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TEACHING SOCIAL MEDICINE:

Education in Social Medicine at the Medical Faculty in Utrecht, the Netherlands, from 1945 to 1999

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ABSTRACT

This article explores the history of social medicine education from 1945 to 1999 at the medical faculty of Utrecht, the Netherlands. It seeks to understand what kind of social medicine educators constructed, and how they integrated social medicine's academic and practical components. The article argues that, although many have declared its demise during the twentieth century, social medicine did not disappear from the medical curriculum. Instead, its purpose was transformed. The article distinguishes four tools relevant to social medicine education. The first three tools, 'Roadmap to Health Landscape', 'Recipes for Research', and 'Social Engagement Manual' were aimed to provide students with general tools for their future careers. However, from the 1970s onwards, social medicine lost its scientific appeal and educational reforms increasingly oriented medical education towards practice. Consequently, a fourth tool, 'Handbook for Social Physicians' gained prominence in the 1990s. Social medicine changed from a general to a specialised subject.

Keywords: Social Medicine – Medical Education – Academic Discipline – Public Health

1. INTRODUCTION

Social medicine 'has forgone to show, that she has her own soul. That is her fatal flaw, her vitium originis', thus spoke Utrecht's professor of hygiene Henri W. Julius in 1949.[1] This provocative statement was part of a bigger argument. Julius argued that social medicine should become a science as well as a practice: 'The intrinsic duality … that characterises medicine and the medical education, social medicine lacks. That is why she is undervalued and excluded!'[2] Medicine, he said, is by nature both a science and an application of that science. So far, Julius concluded, social medicine had only shown its worth in practice, but its scientific side was still underdeveloped and, therefore, lacked 'a soul'.[3]

The distinction between social medicine as scientific endeavour and as medical practice is central to this article. Dutch historian and social physician Toon Kerkhoff has analysed how professors of social medicine used the term to justify their place

[1] Henri W. Julius, "De Sociale Geneeskunde als vak en als wetenschap " *Tijdschrift voor Sociale Geneeskunde.* 27,(12 August 1949): 250. «zij heeft verzuimd te tonen, dat zij een eigen ziel heeft. Dit is haar noodlotsfout, haar vitium originis»

[2] Ibid. «De intrinsieke tweeledigheid … die de geneeskunde en de geneeskundige opleiding kenmerkt, mist de sociale geneeskunde. Dáárom is zij miskend en buitengesloten!»

[3] The tension between medicine as *ars* and *scientia* is not limited to social medicine and has inspired many historians of medicine. See, for instance: Marius Jan van Lieburg, *In het belang van wetenschap en kunst: Een beknopte geschiedenis van de Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst, 1849-1999*, Pantaleon, (Rotterdam: Erasmus Publishers, 1999), 7-8; John Harley Warner, "The History of Science and the Sciences of Medicine," in *Constructing Knowledge in the History of Science*, ed. Arnold Thackray, Osiris A Research Journal Devoted to the History of Science and its Cultural Influences (Chicago: The University of Chicago Press 1995), 164-66.

within the medical faculty but rarely addressed social physicians working in the field. [4] Social physicians, on the other hand, used the term social medicine to distinguish themselves from medical specialists and general practitioners, and show the value of their preventative work to the public. In her book *Health Citizenship*, British historian Dorothy Porter has identified the divergence of the academic discipline of social medicine from practical service provision as one of the reasons for the term's demise in Britain in the 1960s.[5] This divide is also visible in two contemporary initiatives that promote social medicine globally: the scholarly oriented *Global Social Medicine Network* and the practice-oriented *Social Medicine Consortium*.[6]

I suggest that medical education offers a window to explore the integration of social medicine as both medical practice and academic discipline, through the combination of both vocational and scientific training. Moreover, it is a place where we can observe the practical unfolding of social medicine. Teaching always means selecting certain readings, approaches, and topics – and studying which skills educators prioritise to

[4] A. H. M. Kerkhoff, *Opvattingen over sociale geneeskunde: Een genealogische verkenning* (Maastricht: Shaker Publishing, 2009), 183-90.

[5] Dorothy Porter, *Health Citizenship: Essays in Social Medicine and Biomedical Politics*, ed. Brian Dolan, Perspectives in Medical Humanities, (Berkeley - Los Angeles - London: University of California Medical Humanities Press 2011), 192-97. https://escholarship.org/uc/item/9ww2j8q1. Shaun Murphy and George Davey Smith come to the same conclusion in: "The *British Journal of Social Medicine*: What was in a Name? ," *Journal of Epidemiology and Community Health* 51,(1 February 1997).

[6] See https://globalsocialmedicine.org/ and http://www.socialmedicineconsortium.org/

convey to their students can teach us much about the field as a whole. However, very few studies have looked into the history of education in social medicine.[7]

More specifically, this article examines which tools the medical faculty in Utrecht aimed to give to its students through teaching social medicine from 1945 to 1999. By 'tools' I mean certain knowledge areas or practical skills, relevant to medical specialist or medical practitioners in general. The article argues that although, social physicians and historians have repeatedly declared its demise during the second half of the twentieth century, social medicine did not disappear from the medical curriculum. Instead, its purpose transformed from teaching students general tools, relevant for all medical practitioners, to tools for the specialised practice of social medicine as it was defined in the Dutch context. This was the result of the decline of academic social medicine from the 1970s onwards, and of educational reforms that increasingly oriented medical education towards practice.

Traditionally, historians have traced the origin of social medicine in Western Europe to the nineteenth-century physicians who became concerned about social inequalities

[7] J.A. van der Duim-Rogers has looked into education in social medicine at the Rijksuniversiteit Groningen, however, he focused on the appointment of professors and the research topics of their PhD students. This research later expanded into a nationwide bibliography of professors of social medicine and their PhD students. Respectively, *De ontwikkeling van het onderwijs in de sociale geneeskunde aan de Rijksuniversiteit te Groningen in de periode 1865-1965: Een historisch onderzoek* (Groningen: Stichting Wetenschappelijk Onderzoek Sociale Geneeskunde, Vakgroep Sociale Geneeskunde & Epidemiologie, RUG, 1988); J. A. van der Duim-Rogers et al., *Bibliografie hoogleraren Sociale Geneeskunde en hun promovendi in de jaren 1865-1990* (Groningen: Historisch Onderzoeksburo Histodata/Stichting Hogerzeil Fonds, 1995).

and their consequences for the health of the population.[8] They believed that curative medicine was not enough to face these health challenges and advocated for structural change. Revered names in this regard are Jules Guérin in France, Rudolf Virchow in Germany and Samuel Senior Coronel in the Netherlands. However, 'social medicine' refers not only to these lineages of socially engaged medicine but knows many additional interpretations depending on the context.[9] For some, social medicine meant a focus on the community, whereas others more or less equated it with medical sociology.[10] In recent historical research, different origin stories and new voices have come to the fore. For instance, scholars have explored the strong and distinctive development of social medicine in different Latin-American countries and recognised China's barefoot doctors program as an example of practical social medicine.[11] Many

[8] George Rosen, "What Is Social Medicine?: A Genetic Analysis of the Concept," *Bulletin of the history of medicine*,(1947): 678.

[9] Matthew R. Anderson, Lanny Smith, and Victor W. Sidel, "What Is Social Medicine?," *Monthly Review* 56,(2005), https://doi.org/10.14452/MR-056-08-2005-01_3; Dorothy Porter, "How Did Social Medicine Evolve, and Where Is It Heading?," *PLoS Medicine* 3,(2006), https://doi.org/10.1371/journal.pmed.0030399.

[10] Respectively, Sidney Kark and Emily Kark, "A Practice of Social Medicine (first published 1962)," *Social Medicine* 1,(August 2006): 115; Patrick Zylberman, "Fewer Parallels than Antitheses: René Sand and Andrija Stampar on Social Medicine, 1919-1955," *Social History of Medicine* 17,(2004): 81.

[11] Everardo Duarte Nunes, "Juan César García: Social Medicine as Project and Endeavor," *Ciência & Saúde Coletiva* 20,(2015), https://doi.org/10.1590/1413-81232014201.17312014; Howard Waitzkin et al., "Social Medicine Then and Now: Lessons From Latin America," *American Journal of Public Health* 91,(2001); Eric D. Carter and Marcelo Sánchez Delgado, "A Debate over the Link between Salvador Allende, Max Westenhöfer, and Rudolf Virchow: Contributions to the History of Social Sedicine in Chile and Internationally," *Historia, ciencias, saude--Manguinhos* 27,(2020),

of these narratives have decentred the role of European and U.S. influences and of heroic figures like Virchow. [12]

A pitfall in the historiography of social medicine is the (sometimes hidden) agenda of historical narratives on the subject. For instance, British historians Roy and Dorothy Porter have showed how the historian of social medicine George Rosen both commented on and advocated for social medicine in the 1930s and 1940s, which limited him in critically reflecting on the field.[13] Their criticism was particularly focused on Rosen's lack of self-reflection with respect to the racism and social prejudice present in the history of social medicine. Similarly, several Dutch physicians have used medical history to promote state interventions in public health and/or social medicine.[14]

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https://doi.org/10.1590/S0104-59702020000400011; Xiaoping Fang, *Barefoot Doctors and Western Medicine in China*, vol. 23 (Woodbridge: Boydell & Brewer Ltd., 2012).

[12] A good example of this is Abigail Neely's book *Reimagining Social Medicine from the South* (Durham: Duke University Press, 2021). In her analysis of the celebrated Pholela Community Health Center, Neely foregrounds the village's residents and surroundings instead of the center's founders, Sidney and Emily Kark.

[13] Contemporaries of Rosen such as Belgian professor of social medicine René Sand, are not exempted from this critique. Dorothy Porter and Roy Porter, "What Was Social Medicine? An Historiographical Essay," *Journal of Historical Sociology* 1,(1988): 90-106, https://doi.org/10.1111/j.1467-6443.1988.tb00005.x. In 1994, Dorothy Porter presented an alternative to Rosen's heroic history of social medicine inspired by the works of French historian and philosopher Michel Foucault and British professor of social medicine Thomas McKeown (*The History of Public Health and the Modern State*, 1 ed., The Wellcome Institute Series in the History of Medicine, (Amsterdam: Rodopi, 1994).

[14] In his overview of Dutch medical historiography, historian Frank Huisman refers to the works of Arie Querido and Dominicus Cannegieter as twentieth-century examples. Frank G. Huisman, "Vorming, reflectie en activisme. Over het rijke veld van de medische geschiedenis in Nederland," *Studium* 6,(1

In this study, although my own favourable perception of social medicine influenced my choice of topic, I have paid careful attention to my personal bias throughout the analysis.

The shape of this research is influenced by the constructivist tradition in the history of medicine, and by science and technology studies.[15] Arguably, medical education is a form of science 'in action'. It may not be a classical laboratory but the lecture hall is still a place where science is put to work.[16] While teaching, professors try to give meaning to their subject. They decide which parcels of knowledge to convey, and how.

December 2013): 268, https://doi.org/http://doi.org/10.18352/studium.9272. A more recent example is the book by D. Post and J. W. Groothoff *Sociale Geneeskunde of Public Health: Toekomstperspectief van een uitdagend vakgebied*, Maatschappij, arbeid en gezondheid, (Houten: Bohn Stafleu Van Loghum, 2003).

[15] I was, for instance, inspired by Bruno Latour, *Science in Action. How to Follow Scientists and Engineers through Society.* (Milton Keynes: Open University Press, 1987); Ludmilla J. Jordanova, "The Social Construction of Medical Knowledge " in *Locating Medical History: The Stories and Their Meanings*, ed. Frank G. Huisman and John Harley Warner (Baltimore and London: The Johns Hopkins University Press, 2004). For an example of how such an approach is applied to the ascent and descent of disciplines: Daniel J. Kevles and Gerald L. Geison, "The Experimental Life Sciences in the Twentieth Century " in *Constructing Knowledge in the History of Science*, ed. Arnold Thackray, Osiris A Research Journal Devoted to the History of Science and its Cultural Influences (Chicago: The University of Chicago Press 1995).

[16] Here I follow historian of science John V. Pickstone's terminology with respect to the history of science, technology and medicine in understanding '*ways of knowing as work*'. Like Latour, Pickstone shifts the focus from theories to forms of practice. He describes how changes in professional and educational structures and in work routine helped shape knowledge, instead of only theoretical shifts. John V. Pickstone, *Ways of Knowing: A New History of Science, Technology and Medicine* (Manchester: Manchester University Press, 2000), 17; 17-20.

Education is not a ready-made product from a finished science.[17] Instead, professors, and other educators, are affected by their institutional and societal context, educational traditions, and interaction with students. As historian John Harley Warner points out: 'By looking closely at what physicians were being educated to become (healers to be sure, but always more than that alone), we can begin to understand something of the place of science both in the identity of the physician and in the wider culture.'[18]

To my knowledge, no comprehensive history of Dutch medical education exists for the second half of the twentieth century. However, almost all Dutch medical faculties have published their own faculty histories over the past 25 years. For this study, I have relied on a combination of these books, scientific articles within medical education research, and additional archival sources. The university in Utrecht is one of the oldest universities in the Netherlands with a long tradition of academic medicine. The first Dutch professor of social medicine started in Utrecht in 1918, however, the medical faculty increasingly focused on biomedical research instead of research in social medicine over the course of the twentieth century. This has made Utrecht an interesting case to study developments in the education of social medicine.

2 MATERIAL AND METHODS

This article describes developments with respect to social medicine in the medical curriculum in Utrecht, the Netherlands from 1945 until 1999. It is based on archival

[17] Latour, *Science in Action*, 13-17.

[18] Warner, "History of Science," 185.

material from sources including The Utrecht Archives, the special collections of University Library Utrecht, and the Royal Library. [19]

The Utrecht Archives hold different collections concerning the Faculty of Medicine in Utrecht. [20] Available material included minutes of medical faculty meetings, of committees concerned with educational reform from 1945-2000, and from meetings of the board of governors of the university from 1945-56. Additionally, The Utrecht Archives keep study guides, internal policy documents on medical education, and material on the appointment of professors until the year 2000. Personal correspondence and lecture notes by two professors in social medicine, J.G. Remijnse, and R. Hornstra were available at the University Library Utrecht. I also reviewed study material for medical students such as textbooks and assorted literature. Relevant published sources were *Medisch Contact*, the Journal for Social Medicine (*Tijdschrift voor Sociale Geneeskunde*) and its successors, and Bulletin Medical Education (Dutch: *Bulletin Medisch Onderwijs*) (in publication under different titles since 1982). Moreover, student journals provided an additional insight into the students' perspective, namely the Dutch Journal for Medical Students (Dutch: *Nederlands Tijdschrift voor Medische Studenten*) (1955-73), and the local students journals

[19] On archival work I read Arlette Farge, *The Allure of the Archives* (New Haven: Yale University Press, 2013); Martha C. Howell and Walter Prevenier, *From Reliable Sources: An Introduction to Historical Methods* (Ithaca, New York: Cornell University Press, 2001).

[20] I used two archives of The Utrecht Archives (Het Utrechts Archief, HUA) in Utrecht, namely *59 College van Curatoren van de Rijksuniversiteit Utrecht* and *1978 Faculteit Geneeskunde van de Universiteit Utrecht*. In the footnotes, I will cite these as 'HUA, 59' and 'HUA, 1978' followed by the relevant index number.

Fakblad (1970-79), and *Arts & Fiets* (1983-2001). I examined all volumes of these journals available between 1945 and 1999.

I used primary sources, written during the period of interest, and secondary sources, earlier historical analyses on the topic of interest. Many secondary sources dated from the period under study, usable as both a primary and secondary source. I have analysed the primary and secondary sources through a critical appraisal in terms of their reliability, content, author(s), situation in historical debates, and their contexts for creation.[21]

The study investigates how medical educators, such as professors or other staff, operationalised social medicine. With this approach, I have used 'social medicine' as an actors' term, rather than as an analytical frame. I have focused on what kind of social medicine medical educators constructed by studying what they for inclusion in the curriculum, how and why. I chose 1945 as the starting point for analysis since it marked the beginning of the post-war bloom of academic social medicine in the Netherlands, and the study ends when Utrecht University thoroughly revised its medical curriculum in 1999.

3. SOCIAL MEDICINE IN THE NETHERLANDS

In the Dutch context, historians have located social medicine's roots in the nineteenth century with physicians that were interested in the influences of social circumstances

[21] On the use of sources: John Tosh, *The Pursuit of History*, 5 ed. (Longman, 2010), 119-46; Ludmilla Jordanova, *History in Practice*, 3 ed. (London: Bloomsburry Academic, 2019), 206-10; Jacalyn Duffin, *History of Medicine: A Scandalously Short Introduction* (Toronto: University of Toronto Press, 1999), 430-37.

on health, the so-called hygienists.[22] Unlike the socialist ties sometimes found in social medicine elsewhere, Dutch hygienists aligned themselves with the liberals.[23] They found common ground in the idea that improving public health would enhance equal opportunities for all, which would elevate society but disagreed on the desirable level of governmental interference. As Kerkhoff has pointed out, the hygienists were mostly interested in the physical environment, and were not as involved in the social problems of the working class as their counterparts in Germany and France were.[24]

The term social medicine itself first popped up to describe physicians that were executing the recently expanded social security laws at the beginning of the twentieth century, such as 'insurance physicians'.[25] Accordingly, the first professor of social

[22] Duim-Rogers et al., *Bibliografie hoogleraren*, 7; Pieter Muntendam, *Plaatsbepaling van de sociale geneeskunde* (Leiden, 1966), 9; Johan P. Mackenbach, "Sociale geneeskunde en 'Public Health': Historische kanttekeningen bij de Nederlandse situatie " *Tijdschrift voor Sociale Gezondheidszorg* 81,(2003): 251.

[23] Dutch historian Eddy Houwaart extensively studied the political involvement of the hygienists. Eddy. S. Houwaart, *De hygiënisten: Artsen, staat & volksgezondheid in Nederland 1840-1890* (Groningen: Historische Uitgeverij, 1991).

[24] Kerkhoff, *Opvattingen*, 87-107. Kerkhoff has two hypotheses for this. Firstly, he pointed to the matter-of-fact mindset of the Dutch. The hygienists sought consensus rather than revolution. Secondly, the Netherlands knows a relatively late Industrial Revolution. Kerkhoff argued that physicians had already strengthened their position through the Physician's Act of 1865 and with this lost the appetite and need to align with the laboring class when they started to organize.

[25] In 1921, the Association of the Practice of insurance medicine (*Vereniging ter beoefening der verzekeringsgeneeskunde*) changed its name in to Association for social medicine (*Vereeniging voor sociale geneeskunde)*, and in 1938 social medicine was replaced by social insurance medicine (*sociale verzekeringsgeneeskunde*). Ibid., 124-28; A. Querido, "De ontwikkeling van de Sociale Geneeskunde tot specialisme," in *De vooruitgang van de geneeskunde in onze eeuw: Uitgegeven ter*

medicine, J. M. Baart de la Faille, was appointed to teach students about insurance medicine in Utrecht in 1918. Social security laws formed the basis of the Bismarckian welfare system in the Netherlands and their importance likely contributed to a conception of social medicine as insurance medicine.[26]

Additionally, at the turn of the twentieth century, governmental involvement in healthcare had expanded, mainly through local authorities. Additionally, concurrent private initiatives arose to improve and promote health.[27] This created a health field outside clinics and hospitals occupied by municipal health services for the poor, private organizations providing postnatal care, school physicians, and factory physicians, among others. School physicians and municipal physicians joined forces to publish the Social Medical Monthly (*Sociaal-Medisch Maandschrift*) from 1921 sharing the goal of attending to the health of the community instead of the individual.[28]

In contrast to medical specialists, social physicians generally focused on prevention and on the health of (vulnerable) groups, also taking into account how social

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gelegenheid van het 60-jarig bestaan van de Amsterdamsche Specialisten Vereeniging, ed. J. A. van Dongen (Amsterdam: J.H. de Bussy, 1966), 260-66.

[26] In Germany, professor of social hygiene Alfred Grotjahn put forward a similar understanding of social medicine as opposed to what he called social hygiene, the study of social causes of disease. Mackenbach, "Sociale geneeskunde " 454-55; Kerkhoff, *Opvattingen*, 72-76.

[27] Marco H. Strik and Nel Knols, "Public Health, Private Concern: The Organizational Development of Public Health in the Netherlands at the Beginning of the Twentieth Century " *European Journal of Public Health* 6,(1996): 81-86; R. A. A. Vonk and T. E. D. van der Grinten, "Gezondheidszorg en de Verzorgingsstaat: Financiering, organisatie en bestuur ", ed. H. F. P. Hillen, E. S. Houwaart, and F. G. Huisman, *Leerboek medische geschiedenis* (Houten: Bohn Stafleu van Loghum 2018).

[28] In 1923, the name changed into Journal for Social Medicine (*Tijdschrift voor Sociale Geneeskunde*). Kerkhoff, *Opvattingen*, 160-64.

circumstances affected health.[29] Local or private organizations often employed these physicians, so they did not have their own practice. In 1960, the Royal Dutch Medical Association opened an official registry for social physicians, a landmark event in professional recognition. Social physicians registered under their particular branch of social medicine, including occupational medicine, youth healthcare, insurance medicine, and general healthcare, or special forms of social medicine.

The status of social medicine at universities grew after World War II, as interest in both the social sciences and the interaction between health and society had increased since the war had made their relevance painfully clear. Additionally, the Dutch scientific world shifted its orientation from Germany to Anglo-Saxon countries, where social medicine had established itself as academic discipline in the 1930s and 1940s.[30] By the 1950s, every Dutch university employed a professor of social medicine to study interaction between man and environment. In order to develop and legitimize the new academic discipline, the post-war professors of social medicine were preoccupied with defining and demarcating the field's object of study. In 1966, Piet Muntendam, professor of social medicine, defined this as: 'the interaction with regard to health and disease between man and the environment in both material and immaterial sense … as well as the means to influence this interaction for preservation, improvement and recovery of health, and for the prevention of and fight against disease'.[31] Key study

[29] However, this characterization is not always correct. For instance, social physicians in infant care also carried out curative tasks for individual patients.

[30] Virginia Berridge, "Public Health in the Twentieth Century I: 1900-1945," *Public Health in History* (Maidenhead: Open University Press, 2011), http://site.ebrary.com/id/10510864. 176-77.

[31] «de wisselwerking met betrekking tot gezondheid en ziekte tussen mens en milieu, in materiële en immateriële zin … evenals de middelen ter beinvloeding van deze wisselwerking tot behoud,

methods included epidemiology and medical sociology. Interestingly, in their definitions, the professors rarely concerned themselves with what it meant *to work* as a social physician.[32]

Although social medicine had profited from rising interest in medical sociology in the 1960s, the discipline struggled to make its mark on societal developments in the 1970s.[33] Some social physicians attempted to evoke socio-political activism amongst their colleagues, most notably G.F. van Urk in the *Journal of Social Medicine*.[34] However, his contemporary professor of social medicine, Frans Doeleman, concluded that van Urk was relatively isolated; 'By far the majority of social physicians, safely embedded in the establishment, feels rather at ease there and is content with improving side phenomena.'[35] Moreover, social medicine had gotten a bad reputation because of its bureaucratic character, its paternalistic approach, and its inability to

bevordering en herstel van gezondheid als tot voorkoming en bestrijding van ziekte.» Muntendam, *Plaatsbepaling*, 15.

[32] For Kerkhoff's analysis on this: *Opvattingen*, 153-57.

[33] For instance, preventative care played an important role in the Structure document on Healthcare (*Structuurnota gezondheidszorg*) from 1974, however, the document pays little attention to social medicine. Ibid., 174-75.

[34] G. F. van Urk, "Sociale Geneeskunde als specialisme," *T. soc. Geneesk.* 44,(1966): 386-94; G. F. van Urk, "Sociale Geneeskunde als onrust," ibid.48,(1970): 435-38. Although van Urk does not refer to international literature, his plea fits the ideas of nineteenth-century social medicine as described in: Rosen, "What Is," 678; Anderson, Smith, and Sidel, "What Is," 28-30.

[35] «De overgrote meerderheid van de sociaal-geneeskundigen, veilig ingebed in het establishment, voelt zich daar best op zijn gemak en is tevreden met het verbeteren van randverschijnselen.» F. Doeleman, "De kleren van de Keizer," in *Volksgezondheid in ontwikkeling: Liber amicorum ter gelegenheid van de zevenstigste verjaardag van prof dr. Muntendam*, ed. L. Burema et al. (Assen: Van Gorcum, 1971), 14-30; 25.

define a study object.[36] After a study on different conceptions of social medicine amongst European professors, M. Timmer and J. Hansma concluded in 1975 that social medicine's vague definition and objectives prevented it from achieving greater social engagement.[37]

Throughout the 1970s, professors of social medicine still struggled to define what they studied. Other research fields, such as health sciences, started to outshine the outdated social medicine. A 1985-report by the Royal Dutch Academy of Arts and Sciences (Dutch abbreviation: KNAW) on the planning of medical research at Dutch universities explicitly stated that social medicine departments were 'very poorly represented in terms of research', especially in comparison to epidemiology.[38] Epidemiologists increasingly took over chairs of social medicine.[39] Houwaart has identified several reasons for the decline of social medicine, including its unresolved identity crisis, lack of funding in opposition to a strong curative lobby, its low status,

[36] For instance, philosopher Hans Achterhuis criticized the welfare sector for creating its own demand through dependency in *De markt van welzijn en geluk* (Baarn: Ambo bv, 1979). See also: Eddy S. Houwaart, "Public health: Gezondheid en burgerschap," ed. H. F. P. Hillen, E. S. Houwaart, and F. G. Huisman, *Leerboek medische geschiedenis* (Houten: Bohn Stafleu van Loghum, 2018).; N. H. Vroege, 'Factoren bij de keuze van een sociaal-geneeskundige werkkring', *T. soc. Geneesk.*, 23 August 1968, 46, 622-628.

[37] M. Timmer and J. Hansma, "Social Medicine in Western Europe, 1848-1972," *T. soc. Geneesk.* 53, Supplement 1,(1975): 43.

[38] As cited in Timo Bolt, *A Doctor's Order : The Dutch Case of Evidence-Based Medicine (1970-2015)*, , (Antwerpen-Apeldoorn: Garant, 2015), 173.

[39] Historian Timo Bolt has written a historical analysis of Dutch evidence-based medicine. On epidemiology in relation to social medicine, see ibid., 159-86. For this development in the U.K.: Porter, *Health Citizenship*, 159-69.

and fragmented nature.[40] Mackenbach further argues that the epidemiological transition required a new and multidisciplinary approach to prevention, with less space for social medicine as a distinct field.[41]

Many advocated abandoning the term social medicine all together. At the ANVSG symposium of 1977, social physicians discussed whether they should replace social medicine with 'social healthcare' to open the field for interdisciplinary cooperation.[42] In 1983 the *Journal for Social Medicine* was renamed the *Journal for Social Healthcare*.[43] Moreover, social physicians increasingly identified with their own branch of social medicine instead, using 'public health' to refer to their collective effort instead of social medicine.[44] In 1987, the field's shared scientific association, the ANVSG ceased to

[40] Eddy S. Houwaart, "Zijn de laatste dagen van de Sociale Geneeskunde geteld? ," *Tijdschrift voor Gezondheid en Politiek* 4,(December 1986): 12-18. Houwaart's article ignited a discussion on the past, present, and future of the field. For the other contributions see: Guus Bannenberg, "De crisis in de sociale geneeskunde," ibid.5,(March 1987): 51-56; A H M Kerkhoff, "Sociale Geneeskunde is geen vak," ibid.,(November): 45-48; Eddy S. Houwaart and Guus Bannenberg, "Sociale geneeskunde: Visie op een vakgebied," ibid.: 39-40; J. C. de Man, "Sociale geneeskunde mist activisme," ibid.6,(1988): 144-46.

[41] Mackenbach, "Sociale geneeskunde " 453.

[42] E. J. Boer, "De toekomst van de ANVSG: Indrukken van een belangstellende gast op het ANVSG symposium " *T. soc. Geneesk.* 55,(19 April 1977): 284.

[43] "De evolutie van een tijdschrift ", Redactioneel, *TSG* 61,(1983): 1-2.

[44] Johan P. Mackenbach, "De ontwikkeling van de academische public health in Nederland: Twee eeuwen geschiedenis, nog altijd springlevend," *Tijdschrift voor gezondheidswetenschappen* 87,(May 2009): 229, https://doi.org/10.1007/BF03082247.

exist, and branches of social medicine re-formed as separate organizations. Dutch historians have suggested these events demonstrated social medicine's demise.[45]

4. SOCIAL MEDICINE AS A TOOLBOX

In order to make sense of the changes and continuities in social medicine education, I have approached social medicine as a toolbox. In other words, I have focused on what tools – practical or academic - educators in social medicine have tried to give students. I propose that four such tools have been important: a 'Roadmap to the Health Landscape', 'Recipes for Research, ''Social Engagement Manual', and 'Handbook for the Social Physician'. These tools had different purposes in medical education. The following sections analyse these tools, their advent and/or decline.

4.1 Roadmap to the Health Landscape

The university in Utrecht appointed its second professor of social medicine, Johan Gilles Remijnse to teach medical students about the application of social security laws in 1939.[46] Remijnse examined his patients with his students. He let the students sort through patient files and write advisory reports.[47] Additionally, the university wanted Remijnse to introduce the students to the intricate network of healthcare organizations

[45] Kerkhoff, *Opvattingen*, 190; Mackenbach, "Ontwikkeling van," 227-28; Houwaart, "Public health: Gezondheid en burgerschap."

[46]*Kerkhoff, Opvattingen, 120-24.;* Board of governors of Rijksuniversiteit Utrecht to the Direction of the Dutch Medical Association, 14 June 1939, Part IV, Collection prof. dr. Gilles Remijnse, Collection Sociale Geneeskunde, University Library Utrecht, Utrecht.

[47] Remijnse to the President of the board of governors of Rijksuniversiteit Utrecht 'Verslag Afgelopen Cursusjaar 1946/1947', 20 October 1947, Part IV, Collection prof. dr. Gilles Remijnse, Collection Sociale Geneeskunde, University Library Utrecht, Utrecht.

and professionals within social medicine.[48] Therefore, Remijnse organised excursions to places such as municipal health services, living areas of the poor, factories, and the safety museum.[49]

The objective of these activities was not to prepare students for a career in social medicine, neither as researcher nor as practitioner. Instead, social medicine education taught future medical practitioners how to navigate the healthcare system and relate to relevant laws.[50] Social medicine provided every future medical doctor with a general tool, namely a roadmap to the health landscape. In fact, this was the most constant role of social medicine in the medical curriculum in Utrecht evident both in textbooks and in professors' appointments. For instance, a 1963-textbook on social medicine aimed to give insight into 'the nature, extent and structure of healthcare'.[51] In 1971, Associate Professor Cornelis F. Brenkman was appointed to teach: 'Social medicine, in particular the structure and the mode of functioning of societal healthcare'.[52]

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[48] However, they explicitly prioritized insurance medicine over teaching about these organizations. Medical Faculty to board of governors of Rijksuniversiteit Utrecht, 25 May 1939. HUA, 59, 612.

[49] Johan Gilles Remijnse, "De Sociale Geneeskunde in het hoger onderwijs," *T. soc. Geneesk.* 27,(27 May 1949): 211-16.

[50] Illustrative of this is the clinical dialogue Remijnse's successor Robijn Hornstra wrote for a student journal in 1959. Hornstra presented a case from the perspective of a general practitioner and guided the reader through the different social organizations the general practitioner considered to use to help their patient. Robijn Hornstra, "Een gezinsprobleem voor de huisarts," *Nederlands Tijdschrift voor Medische Studenten* 5,(May 1959): 318-20.

[51] J. H. Baaij, *Sociale geneeskunde* (Groningen: J.B. Wolters, 1963), 5. «de aard, omvang en structuur van de gezondheidszorg»

[52] «sociale geneeskunde, in het bijzonder de structuur en de wijze van functioneren van de maatschappelijke gezondheidszorg» Brenkman shared the professorship with epidemiologist Frits de

During the 1970s and 1980s, national interest in healthcare structures grew as rising healthcare costs increased pressures within the system.[53] General healthcare, the branch of social medicine that focused on healthcare management and health services research, grew rapidly.[54] Other universities in the Netherlands started doctoral programs outside of medicine that specifically trained students in this kind of research.[55] At the same time, many universities specialised in one branch of social medicine both as a moneysaving measure and because of increasing differentiation within the field. Utrecht chose the branch of "general healthcare" and appointed economist Guus Schrijvers and physician Joop van Londen as associate professors in

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Waard. Cornelis Ferdinand Brenkman, *Bewogenheid, bewegelijkheid en gemeenschapsgezondheidszorg* (Zutphen: De Walburg Pers, 1972), 1.

[53] In those years, the Dutch government published multiple memoranda on healthcare policy, see Lieburg, *In het belang*, 58; Annet Mooij, *De Polsslag van de stad: 350 jaar academische geneeskunde in Amsterdam* (Amsterdam: Arbeiderspers, 1999), 399-405.

[54] A social medicine textbook from 1977, reads, 'The term "general healthcare" is meaningless and maybe even to-be called unfortunate. However, it is the official name given in 1965 to the branch of social medicine that harbors those social physicians that mainly or completely concern themselves with policy and/ or management in healthcare.' «De term 'algemene gezondheidszorg' is weinigzeggend en misschien zelfs wel ongelukkig te noemen Het is echter de officiële benaming, die in 1965 werd gegeven aan de tak van sociale geneeskunde waarin die sociaal-geneeskundigen zijn ondergebracht die zich hoofdzakelijk of geheel bezighouden met beleid en/of management in de gezondheidszorg.» S. Santema, "Algemene Gezondheidszorg," in *Sociale Geneeskunde in de praktijk* ed. W. F. Tordoir (Utrecht: Bohn, Scheltema en Holkema, 1978), 150.

[55] For instance, in 1982 a doctoral program in General Healthcare started at the new Interfaculty in Rotterdam that focused on policy, management, and coordination in healthcare. F. C. Bleys, "Een nieuwe studie 'Algemene Gezondheidszorg' te Rotterdam, een interview met Prof. J. Moll, voorzitter van de N.V.M.O. ," *Bulletin Medisch Onderwijs* 1,(1982): 14-16.

'general healthcare' in 1987.[56] Even though education in social medicine remained broad in most universities, for some years Utrecht focused exclusively on general healthcare. [57] Schrijvers' and van Londen's teaching encompassed healthcare systems, health education, and environmental hygiene. The literature they appointed dealt almost exclusively with the organization of healthcare.[58]

When 'social medicine' as a term reappeared in the Utrecht medical curriculum in the 1990s, the subject no longer included the study of health systems anymore. In 1998, some Dutch universities taught about health services in parallel with but distinct from social medicine, in modules such as 'Man, physician, society' (Vrije Universiteit Amsterdam) or 'Public Health' (Erasmus University Rotterdam), while others approached the topic as component of social medicine (including Maastricht University, Rijksuniversiteit Groningen).[59] In a 1995-textbook by professors of public health Paul Maas and Johan Mackenbach, healthcare structures are present but no

[56] "Structuurrapport Algemene gezondheidszorg", July 1982, 4-5. HUA, 1978, 589.

[57] In the study guide of 1984-1985, the term 'social medicine' is absent and replaced by 'general healthcare'. To summarize the work of social physicians, 'social healthcare' is used. "Studiegids van de Faculteit der Geneeskunde 1984-1985," (Utrecht: Rijksuniversiteit Utrecht, 1984). On the situation in other faculties: Note on the "AWOG Leiden", 22 Februari 1985. HUA, 1978, 221.

[58] J. M. Boot and Els Jurg, Gezondheidszorg in-stelling (Lochem: De Tijdstroom, 1988); Guus Schrijvers, Een kathedraal van zorg: Een inleiding over het functioneren van de zorgverlening (Utrecht: De Tijdstroom, 1993).

[59] «Mens, medicus, maatschappij» J. F. Wendte, "Een vreemde eend in de bijt? De plaats van de sociale geneeskunde in een medisch curriculum," (Houten: Bohn Stafleu van Loghum 1998), Verslag postersessie sociale geneeskunde, 319-20.

longer considered part of social medicine.[60] The authors presented social medicine merely as a set of vocations (section 4.4).

4.2 Recipes for Research

In 1951, Professor Hornstra delivered his inaugural speech and he did not waste the opportunity to comment on the resistance the establishment of his professorship had faced:

> One was so absorbed in the way of thinking of the natural sciences and the tackling of problems with the possibility of the experiment, - and all of this with so much success - , that one could hardly accept, that also through other ways systematically organised knowledge, for medicine of importance, would be attainable.[61]

Hornstra showed that he was aware of the task that awaited him: proving the scientific value of social medicine.[62] Consequently, he expanded social medicine education to

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[60] P. J. van der Maas, J. P. Mackenbach, and L. J. Gunning-Schepers, *Volksgezondheid en gezondheidszorg* (Utrecht: Bunge, 1995).

[61] «Men was zo geabsorbeerd in de natuurwetenschappelijke denkwijze en aanvat der problemen met de mogelijkheid van het experiment, - en dit alles met zoveel succes - dat men nauwelijks kon aanvaarden, dat ook langs andere weg systematisch geordende kennis, voor de geneeskunde van belang, zou zijn te verkrijgen.» Robijn Hornstra, *Problemen der sociale geneeskunde* ('s-Gravenhage: Van Stockum, 1951), 2.

[62] Looking back on this at the end of his professorship, Hornstra reminisced about the 'laughable' budget and reflected on the work that still lay ahead: 'Scientifically social medicine in fact still has to commence'. «Wetenschappelijk moet de sociale geneeskunde feitelijk nog beginnen.» Robijn Hornstra, 'Plaats en taak van de sociale geneeskunde in de faculteit der geneeskunde', 14 juni 1967, 3, Part II, Collection prof. dr. Robijn Hornstra, Collection Sociale Geneeskunde, University Library Utrecht, Utrecht.

include research techniques, specifically epidemiology and sociology, next to the organization of healthcare. However, over the course of the 1970s, the scientific tools would disappear from social medicine classes as social medicine's scientific underpinnings started to operate on their own. This section will discuss both the inclusion and loss of research techniques in social medicine education in Utrecht.

The medical faculty faced fierce opposition from the board of governors of the university in Utrecht regarding the establishment of Hornstra's chair. The board followed the line of reasoning of J. J. van Loghem, professor of hygiene in Amsterdam. [63] Van Loghem thought that social medicine was not a medical science. He considered it merely the application of medicine in a specific setting with a focus on prevention and the collective. According to van Loghem, social physicians borrowed their science from other specialties. He used insurance medicine as an example: 'The *medical* questions that follow from the legal provisions against the consequences of illness and injury are answered in principality by internist, psychiatrist, neurologist, surgeon, ophthalmologist, otologist and dermatologist.'[64] The board of governors agreed and suggested that each clinical professor should incorporate social security laws in their

[63] Minutes of the meeting of board of governors of Rijksuniversiteit Utrecht, 26 March 1947, 3. HUA, 59, 18.

[64] «De *geneeskundige* vragen, die voortkomen uit de wettelijke voorzieningen tegen de gevolgen van ziekte en ongeval, worden in hoogste instantie door de internist, psychiater, neuroloog, chirurg, ophthalmoloog, otoloog en dermatoloog beantwoord.» J. J. van Loghem, "Sociale Geneeskunde," *Nederlands Tijdschrift voor Geneeskunde* 91,(25 January 1947): 194-98,95.

classes instead of appointing a full professor of social medicine. Alternatively, they proposed that the hygiene professor Julius could take up the subject. [65]

The medical faculty in Utrecht convinced the board of governors to grant social medicine a full professor by pointing towards the untapped potential of medical sociology.[66] John Ryle, professor of social medicine at Oxford, and Francis Crew, professor of social medicine at Edinburgh University, specifically inspired the medical faculty in Utrecht to introduce the social sciences, mainly sociology, in the medical curriculum.[67] The medical faculty proposed Hornstra as candidate precisely because of his familiarity with sociological methods that made up for his inexperience with social security laws.[68]

As described in section 3, the post-war professors had ample discussions on the content of social medicine. Because of this, curricula in social medicine differed across universities. For instance, Hornstra favoured a macro approach to social medicine and Julius, professor of hygiene, taught about the physical environment and health.

[65] Minutes of the meeting of the board of governors of the Rijksuniversiteit Utrecht, 15 September 1947, 2. HUA, 59, 18.

[66] Minutes of the meeting of the board of governors of the Rijksuniversiteit Utrecht, 1 March 1948, 2. HUA, 59, 18. Julius also elaborated on the potential of medical sociology in his speech in 1949, "Sociale Geneeskunde."

[67] Medical faculty to the board of governors of the Rijksuniversiteit Utrecht, 27 June 1949, HUA, 59, 612. The faculty pointed out several potential areas for 'groundbreaking' research inspired by Anglo-Saxon countries, such as research on the fertility of the population, the public opinion on vaccinations, the effect of the current financing system, or substance abuse. It is quite interesting that for this they did not refer to the work of René Sand who had a more pronounced understanding of social medicine as medical sociology than Ryle had. Porter, *Health Citizenship*, 85.

[68] Meeting of board of governors of the Rijksuniversiteit Utrecht, 20 March 1950, 3. HUA, 59, 20.

Accordingly, Hornstra's teaching focused on demographics, sociology, social security laws, and the organization of healthcare.[69] In contrast, students in Leiden learned about microbiology during their social medicine classes since their Muntendam included environmental hygiene in his understanding of social medicine.[70] Despite these differences, the professors agreed that social medicine's key research methods were epidemiology and medical sociology. Not surprisingly, the 1968 textbook *Social medicine: a general introduction* devoted a chapter to each of these methods and presented social medicine as a scientific field with a distinct object of study and study methods.[71]

However, during 1970s research techniques disappeared from social medicine classes in Utrecht. Instead, the Institute of Medical Psychology and Psychotherapy was responsible for teaching students tools about research in the social sciences.[72] In 1974, a committee regarding the strengthening of the social sciences in the medical curriculum even specifically recommended to keep those outside of the 'catchall' term social medicine.[73] The social medicine department removed the information on

[69] *Muntendam, Plaatsbepaling, 51-53.*

[70] *Ibid., 32-33.*

[71] Robert Jacques van Zonneveld et al., *Sociale geneeskunde: Een algemene inleiding*, ed. Robert Jacques van Zonneveld, Academische paperbacks., (Utrecht: Oosthoek, 1968).

[72] They had 185 hours in the medical curriculum to teach about sociology, cultural and social anthropology, andrology, and communication skills. "Ontwikkeling en plaats van het vak medische psychologie in onze fakulteit", 1975, 1-2. HUA, 1978, 229.

[73] «vergaarbak» C. W. Aakster et al., "Sociale wetenschappen en geneeskunde " (Sociale Wetenschappen en Geneeskunde, 'Woudschoten', Zeist, Instituut voor Medische Psychologie en Psychotherapie R.U.U. en Buro vormingswerk- Studium Generale R. U. Utrecht, 20 November 1974 1974).

medical sociology from their assorted literature in 1980 as the institute proposed to focus on hygiene instead of social medicine.[74] They concluded that Hornstra had not succeeded in legitimizing social medicine as an academic discipline: 'We are again 30 years later and still social medicine at the university does not have the image of a distinct and independent scientific discipline.'[75] These developments in Utrecht were in line with the decline of academic social medicine nationally (section 3).

Additionally, with the appointment of associate professors Brenkman, social physician, and Frits de Waard, epidemiologist, social medicine and epidemiology started to drift apart as each professor was responsible for their own educational and research activities. [76] Epidemiology was not necessarily part of social medicine anymore but could stand on its own. The committee responsible for finding a new professor of social medicine concluded in 1985 that epidemiology was hardly integrated in the department of Social Medicine and Epidemiology.[77] Most notably, the epidemiologists in Utrecht studied population-based screening methods for breast

[74] Literatuurmap gezondheidsleer en epidemiologie 1980-1981: Voor het onderwijs aan medische studenten (derdejaars), 1980, Instituut voor Sociale Geneeskunde, Rijksuniversiteit Utrecht, Utrecht.

[75] «Wij zijn nu weer dertig jaar verder en nog steeds heeft de sociale geneeskunde aan de universiteit niet het beeld van een duidelijke en zelfstandige wetenschap.» ibid, 2.

[76] "Studiegids van de Faculteit der Geneeskunde 1978-1979," (Utrecht: Rijksuniversiteit Utrecht 1978).

[77] "Slotrapportage door benoemingscommissie Algemene Gezondheidszorg", 4 July 1985. HUA, 1978, 588.

cancer. They found common ground with social medicine in the focus on the collective and prevention but were mostly uninterested in social epidemiology.[78]

Moreover, the scientific climate in the Netherlands transformed during the 1970s and 1980s. In response to the economic crisis during these two decades, the Dutch government enforced impressive budget cuts on medical faculties and introduced a program of conditional funding for scientific research.[79] This had a big impact on medical research and education. The medical faculty in Utrecht, for instance, sketched how their policy had changed from “attract a good man and everything will be fine” to “attract a good man and place him in a clearly organised scientific environment” to describe the impact of the governmental interference.[80] This more organised and collaborative approach to science fits the international transition from small to big science that occurred during the second half of the twentieth century when medical research increased in scale and complexity.[81]

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[78] “Enkele voorstellen ter bevordering van epidemiologisch onderwijs en onderzoek binnen de Medische Faculteit te Utrecht”, June 1980, 1.1. HUA, 1978, 158; ‘Structuurrapport Algemene gezondheidszorg’, July 1982. HUA, 1978, 589.

[79] Leen Dorsman and Peter Jan Knegtmans, *Universitaire vormingsidealen: De Nederlandse universiteiten sedert 1876*, vol. 1, Universiteit & samenleving, (Hilversum: Verloren, 2006), 99-104; Marius Jan van Lieburg, *Vijf eeuwen medisch onderwijs, onderzoek en patiëntenzorg in Rotterdam: Het Erasmus MC in historisch perspectief*, Pantaleon, (Rotterdam: Erasmus Publishing, 2003), 114-16; Bolt, *Doctor's Order*, 273-85.

[80] «trek een goede man aan en de rest komt in orde» “Beleidsnota Wetenschapskommissie Fakulteit der Geneeskunde”, 1980, 1. HUA, 1978, 339. «trek een goede man aan en plaats deze in een duidelijk georganiseerd wetenschappelijk milieu» ibid., 2

[81] Mooij, *Polsslag* 144; Bolt, *Doctor's Order*, 130; Annemieke Klijn, *Verlangen naar verbetering: 375 jaar academische geneeskunde in Utrecht* (Amsterdam: Boom, 2010), 212-15.

The medical faculty in Utrecht decided to focus its financial means on the departments with a high research output and perform budget cuts in the others.[82] One of the fields that underperformed, in Utrecht and nationally, was general healthcare or social medicine, whereas epidemiological research was 'on the rise'.[83] Existing tensions heightened within the department Social Medicine and Epidemiology, later General Healthcare and Epidemiology. Epidemiologists were increasingly fed up with having to carry the dead weight of social medicine and wanted to split the group: 'The living apart together with general healthcare at the moment is not only unfruitful, it contributes to an undesirable unproductivity.'[84]

As a money-saving measure, the medical faculty in Utrecht introduced a joint curriculum for the first two years of medicine and medical biology in 1989.[85] This gave the curriculum in Utrecht a distinct profile in the natural sciences in line with its prominent research projects. An employee of the department Research and Development of Medical Education admitted, 'scientists more oriented towards the social sciences, don't have a lot to do any more in the first years' of the curriculum'.[86]

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[82]Faculty of Medicine in Utrecht, *Wegen der verbeelding*, 27 March 1986, 4. HUA, 1978, 339; Klijn, *Verlangen naar verbetering*, 273-85.

[83] "Verslag gesprek subcomissie disciplineplan geneeskunde en Rijksuniversiteit Utrecht", 6 June 1985, 1. HUA, 1978, 222; "Conceptrapport adviescommissie opleidingen geneeskundigen", April 1980, 84. HUA, 1978, 269.

[84] «Het living apart together met AGZ van dit moment is niet alleen onvruchtbaar, het draagt bij aan een niet wenselijke inproduktiviteit.» "Slotrapportage benoemingsadviescommissie inzake het ordinariaat epidemiologie", 4 August 1987, 3. HUA, 1978, 614.

[85] "Facultair beleidsplan 1990 t/m 1993", n.d., 1-2. HUA, 1978, 199.

[86] «Voor de meer sociaal-wetenschappelijk georienteerde wetenschappers valt er in de eerste jaren niet zoveel meer te beleven.» J. Gerritsma, "Utrecht kiest exact," *BMO* 7,(1988): 17-18.

However, the national visitation of 1991 deemed this focus on the natural sciences too one-sided and encouraged the faculty to pay attention to ethics, health jurisprudence, and general healthcare, among others.[87] In 1997, the visitation reiterated this critique.[88] The consecutive critical visitation reports played a big part in the curriculum revision of 1999.[89] It is appealing to assume that this biomedical approach negatively affected social medicine education. However, general healthcare had already replaced social medicine before the introduction of the joint curriculum and the term reappeared before the curricular revision of 1999.

4.3 Social Engagement Manual

An often-heard grievance by professors of social medicine was how little enthusiasm students showed for the subject.[90] However, when interest amongst students in the social sciences, the social environment of patients, and in social action was peaking at the end of the 1960s and during the 1970s, the social medicine department in Utrecht appeared a lame duck. Instead, other departments of the medical faculty taught students tools on how to engage with society and social issues as a physician or how to reflect on this critically. Even though this general toolset was not prominent in social

[87] The committee also remarked that it seemed as if Utrecht equaled scientific with the natural sciences only. Vereniging van Samenwerkende Nederlandse Universiteiten, "Onderwijsvisitatie Geneeskunde en Gezondheidswetenschappen," (Utrecht: VSNU, April 1992), 254.

[88] Vereniging van Samenwerkende Nederlandse Universiteiten, "Onderwijsvisitatie Geneeskunde en Gezondheidswetenschappen " (Utrecht: VSNU, 1997), 83-97.

[89] Klijn, *Verlangen naar verbetering*, 305-10.

[90] For instance, professor of social medicine in Amsterdam, Arie Querido, recounted how students in Utrecht would take turns to visit Baart de la Faille's lectures so that this friendly man would not have to face an empty lecture hall. Querido, "Ontwikkeling," 260-66.

medicine education in Utrecht, this section will explore this tool because of the tradition of social engagement in social medicine.

Students in the Netherlands took note of the student protests of May 1968 in Paris that called for the democratization of decision-making at universities. This famously led to the occupation of the administrative building of the University of Amsterdam (het Maagdenhuis).[91] The educational ideas of the Parisian medical students formulated in the *Livre Blanc de la Reforme,* found their way across the border.[92] Medical students wished for active forms of education, an earlier confrontation with patients and their problems, and a clearer picture of future career options.[93] At the same time, a group of 'critical doctors' (Dutch: *kritiese artsen*) and the 'anti-psychiatry' movement questioned medical authority, criticised the biomedical model, and called for the inclusion of psychosocial factors in medical thinking and education.[94] They inspired Dutch students to demand a holistic patient approach, a

[91] In response to the student protests, in 1970 the the University Administration (Reform) Act (Wet op de Universitaire Bestuurshervorming (WUB)) was passed which formally settled the participation of students (and non-academic personnel) in the decision-making at universities. Mooij, *Polsslag* 423.

[92] Physician Jaap Goudsmit published a book on the history of medical education in 1978. Even though the book is coloured by Goudsmit's sympathetic stance towards socialism, it provides a rich overview of sources, especially on student movements. *Anderhalve eeuw dokteren aan de arts: Geschiedenis van de medische opleiding in Nederland* (Amsterdam: Socialistiese uitgeverij Amsterdam), 105-06.

[93] Ibid., 153-56.

[94] For example, Jan Hendrik van den Berg's *Medische Macht en Medische Ethiek* (Nijkerk 1969) was an influential Dutch publication regarding the relation between medical-technological progression and the power of medicine.

socially engaged medicine, and a larger emphasis on prevention and primary care. [95] However, the future physicians were not as vocal as their French peers or Dutch colleagues at other faculties. [96]

In 1969, a group of students and nurses in Utrecht started the GAMMA cycle, a series of meetings to discuss topics that the medical curriculum had omitted:

> It's about time that the physician during the execution of his profession realises a bit more that man is not just an object with transplantable organs but as much a being with a psychological and sociological background and that these three aspects of man, both the patient and the physician, are constantly interacting with each other.[97]

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[95] The critical doctors discussed topics such as district healthcare, mental health, specialist healthcare, and occupational medicine. They wanted to treat patients in their own environment and strengthen welfare and primary care in line with the international primary care movement. On the students and the critical doctors see: "Redactioneel," *N.T.v.M.S.* 17,(December 1970): 155-57; Paul Beek and Bart van der Lugt, "Kongres kritiese artsen te Woudschoten," ibid.,(June 1971): 467-69. On international developments see: Victoria Bates, "Yesterday's Doctors: The Human Aspects of Medical Education in Britain, 1957-93," *Medical History* 61,(2017): 52-54, https://doi.org/10.1017/mdh.2016.100; Virginia Berridge, "Public Health in the Twentieth Century II: 1945-2000s," *Public Health in History* (Maidenhead: Open University Press, 2011), http://site.ebrary.com/id/10510864. 204-06.

[96] Jan Brabers, *Hippocrates op Heyendael: Ontstaan en ontplooiing van de Faculteit der Medische Wetenschappen van de Radboud Universiteit Nijmegen, 1951-2001* (Nijmegen: Valkhof Pers, 2009), 153; A. C. Douwes, "Congres over het medisch onderwijs: Introductie " *N.T.v.M.S.* 14,(July 1968): 225.

[97] GAMMA was one of the projects of the 'Action group medicine' (Aksie groep mediesijnen). «Het wordt tijd dat de arts zich bij de uitoefening van zijn beroep wat meer realiseert dat de mens niet alleen een object met transplanteerbare organen is maar evenzeer een wezen met een psychologische en

GAMMA organised lectures on topics such as euthanasia, abortion, and healthcare systems.[98] One of its founders later reminisced that the students received little support from the faculty, with the exception of the departments of family medicine, medical psychology and the administration office. [99] Another example of a missed opportunity for social medicine was a project on social ethics that reflected on 'collective and individual responsibility' and the consequences of the practice of physicians. Even though, these can be considered typical social medicine topics, in Utrecht, the professor of family medicine instead of social medicine took up this project.[100]

Other Dutch departments of social medicine responded differently to the tumultuous time. In Nijmegen 'the department of social medicine was buzzing with life in the sixties' and had 18 employees in 1970, whereas Utrecht had six. [101] In Amsterdam, on the other hand, Professor Arie Querido fled into early retirement as not only fellow faculty members but also students questioned his status.[102] Victoria Bates noted that in the United Kingdom, a similar mismatch existed between students'

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sociologische achtergrond en dat deze drie aspecten van de mens, tevens de patiënt van de arts, een voortdurende wisselwerking op elkaar uitoefenen.» "Kritische medicijnen cyclus (gamma) te Utrecht," ibid.16,(October 1969): 57.

[98] HUA, 1978, 785 Stukken betreffende diverse studentenacties, waaronder die van 'Aksiegroep Medisijnen', 1969-1978.

[99] Aletta Bakker and Susan Ebers, "Back to the roots," *Arts & Fiets* 5,(February 1988): 25-26.

[100] «collectieve en individuele verantwoordelijkheid» "Verslag stage sociale ethiek, studiejaar 1976/ 1977", 1977, 1. HUA, 1978, 232.

[101] «bruiste de afdeling sociale geneeskunde in de jaren zestig van het leven.» Brabers, *Hippocrates op Heyendael*, 232. ibid.; "Utrechtse Universiteit Gids: '70-'71," (Utrecht: Rijksuniversiteit Utrecht), 113.

[102] Mooij, *Polsslag* 433.

interest in social issues, their interest in social medicine, and the actual presence of the subject in the medical curriculum.[103]

Several factors might have contributed to the inertia of the institute of social medicine in Utrecht. Firstly, between 1967 and 1971, the institute of social medicine was headless and as such, it had struggled to maintain their educational and research activities.[104] In the subsequent years, its employees continued to complain about a lack of financial resources and personnel.[105] Moreover, social medicine had gotten a bad reputation because of its vague identity and bureaucratic nature (section 2). Lastly, medical student H. S. Verburgh speculated that social medicine focused too much on 'the strictly natural sciences view of the 19th century' to be able to engage with the spirit of the time.[106] Verburgh argued that this reductionist approach was not suited to study social laws. Indeed, in the 1970s, the social medicine curriculum in Utrecht had taken up former hygienic objects such as the influence of the physical environment on health instead of engaging with social theory.[107]

Porter's analysis in *Health Citizenship* on the transformation of social medicine in Britain in the twentieth century might provide another reason for the lack of social engagement of social medicine. She demonstrated how social medicine shifted its attention to individual risk behaviour and responsibilities with health education

[103] Bates, "Yesterday's Doctors," 55.

[104] J.C. van Es to the board of the medical faculty, 29 January 1970, 1. HUA, 1978, 452.

[105] Aakster et al., "Sociale wetenschappen en geneeskunde " 105.

[106] «de strict natuurwetenschappelijke denkwijze van de 19e eeuw» H. S. Verburgh, "Het geheel der delen " *N.T.v.M.S.* 15,(June 1969): 316.

[107] F. de Waard and C.F. Brenkman to the board of the faculty of medicine, 24 August 1970. HUA, 1978, 452. Brenkman, C.F. en F. de Waard.

programs as its primary weapon. The rise of clinical epidemiology in response to the epidemiological transition meant a move away from public health's earlier goals, improving the social conditions or providing health services to the poor, towards attempts to attenuate the rise of chronic diseases.[108] A similar attention to health education and risk behaviour appeared in social medicine education in Utrecht at the beginning of the 1980s. The introduction to the assorted literature for the course year 1980-81, for instance, explicitly stated: 'Man can because of his behaviour create the circumstances and preconditions for the start of certain disease causes. Inversely, he can, by changing his pattern of behaviour, by changing life habits, by structuring his life a certain way, prevent the start of certain disease causes.'[109]

This biopsychosocial model in social medicine contrasted with the interest from the students in structural social issues. For instance, a student criticised the individual approach of a chapter on occupation medicine in a social medicine textbook: 'A social-medical textbook especially should clearly sketch the societal context in which all this occurs.'[110] The author accused occupational physicians of prioritizing the interest of

[108] Porter, *Health Citizenship*, 66-71. The epidemiological transition refers to the disappearance of infectious diseases that were strongly linked to socioeconomic circumstances, versus the increase in incidence of chronic diseases. Porter also noted how the biopsychosocial model of disease and prevention contrasted sharply with the structural models of social medicine in Latin America. Ibid., 165.

[109] «De mens kan door zijn gedrag de omstandigheden en de voorwaarden scheppen voor het in werking treden van bepaalde ziekteoorzaken. Omgekeerd kan hij door zijn gedragspatroon te wijzigen, door levensgewoonten te veranderen, door zijn leven op een bepaalde wijze in te richten, het in werking treden van sommige ziekteoorzaken vermijden.» Literatuurmap gezondheidsleer, 54.

[110] «Een sociaal-geneeskundig leerboek zou nu juist bij uitstek de maatschappelijke kontekst, waarin dit alles gebeurt duidelijk moeten stellen.» Frank Boekraad, "Arbeidsgeneeskunde, in dienst van wie? ," *Fakblad* 6,(1974): 15.

the companies, their employers, over those of the labourers. However, this student journal was known for its leftist views and it is unclear how widespread these ideas were amongst medical students.

4.4 Handbook for a Social Physician

Until the 1970s, social medicine teachers mostly discussed the work of social physicians in a descriptive manner to familiarise students with the organization of healthcare (section 4.1). For instance, a 1968-textbook elaborated more on historical developments in the work of social physicians rather than to zooming in on their daily work and dilemmas.[111] However, when academic social medicine had gotten in decline, the practical work of social physicians provided an anchor point for medical reformers that could use it to model medical education. To understand this transformation, it is crucial to discuss some important changes in Dutch medical education.

Firstly, medical students had demanded more influence in the university and in the planning of their curriculum (section 4.3). One of the student demands was to be more in touch with practice, something the professors Brenkman and de Waard, who had started in 1972, took to heart. They launched a new education plan together with the department of educational development and some students in order to make 'the education in Social Medicine more captivating'.[112] During the project, groups of 10 students visited different organizations, for instance a hospital or a factory. The goal was to provide students with a clear idea of the meaning of 'man-environment relation'

[111] Zonneveld et al., *Sociale geneeskunde*, 5.

[112] «het onderwijs in de Sociale Geneeskunde boeiender» F. de Waard and C.F. Brenkman to the board of the faculty of medicine, 24 August 1970. HUA, 1978, 452. Brenkman, C.F. en F. de Waard.

in these different institutions ‘through active confrontation with some aspects of reality’.[113]

The experiment aligned with several trends in educational reform: it was clearly oriented towards practice, it required active participation by the students, and students learned how to operate within a group.[114] Namely, at the end of the 1960s educational scientists entered the debate on medical education.[115] The medical faculty in Utrecht, for instance, appointed Harmen Tiddens as professor in the methodology of medical education as well as in pediatrics in 1969. In the same year, the medical faculty opened a department of educational development. With the advent of new medical programs in Rotterdam (1965) and Maastricht (1974) the first designed, as opposed to historically developed, curricula appeared in the Netherlands.[116] These new universities opted for integrated curricula instead of teaching the subject matter per discipline, for instance through problem-based learning in Maastricht.[117] This move towards integration is

[113] «mens-milieu relatie», «door aktieve konfrontatie met enkele aspekten van de werkelijkheid» “Het projekt sociale geneeskunde”, 27 October 1971, 1. HUA, 1978, 312.

[114] Aakster et al., " Sociale wetenschappen en geneeskunde " 9.; Afdeling Onderwijsontwikkeling, *Wijs Onderwijs*, 13 March 1972, 8-14. HUA, 1978, 311.

[115] Brabers, *Hippocrates op Heyendael*, 185; Klijn, *Verlangen naar verbetering*, 236-39.

[116] Eugène J. F. M. Custers and Olle ten Cate, "A Solid Building Requires a Good Foundation: The Basic Sciences in the Dutch Medical Curriculum, 1865-1965," *Journal of the International Association of Medical Science Educators* 20,(2010): 261-65.

[117] Lieburg, *Vijf Eeuwen*, 104; Peter Jan Knegtmans, *De Medische Faculteit Maastricht: Een nieuwe universiteit in een herstructureringsgebied, 1969-1984* (Assen Van Gorcum, 1992), 117-18.

visible in the curricular revision in Utrecht from 1982.[118] Medical schools all over the world were grappling with questions on the desired form of medical education.[119]

Finally, a series of educational reforms started that, among others, has reoriented medical education to the practice of medicine. In 1968, the Academic Statute changed for the first time since its establishment in 1921, and a subsequent alteration followed in 1973.[120] The changes allowed faculties to adapt their outdated and overloaded curricula.[121] In 1968, a loose description of objectives replaced the earlier rigid list of exam topics and in 1973 the term *basisarts* was introduced.[122] A *basisarts* would be qualified to practice medicine under (indirect) supervision but had to go through training to become a general practitioner, clinical specialist, or social physician before they could practice independently. This new concept caused much confusion at the medical

[118] "Studiegids van de Faculteit der Geneeskunde: 1982-1983," (Utrecht: Rijksuniversiteit Utrecht).

[119] See for instance on the United States, Kenneth M. Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century* (2005), 303-13.

[120] For approximately 100 years, Dutch medical education had looked like this: The 7-year program consisted of a theoretical and practical part. During a premedical (or propaedeutic) year, medical students took classes on physics, chemistry and biology. Then, two years of candidate courses followed which consisted of preclinical sciences, such as anatomy. Two doctoral years on clinical sciences, for instance general surgery, wrapped up the theoretical part. During the last two years, medical students were introduced to the practical work in the hospital.

[121] Medical faculties were also dealing with an explosion of the student population, which an important driver of reform. For more on the curricular reform see: Custers and ten Cate, "Solid Building," 261-75. For the view of the medical faculty in Utrecht*:* Conventcommissie voor de Faculteit der Geneeskunde te Utrecht, *Nota over de artsopleiding,* December 1965.

[122] I will use the Dutch term because of its specific meaning in the Dutch context. For a more elaborate description: Knegtmans, *Medische Faculteit Maastricht*, 53-54.

faculties who had to flesh out what it meant to train a *basisarts.*[123] Discussion arose on the desirable content of the curriculum: What knowledge and skills were essential and what could prospective specialists learn during specialization?

Over the decades, the medical faculties and the Dutch government tried to concretise what it meant to be a *basisarts*.[124] Commonly, these attempts tried to establish what knowledge and skills were needed as medical specialist and how to meet the requirements for postgraduate education in different specialties. Arguably, this has meant a bigger change for social medicine than for other specialties because of the divide between scientific and practical social medicine. Instead of the theoretical discussions that professors had on (the soul of) social medicine, now the practical field became the benchmark for education. Additionally, effective from 1982, the government enforced a two-phase structure on university programs that required the first year of a program to provide students with a broad orientation on their career

[123] The medical faculty in Utrecht also struggled with the concept: “Gedachten over de opleiding van de basisarts*”*, 2 September 1974. HUA, 1978, 228; “Voorstel werkplan kenmerken van de basisarts”, December 1977, 1. HUA, 1978, 233.

[124] In 1974, the medical faculties in the Netherlands published a shared statement on global educational objectives to give more body to the Academic Statute. In 1980, the state advisory committee on medical education plead for a better preparation of medical students for the actual working field. Respectively, Interfacultair Overleg der Nederlandse Faculteiten der Geneeskunde, "Raamplan 1974 van het Interfacultair Overleg der Nederlandse Faculteiten der Geneeskunde betreffende de globale doelstellingen van de Artsenopleiding Nieuwe Stijl," *Medisch Contact* 29,(9 August 1974): 1017-21; *Conceptrapport adviescommissie opleidingen geneeskundigen*, April 1980. HUA, 1978, 269.

options.[125] This was in line with the general philosophy of the 1980s that valued efficiency and (direct) societal relevance, and it is an example of the governmental interference with education in the 1980s.[126]

The work of the medical faculties culminated in a 'Blueprint' (Dutch: *Raamwerk*) for medical education in 1994. The Blueprint detailed the learning objectives of each specialty in terms of skills, attitudes, and knowledge. For social medicine, skills included for instance, 'to recognise risk behaviour and lifestyles', 'to assess health-related absenteeism', and 'to give a health advice, counselling, and supervision to groups and third parties'.[127] These clearly referred to tasks performed by social physicians in the field.[128] The understanding of social medicine as form of service provision is also visible in the textbook by van der Maas and Mackenbach from 1995 as the textbook only discussed social medicine in relation to the practical work of social physicians.[129] Similarly, in Utrecht's study guide of 1990-1991, social medicine only

[125] After a four-year theoretical phase, students could now switch to a more research-minded second phase instead of becoming a *basisarts*. Klijn, *Verlangen naar verbetering*, 271-75.

[126] ibid., 269-71; Brabers, *Hippocrates op Heyendael*, 401.

[127] «herkennen van riskant gedrag en leefstijlen», «beoordelen ziekteverzuim», «geven van een gezondheidsadvies, voorlichtingen, begeleiding aan groepen en derden». J. C. M. Metz et al., "Disciplinegebonden eindtermen sociale geneeskunde," in *Raamplan 1994 artsopleiding: Eindtermen van de artsopleiding* (Nijmegen: Universitair Publikatiebureau, Katholieke Universiteit Nijmegen 1994), 156-60; 59.

[128] Although medical educators complained that, social medicine's objectives were less concrete than those of other disciplines were. Wendte, "Vreemde eend," 319-20.

[129] Maas, Mackenbach, and Gunning-Schepers, *Volksgezondheid*, 4.

referred to the work of social physicians.[130] Moreover, Utrecht finally set up an internship in social medicine in the 1990s, which the visitation applauded in 1991.[131]

5. CONCLUDING REMARKS: FIXING THE INDIVIDUAL OR FIXING THE SYSTEM?

In sum, until the 1970s, professors of social medicine provided students in Utrecht with tools on how to navigate the healthcare landscape and how to do research in the social sciences and in epidemiology. To the students' disappointment, professors of social medicine did not teach them to think critically about the medical system, i.e. did not give them tools of 'social theory'. In the 1980s, Utrecht chose to focus on general healthcare, a branch of social medicine, and the term 'social medicine' briefly disappeared from the curriculum. Partly because of educational reforms during the second half of the twentieth century, social medicine reappeared in the medical curriculum in the 1990s. However, instead of functioning as a general subject relevant for every future physician, social medicine classes now focussed on giving students specialised tools important for future social physicians.

In the United Kingdom where academic social medicine had purposefully separated itself from service provision, the field had already disappeared in the

[130] "Studiegids Faculteit Geneeskunde 1990-1991," (Utrecht: Rijksuniversiteit Utrecht, 1990), 163.

[131] Already in 1949, a state committee on the reorganization of higher education had advised that medical students should have a one-month-long internship in social medicine. However, Hornstra who was professor at the time did not consider it worthwhile to organize an internship for uninterested students. For the visitation report see: Vereniging van Samenwerkende Nederlandse Universiteiten, "Onderwijsvisitatie," 244. For the state committee report: "Rapport van sectie K," in *Rapport van de staatscommissie tot reorganisatie van het hoger onderwijs.* ('s-Gravenshage: 1949), 256-57. For Hornstra's response see: Muntendam, *Plaatsbepaling*, 43.

1960s.[132] Instead, 'community medicine' combined academic social medicine and the practical work of medical officers of health.[133] Social medicine revived in Britain and the United States as an interdisciplinary approach to health in the 1990s.[134] Contrarily, Mackenbach and Kerkhoff criticised Dutch social medicine to be too monodisciplinary - revolving around the contributions of social physicians.[135] Instead, they preferred the term 'public health' to encompass a multidisciplinary research field. This understanding of social medicine as a collective of specific medical specialists reflects the presentation of social medicine in education at the medical faculty in Utrecht in the 1990s. However, it does not acknowledge the tradition of academic social medicine as a way to teach medical students about the health landscape and social sciences.

Despite the critique, in the 1990s, social medicine and public health seemed on the rise in the Netherlands as well. [136] In 1992, the long awaited School of Public Health was founded and the number of dissertations in the field increased.[137] Additionally, in 1992, the registry for social physicians decided to reorganise social medicine's branches into two main directions: community medicine and occupational health.[138] During an interview in 1991, the new professor of social medicine in Amsterdam, Louise Gunning-Schepers, talked about a 'renaissance' of public health or social

[132] Porter, *Health Citizenship*, 188-89.

[133] Ibid., 192-97.

[134] Ibid., 125.

[135] Mackenbach, "Ontwikkeling van," 229; Kerkhoff, *Opvattingen*, 175-77.

[136] D. J. B. Ringoir, "Nieuwe bloei voor sociale geneeskunde? Ontwikkelingen in kaart gebracht," *Medisch Contact* 48,(15 January 1993): 55-56.

[137] Mackenbach, "Ontwikkeling van," 218.

[138] "De toekomst van de sociaal-geneeskundige opleidingen: Geconstateerde ontwikkelingen," *Medisch Contact* 48,(15 January 1993): 58-60.

medicine.[139] She objected the targeting of individual behaviour and proposed to focus research and policy on health equity and on structural causes of health differences. Indeed, these topics are present in the Blueprint of 1994 but they are not linked to social medicine or public health.[140]

Instead, medical educators have criticised the individual approach in many of the Blueprint's objectives regarding social medicine.[141] They argued that the problem-based approach was unsuitable for the collective and structural approach of social medicine. The patient- or problem-oriented curricula might have contributed to a similar focus on the individual in social medicine education. However, as this study showed, social medicine in Utrecht had already missed several opportunities to address structural issues in healthcare in the 1970s and instead adopted the biopsychosocial model. Comparably, the scope of the social sciences in the medical curriculum has increasingly narrowed towards behavioural sciences to elucidate the patient experience and the doctor-patient relationship[142] Therefore, Jonathan Metzl and Helena Hansen presented an alternative approach in 2014. They have proposed to introduce 'structural competency' in the medical curriculum to teach students about the

[139] She used public health and social medicine rather interchangeably. Thea Dukkers van Emden, "Gezondheidszorg is er voor iedereen: Interview met Louise Gunning, hoogleraar Sociale Geneeskunde " *Tijdschrift voor Gezondheid en Politiek* 9,(November 1991): 28-30.

[140] J. C. M. Metz et al., *Raamplan 1994 artsopleiding: Eindtermen van de artsopleiding* (Nijmegen: Universitair Publikatiebureau, Katholieke Universiteit Nijmegen, 1994), 52-53.

[141] Wendte, "Vreemde eend," 320; Niek Klazinga, "Kanttekeningen bij het profiel van de arts in het Raamplan 1994. ," *BMO* 14,(1995): 122.

[142] For this development in the United Kingdom: Bates, "Yesterday's Doctors."

structural forces at play in health rather than being engrossed in the individual encounter.[143]

Finally, this study is by no means exhaustive. Firstly, the article could not elaborate fully on the history of Dutch medical education in the second half of the twentieth century. However, this is exciting terrain for future historians. Topics for exploration include, among others, the medical student movement as driver of reform, the balance between science and practice in medical education, the advent of the (medical) educational sciences, and the establishment of the Blueprint in 1994. Oral histories especially can further our understanding of the choices made in medical education.

Questions also remain unanswered with respect to the history of Dutch social medicine. For instance, historiography has given little attention to the presence of health services research within social medicine. Moreover, a comparative study on Dutch social medicine versus other contexts can deepen our understanding of its history. In terms of comparative studies, another interesting comparison would be between disciplines, for instance academic social medicine versus academic family medicine. In the past, social medicine and family medicine were closely related. For instance, Professor Hornstra helped establish the first chair of family medicine in the Netherlands in 1966.[144] However, in contrast to social medicine, Dutch family medicine

[143] Jonathan M. Metzl and Helena Hansen, "Structural Competency: Theorizing a New Medical Engagement with Stigma and Inequality," *Social Science & Medicine* 103,(February 2014): 126-33, https://doi.org/https://doi.org/10.1016/j.socscimed.2013.06.032.

[144] Roelof Kruisinga, "Woord vooraf," in *Maatschappelijke gezondheidszorg in perspectief: Essays, aangeboden aan prof. R. Hornstra, t.g.v. zijn afscheid als hoogleraar in de Sociale Geneeskunde aan*

would grow out to be a very successful academic discipline by fully embracing clinical epidemiology in the 1980s.[145]

Ultimately, this article aspires to add Dutch perspective to the growing body of literature on the global history of social medicine. Both the use of the medical curriculum as vantage point and the Dutch context make it a unique addition to this literature. Next to this, the study hopes to inspire the ongoing discussion on the place of social medicine in medical education.[146]

de Rijksuniversiteit te Utrecht, ed. J. C. van Es (Assen: Van Gorcum & Comp. - H.J. Prakke & H.M.G. Prakke, 1968), XI-XII.

[145] Bolt, *Doctor's Order*, 255-57.

[146] Jennifer Kasper et al., "All health is global health, all medicine is social medicine: Integrating the social sciences into the preclinical curriculum," *Academic Medicine* 91,(2016): 628-32, https://doi.org/10.1097/ACM.0000000000001054; Michael Westerhaus et al., "The Necessity of Social Medicine in Medical Education," ibid.90,(2015): 565-68, https://doi.org/10.1097/ACM.0000000000000571; Joost van der Gulden, "Sociale geneeskunde verdient meer aandacht in studentenonderwijs," *Tijdschrift voor gezondheidswetenschappen* 90,(2012): 387-88, https://doi.org/10.1007/s12508-012-0131-8; Post and Groothoff, *Sociale Geneeskunde of*, 56-58.