Achieving Health Equity This Generation: The Case for Social Medicine
A Consensus Statement by the Social Medicine Consortium

Why Raise Our Voices?

We have participated in and been complicit with broken health systems whose principles and systems don’t lead to healthier communities.

We have heard the voices of patients throughout the world whose tragic stories of sickness plead for more just, equitable health systems and care.

We have witnessed politics that tolerate xenophobia, racism, sexism, and unregulated capitalism without any accountability.

We have observed economic and social systems that routinely fail to affirm the dignity of all humans and ignore the tremendous assets of all communities.

We have trained in educational systems that acknowledge very little or none of this.

We refuse to stand by and let this happen.

Social Medicine is our response.

What Change Do We Seek?

Social and economic inequities are a root cause of health disparities throughout the world. These inequities drive morbidity and mortality in tragically predictable ways that preferentially afflict the poor and marginalized. They are perpetuated by factors including racism, sexism, economic policy prioritizing productivity and profit, and disregard for historical injustices. We can and must take action to address these root causes of ill health that we as a society have created and sustained.

Social medicine is the practice of seeking to understand the social context of patients and communities and working to remediate the impact of these grossly unequal contexts on
the life and death of the poor and marginalized. Not to be confused with socialized medicine, a political policy that involves centralized management of a health system by the state, social medicine aspires to ensure health by drawing on social analysis and community strengths to change the structural forces that determine health disparities.

The term social medicine has a historical legacy. Its principles align with our aspirations for significant societal change. We acknowledge that the social sciences and the humanities, public health, community activists, and all health professions have a great deal to teach each other about understanding social context and achieving health equity. We aim to build interdisciplinary, inter-professional and inter-community collaborations that deliberately welcome the voices of those often excluded from health equity conversations.

Despite extensive evidence that health is inextricably linked to the social context of patients and communities, integration of social medicine into health professional education has been scattered and inconsistent. Biomedicine, narrowly focused on basic science and pathophysiology, continues to be the crux of health professional education and practice. We are trained to ignore the reality that illness and premature death are heavily rooted in economic, educational, racial, and power inequities. In this way our educational systems are both dishonest and unjust.

While postal code is far more influential than genetic code in defining health, many health professionals enter the workforce unequipped to apply critical lessons about the construction of society or support structural change to promote patients’ health. Many of us complete training uninspired and unprepared to challenge the status quo despite being natural advocates for health equity. Biopsychosocial models now included in clinical training have expanded the pedagogical boundaries beyond pathophysiology. Yet the inclusion of social and psychological factors in training does not equip future health professionals with the resilience, attitudes, and tools necessary to promote sustained equity and challenge structural violence. As a result, many health professionals graduate unable to fulfill their commitment to promote health and well-being.

Today, we believe we have both the political urgency and an unprecedented opportunity to achieve global health equity in this generation, but it requires actively reimagining health professional education.

**How Will We Achieve Our Vision?**

The Social Medicine Consortium is committed to transforming health professional education to support the realization of global health equity through the following actions:

1. **Restructure health professional curricula around the world to incorporate social medicine as a fundamental component of training.**

   **Why?**

   Social medicine offers a prescription for the transformation of health professional training. Social medicine has been endorsed by The WHO Commission on the Social Determinants of Health⁴, the Lancet Commission on Health Professionals for a New Century⁵, and the Institute of Medicine report on a Framework for Educating Health Professionals to Address the Social Determinants of Health⁶ to address the shortcomings of current pedagogy. Despite broad support for social medicine from these well-respected entities and others, many faculty and students do not see the value in social medicine education. The traditional biomedical model is the foundation of much health professional education, and in particular medical education. Therefore, curricula are often based on curative disease treatment, under the assumption that that individual patient behavior and compliance are the dominant determinants of health status, ignoring 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. Because social understandings of health and disease, if covered at all, are taught on the margins relative to biomedical paradigms, students don’t feel empowered to address or solve social problems. Students may feel that social medicine is not within the scope of the health professions and is rather the job of social workers, community health workers and other non-clinical participants in care.

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Action needed:
Integrate social medicine principles longitudinally throughout the education of health professional students, including both content-focused knowledge acquisition, and experiential learning. Restructure competency assessments, exams, and licensing processes to reflect the critical role of social medicine knowledge and practice. Numerous programs throughout the world, some affiliated with the Social Medicine Consortium, offer concrete models for creating such learning opportunities. Appendix B presents a small subset of such programs with which the Social Medicine Consortium is most closely affiliated that were analyzed for their content, structure, and audience.

2. Transform cultural competency and cultural humility curricula into social medicine curricula.

Why?
Ironically the push for health professional students to become culturally competent as the means to improve patient care leads to inaccurate generalizations of patients based on their cultural, tribal, or ethnic background. This approach oversimplifies the social determinants of health and fails 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 complex societies, listen to deeper narratives of illness, explore psychosocial stressors, and identify what is uniquely at stake for each patient. Informed by the disciplines of anthropology and sociology, these curricula teach students to both reflect upon their own social location and work to deepen understandings of patient context. They also teach students about structural analysis which leads to upstream action for advocacy and systems level change.

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

3. 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.

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

**Why?**
Building on existing metrics, such as the social mission score\(^7\), 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 that interrogates social medicine curricula and evaluates educational and clinical outcomes, which occur as a result of this frame shift in education.

5. **Remove institutional barriers that prevent interdisciplinary, interprofessional, and multisectoral collaboration, in order to facilitate effective social medicine education and action.**

**Why?**
Institutions and departments infrequently engage in the training of health professionals in social medicine. Barriers to teaching social medicine include separation of medicine, nursing, pharmacy, social work, public health, and other health professional students, inflexible administrative structures that prevent interdisciplinary and interprofessional classrooms, a lack of interdisciplinary faculty trained in social medicine, and an overemphasis on biomedical research in academic institutions relative to the social

sciences. Rarely are time or incentives provided for busy practitioners interested in incorporating social medicine concepts into clinical teaching and practice. This 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:**
Identify and remove institutional barriers to teaching social medicine and to interdisciplinary, interprofessional, and multisectoral collaboration. Develop models for institutional investment in faculty to ensure interdisciplinary collaboration in health professionals’ education and clinical practice.

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

Why?
Many health professional schools around the world overemphasize test scores and the reputation and ranking of undergraduate schools when selecting candidates, often resulting in a systematic exclusion of underrepresented minorities and students of low socioeconomic status. Diversity of socioeconomic status, experience, culture, ethnicity, race, gender, and other qualities are critical to developing a culture of healthcare that is non-discriminatory and not homogenous in its values, priorities, and clinical practice.

**Action needed:**
Demand that institutions diversify departmental leadership, faculty, and the student body, and meaningfully prioritize diversity and inclusion.

7. **Build collaborations that transcend traditional professional and disciplinary boundaries that have historically limited the scope and impact of health equity movements.**

Why?
Territorialism, power inequities, inertia to change, and hierarchy sustain barriers amongst health professionals and communities that should be natural allies working for health equity. For example, detrimental tension exists between nurses and physicians, family medicine and internal medicine or pediatrics, the social sciences and biomedical sciences, patients and their caregivers, and community-based care models versus clinic-based care.
models. Boundaries forged to protect identity and maintain power have come at the tremendous expense of ignoring the wisdom and partial truths that all have to offer. We acknowledge that the Social Medicine Consortium has been and currently remains driven largely by a group of physicians from elite universities in the Global North, but are committed to changing that fact.

**Action Needed:**
As a consortium, we will take deliberate steps to learn from, dialogue with, and welcome all who have a stake in health equity. Utilizing the principles of constructive dialogue, we commit to actively seek out spaces and conversations, even when uncomfortable, to forge a more inclusive body of members and decision-makers in the Social Medicine Consortium.

8. **Connect the U.S. health equity movement with the global health equity movement.**

   **Why?**
The health equity movement in the U.S. has been traditionally isolated from the global health equity movement. Structural forces of 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 that create health inequity in America. By joining forces to develop a movement to realize global health equity through social medicine, we 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 in countries in the Global South.

   **Action needed:**
Connect healthcare providers globally who are committed to social medicine, creating a platform for multi-sectoral, interdisciplinary and interprofessional, and international collaboration towards health equity through regular conferences, communication platforms, and advocacy campaigns as articulated in the Social Medicine Consortium’s Founding Charter (Appendix A).
Through deliberate, strategic action based on a community-organizing model, the Social Medicine Consortium will work to achieve our aims and transform health professional education. We invite you to join us in the pursuit of global health equity.
Appendix A: 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 an approach that integrates:*

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 B - Social Medicine Curricula Analysis

I. Purpose

By comparing 12 social medicine curricula, this report attempts to assess what role social medicine education currently serves for different audiences and members of health care delivery teams, as well as document shared themes and tools and areas of divergence. Of note, the curricula analyzed are far from a comprehensive survey of all social medicine curricula. They are, however, programs with the consortium is most closely affiliated and provide a starting point for our analysis.

II. Methods

Programs
Table 1 lists the 12 social medicine curricula included in this report organized by audience type. It is important to note that these programs were not randomly selected and that this analysis does not include all existing social medicine programs. The programs were familiar to and respected by the conveners of the Social Medicine Consortium. While other programs exist the conveners felt these were representative of important trends and practices.

Data Gathering
The baseline information for this analysis was taken from several sources. The primary data sources were curriculum documents shared by course directors. For several programs, course creators and support staff were able to provide supplemental information via email or Skype calls. For others, the analysis was based solely on the information available in course documents. Information available was entered into standard forms and subsequently entered into Excel in order to look for trends and differences both across the spectrum of programs and within audience types.

III. Global Overview & Comparison

A. Thematic Categories
Upon review of course objectives and content, several different thematic perspectives through which social medicine is currently being taught emerged: Patient Care, Local
Systems for Care, and Structural Analysis. Course objectives and content topics from all programs were placed into one of these three categories, described below:

(1) Patient Care. These objectives and course topics are concerned with the clinical application of social medicine with regards to individual patients; they reflect a holistic approach to medical care where the patient is viewed within his/her social context.

(2) Local Systems for Care. These objectives and topics stress the comprehension of local health systems, programs, policies, and players. Broadly speaking, most of these are related to understanding and providing country-specific public health and population care at the community level.

(3) Structural Analysis. This category focused on higher-level assessments that broadly examine the determinants of health and illness as well as the practical action steps needed to address them.

These thematic categories are not meant to be exact or mutually exclusive; instead, they serve as a baseline and framework for evaluating similarities and differences across curricula. Therefore, data reported should be understood as a means of showing trends rather than precise quantitative measures.

B. Course Objectives
As the programs served different audiences and filled a range of curricular functions, we found single explicit objective shared across all programs. However, there were several majority themes. 11 out of 12 (92%) of curricula specifically included social determinants of health and illness in their listed objectives. Several other objectives were common, irrespective of the audience. For example, most programs (83%) emphasized country-specific health issues and a majority (58%) included health issues in a global context. Interestingly, the degree to which a human rights agenda was woven into course objectives varied greatly across programs, irrespective of audience. Advocacy was mentioned in 50% of programs’ objectives, and health equity was mentioned in only 25% of them.

The degree to which individual programs drew their remaining objectives from the 3 categories of Patient Care, Local Systems for Care, and Structural Analysis was—not surprisingly—largely reflective of audience type. For example, undergraduate medical
programs tended to draw objectives that revolved around Patient Care and Local Systems for Care, whereas continuing education programs drew more from the Structural Analysis category. It was clear that there were some overarching themes that were important for specific audiences. However, this was not strictly true, and there were other global differences that could not always be accounted for based on audience. Although the overall application of social medicine was clearly different for medical students than for working professionals, even within those groupings there was additional unexpected variation.

C. Course Content

As was the case for course objectives, some course content across social medicine programs was universal, irrespective of course audience. Social determinants of disease were included in 92% curricula content topics. Models of payment and health financing were taught in 66% of programs. Population health and research were less common but still represented in over half of the programs (58%).

Since the thematic objectives guided program content, categories of content topics (Patient Care, Local Systems for Care, and Structural Analysis) roughly followed patterns of objectives. However, individual course content is where the nature of social medicine teaching began to vary, even more divergently than objectives did. Some programs focused on the theoretical frameworks of social medicine, such as global health, social justice, and advocacy. Other programs focused on the practical skills of social and community medicine in primary care or low-resource settings. In general, specific content varied widely and was much less predictable than objectives based on audience.

D. Teaching Methods

Ten out of 12 (83%) programs used a combination of didactic lectures and group discussion with or without tutorials/field experiences. However, teaching style and facilitation methods between programs could not be fully appreciated from syllabi or course descriptions. Reports of “tutorial and field sessions” do not differentiate the significantly different methods of, for example, bedside teaching vs. group visits to a health center. Regardless, it was clear that teaching methodology was not consistent across programs.
E. Course Structure
The structure of the courses varied across and within audiences, such as the duration of the course and whether or not participation was mandatory.

IV. Conclusion

Overall, this report is a preliminary step in establishing:

(1) A social medicine education framework for global social medicine curricula
(2) Curricula defined by minimum standards in social medicine education
(3) A set of “best practices” for transformative learning of these topics

Understanding how program priorities and teaching methods can (and cannot) be adjusted for specific audiences will allow for the continued expansion of social medicine in education—and therefore, in health care delivery—around the world.
<table>
<thead>
<tr>
<th>Program</th>
<th>Location</th>
<th>Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harvard University</td>
<td>USA</td>
<td>Undergraduate (and graduate university Students)</td>
</tr>
<tr>
<td>PIH Engage</td>
<td>USA</td>
<td>Undergraduate university students (also a smaller number of high school students and young professionals)</td>
</tr>
<tr>
<td>Equal Health</td>
<td>Haiti</td>
<td>Medical, nursing, public health students</td>
</tr>
<tr>
<td>Faculté de Médecine et de Pharmacie de l'Université d'Etat d'Haïti/Zanmi Lasante</td>
<td>Haiti</td>
<td>Medical students</td>
</tr>
<tr>
<td>Faculté de Médecine et de Pharmacie de l'Université d'Etat d'Haïti/Zanmi Lasante</td>
<td>Haiti</td>
<td>Nursing students</td>
</tr>
<tr>
<td>Harvard Medical School</td>
<td>USA</td>
<td>Medical students</td>
</tr>
<tr>
<td>SocMed</td>
<td>Uganda, USA</td>
<td>Health professional students</td>
</tr>
<tr>
<td>SocMed (old curriculum)</td>
<td>Rwanda</td>
<td>Medical students</td>
</tr>
<tr>
<td>iSOCO (new curriculum)</td>
<td>Rwanda</td>
<td>Medical, Dental, Pharmacy Students</td>
</tr>
<tr>
<td>Compañeros En Salud</td>
<td>Mexico</td>
<td>First year physicians (interns)</td>
</tr>
<tr>
<td>Global Health Delivery Leadership</td>
<td>PIH sites (Boston, Rwanda, Haiti)</td>
<td>High potential directors and managers at PIH</td>
</tr>
<tr>
<td>UCSF HEAL Bootcamp</td>
<td>USA</td>
<td>Physicians, pharmacists, nurses and other health care professionals</td>
</tr>
</tbody>
</table>

**Table 1.** Social Medicine programs included in this analysis.