BMJ 2015;350:h2378 doi: 10.1136/bmj.h2378 (Published 5 May 2015)

OBSERVATIONS

LETTER FROM NEW ENGLAND

Fishing upstream: health and the social history

The importance of determining the social determinants of health

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It is now fashionable (even in the United States) for doctors to talk about social determinants of health. Polls show that access to healthy and affordable food, controlling drug misuse, and cleaning up the environment are seen as more important to people's health than access to high quality medical care.[1] Groups such as Health Leads train doctors to identify their patients' social needs and to link them to community resources.[2]

Malcolm Gladwell introduced us to Million-Dollar Murray in 2006.[3] Atul Gawande wrote about Jeff Brenner's work among the "hot-spotters" of Camden, New Jersey, in 2011.[4] Both sounded the alarm that unmet psychosocial needs have led to overuse of the healthcare system, largely because emergency departments and hospital wards have become society's safety net. More recently, Rishi Manchada focused our attention on "upstream doctors" who look beyond the symptoms of disease to their source in the community.[5] He estimated that the conditions under which people lived and worked had five times the impact on health and disease as all the pills and procedures in our medical quiver.

Challenges for family medicine

Of course, family doctors have long felt the weight of this, if only in the frustration and challenge of caring for patients we cannot help. We never knew the enemy by name; we were often clueless about its root cause. But our high rate of job dissatisfaction and burnout reflected the limitations of even the best practiced primary care.

Several years ago, our community health center hired a nurse care manager to coordinate transitions from the emergency department, hospital, and rehabilitation facility. Increasingly, we asked for her help in caring for the most challenging patients—those who could not control their diabetes, quit smoking, or lose weight despite the negative effects on their health. Last month we reviewed her caseload and found that her more than 100 patients could be sorted into four general categories: those with unstable mental illness, those with cognitive impairment, those having problems with mobility or transportation, and those needing care that required multiple consultants. There was Rita, 83 years old and morbidly obese, who had been admitted to hospital for an infected panniculus. She was able to manage her weight, blood sugar, bare pantry, and high electrical bill until an ice storm and power outage curtailed her hygiene. Andrew is 75 and has panic disorder and suicidal thoughts. He took an ambulance to the emergency department every week until his daughter introduced him to the director of a nursing home down the street, where he now volunteers. Nicholas is 34 with type 2 diabetes and an HbA_{1c} that consistently hovered above 10%. His severe leg shaking had been a distraction to both of us. Once his severe anxiety was treated, Nicholas could finally focus on diet and exercise and lowered his HbA_{1c} to 5.4%.

It is not just poverty, mental illness, and social isolation that make us sick. Elizabeth Bradley and Lauren Taylor recently explored the US healthcare spending paradox: why does the US spend twice as much as other Western nations on healthcare yet rank so low in measures such as life expectancy and maternal and infant mortality?[6] Because, they concluded, we spend half as much as other similar countries on social services such as transportation, job training, unemployment benefits, maternity leave, and safe housing. They reported that involuntary job loss in middle age could double or triple the risk of heart attack and stroke over 10 years. A 1% rise in unemployment is associated with an increase in the suicide rate of 0.99%. Joining a club halves the risk of dying within the next year.[6]

Doctors (alone) cannot change society. We are not public health experts, city planners, or community activists. But at the very least we should be aware of the social conditions that affect our patients' lives. A recent article in the *New England Journal of*

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Medicine advocated for the adoption of an expanded social history.[7] We should ask, the authors contended, whether our patients feel safe and supported in their primary relationships, if their children are struggling, and if they worry about paying their bills. Do they face legal or housing or insurance issues or find it difficult to access reliable transportation, green space, or fresh and affordable produce? In short, are patients happy or depressed, care free or anxious? Do we even know their preferred name or the name of their spouse? Being understood and having your doctor (or any caring person) take an interest in you and in the most guarded, frightening, and intimate parts of your life is therapy itself.

What next?

The real question is what to do next. Doctors may broadly know the effects of social determinants but not the cost or likelihood of success of a particular intervention. Cigarette smoking is one exception: people who quit before the age of 35 can add 10 years to their life expectancy,[8] and the odds of quitting rise from less than 3%, unaided, to more than 30% with optimal treatment.[9] But comprehensive randomized trials of specific interventions, Bradley and Taylor remind us, have not been done. Curiously, we might learn much by partnering with the commercial insurance industry. It has made an (actuarial) science out of understanding the effects of lifestyle and other factors on illness and premature death and on what motivates people to modify their behavior.

Until then, those of us in primary care are left with an urgent and ambitious research agenda and a mandate to expand our list of necessary colleagues and consultants to those well placed in the community, not just in the hospital.

Competing interests: None declared.

Patient consent obtained.

Provenance and peer review: Commissioned; not externally peer reviewed.

1 What shapes health. NPR, Robert Wood Johnson Foundation, and Hardard T H Chan School of Public Health. Mar 2015. www.rwjf.org/en/library/research/2015/01/what-shapes-health.html.
2 Kelto A. When life overwhelms, this group lends a healthy hand. NPR 12 Mar 2015. www.npr.org/blogs/health/2015/03/12/391872813/when-life-overwhelms-this-group-lends-a-healthy-hand.
3 Gladwell M. Million-Dollar Murray: why problems like homelessness may be easier to solve than manage. *New Yorker* 13 Feb 2006. www.newyorker.com/magazine/2006/02/13/million-dollar-murray.
4 Gawande A. The hot spotters: can we lower medical costs by giving the neediest patients better care? *New Yorker* 24 Jan 2011. www.newyorker.com/magazine/2011/01/24/the-hot-spotters.
5 Manchada R. What makes us sick? Look upstream. YouTube 15 Sep 2014. https://www.youtube.com/watch?v=dJEwC4wCM70.
6 Bradley E, Taylor L. The American heath care paradox: why spending more is getting us less. Public Affairs, 2013.
7 Behforouz HL, Drain PK, Rhatigan JJ. Rethinking the social history. *N Engl J Med* 2014;371;1277-9.
8 Schroeder S. New evidence that cigarette smoking remains the most important health hazard. *N Engl J Med* 2013;268;389-90.
9 Rigotti NA, Rennard SI, Daughton DM. Overview of smoking cessation management in adults. UpToDate.com. Updated 24 Feb 2015. www.uptodate.com/contents/overview-of-smoking-cessation-management-in-adults.

Cite this as: *BMJ* 2015;350:h2378