Reflections on 150 (or even just 30) Years of Social Medicine

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As Global Health and Social Medicine celebrates its 150th anniversary, I will soon celebrate my own 30th anniversary in the department. I first entered the Department of Social Medicine (DSM) in September 1993 as a student in Robert Martensen's course on the Social History of Medicine. I had been a History and Science major as an undergraduate but had done no work in history of medicine; Allan Brandt had been away at UNC for most of my time in college. I met Allan briefly when he returned to Harvard, and he encouraged me to take Rob's course. At that time, Harvard Medical School (HMS) required its students to take one "selective" from a suite of offerings in social medicine. The most popular course by far was medical ethics. But there were also courses on law, literature, health policy, and medical anthropology. Paul Farmer was beginning to loom large in student consciousness. I first heard him discussed as a semi-mythic character who lived in a rectory in Roxbury, having dedicated everything he had to build a clinic in Haiti. Paul soon developed a devoted following among HMS students; the courses he offered quickly rivaled the enrollments of medical ethics. History of medicine didn't generate quite as much buzz: Rob's course that fall drew just four students.

The course, however, was fascinating (and two of the four students—Scott Podolsky and I—are now professional historians). Following a model developed by Allan, Rob presented us with a series of problems that demonstrated how the legacies of history remain very much alive in medicine today. Rob suggested a topic for my research paper, about controversies that ensnared the first randomized clinical trial of coronary artery bypass grafting in 1977; this would, much later, become my first significant publication. Rob hired me as his research assistant that summer, enticing me away from a spot with Paul Epstein and Eric Chivian in their newly established Center for Health and the Global Environment at HMS. Rob had been hired as a consultant by President Clinton's Advisory Committee on Human Radiation Experiments to help understand what had happened during this Cold War binge in human experimentation. This was exciting work that inspired me to apply for a PhD in History of Science.

But what had really captured my interest was the department itself. DSM was very much on the margins of HMS, geographically, institutionally, and intellectually. It was then housed in its pre-renovation warren of twisting hallways and back stairways. It did not convey a sense of accessibility to HMS students, most of whom had no idea where or what the department was. However, anyone who did walk through the front door found a vibrant intellectual alternative universe. Leon Eisenberg strategically located his office near the main entrance, and he was always in it. He would invite me (and everyone else) into his office for conversation. While he seemed to me to be a kindly grandfather, I suspect he was scoping me out to see what potential I might have and making sure that he imprinted his powerful moral and scholarly commitments onto me.

The deep collaboration between history and anthropology was also striking. For me, this remains the intellectual core of social medicine. The methods of the two fields are distinct: the experience of ethnography, of inserting yourself into a community for participant observation, is radically different from a historian's monastic work in an archive. At DSM, however, the two groups asked the same questions. In the mid-1990s, the faculty framed this as the three pillars of social medicine: the social production of disease (who gets sick, and why), the social meanings of disease (especially questions of responsibility and stigma), and the social responses to disease (who gets treatment, and why). The faculty shared a deep commitment to forging these disciplines, and their distinct methodologies, into a form of biosocial analysis that could guide health care delivery to address health inequities and bend the arc of history towards social justice.

Shared scholarly interest in these vital questions knit DSM into a dynamic scholarly community. I could attend a department colloquium, crowding around the dark wood table in the second-floor seminar room, and witness shared intellectual commitments and profound dialogue regardless of the speaker's topic or methods. Even though HMS required its students to take just one selective, I was intrigued by DSM's world and took three (in history, literature, and ethics); I audited a fourth, Paul and Jim Yong Kim's course on poverty and disease that introduced legions of students to the work of structural violence, health equity, and social justice. When I signed on to study history of medicine with Allan Brandt for my PhD, it was simply assumed that I would study medical anthropology as well. Arthur Kleinman welcomed me into his circle. These interdisciplinary experiences were transformative.

In my time in the department as a student, it became clear that social medicine was not simply a scholarly pursuit. The faculty engaged with the here-and-now, with national and global health policy, and with the lives of their patients. After years spent trying to maintain detached objectivity, Allan chose to help the Justice Department in its fight against the tobacco industry. His work had a decisive impact on the Judge Gladys Kessler's finding that the industry was indeed guilty of racketeering. Arthur, Byron Good, and Mary-Jo DelVecchio Good hosted mental health fellows each year from China and Africa. Their alums would often come back to visit, having taken on major leadership roles in their home countries. I remember well the excitement that accompanied the publication of the 1996 World Mental Health: Problems and Priorities in Low-Income Countries, a book that decisively put mental health on the agenda of global health.

Paul and Jim, meanwhile, continued to build Partners in Health into a global force. While I was not involved directly in that work, I could not help but be excited by their successes, and those of my many classmates who worked with them, including Sonya Shin and Keith Joseph. They regaled us with stories of their adventures smuggling antibiotics into Peru, or of their dramatic confrontations with WHO officials at the now-famous 1998 meeting at the American Academy of Arts and Sciences. This work set the stage for the global advocacy that finally convinced health officials in the United States and WHO to commit seriously to treating both MDR-TB and AIDS.

By the time that I graduated in 2001, there was no doubt that DSM, even if on the geographic margins of HMS, was at the center of vital work in the social sciences and in global health care delivery. Its faculty linked cutting-edge scholarship to engaged action at local and global scales. They prioritized accompaniment and caregiving with individual patients worldwide even as they rewrote global health policies. Even though I've sometimes felt like a bystander as a historian who observes without participation, Leon, Arthur, Jim, and Paul always showed unfailing support for historical analysis as a key tool for social medicine. As Paul would say to any audience, we must look around at our contexts and look behind at our history to achieve the comprehensive understanding that will make action for social justice successful. The draw of this vision was irresistible. I followed the examples of my mentors to pursue a career in both history and psychiatry, and I still try to meet the high expectations they set. I can easily picture Leon sitting at his office desk, proud of the community he built.