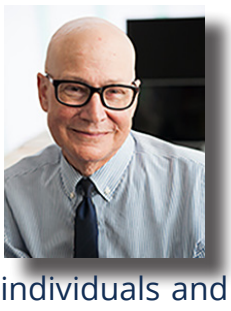
Reflections at 150
Allan M. Brandt
January 30, 2022



As a longtime member of the Department of Global Health and Social Medicine, I have found our 150th anniversary of social medicine at Harvard Medical School a time for celebration, reflection, nostalgia, and recommitment. As an historian, I have found in our seminars and discussions an opportunity to examine continuity and change in approaches to understanding the social determinants of health and disease, the social meanings of disease and health disparities, as well as the nature of suffering and how societies respond to individuals and populations. Over the years, these have constituted essential elements for defining and understanding social medicine, problematizing causality, and caring in response to suffering and inequity.

When I joined the department in 1982 (with a dissertation not yet defended), I had only a cursory sense of the possibilities of social medicine for analysis and advocacy. Having written a dissertation on the history of sexually transmitted diseases, I soon learned that some thought that "social medicine" was considered a euphemism for venereal disease clinics. My grounding in the history of social medicine was superficial, at best. Nonetheless, my reading for the dissertation had included important observers and commentators of social forces on the history of disease. These included Rene Dubos, Henry Sigerist, Erwin Ackerknecht, and George Rosen, among others. Especially influential were more recent works by Charles Rosenberg and Arthur Kleinman. In preparation for my interview for the position, I had discovered the Eisenberg, Kleinman, and Good classic paper on the distinction between illness and disease. My doctoral work had focused on the anomalies of germ theory and the problems of the biomedical model of disease, the impressive and elegant systems that marginalized a wide range of social determinants and deep contextual, structural forces in the production of disease.

Upon my arrival at 641 Huntington, Leon Eisenberg asked me to prepare a "selective" course on the history of medicine for 1st year HMS students. This was something of a daunting task for a new assistant professor, especially since I understood that this would be considerably different from my brief experience teaching undergrads in a history department. I quickly decided that running a longitudinal course that developed a narrative from Hippocrates to the Harvard Community Health Plan would be doomed from the start. But more importantly it would make it difficult if not impossible to direct attention to some of the fundamental questions and values at the heart of social medicine. So, I decided to take up key issues that would avoid a triumphalist narrative and provide a chance to explore fundamental questions in the history of health and disease. Among my goals was to construct a series of sessions that emphasized the social context of understanding and treating disease, problems of causality and outcome, context, and contingency. Above all, I sought to emphasize the materiality of disease and suffering, not just it's meanings, or the significance of new scientific explanations that pitched to the present. Sessions centered on the history of patterns of disease, the patient-doctor relationship and shifts in professional authority, the character of therapeutics, the distinctions between clinical care and population health, and death and dying.

I was advised to only have "moderate" reading assignments, as the medical students might have other "priorities" in their first year, at a time when long lectures and extensive memorization characterized the pre-pathways curriculum. One advantage in those days was that the social medicine selectives were among the only courses where students were actually invited to participate rather than just be interrogated (pimped) about arcane facts. I found that a useful strategy was to pair primary source literature with a historical or anthropological assessment. Reading medical essays from the mid-19th century with care and attention provided important reminders of the problems faced by patients and physicians. We examined what was particular to these times, but also deeper transhistorical aspects of the experience of uncertainty and illness. The goal was to identify with these actors, rather than to dismiss their knowledge and practices as primitive and ignorant.

In the course, we read some classic texts (abridged!) in the wider arc of social medicine. These included excerpts from Rene Dubos, The Mirage of Health; John Berger, A Fortunate Man; Susan Sontag, Illness as Metaphor, all with the aim of putting these books into a deeper historical context of the role and character of medicine.

Among the most important reading for me at that time was Thomas McKeown's The Role of Medicine: Dream, Mirage, or Nemesis. This was a critical work since it so explicitly and powerfully disturbed common understandings of the rise of scientific medicine and its efficacy through the use of historical demographic and epidemiological data. But as a result, I assigned it with some degree of trepidation. First year students, I reasoned, did not come to medical school (especially HMS) to be told by a new PhD in American history that the medical science that they would be learning is largely beside the point; that the major changes in health and disease were not the result of medical interventions, but rather changes in social conditions, especially nutrition and reproduction; that the major decline in tuberculosis occurred long before the discovery of the bacillus and the advent of effective therapeutics.

I often centered attention on a question that McKeown largely elided; namely, if medical care and treatment were marginal factors in accounting for health and longevity, what in fact was the role of the medicine? How did therapeutics work in the past? Why did those who suffered seek the care of expert healers? What was the character of trust in this complex interaction? The point that students often brought to this discussion centered on caregiving regardless of norms of efficacy; there was always something that could be done, even for patients in the most dire circumstance. They learned that to call this the placebo effect was but a trope of contemporary biomedicine.

Although there remains much to admire in McKeown, there was also much that was highly problematic. As many critics (some among us) have pointed out, he inadequately addressed the critical role that public health reforms had played in extending health, and, perhaps most notably, he rejected the value of medical interventions at the very moment that their therapeutic promise might ultimately be realized. To insist on social determinants in a way that largely ignored and diminished biomedical innovation created a false dichotomy that was misleading, if not dangerous.

These were critical issues that my students effectively and articulately brought to light. It was, I found, McKeown's Role of Medicine, with its insights and its errors, that often generated the clearest discussion of the potential of social medicine, which demanded the interconnection of the social determinants of health and disease; delivering effective and essential medicines and therapeutics; and conscientious caring. In this orientation to social medicine, the historical tensions between medicine and public health became all but meaningless. Social medicine would draw on the full array of possibilities for expanding health for individuals and populations.

Much has changed in how we account for social medicine. The work done by members of our department, my colleagues and friends, as well as so many gifted and committed students, has deeply enriched the possibilities and impact of social medicine. At the same time, many of the essential questions, themes, and values have been deeply consistent over time and continue to animate our work today in caring for those most in need; in recognizing the winning combination of healthy environments and high-quality care; and in reducing the wide disparities in health to assure human rights and equity.