VIEWPOINT

Ethics and Spheres of Influence in Addressing Social Determinants of Health

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A massive and ever-growing body of research supports the idea that the social conditions into which individuals are born, live, work, and play—i.e., the social determinants of health (SDOH)—profoundly affect the health of all people. Spurred on by this recognition, as well as recent payment models that reward value (i.e., health outcomes and costs) rather than volume, there has been a major push to integrate upstream social care into the delivery of health care.^{1,2} Clinics have started food banks, hospitals and insurers are investing in housing, and health systems are hiring preferentially from their local communities, among other activities. Efforts to address SDOH show promise for improving health and health equity and for enhancing the well-being of health care professionals, who find meaning and fulfillment in knowing and addressing patients' underlying social needs more directly.

Even when motivated by moral impulse, activities aimed at SDOH raise particular ethical issues. Existing scholarship has implicitly assumed that addressing SDOH is just the right thing to do, emphasized the need to manage unintended consequences, and asked whether SDOH screening should be targeted or universal.^{3,4} Here, we expand this ethical discourse by applying the concept of “spheres of influence” to explore the ethical principles that should shape how clinicians, health care organizations, and the broader community address SDOH.

SPHERES OF INFLUENCE

“Spheres of influence,” as a technical concept, originated in international relations. It refers to the degree of influence one country has over another militarily, politically, economically,

etc. Countries are able to exert more influence on some countries (e.g., those with whom they share borders) than others (e.g., those with whom they have few political or economic ties). Spheres of influence can be both *descriptive* in identifying where influence does occur and *prescriptive* in identifying where influence should occur.

More recently, “spheres of influence” has gained traction in other contexts. For example, the United Nations used spheres of influence in describing companies' roles and obligations related to human rights.⁵ While disagreement exists about just how far spheres extend, it is uncontroversial that individuals and institutions have core spheres—i.e., domains where their influence is most evident, meaning where they have the greatest responsibility. From the standpoint of ethics, core spheres should align with individuals' and institutions' primary ethical commitments. Regarding SDOH, core spheres offer practical ethical insights for clinicians, health care organizations, and the broader society.

CLINICIANS

A clinician's core sphere of influence is in direct patient care, where principles of beneficence/non-maleficence, respect for autonomy, and justice are widely accepted. Clinicians have a special role to play in ensuring that real-world efforts to address SDOH truly improve individuals' health and well-being, promote informed choices, and support health equity. Failing to ensure that SDOH efforts cohere with ethical principles risks disrupting trust in health care and its bedrock, the healing relationships between patients and clinicians.

There are many implications of appreciating this core sphere. First, screening in the clinical setting and inclusion of SDOH in electronic health records create an ethical obligation to act on those results in ways that meaningfully improve health and do not simply “check the box.” Promoting patients' welfare also requires ensuring that SDOH initiatives do not inappropriately distract from other caring activities in today's already time-pressured practice environment. Second, as a matter of respect, patients should be actively engaged and informed of initiatives to address their SDOH, and not be forced or unfairly penalized for not doing so. Third, justice

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requires that efforts to address SDOH do not reflect or perpetuate stigma and biases.⁵ Clinicians should avoid using pejorative labels (e.g., “frequent fliers” or “high needs”) or targeting individuals based on appearances or stereotypes. By definition, all people have social needs.

HEALTH CARE ORGANIZATIONS

Health care organizations have obligations to patients. However, they are not the same—either in scope or stringency—as those between patients and clinicians. Instead, organizations’ remit is to create the structures (e.g., policies, programs, and priorities) that support their clinicians and employees and to create a culture of integrity, understood as true commitment to stated mission and values.⁶ Not upholding fully or limiting the reach of organizational values compromises the organization’s integrity and, perhaps, its longer-term effectiveness and financial solvency.

Practically, health care organizations whose mission and values include addressing SDOH should commit wholly to doing so. This means, first, that organizations should support meaningful and lasting positive changes and avert unintended negative consequences, which could entail going beyond specific financial incentives or quality metrics. It would be inconsistent with a commitment to SDOH, for instance, to cease affordable housing initiatives at 30 days because the financial incentive to avoid a 30-day readmission penalty no longer applies. Second, organizations that commit to SDOH must recognize that addressing social determinants could include obligations beyond patient care, such as meeting needs within their workforce (e.g., paying a living wage) and their community (e.g., via community benefit programs).

BROADER COMMUNITY AND SOCIETY

In some ways, the ability to influence SDOH lies far upstream within the broader community and society. Laws, policies, and regulations create the fundamental social conditions that support equitable health. The question therefore becomes whether and/or which social determinants should be placed within the purview of health care. “Health in all” has become a popular approach to policymaking and rallying cry within medicine and public health, with good reason in the face of current health crises, such as climate change. Properly understood, health in all demands multisector collaboration; it does not necessarily mean health above all, nor that all social needs should fall under health care.

At the community level, we must thoughtfully allocate responsibility for addressing SDOH and avoid unnecessarily medicalizing SDOH. Medicalization occurs when nonmedical issues become defined and treated as medical problems, and medicalization can have negative consequences. Medicalizing SDOH has the potential to minimize the scope of social issues (e.g., by viewing food or housing insecurity as primarily

medical issues rather than the broader social issues that they are). Medicalization can also create less efficient, less effective, and less equitable solutions since health care entities tend to focus on the populations they serve rather than all in need within a community.⁷ These solutions could unintentionally detract from existing community organizations, or discourage investment in public agencies whose primary responsibility relates to particular social needs.⁸ One way to avoid medicalizing SDOH is, wherever possible, to develop partnerships between health care and community organizations.

CONCLUSION

We have described the core spheres of influence and the primary ethical commitments within those spheres, recognizing that other spheres exist and that spheres can intersect. Physicians have ethical obligations to advocate for societal policies that support health, and the way health care payments are structured affects how health care organizations behave. Nevertheless, there is value in focusing on where we have the most influence and the clearest ethical obligations. Physicians and health care leaders may be tempted to ignore the risks of extending too far beyond their spheres. Before doing so, they might consider millennia-old advice from Socrates. He admonished the folly of the artisans who, “because of practicing [their] art well, each one thought he was very wise in the other most important matters,” and thereby jeopardized the respect of the community and its trust.

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Compliance with Ethical Standards:

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