BECOMING A PHYSICIAN

Rethinking the Social History

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Research has established that social environments affect human health.[1] Acknowledged social determinants of health — including racial or ethnic background, occupation, and the use of alcohol and tobacco[2] — also influence the effectiveness of health care delivery.[3] But other social factors, such as the ability to afford medications, access to transportation, available time, and competing priorities, may influence health outcomes even more. Although we believe that exploring these issues constitutes an essential part of the medical examination, the most important and relevant social history questions are rarely asked or acted on.

Applying social science principles to medicine — a practice sometimes called "social medicine" — enables us to contextualize patient care to achieve more sustainable and equitable health outcomes. Social medicine elucidates how patients' environments influence their attitudes and behaviors and how patients' agency — the ability to act in accordance with their free choice — is constrained by challenging social environments.

Physicians often see patients with complex social situations as a burden — requiring extra work that is neither reimbursable nor central to our core clinical expertise. Unfortunately, we inculcate these attitudes in trainees, implicitly and explicitly, perhaps because of our discomfort with hearing difficult stories or our sense of powerlessness or incompetence in addressing these root problems. Whereas biologic pathology may present specific targets for intervention, social or structural pathology is difficult to treat.

Since social problems affect patients' health and treatment effectiveness, however, we cannot afford to ignore them in assessments and treatment plans if we hope to improve outcomes, reduce costs, and improve patient satisfaction. Moreover, clinicians' simple acknowledgment of social forces can strengthen their therapeutic alliance with patients. Patients know clinicians cannot alleviate their poverty, but empathy and concern shown by a clinician who explicitly addresses it constitute powerful medicine.

So how should we teach students and clinicians to explore social determinants of health? How can we encourage health care teams to explore social factors that influence health care delivery? And how should clinical teams address these issues?

To start, obtaining a more appropriate and comprehensive social history can enable proper assessment of a patient's social environment. Although many social barriers exist between patients and providers, deliberate inquiry into the social environment allows clinicians to understand behaviors such as nonadherence to treatment plans, missing of appointments, or failure to fill prescriptions not as products of ignorance or willful misbehavior but rather as results of the complicated interplay of individual factors with a complex social environment.

For example, a proper social history of a "brittle diabetic" patient may reveal a very limited income that precludes purchasing healthy foods. Social isolation may prompt excessive emotional eating, limited mobility may hinder monthly visits to the pharmacy to pick up prescriptions, depression or poor coping skills may thwart lifestyle modifications, family lore regarding "low sugars" may impede adherence to insulin regimens, and life with arthritic knees in a third-story walk-up in a violent neighborhood may make prescribed daily walks seriously challenging.

Adopting the social medicine framework, we revised our list of social history topics in an effort to strengthen our therapeutic alliances, better contextualize patients' diagnostic and treatment plans, and improve health outcomes (see box). Our topics extend well beyond the common "TED" (tobacco, ethanol, drug use) questions, encompassing six categories: individual characteristics, life circumstances, emotional health, perceptions of health care, health-related behaviors, and access to and utilization of health care. Primary care clinicians may find that such a comprehensive history is best obtained over multiple visits, but we believe it is ideal to revisit these questions annually; inpatient clinicians probably need to be more target-

Common Current Topics and Proposed Comprehensive Topics for the Patient Social History.

Common current topics

Racial or ethnic background
Marital status and children
Occupation
Highest level of education
Tobacco, ethanol, drugs ("TED")
Seatbelt and helmet use
Firearms in the home
Victim of domestic violence

Proposed new topics

Individual characteristics
- Self-defined race or ethnicity
- Place of birth or nationality
- Primary spoken language
- English literacy
- Life experiences (education, job history, military service, traumatic or life-shaping experiences)
- Gender identification and sexual practices
- Leisure activities

Life circumstances
- Marital status and children
- Family structure, obligations, and stresses
- Housing environment and safety
- Food security
- Legal and immigration issues
- Employment (number of jobs, work hours, stresses or concerns about work)

Emotional health
- Emotional state and history of mental illness (e.g., depression, anxiety, trauma, post-traumatic stress disorder)
- Causes of recent and long-term stress
- Positive or negative social network: individual, family, organizational
- Religious affiliation and spiritual beliefs

Perception of health care
- Life goals and priorities; ranking of health among other life priorities
- Personal sense of health or fears regarding health care
- Perceived or desired role for health care providers
- Perceptions of medication and medical technology
- Positive or negative health care experiences
- Alternative care practices
- Advance directives for cardiopulmonary resuscitation

Health-related behaviors
- Sense of healthy or unhealthy behaviors
- Facilitators of health promotion (e.g., healthy behaviors among close social contacts)
- Triggers for harmful behaviors and motivation to change (may be determined through motivational interviewing)
- Diet and exercise habits
- Facilitators or barriers to medication adherence
- Tobacco, alcohol, drug use habits
- Safety precautions: seatbelts, helmets, firearms, street violence

Access to and utilization of health care
- Health insurance status
- Medication access and affordability
- Health literacy and numeracy (may be ascertained with specific tools; e.g., "The Newest Vital Sign")
- Barriers to making appointments (e.g., child care, work allowance, affordability of copayment, transportation)

ed but could, with training, obtain similar relevant information. Of course, clinicians should use their judgment regarding the appropriate timing of these conversations, since patients may need to establish trust and rapport before sharing intimate information.

To obtain proper social histories, clinicians could be trained in basic and motivational interviewing techniques and challenged to examine their own biases, since unexplored prejudices influence our ability to obtain or act on important information. We also recommend that clinicians attempt to visit the neighborhoods where the majority of their patients live, since such experiences can enhance clinicians' social perspective and help them understand their patients' "health homes." Such visits might inform clinicians about people or services in their patients' world that could be organized to help them achieve better health and about the forces working against their engagement in health-promoting or harm-reducing behaviors.

In addition to learning how to obtain this social information, clinicians need to learn how to use it — specifically, they need training in ways of developing individualized care plans that take into account patients' personal and structural barriers to good health.[4] Using shared-decision-making techniques and appropriate pedagogical and counseling skills, clinicians can help prioritize patients' goals and empower patients to make lasting changes to achieve self-identified objectives. Increasingly, through shared-savings contracts and reimbursement for care-coordination activities, clinicians will receive financial incentives to make

appropriate referrals to both institution-based and community-based resources and to communicate effectively with social workers, community health workers, lawyers, therapists, counselors, and other service providers.

For example, an individualized care plan for a woman with diabetes might include referrals to a food pantry and farmer's market for purchasing fresh produce; referral to a community-based walking program, where neighbors help her up and down the stairs; sending prescriptions to a pharmacy that delivers medication to her home; referral to a medicolegal group for contract assistance concerning her unsafe housing situation; and referral to a community health center that holds group meetings where she can build relationships, explore new explanatory models of disease, and learn from others' stories of illness and coping. For the most challenging "nonadherent" patients, a structured home visit by medical team members would be ideal.

Medical education curricula could be revised to incorporate this approach. Students and residents could learn how to conduct structured home visits and patient care mapping exercises to better understand all the places, people, and directives that patients must negotiate in seeking better health. What happens, for instance, when a patient with low literacy is discharged after a hospitalization with new prescriptions, orders to follow up with three subspecialists, and a referral to outpatient rehab — and has to contend with the eviction notice, unpaid utility bills, and isolation that await him at home?

Trainees could learn how to assess patients' literacy and health literacy and how to deliver information using well-established pedagogical techniques. They could practice motivational interviewing techniques using role playing and learn, in real clinical settings, how to motivate and empower patients to engage in health-promoting behaviors. Audiotaping or videotaping of history taking, counseling, and care-planning activities can provide opportunities for giving feedback and honing skills. Clinicians-in-training can be taught how to enhance shared decision making, create individualized care plans, and work effectively in teams — all principles that we believe should be incorporated into the U.S. Medical Licensing Examination[5] and the Accreditation Council for Graduate Medical Education and American Board of Medical Specialties core training competencies. If we gear training toward a more comprehensive approach to understanding patients, clinicians will gain tools for developing therapeutic plans that take into account patients' complex social environments.

We hope that the teaching and assessment of such an approach will foster a new generation of clinicians who provide more personalized and appropriate care. Attention to the social forces in our patients' lives would allow us to provide better and less costly care to patients with the most complex conditions and situations — thereby increasing satisfaction among both patients and caregivers. Failure to attend to these forces will perpetuate the cycle of poor outcomes, high costs, and dissatisfaction among our neediest patients.

William Osler said, "The good physician treats the disease; the great physician treats the patient who has the disease." To be able to treat the patient, a physician must ask the right questions and know how to act on the answers.

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