

Introduction

Don Madisa, 19

Flush with a few hundred surplus dollars, the Department of Social and Administrative Medicine published a report of its activities in the spring of 1988. The editor, naively anticipating the continuance of such largesse, called the report a "first annual."¹ Now, five years later, we are issuing a second one, which, although titled after the year in which it appears, is not an annual. It covers the period from the appearance of the earlier report to the present—the years 1988 to 1992.

The department has seen a number of changes since early 1988. Some were routine or expected: Faculty arrived and departed, were promoted, went off on sabbaticals, developed new courses, entered into new research involvements and assumed new administrative or advisory responsibilities—for the School of Medicine and the University, the government and professional organizations. Books, chapters and articles were written, reviewed, rejected or accepted (sometimes both) for publication.

A few changes merit (or will receive) special mention: Bucking the trend in the School of Medicine, the department actually *shortened* its name, dropping "administrative" from the title. Larry Churchill succeeded Glenn Wilson as Chair. Kay Hill succeeded Sally Powell as Administrative Manager. The shower stalls in the men's room transmuted into a new galley-shaped home for copier, fax machine, and coffee maker. And two

¹ Donald L. Madison (editor), *Social and Administrative Medicine, 1987-1988*. (Chapel Hill, NC: Department of Social and Administrative Medicine, University of North Carolina at Chapel Hill, 1988).

lucky members moved into new octagon-shaped "offices," cut from existing alcoves, leaving standing room in the ante-chambers and quite possibly marking some kind of architectural record—twelve faculty offices cut from space where eight student nurses once roomed.

This report, like the last one, records the department's roster of personnel and chronicles its teaching and research activities. In doing so it offers a sample of the diversity and flavor of "Social Medicine," acknowledging that samples, however carefully drawn, frequently fail their intended purpose of accurately representing the whole.

Indeed, it is difficult to discern the fabric of Social Medicine from a list of faculty publications and a description of courses taught. Nowhere in this report, for example, is described a medical student's six-month elective spent helping a Kenyan village organize a health cooperative; or another student's observations of referral patterns between GPs and hospital-based specialists in Great Britain—or others' investigations of the lives and careers of such legendary activists as Benjamin Rush, Dorothea Dix, Harvey Wiley, Alice Hamilton, Margaret Sanger, Norman Bethune, and John Hatch, or medical scientists like Joseph Lister, Mary Putnam Jacobi, William Henry Welch, Frederick Banting, Charles Drew and Kenneth Brinkhous. Nor is there a description of how students explore the health policy questions facing North Carolinians or the dynamics and consequences of introducing modern medical technology into third-world countries. Yet these are all parts of Social Medicine, and all are represented in the teaching activities of the department—as are comparing the bases of medical versus legal thinking; reflecting on George Bernard Shaw's depictions of physicians and William Carlos Williams' depictions of patients; learning how nursing homes are organized, financed and staffed; reading about doctors, nurses, disease, pain and death in poetry, short stories, novels and plays; and discovering who took which side and why during the social insurance debate of 1914-1919 or the Kefauver hearings of 1959.

The report also describes some faculty scholarship. But the brief sketches of research projects do not mention any of the faculty's academic contributions at the state and national level. For example, in the area of prevention, department members served on the Secretary's Advisory Council on Health Promotion and Disease Prevention, worked on the U.S. Preventive Services Task Force to define practice guidelines for primary care clinicians, convened representatives of some of America's

largest businesses to form a new organization, *Partnership for Prevention*, wrote policy syntheses as a part of preparing new vaccine administration guidelines, and hosted a national conference devoted to bringing preventive services under a new universal health care plan. Faculty also served as editors of several professional journals, advisors to government and voluntary organizations, and officers or board members in the Society of Teachers of Preventive Medicine, the Society for Medical Anthropology, the American Association for the History of Medicine, the American Board of Pediatrics, the American Association for Health Services Research, the North Carolina Medical Society, the Society for Health and Human Values and the Institute of Medicine, National Academy of Sciences. Each of these involvements, too, reflects the diversity of Social Medicine.

Every member of the Department of Social Medicine is a practiced respondent to the question: What is it? We've been asked so often that each of us has a set of prepared, tailored responses (individually tailored according to who is asking). But although we can say what we do as individuals and what our department does, there is no simple, permanent answer to the broader question: What is Social Medicine?

Jules Guerin, the French physician-journalist credited with coining the term, used it in the context of the urban revolutions that were sweeping through Europe at mid-nineteenth century. Encouraged by the revolutionary promise of liberal political and economic reforms, Guerin, Rudolph Virchow, and other politically active physician leaders of the time used the term to express their hope that medicine might become a force for social justice and more rapid social improvement.² To them Social Medicine meant applying medicine's insights to social problems, especially the health-associated problems caused by industrialism—in the workplace: long hours, low pay and unhealthy conditions; in the community: poor housing and general environmental filth; and in the society at large: insufficient access to medical care. The term stood for the notion that medicine should have

² Said Virchow: "Only an intimate knowledge of individual living conditions and the life of the people can transform the laws of medicine and philosophy into general laws for the human race. Only then will it be true to say 'scientia est potentia'Certain it is that medicine will suffer no loss of dignity when it doffs the buskin and mingles with the people, for among the people it will find new strength." ("Über die Standpunkte in der wissenschaftlichen Medicin," *Archiv für pathologische Anatomie* 1:6-7, 1847). His better known statement, "Doctors are the natural advocates of the poor, and social problems are very largely within their jurisdiction," appeared in the initial issue of *Medizinische Reform* (July 10, 1848).

social usefulness. Coming out of political revolution, this first meaning of Social Medicine was—not surprisingly—steeped in activism. When after a short time the revolutionary spirit of 1848 gave way to the reaction, so, apparently, did the popularity of the term. Although the phrase “Social Medicine” continued in use over the next half century, it became roughly synonymous with other, more commonly used terms—“state medicine,” “social pathology,” “social hygiene,” and “public health.”

The next specific use of the term came shortly after the turn of the 20th century, after advances in microbiology had already led to effective personal health measures for controlling contagious diseases and the germ theory dominated medical thinking. Wishing to emphasize the importance of “soil” as well as “seed,” a group of epidemiologists, social scientists and public health physicians began using the term Social Medicine for their new epidemiological approach to the study of health and illness and, especially, the multiple factors—environmental and social in addition to biological—in the etiology of disease. In contrast to its original political activist meaning, Social Medicine was now being thought of as a statistics-based “science,” with its bases in social insurance programs, commercial life insurance, social welfare organizations such as the International Labor Organization, the military and, especially in Germany, Austria and Great Britain, medical schools.

Later uses of the term connoted additional meanings, including an activist one. In their 1962 volume, *A Practice of Social Medicine*, Sidney Kark and Guy Steuart collected a group of papers by an interdisciplinary team who had worked in South African health centers during the 1940s and early '50s. (Several of the authors, including the editors, would later join the faculty of the School of Public Health in Chapel Hill.) The health centers delivered what we would now call primary medical care, plus various family-centered outreach and public health services. The essays in the book describe these community-oriented programs and the epidemiological and ethnographic studies used to plan them and measure their accomplishments. In the 1950s and '60s the Division of Social Medicine at Montefiore Hospital in New York City similarly exemplified the activist meaning of its name. The Division was home to several significant innovations in the organization of medical care: a pioneering hospital-based home care program, a prepaid group medical practice, early experiments with health care teams and a comprehensive health center for an underserved neighborhood. All of these programs were directed from Montefiore Hospital to its Bronx community.

The contents of textbooks from the 1950s to the present show how the term Social Medicine merged older meanings with newer ones, and which of its synonyms were preferred at different times and places. A 1966 British text by McKeown and Lowe, *An Introduction to Social Medicine*, addressed a nearly identical list of topics as did two American texts, both titled *Preventive Medicine* (Leavell and Clark, 1953, and Clark and McMahon, 1967). During the 1970s several American textbooks substituted the term "Community Medicine" in their titles, yet their tables of contents were mostly unchanged from those of the earlier "Preventive Medicine" texts. However, Milton Roemer's 1978 book, *Social Medicine*—subtitled "The Advance of Organized Health Services in America"—was concerned less with epidemiology and prevention than with arrangements for medical care delivery.

In his article, "Social Medicine," in the *Encyclopedia of Bioethics* (New York: Free Press, 1978) George Silver returned again to the principles of Guerin and Virchow, arguing that medical ethics must extend its concern beyond the doctor-patient interaction by prescribing a moral responsibility for medicine toward society.

All of these uses of the term Social Medicine, from Guerin and Virchow to the recent textbooks, share at least five ideas in common: 1. community (the society as a whole or some defined part of it); 2. political action (policy); 3. organization of services (arrangements for the delivery of medical care); 4. prevention of disease (both through the work of individual physicians and by community-wide actions); and 5. investigation of the causes and distribution of disease (epidemiology). One also finds frequent references to the social causes of disease, and to cultural interpretations of health and illness. Moreover, frequently made explicit—and always implied—in these writings is that the concerns and actions of Social Medicine are grounded not only in biology and statistics, but in economics, moral philosophy, history and the law. Thus, there is basis in tradition for the social sciences and humanities to hold a pivotal place in an academic department of Social Medicine, whose activities should include both scholarship and activism.

Yet despite this grounding in tradition, a department of Social Medicine in an American medical school can take no automatic, precise meaning from its name. Unlike other medical school departments, it does not mirror an established medical specialty nor claim a portion of the historically traditional medical science curriculum (anatomy, physiology

and *materia medica* from the time of Galen, chemistry from the 17th century, bacteriology from the late 19th century, etc.). Nor will its faculty consist of members of the same clinical specialty or traditional discipline (all dermatologists, all surgeons, all biochemists). Partly for this reason, departments like ours are often seen as outliers, destined to become the medical school repositories of several otherwise homeless, minimally represented disciplines and fields of interest (which may explain why so many of them contain the word "and" in their titles). If affiliation with such a department provides real intellectual interchange for its faculty, then such a polyglot admixture of disciplines can be a real strength for its school. Yet a department such as this also risks becoming a convenient receptacle for the medical school that wants to "add a philosopher" (or any number of other one-of-a-kind representatives) in order to keep up with its peer institutions, stay relevant, be complete. A department of Social Medicine must, therefore, define carefully what it is about. We did this in our 1987 mission statement, and in his essay in this report, Larry Churchill points out that what we do now follows this statement.

During the last few years our department's major task has been to create an interdisciplinary group of scholars from a multidisciplinary one. This is not an easy task. Our faculty represents several different academic fields, no one of them dominant within the department and each with its own way of seeing and its own unique language. We learned these ways during our novitiate, before we were confirmed—long before we began assuming the mien of our respective disciplines. The resulting collection of colleagues, cut from different paradigms, does represent a major strength of our department, but it is not without accompanying complications.

Although so many languages add richness to the discourse, none of them is ever fully understood by the entire group. Yet the happy consequence of our interaction is that a new language evolves, and through the process of its evolution an essential function of the department—team teaching and collaboration in scholarship—is enhanced.

An apt analogy to our situation is the observation by linguists of the distinction between a "pidgin" and a "creole" language. The former is used between foreigners who, wishing to transact commerce but not understanding each others' native tongues, find an in-between language of donated words and new expressions. After a time there may be a generation of people who have learned and spoken the pidgin from birth, at which point it becomes a creole language. This analogy approximates the

shades of difference between “multidisciplinary” (a babel of “native tongues”), “interdisciplinary” (functional use of pidgin), and “disciplinary” (a single new, all-purpose creole language).

The department faculty hasn’t had enough time to adopt a new language of Social Medicine. Nor does it plan to do so. The specter of all of us speaking creole is not a desirable one: we would risk attenuating the strong disciplinary grounding we value and possibly thereby diminishing the collegium—which can only be as strong as its individual members. In any case, a new language doesn’t seem necessary; we have progress to report. Our shared pidgin continues to improve with use, and this report contains evidence that in our teaching and research we are moving closer to the interdiscipline we seek.

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