

What is a social medicine doctor?

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Abstract

Background: In 1970 Montefiore Medical Center created the Residency Program in Social Medicine (RPSM) to train physicians to provide care for the underserved. We investigated the characteristics identified by RPSM residents, faculty, and alumni to be those of a “social medicine doctor.”

Methods: Current residents, faculty, and alumni of the RPSM were eligible to participate in the survey, which was sent via email. The survey had seven items: status (resident, faculty, or alumni); specialty (Family Medicine, Internal Medicine, Pediatrics); the role of social medicine in their clinical practice, how social medicine doctors differed from other primary care physicians (PCP), and questions regarding the RPSM curriculum. Demographic data was tabulated, and comments were grouped into themes and investigated via textual and qualitative analysis.

Results: The survey was completed by 173 respondents (29% of 590 potential participants). Forty-seven percent were in Family Medicine, 30% in Internal Medicine, and 24% in Pediatrics. Fifty-four percent were alumni, 28% were faculty, and

22% were current residents. There were three main themes: social medicine doctors have a broad knowledge of the social determinants of health, they have the ability to translate this broad knowledge of health into a specific treatment plan, and they promote social justice in their work. Sub-themes provided a richer description of social medicine concepts and how social medicine practice contrasted with the practice of other primary care physicians.

Conclusions: Within the model adopted by the RPSM social conditions are seen as integral to clinical care. This model was viewed as fundamentally different from the practice of other primary care physicians.

Introduction:

In the US, public health and the provision of clinical services have traditionally been separated,¹ a divorce that has resisted numerous attempts at reconciliation.² Many current health problems are related to broader societal structures (e.g. education, income, living conditions, discrimination, and disempowerment) that are not easily addressed in traditional clinical models.³ When the WHO Commission on the Social Determinants of Health announced that “Inequities are killing people on a grand scale,” how were clinicians to react? Although the Accreditation Council for Graduate Medical Education (ACGME) calls for teaching residents to “obtain and use information about their own population of patients and the larger population from which their patients are drawn,” there are not many models for how clinicians might use community-derived knowledge within their practices.⁴

Historically, some have embraced a role for clinicians as public health advocates. In the heady days of the 1848 revolutions, Rudolf Virchow proclaimed that the physician was the “natural attorney” for the poor. In 1865 Belgian surgeon Armand-Joseph Meyne documented social disparities in health and defended his right as a physician to present “key reforms and economic

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remedies” as a member of “the great scientific council.”⁵ In the mid-20th century Emily and Sidney Kark in South Africa developed a model of social medicine (later called community oriented primary care or COPC) in which a social understanding of disease was seen as a natural extension of the doctor’s work in a community.⁶ Physician activists in the 20th century have been recipients of two Nobel Peace Prizes: International Physicians for the Prevention of Nuclear War (1985) and Médecins sans Frontières (1999).

Most clinicians, however, seem to be more reserved in their public roles. Writing roughly contemporaneously with Meynne, England’s first Medical Officer of Health, John Simon remarked: “How far (if at all) the ... circumstances of our poorest labouring population tend to better themselves, and how far (if at all) they may be bettered by interference from without, are questions which cannot be discussed without reference to parts of political economy on which I am incompetent to speak.” [quoted in Rosen^{7,p.81}] Writing in *Academic Medicine*, Huddle made a strong case against a compulsory role for physician advocacy, arguing instead that it should be a facultative civic responsibility, rather than an obligatory professional norm.⁸ Indeed, the general thrust of medical research and medical training continues to center on the molecular basis of disease and the development of medical interventions, rather than a critical analysis of structural determinants; this has been described as a “desocialization” of scientific inquiry which represents complicity with societal structural violence.⁹

The Residency Program in Social Medicine (RPSM) was created in 1970 for the purpose of training clinicians to work in underserved areas and incorporated a model of COPC into clinical practice. We are often asked what exactly does it mean to be a social medicine doctor. To better answer this question and to examine how RPSM graduates differed from other primary care doctors, we undertook a survey our residents, faculty, and alumni.

Setting

The RPSM is located in the Bronx, New York, the country’s poorest urban county and one in which a majority of the population are “minority.” The program and its curriculum have been described

previously,^{10,11} and in this section we will briefly review the creation of the RPSM.

The RPSM grew from an activist tradition at Montefiore Medical Center where the first U.S. hospital-based Department of Social Medicine (DSM) was created in 1950. George Silver, who had been the DSM chair since the late 1950’s, left the department in 1965 to work at the Johnson Administration’s Office of Economic Opportunity (OEO), the key agency in the war on poverty. In this role he was instrumental in establishing the first Community Health Centers (CHC) in the United States using the COPC model developed by the Karks in South Africa and imported by H. Jack Geiger, who had studied with the Karks as a student. In 1968 Montefiore opened an OEO-sponsored CHC in the south Bronx, the Martin Luther King, Jr. Health Center (MLKJHC). MLKJHC was established as a model program where interdisciplinary teams of nurses, doctors, social workers, and trained family health workers, would provide comprehensive care to families within the community.

This was a politically and socially tumultuous time in New York City and particularly in the Bronx. The director of the new program was a Canadian internist, Harold Wise, who had experience teaching residents in the city hospitals.¹² Given the difficulties finding doctors to work in interdisciplinary teams in the conditions of the South Bronx, Wise and Pediatrics Chief Resident David Kindig founded the RPSM in 1970 to both staff the MLK Health Center as well as to train a cadre of socially-minded physicians dedicated to providing care for the underserved.¹³ Forty five years after its inception, RPSM residents in internal medicine, pediatrics, and family medicine are still being trained in the vision of RPSM: “promoting health and social justice in the Bronx and beyond.” It remains the only social medicine residency program in the US and has been a model for federal funding of primary care residency programs, receiving Title VII primary care training grants.¹⁰ Although no longer based at the MLKJHC, RPSM residents still have their outpatient training at federally-qualified community health centers. The current RPSM mission statement reads: “In order to improve the health of underserved communities, our mission is to: 1) train excellent primary care physicians grounded in the biopsychosocial model who are effective advocates for social change, 2) deliver quality, community-oriented primary care, 3)

**Table
Description of Respondents (N = 173)**

Specialty N = 141	Family Medicine	66 (47%)	
	Internal Medicine	41 (30%)	
	Pediatrics	34 (24%)	
Training Status N=162	Current Resident N=36 (22%)	Training Year	
		PGY-1: 13 (36%)	
		PGY-2: 10 (28%) PGY-3: 13 (36%)	
	Alumni N=87 (54%)	Graduation Year from RPSM	
		1973-1983	15
		1984-1994	23
1995-2005		30	
Faculty N=45 (28%)	Length of time as faculty		
	0-5 years	23	
	5-10 years	7	
	10+ years	15	

Note: Six faculty members were also alumni so that the number of training status responses totals 162. The percentages reflect this smaller number and thus the total is over 100. Not everyone answered both questions.

generate new knowledge and innovations in health care and medical education, and 4) maintain and enrich the physical, spiritual, intellectual, emotional and material resources necessary for these tasks.” While the exact wording has changed over forty five years, this mission has remained central to the RPSM and is reflected in the career choices made by our graduates.^{10,14}

We undertook this study to identify the characteristics of a social medicine doctor as described by our residents, faculty, and alumni.

Methodology

Data for this paper was taken from a survey of current residents, faculty and alumni of the RPSM.

Subjects & Recruitment:

All current residents, faculty and alumni of the RPSM were eligible to participate in the survey. They were contacted via email through two separate email lists: 1) current department members (207 faculty and current residents) and 2) the social medicine list-serve (SOCMED) which was set up for RPSM alumni and included 433 members. Fifty persons were on both lists so that the survey reached a total of 590 people.

Instruments:

The survey was available on Survey Monkey (surveymonkey.com) for a three month period. The complete survey had seven items which included 1)

current status (resident, faculty, or alumni; length of time with the DFSM); 2) specialty (i.e., Internal Medicine, Pediatrics, Family Medicine); 3) *What characteristics should distinguish an RPSM graduate from other primary care doctors? (Consider knowledge, attitudes, and skills in specific areas)*; 4) *How does social medicine inform our training, teaching and clinical practice?* Three additional questions addressed the effectiveness of our training program with respect to social medicine concepts and are not discussed in this paper.

Analysis:

Information describing the participants (questions 1 and 2) were tabulated. (Table)

Responses to the questions regarding the characteristics of a social medicine doctor were analyzed in two ways. A quantitative textual analysis of words and phrases was done using the Online Text Analysis Tool.¹⁵ The authors also used a modification of the Nominal Group Technique to identify themes.¹⁶ All comments were reviewed by the authors and grouped into thematic categories. These were then grouped into larger themes and a narrative description of the results was prepared.

Ethics:

This study was considered exempt by the Albert Einstein College of Medicine Committee on Clinical Investigation.

Results:

Demographics:

One hundred seventy-three people responded to the survey; not all responded to each question. The overall response rate was 173/590 (29%). The table provides a description of the respondents.

Textual Analysis

The text was composed of 81 sentences and 2062 words. The top phrase containing four words was “social determinants of health” which appeared six times. The most common single words from the text included health (60), social (47), patient(s) (36), communit(ies) (30), care (28), medicine (22), knowledge (21), skills (18), clinical (14), advocacy (11), ability (11), practice (10), factors (10), underserved (9), determinants (9), individual (9), and psychosocial (9).

Qualitative Analysis

We identified three major themes in the responses; each major theme encompassed several sub-themes. Each major theme is presented below. The subthemes are highlighted in italics. Illustrations of the themes and subthemes are provided through quotes from the actual responses.

1. Social medicine doctors have a broad knowledge of the social determinants of health

Respondents reported many ways in which their daily practice illustrated how mental and physical health were subject to social rather than just biological factors. The subthemes that came through in respondents’ qualitative comments included *how class and race impact patients, the role of neighborhood or environmental factors, the concept of community health and exposure to epidemiology/public health.*

There are many in the medical community that (sic) would choose to see physical health and wellbeing as separate from the individual's immediate environment and community. Practitioners of social medicine serve as ever-present reminders that wellbeing cannot be seen in a vacuum. It is subject to the capriciousness of the social situation. It is essential that we train residents to be vigilant about the impact of social conditions on the health of the patients they see.

We see a greater role for how we should practice medicine, how we may need more creative and broader approaches to safeguarding wellness and constructing treatment plans for chronic illnesses. RPSM grads tend to better explore social determinants of health and limit fruitless or wasteful explorations of biological explanations for illness when social etiologies are glaringly present and often unaddressed or ignored by the rest of the healthcare system. Sensitivity to being uninsured, undocumented, unable to speak or understand English, unable to pay your bills or read, is usually highlighted among our graduates and results in more sympathetic care and improved rapport with patients.

The idea of understanding social determinants of health and working towards social justice both in and out of healthcare was also prominent. Knowledge of *social medicine theory, social policy and health care systems* through training helps to create a foundation for practice.

Commitment to social justice, including but not limited to justice in healthcare. Interest & knowledge in social determinants of health.

...social medicine broadens our thinking about illness and wellness. Social medicine addresses not just physical complaints, but in our clinical practice we also work towards reduction of suffering and promotion of mental and social wellness.

2. Social medicine doctors have the ability to translate this broad perspective of health into a treatment plan for individual patients.

Taking the tools provided by social medicine theory and manifested in the social determinants of health, social medicine doctors are able to apply what they know to individual patients. A large part of *advocacy for individuals* comes from *partnering and empowering patients* and *cross cultural practices* (e.g., learning Spanish).

[A] willingness to step out of the clinic and outside of the biomedical model to have a positive impact on health, a commitment to addressing health disparities; an ability to

translate a broad perspective of health and an individual patient's specific social context into effective psychosocial and medical interventions in direct patient encounters or in addressing specific presentations of illness.

[A]ctually making the social determinants of health a part of the treatment plan with each patient (many doctors have an awareness of these issues but it is in a broad and global way rather than how they are applicable to individual patients).

Using a *biopsychosocial model* including a *family-oriented view*, social medicine doctors are able to have a more *holistic/wellness approach* to their patients. The *focus on ambulatory training and working in teams* furthers the goal of creating plans for individual patients.

Willingness and preference for working within multi-disciplinary teams.

Giving social factors the same priority as medical factors in determining how to improve health outcomes.

Always keeping a broader perspective on the patient than simply the chief complaint.

3. Social medicine doctors promote social justice

Social medicine doctors have a commitment to working with *underserved communities* and have a *vision of health care* that includes *stepping outside of the box and the biomedical model* of medicine. Respondents included qualities of *open mindedness, commitment, self-directedness, idealism/altruism* and *leadership* that fuel social medicine doctors to promote social justice.

Leadership and self-starting, self-directed persons with broad goals and idealism/altruism more than typically seen in persons pursuing careers in medicine over time. Willingness to take on challenges and step out of comfort zone to meet patient/community needs. Public health orientation to medical services delivery-/access. Most soc med folks see "the big picture" and want to influence that in a positive way.

Open mindedness, welcoming the understanding of individuals with respect for

their cultural, community, and family connections.

Additionally, in moving outside of the clinic, we are involved with our communities both to fight injustice but also to strengthen social networks.

Goes beyond working in underserved communities – training to become part of a group of leaders to improve health in those communities through social change.

Through *peer education* and the desire for *getting things done*, social medicine doctors advocate for a greater equality in healthcare. Incorporated into practice and mindset are ideals of *advocacy and activism*.

Critical thinking and activism should infuse our practices, and while we accept differences, we do not tolerate the use of healthcare for personal profit, suppression of others, or unethical scientific adventures. Oh-and racism sucks.

Outstanding evidence based training in ambulatory care diagnostic work-ups, treatment, referral patterns, and patient-centered and patient-sensitive care. RPSM grads need to continue the tradition of advocating for a greater professional-/institutional/societal role for medicine and how we as its specially trained social practitioners need to carry the torch in demanding our patients receive better treatment and our society needs to respond to the health rights of all citizens of the world in more comprehensive and equitable-/efficient ways.

Ability to practice in a social and economic context, and advocate for classes of patients, as opposed to only individuals. Approach the current socioeconomic system critically, and fight for the social responsibility of physicians etc. to change healthcare into a service to all, regardless of social class or race.

Conclusion

Historically, social medicine has encompassed many different ideals, practices and philosophies.¹⁷ Our respondents offered a rich and diverse set of

themes which express one particular vision of what it means to be a social medicine doctor. Although the actual amount of text provided by our respondents was not large, their answers show a vision of how social medicine informed their clinical practice as well as served as preparation for activism on a community level. Being a social medicine doctor meant something different from being a “regular” primary care doctor. We suspect that this vision closely reflects Harold Wise’s ideal of a social medicine doctor. The authors were, however, surprised that class and race were each mentioned only twice given the context within which residents are trained.

Strengths of our survey included broad representation by training status (resident, alumni, and faculty), specialty (family medicine, internal medicine, pediatrics) and by year of graduation. Our study was limited by the short nature of the responses and by the fact that only 29% of the potential subjects responded to the survey. This may, however, be less of an issue in qualitative research where the goal is the generation of hypotheses rather than their confirmation. Perhaps the largest limitation of our study is that although we know how members of our program think of themselves, we do not know the extent to which this vision is actually realized in practice. We do not have external validation of how the characteristics of being a social medicine doctor translate into clinical behavior or community outcomes. It is noteworthy that a continuous process of evaluation was a central part of the Kark’s initial model of COPC.¹⁸

The RPSM was an oddity when it was created but is less so today. There are multiple urban programs that train doctors to work in underserved areas, some with an explicit focus on social justice.¹⁹ Internationally, there has been greater interest in medical schools training clinicians who will meet the needs of local populations.²⁰

The RPSM has developed one model in which clinical care is integrated within community medicine. This training model has been successful in training doctors to work in under-served areas. But this leaves us with a number of important questions. To what extent do the characteristics of our graduates reflect a process of self-selection? Do others – patients, community members, colleagues – see social medicine doctors in the same way they see themselves? Why has this model of social medicine not been replicated elsewhere? Does a

practice of social medicine with an attention to social determinants actually result in improved clinical outcomes for patients or communities? Are there other, better ways to do this? Can this model survive in a setting where federal funding for residency education is being cut and clinical departments are increasingly forced to rely on clinical revenues?

Despite these questions, we believe our experience shows that in the right environment trainees can learn and thrive in a setting that attempts to integrate clinical care and population health, and in the process provide more comprehensive care to patients with recognition of the social determinants of health.

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