Introduction

The Many Lives and Afterlives of Social Medicine

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What is social medicine? For many reformers inside and outside the medical profession, the field emerged in the nineteenth century as a means to temper the overzealous scientism of an increasingly narrow biomedical approach to disease and therapeutics. For others, the term itself was a tautology that described the role of social sciences as basic sciences of medicine – for how could health or disease ever be fully understood without including the socioeconomic determinants of health and the life worlds of patients and caregivers? Alternatively, for many politicians left, right, and center, "social medicine" soon became an expression of the strengths or possibilities of new state-based approaches to health and healthcare, from Otto von Bismarck's pioneering German social insurance scheme through the proliferation of national health systems in the wake of the Second World War. But for some public health advocates and community activists who sought to locate disease prevention and healthcare beyond the hospital or clinic, often under the rubric of "community health," the older term itself embodied a form of medicalization: another overreach by the medical profession artificially inflating its impact on the health of populations, when economic transformation, grassroots advocacy, and radical social change might prove better at prevention or care.

There is not, and never has been, a single consensual definition of social medicine. During the twentieth century, on every populated continent, across vastly different political spaces, social medicine came to acquire a constellation of meanings. Yet, as the question of what social medicine might be, or might become, exercised the minds of countless reformers in the twentieth century,

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some general areas of agreement can be traced. Generally, the designation implied depreciation, if not rejection, of reductionist and technical attributes of contemporary biomedicine, especially its narrow focus on individual treatment, laboratory research, and molecular explanation. In contrast, social medicine was imagined as an integrative enterprise, an ambitious, often idealized, attempt to reckon with the social, political, and economic determinants of health and disease in our communities – to think beyond the routinism of pills, potions, and other expedients. It drew on emergent social sciences to reshape and deepen understanding of disease patterns, thereby accommodating health and disease within more complex and realistic sociological configurations. Advocates of social medicine thus might propose radical changes to pathogenic social, political, and economic structures, demanding an overhaul of the systemic inequalities and injustices that make us sick – not mere patching-up or deferral or other conventional medical makeshifts. Always elusive, always escaping precise definition and definitive realization, social medicine came to signify reformist and interdisciplinary impulses within the health professions, socioeconomic inquiries in public health, and occasionally even radical political change.[1]

All the same, by the turn of the twenty-first century, most of the medical world had stopped asking questions about social medicine. Long associated with national reform movements and international health organizations, social medicine appeared incongruent with growing neoliberal globalization. Its reach in medical school curricula had receded from a watermark that had never been that high and it was rarely part of the repertoire of "global health" as it developed from the 1990s.[2] And yet, in a world of widening health inequalities,

[1] Among many versions of the history of social medicine are George Rosen, "What Is Social Medicine?," *Bulletin of the History of Medicine* 21 (1947): 674–733; Dorothy Porter and Roy Porter, "What Was Social Medicine? An Historiographic Essay," *Journal of Historical Sociology* 1 (1988): 90–106; Dorothy Porter (ed.), *Social Medicine and Medical Sociology in the Twentieth Century* (Amsterdam: Rodopi, 1997); and Dorothy Porter, *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times* (New York, NY: Routledge, 2005).

[2] On global health, see Theodore M. Brown, Marcos Cueto, and Elizabeth Fee, "The World Health Organization and the Transition from 'International' to 'Global' Public Health," *American Journal of Public Health* 96 (2006): 62–72; Anne-Emanuelle Birn, "The Stages of International (Global) Health: Histories of Success or Successes of History?," *Global Public Health* 4 (2009): 50–68; Andrew Lakoff, "Two Regimes of Global Health," *Humanity* 1 (2010): 59–79; Vincanne Adams, "Against Global Health: Arbitrating Science, Non-science, and Nonsense through Health," in Jonathan M. Metzl and A. Kirkland (eds.), *Against Health: How Health Became the New Morality* (New York, NY: New York University Press, 2020), 40–60; João Biehl, "When People Come First: Beyond Technical and Theoretical Quick Fixes in Global Health," in R. Peet, P. Robbins, and M. Watts (eds.), *Global Political Ecology* (London: Routledge, 2010), 114–44; Didier Fassin, "That Obscure Object of Global Health," in Marcia C. Inhorn and E. A. Wentzell (eds.), *Medical Anthropology at the Intersections: Histories, Activisms, and Futures* (Durham, NC: Duke University Press, 2012), 95–115; Paul E. Farmer, Arthur Kleinman, J. Kim, and M. Basilico (eds.), *Reimagining Global Health: An Introduction* (Berkeley: University of

depleted public health services, and narrowly focused "precision" medicine, we perhaps need a renovated and reimagined social medicine – that is, a decanonized and revised social medicine – more than ever. Accordingly, we have gathered together these restorative chapters that show us how we might remake a social medicine fit for addressing our alarming and oppressive times. From multiple sites, often drawing inspiration from beyond Western Europe and North America, the contributors to this volume seek usable histories of social medicine and its various proxies, necessary histories that will enable fresh critiques of elite biomedical reductionism, clinical individualism, and professional abnegation. These stories from the militant interstices of canonical biomedicine in the Global North and from the vanguard of health activism in the Global South open to us a planetary vista of what social medicine might become, should become, in the twenty-first century.

Pluralizing the Histories of Social Medicine

What, then, was social medicine supposed to be?[3] The standard narrative, favored by the influential American historian of medicine and public health George Rosen, among others, traces a genealogy back to a European ancestor, liberal pathologist Rudolf Virchow.[4] Many now know Virchow, if at all, through a single useful quotation, in which he asserted that, "medicine is a social science and politics is nothing else but medicine on a larger scale."[5] Virchow, the story goes, was radicalized as a young physician, soon after graduating from medical school in Berlin, when sent in the 1840s to evaluate a typhus epidemic afflicting the recently occupied Prussian territory of Upper Silesia. In a report that continues to resonate today, Virchow concluded the most important determinants of epidemic emergence were poverty, oppression, and dispossession – which implicated Prussian imperialism. Virchow thus became both a hero of biomedical sciences – helping to found the new discipline of cellular pathology – *and* the iconic figure of the socially engaged physician, leading the liberal political reform movement of 1848 and setting forth a progressive and later dominant, agenda for social medicine. If health professionals learn anything about social medicine these days, they come to understand that this European tradition,

California Press, 2013); Warwick Anderson, "Making Global Health History: The Postcolonial Worldliness of Biomedicine," *Social History of Medicine* 27 (2014): 372–84; and Randall P. Packard, *Global Health: A History of Intervening in Other Peoples' Problems* (Baltimore: Johns Hopkins University Press, 2017).

[3] Porter and Porter, "What Was Social Medicine?"

[4] Rosen, "What Is Social Medicine?"; Erwin H. Ackerknecht, *Rudolf Virchow: Doctor, Statesman, Anthropologist* (Madison, WI: University of Wisconsin Press, 1953).

[5] Leon Eisenberg, "Rudolf Ludwig Karl Virchow, Where Are You Now That We Need You?," *American Journal of Medicine* 77, no. 3 (1984): 524–32.

beginning with Virchow, was transported to new worlds, where it might be taken up and transformed by national savants and colonial elites.

Once rendered portable in the twentieth century, once stabilized at multiple national and colonial sites, this moderately progressive style of social medicine, lacking real revolutionary appetite, settled in for the duration of the Cold War. With earlier support from the League of Nations Health Organization (LNHO) and then the World Health Organization (WHO), most nation states could endorse modest programs in social medicine, in small doses, sometimes in homeopathic dilutions.[6] Participants in the post-Second World War nation-based order built up a tolerance for integrating social science and medicine and sometimes for expanding community health programs, while remaining allergic to any serious structural changes, let alone the overthrow of the capitalist world system. What was left out of this institutionalized social medicine is always at least as interesting as what was left in it. Even so, in out-of-the-way places, and sometimes in North America and Western Europe during this period, scattered marginalized and suppressed scholars and activists could still imagine a more incendiary social medicine, one committed to social and racial justice and to health equity, as demonstrated in contributions to this volume.

We aim here to decenter Virchow and to offer alternatives to the anodyne and patchy liberal or reformist visions of the globalized mode of social medicine attributed to him. There are other social medicines that we seek to make visible, many dating from the social movements of the 1960s and 1970s, often from post-colonial Latin America and decolonizing Africa, usually animated by radical, sometimes Marxist, politics. Importantly, it is this postcolonial insurgency – so often omitted from generic histories of social medicine – that we seek to reveal and revitalize in this volume.

The renewed advocacy for social medicine, as many contributors demonstrate, had deep roots in anticolonial struggles and nationalist aspirations, in rural hygiene schemes, and late-colonial "development" regimes. A potent and varied mixture of liberal humanitarianism, Marxism, feminism, liberation theology, and Indigenous organizing would force its growth from the 1960s onward. The germinal beds for this new social medicine, focused on social justice and health equity, were located in Southern Africa and across

[6] Paul Weindling, "Social Medicine at the League of Nations Health Organisation and the International Labour Office Compared," in Weindling, *International Health Organisations and Movements, 1918–1939* (Cambridge: Cambridge University Press, 1995), 134–53; Iris Borowy, "International Social Medicine between the Wars: Positioning a Volatile Concept," *Hygiea Internationalis* 6, no. 2 (2007): 13–35; Iris Borowy, "Shifting between Biomedical and Social Medicine: International Health Organizations in the 20th Century," *History Compass* 12, no. 6 (2014): 517–30; Iris Borowy and Anne Hardy (eds.), *Of Medicine and Men: Biographies and Ideas in European Social Medicine between the World Wars* (Frankfurt am Main: Peter Lang, 2008); and Marcos Cueto, Theodore M. Brown, and Elizabeth Fee, *The World Health Organization: A History* (Cambridge: Cambridge University Press, 2019).

South America and the Caribbean, where revolutionary possibilities seemed imminent and inevitable. Maoist China contributed community health workers or "barefoot doctors," while India took up Gandhian principles of self-reliance. For more advanced riders of this new revolutionary wave, the old European genealogy of social medicine displayed little allure. Although southern advocates of social medicine were supporting the usual efforts to ally social science and medicine, they tended to go further, emphasizing the need to address through radical measures the social determinants of health, the need, that is, to transform public health through reconstructing economic and political systems. In this way, the category of the "social" itself became the target of intervention, as P. Sean Brotherton argues in Chapter 15. The reactivation of the social in social medicine – and its translation into political economies of health – had profound intellectual consequences, not least the development of social epidemiology, seeded by anti-racist white South African physicians who migrated to the United States. The impact of the new wave of social medicine on health outcomes, however, proved variable and infinitely contestable. Any fervor, such as it was, for radical social medicine from the Global South seemed to dwindle toward the end of the twentieth century.

Even as we try to shift focus away from mythologies of Virchow and those who sought to canonize him, we also should acknowledge some radical possibilities lodged deep in his early work that have long been forgotten. Preoccupied with the sociopolitical visions of twentieth-century social medicine, it is easy to forget that for Virchow and others in the nineteenth century, social medicine meant countering distinctly environmental pathologies. Social inequality and worker exploitation appeared to be expressed through pathogenic local environments. But the environmental concerns of early social medicine eventually were displaced later in the century by social pathologies, frequently mediated by the transmission of germs. Some environmental factors persisted in the epidemiological calculus, of course, particularly in specialties like environmental health, toxicology, industrial hygiene, and disease ecology – but mainstream biomedicine and public health were diverted into a semiautonomous social world, full of behavioral risks and threats.[7] Humans might alter their environments but it seemed their environments rarely hit back. In the 1990s, when a fresh cohort of radical physicians and epidemiologists, many of them trained in social medicine, began to recognize the

[7] In the United States in the middle of the twentieth century, some leading figures in social medicine, generally European émigrés, did retain a geographical vision, though often in parallel rather than integrated. See, for example, Henry E. Sigerist, "Problems of Historical-Geographical Pathology," *Bulletin of the History of Medicine* 1 (1933): 10–18; René J. Dubos, *Mirage of Health: Utopias, Progress, and Biological Change* (London, 1959); René J. Dubos, *Man, Medicine, and Environment* (New York, NY: Pall Mall Press, 1968); and Erwin H. Ackerknecht, *History and Geography of the Most Important Diseases* (New York, NY: Hafner, 1965).

impacts on human health of climate change and the degradation of the Earth's life-support systems, they sought a label for the pernicious social and political processes they were describing. Social medicine, long since shorn of its environmental sensibilities, seemed inapt, even irrelevant. Instead, they settled on the name "planetary health."[8] Of course, had they been better attuned to critical and encompassing histories of social medicine, as presented in these chapters, they may have realized that planetary health can be – indeed, should be – social medicine too, only scaled up.

Attending to Multisited Histories of Social Medicine

This collection of chapters brings together a wide assortment of histories of social medicine, most of them written from postcolonial and other critical standpoints, assuming multisited or transnational perspectives. Each chapter foregrounds a different set of politics of social medicine in relation to healthcare professions, the state, and social movements. Taken together, these accounts offer generative intersections and common themes. First, the chapters examine how social medicine can act as a boundary marker or as border-space between healthcare professions, the social sciences, and state bureaucracies. Second, they explore how social medicine works to contest reductionistic approaches of biomedicine from within, while also serving, perhaps perversely, as a site from which to medicalize the wider social world. Third, these chapters collectively highlight the processes by which the field of social medicine could paradoxically be undone by its own success – or, in contrast, thrive while occupying marginal or counterhegemonic positions. The contributors to this volume ask: what is the "social" in social medicine, and what is, or who does, the "medicine" (as opposed to broader conceptions of health) in the well-worn conjunction. When does the yoking together of the social and the medical offer a strong position to intervene in the world and when does amalgamation paradoxically limit the potential impact of its principles?

The first four chapters (by Carsten Timmermann, Chapter 1; Joelle M. Abi-Rached and Lidia Helou, Chapter 2; Eric D. Carter, Chapter 3; Laurence Monnais and Hans Pols, Chapter 4) actively refigure the intellectual legacy of European figures like Rudolf Virchow and Jules Guérin and institutions such as the interwar LNHO, the Rockefeller Foundation, and the postwar WHO, in our understanding of the development of social medicine. These authors seek to reframe this history in broader experiments of inter-imperial contests and through decolonization movements. As Timmermann shows in Chapter 1, the legend of Virchow as an enlightened European whose ideas diffused to the

[8] Warwick Anderson and James Dunk, "Planetary Health Histories: Toward New Ecologies of Epidemiology?," *Isis* 113, no. 4 (2022): 767–88.

far reaches of the world misses a more robust production of the field of social medicine at the edges of empires and within the state formations and civil societies of emergent nations in the global South. His chapter works to decenter the hero-myth of Virchow and re-emphasize the colonial relations of his foundational works. Abi-Rached and Helou, Carter, and Monnais and Pols work to refocus – and at least partially decolonize – the heavily Euro-American authoritative history of social medicine, turning attention to engagements in this field from the Middle East, Southeast Asia, and Latin America – toward these obscured and neglected, yet still determinate, alternative histories.

Abi-Rached and Helou trace in Chapter 2 how social medicine moved through Francophone Arabic engagements in the late nineteenth century as a form of social critique and praxis. The formal concept of social medicine in Arabic (*at-ṭibb al-ijtimāʿī*)was never taken up in the medical or popular literatures despite a prolific practical entanglement with implied precepts of social medicine. Abi-Rached and Helou speculate that there are at least two reasons for this: first, the concept is tautological in Arabic. The *ḥakīm* or doctor (which in Arabic literally means "sage," "judicious," or "wise") has throughout history carried a social responsibility, namely serving as a "wise" and trustworthy counselor for both the rulers and the needy. And second, in contrast to France or Germany where social medicine took a life of its own in the early twentieth century, the Arabic world was caught up in a period of revolutionary buoyancy, in which social medicine seemed a relatively minor concern or even a distraction from truly radical change. The term had been translated into Arabic in 1912, a few years before the revolutionary moments that convulsed the Arab world in the aftermath of the First World War, which would lead to the redrawing of national boundaries. If anything, social medicine was implicit in the practical philosophy of caring for the "wretched of the earth": first, in the face of colonial powers, including the Ottomans; then, in the face of authoritarian and patriarchal regimes in the post-independence period. But it rarely took on an autonomous, active presence.

In Chapter 3, Carter traces the broader history of social medicine in Latin America, thus reconnecting two distinct waves of social medicine in a unified narrative. As he shows, first-wave social medicine, whose protagonists included figures such as Salvador Allende (and other members of the Vanguardia Médica) of Chile and Ramón Carrillo in Argentina, expressed ambivalent relations with the esteemed Virchow – or simply disregarded him. These early explicit formations of social medicine gained strength in the interwar period, leaving an indelible imprint on Latin American welfare states by the 1940s. Second-wave social medicine, marked by the more confrontational Marxist analytical frameworks of figures such as Juan César García, Sérgio Arouca, and Asa Cristina Laurell, took shape in the early 1970s, crystallized institutionally in ALAMES (regionally) and ABRASCO (in Brazil). This radical version

of social medicine was heavily inflected by social theory, including liberation theology and world-systems/dependency theory, vernacular doctrines from Latin America. Yet, as Carter explains, the apparent hiatus between the first and second waves must also be reconsidered as an important and productive period. Reading both "waves" together can accentuate biographies and itineraries of social medicine thinkers (such as Josué de Castro) that do not "fit" one or another formation, revealing how social medicine evolves in complex reactions to both changes in the health field and developments in geopolitics.

Monnais and Pols in Chapter 4 revisit the Intergovernmental Conference on Rural Hygiene in Bandung, Dutch East Indies (now Indonesia), which took place in August 1937 under the auspices of the LNHO. Widely viewed as foundational for social medicine, driving it to prominence in international public health, this sentinel conference should also be recognized as reflecting regional intercolonial rivalry and ambiguous responses to decolonization movements. Bandung is often recounted as a spot on the trajectory toward internationalism, foregrounding the LNHO and anticipating the WHO, even prefiguring the primary healthcare policy enshrined in the Alma-Ata Declaration of 1978.[9] Monnais and Pols, however, seek to recover the distinctly colonial Southeast Asian context. Set against popular nationalist movements, athwart Depression-era poverty across the region, the recommendations made in Bandung cannot be divorced from colonial actors and anticolonial movements.

Tensions between social medicine and socialist medicine would prove a contentious issue over the course of the twentieth century. Chapters 5–8 – by Dora Vargha; Anne Kveim Lie and Per Haave; Jeremy A. Greene, Scott H. Podolsky, and David S. Jones; and Sebastian Fonseca, respectively – emphasize different conceptualizations of the role of the state in social medicine across Eastern Europe, Scandinavian states, the United States, and Latin America. In Chapter 5, Vargha examines the global influence of the "second world" of the socialist bloc, another marginalized but prolific generator of models of social medicine. She describes how the basic tenets underpinning social medicine gained new purchase in the "Global East" with the rise of state socialism and the emergence of a socialist worldview. New socialist or communist governments were sympathetic to theories postulating social, economic, and environmental determinants of health and disease – as well as open to fresh opportunities to extend the remit of the centralized state. And yet, as Vargha

[9] On the significance of the Alma-Ata Declaration and its focus on primary healthcare delivery, see Socrates Litsios, "The Long and Difficult Road to Alma Ata: A Personal Reflection," *International Journal of the Health Services* 32 (2002): 709–32; Marcos Cueto, "The Origins of Primary Health Care and Selective Primary Health Care," *American Journal of Public Health* 94 (2004): 1864–74; Fran Baum, "Health for All Now! Reviving the Spirit of Alma Ata in the Twenty-First Century: An Introduction to the Alma Ata Declaration," *Social Medicine* 2 (2007): 34–41; and Packard, *Global Health*.

shows, there was no single answer to what might constitute socialist medicine. She traces manifold and diverse connections between socialist politics, health policies, and medical practice across Eastern Europe, mapping divergences and overlaps in what became a key point of distinction in Cold War rhetoric, setting apart socialist East and capitalist West.

Kveim Lie and Haave, in Chapter 6, look at the contributions of doctrines of social medicine within the Scandinavian welfare state, an easily romanticized framing of capitalist socialism or socialist capitalism. In Scandinavia, health policies of the welfare state during much of the postwar period were premised on social medicine, which was swiftly established as a core medical specialty. This chapter follows the rise of social medicine within Scandinavia from the interwar period, tracking its ramifications in international health agenda and global health governance, before exploring broader negotiations of social medicine as an academic, activist, and clinical field during the postwar years.

Unlike Scandinavia, the United States quickly turned "socialist medicine" into a red-baiting slur. The inferred proximity between "social" and "socialist" meant that social medicine achieved little institutional stature in the US, leaving it perched on the edges of a few medical schools. Nonetheless, elite American universities did harbor several key figures in global social medicine and the Rockefeller Foundation intermittently preached the mission of social medicine abroad. As Greene, Podolsky, and Jones suggest in Chapter 7, this almost spectral presence poses a challenge for critical scholars: should their historical analysis focus only on renegades who outed themselves as theorists or practitioners of social medicine, or should they cast a broader net to include fellow travelers who identified differently (for example, with social hygiene, preventive medicine, community medicine, and so on) but nonetheless were animated with the spirit of social medicine? The chapter takes a hybrid approach. It reviews celebrated early US theorists of social medicine (such as Henry Sigerist, René Dubos, and George Rosen), showing how their ideas influenced the international health and domestic medical education through entities like the Rockefeller Foundation. At the same time, the authors ask why other key figures working at the intersection of health and the social world, especially Black social theorists like W. E. B. Du Bois, have been excluded from the social medicine vanguard. They trace the growth and fracture of American social medicine as a field that saw itself as liminal – between academic departments and community organizing efforts – thereby hoping to reframe the past, present, and future of the field.

In striking contrast, the history of social medicine in Latin America often takes an assertively Marxist demeanor.[10] Established in 1984, the Latin

[10] See also Herbert Waitzkin, C. Iriart, A. Estrada, and S. Lamadrid, "Social Medicine Then and Now: Lessons from Latin America," *American Journal of Public Health* 91 (2001): 1592–601;

American Social Medicine Association (ALAMES) represents the most stable transnational association in the region, examining the social basis of population health through lenses of Marxist historical materialism. Characterized as a "movement" deeply rooted in populist struggles of the region, the impetus for ALAMES's radical social medicine has generally emerged from public universities and scholarly institutes. As Fonseca shows in Chapter 8, not enough is known about the critical engagement between social movements, academic institutions, and the Pan-American Health Organization (PAHO) in this "second wave" revival of social medicine. Fonseca demystifies the relationship between ALAMES and PAHO, unearthing creative tension and generative ruptures around key actors like Ramon Villareal, the editors of *Educación Médica y Salud* (established in 1966, the PAHO's journal on human resources), and the occupants of multiple public higher education and research institutions. The chapter positions radical Latin American social medicine against the widespread ideological suppression enforced during the Cold War.

The broad theme of South–South transmission of models of community health, community medicine, and collective health shaped different trajectories of social medicine from Pholela to Mississippi, China to Mexico, and across South America and Australasia, as detailed in Chapters 9–12. Abigail H. Neely in Chapter 9 recenters the women of Pholela, South Africa, to recapture their role in the genesis and spread of community health practices that later helped to reconstitute social medicine. She traces one of the more easily elided origin points of the goal of delivering primary healthcare for all the world – as ultimately expressed in the Alma-Ata Declaration of 1978 – to a remote rural health center called the Pholela Community Health Centre. There, a new brand of social medicine – Community-Oriented Primary Care (COPC) – was born. While the health center's first medical director, Sidney Kark, would go on to help write the Alma-Ata Declaration, Neely argues that he learned both theory and practice from the community health workers in Pholela. This chapter explores the experiment in social medicine that took place in Pholela from the perspective of the people who lived in the health center's catchment. In so

D. Tajer, "Latin American Social Medicine: Roots, Development during the 1990s, and Current Challenges," *American Journal of Public Health* 93 (2003): 2023–7; Marcos Cueto and Steven Palmer, *Medicine and Public Health in Latin America: A History* (Cambridge: Cambridge University Press, 2014); Anne-Emanuelle Birn and Carles Muntaner, "Latin American Social Medicine across Borders: South–South Cooperation and the Making of Health Solidarity," in Emily E. Vasquez, Amaya G. Perez-Brumer, and Richard Parker (eds.), *Social Inequities and Contemporary Struggles for Collective Health in Latin America* (New York, NY: Routledge, 2020), 41–58; Eric D. Carter and Marcelo Sánchez Delgado, "A Debate over the Link between Salvador Allende, Max Westenhöfer, and Rudolf Virchow: Contributions to the History of Medicine in Chile and Internationally," *História, Ciências, Saúde – Manguinhos* 27 (2020): 899–917; and P. M. Sesia, "Global Voices for (Global) Epistemic Justice: Bringing to the Forefront Latin American Theoretical and Activist Contributions to the Pursuit of the Right to Health," *Health and Human Rights* 25, no. 1 (2023): 137–47.

doing, it reveals both the possibilities and limitations of this distinctive form of social medicine. As COPC traveled from Pholela, the efforts of the African women who lived around the health center became manifest again, at a distance, in places like Mound Bayou, Mississippi, and elsewhere in the developing world. Focusing on Pholela's residents, this story of social medicine not only offers an important corrective to more common accounts concentrating on medical doctors and bureaucratic luminaries – it also forces us to rethink how we understand social medicine and who makes it happen.[11]

Another key proposition of the Alma-Ata Declaration derived from "barefoot doctor" practices in rural China, a flowering of an alternative vision for social medicine, one that might be called transnational medical Maoism. As Xiaoping Fang shows in Chapter 10, social medicine in post-revolutionary China highlighted the legacies, good and bad, of growing commitment to international health, in which China was both recipient and contributor. Chinese social medicine amalgamated influences from semi-colonial Western hygiene and public health officers, many of them representatives of the Rockefeller Foundation, nationalist physicians, and rural health experts from the LNHO, along with later Soviet advocates of socialist medicine. But China contributed a unique method of tackling social determinants of health and the relationship between medicine and social justice. Fang follows the domestic production and international export of this "barefoot doctor" model at the height of the Cultural Revolution. For the Chinese government, the barefoot doctor system justified its radical transformation of society and publicized its political legitimacy. For the international health community, barefoot doctors became exemplars of how developing countries should deal with infectious diseases and provide primary healthcare. Fang's chapter analyzes the political assumptions and institutional structures that facilitated implementation of the barefoot doctor scheme. He also observes the residual structural inequalities within government administration that may have limited benefits of this form of social medicine – a mode of intervention actively romanticized and promoted around the world. With a sense of changing practice and meaning over time, Fang explores how barefoot doctors meant different things to different audiences, inside and outside of China, during the late twentieth century.

[11] See also Shula Marks, "South Africa's Early Experiment in Social Medicine: Its Pioneers and Politics," *American Journal of Public Health* 87 (1997): 452–9; Theodore M. Brown and Elizabeth Fee, "Sidney Kark and John Cassel: Social Medicine Pioneers and South African Émigrés," *American Journal of Public Health* 92 (2002): 1744–5; Mervyn Susser, "A Personal History: Social Medicine in a South African Setting, 1952–5. Part 1: The Shape of Ideas Forged in the Second World War," *Journal of Epidemiology and Community Health* 60 (2006): 554–7; Mervyn Susser, "A Personal History: Social Medicine in a South African Setting, 1952–5. Part 2: Social Medicine As a Calling: Ups, Downs, and Politics in Alexandra Township," *Journal of Epidemiology and Community Health* 60 (2006): 662–8.

In Chapter 11, Kenneth Rochel de Camargo delineates the autochthonous emergence of Brazilian social medicine at the intersection of academic and state institutions in Rio de Janeiro and Sao Paulo, which crystallized in a movement for "collective health" (*saúde coletiva*). Brazil boasts a long tradition in public health, with roots in the colonial period, when the first medical schools were established, reinforced in later nationalist self-assertion. The recent history of the field was deeply intertwined with the struggle to re-democratize the country after the military coup in 1964. As part of a broad social coalition, the *Movimento da Reforma Sanitária* mobilized left-leaning public health physicians connected to Latin American social medicine, who became instrumental in designing Brazil's National Health System, the Sistema Único de Saúde (SUS), after the restoration of democracy. The creation of the Instituto de Medicina Social (IMS) in 1974 at the Universidade do Estado do Rio de Janeiro (Rio de Janeiro State University) gave additional force to these developments. The professors and researchers at IMS advanced a body of theory as well as galvanizing government action. As Camargo shows, the IMS emerged as a prime mover in Brazilian social medicine and a motivating force in directing domestic and international aid work in the Lusophone world.

Chapter 12 takes a longer view on social medicine from the antipodes, revealing possibilities for integration of the field with community health and community medicine and with environmental and planetary imaginaries. After the Second World War, social medicine manifested in Australia largely through proxies and surrogates, which included tropical medicine (in the north of the continent), Aboriginal health, colonial health (in Papua and New Guinea and parts of the Pacific), pediatrics, geriatrics, and some non-institutional aspects of psychiatry. As Warwick Anderson, James Dunk, and Connie Musolino explain, these fields often emphasized socioeconomic drivers of disease emergence as well as social or political solutions to population health problems. Aspects of social medicine enthralled physicians on the right and the left in Australia, all of them afire with enthusiasm for further state intervention and white population management. From the 1970s, however, radical politicians and public health leaders began to support nationwide projects in "community health," influenced by strong campaigns for women's health, workers' health, sexual health, Indigenous health (based on the Black Panther health movement), and colonial health clinics – as well as by similar schemes in Britain, North America, and Southern Africa. The goal was to "develop" communities through interdisciplinary centers (including social workers, nurses, mental health workers, and sometimes medical practitioners), embedded in and engaging with local structures and leadership. These centers practiced a mixture of disease prevention, counseling, and conventional therapeutic intervention. As Anderson, Dunk, and Musolino detail, "community health" largely displaced "social medicine," with its unfashionable undertones of medical dominance,

even though community health would often function more as a surrogate than a substitute. What was lost in translation – and what was gained – is a focus of this chapter.

The closing chapters of the book, Chapters 13–15, examine the durability of social medicine programs in West Africa, South Asia, and the Caribbean amidst the boom-and-bust cycles of supportive and indifferent governmental regimes and the transnational networks that sustained and were sustained by forms of social medicine from the South. In Chapter 13, David Bannister offers a West African case study in the planning and practice of social medicine in relation to community health. The Medical Field Units (MFU) of Ghana were created by remnant personnel of vertical disease campaigns (against trypanosomiasis and yaws), by a small number of late-colonial activist medical officers working on the rural periphery, who framed the MFU purpose explicitly as promotion of social welfare and countering structural determinants of poor health. The MFU were subsequently embraced and expanded by Ghana's first independent government from 1957, as it became clear that this approach to health provision had been highly successful at reaching populations on the economic and political peripheries. As Ghana went through an economically and politically unstable period following the military overthrow of the first independent government in 1966 (there were seven different governments between 1966 and 1981), Medical Field Units continued to operate successfully as parts of an autonomous medical service, with an independent budget. This chapter is based on research in archives in Ghana and Geneva and on oral histories of urban and rural communities, as well as interviews with current and retired health workers who served from the 1960s to the present.

Social medicine in South Asia is often regarded as the product of European and American ideas, expressed most vividly through the Bhore Committee set up in 1943, which included international experts like John Ryle, Henry Sigerist, and John Grant. Certainly, after independence, the committee's recommendations broadly influenced design of the Indian health services. However, the investment required for a strong state-supported healthcare system was lacking: over subsequent decades, the idea of social medicine waned in the political realm and in professional imagination. Curative medicine became ever more compelling, defining conventional health services and public health. Such is the standard narrative, anyhow. Yet, as Rama V. Baru argues in Chapter 14, the formation of social medicine in India has only one foot in Bhore. The circulation of ideas of critical social medicine from China, Latin America, and Africa gained influence on social and political movements in India, demonstrated in the many community health projects established during the late 1960s and 1970s. Insights from transnational social medicine annealed with vernacular medical theories and practices, including Gandhian speculations, allowing the construction of a specifically Indian form of social medicine, one which often

bypassed a failing state, engaging instead with self-government initiatives and with Indigenous knowledge systems. Baru's chapter knits together these diverse strands to make visible the complex textures of social medicine in the Indian subcontinent.

Finally, in Chapter 15, P. Sean Brotherton explores another famous transnational node of social medicine: Cuba's post-revolutionary exportation of healthcare ideologies and practices. The Cuban Revolution of 1959 was an anti-imperialist uprising committed to agrarian reform and ending racial and gender discrimination, the predatory capitalism of economic exploitation and expendability, rampant structural inequality, and widespread corruption. This amalgam constituted diverse and contradictory political projects, incorporating and building on fragments of hopes, fears, desires, frustrations, and anti-colonial struggles, indexing longer historical trajectories within different populations in Latin America and beyond. Brotherton shows how biomedicine in this context was conscripted to serve a project of social medicine and reparative social justice. Since the early 1960s, Cuba's approach to primary healthcare has elicited heated debate on the dimensions of the country's biopolitical project, leading to questions about the resilience of biomedicine, which might continue to transform, even distort, revolutionary potential. This chapter, however, points to the actual plasticity of biomedicine to draw attention to its possible transformation into a diagnostic and therapeutic system of social justice. In other words, the reparative capacity of biomedicine can be molded and transformed to ameliorate the enduring material and embodied legacies of colonialism, now magnified through global capitalism. Cuba's biomedical focus on human health and, by extension, approaches to care, are two sides of the same coin, configured as therapeutic and affective labor, but also a political technology invested in creating the conditions for individuals, groups, and populations to flourish – thus fashioning a new social medicine.

Our collection of chapters concludes with the Afterwords by Anne-Emanuelle Birn, on the links between social medicine and social movements, and by Helena Hansen, on the need to build a usable past for the interdisciplinary fields of social medicine in order to work collectively toward viable futures.

Sentinels Found and Others Deservedly Lost

This is not simply a historical text. The histories assembled here make critical contributions to the pasts and presents of public health, medicine, and caregiving, emphasizing the influences of radical social movements on healthcare, illuminating processes of medical globalization, and above all, charting new paths for medical professionals and healthcare workers worldwide. As clinician-historians dedicated to training health professionals, the editors know

only too well that even uttering the conjunction of "social" and "medicine" can still elicit skepticism, and sometimes outright hostility, among colleagues and students. The contributors to this volume venture further than ever before into this enemy territory, seeking to give form and substance to the various social and political specters generatively haunting contemporary biomedicine. In so doing, we hope the multiple figurations of social medicine sketched here will soon come to be embraced rather than feared or repulsed.

In one book, we can offer only a glimpse of the protean manifestations of global social medicine; we cannot encompass them all.[12] We imagine this collection as prompt to further exploration of manifold, endlessly inventive, social medicines around the world. Some omissions are inadvertent, indicating scotomas in current scholarship that may soon, we hope, be remedied. Other gaps are deliberate: we chose not to reiterate the common stories of social medicine in twentieth-century Western Europe, the usual homages to Virchow and other public health luminaries, since these accounts are well known and readily available.

We also decided not to dwell, in the chapters that follow, on the alliances in Western Europe and many settler-colonial societies in the 1930s between social medicine and eugenics and fascism. In those interwar years, many medical agitators on the right proposed greater state responsibility for the health of national populations – implicitly white populations. Since our focus is on the neglected affirmative and constructive aspects of social medicine, we spend less time on its dark sides but we should not try to evade them either – if only to demonstrate that what seems progressive to one generation might look fraught to successors.

To be sure, the alliances before Second World War of social medicine and solidifying state bureaucracies did sometimes incline medical reformers toward fascism and eugenics – encouraging them to lean toward forms of racial nationalism. The evidence for these tendencies is perhaps strongest in Western Europe between the World Wars but as contributions to this volume indicate, eugenic yearnings might be detected too in settler states in the Americas and Australasia. Eugenics, of course, was expressed in a variety of modes, from forced sterilization to advocacy of better child and maternal health and nutrition. Ostensibly, eugenics shared with social medicine the yearning for improvements in the health of populations, generally "white" populations.[13]

[12] We do not focus, for example, on the relations of mental health and social medicine but see Anne Kveim Lie and Jeremy Greene, "Introduction to the Special Issue: Psychiatry as Social Medicine," *Culture, Medicine, and Psychiatry* 45 (2021): 333–42; and Anne E. Becker, Giuseppe Raviola, and Arthur Kleinman, "Introduction: How Mental Health Matters," *Daedalus* 152 (2023): 8–23.

[13] Paul Weindling, *Health, Race, and German Politics between National Unification and Nazism, 1870–1945* (Cambridge: Cambridge University Press, 1989); Gunnar Broberg and

But this past affiliation should sharply be distinguished from our contemporary visions of social medicine.

A monitory character, worth considering briefly here, was Alfred Grotjahn, a German physician who combined belief in social etiologies of health and disease with promotion of eugenics.[14] His influential textbook, *Social Pathology* (1912), argued for the importance of social and economic factors in disease causation, an approach he called "social hygiene," drawing on demography and social statistics. Grotjahn believed investments in health education and social support, to reduce disease and debility, should naturally be harnessed to "reproductive hygiene," which would limit proliferation of inferior or degenerate types or weed them out if prevention had failed. Like many others in the field of social medicine at the time, he was particularly concerned with the supposedly low-grade urban white poor, filling up the expanding cities of Europe. Unlike later Nazi emulators, he did not regard Jews, other races, and homosexuals as obvious targets of his eugenic vision of social medicine.[15] Nonetheless, Grotjahn's career, like that of so many votaries of social medicine between the wars, provides an object lesson in how even the most "progressive" ideals can go wrong – and in how careful we should be in identifying intellectual antecedents.

Future Global Social Medicines

For more than one hundred years, physicians, healthcare workers, and political activists organizing around social medicine have sought to reveal the social and economic dimensions of sickness and well-being – and to advocate in the name of health for fundamental structural changes in our societies and economic systems. Yet the development of global health programs since the 1990s, often focusing on modular biosecurity interventions and epidemic technical preparedness, marked a shift away from such broad structural concerns

Nils Roll-Hansen, *Eugenics and the Welfare State: Sterilization Policy in Denmark, Sweden, Norway and Finland* (East Lansing, MI: Michigan State University Press, 1996); Lene Koch, "The Meaning of Eugenics: Reflections on the Government of Genetic Knowledge in the Past and the Present," *Science in Context* 17, no. 3 (2004), doi.org/10.1017/S0269889704000158; and Philippa Levine and Alison Bashford (eds.), *Oxford Handbook of the History of Eugenics* (Oxford: Oxford University Press, 2010). Paul Weindling and Dorothy Porter have argued that the connection of social medicine to eugenics necessarily led to health being a matter for expert advisors and qualified bureaucrats, rather than for political parties, at the expense of democratic principles of accountability and representational politics. The Scandinavian introduction of the sterilization laws did not fit this pattern.

[14] On Grotjahn's early practice as a physician, see Paul Weindling, "Medical Practice in Imperial Berlin: The Casebook of Alfred Grotjahn," *Bulletin of the History of Medicine* 61, no. 3 (1987): 391–410.

[15] Robert N. Proctor, *Racial Hygiene: Medicine under the Nazis* (Cambridge, MA: Harvard University Press, 1988); and Weindling, *Health, Race, and German Politics*.

and political imperatives – accordingly, this new global health, for all its flashy metrics and techniques, has done little to correct the world's growing health inequalities. Hence the need to turn again to diverse histories of social medicine, the rich traditions of progressive activism in healthcare, to learn how we might apply ourselves to current challenges. "A fundamental rethinking of the social role of medicine is required," we are told.[16] In recent years, we failed "to acknowledge the historical debates and struggles that have shaped understandings of the societal determinants of health."[17] Medicine's increasingly narrow and precise focus on molecular biology distracts us from "the large-scale social forces that give rise to human disease and affect its distribution around the globe."[18] As Paul E. Farmer, a rare proponent of social medicine within global health, put it: we suffer from "a tendency to ask only biological questions about what are in fact *biosocial* phenomena."[19] In contrast, social medicine represents "a shared domain of social and medical sciences that offers critical analytic and methodological tools to elucidate who gets sick, why, and what to do about it."[20] It therefore is time for "a revitalization of the field of social medicine as a way to affirm a health agenda that promotes human rights and social justice."[21] For those concerned with human health in a politically unjust and ecologically degraded world, understanding the diverse histories and potentialities of social medicine has never been more urgent.

Contemporary scrutiny of social determinants of health, necessary as it is, does not alone substitute for the political substance and historical depth of social medicine. In 2005, the WHO launched its commission on the social determinants of health, hoping to analyze and attend to growing health inequalities resulting from neoliberal capitalist globalization. The report, *Closing the Gap in a Generation* (2008), effectively assembled evidence relating disease patterns to constellations of economic, social, and political injustices. It urged

[16] Matthew R. Anderson, Lanny Smith, and Victor W. Seidel, "What Is Social Medicine?," *Monthly Review* 56, no. 8 (2005): 27–34, at 34.

[17] Anne-Emanuelle Birn, "Making It Politic(al): Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health," *Social Medicine* 4, 3 (2009): 166–82, at 169.

[18] Scott D. Stonington and Seth M. Holmes, "Social Medicine in the Twenty-First Century," *PLoS Medicine* 3, 10, e-445 (2006), doi.org/10.1371/journal.pmed.0030445.

[19] Paul E. Farmer, Bruce Nizeye, Sara Stulac, and Salmaan Keshavjee, "Structural Violence and Clinical Medicine," *PLoS Medicine*, 3, 10, e-449 (2006), original emphasis.

[20] Seth M. Holmes, Jeremy A. Greene, and Scott D. Stonington, "Locating Global Health in Social Medicine," *Global Public Health* 9, no. 5 (2014): 475–80, at 476. Similar arguments are made in Dorothy Porter, "How Did Social Medicine Evolve, and Where Is It Heading?," *PLoS Medicine* 3, 10, e-399 (2006), doi.org/10.1371/journal.pmed.0030399; and Vincanne Adams, Dominique Behague, Carlo Caduff, Ilana Löwy, and Francisco Ortega, "Re-imagining Global Health through Social Medicine," *Global Public Health* 14, 10 (2019): 1383–400.

[21] Michelle Pentecost, Vincanne Adams, Rama Baru, Carlo Caduff, Jeremy A. Greene, Helena Hansen, David S. Jones, Junko Kitanaka, and Francisco Ortega, "Revitalising Global Social Medicine," *The Lancet* (May 28, 2021), doi.org/10.1016/S0140-6736(21)01003-5.

the international health sector to address inequalities in health – yet stepped back from any fundamental political critiques and any radical proposals for systemic change.[22] According to Anne-Emanuelle Birn, the prevailing discourse on social determinants of health evades critical engagement with the underlying structural causes of inequality and injustice. To do so would require deeper historical understanding of political activism in social medicine.[23] Advocates of social medicine from the Global South like Elis Borde and Mario Hernandez also complain that gestures toward the social determinants of health "remain vague, decontextualized and essentially individual, conveying an idea of social 'risk' factors that affect individuals according to their position in the social hierarchy." They demand a more comprehensive critique of the pathologies of power relations under global capitalism – as offered in social medicines past and present. It is necessary, they argue, "to engage seriously with hitherto invisibilized approaches and research traditions," such as social medicine, if we want a radical transformation of our noxious socio-economic system.[24]

Through reading the chapters assembled here, it will become evident that wide-ranging social medicine in the past has drawn on diverse arrays of specialized knowledge. It has constituted a means to escape the strictures of standard biomedicine. Thus, social medicine has derived, in different times and places, from medical visionaries in alliance with other health workers, social scientists, leftist politicians, feminists, Indigenous activists, and progressive social movements. Such collectives have assaulted biomedical citadels from motley institutional sites, whether in dissenting professional groups, marginalized departments in medical schools, infiltrated health bureaucracies, or community health centers. Although often national in aspiration, advocates of social medicine have looked internationally for models and lessons, creating informal intellectual networks that span the globe. Some of the followers of social medicine have demanded fundamental structural change in their societies; others have concentrated on expanding healthcare access; others again, on developing multidisciplinary community health programs. Some have focused on researching and teaching the social determinants of health; or applying sociological insight to clinical practice. Recently, a few disappointed veterans of social medicine have tried to reintegrate ecological conceptions of health

[22] Commission on the Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (Geneva: World Health Organization, 2008). See also David Mechanic, "Rediscovering the Social Determinants of Health," *Health Affairs* 19 (2000): 269–76.

[23] Birn, "Making It Politic(al)." See also Vicente Navarro, "What We Mean by Social Determinants of Health," *Global Health Promotion* 16 (2009): 5–16; and Fran Baum, "Cracking the Nut of Health Equity: Top-Down and Bottom-Up Pressure for Action on the Social Determinants of Health," *Promotion and Education* 14 (2007): 90–5.

[24] Elis Borde and Mario Hernández, "Revisiting the Social Determinants of Health Agenda from the Global South," *Global Public Health* 14 (2019): 847–62, at 852, 858.

and disease into social and political frameworks. What unites these disparate figures is the conviction that health and disease are more than assortments of molecules, more than an assemblage of particles sometimes in comity, sometimes awry.

The contributors to this volume believe that in a world of widening global health inequalities, depleted public health services, and narrowly focused precision medicine, we need a revived social medicine more than ever. It is time to resuscitate critical social medicine, to return it to life on a planetary scale. Accordingly, we have gathered here these chapters that show us how we might remake a social medicine fit for addressing our alarming and oppressive times. From multiple sites, the contributors to this volume seek usable histories of social medicine and its various proxies, necessary histories that will enable fresh critiques of elite biomedical reductionism, clinical individualism, and professional passivity.