

Poverty, Health, and Graduate Medical Education

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Poverty is potentially the greatest predictor of poor health in the United States. Disease-specific and all-cause mortality rates increase in a consistent gradient with decreasing socioeconomic position.^{1,2} Poverty is associated with a 5-year loss in life expectancy,³ and the loss of quality-adjusted life years for those living with incomes in the bottom one-third of the population is significantly higher than are losses associated with smoking and obesity.⁴ Although access to health care is one piece of a complex set of mechanisms contributing to health inequity, health care contributes only a small fraction of the impact on individual's health in the context of the broader social determinants of health (eg, poverty and low education level).⁵

Given these circumstances, what is the role of medical education in attempting to attenuate this overwhelming problem that crosses all disciplines? One temptation is to intentionally maintain focus on what we can control—teaching and practicing the diagnosis and treatment of medical pathology. After all, as physicians, this is what we are trained to do, and to frame medical education and patient interactions in the context of poverty and the social determinants of health means we are working outside of our expertise.

However, as physicians, we need to be ultimately interested in our patients' health, not just their health care. As the dominant recipient of societal dollars directed at improving the health of the nation, health care institutions and practitioners should be among those at the forefront in mitigating the effect of poverty on health. In addition, graduate medical education is funded, to a significant extent, by the U.S. government. Teaching hospitals already serve a disproportionate share of poor and vulnerable patients in this country,⁶ and implementation of the Patient Protection and Affordable Care Act (Pub L No. 111-148, 2010) will likely result in an increased interaction of these patients with the health care system.⁷

Improving the health of patients and society is a strong motive for individuals pursuing a career in medicine. Indeed, altruistic attitudes and ideals are highest during the

first year of medical school and wane as training progresses.⁸ Because most medical students are raised in more privileged backgrounds than is the general population,^{9,10} it is conceivable that suboptimal training and role modeling on how to interact effectively with, and care for, a heterogeneous population of patients, many of whom are socioeconomically disadvantaged, contributes to frustration and a decline in altruistic attitudes and behaviors. To this point, there is increasing focus among professional societies on training residents and fellows to effectively care for these patients, and the Accreditation Council for Graduate Medical Education stresses that one role of the Next Accreditation System is “to arm the next generation of physicians with knowledge, skills, and attributes that will enhance care in the future and to expand the traditional role of residents in the care of underserved populations.”¹¹

In this issue of *JGME*, Wallace and colleagues¹² describe an experiential curriculum aimed at improving knowledge and attitudes of incoming residents toward patients living in poverty. The curriculum was delivered to incoming residents across several disciplines during 2 days of residency orientation. It included a didactic orientation to the community, interviews with staff at community-based organizations that serve low-income patients, 2 experiential poverty simulations, and a reflection session. Evaluation was performed through survey instruments and qualitative analysis of debriefing comments; the authors report acceptability of the curriculum and the possibility of improved attitudes toward patients living in poverty because of exposure to this curriculum.

That work adds to the graduate medical education literature that describes curricula designed to address patient care and advocacy in the context of the social determinants of health. Reports range from descriptions of structured didactic curricula to service-learning opportunities within existing institutional frameworks to community-based participatory partnerships with community members and organizations. Programs with a longitudinal experiential component for residents and a participatory role for patients and their advocates hold the most promise for success. Existing primary care training programs framed around the social determinants of health may fully incorporate these longitudinal and participatory principles.^{13,14} However, this task is more difficult for traditional training programs, which, under the pressure of busy

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curricula and training requirements, run the risk of creating a “tourism” experience of these sociocultural variables, without generating an understanding of proximal mechanisms and their interaction with the health care system among trainees or tangible benefit for patients and the community.¹⁵ These pitfalls may be carefully navigated through clear institutional leadership and with strong community-academic partnerships.

The work of Wallace and colleagues¹² further adds to existing evidence that educational interventions may improve resident knowledge and attitudes toward vulnerable patients and populations. The next step in demonstrating the role for medical education in the realm of the social determinants of health is to link educational interventions to clinical outcomes and patient-reported outcomes. In addition to traditional health care process and outcome measures (eg, preventive service adherence, chronic disease management), the impact of interventions on more proximal drivers of the intersection between poverty and poor health may be particularly compelling, such as measures of trainees’ actions in linking their patients with institutional and community-based resources. This approach is synergistic with the needs of graduate medical education to train physicians for leadership roles in patient-centered medical homes, where equitable population management is an important pillar of care.¹⁶

Perhaps a less tangible outcome of “social medicine” education is the ability to inspire a vision for the nexus of medicine and public health. The possibility of influencing the relative handful of doctors who will spend their career at this intersection may be a worthy goal. Whether this is most effectively achieved through programmatic curricula or through engagement and mentorship of select individuals is not clear. Indeed, strong role modeling may be the most powerful mechanism to influence behavior change toward underserved populations among trainees.¹⁷ Nevertheless, broadening the focus of medical education from health care to health may help influence the debate of how

to effectively, equitably, and compassionately care for *all* of our patients.

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