Social Medicine at Montefiore: A Personal View

Victor W. Sidel

In 1957, almost a half-century ago, the Chair of the Department of Preventive Medicine at Harvard Medical School suggested to a fourth-year medical student that it would be productive to spend a few days in the Bronx observing the work of the Division of Social Medicine at Montefiore Hospital. This would be, he advised, a way to learn not only about the practice of social medicine but also to glimpse the possible future of the practice of medicine in the United States. I took his advice, made an appointment with Dr. George Silver, the Chair of the Montefiore Division of Social Medicine, and drove from Boston to the Bronx to visit him. Dr. Silver was extremely generous, giving his time and providing information on the Bronx, on Montefiore, and on social medicine to an ill-informed but eager medical student. That visit, it turned out, was extremely important in shaping my later training and my subsequent work in social medicine.

Montefiore, I learned, had been founded in 1884 as the "Home for Chronic Invalids" by leaders of New York's Jewish community. They had recognized the need for a facility caring for patients with cancer, tuberculosis, syphilis, "the opium habit," arthritis, chronic kidney disease and other chronic illnesses—those for whom there was little hope and no expectation of cure. Service to the community had been a priority since Montefiore's beginnings. It had been among the first hospitals in the United States to establish programs of social services (in 1914), home health care (in 1947) and prepaid group medical practice (in 1947).[1]

It was therefore not surprising that the first hospital-based department of social medicine in the United States was established at what had by then become the "Montefiore Hospital for Chronic Diseases." A number of publications in the 1940s, such as those by John Ryle, Regius Professor of Social Medicine at Oxford University,[2] and by Sidney and Emily Kark in South Africa,[3] and a book edited by Iago Galdston and published by the Commonwealth Fund,[4] had generated interest in social medicine in the United States. Dr. Ephraim Bluestone, then the Montefiore Director, had long been concerned about the hospital's role in the community and had advocated significant changes in community medical practice, including radical change in the fee-per-service system and the development of a "hospital without walls." In 1950 Bluestone convinced the Montefiore Board of Trustees to establish a Division of Social Medicine, parallel to the Division of Medicine and the Division of Surgery.[5]

Bluestone appointed Dr. Martin Cherkasky as chief of the new Division. Cherkasky, an internist, had left private practice in Philadelphia to serve as a U.S. Army hospital administrator in Europe during World War II. He returned from the Army to head the Montefiore Home Care Program. In 1949 he had written an article on the Home Care Program in the *American Journal of Public Health,* in which he said:

> *When I was in medical school . . . we were taught that it was important to think of a patient as a whole, and not just to examine a limb or an eye. We have now come to a point*

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From the Department of Family and Social Medicine, Montefiore, Medical Center, Bronx, NY
Conflict of Interest: none declared
Corresponding author: Dr. Victor W. Sidel, Montefiore Medical Center, Bronx, 111 East 210th Street, Bronx, NY 10467
Email: vsidel@montefiore.org

in the practice of medicine where we must broaden that point of view. When we think about a patient, we should think about him (sic) not only as an organic and spiritual whole but, also, as a whole in society. It is no more fair or useful to separate man from his environment than it is to divide him into separate and independent parts.[6]

Bluestone and Cherkasky worked together to develop the new division and set it on its course. Criticism of the name "Social Medicine" arose, largely from outside the hospital. In 1952 Bluestone wrote a letter-to-the-editor of the *Journal of the American Medical Association* explaining that "socialized medicine" and "social medicine" were "two different concepts, the one referring to its identity with government and the other indicating a wholesome and productive partnership between the two covering disciplines of sociology and medical practice. The two look almost alike in print and have been interpreted in an emotional context that prevents an objective viewpoint."[7]

In 1951 the Montefiore Board appointed Cherkasky to replace Bluestone as director of what had become "Montefiore Hospital." Cherkasky named Dr. George Silver as the second chief of the Division. During World War II Silver, a Philadelphia internist like Cherkasky, had served as a medical officer in Europe. The ravages he witnessed had convinced him to shift from the private practice of medicine to public health. He became a regional medical officer in the Migrant Health Service, earned an MPH from Johns Hopkins School of Hygiene and served as a Health Officer in Baltimore.

During the 1950s the Division under Silver's leadership administered a number of Montefiore service programs, including Social Services, Home Care, the Montefiore Medical Group (a prepaid medical group practice), the collection and analysis of social statistics, education and research in social medicine, and "cooperation with all other divisions and independent services of the hospital." Silver expanded his long-standing interest in the delivery of medical care, studying and writing about the elements that went into bringing patient and treatment together in a productive relationship.[8]

The Family Health Maintenance Demonstration, which Silver and Cherkasky initiated, drew on the experience of the Peckham Experiment in England[9] and the work of Sidney and Emily Kark.[3] The Demonstration gave Silver the opportunity to study the long-term effect on the mental and physical health of families of consistent, continuing and comprehensive high-quality medical care. The assignment of each family to a team consisting of physician, social worker and public health nurse enabled Silver and his colleagues to consider the role of each member of the team, and develop techniques for team training. The Demonstration compared the health of two groups of families: the first cared for by a team composed of an internist, a pediatrician, a public health nurse and a social worker; and the second, the control families, who received their care from individual practitioners in the Montefiore Medical Group. The researchers defined health as the capacity to function successfully in four major areas: work, sex, play, and family life. In the end, they found it hard to prove there was much difference in the health of the two groups. On the other hand, they found that the "team organization of medical care was successfully demonstrated and seemed highly satisfactory to the patients."[10] Even though a difference in health results could not be convincingly proven, the Family Health Maintenance Demonstration profoundly influenced future programs in ambulatory care at Montefiore and in the United States.

During the 1950s Montefiore transformed itself, under Cherkasky's leadership, into a major general hospital serving acutely ill patients and its name was again changed, to "Montefiore Hospital and Medical Center." In the 1960s Montefiore formed an affiliation with the nearby Albert Einstein Medical College of Medicine. The Montefiore "divisions," now "departments," had practice, teaching and research responsibilities at Einstein as well as at Montefiore.

The assassination of President Kennedy in 1963 followed by the initiation of the Medicare and Medicaid programs and the "War on Poverty" in the Johnson Administration provided new opportunities for the development of social medicine. In 1965, Dr. Silver left Montefiore for Washington and with his guidance one of the first Office of Economic Opportunity (OEO) Health Centers – the Dr. Martin Luther King Jr. (MLK) Health Center – was organized in the South Bronx. The health center formed the basis for the establishment of the Montefiore Residency Program in Social Medicine (RPSM). Led by Drs. Harold Wise, David Kindig, Jo Ivey Bouford, and others, the MLK Health Center and the RPSM became models for primary care training programs in other cities.

By the early 1970's, however, the War on Vietnam ended the War on Poverty. Richard Nixon had replaced Lyndon Johnson at one end of Pennsylvania Avenue. At the other end the once liberal Congress and Supreme Court were shifting their attention away from social programs and social justice. A pernicious drug culture spread explosively among young people and others who were becoming increasingly alienated from their society. Public education, public medical care, public transportation, indeed public services of all kinds, began to be starved of funds. On the other hand, many medical workers had learned lessons during the 1960s about working and cooperating with people in their communities to attempt to deal collaboratively and constructively with medical and social problems.

In 1969, four years after Silver's departure from the Bronx, Cherkasky asked me to become the third head of the Department of Social Medicine. I had been trained in internal medicine and public health, and had been head of the Community Medicine Unit at the Massachusetts General Hospital. The programs that Silver had nurtured - social services, home care, and prepaid medical care - and new programs that he inspired such as the MLK Health Center and the RPSM had flourished and had become free-standing programs at Montefiore. It was therefore possible to start new Department of Social Medicine programs attuned to the ferment of the 1970s.[11]

Dr. Roberto Belmar was one of the new recruits to the Department. Dr. Belmar, a pediatrician, had helped lead the Chilean National Health Service but was forced to flee Chile when Dr. Salvador Allende, the democratically-elected President of Chile, was murdered in the 1973 military coup. Cherkasky provided the funds to bring Belmar to Montefiore as Deputy Chair of Social Medicine. Working with Sally Kohn and Monnie Callan, Belmar was a major force in the development of the Community Health Participation Program, which trained local residents as community health workers.[12] They worked with community people in the Montefiore neighborhood on health education, on nutrition and housing, and on primary and secondary prevention programs.

Nancy Dubler, an extraordinarily skilled and articulate lawyer, developed the Montefiore medical ethics program and Bioethics Committee. She also worked with Drs. Ernest Drucker, Steve Safyer, Lambert King, and others to strengthen the Montefiore prison health program based at Rikers Island. Drucker, a psychologist and social activist, joined Belmar, David Michaels, Steve Zoloth, and labor union activists such as Anthony Mazzocchi in working on environmental and occupational health issues that included prevention of lead and mercury poisoning.[13] My own reports on health in revolutionary China[14] and other countries,[15;16] on ethics,[17] on war and its impact on health,[18] and on medical practice[19] further expanded the scope and outreach of the department.

In 1985 the Montefiore Department of Social Medicine was merged with the Department of Community Health at the Albert Einstein College of Medicine to become became the Unified Department of Epidemiology and Social Medicine at Montefiore and Einstein, with first Dr. Michael Alderman and then Dr. Thomas Rohan as chairs. In 2004 social medicine leadership at Montefiore and Einstein moved to the Department of Family Medicine and Community Health, which changed its name to the Department of Family and Social

Medicine.

This recent change signals efforts to re-invigorate the teaching of social medicine to medical students at Einstein and residents at Montefiore, to improve the practice of social medicine in the Bronx, and to expand research in social medicine. Education of medical students currently includes a student-run Social Medicine course and student-run free clinic, the Einstein Community Health Outreach [ECHO] clinic. Training for residents includes core courses in Medical Spanish, in "Community Assessment, Research, and Epidemiology," and in "Understanding Health Systems and Health Teams." Each resident in the RPSM is required to undertake a social medicine project involving research, advocacy or program development.

Current issues in which department members are involved include:

- Finding ways to insure universal access to high-quality medical care with no financial barriers to access: In this work social medicine personnel at Montefiore work nationally and locally with Physicians for a National Health Program, which advocates a single-payer medical care financing system. They also work with Doctors for Global Health and the People's Health Movement, which seek to revitalize the goal of "Health for All" in the Alma-Ata declaration. Recent cutbacks in Medicaid and Medicare further endanger access to medical care for the poor in the United States and are being vigorously opposed. More broadly, work is being done on health disparities and social injustice.[20]
- Halting environmental degradation, such as global warming: The increased number of hurricanes, including Katrina, may be related to the failure of the United States to take action to limit the production of greenhouse gases. Lead and mercury pollution continue as health threats. Social medicine at Montefiore works with groups such as Physicians for Social Responsibility and the Union of Concerned Scientists to support programs of environmental protection.
- Curbing militarism in the United States and ending the war in Iraq: These are urgent issues. Members of the Department of Family and Social Medicine at Montefiore joined with Physicians for Social Responsibility and other groups to try to stop the waging of "preventive war" that produced widespread death and injury among civilians and troops in Iraq and is having a major impact on the communities we serve in the Bronx.
- Ending the proliferation and potential use of nuclear, chemical and biological weapons and lessening the number of wars on the planet: Social medicine staff at Montefiore work with the International Physicians for the Prevention of Nuclear War, winner of the 1985 Nobel Prize, and with other groups to achieve these goals. Curbing gun violence, both in the United States and around the world, is part of this effort.[21]

All of these areas of effort, together with its primary responsibility to provide high-quality culturally-sensitive medical care and to train medical students, house staff and faculty members to provide such care, constitute the work of the Department of Family and Social Medicine at Montefiore in the first decade of the 21st century. This work provides contacts with others in social medicine both in the United States and around the world, leads to work on new issues, and has fostered the formation of the new on-line journal, *Social Medicine*.

Ending on a sad note, one of the pioneers of social medicine at Montefiore and in the United States, Dr. George Silver, died in 2005. After 15 years of outstanding work at Montefiore, Silver left in 1965 for Washington for an important role in the Administration of Lyndon Johnson. Designs for health programs were being developed by the Office of Economic Opportunity and Silver's influence was felt across the country as the concept of health teams was included in the OEO Neighborhood Health Center guidelines issued in 1966. Silver served as Executive Associate for Health Affairs at the Urban Coalition and in 1969 was named Professor of Public Health at Yale,

where he had a distinguished teaching and research career. It was a privilege to be able to continue to work with him. [22;23] He was honored at a memorial program in Washington and at the 2005 Annual Meeting of the American Public Health Association.

A visit today to the Montefiore Department of Family and Social Medicine and observation of the work of its members could, like my own experience 50 years ago, be an exciting and provocative experience.

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