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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Diving into Social Determinants of Health

Dr. Chapa:
What if I were to tell you that a patient's health and life expectancy were not only determined by their genetics or their insurance plan, but by something as simple as their zip code? Based on the latest research, this may very well be the case, which is why today we're going to be talking about and exploring a very important topic in medicine, and it's pretty sobering too.

Welcome to *Clinician's Roundtable* on ReachMD. I'm Dr. Hector Chapa, and joining me to discuss social determinants of health and their impact on patients' overall morbidity and possibly even mortality is Dr. David McIntosh. Dr. MacIntosh is Vice-President and Chief Inclusion and Diversity Officer at Wake Forest Baptist Medical Center, in Winston-Salem, North Carolina. Dr. McIntosh, thank you for being to the program. You wanna tell us a little bit about your background?

Dr. McIntosh:
You bet. Thank you, Dr. Chapa for the invitation. I'm really excited to be here.

So I do inclusion and diversity work for our health system, and prior to that, I've done a lot of work in medical schools. I worked at the University of Louisville School of Medicine, and then of course at Texas A&M School of Medicine as well. And so, a lot of my work and research really focuses on race and how race is understood and practiced in an academic environment, and so I think it just lends itself so well to talking about social determinants of health, so I'm really excited about our conversation.

Dr. Chapa:
Absolutely. So, to start us off, Dr. McIntosh, can you tell us, because some may not actually be very familiar with this, what actually is meant by social determinants of health? Why are they important, and how are they impacting a patient's overall health, morbidity, mortality?

Dr. McIntosh:
So, when we think about a person's ability to be healthy, there are a lot of genetic factors that somebody walks in the door with, right? And so there's things that you inherited just by who you are and who your parents were. Those are oftentimes just part of your genetic make-up, and that's where precision medicine comes in, and I think that's a really cool emerging area, when we think about kind of what we have and what diseases or ailments or illnesses we might be predispositioned for. That accounts for a part of a person's ability to be healthy and well. As you well know, there are myriad factors that also impact a person's ability to be healthy and well, and so when we think about somebody's educational attainment, or their employment opportunities, the type of neighborhood they're allowed to live in, their access to transportation, their space in a food desert, so access to healthy foods, access to a clinic. And so, all of these things impact one's ability to be healthy, because you can't be healthy and not have access to good food. You can't be healthy if you don't have a job and you don't have access to health insurance, for example. And education is a huge mitigator of this as well. So, I think there are a lot of factors that are kind of unaccounted for when we think about the clinical interaction. When we talk about how we train our medical school students, and how we train our residents, it's very much about the clinical interaction, but it's almost like we're taking one piece of the pie and we're ignoring the rest of the pie, about how somebody shows up in our clinical spaces. And so, when we talk about, like the education system, and the housing system, and the employment system, and the healthcare system – all of these systems interact together, so no one is in isolation. So, as I think about how we train folks around these things, I think it's important to think about this from a systems perspective, because it's not as easy as just telling our patient, "Well, you need to get higher quality food." Well, that's great, but can you help me get a better job so I can get higher quality food?

Dr. Chapa:

Right. So this is very important, because this is so accurate, and I think most healthcare providers, nurses, anybody in medicine can relate to this issue, where we give a patient a prescription, assume she's gonna go get it filled, you know, in an hour or two, and the truth is – and I've had a patient tell me this, and it was eye-opening for me, Dr. McIntosh –she looked at me and said, "What do I do with this? There's no pharmacy where I live." And I said, "Oh, well jump online and order it online." And the privilege-ness of that statement, it really hit me, because she looked at me, and I'm in College Station. I'm in a major university town, and she said, "My house doesn't get internet." This is astounding to me that it's 2020 –we live in a little bubble. And let's just call it what it is, I mean, we're educated, we're health care workers, and it's a bubble. And I'm thankful for it, and I love what I do, but that's not a lot of the population. And I had to learn what a "food desert" was. I'd never heard of that term until two years ago. This is now in medicine. Now that you've defined that a little bit more, these external social factors that impact patients' ability to get care and improve our care, how can we improve our awareness of social determinants of health?

Dr. McIntosh:
I think there is such an important interaction that has to happen with the patient. I think it's seductive to almost fall into the space of, "Oh, this patient appears before me and they appear to be low socioeconomic status, so you must, therefore, live in a food desert. You must not have an education. You must not have … things." And so, I think we have to be very, very careful about making assumptions about how our patients show up in our clinic. I think it really is about developing that relationship so that we understand our patients really well. And you have to make small talk and build trust with your patients in order to actually affect change and to get them to trust you enough to do the preventative medicine. So when we build trust with our patients, it can really help that patient to not only see us as their partner in health care, somebody who has their best interest in mind, but they're far more likely to actually follow through on the things that we're recommending for their health. And so, I think there's a lot of really good things that we can do in that clinical interaction. Where I used to live in Texas, we used to do training with the medical school students on the curandero, and so, of course, this idea of Mexican folk healing.

Dr. Chapa:
Right.

Dr. McIntosh:
This is terribly critical for our students to learn, because when a patient who believes in the curandero comes into the clinic and says, "I've got this ailment, and I'm treating it with sage." Rather than having that student or that provider say, "Uh, forget the sage, you need penicillin," you say something like, "That's great, continue the sage, and also let's add the penicillin. That will help with the treatment." It's just a small pivot, but it really makes a big difference when we're thinking about kind of the racialized experience that people experience in our clinical spaces. And then, let us not forget we live in a society where there have been social determinants for a long time. We're recognizing them now. When I think about the role of race and racism, as it intersects with health care, we cannot ignore the fact that our hospitals and clinical facilities were legally allowed to be segregated until the middle of the 1960s. So that means, if you were an employee in a hospital, who identified as a person of color, in 1959, and you had a heart attack, you would be loaded onto an ambulance and transported to another hospital that actually treated black patients. And so, when we talk about these things, there is a social context that we have to be aware of.

Dr. Chapa:
And so that's a big take home message there, is that we tend to view social determinants of health as external barriers. In other words, their zip code alone, their food isolation/food desert alone, their social structure – those are external to me, as a provider, right? External to me as medicine. However, there are internal factors at play. None of us want to admit, but it's just human nature for us to default think, and some of that default thinking can be negative. And those internal factors are also part of social determinants of health. And I did something very interesting. This was about a year ago, asked my medical students, and said, "Who do you picture, what is this patient in your mind?" I said it's a 20-year-old, she has been pregnant three times, she has three children, and she comes to the office from some pelvic pain. Who do you see? And invariably, when they raised their hands, they said, "Why do I see, like, a lower socioeconomic, Hispanic patient or an African-American patient? Where does that come from?" I had nothing to say about race. So automatically, because she is young and had three children, she was lower socioeconomic. Isn't that interesting? Now, again, this may be making you a little uncomfortable, and that's our purpose, because part of medicine is getting outside of our comfort zone, and we can't fix a problem unless we understand its diagnosis. These are all internal factors. Would you agree, Dr. McIntosh?

Dr. McIntosh:
100%. And it reminds me of that 2003 Institutes of Medicine report where they described one of the reasons that we have health disparities in our country is a lack of cultural competence and awareness on the part of our care providers. When I think about the research around implicit bias, it is deep and robust, and so we have all of this information and data recognizing that we are socialized to believe certain messages. And so, it's hardly surprising that when you described that scenario, that people have an image that pops into

their mind. The really scary and insidious thing about that is that students of color might have the exact same image pop into their head.

Dr. Chapa:
Absolutely.

Dr. McIntosh:
It's not about a race, it's we're all socialized around the traditionalized message.

Dr. Chapa:
So true.

Dr. McIntosh:
It gets so scary. And there's a bunch of theories about how to overcome bias, right? So, contact theory, where you spend time in communities where you're learning more about communities that you don't have understanding around, that helps you dismantle those socialized messages you've come to believe, and insert positive and realistic messages, so that you're getting a more nuanced understanding, and you're kind of rewiring the way your brain works. I think that's all really good. I think there's a really brilliant question set when you're interviewing your patient about the ailments that bring them into your office, it can be really useful for shifting the balance and the power to the patient, to describe what's going on with them. They're called the Kleinman questions. And the Kleinman questions really do ask the patient, "Tell me about why – tell me about what is hurting. Tell me about what's ailing you. Why do you think that's happening? What do you think is going on?" And they can provide and have authorship over their body. They are ultimately the expert of their own body. And so, they're coming to you for assistance, and it can be uncomfortable for the physician, who is highly trained and highly educated, to seed that kind of control away. But when you do, that makes such a huge difference in building that trust with your patient. And so, when we talk about those internal things, I think there are some ways that we can build internal trust, and really seek to understand our patient in a different way.

Dr. Chapa:
Dr. David McIntosh, thank you for your opinions and your perspectives on this very important topic. It was great having you on the program.

Dr. McIntosh:
Thank you so much.

Dr. Chapa:
I'm Dr. Hector Chapa, and to access this, and other episodes in our series, just visit reachmd.com/cliniciansroundtable, where you can Be Part of the Knowledge. Thanks for listening.