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Turning Virchow upside down: medicine is politics on a smaller scale

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The famed German pathologist and statesman Rudolf Virchow said, 'Politics is medicine on a larger scale'.[1] Income, education, employment, housing, food security, the wider environment – these social determinants of health are the factors that make the biggest difference in whether we will be ill or well, whether our lives will be long or short. Therefore, Virchow's quote is often used to exhort decision-makers to recognise their influence on the health of a population and to see their role as being in service of greater health. This is an excellent idea, and if politicians truly did see themselves as the public's physicians, we would have a far healthier society to show for it.

This understanding of the social determinants of health has grown in recent decades to influence our thinking on politics and public policy. Only now is it starting to influence the practice of medicine. With the concept of the determinants comes the realisation that the healthcare we have tended to emphasise – physicians, pharmacist, hospitals and surgeries – accounts for at most 25% of health outcomes[2] and likely far less. This has made a generation of physicians start to question their practice and think differently about the best ways to improve their patients' health. If politics is medicine on a larger scale, than perhaps the inverse is true. Perhaps medicine is politics on a smaller scale.

Whether it is in their choice of location, practice population or changing their methods, more and more physicians are taking the classic public health parable of the river to heart. Rather than spending all of their time downstream fishing kids out of the river, they want to head upstream and stop them from falling (or being pushed) in the first place. The question is, how do you leverage the frontline presence of the physician to make changes in the causes (or as Sir Michael Marmot would say, the causes of the causes) of illness?

A variety of initiatives around the world seek to answer that question in creative ways. In the UK, a charity called Pathway: Healthcare for Homeless People[3] supports primary care physicians who specialise in healthcare for homeless people, vulnerable migrants and other excluded groups. These physicians now lead Pathway teams in hospitals, working in non-hierarchical multi-disciplinary and multi-agency teams to support and advocate for homeless patients, both within the hospital and with the housing and social care system which should support them on discharge. The central belief is that homeless patients – who tend to live in chaotic circumstances – provide an ideal stress test for our systems, revealing gaps in services and breakdowns in communication. By improving the care of homeless patients, we may improve systems that benefit all of our patients. The health consequences of failing to address health inequities impact rich and poor alike; putting systems in place that offer excellent service for those who are most difficult to treat helps to improve the system for all.

California physician Rishi Manchanda has proposed a new category of healthcare professional called the 'Upstreamist'.[4] This new model of clinician has the skills and responsibility to ensure that her clinic or hospital systematically: (1) asks about where patients live, work, eat and play; (2) addresses upstream problems through interventions at patient, clinic and population levels; and (3) builds partnerships with upstream actors, guided by data and equipped with specific skills for upstream process innovation, performance improvement, advocacy and policy development. He, his co-founder Laura Gottlieb and his colleagues at HealthBegins have identified a goal of 25,000 Upstreamists by 2020.[5]

In Canada, the Centre for Effective Practice group has developed a Clinical Tool for Poverty,[6] which

gives physicians in that province the tools to screen for poverty, to adjust risk for certain conditions as a result and to intervene through identified income supports. Recognising that income is the most influential determinant of health, one practice group has even employed an Income Security specialist in their clinic to assist patients in managing their finances and maximising access to benefits. Another group is developing an electronic survey tool to assess the social determinants of health at the level of the individual patient, connecting the results to a searchable database of a broad range of social supports.

Public Health England is piloting Well North,[7] a project that takes the notion of community involvement further beyond the surgery walls. Tasked with improving the health of the poorest fastest, reducing premature mortality and reducing worklessness, the project begins with hotspot analysis to identify the highest needs patients and neighbourhoods. They then use a 'friendly strangers' model, involving trusted community members, such as postmen, police officers, lollipop ladies and vicars, to do qualitative assessment of the issues facing the community. They then select certain trusted community members to play the special role of 'caristas', training them to be community leaders for health. Providing better care to hard to reach populations takes creative methods, and it takes more than medications. Well North uses the social prescribing model, supporting patients to access employment, physical activity, mental health resources, family violence supports and other services. Taking this social determinants approach to the next level, the Well North teams work with multiple service providers to build services around patient needs, rather than expecting patients to conform to the services as offered.

Physicians involved in this kind of upstream medicine are actively engaged in assisting patients to deal with the most important factors that impact their health outcomes. They are also exposed to frustration as they witness the gaps in services and come to understand the scope of health inequities and the systemic roots thereof. This provides fuel for big picture advocacy in combination with innovative frontline service.

Upstream[8] is a Canadian organisation that serves as a bridge between provider and patient experience and the political realm, creating a space where small-scale politics and large-scale medicine meet. They share stories that illustrate the social determinants of health, connect those stories to evidence-based policy options to improve patient circumstances and campaign for specific and meaningful change in poverty, homelessness, income inequality, education and other key determinants.

The late Aidan Halligan, Director of Well North, co-founder of Pathway with Nigel Hewett and former Deputy Chief Medical Officer for the National Health Service, described this phenomenon of physicians turning their attention in greater numbers and with greater intention as upstream medicine. 'Burgeoning almost like a pall of smoke over a collapsing service, upstream medicine populates the space between our accelerating volume-based primary care services and our increasingly complex specialised services, which are becoming more distant from primary care' (personal email correspondence between Aidan Halligan and Ryan Meili, 7 April 2015).

Perhaps what we are seeing with the innovations shared here, and countless others around the world, is the spontaneous emergence of a new specialty in response to the gap Halligan described, a fascinating blend of primary care and public health that connects one-on-one clinical service with a re-imagining of the advocate role. The development of a dedicated specialty in upstream medicine could give us a cohort of physicians with the skills to respond to illness, but also work to create the conditions for good health at the level of supports for the individual, greater community wellbeing and smarter policy for ideal health outcomes. If politics is seen as medicine on a larger scale with health as its primary goal and medicine as the small-scale expression of that politic of health, we could see something very exciting. We could see a new generation of physicians who have in mind the policy and social realms in which their patients exist, a new generation of political leaders who have the health of their constituents foremost in their mind and a healthier society overall as a result.

Declarations

Competing Interests: RM is volunteer director of Upstream: Institute for A Healthy Society, an organisation that promotes awareness of and action on the SDOH and is cited in the article as example of Upstream Medicine. NH is employed as Medical Director of Pathway charity, an organisation dedicated to improving the quality of healthcare for homeless people. The charity trains and supports Pathway teams, which are referred to in the article as examples of good quality care.

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References

1. Virchow R. *Collected Essays on Public Health and Epidemiology*. Cambridge: Science History Publications, 1985:125.
2. Keon WJ and Pépin L. *Population Health Policy: Issues and Options*. Ottawa, ON: Senate of Canada, 2008.
3. *The History of Pathway*. See http://www.pathway.org.uk/about-us/the-history-of-pathway/ (last checked 7 May 2016).
4. Manchanda R. *The Upstream Doctors: Medical Innovators Track Sickness to Its Source*. New York: TED Conferences, 2013.
5. Morgan B. *Our Ailing Patient*. Medford, MA: Tufts Now, 2014. See http://now.tufts.edu/articles/our-ailing-patient (last checked 7 May 2016).
6. Centre for Effective Practice. *Poverty: A Clinical Tool For Primary Care Providers*. Toronto, ON, November 2015. See http://thewellhealth.ca/wp-content/uploads/2016/05/Poverty_-_A_Clinical_Tool_for_Primary_Care_ProvidersMay-1.pdf (last checked 12 June 2016).
7. *Well North – Manchester Academic Health Science Centre*. See http://www.mahsc.ac.uk/for-patients-and-the-public/well-north/ (last checked 7 May 2015).
8. *Upstream: Institute for A Healthy Society*. See http://www.thinkupstream.net/about_upstream (last checked 7 May 2016).