# Social Justice and Medical Practice

## Life History of a Physician of Social Medicine

Merrill Singer and Rebecca Allen

Routledge

# SOCIAL JUSTICE AND MEDICAL PRACTICE

How do we understand and respond to the pressing health problems of modern society? Conventional medical practice focuses on the assessment and clinical treatment of immediate health issues presented by individual patients. In contrast, social medicine advocates an equal focus on the assessment and social treatment of underlying social conditions, such as environmental factors, structural violence, and social injustice.

*Social Justice and Medical Practice* examines the practice of social medicine using extensive life history interviews with a physician practicing this approach in marginalized communities. It presents a case example of social medicine in action, demonstrating how such a practice can be successfully pursued within the context of the existing structure of twenty-first-century medicine. In examining the experience of a physician on the frontlines of reforming healthcare, the book critiques the restrictive nature of the dominant clinical model of medicine and argues for a radically expanded focus for modern-day medical practice.

*Social Justice and Medical Practice* is a timely intervention during a period when even advanced healthcare systems are facing multiple crises. Lucidly written, it presents a striking alternative and is important reading for students and practitioners of medicine and anthropology, as well as policy makers.

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# ACKNOWLEDGMENTS

# INTRODUCTION

## A Road Less Taken

The long, hard winter of 2014–15 was finally showing signs of retreating into history as Becca Allen and I drove the short distance from the campus of the University of Connecticut to the site of E. O. Smith High School in Storrs, CT. We had come to hear a talk by celebrated physician/anthropologist and author Paul Farmer, co-founder of Partners in Health and an individual who has emerged both as a very prominent public figure because of his tireless efforts on behalf of the health needs of the world's poor, but also as the best-known anthropologist of our time. Our plans were to meet up with Bruce Gould, the physician and University of Connecticut professor whose life and work is the focus of this book.

Although the school sits immediately next to and is partially surrounded by UConn, as the university is colloquially known, I had never been to E. O. Smith before. The high school is named after Edwin O. Smith, a Connecticut politician who served for almost three decades in the Connecticut House of Representatives. Previous to his lengthy political career, however, Smith had been president of Connecticut Agricultural College, which in 1939 was renamed the University of Connecticut. The relationship between the two educational institutions continues into the present. E. O. Smith students are allowed to take classes at the university free of charge, and receive credit on their academic records for both institutions. Additionally, UConn's Community School of the Arts partners with E.O. Smith to provide a non-traditional educational experience for students who need a smaller and more personalized instructional setting. Louis F. DeLoreto, a UConn gradu-ate, is the principal of the high school. Thus there is a flow of students between the two institutions, and we joined that stream to hear Paul Farmer's talk.

To our surprise, we were actually the first to arrive at the public event, and as a result, the three of us were able to claim seats close to the auditorium stage, near the podium where Farmer would speak. Around us, a growing throng of high school and university students, teachers from the two schools, and community

members gathered, several hundred strong. Students from the high school had come as part of the E.O. Smith READS program, which selected as its focus for 2014–15 Tracy Kidder's (2004) book *Mountains Beyond Mountains: The Quest of Dr. Paul Farmer, A Man Who Would Cure the World*. The program, a school-wide initiative, is modeled after UConn READS, further emphasizing relations between the now-sprawling university and the high school it partially encircles. As part of the program, students were given reading assignments and projects based on the award-winning biography in their grades 9–12 English classes, as well as opportunities to participate in conversations about the book and related issues in their other courses. The title of Kidder's book comes from a Haitian proverb: "beyond mountains there are mountains," which has been interpreted to mean that as you solve one problem, another problem looms before you, and so you move on in your life and try to solve that problem as well. In short, the challenges of life are great, but we all must do what we can while we are here on Earth by leading meaningful lives that deeply engage the often punishing social world around us, most notably, in the case of Paul Farmer, by confronting the health problems created around the world by massive social inequality and blatant injustice. Of Farmer, Kidder (2003), a Pulitzer Prize awardee, wrote in the book that he is

> A challenging person, the kind of person whose example can irritate you by making you feel you've never done anything as important, and yet, in his presence, those kinds of feelings tended to vanish. In the past, when I'd imagined a person with credentials like his, I'd imagined someone dour and self-righteous, but he was very friendly and irreverent, and quite funny. He seemed like someone I'd like to know, and I thought that if I did my job well, a reader would feel that way, too.

The goal of the E. O. Smith READS program is to promote college readiness, but more broadly, it seeks to promote life readiness. In selecting Kidder's book, the program embraced an issue that harmonizes with the goals of this book, namely raising the question: what kind of world do you want to live in and how can you help make visions of a better, fairer world a reality? Moreover, who might be a genuine exemplar for living such a life?

An important link in the extended social network connecting the globally active Farmer to a high school in the semi-rural and legally designated village of Storrs, CT was the co-sponsor of his talk, an organization known as Roots of Development that helps marginalized populations acquire the organizational skills and financial resources to achieve the level of empowerment needed to build and strengthen their impoverished communities. Roots of Development traces its origin to a trip its co-founder and executive director, Chad Bissonnette, took to Gran Sous, on the island of La Gonave, Haiti while an undergraduate student at American University in Washington, DC. Bissonnette grew up near Storrs and both of his parents were E.O. Smith teachers. Several years ago, the high school embraced the work of Roots of Development by holding fund raisers and hosting Ending

Apathy rallies among students. These events, which included speakers from various activist organizations and informational booths, were designed to inform students about the many issues facing people around the globe. Bissonnette, who spoke at an End Apathy rally in 2013, was able to link the high school with the always busy and often globe-trotting Farmer because of their respective development and health efforts in Haiti, the poorest country in the Western Hemisphere, despite its earlier history as the breadbasket of the French colonial regime. Moreover, like the individual who is the subject of this book, Bissonnette and Farmer early on in their lives made "all in" decisions, to swim against the tide of complacency, to live meaningful and engaged lives in a troubled and unjust world.

Specifically, this book addresses a fundamental question in contemporary health-care: how do we understand and respond to the pressing health problems of society? The conventional biomedical response to this query involves the practice of a type of care that is based on careful clinical assessment of the immediate health issues presented by each individual patient and the provision of (usually) science-based medical treatment drawn from an arsenal of pharmaceutical, surgical, and other established strategies. As Paul Farmer and colleagues (2006) assert, "the holy grail of modern medicine remains the search for the molecular basis of disease." While there are benefits to the conventional approach to medicine, there are significant costs as well. Thus Farmer et al. (2006) add: "While the practical yield of . . . circumscribed inquiry has been enormous, exclusive focus on molecular-level phenomena has contributed to the increasing 'desocialization' of scientific inquiry: a tendency to ask only biological questions about what are in fact biosocial phenomena."

By contrast with the entrenched and dominant clinical model of medicine, a model that has been critiqued as contributing to a maintenance of the status quo, social medicine places an equal level of focus on the social conditions and structural inequalities that generate and exacerbate health problems, including social stigmatization and discrimination, adverse physical factors in built environments (e.g., overcrowding, impoverished neighborhoods, and inadequate diets), structural violence (a concept that has gained broad usage through the writings of Paul Farmer), and social injustice. Structural violence and related inequalities contribute to a biology of inequality, powered by the ways social disparity and deprivation get "under the skin" and are inscribed by disease on body systems. In other words, "we literally incorporate biologically the world around us," a world we must study to understand fully just "who and what is responsible for population patterns of health, disease, and well-being, as manifested in present, past and changing social inequalities in health" (Krieger 2007: 668). As summarized by the Prevention Institute (2002:3);

> The chief underlying cause of health disparities is increasingly understood to be social and economic inequality, i.e., social bias and institutional racism, limited education, poverty, and related environmental conditions that either directly produce ill health or promote unhealthy behaviors that lead to poor health.

Globally, this understanding has been supported by the findings of a growing body of reach (Mackenbach et al. 2008, Stringhini et al. 2010). Exemplary is a multi-cohort study and meta-analysis that included individual-level data on socioeconomic status drawn from seven high-income World Health Organization member countries, indexed by a set of risk factors (high alcohol intake, physical inactivity, current smoking, hypertension, diabetes, and obesity), and mortality, for a total population of 1,751,479 (Stringhini et al. 2017). The study found that low socioeconomic status was associated with a 2.1-year reduction in life expectancy between ages 40 and 85 years of age. The problem with many international programs to lower mortality, the authors argue, is that they fail to address powerful upstream structural determinants of health.

A reflection of this pattern is the disproportionate disease and mortality burden of African Americans. People of African descent in the US have a mortality rate for all causes that is 1.5 times that of Whites (adjusted by age) (Keppel et al. 2002). Cardiovascular diseases, and their precursor conditions, like hypertension and diabetes, are major contributors to Black/White differences in mortality rates. Thus, the risk of dying from heart disease is 1.3 times greater for African Americans compared to Whites (Mensah et al. 2005). In turn, African Americans are 1.8 times more likely to develop diabetes (CDC 2007) and rates of hypertension are between 1.5 and 2 times higher among African Americans (Mensah et al. 2005). There is a significant body of evidence indicating that these disparities have a social origin involving biosocial linkages that have been found to exist between social discrimination and related structural violence (including poverty), maternal stress during pregnancy, low birth weight, and adult onset of precursor diseases and heart disease (Kuzawa and Sweet 2009). These factors—and not genetic differences (as prevailing racial categories are very poor predictors of genetic patterns)—contribute to a significant lifelong deficit in the health and well-being of African Americans compared to Whites and to notably higher rates of cardiovascular disease. Indeed, it is accurate to say that

> Social inequality kills. It deprives individuals and communities of a healthy start in life, increases their burden of disability and disease, and brings early death. Poverty and discrimination, inadequate medical care, and violation of human rights all act as powerful social determinants of who lives and who dies, at what age, and with what degree of suffering. (Krieger 2005:15)

As discussed more fully in Chapter 1, social medicine traces to the work of Rudolf Virchow and his medical report emphasizing the economic, social, and cultural factors driving the 1848 typhus epidemic in Upper Silesia in Imperial Germany, Rather than recommending a narrow medical solution (e.g., sending more doctors or building more hospitals), he proposed a program of significant social reconstructions that would lead to full employment for laborers, decent wages, the organization of agricultural cooperatives, and universal education (Taylor 1985). In this vein, contemporary practitioners of social medicine seek to

not only address the immediate health problems presented by patients but also the debilitating structural factors that lead to much disease and poor health.

In short, this book accentuates the fact that society as a whole must decide what type of medicine it wants. Unfortunately, given existing structural inequalities, not everyone has an equal voice in this discussion. A narrow clinical approach to health dominates because it generates an enormous amount of wealth—through the sale of treatments and insurance—for a powerful, well-heeled sector of society. While the United States has the dubious distinction of spending far more per capita on healthcare than any other nation in the world, it "ranks behind most [developed] countries on many measures of health outcomes, quality, and efficiency," with poor scores on the three established indicators of healthy lives: mortality amenable to medical care, infant mortality, and healthy life expectancy at age 60 (Davis et al. 2014:1). Problems in the quality of care and care access are especially notable among the poor and among marginalized ethnic minorities. In a recent assessment of the U.S. healthcare system, the country was found to have the worst record among industrialized nations in terms of equity. According to the report:

> Americans with below-average incomes were much more likely than their counterparts in other countries to report not visiting a physician when sick; not getting a recommended test, treatment, or follow-up care; or not filling a prescription or skipping doses when needed because of costs. On each of these indicators, one-third or more lower-income adults in the U.S. said they went without needed care because of costs in the past year. (Davis et al. 2014:1)

In such a system of massive inequality, at the personal level each individual physician must decide what type of doctor to be. Here we do not refer to medical specialty decisions but rather how to think about the source of health problems and, based on this consideration, how to practice medicine The same is true of all healthcare workers whatever their area of focus, including nurses, dentists, and the array of other healthcare providers that populate the prevailing biomedical system. One can practice conventional biomedicine, focusing narrowly on the clinical presentation of the health complaints of patients providing the level of care allowable by for-profit insurance companies, engaging thereby in disease management rather than the promotion of health and social well-being, or one can choose to recognize and act on a understanding of health as socially constructed by the experiences and conditions of life. The latter option, leads healthcare providers to the realization that in this country

> black people pay for racist oppression with life spans ten years shorter than that of whites. Poor and oppressed minorities have 25 percent fewer successful encounters with the healthcare system than more privileged groups. Meanwhile, the rate of death or other harmful outcomes increases with the level of poverty in illnesses like coronary heart disease, cancer of all forms, obesity, growth retardation in children, unplanned pregnancies, and maternal mortality. (Levins 2000:6)

Inequalities in health grow even greater as the focus shifts from developed to developing nations, and hence we live in a world in which the wealth and unparalleled lifestyles of the upper classes of the West are paid for by the poverty and poor health of people living in developing nations. With reference to access to healthy diets, for example, as anthropologists Gewertz and Errington (2010:2) observe, "the foods on our plates are often obtained at the expense of foods not on other people's plates."

Unfortunately, while there are various personal accounts of the experience of becoming or working as a physician (e.g., Austin 2009, Colins 2006, Verghese 1994), at present, existing and prospective medical students have few alternative role models beside traditional individual patient/disease-focused practice. One such unconventional role model is exemplified by Paul Farmer. Farmer, as noted, has been described as "the man who would cure the world," in Kidder's biography. In truth, of course, very few physicians or other healthcare providers can be like Paul Farmer, as few current or prospective medical students can realistically hope to achieve his level of international recognition, media presence, and associated impact. Most physicians, instead, lead local lives and engage with homegrown healthcare challenges. And yet, as this books seeks to show, there are alternative, achievable role models at this level too—physicians who venture outside sanitized clinics into the gritty streets of real world human anguish and social suffering. And, as Bruce knows from the calls he gets from medical students, there are many who want an alternative, socially conscious and compassionate path to medical practice.

Based on extensive life-history interviews with Bruce Gould, this book presents one such alternative model of biomedical practice within the context of the existing structure of twenty-first-century medicine and in light of the consequential current unequal distribution of health, living and working conditions, and medical access. The type of social medicine that Bruce practices is informed by a keen awareness of the social origins of health and well-being. It is not a new approach, however, but dates to the early 1800s and to the launching of the Industrial Revolution. As noted, it came into being during an era in which it was difficult to ignore the extent to which capitalist production had impoverished workers, creating an entwined world of poverty, misery, and disease. The most famous early advocate of social medicine, Rudolf Virchow, is often cited by critical medical social scientists for his assertion that "politics is nothing more than medicine on a grand scale." He called for embedding social justice as a central theme in medical practice.

A commitment to this view of medical practice characterizes the approach adopted by Bruce during the challenging process of becoming a physician. Bruce received his M.D. from the State University of New York (SUNY) Upstate Medical University at Syracuse in 1979. He majored in biology as an undergraduate at Cornell University College of Agriculture. His internal medicine internship was completed at the University of Massachusetts Medical Center in 1980, followed by a two-year residency in internal medicine at the same institution, and one year as the Chief Medical Resident. He now serves as a professor and associate dean for primary care at the University of Connecticut's School of Medicine.

As this "bioblurb" description suggests, Bruce has a fairly conventional biomed-ical pedigree. Graduates of the SUNY Upstate Medical University—as described on the university's website—are expected to demonstrate safe, effective, timely, efficient and equitable patient-centered care that promotes health, quality of life, prevention of illness, and treatment of disease. This includes an assortment of skills, including eliciting an accurate history, performing an appropriate physical examination, constructing a comprehensive problem list and differential diagnosis, developing prioritized intervention and management plans using current scientific knowledge, and interpreting clinical, laboratory, radiologic and pathologic data, that are expected of all physicians of modern clinical biomedicine. Similarly, the University of Massachusetts Medical Center, while expressly committed to training physicians to work in the public sector and in underserved areas of Massachusetts, embraces a standard approach to individual patient-focused biomedical training. None the less, despite traversing traditional pathways to becoming a physician, over the years Bruce has earned a local reputation as a committed advocate for public health, primary care, and preventative social medicine.

Until the later months of this study, Bruce carried out his clinical work as medical director of the Burgdorf Health Center, a community clinic serv-ing the underserved population in Hartford's north end. He had been in this position for 27 years until 2016. Then, as described in Chapter 6, an oppor-tunity arose for him to take a new job as the medical director of the Practice Transformation Network at the Community Health Center Association of Connecticut (CHCACT), a federally funded program designed to help clinicians improve their service to patients, in which he would be able to help the Burgdorf and other community-based clinical centers that treat low-income populations. Despite this job change and his new responsibilities, he also continued to serve as director of the Connecticut Area Health Education Center Program and medi-cal director of Hartford's Department of Health and Human Services. At the same time, he is the founder of and advisor to the Mobile Free Migrant Farm Worker Clinic, which has served Connecticut's low-income migrant farm worker popu-lation since 1998. He also helped to create the Youth Health Services Corps, an award-winning program that trains and places high school students as volunteers in healthcare provider agencies. Through this program, students are able to explore health careers while they acquire real life experience working with disadvantaged populations in community healthcare settings.

Reflecting his tireless commitment to improving health, Bruce has, in addi-tion, long been involved in the development and delivery of the University of Connecticut Medical School's quality improvement and patient safety curricu-lum, as well as its nutrition curriculum. He helped establish the University of Connecticut's Urban Service Track, a special mentorship program designed to pro-duce doctors, dentists, nurses, and pharmacists dedicated to serving Connecticut's urban underserved populations, and the Youth Health Services Corps, a nationally recognized recruitment program that trains and places high school students as vol-unteers in various healthcare agencies. Moreover, Bruce has not backed away from

a decades-long struggle to protect health services for the poor in Hartford, despite the readiness of dominant medical institutions and prominent local players in the healthcare arena to cut costs by downsizing or shutting down programs and venues that care for marginalized sectors of the community. In short, transcending the conventional ways of being a doctor within the sanitized institutions of biomedicine, Bruce has chosen a different pathway that embraces both a sharp critique of medicine as it is usually practiced in the US and the dismal direction medicine is headed in the contemporary world, as well as an alternative vision of what medicine might be in the service of social transformation and justice.

For Bruce, the fact that he has consciously chosen to strive throughout his life and career to be a certain kind of person, and the fact he has been guided in this striving by particular values, are all metaphorically expressed in his favorite poem, "The Way It Is" by William Stafford. That this poem has such deep resonance with Bruce points to the ways he has tried long and hard to steer his life course with meaning and purpose. Despite setbacks and endless challenges, in the face of frustrating and often powerful opposition, and even in moments of self-doubt and personal uncertainty, Bruce has fought to never let go of his guiding thread, his embrace of the moral obligation to struggle for health and social equity for the poor, the underserved, and the publically maligned. Others, he knows, may not share his commitments, but his thread continues, it defines him and it leads him. It is, to again cite words of William Stafford, the hidden river at the core of his being.

Notably, Bruce's vision is shared with Paul Farmer, although the two had never met before the event at E. O. Smith High School. In the minutes prior to the program beginning, however, as people filed into the high school auditorium, Farmer spotted me—a fellow medical anthropologist—in the audience and came over to say hello. As a result, these two practitioners of social medicine were introduced, fulfilling my own imagined choreographing of the opening of this book. After Farmer's talk—which addressed the ebola epidemic in Western Africa in light of the social origins of disease—a diminutive but unintimidated high school freshman began her question by stating "Dr. Farmer you have been a great inspiration for me." While Farmer is an inspiration for many people, including many medical students around the country and beyond, it is, this book argues, actors on the local stages of social medicine, like Bruce Gould, who offer immediate and graspable models for those who choose to put people first and seek to build a social world founded on principles of collective responsibility, caring, and equity.

This model is twofold. On the one hand, it encompasses a particular kind of doctor/patient relationship. The orientation underlying this relationship, the kind that doctors like Bruce or Farmer strive to establish, is nicely captured (under the most difficult of circumstances) in the commencement address of Dr. Kent Bradley at the 2015 Indiana University School of Medicine (National Public Radio 2015). Bradley contracted ebola while working as a physician in Liberia and was the first person to receive ZMapp, an experimental drug used in the treatment of the disease:

In the first seven weeks of treating patients with ebola, we had only one sur-
vivor; one survivor and nearly 20 deaths. Losing so many patients certainly
was difficult. But it didn't make me feel like a failure as a physician because
I had learned that there's a lot more to being a physician than curing illness.
In fact, that isn't even the most important thing we do. The most important
thing we do is to enter into the suffering of others. And in the midst of what
was becoming the worst ebola epidemic in history, we were showing com-
passion to people during the most desperate and trying times of their lives.

Rather than a disease or diseased organ system, a patient in this model is seen as a
fully human, intelligent, and emotional being, a being of meanings and feelings,
while the doctor does not remain at a distance as a neutral expert engaged only in
a sterile clinical diagnostic and disease treatment processes.

On the other hand, patients are not seen as isolated beings devoid of families and
communities, or as people who are not at every moment being impacted by living
conditions, working environments, social arrangements, and the consequences of
living in an unequal social system colored by injustices, indignities, and suffering.
And these wider conditions, which are examined here in some detail, are seen as
every bit as important and as much medical concerns as pathogens, inflammation,
genetics, fever, or failing organs.

# 1

# ALTERNATIVES IN MEDICAL PRACTICE AND THEIR SOCIAL AND PERSONAL IMPLICATIONS

> Wherever the art of medicine is loved, there is also a love of humanity.
>
> *Hippocrates*

## A Molecular Understanding of Disease

Many technical changes and modification of points of view notwithstanding, the central thrust of biomedicine, from research to training, to clinical practice, remains centered on the molecular understanding of disease, as it has since the mid-nineteenth century. The roots of this way of thinking about human health extend deeper in time to the fifteenth century, with the rise of the practice of anatomical dissection in Europe and the belief that opening up corpses would reveal "the causes of pathology lurking in the body" (Lock and Nguyen 2010: 29). In the eighteenth century, medical practitioners began to see the body as an integrated system that could be clinically examined using agreed-upon procedures to determine the nature and location of disease. This conception was significantly advanced with the rise of "germ theory" in the following century, including the view that specific infectious diseases were caused by specific microorganisms that invaded the body. The end result, as Candia, Banavar, and Losert (2013: 3) affirm, was that "gaining a molecular understanding of disease [became] the holy grail of current biomedical research and related interdisciplinary fields."

In clinical practice, as patients know well from personal visits to their doctors, this approach is actualized as individually focused physician review and record-ing of patient symptoms, physical examination, and the use of internal body data collection using various technologies (e.g., radiographic imaging, laboratory tests) to determine if a disease is present, to establish its nature, and to decide on a treat-ment course. Underlying conventional clinical practice is an understanding—or path for comprehending—what disease is from a biomedical perspective. This

understanding is constructed within contemporary biomedicine as the product of a joint project carried out by the fields of molecular biology (which examines the components that make up cells and organisms), biochemistry (which studies the biomolecules of the body and the chemistry behind biological processes), and genetics (especially the analysis of deviance from normal gene patterning). The end result of this approach to health knowledge is a particular way of thinking about disease as a disruption, breakdown, or error at the molecular level that has adverse consequences at higher levels of complexity, especially the cellular and organismic levels.

## The Patient-Centering of Healthcare?

In recent years, however, there has been much internal healthcare establishment and media discussion of a paradigm shift in biomedicine that includes a broadening of understanding about the nature of disease. This shift involves a new emphasis on what has been called patient-centered care that is delivered by a multidisciplinary provider team that incorporates concerns beyond the biological level (Anderson 2014, Beck 2015). Various factors have pushed for change. Most notable was popular dissatisfaction with rising medical costs.

In 2002, the average household was spending about $2,300, or just under 5 percent of its total income, on healthcare. This was an increase from 1999, when the average was under $2,000, or about 4.5 percent of household income. As medical costs continued to increase, employers began shifting more costs to their employees, forcing people in growing numbers to drop health insurance coverage or reduce their purchase of other goods and services. Employer healthcare premiums increased by almost 75 percent in the years 2000–05 and employee contributions for individual and family health insurance plans increased at about the same rate (Kaiser Family Foundation 2016). Smaller companies began to cancel work-based health insurance. As a result, the rate of coverage of employees at smaller companies declined from 68 percent in 2000 to 59 percent in 2005. Overall the proportion of employees who received health coverage from their employer dropped by 4 percentage points and, between 2000 and 2004, the rate of people without insurance for the entire year grew by 1.5 percentage points (Gould 2005). As Elise Gould (2005) notes "many prime-age working adults were left stranded by the drop in coverage and fell into the ranks of the uninsured. Middle-income Americans between the ages of 25 and 54 were 26.7% more likely to be uninsured in 2004 than in 2000."

The Commonwealth Fund Biennial Health Insurance Survey in 2003 showed that over 75 million Americans (or 37 percent of the adult population) were having difficulty paying their medical bills, and many people were beginning to accumulate medical debt. This led people to not seek needed care and suffer the health consequences. Specifically, the study found that almost two-thirds of people with either a medical bill or debt problem were forced to not get needed care. This was three times bigger than the rate of care avoidance in households that were not enduring health-related financial difficulties. Nearly one of every three adults in

the US (approximately 61 million people) reported that they had problems paying medical bills in 2003 (Doty et al. 2005).

Suffering from medical debt also impacted other issues faced by families. A survey of low- and middle-income households found that half reported having medical debt and a quarter of those reported subsequent housing problems as a result (Seifert 2005). Himmelstein and colleagues (2005) studied individuals who filed for bankruptcy in five federal courts and found that about half reported medical factors pushed them into debt. In a follow-up national study, Himmelstein and colleagues (2009) found that over 60 percent of individual bankruptcies were of medical origin, with most people (92 percent) succumbing to debts of over $5,000. Over the period of these two studies (2001–07), the proportion of bankruptcies attributed to medical bills rose by just below 50 percent. Moreover, a telephone survey by the Access Project revealed that low- and middle-income households had to turn to credit cards to pay for medical care, raising their overall debt and increasing their economic vulnerability (Zeldin and Rukavina 2007). Although uninsured respondents had the highest levels of credit card debt, even those with health insurance were not completely exempt. Kohn and colleagues (2005) examined the scope and consequences of medical costs among people living in Kansas and found that medical bills were exhausting family savings and sending households into crushing debt. The result of these dire developments was a rising cry nationally for reform and relief from the far-reaching consequences of rising medical costs.

By 2007, the US had the highest healthcare costs relative to the size of its economy of any in the world, and yet almost 50 million citizens (approximately 16 percent of the population) lacked health insurance coverage (U.S. Census Bureau 2008). Lack of health insurance coverage can be dire. In 2009, a study by researchers at Harvard University (Wilper et al. 2009) found almost 45,000 excess deaths annually in the US among Americans lacking health insurance. Uninsured adults have been found to be at least 25 percent more likely to die prematurely than adults who have private health insurance. This is in no small part because the uninsured are six times more like to go without medical screenings that might detect significant illness in a timely manner, and they are much less likely to have received preventive care. Consequently, the uninsured are more likely to be diagnosed with a disease in an advanced stage than insured individuals. Ironically, in the end, they are forced to pay more for medical care, by as much as 2.5 times, than the insured (Families USA 2012). In his successful run for the presidency, Barack Obama emphasized the need for healthcare reform to cut costs and extend health insurance coverage. This stance was reflected in the passage of the federal Patient Protection and Affordable Care Act (ACA), or so-called "Obamacare," which was signed into law in 2010 and is discussed more fully in Chapter 2. In addition to extending coverage, the new law required that essential health benefits include mental health, preventive and wellness services, and chronic disease management, placing legal pressure on the healthcare system for further reform.

Yet, the ACA notwithstanding, current estimates do not paint a rosy picture. National health spending increases in the US for the period between 2015 and

2025 are projected to average 5.8 percent or about 1.3 percentage points faster growth than the gross domestic product. By the end of this period, healthcare will represent 20.1 percent of the total economy based on the use of actuarial and econometric modeling methods used by health economists (Keehan et al. 2016).

## Unfairness

Another factor pressing for change has been the great health inequalities found in American society. As Oberlander (2006: 246) stresses, "Unfairness is arguably a cornerstone of the U.S. health care system." The 2001 report on healthcare issued by the Institute of Medicine (2000) emphasized that the healthcare delivery system in the US does not provide consistent, high-quality medical care to all people. Rather, and not surprisingly for those familiar with the healthcare system, the report noted that quality of care was found to vary by gender, ethnicity, geographic location, and socioeconomic status. The following year, based on a review of over a hundred studies, the Institute of Medicine (2002) issued a follow-up report entitled "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," that concluded that racial and ethnic minorities in the United States are less likely to receive routine medical procedures and more likely to experience a lower quality of health services. Healthcare inequality, the report pointed out, exists across ethnic lines even among people with similar incomes, insurance coverage, and medical conditions. Thus the report indicated African Americans and Hispanics are less likely to be given appropriate heart medication or receive bypass surgery compared to Whites with similar cardiac conditions. Further, they are less likely to receive dialysis or transplants when suffering from kidney disease. Use of cancer diagnostic tests and established treatments were also found to not be equitably used. As a result of such findings, Alan Nelson, the former president of the American Medical Association and chair of the committee that oversaw the writing of the report, stated: "The real challenge lies not in debating whether disparities exist, because the evidence is overwhelming, but in developing and implementing strategies to reduce and eliminate them" (Roach 2002: 26).

## The Social Gradient

Mounting research findings on the importance of social factors in health has played a role pushing for a rethinking of the dominant biomedical paradigm. A key figure in directing attention to the social determinants of health was Michael Marmot, Professor of Epidemiology and Public Health at the University College of London. During his career, Marmot has conducted trail-breaking work on the role of social and economic inequality in health. As part of this effort, he examined the findings from the famous Whitehall studies of British civil servants. The original Whitehall Study was an investigation of cardiovascular disease prevalence and mortality rates among male civil servants between the ages of 20 and 64. A second study, the Whitehall II Study, examined the health of over 10,000 civil servants aged 35–55.

In his analysis, Marmot found that the lower the employment grade and income of a public employee the higher was his or her risk from most causes of death, a phenomenon called the "social gradient" (Marmot et al. 1978, Marmot et al. 1991a, Marmot et al. 1991b). Notably, even middle-class individuals have poorer health than those above them in the socioeconomic hierarchy, while those in the lowest ranks of employment have the worst health. Expanding on this insight, in 1998, Wilkerson and Marmot (1998), and members of the International Centre for Health and Society at University College London, published "The Solid Facts," a research-based policy statement on how social conditions—like the quality of one's neighborhood of residence—can impact health. In the Scottish city of Glasgow, for instance, research shows that people who live in poor districts have a life expectancy that is twelve years shorter than those dwelling in affluent districts (NHS Health Scotland 2004). Similarly, in the US, African American men who live in poor neighborhoods tend to live much shorter lives than wealthier White men living in more affluent neighborhoods. In Washington, DC, for example, in 1990, the life expectancy gap between White and Black men was 14.4 years and has not radically changed since then (Friedman and Jennings 2013). Among technologically developed nations, people living in the US have the second highest risk of dying from noncommunicable diseases like diabetes and the fourth highest risk of dying from communicable or infectious diseases (World Health Organization 2011). While death rates from noncommunicable diseases like those of the cardiovascular system have everywhere been in decline, it is less the case in the US. In fact, higher mortality is characteristic of the US across multiple categories of diseases, including respiratory diseases, endocrine disorders, congenital anomalies, and neuropsychiatric conditions. The US also has a dramatically higher rate of death from violence, especially gun-related violence. In 2003, the rate of homicide in the US was just under seven times higher than other wealthy countries, but the rate of gun-related homicide was almost twenty times higher (Richardson and Hemenway 2011). As a result of these cross-country differences in mortality rates, there are large differences in life expectancy at birth among wealthy nations. In 2007, men living in Switzerland and women living in Japan had the longest life expectancies by gender, respectively. The US, by contrast, ranked last among males and next to last among females. This translates into shorter lives for people in the US by approximately 3.7 years for males and 5.2 years for females compared to other rich countries (Ho and Preston 2011). Within-country mortality variances also are of note. For example, African American infants in the US are more than twice as likely as White infants to die before their first birthday (National Center for Health Statistics 2012). Among African American males who have fewer than 12 years of education, life expectancy in 2008 was 14.2 years shorter than for White males with 16 or more years of education (Olshansky et al. 2012).

Based on widespread interest in their policy statement, Wilkinson and Marmot subsequently were asked by the World Health Organization Regional Office for Europe to produce an updated edition (Wilkinson and Marmot 2003). The level of interest in the new version of "Solid Facts" is indicated by the fact that in the

first year after it was posted online it received over 200,000 downloads (Marmot and Wilkinson 2005). In 2005, Marmot chaired the World Health Organization's Commission on Social Determinants of Health, which issued the impactful report *Closing the Gap in a Generation* (Commission on Social Determinants of Health 2008). Three years later, he appeared in the widely watched four-hour documentary film series *Unnatural Causes: Is Inequality Making Us Sick?* (California Newsreel 2008), which examined the social determinants of health based heavily on Marmot's work on the Whitehall Studies. In 2015, he published the book *The Health Gap: The Challenge of an Unequal World* (Marmot 2015), which assembled data from around the globe to support a call for a radical change in the conventional biomedical understanding of health by addressing the societal imbalances in power, finances, and resources that create health inequity. The work of Marmot and colleagues is but emblematic of the large body of research and theory affirming the need to address social determinants to improve health; in short, it supports the need for a new consideration of social medicine.

In light of the growing recognition of nonbiological influences on health, the Medical College Admission Test (MCAT), the gateway to qualifying for medical school admission, began to significantly increase the number of questions it asks about psychological and social factors in health. Further evidence of change in this direction is the fact that, compared to 25 years ago, the humanities now play a larger role in the medical education curriculum, as well as in the questions asked on the MCAT. Moreover, as part of accreditation, medical schools are now required to teach future doctors about core skills in patient-provider communication, the health impacts of prevailing societal inequalities, the role in the health-related behavior of patient culture(s), and the effect of provider bias on effective care delivery.

## From the Trenches

Despite these changes, a question remains: how significant and deep-seated are the reforms that have occurred in biomedicine and its perspective in recent years? Has the paradigm really shifted to a new way of thinking about and responding to health issues? Or, as some maintain, have things only been changed enough in small ways to avoid changing at all in big ways? Alternatively, have things actually gotten worse?

In Bruce's view, based on his experience in the trenches at a clinic that serves poor and ethnic minority patients in the inner city, our healthcare system is now dysfunctional. In part, from his perspective, the problems are embedded in the structure of society, in expressions of structural violence like poverty, lack of food security, and unhealthy living conditions, and in part in the institutional racism that governs access to care. As he sees it, many cities across the country, including Hartford, CT, where the clinic he has worked in is located, are broken. Laying out his vision, he says: "My impulse is to say we have to fix Hartford. People [in positions of authority] get all concerned, and say it's not politically correct to call it broken. If you say it's not broken then you're living under a rock." The alternative, the way things should be

headed, he asserts, is through the development with those living in the neighbor-hoods of an evidence-based, prioritized, intersectoral plan that addresses not only health problems in the clinic but the structural problems in those neighborhoods and the wider society that give rise to many of the health problems and health disparities he sees in his patients. What is needed is not a scattershot focus on this one problem or that isolated issue, or an approach that is superficial and only produces tempo-rary or minor improvements—a tactic Bruce, referring to the arcade game, calls the "whack-a-mole" plan—but rather a systematic approach to creating "a healthier city in all aspects." To do this, he maintains, "we need to rebuild the health care system and have adequate resources in places that serve underserved populations so you can assure that people not only have access to health care and medications, but also to adequate housing, healthy food, quality education, jobs . . . that you're addressing social determinants, that you're looking at where they live, and that you can assure that people have the tools and resources they need" to stay healthy. What is needed, in short, is social medicine.

## The Alternative of Social Medicine

While recognizing the contributions of conventional biomedicine, social medicine provides an alternative founded on a recognition of the social origins of health and illness. What precisely is this alternative, the one that Bruce, in word and deed, exemplifies? One answer to this question is found in a survey conducted with the active residents, faculty, and alumni of the Residency Program in Social Medicine (RPSM) founded in 1970 by the Montefiore Medical Center in New York City. Montefiore is noteworthy because it created the first hospital-based Department of Social Medicine in the US a few years after the end of World War II. It also estab-lished the Martin Luther King, Jr. Health Center in the Bronx as a model program for the interdisciplinary provision of community-based healthcare by integrated teams of nurses, doctors, social workers, and family health workers. The RPSM was set up to train socially minded primary care physicians who were dedicated to and trained to provide care for the underserved at the Bronx facility. The goals were to train excellent physicians who conceived of health and treatment within a biosocial understanding, were committed to community-oriented care, and served as advocates for change to improve community health and well-being. The study of the RPSM, involving 173 participants, was designed to identify the key charac-teristics of a social medicine doctor from an insider perspective.

The researchers identified three major themes in the textual responses of participants:

1.  social medicine doctors possess a broad knowledge of the social determinants of health, and, as a result, as one study participant noted, they "limit fruitless or wasteful explorations of biological explanations for illness when social etiolo-gies are glaringly present and often unaddressed or ignored by the rest of the health care system" (Karnik, Tschannerl, and Anderson 2015: 59);

2.   they also have the ability to translate this broad perspective of health into a treatment plan for individual patients by, noted one participant, "willingness to step out of the clinic and outside of the biomedical model to have a positive impact on health" through advocacy, working in the community, and participating in care provider teams (Karnik, Tschannerl, and Anderson 2015: 59);
3.   they see social medicine as an approach for promoting social justice based on a commitment to working with underserved communities and rejecting, emphasized one participant, "the use of health care for personal profit, suppression of others, or unethical scientific adventures" (Karnik, Tschannerl, and Anderson 2015: 60).

These attitudes express core tenets of social medicine, including the idea that social, socioenvironmental, and economic conditions have a profound effect on health and on medical practice; a starting point for policy should be that the health of the population is a critical government and community concern, there is a responsibility to promote health at all levels of society and through all major institutions of society, and, finally, medicine must address the issue of social and health inequality and social justice within and beyond the clinic.

The origin of social medicine traces to the early nineteenth century when the field study of the relationships between society, disease, and medicine began to emerge. One of the early key figures in the effort to examine the social origins of health was the German physician Rudolf Virchow. Well known still for his contribution to understanding the pathologic anatomy of various diseases, Virchow has been described as "a useful role model for physicians in our society" at a time when "many patients lament the fact that their doctor may be more technician and businessman than advisor and confidant" (Reese 1998).

Born in 1821 to a family of modest means in the town of Schivelbein, Prussia, Virchow began to stand out at school from an early age. He trained at the Friedrich-Wilhelm Institut, a division of the University of Berlin that produced medical officers for the Prussian Army. Even as a medical student, Virchow had broad intellectual interests in philosophy, history, and politics and exhibited a propensity toward boundless energy. After graduation in 1843 at the age of 22, he accepted a position as an intern at the Charité, one of Berlin's most renowned teaching hospitals, where he developed an interest in pathology, including the most current biomedical theories on the causes and treatment of disease. At the time, most such theories, each advocated by a different prominent physician, were primarily armchair hypotheses based on limited data. Overthrowing these frameworks and installing in their place a scientific medicine based on direct observation and experimentation became Virchow's goal (Reese 1998).

His own observations began in the autopsy room and laboratory. Within a few years after graduating from medical school, he already had made several major discoveries about the processes of thrombosis and embolism. In addition, he described leukemia as cancer of the white blood cells and differentiated it from severe blood poisoning caused by bacteria and the increase in white blood

cells that occurs during an infection. He coined the now-common medical term "ischemia" to label the consequences of stopping blood flow to an organ or tissue, as occurs during heart attacks. In time, Virchow became the head pathologist at the Charite and in 1847, because his manuscripts were consistently rejected by established medical journals, he launched a still thriving journal, *The Archive of Pathological Anatomy and Physiology, and Clinical Medicine* (now called *Virchow's Archive: The European Journal of Pathology*) that reflected his scientific approach. In the first issue of the new journal, Virchow laid out his perspective: "The science of pathologic physiology will . . . gradually fulfill its promise, not as the creation of a few overheated heads, but from the cooperation of many painstaking investigators- a pathologic physiology which will be the stronghold of scientific medicine" (quoted in Nuland 1988: 313). Virchow read, was influenced by, and cited Frederick Engels' *The Condition of the Working Class in England* and used some of Engels' data to support his assessment of the relationships between poverty and disease.

Early in 1848, Virchow was sent by the Prussian Government to Upper Silesia to investigate a typhus epidemic that had begun the previous year and quickly claimed the lives of thousands of people. At the time, the reigning medical understanding of the cause of typhus was 'miasma' – foul air caused by rotting animal matter. Virchow concluded that the main cause of the epidemic was the appalling and unhygienic conditions in which most of the people were living. He was especially horrified by the extreme poverty of the peasant population and their exceptionally innutritious diet. He blamed the Catholic Church for sapping the people of ambition and local landowners for extracting any wealth generated in Upper Silesia to be spent elsewhere. He, therefore, argued that epidemics like typhus were best treated politically rather than medically. He subsequently applied a similar perspective in analyzing a cholera epidemic and an outbreak of tuberculosis in Berlin during 1848 and 1849. The social contradictions that Virchow most heavily emphasized were those of class inequality, noting that morbidity and mortality rates, and especially infant mortality rates, were markedly higher in urban working-class districts compared to wealthier areas. With undisguised dismay, he wrote:

> May the rich remember during the winter when they sit in front of their hot stoves and give Christmas apples to their little ones, that the ship hands who brought the coal and the apples died from cholera. It is so sad that thousands always must die in misery, so that a few hundred may live well. (Quoted in Waitzkin 2006: 7)

Virchow published his challenging findings during the intense revolutionary struggles of 1848–49. Virchow's political and humanistic views led him to participate, on the barricades (armed with a rusty sword and an antiquated rifle), in the widespread democratic uprisings of those years, struggles that sought German confederation, political freedoms, and radical improvements in living