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Short report

Simmel's dynamic social medicine: New questions for studying medical institutions?

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ABSTRACT

Over the last half century, changes in the structure of medicine have shifted the relationship between the profession of medicine and social institutions. In this paper, I uncover ideas for retheorizing this relationship by analyzing a review by Georg Simmel that has been previously overlooked. In an analytical overview and critical appraisal of Simmel's text, I argue that he considered preventative medical knowledge more influential when this knowledge is located outside the physician–patient relationship. Simmel suggests we need to identify how such knowledge is injected into medical and non-medical settings by the mixtures of professional-, market-, and state-based institutions governing medicine, and pay attention to how these institutions shift. His goals show continuity with a *social medicine* movement in Germany previously thought to be stalled, and are unique too in their focus on targeting institutions over individuals. Through a close analysis of Simmel's ideas, we can see the relationship of public health with social structural studies of medicine in theoretically innovative ways.

In his 1897 review of German physician Arthur Sperling's *Social Medicine*, Georg Simmel seized on an environment of social reform to advance a view of health care that has important consequences for interpreting medicine today.[1] In this paper, I draw on Simmel's lucid review to unearth some of his ideas on the social organization of health and medicine.

"Georg Simmel on Social Medicine" has not been cited in a journal since 1969, when a translation was published in *Social Forces*.[2] This oversight indexes a more general one. It is common for scholars to look to sociology's heritage: to Marx for explaining power imbalances in the physician-patient encounter, to Engels for describing the relationship between poverty and health, to Weber for interpreting lifestyles and health behaviors, and to Durkheim for identifying anomic features of social organization (e.g., Waitzkin, 1979; Williams, 2003; Cockerham et al., 1993; Wray et al., 2008). While Simmel has inspired sociologists to underscore the importance of connectedness to well-being, relative to other classical thinkers, he is rarely invoked by social scientists who study medicine.[3]

In the same way that the growth of organizational sociology has been stunted by looking to management scholarship for its central questions (Scott, 2004: 16), Simmel would argue medical sociology has been limited by the questions posed by members of the medical profession. From his perspective, we would benefit if we distanced ourselves from these questions, and explicitly reframed them into sociological analyses of knowledge, expertise and authority. The perils Simmel described of recasting sociological problems in the

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[1] Simmel's review was first published in *Die Zeit* in 1897; Casparis and Higgins (1969) provide a translation in *Social Forces*.

[2] Although it may seem unsurprising that a book review would go uncited, scholars of intellectual history have recently argued that such reviews should be seen as central venues for scholarship (Muller, 2003: 27–40). There is reason to think this is indeed something Simmel had in mind; since the expansion of review journals at the end of the seventeenth century, the review article was considered a key way to gain attention for one's ideas in the then-escalating level of competition in scholarly culture (Gierl, 1997). And only one year before Simmel's piece did Durkheim introduce the book review into the *Annee Sociologique*, "as a weapon to try to impose the sociology redefined through the Durkheimian concepts in the field of human studies in France," with reviewers charged with reading a specific set of books and interpreting them through a sociological frame (Muller, 1997: 173).

[3] Simmel's relative absence can be viewed in the archives of two central journals in medical sociology. In a full-text JSTOR search of *Social Science & Medicine*, there were 31 articles mentioning him, and 979 mentioning Marx, Weber, or Durkheim. The numbers in the *Journal of Health and Social Behavior* are, including reviews, 21 and 204, respectively. The most frequent subjects in these pieces do not involve the social organization of medicine, and rather address, respectively, the relationship between context and psychological health, and between context and individual health-related actions. In one of few Simmel-inspired pieces on health for a general sociological audience, Pescosolido and Rubin's (2000) rereading of *The Web of Group-Affiliations* is notable for the range of implications it yields for the study of mental illness.

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profession's terms were reasserted 60 years later, and once again after an almost equivalent period (Straus, 1957; Timmermans, 2013). Perhaps the strongest sign of promise in reading Simmel for novel medicine-related sociological questions comes from a physician; only a few years after he wrote his review, Simmel's ideas were described as "critical, imaginative, and… subtle" by Abraham Flexner, perhaps the most well-known reformer of medical training (Flexner, 1940: 140 [cited in Levine et al., 1976]).

While Simmel's popularity in general sociology does not in itself warrant the following reexamination, Simmel's suggestions have the ability to impact the sociology of medicine in innovative ways – namely, his implicit suggestion about the payoff of switching questions. For example, rather than ask whether there have been shifts in the authority of the medical profession, and what kinds of data index those shifts, Simmel would suggest that the real problem is of knowing where knowledge is embedded, how that happens, and how it changes. Generally speaking, then, Simmel may offer new questions to pursue, and ones that are especially salient as social scientists reinvigorate the study of health care institutions (Beckfield et al., 2013) and social medicine (Holmes and Stonington, 2006). With his unique emphasis on institutions over individuals it is possible to see potentially unexamined ties between theoretical work on medical institutions and more normative concerns about public health.

One reason for the oversight of Simmel's piece may be that, as with his other work, its "layered complexity" (Levine and Silver, 2010) benefits from spadework. In tilling land Simmel planted, I do not seek concepts or theories that can be "applied" to empirical cases. Rather, I want to consider how a Simmelian perspective might work to bridge theory and policy, and explore questions this perspective raises that might inform research and theorizing on central topics in medical sociology today. Below, I will introduce the key points of Simmel's perspective, and put them in conversations with recent discussions in medical sociology while also extracting some questions, which, when considering today's theoretical demands and empirical conditions, tell us why we might want to pay attention.

1. Simmel's ideas linking the applied and theoretical

In arguing that educational and civic institutions, and not simply individual citizens, should be targeted in diffusing health knowledge, Simmel showed both that he was concerned about social medicine, and that his perspective differed from epidemiologists and other writers in the movement. The book instigating Simmel's analysis, Sperling's *Social Medicine*, was a product of a period in Europe when public health was a key concern. Its title shared the name of a new wave of health-directed social assistance towards individuals, and emerged at a time when the successes of bacteriological research overshadowed attention paid to public health (Rosen, 1963; Casparis and Higgins, 1969: 331). This concern for social medicine would reach US shores in the early twentieth century, when the *American Journal of Sociology* published articles on matters such as socialized medicine (Haigh, 1928), the rural physician shortage (Smart, 1919), and a series of six annual bulletins on medicine and public health (e.g., Moore, 1928).

According to previous literature, discussions of health care in turn of the century Germany were also centered around the ascendant medical profession (e.g., Anderson, 1989: 80). However, Simmel shows us that earlier discussions, including those involving the role of social factors in medicine and disease, lasted considerably longer than often thought. Moreover, due to Simmel's contributions, we now see that these discussions around social medicine involved other institutional forms than those tied to the state or profession. First, since institutions beyond those organizing the doctor–patient relationship have salient effects on health care, public health efforts should be prioritized. Second, since the social world is so dynamic, any solution to the problems of a single group should be seen as temporary.

1.1. Health knowledge outside the doctor-patient dyad

For Simmel, social problems demand social solutions. Rephrasing Sperling, he argues that institutions must translate health-related findings into practice. With this was the charge that enforcement of public health efforts by the police – then responsible for matters like checking water pollution and reporting infectious disease – led to injustices, especially in rural areas. He thus proposed creating a Ministry of Health that would institutionally separate health and legal matters. More interestingly, he proposed the state should influence local political, economic, and educational institutions in such a way that they incorporated preventative health knowledge.

Health, then, happens because non-medical institutions have been somehow imbued with knowledge in a way that encourages healthy acts. Simmel thinks those organizing institutional contexts should do so by emphasizing prevention, a process he compares to placing value less on punishing criminals and more on seeking to understand, and reorient, salient aspects of their criminal socialization. "It therefore appears desirable to fight theft not through punishment and poverty, not by giving alms", Simmel writes, "but by establishing a social system wherein theft and poverty cannot appear" (Casparis and Higgins, 1969: 332). This concept of institution-driven prevention incorporates contemporary assumptions about the immutability of behavior (where the belief was prevalent, for instance, that the behavior of a person with diabetes reflected a physiological response to glucose levels (Armstrong, 2009: 916)). It reflected Simmel's view that we need ways of thinking about health care that involve injecting healthy influences into strategically chosen institutional arrangements.

Simmel also discusses the importance of linking institutions, arguing that prevention is only successful if health care knowledge is promoted through the joint efforts of organized medicine and state institutions. Physicians should be involved in key decisions regarding these institutions, designing strategically selected venues where individuals can potentially encounter health-care knowledge on a daily basis. For example, if new ideas in prevention are promoted in school, children would "promote these same ideas at home – the importance of cleanliness and fresh air for personal hygiene is one example" (Casparis and Higgins, 1969: 333). By targeting education at particular sites such as schools, these venues can effectively become communication networks acting as a mechanism for spreading health care knowledge.

Simmel would suggest we especially look beyond the professional sites where medical knowledge is institutionalized. Although we take for granted Parsons's (1951) perspective that physicians are the key actors involved in returning people to their everyday roles at work and at home (Freidson (1960) and Zola (1973) notwithstanding), Simmel says we should not focus on professionals when we evaluate the degree to which social conditions make it possible for people to act in ways considered "healthy" or not. They are denied or given health-related expertise long before coming into contact with medicine. Health, then, is very much a product of acts enabled by institutions rather than initiated by individuals – and usually has little to do with professional direction alone.

1.2. Processes shifting the institution-delivered health knowledge

So far I've interpreted Simmel's review as a call to bridge public health and medical sociology by locating individual health in