Social Determinants of Health. Should Doctors Get Involved?

Determinantes sociales de la salud. ¿Los médicos deberían implicarse?

"Medicine is a social science, and politics is nothing else but medicine on a large scale."

Rudolph Virchow (1848)

INTRODUCTION

Think of a doctor who is practicing in a primary care center in one of the many "slums" of the capital city or the suburbs; we see him overwhelmed by the number of patients he has to see and we also feel him overwhelmed not only by the number, but mainly by not being able to solve the determining problems —many of them social issues— that brought these patients to consultation, associated with food, housing, unemployment and others. He knows that the situation will be repeated despite his medical care; he knows it, feels frustrated about it, and this leads to *burnout* (a term that has been used for 44 years).

The clinician who coined the term *burnout* was neither a primary care physician buried under paperwork nor an emergency physician beset by an unwieldy electronic health record. It was Herbert Freudenberger, a psychologist who worked at a free clinic in 1974. Discussing the risk factors for burnout, he wrote about the characteristics of the health care worker (e.g., "that individual who has a need to give") and about the monotony of a job once it becomes a routine. He also pointed to workers in specific settings —"those of us who work in free clinics, therapeutic communities, hot lines, crisis intervention centers, women's clinics, gay centers, runaway houses"— drawing a connection between *burnout* and the experience of caring for marginalized patients. (1)

The same happens to cardiologists working in the public health system, when their patients and they themselves are subjected to intentional bureaucratic paperwork to obtain basic medical benefits, which are unnecessarily delayed.

This fundamental source of *burnout* in health care professionals at all levels has been neglected in recent times.

Clinicians, isolated in their offices, will feel powerless to face the poverty and oppression suffered by their patients, which is a recipe for disappointment because they can only solve the immediate condition, relegating the underlying cause of their problems.

Because "If individual powerlessness is the crux of this source of burnout, then organizing toward collective action should be part of the solution. Each of us can advocate for our homeless patients to be put on waiting lists for public housing. But what would happen if all doctors with homeless patients organized to demand more affordable housing?

Organizing is both strategic and therapeutic — strategic because our collective labor and voice are greater than the sum of their parts; therapeutic in the sense that the activist Grace Lee Boggs articulated: "Building community is to the collective as spiritual practice is to the individual." When we recognize ourselves not as individual actors, each isolated in an examining room, but as a collective joined in a common cause, we start to feel less alone. Beyond whether we must or should do it for our patients, collective advocacy to address the harmful social determinants of health can buoy physicians' morale and thus be an act of self-care; organizing toward collective action means looking after both our patients and ourselves." (1)

As the fourth-year student Leo Eisenstein concludes: "Medical students are trained to think from a vantage point of individual agency, and we become stuck there: "What can I do?" It begins as an earnest, ambitious question, but it so often spoils to a cynical one. If medical schools and residency programs are serious about burnout, they have to teach us about collective action — teach us to ask, "What can we do?" To fight burnout, we should never worry alone about the social determinants of health that patients face. To fight burnout, organize." (1)

MORAL CHOICES

"In the past, an exploration of moral choices might have stopped with these two levels: personal honesty and proper organizational citizenship. But times have changed and the stakes are higher

For example, the drugs patients depend on are experiencing price increases that cannot withstand the scrutiny of public interest or moral compass. New biologics of undeniable value are being priced at levels that are not just like extortion—they *are* extortion, holding patients hostage. Old, invaluable preparations, like insulin, epinephrine, 17-hydroxyprogesterone, colchicine, and others, are being captured or patented under legal loopholes and then priced 10-fold, 30-fold, 100-fold more than their prior, customary levels." (2)

Therefore, the American physician DM Berwick, in his article *Moral Choices for Today's Physician* quoted above, analyzes what the health problems in his country are, and argues that: "If taking the life-years and self-respect of millions of youth (with black

individuals being imprisoned at more than five times the rate of whites), leaving them without choice, freedom, or the hope of growth is not a health problem, then what is?

Second, the harm done to our planet by inattention to and denial of the facts of science is grievous too. If poisoning the air, drying up the rivers, and drowning the cities—our own, and those of the poorest people on earth, and creating a tsunami of displaced people greater than the world has ever known before, is not a health problem, then what is?

Healers cannot deny that leaving refugees at our gates unwanted, or children unfed, or families unhoused, or basic medical care uncovered, or relying on conflict, rather than compassion, are health problems. So is war. So is ignorance. So is hopelessness. So is blaming the blameless."

And Berwick shakes our consciousness when he expresses: "The work of a physician as healer cannot stop at the door of an office, the threshold of an operating room, or the front gate of a hospital.

Professional silence in the face of social injustice is wrong.

[…] To try to avoid the political fray through silence is impossible, because silence is now political. Either engage, or assist the harm. There is no third choice." (2)

In view of this, the question of Gruen et al. (3) arises: what are the public roles and professional obligations of the "physicians-citizens". They respond themselves that for centuries, physicians have been involved in solving health problems in the community. Public roles, however, have become less familiar to physicians because the medical profession has forged its expertise, identity, and influence on remarkable advances in biotechnology, and it is no longer usual for them to approach community prevention issues and accept responsibilities outside regular practice settings.

"[…] But all physicians have a primary ethical and professional responsibility for the health of the community members they serve…"

Physicians are public "witnesses" to socioeconomic determinants of their own patients' health.

"Physicians and the public are likely to agree that physician expertise includes not only the biological aspects of disease but also its social, environmental, and economic relations."

"[…] although individual action is laudable, collective action is a hallmark of professionalism. Physician groups have been particularly effective agents of change in institutional issues, local community matters, legislative action, and much broader issues, such as civil and human rights, prevention of nuclear war, and the banning of land mines…"

"[…] Because patients and physicians are likely to benefit, public roles should not be considered as being antagonistic to individual patient care, and they do not mean acquiescing to the demands of managers and bureaucrats. Public roles are an example of the profession taking charge of its domain -promoting the health of its patients despite the adverse effects that broader social forces, including health and social policy changes, may have on patient care." (3)

WHAT DO PHYSICIANS THINK?

The same group of Gruen et al. conducted a survey in the U.S. on the practice of physicians' attitudes and on the degree of participation in public roles, defined as community participation, political involvement, and collective advocacy. (4)

It was a survey conducted between November 2003 and June 2004 of 1,662 US physicians engaged in direct patient care, selected from primary care specialties (family practice, internal medicine, pediatrics) and 3 non–primary care specialties (anesthesiology, general surgery and cardiology).

Surprisingly, and despite being just a statement, the results showed that the overwhelming majority (90%) rated community participation, political involvement, and collective advocacy as important, and a majority rated community participation and collective advocacy as very important.

However, when problems were quantified by their degree of importance, those problems closest to the patient -such as obesity and insufficient nutrition, immunization, substance abuse and road safety- were rated as very important by more physicians, and higher than access-to-care issues (about half); even less consideration was given to illiteracy or air pollution and unemployment with only 26%.

It is surprising that, in terms of actions taken, two thirds of respondents had participated in at least 1 of the 3 types of activities in the previous 3 years.

Combining the 3 rated items of public roles (community participation, political involvement, and collective advocacy) with a 4-point scale (1, not at all important; 2, not very important; 3, somewhat important; and 4, very important), the total score would range from a minimum of 3 points to a maximum of 12 points. Physicians were defined as having "*civic mindedness*" if they had 10 or more points.

In logistic regression analysis, being of an underrepresented race/ethnicity, graduating from a non-US or non-Canadian medical school, being a woman, and higher professional seniority were significantly related to civic-mindedness.

In their activity in public roles, half of U.S. physicians (54.2%) reported contributing with the l*ocal community* (and its organizations), and more than 1 out of 4 respondents were considered politically active (25.6%) and declared encouraging professional societies (24.3%).

In their article, they conclude that: "Public roles are definable entities that have widespread support among physicians. Civic-mindedness is associated primarily with sociodemographic factors, but civic action is associated with defined specialty and practice-based factors." (4)

CONCLUSIONS

"10 years after the Commission on Social Determinants of Health (CSDH): social injustice is still killing

on a grand scale." This is the title of a comment in Lancet by a member of UNICEF and the Commission. (5)

Kumanan Rasanathan, author of this comment, writes: "[...] although a number of countries actively engaged with the CSDH's ideas and gave policy consideration to social determinants, a revival of austerity policies harmed health and health equity, with stagnating life expectancy and widening mortality gaps in some countries…"

And Rasanathan skeptically expresses that "Research funding on social determinants, even in countries that generated the seminal studies, remains pitiful. It seems hard to argue that the CSDH's report had much impact on the global development agenda…

[...] However, the relationship of universal health coverage (UHC) efforts to social determinants and improving equity is not clear-cut. The CSDH's insights on the importance of going beyond the health sector are absent from too many UHC discussions." (5)

Some years before, he had said that: "Health services that do not consciously address social determinants exacerbate health inequities. If a revitalized primary health care is to be the key approach to organize society to minimize health inequities, action on social determinants has to be a major constituent strategy."

This strategy is reconfirmed by the 8th Global Conference on Health Promotion in Helsinki, Finland (2013), co-hosted by the World Health Organization (WHO) and by the Ministry of Social Affairs and Health of Finland.

"We, the participants of this conference:

Affirm our commitment to equity in health and recognize that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. We recognize that governments have a responsibility for the health of their people and that equity in health is an expression of social justice. We know that good health enhances quality of life, increases capacity for learning, strengthens families and communities and improves workforce productivity. Likewise, action aimed at promoting equity significantly contributes to health, poverty reduction, social inclusion and security."

The conference concludes with this statement: "Policies designed to enable people to lead healthy lives face opposition from many sides. Often they are challenged by the interests of powerful economic forces that resist regulation. Business interests and market power can affect the ability of governments and health systems to promote and protect health and respond to health needs. *Health in All Policies* is a practical response to these challenges." (7)

If we are convinced that social determinants contribute to half of premature mortality, and that unhealthy behaviors reach 80%, and only 20% depend on direct health care, as a survey of all U.S. counties (8) revealed, we should answer the question of the title "Should doctors get involved?"

The physician who once thought that his individual action alone was enough and that he even felt like a hero at times, now feels he has no power at all. Eventually, a physician will encounter patients whose health problems have a core of poverty and marginalization extending for more than a generation, and even the most expert and astute physicians are overwhelmed and powerless to solve their patients' health problems.

So the question is not whether we should get involved, because we are already involved. Because we are "public witnesses" to the circumstances of our patients' lives and —whether we like it or not— our actions will always influence them, both when they are positive as when they are negative.

In this scenario, getting together with others and organizing into collective groups helps physicians build solidarity with their patients and with themselves, taking action to face circumstances that previously seemed overwhelming and impossible to address alone.

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