Leadership from below, change from within: revitalising medical professionalism through social justice

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INTRODUCTION

Doctors occupy a privileged position in society; they encounter at close range the effects of the real world on the bodies and minds of their patients. Given the proximity of doctors to the health outcomes of the material conditions of their patients' lives, it seems logical that rising health inequalities and evidence of the importance of the social determinants of health in causing them should stimulate a response among medical professionals. Moreover, given that the tight tracking of social conditions with health has been known for almost two centuries, it would not be unreasonable to expect this response to be coherent, comprehensive and sophisticated.

This is sadly not the case; the response of the medical profession and health systems to the social determinants of poor health and health inequalities remains sluggish and stunted.

Situated in the UK but with implications for health systems globally, this piece begins by discussing how current approaches to health inequalities fall short and effectively fail both patients and health professionals. It then considers an initiative that provides clues for a more fitting and effective approach to social determinants. WHAM—the Wellbeing and Health Action Movement—suggests a route for the medical profession to address current failings and revitalise itself. To conclude, it summarises some of the further rethinking needed. It suggests that a combination of fundamental philosophical and ethical questioning and close attention to experiences on the ground are needed to provide a satisfactory answer to the question of what it means to be a good doctor in the 21st century.

HEALTHCARE DIVIDED

The evidence for the key role played by the social determinants of health and the creation of health inequality is significant and compelling. The social determinants thesis—based on robust epidemiological evidence—states that most disease is attributable to the social conditions in which people live and work.[1–4] Furthermore, the social gradient in health has the clear implication that action to improve health and reduce inequalities must take place at the social level and that approaches to health promotion that depend on individual behaviour change are reductive and limited.[5] If medicine's aim is to alleviate global morbidity, health professionals in the 21st century will need to contribute to solutions to the social roots of illness, not just biological cures and healthy choices.

However, the predominant biomedical model of healthcare is not adequate to this task.[6] Health inequities and a heavy burden of disease persist despite unprecedented gains in global wealth, partly because a focus on lifestyles and on pharmaceutical, genetic and technological advances fails to address the social causes of ill health.[7 8] A predilection for circumscribed cures over broad-based care and for individuals over wider population concerns contributes to unintended consequences,[9] antibiotic resistance,[10] high-cost treatments[11] and ineffective responses to the growing burden of non-communicable disease.[6] This also has implications for health professional education. The danger is that the narrow and technical framing of mainstream curricula means that even when the importance of social context is acknowledged, the nature and full significance of the social dimension is obscured. By emphasising biological questions about what are in fact biosocial phenomena, scientific enquiry is 'desocialised'.[12]

Medicine's failure to see health through a 'social lens'[13] not only risks perpetuating poor health outcomes but also hamstrings the profession itself. In the UK, a recent report by the Royal College of Physicians called, 'Supporting clinicians to address health inequalities in practice' looked at clinicians' confidence in talking about and understanding health inequalities.[14] It found that most clinicians feel they have not received enough training on health inequalities and would like more as part of their medical education. Of the almost 1000 clinicians surveyed, 67% of respondents had not received teaching or training in health inequalities within a training programme or as part of their degree; only 26% felt confident in their ability to reduce the impact of health inequalities in their medical practice and only 31% felt confident in their ability to talk to patients about the impact of inequalities on their health. At the same time, the latest report from the Workforce Race Equality Standard (WRES)—a programme that seeks to monitor and control diversity and equality in the UK's National Health Service (NHS)—reveals continuing systemic racism. A quarter of NHS workforce is black and minority ethnic. Across almost every region, there were higher rates of harassment and disciplinary action in this group, with fewer opportunities for leadership and professional development.[15] Taken together, both patients and staff are neglected by the same system. The same social forces that marginalise patients are

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also working against the health professionals who serve them, resulting in a divided health system.

NEGLECTING TO SEE 'THE SOCIAL': THE FAILINGS OF CURRENT MEDICAL PROFESSIONALISM

This is not to say that no attempt has been made to address the co-existing challenges of diversity and inclusion within medicine and widening health inequalities. Indeed, the recent proliferation in the medical literature of publications referencing social determinants and health inequalities reflects a growing interest in incorporating these concepts into curricula, practice and models of care. It is too early to form an overall assessment of the effectiveness of these developments, both because of the relative lack of decisive evidence to date and also because there is, as yet, no consensus on what 'effectiveness' should mean in this context. No consolidated conception of 'socially conscious' medical professionalism has begun to emerge. Indeed, the proliferation of initiatives displays a great heterogeneity—a patchwork quilt of approaches—lacking integration or a unified vision.[16]

Stemming from biomedicine's underlying reductive epistemology, this fraught relationship to 'the social' is reflected in the various pillars of the structure of medicine:

Education

One of medical education's functions is to convey the underlying philosophies and orientations of the profession.

A lack of coherence and clarity about medicine's role in relation to social determinants has led to medical schools providing widely variant teaching on the issue. Differences in practice arise largely because of epistemological diversity in conceptualising 'the social' and the perceived role of public health in addressing the social determinants of health and illness. Research indicates that compared with professionals who are taught through more critically reflexive or social scientific lens (eg, social workers), health professionals tend to explain poverty more on the basis of individual responsibility and fatalism and are less likely to link poverty with health inequalities and to advocate for policies to end health inequalities.[17] In many cases, a substantial barrier to further action on the social determinants is the internalisation of discourses and traditions that treat health as individualised and depoliticised.[18]

Research

Medical research also embodies this heavily reductionist and quantitative orientation.

Qualitative research is still relatively poorly represented in medical journals in general, and certainly, when it comes to social determinants of health inequalities, medical research output is almost overwhelmingly quantitative. Quantitative research addresses important epidemiological questions about patterns of causation including the potential effectiveness of interventions, and as such is central to generating knowledge of the social determinants of health and illness itself. However, quantitative studies tend to neglect equally important questions about why inequalities, and associated experiences, matter and their implications for the culture of, and professional identities within, healthcare. Moreover, much quantitative research has a tendency to focus on single interventions or behaviours, neglecting the complex web of factors and systems that shape health and illness and the multiple (interacting) axes of inequality that are relevant to 'real-world' policy and practice.

Health systems

The increasing rhetoric pledging to deal with the social determinants at policy and institutional levels is unmatched in practice, and in particular in how leaders and managers construct and communicate professional roles and responsibilities to teams and individual clinicians. For instance, very few departmental leads in secondary care explicitly encourage a focus on inequalities or a population health perspective from their teams. Clinical pathways and service improvement initiatives are frequently defined around hitting biomedical targets and meeting short-term institutional goals, often with an emphasis on efficiency rather than equity or addressing long-term health needs. This heavily 'technicist' orientation reflects the tendencies in biomedicine towards reductionism and measurement but also suits and reinforces the shift towards more managerial, marketised and fragmented healthcare delivery in recent years.[19]

Clinical roles

The technicist and reductionist emphases within biomedicine create new divisions of labour and forms of role fragmentation and specialisation in relation to health inequalities. For example, on the one hand, doctors are actively encouraged to participate in the research around the social determinants of health and to produce reports on the scale and continued existence of health inequalities. On the other hand, responses to these analyses in the form of action on social factors are often effectively outsourced to other kinds of feminised, more poorly paid professionals, such as nurses, social workers or community health workers.[20]

Similar hierarchical tendencies in medicine are to be found in other, less visible but arguably insidious, ways. For example, there is a danger that special cadres of doctors with fellowships in health inequalities or quality improvement serve as a 'stand in' for the profession-wide changes that are needed. Conferring an obligation on a select group of clinicians to attend to health inequalities can diminish the sense that there is a responsibility for health professionals to collectively respond to the social determinants of health and illness. At the same time, ordinary clinicians are encouraged to get involved by engaging in social prescribing—a helpful but heavily limited response to the social realities of people's lives since this approach typically reacts to individual instances of illness rather than addressing their structural causes at a social level.

Predominant forms of medical advocacy also display this tendency for siloing concern for health inequalities through 'specialism'. When not undertaken by figureheads, such as presidents of Royal Medical Colleges, advocacy has effectively been outsourced to groups which exist to take on that function. Medical advocacy groups, such as MedAct and Doctors of the World, provide a much needed and important voice on issues of social significance. However, their very existence arguably enables the bulk of the profession to 'delegate' the responsibility for transformative change to others. Not only does this carving out of 'doing good' hollow out professionalism for ordinary clinicians, but worse, the outsourcing of advocacy beyond mainstream medicine leaves it with comparatively little resource, status and support.[21]

Without a clear commitment to seeing healthcare through a 'social lens', medicine's response to health inequalities is bound to be inadequate and, whatever the intention, faltering and tokenistic. The message implicit in the way that medical structures deal with social factors in the vast majority of professional roles is that they are essentially not a doctor's responsibility. Not only does this fail to reckon with the issue of health inequalities

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but in recapitulating the prevailing structural and power imbalances of wider society, medicine inadvertently contributes to the problem.

THE VIEW FROM BELOW AND WITHIN: THE WELLBEING AND HEALTH ACTION MOVEMENT (WHAM)

What might an alternative model of medical professionalism look like? This part of the paper discusses a case which shows potential to help answer this question both in theory and practice.

The Wellbeing and Health Action Movement (WHAM) is a 'social incubator' to inform, empower and unite clinicians who fight child poverty and health inequality. WHAM, of which the first author of this paper is a core member, centres on the peer-to-peer sharing of knowledge and practical wisdom. It arose in the UK in the wake of the global COVID-19 pandemic in late 2021 out of a need to bridge the gap between the growing desire of clinicians to address social determinants and the relative lack of support offered for this ambition by conventional medical education and practice, as highlighted above.

The growth of WHAM has been surprising. In just 18 months from inception and with very few resources, WHAM became an established, crowd-sourced, digital platform helping to provide the knowledge, tools and community to help clinicians support families suffering from the effects of health inequalities. How well these levels of activity will translate into benefits for patients is still to be determined but success in terms of professional engagement and development of local practices is already evident: the expanding membership is making changes both in the ways that individuals and teams practice to better address the social determinants of health and in the configuration of local health systems. This includes, for example, using screening questionnaires that have been innovatively iterated to capture deeper social histories while sensitively bridging socio-demographic divides and developing business cases to successfully argue for the introduction of new staff such as community health workers on the basis of local data. WHAM's potential has been recognised by the endorsement of Sir Michael Marmot, Professor of Epidemiology at University College London and Director of the UCL Institute of Health Equity.

What accounts for this success and what lessons does it hold? An overriding feature is arguably that WHAM authentically arises from the 'bottom up'. It is for ordinary clinicians by ordinary clinicians—who are not having to deal with bureaucracy or managerial interference.

The grounds of this success are rooted in three core aims:

Rethinking healthcare

WHAM is strongly purpose driven. The goal is to change the way medicine is done: to rethink the philosophical foundations and practical implementation of healthcare. The guiding ideal is to move away from biomedical one-way streets towards a genuinely more holistic, inclusive and just orientation to health that properly attends to the social realities of people lives.

WHAM helps to turn an otherwise unexpressed 'felt need' among ordinary clinicians into something 'real', tangible and potentially life changing. In practice, this means using but reclaiming the tools of medicine. For example, using the ideas of quality improvement and public health, but seeking to embed a more ambitious and expansive improvement and social mindset within the health workforce.

Building relationships and collective intelligence

WHAM is a grassroots, distributed network of ordinary clinicians (of all stripes, not just medical) who are connected digitally across the UK. WHAM's organisational principles represent leadership from below: the collective operates non-hierarchically to crowdsource and open source, sharing the knowledge and tools to address health inequality in practice.

This has resulted in a key innovation—a health inequalities action heatmap, which helps to highlight and connect clinicians working on similar goals. The increasingly fragmented nature of current health systems can leave individual health professionals feeling alienated and atomised. WHAM's heatmap responds by enabling individual clinicians to connect with others who are in a similar position, both geographically and thematically, providing forms of peer-mentorship and exchange of knowledge and practical wisdom. WHAM is a 'social incubator' for health systems, in that it builds relationships and promotes collective intelligence, helping to provide conditions through which local teams or national projects can germinate and blossom.

Enriching care

By confronting the effects of social deprivation and inequality in clinical encounters that contribute to burnout among the health workforce,[22] WHAM is a community of practice that seeks to nurture learning and practical wisdom. The distributed membership convenes through a series of webinars, or 'WHAMinars', to exchange ideas, inspiration and moral support. In so doing, WHAM helps clinicians to see that 'self-care is not selfish'. In these ways, WHAM supports and cares for the health workforce as well as striving to improve health outcomes and experiences for patients.

REVITALISING MEDICAL PROFESSIONALISM: SOCIAL JUSTICE FROM THE GROUND UP

The case of WHAM signals the possibility of a new kind of professionalism. The approach combines a subversive current—in that it allows for collective interprofessional leadership from below and enables horizontal working—with credibility, in that the impetus for, and character of, change is shaped by health professionals.

Such an approach could fill an important deficit in medical professionalism for the 21st century. The outworkings of neoliberal capitalism have not only intensified economic inequalities but have reinforced a political and popular culture in which collective action is side-lined by comparison to rhetorics of individual responsibility and self-interest. Of course, we are individuals, but we are also collectives and professional groupings. Switching the emphasis has radical implications. What might be achieved if doctors, mobilised by justice-oriented convictions, worked to address health inequality? What alliances might be formed, how could they raise and draw on public engagement and who could such alliances build solidarity within civil society?

This is not to argue that grassroot initiatives and organisations could or should replace medical institutions like the Royal Medical Colleges in the UK or the World Medical Association. These medical institutions wield considerable financial, intellectual and social capital which also can, and are, being used to bring about long-lasting change in the normative foundations of the profession.

However, it is important to make space for other voices at the table. The challenge is for medicine, in conjunction with other health and social professions, to co-produce a vision for health actively and honestly with those who receive as well as deliver

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it. Healthcare agendas and practices need to be crafted not just by elites in charge but also those who perform its everyday graft. By no means intended to be definitive, the example of WHAM ultimately represents an experiment in hope, indicating to fellow clinicians the kind of route necessary to transform the profession and expand its range as a force for good. It offers vital clues for a way forward. Of course, progress also depends on more extensive research, rethinking and redesign. But this must include broadening the conception of relevant research and thinking, including the epistemological base of healthcare.

Systems thinker, W Edwards Deming reportedly said that 'Every system is perfectly designed to get results it gets'. If so, then today's results suggest we need to redesign medicine from the ground up. In the face of patriarchal, colonial and class-interested inertia, collective movements help surface the need for social equality, gender parity and racial justice. Similarly, such movements can promote the voices of indigenous groups, disability rights and the dignity of the LGBTQ+community. As Syed[23] has argued only diverse groups have the 'collective intelligence' you need to solve complex problems, like addressing health inequality or tackling environmental breakdown. Creating space for divergent perspectives with different goals is essential to reorienting the medical profession towards social justice.

There is no question that this requires intersectoral change. Given the privileged vantage point that takes in the broad terrain of health, political economy, and the social experiences and realities of patients' lives, it behoves the health professional community to step up and take the lead in helping to bring about societal transformation. But we can go further. Health systems could model the world we want to live in. Health leaders could strive to create 'justice-oriented systems for health'[24] and ensure the conditions in which women, people of colour and other marginalised groups are equally recognised.

A successful movement for transforming the medical profession will need to work towards a coherent theoretical account of socially responsive health and healthcare including the roles that health professionals can play; ideas and strategies for capability building to enable these newly conceived roles; and mechanisms for bringing about cultural transmission across the profession.

The need for a philosophical reorientation of medicine is urgent, but this endeavour can start from the ground up. A key first step is to recognise that right actions cannot be determined simply on the basis of data or existing professional norms. Professional reflection and ethical analysis in the light of the social realities of inequality are also necessary. A spur to this much needed rethinking, and something missing from the literature, is 'close up' empirical and ethical analysis of the lived experiences of ordinary clinicians trying to navigate these social realities, including those who are trying to lead from below and help forge a path towards greater social justice in health.

WHAM website: https://www.whamproject.co.uk/

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