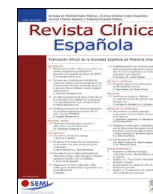




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Consensus document

Social determinants of health: a priority for internal medicine. Position statement of the Spanish Society of Internal Medicine (SEMI) and the Portuguese Society of Internal Medicine (SPMI)[☆]



Determinantes sociales de la salud: una prioridad para la medicina interna. Documento de posicionamiento de la Sociedad Española de Medicina Interna (SEMI) y la Sociedad Portuguesa de Medicina Interna (SPMI)

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ABSTRACT

Introduction: Internal medicine, owing to its comprehensive and cross-sectional approach, is uniquely positioned to lead the integration of social determinants of health (SDOH) into clinical practice.

Methods: Based on the Delphi methodology promoted by the Spanish Society of Internal Medicine (SEMI) and the Portuguese Society of Internal Medicine (SPMI), this study explored perceptions, barriers, and strategies for integrating SDOH into hospital care. Experts from both countries participated in a two-round consultation process, followed by a consensus meeting, which resulted in a prioritized roadmap of action.

Results: Our findings show strong agreement on the relevance of SDOH for health outcomes, the need for mandatory and transversal training at all educational levels, and the importance of validated tools for systematic screening. Key barriers include lack of time, insufficient specific training, limited human resources, and the absence of structured SDOH data in electronic health records. Additionally, the results emphasize the importance of interdisciplinary teams, coordination with social services, and adapting care pathways to patients' social contexts. Emerging determinants include population aging, mental health, climate change, and digital transformation, including artificial intelligence.

Conclusions: This decalogue provides a practical and prioritized roadmap to transform Internal Medicine care towards a more equitable, comprehensive, and SDOH-sensitive model, with training, service organization, technological resources, and collaboration as fundamental pillars.

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RESUMEN

Palabras clave:

Determinantes sociales de la salud (DSS)
 Medicina interna
 Desigualdades en salud
 Modelo centrado en la persona
 Cribado social
 Pacientes complejos
 Cambio climático

Introducción: La medicina interna, por su abordaje integral y transversal, se encuentra en una posición privilegiada para liderar la incorporación de los determinantes sociales de la salud (DSS) en la práctica clínica.

Métodos: A partir de un estudio Delphi promovido por la Sociedad Española de Medicina Interna (SEMI) y la Sociedad Portuguesa de Medicina Interna (SPMI), se exploraron las percepciones, barreras y estrategias para integrar los DSS en la atención hospitalaria. Participaron expertos de ambos países, y el proceso incluyó dos rondas de consulta y una reunión de consenso, que permitió elaborar un decálogo de prioridades.

Resultados: Revelan un consenso claro sobre la relevancia de los DSS en los resultados de salud, la necesidad de formación obligatoria y transversal en todos los niveles, y la importancia de herramientas sistemáticas para su cribado. Entre las barreras se identificaron la falta de tiempo, de formación específica y de recursos humanos, así como la ausencia de integración de los DSS en la historia clínica electrónica. Además, se priorizó el fortalecimiento del trabajo interdisciplinar, la coordinación con servicios sociales y la necesidad de adaptar los modelos asistenciales. También se señalaron como determinantes emergentes el envejecimiento, la salud mental, el cambio climático y la transformación digital, incluyendo la inteligencia artificial.

Conclusiones: Este decálogo proporciona una hoja de ruta práctica y priorizada para transformar la atención en Medicina Interna hacia un modelo más equitativo, integral y sensible a los DSS, articulando la formación, la organización asistencial, los recursos tecnológicos y la colaboración como pilares fundamentales.

Introduction

The World Health Organization defines the social determinants of health (SDOH) as “the conditions in which people are born, grow, work, live, and age”. In this context, the concept of “health inequalities” refers to the impact of factors such as income level, education, occupation, racial or ethnic group, urban or rural environment, and the social conditions of one’s place of residence or work on the distribution of health and disease within the population.^{1,2}

In internal medicine, population aging and increased survival have led to greater chronicity, multimorbidity, and clinical complexity.^{3,4} This scenario brings additional challenges, such as a lack of social support, unwanted loneliness, cognitive decline, disability, and dependence. A nationwide, multicenter, cross-sectional surveillance (point-prevalence) study assessing the impact of social problems on hospital admissions identified 2,342 inappropriate admissions, defined as those primarily related to non-clinical or social conditions, in Portuguese hospitals, representing 11.7% of all inpatients. The prevalence of social-related admissions was 12.8% among adult medical patients and 14.5% among internal medicine services. Of these patients, 74% were over 50 years of age, and half were admitted to medical wards.⁵ In this context, internists approach the patient holistically, focusing not only on the disease but also on the person as a whole. This comprehensive care highlights how social determinants, which influence individual conditions, manifest more intensely and complexly in patients with multiple diseases, further complicating clinical management.⁶

In recent years, several studies have highlighted the limited systematic integration of SDOH within hospital medicine, particularly in departments such as Internal Medicine and Emergency Services.⁷ Although multiple screening tools are available, evidence regarding their effective implementation is limited. Initiatives carried out in U.S. hospitals, while contributing to improved individual comprehensive care, have shown minimal progress in advancing health equity due to shortcomings in data integration, resource allocation, and structural approaches.⁸ Moreover, their effectiveness depends on the presence of well-structured workflows, adequate institutional integration, and sustained political support, factors that are often limited or insufficient.⁹

In light of this context, the objective of this study is to present a consensus among internal medicine professionals, derived through a structured Delphi methodology, on the perception, impact, barriers, and strategic approaches related to the identification and integration of SDOH in clinical practice. The resulting findings will be critically analyzed and synthesized into a decalogue of prioritized actions and recommendations aimed at reinforcing a more comprehensive, equitable, and person-centered model of care capable of addressing emerging

challenges and aligning with the actual needs observed by clinicians in routine hospital settings.

Methodology

We conducted a structured consensus study using the Delphi approach to examine clinicians’ perceptions, perceived impact, barriers, and strategies for integrating SDOH into internal medicine practice. The process comprised two rounds of online consultation, followed by a final in-person consensus meeting of participating experts to adjudicate unresolved items and ratify the recommendations.

The process involved senior representatives from the Spanish Society of Internal Medicine (SEMI) and the Portuguese Society of Internal Medicine (SPMI), including presidents, vice presidents, and other strategic leaders within both organizations. The expert panel consisted of 11 participants, nine men and two women, five from Spain and six from Portugal, with ages ranging from 40 to 70 years. These experts provided in-depth knowledge of the specialty and a comprehensive perspective on the current and future challenges facing internal medicine. Their professional profiles are distinguished by extensive clinical experience in the care of patients with multimorbidity and high social complexity, a solid research background in areas such as SDOH, chronic disease, and public health, as well as active roles in clinical management and the coordination of services, units, and educational programs related to the specialty.

These professionals were selected from various autonomous communities and regions across Spain and Portugal to ensure a broad and contextually rich perspective, as well as diversity in terms of gender, years of professional experience, and hospital settings (tertiary, regional, university, or high-resolution hospitals). Prior to their participation, all experts received detailed information regarding the study objectives, Delphi methodology, participation requirements, and confidentiality of their responses. Informed consent was obtained from all participants for the inclusion of their contributions to the final consensus document.

First Delphi round

In the first round, a structured questionnaire was distributed and organized into six thematic sections (Supplementary Table S1):

Section 0: Identification of emerging social determinants.

Section 1: Relevance and general perceptions.

Section 2: Current practices and feasibility.

Section 3: Perceived barriers.

Section 4: Strategies and proposals.

Section 5: Evaluation of specific strategies.

Each item was rated using a 5-point Likert scale (1 = strongly disagree; 5 = strongly agree), and the participants were encouraged to provide qualitative comments to enrich the interpretation of the results. The data collected included information on priority SDOH, perceived professional responsibility, training needs, organizational barriers, and strategies that were deemed most relevant or feasible.

Second Delphi round

Following the analysis of the first round, a second-round Delphi questionnaire was developed (Supplementary Table S2), in which participants were provided with a summary of the previous results for re-evaluation. This round aimed to explore the following areas in greater depth:

- Section 0: Prioritization of emerging SDOH.
- Section 1: Leadership and responsibility.
- Section 2: Training.
- Section 3: Time and available tools.
- Section 4: Decision-making.
- Section 5: Coordination and networking.
- Section 6: Strategic vision.

Consensus meeting

A face-to-face consensus meeting was subsequently conducted with the participating experts to review the outcomes of both Delphi rounds, resolve areas of disagreement, and reach a consolidated set of final conclusions. During this session, the findings were formally validated, and a structured ten-point framework of priorities and strategic action lines for the integration of SDOH into Internal Medicine was developed. This framework constitutes the principal output of the consensus process and serves as a foundational reference for advancing a more socially responsive model of care in the specialty.

Data analysis

A descriptive analysis of the quantitative responses was performed using frequencies and central tendency measures. Additionally, a thematic analysis of the qualitative comments was conducted to identify emerging categories and enrich the interpretation of findings. The median was used as the measure of central tendency given its robustness against outliers and suitability for ordinal data derived from Likert-scale responses. The degree of agreement or disagreement among experts for each item was assessed using the interquartile range (IQR), following standard Delphi methodology, to determine whether consensus was achieved or if additional rounds were required.

Results

Key findings by section – first Delphi round

Section 1: Relevance and perception

- Impact of SDOH on health (5)
- Responsibility of internists (4)
- Mandatory SDOH training in residency programs (5)

Interpretation: The critical importance of SDOH and the need for formal training are widely acknowledged, although the extent of individual responsibility is nuanced because of systemic limitations.

Section 2: Current practice and feasibility

- Time available to explore SDOH (2)
- Systematic screening tools (1)
- Integration of social factors into clinical decision-making (2)

■ Availability of support staff (3)

Interpretation: A significant gap exists between the theoretical recognition of SDOH and their practical integration, primarily due to constraints in time, resources, and organizational structures.

Section 3: Perceived barriers

- Lack of time (4)
- Lack of training (4)
- Absence of SDOH fields in electronic health records (4)
- Disconnection from community resources (4)

Interpretation: These four barriers were identified as the top priorities. They are predominantly structural and organizational rather than individual, indicating the need for systemic changes to effectively address the identified challenges.

Section 4: Strategies and proposals

- Electronic screening tools (5)
- Clinical protocols adapted to SDOH (5)
- Partnerships with community resources (4)

Interpretation: There is a broad consensus on the need to integrate SDOH into electronic systems and clinical protocols, while establishing community partnerships is viewed as important but requires strategic planning.

Section 5: Evaluation of specific strategies

- Training on SDOH as a priority (4).
- Systematic screening during hospitalization (5)
- Incorporation of SDOH into electronic health records (4)
- Increased availability of social workers and case managers (5)
- Partnerships with community resources (5)

Interpretation: Participants agreed that effective integration of SDOH into clinical practice requires a multidimensional strategy combining training, electronic tools, human resources, and robust community networks.

Key findings by section – second Delphi round

Section 1: Leadership and responsibility

- Internists should lead SDOH initiatives within hospitals (5)
- The impact of SDOH should be included among quality indicators in Internal Medicine (5)

Interpretation: There is a strong consensus that internists must take an active leadership role and that integrating SDOH into quality metrics is key to institutionalizing their clinical relevance.

Section 2: Training

- SDOH training should be mandatory in the Internal Medicine residency curriculum (5)
- SDOH content should also be included in undergraduate medical education (5)
- Structured SDOH training improves clinical outcomes (5)

Interpretation: There was unanimous agreement that SDOH should be embedded throughout medical education and that structured teaching has a positive impact on clinical outcomes.

Section 3: Time and tools

- Need for validated, systematic tools for SDOH screening (5)
- Structured section for SDOH in electronic health records (5)

Interpretation: There was strong agreement that standardizing SDOH screening and integrating it into electronic health records are essential steps toward improving detection and management.

Section 4: Decision-making

- Social context should influence discharge planning (5)
- SDOH significantly affect treatment adherence (5)
- Integrating SDOH into clinical decisions may reduce avoidable readmissions (5)

Interpretation: A clear consensus was reached that incorporating SDOH into clinical decision-making is necessary to deliver personalized care and prevent adverse outcomes, such as readmissions.

Section 5: Coordination and networking

- Stable coordination channels with social services are necessary (5)
- Non-medical professionals (e.g., social workers, case managers) should be included in Internal Medicine teams (5)

Interpretation: There is a strong consensus that coordination and intersectoral collaboration are central components for effectively addressing SDOH in clinical practice.

Section 6: Strategic vision

- SDOH should be integrated transversally into hospital strategy (5)
- SEMI and SPMI should lead a joint Iberian strategy for SDOH integration (5)
- An organizational transformation is needed to incorporate the social perspective into routine care (5)

Interpretation: There was a total consensus that the integration of SDOH requires institutional transformation, led by scientific societies and embedded within organizational frameworks.

Emerging social determinants of health in internal medicine

In the first round of the Delphi process, participants were invited to respond to an open-ended question aimed at identifying the SDOH perceived to have the greatest impact on patient outcomes within the scope of Internal Medicine. In the subsequent round, these determinants were ranked in order of priority based on clinical relevance. The analysis revealed a set of emerging SDOH that warrant consideration in the comprehensive evaluation of medically complex patients. Chief among these is the progressive aging of the population, which is intrinsically linked to a higher burden of chronic disease and is frequently associated with conditions such as unwanted social isolation and an increasing prevalence of mental health disorders. Although ageing and mental health are structural determinants, they were identified as emerging due to their increasing clinical and societal relevance.

Second, climate change has emerged as a significant social determinant of health, primarily linked to the exacerbation of pre-existing chronic conditions. A third relevant factor is the integration of new technologies, such as telepresence and telemedicine, which are substantially reshaping healthcare delivery, particularly in complex clinical settings or areas with limited access to care. Finally, the rapid advancement of artificial intelligence has introduced a transformative dimension to healthcare, with potential implications for both diagnostic processes and clinical decision-making.

Discussion

The findings of this study demonstrate a broad consensus among internal medicine professionals regarding the urgent need to integrate SDOH into clinical practice. Given their comprehensive approach to patient care and coordinating role within the healthcare system, inter-

nal medicine is positioned as a key specialty to lead this transformation toward a more equitable, integrated, and person-centered model of care. In this context, it is essential to implement policies that prioritize prevention, promote healthy lifestyles, and ensure universal, free access to high-quality healthcare services. Effective integration of health and social services is also critical, along with urban planning strategies that promote well-being, environmental justice, and the protection of vulnerable populations. The ethical and equitable use of emerging technologies, such as artificial intelligence, combined with digital and environmental literacy, may serve as a catalyst for transformation. This Delphi study enabled the development of a ten-point framework of priorities and strategic actions (Table 1) aimed at strengthening a care model that effectively addresses the social needs identified in daily clinical practice.

Regarding emerging SDOH, internists identified those linked to major demographic, environmental, and technological shifts as the most concerning. Population aging stands out as the primary determinant because of its association with the growing burden of chronic diseases, increased social isolation, and mental health issues among older adults. This complex scenario demands more personalized and psychosocially sensitive clinical care. Climate change has also been highlighted for its role in exacerbating chronic conditions and increasing vulnerability in less adaptive populations.^{10,11} Additionally, the rise of telemedicine and telepresence is reshaping healthcare delivery, presenting opportunities and challenges in terms of equity, access, and digital literacy. Finally, the rapid emergence of artificial intelligence raises important questions about its impact on diagnostic and decision-making processes, positioning it as a new structural determinant with the potential to significantly alter the physician-patient relationship and traditional care models.¹²

Internists recognize that SDOH critically impact chronic diseases, multimorbidity, and hospitalizations. Growing evidence shows that systematic assessment of SDOH in hospitalized patients is associated with improved outcomes, including reduced mortality and readmissions. Routine SDOH screening enables early identification of social needs, better care coordination, and more efficient resource use.¹³⁻¹⁵ Recent reviews further highlight the importance of standardizing indicators and strengthening evidence on the impact of SDOH interventions on health outcomes.¹⁶ In line with this evidence, recent frameworks such as those proposed by the WHO Working Group¹⁷ and Schneberk et al.¹⁸ highlight the importance of developing standardized methodologies and quality indicators to systematically assess and monitor social determinants of health within hospital settings. Despite assuming some individual responsibility, structural barriers and ethical concerns limit effective action. There is a strong consensus on the need for structured SDOH training and multidisciplinary models of care, including social workers and case managers. These findings support institutional investment and the integration of SDOH into care programs through shared care among internal medicine, primary care, other specialties, and social services to ensure continuity beyond the hospital setting.

Barriers to the effective integration of SDOH into clinical practice include limited consultation time, lack of validated screening tools, and poor integration into electronic health records.¹⁹ Their application remains sporadic and relies on individual initiative, with minimal organizational support. Insufficient support staff and weak connections to community resources further widen this gap. Addressing this requires standardized tools, trained personnel, and supportive structures. The proposed strategies emphasize the integration of electronic SDOH screening into health records, adaptation of clinical protocols to patients' social contexts, and strengthening of workforce capacity. There is a strong consensus on the need for systematic SDOH screening during hospitalization and targeted training for healthcare professionals.²⁰

The second Delphi round confirmed this trend, emphasizing the need to integrate SDOH training across all stages of medical education, from undergraduate to specialized training programs. Such integration would help develop professionals who are more attuned to the social factors influencing health. Recent literature supports this approach, highlighting

Table 1

Decalogue of priorities and actions for the integration of social determinants of health (SDOH) in internal medicine.

- 1. Integrate the impact of SDOH into internal medicine practice.** Strengthening institutional and professional awareness that SDOH are key drivers of health outcomes, particularly in patients with multimorbidity and those in vulnerable situations.
- 2. Implement mandatory SDOH training across all levels of medical education.** Specific training modules on SDOH conceptualization, screening, clinical-social management, and ethical considerations should be included in residency programs, continuing medical education, and professional development curricula.
- 3. Develop and integrate systematic electronic screening tools for SDOH into electronic health records (EHRs).** Integrate validated instruments into EHRs for efficient identification and documentation of relevant social factors, ensuring their usability without increasing the administrative burden.
- 4. Adapt clinical guidelines and care pathways to patients' social contexts.** Evidence-based clinical guidelines and care pathways that integrate social risk stratification into diagnostic and therapeutic decision-making processes should be developed to facilitate more comprehensive, context-sensitive, and patient-centered care.
- 5. Strengthen interdisciplinary support teams within internal medicine services.** Expand and strategically integrate social workers, case managers, and community liaison professionals into internal medicine teams, in coordination with preventive medicine and public health services, to strengthen the healthcare system's capacity to address patients' social needs effectively.
- 6. Enhancing care coordination to ensure management in the most appropriate setting.** Establish shared care models among internal medicine, primary care, other specialties, and social services to ensure continuity of care beyond the hospital.
- 7. Systematically monitor the impact of SDOH and patients' social and health needs.** Outpatient structures and care pathways should be revised to enable the effective identification of social needs and facilitate the collection and analysis of outcome data from related interventions.
- 8. Foster an organizational culture of awareness and accountability regarding SDOH.** Promote SDOH-related training and awareness for clinical, administrative, and support staff, as well as policymakers, to ensure equity-driven care.
- 9. Promote applied research to evaluate SDOH interventions and their associated health outcomes.** Encourage research projects to evaluate the effectiveness of SDOH-focused interventions and develop indicators to measure their integration into clinical practice and impact on health outcomes.
- 10. Embedding SDOH approaches into the strategic planning of internal medicine societies.** Embedding the SDOH perspective into the planning of care policies, chronic care models, home hospitalization, and high-resolution outpatient services ensures a preventive and community-oriented approach.

the importance of incorporating social and health-related content, such as bioethics, public health, and medical sociology, into medical education to address the structural and cultural challenges of contemporary medicine.²¹

Internists' leadership is essential for advancing SDOH integration, given their clinical expertise and central role in hospitals. Incorporating SDOH as quality indicators is proposed to institutionalize their monitoring and guide continuous improvement with an equity-focused approach. Strengthening coordination with social services and integrating non-medical professionals into care teams is also highlighted to support a more comprehensive approach.

Ultimately, the integration of SDOH should become a transversal strategic priority within healthcare organizations, requiring strong institutional leadership, political commitment, and structural reform.^{8,22} Scientific societies such as SEMI and SPMI are positioned to drive a coordinated Iberian strategy, which may serve as a scalable model for other European regions aiming to integrate SDOH into clinical practice and health policies. With their system-wide perspective, internists are uniquely equipped to assess the impact of SDOH on health and inform policy recommendations for health authorities and decision-makers.

Maximizing the impact of SDOH requires health policies that focus on prevention and equity. This includes promoting healthy lifestyles to prevent avoidable chronic diseases, such as obesity, type 2 diabetes, cardiovascular conditions, and some cancers, particularly among socioeconomically vulnerable populations.²³ Ensuring universal, free, and high-quality healthcare access is essential, along with strengthening public health systems and integrating levels of care. Social and health policies must be aligned through coordinated models that share leadership and funding to effectively address health inequities. Engaging municipalities in urban planning is essential for promoting healthy lifestyles and protecting populations from environmental threats such as heatwaves. Climate action must be integrated into public health policies through multisectoral networks, such as the Portuguese Council on Health and Environment,²⁴ which reduce environmental health risks, lower the sector's ecological footprint, raise awareness, train health professionals, and strengthen system resilience to climate-related disasters.²⁵ Furthermore, the responsible use of emerging technologies, including artificial intelligence, along with digital literacy, can help reduce health inequalities and enhance system responsiveness to current and future challenges.²⁶

Finally, several limitations of this position paper should be acknowledged. No estimation of the potential economic or budgetary impacts, such as human resources, training, or electronic health record adaptation, was conducted, as this was beyond the scope of this study. The analysis primarily reflects the perspective of internal medicine specialists, without input from other key stakeholders, such as nursing, social work, primary care, or health management. Moreover, regulatory and structural differences between Spain and Portugal, including variations in social policy, EHR interoperability, and social care service frameworks, were not explored and may influence the applicability of the proposed recommendations.

In conclusion, the findings of this study reflect a clear consensus among internal medicine professionals on the urgent need to integrate SDOH into clinical practice. We propose a ten-point framework (Table 1) that offers a practical and prioritized roadmap for transforming internal medicine care toward a more equitable, comprehensive, and SDOH-sensitive model, with training, service organization, technological resources, and cross-sector collaboration as key pillars.

Declaration of generative AI and AI-assisted technologies in the writing process

During the preparation of this work the authors used Chat GPT-4 (Generative Pre-trained Transformer 4), a language model developed by OpenAI, to improve the writing and translation of the manuscript. After using this tool/service, the authors reviewed and edited the content as needed and take full responsibility for the content of the publication.

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Appendix A. Supplementary data

Supplementary material related to this article can be found, in the online version, at doi:<https://doi.org/10.1016/j.rce.2026.502468>.

Declaration of competing interest

The authors declare that they have no conflicts of interest related to the content discussed in this work. Nonetheless, the authors declare that María Montserrat Chimeno is the current president of SEMI (Spanish Society of Internal Medicine), Luís Duarte Costa is the current president of SPMI (Portuguese Society of Internal Medicine), Vasco Barreto is the current SPMI's vicepresident, José Luis Bianchi is the current SEMI's treasurer, Javier Moreno Díaz is the current SEMI's general secretary, José M. Porcel is the current SEMI's 1st vicepresident and Pablo Pérez-Martínez is the current SEMI's 2nd vicepresident.

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