Social justice: The heart of medical education

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Abstract

Building on the long-standing institution of the Hippocratic Oath, the authors suggest that all physicians-in-training must be taught the principles affirmed by the 1978 Declaration of Alma-Ata. Physicians should recognize that health is a fundamental human right and that gross inequalities in health care are unacceptable for moral, political, social, and economic reasons. Incorporating an explicit focus on social justice in medical education will lead to the training of physicians who understand that to advance the goal of "health for all" they must work toward more equitable distribution of health care and the elimination of health disparities, both within the U.S. and internationally. Learning to understand the social determinants of health, to advocate for equitable health system change, and to advance social justice throughout their careers should be the focus of this training. As this training prepares leaders to press for system change in the U.S., it also aligns with the global trend of recognizing human rights as a core competency of medical education.

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Roots and definition of "social justice"

In medicine, we define "social justice" as equality in access to and quality of health care and the right to health of everyone.[1] This definition recognizes, as the Declaration of Alma-Ata identified more than 30 years ago, that gross inequalities in health status are politically, socially, and economically unacceptable and that health is a fundamental human right.[2]

The modern concept of social justice in health derives from 19th century social medicine, whose founder Rudolf Virchow said, "The physician is the natural advocate of the poor," adding that "medicine has imperceptibly led us into the social field and placed us in a position of confronting directly the great problems of our time."[3]

While concepts of individual justice focus on an individual's rights and obligations within an organized state, the tenets of social justice expand these rights and obligations to include the responsibilities of society to its members and its members' responsibilities to each other.[4] Equity demands that similar cases be treated alike: for there to be equity in medicine, patients with similar conditions must be entitled to similar treatment without regard to their economic status, income, gender, ethnicity, or other social factors. To achieve this, treatment may need to address the unique socioeconomic situations that have led to the condition.[5] A commitment to social justice requires that we not limit our sense of justice simply to the more equitable provision of health

care to those who are ill, but demands that we examine injustices in the distribution of health and the underlying reasons for unjust burdens of illness.

Social justice training fosters an appreciation of how medicine fits into national and international political economies, and emphasizes that combating the social forces that create and enforce poverty is necessary to improve the health of all of the world's citizens.[6] The historical roots of a social justice perspective in the practice of medicine provide a background for understanding recent trends shaping the health care environment and the educational response to it. These include, *inter alia*, understanding health disparities, cross-cultural health care, workforce diversity, health literacy, community-oriented primary care, and global health.

How social justice training moves beyond "professionalism" or "systems-based practice"

Physicians are required to make bioethical judgments in the context of basic human rights as an integral part of their daily work with patients and families, yet few medical schools systematically teach human rights and their relationship to bioethics.[7] Two current graduate competencies introduced by the Accreditation Council for Graduate Medical Education (ACGME), "professionalism" and "systems-based practice," do require physician engagement with the broader health care system. "Professionalism" addresses ethical principles that grow largely out of clinical practice and the patient-physician relationship, including informed consent, patient confidentiality, and the fiduciary duties of physicians to patients. While fundamental to good care, this competency falls short of a view of medicine that encompasses its role in the betterment of the society at large. The "systems-based practice" competency encompasses the wider context of clinical practice, including communicating effectively with the various members of the health care team. But no competency focuses on ensuring the equitable distribution of health resources, understanding the social determinants of health, recognizing injustice within health institutions such as hospitals or clinics, or advocating for positive changes in the larger health care system and in society—issues that remain unaddressed by either "professionalism" or "systems-based practice," but which are crucial to the practice of medicine that recognizes health as a basic human right.

The importance of social justice to the future of medical care becomes evident if we examine some of the critical issues now facing U.S. health care: (a) high costs leading to restricted access to care[8]; (b) inadequate attention to prevention[9]; (c) reimbursement schemes that reward intervention and large numbers of procedures at the expense of engaged, thoughtful analysis of problems; (d) poor population health outcomes, including racial and socioeconomic disparities[10]; (e) improper distribution of specialty versus primary care[11]; (f) a growing imbalance in rural/urban health care; and (g) an increasing population of the uninsured, including children.[12] (Of the 48.6 million Americans without health insurance in 2011, 7.0 million were children.[13])

Social and economic forces are not incidental to medical education: they delineate the face of the profession. Many contemporary global issues—including the HIV/AIDS pandemic and the close interaction between biomedical research and the pharmaceutical industry—require us to inculcate a philosophical orientation that will help learners and practicing physicians recognize and respond ethically to challenges inherent to healthcare delivery. One such challenge is the transnational distribution of the health workforce. Writing in 2005, Mullan noted that international medical graduates constituted 23% to 28% of physicians in the United States, the United Kingdom, Canada, and Australia, and lower-income countries supplied 40% to 75% of these international medical graduates, reducing the supply of physicians in many lower-income countries.[14] Meanwhile, like medical education in the U.S., "too much conventional international health education shrinks from acknowledging the social roots of grotesque inequalities."[15]

Social medicine

As a prescription for the ills of the current health care system, we recommend wider adoption of the materials and methods of social medicine. Social medicine studies the health of collective groups of people along with the power relationships between those groups and the institutions that impact their

health. Social medicine looks historically at the root causes of health and disease and promotes advocacy and activism. It attempts to counter reductionist approaches common to the current practice of medicine, which often reduce medical care to efficient business practices and treat disease as though only isolated organ systems of sick individuals are involved.[16]

As Rudolf Virchow put it: "Do we not always find the diseases of the populace traceable to defects in society?"[17] Physicians must continue to seek and remedy "defects in society" if health is to be recognized as a basic human right. As the introductory editorial in the journal *Social Medicine* observed,

> [T]he social problems of the contemporary world walk into the clinician's office every day. The mundane details of the social determinants of health are writ small in our daily encounters with patients.[18]

Many practicing physicians may gradually realize this on their own; requiring training in social justice would help ensure that physicians seek to remedy these sources of ill health.

Salvador Allende, a physician and early promoter of social medicine in Latin American, identified Chile's subordinate role in the global system of production and exchange as the basis for the poor health of its people.[19] As president of Chile, he sought to limit the role of multinational corporations. For his pains, he became a victim of regime change.

In attempting to understand and correct the mechanisms of social injustice and structural violence, and articulating an explicit "preferential option for the poor," the Liberation Theology movement in Latin America has exerted an influence on the direction of Latin American Social Medicine.[20]

> Unlike most previous theologies, unlike much modern philosophy, liberation theology attempts to use social analysis both to explain and to deplore human suffering. Its key texts draw our attention not merely to the suffering of the wretched of the earth but also to the forces that promote that suffering.[21]

The Declaration of Alma-Ata

The Declaration of Alma-Ata,[22] issued at the 1978 International Conference on Primary Health Care by the World Health Organization (WHO) and the United Nations Children's Fund, reaffirmed the WHO definition of health as "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity."[23] It recognized health care as a fundamental human right. Gross inequalities in health care were proclaimed as politically, socially, and economically unacceptable, and it was affirmed that primary health care (PHC) should be universal as the key to improving health and reducing inequalities in health status. A multisectoral approach and community involvement emphasizing health as a positive state were central features of the PHC strategy, as was an emphasis on health equity.[24] The WHO's Health for All by 2000 initiative was expected to be funded through decreased military spending—a hoped-for development that has not yet occurred.

The social determinants of health

As defined by the WHO,

> The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels[25]

… which is itself influenced by policy choices. "The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries."[25] The social determinants of health include, on the one hand, access to clean water and sanitation, food security, gender equality, economic and social security, and access to appropriate health care resources—and, on the other hand, international sanctions that lead to unhealthy living conditions, the effects of war including consequences for refugees and internally displaced people,[26] and poverty—as well as labor and employment conditions (including occupational safety) and the distribution of resources within and among nations.[27]

The unequal distribution of global resources, rooted in colonial history and sustained in the present through modern market mechanisms, drives much of the social production of disease.[28,29] While we cannot require that all physicians be scholars of world history or global political economy, they should at least be familiar with how large-scale social forces work locally to make their own patients sick. To advocate for social justice, one must be familiar with the mechanisms of injustice, including its ideological and historical underpinnings.

"Structural violence" refers to societal or institutional factors that preserve inequity, injustice, and human misery—the ways that the unequal distribution of suffering becomes embodied and experienced as violence by the powerless. James Gilligan defines structural violence as

> the increased rates of death and disability suffered by those who occupy the bottom rungs of society, as contrasted with the relatively lower death rates experienced by those who are above them.[30]

First introduced by Johan Galtung,[31] the term has helped clarify the structural relations between inequality and illness, most clearly in a series of essays and works by Paul Farmer and colleagues that show in concrete examples the ways that severe poverty constrains personal agency and contributes to unjust health disparities.[32]

The U.K. Department of Health has concluded that "neglecting people's human rights is bad for their health. In contrast, the protection and promotion of their human rights is not only good for individuals' health; it makes for better services for everyone."[33]

Responding to global political and economic forces, some countries are integrating health and human rights into medical education. In South Africa, the Truth and Reconciliation Commission found that many physicians had been active or passive participants in torture. In response, the Health Professions Council of South Africa has made human rights teaching mandatory for higher education institutions: competencies and curricula in health and human rights have been developed, and training programs have been implemented for medical faculty.[34] Such training is perhaps overdue in U.S. medical schools. A Committee of the Red Cross report on "enhanced interrogation techniques" used by the U.S. Central Intelligence Agency on detainees[35,36] notes the participation of health professionals in the process, as reported in *The Lancet*[37] and *The New England Journal of Medicine*.[38]

In envisioning redesign of U.S. family medicine residencies, Leach and Batalden recommend putting "systems issues on the table as legitimate elements of the curriculum."[39] The Institute of Medicine (IOM) has taken a similar stance in the context of racial and ethnic health disparities in the United States. The entrenchment of health disparities despite a well-funded modern health care system is widely recognized as unacceptable. The IOM report *Unequal Treatment* recommends that

> [o]rganizations responsible for the education, training, and licensure of health and medical professionals should develop special initiatives to increase levels of awareness of healthcare disparities among current and future healthcare providers.[40]

This recommendation by the IOM would be advanced significantly by including the principles of social justice in medical education.

The global movement for health and social justice

Studies of structural violence have led to a deeper understanding of the social determinants of health.[41,42] Academic interest in global health equity is burgeoning. In increasing numbers, medical students in the U.S. and other wealthy countries are expressing an interest in global health, inspired by the examples set by organizations such as Partners In Health and *Médecins Sans Frontières*. Trainees who sign up for international electives abroad are increasingly guided by principles of social justice, asking not "What can I learn from this experience?" or "How can this experience help me improve my clinical skills?" but rather "How might I best serve the destitute sick?" or "How might I improve their situation?"[43]

Implementing a social justice curriculum in medical education

Borrowing from the South African model, we suggest several competencies as the basis for a social justice curriculum:

Knowledge:
1. Familiarity with international human rights conventions and professional codes of ethics
2. Familiarity with national legislation pertaining to health and human rights
3. Awareness of services for refugees, immigrants, indigent individuals, and survivors of human rights abuses
4. Understanding the social determinants of health and implications for their own practice community.

Attitudes:
1. Viewing all people as worthy of dignity and respect
2. Willingness to assume an advocacy role and work for change
3. Approaching patients in a non-judgmental and nondiscriminatory fashion.

Skills:
1. Community needs assessment and community development experience
2. Advocacy and lobbying experience
3. Ability to work in interdisciplinary teams and diverse settings.

Focusing on methods to promote self-reflection and critical thinking should guide curriculum development. Site visits, role playing, reading groups, reflective journaling, small group discussions, training on the use of the media, and community projects may all provide opportunities to model and teach the principles of social justice within a medical school or residency curriculum. A focus on the institutional culture and organizational forces within hospitals, academia, government agencies, and payers that may at times be barriers to the effective delivery of care should be examined.

Many medical schools and residency programs have projects that evaluate and address specific health needs in their communities. Education and training in public hospitals, community health cen-

Figure 1. Core competencies of the Doris and Howard Hiatt Residency in Global Health Equity and Internal Medicine

- Evaluate and address the social determinants of health and disease.
- Acquire clinical skills necessary to take care of patients with a wide range of health problems in resource-poor settings.
- Conduct research relating to health disparities and global health.
- Attain skills in advocacy, leadership, and operational management of global health programs.
- Obtain in-depth knowledge about the specific public health and medical problems affecting one geographic region of the world.
- Develop a strong base in the ethics of international medical practice and research.
- Master language fluency to practice medicine, conduct public advocacy and carry out research in the geographic area of interest.

ters, and homeless shelters; cross-cultural health initiatives; health literacy programs; outreach vans; and sustainable global health projects; linkage with population health initiatives; and social medicine reading groups are examples of existing projects that contribute toward satisfying a social justice competency. However, service learning in the context of delivering health care to the underserved must be connected to the need for social justice in health care. By stating that social justice is an integral value to our health care and medical education systems, we set both a standard for learners and a moral compass for health care reform.

The Doris and Howard Hiatt Residency in Global Health Equity and Internal Medicine[44] takes a comprehensive approach toward core competencies (Figure 1).

In 2010, a student-initiated Dean's Certificate of Distinction in Social Justice was introduced at the John A. Burns School of Medicine (JABSOM), University of Hawai'i at Mānoa. The certificate provides formal acknowledgment at graduation for those students who demonstrate yearly progress toward understanding and applying the basic tenets of social justice in medicine by participating in a range

Figure 2. Social Justice Curriculum, John A. Burns School of Medicine (JABSOM), University of Hawai'i at Mano
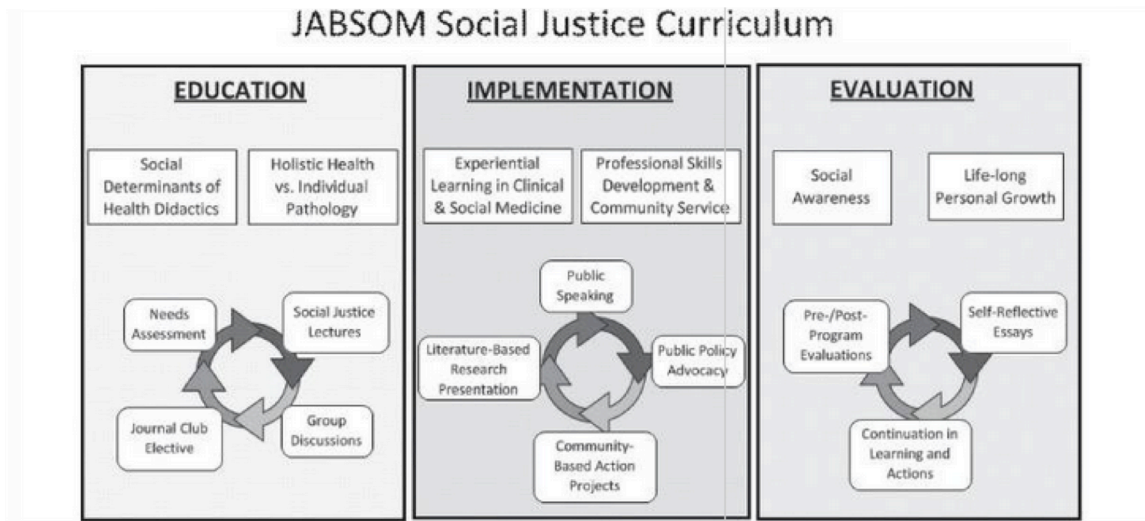
of academic and community activities. Interested students crafted the curriculum for the certificate and shepherded it through the Office of Medical Education and the Dean's Office, obtaining administrative approval with minimal faculty involvement. Key features of the curriculum are summarized in a diagram developed by JABSOM medical students Adrian Jacques Ambrose, Teresa Schiff, and Katherine Rieth (Figure 2).[45]

A Human Rights and Social Justice (HRSJ) Scholars Program was launched in the 2011–2012 academic year at the Mount Sinai School of Medicine.[46] In 2011, Georgetown University School of Medicine began a Health Justice Scholar Track.[47] These projects, like the one at JABSOM, link social accountability to health care outcomes by requiring participants to engage in community and scholarly projects that addresses social determinants of health, and demonstrate that medical students, even without faculty initiatives, recognize that social justice, is, in fact, the heart of medicine. Faculty should encourage and support these efforts and help nourish efforts at other schools.

Conclusion

Just as the health system is being transformed by political, social, and economic pressures, medical education must respond by creating physicians capable of systems-level thinking and of directing evidence-based health system change. Adding training in social justice would lift the educational focus above the hospital and clinic setting and provide a framework to evaluate the dynamic interaction between socioeconomic forces and health.

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