Reflections on Social Medicine by A Faculty Member Who Had the Honor and Privilege to Be Part of The Department of Global Health and Social Medicine Since 1982

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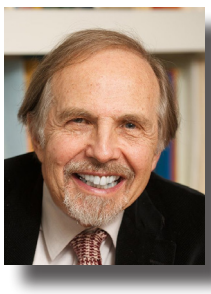

When, early in the 2000s, Jim Kim changed the name of the Department from Social Medicine to Global Health and Social Medicine, there was the possibility that eventually the words Social Medicine could be lopped off in favor of parsimony and the growing global presence that the Department had in international settings from Haiti to Rwanda and from Latin America to China and Indonesia. I know a few outsiders who actually expected this to happen. But not most of us insiders. Because we knew that the very way the Department's faculty approached Global Health was fundamentally based upon the Department's interdisciplinary foundation. A grounds on which social science complements and challenges biomedical science; social problems and health problems are understood to run together as in the idea of social suffering; illness and care are taken to be conditioned and treated through biosocial interactions; and culturally and politically shaped social discourse is seen as a crucial component of both implementation and science.

Social Medicine, as it is practiced in our Department, is inseparable from what we do – history, ethnography, socially-grounded epidemiology, direct clinical care, policy work that is as much about the social world as it is about health, moral engagement, and advocacy. Social Medicine at Harvard takes into account the care of real individuals, and we believe that is the foundation of social care in the community and for society.

Social Medicine is a capacious term that advances imaginative agendas and distinctive empirical projects. It animates social theory and case-based interventions. It is 'not time's fool' but specific to an era, a place, a view from somewhere. Social Medicine exposes the inadequacy of 'magic bullets,' technologies that work alone and are isolated from the social world. (No better example than the Covid vaccine story.) Social Medicine is given to seeing syndemics – viral with opioid, mental with Covid, violence with migration – rather than isolated 'problems.' It recognizes the clustering of mental health conditions among the poor and most vulnerable exactly where all health disparities are located. Social Medicine asks that ethics be grounded in moral life and that epigenetics and neoliberal alienation be sayable in the same sentence. It demands advocacy and engaged scholarship. Social Medicine requires the medical humanities and the healing arts to be recognized as legitimate and valued. Social Medicine reaches to the planet. Environmental effects of climate change are perhaps that part of the global ecology agenda that people connect with most passionately. And our Department is developing pertinent interdisciplinary activities to begin to address planetary health.

My current project on Social Technology for Global Aging and Eldercare in China is a Social Medicine approach to collaborate with engineers, design experts, medical researchers, economists, and policy experts in which medicine and anthropology are equally and continuously present (and in interaction) from planning to implementation.

Oliver Goldsmith's 'Ill fairs the land, to hastening ill a prey, Where wealth accumulates and men decay…' reminds us that Social Medicine's lineaments reach deep into the tradition of systematic social thinking about suffering. Such critical enquiries were undertaken by Adam Smith, Voltaire, William James, Jane Adams, John Dewey, C. Wright Mills, Max Weber, Franz Boas, WEB Dubois, and so many other social thinkers in the engaged tradition for whom social reform and improvement in people's lives are the goal of critique and carry the moral responsibility to animate action.

I see the Department of Global Health and Social Medicine and Partners In Health as the inheritors of that long and honored tradition of critical pragmatism. In order to have a critical understanding of a Social Medicine problem, we must first study its history, context and consequences for human (and non-human) communities. Then we need an understanding of the same aspects of our interventions in order to prevent unintended consequences. In order to make care central to this endeavor, the interventions, once applied, must be about improving relationships, presence, and helping people to endure, not only about organizational efficiency. Quality social care is as important as high-quality personal care. A case-centered approach means that languages which are clinical, existential, humanistic, and close to local idioms for articulating needs and desires must complement economic language in addressing outcomes.

How I see Social Medicine is as a moral and critically pragmatic bridge (the longest) across the Charles and the Atlantic/Pacific. A bridge that connects peoples' ideas, values and affects to the ideas, values and affects of still other peoples worldwide. Along that bridge travel the visions, but also the infrastructure needed to succeed in realizing human well-being. It is democracy at work. It leaves no one out. It is usually imperfect and sometimes barely adequate, yet it is what we have to reimagine and rebuild our world, our communities and ourselves. Associated with popular movements for human rights, social justice and gender and racial equality, Social Medicine commits this Department, and its faculty and students, to the hard, unfinished, and perhaps never-to-be-finished work of repairing and raising the world.