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Critical Pedagogical Approaches to Structural Drivers of Health

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Abstract

Social accountability in health professions education prominently has to do with preparing students and trainees in pediatrics to do 3 key things: prioritize social and structural drivers as preconditions of children's health, work to mitigate health inequity among children by partnering with community members and families, and integrate advocacy for health system improvement for children into practice. This article suggests strategies for health justice advocacy and for strengthening cross-disciplinary teaching about how to screen children for structural drivers of health.

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Critical Pedagogy and Preconditions of Children's Health

Screening children for root causes of health inequity—sometimes referred to as social, economic, political, and historical influences on health and health outcomes[1]—illuminates key questions about the scope of clinicians' roles in public health, particularly with regard to mitigating health inequity among children. This article investigates how a critical pedagogical focus on screening can reveal possible responses to such questions. Critical pedagogy, founded by the Brazilian philosopher and educator Paulo Freire, is an educational philosophy and social movement that sees education as profoundly moral and political and is designed to provide students with the tools to critically critique the status quo, hold authority politically and morally accountable, and act on their sense of social responsibility to address social problems.[2] A health professions education informed by critical pedagogy would help students learn about the structural drivers of health and could increase not only pediatric screening for such drivers of health but also advocacy by medical professionals to address them and promote public health.

Why Critical Pedagogy?

An argument in favor of bringing critical pedagogy into health professions education rests on the premise that the current educational model teaches students to conform to a status quo that supports social inequities in health and health care and that clinicians have responsibilities to acknowledge and to try to transform the social, cultural,

economic, political, and environmental determinants of health.[3,4] At the core of critical pedagogy is a belief that it can, and should, help clinicians "to develop critical health literacy by promoting social justice and the taking of individual or collective action."[4] To center critical pedagogy within health professions education would be to declare the promotion of equity and social justice as core values of health professions education and practice.[5]

One goal of critical pedagogy is to turn students into critically informed social activists. Cavanagh et al suggest that, by asking medical students to think critically about social and structural causes of ill health, they will become well-equipped to screen for and identify drivers of health in their communities and advocate for policy change, actively reconfigure the patient-clinician relationship to better promote collaborative engagement with patients, and actively work to probe and undo structural causes of ill health embedded in their clinics.[6] Similarly, Ross proposes 4 ways that critical pedagogy could improve health education: (1) by embedding the wider social contexts of health in the curriculum, (2) by preparing students for the complexities of the populations they will serve, (3) by ensuring that the effects of place are considered, and (4) by enabling students to enact changes to help achieve equity.[3] A key element in the desire to bring critical pedagogy into medical education is the belief that social accountability should be at the heart of medical school.

The idea that power structures and social inequity influence health is not new and is the basis of what is sometimes referred to as social medicine. Social medicine is interdisciplinary; it examines how social, economic, and environmental factors influence health, disease, and the delivery of care and aims to address health inequities, often through social and political action.[7] A key social medicine framework to help clinicians recognize and understand how socioeconomic, political, and environmental factors affect health is structural competency. Structural competency is the trained ability to discern influences of structural drivers of health in clinical settings.[8] However, while social medicine and structural competency are increasingly being incorporated in health professions education, it is only in the academic year 2023-2024 that the Liaison Committee on Medical Education made coverage of structural competency a requirement, although there is no agreed-upon approach to curriculum development.[9]

An important parallel between social medicine and critical pedagogy is the goal of educating students about the structural underpinnings of inequity and emboldening them to work against oppression. Matthews proposes that Freire's 3-phase model of critical pedagogy be implemented in health education to encourage students to discover their own concerns and develop their own solutions to problems.[4] This model consists of "listening and naming" real-world issues and experiences, facilitating problem-solving through "dialogue and reflection," and promoting "transformative social action" to challenge the ideas and practices that give rise to and support inequality. A crucial part of the process, Matthews notes, is that students "come up with their own ideas about what action to take rather than having other people's ideas imposed on them."[4]

Focusing on the importance of Freire's problem-posing approach to education, Cavanagh et al argue that reconceptualizing problems, knowledge, and patients in health professions education would help students to challenge deterministic concepts of health.[6] Contrary to traditional problem-based education, or "banking" education, wherein questions have a right answer and knowledge is "deposited" into students, problem-posing education encourages students to actively engage with real-world issues

by identifying problems within their own context, critically analyzing them, and collaboratively seeking solutions, thereby fostering a sense of critical consciousness and empowering them to take action. Cavanagh et al see this form of health professions education as fostering reflexive commitment to professional advocacy and social justice.[6]

Onuoha et al propose a more theory-oriented approach to bringing critical pedagogy into health professions education by adopting structural competency, critical race theory (which examines the structures of systemic racism and their impacts), and participatory action research (which emphasizes participation in research by members of communities affected by it with the primary goal of bringing about social change within communities) as frameworks to advance health justice.[10] To implement these frameworks in health professions education, Onuoha et al call for 3 fundamental pedagogical shifts.[10] First, redefine who is considered a teacher via self-directed, learner-community action that recenters notions of health equity expertise in health professions education. Second, implement novel educational tools, such as podcasts, neighborhood walking tours, and street art tours, to help facilitate learners' understanding of neighborhood-level social and structural determinants of health. Third, institutionally embed and incentivize antiracism. These pedagogical shifts highlight the importance of taking theory-driven, pragmatic, actionable steps to change institutional culture.

Another source of inspiration for how to bring critical pedagogy into health professions education is Brazil, which has developed a pedagogy of connection that is deeply rooted in the concepts of critical pedagogy.[11] De Carvalho Filho and Hafferty stress that Brazilian medical education is aligned with Freire's concept of "unfinishedness," suggesting that clinical knowledge is not fixed but continually changing and thus open to improvement.[11] To prevent students from feeling powerless in a health care system perceived as unchangeable, students are exposed to and discuss the health care system as a social mechanism susceptible to influence, including by themselves. By demonstrating how education, health care delivery, and social values evolve together, the Brazilian model aims to foster a sense of hope in students that systems can improve, as well as a commitment to future service and social justice.[11]

One of the great benefits of critical pedagogy is that it helps to instill in students a sense of purpose and hope for the future. Embedded within health professions education, it can help students cultivate the knowledge, skills, and attitudes needed to prevent their "becoming part of a static and inequitable system of healthcare."[3] By centering critical social medicine, critical pedagogy also provides students with tools to help them conceptually convert the private sufferings of patients into public issues that demand action.[12] Ultimately, critical pedagogy questions the standard assumption that social activism is a choice for those with the privilege to engage in it and instead suggests that it is, in fact, an ethical responsibility. Adopting critical pedagogy within health professions education would be a call to health professionals to seek richer understanding of the lived experiences of their patients and to stand in solidarity with the most vulnerable, especially the sickest and those who lack full decision-making capacity and authority, such as children.

Structural Drivers in Health Professions Education

In recent years, due in large part to social movements such as Black Lives Matter as well as the disproportionate impact of the COVID-19 pandemic on minority and at-risk

communities,[13] there has been heightened attention on systemic and social inequity in health, with some health professions educators pushing for greater advocacy for social change within health care.[14] Curricula about structural drivers of health are often limited and elective,[15,16] however, despite the fact that many students are likely to practice in underserved communities and need the confidence and knowledge to do so well.[15] Noting that social and structural forces have more influence on well-being than all health care services combined, Castillo et al advocate that the Accreditation Council for Graduate Medical Education adopt a new core competency to "better train physicians to be enlightened actors to improve health equity."[17] The proposed competency entails training physicians to (1) understand and recognize the social and structural drivers of health, (2) work with communities and non-health care sectors toward eradicating health inequities, (3) advocate for health care system improvements, and (4) adopt a socially responsible attitude toward patient interactions.[17] One goal of this proposal, like that of critical pedagogy, is to challenge the next generation of medical practitioners not to just treat the symptoms but to address the root causes of the structural drivers of health that impact patients, work that has traditionally fallen under the purview of public health.

Concurring on the importance of training health professionals to address structural drivers of health, Andermann and CLEAR Collaboration outline concrete actions that clinicians and administrators can adopt to do so.[18] These include asking patients about their social history, referring them to local support services, and facilitating access to such services. At the patient level, it is important that physicians ask patients about potential, often hidden, social issues in a sensitive and culturally appropriate manner. At the organizational level, senior management can help reduce barriers to care by providing reimbursement or support for transportation and childcare, extending clinic hours, and creating community outreach opportunities and partnerships. At the local level, physicians can serve as advocates by supporting social and political movements that aim to reduce social barriers to achieving health.[18] The American Academy of Pediatrics suggested that screening for and addressing structural drivers of health should be mandatory, not just recommended, in pediatric clinical encounters.[19]

Public Health Obligations

The notion that clinicians have responsibilities not only to individual patients but also to public health is not new. Despite its controversial and untoward impact on health equity, the 1910 Flexner Report recommended that foundational elements of public health be included within medical education.[20] And, today, the American Medical Association's mission statement is "to promote the art and science of medicine and the betterment of public health."[21] Similar to the teaching of structural drivers of health, many health professions schools have adopted an expanded scope of practice that includes issues related to public and population health, but no standard set of outcomes or practices exists for such training.[22]

Maeshiro and Carney note that the COVID-19 pandemic has revealed many ways in which a physician workforce knowledgeable about public health is better equipped to anticipate and contribute during crises.[20] But how might meaningful partnerships be cultivated between clinical and public health communities? According to Maeshiro and Carney, "To achieve more effective medicine-public health relationships in practice, health professions education across the continuum must include explanations of public health systems, the responsibilities of physicians to their local and state governmental public health agencies, and opportunities for collaboration."[20] They add: "Medical

education should also prepare physicians to advocate for public health policies, programs, and infrastructure that will improve and protect the health of their patients and communities."[20] Finkel stresses that, for public health education to be successful, it should be integrated into all 4 years of the medical school curriculum.[23]

Rao et al argue that the COVID-19 pandemic has underscored the need to think about health equity and ways to address the social and structural drivers of health.[24] They suggest that integrating public health into health professions education will better prepare physicians to deal with noncommunicable diseases and to recognize the influence of social determinants of health. It will also enhance data sharing and collaboration. They write: "It is important to note that a public health education also involves training in community organizing, stakeholder communications, working across disciplines and with government agencies toward strategic planning and logistics and innovation, all of which are relevant to clinical practice and have been integral, most recently, in the COVID-19 response."[24] However, they also acknowledge that such a transformation of health professions education will require shifts in clinical mindsets. Maeshiro and Carney likewise emphasize that the challenge is to use recent public health lessons to improve medical education.[20] Johnson et al stress that, while challenging, strengthening curricula and community-academic partnerships is achievable.[22]

Pediatric Practice

While the debate regarding how much public health education should be incorporated in health professions education and how responsible physicians should be for addressing public health issues is perhaps best left to those in the field to resolve, what has become clear is that greater understanding, communication, and cooperation across clinical medicine and public health is needed. Building bridges between medicine and public health is possible. Although health care professionals should not be entirely responsible for addressing the structural drivers of health and ending health inequities, neither should they be permitted to ignore them. The current dilemma is how to change the scope of clinical medicine to incorporate a public health perspective. The first step is to revise health professions education curricula. Adopting critical pedagogy is commensurate with incorporating aspects of public health to address structural drivers of health. If physicians are to be able to effectively screen for structural drivers of health, they need to be better educated about them. As concerns over the feasibility of screening for structural drivers of health highlight,[25] the biggest challenge will be to change the current mindset within medicine about its own responsibility to public health and health equity.[26] Adopting a critical pedagogical lens is a reminder that physicians have a responsibility to use their standing within society to advocate for greater health equity and improve public and population health. It is time that health professions education gives clinicians the tools to do so.

Regardless of whether health care professionals wish to engage in social reform and social justice actions, they should be equipped with the means to advocate for and pursue such changes. At a bare minimum, health professions students should be taught about the structural drivers of health and the important role they play in patient populations. This knowledge will at least allow them to better recognize the impacts of the structural drivers of health when they encounter them in a clinical setting and to be better prepared to talk to patients about them. In pediatrics, structural drivers of health screening is crucial to help improve health outcomes by identifying children who are experiencing challenges like poverty, food insecurity, or housing instability. Screening

can facilitate early intervention and access to needed support services, ultimately mitigating negative health impacts, improving child well-being, and saving lives. Unfortunately, despite the importance of such screening, few physicians report regularly screening pediatric patents.[27] Providing proper training is a crucial step in helping physicians overcome barriers to reducing structural drivers of health, and early education about the structural drivers of health should be considered an important part of such training. Incorporating critical pedagogy and a focus on critical social medicine, including public health obligations, in health care professionals' education is an important step in improving structural drivers of health screening and pediatric health outcomes, as "related residency curricula have been shown to increase detection of social issues, the frequency of screening, provider's comfort in addressing sensitive topics, and their competence in linking patients to resources."[27] Incorporating critical pedagogy into health professions education will also offer health professions students a sense of hope for the future and help them to recognize themselves as empowered agents for social change and health justice.

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