From *social determinants* to *social interdependency*: Theory, reflection, and engagement

William Ventres; Shafik Dharamsi; Robert Ferrer

Abstract

Introduction:

Scholars and practitioners in medicine and public health have devoted significant time and effort to defining the social determinants of health and identifying resulting inequities in health outcomes. Unfortunately, however, health care professionals can be led to believe that the origins of poor health-related outcomes are disconnected from the ways in which social, economic, political, and environmental factors are established and maintained.

Discussion: We introduce the concept of *social interdependency* in health and illness as a way to (1) reinforce the need to identify the root causes of social determinants, and (2) accept not only personal but also shared responsibility for acting to ameliorate their effects. Developing a sound understanding of social interdependency in clinical practice, public health research, and healthcare advocacy involves an iterative process of observation, reflection, and action. Effecting positive change within these disciplines is a shared obligation.

Conclusion: Developing and applying a social interdependency approach means appreciating our human interconnectedness. This approach showcases how we live in a world where none of us is so separate from another that we cannot benefit by envisioning and desiring for others what we might desire for ourselves, and can motivate us to consider work in the health professions as a force not only to attend to disease, but also to encourage health.

Keywords: Attitude of health personnel; bioethics; culture; health inequities; public health; social determinants; social responsibility; vulnerable populations

William Ventres, MD, MA
Title: Research Associate, Institute for Studies in History, Anthropology, and Archeology, *University of El Salvador*, San Salvador, El Salvador; Affiliate Associate Clinical Professor, Department of Family Medicine, Oregon Health & Science University, Portland, Oregon, USA; Urbanización Buenos Aires III, Block H, San Salvador, El Salvador
Email: wventres@gmail.com

Shafik Dharamsi, PhD
Title: Dean, College of Health Sciences, University of Texas at El Paso, El Paso, Texas
Email: shafikdharamsi@utep.edu

Robert Ferrer, MD, MPH
Title: Professor, Department of Family and Community Medicine, University of Texas Health Science at San Antonio, San Antonio, Texas
Email: ferrerr@uthscsa.edu

Submitted: 2/7/2016
Revised: 11/15/2016
Accepted: 11/15/2016
Conflict of interest: The authors declare that they have no competing interests.
Peer-reviewed: Yes

> Social determinants "are the conditions in which people are born, grow, live, work and age... The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries."[1]

Introduction

Knowledge that social factors affect health and illness is nothing particularly new,[2] and scholars in medicine and public health are increasingly devoting time and effort to identifying how social determinants influence health outcomes.[3,4] However, from viewpoints based largely on our experiences in resource poor settings around the world, we are

concerned that social determinants are commonly conceived of as disembodied abstractions — poverty, racism, and violence, for example — and not understood in ways that question prevailing social structures. Indeed, disparities in health outcomes are a result of those who create and support knowingly, unknowingly, or through willful ignorance — conditions that lead to inequality.

We as healthcare professionals can often be led to believe that the origins of poor health-related outcomes exist out there, somewhere else, disconnected from the ways in which social, economic, political, and environmental factors are established and maintained.[5] We can fail to develop a critical awareness of how power and privilege — the "web of causation"[6] — perpetuate social systems that foster injustice and oppression, which, in turn, negatively affect people's health and well-being. We can fail to develop a thoughtful understanding of how our actions are intertwined with the results these systems engender.

Consequently, we suggest that in addition to recognizing the *social determinants* of health, health professionals move toward understanding and applying a *social interdependency* of health and illness. In this article, we introduce the concept of social interdependency (emergent from our personal teaching and practice activities as well as our collective reflections on social medicine, the notion of social determination, and Social Interdependence Theory[7-13]) and advocate for the adoption of a social interdependency approach among healthcare professionals.

Discussion

Conceptualizing Social Interdependency

Social interdependency starts by reinforcing the process of perceiving the root causes of social determinants of health; it further suggests that taking responsibility for changing those root causes is a commitment collectively shared by all members of society.

Conceptualizing social interdependency requires:

- Admitting that social structures profoundly influence health outcomes. The term "structural violence" is useful for understanding how the active establishment and perpetuation of unjust power arrangements harm people's health.[14]
- Recognizing that these societal arrangements are the root causes responsible for health inequities, made manifest through determinants of health.[15]
- Becoming aware, by nurturing "structural competency,"[16] that these arrangements are inherently part of any educational, service, ideological, or economic system that operates to marginalize large sections of the majority world as it centralizes power and maximizes wealth in the hands of a select few.[17]
- Acknowledging that each of us is involved in either the sustenance of social systems that produce adverse health outcomes or the disestablishment of these systems through actions that denounce and disassemble the beliefs, attitudes, ideologies, and practices underlying them.
- Realizing that alternatives to oppressive social structures exist, and that each of us can play important roles in creating and supporting alternate structures that seek to promote health among those most oppressed who disproportionately bear the greatest burden of illness.

Building a Social Interdependency Orientation

Developing an understanding of social interdependency involves an iterative process of perception, reflection, and action. Building this orientation means:

- Seeing the realities of health inequities, in all their complexities, as part of an accurate worldview.[18-20]
- Recognizing the costs of these inequities to human dignity.[21-23]
- Appreciating how economic and political hegemony, concepts of core and periphery, and cultural imperialism, among other social factors[24-26] interact to form an interconnected web of influence that benefits a minutely small, privileged minority at the expense of the vast majority.[27]
- Realizing how none of these factors are immutable, "natural" phenomena, but rather social ones rooted in and perpetuated by the willful actions of human beings.[28]
- Engaging in the broader community as active and concerned citizens of health.[29,30]

Recognizing Shared Context

Fruitful responses to these five points depend on

developing a commitment to pluralism, participation, dialogue, and respectful resistance.[31-33] *Pluralism* means acknowledging that people experience reality from diverse viewpoints; we all think, feel, and act in ways concordant with these different points of view. *Participation* means exploring these varied points of view: actively eliciting, listening to, and thoughtfully considering alternate beliefs, especially when they are expressed by people who have been historically oppressed by such reasons as the color of their skin, the place of their birth, or the degree of their marginalization. *Dialogue* means encouraging honest and open discourse that can mediate the shift from a consciousness of pluralism to a penchant for participation, a process built on transparency, engaged presence,[34] and the willingness to address conflicts of interest with respect.[35] *Resistance* means standing true in the face of unjust asymmetries of power; it represents a viable imperative when human dignity is threatened.

The complex nature of these four concepts is contextual in nature.[30] It is relationally constructed, organized, and maintained. Context is not easily explored using the reductionist approaches that dominate contemporary professional thinking (much of which is either aimed at examining factors such as individual risk and personal choice or maintained by economic incentives that exaggerate its utility.[36]) Growing a contextual awareness of social interdependency requires that health professionals view power dynamics, cultural dogmas, and collective ideologies as part and parcel of disease etiologies, expressions of illness, and their respective remedies. Actively engaging social interdependency means re-imagining individual health in light of the health of the public.

Developing an Interdependency Awareness

Developing a critical consciousness to injustice and identifying the societal factors that contribute to its existence are essential skills for health care professionals interested in growing a social interdependency perspective. Cultivating this perspective also requires examining our own beliefs and feelings (including, for example, personal values, anxieties, interests, and intentions) and working to uncover our implicit biases.[37,38] This suggests that learning to appreciate the historical, economic, and political influences that have shaped our socializations, those that have focused our attention on professional activities of limited overall benefit as well as those that enhance our capabilities to see reality as it is experienced by the economically poor and socially vulnerable, bear witness to the inequities that engender this reality, and work to lessen their effects.[39] Otherwise we risk adding to human suffering by reproducing structures of power that suppress healthy human development among those most in need.

Choosing Active Engagement

Social interdependency suggests that we are confronted with choices in our daily work, whether we are conscious of them or not. In the face of the inequalities in health — the "have nots" of this world disproportionately suffer poorer outcomes in contrast with the "haves"[3,4] — and the knowledge that the current market-based medical-industrial model cannot rectify these inequities.[40,41] Health professionals can choose to passively accept the status-quo, or we can choose to actively work to bring about positive change. This means mobilizing to address the factors that lead to inequities.[42] It means working in solidarity with marginalized members of society to construct new conditions, new ethics of care, and new politics that offer participation, engagement, and hopefulness.[43] It means socializing the next generation of health care professionals to work with vulnerable members of our society, improve and expand systems of primary care, promote fair policies that protect employment and provide dignified work, and broaden just economic, social, and cultural rights, including equitable access to public services that support health and human well-being.[44-49]

Further Considerations

Some may read this and conclude that the concept of social interdependency is too general an idea to apply to the everyday work of healthcare. Others may suggest that the contemporary emphasis on money, power, and high-technology as paths to achieving success makes the idea of social interdependency a utopian dream. Still others may argue social interdependency is not applicable to today's clinical environment: the work of medicine and public health is, and must remain, that of individual and community diagnosis and treatment.

We respond that social interdependency is not about solving all socially mediated problems at once. Its starting points may be actions as simple as choosing to focus one's work in local communities of

need and opting to do that work from a position of solidarity rather than one of authority.[50,51] Unless we are willing to examine the consequences of our individual and collective choices, people will suffer regardless of how adept we are in diagnosing and treating diseases, even aware of social context. Interdependency does not replace determinants; it provides a lens through which we can see their origins and a platform from which to work to uproot them.

Conclusion

Developing and applying a social interdependency approach means appreciating our human interconnectedness. For health professionals, it specifically means working to extend clinical and preventive services to all, rather than putting up barriers to quality care. It means seeing in research activities opportunities for community engagement rather than restricting its use to controlled environments. It means investing in medicine and public health as processes full of potential for common healing rather than simple commercial profit. It means, across these and other dimensions associated with health and illness, recognizing that we live in a world where none of us is so separate from another that we cannot envision and desire for others what we might desire for ourselves.

A social interdependency approach showcases how our well-being is linked to the well-being of others, and vice versa. It enlightens us as to how our day-to-day worlds are intimately linked to the worlds of those for and with whom we work and, thus, lends credence to the ethical principles of dignity, solidarity, service, and resolve. It motivates us to consider our work as a force not only to attend to disease, but also to encourage health, and can help us engage as inspired participants in this quest. This is especially important now, so as to counter dominant discourses that distort the worth of privatized, capital-intensive, and technologically-dependent solutions to system-wide problems.

We believe such considerations can move us all toward seeing the world and our responsibilities in it from new and empowering points of view and, along the way, shift our perspectives from frustration to hope. Related to issues of medicine and public health, we invite you to "think" *interdependency* each time you see or hear the word *determinants*. We invite you, by thus "thinking" social interdependency, to share with us this hope.

Acknowledgements

The authors thank Anne-Emanuelle Birn, ScD, and Virginia Rodríguez Funes, MD, for their thoughtful comments on drafts of this article. They thank David W. Johnson, PhD, for giving us permission to adapt the wording and interpretation of Social Interdependence Theory (from the discipline of Educational Psychology) to fit a health and illness context.

References

1. World Health Organization. What are the social determinants of health? Geneva, Switzerland. 2013. Available at: http://www.who.int/social_determinants/sdh_definition/en/.
2. Kunitz SJ. The health of populations: general theories and particular realities. New York: Oxford University Press; 2007.
3. World Health Organization. Closing the gap in a generation: health equity through action on the social determinants of health. Geneva, Switzerland: World Health Organization; 2008.
4. Marmot M, Wilkinson R. The social determinants of health. 2nd ed. Oxford, UK: Oxford University Press; 2005.
5. Braveman P, Gottlieb L. The social determinants of health: It's time to consider the causes of the causes. Public Health Rep. 2014;129 Suppl 2:19-31.
6. Krieger N. Epidemiology and the web of causation: has anyone seen the spider? Soc Sci Med. 1994;39(7):887-903.
7. Porter D. How did social medicine evolve, and where is it heading? PLoS Med. 2006;3:e399. doi: 10.1271/journal.pmed.0030399
8. Breilh J. Epidemiología crítica: ciencia emancipadora e interculturalidad. Buenos Aires, Argentina: Lugar Editorial; 2003.
9. Spiegel JM, Breilh J, Yassi A. Why language matters: insights and challenges in applying a social determination of health approach in a North-South collaborative research program. Global Health. 2015;11:9. doi: 10.1186/s12992-015-0091-2
10. Johnson DW, Johnson RT, Smith K. The state of cooperative learning in postsecondary and professional settings. Educ Psychol Rev. 2007:19:15-29.
11. Ventres WB. Cultural encounters and family medicine: six lessons from South America. J Am Board Fam Pract. 1997;10(3):232-6.
12. Dharamsi S, Woollard B, Okullo I, Kendal P, Macnab A. Health promoting schools as learning sites for

physicians in-training. Health Educ. 2013;114(3):186-96. doi: 10.1108/HE-09-2013-0048
13. Ferrer RL. A piece of my mind: within the system of no-system. JAMA. 2001;286(20):2513-4.
14. Farmer P, Nizeye B, Stulac S, Keshavjee S. Structural violence and clinical medicine. PLoS Med. 2006;3:e449. doi: 10.1371/journal.pmed.0030449.
15. Ventres W, Kravitz JD, Dharamsi S. PEARLSS: key forces that influence social determinants and shape health outcomes. Acad Med. In press.
16. Metzl JM, Hansen H. Structural competency: Theorizing a new medical engagement with stigma and inequality. Soc Sci Med. 2014;103:126-33. doi: 10.1016/j.socscimed.2013.06.032
17. Silver M. If you shouldn't call it the third world, what should you call it? NPR. January 4, 2015. http://www.npr.org/blogs/goatsandsoda/2015/01/04/372684438/if-you-shouldnt-call-it-the-third-world-what-should-you-call-it. Accessed July 30, 2015.
18. Sen A. Development as freedom. 2nd ed. New York, NY: Oxford University Press; 2001.
19. Ventres W, Gusoff G. Poverty blindness: exploring the diagnosis and treatment of an epidemic condition. J Health Care Poor Underserved. 2014;25(1):52-62. doi: 10.1353/hpu.2014.0025
20. Bourgois P, Holmes SM, Sue K, Quesada J. Structural vulnerability: operationalizing the concept to address health disparities in clinical care. 2017;92(3):299-307. doi: 10.1097/ACM.0000000000001294
21. Phillips SP. Defining and measuring gender: a social determinant of health whose time has come. Int J Equity Health. 2005;4:11. doi: 10.1186/1475-9276-4-11
22. Kawachi I, Kennedy BP, Lochner K, Prothrow-Smith D. Social capital, income inequality and mortality. Am J Public Health. 1997;87(9):1491-8.
23. Navarro V, Muntaner C, Borrell C, Benach J, Quiroga A, Rodriguez-Sanz M, Vergés N, Pasarin MI. Politics and health outcomes. Lancet. 2006;368(9540):1033-7.
24. Stoddart MCJ. Ideology, hegemony, discourse: a critical review of theories of knowledge and power. Soc Thought Res. 2007;28:191-226.
25. Galtung J. A structural theory of imperialism. J Peace Res. 1971;8(2):81-117.
26. Verkerk MA, Lindemann H. Theoretical resources for a globalised bioethics. J Med Ethics. 2011;37(2):92-6. doi: 10.1136/jme.2010.036830
27. Waitzkin H, Iriart C, Estrada A, Lamadrid S. Social medicine then and now: lessons from Latin America. Am J Pubic Health. 2001;91(10):1592-601.
28. Green M, Hulme D. From correlates and characteristics to causes: thinking about poverty from a chronic poverty perspective. World Dev. 2005;33(6):867-79. doi: 10.1016&/j.worlddev.2004.09.013
29. Dharamsi S, Ho A, Spadafora SM, Wollard R. The physician as health advocate: translating the quest for social responsibility into medical education and practice. Acad Med. 2011;86(9):1108-13. doi: 10.1097/ACM.0b013e318226b43b
30. Nichter M. Global health: why cultural perceptions, social representations, and biopolitics matter. Tucson, AZ: University of Arizona Press; 2008.
31. Garrafa V, Porto D. Intervention bioethics: a proposal for peripheral countries in a context of power and injustice. Bioethics. 2003;17(5-6):399-416.
32. Ventres W, Haq C. Toward a cultural consciousness of self-in-relationship: from "us and them" to "we". Fam Med. 2014;46(9):691-5.
33. Hesserl S. Time for Outrage! London, UK: Charles Glass Books; 2011.
34. Hunt MR, Schwartz L, Sinding C, Elit L. The ethics of engaged presence: a framework for health professionals in humanitarian assistance and development work. Dev World Bioeth. 2014;14(1):47-55. doi: 10.1111/dewb.12013.
35. Ventres WB. Building power between polarities: on the *space-in-between*. Qual Health Res. 2016;26(3):345-50. doi: 10.1177/1049732315609573
36. Breilh J. La determinación social de la salud como herramienta de transformación hacia una nueva salud pública (salud colectiva). Rev Fac Nac Salud Pública. 2013;31 Supl 1:13-27. Available at: http://www.redalyc.org/articulo.oa?id=12028727002.
37. Ventres WB, Fort MP. Eyes wide open: an essay on developing an engaged awareness in global medicine and public health. BMC Int Health Hum Rights. 2014;14:29. doi: 10.1186/s12914-014-0029-4
38. Dharamsi. S. Moving beyond the limits of cultural competency training. Med Educ. 2011;45(8):764-766. doi: 10.1111/j.1365-2923.2011.04044.x
39. Greenhalgh T, Russell J. Evidence-based policymaking: a critique. Perspect Biol Med. 2009;52(2):302-14. doi: 10.1353/pbm.0.0085
40. Hart JT. The inverse care law. Lancet. 1971;i(7696):405-12.
41. Labonte R. Global action on social determinants of health. J Public Health Policy. 2012;33(2):139-47. doi: 10.1057/jphp.2011.61
42. Bainbridge L, Grossman S, Dharamsi S, Porter J, Wood V. Engagement studios: students and communities working to address the determinants of health. Educ Health (Abingdon). 2014;27(1):78-82. doi: 10.4103/1357-6283.134330
43. Dawson A, Jennings B. The place of solidarity in public health ethics. Public Health Rev. 2012;34(5):65-79. doi: 10.1002/hast.490
44. Westerhaus M, Finnegan A, Haidar M, Kleinman A, Mukherjee J, Farmer P. The necessity of social medicine in medical education. Acad Med. 2015;90(5):565-8. doi: 10.1097/ACM.0000000000000571
45. Ventres W, Dharamsi S. Socially responsible medical education: the REVOLUTIONS framework. Acad

Med. 2015;90(12):1728. doi: 10.1097/ACM.0000000000000872
46. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005; 83(3):457–502.
47. UN System Task Team on the Post-2015 UN Development Agenda. Social protection: A development priority in the post-2015 UN development agenda. 2012. Available at: http://www.un.org/millenniumgoals/pdf/Think%20Pieces/16_social_protection.pdf.
48. Lopéz Arellano O, Escudero JC, Carmona LD. Social determinants of health: perspective of the ALAMES working group on social determinants. Soc Med. 2008;3(4):253-64. Available at: http://www.socialmedicine.info/index.php/socialmedicine/article/view/271/529
49. National Academies of Sciences, Engineering, and Medicine. A framework for educating health professionals to address the social determinants of health. Washington, DC: The National Academies Press; 2016. doi: 10.17226/21923
50. Ventres WB, Wilson CL. Beyond ethical and curricular guidelines in global health: attitudinal development on international service-learning trips. BMC Med Educ. 2015;15:68. doi: 10.1186/s12909-015-0357-7
51. Ventres WB. The Q-list manifesto: getting things right in generalist medical practice. Fam Syst Health. 2015;33(1):5–13. doi: 10.1037/fsh0000100