

Episode: *Ethics Talk: How Assumptions About Structural Determinants of Health Can Mask Sources of Inequity*

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[mellow theme music]

[00:00:05] TIM HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. Social determinants of health, or SDH, are factors that influence patients' health that can't be fully or robustly remediated during even the most thorough of clinical encounters. Living with poor air quality, a lack of educational opportunities, low socioeconomic status, these are all social determinants that inform a patient's health risk factors. Efforts to integrate education about social determinants of health into health professions curricula have been widely successful. Advancing students understandings of SDH has shown to increase their confidence when working with patients in under-resourced communities, and illuminating SDH can help direct resources of collaborations between various sectors beyond health care, including transportation, housing, and education. Some argue, however, that care must be taken when teaching about SDH to accurately describe root causes.

DR JOHN CHENAULT: If we fail to do so, we'll continue to talk about poverty, but not oppression; race, but not racism; sex, but not sexism; homosexuality, not homophobia. So, to get at the structural issues, the systemic issues that cause these problems, we need to revise our curriculum and instruction to incorporate that type of critical analysis of causes, fundamental causes.

HOFF: Mitigating health inequity needs to go beyond mere identification of its sources. Appreciating the health effects of negative social determinants in particular requires recognition of historical patterns of disenfranchisement that continue to marginalize specific patient populations today. The [January issue](#) of the Journal considers how critical pedagogy, and its focus on interrogating these patterns of marginalization, exploitation, and oppression in order to promote justice, can be operationalized in academic structures of health care.

Joining us on the podcast today is Dr John Chenault, an associate professor and the director of antiracism initiatives for undergraduate medical education in the University of Louisville School of Medicine in Kentucky. Dr Chenault is here to discuss the history of critical theory in health professions education and how faculty can develop critical, affective orientations to their clinical practices and their teaching. Dr Chenault, thank you so much for being on the podcast. [music fades]

CHENAULT: Thank you for inviting me.

[00:02:54] HOFF: So, critical theory has a long history in philosophy and social science, but some might be surprised to see it applied to health professions education. To begin with, can you help our listeners get a sense of how health professions educators have engaged with critical theory over the past few decades or so?

CHENAULT: Well, let me say, not much. It still remains underutilized, I think, for the most part and in part because medicine is very slow to move when it comes to theories of practice. Theories of biomedical, the biomedical model that we use is quite dated and hasn't changed, whereas medicine quickly embraces technological change, as we see. In fact, technology in most instances is operating beyond our real capacity to fully use it, to even understand how it works in many instances. I'll use CRISPR as an example. We can edit genes, but we don't know what genes do, to a great extent. So, technology often gets the focus, and the theory behind how that's developed, how it's utilized lags behind.

So, in reference to critical race theory in medicine, it is, there have only been a few institutions, I think, that have sort of braved the waters. There've been a number of articles that have been written proposing its embrace, its adoption, but very few institutions have followed through. And in the recent, in the past years, past two years I should say, any movement in that direction has been compromised by a full-throated attack against critical race theory, which actually, in my opinion, is a hoax that's being perpetrated nationwide.

[00:05:03] HOFF: Yeah, right. I'm glad you brought up this backlash against critical theory, not necessarily because any of the arguments we're seeing from many at the far right of the political spectra have any merit, but because university curricula is increasingly the target of these bad-faith attacks. But regardless of this, progressive teaching and learning strategies have been demanded by student-led campaigns to push health professions curricular content to include much more than just facts about how patients' and communities' health outcomes are situated by social, racial, cultural, demographic, historical, and any other extra-clinical determinants. So, which successes and failures are you seeing about how medical schools, for example, are orienting themselves to a plurality of demands about what classroom and clinic-based medical school curricula should look like?

CHENAULT: Well, I think medical schools are doing their best to respond to the demands, often from students who want to incorporate a social justice modality, curriculum, even pedagogy into medical education. So, this is a reflexive type of process that's going on, almost knee jerk in the sense that institutions are being pushed. And we saw this in relation to a 2020 protest that swept the country after the killings of George Floyd and Breonna Taylor. That pushed the American Medical Association and the AAMC to issue a series of directives to medical schools to end the use of race in medical education. And so, much of what we see taking place is reactionary, and it hasn't been thoroughly thought through very well. [00:07:01] So, what I see taking place most commonly is an emphasis placed on social determinants of health as an attempt to address health care disparities and health disparities. But there are so many limitations with that approach as well. What is lacking is what critical race theory offers, and that is a structural analysis of the health care systems itself and the underlying social structures that create and support inequities.

[00:07:42] HOFF: So, who might be best suited to help integrate this structural analysis that critical theory offers into health professions education? Is it something that requires sort of a cross-disciplinary effort of legal or sociological educators? Or is it something that health professions educators should, or maybe the better question is, is it something that health profession educators even can take the lead on?

CHENAULT: Well, we definitely need an intersectional approach. There's no question about that. We're currently operating on a biomedical model that originated in the early 20th century, and that model basically teaches that the body is a machine and that disease is basically to be addressed on an individual level by fixing the machine, replacing the machine's parts, etc., etc. But this focus is solely on the body. It does not address the

environment and the society in which the body must function and develop. And as a result, we have this very narrow theory about health and disease that is at the basis of the health disparities that we're experiencing. And not just the health disparities, the health inequities in the system. So, when we think about the current biomedical model, what we're looking at is a deficit model in that it separates the individual from all of the other factors that contribute to health and wellness or disease and illness. And so, that is one of the main problems with current medical education.

[00:09:33] So, we have to go back to the roots of the issue, and that is expanding that model. And it was done back in 1977, at least a proposal was made by George Engel, a psychiatrist. Engel came up with the biopsychosocial map model, and with the inclusion of psychology and sociology, we have a framework, a new paradigm to address the entire person and their lifestyle and their socialization, all of which are factors in terms of their health and health outcomes. Let me quote specifically from Engel, because I think it's so important to recognize the deficit in our model that we currently have. And this is a little bit of a lengthy quote, but I think it's very, very pertinent to what we're talking about here. So, in 1977, Engel said this: "The dominant model of disease today is biomedical, with molecular biology its basic scientific discipline. It assumes disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables. It leaves no room within this framework for the social, psychological, and behavioral dimensions of illness. The biomedical model not only requires that disease be dealt with as an entity independent of social behavior, it also demands that behavioral aberrations be explained on the basis of disordered somatic, (meaning biochemical or neurophysiological) processes. Thus, the biomedical model embraces both reductionism, the philosophical view that complex phenomena are ultimately derived from a single primary principle, and mind-body dualism, the doctrine that separates the mental from the somatic."

[00:11:39] So, others have described this model, this biomedical model, that Engel is critiquing as a culture that cannot recognize its own culture. And that's the fact that medicine is deeply informed by socioeconomic systems and systems of power that hinder its ability to interrogate what it's observing and how to interpret the world. So, the limitations of this model really fail to address the problems that we see in terms of health disparities and health care disparities. And there's a clear distinction. The health disparities, the individual experiences people have in terms of risk and prevalence for diseases—kidney disease, cancer, heart disease, etc.—and health care disparities in terms of how they're being treated and cared for, diagnosed, etc., within the health care setting. And so, that's where they encounter inequities. It's not only inequity in terms of the theory of medicine, but it's inequities in terms of the delivery of medicine.

[00:12:57] HOFF: Yeah, I'm glad you're framing it this way because it leads well into this next question. So, the downstream result of accepting this biomedical model is educators who rely on it to teach their students. So, the integration of critical theoretical pedagogies are a problem for faculty who don't already have a progressive, critical, affective orientation to their clinical practice, and it's a problem for health professions schools who have to manage faculty who maybe don't want to adopt critical theoretical pedagogical practices. These problems also cut close to another bone of contention about who should be regarded as competent to practice and teach others to practice. So, should this problem be viewed as mere conflict among faculty who, quote, "get it" and faculty who don't?

CHENAULT: Well, the problem speaks to education broadly and how we've siloed our disciplines in some cases to the point of exclusion where people feel that they're within a self-contained entity or environment, professional environment, and all the answers come

from within. And this has never been the case with any discipline. In fact, we can look at the evolution of these disciplines and how they often emerge from multiple intellectual foundations and essentially discard some of those external influences as they refine their particular practice and philosophy. So, there has to be a recognition of the limitations of the knowledge that physicians currently possess in relation to society, the economy, politics, etc. Physicians are trained in that biomedical model exclusively.

[00:14:57] And so, when it comes to issues related to environment, where a person lives, the lack of access to adequate nutrition, lack of transportation, well-paying jobs, educational opportunities, doctors don't take these things into account. They'll say, for example, "We have a patient here who I suspect is noncompliant. They're not going to take their medication. Why should I write this prescription? They're not going to take their medication." But that's an assumption that's made. It may be true to some degree, but why? Why is it true? And physicians generally lack the time, in some cases, the interest, in inquiring further why this person may not be able to comply with just basic, with a basic medical regimen for their own therapeutic benefit. There are so many factors that go on in an individual's family life, social life, etc. So, doctors should not be expected to embrace all of that knowledge and acquire all of those skills, but there should be opportunities for doctors to work collaboratively with sociologists, for example, in addressing these problems.

[00:16:21] HOFF: So, elaborate on that for me. What are your views about how this problem of faculty who are unable to integrate critical pedagogies because of the practical concerns you list like time and those who perhaps don't want to, how should this problem be managed by health professions schools and their leaders and other educators?

CHENAULT: I think there's room for different expertise within the medical education environment. So, I think schools have to think strategically about how to maximize the type of non-clinical training that's needed to support and supplement the clinical training. And so, we don't throw out the faculty with the bathwater, so to speak, if they're not grounded in critical race theory, etc. You provide them with the other...with other faculty within the institution that can work with them, that can also train students at the same time that the students are receiving the clinical training.

Let's be clear: Eighty percent of what we're talking about in terms of health care disparities are non-clinical. They have to do with the environment. They have to do with housing. They have to do with poverty. And so, if these underlying causes, these fundamental causes are not addressed, then essentially, we're spinning our wheels when it comes to clinical care. It becomes a revolving door where we're doing triage and then sending the person back out into this environment that's completely contrary to healing and wellness. So, that's the dilemma that we constantly face, and so we need to expand our concept of what medical education consists of. And it has to have a focus on the structural problems that we see: socioeconomic problems, problems of racism, sexism, etc. These have to be integrated into medical education.

[00:18:35] HOFF: Going back to what you were talking about before, you say that it would be helpful to have other faculty and staff who are more acquainted with critical pedagogies and who are more well situated to teach these things to students so that it doesn't all fall to the quote-unquote "clinical staff" to do this work.

CHENAULT: Sure, sure.

HOFF: One potential problem with this approach is the issue of organizations bringing on educators and leaders to focus on anti-racism initiatives, health equity initiatives, things like that, but not providing the resources they need to fully integrate these things into the rest of the work being done, so the folks brought on to do it are faced with the difficult task of illuminating these structural inequities for others without what they need to even do that work well. So, how can organizations set educators who they are asking to do this work up for success so that they can reach students and their peers?

CHENAULT: You're correct about the lack of resources often made available for people attempting to do this work. A couple things there. One, I do believe that the problem is we're trying to make programs. We're trying to create programs, anti-racism initiatives, LGBTQ+ initiatives. So, we start out on the basis of appending these things to an existing body. And let's be clear, the body is toxic, so it's like transplanting a healthy limb onto a gangrenous body. So, we have to go back to fundamentals again and rethink the paradigm of medical education. What are we attempting to achieve in training the next generation of physicians? So, they have to be trained to deal with expanding our biomedical model to recognize the patient is a person and treat the patient as a person. And that requires, again, that collaborative effort on the part of non-clinicians working with clinicians to move this along.

[00:20:44] But to me, the key in all of this is to involve clinicians in the sense of this information that we're talking about to eliminate health care disparities and health disparities, to talk about structural racism, to talk about sexism. This needs to be threaded throughout the entire curriculum so that when you go into your anatomy class, you learn about the history of grave robbing and the exploitation of poor people and enslaved Africans. Every field. Gynecology, for example, the field is grounded in surgical experimentation on enslaved women, poor Irish women, etc. And so, this should not be a separate, standalone type of course. This, again, can be threaded throughout. So, my message here is that we tend to try to program these things and not recognize how they are already normative. The best example of that is diversity. Diversity is a universal condition of human life. We're diverse all the way down to the level of the individual. So, when we talk about diversity and inclusion, we're actually just going around. This is a circular conversation because it exists. It already is. What we are lacking is equity and justice.

[00:22:19] HOFF: So, to wrap up our conversation today, what should students and trainees know about how to apply critical theory to the multiple and often overlapping complexities of health professions practice today?

CHENAULT: Well, I think it begins with self-reflection. It begins with self-reflection because we all need to consider the place that we're coming from, so-called locus of enunciation, if we want to get more philosophical about it. But how we've been socialized is something that we need to really think deeply about because this is what we bring as part of our clinical toolkit when we go into practice. We are who we are. And if we've had an experience of privilege, if we're part of a system of privilege and the status quo of privilege, that should be first and foremost in our minds when we're working with others to recognize through deep introspection what we're actually doing to either perpetuate the systems that are inequitable or to actually intervene and to solve them. So, that's the first thing.

I think the other thing is that we also have to develop the historical consciousness. This is so important. As a standalone, it's not, you know, we don't, it needs to be connected to the clinical reality of today. But we have to understand the medical profession has an extraordinary role to play here in bringing change to this society. And so, we have to start

on that basis of educating students about how structural and systemic racism came about and why. And so, without that historical framework and background, it doesn't help to put it into the context of clinical care. People will not be able to understand why certain people have experienced poverty for generations, for example, or have been segregated into impoverished communities for three generations and why. [mellow theme music returns] And who does that benefit? So, we have to combine the self-reflection with the historical consciousness, and hopefully that will both empower and equip our next generation of physicians.

[00:24:47] HOFF: Dr Chenault, thank you so much for your time and expertise on the podcast today.

CHENAULT: Thank you again for inviting me.

HOFF: That's all for this episode of *Ethics Talk*. Thanks to Dr Chenault for joining us. Music was by the Blue Dot Sessions. Another interview with Dr Chenault will be available on your favorite podcast app on the 15th. But to read the full issue on *Critical Pedagogy in Health Professions* in the meantime, and to listen to that episode now, head to our site, journalofethics.org. You can find that link in the description. For all of our latest news and updates, follow us on [Twitter](#) and [Facebook @journalofethics](#). And we'll be back next month with an episode on the One Health Approach to Human, Animal, and Environmental Health. Talk to you then.