

A Chance to Socialize

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When you learn about the “social determinants of health,” what relationship comes to your mind? Throughout medical school and into residency, I pictured a straightforward and essentially linear correlation. If I were to plot it, the x-axis, the independent variable, would represent these social determinants, like the zip code a patient lives in, their access to healthy food, or a safe place to exercise. The y-axis, the dependent variable, would be health outcomes. However, as one patient encounter brought home to me, there is more complexity in the relationship between social determinants and health, an interplay and intricacy we flatten when we visualize a simple cause-and-effect association.

The patient in question, whom I’ll call Laura, was soft-spoken, almost reticent. She tended to smile self-effacingly as she spoke, coming across as a little shy. I was completing a longitudinal rotation in a Veterans Administration (VA) women’s health clinic, which provided an opportunity to hone my primary care skills and learn from this unique population. It was the first time I met Laura, and I took some time to build rapport. During my rotation, I had started to become accustomed to patients who felt uncomfortable or intimidated when sharing deeply personal details of their lives with yet another young trainee, and I had found ways to build connection and ease this discomfort. As we spoke, Laura’s answers grew longer, her posture more relaxed. Her medical history was complex, with a list of comorbidities including heart failure with preserved ejection fraction, chronic obstructive pulmonary disease, and pulmonary hypertension. I thought I was being expertly cognizant of social determinants of health when I took into account how my level of higher education might differ from Laura’s, as it did with many of my patients at the VA. I was making a conscious effort to frame Laura as the expert in her own health, asking her about her own experience with different treatments and therapies. It was during our conversation regarding her pulmonary disease that she said something that gave me pause.

“It gave me a chance to socialize,” she told me, smiling faintly as she described how she had quite enjoyed pulmonary rehabilitation. With her rollator and portable oxygen, she explained, she often felt

like a burden to those around her, which made it harder for her to connect with family and friends. Pulmonary rehab had given her the opportunity for connection.

It was one of those profoundly moving moments as a clinician. I looked at Laura and found myself at a loss for words (probably not a bad thing, given how frequently we as physicians monopolize the conversation). There was something deeply poignant in her revelation, a constricting melancholy at the thought of this gentle woman fearing she had become a burden, a fear that isolated her to the point that pulmonary rehab was her outlet for connection.

We continued the visit, but I found my thoughts returning to the encounter in the days and weeks that followed. I’d known loneliness was a risk factor for poor health outcomes, a fact that has recently gained wider recognition among the general public when the surgeon general likened its health risks to that of smoking, but somehow, I’d never reflected on how poor health might be a cause of loneliness. How, I wondered, did Laura’s pulmonary comorbidities, her need for oxygen and her mobility limitations impact her social isolation, and how did this in turn impact her disease course? Instead of a linear association, the plot in my head between social determinants of health and patient outcomes had started looking more like a web, with lines of cause and effect running back and forth in an infinitely more involved pattern.

Once I thought about it, this complexity came through in other encounters I’d had. There had been success stories. The grandmother with Crohn’s who, after treatment, could attend her grandchild’s kindergarten graduation. The patient with asthma employed in an ill-ventilated office building, who was able to work from home with a doctor’s note and thus able to afford her other medications. But there were also patients whom, looking back through this newfound lens, I could have served better had I paid more attention to the complexity of social determinants of health.

I can recall a young patient with sickle cell disease in the hospital for a pain crisis, who rushed to wean down his IV opiates before he was adequately treated, ultimately necessitating a longer hospital stay. His friends were throwing a party he badly wanted to

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attend, and his disappointment when he couldn't go was intense. He had felt so isolated and different from his peers that his priority was not missing out on social events, rather than getting his pain fully under control. Could I have disrupted this cycle had I explored with him how his condition affected his social circle? Another patient in my primary care clinic confided that he hadn't been socializing or exercising much since his friend group had stopped inviting him along. "I think they want to hang out with younger folks, not old guys like me," he told me. I never inquired further to see if this perception of his being viewed as "old" was coming from the patient himself or from his peers, or what was contributing to it.

For Laura, pulmonary rehab had been a way of disrupting the cycle of disease and social isolation. She taught me to consider the interplay of disease and social determinants of health with greater sophistication. Now, when I am in clinic, I ask my patients how their disease has affected their lives. I hear a range of answers, learning new and bidirectional connections between health and social context, and influencing the way I practice medicine. Being cognizant of the complexity of social determinants of health might mean

looking into medication copays to decide whether to prescribe a medication my patient could get over the counter so that they have more funds to buy healthy food. It might mean translating specialist recommendations into more understandable language so that patients can better understand their disease and better advocate for themselves. It might mean learning that my original plan does not best serve my patient in their unique medical and social context, and that I need to better partner with them to come up with creative solutions.

I still think about Laura. I remember the gentle, soft-spoken woman and hope that she has found a wealth of social connections, whether in or out of pulmonary rehab. I remember the moment when I felt an overwhelming emotion at her revelation, and I hope that I remember this with every patient, every time I ask about social determinants of health.



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