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# Centering Social Pediatrics in Graduate Medical Education

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## Abstract

This article problematizes the normalization of social pediatrics as extracurricular or optional rather than necessary for children's health care. Drawing on critical pedagogical frameworks like structural competency and accompaniment, this article illuminates clinical, institutional, and structural obstacles to mainstreaming social pediatrics training. This article also identifies examples of how training programs, health systems, and policymakers can facilitate and sustain care environments that support social pediatrics and advance health equity.

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## Social Pediatrics

Social pediatrics is "an approach to child health that focuses on the child, in illness and in health, within the context of their society, environment, school, and family"—that is to say, within the broader framework of their life circumstances.[1] An aspiring social pediatrician must continually work toward structural competency, armed with the tools necessary to help enhance a child's community context while recognizing its intrinsic strengths.[2,3] These tools cannot be crafted in isolation within clinic and hospital walls.[2,3] To truly engage in social pediatrics is not simply to observe an individual child within their lived context, nor is it to impose solutions to complex social problems from within the "ivory tower"; rather, it is to actively engage with communities in their understanding and shaping of their social and material conditions.[4,5,6,7,8] Part and parcel of this notion is the praxis of *accompaniment*: of clinicians walking closely alongside children and their families through health and social crises alike through provision of relationship-based, team-delivered, community-engaged care that can improve equity, reduce costs of care, and save lives.[9,10]

To date, most social pediatrics training is implemented informally within other core requirements or formally in single seminars, didactics, or one-time advocacy events,[11,12] rather than through shared knowledge building over time in longitudinal relationships with proximate communities.[13] While these efforts provide a necessary starting point,

they risk devaluing social pediatrics training as "hidden curricula,"[12] and they frequently presuppose intransigent systems-level barriers to the provision of true social pediatrics education or clinical care.[2,14] While social pediatrics training should ideally be a dialectical, longitudinal, and time-intensive process, it is often relegated to brief "schooling" that reinforces hegemonic, deficit-based views of communities and ignores social complexity.[13,15] It follows, then, that normalizing social pediatrics in medical training and practice will require addressing educational, clinical, institutional, and structural barriers in an integrated fashion.

## Obstacles to Training Social Pediatricians

While definitions of social pediatrics and social medicine are expansive and rooted in rich ideological and theoretical frameworks, most pediatric residents struggle to engage in the praxis of social pediatrics within a health care system that actively disincentivizes structurally competent care.

At the interpersonal level, pediatric trainees and clinicians often face significant time and "bandwidth" constraints when discussing complex socio-structural factors with patients and families. Currently, the American Academy of Pediatrics (AAP) Bright Futures initiative identifies 208 individual screening "actions" to be completed at different time points during a child's 21 well-child visits, none of which explicitly include conversations about structural determinants of health (SDoH) or adverse childhood experiences (ACEs).[16] Pediatricians might notice a patient with elevated body mass index at a well-child check, discuss healthy eating, and identify opportunities for exercise. Yet, without interrogating barriers to consistent healthy food access, pediatricians could miss opportunities to work with school districts on offering more well-balanced lunches or to advocate for affordable whole-food stores in their neighborhood.[17] While even AAP guidance indicates that pediatricians should identify, refer, and advocate for families experiencing food insecurity,[18] clinical educators are often constrained in their role as preceptors to demonstrate medical knowledge of disease processes during busy clinic sessions, rather than simultaneously uncovering socio-contextual health-related factors and advocacy opportunities.

Time constraints aside, at the institutional and systems level, it remains clear that SDoH and ACE screenings are far from a stand-alone solution to achieving health equity.[2] Even when care environments do deploy universal social care screenings, their utility remains limited without their linkage to robust interventions or without sufficient time during the clinical encounter to address the traumatic experiences or socio-contextual challenges identified.[19,20,21] Electronic health record-based screens can be experienced as stigmatizing and biased and, even in their best form, might be immediately outsourced to community health workers or ancillary teams,[22,23] leaving little opportunity for accompaniment by pediatric trainees and clinicians. Amid these complicating factors, it is easy to see how even the most concrete and tangible aspects of social pediatrics education—like identifying and intervening upon a specific social need—can quickly become intractable.

Finally, at a policy level, future pediatricians orienting toward social pediatrics often struggle to contend with the perception of clinical pediatrics as aligned with carceral systems and approaches that can harm children.[24] A key example of this disconnect is categorical mandates for child welfare reporting, particularly because marginalized families are disproportionately shunted into punitive systems that often fail to provide support,[25] cause breakdowns of trust,[26] and exacerbate devastating consequences for

child and family health.[27] Increased reporting does not lead to better identification of children at risk, as only about one-fourth of maltreatment reports lead to substantiation.[28,29] For example, due to vague language in the federal Child Abuse Prevention and Treatment Act, which fails to explicitly define "reasonable cause" reporting standards related to prenatal substance exposure,[30] most jurisdictions interpret the law by requiring that pediatricians categorically report newborns of parents taking medications for opioid use disorder (MOUD).[31,32] These punitive policies actively dissuade birthing parents with substance use disorders from prenatal and postpartum care engagement,[33] decrease adherence to lifesaving MOUD,[34] and prolong newborn hospitalizations for neonatal opioid withdrawal syndrome,[35,36,37] in addition to potentially limiting the ways in which social pediatricians can build trust with their patients and communities. Punitive policies also exemplify that health care systems are not structured to incentivize future pediatricians to undertake the work of creative, meaningful, longitudinal coalition-building to advocate for community-driven solutions.[38]

## Operationalizing Social Pediatrics Training

Although obstacles abound, incorporating and formalizing social pediatrics training in resident education remains essential and can be achieved through a variety of individual, institutional, and structural changes.

First, at the patient-clinician level, clinical training must integrate opportunities for accompaniment. The Accreditation Council for Graduate Medical Education (ACGME) recently enacted new requirements for pediatrics residency programs that explicitly identify community and physician advocacy as a critical tenet for guiding development of the future pediatrics workforce.[39,40] The new ACGME residency program requirements will expand outpatient and behavioral health training, which may present novel opportunities to prioritize interprofessional and community-engaged experiences. For instance, for each half-day of an outpatient clinic, pediatric trainees could be allocated prolonged appointment slots for patients identified as facing socio-structural barriers to health and well-being. These appointment slots could be prioritized for multidisciplinary visits involving interdisciplinary clinical care team members in tandem with community health workers, social workers, or cultural brokers. While program-specific training environments will be heterogenous, embedding SDoH-related services within clinical settings may be another opportunity to reduce administrative burden, motivate conversations about health-related social needs, and facilitate co-enrollment for families seeking access to safety-net resources.[41,42,43] Other possible avenues for accompaniment in pediatrics training might include longitudinal trainee involvement in home visits and hospital-at-home services.[44] Foundational and proximate experiences within and beyond clinical settings—supported by new ACGME competencies and requirements—will enhance how social pediatricians recognize and understand the socio-structural determinants of child and family health.

Second, at the institutional level, social pediatric curricula must equip trainees with structural competency and longitudinal opportunities for direct action.[2,3] For example, at Boston Medical Center, Health Equity Rounds (HER) is a solutions-oriented, department-wide quarterly grand rounds series that aims to confront the effects of intersectional systems of oppression on health and health care.[45,46,47] Similar to a morbidity and mortality conference, HER presentations dissect the "whys" of a clinical narrative in a protected peer environment while striving to identify individual, institutional, and structural opportunities to improve care delivery. Early evaluations of HER from 2016 to 2018 highlighted that at least 88% of attendees felt HER promoted personal reflection

on implicit biases, and at least 75% of attendees intended to make one or more tangible changes to their clinical practice.[47] At our institution, carefully refined HER topics have directly led to trainee-driven media advocacy,[31,48] amplified attention to nationwide crises with key pediatric implications,[49,50,51] reformed clinical teaching teams' care and education approaches,[52] and motivated institution-funded research to inform equity-focused interventions.[53] Perhaps most importantly, HER has continued to serve as a venue for facilitating accompaniment through the recognition of lived expertise as a means of training social pediatricians, as panelists are often recruited from other teams in the hospital or local organizations. Institutions should fund protected time for faculty, staff, and community partners committed to developing dialectical, longitudinally supported, social pediatrics-oriented education of this nature.

The impact of HER has been felt on institutional and systems levels alike. For example, a 2018 HER presentation led to the creation of a new institutional guideline advising that child welfare agency reporting for prenatal substance exposure should be limited to cases in which the multidisciplinary team identified specific, tangible child protective concerns.[53] This guideline in turn motivated a research study to evaluate this novel hospital-level guideline,[53] the implementation of similar guidelines at other area hospitals,[54] endorsements by prominent local news outlets,[55,56] and a 2024 legislative bill that will end state-mandated child welfare agency reporting for the use of prescribed MOUD.[57] Across the country, HER has now been implemented at more than 65 institutions and integrated as a regular article series for the journal *Hospital Pediatrics*.[45,58,59] These impacts reflect ideal outcomes for social pediatrics training: expanding the real-world praxis of social pediatricians, within and beyond clinic and hospital walls.

Finally, at a structural level, social pediatrics can be prioritized in resident education when it becomes more robustly integrated into clinical practice for all pediatricians. One starting place may lie in decoupling carceral and punitive systems from systems of medical care and social support, so that at-risk children can be identified and aided outside the specter of family policing[60] and pediatricians can focus on service linkages and co-enrollment for families seeking safety-net resources ("you can support a family without having to report a family"[61]). Building a noncarceral support model, however, would necessitate the development of avenues for patients and families to confidentially disclose intervenable socio-structural barriers to their health and well-being.[62,63] By supporting policy change that explicitly defines reporting obligations,[64] works toward replacing categorical reporting mandates with risk-based permissive reporting,[65,66] and recognizes that child welfare agencies often prioritize investigation over service provision,[27,60,67] social pediatricians—and therefore pediatric trainees—can better provide structurally competent care.

Integrating social pediatrics into the core fabric of resident education will also require shifting care to community-centered models that incentivize sustained accompaniment by restructuring health system incentives. While evidence and experience suggest these models could improve care outcomes, enhance equity, reduce clinician burnout, and lower costs, restructuring health system incentives will require a multipronged approach.[10,68,69,70,71] Necessary interventions might include ensuring universal access to insurance,[72,73,74] financing creative approaches to address health-related social needs,[21,75] establishing rate parity across payers,[76,77] interrupting cycles of hospital price discrimination,[78,79] improving social risk adjustment,[80,81,82] strengthening rather than penalizing the health care safety-net,[80,83,84,85,86] and continuing to iteratively evaluate

these interventions at every stage.[87,88] Although these structures may seem far-removed from the training and practice of social pediatricians, the sustainability of social pediatrics—and the pediatric workforce writ large[77,89,90]—may hinge upon these fundamental care delivery reforms.

## Conclusion

By drawing upon critical pedagogical frameworks like structural competency and long-standing social medicine paradigms like accompaniment, we argue that social pediatrics training can move toward a future that prioritizes a deeper patient-clinician relationship, necessary professional development for all trainees, and equitable systems reforms that will empower the pediatrics workforce of the future.

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