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Title

Locating global health in social medicine

Permalink

<https://escholarship.org/uc/item/7s3166x2>

Journal

Global Public Health, 9(5)

ISSN

1744-1692

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Publication Date

2014-05-28

DOI

10.1080/17441692.2014.897361

Peer reviewed



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Journal:	<i>Global Public Health</i>
Manuscript ID:	RGPH-2013-0135
Manuscript Type:	Original Article
Keywords:	Global Health, Social Medicine, Social Science, Globalization, Social Determinants of Health

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Locating Global Health in Social Medicine

ABSTRACT

Global health's goal to address health issues across great sociocultural and socioeconomic gradients worldwide requires a sophisticated approach to the social root causes of disease and the social context of interventions. This is especially true today as the focus of global health work is actively broadened from acute (infectious) to chronic (or non-communicable) diseases. To respond to these complex biosocial problems, we propose the relatively young and diffuse field of global health should look to the older discipline of social medicine, a shared domain of social and medical sciences that offers critical analytic and methodological tools to elucidate who gets sick, why, and what we can do about it. Social medicine is a rich and relatively untapped resource for understanding the hybrid biological and social basis of global health problems. Global health must learn from social medicine if practitioners hope to understand the social behaviour, social structure, social networks, cultural difference, and social context of ethical action central to the success or failure of global health's important agendas. This understanding – of global health as global social medicine – could coalesce global health's unclear identity into a coherent framework effective for addressing the world's most pressing health issues.

KEYWORDS: Global Health, Social Medicine, Social Science, Social Determinants of Health, Globalization

WORD COUNT: 1797

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Locating Global Health in Social Medicine

Like ‘evidence-based medicine’, the ideal of ‘global health’ has assumed a certain rhetorical universality in the 21st century. Just as few would claim to practice ‘evidence-free’ medicine, it is quite difficult in this era for anyone to argue *against* global health. The idea that the health of all people across our globe is interconnected now appears as self-evident to us as the interconnection of our cultural and informational worlds through the Internet, or the interconnection of our social and material worlds through the global economy. Consider our apocalyptic visions of bioterrorism and pandemic influenza, our collective acknowledgment of the moral urgency of globally neglected diseases.

Despite an impressive growth in institutional and financial support in the past decade, however, there remains widespread confusion about exactly what global health is. As the Consortium of Universities for Global Health noted in *The Lancet* a few years ago, the field of global health differentiates itself from prior incarnations of public health, international health, and tropical medicine, primarily through a focus on “the mutuality of real partnership, a pooling of experience and knowledge, and a two-way flow between developed and developing countries” (Koplan et al., 2009). Yet the recent rise in interest in global health also includes the renaming in 2009 of Abbott Laboratories from a ‘pharmaceutical company’ to a ‘global health company’, and substantial military investment in counterbioterrorism units (Lakoff, 2010), neither of which are clearly in line with the Consortium’s aims. As some commentators have lamented, ideals of partnership in global health often remain in the realm of ideals (Crane, 2011). In order to represent not

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3 just a set of disparate problems, but also a set of unifying solutions, the diffuse field of
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5 global health needs to be *located* with greater specificity than it has been to date.
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10 To answer this call, we propose the new and diffuse field of global health should look to
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12 the older discipline of social medicine, a shared domain of social and medical sciences that
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14 offers critical analytic and methodological tools to elucidating who gets sick, why, and
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16 what we can do about it. If the field of global health is intended to bring into close
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18 proximity people, resources, and ideas from across great geographic distances, it will
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20 produce meaningful solutions if it grapples seriously with both the social roots of disease
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22 and the implementation of sustainable solutions. In this essay, we seek to describe the
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24 benefits of reconceptualising global health in terms of global social medicine, grounding
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26 the broad field of global health in the epistemological and conceptual approaches
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28 developed in the discipline of social medicine.
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36 To Leon Eisenberg's famous claim that "all medicine is inescapably social" (Eisenberg &
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38 Kleinman, 1981), we might add the additional claim that "all health is inescapably global."
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40 It is both ironic and self-defeating that in an age increasingly concerned with the
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42 globalisation of health that medical education, service delivery, and research have so little
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44 concern with the sphere of the social. Indeed, the challenges and failures of many prior
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46 global health programs—from the aborted malaria eradication program of the WHO to the
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48 spread of multi-drug resistant tuberculosis (MDRTB) must be understood not as biological
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50 problems but as *biosocial* problems that resulted from an incomplete attention to the social
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52 determinants of health and disease. Such problems have only grown outwards in the early
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3 21st century: global biomedical research programs are now fraught with accusations of
4 unethical conduct and controversy over venue shopping (Petryna, 2005), the awkwardness
5 of Western bioethics in other cultural contexts (Stonington & Ratanakul, 2006), and the
6 uneven distribution of ownership and generation of scientific knowledge (Crane, 2011).
7
8 Likewise, prevention programs have met with challenges due to differences in
9 understandings of risk, value, and disease causation across sociocultural and
10 socioeconomic difference. And treatment programs have struggled in the face of different
11 understandings of the body, the mechanisms of treatment and the value of medicine in the
12 face of poverty (Nguyen, 2010; Kalofonos, 2010).
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27 This failure is not for lack of applicable information, but rather a failure to incorporate
28 available expertise on social issues into global health agendas. Scholars from a diverse
29 array of fields have generated powerful understandings of the social in global health – as a
30 fabric of cognitive, cultural, economic, and political factors that determine the ability to
31 live a healthy life, prevent disease, and access and benefit from diverse health services.
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33 This interdisciplinary approach is the province of social medicine, the sub-field of
34 medicine that studies and engages with social aspects of health, illness, and care
35 (Henderson et al., 2005; Porter, 2006). As such, social medicine can be defined by four
36 primary characteristics: multidisciplinary methodologies, roots in social theory, critically
37 interpretive stance, and proclivity to engage with social aspects of clinical and scientific
38 problems. Crucial to all of this work is a commitment to rigorous empirical research in the
39 social world: ethnographic engagement, historical analysis, sociological and social
40 epidemiological analyses, and contextual ethics.
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6 Social medicine emerged in the late 19th century during a time of rapid specialisation and
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8 fragmentation of biomedical knowledge (Rosen, 1947). One of its earliest heroes, Rudolf
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10 Virchow, pioneered the discipline of cellular pathology, yet emphatically rejected the
11
12 notion that mechanistic explanations of disease would ever eradicate illness in human
13
14 populations or explain their devastating differential mortality along socioeconomic
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16 gradients (Ackerknecht, 1953). Rather, medicine was inextricably bound with the realities of
17
18 the social world--as he would famously note: “medicine is a social science, and politics
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20 nothing but medicine on a grand scale.” This wisdom still holds today. The social and
21
22 political aspects of health must be considered seriously if global health research and
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24 practice are to be responsive to the fundamental causes of disease and the context of health
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26 services (Henderson et al., 2005; Porter, 2006; see also Sommer and Parker 2013).
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34 Early social medicine was itself a global movement, it blossomed in locales from South
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36 Africa to South America in the first decades of the 20th century with transnational support
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38 from the Rockefeller Foundation and the League of Nations Health Organisation. In the
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40 context of colonising and decolonising impulses, its proponents sought to shape medicine
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42 as an applied social science that could inform public and private measures to provide
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44 equality – a basic right to health – in the lives of individuals and populations. By the close
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46 of WWII, departments of social medicine contributed to framing the World Health
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48 Organisation, whose 1946 constitution defined health broadly as “a state of complete
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50 physical, mental and social well-being and not merely the absence of disease or infirmity.”
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3 By the 1960s and 1970s, the spiraling costs of healthcare and a series of high-profile
4 misadventures with medical research and iatrogenesis--from thalidomide to Tuskegee--
5 enlivened a sense of urgency for the application of social sciences to an increasingly
6 problematic medical system. British practitioners of social medicine leveled powerful
7 critiques of biomedicine's increasing evacuation of social significance: Thomas McKeown
8 (1962), for example, advanced a demographic critique of the overstated claims of causality
9 between biomedical research and the improvement in morbidity and mortality in the global
10 North. Michael Marmot (1978) demonstrated in the Whitehall Study that gradients of
11 health status could be tracked along social hierarchies. These and other studies formed
12 robust empirical demonstrations of the relative costs of investing solely in biological,
13 rather than the simultaneously social, causes of illness. In this moment of renewed
14 attention to the relevance of social science to medicine, vibrant interdisciplinary centers of
15 medical social scientists were formed in North America. Ironically, at the moment of its
16 greatest recognition, social medicine was dismembered into a set of biotechnical fields: the
17 *British Journal of Social Medicine*, founded in 1947, had by 1978 shifted its title to the
18 *Journal of Epidemiology and Community Health*. While a small number of social medicine
19 departments would prove influential in shaping the interaction of medicine and social
20 science, the discipline would find purchase at only a minority of medical schools around
21 the globe. Instead, in the 1990s and 2000s, interest in the 'social' in medicine was largely
22 eclipsed by enthusiasm for the newer fields of bioethics, health policy, and, increasingly,
23 global health. While these fields broaden the scope of biomedicine, they are based
24 significantly (and often uncritically) on the assumptions, concepts and epistemologies of
25 biomedicine.
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Though its explicit academic footprint may be small, social medicine offers several important and specific tools to help the field of global health meet its promise. First, social medicine is deliberately multidisciplinary, allowing understandings of social phenomena from a diverse array of social science and humanities disciplines and methodologies. Second, its epistemological basis in critical social theory extends beyond the reductionist focus on medical decision-making held by fields such as mainstream bioethics, and allows useful challenges to assumptions within global health that, at times, undermine its effectiveness. There are many contemporary examples of the potentially transformative influence of these tools on global health programs. To take one example, the physician-anthropologist Vinh-Kim Nguyen has recently described in *The Republic of Therapy* how the first waves of HIV treatment programs in West Africa were weakened significantly by a narrow focus on drug therapy that excluded wider social contexts. Patients do poorly on therapy when they do not also meet basic nutritional needs, yet when aid organisations recognised this and gave food with medications, they created an incentive for community members to continue risky behaviour so that they could receive food aid for their families once infected. Through social analysis and engagement, programs were able to realise that success would require poverty-reduction for the entire community (Nguyen, 2010; see also Kalofonos, 2010; Parker, Easton, & Klein, 2000).

Global health's goal to address health issues across great sociocultural and socioeconomic gradients requires a sophisticated approach to the social root causes of disease and the social context of interventions. This is especially true today as the focus of

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3 global health work is actively broadened from acute (infectious) to chronic (or non-
4 communicable) disease profiles. While global health is already understood to be an
5 interdisciplinary field, its lack of integration often results in a retreat to narrower
6 biomedical frames. This lack of a “common language” can obscure its goals for the
7 improvement of health on a global scale (Frenk, Gómez-Dantés, & Chacón, 2010, p. 15).
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9 Social medicine is a rich and relatively untapped resource for understanding this hybrid
10 basis of medicine and public health as a unified field that likewise unifies the biological
11 and the social. Global health must learn from social medicine if practitioners hope to
12 understand the social behaviour, social structure, social networks, cultural difference, and
13 social context of ethical action central to the success or failure of global health’s important
14 agendas. This understanding – of global health as global social medicine – could coalesce
15 global health’s unclear identity into a coherent framework effective for addressing the
16 world’s most pressing health issues.
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References

- Ackerknecht, E. (1953). *Rudolf Virchow: Doctor, Statesman, Anthropologist*. Madison [W.I.]: University of Wisconsin Press.
- Crane, J. (2011). Scrambling for Africa? Universities and global health. *Lancet*, 377, 1388-1390.
- Eisenberg, L., & Kleinman, A. (1981). *The Relevance of social science for medicine*. Boston: Kluwer Boston.
- Eisenberg L. and Kleinman A., *The Relevance of Social Science for Medicine*. Boston: D. Reidel, 1981.
- Frenk, J., Gómez-Dantés, O., & Chacón, F. (2010). Global Health in Transition. In R. Parker & M. Sommer (Eds.), *Routledge Handbook of Global Public Health* (pp. 11–17). Taylor & Francis.
- Henderson G.E., Estroff S. E., Churchill L.R., King N.M.P., Oberlander J., Strauss R.P., (eds.) *The Social Medicine Reader*. Durham: Duke University Press, 2005.
- Kalofonos, I. (2010). All I Eat Is ARVs: The Paradox of AIDS Treatment in Mozambique. *Medical Anthropology Quarterly*. 24(3):363-80.
- Lakoff, A. (2010). Two regimes of global health. *Humanity*, 1(1), 59-79
- Koplan, J.P., Bond, T.C., Merson, M.H., Reddy, K.S., Rodriguez, M.H., Sewankambo, N.K., et al. (2009). Towards a common definition of global health. *Lancet*, 373, 1993-1995.
- McKeown T, Record RG (1962). Reasons for the decline of mortality in England and Wales during the nineteenth century. *Population Studies*, 16: 94–122.

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2
3 Marmot, M. G.; Rose, G.; Shipley, M.; Hamilton, P. J. (1978). *Journal of Epidemiology*
4 *and Community Health* **32** (4): 244–249.
5
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7
8 Nguyen, V.-K. (2010). *The republic of therapy: triage and sovereignty in West Africa's*
9 *time of AIDS*. Durham [N.C.]: Duke University Press.
10
11
12 Parker, RK, D Easton, CH Klein. 2000. Structural Barriers and Facilitators in HIV
13 Prevention: a Review of International Research. *AIDS*. 14: S22-32.
14
15
16
17 Petryna, A. (2005). Ethical variability: drug development and globalizing clinical trials.
18 *American Ethnologist*, 32, 183–197.
19
20
21
22 Porter D., How Did Social Medicine Evolve, and Where Is It Heading? *PLoS Medicine*
23 2006; 10:1667-72.
24
25
26
27 Rosen G., “What is Social Medicine?” *Bulletin of the History of Medicine* 1947; 21: 674-
28 733.
29
30
31
32 Sommer, Marni and Richard Parker. *Structural Approaches in Public Health*. 2013. New
33 York: Routledge.
34
35
36
37 Stonington, S., & Ratanakul, P. (2006). Is there a global bioethics? End-of-life in Thailand
38 and the case for local difference. *PLoS Medicine*, 3, e439.
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