7 American Social Medicine in the Shadow of Socialized Medicine

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Speaking to an international audience of medical educators in 1953, Dr. John Perry Hubbard attempted to describe the stigma attached to social medicine in Cold War America. In the "all-out war" between the medical profession and proposals for national health insurance, the University of Pennsylvania Professor of Public Health and Preventive Medicine lamented that "socialized medicine was held up before the American public as a threatening evil. The average citizen – and many a physician, too – does not really know what he means by socialized medicine but he is sure that it is bad. And social medicine does not sound very different."[1] This confusion has been an enduring challenge.

Social medicine has a long and puzzling history in the United States. Several key figures in global social medicine worked in the US and won renown for their work. The Rockefeller Foundation provided substantial support that advanced the mission of social medicine worldwide – especially through the growing reach of early twentieth-century American imperialism. Yet social medicine achieved little institutional stature in the US, with a formal presence at only a handful of medical schools. This chapter examines this discrepancy. The obscurity of social medicine reflects in part the politics of the US in which "social medicine" was too often heard as "socialized medicine," a red-baiting tactic in US politics. Work that might otherwise have been called social medicine had to pass under other names, from hygiene to preventive medicine or community health. The near invisibility of social medicine poses a challenge for historians: what counts as "social medicine" in a profession whose dominant discourse denied its existence? Is it only those who self-identified as theorists or practitioners of social medicine or does it include people who self-identified differently but worked in the spirit of social medicine?

We take a hybrid approach. We begin with early invocations of "social medicine" in the US, its most visible theorists (e.g., Henry Sigerist), and an

[1] John Perry Hubbard, "Integrating Preventive and Social Medicine in the Medical Curriculum," *New England Journal of Medicine* 251 (1954): 513–19, quote at 514.

important patron, the Rockefeller Foundation. We then pause to examine several Black social theorists whose work can now unquestionably be recognized as social medicine yet who have been largely excluded from this pantheon. The Cold War put social medicine under great pressure in the US. Different threads, however, endured. The first, clinically oriented, focused on community health. The second, based in academic departments, applied the interpretive social sciences to explore the interspace between the clinical and the social. These threads converged in the 1990s and 2000s in new forms of social medicine-informed clinical practice which drew on both community health and critical social theory to define social medicine as healthcare committed to social justice and health equity. This recent synthesis, however, poses another puzzle: why, given growing consensus in US medicine about social justice and health equity, does social medicine remain on the margins?

Early Invocations and Advocates of Social Medicine

There are many ways to trace the histories of social medicine. One approach looks for recognizable intellectual antecedents, for instance theorists who insisted that medicine take social context or social justice seriously. This approach would acknowledge Henry Ingersoll Bowditch, chair of the first state board of health in the United States. In 1874, he called on Massachusetts to use its "moral power and material resources" in the service of preventive medicine, for instance making investments in housing and nutrition for the poor to combat tuberculosis.[2] Milton Rosenau, who became the first professor of preventive medicine at a US medical school, described tuberculosis in 1913 as a sociologic and economic problem and invoked justice and mercy to encourage investments in the health of vulnerable people.[3]

A more restrictive approach focuses on the term "social medicine." The phrase first appeared in the *Boston Medical and Surgical Journal* in 1876, in a review of medical education in Germany. It emerged sporadically over the next several decades, usually as a synonym for "preventive medicine."[4] In 1915, Richard Cabot described social medicine, "done on salary and for the

[2] Henry I. Bowditch, "Preventive Medicine and the Physician of the Future," *Fifth Annual Report of the State Board of Health* (Boston: Wright and Potter, January 1874), 30–60, quote at 33.

[3] Milton J. Rosenau, *Progress and Problems in Preventive Medicine* [Ether Day Address, 1913] (Boston: Jamaica Printing Company, 1913), quote at 28. At the same time, and illustrating the complexities of characterizing proponents of "preventive" or "social" medicine, Rosenau included a chapter (admittedly with caveats) on eugenics in multiple editions of his classic textbook on preventive medicine and hygiene; see, e.g., Milton J. Rosenau, *Preventive Medicine and Hygiene* (New York, NY, and London: Appleton and Company, 1913), 415–25.

[4] See, e.g., Theobald Smith, "Research into the Causes and Antecedents of Disease, Its Importance to Society," *Boston Medical and Surgical Journal* 153 (1905): 6–11; and Theobald Smith, "The Sphere of Social Medicine," *Boston Medical and Surgical Journal* 177 (1917): 299.

public benefit," as one of "the three great fields of medicine – medical science, medical practice and social medicine."[5] The *Journal of the American Medical Association* (*JAMA*) first printed the term "social medicine" in a 1910 review of a textbook of medical sociology that made the case for studying social conditions that threaten health.[6] In 1916, *JAMA* launched a column, variably titled "Social Medicine, Medical Economics and Miscellany" or just "Social Medicine."[7] Most of these essays, however, had nothing to do with a recognizable field of "social medicine." They instead explored myriad topics, from antivivisectionists to the merits of state medicine.

More progressive visions of social medicine emerged at the intersections of medicine and social work. Tuberculosis, housing, and occupational health drew particular attention. Francis Lee Dunham's 1925 *An Approach to Social Medicine* defined it as "a field of preventive science to which social science, psychology, psychiatry, and various other departments shall contribute … Such a field functions more naturally as an attitude, a point of view, rather than as a specific department."[8] Such sentiments encountered increasing resistance in the US as conservatives recoiled from the Bolshevik revolution in Russia. As fears of "socialized medicine" began to circulate in *JAMA* and the *Boston Medical and Surgical Journal* in the late 1910s, social medicine was drawn into the debates.[9] In 1921, a concerned physician warned that, "If in the years to come social medicine has us enmeshed in its irksome bonds, let us blame only ourselves."[10] A 1927 review of "Group Practice" feared legislation that could socialize medicine: "State or social medicine, or compulsory health insurance, is intolerable. We must organize and be ready to strike it down."[11]

Henry Sigerist, who would become one of social medicine's most effective early advocates, arrived in the US in the midst of these debates. He had been invited by William Henry Welch, who played a decisive role in establishing the German vision of scientific medicine in the US.[12] But Welch was also committed to the idea that medicine should not be reduced to science alone.

[5] Richard C. Cabot, "Women in Medicine," *Journal of the American Medical Association* 45 (1915): 947–8.

[6] "Review of *Medical Sociology*," *Journal of the American Medical Association* 54 (1910): 154–5. This also mentioned the establishment of a new chair of social medicine in Vienna.

[7] "Social Medicine, Medical Economics and Miscellany," *Journal of the American Medical Association* 77 (1916): 1390–1. This ran sometimes weekly, sometimes less often, until 1936.

[8] Francis Lee Dunham, *An Approach to Social Medicine* (Baltimore: Williams & Wilkins, 1925), 14.

[9] For an early occurrence, see, Review of "Transactions of the American Surgical Association, Volume 36," *Boston Medical and Surgical Journal* 181 (1919): 749.

[10] J. R. Fowler, "Impending Dangers," *Boston Medical and Surgical Journal* 185 (1921): 217.

[11] Philemon E. Truesdale, "Group Practice," *Boston Medical and Surgical Journal* 196 (1927): 973–83.

[12] George Rosen, "William Henry Welch: 1850–1934," *Journal of the History of Medicine and Allied Sciences* 5 (Summer 1950): 233–5.

After retiring from his deanships at the Johns Hopkins School of Medicine and then the Johns Hopkins School of Public Health, he dedicated his efforts to founding the Institute of the History of Medicine at Hopkins and recruited Sigerist to direct it. Sigerist had studied medicine, and then history of medicine, in Zurich, and joined the faculty at Leipzig in 1925.[13] Working amidst Germany's post-war economic crises, he became interested in the social and political organization of medicine. As he veered toward socialism, he became increasingly critical of the rise of German fascism. Welch invited him to tour the US in 1931. Bewildered by the Depression-era US, he criticized fee-for-service healthcare and mocked American resistance to health insurance. Cultured and erudite, he charmed the leaders of academic medicine. Welch offered him the leadership of the new Institute in 1932.

Sigerist quickly became a successful academic and public intellectual in the US. He presented history as a space for scholarly reflection about the importance of social context in medical care and advocated for a sociological and policy-oriented approach to social medicine in medical education.[14] Sigerist applauded the establishment of chairs of Social Medicine in the UK and closely followed John Ryle's efforts to build an academic field that would guide the new National Health Service.[15] He published an enthusiastic account of Soviet medicine and advocated for national health insurance in the US (frequently butting heads with Morris Fishbein and the American Medical Association, AMA).[16] He used his proximity to Washington to advise President Roosevelt about health policy.

From his base at Hopkins, Sigerist also mentored many physician-scholars who in turn became key figures in American social medicine. George Rosen first contacted Sigerist in 1933, as a medical student studying history and then sociology. With Sigerist's encouragement, Rosen turned his attention to occupational health, a field which made especially visible the pathways through which the social world shaped health and disease on the basis of class, race, ethnicity, and labor. In 1939 Rosen wrote Sigerist seeking advice: "I would like to write my dissertation in the field of social medicine (in the broadest

[13] Elizabeth Fee, "The Pleasures and Perils of Prophetic Advocacy: Henry E. Sigerist and the Politics of Medical Reform," *American Journal of Public Health* 86 (1996) 1637–47. See also Elizabeth Fee and Theodore M. Brown (eds.), *Making Medical History: The Life and Times of Henry E. Sigerist* (Baltimore: Johns Hopkins University Press, 1997).

[14] Henry E. Sigerist "Trends in Medical Education: A Program for a New Medical School," *Bulletin of the History of Medicine* 9 (1941): 177–98; Leslie Falk, "Medical Sociology: The Contributions of Henry E. Sigerist," *Journal of the History of Medicine and Allied Sciences* 13 (1958): 214–28.

[15] Sigerist to Ryle January 28, 1944. The Henry E. Sigerist Collection at the Alan Mason Chesney Medical Archives of The Johns Hopkins Medical Institutions (hereafter, SigH), 3.1R. The pair kept up a lively exchange of letters and students and visited each other when possible.

[16] Emily Ann Harrison, "Indicating Health: Leona Baumgartner, Global Development, and the Metrics of Infant Mortality (1950–1980)," PhD, Harvard University, 2017, 43–4.

sense of that term)."[17] Rosen continued to seek Sigerist's help and advice as he moved onto his next projects, a history of public health and his essay, "What is Social Medicine?," which established Virchow as an icon for the field – as discussed in Carsten Timmerman's contribution to this volume.[18]

Enthusiasm in the US for the USSR cooled quickly after the Soviet–Nazi pact and the Soviet invasion of Finland in 1939. Sigerist, however, continued to push for socialized medicine in the early 1940s. By 1944, though, rising anti-communist sentiment ended his advisory work for the US government. He participated in analyses of healthcare in Canada and then in India, serving with Ryle on the Bhore Commission.[19] He invited Ryle to visit the US to help evangelize for social medicine. "Your presence," he explained, "would give an enormous stimulus to the development of social medicine in this country which is still in its early beginnings."[20]

Sigerist also strategized with Iago Galdston, a psychiatrist and historian at the New York Academy of Medicine (NYAM). In 1947, NYAM hosted an Institute on Social Medicine, a three-day conference that included, among others, Sigerist, Rosen, Ryle, other prominent historians (e.g., Richard Shryock, Ludwig Edelstein, and Owsei Temkin), and Alan Gregg, the Associate Director of Medical Sciences for the Rockefeller Foundation.[21] "In this country social medicine is everybody's business but nobody's responsibility," NYAM President George Baehr reflected, "We know that poverty, food, housing, conditions of work – all have an important bearing upon the prevalence of certain diseases; but we have not yet proceeded very far in investigating and eliminating the specific causative factors that have the greatest social import."[22] Sigerist congratulated Galdston on a "superb Institute," and hoped social medicine might play an important role in progressive postwar social reforms.[23]

[17] This led to George Rosen, *The History of Miners' Diseases: A Medical and Social Interpretation* (New York, NY: Schuman's, 1943).

[18] Rosen to Sigerist, October 21, 1944, SigH 3.1R; George Rosen, *A History of Public Health* (New York, NY: M.D. Publications, 1958); George Rosen, "What Is Social Medicine? A Genetic Analysis of the Concept," *Bulletin of the History of Medicine* 21 (1947): 674–733.

[19] For the Bhore Commission, see Sunil S. Amrith, *Decolonizing International Health: India and Southeast Asia, 1930–65* (New York, NY: Palgrave Macmillan, 2006); Kiran Kumbhar, "Healing and Harming: The 'Noble' Profession of Medicine in Post-Independence India, 1947–2015," PhD, Harvard University, 2022.

[20] Sigerist to Ryle, February 6, 1945, SigH, 3.1R. This letter is the first we have found arguing explicitly for the field of "social medicine" in the US.

[21] "Institute on Social Medicine – March 19, 20, and 21, 1947," Archives, New York Academy of Medicine. Centennial. Institute on Social Medicine [Correspondence and miscellaneous papers. New York, 1946–47. 26 letters and 16 miscellaneous items]. The meeting was sponsored jointly by NYAM's Committee on Medicine and the Changing Order and its Committee on Medical Information.

[22] George Baehr, "Foreword," in Iago Galdston (ed.), *Social Medicine: Its Derivations and Objectives* (New York, NY: Commonwealth Fund, 1949), v–vi.

[23] Galdston to Sigerist, March 28, 1947, SigH, 3.1R.

But his impact in US health policy had already waned and as Sigerist retired to Switzerland that year, he became increasingly disillusioned with both social and socialized medicine in the US and USSR, while Galdston in New York tried to find new futures for the field.[24]

Globalizing American Social Medicine

As they worked to theorize and foster social medicine in the US, Sigerist, Rosen, Galdston, and like-minded colleagues had gained substantial moral and financial support from the Rockefeller Foundation. In the first half of the twentieth century, the Foundation was the most important philanthropic institution for medical research and international health. Internal tensions between its two poles – reductionist biomedicine and social medicine – were pervasive.[25]

John D. Rockefeller established the Rockefeller Institute for Medical Research in 1901 but interests soon expanded from basic science to public health. The Rockefeller Sanitary Commission for the Eradication of Hookworm found partial success in the American South with programs that targeted doctors, schools, newspapers, and legislatures. This experience inspired the Rockefeller Foundation, founded in 1913, to establish its International Health Board (renamed the International Health Division in 1927) to pursue hookworm programs in other countries whose geographical reach meshed closely with changing forms of US imperialism.[26]

The International Health Division (IHD), with its mix of health workers, Christian charity, and public health interventions, soon expanded beyond hookworm to tackle tuberculosis, malaria, yellow fever, and other diseases of poverty.[27] It focused particularly on what would later be termed the social determinants of health in rural areas, from the American South to France, Eastern Europe, China, and India. The Rockefeller Foundation facilitated an international commerce in rural health expertise. It supported the work of Andrija Štampar, a socialist public health reformer, in Yugoslavia, and then sent him as an advisor to China. It sent another socially minded medical consultant, D. L. Hydrick, to Java to advise the Dutch on rural health. Victor Heiser, who led Rockefeller Foundation efforts in the US-occupied Philippines, used the opportunity to test theories of ecological intervention

[24] Iago Galdston, *The Meaning of Social Medicine* (Cambridge, MA: Harvard University Press, 1954), 1–30.

[25] Angela Matysiak, *Health & Well-Being: Science, Medical Education, and Public Health* (New York, NY: Rockefeller Foundation, 2014), 11.

[26] Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines* (Durham, NC: Duke University Press, 2006).

[27] John Ettling, *Germ of Laziness: Rockefeller Philanthropy and Public Health in the New South* (Cambridge, MA: Harvard University Press, 1981).

and race uplift.[28] As Laurence Monnais and Hans Pols describe in Chapter 4 in this volume, this Rockefeller vision of social medicine had a significant impact on the health programs of the League of Nations, especially as seen in the 1937 Bandung Conference.[29]

As Anne-Emanuelle Birn and Elizabeth Fee have shown, the IHD "befriended dozens of governments around the world by tackling diseases deemed to cause underdevelopment, helping build and modernize health institutions, promoting the importance of public health among countless populations, and preparing vast regions for investment and increased productivity."[30] It also helped found schools of public health across Europe, Asia, and the Americas. Birn and Fee describe how, by 1951, "the IHD had spent the current-day equivalent of billions of dollars on scores of hookworm, yellow fever, and malaria campaigns, as well as on more delimited efforts against tuberculosis, yaws, influenza, rabies, schistosomiasis, malnutrition, and other health problems in some 93 countries and colonies."[31]

Deep tensions ran through these programs. On the one hand, the Foundation supported reductionistic, "magic-bullet" approaches to public health.[32] Birn and Fee critique how its narrowly focused disease control campaigns "tended to be run with business-like efficiency: specific interventions were planned with measurable goals and results regularly reported to the central office, serving to hold field officers accountable as well as to quantify progress in quarterly reports reviewed by trustees, who were leading men from the worlds of medicine, education, and banking."[33] On the other hand, the Foundation (or at least factions within it) explicitly supported social medicine. Birn and Fee describe how the Rockefeller Foundation "diverged at times from its own principles, funding studies of universal health insurance and supporting certain social medicine efforts that integrated the sociopolitical conditions underlying health with overall public health work."[34] Birn later explained that "the RF remained tolerant and even intellectually open to alternatives to its techno-medical focus and afforded long-time RF officers the leeway and independence to pursue

[28] Anderson, *Colonial Pathologies*, 217.
[29] See also Amrith, *Decolonizing International Health*, 26–46; Patrick Zylberman, "Fewer Parallels than Antitheses: René Sand and Andrija Stampar on Social Medicine, 1919–1955," *Social History of Medicine* 17 (2004): 77–92.
[30] Anne-Emanuelle Birn and Elizabeth Fee, "The Rockefeller Foundation and the International Health Agenda," *Lancet* 381 (11 May 2013): 1618–19, quote at 1618. See also Matysiak, *Health & Well-being*, 11.
[31] Birn and Fee, "Rockefeller Foundation," 1618.
[32] Amrith, *Decolonizing International Health*, 18; Zylberman, "Fewer Parallels than Antitheses"; E. Richard Brown, *Rockefeller Medicine Men: Medicine and Capitalism in America* (Berkeley: University of California Press, 1979).
[33] Birn and Fee, "Rockefeller Foundation," 1618.
[34] Birn and Fee, "Rockefeller Foundation," 1619.

these interests, albeit under financial, time-horizon, and other constraints."[35] It provided funding for academic programs, for instance establishing the Institute of Human Relations, led by Milton Winternitz, at Yale University in 1929, designed "to bridge the gap between medical and social knowledge of human behavior," to create "clinical sociology" and medicine for the "whole person."[36] It supported Sigerist, Štampar, Ryle, and René Sand, who became Professor of Social Medicine at the University of Brussels in 1945.[37] It supported progressive public health programs in Latin America in the 1930s as part of US State Department efforts to counter growing German influence. And it collaborated with the League of Nations Health Organization on a series of social medicine projects.[38]

Rockefeller officials became key players in social medicine on a global stage. John Grant began his career working with the Rockefeller Sanitary Commission's campaigns against hookworm in North Carolina. He then studied public health at Hopkins. The Foundation sent him to China in 1921, where he worked for many years to support Peking University Medical College. He adapted ideas from European social medicine to design prevention campaigns there.[39] For instance, he worked with C. C. Chen to implement a sophisticated healthcare system for the rural villages in the Tinghsien region. He served for several years in India in the 1940s, introducing social medicine there through his work (with Sigerist and Ryle) on the Bhore Commission, and then through the establishment (via grants from Rockefeller Foundation) of professors of Preventive and Social Medicine at Indian medical colleges. He also supported the work of Sidney and Emily Kark in South Africa (see below and Chapter 9 by Abigail H. Neely in this volume).[40]

The Second World War disrupted this work. The Rockefeller Foundation, however, remained integrally involved in global social medicine. Many people with ties to the Foundation participated in the international health conference in New York City (NYC) in 1946 that led to the establishment of the

[35] Anne-Emanuelle Birn, "Philanthrocapitalism, Past and Present: The Rockefeller Foundation, the Gates Foundation, and the Setting(s) of the International/Global Health Agenda," *Hypothesis* 12 (2014):e8, doi:10.5779/hypothesis. v12i1.229: 6.

[36] Matysiak, *Health and Well-being*, 153; Harrison, "Indicating Health," 63; Dorothy Porter, "How Did Social Medicine Evolve, and Where Is It Heading?" *PLoS Medicine* 3, no. 10 (October 2006): e399, 1667–72; A. J. Viseltear, "Milton C Winternitz and the Yale Institute of Human Relations: A Brief Chapter in the History of Social Medicine," *Yale Journal of Biology and Medicine* 58 (1984): 869–89.

[37] Porter, "How Did Social Medicine Evolve"; Andrew Seaton, "The Gospel of Wealth and the National Health: The Rockefeller Foundation and Social Medicine in Britain's NHS, 1945–60," *Bulletin of the History of Medicine* 94 (2020): 91–124, at 99.

[38] Birn, "Philanthrocapitalism"; Porter, "How Did Social Medicine Evolve."

[39] Matysiak, *Health and Well-being*, 100; Socrates Litsios, "John Black Grant: A 20th-Century Public Health Giant," *Perspectives in Biology and Medicine* 54 (2011): 532–49.

[40] Litsios, "John Black Grant," 540–4; Seaton, "Gospel of Wealth," 102.

WHO in 1948. Rockefeller social medicine shaped the preamble of the WHO through the influence of Štampar, who served on the preparatory committee.[41] As Dorothy Porter has argued, the "international social medicine movement," stoked by the Foundation, "aimed to create a new social role for medicine in order to grapple with the epidemiological transition created by economic and social developments in the twentieth century."[42] With the establishment of the WHO, the Rockefeller Foundation wound down some of its own operations, for instance closing its IHD in 1951. However, it remained active in various ways. Some were narrow and technocratic, whether its support of Fred Soper's work on DDT and malaria eradication or its advocacy for family planning in the global south.[43] Other work preserved its interests in social medicine, especially its social medicine programs in India. Yet overall, there was less and less room for social medicine in the increasing economic rationality of international health in the 1950s.[44]

Excluded Voices

As social medicine developed in the United States, scholars and physicians of color were excluded from the field, despite having considerable expertise in what we would now call social medicine. Traditional histories of social medicine have perpetuated this by failing to recognize their contributions to the genealogy of social medicine. We must understand the structural processes by which minoritized voices (whether by race, sex, gender, or other markers of difference) have been systematically excluded from genealogies that emphasize its white men.[45]

The polymath W. E. B. Du Bois is an important starting point. In 1899, Du Bois published what is now recognized as a landmark study in sociological theory and method: a radically different take on "the Negro question" entitled *The Philadelphia Negro*. Du Bois drew on extensive, almost ethnographic, interviews with families in Black neighborhoods and a rich analysis of quantitative economic and demographic data. He showed how every aspect of African American life in the US was shaped by racism, segregation, and the legacies of slavery. He hoped that his scholarship would

[41] Amrith, *Decolonizing International Health*, 74.
[42] Porter, "How Did Social Medicine Evolve," 1668.
[43] Amrith, *Decolonizing International Health*; Mathew Connelly, *Fatal Misconception: The Struggle to Control World Population* (Cambridge, MA: Harvard University Press, 2010); Nancy Leys Stepan, *Eradication: Ridding the World of Diseases Forever?* (London: Reaktion Books, 2011).
[44] Amrith, *Decolonizing International Health*, 93.
[45] This section draws on Alexandre White, Rachel L. J. Thornton, and Jeremy A. Greene, "Remembering Past Lessons about Structural Racism: Recentering Black Theorists of Health and Society," *New England Journal of Medicine* 385 (2021):850–5.

fuel activism: it should "act as a spur for increased effort … and not as an excuse for passive indifference, or increased discrimination."[46] He followed this with his 1903 *Souls of Black Folk*.[47] Du Bois demanded that goals of social analysis must shift away from blaming social ills on those oppressed by economic or racial degradation. It should instead seek a more complex understanding of the myriad ways in which power relations shape everyday life and health outcomes.

Only recently has Du Bois's work been recognized as foundational for US sociology writ large and it deserves similar stature within social medicine.[48] Du Bois demonstrated that racial disparities in mortality from tuberculosis, "the most fatal disease for Negroes,"[49] were themselves a product of social forces: the racial disparities in health so evident in the streets of Philadelphia were the products of a social force, racism, rather than any inherent biological difference between the races. He detailed the pathways by which the health of middle-class, working-class, and unemployed Black Philadelphians alike were affected by the racial segregation of housing, economic opportunity, and access to healthy food and environments. Du Bois grounded his social theory in data visualization, charts, survey data, and careful statistical analysis. As he explained, to compare the health of White Philadelphia and Black Philadelphia was not only to view "side by side and in intimate relationship in a large city two groups of people, who as a mass differ considerably from each other in physical health," but to apprehend the social, economic, historical, and legal structures that produced racial disparities in health.[50]

By linking tuberculosis and other health inequities to these social forces, Du Bois extended his work to become a study of power relations, what we now term structural violence and racism, and the ways these become historically constituted inequalities. Du Bois painted a nuanced picture of communities that were further impoverished because of their disproportionate burden of illness. They suffered from inadequate housing made worse by landlords' refusals to repair racially segregated housing. This demonstrated both the general effects of living conditions on individual health and the specific, pervasive, and toxic role of racism as a structural and organizing social force.

Du Bois was not alone in this endeavor. Howard University's Kelly Miller produced detailed analyses of the pathways by which the sociology of racism – and not some predetermined biology of racial differences – determined the

[46] W. E. B. Du Bois, *The Philadelphia Negro: A Social Study* (Philadelphia: University of Pennsylvania Press, 1899).
[47] W. E. B. Du Bois, *The Souls of Black Folk* (Chicago, IL: A.C. McClurg & Co., 1903).
[48] See, e.g., Aldon Morris, *The Scholar Denied: W. E. B. Du Bois and the Birth of Modern Sociology* (Oakland, CA: University of California Press, 2015).
[49] Du Bois, *Philadelphia Negro*, 107. [50] Du Bois, *Philadelphia Negro*, 114.

stark health inequities between Black and white Americas.[51] Yet the work of Miller, Du Bois, and other Black scholars of race and health in the early twentieth century was largely sidelined by mainstream medical and scholarly journals. Instead, physicians and social scientists looked to figures like the University of Chicago's Robert Park to define the new field of American sociology and its health consequences. Park and his colleagues assumed that racial differences were fixed and health disparities therefore inevitable.[52]

Du Bois, Miller, and others forcefully insisted that Black people were not a "problem" to be explained or solved by social-scientific or medical expertise, but human beings deserving of full personhood. Yet their calls were ignored by (mostly white) physicians for far too long. That is not surprising, especially in a medical profession that routinely excluded Black physicians from membership in local, state, and national medical societies from Reconstruction until the era of Medicaid and Medicare.

Although W. E. B. Du Bois lived in Baltimore during the Sigerist years, we have found no evidence of the two meeting. When Sigerist attended the first NYAM Institute on Social Medicine in 1947 on the eve of his departure from Johns Hopkins, he had taught no Black physicians, historians, or sociologists while serving on the faculty. The school, which ran a segregated hospital, had to date categorically denied entrance to every applicant of African or African American heritage.

Social Medicine and Socialized Medicine in the Cold War

As advocates worked to revitalize social medicine in the US after the Second World War, they took the problem of race more seriously. This was, in part, an outgrowth of the field's new focus on urban health. Following the 1947 NYAM Institute for Social Medicine, organized by Galdston and Sigerist, NYC became an important center for US social medicine. One key figure was René Dubos.

Dubos, a French microbiologist, joined Oswald Avery's laboratory at the Rockefeller Institute in 1927. His work on enzymes produced by soil microbes led to the discovery of several antibiotics in the 1930s and 1940s. This work epitomized the "magic-bullet" tradition of biomedical science. However, Dubos's interests soon broadened to include the interplay between organisms and their environments. In 1952, he and his wife, Jean Dubos, published a

[51] Samuel Kelton Roberts, *Infectious Fear: Politics, Disease, and the Health Effects of Segregation* (Chapel Hill, NC: University of North Carolina Press; 2009); Lundy Braun, *Breathing Race into the Machine: The Surprising Career of the Spirometer from Plantation to Genetics* (Minneapolis, MN: University of Minnesota Press, 2014).

[52] Morris, *The Scholar Denied.*

history of tuberculosis.[53] While this book did not use the phrase "social medicine," it has been adopted as a work of social medicine. They saw the tuberculosis pandemic as the result of mismanaged industrialization and urbanization. Produced by social forces, tuberculosis could be addressed through social action: "We need to develop a new science of social engineering," Dubos concluded, "that will incorporate physiological principles in the complex fabric of industrial society."[54]

If *The White Plague* was a study of social disease, Dubos's 1959 *Mirage of Health* described social medicine as a space for exploring the relations of disease, medicine, and society. Dubos traced how enlightenment scholars pursued "a scientific philosophy of public health which emphasized complex relationships between social environment and the physical well-being of man."[55] The epidemics of cholera and tuberculosis in nineteenth century motivated communities to grant power to health departments "for the regulation of community life."[56]

Dubos influenced many New York physicians who would go on to shape the practice of social medicine. Walsh McDermott led clinical trials of antibiotics at New York Hospital in the 1930s and 1940s. He was drawn to the Navajo Reservation in 1952 because of the opportunities it offered to test new antibiotics for tuberculosis.[57] While there, he found that tuberculosis was the tip of the iceberg: antibiotics alone could not address the stark health disparities suffered by a community mired in rural poverty. He teamed up with Dubos in 1953 and 1954 to conduct health surveys of the Navajo. They found terrible problems with infant and child mortality, especially from diarrhea, pneumonia, and tuberculosis. Much of this burden of disease could be prevented by proper medical and public health systems. McDermott credited Dubos with envisioning a new model of medicine, a "hospital without walls" that would manage the "total health" of the population.[58] This became McDermott's healthcare experiment at Many Farms.[59]

[53] René Jules Dubos and Jean Dubos, *White Plague: Tuberculosis, Man, and Society* (Boston: Little, Brown, and Company, 1952).
[54] Dubos and Dubos, *The White Plague*, 228; see also vii–viii.
[55] René Dubos, *Mirage of Health: Utopias, Progress, and Biological Change* (New York, NY: Harper, 1959), 23.
[56] Dubos, *Mirage of Health*, 234.
[57] David S. Jones, "The Health Care Experiments at Many Farms: The Navajo, Tuberculosis, and the Limits of Modern Medicine, 1952–1962," *Bulletin of the History of Medicine* 76 (2002): 749–90; David S. Jones, *Rationalizing Epidemics: Meanings and Uses of American Indian Mortality since 1600* (Cambridge, MA: Harvard University Press, 2004).
[58] John Adair and Kurt W. Deuschle, *The People's Health: Medicine and Anthropology in a Navajo Community* (New York, NY: Meredith Corporation, 1970), 144.
[59] Walsh McDermott, Kurt Deuschle, and Clifford Barnett, "Health Care Experiment at Many Farms," *Science* 175 (January 7, 1972): 23–31.

McDermott's interest in community, ecology, and disease was influenced by others in the NYC medical scene at the time, including Galdston, Alexander Leighton, and Lawrence Hinkle. While McDermott and his team did not use the phrase "social medicine," their work was very much in that spirit. Many alums of the project applied its insights throughout their careers. Kurt Deuschle, for instance, worked at Many Farms from 1954 to 1960. This experience led him to reorient his career toward the emerging field of community medicine. He recognized that medical interventions required both technical knowledge and human considerations – a comprehensive, holistic approach to medicine, a "united effort by modern medicine and social science in the translation of technical knowledge into improved and expanded health services that are medically sound, economically feasible and capable of reaching entire communities."[60] He left Many Farms to become chair of the Department of Community Medicine at the new School of Medicine at the University of Kentucky (the first such department in the US).[61] At Kentucky, he continued to work to achieve Dubos's vision of a hospital without walls. In 1968, he moved to New York to lead community medicine at Mount Sinai Hospital and its new medical school.

Another New York hospital took a lead role in reimagining social medicine at an urban hospital. Montefiore Hospital had long focused on the social and community aspects of care delivery.[62] By 1950, Montefiore's director, Ephraim Bluestone, had founded the country's first explicit hospital-based program in social medicine. Interested in the social organization of medical practice and the social factors impacting care, he saw social medicine as a way of situating care in the community, both before and after hospitalization. The Division of Social Medicine oversaw the hospital's social work services, home care, a prepaid medical group practice, and relevant teaching and research.[63] As Bluestone explained in *Modern Hospital*, the social medicine division would

[60] Donald L. Hochstrasser, G. S. Nickerson, and Kurt W. Deuschle, "Sociomedical Approaches to Community Health Problems," *Milbank Memorial Fund Quarterly* 44 (July 1966): 345–59, quote at 346.

[61] Alan L. Silver and David N. Rose (guest eds.), "Urban Community Medicine: The Mount Sinai Experience Honoring the Work of Kurt W. Deuschle," *Mount Sinai Journal of Medicine* 59 (1992): 439–68.

[62] Victor W. Sidel, "Social Medicine at Montefiore: A Personal View," *Social Medicine* 1 (2006): 99–103; Dorothy Levenson, *Montefiore: The Hospital as Social Instrument, 1884–1984* (New York, NY: Farrar, Straus & Giroux, 1984). Ernest Boas (son of Franz Boas) directed the hospital in the 1920s. With Sigerist's support, he asked the Rockefeller Foundation in 1947 to fund a *Journal of Social Medicine*; the Foundation declined. See Dorothy Levenson, "The Origins of the Department of Social Medicine at Montefiore," *Montefiore Medicine* 5 (1980): 49; George Rosen, "In Memory of Henry Ernest Sigerist," *Bulletin of the History of Medicine* 13 (1958): 126.

[63] E. M. Bluestone, "Social Medicine Arrives in the Hospital," *Modern Hospital* 75 (August 1950): 59–62.

be the "conscience of the hospital … which will continuously draw attention to the human being as an individual during sickness and near-sickness, psychosomatically and in relation to his family and his environment, and which will care for him completely, comprehensively and continuously."[64] Any conscientious physician, he continued, must include the social world when thinking of a patient's history, physical examination, assessment, and therapeutic plan:

> The study of the signs and symptoms of disease is vital to the practice of medicine, but additional vital factors must be studied with equal diligence, such as the living quarters of the patient, his food, his family, the climate in which he lives (literally and figuratively), the way in which he makes a living, as well as the pressures, the resistances and the tensions that characterize his struggle for existence and survival.[65]

When Montefiore Hospital affiliated with the Albert Einstein College of Medicine in the 1960s, the Division became a Department of Social Medicine. Victor Sidel became its chair in 1969.[66]

Yet few schools or hospitals followed Montefiore's lead. Part of the problem was the ongoing politics of socialized medicine. As Bluestone lamented in *JAMA* in 1952, "'social medicine,' which is the finest flower of modern medical practice, has been tarred of late with the brush of 'socialized medicine.'"[67] Hubbard, quoted at the outset of this chapter, explained to international social medicine educators that US medical schools "avoided" the term, though he considered that in the "broad sense there is little difference between the meaning of preventive medicine in the United States and the meaning of social medicine."[68] Each, he related, "recognizes the relation between man and his environment; each implies the importance of social factors as they influence health."[69] But the Cold War was heating up and red-baiting reached to new heights.[70] The AMA furiously opposed President Truman's efforts to enact national health insurance, labeling it as a dangerous form of "socialized medicine." This limited the space in which proponents of social medicine could work.

The American Association of Medical Colleges (AAMC), meanwhile, turned to "preventive medicine," mandating its teaching at all US medical schools

[64] Bluestone, "Social Medicine Arrives," 60.
[65] Bluestone, "Social Medicine Arrives," 61.
[66] Sidel, "Social Medicine at Montefiore," 100–1. By 1985, the department would merge with the Department of Community Health to become the Department of Epidemiology and Sociology; by 2004, it would become the Department of Family and Social Medicine.
[67] E. M. Bluestone, "'Socialized Medicine' and 'Social Medicine' [Letter to the Editor]," *Journal of the American Medical Association* 148 (1952): 1358.
[68] Hubbard, "Integrating Preventive and Social Medicine," 514; see also George A. Silver and William Kissick, "A Social Medicine Residency Program," *Journal of Medical Education* 37 (1962): 1217.
[69] Hubbard, "Integrating Preventive and Social Medicine," 514.
[70] Levenson, "Origins of the Department," 52.

in 1945. Students were to consider: "the general and specific relationship of social environment on community and individual health; housing in relation to public health; the correlation of morbidity and mortality with low income; … the social order, its effect upon public health and practices, and its influence on the practice of medicine."[71] In this vision, preventive medicine could cover the ground of social medicine without the baggage of socialized medicine.

Social Medicine As Community Practice

As the AAMC pushed schools to adopt preventive medicine, other schools turned to "community medicine" instead. The movement had many origins. The most famous began in South Africa. Inspired by the work of Rudolf Virchow and Henry Sigerist, Sidney and Emily Kark established a health center for Black South Africans in Pholela, Natal, in 1940. This work was funded by the Rockefeller Foundation. The Karks recognized that it was necessary to change the social order to improve health. This required interventions at both the individual and community level.[72] As Neely describes in Chapter 9 in this volume, the clinic's success depended on the work of the women and other community members in Pholela.[73] After a 1942 National Health Services Commission recommended expanding their model across South Africa, the government opened 44 community health centers. However, the movement lost support after the 1948 elections cemented the ascension of the National Party and the establishment of the Apartheid regime. The community clinics, and the academic units that had supported them, had all closed by 1960.[74]

Though short-lived, the community-oriented social medicine developed in Pholela had a far-reaching legacy. While a medical student at Case Western in 1957, Jack Geiger traveled to South Africa and worked for four months with the Karks. Inspired by that experience, he dedicated his career to developing community health centers in the United States. Geiger studied with John Grant at the Rockefeller Foundation. He then completed his medical training in Boston

[71] H. S. Mustard, Jean A. Curran, Hugh R. Leavell, and Charles E. Smith, "Final Report of the Committee on the Teaching of Preventive Medicine and Public Health," *Journal of the Association of American Medical Colleges*, 20 (1945): 152–65, quote at 164.

[72] For a detailed description of their model, see Sidney Kark and Emily Kark, "A Practice of Social Medicine," in Sidney L. Kark and Guy W. Steuart (eds.), *A Practice of Social Medicine: A South African Team's Experiences in Different African Communities*, (Edinburgh: E&S Livingstone, Ltd., 1962), 3–40, reprinted in *Social Medicine* 1 (August 2006): 115–38.

[73] See Abigail H. Neely, Chapter 9, this volume. See also, Abigail H. Neely, *Reimagining Social Medicine from the South* (Durham, NC: Duke University Press, 2021).

[74] Mervyn Susser, Zena Stein, Margaret Cormack, and Michael Hathorn, "Medical Care in a South African Township," *Lancet* 268 (1955): 912–15; Shula Marks, "South Africa's Early Experiment in Social Medicine: Its Pioneers and Politics," *American Journal of Public Health* 87 (1997): 452–9.

and joined the faculties at Harvard and Tufts. Active in the civil rights movement, he worked on the "Freedom Summer" in Mississippi in 1964. He joined other physicians to establish the Medical Committee for Human Rights.[75] He pitched his plan for community health centers to the Office of Economic Opportunity (OEO), which had been created by the Economic Opportunity Act of 1964 as part of President Johnson's "War on Poverty." The OEO awarded its first grant, in June 1965, to Geiger and his colleague Count Gibson, to create two health centers. Geiger and Gibson opened the first in renovated apartments in the Columbia Point housing project in South Boston. Geiger opened the second in Mound Bayou, in Bolivar County on the Mississippi Delta.[76] Community members set the clinics' priorities. The clinics provided health education, prevention, and healthcare. They developed community partnerships to break the cycles of poverty, ill-health, and unemployment. The OEO funded six other community health centers in 1966.

Geiger's work in South Boston caught the attention of Massachusetts Senator Edward Kennedy, who visited Columbia Point in August 1966 and spent the afternoon speaking to staff, patients, and community leaders. Impressed by what he saw, Kennedy pushed through legislation to create the Office of Health Affairs within the OEO to create a national network of neighborhood health centers. Kennedy hoped that the $50 million in funding would establish 800 clinics and restructure the US healthcare system. Alice Sardell has called this attempt the only serious attempt to implement social medicine in the US.[77] Opposition from the Nixon and Ford administrations soon stymied progress; only 150 clinics were established.[78] The surviving clinics and neighborhood health centers struggle to maintain their commitment to community-centered healthcare within a larger healthcare system that does not prioritize community interests.

While Geiger is often identified as a foundational figure for community health in the US,[79] his was not the only model. Several minoritized communities also took matters into their own hands. For example, the Black Panther Party was established in 1966 to take a stand against police violence.

[75] Bonnie Lefkowitz, "The Health Center Story: Forty Years of Commitment," *Journal of Ambulatory Care Management* 28 (2005): 295–303; H. Jack Geiger, "The First Community Health Centers: A Model of Enduring Value," *Journal of Ambulatory Care Management* 28 (2005): 313–20; John Dittmer, *The Good Doctors* (Jackson, MS: University Press of Mississippi, 2017).

[76] Thomas J. Ward, *Out in the Rural: A Mississippi Health Center and Its War on Poverty* (New York, NY: Oxford University Press, 2016); Judy Schader Rogers, "Out in the Rural," film, 1970, at: https://vimeo.com/9307557.

[77] Alice Sardell, *The US Experiment in Social Medicine: The Community Health Center Program, 1965–1986* (Pittsburgh, PA: University of Pittsburgh Press, 1988).

[78] Lefkowitz, "The Health Center Story"; Geiger, "The First Community Health Centers."

[79] Denise Grady, "H. Jack Geiger, Doctor Who Fought Social Ills, Dies at 95," *New York Times*, December 28, 2020.

Its mission expanded to include community empowerment and social welfare programs. Party leaders argued that urban Black communities had been excluded from or abused by the healthcare system. They demanded access to care and "emancipation from 'medical apartheid.'"[80] They drew inspiration not from the traditional icons of social medicine, but from Mao Zedong, Che Guevara, and the Martinique-born French psychiatrist Franz Fanon, whose work documented the harms of colonialism and racism. The party established its first Peoples' Free Medical Clinics in 1968, in Kansas City, Chicago, and Seattle. In April 1970, party president Bobby Seale called on all party chapters to open their own clinics.

By 1971, the Panthers had established a network of thirteen health clinics nationwide. In Alondra Nelson's telling,

> the Party brought to the efforts of the radical health movement its own social health perspective. This agenda, reflecting the formative influence of the social medicine tradition, assumed a holistic view of disease and illness and incorporated antiracism, Marxist-Leninist ideology, and a critique of medical authority. Conceived as sites of social change, Party medical clinics attended to more than just narrowly defined health needs.[81]

A parallel movement of Latinx activism, most evident in the work of the Young Lords, also pursued a radical vision of community health. They commandeered health services, including a brief takeover of a New York hospital, to demand healthcare that prioritized community needs.[82] These health revolutionaries faced a difficult choice: to rely on the community's own expertise (since doctors were part of the problem/system) or to accept allies from within a healthcare system dominated by white doctors and nurses.

These "bottom-up" radical community health campaigns also carefully negotiated federal and state efforts to establish neighborhood health centers and alternately depended on and critiqued the limitations of existing antipoverty measures, such as the "ghetto medicine" programs of the late 1960s. The state of New York, for instance, enacted a "Ghetto Medicine Law" in 1968 that made funds available for academic medical centers to provide care to minoritized residents in nearby neighborhoods.[83] These partnerships struggled to overcome long-standing mistrust that was often made worse by the programs' limited and short-term funding.

[80] Alondra Nelson, *Body and Soul: The Black Panther Party and the Fight against Medical Discrimination* (Minneapolis, MN: University of Minnesota Press, 2011), 20.
[81] Nelson, *Body and Soul*, 114.
[82] Joshanna Fernandez, *The Young Lords: A Radical History* (Durham, NC: University of North Carolina Press, 2020).
[83] Betsey J. Bernstein, "What Happened to Ghetto Medicine In New York State?" *American Journal of Public Health* 61 (1971): 1287–93.

Harlem became an iconic site for both demonstrating the health disparities of the "medical ghetto" and for imagining solutions to resolve them. In their time working with the Navajo, McDermott and Deuschle had come to see the Navajo Reservation as a "Third World country within the United States," underdeveloped economically, socially, and medically.[84] When Deuschle arrived in NYC to establish community medicine at Mount Sinai, he saw a similar situation in Harlem.[85] Deuschle sought ways to provide appropriate medical technology in ways that would benefit the community. He found a key ally in Carter Marshall, an African American physician and East Harlem resident. Marshall envisioned a neighborhood health program that would stretch directly from Mount Sinai Hospital into Harlem's public housing. He used cable television technology to establish a video link between the Wagner Homes Projects and the hospital. "There are two ways you can look at problems that involve the delivery of health services," Marshall told the *New York Times*. One of them was to fix the structure of the healthcare system itself. The other was to use technology to circumvent these fundamental problems. "Our interest here," he continued, "is how we can adapt technology to the delivery of health services, regardless of the organizational framework."[86]

Marshall, whose *Dynamics of Health and Disease* placed health in its social contexts, joins Du Bois as an underrecognized African-American theorist of social medicine.[87] Yet despite writing more than 400 pages that documented the social determinants of disease, he scarcely mentioned the term "race" and did not use "racism" once. Later scholars faced substantial pushback when they tried to make racism a valid category of academic analysis. When David Williams conducted his far-reaching Detroit Area Study in the 1990s, a pioneering work of health disparities research, he likewise faced critics who argued that racism could not be measured and was not a valid subject for public health or medical research.[88]

Social Medicine As an Academic Field

After the establishment of social medicine as a division at Montefiore Hospital and community medicine as a department at Mount Sinai, two other medical

[84] Kurt Deuschle, "Cross-Cultural Medicine: The Navajo Indians as Case Exemplar," *Daedalus* 15 (1986): 175–84, quote at 176.

[85] Hugh S. Fulmer, Anthony C. I. Adams, and Kurt W. Deuschle, "Medical Student Training in International Cross-Cultural Medicine," *Journal of Medical Education* 38 (1963): 920–31.

[86] "Child Clinic Gets Physicians via TV: Mt. Sinai Doctors Examine Patients in East Harlem," *New York Times*, June 6, 1973, p. 94.

[87] Carter L. Marshall, *Dynamics of Health and Disease* (New York, NY: Appleton-Century-Crofts, 1972).

[88] David R. Williams and Michelle Sternthal, "Understanding Racial–Ethnic Disparities in Health Sociological Contributions," *Journal of Health and Social Behavior* 51, suppl 1 (2010): S15–27.

schools in the United States established academic departments of social medicine in the 1970s and 1980s: Harvard Medical School (HMS) and the University of North Carolina (UNC).[89] These demonstrated diverse visions of what social medicine was or could be.

When HMS inaugurated its Department of Preventive and Social Medicine in 1971, it built on a century of work under the mantle of hygiene and then preventive medicine. The school had periodically offered lectures on social medicine but had no formal programs under that name. Political unrest in the 1960s, and especially the assassination of Martin Luther King, Jr. in 1968, prompted Dean Robert Ebert to rethink the long-standing Department of Preventive Medicine and the relationships between medicine and society. A faculty committee deemed that "Preventive Medicine" had become an "anachronism."[90] It preferred "Social Medicine," explaining that the societal upheaval and self-reflection of the previous decade had made it important not only to teach anatomy, pathophysiology, and diagnostics to medical students, but "something of the anatomy, physiology, and even pathophysiology of the medical care system of which they will soon become a part."[91]

Wanting to broaden the mandate to include "the relationship of medicine to society as a whole," HMS initially grafted "Social Medicine" onto its Department of Preventive Medicine in 1971.[92] Students pushed for more and demanded that they be prepared for careers of social and political activism: "Where alleviation of a health problem requires political action, as in housing and lead poisoning, some physicians must be prepared to participate effectively in the political process."[93] HMS respected this vision. Ebert recruited pediatrician Julius Richmond, whose career moved back and forth between government and academia, to be the inaugural chair.[94] Conceptions of social medicine itself also shifted, with a growing interest in bioethics

[89] University of California San Francisco (UCSF) established its Department of History, Anthropology, and Social Medicine in 1998 by merging long-existing programs in history and anthropology; it never developed the social medicine component. See "History of the Department of History & Social Sciences," University of California San Francisco, 2022, at: https://humsci.ucsf.edu/history-department-history-social-sciences.

[90] "Minutes of Meeting of Ad Hoc Committee on Department of Preventive Medicine, 7/16/69," p. 5, in Box 31, ff 5, HMS Archives 00154.

[91] Charles Lewis, "Why Social Medicine?" p. 4, Box 31, ff 5, HMS Archives 00154; "Minutes of Meeting of Ad Hoc Committee on Department of Preventive Medicine, 7/16/69," p. 6, in Box 31, ff 5, HMS Archives 00154.

[92] "Report of the Ad Hoc Committee on the Future of the Department of Preventive Medicine," pp. 3, 8, Box 31, ff 5, HMS Archives 00154.

[93] Don Berwick, Howard Graves, Mark Chassin, Gordon Mosser, David Calkins, Bob Kirkman, Diana Petitti, and Andy Vernon, "Teaching of Preventive and Social Medicine at Harvard Medical School," p. 6, March 1972, Box 31, ff 1, HMS Archives 00154.

[94] Richmond had initiated Project Head Start and would later be recruited to become Surgeon General.

and the medical humanities.[95] A new dean, Daniel Tosteson, finally split the department in 1980 into the Department of Preventive Medicine and Clinical Epidemiology and the Department of Social Medicine and Health Policy, chaired by psychiatrist Leon Eisenberg.[96] That department, in turn, split – in 1990 – into two separate departments of Social Medicine and of Health Policy. Under the leadership of Eisenberg and then Arthur Kleinman, social medicine at Harvard adopted an academic orientation, focused on "the social sciences basic to medicine," especially anthropology, sociology, history, and economics. Its faculty pursued studies of the social production of disease, the social meanings of disease, and the social responses to disease.

A similar vision developed in parallel at the University of North Carolina. As early as the 1920s, sociologists at UNC had studied the health outcomes of the South's economic and social problems.[97] The Department of Epidemiology hired both Rosenau (who had retired from Harvard in 1946) and John Cassel, who had worked with the Karks in Pholela. When UNC upgraded its medical school in 1952, it established the Department of Preventive Medicine, led by Cecil Sheps. Sheps had studied social medicine with Rockefeller's John Grant.[98] This department taught epidemiology and preventive medicine to medical students and supported research in social and community medicine.

In the 1970s, UNC implemented reforms to foster community medicine, family medicine, and hospital administration. These were reorganized in 1980 as the Department of Social and Administrative Medicine. Glenn Wilson, who led the department, argued that "the best science and technology in the world will be of little value if it is applied without an understanding, or with misunderstanding, of the social situations of those it aims to benefit."[99] His successor, Donald Madison, articulated a vision of social medicine that included five

[95] Dieter Koch-Weser, "Present and Desirable Activities of the Department of Preventive and Social Medicine," addressed to Deans Adelstein, Federman, Meadow, Spellman, and Tosteson, 7/24/78, Box 53, "Preventative and Social Medicine, 1977–1981," HMS Archives 00154. See also: Jeremy A. Greene and David S. Jones, "The Shared Goals and Distinct Strengths of the Medical Humanities: Can the Sum of the Parts Be Greater than the Whole?" *Academic Medicine* 92 (2017): 1661–4.

[96] "Departmental Fission" [In "The Dean Reports"], *Harvard Medical Alumni Bulletin* 54 (December 1980): 2; "Two New HMS Departments Created from Partition of Preventive & Social Medicine," *Harvard Medical Area Focus*, 10/23/80, pp. 6–7.

[97] Donald L. Madison, "Introduction," in *Social and Administrative Medicine, 1987–1988* (Chapel Hill, NC: Department of Social and Administrative Medicine, University of North Carolina at Chapel Hill, 1988), 1–3, at: www.med.unc.edu/socialmed/about/department-field/.

[98] Donald L. Madison, "Introduction: Where Medicine and Society Meet," in *Social Medicine, 1998* (Chapel Hill, NC: University of North Carolina, Chapel Hill, 1998), 7–18, at 8, 10, at: www.med.unc.edu/socialmed/about/department-field/.

[99] I. Glenn Wilson, "From the Chair," in *Social and Administrative Medicine, 1987–1988* (Chapel Hill, NC: Department of Social and Administrative Medicine, University of North Carolina at Chapel Hill, 1988), 4–7, quote at 6. Wilson offered UNC's expansive definition of social medicine:

ideas – community, political action, organization of healthcare services, prevention, and epidemiology – with attention to the social sciences and humanities more broadly.[100] Social medicine would, by necessity, be "a polyglot admixture."[101] The faculty showcased its vision by producing a series of social medicine readers.[102]

Yet many of the most important developments for the field again took place outside academic medicine. In the 1970s and 1980s, Black feminist theorists Audre Lorde and Kimberlé Crenshaw demonstrated how socially inscribed forms of difference such as race, class, gender, and sexual orientation did not inhabit separate planes. These forces, instead, intersected in powerful and synergistic ways. Understanding intersectionality is crucial to elucidating how power relations produce social disparities. These perspectives have now become part of the basic toolkit for understanding health disparities. Not only did mainstream medicine fail to acknowledge their contributions for decades, but genealogies of social medicine have continued this erasure as well.

Social Medicine at the Bedside: Resurgence and Persistence in Twenty-First-Century American Medicine

Despite its small institutional footprint in the 1990s, at just Mount Sinai, Harvard, and UNC, and despite the ongoing political liability of "socialized medicine," the idea of social medicine has remained alive in the US. Clinicians have repeatedly been drawn to its theories and practices as they sought solutions to health threats facing their communities. Just as tuberculosis, the "social disease," had motivated social medicine theorists in the nineteenth and twentieth centuries, HIV/AIDS demanded social medicine in the late twentieth century.

When Paul Farmer, then a young medical student, first traveled to work in rural Haiti, he struggled – like so many before him – to imagine how to provide healthcare for people living in rural poverty. Trained in Harvard's mode of medical anthropology and biosocial analysis, he offered diagnoses of structural violence and social suffering.[103] For treatment, he turned to liberation

> Nearly every sector of society has has [*sic*] some influence upon our understanding of illness, disease and health. All human activity – art, literature, theatre, cultural symbols, history, the economic system, the system of government, the moral values, the entire way of life of a people – contributes to the understanding of health, illness, and the role of the physician.

[100] Madison, "Introduction," 11. [101] Madison, "Introduction," 12.

[102] Gail Henderson, Nancy M. P. King, and Ronald P. Strauss (eds.), *The Social Medicine Reader* (Durham, NC: Duke University Press, 1997). Revised editions have been published in 2005 and 2019.

[103] Paul Farmer and Arthur Kleinman, "AIDS as Human Suffering," *Daedalus* 118 (Spring 1989): 135–61; Paul Farmer, *AIDS and Accusation: Haiti and the Geography of Blame* (Berkeley: University of California Press, 1992); Paul Farmer, "On Suffering and Social Violence: A View from Below," *Daedalus* 125 (Winter 1996): 261–83.

theology's call for a preferential option for the poor. He argued that physicians must not blame poor people for their plight. Instead, physicians had a moral obligation to develop programs that could provide them with care and work toward health equity. He teamed up with like-minded health activists and philanthropists to found Partners in Health (PIH) in 1987. PIH began by creating health services based around community health workers and accompaniment, an idea adopted from liberation theology and Latin American social medicine.[104] But simply bringing medical care to individuals was not enough. PIH addressed its patients' social and economic needs by providing food, housing, and education. It intervened against global health policy to challenge the logics of cost-effectiveness analysis and drug pricing to change what was possible for healthcare for the poor. And it has worked with governments to pursue health systems strengthening in order to ensure that the needed space, staff, stuff, and systems are available.[105]

PIH was not alone in this work. The call to take social suffering seriously drew in scholars who had worked in many parts of the world.[106] Nancy Scheper-Hughes, for instance, authored a devastating ethnography of urban poverty in Brazil.[107] She and Farmer became leaders of the new movement of critical medical anthropology that called on anthropologists to intervene to aid the communities they studied. In the 2010s, two scholars in the next generation of MD–PhD social scientists, Helena Hansen and Jonathan Metzl, formulated "structural competency."[108] They argued that social medicine had to be a basic component of medical education so that physicians could recognize – and engage with – the structural forces that determine who gets sick and who gets access to care. Another group linked analyses of structural violence and a commitment to health equity to build a global community of healthcare provider–activists, the Social Medicine Consortium (SMC).[109] Established in 2015 by Michele Morse and Michael Westerhaus, the SMC offers a new definition of social medicine: social medicine is what happens when medicine commits itself to social justice and health equity.

Recent decades have seen a resurgence of social medicine at places old and new. The group at Montefiore founded the journal *Social Medicine* in 2000.

[104] Heidi L. Behforouz, Paul E. Farmer, and Joia S. Mukherjee, "From Directly Observed Therapy to Accompagnateurs: Enhancing AIDS Treatment Outcomes in Haiti and in Boston," *Clinical Infectious Diseases* 38, suppl 5 (2004): S429–36.

[105] Paul E. Farmer, *Fevers, Feuds, and Diamonds: Ebola and the Ravages of History* (New York, NY: Farrar, Straus and Giroux, 2020).

[106] Arthur Kleinman, Veena Das, and Margaret Lock, *Social Suffering* (Berkeley: University of California Press, 1997).

[107] Nancy Scheper-Hughes, *Death without Weeping: The Violence of Everyday Life in Brazil* (Berkeley: University of California Press, 1992).

[108] Jonathan M. Metzl and Helena Hansen, "Structural Competency: Theorizing a New Medical Engagement with Stigma and Inequality," *Social Science and Medicine* 103 (2014): 126–33.

[109] Social Medicine Consortium, at: www.socialmedicineconsortium.org/.

The City University of New York (CUNY) Medical School has founded a Department of Community Health and Social Medicine.[110] The Department of Medicine at UCSF founded a Social Medicine Core.[111] Berkeley established a Center for Social Medicine in 2013.[112] The University of California Los Angeles (UCLA) opened a Center for Social Medicine and Medical Humanities in 2015.[113] Johns Hopkins founded its Center for Medical Humanities and Social Medicine in 2017.[114] Zuckerberg San Francisco General Hospital established a social medicine program in 2017.[115] Columbia University started the Division of Social Medicine and Professionalism in 2018.[116] The activity across different geographies and institutions suggests that "social medicine" still has useful work to offer in motivating progressive commitments to social justice and health equity.

This resurgent interest in social medicine has been invigorated and validated amidst the pandemics of the present. The Covid pandemic may have been caused by a new virus, but it echoed old analyses of tuberculosis in the nineteenth century and AIDS in the 20th. Covid struck hardest at the most vulnerable, revealing deep fault lines in American society and profound failures in our systems of care and caregiving. The murder of George Floyd a few months

[110] "Community Health and Social Medicine Department," CUNY School of Medicine, at: www.ccny.cuny.edu/csom/communityhealthandsocialmedicinedept.

[111] "Social Medicine Core," UCSF Hospital, Department of Medicine. "The goal of Social Medicine Core is to develop a group of DHM faculty and staff to engage in dialogue, identify gaps, and design solutions around issues of equity, advocacy, diversity, and inclusion that impacts our patients, learners, and ourselves," at: https://ucsfhealthhospitalmedicine.ucsf.edu/social-medicine-core. It was established "Years ago": "Message from the Chief – August 2020," at: https://ucsfhealthhospitalmedicine.ucsf.edu/about-us/message-chief#Message-from-the-Chief--August-2020.

[112] Berkeley Center for Social Medicine, "About," University of California, Berkeley, available at: https://issi.berkeley.edu/centers/bcsm/about-bcsm:

> Founded in 2013, BCSM links to the discipline of social medicine internationally by bringing together Bay Area scholars from the social and historical sciences who are working on questions related to medicine, the health sciences, public health, global health, the social structuring of suffering, violence and the body. BCSM brings together faculty and students with expertise in the social sciences of health from across campus and beyond, primarily from the fields of medical anthropology, medical sociology, medical history, and critical public health. The Center promotes research, interdisciplinary writing and publication, graduate and undergraduate training, as well as conferences, colloquia and other events that engage broad publics.

This program "critically engages the intersection of social systems, social difference, health and health care in the United States and across the globe."

[113] Center for Social Medicine and Medical Humanities, UCLA, at: https://socialmedicine.semel.ucla.edu/.

[114] Center for Medical Humanities & Social Medicine, at: https://hopkinsmedicalhumanities.org/.

[115] Natalia Gurevich, "SF General Treats Patients by Considering 'Whole Life Story'," *San Francisco Examiner*, May 20, 2024 (updated May 23, 2024).

[116] Division of Social Medicine and Professionalism, Department of Medical Humanities and Ethics, Columbia University, at: www.mhe.cuimc.columbia.edu/division-social-medicine-and-professionalism.

later made visible once again the bodily costs of another, intersecting pandemic of structural racism. Social medicine had much to offer as physicians worked toward solutions of both sets of problems.

But social medicine has a complex legacy in the US, simultaneously marginal and vibrant, at both elite medical centers and neighborhood clinics. It remains a field in flux. If early twentieth-century American social medicine was not as egregiously racist as its Australian counterpart (see Anderson, Dunk, and Musolino, Chapter 12 in this volume) it has nonetheless had a mixed tracked record, both eliding or drawing attention to racism as a social driver of health and illness. In contrast to Norway or the UK (see Kveim Lie and Haave, Chapter 6 in this volume), in which the state played a central role in defining social medicine, American social medicine practitioners tended to see themselves as operating from the margins: social medicine picked up where the state left off. This definition, however, has allowed subsequent iterations of American social medicine to elide and ignore those unsavory histories where medically informed social policy *was* picked up by the state, especially with the eugenics movement.

Adherents of social medicine today – as in the 1940s – remain divided over the relationship of social medicine to politics. On the one hand, it could be apolitical: a set of empirically justified theories and practices – a basic science of medicine – that all physicians should understand. On the other hand, it is deeply political, led by its social analyses to call for the fundamental restructuring of healthcare, and of society more broadly. It is a mode of academic analysis and a call for engagement through medical and political action.

Yet it is not clear that social medicine needs to resolve its internal inconsistencies to be relevant. Throughout the variety of forms it has taken over the past century, social medicine in the United States has remained a field that is not easily intelligible to those who do not already consider themselves to be part of it. Perhaps too many people simply do not know what the term "social medicine" means for it to have become a commonplace term. Perhaps too many still hear social medicine as "socialized medicine." Despite these obstacles, the basic ideas of social medicine have repeatedly resurfaced and been developed and deployed by physicians working in many settings – and their patients have benefited. The most essential challenge lies in translating the relevance of the work that social medicine *does* in a world of unequal health and steep social disparities into the critical and clinical tools that it can provide to future generations.