase in the social medicine framework throughout clinical education and practice for health professional students.

3. Join the global health equity movement with the American health equity movement

Why?

The health equity movement in America has been traditionally isolated from the global health equity movement. Yet structural forces (prejudice including racism and sexism, and forms of economic and political inequity in power and priority setting) which create health inequity around the world are similar to the structural forces which create health inequity in America. Collaborating to develop a movement that realizes global health equity through social medicine, will be more effective in identifying, bringing attention to, and changing the true sources of health inequity with one unified global voice. We believe that the movement for health equity in America has much to gain through learning from past global successes, such as the movement for HIV/AIDS treatment access.

Action needed:

Connect healthcare providers globally who are committed to social medicine, creating a platform for multi-sectoral, interdisciplinary, and international collaboration towards health equity through education, research and advocacy campaigns that create strong relationships and effective ongoing communication. (See Appendix B)

4. Conduct research to affirm the transformative potential of social medicine education

Why?

Building on existing metrics, such as the social mission score (Mullan 2010), more research is needed to confirm the impact of social medicine education on clinical practice and the patient experience. This

additional data will amplify incentives for universities around the world to incorporate social medicine education and practice as a critical facet of evidenced-based education and care.

Action needed:
Develop research which applies social medicine curricula and evaluated educational and clinical outcomes.

5. Remove institutional barriers to teaching social medicine and to interdisciplinary and multi-sectoral collaboration, in order to facilitate effective social medicine learning and action towards equity

Why?
Institutions and organizational structures function in silos that infrequently engage in health professional training in social medicine. Barriers to teaching social medicine include separation of disciplines and fields of sciences. Training in medicine, nursing, pharmacy, social work, public health, and other health professional students, reflects inflexible structures. These in turn obstruct interdisciplinary learning, and interdisciplinary faculty trained in social medicine. They instead almost exclusively emphasize biomedical rather than social science research. . Neither protected time nor incentives are provided for busy practitioners interested in incorporating social medicine concepts into clinical teaching and practice, and this rewards system must change. Without effective role models to teach and practice social medicine, changing the status quo of health care globally is impossible.

Action needed:
Remove institutional barriers to teaching social medicine and interdisciplinary and multisectoral collaboration. Develop models for institutional investment in faculty to ensure interdisciplinary collaboration in health professionals' education and clinical practice.

6. Require structured opportunities for health profession students to work in partnership with patients, families, and communities

Why?
Academia does not reward or prioritize community engagement. Additionally, it is difficult for those passionate about social medicine to gain relevant experience and methods for practice. In order to be effective change agents and clinicians, health professionals must venture beyond the clinic, working in solidarity with their patients and the communities in which they live.

Action needed:
Implement mandatory longitudinal experiences, which span the educational spectrum for health professional students, wherein students interact deeply with patients and their communities and purposefully reflect on these experiences. (See Appendix C)

7. Demand a diverse student body and faculty, which are fundamental to health professional education and the practice of social medicine.

Why?
Health professional schools around the world overemphasize test scores and grades when selecting candidates, resulting in exclusion of underrepresented minorities and less privileged students. Diversity of socioeconomic status, experience, culture, ethnicity, and other qualities are critical to developing a culture of healthcare that is non exclusive and not homogenous in its values, priorities, and clinical practice.

Action needed:

Demand that institutions to diversify departmental leadership, faculty, and the student body, and meaningfully prioritize diversity and inclusion.

Appendix A: **Historical Perspective: Social Medicine in the 20th Century**

Appendix B: **The Social Medicine Consortium Founding Charter**

Appendix C: **Social Medicine Curricula Analysis**

Appendix A - Historical Perspective: Social Medicine in the 20th Century

Appendix B - The Social Medicine Consortium Founding Charter

Guiding Principles of the Social Medicine Consortium

The Social Medicine Consortium is a collective of committed individuals, universities and organizations fighting for health equity through education, training, service and advocacy, with social medicine at its core. Recognizing that the perspectives of many are systematically excluded from dialogue and decisions, and convinced that we are all more effective when a wide variety of voices are included, we actively seek diverse geographic, professional, racial, and class perspectives in our consortium.

The following definition of social medicine is rooted in our experience as practitioners and community members, as well as a deep historical context.

We define social medicine specifically as:

1. Understanding and applying the social determinants of health, social epidemiology, and social sciences approaches to patient care
2. An advocacy and equity agenda that treats health as a human right
3. An approach that is both interdisciplinary and multisectoral across the health system
4. Deep understanding of local and global contexts, ensuring that the local context informs and leads the global movement
5. The voice and vote of patients, families, and communities

Goals of the Social Medicine Consortium

We aim to drive a global transformation in health professional education that deepens engagement with social medicine as a core component of training so that health professionals emerge better prepared to partner with patients and communities, identify and respond to the social determinants of health, and advance health equity.

Functions of the Social Medicine Consortium

1. Education
Objective: Social medicine training is longitudinally integrated, rather than elective, in all health professional school curricula globally based on minimum standards
Actions:

- Define minimum standards for social medicine education and curricula
- Create practice of social medicine cases which will be used as open access education tools globally to teach social medicine concepts
- Create social medicine faculty development opportunities

2. Advocacy
Objective: Build the social medicine movement and foster ownership by local leaders and partners
Actions:

- Create a consensus statement defining key principles and paths forward for social medicine and lead a campaign encouraging health profession schools to endorse the statement
- Expand the number of institutional members of the Social Medicine Consortium

- Establish partnerships with key groups (e.g. LCME, deans of medical schools, local governments, student organizations, patients, community-based organizations, and civic society)

3. Research

Objective: Promote research to (a) inform the goals of the movement and (b) provide evidence of the importance of social medicine in education of health care professionals

Actions:

- Establish partnerships to define and implement a research strategy on social medicine education and health inequities
- Support leadership by social medicine faculty to lead research to define social medicine educational outcomes

Appendix C - Social Medicine Curricula Analysis

References

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