150 Years of Social Medicine at Harvard University
Reflections from the Department Chair

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"All medicine is inescapably social medicine."
—Leon Eisenberg, 1999

Proponents of social medicine have long appreciated the fact that social forces—poverty, racism, gender inequity, incarceration, political neglect, economic inequality, and other such relations of power—have a part in determining who falls ill, who lives to get better, and who dies. Many clinicians are accustomed to observing these forces at work in the lives of their patients: they come to the surface during the quest for relief, care, and expert mercy. For epidemiologists, economists, and demographers, such forces may manifest as quantifiable disparities in population-level data, or in analyses of the global distribution of disease and health services, or as shifts in health indicators recorded across time and space. Anthropologists, sociologists, and historians routinely trace the linkages between large-scale social change and health and human flourishing; the best of those social scientists train at least some of their attention on lived experience.

Some have evaluated these linkages as expressions of structural violence, which is one way of naming the ways uneven social arrangements cause harm—some arrangements causing more harm than others and some people receiving more of the harm. Yet, while structural violence and related concepts help us see why some are shielded from hurt while others are exposed to a great deal of it, social analysis remains a regrettably underutilized tool in medical practice. "The key task for medicine," argued our own Leon Eisenberg and Arthur Kleinman in 1981, "is not to diminish the role of the biomedical sciences in the theory and practice of medicine but to supplement them with an equal application of the social sciences in order to provide both a more comprehensive understanding of disease and better care of the patient. The problem is not 'too much science,' but too narrow a view of the sciences relevant to medicine."

For those of us affiliated with the academic department that both Eisenberg and Kleinman once headed, this argument is neither controversial nor unfamiliar. For 150 years, the Department of Global Health and Social Medicine, in its past and present incarnations, has helped define social medicine as a rigorous field of research and scholarship, as an analytic and teaching toolkit, and as a robust framework for praxis. It has prompted those engaged in clinical care, basic science, and public health to more carefully attend to social context—that is, to look around (at what occurs outside the laboratory or the hospital, for example) and to look back in time (at the history of the conditions that shape one's social world)—with the goal of achieving "a more comprehensive understanding of disease and better care of the patient," which has in turn sparked an emerging field of "delivery science."

In so doing, the Department has demonstrated that the social drivers of suffering are as worthy of scrutiny, analysis, and corrective intervention as are the molecular and cellular mechanisms of disease, but that none of these mechanisms are to be ignored. Far from dichotomizing these categories, practitioners of social medicine have shown that they are in fact tightly linked in what might best be termed biosocial interactions. This is an impressive feat, not least because it has transpired within one of the world's great engines of biomedical progress—the same institution where, for instance, the first kidney transplant was successfully performed, and where the first remissions of childhood leukemia were achieved with the use of chemotherapy. Global health delivery and social medicine are now indispensable parts of what Harvard Medical School represents in the world, and what it must continue to champion if it is to fulfill its mission of "alleviating suffering and improving health and wellbeing for all."

Of course, the Department has not always worn the same name, nor has its mission been static over time, but its members have always concerned themselves with the health of the broader public, including people living far from the Fenway. Thanks to the investigations of our historically inclined faculty and staff, and with the help of colleagues at the Countway Library of Medicine, we can trace our origins to 1871, when a surgeon who had served in the Union Army was appointed Professor of Hygiene at Harvard Medical School. In 1909, the department renamed itself the Department of Preventive Medicine and Hygiene, which would be integral to the Harvard-MIT School for Health Officers, organized in 1913 as the first professional public health training program in the United States; it would operate as a joint unit between Harvard Medical School and the Harvard School of Public Health from 1922 to 1946, when the School of Public Health became a degree-granting body independent of the Medical School.

In 1947, the physician David Rutstein became head of what was by then the Department of Preventive Medicine, chairing it until 1969. It would be called the Department of Preventive and Social Medicine from 1971 to 1980 and then the Department of Social Medicine and Health Policy until 1988, when it split into two departments, Social Medicine and Health Care Policy. In 2008, we assumed our current title, Global Health and Social Medicine, to acknowledge the burgeoning interest in global health equity among our students and faculty and to better reflect the breadth and depth of their engagement across the globe. This process was accompanied by a formalization of the Global Health Delivery Partnership—a vibrant and ongoing collaboration among the Department, the nonprofit organization Partners In Health, and the Division of Global Health Equity at Brigham and Women's Hospital, meant to connect the standard goals of the university (teaching and research) to direct service and care delivery in medically impoverished settings. These usually and promptly became less medically impoverished.

This is an intriguing history, marked by both gradual change and occasional ruptures in departmental vision, leadership, motives, activities, educational programs, and research agendas. There have been a few disappointing detours along the way, and for most of this history, the department was led and populated by a handful of men. As we lift our eyes from the Longwood Medical Area to embrace global health, and rethink how inclusion and diversity will improve our work, we may remain proud that the fundamental intuition that what occurs outside the body influences what occurs within it has been a constant throughout the Department's evolution; it continues to serve as a powerful rationale for the presence of social medicine at a medical school. Our current peril has brought this rationale heightened attention, as a newly recognized coronavirus has invaded the cracks and fissures in society with startling opportunism. Efforts to stem its toll have been patterned by both the predictable inequalities and some new ones (such as unequal access to reliable information). Similarly uneven have been the rollouts of interventions such as vaccines, testing, contact tracing, oxygen, ICUs, and the specific medical therapies now coming online.

That the contours of the COVID-19 pandemic are molded by social forces, most of them predating the virus's emergence, should also be cause for optimism, however. Social ills are neither inevitable nor irreversible, an observation made by the sociologist Pierre Bourdieu when he wrote, "What the social world has made, the social world—armed with knowledge—can undo." The Department of Global Health and Social Medicine, for its part, has routinely sought to participate in the undoing of inequitable social structures, especially as they shape health and illness, and in the creation of knowledge that might arm us to do so. Indeed, deep prior experience in coupling sound social analysis with meaningful social action is why so many in our ranks have been able to turn so nimbly towards confronting COVID-19 and its attendant complexities.

As we commemorate the Department's rich history, it's also worth applauding the qualities which distinguish its current incarnation, and which make it uniquely equipped to take on what Eisenberg and Kleinman called "the key task for medicine." Our strengths are many, but there are four that I'd like to highlight.

First, a singular dedication to integrating varied disciplines, methodologies, and forms of knowledge in order to address health disparities, and the pathogens and pathogenic forces that entrench them. While recent decades have seen terms like "multidisciplinary" and "mixed methods" assume widespread prominence, putting them into practice remains elusive in every scholarly milieu, and academic medicine is certainly no exception. For this department, however, such integration is precisely our modus operandi, and has been for the better part of the past 150 years. Our work routinely draws on ethnography, social history, epistemology, bioethics, economics (including political economy), epidemiology, ecology, pathophysiology, and the biomedical sciences, among other fields.

Second, the elevation of care, including treatment of the sick, and of caregiving and accompaniment as urgent moral practices. Here, we might note that discussions about the "social determinants of health," though typically well intentioned, may at times belittle the importance of clinical care and its equitable provision, perpetuating a fallacy that reliably punishes the sick, and especially the destitute sick. Our department steers clear of this trap, recognizing that even as social transformations are needed to tackle what are invariably social pathologies, advances in modern medicine—a field Lewis Thomas once called "the youngest science" and thus a field that is by definition still evolving—must also be counted among our instruments of social change if medicine is to help narrow disparities rather than widen them.

Third, the application of biosocial analysis to build a proper science of health care delivery, one capable of rapidly (and equitably) lessening the global burden of disease, whether from infectious pathogens, injuries, mental illness, or noncommunicable maladies such as diabetes, cancers, heart diseases, and various surgical pathologies. We accomplish this eminently pragmatic task, like our own longer-term scholarship in (say) anthropology and history, through research, novel and diverse training programs, and sustained partnership with service organizations that are the Department's "effector arms," extending its reach into far-flung places. These include settings marked by great material privation (like Haiti, Rwanda, Malawi, Lesotho, Madagascar, Uganda, Liberia, and Sierra Leone), as well as those of greater, if unevenly shared, abundance (like Peru, Mexico, India, Indonesia, Fiji, Lebanon, China, Russia, and the United States).

And fourth, a dogged pursuit of global health equity, a quest guided by the lived experience and expertise of communities disproportionately suffering from structural violence. Sometimes, academia is prone to timidity when it comes to matters of social justice, in part because service, activism, and other expressions of moral values have come to be seen as incompatible with the enduring search for "scientific objectivity." But as Drew Gilpin Faust reminded us in her 2016 Harvard commencement address, "There is no value-free science. There is no algorithm that writes itself." By embracing the notions of decency, compassion, justice, and pragmatic solidarity—and acknowledging the ways they inflect the questions we ask, the knowledge we generate, the pedagogy we adopt, and the collaborations we forge—the Department has pioneered a social medicine that is rooted in the fight for global health equity.

Allow me to close by turning once more to Drew Faust's remarks. In the same speech, the former Harvard University president went on to examine the obligations of the modern research university in a world riven by inequity, highlighting as she did so Harvard's commitment to global health. "From across the University," she said, "we see a remarkable enthusiasm for the field of global health, because it unites the power of knowledge and science with a deeply felt desire to do good in the world—to lead lives of meaning and purpose." As we mark the 150th anniversary of the Department of Global Health and Social Medicine at Harvard Medical School, let's celebrate this remarkable enthusiasm, and the years of concerted investments that have sparked or fanned it. And let us redouble our efforts toward a world in which everyone, everywhere enjoys the right to good health, to dignified care when prevention fails, and to well-woven safety nets to catch us when we fall.