The Royal Society of Medicine

Journal of the Royal Society of Medicine; 2014, Vol. 107(5) 183–186
DOI: 10.1177/0141076814525069

All medicine is social

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This article is the second in a three-part series entitled 'Sense and Sensibility: Society, Medicine and its Practitioners'.

Introduction

Medicine as a discipline cannot function in a social vacuum. Society determines the type of medicine being practised. It is the members of society directly or through their representatives who determine what sources are needed for training of healthcare professionals and delivery of healthcare across all medical disciplines. In addition, especially in psychiatry, society will determine and dictate deviance and how deviance is to be dealt with. The social contract originally between the monarchs and their subjects is simulated between physicians and society as a whole, but through its representatives, who will also dictate how the professions are regulated. It is the regulatory bodies to whom physicians answer regarding clinical practice and standards of healthcare delivery. Certain aspects of clinical medicine will remain social and be very strongly influenced by prevalent social factors. These can be applied to causative or contributory factors as well as in the intervention and management strategies. Society and cultures also determine child-rearing patterns and cognitive schema as well as the way we learn to look at the world. Furthermore, for certain psychiatric conditions cultures and societies play a major role in moulding the symptoms and developing illnesses. Societies define sickness behaviour, thereby dictating what type of illnesses allows individuals to behave in acceptable ways.

Historically, in different schools of medicine, for example in the Greek or Ayurvedic system, physical or mental disorders are seen to be caused by a number of factors, e.g. familial, diet, taboos, stars and weather. These factors interact with each other and will, therefore, determine the type of illness, its potential treatment and likely outcome. The initial understanding of physical and mental disorders was largely social, and it is with the knowledge of human anatomy and physiology and relatively recent technological advances that it became possible to understand biological aspects of aetiological and management factors. Physical environment and the conditions in which individuals live have been significant factors in causation of disorders, and remain so. Fathalla[1] suggests that as more physicians became technically oriented, the less socially conscious they became. As poor housing, overcrowding and other factors contributed to tuberculosis, physicians used clean air and sanatoria as treatment. Once bacillus was discovered, and antibacillus treatments made available, curative aspects became more operative than social management. However, even now overcrowding, poverty and migration can contribute to developing tuberculosis. In psychiatric disorders, something similar emerged with the introduction of antidepressants and antipsychotics, and the focus shifted to physical treatments than social ones. Poor socioeconomic conditions have an adverse influence on human beings and poverty and unemployment can directly or indirectly cause major psychiatric problems.

The history of medicine as a social construct commenced in the 19th century. The relationship between society, disease and medicine is integral to our understanding of what doctors should be doing with the patient in front of them. Three common principles have emerged in this context and include social and economic conditions which impact health, disease and practice of medicine; health of the population; and promotion of health by the society using both social and individual means.[2] Virchow[3] highlighted the social origins of illness.[4–6] Anderson *et al.*[2] note that Virchow's perception was that illness was an indictment of the political system. Virchow is said to have gone further and argued that 'medicine is a social science and politics is nothing else but medicine on a large scale'. The role medicine has played in medicalising normal variants such as homosexuality as a result of social pressures reflects the degree to which medicine is all social.

Salvador Allende and Che Guevara were both physicians who set about raising an awareness of the origins of disease, social factors and suffering. Latin American social medicine has adopted a

highly critical stance towards traditional thinking in medicine and epidemiology. Rather than seeing disease in isolation, social medicine sees health-illness dialectic in a fluid complex relationship between the normal and the pathological. Community medicine must take on public health aspects of medicine and educate the populations it serves.

Disease versus illness

McHugh and Slavney[7] offer four different perspectives to psychiatry, although some of these are equally applicable to other branches of medicine. They put forward four standard methods for explaining mental disorders implicit in current psychiatric clinical practice. These include disease, dimensional, behavioural and life story perspectives. Disease perspective focused on clinical entity, pathological condition and aetiology. Dimensional perspective is applicable to the logic of quantitative gradation and individual variation. This perspective struggles with normal variation based on attributes such as intelligence or personality trait. Therein lies the abnormality which can be quantified. Behavioural perspective is focused on goal-directed and goal-driven features of human life and identifies abnormalities in some features such as sexual functioning, eating disorders, etc. Life story perspectives rely on disturbing experiences such as loss leading to grief. However, this also allows the clinician to understand the developmental aspects of the individual.

The distinction between disease and illness is crucial in our understanding of the patient as a whole individual. Diseases are literally dis-ease and physicians diagnose and treat diseases.[8] Patients suffer 'illnesses' which are experiences of disvalued changes in states of being and in social functioning.[8] Sickness, on the other hand, is defined by the society. Disease is often at the heart of the illness experience, but not always. Patients are interested in getting rid of the illness whereas physicians are interested in 'curing' disease. This is the first point of tension. Second, illness is constituted of social functioning, and focusing on disease will simply ignore this social functioning. Using hysteria and changes in its symptoms and military neuropsychiatric casualties, Eisenberg[8] highlights changes in the observed pathology over the decades. Hysteria often has no underlying brain pathology and does not fit into the disease model and is thus an illness. He further points out that the very limitations of technology kept indigenous healers (and perhaps doctors too) more responsive to the extra-biological aspects of illness, which were perhaps easier to manipulate. The models used for explanation of diseases in psychiatry include the individual's role in the social system. It is crucial that the interaction between the patient and their proximal social contacts (family, peers and friends) and distal social contacts (society at large) is part of the clinical assessment and management. Medical care is a complex social process influenced by and embedded in the cultural values and social framework. Physicians from other cultures need to become aware of their own cultural values and prejudices.

In an illuminating essay, Porter[9,10] reminds us that 19th century health and social reformers had been concerned with developing the political role of medicine with possible extension into training of medical students.[3] From social structures to social behaviour to the rise of 'lifestyle medicine', these changes reflect changing social attitudes and also the increasing dichotomy between therapeutic or curative medicine and preventive or social medicine. The contrasting theoretical perspectives between the two models, where therapeutic medicine covers disease and preventive medicine, focuses more on illness and its consequences. Preventive medicine also depends upon more behavioural perspectives, thereby challenging behaviours which may contribute to ill health. Porter[9] urges the development of a broader framework to understand the complex interaction of biology with the political, economic, social and cultural relations of the 21st century.

In an editorial on social medicine in the special issue of *PLOS Medicine*, Stonington and Holmes[11] suggest that domains of social and cultural aspects, e.g. patients' beliefs, practice and experiences and culture of the medicine itself which is affected by healthcare and health systems and social determinants of disease need to be brought together. Holtz *et al.*[12] emphasise that the field of social medicine includes social and cultural studies of health and medicine and determinants. In spite of the breaking of the genetic code, social determinants continue to play a major role in the genesis and perpetuation of medical disorders. Even within the context and exposure of populations to natural disasters, the role of human behaviour and social organisations in determining at-risk groups and protecting them was ignored. Social determinants such as poverty, debt, unemployment, lack of green spaces and poor access to public transport all contribute to the increased likelihood of developing psychiatric disorders. Ethnicity and racial groups, socioeconomic and educational status all play a role in this disparity. Disparities and exposure to infectious diseases in the early part of the last century are now giving way to disparities in certain cardiovascular and psychiatric diseases[13] but not all disparities are attributable to biological variations. Racial or ethnic identity determines the type of

treatment in medical settings.[13] Social factors and social sciences are often excluded from the overall aetiology, first because of an attraction towards creating a 'scientific and technological' model which indicates a more advanced approach in the understanding of the disease. Social scientists are seen as interloping challengers and are thus excluded.[12] These authors go on to emphasise that the roots of disease are still social. All of the disease, whether it is infectious, genetic, metabolic, traumatic, malignant or degenerative, has social components in the larger perspective or a narrower one. Social determinants play a major role in health discrepancy and hence the remedies must be social.[14,15] For prevention of mental illness, social interventions are essential.[16,17]

Models of aetiology and management are simply ways of understanding a patient's reality. However, the models which physicians use have decisive effects on their behaviour, whether it is in research settings or in clinical ones. Patients come for relief from dysfunction and discomfort. The therapeutic impact is derived from medical presence.

Does the health profession need to be more socially conscious? Without a doubt. The cult of technology is important and seductive, like most cults, and will attract followers in droves. Medicine is about humanity and medical professionals must not lose their human dignity and touch. It is well known and understood that a large number of conditions – including malnutrition, infections and trauma – result from social factors such as poor socioeconomic conditions, overcrowding and unemployment. Doctors may not feel that these are anything to do with them, but they have a social conscience, a responsibility to be advocates for their patients and be agents of change. As Fathalla[1] argues, the medical community has limited capacity and credibility for taking direct action outside the health sector. However, it is critical that physicians of all specialties, colour and creed speak out for their patients, as no one else is likely to be heard in these times of extreme economic downturn.

The social responsibilities of psychiatry and medicine are multifaceted. Prevention and health promotion are one, but understanding the impact of social factors on the causation of disease and influencing the development of interventions which can work on individuals, families and societies are equally important.

Medicine and psychiatry also have a responsibility to focus on the appropriate use of healthcare resources made available to the profession along with provision of high quality high standard healthcare to all those who need it. The core of the professionalism includes up-to-date knowledge and altruism. The delivery of healthcare is between the physicians and their patients, but the system within which such encounters take place is entirely social. The State taking charge of healthcare represents the social control and delivery of medicine. However, the society takes control of the individual's health needs, perhaps moving the individual into a more isolationist and yet dependent role. Foucault[18] sees the Beveridge plan for health as entering the field of macroeconomics. Interestingly, he sees this as the development and growth of 'somotocracy' where the regime takes care of the body, corporal health and the relationship between health and illness. Medicine has been and remains a social activity.

Conclusions

Medicine in its social role is responsible for health promotion and ill health prevention. It is equally important to place its role in the social context within which it is practised. Equally crucial are aspects of social determinants and social inequality which can contribute to aetiology of diseases. Furthermore, clinicians must, therefore, take into account social factors which may directly lead to disease and illness. Medicine is not a pure science; it is a mixture of arts and science and, in order to pretend that this is a science, we should not ignore its social aspect.

Declarations

Competing interests: None declared

Funding: None declared

Ethical approval: Not applicable

Guarantor: DB

Contributorship: DB conceived, designed and wrote the paper.

Acknowledgement: The author would like to thank Kamran Abbasi and Robert Bartholomew for their valuable comments on an earlier draft of this manuscript.

Provenance: Not commissioned; peer-reviewed by Robert Bartholomew.

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