Strengthening Social Determinants of Health Education in Canadian Medical Schools

Renforcement de l'éducation des déterminants sociaux à la santé dans les facultés de médecine canadiennes

Parastoo Golzarian[1*]

1. Toronto Metropolitan University, Toronto, ON, Canada
*Corresponding author. Email: parastoo.golzarian@gmail.com

Abstract | Résumé

The social determinants of health (SDOH), including income, housing, and education, are major drivers of health outcomes in Canada. Ignoring these factors can lead to misinterpretation of patient behaviours and reinforcing inequities. Housing insecurity and poverty increase risks of mortality, poor perinatal outcomes, and cancer disparities, with disadvantaged, immigrant, Indigenous, and racialized groups disproportionately affected. Canadian medical schools teach SDOH through lectures, case discussions, and service-learning, yet current approaches are fragmented and often optional. This paper argues for structured, longitudinal advocacy training to better prepare future physicians to address inequities and advance social accountability in healthcare.

Les déterminants sociaux de la santé (DSS), notamment le revenu, le logement et l'éducation, sont des moteurs majeurs des résultats de santé au Canada. Ignorer ces facteurs peut conduire à une mauvaise interprétation des comportements des patients et renforcer les inégalités. L'insécurité du logement et la pauvreté augmentent les risques de mortalité, de mauvais résultats périnataux et les disparités liées au cancer, affectant de manière disproportionnée les populations défavorisées, immigrées, autochtones et racialisées. Les écoles de médecine canadiennes enseignent le DSS à travers des conférences, des discussions de cas et l'apprentissage par le service, mais les approches actuelles sont fragmentées et souvent optionnelles. Cet article plaide pour une formation structurée et longitudinale au plaidoyer afin de mieux préparer les futurs médecins à lutter contre les inégalités et à promouvoir la responsabilité sociale dans le secteur de la santé.

Keywords: Medical education; Social accountability; Social determinants of health; Curricula; Clinical reasoning

Introduction

In Canada, medical schools teach students about the social determinants of health (SDOH). These are factors such as income, housing, and education that strongly shape patient outcomes (1). If physicians overlook these factors, they may misinterpret a patient's situation. Oftentimes, physicians label someone "non-compliant" with medications when the real issue is that they cannot afford the prescription or that they lack transportation to the pharmacy (2).

Housing instability is strongly linked to higher mortality, yet these risks are often overlooked in clinical encounters if physicians are not trained to ask about them (3). Living in rental housing versus ownership is associated with higher rates of preterm birth, stillbirth, and infant mortality, showing how housing insecurity directly shapes clinical outcomes (4). Research shows moving patients into stable social housing significantly improves mental health and overall patient outcome, showing how attention to SDOH can transform outcomes beyond what can be achieved by medical treatment alone (5, 6).

Housing is one example of a broader pattern, across multiple health domains, of social conditions that predict who gets sick, who gets diagnosed, and who survives. Cancer is one of the most common diseases in Canada. It remains the leading cause of death, responsible for an estimated 85,100 deaths in 2022 and accounting for nearly one in four deaths nationwide, with recent reports projecting a continued substantial burden on patients and the healthcare system (7, 8). Advances in screening, diagnosis, and treatment have reduced mortality rates for many cancer patients (8), yet significant disparities in morbidity and mortality remain. These disparities are strongly linked to SDOH. From screening to diagnosis to treatment, patients from socioeconomically disadvantaged communities in Canada experience worse cancer outcomes (9). For instance, lower-income and rural Canadians face a higher risk of both developing and dying from cancer (10). Persistent inequities in cancer screening are evident, as recent immigrants and Indigenous communities (often facing socioeconomic disadvantages) consistently show lower

participation rates (11–13). These disparities are not limited to socioeconomic status or immigration experience; racialized communities face compounding disadvantages even when controlling for income. Black, African-Caribbean, and South Asian Canadians are screened less often and experience higher cancer and mortality rates (14, 15), reflecting how race and ethnicity independently shape access to care. Beyond these groups, Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex, and other sexual/gender minority patients with cancer often report worse healthcare experiences and greater unmet support needs compared to other patients (16), illustrating how inequity in cancer care cuts across multiple dimensions of identity and social positioning. These disparities are perpetuated in part through clinical encounters shaped by inadequate training. Addressing these inequities requires structured training. Without proper training in SDOH, physicians are not equipped to take a meaningful patient social history, recognize structural barriers, or connect patients to appropriate community resources (2). A physician who does not know to ask about housing, income, or immigration status cannot identify the conditions driving a patient's poor health outcomes, and without that identification, no referral and no systemic intervention can follow. Patients from lower-income, Indigenous, immigrant, and racialized communities bear the greatest burden of these missed opportunities as their health outcomes are most sensitive to whether a physician can look beyond the clinical presentation and address the conditions shaping it (1). The training gaps described in this paper are therefore not abstract educational concerns, but instead translate directly into the inequities that disadvantaged Canadians continue to experience.

This gap exists not for lack of formal recognition. Frameworks such as the Future of Medical Education in Canada and the CanMEDS Health Advocate role have long required students to understand these issues, and many schools highlight social accountability in their curricula (1, 17). Students are exposed to SDOH through lectures, case discussions, community projects, and some clinical placements. This paper argues that while Canadian medical schools have made progress in teaching social determinants of health, more structured and longitudinal clinical reasoning training and social accountability are required to prepare future physicians to address these inequities in patient care and improve their clinical reasoning (18).

Current Efforts and Gaps in Education

Most SDOH curricula include a mix of classroom lectures and community exposure, with many implemented longitudinally over time (1). Some Canadian medical students also participate in extracurricular programs, such as the Longitudinal Advocacy Training Series, which offers virtual workshops on skills developed by the Canadian Federation of Medical Students (19). Schools also use service-learning models, where students engage with communities outside of clinical settings to connect theory and practice (20).

Across Canada, the depth and structure of SDOH training varies considerably between institutions. The University of British Columbia's Flexible Enhanced Learning program offers students self-directed scholarly activities across first to fourth years that can include community health and advocacy projects, with social accountability explicitly embedded as a curricular goal. However, students self-direct their topic, meaning SDOH content is not guaranteed (20). The University of Toronto runs a mandatory two-year longitudinal program called Health in Community, connecting students with community partners and co-educators to develop SDOH competencies in real-world settings (21). McMaster University integrates service-learning into its curriculum as a structured community placement experience focused on SDOH and social accountability; however, it is registered as a horizontal elective and requires a minimum of only four hours, making it effectively optional and leaving the depth of engagement entirely up to individual students (22).

The University of Ottawa delivers SDOH content primarily through didactic lectures in the first and second years, complemented by 10 mandatory experiential learning logs completed during third-year clerkship that require students to reflect on social accountability in clinical settings. Additional community exposure is available through the student-led Health Initiative Partnership Clinic; however, participation remains voluntary and dependent on student initiative rather than being embedded in the formal curriculum (23, 24). While each of these models reflects institutional commitment to SDOH, none consistently progress students through all three competency levels, and most focus on knowledge and exposure rather than applied or structural change.

A challenge with many courses on SDOH are that they are short and uneven in depth, often treating SDOH as "facts to be known" rather than conditions to be changed, which leaves students with little practice in applying this knowledge at the policy or system level (2, 25). Moreover, knowledge about SDOH is also usually embedded only in public health or social medicine courses and community clerkships, and less often built across all years of training in a cohesive progression. This causes many students to never get the opportunity to apply what they learn (26). Service-learning projects also help students understand community health, but they vary between schools, and in many cases, they are optional, so not every student benefits from them (27).

This raises an important equity concern within medical education itself: optional experiences disproportionately benefit students who have more available time, prior experience, and fewer financial constraints. Students who work part-time jobs, have caregiving responsibilities, or who come from backgrounds with less exposure to community advocacy are less likely to participate. As a result, clinical reasoning skills become unevenly distributed across the graduating physician workforce. This has implications for which communities ultimately receive care from physicians equipped to address structural barriers. Making service-learning and experiences mandatory rather than optional is therefore not only a curricular decision but an equity imperative (27).

Addressing Gaps in Education

To strengthen current efforts, medical schools could adopt structured, longitudinal pathways so students progressively build skills rather than receive isolated exposure. For example, integrating clinical reasoning competencies into core clinical rotations, adding mandatory workshops or modules on structural determinants and policy, and embedding SDOH assessment tasks into patient encounters would help. Schools could also expand partnerships with community organizations and legal, housing, and social services to give students real opportunities to intervene. Further, aligning assessment and evaluation so that SDOH competencies are graded and included in big exams or high-stakes assessments (instead of being optional) would signal their importance institutionally. Currently, SDOH-related clinical reasoning skills are rarely included in formal evaluations, signalling to students that they are supplementary rather than core (2). Concrete strategies to address this include I) Objective Structured Clinical Examination stations that assess students' ability to identify social risk factors and respond appropriately during a patient encounter (28, 29), II) Entrustable Professional Activities tied specifically to SDOH-informed care, such as conducting a social history or connecting a patient to community resources (30), III) structured reflective assignments following community placements, requiring students to analyze the structural conditions affecting the populations with which they worked, and IV) community-based assessments, evaluated jointly by faculty and community partner organizations, giving weight to reasoning skills that cannot be measured in a clinical setting alone. Embedding these tools into formal grading would institutionalize understanding SDOH factors as a core expectation rather than an optional enhancement and it would provide the kind of accountability that encourages faculty to consistently model and teach these skills.

Conclusion

Canadian medical schools made meaningful progress in teaching SDOH, but the evidence presented in this paper makes it clear that awareness alone is insufficient. Housing instability, cancer disparities, and inequities in screening and survival among Indigenous, immigrant, racialized, and Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex, and other sexual/gender minority Canadians are not inevitable. Instead, they are shaped by structural conditions that a well-trained physician can help identify, address, and challenge (3–16).

Closing this gap requires a deliberate, three-part curricular model. First, all medical students should develop a foundational understanding of SDOH, not as background knowledge, but as clinical information essential to accurately diagnosis and provide patient-centered care (1, 20). Second, this knowledge must be translated into clinical skills: taking social histories, screening for housing instability and food insecurity, recognizing when "non-compliance" reflects structural barriers, and connecting patients to appropriate community resources (2, 21). Third, students must be trained to advocate for structural change and health system reform, and engage with policy and community organizations to address the root causes of the inequities they encounter in practice (21, 25).

Achieving this requires concrete institutional commitments: mandatory rather than optional service-learning; Objective Structured Clinical Examination stations and Entrustable Professional Activities that formally assess SDOH competencies; structured reflective assignments following community placements; faculty development programs that equip teachers to model these skills; sustained partnerships with community organizations and legal, housing, and social services (19). Without these structural supports, curricular reform will remain aspirational.

Physicians who are trained to see beyond the clinical presentation, to ask about housing, income, immigration status, and identity, are better equipped to interrupt the pathways through which SDOH produces preventable harm. By making structural competency core expectations rather than supplementary experiences, Canadian medical education can fulfill its broader mandate of social accountability and begin to reduce the health disparities that disadvantaged Canadians continue to experience (1, 17).

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