Introduction:

Where Medicine and Society Meet

THIS REPORT MARKS the completion of our second decade as a faculty of Social Medicine. In that time we have heard the question "What is it?" countless times. To the uninitiated, "social medicine" will surely sound less familiar than "family," "internal," or even "nuclear" medicine. Yet, our name is neither a new term nor a recent calling—

which is why the editorial introductions to both of the department's earlier reports sought to remind the reader of social medicine's heritage. The first report 10 years ago contained a brief account of social medicine activity at the University of North Carolina since 1952. And in *Social Medicine 1993*, I recounted several of the connotations (and aliases) that the term "social medicine" has carried since Jules Guerin, Rudolph Virchow and other physician participants in the political revolutions of 1848 first used it to underscore their conviction that medicine should address the human misery brought by industrialization. I pointed out that every use of the term—from 1848 to the present—has embraced the same set of core ideas: investigation of the causes and distribution of disease, prevention, the organization and delivery of medical care, a focus on "community," and the importance of political action and public policy in matters of health.

Regardless of which of these ideas received greatest emphasis at any particular moment—

and each has had moments in the spotlight—social medicine's central focus is always on the relation of medicine to the broader society. This connection more than anything defines both where and what social medicine is. Its history, therefore, is of the understanding between medicine and the body politic, and of the gradual emergence of a "wider" medical profession in response to technological change and human society's shifting configuration and values.

This essay is more ambitious than the introductions to the two earlier reports. My aim is to trace the antecedents of some of the interests and areas of scholarship represented by our faculty. How and when, I've wondered, did medicine come to incorporate social and individual ethics, become interested in the power of culture, or the "science" of preventive medicine, or epidemiology, and especially, how did the doctor's work become an issue of social policy? In preparing my thoughts on these questions I've looked at many sources. But one in particular got me started.

IN THE SPRING OF 1947 the New York Academy of Medicine celebrated its centennial with an "Institute on Social Medicine." The introduction to the published volume of papers was written by the Academy's director, Howard Reid Craig, who commented:

"To introduce a book on social medicine is a high adventure in the realm of the philosophy of modern medicine and its relationships to man and the world in which he lives. Economists, sociologists, even statesmen and governments, are thinking in terms of people as humans and of the world as an integrated association; but medical men (sic) as a group have been more than slow in initiating this type of thinking in their own particular field of endeavor. This lag is understandable, for the average physician is very close to the sickbed; it is only the exception who can raise his head skyward for a broader view and a better understanding of what is going on about him. ...it would be well for medicine as a whole to become acutely aware of the tidal movements in the affairs of man, for medicine to recognize that, although it is an important constituent, it is only one element in the whole social organism. It is perhaps more important still for medicine to fully realize that it is an integral, interrelated, and interdependent part of a functioning social and economic system which to be viable must exist in a continuing state of flux."[1]

Social medicine was surely in a state of flux in 1947. It had been less than two years since World War II's end. The British National Health Service and the World Health Organization were preparing to commence the following year. And 1947 was also the year when the Canadian Province of Saskatchewan enacted the first social health insurance program in North America.

In Washington, the disinclination of the new Republican Congress to act on national health insurance prompted organized labor to revise its strategy for securing the welfare of workers; fearing that a national social insurance program for health care was now unlikely, unions began demanding *private* benefits from *private* employers. Already, the number of workers covered for health insurance had doubled since the end of the war. After 1947 the growth of employment-linked private insurance would sharply accelerate because of collective bargaining. Two non-profit "prepaid group practice plans" (the term "HMO" would not be heard for another 23 years) began operation in 1947. One, the Health Insurance Plan of Greater New York, was an initiative of the former New York City Mayor, Fiorello LaGuardia; the other, the Group Health Cooperative of Puget Sound, had roots in the cooperative and labor movements of the Pacific Northwest. A year earlier, Henry J. Kaiser's group practice program for his wartime shipyard workers had opened to the public. Implementation of the Hill-Burton program (of federally-assisted hospital construction) was just underway. And American medical schools were beginning to feel the effects of a major metabolic change, brought on by a flood of new specialty training programs, full-time faculty members, and an unheard of federal largesse in the form of new research grants. But despite these shifts and the social forces behind them, Craig's assessment was probably correct: by all accounts "medicine as a whole" had not yet recognized that the profession's seemingly insular work was in reality "an integral, interrelated, and interdependent part" of the larger social fabric.

One further event worth our remembering occurred in the Spring of 1947. A young Manitoba physician, who had helped plan Saskatchewan's social insurance program, found a summer job teaching biostatistics at the University of North Carolina. Cecil Sheps had just completed a Rockefeller Foundation Fellowship, using it to study medical care under Franz Goldmann at Yale. On his way south he stopped in New York to pay a call on his Foundation patron, Dr. John Grant, who noted in his diary:

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[1] Howard Reid Craig, "Introduction," in Iago Galdston (editor), *Social Medicine: Its Derivations and Objectives: The New York Academy of Medicine Institute on Social Medicine, 1947.* New York: Commonwealth Fund, 1949, p. vii.
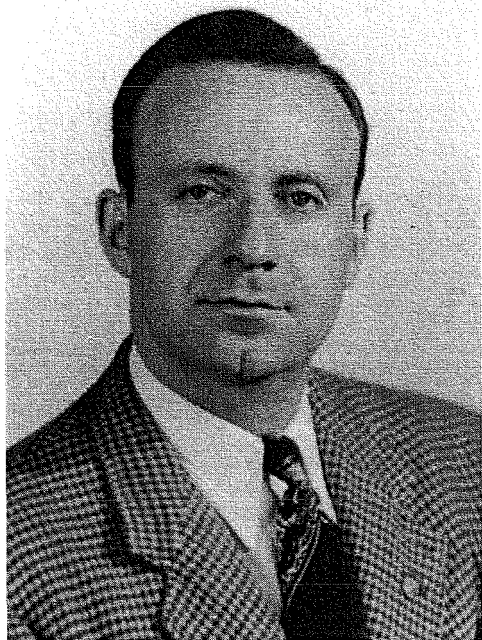
Dr. Cecil G. Sheps in 1948

"S. is certainly bright, and one judges (he) will make an excellent and enthusiastic teacher."[2] At summer's end, Sheps was asked to stay on as a member of the School of Public Health faculty. Three years later, he received a Rockefeller grant (via Dr. Grant) that allowed him to lead the planning of a teaching and research program in social medicine that would focus on the strategic mission of the new clinical faculty and hospital (scheduled to open in 1952): *To serve the people of North Carolina.*

WHILE THE YOUNG Dr. Sheps made his way to Chapel Hill, bringing his vision of social medicine, the New York Academy's Institute on Social Medicine opened with papers by the four leading historians of medicine in the United States—George Rosen, Richard Shryock, Henry Sigerist, and Owsei Temkin.[3] Together, they traced some of the

[2] John Grant, "New York, June 6, 1947, Dr. C. G. Sheps" (Rockefeller Foundation Archive, Record Group 12, Box 21, John Grant 1947 diary).

[3] Owsei Temkin, "Changing Concepts of the Relation of Medicine to Society: In Early History"; George Rosen, "In the Age of Enlightenment"; Richard H. Shryock, "In the 1840's"; Henry E. Sigerist, "From Bismarck to Beveridge"; all in Galdston, *Op Cit.*

history of the medical profession's response to the larger society. In his review of the medical work of the ancients, Temkin mentioned that the contemporary medical literature "deals almost exclusively with such medical problems as are encountered in private practice, especially among well-to-do citizens."[4] He said that the Greek and Roman physicians had felt bound to society only by the intrinsic values of medicine and that the emperors and communities who gave certain privileges and immunities to the better doctors and provided them with offices, even lecture rooms and pupils, could not count on a code of social responsibility from those they had favored.

This state of affairs began to change in the Middle Ages, when two new social elements were superimposed on medicine: the town and the idea of a Christian commonwealth of nations. The medieval town brought a new corporate life, which included self-regulating guilds complete with rules governing admission, training, intercourse among members, and elimination of competition from outsiders. The medical guilds also took on supervision of quality and assumed responsibility for preventing or punishing malpractice. Such intramural activism also extended at times to the broader community; doctors were expected to cooperate when asked by the authorities in matters of public health and safety. Surgeons from the 14th century on were required to report all injuries that came to their attention; and by law physicians reported all cases of leprosy and syphilis. When plague threatened, doctors helped plan how the town would combat the disease.

These questions of supply, education, distribution and quality of doctors, and their responsibility for the public health, are still with us. At times the larger community has trusted the profession to decide these things on its own; at other times, society has expressed its concern in the guise of legislation and new institutions. But issues of professional control continue prominently on today's social policy agenda.

The social responsibility that the medical profession took on in order to accommodate the

[4] Temkin, *Op. Cit.* p 4

institutions of medieval life was a narrow one that rarely extended beyond the immediate concerns of guild and town. A much wider and more decisive force came from the establishment of an official and comprehensive religion, one that emphasized charity and brotherly love as high moral virtues.

Although charity as an individual ethic had existed in antiquity, the medieval concept of charity based on Christianity transformed it into a social ethic that bound every member of the community. Wherever Christianity dominated, the treatment of the sick poor soon became a social priority—leading, for example, to the institution of hospitals. Yet, for the medical profession charity as universal imperative could cause problems. As Temkin explained, "It was not a question of whether the individual physician wanted to be charitable; society had a right to expect charity from him."[5] And what if the doctor didn't wish to care for the poor? The town (or the state) might devise regulations designed to assure that he would perform his Christian duty: fees fixed by ordinance, physicians assigned to charitable duty on a fixed schedule, or laws guaranteeing the poor free care.

If regulation weren't enough, public criticism of doctors for their avarice and love of riches was also common. A Strasbourg preacher named Geiler von Keisersberg advised physicians where they should place their priority and from whom they should seek their remuneration:

"A physician should...not only help (the poor person) from compassion and for God's sake, but he should also be at his service every day. Afterwards he may take all the more from the rich who can afford to pay."[6]

Paracelsus' criticisms were harsher. The "doctoral custom," he declared, had failed to fulfill "the commandment of love." Physicians were instead following the law of

"...grab, grab, whether it makes sense or not. Thus they receive golden chains and golden rings, thus they go in silk raiment
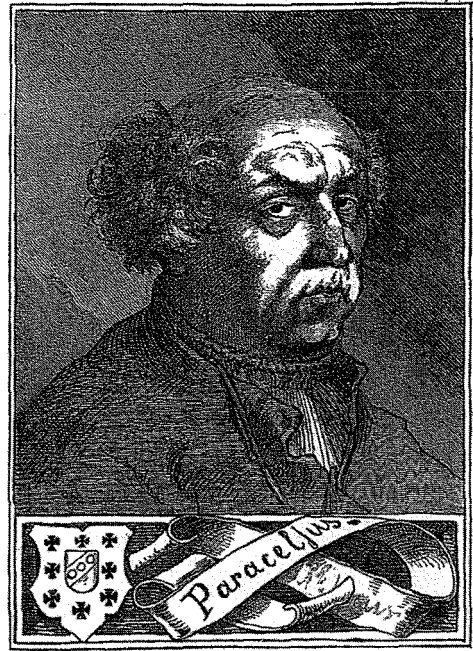
Theophrastus Bombastus von Hohenheim, known as Paracelsus (1490-1541)

and thus display their manifest shame before all the world, which they deem an honour and well suited to a physician. To walk around thus decked out like a picture is an abomination before God."[7]

Society's expectation of medicine, whether voiced as regulation, exhortation from the pulpit, or in literature, has always commanded a response from the profession. And so we have come to appreciate the importance of this particular social nexus—of ethics, cultural norms, and medical behavior—so much that it now imbues our social medicine teaching.

PROFESSIONAL SELF-INTEREST and civic duty together with religion-based morality were the bases of medieval social medicine. Science played little part. But social medicine's foundations began to shift in the Age of Enlightenment. One of the main movers was William Petty, an English army physician, anatomist, professor of music,
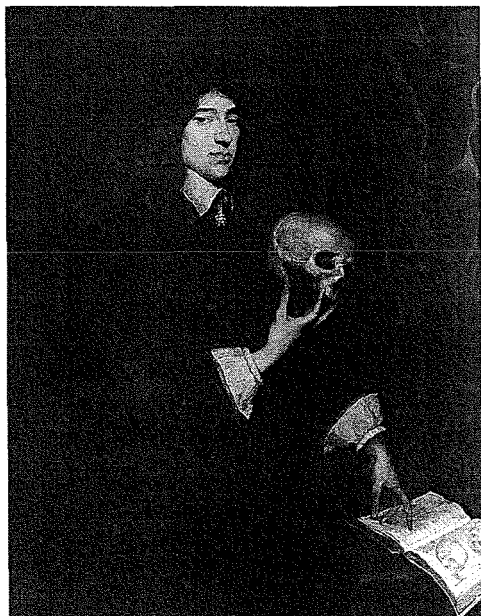
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[5] *Ibid*, p 9.

[6] L. Kotelmann, *Gesundheitspflege im Mittelalter*. Hamburg and Leipzig: Voss, 1890 (quoted in *Ibid*, p 10).
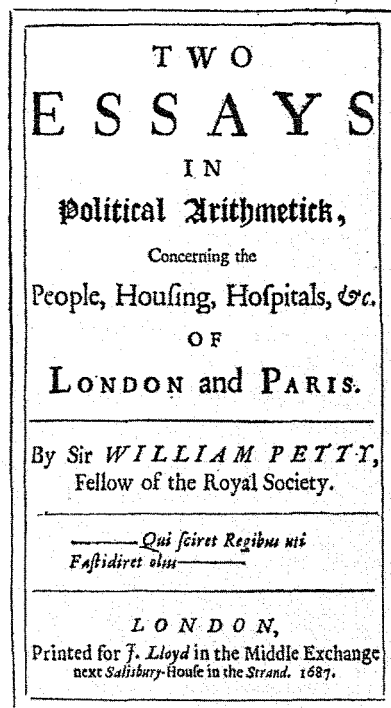
[7] Paracelsus, "Seven Defensiones," in Henry E. Sigerist (editor), *Four Treatises of Theophrastus von Hohenheim*. Baltimore: Johns Hopkins Press, 1941, p. 31.

statistician, member of Parliament, and founder of the discipline of political economy. One of Petty's fascinations was with the concept of value and how to conserve it, an understandable interest given the momentous changes that were occuring in European commerce during the 17th century.

Industrial capitalism was then displacing medieval commercial capitalism and production overtaking exchange as the chief economic concern. The new importance of production meant that labor—in Petty's words the "value of the people"—would henceforth have a much higher worth, higher even, thought Petty, than capital and land combined. Human illness and premature death, therefore, brought major economic consequences for both private producers and the state. Clearly, having the largest possible number of healthy productive workers would bring the greatest return to the state. It followed, therefore, that records, reliable public statistics and government expenditure on health measures could be seen as economic investments. Centrally important to Petty were the most productive groups in society—farmers, manufacture, merchants, seamen and soldiers—while "all other great professions do arise out of the infirmities and miscarriages of these."[8]

TWO ESSAYS
IN
Political Arithmetick,
Concerning the
People, Houſing, Hoſpitals, &c.
OF
LONDON and PARIS.

By Sir *WILLIAM PETTY,*
Fellow of the Royal Society.

——— *Qui ſciret Regibus uti*
Faſtidiret olus———

LONDON,
Printed for *J. Lloyd* in the Middle Exchange next *Salisbury*-Houſe in the *Strand.* 1687.

The title page of Petty's *Two Essays* (1687), a volume owned and often cited by another influential economist, Karl Marx

Petty's economic calculation, which he called "political arithmetick," was a new feature of "social medicine." It showed the practical wisdom of protecting the people's health, something that an enlightened ruler could accomplish readily (in an age of absolute monarchy) by appointing public officials who would be guided by "policy." In Germany, this doctrine, called *Medizinalpolizei* (medical policy or police) was carried out by physician administrators, who became the first public health officers and professional medical regulators. The social medicine pioneer Johann Peter Frank explained the purpose of medical police:

> "(It) is an art of defense, a model of protection of people...against the deleterious consequences of dwelling together in large

Dr. William Petty (1623-1687)

[8] William Petty, (C. H. Hull, editor), *The Economic Writings of Sir William Petty.* Cambridge: 1899, volume 1, p. xiii (quoted in Rosen, *Op Cit,* p. 14).

numbers, but especially of promoting their physical well-being so that (they) will succumb as late as possible to their eventual fate from the many physical illnesses to which they are subject."[9]

Petty, Frank and others of their late 17th and early 18th century contemporaries contributed an effective rationale and the necessary statistical tools and administrative methods for an organized preventive medicine. The application of statistics to *clinical* medicine came later. It developed largely in France, possibly beginning with Diderot's *Encyclopedia*, which contained an influential article on probability that prompted administrators of all kinds to engage in numerical analysis. After the French Revolution, the practice of counting events and expressing the results in percent spread to the Paris hospitals, where it was carried on, most notably, by Benjamin Franklin's Parisian friend, Phillippe Pinel. As physician in charge of the Bicêtre hospice, the largest asylum in Europe with 8,000 patients, Pinel was uniquely situated to collect and apply numerical data in patient care. In the early 19th century Pinel's methodological successor Pierre Louis devised his "numerical method" for analyzing outcomes of therapy and set the course for what we now call "clinical epidemiology."

The value of healthy workers may have been foremost in the minds of the 17th century political economists, but the question of what to do about the poor continued to stir the consciences of Christian moralists, just as it had in the Middle Ages. The plight of poor workers also incited the creativity of some early inventors of "projects" (public schemes by which income maintenance and social services, including medical care, could be more effectively distributed and organized). Daniel Defoe, for example, in his *Essay upon Projects* (1697) imagined a social security plan for the laboring class based on collective self-help. It would include

pre-paid surgical attention for "every... subscriber if by any casualty (drunkenness and quarrels excepted) they break their limbs, dislocate joints, or are dangerously maimed or bruised..."; visitation by physicians and prescriptions "if [the subscribers] are at any time dangerously sick"; and hospitalization "if they become lame, aged, bedrid, or by real infirmity of body (the pox excepted) are unable to work, and otherwise incapable to provide for themselves...."[10] Other early 18th century visionaries proposed public hospitals open to all citizens and government programs of health insurance. But the time for such projects was not yet, and none of these proposals was realized.

SOCIAL MEDICINE HAS LONG been interested in the alleviation of poverty and the welfare of the poor. This, in fact, was the key concern behind Guerin's invention of the term "social medicine," and it was underlined by Virchow's memorable statement in the very first issue of *Medizinische Reform* (July 10, 1848): "Doctors are the natural advocates of the poor, and social problems are very largely within their jurisdiction." It is not surprising, therefore, that social medicine should have often aligned itself with—and considered itself part of—the related field of social welfare, and that the two fields have asked many of the same questions: Must essential human services for the poor always be provided apart from those to the rest of the population? What is gained and lost by segregating recipients according to their economic status?

Probably the most instructive national example in modern history of social welfare policy and the poor, including their health care, is that of Great Britain. Partly this is because the industrial revolution, which so exacerbated the problem of poverty, began there. In addition, while British attitudes on social welfare were never unanimous, they were usually expressed loudly and unambiguously. The great shift in attitude toward the welfare of the working classes from the Elizabethan period to the post-World War II years shows well some of the extra-

[9] Johann Peter Frank, "Introduction to Medical Police" in Erna Lesky (editor), A System of Complete Medical Police: Selections from Johann Peter Frank (translated from the third, revised edition of Vienna, 1786, by E. Vilim). Baltimore: Johns Hopkins University Press, 1976, p. 12.

[10] Daniel Defoe, *Essay Upon Projects* (1697) quoted in Rosen, *Op. Cit.*, p. 16

scientific impetus of social medicine. It also shows how the economic, political and moral environment can change, and why medicine must constantly gauge its own course to determine whether it is following, leading or resisting the broader movement of society.

In Britain, as in most industrialized nations, transformations in the lives of the poor, including changes in health, became integral to national policy, economic growth, and class relations. A summary account of this experience must begin with the Elizabethan Poor Law Act of 1601. Behind the Poor Law and the local customs that preceded it lay an assumption: the poor must be given relief lest they become a nuisance. Overseers in each parish would dispense a small allowance to poor families until the breadwinner could find work. Given relief the recipients were more likely to stay in their homes and not become roving vagabonds or turn to begging. This kind of "outdoor" relief, however, co-existed with "indoor" relief (tied to residence in the workhouse). Since the prevailing belief held that most people's poverty was caused by their own disinclination to work, the able-bodied poor—with their entire families—were made to live in "workhouses" to receive their subsistence. It soon became clear, however, that poor health accompanied indoor relief. A committee appointed by the House of Commons in the late 18th century found that "only seven in a hundred" infants born in the workhouse had survived beyond two years. Clearly, removal "from more salubrious air to such mansions of putridity" took a severe toll.[11]

At about this same time a new group of able-bodied poor were emerging in England—rural subsistence workers whose home industries couldn't compete with the steam-powered mill. Further, such workers were no longer being allowed to grow vegetables or graze a cow on what had once been public access lands. If the "enclosure of the commons" were not by itself a sufficiently calamitous economic event for these landless rural poor, it arrived concurrently with the first industrial revolution, which provided employment—but the jobs were often unstable with wages insufficient to feed a family. Oliver Goldsmith depicted the plight of the unfortunates in his poem, "Deserted Village" (1770):

> Where then, ah! where shall poverty reside,
> To 'scape the pressure of continuous pride?
> If to some common's fenceless limits strayed
> He drives his flock to pick the scanty blade,
> Those fenceless fields the sons of wealth divide,
> And e'en the bare-worn common is denied.

Near the end of the century, the war with France combined with a succession of poor harvests precipitated a rise in prices that resulted in food riots. One response was a new system of "outdoor" relief that soon spread throughout England. Local parishes gave workers a supplement to their wages, up to the minimum required for a family to subsist (the amount was linked to the size of the family and the price of bread). The wage supplement scheme soon failed. Without a minimum wage law, the employers' incentive was to keep wages low, since they could be confident that the supplement would bridge the gap between what they were paying and subsistence. The new "outdoor" relief scheme also prompted a more general critique—that a workman's income shouldn't be determined solely by the size of his family and not at all by his skill or diligence. Finally, the parishes' ability to pay the supplement usually required a steep increase in local tax rates.

A reaction was inevitable. It came in 1834, when the Whig government enacted a New Poor Law and Britain reverted to a system of strict "indoor" relief, designed this time to end once and for all what was regarded as the coddling of those who wouldn't work. One result of the new law was a decline in relief expenditures. But the return to the workhouse also brought other consequences. All categories of dependents—the able-bodied poor, the ill, feeble-minded, insane, crippled, and blind—were commonly housed together in the workhouse; yet members of families were separated, assigned to different

[11] John Scott, *Observations on the Present State of the Parochial and Vagrant Poor, 1773.* (quoted in Karl de Schweinitz, *England's Road to Social Security: From the Statute of Laborers in 1349 to the Beveridge Report of 1942.* Philadelphia: University of Pennsylvania Press, 1943, p. 66.

sections of the institution. The specter of being sent to the workhouse indeed proved to be a most effective deterrent for any member of the underclass who was tempted to ask for relief. How the poor managed to survive, both in and out of the workhouse, would be depicted starkly to the world by Charles Dickens and Frederick Engels.[12]

Most members of the dominant middle-class approved of the New Poor Law. The punitive rationale behind it in fact took on the force of a moral code, strong enough to guide Britain's social welfare policy for the next 75 years. At the end of the 1860s came a new intellectual justification for the harsh treatment of the poor. Social Darwinism applied "the survival of the fittest" to human society and taught that material charity would only perpetuate human weakness and degeneracy. The conventional wisdom is illustrated by a Cambridge professor's warning that philanthropy was provoking "demands" from "so many of the working-classes…that parents should not be required to pay for their children's education, but that all schools should be free…. (Such demands) simply show how many there are who will always try to escape from the responsibility of their own acts."[13] Voluntary charity societies saw the poor as sinners, responsible for their own plight but in need of physical sustenance and moral uplift. Yet few of the would-be uplifters perceived any social problem—except pauperism, or any social solution—except the workhouse.

Middle class and business interests have also from time to time defined the agenda of social welfare (and of social medicine). In fact, by the middle of the 19th century the increasingly wealthy and influential business class had discovered a new motivation to act that was more powerful than Christian moral uplift—concern for one's own personal health and economic self-interest. When the teeming industrial slums combined with epidemic disease raised the alarm, a closer examination of health conditions among the urban working class gave rise to the sanitary movement. Its leaders were with a few exceptions middle-class humanitarians (many were physicians) who directed their appeals to the economic interest of the state.[14] What emerged was greater official attention to environmental measures. Edwin Chadwick's finding that place of residence and economic class were related to mortality (among the Liverpool gentry the average age at death was 35; in families of laborers it was 15); William Farr's observation of a positive correlation between population density and mortality; and John Snow's demonstration that cholera was spread by water, led to the establishment of official boards and offices devoted to public health.

None of this early public health activity, however, involved medical care. The earlier interest in seeing that the poor received medical attention now took a back seat to sanitation. In the mid-19th century this order of priority made sense—on two counts: First, in political-economic terms, sanitation simply overwhelmed medicine in terms of what each could offer in saving lives of rich and poor alike (although this began to change after about 1875, when the development of bacteriology made surgery "safe" and direct prevention of certain communicable diseases possible). Second, free medical care for the poor was considered another form of Poor Law relief, to be limited to the destitute and doled out meagerly so that there would be no question that its quality was inferior to that received by persons not on relief. The low stipends and status of the Poor Law medical officers confirmed the value that the society placed on their positions; they shared the scorn directed toward their clients, despite the efforts of pathologist Thomas Hodgkin to champion their cause by advocating higher qualifications and a reorganization of Poor Law medicine using voluntary prepaid clinics.

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[12] Dickens' *Oliver Twist* appeared during 1837 and 1838 (as a newspaper serial) and *Hard Times* came out in 1854. Engels published *The Condition of the Working Class in England* in 1845.

[13] Henry Fawcett, *Pauperism: Its Causes and Remedies* (1871), quoted in de Schweinitz, *Op. Cit.*, p. 142.

[14] Prominent among them were William Farr and Edwin Chadwick in England, Louis-René Villermé in France, Rudolph Virchow in Prussia, and Lemuel Shattuck and Stephen Smith in the United States.

CONTROLLING AS THE POOR law philosophy was of Victorian views on social welfare, at least five contrarian forces also found voice and built momentum throughout the 19th century. All were linked to medicine—although if viewed by today's strict categorical terms, they may not appear so.

The first counterforce came on behalf of—and finally from—the working class. It began early in the century as a campaign for worker protection. A law forbidding textile mills from employing apprentices below the age of nine was followed by a second law limiting the work day for women and children to ten hours. Late in the century a second industrial revolution followed the introduction of electricity, and new manufactured products resulted in millions of new wage workers. When the proportion of wage workers increases sharply, as occurred with both industrial revolutions, insecurity grows until the wage-earning class becomes restive enough to protest its powerless condition, whereupon the existing order is apt to make a corrective response. One such response in the 19th century was to extend suffrage to urban laborers, then to miners and agricultural workers. The first trade unionists entered Parliament in the 1870s. Their ranks grew, until by the end of the century the workers themselves had become a formidable political counterforce.

A second counterforce was personified by two remarkable social medicine crusaders—Dorothea Dix and Florence Nightingale—who were similar in their life situations, dominating single-minded personal styles, public reputations and influence, and in what they accomplished. The American Dix, who took her crusade to the British Parliament and Scotland, effectively rescued the insane from workhouses, jails and other odious receptacles, and removed them to special asylums. Nightingale resuscitated hospitals physically and organizationally, and thereby abetted their growth later in the century when they were becoming essential to healing. One consequence of a science-based medicine centered at hospitals was that its costs increased beyond the purchasing power of the population, which in turn prompted a widely shared conviction that medicine's benefits

Dorothea Dix (1802-1887)

should be available to the entire population irrespective of social class or ability to pay.

A third counterforce took the form of a series of reports on the condition of the poor. First came Edwin Chadwick's 1842 *Report upon the Sanitary Condition of the Laboring Population of Great Britain*,[15] followed by Henry Mayhew's 1849 articles on "London Labour and the London Poor," and near the end of the century by industrialist Charles Booth's social surveys—17 publications in all—on the life and work of Londoners. Each of these influential documentaries turned public opinion yet another degree toward the view that the poor should not be held wholly at fault for their destitution and that the state might have a greater role to play.

[15] The Chadwick Report more than any other document was responsible for launching the public health movement. Its author, ironically, was the same ambitious, single-minded civil servant (and gifted polemicist) who drafted the regressive 1834 Poor Law. After concluding that an unsanitary environment was the major cause of excessive sickness, which not only reduced the available labor but increased the expense of the Poor Law, Chadwick persuaded the English ruling class that removing the cause of disease would be cheaper than paying the relief that inevitably accompanied so much individual illness and premature death.

Florence Nightingale (1820-1910)

Yet a fourth counterforce was British social-ism, which although it could claim powerful intellectual antecedents like Robert Owen, the Rochdale cooperators, Karl Marx and Frederick Engels, had only minor political importance—until the founding of the Fabian Society in 1883. A remarkable group of thinkers and ac-tivists, the Fabians set an ambitious course for themselves, aiming to accomplish a series of ma-jor political, industrial and social reforms—founding of a Labor Party, the eight-hour day, public water, public education, women's suffrage, a minimum wage, abolition of the Poor Law, and social insurance.

Finally, one counterforce came from abroad. In 1883 German Chancellor Bismarck prevailed over the conservatives of the Liberal Party and the radical Social Democrats and enacted the world's first social insurance law, thus setting in place an example for other nations to copy—directly or eventually. Since Bismarck's goal was to reduce the social insecurity of the German worker, which he believed imperiled the state, his program was primarily designed to mollify low-wage industrial laborers and win their loy-alty. After Bismarck's rule ended, the program was expanded gradually, mostly by the Social Democrats, until it covered not only low-in-come workers, but all workers.

O VER THE COURSE of the late 19th and early 20th centuries these counterforces in combination proved more du-rable than the Poor Law morality. Unemploy-ment, poverty, and health and illness became more significant matters of national policy; and discussion of these issues uncovered class ten-sion, prompted moral inquiry and ethical de-bate, and pointed social reform in a different direction.

The first cracks in the workhouse foundation appeared in 1885, when the city of Birming-ham instituted a program of public works for the unemployed. Eleven years later the Local Government Board recommended that those aged poor who had "habitually led decent and deserving lives" not be required to enter the workhouse in order to receive relief, and that workhouse inmates of good moral character be allowed separate sleeping cubicles. In another thirteen years the Royal Commission on the Poor Laws and Relief of Distress would find the "effect of a sojourn in the workhouse...wholly bad" and acknowledge, finally, the part played by "our industrial system" in creating unemploy-ment and distress. That Commission also rec-ommended certain corrective measures—child labor laws, reduction in the length of the work-day, a national labor exchange, unemployment insurance, and sickness insurance.[16]

In 1908, Board of Trade President Winston Churchill demonstrated the pragmatism in the new thinking:

"I do not agree with those who say that every man must look after himself, and that the intervention by the State in such matters...will be fatal to his self-reliance, his foresight, and his thrift.... The mass of the laboring poor have known that unless they made provision for their old age betimes they would perish miserably in the workhouse. Yet they have made no provi-sion; ...for they have never been able to make such provision....It is a great mistake to suppose that thrift is caused only by fear;

[16] *Report of the Poor Commission on the Poor Laws and Relief of Distress, 1909* (The Majority Report), quoted and sum-marized in de Schweinitz, *Op. Cit.*, pp. 189, 190, 198.

it springs from hope as well as from fear; where there is no hope, be sure there will be no thrift."[17]

And Chancellor of the Exchequer David Lloyd George declared (also in 1908) his government's philosophy on social welfare:

"There is plenty of wealth in this country to provide for all and to spare. What is wanted is fairer distribution.... [in order that] those whose labor alone produces that wealth are amply protected with their families from actual need...owing to circumstances over which they have no control. By that I mean...that the spare wealth of the country should, as a condition of its enjoyment by its possessors, be forced to contribute first towards the honorable maintenance of those who have ceased to be able to maintain themselves."[18]

Riding on the wave of interest in improving the welfare of workers, a spate of social legislation emerged from Parliament after 1905. All of it pointed away from the Poor Law. The single most important of these initiatives followed a visit by Lloyd George to Germany. He immediately launched a two-year campaign for social health and unemployment insurance, which Parliament enacted in 1911. Unlike German sickness insurance, however, the British version of health insurance was never extended beyond its original target—low income workers.

In 1925, Great Britain added yet another social insurance program—old age and survivors' benefits—thereby setting an example that the United States would copy ten years later (with the Social Security Act of 1935). Unlike the 19th century programs of relief for the poor, few of these new programs required a demonstration of financial need or someone to vouch for the recipient's worthiness. The services and payments were simply delivered to the insured person as promised, when and if the previously-agreed-upon contingency arose. In this respect, social insurance was the opposite of Poor Law relief. Finally, in 1918 Britain made suffrage universal by extending it not only to women, but also to people on relief, an action that further eroded the Poor Law legacy.

All of these steps were leading up to the major turning point in Britain's shift from Poor Law to welfare state. It came in 1941, at a time when the nation faced imminent invasion. The appointment of an Interdepartmental Committee to study social insurance resulted in publication of the Beveridge Report the following year. Sir William Beveridge was an internationally renowned educator, economist and insurance expert. His report was built upon two underlying concepts—Comprehensiveness and Equality—and it embodied well the war-born social sentiment of Britain in the 1940s. He proposed that the nation attack the "five Giant Evils (of) Want, Disease, Ignorance, Squalor and Idleness" with a complete system of social insurance for all citizens *as of right*.[19] As a later report amplified, the equality motif was basic: "In a matter so fundamental, it is right for all citizens to stand in together without exclusions based on differences of status, function or wealth."[20]

Beveridge made three fundamental social policy assumptions: there would be guaranteed full employment, a system of child allowances, and a comprehensive national health service that would assure every citizen "whatever medical treatment he requires, in whatever form he requires it, domiciliary or institutional, general, specialist or consultant, and also...dental, ophthalmic and surgical appliances, nursing and midwifery and rehabilitation after accidents."[21]

[17] Winston Spencer Churchill, *Liberalism and the Social Problem.* London: Hodder and Stoughton, 1909. pp 208-210.

[18] David Lloyd George, *Slings and Arrows; Sayings Chosen from the Speeches of the Rt. Hon. David Lloyd George.* London: Cassell and Co., 1929. p. 8.

[19] *Social Insurance and Allied Services: Report by Sir William Beveridge, Presented to Parliament by Command of His Majesty, November, 1942.* New York: Macmillan, 1942. paragraph 456.

[20] *White Paper on Social Insurance,* 1945. Quoted in Harry Hopkins, *The New Look: A Social History of the Forties and Fifties in Britain.* Boston: Houghton Mifflin, 1964, p. 126.

[21] *Social Insurance and Allied Services,* p. 158.

William Beveridge in 1942

The importance of the Beveridge Report to the National Health Service, which went into operation six years later, was not in the specifics of the author's proposal; others worked out the political strategy and the details of how the NHS would operate. What makes William Beveridge a major figure in the history of social medicine is that he placed medical care policy in the context of a more general social policy. He saw the NHS as a practical expression of the ethic of solidarity, born of the war, but chosen by the British people in the post-war years to replace an older social morality that they realized was outmoded.

TODAY'S SOCIAL MEDICINE still refers to all of these antecedent problems, visions and solutions. At the end of the 20th century society is concerned with the social

ideals of its medical practitioners, questioning the goals of the new "health care industry," and continuing to examine the ethical values that underlie healing. As we respond to these contemporary concerns, we should keep in mind that our disciplines and areas of interest—public health and preventive medicine; epidemiology; medical care financing, organization and policy; biomedical ethics; and the sociology, anthropology, and political economy of health—all began at the same juncture where we experience them now. They represented areas of inquiry, methods, and actions at the interface of medicine and society, attempts by the social medicine pioneers to understand, in some cases measure, but always respond to shifts in the social environment on the one hand and in the profession of medicine on the other.

As both medicine and society have enlarged, so has their area of convergence—to the point where a Department of Social Medicine cannot begin to cover it all; nor should it try. Howard Reid Craig was correct when he said: "It would be well for medicine as a whole to become acutely aware of the tidal movements in the affairs of man." Yet, medicine *as a whole* has a more elusive identity now than it did in 1947; and it would not be wise, nor possible, for its heterogeneous membership to rely on a single antenna—a popular leader or even a single organization—to detect new signals in the air and respond for all. Every sector of medicine, from each clinical specialty to the drug trial judges and genome mappers—and every individual professional—should be aware of the "tidal movements," attempt to understand them, and participate actively at the social interface of the profession. This is what the Social Medicine faculty tries to represent, and it is this understanding and behavior that we hope to instill in our students.

DLM