

## **What is Social Medicine?**

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The past two decades have seen a rapid expansion of the corporate agenda in the field of health and health care. Rather than moving toward a system of universal access to medical care in the United States, the access to and quality of clinical services is being turned over increasingly to the insurance industry. Patients are now “clients” and clinical services are “product lines.” More clinical research is now funded by the pharmaceutical industry than the National Institutes of Health; pharmaceutical dollars pay the salaries of top academics and set the national research agenda. Clinicians and patients alike are wooed by sophisticated advertising campaigns (often disguised as education) that promote expensive drugs of dubious efficacy. The insertion of “market rationality” into health care has not brought the hoped for curbing of health care costs. The United States, despite spending more per capita on medical care than any other country in the world, continues to perform poorly on many health indicators, with a life expectancy at birth that ranks twenty-seventh in the world.

This corporate agenda, however, has not gone unchallenged. And rather than being pessimistic or defeatist, we think it might be useful to consider the long and rich history of progressive activism in medicine. This history dates back (at least) to the early nineteenth century when the systematic study of the relationships between society, disease, and medicine began in earnest. This study—and the forms of medical practice derived from it—became known as “social medicine.” Over time the term “social medicine” took on varied meanings as it was adapted to differing societies and diverse social conditions. Nonetheless, certain common principles underlie the term:

1. Social and economic conditions profoundly impact health, disease, and the practice of medicine.
2. The health of the population is a matter of social concern.
3. Society should promote health through both individual and social means.

In this essay we explore the origins of these concepts in nineteenth-century Europe and their subsequent development in Latin America, South Africa, and the United States. While this brief essay cannot provide a comprehensive examination of social medicine, we hope it will suggest ways in which the historical experience of social medicine can shed light on some of the most vexing problems in modern health and health care.

## **How Social and Economic Conditions Impact Health and Disease**

Although he was not the first to point out the links between society and health, the German physician, Rudolf Virchow, is considered by many to be the founder of social medicine. Virchow was one of the great pathologists of the nineteenth century, most notably contributing to the understanding of disease at the cellular level. He was also keenly aware of the social origins of illness. In 1848, while working as a staff physician at the Royal Charité Hospital in Berlin, he investigated an outbreak of typhus in the Prussian province of Upper Silesia. Virchow identified social factors, such as poverty and the lack of education and democracy, as key elements in the development of the epidemic. The experience led him to the concept of “artificial epidemics” arising in periods of social disruption:

Artificial epidemics...are attributes of society, products of a false culture or of a culture that is not available to all classes. These are indicators of defects produced by political and social organization, and therefore affect predominately those classes that do not participate in the advantages of the culture. (Cited in G. Rosen, *From Medical Police to Social Medicine* [New York: Science History Publications, 1974].)

These words seem prescient when we consider the AIDS pandemic. Social inequalities and disruptions have been central to the spread of the HIV virus. The links between the broader social context and individual stories of HIV-infected Haitians have been poignantly described by Paul Farmer. The struggle against AIDS is not only the fight against an infectious disease, but also a struggle for the rights of women, children, sex workers, and sexual minorities.

The struggle against AIDS is also a struggle to deliver clinical care to some of the world's poorest people. Here we can truly speak of living in the best of times and the worst of times. It is certainly one of the miracles of modern biomedicine that it was able rapidly to identify the causative agents of AIDS and to develop highly effective treatments for it. In the United States AIDS is now largely treatable, although not yet curable. But it is a great outrage—and also characteristic of modern medicine—that most people who need the medications are denied access to them. Of the estimated six million poor people who urgently need AIDS medications only an estimated 440,000 are actually getting them. Why are AIDS patients denied the treatments they so desperately need? The answer is not really the cost of the drugs. The “cocktail” of AIDS medications can be purchased for about \$250 per year. But the U.S. government, working through the World Trade Organization, has fought long and hard to restrict the abilities of poorer countries to produce or purchase generic medications. The rights of pharmaceutical corporations to their “intellectual property” have trumped public health.

Nonetheless, organized medicine has traditionally been slow to accept the fact that social factors play an important role in disease. In the late nineteenth

century the striking advances made in pathology and microbiology made social factors seem less germane in the etiology of disease. But humans are, in Aristotle's words, "social animals" in whom the biological and social are inextricably linked. The Russian philosopher, Georgi Plekhanov, used the "laws of digestion" to illustrate this in his characteristically sharp style:

Once the stomach has been supplied with a certain quantity of food, it sets about its work in accordance with the general laws of stomachic digestion. But can one, with the help of these laws, reply to the question of why savory and nourishing food descends every day into your stomach, while in mine it is a rare visitor? Do these laws explain why some eat so much, while others starve? It would seem that the explanation must be sought in some other sphere, in the working of some other kind of laws. (G. Plekhanov, *The Development of the Monist View of History* [New York: International Publishers, 1947])

Much of the early inspiration for social medicine came from European health statistics demonstrating major mortality differences between classes. Health and disease were correlated with wealth and poverty. Unfortunately, this remains true today and health inequalities are an active area of research and activism.

### **The Health of the Population is a Matter of Social Concern**

Various explanations are offered for the fact that the rich are healthier than the poor. Perhaps they have better genes. Or better lifestyles. Many saw these disparities as a call for social reform or revolution. Thomas Hodgkin, known for identifying Hodgkin's lymphoma, and the Canadian surgeon, Norman Bethune, who worked to preserve the Republic during the Spanish Civil War and died helping the Chinese revolutionaries, are just two examples of physician activists.

Virchow was another. If disease was socially derived, then ill health was to him an indictment of the political system. He stood on the barricades during the March 1848 Berlin uprisings and later played an active political role, serving as Berlin city counselor, a founder of the German Progressive Radical Party, and a member of the Prussian and German parliaments. During the revolutionary days of 1848 his journal proclaimed that "Medicine is a social science, and politics nothing but medicine on a grand scale."

During the twentieth century Latin America developed one of the most active centers of social medicine. Two of its most prominent members—Salvador Allende and Che Guevara—are known primarily for their political engagement.

In the 1930s, Allende, a public health physician, served as Chilean minister of

health. He produced an analysis of the social origins of disease and suffering in Chile: *La Realidad Medico-Social Chilena*. He argued that the solution to health problems lay not simply in improved medical care but also in better sanitation, housing, nutrition, and working conditions. Echoing Virchow, Allende wrote: “[I]t is not possible to provide health and knowledge to a malnourished people, dressed in rags and working under merciless exploitation.” These ideas were eventually embodied in the political program of the democratically-elected Popular Unity government in Chile. Allende served as president of the Popular Unity government from 1971 until 1973 when he was assassinated in the U.S. organized coup d’etat.

Che Guevara, an Argentinean physician, joined Fidel Castro’s insurrection in Cuba, eventually becoming minister of the economy in the revolutionary government. Echoing Virchow, Che saw politics as medicine on a grand scale:

[T]he revolution’s task—the task of training and nourishing the children, the task of educating the army, the task of distributing the lands of the old absentee landlords among those who sweated every day on that same land without reaping its fruit—is the greatest work of social medicine that has been done in Cuba. (Cited in David Deutschmann, ed., *Che Guevara: A Reader: Writings on Guerilla Strategy, Politics and Revolution* [New York, Ocean Press, 1997].)

Like Salvador Allende, Che Guevara would die fighting for his beliefs.

Despite these deaths, Latin American social medicine flourished. Latin American social medicine developed a rich body of theoretical and practical work examining the relationship between health and society. It emphasizes praxis: developing a close relationship between theory and practice. Practitioners have been involved with community organizations, unions, and political movements; many others fell victim to political repression.

Latin American social medicine has also adopted a highly critical stance toward traditional thinking in medicine and epidemiology. Rather than seeing disease as an isolated state or event, it emphasizes the “health-illness dialectic,” a concept that expresses the fluid, complex relationship between the normal and the pathological. This dialectic exists within a social structure that creates distinct patterns of diseases and distinct medical ideologies to explain and treat those diseases. Latin American social medicine influenced North Americans involved in the Central American antiwar movement in the 1980s, notably in the formation of “liberation medicine.”

Unfortunately, the work of Latin American social medicine has been largely unavailable to English-speaking audiences, a situation partially remedied by the publication of several recent review articles and the creation of a website

devoted to Latin American social medicine at the University of New Mexico.

### **Society Should Promote Health through Both Individual and Social Means**

A desire for new—more democratic, less hierarchical—models of health care was not just felt in Latin America. Indeed, if politics is medicine writ large, it is also apparent that medicine is politics writ small. The way in which clinical care is provided has important political ramifications. Socially-minded physicians began to look for ways in which their clinical practice might reflect different social values.

Extremely important in this search was the development of community medicine, a movement in part associated with the South African doctors Sidney and Emily Kark. In 1940, at a particularly favorable time in South African politics, the Karks were charged with setting up a model health unit in Pholela in Natal (now in KwaZulu/Natal). The health center served as a testing ground for what the Karks initially described as “a practice of social medicine” but would later be dubbed “community oriented primary care.” The project was expanded in 1946 into an Institute of Family and Community Health in Durban with eight health centers and a major teaching program. As political winds in South Africa changed the institute ceased operations in 1959. The Karks eventually settled in Israel to work on a World Health Organization (WHO)-Israel Social Medicine Project.

The community-oriented primary care model incorporated innovations based on social medicine principles. Planning began with a “community diagnosis.” Based on epidemiological work, Pholela’s three most common conditions were identified as “malnutrition; communicable diseases; and psycho-social problems,” the triad composing the “community syndrome.” This diagnosis led to nontraditional health interventions, such as a milk distribution program for children and the planting of a community garden.

Clinical care was the responsibility of a team composed of a primary care doctor, a community nurse, and a health educator (typically someone drawn from the community). The team served a neighborhood of homes that they knew intimately, conceiving their “patient” as a family, not an individual:

Continuity of care by this team introduced personal relationships between the families and their doctors and nurses, of the same kind as those the old family doctor had in his village or neighborhood practice. (S. L. Kark and G. W. Steuart, *A Practice of Social Medicine* [Edinburgh: E&S Livingstone Ltd., 1962])

Unlike the traditional family doctor, the health team would systematically consider the implications of the broader social context for individual patients

and the possible epidemiological implications of new diagnoses in their individual patients.

In the 1960s, the U.S. Office of Economic Opportunity funded the first two community health centers in the United States: one on Boston's Columbia Point peninsula and another in Mound Bayou, Mississippi. The latter was founded by Jack Geiger, who had worked with the Karks in South Africa, and his colleagues. Congress eventually funded a national program of community health centers that continue to provide care today to the "third world" within the United States. Two of the authors of this paper (Matt Anderson and Lanny Smith) provide care at such centers.

Many of the ideals of the community health movement were embodied in the "Declaration of Alma-Ata" issued by the World Health Organization's 1978 International Conference on Primary Care. The declaration reaffirmed the WHO's holistic definition of health as "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity." It went on to signal that the "existing gross inequality in health" was unacceptable, that people have a right to participate in the organization and implementation of health care, and that primary care should be universally available. Finally, signaling the responsibility of governments for health, the declaration launched the ambitious goal of "health for all" by the year 2000. Alas, the neoliberal economic agenda has prevailed over this progressive and farsighted vision. Today "health for all" has been replaced by a variety of disease-specific initiatives such as the (seriously underfinanced) Global Fund to Fight AIDS, Tuberculosis and Malaria. But the ideals expressed in Alma-Ata continue to animate a broad-based international community health movement, now organized as the People's Health Movement.

### **Is Social Medicine Relevant to Medical Practice Today?**

Sometimes it is useful to state the obvious. Two decades of "market reform" in U.S. health care have not given all Americans affordable, quality health care nor is it likely to do so. This emperor has no clothes. HIV treatment for all who need it could be supplied for a tiny fraction of what the U.S. government has spent to pursue Saddam Hussein and his nonexistent weapons of mass destruction. The essence of the problem is a political one.

What, then, is to be done? Clinicians know the lives of their patients intimately and thus are uniquely suited to understand the political and social dimensions of their patients' problems. Virchow stated succinctly that the physician was the natural advocate for the poor. And, indeed, we have contemporary examples of physicians taking up this challenge. It is this mission that has been recognized by the Nobel Peace prize to Doctors without Borders in 1999 and to International Physicians for the Prevention of Nuclear War in 1985.

Those familiar with the history of social medicine understand that the United States' health problems will not be solved by more of the same—more doctors, more medicines, more quality control initiatives, more computers, more audits, and faster discharge times. A fundamental rethinking of the social role of medicine is required. Those progressive physicians who fashioned a medicine that was explicitly social can serve as a guide. Virchow's prescription for the Silesian typhus epidemic seems more germane than ever:

The logical answer to the question as to how conditions similar to those unfolded before our eyes in Upper Silesia can be prevented in the future is, therefore, very easy and simple: education, with its daughters liberty and prosperity. (Cited in G. A. Silver, "The Heroic Model in Medicine: Health Policy by Accolade," *American Journal of Public Health* 77, vol. 1 [1987] 82–88.)

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