

Juan César García interviews Juan César García

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Q: Is there a field of scientific knowledge that addresses the social aspects of the health-illness process and of health services delivery?

A: Yes and this field has received a variety of names. Among others, it has been called Social Medicine, Social Sciences Applied to Health and the Social Sciences of Health. Historically it first “appeared” as “Social Medicine” which refers, generally, to the subject matter of this discipline. The other names designate disciplines which are either included in this field of study or in some circumstances to distinct disciplines, in other words, to the perspectives of the social sciences, medical sociology, medical economy, the political economy of health, etc., and from the medical sciences, social epidemiology, and social hygiene.

Q: How do you explain the existence of so many names for a single field?

A: The variety of names implies, in part, different definitions about the subject matter, varying perspectives on how to undertake its study and the divergent frameworks used by those that participate in the practice of this field. There is, however, a certain degree of agreement about the fundamental objects that comprise this field: “the study of the social determinants of health and of health services.” Based on these fundamental themes a certain consensus could be reached concerning the content of a field that is considered

interdisciplinary. This is why some authors insist on the use of more general terms such as Social Medicine or Public Health [Salud Colectiva] instead of specific disciplines or groups of disciplines such as Social Sciences of Health or Medical Sociology. In this way both social and “medical” disciplines such as epidemiology, hygiene and sanitation can contribute to the field by using a common theoretical framework.

Q: What are the history and the meaning of the term “social medicine”?

A: The concept of social medicine was born in 1848. This was also the year of great revolutionary movements in Europe. Like the 1848 revolutions, the concept of social medicine emerged almost simultaneously in several European countries. Salomon Neumann and Rudolf Virchow speak of social medicine in Germany, Jules Guerin in France, William Farr in England, and Francesco Puccinotti in Italy. It was also the year of the political poets: Heinrich Heine and Lamartine. How are all these events related? Is it mere coincidence or is there something deeper that unites these disparate events into a structured whole? The answer to this question has fascinated the many writers, economists, poets, sociologists and politicians who have studied this particular historical period.

Dr. Guerin¹ coined the term social medicine in a Parisian medical journal which survived only a few months. In Berlin Dr. Virchow introduced the term in another short-lived journal. In both cases, the journals’ content was confrontational and supported the fundamental principles of the 1848 revolutions. The concept of social medicine, although its use was ambiguous, tried to emphasize that illness was related to “social problems” and that the State should actively intervene in the solution of health problems. The term “social medicine” was interrelated with the new quantitative

This text was published originally in: Everardo Nunes (editor) *Ciencias sociales y salud en América Latina. Tendencias y perspectivas*. Pan American Health Organization, 1986.

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conceptualizations of health and illness, abandoning the idea that the two states were qualitatively different. In this way, social medicine emerges as a “modern” discipline, adapted to the new forms of production then developing throughout Europe. Nevertheless, the term social medicine was little used after that time and only re-emerged in England in the 1940s when the National Health Service was being formed. The term gained popularity in Europe but was not accepted in the US because during the 1950s McCarthyism made it impossible to name anything “social” as this would associate it with “socialism”. For this reason, US medical schools used the term preventive medicine, a discipline which included social science themes. Sociologists and anthropologists were the first social scientists to participate in the new discipline and to begin conducting research in the field of health.

It is worth mentioning that at the end of the 1930s and throughout the 1940s, a group of Marxist social scientists, among whom Stern is notable, taught and conducted research on health questions. This current, however, was overwhelmed and its work forgotten due to the rise of positivism in the 1950s and the climate of intellectual repression produced by McCarthyism.

Q. How was the name social medicine disseminated throughout Latin America?

A: During the 1950s, PAHO became interested in reorganizing the teaching of Preventive and Social Medicine and organized regional seminars on this topic. Several events, such as the creation of National Health Services first in England in 1948 and then in Chile in 1952, together with the Colorado Springs Conference, highlighted the need to form doctors more adequately prepared for the new environment. This movement was based on the premise that doctor would be transformed through changes in medical education. Medical education in Latin America was judged to be scientifically backward, disconnected from prevention, undisciplined, and methodologically anachronistic. PAHO, the Rockefeller Foundation, the Milbank Foundation, and the Point Four Program undertook to correct these deficiencies. Accordingly, PAHO

took in charge of the “modernization of the teaching of preventive and social medicine.” The Rockefeller Foundation created and supported small pilot schools in relatively isolated areas far from major urban centers. The Milbank Foundation concentrated on social health sciences and the Point Four Program incorporated social scientists, particularly anthropologists, into its activities.

In 1955 and 1956 PAHO organized two seminars on the teaching of preventive and social medicine. At the first seminar there were no social scientists present; at the second there is mention of only one. It is difficult to determine what impact these activities had, although indirect measures appear to indicate that it was significant. A number of schools began hiring social scientists, although soon afterward there developed problems of status, of work environment, of hierarchy and authority, and of methodological and conceptual differences in relation to health problems and their investigation. On the one hand, the public health professors did not have a clear idea of the role of social scientists, whom they considered capable only of making “questionnaires,” of producing reports about the culture of a region and above all of teaching basic concepts. For their part, the social scientists now being incorporated into teaching and other activities came from social science schools of low quality and had little research experience.

We should remember that at the end of the 1950’s the Latin American School of Social Sciences, has only recently been set up by UNESCO to improve teaching of social sciences, had only recently been created. At the same time, scholarships were being given for study abroad. These initiatives, along with others, attempted to create a “critical mass” of social scientists. Of course, the training took place under the hegemony of sociological positivism, it could not be otherwise. This does not mean however that other schools of thought were kept from flourishing and some students reacted against the prevailing teachings.

Q: It follows from what you have said previously that social medicine was introduced into Latin America in way that linked it intimately to

preventive medicine and public health and also put it in a position of low social and technical esteem. When and how did social medicine manage to separate itself from preventive medicine and public health?

A: Within the world of academia, the separation between preventive medicine and social medicine has still not yet come about. To some extent this has delayed the legitimization of social medicine within the field of medicine. A history of this relationship in Latin America would help to illuminate these obstacles, and in broader terms, would serve as an example of the process by which disciplines are created.

From the start the relationship between old school public health specialists and the young anthropologists and sociologists was tense. They differed in the kinds of questions they asked, their worldviews and the methodologies they employed. The public health specialists were interested in solving tangible problems in their communities. For this, they required, for example, the collection of descriptive data. The anthropologists and sociologists, on the other hand, sought to address more abstract problems such as the power structure in a population. These differences played out within the hierarchical structure of an academic unit where the social scientists occupied the lowest rung.

In the meantime during the 1960's, other institutions such as the Milbank Foundation initiated a series of gatherings of social scientists and public health specialists interested in social sciences. A compilation of work on the subject was also put together. These gatherings and their bibliography were specifically named "social sciences of health".

Q: When does the term "behavioral science" appear in Latin America?

A: The term "behavioral science" has a very short history and had as its purpose to integrate anthropology, sociology, and social psychology under the idea that the behavior of sick persons and the performance of institutions should be explained at the individual level: motivation, attitudes, small groups. Even more common was the use in the early 1960s of the term "Social sciences applied to

health" by certain international institutions such as the Milbank Foundation. By this time several books on medical anthropology and sociology had already been published in the United States. In a way it is logical that in the 1960s the prevailing concepts were from the social sciences or its specialized branches such as sociology, anthropology, and economics (incorporated only later), and that the predominant framework was positivism. Several social science schools were created, including the Latin American Faculty of Social Sciences (FLACSO), supported by UNESCO. By the mid 1960s there already was a critical mass of professional social scientists, some of them trained at FLACSO, others in national schools and some abroad.

Few of the sociologists who graduated in the 60s specialized in health. In truth the chief concern was politics, methodological problems, education, etc.

The Milbank Foundation, through a variety of means, managed to gather and financially support social scientists and other professionals interested in social sciences of health both in Latin America and the United States. The Foundation organized seminars, regular meetings of a network of fellows who had received 5 year scholarships and called gatherings on various topics to maintain some group cohesion. In addition to the group of institutional fellows, composed of social scientists, the Foundation (in concert with PAHO) funded two large studies: one on the human, financial and material resources in health in Colombia, and the other on the teaching of medicine in Latin America. This strategic plan had a profound impact on the development of social science as applied health in Latin America. It was due to this that minor experiences such as the integration of social and clinical sciences on a ward of the San Borja Hospital in Santiago, Chile became known, expanded on and disseminated, attracting new followers (until 1973).

The study co-sponsored by PAHO and the Milbank Foundation on medical instruction was initially proposed as an examination of the teaching of preventive and social medicine in order to evaluate the seminars of these classes in 1954-1955. However, it was evident that what had happened

within these classes could not be understood without relating it to the overall structure of the school, to the relationship between professors and students, and to the broader social structure; this change was not easily accepted by the Advisory Committee, which allowed the researcher freedom to choose his own research strategy, arguing that there is no “research by committee.”

At the heart of Milbank’s strategy was a fellowship program with a small number of participants selected through a long process in which personal leadership capability was key. This program attempted to complete the training of national leaders in public health and social medicine. Frequent gatherings would allow for an effective union between the participants. The climate of tolerance that characterized the program allowed for the inclusion of fellows belonging to diverse schools of thought.

Between 1968 and 1973 PAHO created another strategic initiative geared towards promoting social sciences of health. This program developed slowly and with little structure, resulting from the experience of working with Latin American intellectuals. The failure of this development program is well known. The program’s birth was intimately related to the study of medical education in Latin America. Visits to every school revealed, with few exceptions, a qualitative and quantitative backwardness in the teaching of social and preventive medicine, especially when compared to the recommendations of the seminars of 1955-1956. This preliminary data sparked PAHO’s interest in starting a program to teach social science to the professors of the subjects. At the same time, materials were produced, translating a large quantity of foreign journal articles, most with a positivist framework.

With the help of PAHO, an increasing number of national and regional seminars were organized. The objective was not fundamentally to improve knowledge, or to disseminate poorly known written materials, but also to provide a network for those working in the field, and above all to discover the best social scientists in terms of theoretical and methodological rigor. Given the important number

of gatherings held during this period (1968-73), the most outstanding students were hired as professors in seminars carried out in other countries, always with the objective of discovering new values.

The loose structure that these seminars developed allowed for intense critiques of the prevailing social sciences which were seen as inadequate to explain the Latin American reality. The seminars on methodology, which began after those on teaching, were also subjected to similar criticism.

By the end of the 1968-73 period, conditions seemed ripe for social medicine to be accepted as a legitimate discipline. First of all, there was the creation of two post graduate courses with the name “social medicine”: one supported by the Kellogg Foundation in Brazil, and the other at the Autonomous University of Mexico (UAM) - Xochimilco with the assistance of PAHO. Both were well received internationally. The title of the courses, as well as the organization of the teaching by “theme,” was an attempt to break away from the traditional focus on disciplines. It should not be forgotten that all of this transformative activity occurred during a period of great student unrest in nearly all countries of the world; initially this occurred in just a few countries, but later it spread – or was copied – in others. Numerous magazines, journals, books, articles and pamphlets attempted to explain the phenomenon by relating it to a wide array of factors, including the Vietnam War in the US, cultural factors in France, and student repression in Mexico, etc.

Marx’s concept of economic cycles was the one theory which might have provided the explanation, but it was ignored. A period of economic prosperity ends when it is impeded by existing social relations. A great number and variety of products find no market, resulting in a relative overproduction. Since this dissatisfaction is non-violent, it is expressed in diverse forms (theft, deceit, etc). This contradiction and the various proposals for its solution are most clearly and consciously presented at a cultural level. Within educational institutions, expectations of a promising future job are threatened by, among other

things, the development of a labour hierarchy itself based on an educational hierarchy.

Particularly in the developed capitalist countries, but also in certain underdeveloped ones, the period between 1968 and 1972 led to a real protest against established institutions, and especially against science and scientism. At the same time a student movement developed in various countries, comparable only to the Latin American movement of 1918. Irrationality spread rapidly and religion extended its sphere of influence, particularly religions that were fundamentalist, novel or unstructured. The critique of capitalism in the political arena and the critique of positivism in science became more frequent, rejecting the accomplishments of both capitalism and socialism, and proposing third ways, such as the “New Left”.

This general movement, within the background of relative tolerance resulting from “developmentalism”, produced a strong and original Marxist stream in political science and sociology. Editorial houses publishing Latin American and progressive European authors flourished.

The social medicine seminars could not remain unaffected by these currents and the need was felt to more clearly define the field. In particular the strategic program lacked ideological “cement” that would allow it to grow beyond relationships among friends, and to differentiate social medicine from public health and separate it from preventive medicine.

These goals were partially accomplished at the Cuenca gathering. This declaration decisively attacked positivism as insufficient to understand health problems, underlining the need to seek out new methodologies and theoretical frameworks that could bridge social structure with social process. The difference between the PAHO strategy and the Milbank strategy was the latter’s ideological cohesion and adherence to certain principles. The issue on the table was to find a name that did not bring to mind a pre-existing discipline and would allow for a multidisciplinary approach. In response to this dilemma, research had begun a short time before on the historical origin, the uses and meanings of the most common concepts in relation

to social medicine and how their meanings had changed over time. The material was limited and it was distorted by the perspectives of authors in the 1940s (Sand, Ross). Hence, the relevant articles in journals published by Guerin (French) and Virchow (German) were translated and their content was analyzed in relation to specific events of the moment.

In 1972 and 1973 the long process of becoming a discipline came to an end. One sign of this was the creation of postgraduate courses. The Institute of Social Medicine at the school of Xochimilco was created in 1972; the plan of studies was thematically integrated and avoided mention of particular disciplines. In this way it was in sync with the new educational trends. By this time already there were three different types of post-graduate programs in the field, reflecting differing histories, institutions and funding agencies: a) public health schools with a long tradition, some of them supported by the State in order to train their technical-professional personnel. The students were drawn from State employees and absorbed into the Ministry; b) post graduate schools or internships in social and preventive medicine, directly dependent of the University and drawing students from within the University. The programs had an academic character with training opportunities provided by the schools within what was called the pilot area. Attention was given to research and these schools tended to specialize in epidemiology and preventive medicine; c) the third type of postgraduate school resulted from the long process of separating social and preventive medicine, public health, and social medicine. These schools are another example of the process of creating a discipline. The choice of the name implied a lack of “disciplinization”, opting rather for a set of principles on which to elaborate a body or central theoretical framework.

There is an ongoing attempt to unite, or at least gather with some frequency, the representatives of all these schools in an already existing Association of Public Health Schools supported by the PAHO.

The different approaches and theoretical traditions of the three schools mentioned above translates into a difference in their vocation, their

recommendations, and their future. Apart from these differences, there is a division between social scientists (sociologists, anthropologists, economists, etc.) and medical specialists that work on social aspects of health (epidemiologists, ecologists, occupational health specialists, etc.).

Q. Knowing that PAHO participated in the creation of a Latin American social medicine, is it possible to know the variables that contribute to change in a given sector, and therefore, to count on a “strategic” package that could lead to a similar change in the future? This would undoubtedly be a great accomplishment in the social sciences.

A. Setting aside the irony with which the question is asked and a certain scepticism about the possibility implied by it, the answer is “Yes, within certain limits.” Not only are there theories about how an invention or a new object or a theory comes to be created, but also about how innovations are disseminated and adopted. There are also proven theories about how one creates structural change within societies. Because it is not possible to (voluntarily) manipulate all the variables, this knowledge makes change “possible” but not inevitable. Thus, Lenin, the great strategist of change, pointed out that in a society where living conditions are deteriorating and there is a desire to change them, change also *requires* that the society be in a period of decomposition (having exhausted all of its historical possibilities) and that there be a political vanguard.

Q. According to some definitions, PAHO is an ideological institution; it produces and critically analyzes current technical ideas and it helps to

disseminate and critically adapt them within countries. However, it would seem that little has been written or developed concerning the theory and methodology of how to achieve what is called the dissemination of “innovations” or “new technologies” (including new procedures).

A. PAHO “does not” generally create at the scientific and technical level; rather it disseminates “ideas” or procedures that improve the physical and mental potential of human beings. It follows that the resources that it has and uses are those that would allow for the dissemination or adaptation of already existing “ideas” or artefacts. The most frequently used tools for achieving these goals are: scholarships, meetings, consultancies, certain supporting material, and (small) subsidies. The “arrangement” or the combination of resources and mechanisms “could” lead to adaptation or dissemination. In this case we might speak of a “theory” and of a methodology. It would “appear” that the PAHO does not explicitly have a theory of dissemination to facilitate their efforts.

Q: *Does it then work by intuition?*

A: Not necessarily...

June 3, 1984. Juan Cesar García

References

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