Translational social medicine for global health: introducing Cases in Global Social Medicine

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"Why treat people and send them back to the conditions that make them sick?", one of us (Michael Marmot) has asked, based on overwhelming evidence that social forces are among the strongest determinants of health and disease.[1] As the epidemiologist Jaime Breilh has pointed out, social "structural processes incompatible with life and health are being globally accelerated… with an exponential growth of inequity".[2] Addressing such social forces involves action at individual, clinical, collective, and policy levels. There is a great deal people who work in health care can do. Yet many health professionals feel unequipped to analyse and respond to forces outside the clinic. To provide insights and fresh perspectives about some of the social forces affecting health in different settings, *The Lancet* launches Cases in Global Social Medicine, a new monthly section in Perspectives. The first case is published in this issue.[3]

The discipline of social medicine lies at the nexus of the social and medical sciences, offering methodological, analytical, and theoretical tools to investigate who gets sick, why, and what medicine can do about it.[4-6] Cases in Global Social Medicine is informed by ideas from translational social medicine.[7,8] Since the early 2000s, translational medicine has aimed to move evidence from bench to bedside and back again, bringing innovations from the research laboratory to clinical care and developing generalisable lessons from patient outcomes.[9] Cases in Global Social Medicine also draws on a form of multidirectional translation, although one focused on how social forces influence health and health care.[10,11] Translational social medicine tools emerge from collaborations among clinicians, scholars, and communities, moving evidence from society to bedside and back again. This form of translational social medicine requires building from insights across usually separate domains: theoretical understandings of social forces (usually the domain of social sciences and humanities), contexts in which clinicians operate (usually the domain of medicine), and the everyday realities of patients and communities (a form of community expert knowledge). In this way, translational social medicine can support health professionals, health systems, and societies to respond to the joint biological and social factors that shape health and disease. There are many concepts from social sciences and humanities of health to help in these efforts.[12] While many health professionals are familiar with the applied frameworks of cultural competence and cultural humility,[13] scholars have more recently advocated for structural competence as a framework to understand and respond to the social structural processes affecting health.[7,14-17]

Translational social medicine must balance the reality that social forces are highly contextual with the fact that research has been geographically and disciplinarily siloed. Much discussion of social forces in medicine has historically focused on concerns important to the professional classes of what is often referred to as the Global North. Insights and theory from scholars, practitioners, and social movements from many settings globally have had limited penetration into the English-language medical literature. With this in mind, Cases in Global Social Medicine aims to share insights from professionals, scholars, and communities beyond the Global North that are both actionable in their local contexts and flexible enough to be instructive elsewhere.

The examples we will present in Cases in Global Social Medicine do not follow the traditional form of a master clinician clarifying a differential diagnosis, the rare presentation of a common disease, or the common presentation of a rare disease. Rather, the cases are co-analysed by clinicians alongside scholars from the social sciences and humanities, as well as in some cases by members of involved communities themselves, to elucidate the social forces affecting the patient or community. Each case focuses on an inflection point—a pivotal moment that affects an outcome, driven by a social force—that may be an opportunity for action through which the outcome could have been changed. Each case then sets out to explain the social force in a way that can help clinicians, policy makers, health system leaders, and communities approach similar forces in their own contexts. Some cases are based on the lived experience of authors or other professionals, others are about an individual patient, a composite case based on different patients, or a collective or community case.

The toolkit of concepts from these cases encourages the juxtaposition of local realities in global perspective. As such, our aim is for these cases to provide new lenses for local action and for understanding global phenomena such as the effects of increasing forms of discrimination, authoritarianism, and inequities on health and health care. We hope that these cases will help orient health-care practice and become a source of solidarity as we organise to confront obstacles to health and wellbeing for all in an interconnected world.

Work for the Cases in Global Social Medicine project was funded by The Neubauer Collegium, University of Chicago, The Hub for Global Social Medicine, University of Barcelona, The Pasqual Maragall Foundation, Barcelona, Riksbankens Jubileumsfond, Center for Medical Humanities, Uppsala University, the Berkeley Center for Social Medicine, University of California, Berkeley, and the National Institutes of Health, USA. The project was co-funded by the University of Chicago (the Franke Institute for the Humanities, the Bucksbaum Institute for Clinical Excellence, the MacLean Center for Clinical Medical Ethics, the Pozen Family Center for Human Rights, the Committee on Environment, Geography and Urbanization, the Center for Latin American Studies, and the Center for the Study of Gender and Sexuality); the University of California System, Alianza MX and Berkeley (Institute of East Asian Studies, the Center for Chinese Studies, the Center for Middle Eastern Studies, the Institute of Slavic, East European, and Eurasian Studies, the Center for Japanese Studies, the Social Science Matrix, the Townsend Center for the Humanities, the Othering and Belonging Institute, and the Center for Race and Gender); Harvard University (the Department of Global Health and Social Medicine); The European Research Council (101045424); and The Spanish Ministry of Research (CNS2023-144290). We are all members of the Global Social Medicine Case Project Team and are grateful to the Project Assistants: Jeremy Gottlieb (UC San Francisco and Berkeley, USA); Zoe Boudart (University of Michigan, USA); Theodore Michaels (UC San Francisco and Berkeley, USA); Sadia Demby (UC San Francisco and Berkeley, USA); Cristian Yanes (UC Los Angeles, USA); and E M Richmond (University of Chicago, USA).

Seth M Holmes, Mayssa Rekhis, Scott D Stonington, Mirko Pasquini, Luke Messac, Eugene Raikhel, Junko Kitanaka, Valéria Macedo, Paola Sesia, Carlos Piñones Rivera, Tinashe Goronga, Salmaan Keshavjee, Benson A Mulemi, Margareta Matache, Michael Marmot
sethmholmes@berkeley.edu

Hub for Global Social Medicine, Department of Social Anthropology, University of Barcelona, 08001 Barcelona, Spain (SMH); Berkeley Center for Social Medicine, Division of Society and Environment, University of California Berkeley, Berkeley, CA, USA (SMH); ICREA Catalan Institution for Research and Advanced Study, Spain (SMH); Department of Anthropology and Department of Internal Medicine, University of Michigan, Ann Arbor, MI, USA (SDS); University of Gothenburg, Gothenburg, Sweden (MR, MP); Harvard Medical School, Boston, MA, USA (LM, SK); Department of Comparative Human Development, University of Chicago, Chicago, IL, USA (ER); Department of Human Sciences, Faculty of Letters, Keio University, Tokyo, Japan (JK); Universidade Federal de São Paulo, São Paulo, Brazil (VM); Centre for Research and Advanced Studies in Social Anthropology, Oaxaca City, Mexico (PS); Universidad de Tarapacá, Iquique, Chile (CPR); EqualHealth, USA (TG); Center for Health Equity, Harare, Zimbabwe (TG); Centre for the Advancement of Scholarship, University of Pretoria, Pretoria, South Africa (BAM); Department of Social and Behavioral Sciences, Harvard T H Chan School of Public Health and FXB Center for Health and Human Rights, Harvard University, Boston, MA, USA (MMat); Cu Alte Cuvinte, Romania (MMat); UCL Institute of Health Equity, UCL Department of Epidemiology and Public Health, University College London, London, UK (MMar)

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