TIME AND TIMES: THE TIMES IN WHICH WE LIVE AS A SOCIAL DETERMINANT OF HEALTH

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ABSTRACT

Where someone lives, how much education they have, their income, all are recognized as social determinants of health, and as being of greater importance in their overall health status and outcomes than are their doctors and medicines. But all of these are affected by times in which they have lived. These encompass the physical world, the social forms, institutions, economic activities, material goods, the customs, beliefs, morals, laws, norms, and arts of the world in which we move, and all change over time. The experiences of a body moving through time alter that body in direct and indirect ways, to create change that is persistent through time. A patient might reasonably say "to understand me you need to understand the times in which I have lived." Similarly the health of a population can only be fully understood if the history of that population is considered. A case study of an individual within a specific population is used to illustrate these points.

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TIME

Where someone lives, how much education they have, their income, all are recognized as social determinants of health, and as being of greater importance in their overall health status and outcomes than are their doctors and medicines. But all of these are affected by when the individual has lived. I speak not simply of their age, but of the times in which they have lived. And when social factors change over the lifetimes of people, we must consider the times of the lives, and their lasting effects, if we are to more fully understand the people.

What are the conditions of our times? They include the conditions of the physical world, the various places in which one may have lived. Yet these are not static in time. Once people largely lived close to where they worked, when cities were generally smaller. We can see this still in cities, in older neighbourhoods, but as the economic times change, with industries, entire sectors of the economy rising or falling, our living environments change. Our cities have changed, becoming larger, more densely populated, with greater diversity in those populations. And we are now more likely to move, so that we live and move in a range of environments, not one.

The conditions of the times are more than just that physical world. We must also consider the complete culture; the social forms, institutions, economic activities, material goods, the customs, beliefs, morals, laws, norms, and arts of the world in which we move, that determine how we live. All of these change over time.

All are specific to the individual, as no two people have the same experiences of a lifetime, and it is inevitable that each person will react in their own way to whatever acts upon them. And so any way in we might view any grouping of individuals, whether the group is small, a household, an extended family, or large, a community, a city, a working segment of society, will give us a range of responses. Their adaptation to change may see a weakening, or a strengthening, of their power in their world.

Hippocrates, no less, writing in the 5th century BC advised "anyone coming to a new city to make enquiries in order to assess whether it was likely to be a healthy or an unhealthy place to live, depending on it geography and water supply ('soft, hard, or salty') an on the behaviour of its inhabitants ('whether they are fond of excessive drinking and eating, and prone to indolence, or else fond of exercise and hard work" (Rose 1992). So the idea that the physical and social environment were important to health was long present, but the greater influence of these, over direct medical care, was not recognized until the 1990's (Braveman, 2014) with Rose's book "The Strategy of Preventative Health," (1992) giving a strong argument. A 2004 paper codified the concepts of urban bioethics specifically (Blustein, 2004), speaking of the importance of density, diversity, and disparities to health in urban environments, and by 2010 it was seen as a useful tool by researchers attempting to understand how racism affects health (Yearby, 2020). So it became understood that we could discuss such factors as the place in which people live as important to their health, and with this concept in place we can also recognize how the determinants combine to form the times in which we live, for we live not only in space, but in time.

We, the general population that is, frequently now speak colloquially of generations:boomer, millennial, X, Y, Z, and surely more to come. Supported, even encouraged by popular media, we attribute to each of these various characteristics of behaviour: "Oh, they can't handle change from what it was like in their time." "They won't commit to their work they way we used to." "They only care about financial success." And so on. These are rough, prejudicial, and often pejorative assessments, and as expectations of people, they are no more meaningful or valid than nonsensical astrologically-based attributions of personality to the time of year in which one was born. They are therefore potentially very harmful, for each individual is just that, individual, and will respond differently to whatever stimulus to which they are exposed. In fact there can be very real reasons for these differences. Young people seeking regular work for the first time may enter the job market in a strong economic time, when work was easy to get and well-rewarded, while at another time people of the same age may first look for employment in a time when it is hard to find, and pays poorly. Each cohort, certainly with diversity within them, is left with their own early financial situation affecting them through their lives, and with their experiences forming their own attitudes towards work and the socio-political economy. But the readiness to resort to such rough groupings and characterizations does suggest a vague recognition of the concept that we can be, to some extent, the products of our times, that there is at least the recognition that we may well be different for having been born in the world of that time, different from those born in another.

CHAPTER 2

HOW THE TIMES ACT UPON US

There are mechanisms, pathways if you will, by which the times act upon us. These may be direct in their action, such as the immediate physical environment, and how it changes. Others may be more indirect, amorphous, a sense, perhaps not easily identified or defined, of how we live and this is what we do, now. There are formal mechanisms, via changes to public policy, legislation, and regulation, by which the expected behaviours and actions of society are codified, and enforced. These are then fed back to make further changes to that policy. All of these entangle. We can examine only some more closely, while realizing that the times are pervasive, a saturation all of human behaviour.

TIME AND THE PHYSICAL ENVIRONMENT

The physical environment in which we live is a direct pathway of impact upon the body, and therefore changes in it over the times of our lives are significant. At the most basic levels of physical life, do we have clean air to breather, clean water available to us, and nourishing food? These should be chronic, and positive conditions of life. We could assume that in rare instances adverse and ephemeral events such as extreme weather could cause injury or death. Generally though, we could have a reasonable hope of if not fully benign surroundings, at least those we could rely upon to plan for the future.

But through the greatest environmental change ever, global warming, with its massive range of effects, we are seeing enormous changes over relatively short time. Indirectly, but no less importantly, the environments that individuals and communities came to expect and upon which they built their ways of life may now be at risk of, or are actively

being, disrupted to and beyond the point of destruction. Were homes built upon what had seemed solid and safe ground now at risk of erosion from rising waters, changed waterways, increased precipitation? Are livelihoods being lost to environmental changes that no longer allow certain crops to be grown, certain industries to flourish? Is there increasing likelihood of trauma to the community, to the body, from more frequent extreme events such as killing heat waves, flooding, tornadoes? Are the changes such that it becomes no longer sensible to stay and fight them, but rather flee and become environmental refugees, that there might be some sustainable future elsewhere?

It is becoming increasingly apparent that global warming, and the changes it is bringing, are going in one direction only, that cannot be reversed. It has been calculated that children today are several times more likely than those of only two generations previously to live through severe climate events (Thiery, 2021). These children have no means of changing this movement. People alive today may be living in a time unique in human history, when there may not be again any assurance of a safe, nurturing world.

TIME AND THE RACIALIZED ENVIRONMENT

The times act on us through racism, a chronic situation, a very lesion, on society, in that it continues, ever present, a factor that damages and limits health.

Throughout the twentieth century and into the twenty-first, for Black Americans racism has often functioned in limiting or excluding them from the mainstream of economic and social life. The very fact of being Black, where one was allowed to live, what limited education might be had when schools were separate, but certainly not equal. At times it has acted with immediate, brutal impact, as by lynching, which, if no longer as prevalent, continues, as we see in the histories of Ahmaud Arbery, George Floyd, and

Breonna Taylor. Today more commonly the direct effect is more insidious and less easily identified. Dr. Arline Geronimus articulated the concept of weathering to describe the cumulative weight of the stress of racist acts against the body as weakening it over a life time, resulting in poorer health and reduced life spans
(Geronimus, 2023).

In more indirect pathways, while open segregation is no longer present, there is no question that race continues to a social determinant of health through other means. Subtle, but still powerful, biases based on race in employment, in access to education, in obtaining loans, still function. The right for all to fully participate in the democratic process may be enshrined in law, but by newly developing means of gerrymandering, artificial barriers to make voting difficult, dirty tricks to deceive voters, and outright threatening at the polls, the agency of minorities is suppressed.

The means by which racism acts then has changed over time to be different, more subtle, but certainly still damaging, and perhaps less easily detected. At least we can live in times in which racism is recognized, acknowledged, and understood for the scourge it is, and that there is some hope that with time it will be lessened, if it may never be ended.

TIME AND ECONOMICS

Obviously, living itself, passing through time as we age is stressful, but the particular stresses change over time. On a time scale much larger than a single life the differences are clear. Moving through time (and place) from hunter-gather societies, to agricultural ones, to industrial manufacturing centred economies, to the most recent information based economies, the changes for most people, though certainly not all, the major stresses they experienced would have changed from simply staying alive by safely

finding food, through fighting against weather and disease in crops and livestock, then brutal, dangerous working conditions and unsafe, crowded living conditions, and within the lifetimes of those today, some come to the frantic race for information and technology. All of these changes create their own health issues.

Consider the economic environments in which we live over our lives as an indirect mechanism of the social determinants of health. How much money one individual has to devote to their basic aspects of living, such as housing, food, transportation, communication, and so on, that all have massive effects on our opportunities for health similarly as direct health care needs, are all highly subject the general economic environment, which can be highly variable over a lifetime. To have lived in a time of economic downturn, recession, or even depression, one may have effects that persist through the rest of life: loss of long term savings and investments, career development delayed or lost entirely, unable to move to better living conditions elsewhere, educational opportunities not taken up. The environmental changes entangle with economic and political changes in reaction.

These can certainly be factors in long term health, through the social determinants of health. There can also be a more direct means in which economic change over time can affect us more directly upon the body. Can one recover from health problems that were linked to difficult economic times? A child's early years spent in times of a poor economy may well be marked by poor nutrition due to inadequate access to food, or may have chronic health issues, or be at greater risk of them, due to improperly treated care when it could not be afforded by the family. These problems could be common across a wide population sharing those times, and we can see that this does happen. There is in the

ACEs (Adverse Childhood Experiences) screen about common negative experiences in childhood, the item "Your family sometimes cut the size of meals or skipped meals because there was not enough money in the budget for food," which in one study was agreed to by 7% of responders (Wade 2016). This could in fact represent a huge number of people in a population, and no one should ever be without nutrition, so it is very significant. It was determined that ACEs, which are heavily weighted in the directions of direct mistreatment of children in the household rather than wider economic matters, gave results that were associated with longer term health outcomes; again there is persistence through a lifetime.

The system of health care funding too is of course a social determinant of health. Where one lives, and the systems of funding and access will affect how, and even whether, one obtains adequate care, but it can change over time outside the control of individuals. Note for example the Canadian system of centralized single-payer health care, which was only instituted nationally in the 1960's, prior to which it was a fully privatized, for-profit field. With that change, access to health care could be assumed as at least a privilege of being Canadian, if not a right. Generally then health was not a significant financial factor for most people. An illness or accident was not a near certain path to financial crisis or ruin; one could change jobs without health care being an issue. Money was simply less of a factor for Canadians in dealing with their health care.

For a while it was the common wisdom that no Canadian politician would think of campaigning on a platform of privatizing the public health system (just as no American politician would dare advocate a socialized system), yet now that is changing, itself the

result of massive changes in prevailing political and economic thought and practice taking Canada, as with much of the world, ever further to the right, over only the last few generations. For someone to live in any of these periods, and to pass through them in a lifetime, is to have to be re-assessing one's economic and health situations and how they relate. Simply, one might, or might not, have to consider this relationship, depending on when the possible relationship existed. It can also be a factor in changing one's own political/economic views, as the personal situation changes, and thus becomes collectively a factor in population changes.

TIME AND CULTURE

Popular culture is a pathway by which the times of our lives come to affect us. It can be surprisingly influential on both an individual and a larger population. The music of John Lennon as a solo artist, such as "Instant Karma" and his first solo album, "Plastic Ono Band" demanded to be listened to seriously, to be thought about, and felt on a deeper level. The songs spoke, uncertainly but backed with the emotional power of stark poetry and in the hard rock music of the time, of pain and fear in life, and they affected this writer very strongly, and must have affected others, in their own way (Kinloch 2021, Appendix A). But the style of that music, and the very fact that crushing anxiety, confusion over life's meaning, and death itself, could be serious subjects in popular song, were the result of the time when these recordings were made. They simply would not have been heard earlier, when pop music was more likely to be intended for mere entertainment in good times, and when Lennon was seen merely a clever tunesmith with a pop group, before becoming so large a figure in popular music and the cultural world of his time that he demanded to be heard. They could be seen as one way in which issues

of mental health and attitudes towards death started to be brought into the forum of public awareness, where once they had been topics one did not discuss. The changes were wrought in part by Lennon and the other Beatles, and so many others, and were unique to their times.

Popular culture not only reveals and reflects the thoughts and feelings of a community but can influence that larger group of people in relation to their commonality. Nina Simone's song, with lyrics by Weldon Irvine, "Young, Gifted, and Black," recordedby Simone herself in 1969, and by Aretha Franklin in 1972, speaks directly of the newlyrising pride and determination of the Black community of the time, with powerfully inspiring lyrics: "Oh what a lovely precious dream / To be young, gifted and black / Open your heart to what I mean" (NinaSimoneMusic, 1970). It demanded to be heard differently from songs of the past, urging its listeners to look forward to, to demand, a better future. It belonged to its time. It would not have been heard in earlier times when popular music was entertainment, well crafted and often emotionally moving, but essentially without social or political message. But it was heard then, and its message heard, as YouTube viewer arlenecrawford6184 wrote in 2022: "I remember this inspirational song which empowered us who were Black teenagers in the 70's. Thank you Lady Nina Simone for such wonderful lyrics that reminded us of our rich heritage and worth as Black People" (NinaSimoneMusic, 2013). The involvement and influence of Black popular musicians in the civil rights movement is perhaps unrecognized. Similarly, the "protest songs" of the '60's were part of a generation's shift in political thinking, and perhaps more importantly, these may have influenced how political thought was expressed and demonstrated in those times, and contributed to lasting change.

CHAPTER 3

PERSISTENCE THROUGH TIME

The times in which we live persist in us through our lives. The experiences of the social determinants of health on us, and our responses to them will shape us, cannot be undone, and cannot be foreseen.

The COVID-19 pandemic may be ending as this is written, but in time to come, indeed already now, but extending into the future, it will be necessary to consider what it meant for people and peoples to have lived in the times of the COVID-19 pandemic. There are the direct effects on health of individuals that become part of their past medical history, but there some whose health will have been permanently altered, carrying myriad, and as yet not always recognize or understood, effects of long COVID-19 into chronic, possibly quite serious, injury to the body (Sutherland, 2023). But beyond that there will also be the experience of simply having lived during the pandemic, which will certainly have had an impact even if one themselves was not directly harmed by infection or never even contracted the virus.

Were there educational opportunities missed, or lesser quality education obtained as the result of the disruption to schools? Certainly a person's education has life-long effects on their health, and they could be more severe for young people earlier in their education. Were they able to catch up? Did it change their attitude towards learning? Were children not learning common social skills due to isolation, and how might this affect their social function in the future? What might that mean about how we all relate to one another? Might it mean that some work requiring such skills is not available to them,

and thus their economic prospects are weakened? Might there become a prejudice against those who had lost the chance for some experiences in their lives, a suspicion that they are not fully attuned to society? Might they find themselves more subject to loneliness as they age? What were the effects on families through loss of members to death through COVID-19? How did this affect their feelings towards their families? We cannot be certain of any answers to these yet. All this would be true for the less formal structures of our circle of friends as well. Understanding the sources of problems in these areas will require understanding the experiences of people in the times of COVID-19.

Did it change the attitudes of people towards medicine and the health care system? Might they have developed doubts about the capability of the system to providing effective care, even to the point of denying any value, of becoming suspicious of malign intent? These may in some become attitudes which could persist long after the pandemic may finally end, such that they refuse needed, safe, and effective care, perhaps even opposing it being available to others. In this way they could create a new cultural environment in which health care functions. All these matters are much in our minds now, but we must continue to recognize them lest they be forgotten, and no longer understood as factors in personal and public health.

CHAPTER 4

HOW WE RELATE TO TIME

AGENCY

We have often heard the phrase "the life and times of . . . " in relation to the stories of the famous, the powerful. In biographies and autobiographies we can learn not only how these individuals reacted to the events and conditions of their times, but, because they are the people they are we learn too about how they influenced their times, changed them in some way, possibly greatly. Yet the vast majority of the population can tell no such story, for they lacked the agency to change their times, at least in ways and to such extent that they may be immediately evident. Biographers and historians debate just what and how much change their subjects may have had on their times, but the vast majority of people have no such books written of them, for they are not seen to have significant individual influence upon the world of their time.

The effect we have on the world may be indirect. We all know of family and friends who had profound effects on our very nature and the paths of our lives, teachers who steered us in a different direction than we might have otherwise taken, colleagues at work who helped us in our careers. They have all made the world of their times better, in ways and by means not easily recognized or understood. There are these ways in which so many "common" people, not just the rich and the powerful have made the world in some ways better. Yet it can be hard to say what this might really amount to for each person, hard for us to recognize our own effect.

But it probably remains true that for most of us the world's influence on us will always be greater than our influence on the world. That is, we react to our times more

than we act upon them. What does it mean for us to be only reactive to our times, unable to be proactive, to have had any real agency? There is the overwhelming burden of all that is the world in which we live at any moment in our lives, and to which we must, and will react, even without will. What is there left to us that we might be proactive?

PACE OF CHANGE

As the pace of change itself changes over time, we can find it more difficult to adjust, as though we were on an ever-accelerating treadmill, not knowing how it fast it might go, unable to pace ourselves.

That pace of change, a function of time, can be terribly important. In Tuohy's work on issues of immigration and health for Mexican-American men (2020) one can be struck by the fact of the exact legal immigration status of each individual, and thus important life factors such their family relationships, security of residence, and access to health care, can be highly dependent upon the particular regulations in effect at the time of their entry, by whatever means, into the US. The times of these people's lives are sub-divided, sliced thinly, such that members of a single family who are in much the same circumstances as regards living conditions could nonetheless each be subject to a very different legal status, and all that can follow from it, simply because they arrived at different times, which could be in fact as little as days apart.

CHAPTER 5

WHY OUR TIMES ARE SO IMPORTANT

The times of our lives are pervasive in every aspect of those lives, at every scale, from individuals, through communities, nations, and the global mass of humanity.

At the level of interactions and relationships between a single patient and their physician, the effect of having lived through times and change can make a difference in the benefit to the patient. The doctor/patient relationship has itself changed over time in terms of what is expected by the patient, and by the doctor, about what the patient is to know about their health or illness, how the patient is to be involved in managing their health. If there is a mismatch between doctor and patient, it could well be because they two parties came to their understanding of these at different times, when very different ideas prevailed.

Let us use smoking and smoking cessation as an example. There was a time when smoking was seen not only as acceptable, but fashionable, even almost compulsory. Celebrities were role models. The Marlboro Man advertising was certainly intended to suggest that a man needed to smoke, and the right brand, to be fully a man, and the fact is the population as a whole bought it (Tramain, 2021). Doctors were cited in advertising as smoking particular brands, to ensure it was not seen as unhealthy (graficsfx, 2007). Advertisers used, co-opted one might say, the changing view of women in society by promoting smoking as a means by which a woman might express her freedom, independence, and strength (Vernadeau, 2022). These advertisements can be seen today on YouTube, and they seem as windows into a very different world. It was nonsense of

course, but we can see how the cultural milieu can affect the health of a population at a particular time, for someone exposed to this barrage could be very resistant to any change in their habits when the times change. With the US Surgeon General first reporting on the health risks of smoking in 1964 there was the basis for change (Institute of Medicine, 2010). Attitudes and general knowledge changed, tobacco advertising became restricted, enforcement of non-smoking rules in public spaces and workplaces came into effect, and smoking rates dropped (American Lung Association, 2018).

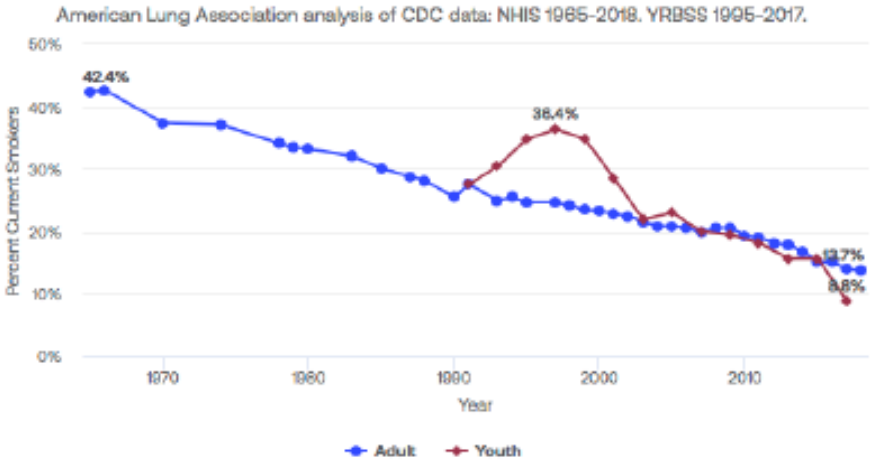

Figure 1. American smoking rates, 1965-2018

What is possible medically has advanced enormously, accelerating, through only recent times. Examples could be all but endless. Until the advent of sulfa drugs to treat infections, first seeing widespread use during World War II, there was actually very little a physician could do for a patient with infections. In 1945 the President of the US, Franklin Delano Roosevelt, who would have had access to the best possible medical care of the time, had dangerously high blood pressure. His doctors knew that it could, and would, kill him, but short of advising him to cut back on smoking and alcohol consumption -- far too late to have any effect -- there was nothing could be done;

immediate treatment with medication now readily available to prevent and reverse the condition was simply non-existent then.

It is perversely ironical that wartime, in which killing is the very intent, should produce anything positive for health, but there is that uncomfortable truth. The field hospitals of the US Civil War became long-lasting models for American civilian trauma centres, and the experience of doctors, especially surgeons, in treating trauma made battlefields through the increasingly violent 19th and 20th centuries a site for medical education (American College of Surgeons, 2023). New health care techniques continue to be learned. In 21st century warfare in Afghanistan and Iraq, improvements in care for the injured have brought fatalities from injury (amongst US combatants only, those for whom that care is available) to an all-time recorded low of 9.3% (Berwick, 2016). We can count ourselves fortunate to live in times when so much more can be done for us, even though it can never weigh in the balance against the massive tragedies of war, and that we live in relatively more peaceful times in which to benefit.

Medicine now knows about neuroplasticity, the process by which the brain can, and does, change in structure and functionality in response to outside stimulus, and can continue to do so throughout a lifetime (Fuchs, 2014). Consider how this advance can affect us. Previously it had been thought that the affects of aging were unavoidable, while now there is the understanding that we can continue to grow and change at all times in our life. While this can be encouraging, one might feel a societal pressure to make use of this new knowledge, to age in a 'proper' way, lest we be subject to shaming for not having taken responsibility for changing how our bodies pass through time. Yet this might be

hard for someone to accept if their life was spent in times when aging was seen as almost inevitably linked to decline, an added stress.

What has not changed as much over time in comparison to the massive technological advances, is the distribution of the ever better medical care. It can even be seen that the combination of these two at different rates of change has only increased the disparity in the availability of treatment.

There are ways in which the readily observable conditions of our time act very directly upon the body. If we consider the body as spectacle, that is, what is seen by the world as our presentation of that body, then we can see how changes over time in the most desirable body image can in fact be very important for health. Perhaps at the moment for women there is one ideal, promoted through the mass media by means of celebrity images, that is highly curvaceous, emphasizing the breasts and buttocks, very slim at the waist. This is not realistically achievable for most, who cannot afford the time or money for lengthy gym workouts with personal trainers, complex and expensive diets, surgical or injection enhancements, any more than is the absurdly slim ideal that has been a trend. In other times, we can see from older advertising for example, other shapes were seen as the most beautiful.

We cannot dismiss this as mere trivial "fashion," easily ignored. The societal expectations are extremely powerful, not easily avoided by even the strongest individualists, nor should the desire to look attractive be negatively judged. The problem is what people might do to in order to live up to a currently ideal body image, perhaps going so far compromise their health. Could they deny themselves necessary nutrition by eating very little food in total to reduce weight? How dangerous are procedures such as

injection of botox to emphasize facial features, and the "Brazilian butt-lift"? The latter is a very popular, but very risky enhancement of the appearance of the buttocks, with a mortality rate of 1 in 6241 cases to possibly as high as 1 in 2351 (Pazmiňo, 2023). With new medical procedures available come greater risks of misuse. Currently one is seeing Ozempic, a drug intended to manage Type II diabetes, being used for rapid weight loss by people would are not diabetic, and may have no other illness requiring medicine. Yet it carries multiple health risks, such as nausea, dehydration, diarrhea, constipation, pancreatitis, severe vomiting, and gallstones, and there is much about its effects that are simply unknown (Blum, 2022). The desirable body image, and the available means of achieving it, and the accompanying consequences for health, can change so rapidly, so apparently arbitrarily.

The issue of desirable body image, and how that varies over time, should not be thought of as a strictly female matter. The male ideal can be seen in athletes. Babe Ruth was an admired athlete of the highest achievement in the 1920's but would be seen now as unfit, ordinary, if not unattractive. In the 1960's even football players were relatively slim in comparison with the enormous builds seen today, while films promote fantasy super-heroes with bodies that are just that, fantasy, for most. Compare the role of Superman as portrayed by George Reeves in the 1950's, a fit-looking but by no means absurdly muscled man, with the outlandishly-built Superman, duplicating precisely the fantastic comic book drawings of the character, played by Henry Cavill in 2013. Highly paid actors can create these looks with long hours of training that cannot possibly be done by most working people. Again, there is nothing wrong with wanting to have strength and look fit, yet there are many who will attempt to achieve those extreme looks through

body-building techniques that leave long-lasting damage to the body, or risky use of steroids. Nor are these practices restricted to males.

There can be effects on the population at large. Consider the classic "Whitehall study" in which male civil servants in London were medically examined between 1967 and 1969, with follow-ups on their mortality, and which provided a wealth of data for study. In one such study of the data relationship between employment grade and coronary heart disease there is a clear recognition of the class issues in Britain of that time, that class makes for a significant factor in health (Marmot, 1978). The authors note there is a "striking positive association between grade and height" (Marmot 1978, 245) with height clearly being assumed as an aspect of better health, and indeed their data support a correlation. The authors note the possibility of self-selection into different employment grades, implying that it might that have been more prevalent, more likely, in the traditionally class-conscious British society of that time. Or, it might it be result of selection by the privileged of who is to join them, not the shorter, less physically attractive people who could be relegated to poorer paying fields of work, based on prevailing class notions of the time and the tacit acceptability in certain economic areas. of such discriminatory practices. If these forces in society were to change over time, then social mobility were to change, the acceptability then the self-perception of individuals' capacity, their agency, to select and succeed in different occupations could change.

To fully understand their patient a clinician must know and consider not just the history of their present illness but also their past medical history, family health history, and the somewhat vaguely defined social history to be able to confidently arrive at a diagnosis and determine best treatment. Has that social history developed and changed

through the patient's lifetime? Almost certainly it has. A patient might reasonably say "to understand me you need to understand the times in which I have lived." What might be missed if this is not recognized? Doctors commonly assess a patient through not only the history of their present illness, but their past medical history. They should also be exploring the social history, where and in what conditions do they live, what is their financial situation, what is their employment, what do they do for recreation, what education they have, do they see friends, and so on. We can see that this is looking at the social determinants of health as used to understand populations, and there is encouragement for doctors to see it exactly that way, and there are screening tools, one such being the Accountable Health Communities Health-Related Social Needs Screening Tool, termed HRSN, intended to enable that (O'Gurek, 2018). But do physicians extend that part of the history back through time, do the screening tools recognize effect of time?

The HRSN screening tool asks about living situations today. But what might have led to that situation, and how might it affect changes in such situations in the future? A patient who has been hit hard by financial changes, say losing a house during an economic crash, and was thus able to afford only substandard housing now, will likely find it difficult to recover from those events and change their situation. As regards food, it asks about eating habits and the availability of food over the past 12 months. What about the longer term? Did the patient grow up in a time when what constituted and was promoted as a healthy diet is considerably different from what we now consider? It will be harder for them to change something as deeply ingrained as preferred diet.

Safety in the home, in terms of freedom from physical assault or emotional abuse is included in this screening. But what is the social history of this? For example, there was a time when physical assault on a married woman by her male spouse was seen by many as normal, acceptable, and certainly not something one should reveal, not a matter for discussion with a health care provider. Fewer now adhere to this in these times, but for someone who lived with such attitudes as current, might they be reluctant to see it as something to even be discussed with the doctor? Similarly with substance use, what has been seen as unimportant, risky, unhealthy, immoral, shameful, acceptable, private, dangerous, and so forth, has very much changed over time, and could well affect the patient's willingness to reveal such usage, their willingness to make healthful changes.

Consider the ACEs (Adverse Childhood Experiences) screen, a questionnaire intended to elicit information about aspects of patient's childhood that might indicate greater risk of health problems later in life (Shonkoff, 2015). The questions centre on potentially harmful behaviours of and treatment by the parents, such as physical or sexual assault, verbal abuse, and substance abuse within the family. With the exception of one question that asks, in part, about having enough to eat, proper clothing, or being given direct health care when needed, as Shonkoff notes, it misses much that addresses the social determinants of health in the child's environment of the time: community violence, racism, other forms of discrimination, natural disasters, housing insecurity. The test itself can be seen as a function of the time when the social determinants of health were not considered so significant. Yet these are the factors that can change so very readily and have such a great influence on the person. So, without the background of knowing the

patient's cultural history through their times, this screening may not so effective a tool for understanding the patient.

We might add to that the benefit of better understanding the patient over time, without which the clinician might compromise their ability to develop empathy with the patient. A patient having difficulty making changes to their life, from taking different medications, to new levels and types of activities, should not be blamed by the care giver. It is not their fault if they may need to work against their lived experience through times, perhaps having internalized the common "wisdom," the inadequate or faulty knowledge, the prejudices of their times.

The very fact of such screening being done, or even being considered implies an awareness by the care giver of the importance and need for such is not something that would have happened in the past The HSRN tool itself dates only from 2017, and the use of it, or other such tools, was by no means standard clinical practice as yet. The fact of the capability of doing it, simply that it be possible in a physician's time, is noted by O'Gurek, and must be seen as possible only if the economic and political factors allow it, which too would not always have been the case, may not be again. The publisher of the tool, the Center for Medicare and Medicaid Services, is itself a product of change in the US health care system, for these programs were not always in place, and may not be in the future, should the political winds continue to shift further in the direction of less government involvement in social services, health care, and research.

A clinician's very style of relating to the patient may be at odds with the patient's expectations, making the connection between clinician and patient more difficult to establish, less effective. It is known that this is a major factor in the effectiveness of the

care given. It could result from a mismatch based upon the lived experience of each through changing times, as there was a move from what could be seen as an authoritarian attitude by physicians towards patients, to a more patient centred, patient engaged mode. A physician trained at an earlier time may be expecting to be able to tell the patient what they must do, or to withhold information on the physician's own judgment, and they might then be at odds with a younger patient who has largely or always lived in a situation where they can expect to be informed and have choices, and have those choices respected. The reverse could also apply.

This lack of connection between health care provider can elevate to the level of massive distrust as a result of the prevailing attitudes of the times. For so long in the US and still today there is a high level of distrust of the health system within the Black population. It can stem, quite understandably, from when racism was more overtly expressed, more readily visible, and more likely to be seen by racists as acceptable. The disgust over the actions by researchers such as in the notorious "US Public Health Service Study of Untreated Syphilis in the Negro Male," commonly referred to simply as the 'Tuskegee study,' which started in 1933 and carried on until 1972 (McVean, 2019). Its stated intention and methods were to observe and document the progression of disease in a community. In fact however those conducting the study lied to subjects, who had been recruited on the basis of having syphilis, discouraging them from seeking treatment by telling them they were receiving medication for "bad blood," but fact no treatment at all was given. Those who did receive treatment by other routes -- penicillin having become generally available by 1947 -- were simply dropped from the study. The racist attitudes of the study managers are clear. By the time the horror was publicly exposed and forced to

end after 39 years, 399 male subjects had been carrying the infection,128 of which had died unnecessarily from syphilis, 40 spouses had been infected, and 19 children had acquired congenital syphilis Surely this gives justification to the continuing distrust of the medical system felt by many Black Americans.

We can see this too in relation to women's health, most importantly in the area of reproductive health. With the approval in the US of safe and effective pharmaceutical oral contraception in 1960, for women the questions of when and how many children to bear, or not having children, were now more readily effected choices (Planned Parenthood Federation of America, 2015). By 1967 "the pill" was being used by nearly 13 million women world-wide, and the much touted "sexual revolution" of the '60's was well under way. The times had indeed changed. It was an important part of a movement towards women having more control over their bodies, and their health, as a whole. Yet some care providers may not have changed with the times, and continued to hold male-privilege ideas, demanding retention of control. With such outmoded moralistically based attitudes present in law makers, and not just older ones, nor just males, there has been a sudden and massive reversal of the gains of a relatively recent past, taking advantage of a shift in political power. Abortion rights were codified in law in the US in 1973, only to be taken away in 2022, and there is a serious push to end contraceptive rights. One can expect this to have direct effects on mortality rates in pregnancy and poorer long term health from unwanted pregnancies and illegal abortions, and long term negative effects on the attitudes of women to the health care system.

For older people, with increasing life spans we are more likely to have lived through more time, more times, more change, and can expect to see more to come, a great

unknown. When we have lived long enough to have experienced change and understand change has happened, we might develop the wisdom to foresee the certainty of change, and the uncertainty of what that change might be, possibly develop the means and the strength to manage the effects of change. Or might we withdraw from the change, having learned to fear it, and so stubbornly resist it? Which is healthier?

And so there is that greater anxiety. With age one can come to see how social norms are very subject to change. The world into which we are born is not the world in which we became and lived as adults, not the world in which we become "seniors," will certainly not be the world in which we will die.

The very idea of what constitutes normal aging has changed. The rate and manner of age related decline is seen very differently. When was the age that "senility," in term of the times, would be considered as inevitable, normal, expected? When were aspects of physical decline -- restricted mobility, reduced level of activity, greater risk of injury in normal daily activities -- also seen as only to be expected, and therefore perhaps not properly investigated, perhaps not treated when treatment might yet have been possible?

Where once seniors may have themselves expected, or others may have expected of them -- to move without complaint into an extended family situation for support, or later to go willingly, into an institutional setting, there is the idea that it is better to maintain independent living as long as possible.

There is now a pressure to "age well." Seniors are expected to maintain high levels of physical and mental health, of social connections, of activity in all these, but it may not be possible for everyone, perhaps due to personal economic circumstances, or health decline that has already taken place.

There could be problems with the availability of such resources such as physicians, physical therapists, social workers, who may be able to assist with the aging process, which might not have kept pace with the growth of growing population of older people, so the environment into which people are aging is itself changing over time as the seniors themselves do, but in opposite directions of need and availability.

Perhaps, even soon, there will be means of identifying, preventing, lessening, stopping, even reversing, age-related dementia. Again there will be the issue of availability and distribution of such capabilities, but it is likely that some will miss out simply because of the timing of when they might be available, and so yet again increasing disparity.

Will we age into a time when what is possible for, and therefore expected of, the elderly is full physical and mental capabilities being retained up to the point of death? It is hard to see that ever being achieved, but as reaching that goal comes closer there will be more people disadvantaged.

This is speculation, but surely a real possibility. To be aware of expecting a very different world of the future within one's own lifetime, to be unable to plan for an unknown future in which one cannot be sure of even basic security of life is difficult. The very uncertainty of the times to come adds a weight of stress on the older of us.

CHAPTER 6

A CASE STUDY

I have stated that a patient can fairly say "to understand me you needed to understand the times in which I have lived." To illustrate more fully, more specifically, I cite an example of all of this for a particular population, those who are transgendered, and a particular individual, myself, for I can see it in detail from the patient's side. I quote from a paper I wrote in March 2020:

> Comparatively late in life I finally dealt with the fact of being trans-gender by choosing to transition to living as female, having realized that was my true being. My trans identity carried with it the stresses of depression and risk of suicide, and while those might be seen as medical, not social matters, the fact is that it is the situation of having to meet the societal expectations of one's assigned gender that is the source of the stresses. By living openly according to my own innate sense of who and what I am, the internal stress was gone. However my assessment is that this transition would not have been a possible choice had I not been living in very particular time and place, and been in a privileged position. Being openly and readily recognizable as trans creates a new social determinant of health, for not every society is accepting of trans individuals. I certainly would not have had the strength to overcome the massive transphobia, and homophobia, that have existed in US society, and continue to be prevalent in many places. A few others did, and I applaud them, and will forever thank them for what they did to make my transition possible.
>
> By the time I began to even consider that being trans-gender was the source of so much of my depression and anxiety, there was more knowledge of the subject, there were more role models, more communication within and outside the trans community -- driven in large part by the internet -- and there was greater, if not universal public understanding and acceptance of the idea. (I doubt these can ever be universal.) Simply, transition seemed possible to me in a way that it could not have not been only a short time earlier. I was also living in a specific place where all these positives were only greater; some have speculated that Philadelphia is the capitol of the trans-gender world. The resources in this city abound even as they are scarce or non-existent elsewhere, and I was able to access them because of my privilege.
>
> Ironically however, by being openly and readily identifiable as a trans woman I have put myself at greater risk of assault, though being white that risk is considerably less for me than for a trans woman of colour and in some other places, particularly the US south. The risk is still there for me, and I have been threatened, but it is much less a factor in my health than what I had experienced pre-transition. (Kinloch, 2020)

When I wrote this a mere three years ago, I had a relatively positive outlook on the future for the community of the trans-gendered. I, we, cannot with confidence have that today. Anti-trans opinions, and a great deal of mis-information, and outrageous accusations, that, for example, trans people are "groomers" who seek to prepare young people to be subjects for sexual abuse, are openly voiced without consequence to those making them. Many US states have enacted, or are in the process of enacting, legislation that would limit or even completely bar the possibility of any steps in transitioning for young people, some 440 proposed in 44 states as of this writing (tracklegislation.com, March 31, 2023). Some include the beginning of limitations on access for adults. At one near extreme former US President Donald Trump, a candidate again for that office, has stated a new Trump administration would force everyone to be gender-identified by their assignment at birth, without possibility of change, without recognition of any gender identity other than male or female, thus virtually eliminating the very concept of transitioning for anyone who is trans-gendered, and any possibility of living openly as non-binary (Cooper, 2023). Clearly he is using what he sees as a popular, though not necessarily majority, opinion for his own political advantage. There is anti-trans activity too in Canada, where I now live (cbc.ca-Day 6, 2023). The change has been rapid, the pace accelerating, with significant movement taking place in not years, but months and even weeks. I have to question whether I would have the strength to make that change in these times, not so far away from when I did.

For younger people there is not only the problem of what the public attitude toward them is now, and what care is available to them, now, but how that will affect them in the future. If they cannot obtain puberty blocking medication and must go

through the harder to reverse effects of puberty, what will this mean for their future physical health? If they are prevented from undertaking a social transition when young and must continue to live presenting in a gender that is not truly theirs, at this time in their lives when their experience is still forming them, what will this mean for their future mental health? How will they view their futures when they cannot know what possibilities exist for them, whether they may be living in a time of further regression of of their rights? There can be no answers yet to these questions. The times in which they face these questions about themselves will, each in their own way, cannot but have enormous effects on these lives.

CHAPTER 7

CONCLUSION

The times in which we live, encompassing all that makes up our world, are what make us who we are, and who we will be. Without understanding those times, and how people move through their times and react to them, can we succeed in diminishing the disparities in a people's health, to make their present, and their future, better for them and those to come?

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APPENDIX A

JOHN LENNON'S "INSTANT KARMA" AND ME

At the start of 1970 I was 18 years old, though much less mature than I might have been, certainly less so than most were at that age, and unusually dour, serious, and socially rather badly adjusted. In a term of those times, I was a bringdown. And I was what might be called now a nerd: my head always in books, always thinking, thinking, thinking, about everything, worthy and correct or not. In those days, in that place, we were called "browners." I think the scatological origin of the term is obvious, and it says what you need to know about how we were expected to be seen by our contemporaries. Oddly though, it did not bother me. Perhaps I was starting to turn myself away from trying to meet other people's expectations of me. It certainly did nothing to change my behaviour.

I was also completely fascinated by the Beatles, and all things Beatle-y then, and still now. At least in that I was not so unusual, but my approach to them, oh so very serious, was probably out of the ordinary, though certainly not unique. It may, however, have been just what the Beatles themselves hoped for, people listening to their new work as serious, deserving of thought, and so I was vulnerable to any message I might glean, or interpret from their work. I had come to them late, having dismissed their early work as not worth serious consideration. But as they progressed, from "Help!" -- the first of their albums I listened to intensely -- I was desperately trying to discern meanings that were most likely not there and could only be inferred at great risk to sense.

By 1970 I could not hear the work of any of the four as anything less than essential elements in my personal growth and understanding of the world. John Lennon was then starting to move away from The Beatles, to begin his all-too-short career as a solo-artist, and one of his first single releases, on 45-rpm vinyl, was "Instant Karma," in February of that year. It was not the massive hit that any of the Beatles releases had been, but it did sell and was heard on radio a lot, more so in my home of Canada than anywhere else, oddly. I don't remember my hearing it for the first time, but I knew immediately I had to have it.

Lennon certainly knew how to create a record that grabbed you from the start and compelled you to hear it again and again. Somehow it felt like I had always known this song, that it was, had to be, part of my world. I would learn later, to some surprise, that the song's chords were nothing more, or less, than a slight variation of the "oldies progression" (I-vi-IV-V or sometimes I-vi-IV-V7, for those of you musically inclined,) ubiquitous in pop music from the 1940s and into the 2010s. Those chords, heard in literally thousands of songs, have the ability to work magic on many of us. Does their power derive from familiarity, or is their familiarity the result of song-writers being completely aware of their power? Certainly John Lennon would have known just how strongly they could grab our souls. In other hands a song with such a common sound could have been bland, ordinary, a mere pop confection.

Ah, but the lyric, the performance, and the production of "Instant Karma" were like nothing I, and perhaps anyone, had heard before in pop music, and, perhaps, anywhere else. Lennon does not so much sing as howl with life or death urgency; the drums, recorded at high volume as a lead instrument, hammered the ears, sometimes

faster than the song allowed, in time-compressed off-tempo breaks; the vocal chorus and other instruments sounded like chants and storm winds from another world. I felt assaulted by the sound, yet also, somehow, lifted by its immense energy. What was this impressionable 18 year old hearing?

The lyrics were, as we used to say, heavy:

Instant Karma's gonna get you, gonna knock you right on your head

Better get yourself together, pretty soon you're gonna be dead.

John Lennon was speaking directly to me. I know you are hurting in this world. It's bad, and maybe only to get worse, or maybe not. No, I can't say I quite understood what this 'instant karma' might be. 'Karma' I knew, or thought I knew, to be, in some vague sense, a retribution for what one might have done is this world, for good or bad, though I never bought into any mystic aspects of it. Still, there was the idea of being responsible for one's actions and their consequences. There was an overall sense of what life as an adult needed to be, and a sense that death was the ultimate consequence, almost a punishment, for living.

I was hearing too, if only briefly, what I needed to do to live properly:

Better get yourself together, join the human race

and

Better recognize your brothers, everyone you meet

and

Why on earth are you there? When you're everywhere, gonna get your share.

and most importantly:

What on earth are you trying to do?

It's up to you, yeah you.

It was roughly formed, it was not any sort of complex explication of what I now might see as principles of solidarity and social justice, and at times it was hard to grasp what was meant, but it hit me, and hard. Whatever message I heard, correctly or not, became more complicated, and, I think, all the more powerful, because of what I misheard. Printed on the green Apple label were the words "PLAY LOUD." This I tried to do. Oh yes, it made a difference. Somehow the recording's power was amplified, made all the more essential to my tenuous grasp on the world. I tried to play it loud, though it was merely the best my poor record player, with poor tracking, likely a very worn needle, from the increasingly worn grooves of the 45, and certainly those detachable, tiny, weak speakers, could manage. Through the chaotic fury I heard Lennon howl these words:

"Why on earth are we here?

You're old enough to live in pain and fear."

Those words, set in that sonic barrage, heard with such power behind them, stayed with me for many, many years. More than anything else, this was the message of the song; it seemed to make sense to me. Life will be pain and fear. And, for all those years, it was. I do not blame Lennon for that. I was obviously primed for it, and so I barely heard, grasped the positive parts of his message in the song. He was simply telling me what is.

That December would come Lennon's solo album, "John Lennon/Plastic Ono Band," a record drenched in pain and fear, possibly the most anguished work ever commercially released by a major "pop" artist. I remember leaving my parents the

afternoon of December 25 to stay instead in my off-campus co-operative student residence, alone. There I listened repeatedly to the album, and I became more and more introspective, more and more gloomy. It amplified and solidified what "Instant Karma" had first put musically in place in my being. Life would be pain and fear. Though it was unsaid by Lennon, I drew the conclusion that death might be release from those. The artist can only produce the art with whatever intention they might have. Those who observe the art create within themselves its meaning for themselves, rightly or wrongly.

Death is heard much in Lennon's work. He could not have imagined the specifics of his terrible murder -- an event that I still have trouble believing in my soul really did happen -- but death was clearly much on his mind. It was, however, "Instant Karma" that spoke to me, from which I took so much about my view of death. It will happen, and maybe it is not so bad, for maybe it will release you from the pain and fear of life.

The mishearing? About 30 years later I first properly heard "Instant Karma" from a good recording, on a decent quality system, through fine headphones. What I had heard was not what Lennon sang. He had said:

Why on earth are we here?

Surely not to live in pain and fear.

I think I had heard, first in 1970, and many times since then, and repeated in my mind so many more times, what I wanted to hear. The seed of depression had been planted, somehow, and a masterful piece of music, misheard, along with much much else in life, helped water it to its full, horrid growth.

By the time my hearing of Lennon's words was corrected I had changed, grown, advanced, in many ways, but the gloomy vision of life, and the almost attractive solution

of death I had inferred, were not easily or quickly abandoned. Knowing then what I should have heard so long before was at least some small part of changing that vision.

Michaella Kinloch, July 2021

"Instant Karma (We All Shine On)"

Composed by John Lennon

Performed by John Lennon and the Plastic Ono Band

Can be heard on many recordings, and on YouTube at:

https://www.youtube.com/watch?v=WCxr7nV3yio

(This is the single as originally released and which I heard. There is a TV performance as well, though I think it not quite as powerful.)

APPENDIX B

OUR TIME AND TIMES – A POEM

What are the conditions of our times? The times of our lives

not just the physical world

specific to the individual,

or a particular population

list

the various places in which one may be

once people largely lived close to where they worked

we can see this in cities, older neighborhoods

but over time that has changed

consequences of that

travel more common

we live and move in a range of

environments

not one

and that too has changed

For we have always travelled in time

~~~

At an early stage in the writing of this thesis I assembled some notes from the start of the text, and put them, for convenience, in a series of increasingly independent lines. The result was seen, unintentionally, as poetry by one reader, who quite liked it. Respecting that, I have preserved that original piece here, with only slight changes.
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