Defining Health and the Physician's Social Responsibility

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The notion of health as a human right has become a persuasive rallying cry around which to mobilize the general public in hopes of achieving equitable standards of health care across the globe. Unfortunately, however, the comprehensive socio-political, economic and historical analyses operating out of an anti-oppressive framework that ought to accompany such a laudable ideal remain fairly undeveloped within much of the medical world. Indeed, until deep-rooted structures are scrutinized, and more uncomfortable questions are asked, achieving health through human-rights advocacy will remain a pipe dream.

It may be argued that we find ourselves situated in humanity's most hypocritical hour, when inordinate poverty and suffering for the many reigns amidst unparalleled wealth and comfort for the few, despite an ostensibly evolved sense of morality. The disparity afflicting the inhabitants of the world is pervasive and can assume myriad disguises. For example, in India, as of 1998, 200 million people did not have access to safe drinking water, while another 600 million lacked basic sanitation.¹ In the United States of America, 43.4 million people had no health insurance coverage as of September 1998.² In Canada, as recently as 1997, 1 in every 5 children lived in poverty.³ In Rwanda and Burundi, a genocide beginning hardly a decade ago resulted in the murder of thousands of civilians. In Iraq, over 500,000 children have died as a result of UN-imposed sanctions since 1991.⁴ Of the 150 million children in developing countries who are malnourished, 78 million are in South Asia and another 32 million are in sub-Saharan Africa.⁵ The disparity may be epitomized by the United Nations Development Programme's 1998 calculation that "it would take less than four percent of the combined wealth of the 225 richest individuals in the world to achieve and maintain access to basic education, basic health care, reproductive health care, adequate food, safe water, and adequate sanitation for all people living on the planet."⁶ Over time, it seems that these surreal and dizzying statistics have resulted in the systematic desensitization of those in society privileged enough to initiate change. The grassroots movement that resisted the U.S.-led invasion of Iraq reached a critical mass of people willing to ask important questions. However, it is imperative that those engaging in this fight within the medical community appreciate the etiology of the inequitable nature that frames our current reality and its deleterious effects on global health. The abovementioned examples are not intended to suggest that disparity operates exclusively in an economic realm, but rather to propose that the reinforcement and perpetuation of this disparity is ensured by societal illnesses like colonialism, imperialism, sexism, racism, fundamentalism and elitism. Implicit in these pernicious ideologies is the asymmetric distribution of human rights where the haves consistently enjoy freedoms accrued at the expense of the have-nots.

Within the medical world, it is high time to address all of these inter-related issues. However, as with most attempts at effecting social change, reflection and introspection are of paramount importance. Consequently, physicians must first acknowledge our own role in the perpetuation of counter-productive power dynamics that invest the "help" we offer "vulnerable" populations. That is, the medical establishment's elitist and insular nature must be recognized as being responsible for creating boundaries which make medical knowledge and therefore health care fairly inaccessible for those who need it most, while paradoxically and concomitantly marginalizing them. For example, in the Canadian context, the Aboriginal

and refugee populations are two particularly vulnerable groups which are markedly marginalized. Thus, while their needs are substantial, their autonomy and ownership over their own health and the care they receive are severely undermined by the barriers (e.g., social, political, economic, etc.) erected by the managers of the society in which they live. Similar analogies can be made to a multiplicity of other situations predicated on unequal power dynamics, both here and abroad. Thus, physicians must first be compelled to divest from the power which infuses their relationships with those they are trying to help. Notions of charity must be replaced by principles of solidarity and justice.

A particularly injurious trait of Western medical culture is its concern with the relatively privileged members of the Western world, first and foremost. This ethnocentrism is perhaps best illustrated in the domain of medical research. For example, only 11 of the 1,393 new chemical entities developed between 1975 and 1999 were for the treatment of tropical diseases.⁷ This despite the fact that diseases like malaria and tuberculosis account for a substantial burden of illness in the world. Similarly, 90% of research funding is funnelled into diseases affecting only 10% of the population.⁸ It is left to the reader's imagination to determine which strata of the echelon of wealth those 10% occupy. Physicians, as social advocates for the marginalized, need to confront these realities head-on. The postulate that the rate of scientific advancement should be significantly diminished in the Western world until the benefits hitherto gained can be apportioned to the entire population needs to be impressed upon the medical community. This is not to suggest that the gains made during the past half-century or so of medical advancement in the Western world should not be made available to its constituents. Rather, by limiting the development of "cutting edge" research, and concurrently working on achieving equal access to these same resources for everyone everywhere, a process of equilibration will be facilitated. Once achieved, scientific progress can continue unfettered once again, whereby the spoils stemming therefrom can be shared among all members of the global community; the betterment of humanity, rather than personal gain, would serve as impetus for all research.

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Otherwise, the runaway train that is scientific progress will continue to leave an ever-growing population lagging far behind.

The physician's responsibility as health advocate finds itself at a crossroads. The argument that physicians should remain "apolitical" continues to provide a convenient excuse for many who do not wish to completely engage in the struggle for social justice, which is a categorical imperative for achieving equitable levels of health worldwide. Interestingly, recent events in the province of Quebec whereby medical students, residents and specialists protested draconian policies proposed by the government (which would force physicians to practice in rural settings) illustrate the propensity of the medical community to become politicized. If medical students and physicians are inclined to take political stances to protect their own interests, one would expect the same willingness from health advocates to become politicized for the causes they are engaging in. For example, demanding affordable access to anti-retroviral treatment is imperative in the fight for justice in many sub-Saharan countries given the prevalence of HIV disease. However, there is a commensurate responsibility on the part of physicians to speak out against neo-liberal policies imposed by Western nations on developing countries, which entrench and exacerbate class disparities within these societies, thereby further deteriorating the health of the overwhelming majority.

A transformation of the collective consciousness is much needed in the physi-

cian's realm. Instead of considering the welfare of humanity as an ancillary and unrealistic goal, physicians must begin viewing global health as a personal responsibility, a duty of sorts, based on codes of universal justice. Hundreds of years from now (assuming our species survives until then), our descendants will look back upon this critical phase in human development with great interest. They will wonder whether their ancestors were moved to redress the grave inequities facing the human population, or whether we stood idly by and watched the insidious decimation of entire peoples. Framed in such a binary paradigm, the road we ought to travel on, although perhaps only dimly illuminated, is obvious.

What is health? Health is not: war, starvation, exploitation, poverty or oppression. A definition of health is meaningless without invoking notions of peace, justice, and freedom. These are not abstract terms, but rather concrete and meaningful principles upon which a vision of a more just world is based: a world where trade relations between nations and economic policy within nations are no longer governed by the dictates of capitalism, imperialism and colonialism; where women are liberated from the shackles of patriarchy; where class-based systems of oppression are exposed for their inherent injustice and eliminated; where racism is debunked and expunged from human consciousness; where nationalistic and religious fundamentalism gives way to tolerance and respect for one another; where not only

health, but security, access to shelter, food, education, and an autonomously-chosen livelihood are all considered practically, not only conceptually, as fundamental and inalienable human rights; where we work not solely for personal gain, but for collective betterment through mutual support and mutual aid. The multiple and intertwined systems of oppression and domination must be recognized, challenged and overthrown, if we are to hope for any substantive and salubrious change in the course of the human species. Until members of the medical world begin to concretely explore these issues and their effects on determinants of health, any attempt at defining health will remain an exercise in futility.

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