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Commentary

Integrating social determinants of health into Iran's undergraduate medical curriculum: a strategic imperative for health equity

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Abstract

Social Determinants of Health (SDoH) significantly influence health outcomes and inequities. In Iran, the undergraduate medical curriculum remains largely biomedical, while the country's health needs demand physicians who can recognize and respond to social risks. This commentary argues that integrating SDoH is not an optional addition but a strategic imperative for advancing health equity and responsive practice. SDoH education must move beyond awareness toward clinical competence through horizontal and vertical integration across the curriculum, faculty development, and alignment with assessment systems. Systemic reforms—including national exam modifications, institutional steering committees, and action-research pilots—are essential to translate policy into practice and foster socially accountable medical education in Iran.

Keywords: social determinants of health; education, medical; curriculum; health equity; social accountability

Introduction

Social Determinants of Health (SDoH) have a major influence on health outcomes and inequities as well as on how patients experience illness. In undergraduate medical education, the question is no longer whether SDoH should be taught. The more practical question is how they can be incorporated into training so that graduates can recognize social risks and respond to them in clinical practice. This question is particularly relevant in Iran. The undergraduate medical curriculum is still largely biomedical in its orientation. At the same time, the country's present and emerging health needs require physicians who can recognize barriers to care, understand patients within their social circumstances, and work within a health system that is accountable to the communities it serves. Integrating SDoH into medical education should therefore not be regarded as an optional addition to the curriculum. It is a requirement for advancing health equity and responsive practice [1].

The international literature also shows that simply introducing the concept of SDoH is not sufficient. Abdalla and colleagues found in a scoping review that although social accountability has become an important educational concern, its integration into undergraduate medical education remains slow and uneven. Progress depends on factors such as institutional readiness, faculty commitment, and curriculum design [2]. Earlier work reached a similar conclusion. Many educational interventions have focused on delivering information about SDoH while giving less attention to their continued use in clinical training and to the assessment of related

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competencies [3]. Solomon and colleagues examined SDoH-related curricula across undergraduate, graduate, and continuing medical education and found that many programs continue to focus on awareness and social risk screening. Less attention is given to alignment, advocacy, and responses at the system level [4]. The issue therefore goes beyond a lack of content. A more fundamental problem is the tendency to stop with conceptual knowledge rather than develop skills that students can use in clinical practice. This distinction matters in Iran. Students may learn general definitions of poverty, vulnerability, and inequality without learning how these conditions should influence history-taking, diagnosis, treatment planning, or referral decisions.

Recent educational work provides further support for bringing SDoH into routine clinical training. A phase I educational scholarship and action research study on the integration of SDoH into patient history-taking showed that these determinants can be taught as a clinical skill rather than as a separate theoretical subject [5]. A recent scoping review of social accountability in clinical education reached a related conclusion. Socially accountable training is more useful when it is incorporated throughout educational and clinical settings and when learning outcomes, workplace practice, and assessment are aligned [6]. The message from this body of work is straightforward. If physicians are expected to respond to social adversity, they need to learn how to recognize social risk, ask about it appropriately, and take it into account when caring for patients.

The Iranian curriculum gap

In Iran, the problem is made more difficult by the gap between policy statements and what happens in the curriculum. National health and education frameworks endorse community orientation, responsiveness to social needs, and health equity. These principles however are not consistently reflected in undergraduate teaching and assessment [7]. A hidden curriculum consequently remains in place. Biomedical knowledge and diagnostic performance receive more reliable recognition than socially informed reasoning. Students may graduate with strong clinical knowledge while having limited experience in recognizing food insecurity, unstable housing, financial difficulties, family stress, and other conditions that affect adherence, follow-up, and overall health outcomes. The problem is especially relevant to mental health care, chronic disease management, and the care of underserved groups. In these settings, the social circumstances of a patient are often closely tied to the clinical problem itself. Several cultural and structural factors help maintain this situation. The hidden curriculum favors biomedical mastery over socially informed reasoning. This tendency is reinforced by high-stakes examinations such as the Pre-Internship Comprehensive Exam which almost exclusively test biomedical recall rather than the recognition of social risk. Clinical faculty have themselves been trained within this tradition. Many have had little formal preparation in SDoH and without dedicated faculty development may regard social determinants as the responsibility of another part of the health system. Time pressures create another barrier. Large student cohorts and heavy patient loads leave little room for detailed social history-taking. Academic career advancement in Iran is also closely linked to clinical workload and biomedical publication. There are few institutional incentives for faculty to invest time in socially accountable teaching. These factors make it possible for well-intended curricular reforms to be absorbed by the existing system without producing much change in everyday practice. Changes in the reward structure are therefore needed alongside curricular reform.

From awareness to clinical competence

The response should not be a single isolated course on SDoH. A separate module may introduce the subject and raise awareness but it is unlikely on its own to change clinical practice. SDoH need to be integrated across the preclinical, clinical, and community-based stages of training [8]. In the early years, students can learn the basic concepts of health inequity, structural vulnerability, and the relationship between social conditions and disease distribution. During clinical training, they can apply these concepts to history-taking, case discussions, and patient management. Community placements can then expose students to the everyday effects of social risk and to the work of multidisciplinary teams, family medicine services, and local support networks. In this form, SDoH becomes part of routine professional practice rather than an additional topic that students may or may not consider relevant.

Faculty development must accompany this change. Curriculum reform cannot succeed if teachers are not prepared to teach and assess socially responsive practice. Faculty need support in presenting SDoH in clinical contexts and in using case-based and reflective approaches. They also need appropriate ways to judge whether students can recognize and respond to social needs. Assessment deserves particular attention because

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students naturally give priority to what is assessed. When examinations reward biomedical recall alone SDoH will remain peripheral regardless of what appears in formal curriculum documents. Structured clinical examinations, workplace-based assessment, reflective portfolios, and community-oriented projects can instead reinforce the expectation that competent physicians need to consider both the biological and social dimensions of illness [9].

The issue also belongs within the broader concept of social accountability. Medical schools are not simply places where professional knowledge is transmitted. They have responsibilities to the populations they serve. A socially accountable medical school links education, research, and service to the health needs of its community. In Iran SDoH teaching should therefore be seen as more than a pedagogical issue. It can help make medical training more relevant to the circumstances of Iranian patients and communities. Students who learn to interpret illness in its social context are better prepared for primary care, prevention, mental health care, continuity of care, and patient-centered decisions. SDoH education can thus support both equity and the quality of care.

A practical route for reform in Iran

Ultimately the integration of SDoH into Iran's undergraduate medical curriculum requires a change in educational purpose rather than simply the addition of new content. Moving from policy statements to actual practice will require action at more than one level. One practical starting point is for medical schools to conduct structured action-research projects at selected clinical sites, such as internal medicine, psychiatry, and family medicine wards. These projects could be used to develop and test practical educational tools including revised social history-taking protocols, SDoH-focused Objective Structured Clinical Examination (OSCE) stations, and community-based learning modules. Local pilot projects would provide evidence from the Iranian setting and give faculty experience with the new approaches before wider adoption. At the same time, systemic changes are needed if these efforts are to continue. National educational authorities should signal the importance of SDoH by including related competencies in mandatory national licensing examinations. At the university level each medical university should establish an SDoH integration steering committee to map existing curricula, allocate resources for faculty development, and monitor progress. The purpose is not to create another administrative layer without a clear function. The committee should provide a mechanism for coordinating curricular work and keeping SDoH visible in teaching and assessment. Ultimately SDoH education should be treated not as an abstract educational ideal but as a measurable part of institutional performance in social accountability.

Ethical considerations

Not applicable.

Artificial intelligence utilization for article writing

The authors declare that no artificial intelligence tools were used in the writing, drafting, or revision of this manuscript.

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Conflict of interest statement

The authors declare no conflict of interest.

Author contributions

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