Teaching Social Medicine as Collaborative Ethnographic Research and Advocacy on Homelessness and Serious Mental Illness

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The Problem: How Can Social Science Methods and Theory Engage Theoretically and Practically in the US Medical School Context with the Urgent Challenges of Rising Social Inequality and Health Disparities

Health, disease, health-care delivery, and medical science are deeply shaped by social, political, economic, and cultural structures [1]. Critical social science perspectives, however, remain underdeveloped in US medical schools. A growing number medical schools are promoting versions of "social medicine" and devoting more curricular time to "cultural competence", "social determinants of health" [2], and "structural competence" [3–5], but most of this curriculum is taught by clinicians without graduate-level social science training and does not systematically integrate the methods and theories of medical social sciences. As two of only a handful of senior social scientists on the faculty of the medical school at the UCLA, we have taken it upon ourselves (with encouragement from a progressive dean's office) to develop ways of incorporating social science methods and theory into both the undergraduate medical school curriculum as well as the larger intellectual community of clinical researchers, postdocs, fellows, and clinicians throughout the medical school. This also involves increasing interdisciplinary linkages between the medical school and social science and humanities departments across campus.

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Our guiding questions are: (1) how can we build social medicine as a discipline and vibrant intellectual community in a public medical school that goes beyond its standard, well-intentioned but only token presence within the curriculum; and (2) how can we integrate critical thinking about the impacts of social forces on health into the very fabric of medical education, intellectual socialization, clinical practice, research, and advocacy? We believe that social medicine ought to encompass a larger epistemological and moral frame, one that allows for a critical self-reflexive engagement with both medicine and society and become the basis for a vision of research and clinical practice dedicated to social justice for structurally vulnerable populations. As a medical anthropologist (PB) and a medical historian and psychiatrist (JB), we share a sensibility for the importance of understanding the historical, social, and cultural context of our objects of study as well as our own prejudices. We both also want to make sense of Los Angeles, the community we live in, through a theoretical and practical understanding of how social structural forces shape social inequality and damage the health and life chances of vulnerable underserved populations. Arguably the sprawling suburbanized megalopolis of Los Angeles is the global city of the future, incubating many of the most dramatic structural inequities facing the United States.In fact, social contradictions and suffering becomes exceptionally visible in our city because of its large and exaggerated scale. In fact historically, political, economic, and sociocultural trends in California, primarily driven by Los Angeles, the most populous county in the nation have presaged future developments across the country. In recent generations this has ranged from the 1960s countercultural hippie peace/love/sexual liberation movements and legistlation of civil liberty protections, to the 1978 right-wing populist taxpayer revolt of proposition 13 that contributed to the 1980 presidential election of Ronald Reagan and set the US on the path to punitive neoliberalism [6] followed by a series of legislative "reforms" that resulted in the state of California having the fastest rising rates of mass incarceration during peacetime of any nation in world history from 1980 through the mid-1990s [7].

We both live on the Westside of the city near campus, where average house values exceed $1.5 million. This inflated opulence, however, is undone by – and comes at the cost of – nearly 50,000 homeless individuals in Los Angeles County, many of whom call the streets, alleys, and freeway underpasses surrounding us their home.

We either walk (JB) or bicycle (PB) to work and are bombarded daily with the contradictions of dramatic social inequality besetting our city. We each pass dozens of homeless individuals on our separate short commutes to and from work. We catch ourselves reflexively avoiding eye contact when we pass distressed individuals who often find themselves in frantic states of florid psychotic decompensation or paralyzed by despair. Despite our personal political, intellectual, and professional proclivities, and despite our multiple publications on the structural policy and economic forces promoting homelessness at the daily level, we de facto reproduce society's growing indifference to the rising levels of social suffering and survival insecurity that is imposed on increasing numbers of our homeless, often seriously mentally ill, neighbors [6, 8, 9]. Survey data estimates that only some 30% of the Los Angeles homeless population suffers from serious mental illness [10] but they are the most visible of all the homeless, marked by the accumulated dirt and grime embedded in their rags and skin and by their frequently odd public behaviors. One does not need

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psychiatric training to know that their mental illness is inseparable from their homelessness. Ironically our offices are located on the ground floor of UCLA's repurposed neuropsychiatric hospital that was opened in 1961 as a subsidized therapeutic facility during the golden age of public mental health that would have considered our current practice of abandoning to the streets or incarcerating those afflicted with psychosis to be a barbaric relic of early nineteenth century practices. The old state-funded neuropsychiatric hospital, however, has succumbed to the invisible hand of neoliberalism. Rechristened the Stewart and Lynda Resnick Neuropsychiatric Hospital after billionaire philanthropists who offset dwindling state support with a sizable gift, the hospital no longer regularly cares for the indigent. It has changed its priorities to serving patients with private health insurance. Relocated within the newly built and aptly neoliberally named Ronald Reagan Medical Center, the ostensibly public the Resnick Neuropsychiatric Hospital boasts a US News and World Report ranking of 8th in psychiatric hospitals, but it is off-limits to the sickest, most vulnerable homeless indigent individuals with serious mental illness. They can be seen every day, wandering the streets and alleyways surrounding the hospital, often in states of unimaginable terror and distress. All too often they are forcibly removed or shoo-ed away by police or security guards. Nevertheless, along with our clinical colleagues we routinely ignore and avoid them.

Theoretical Orientation

More of a perspective than a grand theoretical orientation, we both seek to understand the ways in which larger political economic forces underpin relationships of power and how those relationships, in turn, shape social, cultural, and psychological life. This critical social science approach, combined with our everyday context of living in Los Angeles has shaped our appraoch to training medical students and residents. We see the city as a natural laboratory for critiquing the negative health effects of rising levels of social inequality, financialization of public resources and policy planning and implementation that promotes segregated gentrification processes.

Year after year, we have been amazed at the idealism, enthusiasm, and fundamental humanism animating many, if not most, of the entering classes of medical students. As these same students progress through their medical training, however, they steadily lose (or misplace) their commitments to social justice. We believe that social medicine teaching, no matter how one conceives of it, should foster and protect this early idealism and provide a productive analytical framework that helps students mature into socially responsible physicians and/or researchers committed to a broader notion of health, social equality, and solidarity for the suffering imposed on structurally vulnerable populations by social forces and policies.

Our views on medical education fit into how we hope to more generally situate our scholarship. We aspire to being public intellectuals or, more humbly, "good-enough [11] specific intellectuals [11]" to meld the provocatively self-critical terms of Nancy Scheper-Hughes [11] and Foucault [12, 13]. We share a political and intellectual commitment to bringing the methods and theory of a critical social science of medicine approach to bear on the urgent social problems of the larger community

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surrounding us and what we see as the central or emerging contradictions of our historical era plagued by rising local and global social inequality. We hope that both us and our students become more than bystanders in the face of contemporary inequalities and rise to the challenge of helping to create a medical practice and research that reflects these values that originally inspired JB to become a physician and PB to develop social medicine training programs in medical schools.

The Path

Reproducing Ourselves

Since the late 1990s, each of us has been building social medicine programs in medical schools (at the University of California, San Francisco; the University of California, Berkeley; the University of Pennsylvania; and now together at the University of California, Los Angeles). In each setting, we have had distinct institutional homes – as a full department with dedicated hard-money faculty salaries at the University of California as San Francisco and Berkeley, as a doctoral program track with only part-time faculty within a larger social science department and a fledgling public health program at the University of Pennsylvania, and as a center with both full-time and part-time faculty at UCLA who are appointed in multiple departments across campus and public sector agencies in the city (Department of Mental Health) and the region (Veterans Associations). The overarching goals of our programs, however, have changed little over the years: namely, to build an intellectual community of researchers, students, and clinicians dedicated to bringing the methods and theories of a critical social science of medicine approach to bear on understanding how social inequality impacts health, caregiving, and scientific knowledge.

Despite the very distinct institutional settings and funding streams of each of our social medicine programs over the years, they have been anchored by MD/PhD training programs funded with support from NIH Medical Scientist Training Program (MSTP), supplemented by sometimes generous dean's offices as well as an unstable scramble of public and private grants and elusive philanthropy. This has enabled us to admit 1–3 doctoral students per year to an interdisciplinary cross-school 9-year program that supports integrated MD (4 years) and PhD (4.5–5 years) training in the social sciences/humanities (primarily anthropology, sociology, and history in our cases). The exceptional intelligence, discipline, and appeal of these students and – more practically – their guaranteed funding and tendency towards ambitious over-achievement facilitates our engagement with the larger intellectual community of social science PhD programs across the campus. Most practically it attracts new interdisciplinary faculty colleagues eager to serve as mentors and members of a social medicine intellectual community who often become excellent unpaid faculty affiliates in our Center. The MD/PhD students rise to the challenge of merging theoretical perspectives and practices from the medical and social sciences. This seemingly intractable epistemological contradiction spawns what can be called (following Bourdieu, 2008 [14]) a productive "fractured [disciplinary/vocational clinician-social scientist] habitus" that makes these budding MD/PhDs reflexively

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uncomfortable (on both conscious analytical and also preconscious emotional levels) in the two occupational worlds (clinical practice versus social science academia) that organize their lives, shape their intellectual maturation processes, and fund them. Their simultaneous training in multiple contradictory epistemological worlds sometimes promotes exceptionally creative – what Bourdieu would call "non-doxic" – critical thinking [15]. Most of the trainees pursue careers in academic medicine informed by their critical social science perspective but also committed to practical professional engagement with caregiving. This often pushes those that do not become seduced or distracted by the exceptionally high salaries paid to US practitioners to challenge the accepted status quo boundaries of thinking among their colleagues within their distinct institutional settings. At all four universities where we have worked, the social medicine program did not flower until it benefited from the MD/PhD training program which provided funding, symbolic institutional legitimization, and a logistics of practical collaboration fomenting faculty collegiality.

Our MD/PhD students repeatedly prod us to engage formally with the existing undergraduate medical school curriculum. This is especially the case during their first 2 years of medical school, when they are excited about trying on their new dual identities of social scientist and physician. Medical education claims to be moving away from rote memorization, but standardized national certification exams structure the learning and teaching experience and our social science and social justice-oriented students find little in their formal medical curriculum to address their interest in the social context of disease or health disparities. As a result, the MD/PhD students often spontaneously develop social medicine pedagogical initiatives on their own. They often become lecturers, trainers of small group preceptors, and even organizers of entire courses or thematic threads within the undergraduate medical school curriculum [16]. Again, their unique positionality as medical-student-socialscientists-in-training at the frontlines of social medicine pedagogy offers us insiders' participant-observation perspectives on the "pulse" of changing generational sensibilities of medical students towards critical thinking. Our students, independently from us, enrich the intellectual environment of the medical school and motivate other students to pursue their commitments to health and social equality. Some have even gone on to found or lead political advocacy and physician/social scientist disciplinary organizations [17].

Social Medicine for All

Despite the pedagogical enthusiasm of many of our MD/PhD students, developing and administering a core required curriculum in social medicine for all MD students remains an unachieved challenge for us. Medical student teaching is poorly rewarded institutionally. Furthermore, staking out territory for social medicine in an already crowded clinical curriculum often riddled with alpha personalities convinced, like us of the universal importance of their particular medical/intellectual sub-disciplines is a thankless task.

Medical schools are notorious for repeatedly "reinventing" their curriculum but failing to achieve substantial change. Indeed our experience with introducing social medicine into those ambitious curriculum-wide overhauls have often felt like

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excercises in slamming our heads against brick walls. Over our years of fits and starts, we have organized multiple social science initiatives to energize our emerging intellectual community of social medicine practitioners and researchers and to increase its size, diversity, relevance, and presence in pedagogy throughout our medical school. These initiatives have in the past included or are in the process of hopefully becoming: (1) a social medicine thread of strategic lectures and small group sessions in the required first-year doctoring course; (2) a 2-week social medicine block in the first year of medical school followed by a longitudinal component that threads through all 4 years; (3) short elective courses for medical students offered in the first-year, fourth-year, and over summer sessions; (4) taskforces of faculty members from across campus to propose and revise – yet again! – the core social medicine curriculum and redefine cultural competency as "cultural humility" and/or [18] structural competency [4]; (5) bimonthly social medicine seminars organized around social science readings relevant to our current research projects that attract medical students, MD/PhD and social science graduate students, postdocs, residents, and faculty; (6) a quarterly social medicine grand round series; (7) social science clinical case conference series; (8) positions as attending social scientists in clinical case conference series within hospital residency training programs in which the residents present patients whose conditions are complicated by social conditions in which we have some expertise (such as psychosis, substance use disorder, homelessness, incarceration); (9) monthly clinical self-reflexive ethnographic fieldnote methods seminars; and (10) introducing "structural vulnerability" checklists [5] to residencies to adapt and implement within their specific clinical settings, community social services resource bases and larger social structural risk environments.

Engaging the Social

Over the last few years, somewhat more humbly and/or opportunistically, we have aligned our teaching more closely with our research commitments and policy engagement. This has the immediate practical advantage of reducing the double-bind of the zero-sum time conflict between teaching, research and unstable research funding and engages us spontaneously into conveying inadvertently our passion for a social medicine that addresses urgent health disparities and social problems. Our current research commitments, for example, arise directly out of our daily passage through the contradictory landscape of growing social inequality, homelessness, and indigent serious mental illness in our rapidly gentrifying city. Just as tragically and structurally inseparable from its levels of homelessness, Los Angeles law enforcement agencies arrest and incarcerate more seriously mentally ill individuals than any other city on the planet. The Los Angeles County Jail has become the largest de facto psychiatric institution in the world according to the United Nations [19], with between 4000 and 5000 seriously mentally ill inmates behind bars on any given day, with many of them floridly decompensating in solitary cells. Starting first as a trickle in the 1970s and then, over the last 40 years, becoming a torrent, people

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with serious mental illness have been increasingly churned into intractable cycles of homelessness, acute hospitalization, and incarceration. From 2009 through 2018 the absolute and relative number of Los Angeles County Jail inmates with serious mental illness increased 80 percent [20–22]. We have worked together to understand the larger structural political economic forces and the specific changing regional policy initiatives that inadvertently sustain this nefarious cycle of institutionalized suffering in our sprawling megalopolis. We are documenting how these macro-level forces and the systems-level fragmentation of public and private safety net agencies translate into the intimate experience of everyday suffering, despair and serious mental and physical illness?

Although we had often collaborated closely with individual MD/PhDs and other social science graduate students on specific research projects in the past, we initially conceived of our current collaborative team research as being largely separate from – and in zero-sum time competition with — our pedagogical interests in and obligations to undergraduate medical school education. Generally, our multiple formal teaching initiatives have tended to burn us out, sabotaging their effectiveness in practically modeling to our students the practicality of sustainable socially responsible practices on behalf of underserved populations in academic medicine. Partially out of frustration, consequently, we experimented with aligning our teaching more closely with our personal research commitments. JB had just obtained a large contract to evaluate a program administered by the Los Angeles County Department of Mental Health (LACDMH) to address the growing problem of individuals cycling through homelessness, acute psychiatric hospitalization, arrest and incarceration. We were excitedly scrambling to find time and personnel to develop a multi-method, clinically informed quantitative/qualitative/ethnographic evaluation that would explicitly link larger social forces to everyday suffering and disease: the essence of our (perhaps idiosyncratic) critical definition of social medicine around political economic power vectors.

Theory and Practice: Teaching Social Medicine as Applied Sociomedical Practice

We began by killing two birds with one stone and subordinated a required first-year medical student teaching module under the priorities our new applied research effort. We developed a 6-week summer elective that took advantage of existing medical school stipends available to first-year medical students transitioning into second year who were seeking to temporarily apprentice on existing faculty research projects. We also integrated two incoming members of our class of social science track MD/PhDs who already had formal undergraduate training in the social sciences and were familiar with ethnographic qualitative methods. They served as peer leaders for the less experienced medical students. We organized the theme of the elective as an exploratory “ethnographic diagnostic overview” of the unmet mental and physical health needs of the homeless in Los Angeles.

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We began with a very brief theoretical training in the historical, social, and political economic context of inequality and homelessness in Los Angeles. The bulk of those introductory sessions focused practically on the logistics of participant-observation ethnographic methods and the sensibilities of critical self-reflection and cultural relativism. Most importantly, at the end of the first class, both faculty members accompanied the students to conduct an evening of fieldwork in a homeless encampment two blocks from our classroom where JB had developed some friendly acquaintances. The faculty members wrote up the first draft of that evening's ethnographic field note. The students then added their additional observations on subsequent drafts, with each student using a different colored text to identify their positionality and voice. This collaborative technique became the model for the collaborative group ethnography over the next 6 weeks. They went on fieldwork outings in pairs with one of the students taking the lead in writing the field note and the other adding observations to the original note. Sometimes one of us or a faculty member or the ethnographer staff member (Ronald Calderon) from our Center accompanied them, providing a third experienced perspective, as well as facilitating ongoing logistical coordination and local institutional or community-entre to new sites. The notes were posted to a HIPAA compliant server, and we all met once a week to discuss our findings, emerging hypotheses, and brainstorm future sites for fieldwork and for supplemental archival data collection.

The Key Learning

This tentative experiment exceeded our expectations. The medical students enthusiastically fanned out across the city to strategically selected distinct urban ecologies of Los Angeles where large populations of homeless congregate: Skid Row, West Hollywood, sex strolls, Venice, the Boardwalk, MacArthur Park in East Los Angeles, and Veterans Park in Westwood. Smart, motivated medical students make excellent ethnographers. Their non-threatening positionality as eager-to-learn youth, not yet jaded by long hours of clinical call or dispiriting hierarchies of hospital life, facilitate sympathetic access to a diverse range of often overwhelmed social service providers, stakeholders and homeless individuals who are sometimes distrustful of academic clinical researchers. Even conservative police officers openly hostile to the politics of public health and social science researchers let down their guard and opened up generously to the students inviting them to shadow them on patrols.

At the same time, the quality of their clinically informed and anthropology-inspired, culturally relative field notes caught us by surprise. They became a useful set of comparative field notes that triangulated multiple political perspectives and ethnic/class/gender/sexuality positionalities. Their field notes on difficult-to-engage street settings including gang-controlled drug-selling scenes became a valuable part of our applied research/service data archive.

The students also bonded intellectually as a cohort through the intensity of the experience of street-based fieldwork among indigent vulnerable populations on unfamiliar social turf. In fact, in subsequent years, these students became a new set

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of core participants of our applied social medicine intellectual community, eager to bring their skills to bear on the urgent social problems in our surrounding community or in the larger global environment. The students told us that the ethnographic practicum was the first time they had engaged in a substantial manner with the larger Los Angeles community from which they had felt isolated during their first year. They were moved by the stakes of the suffering they encountered on the street. This gave them a sense of the possibility of becoming clinicians on behalf of the underserved. It opened their imagination to longer-term career commitments in social medicine, public service, and health and social service including political and clinical advocacy. They urged us to scale up this kind of participant observation in an applied, community-based, and clinical/social science research/service opportunity and even argued that all the medical students in their class should be required to engage in projects led by multiple different research coordinators in local or global contexts.

On a more personal level, each of the summer ethnographers admitted to having experienced a creeping, corrosive alienation during their first year of classroom learning that distanced them from the values of medicine as a healing vocation that had attracted them to medical school in the first place. A couple of the students even confessed to having considered dropping out of medical school during their first year of coursework because of the disconnect between what they were being taught in the classroom and their commitments to social justice as well as their everyday experience of inequality in Los Angeles. They all expressed relief at having finally found a community of open-minded progressive "fellow travelers" in the otherwise competitive sprint through medical school. Indeed, through their next year of coursework, they continued to meet with one another and attend many of our bimonthly social medicine seminars and quarterly grand rounds. We furnished a set of cubicle alcoves for medical students and they began hanging out in our Center for Social Medicine office space alongside the MD/PhDs. They even started a basketball team and practiced on the court outside of our center's offices. Several of them went on to take leadership in student organizations and in free clinics for the homeless affiliated with UCLA again completely independent from us.

Emerging Projects and Lessons Learned

While we have not completely given up on creating a core, didactic required curriculum of social medicine for all medical students, we realize that it is a limited goal that may not be as impactful as we might like it to be. Despite a few notable exceptions, stable social medicine programs in medical schools [23] remain anomalies dependent upon soft money and the personal charisma of leadership. Social medicine will never be as central a part of medical school life, values, and epistemology as are the basic laboratory and clinical sciences. Our practical ethnographic experiment with the summer group medical student practicum of clinically informed ethnography demonstrated to us that social medicine needs to be seen as both a theory and a clinical practice, where everyday suffering must be accessed

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experientially with humility for it to be documented, explored theoretically and hopefully ultimately engaged with practically and sustainably.

We have continued to initiate team ethnographies on applied research projects with medical students and expanded it to include clinical residents and additional clinical faculty. Most recently, this includes documenting the wounds, scars and life stories of Central American refugees in the migrant caravan who are seeking asylum from organized crime but have become trapped in temporary detainment camps in Tijuana. We also continue our more labor-intensive pedagogical efforts with new cohorts of medical students expanding it to include clinical residents. Most productive has been our extension of ethnographic experiential training in nonclinical settings to residents. In the Department of Psychiatry, for example, residents have worked with us to initiate a formal clinical rotation in the Los Angeles County Jail's Mental Health Unit. This is a collaboration with the Department of Health Services' Correctional Health Services Unit that delivers all health services in the nation's largest County jail. This psychiatric rotation will also include a once a month afternoon session of clinical field note circulation and discussion to reflect on the contradictions and limits to therapeutic care in a carceral setting. This rotation cum ethnographic reflection protocol originated from field trips we have been taking with psychiatry residents in the county jail and their disorientation at the shock of witnessing face-to-face the routinized institutional violence of the criminalization of psychotic illness in contemporary California.

As we continue to explore how we might bring our pedagogical research practicums to scale, we continue to learn from and be inspired by the energy of our students and clinical trainees. They have reinvigorated our pleasure in teaching and mentoring by breaking the zero-sum contradiction between research and teaching. Though obvious to us in retrospect, we have learned that the most effective way to teach social medicine more sustainably in a way that reinforces idealistic commitments to social justice is to engage students in the same social and medical research problems and urgent human existential contradictions that animate our research.

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