EDITORIAL

Introducing *Social Medicine*

The Editors

If a reader picked up a journal entitled *Cardiology* or *Dermatology* s/he would have a fairly clear idea about the types of articles likely to be found inside. It is less clear exactly what might be the content of a journal entitled *Social Medicine*. As a discipline, Social Medicine has many roots and many branches. Social Medicine has taken on a variety of meanings as diverse schools of social medicine (or its offspring community medicine) have grown up in different parts of the world. What, then, is a reader to expect of this journal *Social Medicine*?

The nature of Social Medicine

Despite the diversity in its expression certain fundamental ideas lie behind the concept of social medicine. The most important is that the structure of a society profoundly influences who will be healthy and who will be well. Societies have certain characteristic patterns of illness and particular – often radically divergent – conceptions of what constitutes health. How we go about caring for human suffering responds to social as well as biological imperatives. In short, the biological reality of human existence is inextricably a social matter.

As an academic discipline – rather than an intuitive understanding – these ideas can be traced to European physicians of the period around the Industrial Revolution. At that time statistical data became increasingly available for the large towns of Europe and it was possible to demonstrate in statistical ways what was visible to the untutored eye: the poor and working class lived short, unhealthy lives compared to those of the wealthy. Physicians were well aware that the social conditions of the working class were central to the production of disease and many used this knowledge to critique the political and social conditions of early capitalism.

By the end of the 19th century pathology and microbiology seemed to provide definitive answers to the questions of how and why people got sick. Social explanations fell from favor. Since social explanations raised politically "difficult" questions they were best left out of the education of a profession that sought to create a monopoly on health care.

The resultant form of medicine, baptising itself "biomedicine", proclaimed that it was grounded in biology and highly scientific. Yet with time we have grown to appreciate that the program of biomedicine is quite restricted. We can, for instance, understand in great molecular detail the hows and whys of the HIV virus. This understanding does little to explain the patterns of spread of the virus. More importantly, although we may develop the technical means to treat the virus (and hopefully the vaccine to prevent it), microbiology and pathology have not told us how to deliver those interventions to the people that need them the most. Can we hope to combat the pandemic of Type II diabetes without consciously understanding – and critiquing - the political economy of agriculture in the modern world? A medicine that is not consciously social is a giant with feet of clay.

Modern biomedicine considers itself impervious to social considerations and concerned only with hard biology. In doing so, it only highlights the degree to which it is unconscious of the very forces that move it along. When Abraham Flexner revolutionized the teaching of medicine in the United States one of the results was a sharp restriction on the access of women and blacks to the profession. This can hardly have responded to any imperatives of biological science. Yet this was a decision that continues to profoundly impact the character of medical practice today. A socially neutral biomedicine is, quite simply, a nursery tale.

It is our hope that this journal may serve as a catalyst to revitalize the discussion within the house of medicine concerning the role and importance of social factors. The care of individual patients cannot occur in the absence of a conscious appreciation of the social context.

The Physician as the Natural Advocate for the Poor

In this first issue we publish Rudolf Virchow's 1848 report on the Silesian typhus epidemic, a cornerstone document in social medicine. In the conclusion of his report, Virchow writes: "Medicine has imperceptibly led us into the social field and placed us in a position of confronting directly the great problems of our time."

We intend that *Social Medicine* stand firmly in this rich interface between clinical care and social criticism. There is a reason that, again quoting Virchow, physicians are the natural advocates for the poor. The daily work of most clinicians involves interacting with the lives of people who are not rich and powerful. Malnourishment, lack of health care, poor living and working conditions, substance abuse, violence – the social problems of the contemporary world walk into the clinician's office every day. The mundane details of the social determinants of health are writ small in our daily encounters with patients.

In concrete terms what does it mean to be a natural advocate for the poor in the early 21st century? The broad social context for the emergence of social medicine lay in the Industrial Revolution. The broad social context in which health and health care is evolving today is that of increasing globalization within the context of modern imperialism. This context confronts us with widely divergent views on the meaning of health and the role of health care.

The World Health Organization, formed in the aftermath of the Second World War, enunciated a broad and holistic view of heath as a state of well-being. This was a vision later expanded in the WHO's 1978 Alma Ata declaration which critiqued the international division of labor, called for the expansion of primary care and set the goal of health for all by the year 2000. Animating this vision were the ideas that health is an intrinsic good, that access to health care should be a fundamental human right and that the responsibility for the promotion and preservation of health lies not only with the individual, but also with the State.

Nothing could be farther removed from the realities of the global health system that is currently emerging. While every country is different, yet in each the plan is the same. Health is seen, not as a public good or a human right, but as a tool to produce healthy workforces (i.e. as a support for economic development) or as a commodity to be bought and sold. We are told that the rational distribution of health resources will occur only in a more or less regulated marketplace. This is a position that has no basis in any historical experience. And so the public financing of healthcare is increasingly challenged or funneled into private corporations. Health care becomes a commodity, patients become customers, clinical services are product lines. It is only rational, therefore, that academic medicine and medical research become handmaidens to big Pharma.

Since it is obvious – even to the most extreme ideologues - that the market will not solve the health problems of the poor, we now have a series of stripped-down, on-the-cheap health programs for them, currently embodied in the Millennium Development Goals. Only the most limited, cost-effective, "evidence-based" interventions will be funded. Instead of primary care and a vibrant public health system the poor get a global fund for AIDS, Tuberculosis and Malaria. The grand goal of Health for All by 2000 has been consigned to the dustbin of history. This is the well-funded, well-heeled and well-promoted ideology of corporate and imperialist healthcare in the 21st century. Sadly, the many lessons of social medicine have been forgotten. AIDS, tuberculosis and malaria are all diseases embedded in a social context. They will not be eradicated without addressing that context. The difficulties in fully funding the Global

Fund and the Millennium Development Goals simply underscore the global social realities which have allowed these diseases to flourish.

What does it mean to the "natural advocate for the poor in 2006? It means to promote the vision of holistic health that is made available to all.

The distinctive role of Latin American Social Medicine

Latin America has seen the development of a distinctive school of social medicine that has managed to be both an active participant in the political arena and to maintain a high degree of critical and autonomous thought. The model espoused by Latin American Social Medicine is captured in Débora Tajer's analysis of the ways in which Social Medicine differs from traditional clinical medicine and public health:[1]

1. Social Medicine studies populations as collective groups and not simply as an assortment of isolated individuals.
2. Social Medicine examines the internal logic and social role of health institutions. If health care institutions have the capacity to reinforce existing social relations of domination, they can also to develop alternatives to those relations.
3. Social Medicine looks at health and disease in a dialectical manner. Health care does not exist in isolation. It is part of a historical process.
4. Social Medicine emphasizes that social and historical processes are determinants of the relationship between health, disease and health care both for individuals and social groups.
5. Praxis, the interweaving of theory and political activism, allows for theoretical approaches to health that do not merely describe reality but also promote social change.
6. Social Medicine seeks to develop a methodology that enriches both quantitative and qualitative research with historical perspectives. In doing so it tries to overcome the limitations of the positivistic and reductionist approaches common to both traditional clinical medicine and public health.

The rich historical experience of Latin American Social Medicine allows a certain optimism at this beginning of the 21st Century. There are diverse national schools throughout the region and a cadre of practitioners with extensive political and technical experience. The poverty and polarization that exist throughout the Continent, reminiscent in many ways of the conditions of the early Industrial Revolution, force any theoretical discussion to remain firmly planted in the regional reality.

This Latin American tradition has been relatively unknown within the English speaking world. One of the goals of this journal is to break down that linguistic blockade and begin a discussion between Latin American Social Medicine and the English-speaking world.

What principles guide this journal?

1. Social Medicine has a rich historical legacy, much of which has been lost or suppressed. The current debates on health inequalities and equity have been prefigured in some of the early work in social medicine. We can turn to this literature for inspiration and edification.
2. Any discussion of health is inevitably an international discussion. Our journal addresses a global audience and seeks to further an international conversation. Thus, we will publish initially in both English and Spanish, hoping to add additional languages with time.
3. Academic publishing has largely been in the hands of the developed countries. We recognize this and will organize the journal in such a way as to be as welcoming as possible for authors and readers from a variety of countries.
4. We will seek to publish material that is ignored or unwelcome elsewhere. The 2005 meeting of the People's Health Assembly went almost without comment in the world press and particularly the medical press (the British Medical Journal and PLoS were notable exceptions). We will strive to make sure that voices

like that of the PHA are given more international attention.

5. The journal will seek to promote activism and political organization in support of the WHO Alma Ata goals of Health for All and the holistic vision of health contained in the WHO charter. This will require a civil mobilization for the recognization of a right to health as a fundamental human right and for universal public systems of health care.
6. The journal will produce materials that are scientifically sound, intellectually honest, free of commercial biases, clearly written and well presented. Access to the journal will remain free for both authors and readers.

What are our plans for the journal?

Social Medicine will be published on a quarterly basis. It will be published initially in English and a mirror version in Spanish will be available in the next few months. By the end of the year simultaneous English and Spanish journals will come out in January, April, July and October.

We will function in many ways as a traditional academic journal, following the codes of the ICMJE, using a system of rigorous peer review and focusing on scientific papers. However, there will be a number of important differences in the way our journal functions. We will not accept advertising or funding from drug companies. Thanks to the availability of free journal software from the Open Journal Systems we can operate on a relatively small budget. We do not intend to charge authors or readers and we will not accept advertising. All the editors work as volunteers. We do have significant translating and copy-editing expenses and will gladly accept donations. We will adhere to the Commons Copyright agreement that allows non-commercial reproduction of our papers with attribution except where otherwise indicated. We are hoping to use some of the special features of an on-line journal such as the ability of post video and audio feeds.

We intend to use the peer-review system not only as a means of assuring scientific quality, but also – when appropriate - as means of mentoring authors. Authors from the non-English speaking world face a number of hurdles in seeing their work published in the international medical literature. We intend to offer those authors whose papers we think have merit, the opportunity to work with a peer reviewer/mentor to improve the quality of their work. It is our hope that this system will open the medical literature to articles that would otherwise not get published.

Initially the journal will publish with six sections and an editorial column. Additional sections may be added with time. Authors are welcome to submit work to the following sections.

1. Original Research
2. Classics in Social Medicine
3. Case Studies in Health Activism
4. Social Medicine in Practice
5. Social Medicine Black Bag
6. News & Events

Authors should consult our website for detailed information regarding submissions to these sections. Authors should understand that their work will be translated into both English and Spanish and published in both the English and Spanish Journals. For more specific information, please consult our website.

Welcome to our journal.

The Editors

References

1. Tajer D. Latin American social medicine: roots, development during the 1990s, and current challenges. Am J Public Health 2003; 93(12):2023-2027.