Comment

That which we call social medicine . . .

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Fifty years ago the *British Journal of Social Medicine* published a mix of articles very similar to that found in the 1995 issue of the *Journal of Epidemiology and Community Health*.¹ Still, if you were to ask almost any of the current authors, whether in Britain or on the continent, if social medicine is an important discipline they would probably respond negatively. Those epidemiologists or health services researchers who publish in the journal will not see themselves as working in the area of social medicine. The scientific interests and the methods have not changed apparently, but the name has. Why?

Social medicine and idealism

If you read the very informative contribution by Shaun Murphy and George Davey Smith¹ in the February issue of this journal, you will have been struck again by the enormous expectations of "progress in society" of the early leaders in the field of social medicine. As the authors point out, this coincides with the post-war optimism and the sense that now, finally, fundamental changes in society and medicine might be feasible. It is interesting to observe in retrospect that they were right and that very fundamental changes did occur, but that very few of them can be attributed to social medicine.

This social reform idealism as the foundation of a new movement in medicine is by no means new. If we look at the history of public health it occurs over and over again in many European countries.² Just think of the sanitary movement in Britain, or "hygienists" as they were called in other countries, at the end of the 19th century,³ the Fennomanics, a nationalists movement at the birth of the research into socioeconomic backgrounds of populations health in Finland,⁴ and the era of religious involvement in private public health initiatives in The Netherlands in the 1920s and 30s⁵ coinciding with the birth of the *Dutch Journal of Social Medicine* in 1923 (which kept its name for more than 50 years, only to change it to *Social Health* in the 1970s).^{6,7}

The interest in what could be called social medicine grew in the second half of the last century. Doctors became aware of the power of science in providing evidence of the major determinants of disease and of the limitations, at that time, of the potential of curative medicine compared with the possibilities of pre-

vention through major structural reforms both in sanitation and social legislation. It has always been the combination of scientific rigour and political will that has generated the most successful public health achievements. Somehow that combination was not strong enough for the British movement of social medicine to be successful in the 1950s.

Why is it so difficult to bring the two elements of science and idealism, both necessary basic conditions for a lively public health discipline, together in a stable partnership one hundred years after the golden age of public health? Part of the answer might lie in the changing disease patterns, which necessitate different policy approaches. In the era of infectious diseases the causal relationships were easily understood and social reforms were able to achieve visible results in the short term. Nowadays, the time lags between exposure to risk factors and the incidence of chronic diseases are so long that few politicians will reap the benefits of their policies. The natural partnership between the politician interested in social reform and the scientist providing evidence of social deprivation is no longer so self evident. But also, and perhaps even more importantly, with the growing prevalence of chronic diseases and limited resources for the health care system, access to health services has become a pressing public health policy problem. This may well explain the surge in the interest in health services research reported by Murphy and Davey Smith. The focus of attention of "social" policy may well have shifted from prevention to health services purchasing.

Social science and social medicine

The "social" of social medicine, as one can read from the quotes in the paper by Murphy and Davey Smith, denoted a wish to incorporate some of the scientific techniques of what we would now call social sciences in their scientific work. Scientifically, they did not succeed in creating an alliance with the social sciences, as is attested by the classification of publications. More interesting is the fact that when you read the contribution by Margot Jefferys on the development of medical sociology, in last year's special issue of the *European Journal of Public Health* on the history of public health, there is no mention of the importance of the area of or of the development of the interest in social medicine.⁸ Apparently

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the eagerness to join forces in a field called *social medicine* was not felt by the mainstream of the sociologists, just as it was not acclaimed by the mainstream of doctors. In fact, the social scientists who cross over to departments of public health, the sociologists in medicine, are somehow no longer considered “real sociologists”, just as doctors who go into social medicine still seem to lose the identity of a “real doctor”. Somehow, multidisciplinary work might be much acclaimed in general but still perceived as threatening by the professions themselves.

This controversy between sociologists in and out of medicine seems to have been more acute in Britain, however, than it has been in other countries.⁹ This might account for the fact that in the Nordic countries, for instance, the importance of social scientists in health research has been much more pronounced. But the attribution of a certain field of work by certain professions continues, as can be illustrated by the current debate in The Netherlands as to whether the registration of epidemiologists should be restricted to doctors, by the continuing debate in the UK Faculty of Public Health Medicine about its membership, and maybe even by the fact that the European Society for Medical Sociology has still not considered joining forces with the European Public Health Association.

Science and practice

Social medicine as described by those opposed to it is often associated with “socialised” medicine, “socialist society”, and “social class” etc. In reality, however, it appears to be best described as those trying to combine science with ideals. That is also the image that emerges from the historic quotes in this paper. It is clear that the first generation of professors in social medicine combined good science and ideals, but also that they did not combine the two with the practice of public health (as we would now call it). To an outsider that is the most striking element in the description of the rise and the fall of social medicine in Britain. The almost open hostility of the medical officers of health and the emphasis on (social) aetiology of disease rather than on the evaluation of preventive interventions is different from what was found in some of the continental countries in that same period.⁷ In the Netherlands, for instance, it was often the equivalent of a medical officer of health who was appointed as the first professor of social medicine. But the gap between science and practice in public health seems nowadays to be almost universal. Not long ago I had a discussion with one of the former directors of the public health department of Boston, who painted a picture of the gap between his department and the Harvard School of Public Health which looked only too familiar.

Departments of social medicine have continued to do great research on the aetiology of health problems in populations and some of the social determinants. They have increasingly called that research “epidemiology,” and have

expanded their research efforts into the field of health services research as their quantitative methods proved well suited to analysis of the importance of certain health services interventions at a population level. However, their links with those out in the field in positions where they have to take decisions about priorities for preventive interventions or for the purchasing of the appropriate health services for a specific population have been very weak indeed. What we seem to miss in the experiences of many countries in this century is the very fruitful combination of science, idealism, and practice.

Where many scientists in the traditional laboratory disciplines feel the clinician breathing down their neck, pushing them to come forward with a new therapy for their patients, the current generation of public health practitioners does not seem to feel that it has a special right or need to use the results of academic research in daily practice. It is a strong alliance between science and practice which guards health services from doing the “right” thing based on moral rectitude rather than on scientific evidence.

An example may help illustrate this point. The current vivid scientific interest in social inequalities in health is one of the most pure forms of research in social medicine. However many of the papers published in this field describe yet again differences in some health indicator in relation to social class, educational level, or indicator of deprivation. Their conclusions often appear to point at the politicians who apparently are not willing to reduce income inequalities, attack poverty, improve living conditions, etc. It is a strong case of moral indignation and idealism combined with powerful scientific evidence. However, it does not do much to help the responsible public health doctor know what to do next. The fact that so many local governments are prepared to take action and have started interventions is an illustration that the willingness to act is present. However, the evidence of which effective interventions are available is very limited, and evaluating them apparently has a relatively low priority in the scientific world.

Conclusion

Nowadays, the science of social medicine is still concerned with the same issues, but calls itself epidemiology. The revival of the ideals is currently known under the name of “new public health”, but could just as well have been named social medicine. So we have the science and we have the idealism. But we must make sure it does not suffer the same fate as it did in the 1950s. Avoiding the marginalisation that occurred then might well depend on our ability to move beyond science and ideals into practice, to forge a new alliance between the scientific community and the practitioners in public health.

This will depend on the willingness of both parties to bridge the existing gap. Scientists must move beyond aetiological research on the social determinants of health. They must be

willing to apply their energy to evaluation research not only on clinical interventions, as is often done in health services research, but also on public health interventions, despite the problems associated with these kinds of effectiveness studies. On the other hand, the practitioners in public health, be they public health doctors or those working in the more multidisciplinary field of health promotion, will have to accept the scientific rigour of evaluation research before interventions are applied outside the experimental situation.

After all it is much easier to start an intervention programme based on good intentions than to limit activities to those things that have proved to be effective. Of course, we should not demand of ourselves more than we demand of our clinical colleagues. Some interventions, such as not cutting off gas or electricity supplies in cold weather, are so obviously effective that they need not be proved to be so in a trial situation. But for preventive interventions there are a number of additional reasons for wanting to be absolutely sure that they do no harm. We are quite familiar with this concept in our medical preventive interventions such as screening programmes, where the side effects of interventions are very carefully weighed against the potential benefits, but the same applies to social interventions as well. It is specifically in the field of evaluation of social interventions that we might reconsider a new alliance with the social scientists ... although perhaps not so much with sociologists as with economists. The evaluation of economic adjustment pro-

grammes may well provide a very fruitful ground for cooperation to the benefit of both parties.¹⁰ Economists looking for social indicators of success, of which health indicators are an important part, may benefit from our experience in measuring these, while we may greatly benefit from the methodologies of the evaluation of structural social reforms that are considered acceptable in economics.

If social medicine can move from only describing social determinants of health into the field of providing evidence for those trying to improve these conditions we might well start a new "golden age of socio economic public health research".⁴

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