Introduction

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A little over ten years ago a new department of Community Medicine and Hospital Administration began operating within the University of North Carolina School of Medicine. Its immediate forebears were the Department of Hospital Administration and the Department of Family Medicine. The former was merged into the new department along with the remnant of its staff—Harvey Archer and Lorin Campbell, while five non-clinical faculty members (Cecil Sheps, Don Madison, Glenn Wilson, Gordon DeFriese and Larry Churchill) came over from Family Medicine. Having itself been formed seven years earlier from the Department of Preventive Medicine, Family Medicine counted several from among its primary and secondary faculty whose interests and activities centered on the "community" and "social" themes of their department's charge rather than its family practice emphasis.

The words "social" and "community" have been in the Chapel Hill lexicon for a long time. They express one of the University's most important and influential themes. Since at least the late 1920s, when sociologists Howard Odom, Guy Johnson and Rupert Vance were inventing their new "regionalist" approach to study the South's social and economic problems, the University was regarded as an institution that responded to its community. Work on social themes continued through the 1930s and into the post-war years from units as diverse as the Department of Dramatic Art and the School of Public Health, adding to the North Carolina reputation for academic contributions to social issues. This reputation applied as well to the medical school. Coincident with its expansion in 1952 to a four-year school, the UNC School of Medicine established a Department of Preventive Medicine under the leadership of Dr. William Fleming. Besides teaching epidemiology and preventive medicine to medical students, this department took on a further responsibility—leading the development of a research program in social and community medicine. Among the products of the Department of Preventive Medicine were some landmark studies in ambulatory medical care, mostly based in the general medical clinic of the North Carolina Memorial Hospital, measuring its service to the people of the state. Those studies, which still stand as models of excellence in health services research, were conducted by an interdisciplinary group of clinicians and social scientists that included some well-known names in social medicine and medical care: Bernard Greenberg, Robert Huntley, Osler Peterson, Kerr White, and Franklin Williams.

When the North Carolina Legislature enacted a law in 1970 establishing a Chair of Family Medicine, that department subsumed Preventive Medicine. It was the School of Medicine's intention that a strong "community medicine" focus should develop within the new department alongside its clinical program of family practice. Yet, although the Family Medicine faculty were, by any measure, productive in research and in their service efforts— leading to the establishment of community health centers in Prospect Hill, Durham, Moncure, Carrboro, Warren County and Madison County, a family nurse practitioner training program, a state program of rural health centers, a national program of model rural practices, and the North Carolina Area Health Education Centers Program—no clear academic focus in "community" and "social" medicine developed.

Between 1972 and 1975 three separate committees—two within the Department of Family Medicine, the third appointed by Dean Christopher Fordham and chaired by Robert Crounse—issued reports, all of which recommended a separate academic unit for the faculty in "community medicine." The Crounse committee called for a new department, suggesting the name "Community Medicine and Hospital Administration" (a title that would reflect the School's community orientation and at the same time memorialize a unit that the the new department would absorb). The charge was broad: to develop a focus of teaching and scholarship within the School of Medicine "relative to community medicine and health care delivery systems" (Crounse Committee Report, 1975).

In July, 1977, Glenn Wilson, the Director of the Area Health Education Centers program, was appointed Chair-designate, and the new department became operational in early 1978. Wilson began by expanding the faculty. At the junior level he recruited Jim Begun (now at the Medical College of Virginia) and Alan Cross, and at the most senior level possible he added three former deans: Isaac Taylor, Christopher Fordham, and Alfred Gellhorn. Taylor and Fordham had both served as Dean of the UNC School of Medicine (Fordham also as Vice Chancellor for Health Affairs) and Gellhorn, who joined the department for one year as a visiting professor, had been dean of two medical schools—the University of Pennsylvania and the Sophie Davis Biomedical Program of the City College of New York. With advice from his new faculty, Wilson set out to plan a teaching program and to recruit additional members for an interdisciplinary collegium.

One early faculty request was for a more suitable name than what the Crounse committee report had recommended. The department was not involved at all in hospital administration and "community medicine" represented only part of its anticipated program. Isaac Taylor suggested "social medicine," a term that had served with distinction in Europe and elsewhere in the United States and which described accurately the broad range of the new department's concerns and the content of its teaching and proposed research. The name was changed officially in 1980.

This is the first published annual report of the Department of Social and Administrative Medicine. It was produced by a committee, with contributions from many members of the faculty—primary, secondary, adjunct and emeritus. The report stands as a record of growth and marks a moment in the department's development when by measures of faculty size and productivity in teaching, research and service it can claim to have reached maturity.

After nearly eleven years of guiding the department and leading its academic program, Glenn Wilson has resigned the Chair, effective at the end of 1988. Larry Churchill will be Acting Chair during an interim period. Under Wilson's leadership a talented young faculty has been recruited, the teaching program has matured, and a significant program of research in several areas of social medicine is underway.

Building the Department of Social and Administrative Medicine is not yet finished. Nor, indeed, is it ever likely to be. The field of social medicine necessarily mirrors movements within medicine and society and between them. As the social problems facing health workers and medical institutions continue to shift and as some socially related health problems subside and new ones emerge, the department's program must be ready always to adjust. In this era, when all medical fields can benefit from a spirit of flexibility, social medicine will need to be more adaptable than most. That is one of its challenges. Yet, the members of the faculty, as they enter the next phase of the department's development, enjoy an important advantage. Glenn Wilson's legacy is the vision of social medicine he imparted and the foundation of academic excellence he insisted upon. For the faculty these constitute a valuable guide for accomplishing the department's mission.

From the Chair

The great hope that we place in modern biomedical science to heal the ills of people relies in large measure upon the ability of those who understand science and its applications to know and understand also the lives of the people they would benefit.

If health, illness and disease are not static, well-defined, well-understood terms, as it appears they are not, then the study of their meanings would seem to be a proper academic pursuit. These are terms that have always meant different things to different people in the same society, based upon their social class, culture, values, and economic standing. And they certainly hold different meanings in different societies and at different times in history.

The Department of Social and Administrative Medicine has made progress over the past ten years in defining illness, disease and health in relation to its teaching, research and service activities. These concepts represent more than physiological or biological phenomena. They signify more than the presence or absence of a discrete bacterial infection or a patterned response to a particular psycho-pathological process. The history of a people, its values and culture, and the way of life of a society determine in large measure whether or not an individual person's experience is an "illness" or "disease." A disease, clearly defined as such within one cultural group, may not be perceived that way in another. Indeed, medicine's own set of definitions were and are based on a common language and understanding, but these definitions may run counter to an alternative understanding of the same human experience in a different group. Mastering the skill of diagnosing disease requires mastery of the scientific method and intimate familiarity with the knowledge it has produced. But application of this skill also requires of the practitioner an understanding of social and cultural influence.

This is an appropriate time in the history of medical education to conduct research and teach about the anatomy of society, which is if anything even more difficult to approach and encompass than human anatomy. "Social anatomy" cannot be approached in the same way that medical students have traditionally studied human anatomy. Society includes far too many systems and subsystems, and unlike those of the

human form, social systems sometimes vanish or they may multiply rapidly. Indeed, the definition of social medicine must be made by exclusion. Yet the anatomy metaphor holds. Nearly every sector of society has has some influence upon our understanding of illness, disease and health. All human activity—art, literature, theatre, cultural symbols, history, the economic system, the system of government, the moral values, the entire way of life of a people—contributes to the understanding of health, illness, and the role of the physician.

A great deal of time and energy has been spent by the Department of Social and Administrative Medicine exploring how these social science and humanities disciplines can contribute to the learning of future physicians. It was evident from the beginning than neither the clinician, biomedical scientist, social scientist nor humanist, acting alone, would be adequate to the task of integrating the knowledge necessary for understanding and teaching social medicine. An interdisciplinary department would be needed. In the past ten years we have succeeded in gradually establishing such a department. Its eleven primary faculty, two of whom are also clinicians, represent the disciplines of anthropology, economics, epidemiology, ethics and philosophy, hospital administration, law, medical care organization, preventive medicine, and sociology. They teach these subjects in addition to biostatistics, history, literature, and public policy. Over the past 10 years the department's primary faculty have authored nine books and more than 250 other publications. In addition, the department prepares each year new editions of syllabi for the three major courses we are responsible for teaching.

There has never been a more important time in the history of American medicine for an integrated social medicine. Not very long ago, when most of applied medical science could be carried in the doctor's black bag, the issues were much simpler. But now, at the end of the twentieth century, medical practice in the Western world, though widely varied, is markedly more complex, both technically and organizationally, over what it was only a generation ago. Yet the best science and technology in the world will be of little value if it is applied without an understanding, or with misunderstanding, of the social situations of those it aims to benefit.

We are currently evolving a redefinition of the way we distribute productivity, including health care. How shall we expend our national productivity? How shall we use our financial resources? Choices must be

made between arms, schools, roads, housing, and the personnel and equipment required for health care. Having decided how much we are willing to spend on health care, we then face the task of determining which variety of health care, which part and which level, will receive the highest priority for expenditure of our health resources. These decisions form the social basis of all our medical science and its application.

The great hope that we place in modern biomedical science to heal the ills of people will depend in large measure upon the ability of those who understand science and its applications to know and understand also the lives of the people they would benefit. Research and scientific activity is never conducted in isolation from society. It is an integral part of the social order. The role of the Department of Social and Administrative Medicine is to help bridge the distance—in social and cultural understanding and personal experience—between those who hold the knowledge of scientific medicine and those who would receive the fruits of that knowledge to the mutual benefit of both.

I. Glenn Wilson