Case studies in social medicine: a review

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Case Studies in Social Medicine is a new series in the *New England Journal of Medicine* that began in 2018 and concluded in March of 2020, totaling 15 brief cases along with an introduction and conclusion. Authored by a group of clinicians and scholars in the social sciences and humanities, each piece is an attempt to use "the case" to sharpen the value of social interventions in clinical practice. The social, cultural, and political dimensions of health have long been deemphasized in medicine. As the creators of the series put it in their introduction, medical training and research are built on an "assumption that in clinical medicine, the biologic and behavioral world of a patient's body is more important than the social world outside it." The series is an answer to this problem, elaborating clinical cases using social theory.

Social structures, write the case series' creators, "are integral to the problems clinicians face every day. We are convinced that it is time to develop approaches to addressing those forces, allowing clinicians to participate in building more effective health systems and a healthier society." Central to the framing of these cases, *structure* is a concept with a long legacy in the social sciences that has been recently deployed in the context of *structural competency* in health care (Metzl and Hansen 2014). The structural competency framework is both a response to as well as a refinement of pedagogies of cultural competency, which often focus on questions of personal meaning to the exclusion of social and economic forces, and risk reproducing simplistic stereotypes of ostensibly cultural health behaviors. This series uses patient cases to illustrate the ways that social structures impact health, and suggest ways that doctors can use a structural understanding of health in practical ways.

The cases are all authored by different people (though there are a few individuals who contributed to multiple pieces), and the collection is heterogeneous in some ways. But overall, what ties the series together is a goal of using the case to argue for the relevance of social theory to medicine. Each text is presented in a clinical case format, centered on a single patient and a presenting problem (or in some cases, a comparison of two patients with the same presenting problem). The clinical case is ubiquitous in medical literature and education, and it functions to transform the uniqueness and complexity of a patient's story into a recognizable

instance of a generic underlying pathology. For this series, rather than illustrating a biomedical principle, each case is used to demonstrate the utility of a social theoretical concept, which is used as a lens to understand and unlock the case.

Some examples from the case series give a sense of how, while the terms presented vary, the case format is used to demonstrate a single social theory concept, which in turn leads the way to the clinical next steps. In one case, the authors present the case of a 43 year old man with rheumatoid arthritis who is blocked from obtaining his long-prescribed pain medications by a combination of clinic practices and insurance policies, and must purchase opioids from a friend. This demonstrates the concept of “structural iatrogenesis,” defined as, “the causing of clinical harm to patients by bureaucratic systems within medicine, including those intended to benefit them.” In another, we read about a 32 year old transgender man who presented to an Emergency Department with intermittent abdominal pain and a positive pregnancy test, but because of his gender presentation, was not determined to be pregnant for several hours. An emergency caesarean delivery was performed, but they baby did not survive. The authors analyze this case in relation to the concept of “classification,” writing: “In medicine, classification provides powerful tools for diagnosis. However, classifications — including those of race and sex — often fail to capture complexity, preventing practitioners from taking the best course of action.” While classification is a broad concept, other cases are anchored on more discrete and specialized theories from the social sciences. In a third example, the authors discuss the case of Mr. P, a 53 year old black man with schizoaffective disorder, PTSD, and substance use disorder who was thriving with the support of a psychiatrist and wrap-around social services intervention, until his documented clinical improvement prevented him from receiving SSI income, at which point he stopped attending appointments and was hospitalized. This case introduces the concept of biological citizenship, defined as a system in which “claims to resources and access to care are contingent on a particular biologic status, such as an injury or disease state.”

These ideas from medical social sciences and humanities can shift how clinicians think and work. What is particularly successful here is how the series goes beyond a common-sense invocation of humanism or empathy, instead presenting a version of structural competence that deploys a careful analysis of social phenomena. Each case, in addition to the patient’s story and an analysis in terms of one concept from social theory, gives several recommendations for clinical practice. These vary, but common themes include being aware of the social and structural determinants of health, using the authority of physicians to advocate for patients, collaborating with other professionals and communities with specific skills or direct knowledge, and working on a community-wide or

policy level to enact broader change.

Each text is short: a focused explication of a single idea. This helps avoid the pitfall of social theory which seeks to do too much, resulting in a vague sense of complexity and contingency. At the same time, such atomized cases run the risk of clinicians who engage them feeling that they have simply observed the obvious and then attached a complicated label to it. What are the consequences of this approach, and what might be the alternatives?

The clinical case and forms of ethnographic writing such as the fieldnote differ in their objectives and in the way that those forms of writing emphasize the production of knowledge from a particular fieldworker's experience at a specific time and place. At work in the construction of a clinical case is a kind of generalization that diverges from much ethnography but is necessary in medical literature; consider, in contrast, what Arthur Kleinman and Peter Benson describe in their own critique of cultural competency and call for clinicians to practice a kind of mini-ethnography: "…focus on the patient as an individual, not a stereotype; as a human being facing danger and uncertainty, not merely a case; as an opportunity for the doctor to engage in an essential moral task" (2006). Yet thinking in cases can be used in different ways, including calling into question the very expertise upon which the construction of the case depends, as Emily Yates-Doerr and Christine Labuski suggest in their series on the ethnographic case. *Case Series in Social Medicine* invites us to reconsider the clinical case, as it brings the social world into the domain of medical knowledge, while simultaneously attempting to turn a critical eye to medicine itself.

In thinking about the goal of applying social theory to medicine, it is worthwhile revisiting a well-known essay by Nancy Scheper-Hughes. In it, she critiques what she terms a "clinically applied medical anthropology." Like the colonial allegiances of 20th century anthropology as a discipline, she argues, clinically applied medical anthropology offers no serious challenge to the broader power structure—in this case, biomedicine—that enables it: "Clinical medical anthropology has become a new 'commodity', carefully sanitized, nicely packaged, pleasant tasting (no bitter after-taste)—the very latest and very possibly the most bourgeois product introduced into the medical education curriculum" (1990:191). She offers in its place a critical medical anthropology, though one defined in uncertain terms, with multiple divergent possible trajectories. Yet the enduring value of her critique is to question whether it is possible for social science to be radical or even truly critical while remaining in the good graces of medicine's powers-that-be.

The *Case Series in Social Medicine* illustrates this tension. The cases'

authors are working in the tradition of critical medical anthropology that Scheper-Hughes advocated (in particular, within her third proposal for a critical medical anthropology, the “radicalization of medical knowledge and practice”). In one example, Dr. R, a physician in a poor community in Mexico, gradually recognizes that biomedicine could not provide the necessary tools to address his patient’s underlying malnutrition, and so Dr. R partnered with community members to foster long-term efforts to improve health and nutrition. These cases problematize the epistemology and politics of contemporary biomedicine and illustrate its limits. And yet, the project as a whole is circumscribed by the demands of medical ways of knowing: presented in a case format with a strict word limit, pared down to the essentials needed to elucidate a single concept, and circulated in the prestigious and paywalled *New England Journal of Medicine*.

Scheper-Hughes writes, “To the young, up-and-coming medical anthropologist I would say: ‘Take off that white jacket, immediately! Hang it up, and put on the white face of the harlequin. Don’t be seduced; be the seducer! Don’t be subverted; be the subverter!’” (1990:195). While this seems to imply a neat dichotomy, the reality is blurrier, as valuable critical insights emerge in part from the practice of medicine itself, rather than solely from critical scholarship. This is evident in the case of J, a 16 year old boy with conduct disorder. The authors of this case discuss J’s therapy in relation to the concept of dialogic praxis, and more broadly, the work of Paulo Freire. But they also point out that this way of working with patients was shaped by the clinical training J’s psychiatrist had received in the 1990s. While that training itself derived from the writings of Freire and others, this is a good reminder that the lexicon of a 21st-century *Case Studies in Social Medicine*is in some sense a mode of labeling practices that already exist in medicine, even as it works to make contemporary biomedicine more responsive to social forces at play in the clinic and beyond. As the creators of the *Case Series in Social Medicine* note, “the centrality of social factors in clinical care has long been recognized by physicians.”

The *Case Series in Social Medicine* is a valuable tool for engaging students and practitioners in clinical disciplines and the social sciences. Yet if we understand these cases as simply offering biomedicine what it lacks—insight into the social context of its practices—they will become exercises in precisely the kind of clinically applied medical anthropology that Scheper-Hughes decried 30 years ago. We should think of the role of the case study in social medicine instead as an entry in to a set of debates that already exist among clinicians and engaged social scientists. In this way, they can serve as a point of departure for the necessary work still to be done in social medicine.

Works Cited

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