Thank you very much for inviting me. I am honor to talk about Social Medicine and the humanities.

I do, however, have a confession to make. I am not really sure what “social medicine” is, much less, medical humanities. I’ve always been confused about whether it is a discipline or is it a way of understanding medicine. Quite honestly, I hadn’t really heard of social medicine as a distinct “thing” regardless or whether it was a discipline or perspective until long after medical school, residency and PhD.

As you know, I was asked to talk about social medicine in part because of our efforts at UCLA to build a social medicine curriculum into the medical school. This effort has made me think much more seriously about what social medicine is and how to define it. To give away my personal feelings about social medicine and medical school curriculum, I believe it should aim, above all else, at helping to maintain the idealism that motivated students to become doctors in the first place. Especially given that UCLA is a public university, I think social medicine should help students maintain a belief in the humanitarian values that brought them to medicine in the first place.
Organization of today's talk

• A brief comment about myself
• What is Social Medicine?
• Los Angeles and the Social World
• Social Medicine at UCLA
The fact is that psychoanalysis is a scientific method which, before it can be more generally accepted, will have to wait until much more water has flowed under London Bridge.
Time Magazine  
(1956)

Then came Sigmund **Freud** to champion a newer hypothesis: man, without a God, is largely governed by a strange, little-known power called the Unconscious. It was a startling, indeed a discomfiting theory (though it had been hinted at even before Oedipus confronted the Sphinx), for it asked man to alter his vision of himself and almost everything that he valued, from his religion to his mode of dress.
Psychoanalysis is built on quicksand. It's like a 10-story hotel sinking into an unsound foundation. And the analysts are in this building. You tell them it's sinking, and they say, 'It's O.K.; we're on the 10th floor.'
Over the years, I have become increasingly interested in understanding how social inequality shapes health, health outcomes, and the delivery of health. Of course this concern is not new.
It was born in the mid-1800s right when modern scientific methods and medical disciplines as we recognize them today began to emerge. Rudolph Virchow, the scientist who also founded cellular pathology is often credited with founding the discipline called social medicine, when in 1848 as a 28 year old physician and health inspector he was sent by the Prussian government to investigate a devastating typhus epidemic in Upper Silesia, a depressed province inhabited by an impoverished and stigmatized ethnic minority population of Polish-speaking Prussians. His methodology was rigorous, grounded and quantitative. To quote Virchow, "We will count the dead, weigh life for life and see where the dead lie thicker, among the workers or among the privileged." Once he finished counting, his solution to the typhus epidemic was to tackle the root causes by developing a program of socio-economic reconstruction that included raising wages, promoting full employment, founding agricultural co-operatives, and instituting universal education. He was a true scientific humanitarian visionary.
I want to end this section by returning to Rudolf Virchow,

**Medicine is a social science and politics is nothing else but medicine on a large scale.**

-Rudolf Virchow

Virchow saw the quintessentially political nature of health, medicine, and how policy plays a large role in who gets sick and who doesn’t.

Perhaps this quote is one that we can keep in mind as we imagine structural ways of addressing health inequalities within our workplaces, our communities, and our country.

Thank you.
If medicine is to fulfill her great task, then she must enter the political and social life. Do we not always find the diseases of the populace traceable to defects in society?

—Rudolph Virchow, 1848
Roar: behavior problems respond to Serpasil
Assaultive and belligerent? Cooperation often begins with HALDOL (haloperidol) a first choice for starting therapy

Figure 2. 1974 Haldol advertisement, Archives of General Psychiatry [41]
In the mid-1960s, Americans were widely coming to recognize how tremendous inequality, racism and economic and social oppression was harming the health of African American children and adults.

The Black Panther Party in the 1960s mandated that each of its chapters create a People’s Free Health Clinic as a response to these structurally-rooted health inequities, and to specifically address lack of access to medical care and abuse of blacks by medical systems (through, for example, unethical experimentation on blacks).

These “no-cost” clinics accomplished a great deal, offering basic health care services like immunizations, screenings for TB, lead poisoning, SCD and more. They drew upon the WHO’s inclusive definition of health and provided legal aid, housing assistance, and meals for children as well as health care.

The clinics were staffed by party members and health professional volunteers including medical students. Many of the volunteers came from more privileged backgrounds, and so as they volunteered, they were required to attend classes where they read and discussed important post-colonial writings to build solidarity between these medical professionals and the community coming to these clinics. These volunteers treated patients while also training party members as physicians’ assistants.
—clinic; intrapersonal; interpersonal; policy (of a party)

After the Freedom Summer of 1964 in the South, a new England physician named Jack Geiger and doctors in Mississippi came together to conceive of a way to provide community-based curative care in communities affected by racism and poverty.

Geiger applied for funding from the new, federal Office of Economic Opportunity, established through the Great Society reforms in the 1960s.

Geiger and his collaborators wanted to “meet the health needs of the poor in a new way” that could generate a social movement and “provide a base for change in the [health care] system itself” through the Community Health Center model (16).

The first CHCs were started in a housing project in Boston and in rural Mound Bayou, MS. Community organizing was the clinics’ foundation and basis for growth. In MS, for example, community members expressed a need for food security and improvements in sanitation and housing. They developed action plans for the Community Health Center to provide technical assistance on development projects like a cooperative farm.
The health centers, in addition to providing curative services, also operated as training centers in basic literacy, leadership and job skills, and medical skills. 13 members of the Mound Bayou community went on to higher education and many returned to become local and regional political and medical leaders. In Boston, researchers from local medical schools documented the health and socioeconomic outcomes of CHC activities.

Based on their successes, Sen. Edward Kennedy sponsored a bill to fund a national network of such health centers in 1966. These live on, in a more medically-specific, but nonetheless influential form as FQHCs today — taking care of tens of millions of low-income people across the US.

SOURCES:

Between 2000-2010, the city of Philadelphia had a two-year-long waitlist for federally financed housing subsidies. What’s more, city regulations excluded HIV+ people from the waitlist until they could prove diagnosis of full-blown AIDS; and active drug and alcohol users were disqualified from housing assistance.

At the same time, a medical student and physicians from a local medical school, and an advocacy group called ACT-UP Philadelphia united to take action on this issue. ACT-UP launched an advocacy campaign to allow low income Philadelphians living with HIV access to housing. ACT-UP volunteers collected accounts of survivors to demonstrate the link between health and subsidized housing and published an advocacy report distributed to community organizations, homeless shelters, and government offices.

The medical professionals conducted a literature review about housing status and HIV treatment, and organized 80 physicians and public health professionals to sign on to a consensus statement about the qualitative and quantitative evidence for housing and harm reduction. Together, the health care providers and activists demonstrated outside of city hall and were able to obtain a meeting with the Mayor and city councilors.

While the policy change was not complete in their vision, the city did change the criteria...
for entering city-run, federally funded housing — and people with HIV and active drug and alcohol users were admitted to the list for housing vouchers. An independent, comprehensive needs-assessment for unstably housed people living with HIV was also established.

Social Determinants of Health

Structures

- Policies
- Economic systems
- Racism (etc.)

Poverty/Inequality

Poor health outcomes

“Structural determinants of the social determinants of health”
Social Structures:

• The policies, economic systems, and other institutions (judicial system, schools, etc.) that have produced and maintain modern social inequities as well as health disparities, often along the lines of social categories such as race, class, gender, and sexuality.
Structural Violence

- "Structural violence is one way of describing social arrangements that put individuals and populations in harm’s way... The arrangements are structural because they are **embedded in the political and economic organization** of our social world; they are violent because they cause injury to people."

  — Farmer et al. 2006
Structural Violence

• “Racism is both overt and covert...We call these individual racism and institutional racism...The second type is less overt, far more subtle, less identifiable in terms of specific individuals committing the acts. But it is no less destructive of human life. The second type originates in the operation of established and respected forces in the society, and thus receives far less public condemnation”

• Institutional racism leaves individuals and communities “destroyed and maimed physically, emotionally and intellectually because of conditions of poverty and discrimination in the black community, that is a function of institutional racism…”

- Stokely Carmichael, Black Power: The Politics of Liberation
Inequality & Poverty

Clinical Care
20-39%

Social, Economic, Environmental and Behavioral
60-70%

Health Outcomes
U.S. HEALTH CARE RANKS LAST AMONG WEALTHY COUNTRIES

A recent international study compared 11 nations on health care quality, access, efficiency, and equity, as well as indicators of healthy lives such as infant mortality.

<table>
<thead>
<tr>
<th>Country</th>
<th>Overall Health Care Ranking</th>
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<tbody>
<tr>
<td>Switzerland</td>
<td>High</td>
</tr>
<tr>
<td>Japan</td>
<td>High</td>
</tr>
<tr>
<td>France</td>
<td>High</td>
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<td>Netherlands</td>
<td>High</td>
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<td>Austria</td>
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<td>Denmark</td>
<td>High</td>
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<tr>
<td>Australia</td>
<td>High</td>
</tr>
<tr>
<td>Canada</td>
<td>High</td>
</tr>
<tr>
<td>United States</td>
<td>Low</td>
</tr>
</tbody>
</table>

Some of these points were made in a recently published book called The American Health Care Paradox by Elizabeth Bradley and Lauren Taylor, who are researchers at Yale’s School of Public Health.

1. Their work shows that the US spends relatively little on social programs, and the resulting poor social conditions lead to higher disease burdens and higher health costs.

2. For example: In western Europe, for every $1 spent on health care, $2 are spent on social programs. But in the US, for every $1 spent on health care, only $0.55 are spent on social programs.

3. They suggest that this discrepancy between health and social spending results in higher levels of social determinants of health and higher health costs.
Death rates decreasing throughout Europe but increasing in US!

Fig. 1. All-cause mortality, ages 45-54 for US White non-Hispanics (USW), US Hispanics (USH), and six comparison countries: France (FRA), Germany (GER), the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE).

Increasing Inequality in Where Americans Live

The percentage of middle-income neighborhoods has been shrinking, while the percentage of both very high-income and very low-income neighborhoods has increased.

Prepared for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco.


Very low-income neighborhoods have median family incomes less than $10,000 of the metropolitan area median. Other income ranges include: low income ($10,000 to $14,999), middle income ($15,000 to $34,999), high income ($35,000 to $59,999) and very high income (> $50,000).

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www.csmr.ucsf.edu/wedh
Smoking has declined for all, but not equally
Change in U.S. adult smoking rates from 1966 to 2015, by education level

Source: National Health Interview Survey

THE WASHINGTON POST
Household Income and Life Expectancy

Figure 1: Life Expectancy vs. Income in the United States

Women, Birth: 78.8
Women, Top 1%: 88.9
Men, Birth: 72.7
Men, Top 1%: 83.3

Income Percentile vs. Life Expectancy
Los Angeles
Growing Inequality in Los Angeles
Income Inequality
Los Angeles vs US, 1979-2014
Increasing Income Inequality

• 1997: Los Angeles Ranked #19
• 2014: Los Angeles Ranked # 7
• Los Angeles (.50) > San Francisco Bay Area (.48) > San Jose (.46)
Residents of the Poorest LA Neighborhoods die 16 years earlier than the wealthiest (LAC DPH, 2010)
Social Medicine at UCLA
Amounts of Charity Care as a Percentage of Operating Expenses at University of California and Other California Medical Centers
Fiscal Years 2006-07 Through 2011-12

*Source: California State Auditor's analysis of data from the California Office of Statewide Health Planning and Development (OSHPD).

*Note: The change in dollars and change in rate is due to differences in the fiscal year balance sheet presented in OSHPD by each of the responsible California medical centers.

Charity care is measured based on the hospital's reported patient services.
- School of Medicine
- School of Law
- School of Public Affairs
- History
- Anthropology & Sociology
- School of Public Health
Center for Social Medicine & Humanities Researchers

Philippe Bourgois, PhD
- Medical Anthropology

Joel Braslow, MD, PhD
- History & Psychiatry

Laurie Hart, PhD
- Cultural Anthropology

Erin Kelly, PhD
- Social Psychology

Ippolytos Kalofnos, MD, PhD
- Psychiatry & Anthropology

Marcia Meldrum, PhD
- History of Medicine

Sarah Starks, PhD
- Health Services Research

Enrico Castilla, MD, MPH
- Health Services Research & Public Psychiatry
Current Core Project

- Close Collaboration with the Los Angeles County Department of Mental Health
- Aim: Understand forces that lead those with severe mental illness into homelessness and incarceration in order to guide policy
- Interdisciplinary
  - Historical
  - Socioeconomic
  - Health services research
  - Clinical
These are some of the individuals I walk past.
You might even recognize some of them. I am ashamed that I barely notice them, despite the fact that they are desperately sick, often yelling at disembodied voices or at a random passerby. I try to make myself invisible by averting my gaze, hoping our eyes don’t connect so that he or she does not pull me into their psychotic world. That, at least, is what I tell myself. More honestly and more shamefully, I avert my gaze so I am not reminded of their humanity and my guilt for having turned them into less-than-human obstacles to avoid on my way to walk to work.
My daily trek ends across the street from the Ronald Reagan Medical Center. Designed by architect I. M. Pei at a cost of over a $1 billion, the hospital opened in 2007.

Working here we often forget Ronald Reagan’s legacy. Nevertheless, the building evokes much of majesty of Reagan’s economic and social policies as a palace for the medically ill rich and famous in Los Angeles. Also, I can’t help but be struck by the ironies of my walk through one of the wealthiest neighborhoods in the United States, past the dozens of homeless and often psychotic souls, and then to end my short journey at the medical center that takes its name from the man most publicly identified with the neoliberal social and economic policies that have shaped the role of the state in mental health care for the last 30 years or so.

- **Major question for me:** The social, cultural, and clinical circumstances that allow me, on the one hand, to ignore nearly unfathomable depths of psychiatric suffering (despite my training as a psychiatrist) and, on the other hand, practice psychiatry in ostensibly one of the county’s best psychiatry departments are fundamentally historical questions.
- I also feel ethically compelled to try to make sense of these contradictions as a scholar marooned next to the Ronald Reagan Medical Center.

Over the course of this year, I hope to understand better understand what has led us to this
point where our focus as psychiatrists have narrowed to such that we have no choice but to ignore the vast amount of suffering we see on a daily basis.
Figure 1

Number of admissions and resident patients in state and county mental hospitals, United States, for selected years, 1851–2005.

The missing years are interpolated. Sources: 1851–1900 data are from Knap and Mason's Crisis (115). 1901–1960 data are from the National Institute of Mental Health (NIMH). Table 1. 1961–2001 data are from the NIMH and Substance Abuse and Mental Health Services Administration (SAMHSA) (116); and 2002 data are from SAMHSA (127).
2016 Los Angeles CoC Results

- The total estimated number of homeless persons enumerated in January 2016 was **43,854**, an overall increase of **2,680** or **6.5%** from 2015 (41,174)

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sheltered</td>
<td>33,276</td>
<td>33,874</td>
<td>1.8%</td>
</tr>
<tr>
<td>Unsheltered</td>
<td>20,445</td>
<td>20,388</td>
<td>0.0%</td>
</tr>
<tr>
<td>Youth Count</td>
<td>-</td>
<td>2,388</td>
<td>N/A</td>
</tr>
<tr>
<td>Total</td>
<td>41,174</td>
<td>43,854</td>
<td>6.5%</td>
</tr>
</tbody>
</table>

Youth Count also included in Unsheltered Count Totals
People experiencing chronic homelessness, people with mental illness, and people with substance abuse represent a large share of the homeless population.
Figure 1
Percentage of Jail and Prison Inmates
With Serious Mental Illness

*Data estimates based on aggregated reports from that time.

Year


0% 5% 10% 15% 20%
Out of sight...
America’s mentally ill held in:
Per 100,000 adults

Source: B.E. Harcourt, "An Institutionalisation Effect"
Figure 17. Male Mental Health Expansion in LASD

Male Mental Health Expansion in LASD

(Data Source: DHHS)
I became what I call a social scientist of medicine who wants to understand how and why poverty and social inequality makes us sick and what we can do to mitigate that.

• Philippe Bourgois
I asked my father shortly before his death again, “why he lobotomized patients”? His simple reply, which I have thought a lot about since then was: “Because it worked”

History, for me, is more a way of thinking about the world rather than a specific set of methods and procedures. History is fundamentally about asking “why” the world is as it is. When my father told me “lobotomy worked, or, for that matter, when I tell my psychiatry residents that olanzapine (zyprexa) works, a historical perspective asks not only what does it mean for a treatment to “work,” what are the behaviors, thoughts and feelings that define treatable disease, but, crucially, what are the social, cultural and historical circumstances that led physicians (and, less often) patients to deem those behaviors, etc... objects of therapeutic intervention and, inversely, measures of therapeutic success.

By helping to unpack the necessary from the contingent, history can provide a greater spoke of choice for policy makers. In the case of mental health policy, where ideology has driven policy from the birth of psychiatry to the present, an historical perspective may not offer clear answers but it can help make the choices clearer.
1. Begin with a personal story (photo of Lawry)
   1. Father was a surgeon—being a physician was fundamental to his identity
2. Graduated from medical school in 1939 (photo on the steps of Los Angeles County Hospital)
3. In searching for a couple of photos to show, found myself gravitating towards ones taken during WWII while he was oversees.
   1. Slide of Newspaper article—He saw medicine as a heroic venture (photo of newspaper) and, no doubt his three years as a flight surgeon in New Guinea Shaped how he saw medicine
   2. However heroic, I know he cared about his patients. As a child, we had no television and my only chance to watch tv was to go with him in the evenings when he made rounds and then I’d sneak off to the doctors lounge after he had taken me in tow for the first few patients. It was clear he cared for them. I vividly remember watching him gently removing a surgical dressing, reassuring a patient that he or she would be fine.
4. Nevertheless, he was a typical surgeon and, at least like the surgeons I know, loved to talk of his surgical exploits, especially at the dinner table. (photo him doing surgery)
5. One of his favorite stories was his brush with fame while he was at Camarillo State Hospital in the early 1950s.
Camarillo is located in Southern California, North of Los Angeles and south of Santa Barbara
It was built in 1936 and, by the time that my father briefly worked there in the early 1950s, it had a patient population of 7,000.
Dr. Egas Moniz of Portugal, who took prize for his development of surgical technique that opened up new possibilities in treatment of mental illnesses.

Dr. Walter B. Hess of Switzerland, who received the award for the discovery of how certain parts of the brain control the organs of the body.

Associated Press
“One takes a thing that looks like an ice pick and positions it right above the eye. Using a hammer, you pound the pick through the skull. Then ping! the bone breaks easily into the brain. You then swing the pick back and forth a few times and pull it out. That’s it.”