

Emerging the Social Medicine and making the truth of Social Regulation: Critical View from Foucauldian Lens

JOYDEB PATRA

Doctoral Research Scholar
Department of Sociology
Vidyasagar University, Kolkata, India

Abstract: Modern medicine is a Social medicine, recognized as one of medical specialties in many countries since ancient period. However, social medicine has never been formally come out in many countries until mid nineteenth centuries, presumably because the term and its principles were not accepted for some years in the past in bio- medicine, which has strongly influenced Greek medicine, characterized as collective or social. This paper describes the origins and evolution of social medicine and briefly discusses contemporary trends social medicine. Social medicine was initiated in France and Germany in 1848. Since then, it has expanded globally and developed in diverse ways. Included in core principles of social medicine is that social and economic conditions have important effects on health and disease, and that these relationships must be subjected to scientific investigation. Upon which systematic development of social medicine can be based social regulation framework .It is often remarked with the notion of social regulation of modern medicine, started with socializing the objects, the human body and later its socio-corporal space, being linked to the capitalist market economy. Foucauldian angle, medicine did not bother itself at the start with human body rather as a powerful discourse. So, human body is a bio-political reality, and social medicine is bio-political strategy.

Keywords: Social medicine, history, social regulation, Truth, Foucauldian approach.

1.Introduction:

The academic discipline of social medicine has struggled to find a precise definition for over a century. This struggle is exemplified by the classic social medicine course book, *The Social Medicine Reader*, edited by faculty from the Department of Social Medicine at the University of North Carolina, Chapel Hill, which offers an expansive view of social medicine's concerns .These concerns range from early visions of the discipline, focusing on topics such as the social and economic structure of health-care provision, health policy, and clinical holism, through to evolving concepts of the field, such as concerns with doctor/patient relations in culturally diverse societies. The evolution of social medicine as an academic subject has been internationally diverse and a coherent definition of the discipline has remained elusive. Social medicine course is offered at many medical schools in European countries . Some medical schools in the US have an academic department named social medicine or social medicine in combination with another discipline, such as the Department of Global Health and Social Medicine at Harvard University Medical School, the Department of Family and Social Medicine at the Albert Einstein College of Medicine, and the Department of Social Medicine at the University of North Carolina at Chapel Hill Medical School. And there are medical schools that have the Department of Preventive and Social Medicine in numerous countries, including New Zealand, Malaysia, Thailand, Myanmar and India. The first edition of *The Social Medicine Reader*, edited by the faculty members of the Department of Social Medicine at the University of North Carolina at Chapel Hill Medical School, was published in 1997 , and the second edition, published in 2005, was expanded into three volumes . These facts indicate that social medicine is recognized as a specialty of medicine in many countries.

The evolution of social medicine has been internationally diverse, so that its concerns and subject matters may vary to some extent among different national contexts.

2. THE ORIGINS, CONCEPTS AND INTERNATIONAL DIFFUSION OF SOCIAL MEDICINE

With the rapid industrialization and urbanization at the turn of the 19th century, European countries faced many of the social problems, including increased low-wage workers, poor working conditions, lack of housing and sanitation facility. Diseases and deteriorating health conditions among industrial workers and in the low-income population were also serious. Under these circumstances, a group of reformist French physicians and hygienists conducted surveys and statistical studies about the relationships between health problems and social conditions . Furthermore, the first 30 years of the 1800s mark the development of modern clinical medicine to replace classical medicine. French physicians realized that many traditional therapeutic techniques were ineffective and, as an alternative, directed attention to hygiene and the influence of social factors on health and disease. Presumably, in addition to such health problems and state of medicine, the zeitgeist in the time of social revolution had made reformist physicians conceive of social medicine.

The term 'social medicine' was first used in 1848, when French Revolution took place in February. In March of the same year, when revolutionary hopes were still running high, Dr. Jules Guérin used the term writing in *Gazette Médicale de Paris*. In that

writing, he appealed to the French medical profession to act for the public good and to help create new society expected from the revolution. Guérin argued that the goal could be effectively achieved if knowledge and information regarding the relationships among medical issues, social factors and public affairs were systematically integrated into the framework of social medicine.

In Germany, a group of medical doctors and others led by Salomon Neumann, Rudolf Virchow and Rudolf Leubuscher promoted health care reform after the revolution in March 1848. They fully understood the effect of social factors on health problems. Virchow was a pathologist who provided empirical data supporting the argument that social conditions are important factors in the outbreak of an epidemic. His report, produced in 1848, on the typhus epidemic in the Upper Silesia region of Prussia is considered as a classic in the history of social medicine.

People are simultaneously biological and social organisms, and thus human health and disease are affected by social factors as well as by biological factors. Included in the basic idea and concept of social medicine is that the interdisciplinary program between medicine and social science would provide medicine with knowledge and skills needed to analyze the social causes of health and illness in the same way as the alliance between medicine and laboratory sciences had provided new insights into the biological, chemical and physical bases of disease..

Rudolf Virchow and his colleagues proposed three basic principles regarding the academic and practical aspects of social medicine that were summarized by Rosen as follows: 1) the health of the population is a matter of direct social concern; 2) social and economic conditions have an important effect on health, disease and the practice of medicine, and these relations must be subjected to scientific investigation; and 3) steps must be taken to promote health and to combat disease, and the measures involved in such action must be social as well as medical. These principles are retained until now, without fundamental changes, even while being adapted to different societies and conditions over an extended period of time.

Although social medicine was initiated in France and Germany around the same period, its theory was more actively developed in Germany. The literature on social medicine appeared during the period from 1900 to 1920 in Germany is extensive. Probably, for this reason, Rudolf Virchow is commonly considered as the founder of social medicine. The theory of social medicine developed in Germany had a wide influence on the development of this field in many other European countries. Many medical schools in these countries have retained a commitment to its foundational ideas from the early stage to the present day. For example, a study of the curricula of 32 medical schools in 18 European countries conducted in 2002 revealed that over half of the schools were offering social medicine courses.

Social medicine was introduced to Latin America and the US in the 20th century. Social medicine in Latin America was at its prime in the 1930s when Salvador Allende, who later became the president of Chile, was central in promoting the field.. In the US, interest grew in social medicine, and discussion of the topic was popular during the period after the end of World War II. For instance, the New York Academy of Medicine hosted an academic conference on social medicine in the spring of 1947 and published the report of the proceedings. In November of the same year, the Milbank Memorial Fund held a roundtable discussion on social medicine. Thereafter, the American medical community avoided using the term social medicine for a substantial period of time. The reason for the avoidance was that the phrase 'social medicine' sounded very much like 'socialized medicine' and the concept incorporated the politically suspect idea of national health system. By the early 1950s, the American social medicine movement lost its momentum during the red scare of what is known as the era of McCarthyism.

It seems that the term social medicine was no longer considered taboo in mid-1960s. In a survey of American scholars in the fields of preventive medicine, community medicine and public health, conducted during the period from August 1965 to March 1966, it was found that the majority of respondents preferred social medicine as the name of their field of study. Papers on social medicine continued to be published, although not many, discussions on social medicine education began, and practical changes took place as well. Recently, on April 30, 2016, the Social Medicine Consortium composed of individuals, universities and organizations striving for equity in health held a symposium on social medicine at the University of Minnesota, exemplifying the current perception of an interest in social medicine in the US.

3.INSTITUTIONALIZATION OF SOCIAL MEDICINE AS AN ACADEMIC DISCIPLINE

Most of established academic disciplines have some common institutional arrangements, such as courses on the disciplinary subject offered by an autonomous organizational unit at colleges or universities and an academic society for the discipline. From early in the 20th century, social medicine began to become institutionalized as an academic discipline, and the institutionalization had been expedited around the end of World War II.

The University of Vienna began to offer a social medicine course in 1909, and the University of Zagreb in Croatia appointed a faculty member of social medicine in 1931. In the UK, the appointment of the first chair of social medicine by Oxford University in 1943 provided a great stimulus to social medicine as an academic discipline. Some two years later, the University of Edinburgh, the University of Birmingham and Trinity College Dublin appointed a faculty member of social medicine. The Interim Report of The Royal College of Physicians of London, 1943, recommended that every medical school should establish a Department of Social and Preventive Medicine and made recommendations on how the subject should be taught. In 1956, the Society for Social Medicine was established.

According to Rosen, at least until the early 1970s, the content of courses offered by a Department of Preventive Medicine in American medical schools were essentially the same as that offered by a Department of Social Medicine in British medical

schools. The history of the Department of Social Medicine at the medical school of the University of North Carolina at Chapel Hill exemplifies the traditional relationship between social medicine and preventive medicine. The Department, originated from the Department of Preventive Medicine in 1952, has kept its current name since 1980 after going through a few instances of reorganization and renaming. Furthermore, the department is responsible for the resident training program for preventive medicine now .

The majority of the medical schools in India have the Department of Preventive and Social Medicine upon the recommendation made at a medical education conference in 1955 .In addition, as mentioned earlier, many medical schools across the world, including those in New Zealand, Malaysia, Thailand and Myanmar, have the Department of Preventive and Social Medicine.

4.DEVELOPMENT OF MEDICINE AND SOCIAL MEDICINE

The main medical interventions in modern health care are based on biomedical sciences and technologies that have been developed with advances in human biology, other natural sciences and engineering. New effective biomedical interventions are continuously developed, so that increasingly more diseases can be prevented and treated. However, the fundamental limitations of biomedical interventions should not be overlooked.

As described before, health and disease are affected by social factors as well as by biological factors. For example, people may suffer from preventable communicable diseases due to unsanitary living conditions of slum area and people may die from curable diseases because of delay in seeking adequate medical services due to financial burden. Although the direct cause of their suffering and death was disease, the underlying cause was poverty which is not a biomedical problem. Generally speaking, the social causes of, experiences of and response to diseases and other health problems do not belong to the domain of biomedical science or intervention. Furthermore, many problems in health care associated with the increasing effectiveness and value of medical services, changes in the pattern of illnesses, aging of population and continuous increase in health expenditure are more social than medical.

Advancements in medicine and the development of modern health care changed major causes of morbidity and mortality from infectious to chronic and degenerative diseases. In response to such changes in patterns of disease, health policy focused on changing health behavior and promoting healthy lifestyle. From the 1960s, social medicine also increasingly concentrated on relations between health, illness and social behavior .But empirical studies revealed the limitation of a model of prevention that primarily focused on changing individual behavior and therefore policy and research interest was shifted to addressing the social structural determinants of health and disease. Recently, policy efforts give added emphasis on developing approaches directed to social determinants of health as concern with health inequalities is increased .

Social medicine explicitly investigates social determinants of health and disease, rather than treating such determinants as mere background to biomedical phenomena [36]. In line with this perspective of social medicine, Link and Phelan [37] argued that epidemiological studies should pay greater attention to basic social conditions questioning the emphasis on such individually-based risk factors as diet, cholesterol level, exercise and the like. They indicated two reasons for this claim. One of their argument is that individually-based factors must be contextualized to craft effective interventions to improve population health. The other is that social factors such as socioeconomic status and social support are likely fundamental causes of disease.

Eisenberg more specifically argued that the distribution of health and disease in human populations reflects where people live, what they eat, the work they do, the air and the water they consume, their activity, their interconnectedness with others and the status they occupy in the social order. Holtz et al. also indicated that each of the risk of exposure, host susceptibility, course of disease and disease outcome is shaped by the social matrix, whether the disease is labeled infectious, genetic, metabolic, malignant, or degenerative. Both of the papers provided illustrations of the social roots of diseases.

Although infectious diseases are clearly caused by biological factors, the patterns and duration of the infection vary according to the characteristics of population, such as size, structure, density, their utilization of health care services and living conditions .By definition, an infectious agent is a necessary cause of the disease. Eliminating the agent eliminates the disease. But it is not a sufficient cause, for not every person exposed to the agent develops clinical disease. The resistance of the host is as decisive as the virulence of the agent. Moreover, the epidemiology of infectious diseases is affected by human organizations as well as by the characteristics of the infectious agent. For example, the penetration of an infectious agent, which is virulent and infectious only in acute phase, into a small community would rapidly kill or immunize so high a proportion of the population that the agent is no longer able to propagate itself. On the other hand, in big cities, such agents have a large enough reservoir to maintain the chain of transmission. And social stratification is to be made in large communities, and disease epidemiology begins to correspond to the stratification.

The change in the prevalence of type 2 diabetes (NIDDM) among the people of Nauru, a small island in the South Pacific, is a good example of the relationship between socioeconomic factors and diabetes .Until World War II, the main job of Nauruans was fishing and farming for subsistence which required high energy expenditure. After the war, introduction of phosphate mining by foreign companies yielded rental income for Nauruans that rapidly transformed them into wealthy and sedentary people. Virtually all foodstuffs were imported, and most had a high calorie content; obesity became ubiquitous. NIDDM, previously minimal, began to reach epidemic proportions in the 1950s, and in the late 1990s, afflicted almost two-thirds of 55-year-old to 64-year-old adults. The distribution of the disease among Nauruans has continued to change during the past 50 years. Health surveys revealed

that the age standardized prevalence of impaired glucose tolerance rose to 21% in the mid-1970s and then declined to half that value by the late 1980s; yet, the risk factors persisted. According to Eisenberg the plausible explanation for the rise and subsequent fall is that NIDDM resulting from the affluent lifestyle has already afflicted most of the genetically susceptible Nauruans, leaving a residual population of relatively resistant individuals.

Neel has proposed the “thrifty genotype” hypothesis to explain the epidemiological changes in diabetes, like those observed in Nauru. In a situation where there is a fluctuating food supply and frequent famines, greater fat stores would be helpful for surviving subsequent periods of starvation. Individuals with thrifty adaptations (i.e., those able to release insulin rapidly when a temporary food glut becomes available) can convert most of their ingested calories into fat. The very same genotype becomes a handicap in the presence of abundant high calorie foodstuffs and reduced physical activity. This hypothesis indicates that social conditions, through interaction with genotype, can influence the distribution of diseases in a population.

The prevalence of heart disease and diabetes is two to three times higher in African Americans than in whites, but representative surveys of Caribbean populations of African origin have revealed prevalence rates two to five times lower than those of blacks in America or Britain. This suggests that racial disparities in health status observed in the US are associated with social contexts rather than with biological attributes including genotype.

The Center for Interdisciplinary Health Disparities Research at the University of Chicago (CIHDR) proposed a downward causal model or a multilevel causal model of the mechanism through which social factors cause diseases and influence health outcomes. According to the model, upstream determinants at the social and environmental levels influence and regulate events at lower levels, that is, from individual behavior and physiology to the cellular and genetic interactions with health and disease. And feedback also occurs from lower to higher levels, with genetic and biological factors, influencing phenomena above them. In the US, despite the fact that white women are more likely to develop breast cancer, black women are more likely to die from it. Through the study of this disparity, CIHDR illustrated the applicability of the model for understanding the causal role of certain social factors in developing diseases.

Several empirical studies on the effects of social factors on health and disease were briefly reviewed. These studies indicate the inherent social basis of disease causation that is part of the basic concept and theory of social medicine. And they provide some rationale for Eisenberg’s claim that all medicine is inescapably social.

5. Evolve of Social Medicine :

In its launch issue in October 2004, *PLoS Medicine* signaled a strong interest in creating a journal that went beyond a biological view of health to incorporate socioeconomic, ethical, and cultural dimensions. For example, that first issue contained a policy paper on how the health community should respond to violent political conflict, a debate on whether health workers should screen all women for domestic violence and a study on the global distribution of risk factors for disease

Two years on, our October 2006 issue takes our interest even further. It contains a special collection of ten magazine articles and five research papers devoted entirely to social medicine. We are delighted that the collection features many of the leaders in the field, including the renowned medical anthropologists Paul Farmer and Arthur Kleinman, the former United States Surgeon General David Satcher, and the Harvard professor of social medicine and psychiatry Leon Eisenberg.

Most of our readers have welcomed our inclusive view of what a medical journal should highlight. Some, however, have been critical, suggesting that we should publish “less soft stuff” and more “hard science.” These critics might argue that in this era of stem cell research and the human genome project, of molecular medicine and DNA microarray technology, the notion of social medicine seems irrelevant and outmoded.

But the ultimate role of a medical journal is surely to contribute to health improvement, and that means looking not just at molecules but at the social structures that contribute to illness. The stark fact is that most disease on the planet is attributable to the social conditions in which people live and work. The socially disadvantaged have less access to health services, and get sicker and die earlier than the privileged. Despite impressive technological advances in medicine, global health inequalities are worsening.

“All medicine is inescapably social,” said Leon Eisenberg, and we entirely agree. Take, for example, the announcement of the sequencing of the human genome, which the BBC predicted would mean we could “banish inherited disorders, screen people for their vulnerability to diseases, tailor treatment to an individual’s genetic make-up, create thousands of new drugs and extend human lifespan”. In time, perhaps these predictions will be partly or fully realized. What is certain, though, is that the human genome project has also opened up an immediate Pandora’s Box of complex ethical, legal, and social issues. These issues include ensuring equity in patients’ access to the fruits of the project and balancing the benefits, risks, and economic costs of genetic screening. Even the human genome is “inescapably social.”

And so, to complement the papers on molecular medicine that we have published over the last two years—such as papers on genetic mutations that confer resistance to cancer drugs or on differentiation of insulin-producing cells from human neural progenitor cells. we have also dedicated space in the journal to considering the large-scale social forces that give rise to human disease and affect its distribution around the globe. These include economics, politics, legal institutions, and power structures.

Throughout our special collection, one pioneer in understanding these large-scale social forces is repeatedly acknowledged—Rudolf Virchow. In his 1848 medical report of an outbreak of typhus in Silesia, Virchow concluded that poverty and living conditions, not biology, were the prime causes of the epidemic. While an understanding of these large-scale forces remains social medicine's base and one of its most important tasks, this special collection shows the ways in which finer-grained social forces have an equally important effect on health. The different levels at which social forces operate can be considered as four primary domains, beginning in the clinical encounter and opening outward to society and the globe.

The first domain, then, is made up of the cultural and social aspects of the relationship between patients and health professionals. This relationship is a social negotiation affected by beliefs, practices, interests, and power dynamics. Communication within this relationship can have a powerful impact upon health outcomes. The influence of this relationship upon health is not limited to Western, allopathic, biomedical systems but is equally as important in other medical systems throughout the world.

The second domain involves patients' beliefs, practices, and experiences. Patients' experiences of and responses to suffering are not confined to the clinical encounter and vary dramatically among different populations. Understanding the specifics of people's everyday lives is essential to engaging with them and their illnesses.

The third domain is the culture of medicine itself. Health professionals and institutions have their own cultures that also go beyond clinical interactions. Health systems and health research both contain agendas, prejudices, and beliefs that can lead to certain perspectives being favored as the most legitimate. Understanding the culture of medicine is essential to understanding health professionals' attitudes toward illness, patients, and treatments.

II

Health refers to the extent of a person's physical, mental, and social well-being. This definition, taken from the World Health Organization's treatment of health, emphasizes that health is a complex concept that involves not just the soundness of a person's body but also the state of a person's mind and the quality of the social environment in which she or he lives. The quality of the social environment in turn can affect a person's physical and mental health, underscoring the importance of social factors for these twin aspects of our overall well-being.

Medicine is the social institution that seeks both to prevent, diagnose, and treat illness and to promote health as just defined. Dissatisfaction with the medical establishment has been growing. Part of this dissatisfaction stems from soaring health-care costs and what many perceive as insensitive stinginess by the health insurance industry, as the 2009 battle over health-care reform illustrated. Some of the dissatisfaction also reflects a growing view that the social and even spiritual realms of human existence play a key role in health and illness. This view has fueled renewed interest in alternative medicine. We return later to these many issues for the social institution of medicine. In all societies, forms of social control are established in order to maintain the norms of that society. The values and behaviors that a society deems acceptable are called social norms. Social control is the set of mechanisms that societies use to keep individuals acting appropriately.

While economic regulations dominated administrative law in the first half of the 20th century, social regulations have driven the increase in regulatory activity since the late 1960s. Social regulations are designed to address issues related to health, safety, security, and the environment. The Environmental Protection Agency, the Occupational Safety and Health Administration, the Food and Drug Administration, and the Department of Homeland Security are examples of agencies that administer social regulations. Their activities are generally limited to a specific issue, but they also have the power to regulate across socio-spatial boundaries. The normative justification for social regulations is often "externalities" or "information asymmetries." Regulating Risks Environmental, health, safety, and homeland security regulation tends to be aimed at reducing risk of sickness, death, or injury. However, regulations cannot eliminate all risk. Everything we do involves risk, whether we choose to go for a jog, drive a car, or lie in bed all day. We are willing to accept risks because the actions that involve the risks also provide benefits.

It turned out that the allocation of resources tracked public perception of risks very well, but these perceptions did not reflect reality. This phenomenon can also be seen on a global scale. Since 2004, the Copenhagen Consensus—a panel of experts including several Nobel laureates—has ranked world problems based on how cost-effectively they could be addressed. Addressing climate change, to which governments devote great resources, consistently ranks low on the group's list of world problems to address after considering costs and benefits. Malnutrition and HIV/AIDS top the experts' list, but are rarely government priorities. Numerous studies have shown that a reallocation of current spending from lower risk to higher risk problems could greatly improve the life-saving results of regulations designed to reduce health and safety risks, even if each agency continued to impose the same total regulatory costs but merely targeted its efforts more efficiently. Misdirected regulatory efforts not only pass over opportunities for greater risk-reduction benefits, but by imposing unnecessary costs, they can actually increase health risks by lowering incomes. The positive correlation between income and health has long been recognized; not only are life expectancies longer and health better in wealthier nations, but wealthier individuals within nations tend to be healthier and live longer. Thus, the key questions for risk regulation are, "To what extent does the regulation reduce risks?" and "At what costs?" Answering these questions requires two phases of analysis—"risk assessment" and "risk management"—first laid out in a framework established by the National Research Council (NRC) in 1983: Regulatory actions are based on two distinct elements, risk assessment . . . and risk management. Risk assessment is the use of the factual base to define the health effects of exposure of individuals or populations to hazardous materials and situations. Risk management is the process of weighing policy alternatives and selecting the most appropriate regulatory action, integrating the results of risk assessment with engineering data and with social, economic, and political concerns to reach a decision. This distinction should not be interpreted to suggest that the disciplines involved in the risk management phase have no "factual base." Rather, it attempts to differentiate positive analysis

(what risks are present) from normative analysis (how should they be addressed). Even in the risk assessment phase of an analysis, scientists will never have complete information to predict outcomes with absolute certainty. Risk assessors rely on what the NRC calls “risk assessment policy”—assumptions, judgments, and rules of thumb—to guide the use of scientific information in analyses that inform policy in the face of uncertainty. In each step [of the risk assessment process], a number of decision points (components) occur where risk to human health can only be inferred from the available evidence. Both scientific judgments and policy choices may be involved in selecting from among possible inferential bridges, and we have used the term risk assessment policy to differentiate those judgments and choices from the broader social and economic policy issues that are inherent in risk management decisions.

6. Making the Truth: From Foucault Perspectives

Knowledge-power relationship is Foucault’s major contribution to postmodernism. Power and knowledge entail one another. Knowledge ceases to be liberation and becomes enslavement. Foucault examines the discourses of madness, clinic, sexuality and punishment from the perspective of power-knowledge relationship. The power is exercised through surveillance, monitoring and other forms of regulation of people’s lives. The history of all social institutions is the history of power relations. Power originates from knowledge. It is the knowledge-power relationship which controls and governs the society in the postmodern age. Like other poststructuralists, Foucault sees world as created by language, it is the poststructuralist perspective that helped Foucault to develop postmodernism. Foucault thinks that the meaning of language is conditioned by social structure, culture and discourses. As the meaning of words is related to other word and the whole language, a discourse is related to other discourses and likewise other texts. The central theme of Foucault’s work is in the field of epistemology. He wanted to uncover knowledge and his search for knowledge led him to find out power. Ultimately, he connected power with truth. Before Foucault took up the search for truth, Nietzsche analyzed good and evil in his work, *Genealogy of Morals*. He argued that there were no essential, or original, definitions of truth. This argument was further carried on by Foucault who interpreted that truth was tied to the operation of power and domination. Truth is, therefore, produced by power, and the consequences of the exercise of power are formulated as truth. Foucault observes that Power and knowledge directly involve one another. There is no power relation with correlative constitution of a field of knowledge, nor any knowledge that does not pre-suppose and constitute at the same time power relations. Foucault establishes through his various case studies that power, knowledge and truth are interconnected. Power is diffused throughout society. It is always in circulation. It is not localized here or there, never in anybody’s hands. It is also not appropriated as a product or piece of wealth and do not individuals flow between its threads. They are also in the position of simultaneously undergoing and exercising power. Yet another important theme of Foucault’s work is his concept of discourse. Power, knowledge and truth are connected through discourses and texts. Discourse, in simple terms, means social institutions and disciplines. Crime is a discourse, so are corruption, leadership, village development, industrialization, capitalism and environment. According to Foucault, discourses are everywhere. They are the very stuff of society and mediate all aspects of life. It exists in concrete social situations. It has very real effects. Foucault’s study of *Madness and Civilization*, discourse could be said that professional discourse in course of time employed scientific knowledge to make distinction between the sane and the insane, the normal and the abnormal. Discourse is characterized by tradition, modernity and post modernity. For example, it is the discourse, which distinguishes between legal and illegal killing; or between proper and improper sexual conduct. The discourses are always historical particulars, variable from culture to culture. These are always subject to change. The term episteme is the set of relations between discursive positivity, knowledge and science that archaeological analysis examines at the threshold of epistemologization. The episteme is not itself a form of knowledge. It has no general content in and of itself. It is not a world view or slice of history common to all branches of knowledge in a given period. The term refers only to a level of relations involving knowledge and science as they emerge within a discursive positivity. These relations are various and shifting, even for a single period. Historical a priori the positivity is that constitute discursive formations and relations form a historical priori. It is a level of historical language which other modes of analysis depend on but fail to address. Discourse functions at the level of things said. Thus, any analysis of the formal structure, hidden meaning, or psychological traces of discourse take the level of discourse itself for granted, as a kind of raw material that is difficult to recognize due to its operation at the level of existence itself. It is important to note that the historical a priori constituted by the positivity of discourse is not a priori in the usual sense of a formal philosophical principle. Instead, the historical a priori is simply a feature of the level of discourse as opposed to other levels of analysis; it does not remain stable as a single principle with a single content but rather shifts with the transformations of the positivities themselves. Foucault’s aim in his studies was to work on the trinity of knowledge, power and truth. His methodology is apparent in two of his major works: *The Archaeology of Knowledge* and *Genealogy of Power*. Archaeology focuses on a given historical moment, while genealogy is concerned with a historical process. More specifically, “genealogy offers us a procession perspective on the web of discourse, in contrast to an archaeological approach which provides us with a snapshot, a slice through the discursive nexus”. Actually, Foucault discoursed about knowledge in his archaeology but soon realized that his discussion was silent on the issue of power. He also could not establish link between knowledge and power. Therefore, the *Genealogy of Power* establishes relationship between knowledge and power. Foucault’s major concern is knowledge, truth, and power. He contends that problem in the society becomes the construction of discourse. He presents the problem to see how men are governed by themselves and others and by the production of truth. Such society must be rejected as immutable truths with the idea of rationality as a natural human quality.

7.FOUCAULT: A CONCEPTUAL “TOOLKIT”:

Most of Michel Foucault’s theoretical schemas are posed in oppositional terms. He urges individuals to “refuse what we are” (1982, p. 216), meaning that we should refuse to remain tied to fixed identities to which people are subjected. He linked his own project with all those who struggle against the ways in which they are individualized, particularized, and objectified by controlling discourses. It is important, at this stage, to map out a number of key Foucauldian concepts that will later be used to address the relationship between social medicine and changing welfare role of state medicine. These key concepts include: genealogy and discourse, power/knowledge, and technologies of self. The point of Foucault’s analysis, called a genealogy because of its emphasis on tracing historical pathways that have contributed to contemporary circumstances, was to identify discourses. His concept of “discourse” is a key term both in understanding Foucault’s work and in explaining facets of social welfare. Foucault identified discourses as historically variable ways of specifying knowledge and truth. They function as sets of rules, and the exercise of these rules and discourses in programs that specify what is or is not the case—what constitutes “. This power would include that operated by professionals through institutions and face-to-face interactions with their patients and clients. Power is constituted in discourses, and it is in discourses such as those of “social work” that power lies. Genealogy is concerned, then, with the historical limits and conditions of socially determined discourses, which then direct and distort the personal and institutional narratives that can subsist within them. When a discourse has stabilized historically, it can be referred to as a “discursive formation,” which can come to characterize a particular period of welfare development and the associated possibilities for identity performance that it contains. Foucault (1967) was particularly interested in the limits and possibilities of discourses from “human sciences” because of their attempts to define human subjectivity. His attention shifts to the power of professionals because Foucault found that the conditions of possibility for “true” discourses about human subjects include complex relations between knowledge about people and systems of power. Here Foucault focuses on the techniques of power/knowledge that operate within an institution and that simultaneously create “a whole domain of knowledge and a whole type of power” (1977, p. 185). These domains effectively destroy the legitimacy of other, competing, discourses; just as a professional medical opinion might de-legitimize voices arising from folk medicine or informal care. The genealogical work of unmasking these power relations is characterized, by Foucault, as setting out the “political regime of the production of truth” (Davidson, 1986, p. 224). The effects of the reflexive relationship between power and knowledge that is implied here would include the tendency for professional power to be reinforced by the sorts of questions professionals ask and the data they collect. This knowledge then progresses to a certain definition of a problem area that then feeds back to stabilize the original formulation of the “problem” itself. By the same token, different policy positions point professionals to seek out certain forms of knowledge that tend to reinforce the ideological position of that policy and its associated discourses. As part of this process, certain powerful voices increase their legitimacy, while other, often dissenting, voices become de-legitimized. An effect of the mutually reinforcing relationship between power and knowledge that emerges from the above is to construct individuals simultaneously as subjects and as objects. First, people are seen as objects by someone else, through control and restraint. Second, people are deemed to actively subject their own identity to personal direction through processes such as conscience and mediated self-knowledge. Foucault (1988) refers to this second process as “technologies of self.” Foucault’s formulation of “technologies of self” claims that individual lives are never quite complete and finished—that in order to function socially individuals must somehow work on themselves to turn themselves into subjects. The notion of “technologies” offers the scope for an analysis of the sites whereby certain effects on old age are brought about. As Foucault puts it: “Both meanings [of control and self-conscience] suggest a form of power which subjugates and makes subject to” (1982, p. 212). In terms of social welfare, itself a discourse, both clients and social workers would need not simply to follow the rules that legitimize what they can say and do, but also to work on them so each can become the sort of person who can be seen and heard within that discourse. If they are not careful, both professionals and users of health and welfare systems become trapped in a dance of mutually maintained positions that serves to sustain a particular view of aging and the remedies, the technologies, that can be brought to bear on it. An analysis of power, which follows the Foucauldian pathway as it is outlined above, must examine at least three aspects of how such power is created and maintained. First, the analysis must examine the genealogy of existing relations, how they have emerged, and the discourses they both reflect and reinforce with respect to aging. Second, attention must be given to the distribution of power and knowledge that these relations imply. Finally, technologies of welfare such as psycho-casework and case management will need to be critically assessed as approaches to the self that hold certain webs of power in place. Each will contribute to the ways in which subjects enmeshed in certain relations apply techniques of identity control to themselves.

Foucault's conception of power is important to medical anthropologists who are concerned with the social regulation of the physical body. "Bio-power" is a useful concept for sociology of the body both because it focuses on the body as the site of subjugation, and because it highlights how individuals are implicated in their own oppression as they participate in habitual daily bodily practices and routines. While many medical sociologists have considered how bodily habits and practices are socially and culturally driven and constrained, few have taken advantage of Foucault's useful framework to illuminate how both the individual and society are implicated in perpetuating such practices. Yet while Foucault's concepts are enlightening, his writing is frequently abstract, lacking concrete, specific examples from everyday life to ground it. The contribution of this paper is thus to bring together an abstract body of theory and concrete, mundane examples of bodily practice in Western culture so that each might help to illuminate the other.

According to Foucault, political order is maintained through the production of "docile bodies"—passive, subjugated, and productive individuals. Through its many institutions—schools, hospitals, prisons, the family—the state brings all aspects of life under its controlling gaze. The institutional disciplining, surveillance, and punishment of the body creates bodies that are habituated to external regulation, working "to discipline the body, optimize its capabilities, extort its forces, increase its usefulness and docility, integrate it into systems of efficient and economic controls"

(Foucault 1980a:139), and thus produce the types of bodies that society requires. As such, Foucault's concept of power stands in opposition to the "repressive hypothesis", a perspective which conceives of power as domination, coercion, and the suppression of desire and truth, operating by way of law, taboo, and censorship (Dreyfus and Rabinow 1982). For Foucault, power is productive, not repressive. It operates by producing "knowledge and desire". The scientific discourse of medicine, the criminal justice system, psychiatry, and the social sciences produce new forms of knowledge. This knowledge is not neutral or objective; It represents particular perspectives, conventions, and motivations. The type of knowledge produced influences our behavior and has a controlling effect on our bodies, such that knowledge is inseparable from power:

... power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations. (Foucault 1977)

For example, in *The Birth of the Clinic*, Foucault describes how the medical profession gained prestige by employing "scientific" knowledge, which gave it considerable power in defining reality (Foucault 1975).

Medicine, through such means as the creation of disease categories, acquired the power to define the "normal" and identify the "deviant". The medical profession thus had the authority to create statistical measures--norms against which all individuals could be judged. Through the process of normalization, power is both "totalizing", because it controls all aspects of life by creating pressure to conform to norms, and "individualizing", because those who fall outside the norm are marked as deviant and targeted with disciplinary strategies designed to neutralize their deviance. However, such conformity is not achieved through coercion or force, but rather through desire. By constructing conceptions of normality and deviance, power makes the norms appear moral or "right" and creates the desire to conform to these norms:

... power would be a fragile thing if its only function were to repress, if it worked only through the mode of censorship, exclusion, blockage and repression, in the manner of a great Superego, exercising itself only in a negative way. If, on the contrary, power is strong this is because, as we are beginning to realize, it produces effects at the level of desire--and also at the level of knowledge. Far from preventing knowledge, power produces it (Foucault 1980b:59)

Power thus operates through both the production of knowledge, and the creation of a desire to conform to the norms that this knowledge establishes. This desire to conform leads people to sustain their own oppression voluntarily, through self-disciplining and self-surveillance. Self-monitoring is achieved on two interacting levels: practice and discourse. Individuals feel compelled to regulate their bodies to conform to norms, but also to talk about what they "should" and "should not" do and to "confess" any deviation from these norms. Power is strongest when it is able to mask itself: "Its success is proportional to its ability to hide its own mechanisms" (Foucault 1980a:86). The manipulation of desire is one mechanism by which power masks itself--by making that which is constraining appear positive and desirable. Power can also be disguised as resistance. For example, Foucault sees the repressive hypothesis as a deception. While seemingly opposing power by pointing to its coercive and repressive nature, it draws attention away from the more subtle mechanisms of power on the "micro-levels" of everyday life. When power meets with resistance, it is not overcome; it simply finds new ways of manifesting itself: "... power can retreat here, re-organize its forces, invest itself elsewhere ... and so the battle continues" (Foucault 1980b:56). There is a constant interaction of power and resistance in which power asserts itself, meets with resistance, and responds by re-asserting itself in a new guise.

"This book is about space, about language, and about death; it is about the act of seeing, the gaze." (ix) So begins **The Birth of the Clinic: an Archaeology of Medical Perception** by Michel Foucault. As he often begins his histories, Foucault reminds us of an important fact about our contemporary understanding of life, death and disease: that each of these are historically contingent and are bound up with other seemingly disparate discourses of social reality: biology, to be sure, but also economics, politics, geography, and language itself.

For Foucault, the 18th century relationship between the patient, his/her disease and the physician is exemplified by the question, 'What's the matter with you' - a question which implies a certain antiquated conception of life, death and disease. By the time of Bichat at the turn of the 19th century, this question and the conception of life, and disease it entails has been transformed into the question 'Where does it hurt?' It is at this moment, Foucault concludes, that we have entered the age of modern medicine. However what most interests Foucault is not the discovery of this moment itself, but rather all of the seemingly minute and invisible transformations of our discursive reality that makes this moment - and modern medicine itself - possible in the first place. It is the broader social transformation marked by this change - conceived together as the 'historical a priori' of modern medicine - which Foucault sets out to analyze in *BC*. Thus the task set out in *BC* is one of "...determining the conditions of possibility of medical experience in modern times." (xix)

A] Spaces and Classes: One of Foucault's major tasks in *BC* is to show that the question 'Where does it hurt', which we take as given standard medical procedure of diagnosing the diseased body, is actually part of an interpretive grid of medical perception that is contingently constituted and quite recent. An interpretive grid of medical perception involves for Foucault a very specific type of configuration of concepts, objects and statements. This is why the question 'What's the matter with you' does not register quite right in the web of statements which constitute our modern medical experience. Such a question, Foucault shows, belongs to another field of medical experience altogether, that of 18th century medical experience. According to Foucault, 18th century medical experience operated, as all other kinds of classical knowledge systems, on the basis of the classificatory structure of species and classes. Classificatory medicine therefore maintained a certain spatial configuration and conceptualization of disease which operated along four fundamental principles: the table, the analogy, and similarity (6-7). More importantly, the medicine of

spaces, classificatory medicine, holds that disease manifests its essence in its natural locus. Because of this, both the patient and the doctor were thought to be accidents and even barriers to learning the true essence of the disease, as both the hospital and the patient's body itself distorted the true manifestation of the nature of the disease itself. Because of the primacy that 18th century medicine placed on the spatialization of disease, as opposed to what Foucault will call the *secondary* spatialization of disease – the individual human body - he refers to as the *primary spatialization* of classificatory medicine. Although classificatory medicine had a conception of *secondary spatialization* – the presence of disease in the human body – it held that such embodiment was not necessarily relevant to understanding the structure of the disease. Unlike modern medicine, the anatomical location and re-location of disease was not relevant to the essential nature of the disease itself. As for what he calls *tertiary spatialization*, Foucault refers to the social network in which and through which disease and the management of disease operates; it is the institutional, often non-discursive space which also influences the organization and negotiation of medical knowledge. Tertiary spatialization refers to all those "...heterogeneous figures, time lags, political struggles, demands and utopias, economic constraints, social confrontations" which make up the social experience of disease. (16)

B] A Political Consciousness: This medicine of spaces, according to Foucault, begins to disappear with the emergence of a collective consciousness of disease brought on by several specific institutional changes. The first change was the collaboration of the 18th century practice of private home care with state supervision. Because the home and the family were considered the most natural locus for disease– as opposed to for example the hospital – medical assistance had to be supervised and given a certain legal status by the state. In this respect, restoring health becomes a task of the nation: "Good medicine would be given status and legal protection by the state; and it would be the task of the state 'to make sure that a true art of curing does exist' [40] The second and more drastic change come with the institutionalization of epidemic medicine. For Foucault, it was the founding of the Societe Royale de Medecine in 1776 and its conflict with the *Faculte* doctors that signals a major turn in medical consciousness. The founding of the SRM was the result of a disease that broke out in southern France which forced the Controller General of Finance to order the killing off of suspect animals, which in turn led to economic instability. As a result, it was concluded that epidemics must be made a national medical issue, an issue for the entire nation. (26) Such a medicine of epidemics, however, would require a health 'police' which would gather statistics and information of all kinds, down to the last detail, about the life and health of the nation. (25-26) Most significantly, this led to a new totalization of knowledge, which began as a control body for epidemics, but gradually became "...a place for the centralization of knowledge, an authority for the registration and judgment of all medical activity....it had become the official organ of a collective consciousness of pathological phenomena." (28)

The development of this generalized medical consciousness, which implied the centralization of and dispersion of the medical gaze, were supported by two great myths around the time of the Revolution: a) a nationalized medical profession of doctors as priests of men's bodies, and b) the total alleviation of disease throughout a completely healthy social body. These myths reinforced the collective consciousness of the medico-administrator as one who advises not only bodies, but souls and even cities or nations: "The first task of the doctor is therefore political: the struggle against disease must begin with a war against bad government." (33) The myth of the free gaze developed during the Revolution envisioned the institutionalization of the medico-administrator making obsolete the academies and hospitals, and the abolition of disease created by tyranny and slavery, and extremes of wealth and poverty. (33) These myths played an important role: they linked conceptually the function of medicine and medical knowledge to the functioning of the state. Instead of retaining a role of negative restoration of health, medicine was given the task "...of establishing in men's lives the positive role of health, virtue and happiness." Its goal was heretofore "...to ensure that the life and activity of the nation was based on the only lasting condition of happiness, namely, their benefit to the state. [37]" (34) Thus we eventually at the transition from a medicine of health in the 18th century to a medicine of normality in the nineteenth century. From this point, life is measured according to the bipolarity of the normal and the pathological. The race, the population, and the nation "...is a living being that one can see degenerating" (35) Medicine, from this point on, functions according to the norm (eventually for Foucault, that around which bio-power and disciplinary power revolve in a normalizing society). The science of life (medicine) thus provides the theoretical basis for the sciences of man that develop in the 19th century (biology, economics, linguistics) which Foucault treats in *Les Mots et Les Choses* (1966)

C] The Free Field: In the late 18th century, the medicine of spaces and classes (classificatory) and the medicine of social normality converge upon a common demand and goal: the abolition of all institutions and barriers which stand in the way of the new generalized medical gaze. In other words, the medical technology of the old classificatory medicine and the political technology of the normalizing medicine begin to demand the removal of barriers that stand in the way of the sovereign liberty of the gaze. Hospitals must go, because they distort the natural environment of the disease (and thus the laws of its manifestation); they must go also because they are a liability to society in terms of funding and labor. Likewise the guilds and associations of doctors must go because they prevent the formation of a centralized medical consciousness; and the university Faculties must go for they regard medical knowledge as a social privilege for themselves. These are opposed to the generalized medical gaze of this era because it the medical gaze is the light of liberty which "...which to an end the unbounded, dark kingdom of privileged knowledge and establishes the unimpeded empire of the gaze." (39) These structural reforms begin, for Foucault, from 1789 to the reactionary period of Thermidor Year II (around 1794).

After a certain decentralization due to logistic barriers, the rationalities of the medicine of spaces and normality converge upon the local hospital which serves several functions originally. First, as a space of protection. Second, as a space of training and distribution, whereby each hospital devoted itself to a certain category of patients, families or diseases and admitted patients on

that basis. Thus the hospital becomes the new family, the locus for the natural manifestation of disease in its essence, in its truth. Here in the hospital, the truth of the disease can be isolated and learnt. In the teaching hospital therefore, there is a double gaze: one that sees disease as part of a general social disorder, and one that isolates it, “with a view to circumscribing its natural truth.” (43) It is eventually in the hospital that modern medicine finds for itself the principle for the articulation of a medical gaze which transforms the experience of *seeing and saying* in clinical practice.

One of the war cries of the Revolution was ‘No more alms, no more hospitals.’ It was the goal of the Revolution to make these institutions unnecessary. Since hospitals represented the institutionalization of poverty and the sickness of the nation, they must be abolished. (43) Thus the idea of public medical assistance by the state (through home care) and abolition of the hospitals was accepted. The Girondists, for example, demanded total freedom in medical teaching:

In this regime of economic liberalism and competition, education returned, in a sense, to the freedom of the ancient Greeks: knowledge is spontaneously transmitted by the Word, and the Word that contains most truth prevails...Fourcroy proposed that after twenty-five years of teaching, the masters should, like so many Socrates recognized at last by a better Athens, be housed and fed throughout their long old age. (49)

However, the dream of the free field of medical practice (government assisted practitioners competitively spreading the light of medical knowledge for everyone) came up against several (familiar) obstacles: quality control, abolition of the guilds, the disappearance of the society of medicine and the closing of the universities. Less radical reformist solutions, however, eventually prevailed. These solutions entailed the reorganization of the Schools of Medicine, compulsory practical medical training regulated by a Royal Institute, a residential medical school, and organized medical field work. (47) Bouquier, a member of the Committee of Public Instruction, proposed a compromise by introducing the medical *Insituteurs* and proposing the eventual nationalization of the hospital funds as well as closing the University Faculties and Schools of Medicine.

Throughout this entire period, Foucault notes, the entire reorganization of medicine failed on account of two things: first, medical knowledge still obeyed two types of regularity: individual medical perception mapped out in accordance with the classificatory system of diseases, and the generalized and centralized statistical gathering of qualitative information on climates and places. (51) Because medical knowledge was essentially still operating within the same interpretive grid of seeing and saying, visible and invisible, the subject of medicine remained the same. It had reorganized already-constituted elements of the same knowledge-grid. (51) Medicine still operated on the basis of the same set of concepts, rules, and ways of knowing/perceiving. It would take the structural reorganization of basic medical practice (*savoir*) and perception (*regard*) to lay the foundations for a new kind of medical experience. For Foucault, that reorganization would occur in the turn of the century clinics, whose lesson would be the hospital?



8.CONCLUSION:

It was observed that social medicine is recognized as a specialty of medicine in many countries. In medical community, however, does not seem to be aware of that social medicine is one of medical specialties, but it does not mean that nothing about social medicine is dealt with in medical colleges or none of social medicine approaches is employed in health care services. Since social medicine has evolved in diverse ways in different countries, the main concerns and subject matters of teaching and research may differ to some extent among countries. Based upon these observations, this paper is intended: 1) to improve medical profession understands of social medicine in Korea through providing the description of its origins and development; and 2) to assess the current state of social medicine in Korea and suggest agendas for its future development.

Included in the core principles of social medicine are: 1) that social and economic conditions have an important effect on health, disease and the practice of medicine, and these relations must be subjected to scientific investigation; and 2) that the measures to promote health and combat disease must be social as well as medical. Interests in the relationships between health and social factors began in the 18th century, but the term ‘social medicine’ was first used in 1848 by a French doctor, Jules Guérin in the year of the February Revolution in France. In the same year, Rudolf Virchow and his colleagues initiated social medicine in Germany.

Social medicine initiated in France and Germany had a wide influence on the development of this field in many other European countries. Interest in social medicine grew and discussion of the topic was popular in the US for some time after World War II. However, the American medical profession avoided using the term for a substantial period of time. The reason for the avoidance was that the phrase ‘social medicine’ sounded very much like ‘socialized medicine’ and the concept incorporated the politically suspect idea of national health system. By the early 1950s, the American social medicine movement lost its momentum during the red scare of what is known as the era of McCarthyism.

Understanding of patterns of health and illness in groups of people and making interventions at the population level to improve their health require consideration of the effects of various social factors on health, disease, and health care delivery system. The term social medicine is rarely used but many of its subject matters are included in preventive medicine as reflected in a textbook.

But it is not likely that further systematic development of social medicine would be made because there has never been any academic discussion of the concepts and theory of social medicine, upon which such development can be based. Indication is that efforts should be made to supplement social medicine contents of preventive medicine through formalizing the linkages between preventive medicine and social medicine. Often deeds with social medicine turns into social regulatory forms through the medical gaze, in where, Foucault, explains that the gaze not only expands the body and the disease but also creates the empirical vigilance of the state. The hospital is then intrinsically connected with larger social and political structures that operate in society. By looking at issues like the kind of investment in hospital structures and what determines that or rather who, and the various laws of medical practice and teaching, and how this in turn shapes the priorities of the discipline, namely public health or social medicine. Medicine also gets linked to the destinies of the state, through the matters of epidemics, plagues and their control. The rise of a policed state merges into the formulation of the gaze, diseased bodies, medicine, the poor and the bourgeoisie. This formation of state and medicine then created systems of a guardianship of public morals and public health alike. They have since been creating contemporary disciplines and disciplinary policies, (namely epidemiology and family planning programmes). And have set in other displacements where the body is finally and fully displaced to being only a number (modern Health information management systems), and number that represents the Nation-state's priorities, achievements and incompetence. So we encounter the twist to Foucault's argument. By turning medical discourse upon itself, we find that medicine itself fits the description of disease. Its existence is tied to the body of the patient. Its characteristics are indistinguishable from that body's functions, except through the interpretation of those functions through visual/linguistic discourse. These themes resonate as we continue to add technological prostheses and mechanic translators to the already-fraught doctor-patient relationship.

9. Acknowledgements: Thanks to all of the following people for their inspiration and useful suggestions , My Mom, Dad , Brother and Grandmother and my supervisor

V

10. References:

- [1.] Dusek T, Bates T. Analysis of European medical schools' teaching programs. *Croat Med J.* 2003;44(1):26–31.
- [2.] Henderson GE, King NM, Strauss RP, Estroff SE, Churchill LR. *The social medicine reader.* Durham: Duke University Press; 1997.
- [3.] King NM, Churchill LR, Estroff SE, Henderson GE, Oberlander J. *The social medicine reader, 2nd ed., vol. 1: patients, doctors, and illness.* Durham: Duke University Press; 2005.
- [4.] Henderson GE, Estroff SE, Churchill LR, King NM, Oberlander J, Strauss RP. *The social medicine reader, 2nd ed., vol. 2: social and cultural contributions to health, difference, and inequality.* Durham: Duke University Press; 2005.
- [5.] Oberlander J, Churchill LR, Estroff SE, Henderson GE, King NM, Strauss RP. *The social medicine reader, 2nd ed., vol. 3: health policy, markets, and medicine.* Durham: Duke University Press; 2005.
- [6.] Lee JC. The development of German social medicine in the nineteenth century. *Uisahak.* 1994;3(1):20–29. (Korean)
- [7.] Porter D. How did social medicine evolve, and where is it heading? *PLoS Med.* 2006;3(10):e399
- [8.] Rosen G. The evolution of social medicine. In: Freeman HE, Levine S, Reeder LG, editors. *Handbook of medical sociology.* 2nd ed. Englewood Cliffs: Prentice-Hall; 1972. pp. 30–60.
- [9.] Starr P. *The social transformation of American medicine: the rise of a sovereign profession and the making of a vast industry.* New York: Basic Books; 1982. p. 55.
- [10.] Cockerham WC, Ritchey FJ. *Dictionary of medical sociology.* Westport: Greenwood Press; 1997. pp. 119–120.
- [11.] Hobson W. What is social medicine? *Br Med J.* 1949;2(4619):125–130.
- [12.] Rosen G. What is social medicine? a genetic analysis of the concept. *Bull Hist Med.* 1947;21(5):674–733.
- [13.] Taylor R, Rieger A. Rudolf Virchow on the typhus epidemic in Upper Silesia: an introduction and translation. *Sociol Health Illn.* 1984;6(2):201–217.
- [14.] Waitzkin H. One and a half centuries of forgetting and rediscovering: Virchow's lasting contributions to social medicine. *Soc Med.* 2006;1(1):5–10.
- [15.] Anderson MR, Smith L, Sidel VW. What is social medicine? *Mon Rev.* 2005;56(8):27–34.
- [16.] Waitzkin H, Iriart C, Estrada A, Lamadrid S. Social medicine then and now: lessons from Latin America. *Am J Public Health.* 2001;91(10):1592–1601.

- [17.] Waitzkin H, editor. Social medicine: its derivations and objectives; the New York Academy of medicine institute on social medicine, 1947. New York: Commonwealth Fund; 1949.
- [18]. Rosen G. Approaches to a concept of social medicine; a historical survey. *Milbank Mem Fund Q.* 1948;26(1):7–21.
- [19.] Morman ET. George Rosen, public health, and history. In: Rosen G, editor. *A history of public health*. Expanded ed. Baltimore: Johns Hopkins University Press; 1993. pp. Ixix–lxxxviii.
- [20]. Susser M. Teaching social medicine in the United States. *Milbank Mem Fund Q.* 1966;44(4):389–413.
- [21.] Madison DL. In: *Social medicine, 20th anniversary report of the Department of Social Medicine, School of Medicine, University of North Carolina*. Chapel Hill: University of North Carolina; 1998. Introduction: where medicine and society meet; pp. 7–18.
- [22]. Westerhaus M, Finnegan A, Haidar M, Kleinman A, Mukherjee J, Farmer P. The necessity of social medicine in medical education. *Acad Med.* 2015;90(5):565–568.
- [23.] Kasper J, Greene JA, Farmer PE, Jones DS. All health is global health, all medicine is social medicine: integrating the social sciences into the preclinical curriculum. *Acad Med.* 2016;91(5):628–632.
- [24]. Social Medicine Consortium. Conference 2016: reimagining social medicine [cited 2016 May 1]. Available from: <http://www.socialmedicineconsortium.org/conferencedetails/>
- [25]. Pemberton J. Origins and early history of the Society for Social Medicine in the UK and Ireland. *J Epidemiol Community Health.* 2002;56(5):342–346.
- [26]. Society for Social Medicine Constitution of the society. 2015 [cited 2016 May 1]. Available from: <https://socsocmed.org.uk/about/constitution/>
- [27]. UNC School of Medicine. UNC social medicine [cited 2016 May 1]. Available from: <http://www.med.unc.edu/socialmed>.
- [28]. Thakur HP, Pandit DD, Subramanian P. History of preventive and social medicine in India. *J Postgrad Med.* 2001;47(4):283–285.
- [29]. Porter D. Transformations in social medicine. *Lancet.* 1999;354 Suppl:SIV57.
- [30.] Marmot M. Social determinants of health inequalities. *Lancet.* 2005;365(9464):1099–1104.
- [31]. Farmer PE, Nizeye B, Stulac S, Keshavjee S. Structural violence and clinical medicine. *PLoS Med.* 2006;3(10):e449.
- [32.] Syme SL. Reducing racial and social-class inequalities in health: the need for a new approach. *Health Aff (Millwood)* 2008;27(2):456–459.
- [33]. Gehlert S, Sohmer D, Sacks T, Mininger C, McClintock M, Olopade O. Targeting health disparities: a model linking upstream determinants to downstream interventions. *Health Aff (Millwood)* 2008;27(2):339–349.
- [34]. Braveman P, Egerter S, Williams DR. The social determinants of health: coming of age. *Annu Rev Public Health.* 2011;32:381–398.
- [35.] World Health Organization. Health topics: social determinants of health [cited 2016 Apr 26]. Available from: http://who.int/topics/social_determinants/en/
- [36]. Krieger N. A glossary for social epidemiology. *J Epidemiol Community Health.* 2001;55(10):693–700.
- [37]. Link BG, Phelan J. Social conditions as fundamental causes of disease. *J Health Soc Behav.* 1995;Spec No:80–94.
- [38]. Eisenberg L. Does social medicine still matter in an era of molecular medicine? *J Urban Health.* 1999;76(2):164–175.
- [39]. Holtz TH, Holmes SM, Stonington S, Eisenberg L. Health is still social: contemporary examples in the age of the genome. *PLoS Med.* 2006;3(10):e419
- [40]. Neel JV. Diabetes mellitus: a “thrifty” genotype rendered detrimental by “progress”? *Am J Hum Genet.* 1962;14:353–362.
- [41]. Cruickshank JK, Mbanya JC, Wilks R, Balkau B, McFarlane-Anderson N, Forrester T. Sick genes, sick individuals or sick populations with chronic disease? The emergence of diabetes and high blood pressure in African-origin populations. *Int J Epidemiol.* 2001;30(1):111–117.

- [42]. Yoo HJ. Two major harms from the viewpoint of hygiene. *Gaebuyuk*. 1920;1:108–111. (Korean)
- [43]. Jeon WT. Social medicine. *Yonsei J Med Educ*. 2001;3(2):1–13. (Korean)
- [44]. Chun WT, Kim S, Yang EB. A study on the development of social medicine curriculum. *Korean J Med Educ*. 2001;13(2):201–212. (Korean)
- [45]. Stevens R. *American medicine and the public interest*. New Haven: Yale University Press; 1971. p. 330.
- [46]. Korean Society for Preventive Medicine . *Preventive medicine and public health*. Rev. ed. Seoul: Gyechuk Munwhasa; 2011. p. 19. (Korean)
- [47]. Rose G. Sick individuals and sick populations. *Int J Epidemiol*. 1985;14(1):32–38.
- [48]. Rose G. *The strategy of preventive medicine*. Oxford: Oxford University Press; 1992.

