Teaching the Social Determinants of Health: A Path to Equity or a Road to Nowhere?

Malika Sharma, MD, MEd, Andrew D. Pinto, MD, MSc, and Arno K. Kumagai, MD

Abstract

Medical schools are increasingly called to include social responsibility in their mandates. As such, they are focusing their attention on the social determinants of health (SDOH) as key drivers in the health of the patients and communities they serve. However, underlying this emphasis on SDOH is the assumption that teaching medical students *about* SDOH will lead future physicians to take *action* to help achieve health equity. There is little evidence to support this belief. In many ways, the current approach to SDOH within medical education positions the SDOH as "facts to be known" rather than as "conditions to be challenged and changed." Educators talk about poverty but not oppression, race but not racism, sex but not sexism, and homosexuality but not homophobia. The current approach to SDOH may constrain or even incapacitate the ability of medical education to achieve the very goals it lauds, and in fact perpetuate inequity. In this article, the authors explore how "critical consciousness" and a recentering of the SDOH around justice and inequity can be used to deepen our collective understanding of power, privilege, and the inequities embedded in social relationships in order to foster an active commitment to social justice among medical trainees. Rather than calling for minor curricular modifications, the authors argue that major structural and cultural transformations within medical education need to occur to make educational institutions truly socially responsible.

Year after year, black mothers bury sons who die in police custody, young undocumented women develop preventable invasive cervical cancer, and blue-collar workers struggle to return to work after premature heart attacks. Health care providers find themselves asking, Why are homicide rates, incidence of heart disease, and cancer deaths spread unevenly across our populations? Why do some people with diabetes have their disease under control while others progress toward lower limb amputation, cardiovascular events, or recurrent hypoglycemia?[1] How does poverty impact an individual's experience of the health care system?[2] Health care providers and their institutions are increasingly using the concept of *social determinants of health* (SDOH) as a means of answering these individual- and population-level questions.[3]

The ostensible goal of education on the SDOH is to understand factors leading to the development and perpetuation of inequities in health care and ultimately to improve health outcomes and reduce health disparities.[4–6] Implicit in this goal is the belief that teaching medical students about the SDOH will lead future physicians to take action to help achieve health equity. Yet, there is little evidence to support this assumption. In fact, the current SDOH approach constrains the ability of medical educators to achieve the very goals they espouse. What is worse, this approach—which emphasizes knowing *about* rather than knowing *how*—perpetuates inequity by maintaining the status quo and curtailing the ability of medical professionals to engage in transformative social change.

M. Sharma is an infectious diseases physician and Canadian Institutes of Health Research (CIHR) Canadian HIV Trials Network (CTN)/Canadian Foundation for AIDS Research (CANFAR) postdoctoral fellow, St. Michael's Hospital, University of Toronto, Toronto, Ontario, Canada.

A.D. Pinto is a family physician and public health specialist, Department of Family and Community Medicine, St. Michael's Hospital, assistant professor, Department of Family and Community Medicine, Faculty of Medicine and Dalla Lana School of Public Health, University of Toronto, clinician–scientist, Centre for Urban Health Solutions, Li Ka Shing Knowledge Institute, St. Michael's Hospital, and director, The Upstream Lab, Toronto, Ontario, Canada.

A.K. Kumagai is endocrinologist, professor, and vice chair of education, Department of Medicine, University of Toronto, and F.M. Hill Chair in Humanism Education, Women's College Hospital, University of Toronto, Toronto, Ontario, Canada.

Correspondence should be addressed to Malika Sharma, Maple Leaf Medical Clinic, 14 College St., Suite 501, Toronto, ON, M5G 1K2; telephone: (416) 465-0756 ext. 3; e-mail: malika.sharma@mail.utoronto.ca.

Acad Med. XXXX;XX:00–00.
First published online
doi: 10.1097/ACM.0000000000001689

Understanding the SDOH

The SDOH are defined by the World Health Organization as the conditions in and under which people are born, grow, work, and live, and the broader set of forces and systems that shape the conditions of daily life.[7] These forces can include political and economic policies and systems, social policies and norms, and societal institutions. On an individual level, SDOH such as housing, employment status, and working conditions impact people's daily lives, determining their risk of illness and ability to access preventive and curative health care measures. At a collective or societal level, inequities between groups of people shape how society is organized, often into hierarchies based on factors such as income, gender, and race. Where people are in a social hierarchy ultimately affects their health.[8]

SDOH in Medical Education

A key challenge in understanding how the SDOH are taught in medical schools is locating the SDOH in the medical curriculum. Some curricula deal only with specific SDOH, such as homelessness, poverty, or race, and do not use the larger umbrella term.[9–13] Varied terms such as population health, community-based care, service–learning, marginalization and vulnerability, social justice, and advocacy are all used to describe

curricula pertaining to the SDOH.[14–21] Curricular interventions range from single didactic lessons to service–learning opportunities.[22–28] Several newer initiatives outline multipronged approaches that include didactic training, mentorship, collaborative longitudinal service and advocacy projects with community partners, career seminars, and research.[6,20,29]

Educators are clearly interested in incorporating the SDOH into the curriculum. However, there is little evidence that teaching the SDOH—even as broadly captured by the various terms and pedagogical approaches above—does anything to alleviate inequity. Most of the literature to date focuses primarily on curricular implementation rather than evaluation.[17,24] Several studies have demonstrated increased awareness of and reflexivity around the SDOH among students, but whether this impacts patients in tangible ways is unknown.[27,28,30,31] Other studies have consisted of pre–post evaluations focusing on student self-assessment or confidence, which have been criticized as unreliable measures of skill,[22,32–34] while still others emphasized participation and satisfaction but failed to prove changes in student behavior.[23]

In contrast, some groups have attempted to assess patient-related outcomes after implementation of SDOH-related curricula. Klein and colleagues[4] evaluated the impact of a video-based SDOH curriculum for postgraduate pediatric trainees, noting that trainees increased their screening for domestic violence and depression and distributed more baby formula to food-insecure families. Their evaluation of a multimodality SDOH curriculum, however, demonstrated no differences in screening or referral rates, possibly due to the small number of subjects.[5] A systematic review of service–learning and community-based education found that although educators felt that educational models were useful to teach complex ideas like the SDOH, there was considerable heterogeneity across projects, and most did not involve community members in identifying local health priorities.[18]

SDOH Education in Its Current Form Does Not Reduce Health Inequities

Although most educators may accept that social factors are key determinants of health outcomes, most SDOH approaches place far less emphasis on the fact that it is the *unequal distribution* of money, power, and resources at global, national, and local levels that results in health disparities. Instead, the SDOH are more often presented as a "laundry list," including income, education, food insecurity, disability, and the like.[35] Importantly, there are two tacit assumptions behind such educational efforts: first, that the SDOH are somehow "natural"—that is, not due to human-made societal systems of power and privilege that give rise to inequities but, rather, to immutable facts of nature.[36] Second is the assumption that teaching about the SDOH will somehow result in action to alleviate these inequities.

For trainees, learning about the SDOH as a content area, or *something we should be aware of*, sends a very specific message. Awareness is not the same as action. When trainees are taught about the SDOH they are also taught (perhaps inadvertently) that *knowing about* is by itself a sufficient educational goal and is more important than *doing something about*. When actions are addressed, there is more focus on individual actions by health providers rather than on systems-level or societal change. For example, a textual analysis of how the role of "health advocate" is described in the CanMEDs medical education frameworks demonstrated a shift away from concrete actions or behaviors, and away from collective systems-level action to individual behavior-focused intervention.[37] Thus, trainees are led to believe that the conditions, circumstances, and processes that comprise the social determinants are somebody else's problem to solve (if they are indeed solvable at all). This is a powerful message about what our role as physicians entails and where our priorities should and should not lie. A focus on the SDOH as a content area, rather than as an actionable item with attendant skills, means that trainees are underequipped to address the social determinants for their patients, to institute organizational change that addresses SDOH, or to take social or political action to help achieve equity and eliminate disparities.[38–40]

It is also essential to understand how equity can be undermined (or inequity perpetuated) in medical training. For instance, Masson and Lester[41] have demonstrated that as students progressed through their training, their attitudes toward homeless people became increasingly negative. Trainees were keenly attuned to the ways in which senior staff suggested that homeless people were "less worthy of medical care than other patients."[41(p870)] Such attitudes toward homeless people are a major barrier in access to care.[42] Any educational program on the impact of race on health is similarly undermined when students are faced with racist jokes or comments made by senior staff members.[43] A recent report highlighted the negative impacts of racism *enacted by health care providers* on access to health care for Canada's Indigenous peoples.[44] These lessons, taught to trainees in hallways and on the wards, are examples of how the hidden curriculum can either amplify or undercut what we purport to teach in our classrooms.[45] When the hidden curriculum is addressed, it is often at the level of individual and interpersonal action and interaction rather than at the organizational, systemic, and sociopolitical levels required to make real change.[46] Similarly, training practitioners to address the SDOH can at most lessen the impact of the SDOH on the homeless and other marginalized communities, but broader social change is essential to truly achieving equity.[38] A first step to participating in social change is the recognition that such change needs to occur at all.

For educators, this content-rich, action-poor approach to the SDOH has implications. If this approach is *assumed* to impact equity, educators are not forced to ensure that this goal is achieved. One can check the right boxes, confirm that the SDOH were covered in the curriculum, and be done with it. This argument could be made for many areas in health professions education, where patient-level impact is difficult to "prove" and likely unattainable.[47] However, our current educational model around the SDOH likely perpetuates, rather than alleviates, inequity. Current

medical training enables students to identify the effect of the SDOH on a particular patient in a particular clinical encounter but does not equip them with the skills to understand and *change* the broader structural contexts in which that encounter takes place.[48] Teaching students to be aware of the SDOH, without teaching them to question the "naturalness" of these SDOH, upholds the status quo and requires no meaningful challenge to one's own privilege. A discussion of the SDOH that fails to examine power and privilege therefore does nothing to help trainees "stretch beyond simply thinking about ourselves and events in order to solve problems and do better the next time."[49(p148)] A focus on the SDOH as content area rather than equity-focused skill set creates very limited space in the curriculum for educators who participate in activism and equity work to discuss their work in respected and legitimized ways.[40,50] Yet, engaging with the SDOH critically means educators must also understand their own internal conflicts and how they benefit from current SDOH discourse.[51] Notions of social responsibility may inspire educators to undertake the potentially painful work of acknowledging how they themselves may benefit from the status quo, but are likely insufficient to prompt such change at a systemic and sustainable level.

Social accountability demands that medical institutions must be held accountable to society to ensure that societal needs are being met through research, education, and service provision.[52–54] Being able to identify specific and discrete areas in the curriculum where SDOH are addressed means that institutions can herald their social accountability without having to get "too political."[55] The emphasis can be placed squarely on health rather than on areas of broader social policy like taxation, housing, education, or food security. Of course, a redistribution of funding to these broader social services may come at the expense of health care funding, in which medical practitioners and institutions have a vested interest. A relatively apolitical implementation of SDOH curricula thus means relatively little challenge to the social positions of those in power in these medical institutions and in society. As a profession, we can get away with talking about the SDOH in a way that is devoid of power and discussions of redistribution. We can talk about poverty but not oppression, race but not racism, sex but not sexism, and homosexuality but not homophobia. Undoubtedly, there are major barriers at the individual and institutional levels to engaging in this kind of critical and redistributive work, a critically important topic that is beyond the scope of this article.

In this context, patients become uniquely trapped by the SDOH "laundry list" paradigm. They ride an odd teeter-totter between individual choice and responsibility for their own health (through "bad choices" and "lifestyle decisions") and immutable social determinants over which they have no agency or control.[56] If trainees are taught actionable interventions at all, they often focus on lifestyle modification rather than policy-based prevention.[57] This emphasis creates a "blame game" and precludes the potential for solidarity between patient and provider. At the community level, if trainees are taught that SDOH are immutable facts rather than dynamic issues requiring action, their participation in community or grassroots movements can only be minimal. Physicians may be seen as upholders of the status quo rather than as allies in social struggle. This divide is at odds with evidence supporting the powerful role that physicians can play as allies and effective advocates.[58,59]

Teaching to Reduce Inequity: Ways Forward

Medical education *can* play a role in addressing health inequities by addressing the structural role that medical schools play in maintaining societal inequities, and by providing trainees with the knowledge and skills to work toward social change.[60] Some educators have suggested that SDOH-related training be experiential, with seamless integration of SDOH as a content area and advocacy (as a skill or action).[26,29,38,61,62] Rather than simply doing better, we suggest that what is needed is doing something altogether different—a transformational reorientation of medical education, with critical reflection on its overall purpose and ethos. Kumagai and Lypson[63(p782)] call this reorientation "critical consciousness—which places medicine in a social, cultural, and historical context and is coupled with a recognition of societal problems and a search for appropriate solutions." Critical consciousness involves reflecting on power, privilege, and the inequities embedded in social relationships, with an active commitment to social justice. If the SDOH are human-made, then they can also be dismantled through human efforts. Such transformational learning must infuse all elements of the curriculum. Kumagai and Lypson describe the use of small-group settings and theater to explore ideas of moral action, the explicit inclusion of current social and political phenomena into educational spaces, and extensive faculty development to help students navigate the "cognitive disequilibrium" that can result from a recognition of one's complicity in injustice. Wear and colleagues[64] describe a "curriculum for social justice" in the wake of Freddie Gray's death, drawing on notions of structural competency and antiracist pedagogy, which involves critical reflection and action on oppressive power relations. They outline elements of and resources for such a curriculum, including literature and texts such as Ta-Nehisi Coates's *Between the World and Me*, a book-length letter from father to son on being black in America. They describe the use of film; bioethical inquiry; and thoughtful, contextualized experiential learning opportunities. As educators, such transformative pedagogy involves a reorientation of our own practice—an acknowledgment that it is part of our job to support skill building for trainees to *intervene* on the SDOH, which are anything but "natural."

Perhaps another way of thinking about this reorientation is that for the SDOH to be made tangible and actionable, students must be taught not just *what* they are but also *how* they came to be; *who* benefits and *who* suffers; and *what* can be done about them, *how*, and *by whom*. One way of making the (in)equity explicit is by talking about the social determinants of equity (SDOE) rather than the SDOH.[8] This approach emphasizes the unequal distribution of the SDOH across society. The SDOH, then, are "shaped by historical injustices and by contemporary structural factors that perpetuate the historical injustices. The SDOE are the factors that determine

the range of contexts observed in a given place and time, and the distribution of different populations into those different contexts."[8(p2)] Placing social justice and injustice at the center of this framework can allow for a more critical, action-oriented reading of these social contexts.

Were medical training to be reoriented in these ways, the student experience would be fascinatingly different. Equity in admissions may include mentoring of children and young students, waiving application fees, and considering "multiple kinds of excellence" in the admissions process.[60] During their training, students would be expected to reflect on their own privilege, understand how they benefit from societal structures, and work toward systemic change. Students may experience *cognitive disequilibrium*, when students encounter unfamiliar ideas and are made to turn "a critical gaze on one's own values, assumptions, experiences, and opinions and questioning the moral validity of the state of affairs in the world."[63(p786)] Students would be expected to work toward developing skills and tools to address health inequities that are rooted in injustices rather than just acquiring abstract knowledge. They would come away from medical training with a different understanding of professional identity. They might see knowing how to challenge inequity at individual, organizational, community, and societal levels as part of the job, just like making the right diagnosis, ordering the right tests, and documenting allergies. This orientation becomes part of the development of what Metzl has called "structural competency" with which physicians consider the "structural vulnerabilities" of patients to meaningfully address issues of disparity and injustice.[48,65] Such competencies include not only identifying the societal and institutional structures that shape clinical interactions and outcomes but also recognizing that what are often deemed "cultural differences" are in fact structural inequities. The notion of structural competency is a pragmatic one, demanding that students develop a language to talk about structural issues and imagine structural interventions to impact the health of patients and communities.

For educators, a reorientation of SDOH training could be personally and professionally transformative. Rather than being evaluated on whether they "covered the (SDOH-related) material," they would be questioned as to *how* they covered it and whether they covered it *continuously*. For some educators, such a reorientation might free them to make connections to broader social issues and fear less political repercussion for addressing or naming issues of power. Educators would also be asked to be reflexive of their own privilege. Boler[66(p96)] describes a *pedagogy of discomfort* whereby both teachers and students "may begin to realize, undoubtedly with some discomfort, that they have great incentives to remain privileged, that their world view is based on their social status and medical training, and that the way they explain poverty … is based on selective sight arising from social status." For both trainees and students, such reflection may inspire more vocal and explicit advocacy.[67]

Concluding Remarks

Tackling the SDOH in this way, or reframing them entirely as SDOE, would involve a major reorientation to curriculum to be truly meaningful in addressing equity.[8,63,68] The SDOE would need to be integrated throughout training, but even this would be insufficient to create "critically conscious" physicians or to make much progress to achieve equity for patients. In an emancipatory educational framework, "it becomes absurd to teach social justice as a subject matter, a skill set or knowledge base; rather, by teaching all relevant subjects, including social issues, in a new way, social justice becomes an integral part of the process of education itself."[21(p248)]

With this understanding comes major implications for medical education institutions and health care institutions. No longer are they able to meet their social accountability mandates without "getting political" and delving into the complex and messy areas of bigotry and discrimination, fiscal policy, food insecurity, inequities in education, taxation, and housing. Health equity and social change become inextricably bound, and achieving the former is understood to be impossible without affecting the latter. The educational mandate of training institutions also shifts, from developing competent and socially accountable physicians to training "doctor–citizens" who are engaged in the work toward social justice.[21,69]

Finally, a transformational restructuring of medical curricula has implications for patients and communities. It is difficult to say whether curricular change can contribute to the large-scale social change that is required to achieve health equity. However, restructuring medical education to train critically conscious, engaged physician–citizens could change the physician–patient and physician–society dynamic in meaningful ways. The power differential between physicians and patients will not disappear, but it may be acknowledged and mitigated. Patients may experience less stigma, blame, and discrimination in the health care system. There may be more opportunities for patients and physicians to see themselves in solidarity with one another, working toward similar goals. A social justice orientation for medical education can position physicians as allies or partners in social movements. As physician–citizens, we would fail to uphold our professional responsibilities if we did not respond in some way. Given the tremendous social and health inequities in societies, both domestic and global, physicians would learn to act as agents of moral change rather than as upholders of the status quo. As educators, it is time for us to question and change the assumptions and learned helplessness underlying the SDOH educational status quo as well.

Acknowledgments: The authors wish to thank Drs. Ayelet Kuper and Cynthia Whitehead for invaluable discussions.

Funding/Support: M. Sharma's work was supported by the Clinician Educator Training Program through the Department of Medicine at the University of Toronto. A.D. Pinto is supported by the Department of Family and Community Medicine, St. Michael's Hospital and Li Ka Shing Knowledge Institute, St. Michael's Hospital, and the Department of Family and Community Medicine, Faculty of Medicine and Dalla Lana School of Public Health, University of Toronto. A.K. Kumagai is supported by an endowment from the F.M. Hill Foundation of Women's College Hospital.

Other disclosures: None reported.

Ethical approval: Reported as not applicable.

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