Social Medicine
Health For All
ISSN: 1557-7112

THEMES AND DEBATES

The Social Determination of Medical Practice

Sobre la determinación social de la Práctica Médica

José Arturo Granados Cosme. Universidad Autónoma Metropolitana, Unidad Xochimilco, México.
Email: jcosme@correo.uam.xoc.mx, https://orcid.org/0000-0002-0583-1239

Eduardo Minero García. Universidad Autónoma Metropolitana, Unidad Xochimilco, México.
Email**:** eduardo89minero@gmail.com, https://orcid.org/0009-0008-5493-9968

Rosa Georgina Pérez Castillo. Universidad Autónoma Metropolitana, Unidad Xochimilco, México.
Email: rgperez@correo.uam.xoc.mx, https://orcid.org/0000-0003-3239-9362

Received: July 30, 2024.
Accepted: August 20, 2024.
Conflicts of interest: none.

DOI: https://doi.org/10.71164/socialmedicine.v18i1.2025.1921

Abstract

Social Medicine and Collective Health are a field of scientific knowledge about the historical and social processes that determine the health conditions of human groups. The differentiated distribution of the health-disease process and the organized social response. Among its fundamental premises it states that such points are socially determined; This study discusses this approach with respect to the second point and proposes starting from the distinction of different domains: the economic, the political, the cultural and the ideological. By recovering general conceptual categories with concrete examples, this study seeks to break down, in a schematic and general way, the articulations between the main theoretical references of the field. The above provides a general explanation of the social determination of medical practice that subsequently can be applied to specific health problems.

Keywords: medical practice, health policy, social determination

Resumen

La Medicina Social y la Salud Colectiva son un campo del conocimiento científico sobre los procesos históricos y sociales que determinan las condiciones de salud de los grupos humanos. Este campo cuenta con dos objetos de estudio: la distribución diferenciada del proceso salud-enfermedad y la respuesta social organizada. El presente trabajo discute este planteamiento respecto del segundo objeto y propone partir de la distinción de distintos dominios: el económico, el político, el cultural y el ideológico. Al recuperar categorías conceptuales generales con ejemplos concretos, el trabajo busca desglosar, de forma esquemática y general, las articulaciones entre los principales referentes teóricos del campo. Con lo anterior se aporta una explicación general de la determinación social de la práctica médica que puede posteriormente, aplicarse a problemáticas sanitarias específicas.

Palabras clave: práctica médica, política sanitaria, determinación social.

Introduction

The field of Social Medicine and Collective Health (SM/CH) is comprised of two objects of study: the distribution and determinants of the health-disease process, and the organized social response. Regarding the latter, it generally refers to the knowledge and practices that society develops to address its health issues, which in turn enable its social reproduction.

A fundamental proposition in the critical analysis of these facts is that they are socially determined. This signifies a radical epistemological shift, as previous definitions maintained the notions of health and disease as strictly biological phenomena, reserved for the biological sciences. In contrast, this epistemological break positions the Health-Disease-Care Process as a social phenomenon.[1, 2, 3]

The concept of social determination became solidified with the development of Latin American Social Medicine. The analysis of class differences, stemming from industrial labor, enabled the development of a solid theoretical framework that provided an explanatory understanding of social inequalities in health. As a result, the concept of the social determination of health and disease gathered substantial evidence. In the case of the organized social response (the second area of study), the premise is not as evident and requires further discussion.

For its concrete analysis, this object of study can be broken down into three fundamental axes: Medical Practice (MP), Health Policy (HP)[4], and the training of health professionals.[5] In this text, the social determination of MP is analyzed based on a minimal set of conceptual references that have been revisited by SM/CH.

Medical Practice as an Object of Study

Among the fundamental theoretical premises of SM/CH, we wish to highlight two: first, that the objects of study are not given; rather, as they are defined by analytical judgment and a particular perspective on society, they are constructs. In this sense, the viewpoint that defines the theoretical current which forms their existence, development, understanding, explanation, and intervention is fundamental. Additionally, MP and HP are considered social facts in themselves and historically determined.

This work develops an explanatory analysis of the social determination of MP and HP. This approach allows us to understand the constitutive traits of the interventions that society, through the State, designs and implements in distinguishable historical moments, while also illuminating the relationship between MP and HP.

The discussion on the scientific nature of knowledge includes an ongoing debate about whether the objects of study in the social sciences and humanities can be fully considered scientific. The questioning is justified because, in these sciences, the knowing subject is simultaneously the object of knowledge; this implies a contradiction from the outset with the hegemonic forms of approaching phenomena in reality. This discussion enables a critical analysis of the hegemonic forms of knowledge generation and a reevaluation of common terms such as "hard sciences."

Positivist science, as a social and historical fact, has gained hegemony as the most legitimate way to produce explanations of reality and scientific knowledge. However, its criteria for determining what constitutes a scientific explanation are often accepted uncritically, as they adhere to their own logic; therefore, other modalities may not be able to meet these criteria.

Positivist science posits that phenomena exist independently of the subject analyzing them, and that their behavior follows laws that can be replicated everywhere and at any time, reproducing the conditions that generate them. This leads to the derivation of the principles of objectivity and externality, which researchers integrate into the validity criteria of the generated knowledge. The analytical perspective of the researcher is required to come "from outside" the phenomenon, and such perception should not be influenced by prior emotions, opinions, or political positions; that is, the subject must deny their subjectivity.

The supposed independence of the object is easily justifiable for phenomena of interest in physics, chemistry, astronomy, and the so-called hard sciences. However, even in these cases, facts are social constructs insofar as they are perceived and interpreted through a framework of prior references to the subject. This raises a discussion when the object of knowledge is also the subject, whether that subject is an individual or society. Such is the case with the social medical approach to MP; therefore, the first thing to consider is that MP, as a social fact, encompasses both the object and the subject of knowledge.

The reproduction of phenomena through experimentation, the pursuit of universal ahistorical laws, and the strict separation between subject and object, as well as between subjectivity and objectivity—principles deemed essential by positivism—pose significant challenges for social sciences in their quest for recognition as 'true' sciences. One approach has been to adjust their practices to these criteria, while another has been to recognize their distinct nature and produce their own criteria for scientific rigor. These possibilities have generated sociological traditions and theoretical currents that, although sharing society and the subject as objects of study, have substantial differences.[6]

Recognizing that in the case of societal phenomena, differentiated notions develop regarding what the subject is, what determines its position in relation to the social whole, how it connects with other subjects and institutions, and what these institutions are and should be, allows us to acknowledge that the researcher, as a knowing subject, is part of their object of study and consciously or unconsciously assumes an ideological and political position regarding the particular phenomenon they study. This leads to modalities of knowledge generation that are often opposed.

For the scientific study of MP, the approach of SM and CH distinguishes structural functionalism and historical materialism as the main theoretical currents.[6] The former, in the face of the predominance of so-called hard sciences, sought to validate social sciences as scientific by adopting and striving to meet the validity criteria imposed by the hegemony of "hard" sciences, therefor the work of Durkheim,[7] which aimed to establish the rules of sociological method, embracing the premises of positivism.

Parsons applied the principles of this theoretical framework to MP,[8] asserting that the practice of medicine operates within a social system that assigns it specific functions essential for societal integration and dynamics. Broadly speaking, he conceives of society as a harmonious whole composed of parts that contribute to the reproduction of the system through their interactions. Within this framework, health is understood as balance, and illness as disruption, with scientific medicine seen as part of the system responsible for identifying, isolating, repairing, and reintegrating the altered (sick) parts to ultimately restore social order through the ongoing restoration of these altered parts. In other words, this refers to the social assignment of roles and functions.

In its micro-social expression, the role of the doctor, as an agent of the medical institution, consists precisely in intervening in sick bodies so that individuals can reintegrate into their place in society and fulfill their functions as soon as possible. Meanwhile, the role of the patient involves accepting therapeutic interventions, adhering to the doctor's instructions, and contributing to the success of the therapy designed for restoring their functionality.

This analysis reveals part of the social nature of MP and the role it plays in modern societies; however, it has several limitations: it reduces the dynamism of society to the moment it is analyzed and does not consider its prior determinations, it assumes a system and social order without questioning their points of origin, it presumes that the parts act with an integrative purpose for that order, and it omits the hierarchies established in the interrelation of the parts, thereby rendering the effects of power invisible.

On the other hand, historical materialism posits that society is a complex totality, whose parts interrelate in a conflicted manner. It proposes understanding the historical context of society as a product of transformative conflict that continually

establishes new orders as a result of social stratification, which defines the antagonistic positions in which individuals and groups are situated. It considers institutions as power entities that disseminate norms and exercise normalizing functions of social regulation, rather than as mere parts. From this perspective, MP is a social practice that results from distinguishable historical processes, and thus is socially determined, establishing relationships of hegemony and subordination with other forms of knowledge in its constitution and institutionalization. This view allows us to understand the relationship between the development of capitalism and the development of what is known as scientific medicine, as well as the role it plays in the structuring of class society.[9]

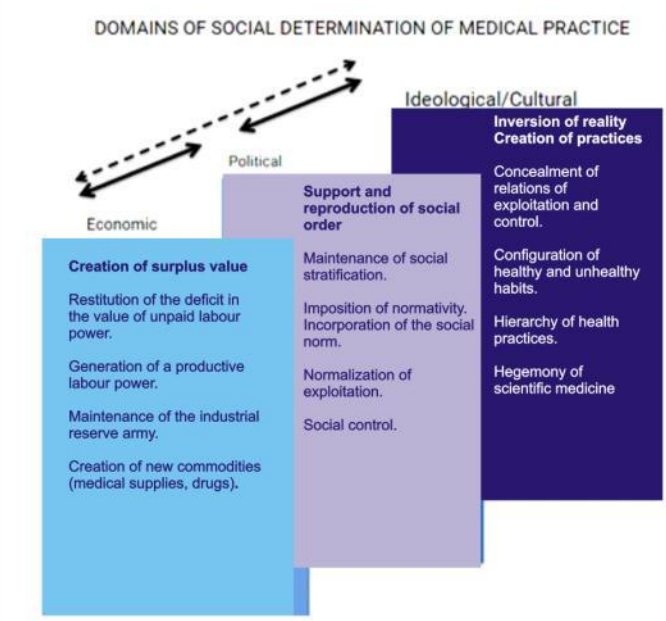
Domains of the Social Determination of Medical Practice

From a critical perspective of reality and based on historical materialism, more recent currents have made significant contributions to the inclusion of culture and power in the understanding of society, which are essential for studying MP and have been integrated into the theoretical framework of SM/CH.

Thus, the social processes that determine MP are, at the same time, interrelated and distinguishable in the economic, political, and cultural or ideological domains. This distinction is pedagogical since the domains operate simultaneously in reality, contributing to an investigative process that benefits from clearly defining the focus of study, whether it be to delve deeper into a specific domain or to establish a finite set of relationships among the domains to address a specific problem.

As a social fact, the essence and characteristics of MP are determined by the transposition (which, although complex, is comprehensible) of three domains (Figure 1). The economic domain refers to the material conditions that enable social reproduction, whose historical modalities are specific to the particular development of the productive forces of a given society.

Figure 1.



Source: Own elaboration.
Diagram of the three domains of the social determination of medical practice, representing the social processes that operate simultaneously and determine MP.

Figure 2.

Source: Own elaboration.
The economic domain of the social determination of MP to explain labor from a historical materialism perspective and its role in the forms of life, illness, and death, as well as in organized social responses.

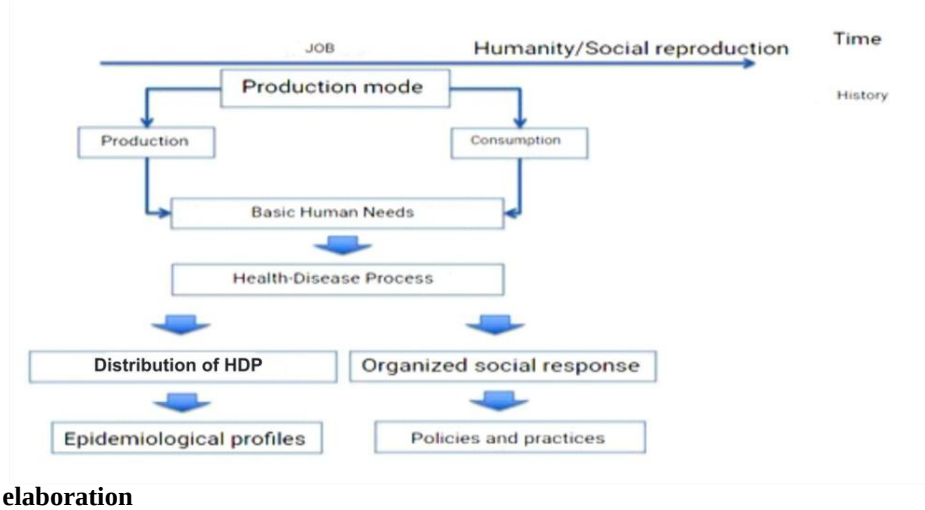
The Economic Domain

SM and CH draw from historical materialism the notion of labor,[10] defining the material conditions in which individuals and social groups reproduce life based on their moments of production and consumption. From labor, human groups can be distinguished within a social totality, whose position determines ways of living and, consequently, ways of falling ill and dying. Each group exhibits a specific and characteristic pattern of wear and tear related to its position within the labor process,[11,12] or epidemiological profile.[13]

MP is also determined by the prevailing mode of production, which, in its capitalist period, is oriented towards generating surplus value and capital accumulation. In this historical period, MP acquires distinguishable traits but is delineated by functionality in the same sense as capital accumulation. Labor, as a general concept, refers to the historical way in which the subject transforms nature to satisfy their needs and includes a moment of production in which the subject consumes themselves while transforming nature, resulting in wear and tear,[14] which is replenished by the consumption of need-satisfying goods that allow for the continuity of the life reproduction cycle. In simple terms, what is produced must equate to what is necessary to consume, and replenish what is spent in labor. However, capitalism is based on an essential contradiction between labor and capital, as this mode of production implies an accumulation of the product of labor that objectively can only arise from not paying the real value of the labor force, a portion that is extracted in the form of surplus value and appropriated for capital accumulation. The consumption deficit that results from surplus value extraction generates wear and tear that consists of a shortening of life and a set of health damages characteristic of each social class (Figure 2).

In this framework, MP in its public policy modality has its genesis and subsequent configuration in HP. Given that in capitalism, basic needs are met through commodities and the real value of labor is not compensated, the resulting consumption deficit implies the need for

Figure 3.



Source: Own elaboration

The political domain of the social determination of medical practice to identify its economic functionality through the implementation of public policies and practices.

replenishment through other means. This is where public health actions gain functionality, primarily stemming from the State in modern societies.[15]

The generation of capital is only possible through exploitation, which is the appropriation of others' labor to promote the reproduction of the mode of production, which then interferes with the reproduction of individuals' lives. The capital/labor contradiction not only produces two social classes (owners of the means of production/workers) but also a confrontation between sectors that seek the permanence of a socially exploitative system and those who resist and seek to transform their living conditions.

This social conflict inherent in capitalism makes such a project unviable in its historically and socially determined period, governed by neoliberal economic and ideological doctrines, which question the role the State should play and propose reducing it to allow the free play of market forces, instrumentalizing the State to serve the interests of capital. However, the existence of the State is necessary for intervention in and reduction of this conflict through a social contract.

Health services, as an expression of MP, are provided by the State with various functions, but fundamentally to intervene and diminish the capital/labor contradiction through several actions: compensating for the deficit imposed by surplus value extraction; addressing the wear and tear imposed by labor; reducing the cost of labor by offering medical care (at no cost or through prepayment); producing a productive labor force (by addressing illness, increasing life expectancy, and regulating biological reproduction) and thereby promoting capital generation. In this way, MP assumes essential traits: it addresses illness (not health), emphasizes cure at the expense of prevention (which would involve modifying the living conditions of the working classes), emphasizes the techno-scientific development of medicine rather than the collectivization of knowledge, and commodifies the medical work process.

The Political Domain

According to Jaime Osorio [(16)], capitalism is a duality that can be understood as a coin with an economic face and a political tail. Historical analyses following Marx's contributions sought to transcend economistic explanations and made significant contributions that are incorporated into the framework of Social Medicine and Community Health (SM/CH). MP has an economic functionality but can only be implemented through political mechanisms and, fundamentally, as a political practice.

The State's intervention in the capital/labor contradiction is predominantly political for several reasons: it reconciles contradictory class interests by managing the workforce in relation to capital; it produces and is constituted by institutions that issue social norms, which also serve the social project of capitalism; it regulates the relationships among social sectors and subjects; and, finally, it produces functional subjects. These actions, as normative, require the exercise of public power (Figure 3).

Foucault[17] describes the State as the instance of power of modern society. From this perspective, MP can be considered part of a set of actions encompassed within what are referred to as social policies (health, education, food, housing), which aim to "complete" the consumption of goods necessary for the reproduction of life. By critically observing modern society, Foucault identifies historical modalities of power and the social entities that deploy it, identifying bio-politics and scientific medicine/public health as the modality and entity, respectively, associated with the development of capitalist society.

Every social project requires relationships among subjects and sectors, as well as institutions whose actions are consistent with the social norms that underpin the prevailing social order. The legitimization of the following norms implies imposing actions against others, which therefore generates resistance from subordinate social sectors: exploitation as the norm for organizing work in capitalist society; heteronormativity as the modality through which the workforce is biologically reproduced; and health and medical norms, which are ultimately impositions implemented through devices that seek to regulate society by homogenizing individuals.[18]

Foucault[17] identifies the emergence of public health actions as part of the interventions of public power on social bodies and individual bodies. The main objectives of bio-politics are fundamentally to prolong life. In this sense, MP directs the generation of knowledge and its own practice by imposing new dichotomous structures, considered essential in anthropology for the configuration of human bodies and for ordering society: normal/abnormal or health/disease. MP thus assumes social functions consistent with preventing death by addressing health risks and damages, controlling birth rates, regulating behaviors, pathologizing some while legitimizing others, and medicalizing behaviors. The imposition of heteronormativity and the pathologizing of non-reproductive sexual behaviors serve as good examples of the political essence of MP. In the bio-political imposition of heteronormativity, private property is safeguarded and reproduced, representing the second essence of capitalism [(18)]; however, in the exercise of MP, many directives, whether or not they contribute to health, are fundamentally normative.

The Ideological and Cultural Domain

Every mode of production requires a social system that establishes relationships among its parts according to its own logic, as well as producing individuals shaped by the culture established by that system, thereby giving it meaning as an entirety.

We can distinguish the economic determination of MP by detailing its functionality within the system of exploitation imposed by capitalism in its various phases. Fundamental concepts in the economic domain include the State, Social Policies, and Health Policies. Explaining the healthcare system of a society, its health programs, its financing modalities, and their impact on the social structure through the stratification these elements generate[19] can be understood and explained from the perspective of economic determination. Critical analyses of this breakdown have warned of a certain economic reductionism, which necessitates the exploration of the political, ideological, and cultural domains.

When considering culture as the set of integrative notions that provide the subject with a sense of meaning and belonging to the social whole, Bourdieu[20] explains the configuration of *habitus* as a tool that helps understand the structured and structuring nature of observable practices in individuals and groups concerning their health. The *habitus* category is highly explanatory of health practices, such as diet, physical activity, and other preventive measures like condom use or contraception, starting from a radically different premise than the traditional notion of lifestyles.[21]

Ultimately, individuals do not choose what they consume or the practices they engage in; the supposed "choice" is defined by a finite number of options that are, in turn, constrained by more general determinations. The consumption of certain foods is defined by their availability and

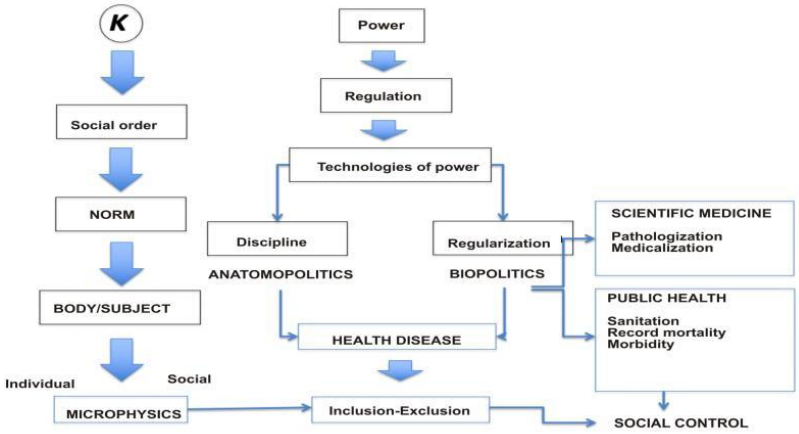
accessibility; the ability for people to engage in physical activity depends on the availability of time and safety in public spaces; the use of contraceptives depends on the meanings attributed to the exercise of sexuality and gender inequalities. From a social medical perspective, individuals' will be actually dependent on a limited margin of material dispositions that are shaped outside their decisions but have a significant impact on their health.

In another domain of its social determination, MP can be considered an instance of power, in the sense defined by Foucault.[22] In its parallelism with the establishment of modern reason and its articulation with the development of capitalism, scientific medicine, and its expression in the social body, public health implements significations that translate into normative practices. These practices, in their application, generate actions of social control for the preservation and reproduction of the social order, as well as actions of resistance to domination that enable social transformation. The focus on the political domain contributes concepts such as medicalization and pathologizing, which reveal part of the function of imposing the social norm assigned to medicine. It also provides us with notions of bio-politics that allow us to understand the normative character of MP and its social function in the regulation of individuals (Figure 4).

The category of ideology enables a critical and demystifying analysis of MP as a social construct, in the sense that it is not neutral, purely scientific, or technical, but rather responds to ideas, interests, and political positions. This challenges the notion that medicine is an apparatus of strictly scientific concepts, "purified" of political interests or positions, and instead highlights it as a field where ideas are confronted and where unequal power relations operate—from the microphysics of the doctor-patient relationship to the institutional level that implements norms for the reproduction of a social order based on exploitation. The approach, grounded in the theoretical frameworks of the social medicine/collective health (SM/CH), reveals the susceptibility of MP and public health to being part of the scaffolding in the intervention of reality.[23] The vulnerability of healthcare services and the very vision of health policy as inherently positive are expressions of ideological mechanisms aimed at perpetuating forms of governance based on exploitation.

Addressing the constitutive elements of the domains of the social determination of MP allows for an assessment of the conceptual foundation of the theoretical framework of social medicine/collective health (SM/CH) regarding its second object and reaffirms MP and public health (PH) as phenomena historically and socially determined. In this way, the central epistemological position is recovered, which posits that MP, as a social fact, contains within itself both the object and the subject of knowledge, contrary to positivist science that focuses on the demands of objectivity and externality.

Figure 4.



Source: Own elaboration

The ideological and cultural domain of the social determination of MP is seen with capital and power as the guiding forces behind public policy and practice choices.

Conclusions

The above leads to a critical approach to the position of knowledge in MP and its relations of subordination with other forms of knowledge. Through the discussion of the social determination of MP and PH, it is possible to understand and integrate into the analysis how subjects are configured, how their positions are determined, and how they relate to society and the State.

For any specific health phenomenon, it is essential to first characterize the economic, political, and cultural or ideological domains that determine it, beyond its particularities. This ensures that, when delving into the specifics of each research problem, no potential theoretical oversight occurs. For each domain, it is necessary to establish the hierarchies of categories based on their general and particular explanatory levels, as well as to clearly understand the connections between the domains themselves. This involves considering micro-social expressions, such as the role of the doctor, which simultaneously has economic, political, and ideological dimensions.

Regarding the political dimension of MP, which is found in PH and takes shape according to the role the State assumes at a given social moment, in the neoliberal expression of capitalism, the State is instrumentalized to strengthen class privileges, in the interest of greater capital accumulation, defending the interests of the free market, and turning basic needs for the reproduction and care of life, such as health, into commodities.

Finally, it is necessary to consider the elements that shape MP and position it as a commodified practice that emphasizes disease care, healing, and the development of techno-scientific knowledge. The objective is to propose socially organized responses around health, prevention, and well-being by modifying the structural conditions of life, collectivizing knowledge, and integrating different forms of knowledge, with a public health system in favor of health as a human right.

References

1. Laurell A. Investigación en sociología médica. Revista Salud Problema 1978; (1): 5–9.
2. Menéndez E. Salud Pública: Sector Estatal, ciencia aplicada o ideología de posible. En: OPS, editor. La crisis de la salud pública: reflexiones para el debate. Washington: OPS; 1992. P. 103-122.
3. Laurell A. Sobre la concepción biológica y social del proceso salud-enfermedad. En: Rodríguez M. Lo biológico y lo social: su articulación en la formación del personal de salud. Serie Desarrollo de Recursos Humanos 101, OPS. Washington. 1994: 1-12.
4. Tetelboin C., Granados J, Módulo III. Política médica y política sanitaria. 2022.
5. Jarillo E. Módulo V. Seminario de formación docente. 2022.
6. Tetelboin C. Problemas en la conceptualización de la práctica médica. Antropbio [Internet]. 23 de octubre de 2013 [citado 30 de mayo de 2024];8: 488- 510. Disponible en: https://www.revistas.unam.mx/index.php/eab/article/view/42875
7. Durkheim E. Las reglas del método sociológico. México: Ediciones Coyoacán; 2001.
8. Parsons T. Estructura social y proceso dinámico. El caso de la práctica médica moderna. En: Parsons T, editor. El sistema social. Madrid: Revista de Occidente; 1951: 430–78.
9. Donnangelo MCF. Salud y sociedad. Universidad de Guadalajara; 1994.
10. Marx K. Capítulo V. Proceso de trabajo y proceso de valorización. En: Marx K, editor. El Capital. México: Siglo XXI; 1975. p. 215-240.
11. Laurell A. Proceso de trabajo y salud. Cuadernos Políticos [Internet]. julio-septiembre 1978;59–79. Disponible en: http://cuadernospoliticos.unam.mx/cuadernos/contenido/CP.17/17.7.AsaCristina.pdf
12. Noriega M, Laurell A. La Salud en la Fábrica, Estudio sobre la Industria Siderúrgica en México. México: Ediciones Era; 1989.
13. Breilh J. Epidemiología crítica: ciencia emancipadora e interculturalidad. Lugar Editorial; 2003.
14. Laurell A, Márquez M. El desgaste obrero en México: proceso de producción y salud. Ediciones Era; 1983.
15. Granados J, Tetelboin C, Torres A. Salud y seguridad social en México. Redefiniciones en la política sanitaria e impacto en la provisión de servicios. En: Eibenshutz C, Cervantes R, López O, López S, Adriano M, Caudillo T. ¿Hacia dónde va la salud de los mexicanos? México: OPS, UAM, UNAM, IPN, FES Zaragoza; 2006. p. 76–96.
16. Osorio J. Estado, biopoder, exclusión. 1ª ed. Universidad Autónoma Metropolitana. Disponible en: https://casadelibrosabiertos.uam.mx/gpd-estado-biopoder-exclusion.html

17. Foucault M. Defender la sociedad. Fondo de Cultura Económica.; 2000.
18. Granados J. Normalización y normatividad de la sexualidad: una definición desde el esclarecimiento de las funciones sociales de la medicina. Salud Problema [Internet], 2014 Jul-Dic; 8(16): 88-12.
19. Esping-Andersen G. As tres economías políticas do welfare state. Lua Nova [Internet], 1991 Sep;(24): 85-116. https://doi.org/10.1590/S0102-64451991000200006
20. Bourdieu P. El sentido práctico. Taurus Ediciones; 1991.
21. Coreil J, Levin J, Jaco E. Life style - An emergent concept in the sociomedical sciences. Cult Med Psych [Internet], 1985 Dic; 9(4): 423–437. https://doi.org/10.1007/BF00049232
22. Foucault M. El nacimiento de la clínica. Siglo XXI; 1979.
23. Danel F. Ideología y epistemología. ANUIES; 1977.

Social Medicine
Health For All
ISSN: 1557-7112