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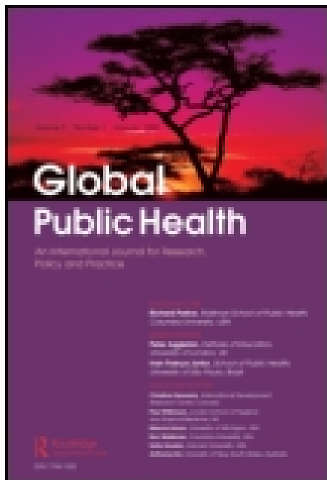

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Locating global health in social medicine

Seth M. Holmes[ab], Jeremy A. Greene[c] & Scott D. Stonington[de]

[a] School of Public Health, University of California Berkeley, Berkeley, CA, USA

[b] Graduate Program in Medical Anthropology, University of California Berkeley, Berkeley, CA, USA

[c] Departments of Medicine and the History of Medicine, Institute of the History of Medicine, The Johns Hopkins University, Baltimore, MD, USA

[d] Department of Medicine, Brigham and Women's Hospital, Boston, MA, USA

[e] Department of Global Health and Social Medicine, Harvard Medical School, Boston, MA, USA
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Seth M. Holmes[a,b]*, Jeremy A. Greene[c] and Scott D. Stonington[d,e]

[a]*School of Public Health, University of California Berkeley, Berkeley, CA, USA;* [b]*Graduate Program in Medical Anthropology, University of California Berkeley, Berkeley, CA, USA;* [c]*Departments of Medicine and the History of Medicine, Institute of the History of Medicine, The Johns Hopkins University, Baltimore, MD, USA;* [d]*Department of Medicine, Brigham and Women's Hospital, Boston, MA, USA;* [e]*Department of Global Health and Social Medicine, Harvard Medical School, Boston, MA, USA*

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Global health's goal to address health issues across great sociocultural and socio-economic 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 to chronic and from infectious to non-communicable diseases. To respond to these complex biosocial problems, we propose the recent expansion of interest in the field of global health should look to the older field 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 can learn much from social medicine to help practitioners 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 – can 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; globalisation

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What is global health?

Like 'evidence-based medicine', the ideal of 'global health' has assumed a certain rhetorical universality in the twenty-first 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 (see Adams, 2010). 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, and 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,

*Corresponding author. Email: sethmholmes@berkeley.edu

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the 'new' 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). Other authors have suggested that attention to global health in the twenty-first century differs from attention to international and tropical medicine in the twentieth century in its focus on discomfort with inequalities of disease burdens between rich and poor countries, or in its extension beyond the professions of medicine and public health to include actors with expertise in law, economics, environmental science and engineering (Macfarlane, Jacobs, & Kaaya, 2008). Yet such distinctions work to smooth over underlying continuities: Many advocates of the primary health care concept in the 1960s and 1970s were motivated by concerns about economic and health inequalities. Likewise, when one looks at the expert advisory committees attached to mid-century World Health Organization (WHO) initiatives such as the Global Malaria Eradication Programme, one finds economists, engineers, lawyers and environmental scientists at work on similar projects. Nor do these descriptions fully capture the actions of other twenty-first-century stakeholders: Note, for example, that 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 counter-bioterrorism units (Lakoff, 2010), neither of which are clearly in line with the aims of the Consortium of Universities for Global Health. 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 just a set of disparate problems, but also a set of unifying solutions, the diffuse field of global health needs to be *located* intellectually and politically with greater specificity than it has been to date.

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All medicine is inescapably social and all health is inescapably global

To answer this call, we propose that the new 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. The discipline of social medicine is made up of scholars broadly sharing interests in linking macro social phenomena to more local experiences, meanings and health outcomes (see Stonington & Holmes, 2006). Scholars in this discipline often have training in such fields as medical anthropology, medical sociology, medical history, critical social epidemiology and critical bioethics. If the field of global health is intended to bring into close proximity people, resources and ideas from across great geographic distances, it will produce more meaningful solutions if it grapples seriously with both the social roots of disease and the implementation of sustainable solutions. In this essay, we seek to describe the benefits of reconceptualising global health in terms of global social medicine, grounding the broad field of global health in the epistemological and conceptual approaches developed in the discipline of social medicine.

To Leon Eisenberg and Arthur Kleinman's claim that 'all medicine is inescapably social' (1981), we might add the additional claim that 'all health is inescapably global.' In an age increasingly concerned with the globalisation of health, many spheres of medical education, service delivery and research are reconsidering the relevance of the social sciences in the complex practices of systems-based care. In this light, the challenges and failures of many prior global health programmes – from the aborted malaria eradication programme of the WHO to the spread of multi-drug resistant tuberculosis (MDRTB) – should be understood not as biological problems but as *biosocial* problems that resulted

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from an incomplete attention to the social determinants of health and disease (see Farmer, Kleinman, Kim, & Basilico, 2013; Keshavjee & Farmer, 2012). Success in both of these arenas of intervention is as dependent upon careful attention to economics, history, ethnography and political science as it is to any basic biomedical science alone. Complex global biosocial problems have grown only outwards in the early twenty-first century: Global biomedical research programmes are now fraught with accusations of unethical conduct and controversy over venue shopping (Petryna, 2005), the awkwardness of Western bioethics in other cultural contexts (Stonington & Ratanakul, 2006), and the uneven distribution of ownership and generation of scientific knowledge (Crane, 2013). Likewise, prevention programmes have met with challenges due to understandings of risk, value and disease causation across sociocultural and socioeconomic difference. And treatment programmes have struggled in the face of different understandings of the body, the mechanisms of treatment and the value of medicine in the face of poverty (see Nguyen, 2010; Kalofonos, 2010).

This failure is not for lack of applicable information, but rather a failure to incorporate available expertise on social issues into global health agendas. Scholars from a diverse array of fields have generated powerful understandings of how social sciences can come to inform global health interventions – by focusing on the fabric of cognitive, cultural, economic and political factors that determine the ability to live a healthy life, prevent disease and access and benefit from diverse health services. This interdisciplinary approach is the province of social medicine, the sub-field of medicine that studies and engages with social aspects of health, illness and care (see Henderson et al., 2005; Porter, 2006). As such, social medicine can be defined by four primary characteristics: multi-disciplinary methodologies, roots in social theory, critically interpretive stance and proclivity to engage with social aspects of clinical and scientific problems. Crucial to all of this work is a commitment to rigorous empirical research in the social world: ethnographic engagement, historical analysis, sociological and social epidemiological analyses and contextual ethics.

The discipline of social medicine and its development

As several medical historians have documented, the field of social medicine emerged in the late nineteenth century during a time of rapid specialisation and fragmentation of biomedical knowledge (Rosen, 1947; see also Porter, 2006). One of its earliest heroes, Rudolf Virchow, pioneered the discipline of cellular pathology, yet emphatically rejected the notion that mechanistic explanations of disease would ever eradicate illness in human populations or explain their devastating differential mortality along socioeconomic gradients (Ackerknecht, 1953). Rather, medicine was inextricably bound with the realities of the social world; as he would famously note: 'medicine is a social science, and politics nothing but medicine on a grand scale' (Ackerknecht, 1953, p. 243). This wisdom still holds today. The social and political aspects of health must be considered seriously if global health research and practice are to be responsive to the fundamental causes of disease and the context of health services (Henderson et al., 2005; Porter, 2006; see also Sommer & Parker, 2013).

Although Virchow's nineteenth-century forays into social medicine were localised to Prussia and Upper Silesia, social medicine in the early twentieth century swiftly became a global movement, blossoming in locales from South Africa to South America in the first decades of the twentieth century with transnational support from the Rockefeller Foundation and the League of Nations Health Organisation. In the context of colonising and decolonising impulses, its proponents sought to shape medicine as an applied social

science that could inform public and private measures to provide equality – a basic right to health – in the lives of individuals and populations. By the close of World War II, departments of social medicine contributed to framing the World Health Organization, whose 1946 constitution defined health broadly as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (Grad, 2002).

By the 1960s and 1970s, the spiraling costs of healthcare and a series of high-profile misadventures with medical research and iatrogenesis – from thalidomide to the Tuskegee syphilis research controversy – enlivened a sense of urgency for the application of social sciences to an increasingly problematic medical system. British practitioners of social medicine leveled powerful critiques of biomedicine's increasing evacuation of social significance: McKeown and Record (1962), for example, advanced a demographic critique of the overstated claims of causality between biomedical research and the improvement in morbidity and mortality in the global North. Marmot, Rose, Shipley, and Hamilton (1978) demonstrated in the Whitehall Study that gradients of health status could be tracked along social hierarchies. These and other studies formed robust empirical demonstrations of the relative costs of investing solely in biological, rather than the simultaneously social, causes of sickness. In this moment of renewed attention to the relevance of social science to medicine, vibrant interdisciplinary centers of medical social scientists were formed in North America. Ironically, at the moment of its greatest recognition, social medicine was dismembered into a set of biotechnical fields: The *British Journal of Social Medicine*, founded in 1947, had by 1978 changed its title to the *Journal of Epidemiology and Community Health*. While a small number of social medicine departments would prove influential in shaping the interaction of medicine and social science, the discipline would find purchase at only a minority of medical schools around the globe. Instead, in the 1990s and 2000s, interest in the 'social' in medicine was largely eclipsed by enthusiasm for the newer fields of bioethics, health policy and, increasingly, global health. While these fields broaden the scope of biomedicine, they are based significantly (and often uncritically) on the assumptions, concepts and epistemologies of biomedicine.

Global health as global social medicine

Though its explicit academic footprint may be relatively 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 programmes. To take one example, the physician-anthropologist Vinh-Kim Nguyen (2010) has recently described in *The Republic of Therapy* how the first waves of HIV treatment programmes 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, once infected, they could receive food aid for their families. Through social analysis and engagement,

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programmes 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 socio-economic 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 global health work is actively broadened from acute to chronic and from infectious to non-communicable disease profiles. While global health is already understood to be an interdisciplinary field, its lack of integration often results in a retreat to narrower biomedical frames. This lack of a 'common language' can obscure its goals for the improvement of health on a global scale (Frenk, Gómez-Dantés, & Chacón, 2010, p. 15). Social medicine is a rich and relatively untapped resource for understanding this hybrid basis of medicine and public health as a unified field that likewise can unify the biological and the social. Global health must learn from social medicine if practitioners hope to understand the social behaviour, social structure, social networks, cultural difference and social and political 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 – can coalesce global health's unclear identity into a coherent framework effective for addressing the world's most pressing health issues.

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