

Theory vs Practice: Should Primary Care Practice Take on Social Determinants of Health Now? No.

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Recently, the recognition that medical care may contribute less to overall health than other aspects of people's lives do has led policy makers, academics, and even some physicians to argue that clinicians should make screening and action on the social determinants of health their responsibility. Although such an expectation is understandable, the additional requirements (that will fall largely on primary care) are likely to have serious unintended consequences and be unlikely to produce the hoped-for benefits.

First, anyone proposing any new responsibilities for primary care clinicians must be unaware of the degree to which most of them already feel overworked, stressed, and discouraged. There is little joy in Mudville. Shanafelt et al's national survey of 7,300 physicians in 2012 reported that 46% of them had at least 1 symptom of burnout, 38% screened positive for depression, and 37% felt that their work schedule didn't leave enough time for personal or family life.¹ Those in family or general internal medicine were at the wrong end of each of these spectrums among all medical specialties. Our recent unpublished survey from the 2013 COMPASS project of 700 primary care physicians in 18 widely diverse medical groups in 8 states found 30% reported feeling burned out; 12 months later this number had risen to 37%. Will an additional large responsibility help this unsustainable situation?

Much of this workload and stress comes from all of the expectations that have especially been added for primary care physicians since I began doing patient

care 43 years ago. Over the years, society seems to have decided that diagnosing and treating the problems that patients brought to our door was not adequate. Clinicians and care systems must now also screen and act upon assorted preventive services, fully control chronic conditions (not just relieve symptoms), provide the mental health care that an insufficient number of mental health professionals cannot, help patients modify a wide range of health behaviors, coordinate with a variety of community agencies, provide much more complete documentation, complete a bewildering number of forms, and proactively reach out to all of the people who had ever been seen in the practice in order to practice population medicine. In order to facilitate these tasks, clinicians have also been required to use electronic medical records and lead multidisciplinary teams that, while offering some clear advantages, also take a great deal of time. Many clinicians feel these added responsibilities are inefficient and not why they went into medicine. Finally, many of those social determinants (broken and dysfunctional families, substance abuse, homelessness, etc) have become much more frequent and problematic, often requiring greater time and adding stress to providing even traditional medical services.

Simultaneously, we are in the midst of a great national effort to transform primary care in order to achieve much-needed improvements in quality, costs, and patient experience. Making all the changes in clinic workflows, communications, and roles to be consistent with the patient-centered medical home requires considerable time and flexibility from clinicians. Although the evidence for these benefits is still not strong, the changes seem desirable enough to ask all the members of care systems to work on adapting them to their practices and patients. We know change is very slow, requiring many years under the best circumstances. It seems unlikely that care clinics can simultaneously address both these changes and social determinants, so upon which should they train their focus?

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Finally, there is no evidence that clinicians and care systems can either add this to their plates or have much impact on the social determinants of their patients. They certainly have no expertise or resources for this work, work that even the social service agencies created for this purpose find to be difficult, frustrating, and of limited success. Published literature on the topic is mostly theoretical or commentary, with the very few studies in small and atypical practice settings.²⁻¹⁰ The article by DeVoe and colleagues in this issue of *Annals* recommends a very reasonable approach of collecting community and patient data before taking individual patient and panel actions and then adding automated supports.¹¹ Before we ask practices to take on these tasks, however, we need much more evidence that it is both feasible and effective. We also need to know that taking on this added responsibility won't divert care systems from the important task of transforming the way we accomplish existing responsibilities and won't cause clinic personnel even greater stress.

As far back in history as we can track, healers of all kinds have focused on providing people with answers to what caused their problems, predicting what was likely to happen next, and relieving distress. Modern medicine has added the ability to actually change the course of many medical problems, but we need to improve our performance in all of those tasks. Do we or our patients really want to risk losing that focus and opportunity for the sake of yet another new responsibility, one that we have no reason to believe we can succeed at and one that may lead clinicians to no longer respond adequately to the medical needs of their patients?

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